

GAO

Report to the Ranking Minority Member,
Subcommittee on Children and Families,
Committee on Labor and Human
Resources, U.S. Senate

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MEDICAID

Early Implications of Welfare Reform for Beneficiaries and States





**United States
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**Health, Education, and
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The Honorable Christopher J. Dodd
Ranking Minority Member
Subcommittee on Children and Families
Committee on Labor and Human Resources
United States Senate

Dear Senator Dodd:

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996¹ instituted the most fundamental reform to welfare since its inception more than 60 years ago. To promote work rather than welfare dependence and to provide states more flexibility in designing their welfare programs, the new welfare reform law made a number of changes to the nation's cash assistance programs, including Aid to Families With Dependent Children (AFDC) and the Supplemental Security Income (SSI) program. The law also had important implications for Medicaid, which in fiscal year 1996 spent \$160 billion to finance health care coverage for low-income families and blind, disabled, and elderly people. Previously, eligibility for cash assistance and Medicaid benefits were directly linked by federal law. Welfare reform, however, generally severed that link.

Few changes were made directly to Medicaid as a result of welfare reform. However, many believed that state Medicaid programs could be significantly affected, since states could use their newly authorized flexibility to change the eligibility criteria for cash assistance—which, prior to welfare reform, was often the basis for Medicaid eligibility—or to limit Medicaid coverage for aliens already receiving benefits. Also unclear was the states' ability to administratively handle the potentially large number of individuals—such as aliens and disabled children—who might lose SSI benefits due to welfare reform and would need their continued eligibility for Medicaid to be redetermined. Some estimates projected that over 1.5 million individuals could be involved in such redeterminations and that nearly 1 million previously eligible aliens and disabled children would no longer qualify for Medicaid benefits. There have also been concerns that, under the new law, people losing AFDC or SSI benefits may not be adequately informed about their continued Medicaid eligibility.

The welfare reform law provided states several options for administering Medicaid in a post-welfare-reform era. States' responses to these

¹P.L. 104-193.

options—and the resulting impact on beneficiaries and states—were uncertain at the time of the law’s enactment. In light of the potential for significant change and your interest in determining what Medicaid-related actions states have taken in the first year of welfare reform, you asked us to

- briefly describe the Medicaid-related options the welfare reform law gave states and discuss the approaches states have chosen;
- identify the implications of these state choices for Medicaid eligibles and for the states’ administrative processes; and
- identify steps states have taken or plan to take to educate and enroll Medicaid eligibles, in view of their changing eligibility for cash assistance programs.

To identify the Medicaid-related options states were provided under welfare reform, we analyzed the law and interviewed issue area experts, including those representing the American Public Welfare Association and The George Washington University’s Center for Health Policy Research. To identify the choices states have made for their Medicaid programs and the resulting impact on beneficiaries and state administrative processes during the first full year of the law’s implementation, we contacted officials from the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS). We also visited nine states—California, Connecticut, Florida, Georgia, Iowa, New Jersey, New York, Texas, and Wisconsin—between March and June 1997. During these visits and in subsequent follow-up contacts, we also asked state officials about their efforts to educate and enroll Medicaid-eligible populations following welfare reform. We judgmentally selected these states because of their geographic and demographic diversity, the size of their Medicaid programs, and differing degrees of welfare reform experience prior to the law’s enactment. We also chose California, Florida, New York, and Texas because of the large number of aliens in those states. (For more information on our scope and methodology, see app. I.) Our work was performed between November 1996 and January 1998 in accordance with generally accepted government auditing standards.

Results in Brief

During the first full year of welfare reform, the nine states we reviewed chose welfare reform options that generally sustained Medicaid coverage for their previously eligible populations. The options provided to states

included establishing different income and resource (asset)² standards for their Medicaid and cash assistance programs, administering the two programs separately, imposing Medicaid-related penalties for welfare recipients not complying with state work rules, and discontinuing Medicaid coverage for aliens. Four of the nine states we visited had separate income or resource standards for their Medicaid and cash assistance programs. According to officials in these states, eligibility standards had been separated as part of state welfare experimentation, which began before the 1996 federal welfare reform. Consistent with the options offered states by the welfare reform law, these separate standards often provided more generous income or resource limits for Medicaid than for welfare recipients, thus protecting eligibility for medical assistance. To foster administrative efficiencies for states and public assistance applicants, all nine states chose to continue using a common application for their welfare and Medicaid programs and eight chose to continue using a single agency at the local level to determine applicant eligibility. While the welfare reform law offered states the option of withholding Medicaid as a sanction for noncompliance with state work rules, as well as discontinuing Medicaid coverage for most aliens, none of the nine states chose to do so.

The initial choices that these states made resulted in little structural change in their Medicaid programs. There were initially some concerns that new SSI eligibility restrictions for certain aliens and disabled children would affect their Medicaid eligibility. However, subsequent legislation modified and reversed, to some extent, the provisions that restricted SSI eligibility for these populations. For example, the Balanced Budget Act of 1997³ created a new Medicaid eligibility category for disabled children who had been receiving SSI coverage but lost eligibility due to welfare reform. However, we found that in October 1997, one state temporarily terminated about 1,700 children from Medicaid without granting continued eligibility under the new category. With regard to other administrative processes, some states with more experience in using the new welfare reform flexibility pointed out that some adjustments will be needed, especially to establish separate welfare and Medicaid eligibility determination processes. The extent and cost of these adjustments are not yet clear. And although welfare reform authorized states to use private contractors to determine applicant eligibility for welfare, this authority was not extended

²“Resources” is the term that the welfare reform law, as well as federal and state welfare agencies, use to refer to assets such as bank accounts, liquid assets, real estate, automobiles, and other personal property.

³P.L. 105-33.

to Medicaid, thus necessitating duplicative administrative processes in some cases. For example, in one state, public assistance applicants must be interviewed twice: once by a private contractor to apply for cash assistance and once by a public employee to apply for Medicaid.

Welfare reform also poses new challenges for states' Medicaid beneficiary education and enrollment activities. Even prior to welfare reform, significant numbers of children—3.4 million in 1996—were eligible for Medicaid but not enrolled. Welfare reform increases the number of Medicaid eligibles who do not receive cash assistance—individuals who are often difficult to identify and enroll in Medicaid. Some states are beginning to modify their education and enrollment strategies to reach this population. Wisconsin, for example, has begun targeting public assistance eligibility workers, individual providers, and Medicaid-eligible individuals to communicate that people may qualify for medical assistance even though they do not qualify for welfare. State officials acknowledge that implementing an effective strategy to reach all eligible individuals will be a significant and continuing challenge.

Background

The Personal Responsibility and Work Opportunity Reconciliation Act was intended to provide states the flexibility to design cash assistance programs that encourage work and end welfare dependence. Although the act greatly affected AFDC and SSI, few changes were made to Medicaid to help ensure continued health care coverage for low-income families and children.

Since its inception in 1935, AFDC—a state and federally funded entitlement program administered by HHS' Administration for Children and Families and the states—guaranteed cash assistance to needy families with children. The new welfare reform law replaced AFDC with a block grant program, Temporary Assistance for Needy Families (TANF), that ended open-ended federal funding and eliminated the entitlement to cash assistance for eligible families. Unlike the former AFDC program, TANF and the Administration for Children and Families have placed few requirements on how states design and administer their programs. But to encourage work and discourage long-term dependency on public assistance, TANF requires that adults begin working within 2 years of receiving benefits and places a 5-year lifetime limit on benefits.

