

# **Transitional Medicaid Assistance: Health Coverage for Families Leaving or Diverted from Welfare**

## *A Briefing Paper*

Research indicates that the uninsured population is constantly changing—people continually gain and lose insurance coverage.<sup>1</sup> As a result, according to the Commonwealth Fund, “one key challenge is to find ways to help people avoid spells of uninsurance, perhaps by developing forms of coverage that allow people to remain insured as their circumstances change.”<sup>2</sup>

Transitional Medicaid Assistance (TMA) is one such program. It is designed to provide *temporary* health coverage to families moving from welfare to economic self-sufficiency. Individuals are eligible for transitional Medicaid if they have lost their Medicaid<sup>3</sup> eligibility due to an increase in household income or child support. Three possible strategies for using transitional Medicaid to expand coverage to additional low-income uninsured Oregonians include:

- More aggressive outreach directed at those currently eligible for transitional Medicaid.
- Expanding eligibility for the transitional Medicaid program.
- Increasing employer-sponsored insurance options through transitional Medicaid.

### **Transitional Medicaid: The Legal Context**

Transitional Medicaid is defined in Section 1925 of the Social Security Act. By statute, all states must provide transitional Medicaid to families who lose their eligibility for Medicaid (because of hours of work; income from employment; increase in child support). Congress established the transitional Medicaid program in 1989, but its importance has grown as a result of the welfare reform act of 1996 (Personal Responsibility and Work Opportunity Reconciliation Act). This act represented a major shift in federal welfare policy because it placed a strong emphasis on getting people back to work quickly. As a result, states now focus their efforts on providing services and programs to help families retain employment and achieve long-term self-sufficiency<sup>4</sup>—programs like transitional Medicaid.

The welfare reform act created a new state-run program called Temporary Assistance for Needy Families (TANF) and eliminated the Aid to Families with Dependent Children (AFDC) program. In addition, the act ended the automatic link between Medicaid eligibility (health coverage) and eligibility for welfare (which generally includes cash assistance). This “delinking” has made Medicaid more complex but has also created new opportunities. For example, the act established a new eligibility category called the “Section 1931 group.” Section 1931 was designed to

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<sup>1</sup> Continuity and Turnover in Medicaid Managed Care: The Oregon Health Plan. Portland OR: Center for Outcomes Research and Education. September 2000.

<sup>2</sup> Sherry A. Glied. Commonwealth Fund Report: Challenges and Options for Increasing the Number of Americans with Health Insurance. December 2000.

<sup>3</sup> For the purposes of this briefing paper, the term Medicaid refers to federally mandated health coverage available to categorical eligibles, including those who qualify for TANF. This is sometimes referred to as traditional Medicaid. In this context Medicaid is distinct from the Oregon Health Plan.

<sup>4</sup> National Governors Association Report. State Policy Options for Health Care Coverage for Families on, Leaving, or Diverted from Welfare, September 2000.

preserve Medicaid coverage for low-income families with children. States can use Section 1931 to:

- 1) ensure that families on welfare, leaving welfare, or diverted from welfare are Medicaid-eligible;
- 2) and/or extend Medicaid coverage to a broader group of low-income families.

### Who is Eligible for Transitional Medicaid?

Eligibility for transitional Medicaid is triggered by an increase in income or child support that causes the loss of Medicaid eligibility under the income standards defined in Section 1931. Further, under Section 1925, a family is eligible for transitional Medicaid only if they have received Medicaid in three out of the preceding six months before becoming ineligible. States are required to provide an initial six-month period of transitional Medicaid. If earned income does not exceed 185% of the federal poverty level (FPL) a family may be recertified for an additional six months.

Because many of those eligible for transitional Medicaid assistance (TMA) are also eligible for the Oregon Health Plan it is useful to compare the two programs:

	<b>Transitional Medicaid</b>	<b>Oregon Health Plan</b>
<b>Target population</b>	Those who leave Medicaid/welfare due to employment and increased earnings (or increased child support).	Open to all (within specified income range).
<b>Income range</b>	Between 52% and 185% of FPL	Families/individuals—less than 100% of FPL Children under 6—133% Pregnant women—170%
<b>Deprivation standard</b>	Prior deprivation standard applies. Therefore most TMA eligibles are (or recently were) single parent households, the under-employed or unemployed.	No such standard (open to everyone within income range)
<b>Length of eligibility</b>	12 months (only 4 months if eligible because of an increase in child support).	6 months, but can recertify if remain income eligible.
<b>Health Coverage</b>	Identical	
<b>Premiums</b>	No	Yes, for non-pregnant adults

According to Adult and Family Services (AFS), staff actively enroll eligible persons into transitional Medicaid. For those who might also be eligible for the Oregon Health Plan, AFS believes that transitional Medicaid offers a better way to “stabilize families in transition” because it offers a longer effective continuous enrollment period and because the program does not require premium payments. In any given month about 30,000 Oregonians are covered through transitional Medicaid. This number rose slightly in 1997 (immediately after the 1996 welfare reform act) but has remained steady ever since.

