
Policy Options to Assure Access to Health Care for People Leaving Welfare for Work

Prepared for

The Annie E. Casey Foundation

by

Jack Meyer

Sharon Silow-Carroll

The Economic and Social Research Institute

18th Street, N.W., Suite 210

Washington, DC 20036

September 1996

About the Authors

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

Jack A. Meyer, Ph.D., is President of the Economic and Social Research Institute. He is an economist who has written widely and conducted extensive policy analysis in the areas of health system reform, welfare reform, and social services. Dr. Meyer is also President of New Directions for Policy, a research and consulting firm located in Washington, DC.

Sharon Silow-Carroll, M.B.A., M.S.W., senior vice president of ESRI, specializes in analyzing and modeling health care reform proposals to assess their long-term impact on the U.S. and key sectors of society. She has also surveyed and evaluated promising public and private sector initiatives in health care cost control and access expansion.

Acknowledgments

The authors would like to thank **Maya Tudor** and **Elliot K. Wicks** for very helpful assistance in preparing this report.

ESRI would also like to thank the **Annie E. Casey Foundation** for supporting this project.

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Executive Summary

This report develops a series of policy options for state and federal officials to assure that people leaving welfare have access to health care. In light of a flurry of state innovations in recent years and the recent federal welfare legislation, the locus of attention for welfare issues is shifting to the states. Thus, this report highlights a variety of state initiatives. Because significant funding for cash assistance is still provided on a national level, the federal government remains an interested and relevant party. Federal involvement in Medicaid, regulations supporting community health centers, and nutrition and child care programs provide an ongoing role for the federal government.

The conceptual framework for the study envisions two ways to assure access to health care for those leaving welfare to work. First, we analyze several options designed to help people obtain either publicly supported or private insurance. These constitute “demand-side” strategies.

Second, the health care delivery system must be redesigned to accommodate the special needs of the group we are targeting for assistance. A significant number of people terminated from cash assistance will be without jobs—either because they fail to find a job in the first place or because they lose the job they took after leaving welfare. Indeed, there will be a good deal of churning in and out of jobs among this population, whose work experience and educational attainment are relatively low. Moreover, among those who obtain and retain jobs, many will not have health coverage. It is worth recalling that about two-thirds of the uninsured are living in the household of a full-time worker.

Therefore, to complement the “demand-side” strategies, we have outlined “supply-side” strategies. The supply of health services in underserved areas must be augmented and redesigned to assure that people with marginal or intermittent labor force attachment and those working in jobs without health care coverage have access to timely and cost-effective health services. We cannot presume that the health care system is ready to embrace an individual coming off welfare. Barriers related to income, health risks, language, transportation, and education abound. Thus, we must build up the public health infrastructure even as we empower people to buy into the mainstream medical system.

Demand Side Strategies

Recommendation 1:

To ease the transition from welfare to work, states should consider extending eligibility for transitional Medicaid benefits beyond one year. A number of states have already moved in this direction. This extension could appropriately vary in length, depending on the use of other work incentives such as the income disregard, other transitional benefits

such as child care, and the administration of the program. States may, however, want to retain some time limit on Medicaid benefits to hold down the incidence of people leaving private, employer-sponsored coverage for Medicaid.

Recommendation 2:

To encourage more state experiments with the delivery and financing of health care, the federal waiver process should be modified by relaxing certain rules that states consider unduly restrictive, establishing a new Medicaid waiver authority for projects that expand access and meet specified guidelines, and establishing a mechanism for making waivers indefinitely renewable.

Recommendation 3:

States should continue to use innovative methods to expand health coverage, although they should be cautious about relying too heavily on savings from managed care to finance the expansions. To promote savings while encouraging provider participation, states pursuing managed care should negotiate fair, capitated payments and caps on premium growth in future years. They should ensure adequate provider networks for the enrolled population, and that quality control and access monitoring mechanisms are securely in place.

States should be careful not to enact laws that work against the very types of cost savings they are trying to achieve through managed care. They should also consider trimming the Medicaid benefit package to help finance coverage for the working poor if managed care savings are inadequate.

Recommendation 4:

Any federal Medicaid reform legislation should maintain the current expansion schedule to cover all poor children, up to age 19, by 2002. If this does not occur, states should attempt to continue the previously scheduled expansion on their own.

Recommendation 5:

Children's health plans, which are less expensive and enjoy greater public support than programs for adults, should be encouraged at the federal, state, and county levels.

Recommendation 6:

In the short term, states could encourage small employers to contribute to workers' coverage directly or could offer subsidies to employers meeting specified criteria. States need to target small firms in a publicity campaign to inform them of this new option; they must offer enough of a subsidy to be attractive; and they should guarantee the continuation of the subsidy for a period of years.

In the long term, states should consider requiring employers that do not provide coverage directly to contribute to the cost of covering employees (with reduced contribution levels for part-time workers), through some kind of efficient pooling mechanism that would permit workers to retain coverage with the same plan if they change jobs.

Supply Side Strategies

Recommendation 1:

States and counties should assist their public hospitals to become more aggressive and efficient providers of care. This could include technical assistance and training for management, which could be facilitated through such organizations/agencies as the National Public Health and Hospital Institute, or the U.S. Department of Health and Human Services' Health Resources and Services Administration, which offers similar services to community health centers.

Also, Medicaid reform should stipulate that states' ability to reduce disproportionate share hospital payments is contingent on the development and implementation of new programs that provide health care services to the uninsured or direct health-related subsidies to low-income people.

