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Coverage of the TANF Population Under Medicaid and SCHIP

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Summary

Health insurance is an important support for individuals receiving, leaving or diverted from the Temporary Assistance for Needy Families (TANF) welfare or cash assistance program for low-income families. Medicaid and SCHIP (State Children's Health Insurance Program) are key vehicles for providing such coverage. While there is no formal link between TANF and either Medicaid or SCHIP, some TANF-eligibles, especially children, are likely to qualify for one of these programs. But state eligibility rules can be complex and often differ for parents versus children, leaving some parents, in particular, without coverage. Finally, transitional medical assistance (TMA) for families losing Medicaid coverage for work-related reasons is set to expire at the end of March 2005.

Background

Medicaid provided access to medical services for approximately 51.4 million people in 2002 (the latest official enrollment figure). To qualify, applicants' income and resources (also called assets) must be within program *financial standards*. These standards vary considerably among states, and different standards apply to different population groups within a state. Medicaid eligibility is also subject to *categorical restrictions* — generally, it is available only to low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children.

The Temporary Assistance for Needy Families (TANF) program provided cash assistance to 2.2 million families in FY2003. TANF is structured as a flexible block grant to states, and it was the centerpiece of the 1996 welfare reform law, replacing previous entitlements to cash assistance. Under TANF, eligibility thresholds and benefit levels are established by states, but federal law imposes work requirements and time limits on benefits.

Prior to TANF, families qualifying for cash assistance under the former Aid to Families with Dependent Children (AFDC) program were automatically eligible for, and in most states, automatically enrolled in, Medicaid. In contrast, there is no direct link between eligibility for TANF and eligibility for Medicaid. Although TANF eligibility does not confer automatic Medicaid eligibility, Medicaid entitlement was retained for those individuals who meet the requirements of the former AFDC program as in effect on July 16, 1996. These old state-specific AFDC-related income standards are typically well below the federal poverty level (FPL). However, states may modify (i.e., liberalize or further restrict) these criteria for determining Medicaid eligibility for low-income families like those receiving TANF. Anecdotal evidence suggests that some states have chosen to align income rules for TANF and Medicaid, thus facilitating Medicaid coverage for some TANF recipients. While some states also provide Medicaid to higher-income adults under waivers of program rules, the AFDC-related rules are the main pathway into Medicaid for low-income, working parents.

For families who lose Medicaid due to increased hours of work, earnings, or child support payments, transitional medical assistance (TMA) for a period of 4 to 12 months is available. TMA can be particularly important for low-income parents, since there are few other ways through which such adults can maintain Medicaid coverage or private health insurance. However, over the years, Congress has created several other mandatory and optional coverage categories for children that are tied to income levels at or above the poverty line (up to 185% of the FPL for infants at state option).

Another pathway for low-income children in particular is the SCHIP. Established in 1997, SCHIP builds on Medicaid by providing health insurance to uninsured children in families with income above applicable Medicaid income standards. TANF children ineligible for Medicaid due to income are likely to qualify for SCHIP if they meet other eligibility rules. Each state defines the group of children who may enroll in SCHIP using factors such as geography, age, income and resources, residency, disability status, access to other health insurance, and duration of SCHIP eligibility. As of July 2003, 39 states covered at least some groups of children in families with income at or above 200% FPL. States provide SCHIP children with health insurance that meets specific standards for benefits and cost-sharing, or through their Medicaid programs, or through a combination of both.

Coverage for adults under SCHIP is restricted to special circumstances. As of September 2004, 10 states (Arizona, California, Colorado, Illinois, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, and Wisconsin) have been granted approval specifically to enroll one or more categories of adults with children, typically parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women; four states also cover childless adults. Parents may also be covered through SCHIP programs providing premium assistance with employer-sponsored health insurance for eligible SCHIP children.

Concerns about under-utilization of SCHIP were raised early in the program and are still voiced by some today. But enrollment is growing. In FY2003, the number of children ever enrolled in SCHIP during that year reached 5.9 million. During that same year, nearly 484,000 adults were enrolled in the program.

The Medicaid picture is more complicated. Analyses of program administrative data show that, between 1995 and 1998 — during the early years of the newly established TANF program — the number of able-bodied adults and children on Medicaid fell, while the number of aged beneficiaries stayed roughly constant, and the number of persons of all ages with disabilities rose slightly. For adults and children, reductions were greatest among those eligible for Medicaid via AFDC-related pathways, perhaps due to confusion about the relationship between TANF and Medicaid eligibility. These losses were only partially offset by enrollment gains through other eligibility routes, especially among children. In the late 1990s, enrollment declines were also affected by a strong economy, high employment rates, and rising income; lack of awareness of continuing eligibility; cultural/language barriers and immigration issues (e.g., five-year ban on Medicaid enrollment for certain aliens entering the U.S. after August 22, 1996); Medicaid's historical ties to welfare and its associated stigma; the often arduous enrollment process itself; and agency errors.

A different enrollment picture emerged at the beginning of the 2000 decade. Program administrative data for the FY2000 through FY2002 period show steady increases in enrollment in Medicaid overall and for all types of beneficiaries. The highest rates of growth were observed for adults (10-14% per year) and children (6- 9% per year). Increases in enrollment were smaller for the aged (3-8% per year) and persons with disabilities (3-5% per year). In FY2002, the number of adults and children ever enrolled in Medicaid during that year reached 13.2 million and 25.4 million, respectively. Reasons for the increased enrollment among children and adults include the economic downturn that began in 2001, a drop in employer-sponsored insurance, and new or expanded Medicaid eligibility pathways through waivers and liberalization of income requirements for the AFDC-related group.

Future Considerations

Both Medicaid and SCHIP have eligibility rules that leave some members of low-income families without coverage, most notably parents. Without further congressional action, TMA under Medicaid will expire at the end of March 2005. Some states have used waiver authority to cover childless adults and parents under Medicaid and SCHIP. As Congress considers reauthorization of SCHIP (currently authorized through FY2007), the definition of the core, eligible population may be refined (e.g., limited to children only, or children and their caretaker relatives such as parents).

In general, further simplification of program rules, streamlining of enrollment processes, and additional outreach have been deemed necessary for improving coverage rates for TANF eligibles and other groups. Even though states received some fiscal relief from the federal government in FY2003 and FY2004 to help offset Medicaid and other shortfalls, expanded coverage of the TANF population under both Medicaid and SCHIP may be affected by continuing federal and state budget constraints that have surfaced recently.

For More Information

CRS Report RS20552, *Welfare Reform and Medicaid: Brief Overview*, by Vee Burke.

CRS Report RL32277, *How Medicaid Works: Program Basics*, by Elicia Herz, Jean Hearne, Julie Stone, Karen Tritz, Evelyne Baumrucker, Christine Scott, Chris Peterson, and Richard Rimkunas.

CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady.

CRS Report RL32389, *A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics*, by Elicia Herz, Evelyne Baumrucker, and Peter Kraut.