Currently Adult and Family Services does not enforce the requirement that an individual must have received Medicaid for three of the last six months. Nor does it attempt to recertify families after 6 months to determine if they continue to meet income guidelines. As a result, according to a recent study completed by AFS, about 44% of those receiving transitional Medicaid do not meet one or both of these guidelines. The Health Care Financing Administration (HCFA) objects to Oregon’s approach; HCFA and the state are discussing options. If Oregon were to comply with the letter of the law, an estimated 13,000 individuals would lose health coverage through transitional Medicaid and it isn’t clear how many would be eligible for other programs. Meanwhile, pending federal legislation would simplify the rules for transitional Medicaid and perhaps allow Oregon to continue its current practice.

### **When People Leave Transitional Medicaid**

When a family’s eligibility for transitional Medicaid ends, Adult and Family Services sends a letter explaining loss of coverage and outlining options. As of September 2000, AFS began including enrollment materials for the Oregon Health Plan. Based on AFS statistics, each month:

- 1,000 individuals leave transitional Medicaid and transfer back to TANF.
- 600 leave transitional Medicaid and transfer to OHP.
- 1,800 leave transitional Medicaid and do not transfer to any other state-organized medical program.

There isn’t much data available about the 1,800 individuals in the third category. Since they are no longer enrolled in any state program they are not tracked. Extrapolating from research done in other states, most are employed but few have access to affordable, employer-based coverage. AFS recently began a more detailed study of what happens to individuals after their transitional Medicaid coverage lapses. Results will be available by first quarter, 2001.

### **Eligible Persons who Never Enroll**

Other states have reported that a large number of individuals are probably eligible for transitional Medicaid but have never enrolled in the program.<sup>5</sup> Some are TANF recipients; some have been diverted from TANF.

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<sup>5</sup> Jocelyn Guyer. Health Care after Welfare: An update of Findings from State-Level Leavers Studies. Center on Budget and Policy Priorities. August 2000.

### ***TANF recipients***

While the research is scant, a study done by the state of South Carolina (March, 1998) found that about 25% of those eligible for transitional Medicaid did not know they were eligible and had failed to enroll. In Washington researchers found that 58% of the respondents left welfare due to an increase in earnings but only about 33% received Medicaid coverage for the parent (July, 1998). In Oregon, the situation may be different because AFS actively enrolls TANF recipients; however no definitive Oregon-specific research has been conducted.

### ***Diverted from TANF***

With all the emphasis on back-to-work strategies, many states (including Oregon) have created programs to eliminate the need for welfare (lump-sum payments, job search requirements, alternative resources). As a result, an unknown number of very low-income families are informally diverted from welfare and are not currently eligible for transitional Medicaid. To the extent that these diversion programs are successful this category of *eligible-but-never-enrolled* is probably growing (nationally, welfare case loads have decreased 40% since 1996<sup>6</sup>). Again, Oregon may be different because of its more inclusive eligibility policies.

## **Options to Increase Health Coverage via Transitional Medicaid Assistance**

Note: All options listed are preliminary; no cost/feasibility analysis has been completed as of yet.

### ***More active outreach to those currently eligible***

- 1) Increase the “capture rate” by educating families about transitional Medicaid.

According to the Center on Budget and Policy Priorities (CBPP), “recent evidence suggests that state systems are not always effectively continuing Medicaid on a transitional basis to families that leave welfare.”<sup>7</sup> CBPP recommends a series of outreach/educational/administrative procedures to assure that Medicaid benefits continue for eligible families when they leave TANF.

Because AFS so actively enrolls eligibles for transitional Medicaid, this strategy might not be appropriate for Oregon. However, no research has ever been done to determine Oregon’s capture rate. Outreach efforts would probably qualify for Medicaid matching funds.

- 2) Convert transitional Medicaid to OHP.

Because of the overlapping income requirements, some of those on transitional Medicaid are (or will become) eligible for the Oregon Health Plan. Outreach efforts to this group have been improved recently but AFS has not yet evaluated the impact of these efforts.

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<sup>6</sup> National Governors Association Report.

<sup>7</sup> National Governors Association Report.

## ***Expand Eligibility***

### 1) Increase the coverage period to two years.

Current law mandates that transitional Medicaid must be available to eligible individuals for 12 months. However, states can use the flexibility granted under Section 1931 to increase this coverage period. Currently 13 states have expanded eligibility to two years. A few have done this via existing waivers, most have taken advantage of Section 1931's liberalized guidelines for using income and asset disregards. Because it is spelled out in statute, this approach does not require a waiver (however Oregon would have to file a state plan amendment). Such an expansion would be eligible for Medicaid matching funds.