Recommendation 2:

Efforts should be enhanced to help both federally qualified and non-federally qualified community and migrant health centers adapt to the increasingly competitive managed care environment, and bring them into managed care networks. States should encourage managed care plans to team up with health centers and other essential community providers by requiring health plans, as a condition of licensing, to develop action plans for serving high-risk and special needs populations.

Recommendation 3:

The federal and state governments should enhance the supply of appropriate health care practitioners and services, and expand outreach efforts in underserved areas. The federal government could increase funding for the National Health Service Corps to encourage physicians and allied medical personnel to practice in underserved areas.

States and communities should make special efforts to invest in preventive health, family planning, and support services tailored to high-risk people in the community. Communities should also invest in innovative outreach efforts to bring services to where the patients are.

Recommendation 4:

States should promote programs at the state and community levels that integrate health and social services. In this way, limited funds could be targeted toward special high-risk segments of the population leaving welfare and help assure access to relatively low-cost health and social services that are likely to help achieve the long-term goals of welfare reform.

Outlines of Welfare Reform

Introduction

This report develops a range of policy options for state and federal policymakers to assure access to health care for people leaving welfare to work. The aim of welfare reform is to help people make the transition from long-term dependence on public assistance to work and self-sufficiency. A major stumbling block in this transition could be the loss of health coverage. If the goals of welfare reform are to be realized, ways must be found to assure that people—including those who “play by the rules” in terms of training, education, work, and family responsibility—are not penalized by losing health coverage. If they do lose coverage, we need to assure that they will have access to care through a more effective, efficient, and integrated safety net system.

We will use the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, passed by Congress and signed by the President on August 22, 1996, as the takeoff point for our analysis.

Our conceptual framework involves a two-pronged approach to help ensure that people coming off welfare obtain the health care they need in a timely fashion. First, lower-income people must be able to afford the care that is available, either by retaining public coverage or by obtaining private coverage. Thus, our first set of strategies involves working on the demand side of the health care market to assure access to health coverage. Obtaining private coverage may be complicated by the likelihood that many of the jobs for which welfare recipients will qualify will not include employer-sponsored health coverage.

The second set of strategies involves building up and improving the supply side of the health care market to better serve at-risk populations, particularly people who lose health coverage through welfare reform. It involves assuring an adequate number of appropriate health care providers in underserved areas, helping health care providers in these areas become more efficient and competitive players in today’s market, and integrating medical services with other critical social services to more effectively treat the “former welfare” population.

Key Features of Welfare Reform

There are important links between Medicaid and welfare. First, many people who have been covered by Medicaid are eligible because they have qualified for cash assistance under provisions of welfare legislation. Second, there is some evidence that the prospect of losing Medicaid coverage has been a factor keeping people on welfare or causing them to return to welfare. (The relationship is more complicated than sometimes portrayed, as explained in Appendix I).

Because the new welfare legislation limits eligibility for cash assistance, it also will cause many who are now covered by Medicaid eventually to lose coverage. “Hold harmless” provisions included in the legislation protect people who qualified for Medicaid under the AFDC criteria of July 16, 1996, as long as they meet the work requirements stipulated in the new law. No one can immediately lose Medicaid coverage if states tighten up their cash assistance eligibility standards. But as people leave welfare for work, many will lose their Medicaid coverage after an adjustment period during which they receive transitional Medicaid benefits.

The point is that welfare changes will jeopardize health coverage not because non-workers have their Medicaid taken away, but rather because people moving from welfare to work are only protected temporarily from Medicaid loss. Many of the jobs they will take do not include employer-sponsored health coverage. (For a summary of the provisions of the welfare legislation, see Appendix II.)

To assess the impact of welfare changes on health coverage, it is useful to answer a series of related questions.

How many people will become ineligible for cash assistance?

New legislative rules that move people off cash assistance will eventually reduce the number of people eligible for Medicaid, although some provisions of the law attenuate this effect. The most important provisions of the new law include the following:

- The new law replaces the AFDC program with capped block grants to states for a program called Temporary Assistance to Needy Families (TANF).
- Parents with children who have received cash assistance for a period of 24 continuous months can continue to receive benefits only if they are working (part-time work counts), looking for work, enrolled in a training program, or in school.
- Families that have received cash welfare for a total of five years (at any time after the effective date of the legislation) become ineligible for cash assistance (with exemptions for up to 20 percent of the state’s caseload). Cash assistance is not available to families without a minor child, teenage parents not in school, or teenage parents not living in an adult-supervised setting.
- Legal noncitizens newly entering the U.S. are ineligible for cash assistance and a range of social benefits, including health benefits, for a minimum of five years. For those noncitizens already in the country legally, the legislation eliminates eligibility for SSI and Food Stamps unless they are veterans of the U.S. military or have worked

and paid taxes in the U.S. for at least ten years. States have the *option* of providing Medicaid benefits to noncitizens already in the country.

- States continue to have the right to reduce their cash assistance standards to levels established in May 1988. But the “hold harmless” provision requires that such states continue to provide Medicaid coverage to people eligible under the previous income thresholds until they become ineligible because their earnings or other income carry them over such thresholds. Starting July 16, 1997, states will be required to redetermine Medicaid eligibility for all welfare recipients because the two benefits will be uncoupled. The 1996 legislation provides \$500 million to assist states with new costs incurred in administering the new system. Nevertheless, the delinking of cash welfare and Medicaid may cause a decline in the number of people served by Medicaid because the “take-up” rate of people joining Medicaid is lower when people have to apply separately. States may increase their income eligibility standards, but at a percentage increase no greater than the percentage increase in the Consumer Price Index (CPI).
- By the year 2002, 50 percent of single-parent families and 90 percent of two-parent families must be engaged in work activity; the required participation rate is adjusted down one percentage point for each percentage point that the caseload is below the level of the preceding fiscal year (eligibility changes not taken into account). If the newly employed family’s income rises above the income threshold as a result of work income, the family would become ineligible for Medicaid on an ongoing basis, but could receive at least one year of transitional benefits.
- States must require applicants for public assistance to cooperate in establishing the paternity of their illegitimate children and in enforcing child support orders. States must maintain automated data systems for tracking all child support orders established after October 1, 1988.
- Eligibility for SSI among children with disabilities is tightened by discontinuing “individualized functional assessments,” under which children whose impairments are not equivalent to those on a federal list were reviewed under a less stringent process. Maladaptive behavior is eliminated as a symptom of a disabling mental impairment.

