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MEDICAID

Transitional Coverage Can Help Families Move from Welfare to Work

Statement of William J. Scanlon
Director, Health Care Issues

GAO-02-679T

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you consider the role of Medicaid in helping families' transition from welfare to the workforce. Since 1988, the Medicaid program has offered transitional Medicaid assistance, which provides certain families who are losing Medicaid as a result of employment or increased income up to 1 year of additional Medicaid health insurance coverage. Transitional Medicaid assistance was originally enacted for a 10-year period, and has twice been extended to help provide continued health insurance coverage to families moving into employment.[1]

The enactment of federal welfare reform in August 1996 significantly changed federal welfare policy for low-income families with children in several ways, including establishing a 5-year lifetime limit on cash assistance.[2] The welfare reform law also extended transitional Medicaid assistance through 2001, thus continuing an important link to health insurance coverage for individuals as their economic circumstances changed. States have implemented a variety of initiatives intended to help families move from cash assistance to the workforce, including some enhancements to transitional Medicaid. These initiatives have likely contributed to a drop in cash assistance caseloads of more than 50 percent from 1996 through mid-2001.[3]

Because the transitional Medicaid provision is due to expire in September 2002 and you are considering its extension, you asked us to provide information on the role this program plays in supporting transitions from welfare to work. Accordingly, my remarks today will focus on how

[1]The Family Support Act of 1988 created the transitional Medicaid assistance program as § 1925 of the Social Security Act, and was scheduled to expire on September 30, 1998. *See* Pub. L. No. 100-485, § 303(a), 102 Stat. 2343, 2385, and 2391. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 extended states' obligation to provide transitional Medicaid assistance through 2001. *See* Pub. L. No. 104-193, § 114(c), 110 Stat. 2105, 2180. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended the sunset provision to September 30, 2002. *See* Pub. L. No. 106-554, Appendix F, § 707, 114-2763A-463, 114-2763A-577.

[2]See The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 103, 110 Stat. 2105, 2137.

[3]See U.S. General Accounting Office, *Welfare Reform: States Provide TANF-Funded Work Support Services to Many Low-Income Families Who Do Not Receive Cash Assistance*, GAO-02-615T (Washington, D.C.: April 10, 2002).

- transitional Medicaid assistance provides low-income working families an option to maintain health insurance coverage and

- states have used transitional Medicaid to provide health insurance coverage to families.

My comments are based largely on our previously issued reports and testimony on Medicaid and welfare reform.[4]

In summary, transitional Medicaid assistance is a key protection offered to families at a critical juncture in their efforts to move from welfare to work. Employment in low-wage or part-time positions—which is common for these newly working individuals—frequently does not provide adequate access to affordable health insurance, whether through employer-sponsored or individually purchased health insurance, thus making transitional Medicaid coverage an important option. Our earlier work showed that, for the 21 states we reviewed, the implementation of transitional Medicaid assistance varied across the states and that certain state practices had enhanced beneficiaries' ability to retain Medicaid coverage. For example, some states reported increasing training for state eligibility determination workers to better inform beneficiaries of this entitlement and how to access it. We also found, however, that many families did not receive their full transitional Medicaid assistance benefits because they failed to report their income three times, as required, throughout the 12-month period of coverage. Amending the Medicaid statute to provide states with additional flexibility to ease income-reporting requirements for the coverage period of transitional Medicaid assistance, as has been done for other aspects of the Medicaid program, could further facilitate uninterrupted health insurance coverage for families moving from cash assistance to the workforce.[5]

[4]See GAO related products at the end of this statement.

[5]See U.S. General Accounting Office, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary,* GAO/HEHS-99-163 (Washington, D.C.: Sept. 10, 1999). In this report, we recommended that the Congress consider allowing states to lessen or eliminate requirements for beneficiary income reporting in transitional Medicaid assistance. We also recommended that the Administrator of the Health Care Financing Administration (HCFA) (1) determine the extent to which transitional Medicaid is reaching the eligible population and (2) provide states with guidance regarding best approaches for implementing this benefit. Since that time, HCFA, now the Centers for Medicare and Medicaid Services, has acted on the second recommendation but not the first.