The Balanced Budget Act of 1997 modified several provisions of the welfare reform law that affected SSI eligibility criteria for aliens and

Medicaid eligibility for disabled children. SSI—a federal income assistance program that provides monthly cash payments to needy aged, blind, or disabled persons—is administered by the Social Security Administration.⁴ The welfare reform law eliminated SSI eligibility for most aliens and tightened the eligibility criteria for children to qualify for disability assistance, with projected savings of more than \$21 billion over a 6-year period, according to Congressional Budget Office estimates. The Balanced Budget Act, in part, reinstated Medicaid coverage for those aliens and disabled children who were enrolled in SSI when the welfare reform law was enacted on August 22, 1996.

While major changes were made to cash assistance programs, relatively few changes were made to Medicaid—a federal-state funded program that the states administer under broad guidance from HCFA. Welfare reform, however, had the potential to directly affect Medicaid eligibles who, prior to the reform, were automatically enrolled in Medicaid based on their eligibility for cash assistance under AFDC. This population accounted for less than 40 percent of the total Medicaid population in 1996.⁵ To ensure continued Medicaid coverage for low-income families, the law generally set Medicaid eligibility standards at AFDC levels in effect on July 16, 1996. By setting Medicaid’s eligibility standards at this level, the law ensured that low-income families who would have been eligible for Medicaid before welfare reform continued to qualify for services regardless of the states’ cash assistance reforms.

In addition, the Balanced Budget Act established the State Children’s Health Insurance Program and authorized over \$20 billion over a 5-year period in federal matching funds to expand health care coverage to uninsured, low-income children who do not qualify for Medicaid. The Balanced Budget Act offers states several options regarding this program. States can use their federally set allotments to (1) expand their existing Medicaid programs to include children who do not qualify under the

⁴Thirty-eight states make SSI recipients automatically eligible for Medicaid. While welfare reform did not affect the link between Medicaid and SSI, by tightening SSI eligibility criteria, the law in effect also impacted Medicaid eligibility for individuals in these 38 states.

⁵The Medicaid population can be divided into three broad categories: (1) people whose Medicaid eligibility is primarily based on receipt of cash assistance, (2) people who do not receive cash assistance, and (3) people who receive cash assistance but could qualify for Medicaid under an alternative eligibility category. For fiscal year 1996, people in the first category represented about 36 percent of the Medicaid population. The second category, as well as some individuals in the third category, are part of the so-called Medicaid “expansion” population—pregnant women, infants, and children born after September 30, 1983—who states must cover based on income. The Medicaid expansion population was not directly affected by welfare reform. In addition, states can extend Medicaid coverage to certain categories of individuals with too much income to receive cash assistance but who are considered medically needy because of their large medical costs.

state's March 31, 1997, Medicaid rules; (2) create or expand a separate children's health insurance program; or (3) use a combination of Medicaid and State Children's Health Insurance Program funds to increase health coverage for children.

States Generally Opted to Administer Medicaid as They Did Prior to Welfare Reform

Although the new welfare reform law provided states with certain choices regarding Medicaid eligibility and administration, the states that we visited chose welfare reform options that sustained Medicaid coverage for their previously eligible populations. Medicaid-related options involve income and resource criteria for determining eligibility, aspects of program administration, sanctions for noncompliance with TANF work requirements, and continued Medicaid coverage for certain aliens residing in the United States at the time of the law's enactment. Table 1 shows the Medicaid-related choices that the nine states we visited made.

Table 1: Nine States' Medicaid-Related Choices, August 1997

State options	Calif.	Conn.	Fla.	Ga.	Iowa	N.J.	N.Y.	Tex.	Wis.
Common eligibility criteria for Medicaid and TANF for low-income families									
Income standards		X	X	X	X		X	X	
Resource standards	X	X	X	X	X				X
Income determination methodologies		X	X		X				X
Resource determination methodologies		X	X	X	X				X
Common program administration for determining eligibility									
Single state agency	X ^a	X	X	X	X	X	X ^a	X	
Single application	X	X	X	X	X	X	X	X	X
Medicaid as a TANF work sanction ^b									
Medicaid coverage for qualifying aliens ^c	X	X	X	X	X	X	X	X	X

^aThese states have state-supervised, locally administered programs. Medicaid and TANF eligibility determinations are made at the local level by city or county social service caseworkers.

^bNone of the states we visited chose this option.

^cState officials provided this information prior to the enactment of the Balanced Budget Act on August 5, 1997.

Source: GAO analysis.

In the first year of welfare reform implementation, states generally chose to maintain the linkages formerly in place between their Medicaid and

cash assistance programs. In some states, financial eligibility criteria for Medicaid and cash assistance had begun to diverge prior to welfare reform, as a result of state welfare experimentation. This divergence was consistent with the flexibility that the 1996 federal welfare reform law offered states.

States' Choices Regarding Medicaid Eligibility

The Congress included a provision in the welfare reform law to protect Medicaid eligibility for low-income families. This provision—which requires states to use AFDC's July 16, 1996, standards as the criteria for determining Medicaid eligibility—also provides several exceptions, only one of which allows states to impose more restrictive standards. Specifically, the law permits states to (1) increase their AFDC July 16, 1996, income and resource standards by as much as the year's consumer price index; (2) use less restrictive methodologies for calculating family income and resources than used on July 16, 1996; or (3) lower their AFDC July 16, 1996, income standards but not below May 1, 1988, levels.⁶ At the time of our visits, none of the nine states indicated that they intended to lower their AFDC income standards from July 16, 1996, levels, which could have disqualified some individuals from the Medicaid program.⁷ Florida, however, increased its income standard. States desiring to modify their standards or methodologies are required to submit their amended Medicaid state plans to HCFA.

However, because of Medicaid's historic linkage to cash assistance, choices that states must make regarding eligibility for TANF can also affect Medicaid participation rates for low-income families. For example, states must choose who will be eligible for TANF and how much income and resources TANF recipients may have. Less generous standards could

⁶The welfare reform law did not permit states to lower their resource standards or to use more restrictive income and resource methodologies. The language that allows a state to lower its income standard (but not below May 1, 1988, levels) was retained from a previously established provision of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). Although states have the flexibility to lower their Medicaid income standards, those states choosing to participate in the new State Children's Health Insurance Program cannot lower their Medicaid eligibility standards below June 1, 1997, levels. In this report, we refer to the July 16, 1996, AFDC standards as the continuing standard for Medicaid eligibility subsequent to welfare reform.

⁷AFDC regulations required families to pass several income tests. First, gross income could not exceed 185 percent of the state's need standard for the relevant family size. (The need standard represented the amount of income each state determined as essential for a minimal standard of living.) Second, net income could not exceed 100 percent of the state's need standard. Net income also had to be below the state-set payment standard, which in most states was less than the need standard and represented the maximum AFDC cash assistance payment the family was entitled to receive. In about a dozen states in January 1996, actual maximum AFDC benefits were also below state payment standards. HCFA has interpreted "AFDC income standards" as including the need and payment standards as well as the 185-percent gross income test.

discourage people from going to welfare offices where they could receive information on Medicaid eligibility. The welfare reform law gives states the option to continue using their July 16, 1996, AFDC categorical and financial standards for both programs or to develop separate standards for TANF.⁸

Four of the nine states we visited reported having separate income or resource standards for Medicaid and TANF. (See table 1.) Officials in these states told us they began using different standards for their Medicaid and cash assistance programs under time-limited welfare demonstration projects that began before the passage of federal welfare reform legislation.⁹ State officials indicated that their attempts to identify the proper mix of incentives that would encourage work and discourage welfare dependency frequently led to more generous Medicaid income limits that allowed working families to remain eligible for Medicaid—as was the case in California and New Jersey.¹⁰ (App. II provides more detail on income and resource standards for the nine states.)