According to one estimate, 1.77 million adults would lose cash assistance as a result of a five-year cap on lifetime benefits (Zedlewski and Sawhill 1995). In total, between 1.8 and 2.0 million adults are likely to lose cash assistance, along with an estimated 4 million children.

The Congressional Budget Office has estimated that the new welfare law will lead to a net reduction in federal spending of \$3 billion in FY 1997 and \$54 billion over the FY 1997-2002 period.

Of those losing cash assistance because of time limits or other reasons, how many will find jobs?

The employment rate of those who leave welfare and enter the work force will be determined in part by the degree of slack or tightness in their local labor market and in part by their personal characteristics—educational attainment, skill levels, knowledge of the world of work, and the presence or absence of serious behavioral health problems (e.g., substance-abuse problems, mental health problems). The data on the personal characteristics of welfare recipients suggest that these individuals may face large obstacles as they seek jobs. *For example, 46 percent of the overall AFDC population have not earned a high school diploma (Acs et al. 1993). More important, of those who have stayed on AFDC for more than five years, 62.8 percent did not graduate from high school, and half of those on AFDC for more than five years had no work experience in the year prior to receiving assistance (Pavetti, 1995).* About 18 percent of women receiving AFDC have some disability that limits work. Almost 30 percent of families receiving AFDC include either a disabled mother or child; two-thirds of these families, or 20 percent of all AFDC families, include either a disabled mother or a severely disabled child (Loprest and Acs 1996). In a study of non-disabled General Assistance beneficiaries (considered most similar to welfare recipients) who lost their benefits in 1991, *more than half of the high school graduates and 72 percent of the high school dropouts were unemployed two years later*—reflecting the difficulties in and obstacles to finding lasting employment for this population (Danziger and Danziger 1995). Moreover, nearly three of every four AFDC, public assistance, and food stamp recipients performed in the lowest two of five levels of literacy as defined in the National Adult Literacy Survey (NALS). An estimated 48 percent of adults in the total population scored in the lowest two levels of the prose section of the NALS, while 70 percent of people on AFDC or public assistance scored at this level. On the NALS quantitative section, 47 percent of the total population scored in the lowest two levels of literacy, as compared to 72 percent of the welfare population.

These findings, taken together, suggest that many people who lose cash assistance will have difficulty both finding and keeping jobs.

Of those finding jobs, how many will obtain employer-sponsored group health insurance?

Among those who do attain employment, many will not receive employer-sponsored health coverage. Availability of coverage will be determined in part by the nature of the employment—the industry, occupation, hours employed, and employer size. Coverage will be less widespread for part-time workers and temporary workers than for full-time workers. There will be a lower incidence of coverage among those employed by small businesses and for those working in such settings as hotels, restaurants, and retail trade.

The characteristics of the AFDC population—low skills, low education levels, and a lack of work experience—make them prime candidates for the low-wage, part-time, or temporary jobs that frequently do not provide health insurance coverage for workers or their dependents. Yet their earnings, small as they are, will often make them ineligible for cash assistance or Medicaid. For example, an analysis of the labor market experiences of

workers who were hired at low wage rates in the mid to late-1980s found that only about 9 percent of new low-wage (less than \$5 per hour) workers received health coverage through their employers initially. Another 46 percent received coverage from another source (e.g., a spouse's coverage), and 45 percent had no coverage at all. Coverage through spouses would be unlikely for AFDC recipients, who are primarily single mothers and children. The researchers found that for those low-wage workers still employed after one year, nearly one-third remained uninsured (Congressional Budget Office 1993).

A continuation of recent trends of declining employer-sponsored health coverage will exacerbate the access problem for welfare recipients entering the labor force. For example, the proportion of children under 18 years of age covered by private health insurance declined from 73.6 percent in 1987 to 65.6 percent in 1994 (Census Bureau, 1996).

Of those receiving employer coverage, in how many cases will the coverage extend to dependents? Will the cost-sharing obligations of the worker be affordable?

Even if employers offer coverage, the employee share of the premium may be more than these generally low-wage workers can afford. Employers of low-wage workers are especially unlikely to make generous contributions to the premiums of dependents.

Of those working in jobs without private employer-sponsored coverage, how many will benefit from transitional Medicaid, and for how long?

States are required to continue to provide Medicaid coverage for people who become ineligible for Medicaid. Transitional Medicaid is extended for a year if the ineligibility results from increased earnings or employment and for four months if the ineligibility results from increased child support.

After transitional Medicaid falls away, will the children continue to be covered by Medicaid?

This will depend on whether the parent's income remains under the poverty line, in which case automatic coverage for children up to age 12 is provided. Children may also continue to be insured by state-only children's program with eligibility levels above the poverty line (Note: these programs may provide only partial coverage, e.g., for preventive services). As long as the income of the family is less than the federal poverty line, children up to age 12 can receive Medicaid, even though the parent's coverage will end when transitional Medicaid benefits are exhausted.