### 2) Offer transitional Medicaid to families who have not used TANF.

As the welfare rolls are reduced, fewer families come into contact with the TANF system. However, many may still need temporary help. Under Section 1931 of the Social Security Act the state could choose to enroll individuals in transitional Medicaid even if they have not been enrolled in TANF.

These two options use the flexibility of Section 1931 to increase the reach of transitional Medicaid. In essence Oregon has a choice about how it might use Section 1931 as a tool to expand coverage. Using transitional Medicaid as the primary vehicle could be defined as a narrow focus strategy since this program is time-limited and only reaches some of the working poor. In contrast, Section 1931 could also be used to devise a broad expansion of coverage to all low-income families.

### 3) Adopt continuous Medicaid eligibility for children under age 19.

Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Since transitional Medicaid is meant to cover families, children are generally also covered. However, adopting continuous eligibility would, in principle, protect children from loss of coverage because their parents or guardians face administrative barriers to continued coverage (such as recertification—required after 6 months on transitional Medicaid). Since Oregon doesn't currently require recertification for transitional Medicaid, this program probably wouldn't expand coverage. However, if HCFA insists that Oregon begin recertification, this option bears closer scrutiny.

## ***Employer-based Strategies***

### 1) Extend the Health Insurance Premium Payment (HIPP) program to those receiving Transitional Medicaid.

HIPP is an optional Medicaid program that allows states to use Medicaid funds to cover the cost of employer-sponsored health insurance for certain Medicaid-eligible individuals. Individuals must work for an employer that offers health insurance and the insurance must be cost-effective. If the employer's benefit package is not as comprehensive as the mandatory Medicaid package (as stipulated in Title XIX guidelines) the state must

supplement coverage with “wrap-around” services. Because of such limitations, enrollment in HIPP is very small. However, HIPP could be expanded in at least two ways:

- a) Create a minimum enrollment period: Under current policy HIPP eligibility ends when an individual or family is no longer Medicaid-eligible. However, under certain circumstances Oregon may continue HIPP payments to recipients even if they lose their eligibility for Medicaid benefits. According to Medicaid rules a state may establish (or “deem”) a minimum enrollment period for HIPP. If a state does so, a family could participate in HIPP for the length of that period, even if the family loses its Medicaid eligibility. So, for example, Oregon could extend transitional Medicaid by deeming a 24 month minimum enrollment period. For the first 12 months the family would be covered by transitional Medicaid; for the second 12 months the family would be covered under HIPP.
- b) Establish co-pays/cost sharing arrangements: Employer-sponsored insurance is considered cost effective if the total cost is less than Medicaid expenditures for an equivalent set of services. As of now, if the actual cost is even a dollar more than Medicaid costs, the insurance is not considered cost effective. AFS has proposed an experiment with cost sharing approaches that would ask the eligible family to pay the difference between the cost effective amount and the actual amount.

2) Seek a waiver to allow more flexible employer buy-in strategies.

Under current Medicaid regulations, using public money to subsidize employer-sponsored insurance (ESI) is difficult to implement. The Social Security Act stipulates minimum benefit levels, minimum employer contribution levels and cost-effectiveness tests. To gain flexibility states can seek Medicaid or CHIP waivers, and in theory Oregon could file for a waiver to make it easier to use transitional Medicaid dollars to subsidize ESI.

However, most states are exploring CHIP buy-in options instead of transitional Medicaid options. According to the Academy for Health Services Research and Health Policy CHIP is a better vehicle for buy-in strategies: transitional Medicaid is of limited duration, CHIP is not; state funds dedicated to transitional Medicaid receive a lower Federal match rate than CHIP funds; no states have received a transitional Medicaid waiver, three states have already earned CHIP family-coverage waivers that support ESI approaches.

## Summary

Transitional Medicaid is an attractive option because it so clearly supports families making the switch from welfare to work and directly addresses the needs of the temporarily uninsured. In addition, the program, as currently configured, allows for *continuous* enrollment for 1 year (independent of short term changes in income levels). This continuous coverage is important given that many low-income individuals go on and off health coverage. Transitional Medicaid provides a small but real push in the direction towards stability.

However, transitional Medicaid programs have limited scope. Only a portion of the uninsured would be eligible for any of the transitional Medicaid options under consideration. Moreover,

transitional Medicaid is time-limited and conditioned on a family's ability to meet reporting requirements that burden families and states alike.

If the public policy goal is universal access to health care, then other remedies are likely to be more effective (for example, Section 1931 expansion to low-income working families, CHIP expansion to parents). However, if the goal is incremental change that builds on short-term back-to-work strategies then transitional Medicaid could play an important role.

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