In addition to experimenting with income and resource standards before welfare reform, states experimented with different methodologies for determining financial eligibility and the amount of cash assistance a family could receive. AFDC regulations allowed states to disregard (not count) certain types of income and resources. For example, states could disregard \$265 of a family's monthly income—\$90 for work-related expenses and \$175 per child for child care expenses¹¹—when determining income eligibility for AFDC and Medicaid. While TANF does not require states to use this or any of the other former AFDC determination methodologies, the welfare reform law requires states to continue using

⁸For categorical AFDC eligibility, a family had to include a dependent child who was under age 18 and deprived of parental support because of an absent, deceased, unemployed, or incapacitated parent. To qualify financially, family income and resources had to be below state-specified levels.

⁹Under section 1115 of the Social Security Act, which authorizes the Secretary of HHS to waive specified requirements of AFDC and Medicaid law, states were testing the feasibility and cost-effectiveness of alternative approaches to providing cash assistance and Medicaid services. By October 1996, 43 states had waivers from AFDC requirements involving, for example, recipient income and assets as well as family size and composition. The new welfare reform law allowed states to continue their welfare demonstration projects—without regard to conflicting provisions—through the life of the project.

¹⁰Thirty states had welfare waivers allowing more generous treatment of earned income for determining Medicaid eligibility than allowed by law. Twenty-eight states had waivers allowing families more than \$1,000 in personal property (resources) to retain Medicaid eligibility, and 25 states allowed more than \$1,500 in vehicle equity.

¹¹AFDC regulations allowed \$200 for children under 2 years of age.

their AFDC July 16, 1996, methodologies for determining Medicaid eligibility.¹²

Five of the nine states we visited told us they have different income and resource determination methodologies for their Medicaid and welfare programs. For example, New Jersey officials told us they use more liberal Medicaid income and resource determination methodologies as incentives to encourage cash assistance recipients to begin working. The state disregards 100 percent of the first month's earnings and 50 percent of subsequent months' earnings to redetermine continued Medicaid eligibility for welfare families who have begun to work. Also, by disregarding the first \$1,000 of personal property, the state has effectively raised its Medicaid resource standard to \$2,000—the limit for individuals applying for Work First, New Jersey's TANF program. In contrast, Wisconsin counts all income in determining whether an applicant is below the 115-percent federal poverty level and eligible for the state's TANF program—Wisconsin Works, or W-2—but adheres to its July 16, 1996, AFDC rules to determine Medicaid eligibility.

States Generally Did Not Opt to Separate Medicaid and Cash Assistance Program Administration

Prior to welfare reform, federal law provided that a single state agency be responsible for making both AFDC and Medicaid eligibility determinations. As a result, local public assistance caseworkers were generally responsible for accepting applications and determining eligibility for both AFDC and Medicaid.¹³ Welfare reform gave states the option to continue using a single agency to determine eligibility for Medicaid and TANF or to assign those duties to separate agencies. Additionally, the law gave states the option of using a single application for both programs or separate forms.

All but one of the states we visited planned, at least in the near term, to maintain the administrative and application linkages between the two programs. All nine states use a common application for the programs, and only Wisconsin has separate agencies for determining applicant eligibility. State officials, including those in Wisconsin, believe that common applications are less burdensome for families seeking assistance and simplify the interview process for caseworkers.

¹²The Medicare Catastrophic Coverage Act allows states to use more liberal income and resource methodologies for determining Medicaid eligibility for certain individuals, such as pregnant women, infants, and children born after September 30, 1983. The welfare reform law, however, requires that states use the AFDC July 16, 1996, rules in determining Medicaid eligibility for a family.

¹³Caseworkers also processed applications for Medicaid-only services. Medicaid applicants can apply for services at outstation locations, such as selected hospitals and health clinics. In some states, they can also apply by mail.

Florida officials, for example, told us that the state has used a common application for its assistance programs since 1992. Following the passage of federal welfare reform, Florida further streamlined the application process by converting its state unemployment offices into one-stop public assistance centers. At these centers, Florida residents can complete a single application to apply for Medicaid, job search assistance, child care, housing, and emergency assistance. There are 65 such centers located throughout the state.

Wisconsin officials told us that although a single state agency will no longer determine applicant eligibility for Medicaid and TANF, the state will continue to use a single application for both programs. Wisconsin's Department of Workforce Development determines eligibility for W-2 and the Department of Health and Family Services determines Medicaid eligibility.¹⁴ Wisconsin officials explained that both agencies use the same electronic application and have access to information in the state's client database. Wisconsin's interactive application guides caseworkers and applicants through the interview, prompting workers to input data sufficient to identify the full array of services and benefits applicants may receive.

States Generally Did Not Opt to Use Denial of Medicaid Benefits as a Welfare Sanction

Under the new welfare reform law, states can sanction TANF recipients for not complying with cash assistance rules. States may reduce or terminate recipients' cash assistance or temporarily terminate Medicaid coverage for an adult head of a household. The law cites "refusing to work" as a reason for terminating Medicaid¹⁵ but does not permit states to terminate Medicaid benefits for pregnant women, infants, or children who are not a head of a household. The law also limits the length of a Medicaid sanction to when the recipient begins complying with the state's rules. None of the nine states we visited denied Medicaid as a program sanction for

¹⁴Wisconsin applies different criteria for determining W-2 and Medicaid eligibility. Among the W-2 program's 14 nonfinancial criteria, 3 are notably different from Medicaid. W-2 participants must be (1) custodial parents who are at least 18 years of age, (2) state residents for more than 60 days, and (3) willing to accept any bona fide job offer. Unlike W-2 criteria, for an entire family to be eligible for Medicaid, the household must include a child who is under age 18 and deprived of parental support because of an absent, deceased, unemployed, or incapacitated parent. Also, Medicaid does not have similar durational state residency or job acceptance requirements.

¹⁵The new welfare law requires that adult recipients begin working within 2 years of receiving cash assistance; however, states are free to establish even shorter timetables.

noncompliance with state work rules.¹⁶ In our interviews with state officials, few thought it appropriate to use Medicaid as a sanction for noncompliance with TANF work requirements.

Four States Use Own Funds to Provide Medical Assistance for Qualified Aliens Not Eligible for Federal Benefits

Four of the nine states we visited intended to provide state-funded medical assistance for aliens not eligible for federal assistance. Before welfare reform, aliens who were legally admitted to the United States were generally eligible for Medicaid coverage on the same terms as citizens.¹⁷ The Personal Responsibility and Work Opportunity Reconciliation Act recategorized all aliens into two broad categories: qualified and nonqualified.¹⁸ States generally had the option of providing Medicaid coverage to all qualified aliens who were in the country on August 22, 1996,¹⁹ except that refugees, asylees, and aliens whose deportations are being withheld are eligible for the first 5 years on the same terms as citizens. With certain notable exceptions,²⁰ those qualified aliens who entered the country after August 22, 1996, were prohibited from being eligible for Medicaid for 5 years.