At the same time as rules are changing under welfare reform, looming changes in the Medicaid program could result in sweeping changes in who gets covered, what services are covered, and for what period of time. Tight limits on federal spending growth will inevitably lead to cutbacks in eligibility and/or scope and duration of covered services once inefficiencies are squeezed out of the system.

Congress is now considering reductions in Medicaid spending in the range of \$60 billion to \$70 billion over a six-year period. These cutbacks in the growth of Medicaid spending will add significant challenges and intensify the negative impact of welfare reform on

health coverage. In addition, some in Congress favor converting Medicaid from an open-ended entitlement to a federal block grant to the states, with annual funding increases that are much lower than the actual spending increases over the past several years.

Labor Market Implications

What effects might this influx of former welfare recipients have on labor markets? While 2 million new workers represent only 1.6 percent of total U.S. employment, they will be concentrated in the low-wage sector of the economy. Whether they will get jobs and how this addition to the labor supply will affect other workers depends on a number of factors. Perhaps the most important is the health of the economy at the time. Clearly, a growing economy can more easily absorb new workers, both because the number of jobs is increasing and because as labor markets tighten, employers may be willing to hire people with somewhat lower levels of qualifications. Since most of the previous welfare recipients will have limited job skills, they will be entering the labor force at the bottom. Most would probably not qualify for jobs that pay much more than the minimum wage, so their addition to the labor supply would probably not have a significant depressing effect on wages. The scheduled increases in the minimum wage would, however, probably make it somewhat more difficult for these new labor market entrants to find jobs, since the productivity of some may not be high enough to justify employers' paying the minimum wage. Even when employers can profitably hire such workers at the minimum wage, it will be difficult for them to offer health benefits since that adds significantly to their cost of employment. The new workers will, of course, be competing with other low-wage workers, making it more difficult for these existing workers to find work when they leave a job and constraining upward pressures on wages in the low-wage sector that might be present in a tight labor market.

Recommendations for Smoothing the Transition from Welfare to Work

States, counties, and cities will need to develop a variety of new strategies for assisting people making the transition from welfare to work. First, many people will need help in preparing a resume, answering interview questions, developing self-esteem, learning acceptable work habits, using computerized listings of jobs, and so on. Others would be greatly helped by getting a high school diploma or a GED. And a substantial number of people are dealing with substance abuse problems (either their own or those of family members), and family violence, etc.

Many people who will be sanctioned for noncompliance or terminated because they reach the cash assistance time limits will not be prepared for work. States need to refine their capability to distinguish welfare recipients who are job-ready from those who are not. For those who are not ready, states need to figure out who can become job-ready with just a short course in the basics of how to interview, dress for work, etc., who requires drug rehabilitation, treatment for mental illness, and related assistance, and who needs

remedial education and training. Of course, the alternative is just to throw everyone terminated or sanctioned into the pool, but many are likely to be unable to swim. They will still be a drain on public resources, and in many cases, the children will suffer because of either the noncompliance or the limited skills of their parents.

This is not to suggest spending billions of dollars on job training programs, which have shown mixed results, at best. Instead, states should develop ways to assess and track people leaving welfare, recognizing that some may have a much better chance of achieving independence if various support services are provided. Such assessments are not inconsistent with a “work-first” approach and, indeed, can help make such a strategy realistic and achievable.

Some states do not have data systems that are geared to tracking the experiences of people leaving welfare for work. In order to understand the types of strategies that are working, states will need information on both the costs of work readiness and job placement programs and the associated savings, in the form of reduced public assistance payments and increased tax collections.

States should consider using private contractors to help place welfare recipients in jobs. States need to develop specifications for such work and to build in reporting requirements that facilitate assessments of the cost-effectiveness of different strategies. They also need to develop performance-based contracts that reward outside contractors for placing and retaining welfare recipients in jobs. Instead of being paid for effort, irrespective of the outcome, contractors should be paid for results. Thus, states need to learn how to share risk with providers in welfare-to-work initiatives just as they are learning how to do this in Medicaid. The experience gained from an initiative undertaken by the state of Indiana and the city of Indianapolis should provide useful guidance. The state and the city have contracted with private contractors to train and place welfare recipients in jobs, and have introduced elements of performance-based contracting into their agreements (Meyer et al. 1996).

States should also recognize that many welfare recipients—and the private organizations who contract to place them in jobs—are not well acquainted with transitional benefits. States should work with such contractors, and directly with recipients, to familiarize them with the terms of the Earned Income Tax Credit, transitional Medicaid, child care assistance, and other benefits for which people making the transition from welfare to work will qualify.

These are some of the challenges that states face as they struggle with placing people terminated from cash assistance into the world of work. The balance of this report addresses how states can help assure access to health care for those making this transition—both for those who get a job and those who do not, as well as those who lose the job they initially obtain.

Demand Side Strategies

Assuring that People Leaving Welfare Can Retain Public Coverage or Afford Private Coverage

With added flexibility for states under welfare reform and perhaps Medicaid reform, the extent of the loss of health coverage will depend largely on what individual states decide to do. States will need to address an increasing demand for health care with fewer dollars. There will inevitably be reductions in eligibility and scope or duration of Medicaid coverage.

Some states are experimenting with innovative approaches to move people off cash assistance, while protecting their Medicaid coverage. A number of states are conducting Medicaid demonstration projects under federal waivers that attempt to expand eligibility for coverage while containing costs. Some states have initiated special programs targeting uninsured children and others outside the Medicaid program. It is instructive to examine these kinds of approaches, as this may provide lessons about the kinds of actions more states could initiate now that national welfare reforms have been enacted.

Lesson 1: Transitional Medicaid and child care are important sources of protection for people losing cash assistance.

