Order Code RS22035
Updated March 8, 2006

Coverage of the TANF Population Under Medicaid and SCHIP

name redacted
Specialist in Social Legislation
Domestic Social Policy Division

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, six to 12 months of transitional medical assistance (TMA) for families losing Medicaid coverage for work-related reasons expired on December 31, 2005, but was reinstated retroactively to this date, and extended through 2006 under the Deficit Reduction Act of 2005 (P.L. 109-171).

Background

Medicaid provided access to medical services for approximately 55.4 million people in FY2003 (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.

Transitional medical assistance (TMA) is available for families who lose Medicaid due to increased hours of work, earnings, or child support payments. There are two separate TMA provisions in Medicaid law — one that permanently requires four months of coverage and another that requires six to 12 months of coverage, but is subject to a sunset rule. Under the latter provision, qualifying families receive an initial six months of TMA. A second six months of TMA is provided to those families who were covered during the entire first six-month period and whose earnings are below 185% of the poverty level. The six- to 12-month TMA provision expired on December 31, 2005, but was reinstated retroactively to this date, and extended through 2006 under the Deficit Reduction Act of 2005 (P.L. 109-171).

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 October 2004, 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 May 2005, nine states (Arizona, California, Colorado, Illinois, Minnesota, New Jersey, Oregon, Rhode Island, and Wisconsin) had 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; three states also covered 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 FY2004, the number of children ever enrolled in SCHIP during that year reached nearly 6.2 million. During that same year, about 646,000 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 Medicaid enrollment picture emerged at the beginning of the 2000 decade. Program administrative data for the FY2000-FY2003 period show increases in enrollment in Medicaid overall and for all types of beneficiaries, with the largest enrollment gains for adults and children. In FY2003, the number of adults and children ever enrolled in Medicaid during that year reached 14.4 million and 27.4 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. Reinstatement and extension (through 2006) of six to 12 months of TMA for TANF recipients who move from welfare to work was included in the recently passed Deficit Reduction Act of 2005 (P.L. 109-171).

Some states have used waiver authority to cover childless adults and parents under Medicaid and SCHIP. However, P.L. 109-171 bars coverage of non-pregnant, childless adults through new waivers using SCHIP funds.

In general, further simplification of Medicaid and SCHIP 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 RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by (name redacted).

CRS Report RL33202, *Medicaid: A Primer*, by (name redacted).

CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia Herz, (name redacted), and Chris Peterson.