¹⁶However, we identified two states that use Medicaid to sanction other types of noncompliant actions. In Florida, Medicaid enrollment is blocked for non-pregnant women who will not comply with their Department of Revenue's efforts to establish paternity and collect child support. According to New York's Welfare Reform Act of 1997, public assistance recipients—singles; childless couples; and individuals who are not disabled, blind, or pregnant—who are suspected of substance abuse and refuse to comply with the state's investigation and state-required substance abuse treatment can be terminated from Medicaid. Only noncompliant members of the household are included in the sanction.

¹⁷Although legally admitted into the United States, tourists, students, and temporary workers who immigration law classifies as nonimmigrants could receive only emergency Medicaid services.

¹⁸Qualified aliens include legal permanent residents (sometimes referred to as immigrants), asylees, refugees, aliens paroled for at least 1 year, prospective deportees whose deportation is being withheld, and certain aliens granted conditional entry. (Parolees are persons granted temporary admission into the country for humanitarian reasons or when it is determined to be in the public interest.) All other aliens were considered nonqualified. Nonqualified aliens were made ineligible for all but a very narrow range of emergency and other services.

¹⁹The welfare reform law required that resident aliens who were receiving Medicaid benefits on August 22, 1996, continue receiving Medicaid until January 1, 1997. In addition, veterans and active duty military personnel, as well as their spouses and unmarried dependents, and certain permanent resident aliens who had worked 40 qualifying quarters under the Social Security Act continued to be eligible for Medicaid coverage on the same terms as citizens. (A qualifying quarter is a 3-month work period with sufficient income to be counted as a social security quarter; for those quarters after December 31, 1996—according to the welfare reform law—no federal means-tested benefits were received.)

²⁰Veterans and people on active military duty (as well as their spouses and unmarried dependent children) were excepted from the 5-year ban on Medicaid eligibility. Refugees, asylees, and persons for whom deportation has been withheld were also excepted, but their eligibility was limited to the first 5 years after they established their respective status. (The welfare reform law does not preclude refugees, asylees, or aliens from applying for citizenship or for a change in admission status.)

The Balanced Budget Act of 1997 amended the provisions related to eligibility of qualified aliens for Medicaid and certain other federal programs. For example, it provided that qualified aliens who were receiving SSI on August 22, 1996, would continue to qualify for SSI and for Medicaid on the same basis as nonaliens. In addition, the act lengthened the period during which refugees, asylees, and aliens whose deportation has been withheld would remain eligible for Medicaid from 5 years to 7 years. The Balanced Budget Act did not, however, lift the 5-year ban on using federal funds for qualified aliens who entered the country after August 22, 1996.

The original limitations of the welfare reform law on qualified aliens' eligibility for Medicaid and other federal programs were controversial. Although the limitations were seen as a major cost-saving measure, there were concerns, especially in states with large numbers of aliens, about the continuing subsistence and health care needs of these people. All nine states we visited informed us that, even before passage of the Balanced Budget Act, they intended to continue Medicaid coverage for qualified aliens already enrolled. In addition, four of the nine states indicated that they intended to provide state-funded medical assistance for aliens not eligible for federally funded assistance. Table 2 shows which groups of aliens not eligible for federal assistance will receive state-funded medical services in these four states.

Table 2: State-Funded Medical Assistance for Aliens Not Eligible for Federal Assistance, September 1997

	Calif.	Conn.	Fla.	N.Y.
Pregnant women	X	X		X
Children and infants		X		
Families		X		
Institutionalized individuals	X			X
Aged or disabled		X	X	

Source: GAO analysis.

Although state statute requires California to provide its low-income residents—regardless of citizenship status—prenatal and long-term care, proposed changes to state regulations would eliminate state-funded nonemergency services for nonqualified aliens who are not eligible for federal assistance as well as for aliens paroled into the United States for less than 1 year and for those aliens who immigration law considers as nonimmigrants. In December 1996, California's Department of Health Services proposed regulations that would make state policies regarding

aliens consistent with federal welfare reform law. The Department proposed and filed regulations to end state-funded nonemergency prenatal care by December 1, 1997. Advocates challenged the regulatory change, and the regulations were enjoined by a California Superior Court.²¹ The Department also filed regulations that would eliminate state-funded long-term care services but did not set a date for terminating funding. California officials told us they are uncertain if and when state funds for either group will be terminated.

The state estimates that about 2,800 aliens apply each month for Medi-Cal—California’s Medicaid program—and it is likely that most will be subject to the 5-year federal ban on nonemergency medical assistance.²² Because the state has not amended its laws redefining Medi-Cal eligibility for aliens, the state-funded program will cover services for those aliens who lost eligibility for nonemergency medical assistance due to federal welfare reform’s restrictions on aliens. According to California’s November 1997 Medi-Cal estimates, the state-funded program may incur an additional \$25.3 million during the state’s 1998-99 fiscal year and as much as \$56.9 million annually by the state’s 2001-02 fiscal year.

In July 1997, the Connecticut legislature authorized state medical assistance expenditures for aliens admitted into the United States on or after August 22, 1996, who are subject to the 5-year ban but who meet other Medicaid eligibility criteria and have been state residents for at least 6 months. Connecticut’s state-funded medical assistance package will not cover long-term care or community-based services. The legislature also only authorized funding for 2 years. According to state estimates, about 350 aliens qualify for state-funded medical assistance.

The Florida legislature passed the Humanitarian Aid to Legal Residents Act of 1997 to provide medical and financial assistance and Food Stamp benefits to elderly and disabled aliens who were state residents on June 30, 1997. Annually, about 12,000 aliens legally enter Florida, many of whom are over 65 years of age with no other means of support and would not be able to become United States citizens due to mental or physical incapacity. State legislators were particularly concerned with the well-being of aliens who would be subject to the welfare law’s 5-year ban on federal assistance.

²¹On January 23, 1998, a state appellate court issued a stay of this injunction. According to California officials, the state plans to proceed with its original intention to discontinue prenatal care.

²²California officials estimate that, on average, approximately 940,000 aliens have nonemergency Medi-Cal coverage per month.

The New York legislature was similarly concerned about the fate of elderly and other aliens who are subject to the 5-year federal ban. New York's Welfare Reform Act of 1997 provides state-funded medical assistance for aliens who were enrolled in Medicaid on August 4, 1997, and in nursing homes or residential care facilities licensed by the state's Office of Mental Health or by the Office of Mental Retardation and Developmental Disabilities. State officials estimate that it will cost about \$32 million annually to care for the approximately 1,000 aliens who are in those qualifying nursing homes and residential care facilities. New York also provides prenatal care for all aliens and does not distinguish between those who are or are not subject to the 5-year ban.²³ State officials were unable to estimate the cost of these services.