Since 1990, states have been required to extend Medicaid coverage for twelve months to families who stop receiving AFDC due to increased earnings and for four months for those who become ineligible due to increased child support. For increased earnings, transitional coverage must be provided without a premium contribution by the beneficiary for the first six months. For the second six months, states must provide coverage for families with incomes below 185 percent of the poverty line, but they may ask the beneficiaries to share the premium cost if their incomes exceed the poverty line.

Transitional Medicaid also requires a family to meet other requirements:

- The family must have received AFDC for at least three of the six months prior to losing AFDC eligibility.

- The family must have lost AFDC coverage as a result of some improvement in employment condition (e.g., increased income from employment, increased duration of employment).
- The family must have a dependent child in the home.

Provisions for transitional Medicaid have reduced some of the disincentives for welfare recipients to obtain employment since many low-wage jobs do not provide employer-sponsored health coverage, as noted above. Many states that have received federal waivers involving time limits on cash assistance or other welfare reforms have also expanded the transitional Medicaid period.

At least twelve states have increased the duration of transitional Medicaid to two years. Two states, Virginia and Vermont, have increased the program to three years for families with incomes below 150 and 185 percent of poverty line, respectively. Wisconsin’s new welfare reform plan, Wisconsin Works, has no time limit on transitional Medicaid assistance, although it does have an income cap on eligibility.

Eight states have eased their eligibility requirements for transitional Medicaid. For example, Pennsylvania and South Carolina have increased the maximum income a family may have and still participate in transitional Medicaid. Pennsylvania raised the limit to 235 percent of the Federal poverty level; South Carolina uses 185 percent of poverty plus the cost of child care.

The 1996 welfare reform legislation extended the transitional Medicaid program until 2002. This program had been scheduled for “sunset” provisions in 1998.

Examples of innovative transitional Medicaid programs

- Under the Wisconsin Works (W-2) program, cash assistance is limited to 24 months within a four-year period, with some exemptions. Education (e.g., referral to a GED program), child care, and training are provided during the first 12 months, and work experience—unsubsidized or partially subsidized—may be required. Transitional child care, Medicaid, and food stamps are indefinitely available for families with incomes up to 165 percent of the poverty line. Child care and Medicaid are also available on a sliding-scale basis for families with incomes exceeding 165 percent of the poverty line.
- Implemented statewide in July 1994, Vermont’s Welfare Restructuring Project (WRP) requires unemployed parents receiving AFDC to participate in subsidized community service jobs after the 30th month (15th month for AFDC-UP recipients); requires pregnant and parent minors to attend school or training activity; provides a permanent earned income disregard; eases AFDC-UP eligibility; and institutes other changes. As noted earlier, WRP extends transitional Medicaid coverage for 36 months, or until a family’s income reaches 185 percent of poverty, whichever comes first.
- Nebraska’s Welfare Reform Waiver Demonstration provides transitional Medicaid for up to 24 months to families who lose AFDC due to employment or the state’s 24 month time limit on cash assistance.
- California extends transitional Medicaid to families that lose AFDC eligibility when marriage or reunification of spouses increases income or assets above the eligibility thresholds.

- Both Connecticut’s A Fair Chance program and Delaware’s A Better Chance program extend transitional Medicaid benefits to 24 months.
- Both Kansas and Maine will extend transitional Medicaid for up to 24 months. Kansas will also eliminate quarterly reporting, income, and continuous employment requirements. Both states would institute copayments for the second 12 months (e.g., 25 percent in Kansas); this would essentially constitute a “buy-in” to the Medicaid program for former recipients (CRS 1995).

Transitional child care assistance is also an important factor in aiding individuals as they leave welfare. This assistance eases the economic hardship of paying at least \$4000 annually for child care on an annual entry-level salary, which is typically in the range of \$13,000 for people leaving welfare to work (Meyer et al. 1996). The welfare reform bill consolidated seven former federal child care programs into a single block grant to states with two funding sources. It also authorizes \$22 billion in funding over the next six years, of which \$14 billion is mandatory. This represents a \$3 billion increase above current levels of funding.

The importance of transitional benefits is illustrated by the example (shown in the table below) of a single parent with two children receiving a salary of \$13,551 (the income level at which such an individual becomes liable for federal taxes). This family can obtain a \$3,600 Earned Income Tax Credit (EITC). From a total income of \$17,151, a single parent would likely pay at least \$5000 a year for health insurance and at least \$4000 a year for child care (these are conservative estimates). In other words, half of the parent’s total income is spent on these necessities before food or rent has been paid. Transportation is often an additional expense. Thus, the prospect of losing Medicaid and child care assistance is daunting and highlights the importance of transitional Medicaid and child care benefits for low-wage workers coming off cash assistance.

Figure 1: Sample Annual Budget for a Single Parent of Two Children After Transitional Benefits End

Resources	
Salary	\$13,351
Earned Income Tax Credit	\$3,600
<i>Total Resources</i>	\$17,151
Expenses	
Health Insurance	\$5,000
Child Care	\$4,000
<i>Total Expenses for Former Benefits</i>	\$9,000
Net Income Available for All Other Living Expenses	\$8,151

States may want to be cautious, however, about extending Medicaid benefits indefinitely to working families. If they do this, some private employers may be encouraged to switch their workers from their own health plans to the government’s program. Take the case of a low-wage employer paying the average wage of \$6 an hour. If the annual cost of health

insurance to the employer is \$4000 per family, this represents a 33 percent add-on to the \$12,000 annual wages each worker receives. It might occur to the employer to strike a deal with employees under which their wages increase to \$6.50 an hour and they all switch to Medicaid. In this case, both the worker and the employer are better off than before: the worker receives \$13,000 a year instead of \$12,000 and has Medicaid coverage, which is almost always more generous than private coverage (particularly in the case of low-wage employees). The firm has a net savings of \$3,000 per worker (\$4,000 in saved health contributions less \$1,000 in additional wages). Of course, switching to Medicaid could occur under a program with clearly defined time limits, but it seems less likely that employers would be moving back and forth under these circumstances.