Background

Transitional Medicaid assistance offers families moving from cash assistance to employment the opportunity to maintain health insurance coverage under Medicaid, a joint federal-state health insurance program. Medicaid spent about $216 billion in fiscal year 2001 on coverage for certain low-income individuals.[6] Transitional Medicaid assistance provides certain families losing Medicaid as a result of employment or increased income with up to 1 year of Medicaid coverage.[7] Families moving from cash assistance to work are entitled to an initial 6 months of Medicaid coverage without regard to the amount of their earned income, and 6 additional months of coverage if family earnings, minus child care costs, do not exceed 185 percent of the federal poverty level.[8] To qualify for either 6-month period, a family must have received Medicaid in 3 of the 6 months immediately before becoming ineligible as a result of increased income.[9]

[6]States administer Medicaid within broad federal guidelines that specify the categories of low-income individuals that states must cover and the categories that are optional. However, not all low-income individuals are eligible for Medicaid; for example, most childless adults are not eligible. In fiscal year 1999 (the most recent enrollment data available), Medicaid financed coverage for nearly 41 million individuals.

[7]Prior to welfare reform, some states received waiver authority under § 1115 of the Social Security Act to extend Medicaid benefits beyond the 12 months allotted in § 1925 of the Social Security Act. After August 22, 1996, this waiver became subject to a budget neutrality test, which meant that the cost of extending coverage had to be offset by transitional coverage.

[8]In 2002, the federal poverty level for a family of three was $15,020, or about $1,252 per month.

[9]GAO/HEHS-99-163, September 10, 1999.

When federal welfare reform was enacted in 1996, states implemented a variety of initiatives intended to help families move from welfare to the workforce. Welfare reform provided states additional flexibility in helping cash assistance recipients to both find work and achieve family independence. As a result, states have expanded and intensified their provision of work support services such as those for job search, job placement, and job readiness.[10] Many individuals in this population had low skills and faced a number of barriers to maintaining work and independence. For example, our work has shown that factors such as limited English proficiency, poor health, and the presence of a disability were some of the factors that affected the extent to which former cash assistance recipients were able to find and keep employment.[11]

Maintaining health insurance coverage is important to persons entering the workforce because there are important adverse health and financial consequences to living without health insurance. The availability of health insurance enhances access to preventive, diagnostic, and treatment services as well as provides financial security against potential catastrophic costs associated with medical care. Research has demonstrated that uninsured individuals are less likely than individuals with insurance to have a usual source of care, are more likely to have difficulty in accessing health care, and generally have lower utilization rates for all major health care services. Uninsured individuals are more likely than those insured to forgo services such as periodic check-ups and preventive services, well-child visits, prescription drugs, dental care, and eyeglasses. As a result, individuals not covered by health insurance may need acute, costly medical attention for conditions that might have been preventable or minimized with early detection and treatment.

[10]GAO-02-615T, April 10, 2002.

[11]See U.S. General Accounting Office, *Welfare Reform: Moving Hard-to-Employ Recipients Into the Workforce*, GAO-01-368 (Washington, D.C.: March 15, 2001).