Balanced Budget Act Softened Welfare Reform's Impact on Medicaid Beneficiaries; Impact on Administrative Processes Is Unclear

Because of the Medicaid-related welfare reform options that states exercised, the states we visited reported few structural changes for their Medicaid beneficiaries. In addition to questions about what options states would exercise in the first year of welfare reform, there were concerns about the potential adverse impact of the new law's more restrictive SSI criteria on children's Medicaid eligibility. Moreover, the Balanced Budget Act of 1997 largely mitigated the concerns about lost Medicaid coverage in most states. However, we found that in one state we visited, about 1,700 children who lost SSI eligibility due to welfare reform were inappropriately terminated from Medicaid. Despite limited structural changes, some states we visited were concerned about the impact on their administrative processes as they manage Medicaid programs using July 16, 1996, AFDC eligibility criteria or contract with private firms to determine applicant eligibility for cash assistance and work with welfare clients. Although some state officials expressed concerns about the anticipated costs resulting from these new administrative requirements and associated changes to their information systems, most could not provide firm cost estimates at the time of our visits.²⁴

²³New York claims Medicaid federal matching funds for these prenatal care services. State officials told us that because the *Lewis v. Grinker* (CV-79-1740) court order has not been vacated, the state and federal governments must continue to provide prenatal care for all Medicaid-eligible aliens in New York. Because of the court order, the state does not inquire into citizenship status before providing prenatal care.

²⁴Welfare reform provided an additional \$500 million to the states to help respond to the new administrative costs for their Medicaid programs. HCFA issued regulations allocating these funds in May 1997. HCFA's two-part allocation gave each state \$2 million plus an amount, ranging between about \$500,000 and \$81.7 million, that was based on the state's AFDC caseload and Medicaid expenditures. HCFA regulations limit use of these funds to those activities associated with the transition from AFDC to TANF, including Medicaid eligibility determinations, education, and outreach. At the time of our state visits, most states had not determined what their additional administrative costs would be or how they planned to use the new funds.

Balanced Budget Act Lessened Potential Impact of Medicaid Coverage for Disabled Children

The 1996 welfare reform law enacted several provisions that affected ssi eligibility for children. First, the law changed the definition of childhood disability from an impairment comparable to one that would prevent an adult from working to an impairment that results in “marked and severe functional limitations.” Second, the law eliminated the individualized functional assessment (IFA) process as a basis that the Social Security Administration could use for determining childhood disability. Third, the law revised how maladaptive behavior (behavior that is destructive to oneself, others, property, or animals) is considered when assessing whether a child has a mental impairment. For example, before welfare reform, a child could qualify for ssi if the impairment kept the child from functioning similar to other children of the same age. The welfare reform law specified that a child’s impairment, or combination of impairments, could only be considered disabling when it results in marked and severe functional limitations.

Soon after welfare reform’s enactment, HCFA took steps to lessen the administrative burden on states of performing ssi-related Medicaid eligibility redeterminations. Medicaid regulations require states to redetermine Medicaid eligibility for individuals losing ssi. Advocates were concerned that because of the large number of individuals potentially losing ssi, states would inappropriately terminate Medicaid for individuals who might qualify for coverage under alternative eligibility categories. To address these concerns and allow states to better manage their resources, HCFA nearly tripled the time frames for states to complete Medicaid redeterminations related to welfare reform.²⁵

The Balanced Budget Act softened the immediate impact of these ssi eligibility changes on children’s Medicaid coverage and extended the deadline for terminating cash payments for these children. For example, the act specifically authorized a new Medicaid eligibility category exclusively for children losing ssi due to welfare reform and who were receiving benefits on August 22, 1996.²⁶ Previously, under welfare reform, the Social Security Administration had until August 22, 1997, to use the new criteria to redetermine the eligibility of about 300,000 children whose disability had been based on maladaptive behavior or an IFA determination.

²⁵After receiving notice that an individual has lost eligibility for SSI, states typically have 20 to 45 days to complete the redetermination process for Medicaid eligibility. On January 13, 1997, HCFA issued a regulation and allowed states up to 120 days to redetermine the Medicaid eligibility of individuals losing SSI because of welfare reform.

²⁶This new eligibility category was established in addition to the requirement that states redetermine (or test for) alternative eligibility categories before terminating Medicaid coverage.

By extending the deadline to February 22, 1998, the act gave the Administration more time to complete its redeterminations.

Despite federal efforts to lessen the potential impact of Medicaid eligibility redeterminations for those losing SSI, the process did not always go smoothly. On October 1, 1997, Georgia inappropriately terminated Medicaid coverage for about 1,700 children who no longer met the SSI disability criteria. Eight days later, advocates filed suit on behalf of the children, contending that the state (1) had not continued Medicaid coverage for children meeting the criteria for the newly created eligibility category, (2) had not appropriately redetermined the children's eligibility for alternative Medicaid categories before terminating coverage, and (3) was not continuing Medicaid coverage during the SSI appeals process. Georgia officials attributed the inappropriate terminations to its inability to obtain requested data from the Social Security Administration on a timely basis and to administrative and automated-system weaknesses in recognizing the children's continued eligibility under the newly authorized category. HCFA and Georgia officials informed us that the children who lost Medicaid coverage have been reinstated. In addition, the state is continuing to manually redetermine Medicaid eligibility for those disabled children losing SSI eligibility, while remedies to its systems problems are being developed.

State Concerns About Administrative Processes and Privatization Efforts

The provision of the welfare reform law that protects Medicaid eligibility for low-income families also carries administrative implications for the states. Some state officials expressed concern about aspects of the welfare reform law that could require changes to their administrative processes. Specifically, some viewed the requirement to use AFDC's July 16, 1996, criteria to determine Medicaid eligibility and the new authority to contract with private firms for welfare eligibility determination—but not for Medicaid—as problematic.

In some cases, HCFA-approved amendments to a state's Medicaid plan can resolve program eligibility differences. For example, according to Florida's Welfare Reform Administrator, the state had developed a simplified application process that it now uses for its TANF program—Work and Gain Economic Self-sufficiency (WAGES)—as well as for Medicaid and Food Stamp benefits. Under WAGES, Florida raised its cash assistance resource standard to \$2,000 and liberalized its resource determination methodology. According to Florida officials, to maintain consistent eligibility criteria for WAGES and Medicaid, the state amended its Medicaid state plan,

incorporating the WAGES program's \$2,000 resource standard and determination methodology.

In other cases, extensive changes to automated administrative systems may be needed. For example, as part of several of its welfare demonstration projects, Iowa tested the impact of having consistent eligibility criteria for its Family Investment Program (FIP), the state's cash assistance program for families; Medicaid; Food Stamp benefits; child care; and foster care and adoption assistance. The state also tested the impact of time-limited benefits and work incentives. Demonstration project participants were allowed to keep more income and resources than cash assistance recipients not involved in the demonstration. Upon acceptance of the TANF block grant, Iowa officials separated FIP eligibility from Medicaid so that work-related income and resource incentives, as well as financial penalties for noncompliance with FIP rules, would not infringe upon clients' Medicaid entitlement. Iowa officials are now considering the cost implications of separating the programs and the systems modifications that might be needed. Florida and Wisconsin officials also discussed with us similar systems issues that they must resolve as they implement their welfare reform programs.

States that opt to fully contract out—or privatize—TANF case management services may face additional administrative issues, including duplicate application procedures. The new welfare reform law specifically allows states to contract with private firms for conducting TANF activities—including determining applicant eligibility—but the law does not specifically include Medicaid or other federal means-tested programs in that provision. Concerned about the law's silence regarding Medicaid, Texas and Wisconsin appealed to HCFA and to the Department of Agriculture's Food and Consumer Service, which administers the Food Stamp program,²⁷ for policy changes that would allow states to unify and contract out their eligibility determination processes for the Medicaid and Food Stamp programs as well as TANF.