The new plan to cover children in Massachusetts, described below, guards against employers off-loading their workers to public coverage by denying eligibility to people enrolled in a private health plan in the eighteen months prior to applying for state coverage.

Recommendation 1:	Eligibility for transitional Medicaid benefits should be greater than one year. Adequate support for child care is also essential. This extension could appropriately vary in length, depending on the use of other work incentives such as the income disregard, other transitional benefits such as child care, and the administration of the program. Transitional benefits with no time limit, however, could lead to people switching from private to public coverage. States also should also consider taking advantage of their option to consolidate their Medicaid application process with the application for cash assistance under the TANF program.
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Lesson 2: Section 1115 waivers have provided an important mechanism for states to expand Medicaid eligibility in innovative ways.

States can use section 1115 waivers to expand Medicaid eligibility to lower-income people who would otherwise not qualify, thereby reducing the number of uninsured. The expansion of coverage must be accompanied by initiatives to move low-income families into managed care plans. The waiver process could be a key option for states to protect vulnerable populations if welfare reform leads to additional losses of Medicaid coverage under the program's basic eligibility criteria.

Between 1991 and June 1995, ten states received federal approval for 1115 waivers. Unfortunately, obtaining an 1115 waiver can be a long and onerous process, and approval is for a limited amount of time.

The Congressional Research Service has analyzed several policy options that could streamline the waiver approval process:

- Relax certain rules that states consider unduly restrictive. Congress could repeal or modify certain restrictions that may discourage creative improvements in the Medicaid program. These include a requirement that to establish a managed care plan, risk contractors must have 25 percent private enrollment, and beneficiaries must be allowed to change plans at any time.
- Establish a new waiver authority for projects that expand access and meet certain guidelines. Congress could enable states to make certain types of changes that meet quality, access, and financial standards without undergoing a lengthy waiver approval process. For example, managed care, primary care case management, and modification of covered populations or benefit packages could be automatically allowable if the standards are met.
- Establish a mechanism for making waivers indefinitely renewable. The waiver process could be modified so that at the end of a waiver period, state demonstrations could be automatically renewed if they continue to meet specific conditions and standards. This would change the concept of the waiver program from a mechanism for experimentation to a means for real program reform. (CRS Report 1994)

Demonstration waivers could be used to establish a “buy-in” to Medicaid, permitting people with incomes above traditional Medicaid standards to obtain coverage and share the cost on a sliding-scale basis. An important issue here is how to structure the beneficiary contribution to premiums and copayments and deductibles so that the program is financially viable while cost-sharing is affordable. The waiver could also be used to expand the income threshold for certain sub-populations, or for expanding eligibility while limiting covered services. A key question here is what services should be included in the benefits package. How can the package be kept affordable while not cutting back on services that are cost-effective? Another important issue involves how long coverage should be extended. A number of states have been able to build in strategies to promote the transition to employer-sponsored coverage.

Examples of states operating 1115 waiver programs

- Oregon - Medicaid eligibility is expanded to people with incomes up to the federal poverty level while coverage is limited to a list of services that excludes certain less cost-effective services, as determined by a public priority-setting process.
- Hawaii - Medicaid eligibility is expanded to people with incomes up to 300 percent of the federal poverty level, with cost sharing for most residents above the poverty level.
- Tennessee - Medicaid eligibility is expanded to uninsured people, regardless of income, with cost sharing for those with incomes above the federal poverty level. (To manage the process, the state is currently enrolling people who are Medicaid eligible or considered “uninsurable.”)
- Rhode Island - Medicaid eligibility is expanded to pregnant women and children up to age 6 with family incomes up to 250 percent of the federal poverty level (U.S. GAO 1995a).

Recommendation 2: To encourage more state experiments, the federal waiver process should be modified by relaxing certain rules that states consider unduly restrictive, establishing a new waiver authority for projects that expand access and meet specified guidelines, and establishing a mechanism for making waivers indefinitely renewable.

Lesson 3: Programs that channel Medicaid recipients into managed care health plans are potential sources of savings for financing Medicaid expansions, assuming that the legislative environment is consistent with operating efficient managed care plans. But states should have realistic expectations about the size of savings.

Many states have taken steps to enroll Medicaid recipients in managed care plans. The trend is likely to continue because the evidence shows that shifting recipients from fee-for-service providers to efficient managed care plans can produce significant savings. Through better coordination and management of care, such plans have been able to reduce utilization rates for medical services and to substitute less costly forms of care, for example reducing use of emergency rooms for non-emergent care and eliminating duplication or inappropriate combinations of prescription drugs. Public purchasers are appropriately following the lead of many private purchasers in promoting managed care as a significant tool for containing costs. But it would be a mistake to view managed care as a panacea for dealing with the health care cost problem.

Unfortunately, some states seem to have unrealistic expectations about the savings to be realized from managed care. Some states mentioned above and others receiving federal Medicaid waivers are assuming that they can finance their Medicaid expansions primarily through savings from moving enrollees into managed care plans. Tennessee's TennCare, for example, is intended to finance coverage of all low-income people who lack health coverage by switching people into HMOs and PPOs. Early experience indicated, however, that the state may have moved too quickly, enrolling greater than expected numbers of people into managed care plans with inadequate provider networks. Premiums were found to be 40 percent below actuarial soundness, providers were largely dissatisfied, and there were concerns that the state did not adequately monitor access and quality (Gage 1995; U.S. GAO 1995b).