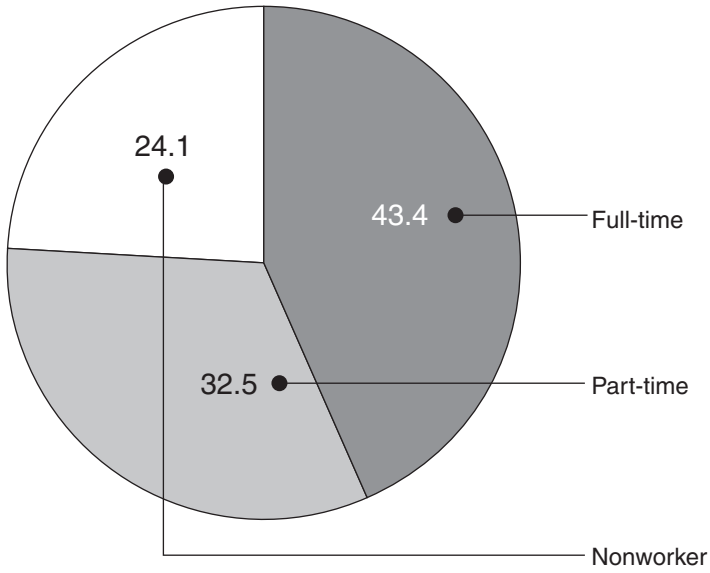
Transitional Medicaid Assistance Can Fill Gaps in Accessibility of Private Health Insurance for Low-Income Workers

Limitations in private sources of coverage underscore the importance of transitional Medicaid assistance as an option for those moving from cash assistance to employment. Private health insurance is not accessible to or affordable for everyone. Although most working Americans and their families obtain health insurance through employers, many workers do not have coverage because their employers do not offer it or the coverage offered is limited or unaffordable. Lack of insurance is more common among certain types of workers, employers, and industries and may disproportionately represent individuals transitioning from cash assistance to work. For example, individuals who work part-time or are employed in low-wage jobs are less likely to have access to affordable employer-sponsored coverage. Furthermore, those who do not have employer-sponsored coverage may find alternative sources of coverage, such as the individual insurance market, expensive or altogether unavailable. Without continued access to Medicaid, some of these individuals, who are often in low-wage jobs, will have limited or no access to alternative coverage and could end up uninsured.

Private Sources of Health Insurance Are Not Universally Available and May Have Coverage Limitations

Employment-based coverage is the primary means for nonelderly Americans to obtain health insurance, and over two-thirds of nonelderly adults obtained their coverage through an employer in 2000. However, a significant number of workers do not have health insurance because either their employers do not offer it or they choose not to purchase it. In 2000, 30 million nonelderly adults were uninsured, even though 75 percent worked for some period during the year. (See fig. 1.)

Figure 1: Percentage of Uninsured Nonelderly Adults That Were Employed, 2000



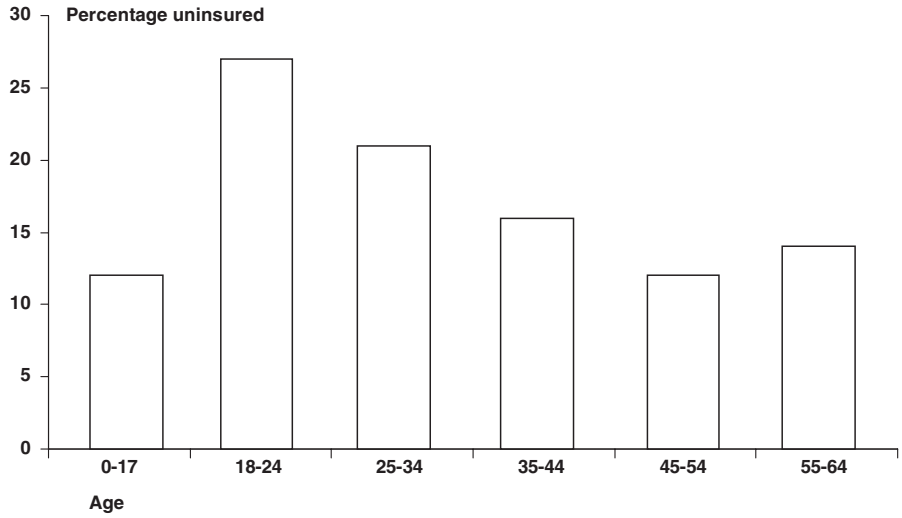
Source: GAO analysis of the March 2001 Supplement, Current Population Survey of nonelderly adults (18- to 64-year-olds).