As recently as June 1997, Texas planned to solicit public and private sector bids to design and implement the Texas Integrated Eligibility Services (TIES) project. Under TIES, Texas wanted to reengineer and consolidate eligibility determination services for all of the state's assistance programs into one overall system that contractors could manage. When Texas

²⁷Food stamps are a federally funded, means-tested benefit that increases the food purchasing power of eligible households. Food Stamp benefits make up the difference between the amount judged sufficient for an adequate low-cost diet and 30 percent of the participating household's income. Like Medicaid, households qualifying for AFDC and SSI are automatically eligible for Food Stamp benefits.

officials queried federal officials about the possibility of using private contractors to interview and determine applicant eligibility for TANF, Medicaid, and Food Stamp benefits, they received letters from HHS that questioned the advisability of proceeding with the state's plans. One HHS letter stated that Medicaid's authorizing legislation and the Food Stamp Act preclude private contractors from evaluating applicant information and certifying eligibility. Texas officials told us that because of HHS' interpretation and other concerns that the state legislature had with the TIES project, the legislature subsequently limited the bid solicitation to developing new social service eligibility determination processes and the information management systems to support them.

Wisconsin officials considered HHS' interpretation problematic and appealed the decision. As part of the state's welfare reform, Wisconsin allowed its counties and local governments to decide whether they would administer the W-2 program or allow the state to competitively select private organizations that would perform case management services. Nine of Wisconsin's 72 counties—including Milwaukee County—opted to allow the state to contract out for services. State officials told us that because of HHS' interpretation, public assistance applicants in those nine counties are interviewed twice: once by the private contractor for W-2 services and once by a county or local government employee for Medicaid and Food Stamp benefits. In both instances, case managers use the state's interactive, universal application to conduct the interviews. State officials told us that they are continuing to work with HCFA to streamline the application process in privatized counties.

As designed, a single case manager would help W-2 participants coordinate the necessary supportive services—such as medical and transportation assistance, child care, and Food Stamp benefits—and track the recipient's progress or recommend appropriate sanctions for willful noncompliance. Wisconsin officials believe that dividing program responsibility between private contractors and public employees dilutes the state's ability to monitor recipients' progress and compliance as well as its ability to realize administrative efficiencies.

Medicaid Education and Enrollment Become Increasingly Important in Post-Welfare-Reform Era

Welfare reform poses additional Medicaid education and enrollment challenges for states. The historic link between Medicaid and cash assistance provided states a strong avenue for ensuring that individuals who were qualified for cash assistance were also enrolled in Medicaid. But as welfare rolls shrink, there is concern that those who qualify for Medicaid may not enroll. To help ensure that Medicaid-eligible individuals enroll in the program, the states we visited are beginning to consider how to adapt or create new education and enrollment strategies.²⁸

States Are Challenged to Identify and Enroll Potentially Eligible Individuals

Welfare reform expands the number of Medicaid beneficiaries whose eligibility is not tied to cash assistance. Medicaid eligibles who do not receive cash assistance are difficult to identify and enroll in the program. Prior to welfare reform, significant numbers of pregnant women and children qualified for Medicaid based on their age, family income, or both, rather than their link to AFDC or SSI. For these expansion populations, states were already faced with developing strategies to identify and enroll them in Medicaid.²⁹ More recently, the Balanced Budget Act's State Child Health Insurance Program increased—at state option—the availability of federal funding for health care coverage for uninsured children. These various initiatives will, in all likelihood, result in many states rethinking the methods they use to reach and enroll eligible populations in state health programs.

Although the welfare reform law preserved Medicaid eligibility for families who would have previously qualified for Medicaid, data show that eligible children in low-income families who do not receive cash assistance are much less likely to enroll in the Medicaid program than those who receive cash assistance. As more former welfare recipients join the ranks of the working poor, some fear that many who are eligible for Medicaid may not be aware of their eligibility and, therefore, may not enroll in the program. We estimate that in 1996, about 23 percent of—or 3.4 million—children who are eligible for Medicaid were uninsured by public or private coverage. Of the states we visited, only Iowa and Georgia provided us with estimates of the percentage of the Medicaid-eligible children enrolled in their programs. Iowa estimated that as of March 1997, more than 80 percent of its Medicaid-eligible children were enrolled; Georgia

²⁸We are currently analyzing the demographic characteristics of children who are eligible but not enrolled in Medicaid, the reasons these children are not enrolled, and strategies that some states are using to increase their enrollment. Our report on the results of this analysis is expected to be issued this spring.

²⁹The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) added the requirement that states “outstation” eligibility workers at locations other than local welfare offices, allowing mothers and children to apply for Medicaid at the sites where they receive health care.

estimated that as of May 1997, roughly 75 to 80 percent of its Medicaid-eligible children were in the state's program. The other states did not have estimates of the number of Medicaid-eligible children who are—or are not—enrolled in their Medicaid programs.

Some provisions of the welfare reform law may also serve as a deterrent for families seeking Medicaid. For example, some state officials and beneficiary advocates believe that the new 5-year lifetime limit on the receipt of cash assistance could deter people who are eligible for Medicaid benefits from applying, fearing that Medicaid benefits will count against their time limit. Advocates are also concerned that under state diversionary programs—which provide welfare applicants one-time payments or work-related direct support services, such as child care or transportation assistance, in lieu of ongoing cash assistance—individuals may not be advised about their Medicaid eligibility.

In Wisconsin, the only state we visited with a statewide diversionary program in place, caseworkers screen for eligibility for all assistance programs, including Medicaid, during the applicant's first visit. According to state officials, in the nine counties that have privatized W-2 case management services, individuals who are provided diversionary assistance are informed of their potential Medicaid eligibility and directed to a county worker for further information. State officials told us that county workers are stationed in the contractors' offices.

States Realize the Need to Adapt or Restructure Their Education and Enrollment Plans to Meet New Program Demands

All nine states we contacted had a variety of outreach efforts, including outstationed eligibility workers in selected hospitals and health clinics. Most of the states we visited recognized the need to adapt or create new education and enrollment approaches to ensure that eligible individuals continue to enroll in Medicaid. States with extensive education and enrollment programs already in place—such as Florida and Georgia—are considering what changes in the focus of their messages may be needed to reach new groups of Medicaid-eligible individuals. Of the states we visited, Wisconsin appeared to be the furthest along in restructuring its education and enrollment strategies to improve the likelihood that Medicaid-eligible individuals would enroll in the program.

According to Florida officials, before the new welfare reform law, the state targeted its education and enrollment efforts toward current and potential beneficiaries in remote locations. At the time of our visit, they had made some revisions to reflect welfare changes. To inform beneficiaries of the

new law, the state included—with monthly benefit cards—notices that outlined welfare reform’s changes and the potential effects on Medicaid benefits. To help ensure that non-English speaking individuals were knowledgeable about how the new law might affect their benefits, these notices and other written information were also printed in Spanish and Creole. Florida also used community presentations and public service announcements to inform individuals about the state’s medical assistance programs and where to apply for benefits.

The state has also expanded its use of Medicaid “outstations.” According to state officials, beneficiaries can now receive information and apply for medical assistance at one of the state’s 65 one-stop centers located throughout the state as well as from hospitals and community health centers. State documents reveal that although one-stop center staff are primarily responsible for TANF-related activities, they also accept and process Medicaid applications and arrange for employment-related support services such as transitional Medicaid benefits,³⁰ child care, and transportation.