States are finding, moreover, that they must supplement their financing from sources beyond savings from managed care, and they are using a range of mechanisms including disproportionate share hospital payments (DSH), new federal money, funds from other health programs, new tax revenue, and enrollee cost-sharing.

Savings from managed care are limited largely because of the difficulty in enrolling and properly serving the disabled populations—who account for about 70 percent of Medicaid costs—in managed care. Still, some states are more successful than others at realizing savings from managed care, and others can learn from them. For example, it has been found that savings are more likely when states use prepaid, capitated arrangements,

and when they negotiate low premium growth rates. At the same time, states are finding that they must offer “fair” payments in order to attract managed care organizations to participate (State Initiatives 1995).

In contracting with managed care plans, states should build in requirements not only for preventive and primary care services, but also for appropriate staffing and social services related to health that will meet the needs of high-risk, vulnerable populations (discussed further below).

In addition, states could maximize savings by avoiding legislation that raises the plans’ costs. Well-run, cost-effective managed care plans realize savings in a number of ways. They select, recruit, and retain physicians whose history of practice demonstrates that they provide high-quality care in a cost-effective, economical way. They attract such providers by guaranteeing them a high volume of business, often in exchange for somewhat lower fees per unit of care provided. The plans are able to make such guarantees because they limit their provider networks to just the needed number of providers given enrollment levels, and because they provide strong financial incentives for patients to get care only from network providers. Unfortunately, a number of legislative proposals that have passed in some states and are being considered in others jeopardize managed care plans’ capacity to contain costs in appropriate ways:

- “Any willing provider” laws require managed care plans to accept any provider who meets their selection criteria and their participation requirements. Such laws thwart the efforts of plans to select only efficient providers and reduce the leverage of health plans over provider charges and practice patterns by diluting the volume of enrollees per provider. Administrative costs also increase because the provider networks are larger, more providers must be educated to meet the plan’s requirement and monitored to ensure they conform to these requirements, and separate paper work related to billing and payment is required for each provider.
- “Freedom-of-choice” laws force health plans to provide consumers with unrestricted freedom of choice in their providers, thereby thwarting efforts to form limited networks of cost-effective providers and thus raising costs.
- “Fair reimbursement” laws limit or prohibit differentials in payment to network and non-network providers, thereby largely eliminating financial incentives for enrollees to select network providers, who generally accept lower reimbursement rates and keep plan costs down.
- Scope-of-practice limitations block the expanded use of allied medical personnel in cost-effective ways.

While it is reasonable to look to managed care and other efforts to improve efficiency as the first step to realizing savings, as a last resort, states may have to consider shrinking the benefit package in order to serve a broader number of lower-income families. Currently, families receiving Medicaid receive very comprehensive coverage, enjoying some benefits that many employer-sponsored plans lack. Indeed, serious equity problems can result from providing the most expensive package of health benefits to the non-working poor while providing no help with health care expenses to the working poor.

These equity problems can continue as people leave welfare for work and receive transitional Medicaid. If Medicaid coverage is more extensive than employer-provided coverage, then a worker who recently left welfare to work will be better covered than the worker next to her who was never on welfare. This argues for bringing Medicaid benefits in line with employer-sponsored benefits and using the savings to assist more people.

States should make every effort to finance a broadening of eligibility through enrolling Medicaid beneficiaries in managed care plans. But if this strategy, coupled with other sources of new funding, falls short of financing help for additional needy families, some reduction in the level of public subsidies per household should be considered so that more people can become eligible for coverage. A more basic benefit package for all in need would be preferable to expensive help for some and no assistance for others equally situated. It should be noted that this approach is consistent with both trimming coverage in areas with marginal benefits and expanding coverage in areas shown to be cost-effective. Examples of such cost-effective expansions are highlighted in the next section. The important point is that states may need to *prioritize* services based on cost-effectiveness in order to serve as many people as possible within a given budget.

The state of Oregon provides perhaps the most prominent example of a state that has taken this approach. Following a long deliberative process that included a great deal of input from the public, the state created a ranking of all Medicaid services in order of priority based on cost-effectiveness and other criteria. Having decided to cover additional people under a defined budget, the state then drew the line at the point in the list of services that was consistent with meeting the budget limit.

Recommendation 3: States should continue to use innovative methods to expand coverage, although they should be cautious about relying too heavily on savings from managed care to finance the expansions. To promote savings while encouraging provider participation, states pursuing managed care should negotiate fair, capitated payments and caps on premium growth in future years. They should ensure that the provider networks are adequate for the enrolled population, and that quality control and access monitoring mechanisms are securely in place.

States should be careful not to enact laws that work against the very types of cost savings that they are trying to achieve through managed care. They should also consider trimming the benefit package to help finance coverage for the working poor if managed care savings are inadequate.

Lesson 4: Scheduled expansions of Medicaid coverage for infants, children, and pregnant women have been an important source of coverage for low-income people.

In the 1986-1990 period, Congress passed a number of laws that expanded Medicaid eligibility for infants, children, and pregnant women. The laws made children eligible for Medicaid on the basis of income and age, even if they are not receiving AFDC. Currently, states are required to:

- cover pregnant women, infants, and children up to age 6 with family income at or below 133 percent of the federal poverty level;
- expand coverage to poor children over age 6 by one year of age each year so that all poor children up to age 19 are eligible by the year 2002 (in 1996, poor children 12 years of age and under are eligible for Medicaid) (GAO 1995b).