Lack of insurance coverage is more common among certain types of workers, employers, and industries. Part-time employees and employees of small firms (fewer than 10 employees) are more likely to be uninsured than employees who work full-time or for a large company. Individuals working in certain industries are less likely to be offered health insurance. For example, in 1999, more than 30 percent of workers in the construction, agriculture, and natural resources (for example, mining, forestry, and fisheries) industries were uninsured, as were about 25 percent of workers in wholesale or retail trade. In contrast, 10 percent or less of workers in the finance, insurance, real estate, and public employment sectors were uninsured. These patterns may disproportionately affect individuals leaving cash assistance because they often work in low-wage jobs, part-time, or in industries such as retail that often do not provide health coverage.

Young adults, aged 18 to 24, are more likely than any other age group to be uninsured, largely because certain characteristics of their transition to the workforce—working part-time or for low wages, changing jobs frequently, and working for small employers—make them less likely to be eligible for employer-based coverage. Among those aged 18 to 24, 27 percent were

uninsured, and among those aged 25 to 34, 21 percent were uninsured in 2000. (See fig. 2.)

Figure 2: Uninsured Population By Age Group, 2000



Source: GAO analysis of the March 2001 Supplement, Current Population Survey of nonelderly (under 65 years).

Even when employer-sponsored coverage is available, its costs may be prohibitive or its benefits very limited. Employer-sponsored health plans may not subsidize coverage for dependents, may restrict or exclude certain benefits, or may subject participants to out-of-pocket costs either through premium contributions or cost-sharing provisions that low-wage workers may find unaffordable. For example, a 2001 survey by Mercer/Foster Higgins found that, on average, large employers (500 or more employees) require employees enrolled in preferred provider organizations (PPO) to contribute $56 each month for employee-only coverage, or $191 each month for family coverage.[12] For lower-wage workers, such as individuals leaving cash assistance and entering the workforce, even coverage that is

[12]Mercer/Foster Higgins, *National Survey of Employer-sponsored Health Plans 2001: Report on Survey Findings* (New York: William H. Mercer, 2002), p. 13. The Mercer/Foster Higgins survey is representative of all employers in the United States with at least 10 employees.

affordable for a worker may be too expensive for covering the rest of the family members.

Those without access to employer-sponsored coverage may look to the individual insurance market to obtain coverage, and in 2000, 5 percent of nonelderly Americans (or 12.6 million individuals) relied on individual health insurance as their only source of coverage. However, restrictions on who may qualify for coverage and the premium prices charged can have direct implications for consumers. For example, depending on their health status and demographic characteristics such as age, gender, and geographic location, individuals in the majority of states may be denied coverage in the private insurance market or have only limited benefit coverage available to them. In addition, while all members of an employer-sponsored group health plan typically pay the same premium for employment-based insurance regardless of age or health status, in most states individual insurance premiums are higher for older or sicker individuals than for younger or healthier individuals, potentially making this option unaffordable.[13] For example, a recent study examined individual insurers' treatment of applicants with certain preexisting health conditions, such as hay fever. The study of insurers in eight localities found that for applicants with hay fever, 8 percent would decline coverage; 87 percent would offer coverage with a premium increase, benefit limit, or both; and 5 percent would offer full coverage at the standard rate.[14] Cost differences are often exacerbated by the fact that individuals must absorb the entire cost of their health coverage, whereas employers usually pay for a substantial portion of their employees' coverage.