Prior to welfare reform, Georgia had in place an education and enrollment program that many recognized as innovative. Since it began its “Right From the Start” Medicaid outreach project in July 1993, Georgia has aggressively sought Medicaid-eligible individuals. To educate and inform the public about Medicaid eligibility, Right From the Start targets its efforts toward working families unfamiliar with entitlement programs, pregnant women, households receiving food stamps, and children under 19 years of age. Officials we interviewed indicated that the state plans to enhance its program to target parents.

The state also has partnered with businesses and community-based organizations to gain community recognition and form local referral networks. In one Hispanic community, the state’s efforts to serve the community led to a cable television spot. Outreach efforts also have led to the state’s participation in many community activities, including health fairs, immunization programs, and the state fair. With a statewide, toll-free number and extended staff work hours—including evenings and

³⁰The Family Support Act of 1988 (P.L. 100-485) added the requirement that states provide 12 months of Medicaid coverage to families who lose AFDC eligibility because of increased earnings, increased hours of employment, or loss of the earned income disregards. Medicaid coverage during this period is commonly called transitional Medicaid. As components of their welfare demonstration projects, some states provide transitional Medicaid benefits for more than 12 months. Among our nine sample states, three offer transitional Medicaid for more than 12 months. Connecticut and New Jersey offer transitional benefits for 24 months, and Texas offers benefits for 18 months. The welfare reform law reauthorized transitional Medicaid expenditures through 2001.

weekends—Georgia has also been able to educate and enroll individuals who might otherwise not have had the time or access to enroll in Medicaid. In addition, in cooperation with a shoe store, Georgia placed informational flyers on Medicaid in women’s and children’s shoe boxes. State officials told us, following welfare reform, they plan to update their Medicaid brochures and possibly some of the state’s activities so that families are informed of their continuing entitlement to Medicaid.

According to state documents, Wisconsin has begun to focus on maintaining enrollment for Medicaid-eligible individuals in a post-welfare-reform environment and on helping Medicaid beneficiaries make appropriate use of health care resources. To encourage clients to sign up for Medicaid, the state has created brochures for distribution to potential and current beneficiaries at county offices and other locations. The state also uses hotlines and advocates to respond to beneficiary questions and concerns about access to Medicaid. Since July 1997, the state has been planning for and is beginning to outstation eligibility workers at additional provider sites to process Medicaid applications and conduct on-site eligibility redeterminations.

Given that Wisconsin’s welfare and Medicaid programs are now separately administered, the state has developed an initiative to explain eligibility changes to its staff and to Medicaid providers. The state plans to use newsletters, Medicaid handbooks, and training to inform health care professionals who serve Medicaid eligibles of eligibility issues. The state also has toll-free numbers that providers and beneficiaries can call to obtain assistance. Moreover, the state provides public and private entities that work with current or potential Medicaid beneficiaries enhanced support and information on program eligibility in light of welfare reform. The state is also building upon the statewide functions of its managed care enrollment contractor to include assistance for community agencies that work with Medicaid eligibles and encounter questions and concerns regarding Medicaid eligibility.

Conclusions

While the 1996 welfare reform law reshaped federal cash assistance programs, the law also provided states with Medicaid-related options—options that could have reduced the number of people who would be eligible for Medicaid. However, the states we visited made few structural changes to their Medicaid programs during the first full year of welfare reform, thereby demonstrating their desire to maintain Medicaid benefits already in place.

The Balanced Budget Act also reinstated Medicaid eligibility for many aliens and disabled children; however, implementation of the act's provisions was not always smooth and error-free, as was the case when children were inappropriately terminated from Medicaid in at least one state. States that we contacted—especially those that have done more to separate their welfare and Medicaid programs—raised concerns about the resulting changes that will be needed for their administrative systems as they develop separate eligibility determination processes. While it is unclear how extensive or expensive these system adaptations will be, this is an issue that will bear watching over time—particularly to ensure that Medicaid eligibility determinations and redeterminations made apart from welfare decisions are accurate. Some states also believe that the welfare reform provision allowing them to privatize cash assistance eligibility determinations, while being silent on Medicaid and other federal means-tested programs, is problematic for states that wish to delegate all client case management services to private contractors.

Finally, welfare reform poses additional challenges for states to educate and enroll individuals who are eligible for Medicaid. States we visited generally recognized the need to educate beneficiaries of their Medicaid eligibility apart from their eligibility for welfare and to protect Medicaid beneficiaries from inappropriate terminations. State officials also recognized the importance of adapting their education and enrollment efforts to better identify and enroll Medicaid-eligible individuals now that the automatic link between cash assistance and Medicaid no longer exists. However, implementing effective approaches to identify and enroll potential Medicaid beneficiaries and to prevent inappropriate terminations will be a continuing challenge for states.

Agency and Other Comments

We provided a draft of this report to the Administrator of HCFA. We also provided a draft to Medicaid and welfare officials in each of the nine states we visited and to independent experts and researchers from the American Public Welfare Association and The George Washington University's Center for Health Policy Research. A number of these officials provided technical or clarifying comments, which we incorporated as appropriate. Others offered additional perspectives, which are summarized below.

In discussing our report findings, HCFA officials acknowledged that, in some cases, states beginning to use the welfare reform law's new flexibility also found increased administrative complexity for their Medicaid programs. HCFA officials pointed out, however, that this tension

between the states' desire for administrative ease and the Congress' intention to preserve Medicaid eligibility for selected populations was not unexpected. Recognizing the potential new costs accompanying this policy change, the Congress provided additional funds to help states make the necessary initial administrative adjustments.

The Director of the Center for Health Policy Research commented that—beyond our discussion of issues associated with redetermining Medicaid eligibility for individuals losing SSI—additional attention is needed on the issue of appropriately functioning Medicaid redetermination procedures. Because the basis of Medicaid eligibility frequently changes—particularly for children—and the states' welfare reform initiatives could speed up this “churning” process, the procedures that states use to redetermine eligibility need to ensure uninterrupted coverage for those who qualify under alternative categories. She also noted that if the Medicaid redetermination systems cannot work properly, policymakers may need to devise other methods.

In terms of outreach and enrollment initiatives in a post-welfare-reform environment, Wisconsin officials offered a perspective on its own program that is pertinent to other states. They stated that their experience in developing an outreach plan for Medicaid is a dynamic one that is being continually adjusted as new issues are identified and new stakeholders become involved. The landscape continues to change as the transition is made from AFDC to TANF, as significant changes are made to state administrative and automated systems, and as the new State Children's Health Insurance Program is designed and implemented.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of HCFA, the directors of the state programs we visited, and interested congressional committees. Copies of this report will also be made available to others upon request.

If you or your staff have any questions about the information in this report, please call me at (202) 512-7114. Other contributors were Enchelle D. Bolden, Shaunessye D. Curry, Barbara A. Mulliken, Karen M. Sloan, and Craig H. Winslow.