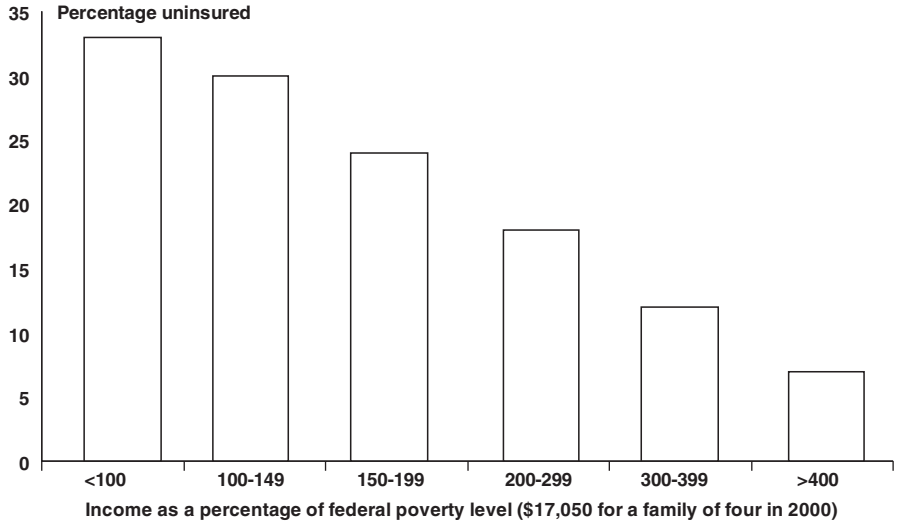
[13]The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees some individuals leaving employer-sponsored group health plans access to continued coverage or to a product in the individual market. *See* 29 USC § 1181 (2000), 42 USC § 300gg (Supp. II 1996). Although individuals leaving public insurance programs, such as Medicaid, are not eligible for this HIPAA protection, they may obtain coverage in most states from high-risk pools that provide coverage for applicants denied individual coverage due to health status. These policies tend to cost 25 to 100 percent more than rates charged to healthy individuals.

[14]Georgetown University Institute for Health Care Research and Policy and K.A. Thomas and Associates, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington D.C.: The Kaiser Family Foundation, 2001), http://www.kff.org (downloaded on August 14, 2001). The authors examined underwriting treatment of hypothetical applicants by 19 insurers in eight markets around the country.

Transitional Medicaid Assistance Can Provide Continued Insurance Coverage

Because of limitations in the availability of private insurance—especially for low-paid, part-time workers and those in certain industry sectors that often characterize jobs available to individuals moving from cash assistance to work—transitional Medicaid assistance is an important option for health insurance coverage. Individuals with lower incomes have a much higher than average probability of being uninsured. (See fig. 3.) Typically, former welfare recipients entering the workforce work part-time or in low-wage jobs that are less likely to provide health coverage or only provide coverage at a prohibitive cost. For example, we noted in our 1999 report on states' experiences in implementing transitional Medicaid assistance that one state found that out of nearly 1,600 former welfare recipients surveyed, 43 percent of the heads of households worked fewer than 32 hours per week and did not have health insurance, and 32 percent held low-wage jobs, such as in retail stores, hotels, restaurants, and health care establishments.

Figure 3: Uninsured Population, by Income as a Percentage of Poverty Level, 2000



Source: GAO analysis of the March 2001 Supplement, Current Population Survey of nonelderly individuals (under 65 years).

In addition, although some employers of former cash assistance recipients may not offer health insurance, numerous studies have shown that a significant number of these individuals have access to employer coverage but choose not to accept it. For example, a recent study showed that although about 50 percent of individuals transitioning from cash assistance to employment had access to employer coverage, only about one-third opted to participate in the employer-sponsored plan.[15] The relatively low "take-up" rate is due largely to the high costs of many employer health plans. Transitioning workers, who commonly earn between $7 and $8 an hour, may simply be unable to afford their share of the premium, since their annual earnings range from 73 percent to 111 percent of the federal poverty level. (See table 1.)

Table 1: Hourly Wages as a Percentage of the Federal Poverty Level for a Family of Three, 2002

Hourly wage	Hours per week	Annual earnings	Salary as a percentage of the federal poverty level
$5.15[a]	30	$8,034	53
	40	$10,712	71
$7.00	30	$10,920	73
	40	$14,560	97
$8.00	30	$12,480	83
	40	$16,640	111

[a]Represents the minimum wage, which was last increased on September 1, 1997.

Source: GAO analysis of salaries in relation to the 2002 federal poverty level of $15,020 for a family of 3.

[15]Gregory Acs, Pamela Loprest, and Tracy Roberts, *Final Synthesis Report of Findings from ASPE "Leavers" Grant* (Washington, D.C.: The Urban Institute, 2001). To conduct studies of families that had left welfare, the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services awarded competitive grants to select states and large counties in September 1998. This report synthesizes the findings from 15 of these studies.

States' Efforts Encouraged Use of Transitional Medicaid, but Not All Eligible Families Received Assistance

While the Medicaid statute provides families moving from welfare to work with up to 12 months of transitional Medicaid coverage, we have reported that certain states had obtained waivers from HCFA to extend the length of coverage provided, and that the share of eligible families that actually received this entitlement varied significantly by state. States offered from 1 to 3 years of transitional Medicaid assistance in 1999. In the several states that were able to provide data on participation in transitional Medicaid assistance, we found that participation rates among newly working Medicaid beneficiaries ranged from 4 to 94 percent. Several states had made efforts to facilitate beneficiaries' participation in transitional Medicaid. For example, nine states reported developing outreach and education materials to inform families and eligibility determination workers about transitional Medicaid assistance. While such approaches helped make transitional Medicaid more available, beneficiaries' failure to report income as required often resulted in their losing eligibility after the first 6 months.

Length of Coverage and Program Participation Was Mixed Among States

States' implementation of transitional Medicaid coverage varied, resulting in differing lengths of time for which coverage was provided and differing rates of family participation. As of 1999, the most current national data reported, 10 states—Arizona, Connecticut, Delaware, Nebraska, New Jersey, Rhode Island, South Carolina, Tennessee, Utah, and Vermont—provided over 1 year of coverage, while the remaining states provided 1 year of coverage. (See fig. 4.) In the several states that were able to provide such data, transitional Medicaid participation rates ranged from about 4 percent of the families moving from cash assistance in one state to 94 percent of such cases in another. However, low participation rates in transitional Medicaid assistance did not always indicate that families had lost Medicaid coverage altogether. For example, officials in the state with a 4 percent participation rate said that most families losing cash assistance were still enrolled in Medicaid through other eligibility categories for low-income families.

Figure 4: Number of Months States Provided Coverage for Transitional Medicaid Assistance, 1999

[a]Rhode Island and Tennessee provided 18 months' eligibility, and Vermont provided 36 months.

Source: Department of Health and Human Services, Administration for Children and Families, *Annual Report to Congress* (Washington, D.C.: 1999).

States' Initiatives Facilitated Beneficiary Use of Transitional Medicaid Assistance, but Not All Families Maintained Coverage

We found that several states had initiatives in place to facilitate beneficiaries' access to transitional Medicaid assistance. The following are examples of such initiatives.

- Nine states reported developing specific materials regarding transitional Medicaid assistance in easy-to-understand language for eligibility determination workers and beneficiaries.

- One state revised its computer systems so that eligible families leaving cash assistance due to employment were automatically transferred to transitional Medicaid assistance coverage. In addition, this state's eligibility workers randomly contacted families who were leaving cash assistance to determine their health insurance status and to ensure that they obtained the additional months of Medicaid coverage for which they were eligible. As a result of this state's efforts, about 70 percent of the families leaving cash assistance or Medicaid received transitional Medicaid coverage.

- Officials in three other states encouraged increased participation in transitional Medicaid assistance by contacting families with closed cash assistance cases to determine whether these families had obtained the additional months of Medicaid coverage if so entitled. One of these states, which also provided 24 months of transitional Medicaid assistance, reported that 77 percent of eligible families were receiving this benefit.

However, even with such successful enrollment efforts, many families did not receive the full transitional Medicaid assistance benefits because they failed to periodically report their income as required. The Medicaid statute requires that beneficiaries report their income three times during the 12 months of transitional Medicaid assistance: once in the first 6-month period and twice in the second 6-month period. Failure to report income status in either of these 6-month periods results in termination of transitional Medicaid benefits.