Sincerely yours,



Kathryn G. Allen
Associate Director, Health Financing
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Abbreviations

AFDC	Aid to Families With Dependent Children
FIP	Family Investment Program
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IFA	individualized functional assessment
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TIES	Texas Integrated Eligibility Services
WAGES	Work and Gain Economic Self-sufficiency

Scope and Methodology

To describe the Medicaid-related welfare reform options contained in the Personal Responsibility and Work Opportunity Reconciliation Act and the states' approaches to those options, we analyzed the law and interviewed officials from HCFA's former Medicaid Bureau and Office of Research and Demonstration in Baltimore, Maryland. (In a subsequent reorganization, HCFA established the Center for Medicaid and State Operations.) We also interviewed issue area experts, including those representing the American Public Welfare Association and The George Washington University's Center for Health Policy Research. We judgmentally chose nine states—California, Connecticut, Florida, Georgia, Iowa, New Jersey, New York, Texas, and Wisconsin—to include in our study because of the amount of their Medicaid expenditures, varying beneficiary demographics, diverse geographic locations, and differing degrees of welfare reform experience. These states accounted for over 46 percent of fiscal year 1996 Medicaid expenditures and included states among the highest (Connecticut) and lowest (California) per capita Medicaid expenditures. These states also collectively accounted for 78 percent of the aliens receiving federal cash assistance, according to the Social Security Administration's 1996 statistics. Although these states are illustrative of the actions states are taking nationwide, the results of our 9-state survey cannot be projected to all 50 states.

To collect consistent information on (1) states' Medicaid-related choices, (2) implications of those choices on Medicaid eligibles and state administrative procedures, and (3) steps states have taken or plan to take to educate and enroll Medicaid eligibles, we developed a standardized protocol. We pretested the protocol in Iowa and Florida and revised the protocol based on those tests. The revised protocol was our primary data collection instrument, which guided our site visits to the nine states and our interviews with high-level officials having knowledge of Medicaid and welfare eligibility policies and procedures. We completed our on-site visits in June with subsequent follow-up contacts through January 1998. We also discussed the implications of the states' actions with representatives from several advocacy groups including the Children's Defense Fund, the National Health Law Program, and the National Immigration Law Center.

We also used the protocol to collect information on the nine states' Medicaid beneficiary education and enrollment efforts. We identified the states' current methods, planned program changes, as well as the Medicaid education and enrollment challenges they face. We also reviewed current materials to identify the type of Medicaid information states used to educate Medicaid eligibles. We further discussed with representatives

Appendix I
Scope and Methodology

from the Southern Institute on Children and Families, the National Governor's Association, and the Center on Budget and Policy Priorities their concerns about beneficiary education and enrollment.

Nine States' Income and Resource Standards

Income and resource standards were among the financial criteria that welfare officials used to determine applicant eligibility for AFDC and for Medicaid coverage that accompanied cash assistance. These standards represented the upper limits of earned and unearned income, such as child support, as well as the value of assets a family could have to qualify for cash assistance. Because each state sets its own standards, the amount of income and assets families could have and still qualify for AFDC varied among the states. Table II.1 shows the income and resource standards for the nine states we visited.

Table II.1: Nine States' Monthly Income and Resource Standards for a Family of Three, September 1997

State	Medicaid		TANF	
	Income standard ^a	Resource standard ^b	Income standard ^a	Resource standard ^b
California	\$934	\$2,000-3,000	\$735	\$2,000-3,000
Connecticut	872	3,000	872	3,000
Florida	1,111	2,000	1,111	2,000
Georgia	424	1,000	424	1,000
Iowa	849	2,000	849	2,000
New Jersey	985	1,000	636	2,000
New York ^c	577	1,000	577	2,000-3,000
Texas	751	1,000	751	1,000
Wisconsin	647	1,000	1,278	2,500

^aThese figures represent the states' need standards.

^bWe did not include state vehicle allowances in these figures.

^cNew York's income and resource standards vary by district. These figures represent the standards for a New York City family with heat included in the rent.

Source: GAO analysis based on data from states and the American Public Welfare Association.

Seven states reported having the same income or resource standards for their Medicaid and TANF programs. Five states—Connecticut, Florida, Georgia, Iowa, and Texas—have common income and resource standards for their programs, while New York uses a common income standard and California uses a common resource standard. Officials in these states thought it important and administratively efficient to maintain some comparability between the programs, at least during this first year of welfare reform.

Two states—California and New Jersey—have more generous income standards for Medicaid than for their cash assistance programs. A

Appendix II
Nine States' Income and Resource
Standards

California family of three may have a monthly income of \$934 plus allowances for work and child care expenses and be eligible for Medi-Cal—the state's Medicaid program. To qualify for CalWORKS, the state's TANF program, the same family may have no more than \$735 in income.³¹ A New Jersey family of three may have a monthly income of \$1,822, which is 185 percent of the state's need standard, and qualify for Medicaid. However, applicants for Work First New Jersey, the state's TANF program, are limited to a monthly income of \$954, which is 150 percent of the state's \$636 maximum benefit payment for a family of three.

In contrast, we found that Wisconsin's welfare experimentation led to less generous income and resource standards for Medicaid than for W-2, the state's TANF program.³² Under W-2, families may have assets up to \$2,500, vehicle equity up to \$10,000, and earned income up to 115 percent of the federal poverty level—about \$1,278 per month for a family of three. Under Medicaid, however, family resources are limited to \$1,000, vehicle equity to \$1,500, and net income to less than \$520 per month (based on the state's former AFDC need and payment standards).³³

³¹CalWORKS eligibility is based on the state's minimum basic standard for adequate care, which is somewhat comparable to the need standard, plus nonfinancial criteria.

³²As part of a proposed new health insurance program for low-income families, Wisconsin is attempting to make its Medicaid income and resource standards comparable to or higher than its TANF standards.

³³While Wisconsin's monthly need standard is \$647, as shown in table II.1, the state's payment standard is \$518 per month.

Related GAO Products

Welfare Reform: States' Efforts to Expand Child Care Programs
([GAO/HEHS-98-27](#), Jan. 13, 1998).

Welfare Reform: State and Local Responses to Restricting Food Stamp Benefits ([GAO/RCED-98-41](#), Dec. 18, 1997).

Social Service Privatization: Expansion Poses Challenges in Ensuring Accountability for Program Results ([GAO/HEHS-98-6](#), Oct. 20, 1997).

Supplemental Security Income: Review of SSA Regulations Governing Children's Eligibility for the Program ([GAO/HEHS-97-220R](#), Sept. 16, 1997).

Child Support Enforcement: Strong Leadership Required to Maximize Benefits of Automated Systems ([GAO/AIMD-97-72](#), June 30, 1997).

Welfare Reform: Three States' Approaches Show Promise of Increasing Work Participation ([GAO/HEHS-97-80](#), May 30, 1997).

Welfare Reform: Implications of Increased Work Participation for Child Care ([GAO/HEHS-97-75](#), May 29, 1997).

Welfare Reform: States' Early Experiences With Benefit Termination
([GAO/HEHS-97-74](#), May 15, 1997).

Food Stamp Program: Characteristics of Households Affected by Limit on the Shelter Deduction ([GAO/RCED-97-118](#), May 14, 1997).

Health Insurance for Children: Declines in Employment-Based Coverage Leave Millions Uninsured; State and Private Programs Offer New Approaches ([GAO/T-HEHS-97-105](#), Apr. 8, 1997).

Welfare Waivers Implementation: States Work to Change Welfare Culture, Community Involvement, and Service Delivery ([GAO/HEHS-96-105](#), July 2, 1996).

Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate ([GAO/HEHS-96-129](#), June 17, 1996).

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