In 1999, we reported that families' failure to periodically submit required income reports often resulted in their not receiving transitional Medicaid coverage for the full period of eligibility. For example, officials in three states we reviewed told us that families typically received only 6 months of transitional Medicaid, generally because they failed to submit the required income reports—and not because of a change in income that made them ineligible for transitional Medicaid. In contrast, the state that had a 94

percent participation rate for transitional Medicaid offered coverage for 24 months and had received HCFA approval to waive the periodic income-reporting requirements. Overall, we found that states that waived income-reporting requirements reported higher participation rates than states that did not.

In implementing public programs such as Medicaid, difficult trade-offs often exist between ease of enrollment for eligible individuals and program integrity efforts to ensure that benefits are provided only to those who are eligible. The experience of some states in easing statutory periodic income-reporting requirements proved successful in increasing participation for eligible beneficiaries. In view of concerns that beneficiary reporting requirements were limiting the use of the transitional Medicaid benefit, HCFA proposed legislation to eliminate beneficiary reporting requirements for the full period of eligibility (up to 1 year). To date, no action has been taken on this proposal. In our earlier report we recommended that the Congress may wish to consider allowing states to lessen or eliminate periodic income-reporting requirements for families receiving transitional Medicaid assistance, provided that states offer adequate assurances that the benefits are extended to those who are eligible. Precedent for a full year of coverage in Medicaid has been provided in other aspects of the Medicaid program. For example, the Balanced Budget Act of 1997 allowed states to guarantee a longer period of Medicaid coverage for children, such as 12 months, regardless of changes in a family's financial status.[16] As of July 2000, 14 states had implemented this option.[17] A similar approach could facilitate uninterrupted health insurance coverage for families that are moving from cash assistance to the workforce.

[16]See Pub. L. No. 105-33, § 4731, 11 Stat. 251, 519 (1997). According to an official from the Centers for Medicare and Medicaid Services (CMS), the transitional Medicaid assistance reporting requirements override other Medicaid provisions, such as continuous eligibility. Thus, according to CMS' interpretation, a state's use of continuous eligibility does not eliminate the periodic income-reporting requirements for transitional Medicaid assistance.

[17]Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures, Individual State Profiles* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, October 2000).

Concluding Observations

Transitional Medicaid assistance can play an important role in helping individuals move successfully from cash assistance to employment, thus further advancing the goals of welfare reform. Without access to Medicaid coverage, these individuals, who are often in low-wage jobs, might have limited or no alternative health coverage and join the ranks of the uninsured. While our earlier work demonstrated that states varied in the extent to which families were participating in transitional Medicaid assistance, states that worked to minimize obstacles—particularly by reducing or eliminating income-reporting requirements—had higher participation rates. Removing periodic reporting requirements would help further increase the use of transitional Medicaid assistance, provided that sufficient safeguards remained in place to ensure that only qualified individuals receive the benefits.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

Contacts And Acknowledgements

For more information regarding this testimony, please contact William J. Scanlon at (202) 512-7114 or Carolyn L. Yocom at (202) 512-4931. Susan Anthony, Karen Doran, JoAnn Martinez-Shriver, and Behn Miller made key contributions to this statement.

Related GAO Products

Welfare Reform: States Provide TANF-Funded Work Support Services to Many Low-Income Families Who Do Not Receive Cash Assistance. GAO-02-615T. Washington, D.C.: April 10, 2002.

Health Insurance: Proposals for Expanding Private and Public Coverage. GAO-01-481T. Washington, D.C.: March 15, 2001.

Welfare Reform: Moving Hard-to-Employ Recipients Into the Workforce. GAO-01-368. Washington, D.C.: March 15, 2001.

Welfare Reform: Progress in Meeting Work-Focused TANF Goals. GAO-01-522T. Washington, D.C.: March 15, 2001.

Health Insurance: Characteristics and Trends in the Uninsured Population. GAO-01-507T. Washington, D.C.: March 13, 2001.

Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary. GAO/HEHS-99-163. Washington, D.C.: September 10, 1999.