These changes could protect some of the children that will lose AFDC benefits under welfare reform. There has been an increase in the number of children covered by Medicaid. In 1994, over two-thirds of working poor children who received health care coverage received it from Medicaid (Kids Count 1996). However, there was no decrease in the number or percentage of uninsured children because the number of children with employer-based coverage continued to decline. In fact, 27 percent of children from working poor families are neither publicly nor privately insured (Kids Count 1996). Nevertheless, Medicaid expansion provisions would help to protect most poor and many near-poor children as their parents leave welfare for work.

The proposed Medicaid block grant under HR 2491, pending in the House Committee on Budget, and the governors' reform proposal, however, would freeze the guaranteed expansion of children's coverage at age 12. Some of the children and pregnant women cut from AFDC would have re-qualified for Medicaid coverage through this expansion. Freezing the expansion could deny Medicaid coverage to approximately three million teenagers who would otherwise be eligible for the program in 2002. In fact, it is this group of children who are most vulnerable to an array of problems related to health, drug and alcohol abuse, pregnancy, violence, and mental health—and who would suffer greatly without coverage.

Recommendation 4: Any federal Medicaid reform legislation should maintain the current expansion schedule to cover all poor children, up to age 19, by 2002. If this does not occur, states should try to continue the previously scheduled expansion on their own.

Lesson 5: Children's health insurance programs have great potential as a mechanism for expanding coverage at relatively low cost.

Minnesota was the first state to establish a children's health insurance program unrelated to Medicaid expansions. Twenty-two more states have begun similar programs, many as

public-private partnerships. Fourteen states subsidized coverage to uninsured children who were ineligible for Medicaid in 1995. Altogether, thirty-one states had either a publicly or privately funded program that provided health insurance coverage for children. In 1994, those programs enrolled from 39 to 98,538 children with budgets ranging from \$240,000 to \$71.5 million (GAO 1996). Many of the children who enroll in state health insurance plans are dependents in working families.

States have financed the programs through cigarette taxes, taxes on health care providers, enrollee premiums or copayments, and/or Medicaid dollars obtained via Medicaid section 1902(r)(2) (The Medicaid Letter 1995). The newest children's coverage program was enacted in Massachusetts, and is funded by an increase in cigarette taxes (see box insert). At least 20 states have implemented Caring programs, which provide coverage to uninsured children using primarily private funds or donations, and are often administered by Blue Cross/Blue Shield plans. (State Initiatives 1995).

Massachusetts Act for Improved Access to Health Care

- The recently passed legislation provides for a \$0.25 excise tax per pack of cigarettes. Revenues raised will establish the Children's and Senior's Health Care Assistance Fund, a fund intended to wholly support the costs of extending full or partial medical benefits under the MassHealth to low-income individuals ineligible for Medicaid.
- MassHealth extends insurance coverage to all children in low-income households who are neither privately nor publicly insured by providing :
 - full medical benefits to children through the age of twelve whose financial eligibility as determined by MassHealth does not exceed 200% of the federal poverty level.
 - full medical benefits to children ages thirteen through eighteen whose financial eligibility as determined by MassHealth does not exceed 133% of the federal poverty level.
 - partial medical benefits to children thirteen through eighteen whose financial eligibility as determined by MassHealth exceeds 133% but not 200% of the federal poverty level.
- MassHealth also provides insurance coverage to adults aged nineteen through sixty-four whose eligibility as determined by MassHealth does not exceed 133% of the federal poverty level and are otherwise ineligible for Medicaid.
- MassHealth may deny eligibility to:
 - persons with incomes in excess of 133% of the federal poverty level who were enrolled in a health insurance plan not administered by a state or federal government in the eighteen months prior to applying to MassHealth.
 - persons who, at the time of application, are eligible for employer-sponsored insurance.
 - noncitizens (MassHealth must deny eligibility to persons establishing state residency solely for the purpose of receiving medical benefits).
- MassHealth will establish premium and copayments on a sliding scale basis commensurate with beneficiary income levels.
- Availability of MassHealth benefits is contingent upon budget neutrality of the project, that is, the revenues for MassHealth must be solely provided for by the revenues of the cigarette tax.

Eligibility requirements for children's health plans vary from state to state; some include only young children, for whom health costs (immunizations, well-child visits) are relatively low, and some extend eligibility to adolescents and teenagers. To discourage families from dropping private coverage, many states prohibit anyone from giving up employer-based coverage in order to enroll in the state subsidized program.

Income requirements vary as well, from less than 100 percent of the federal poverty level (Virginia) up to 275 percent of the federal poverty level in Minnesota. Some states base their contribution levels on the enrollee's income, with full subsidies provided only to those below a certain income. These "buy-in" programs have expanded coverage while limiting the added financial burden to the states.

State children's health plans generally cover preventive and primary care services because these are deemed cost-effective. They include immunizations, routine examinations, blood lead level screening and treatment of minor outpatient illnesses. Some states cover additional services, with Minnesota's program providing comprehensive coverage including inpatient and outpatient services, drug treatment, and dental care.

In addition to providing needed health coverage, state and community health plans can have a favorable impact on welfare rolls. Promise of health coverage through the plans alleviates the fear of losing Medicaid if one leaves AFDC. MinnesotaCare reduced AFDC caseloads by 4 percent in 1994 (State Initiatives 1995).

Examples of state and community health plans for children

- What began as the Minnesota Children’s Health Plan in 1988 has expanded enrollment to adults who can’t afford health insurance but do not qualify for Medicaid. It is a buy-in program with a sliding scale fee schedule for those with a family income up to 275 percent of the federal poverty level. The state-subsidized MinnesotaCare program enrolled over 88,000 individuals at the end of 1995, and continues to receive 2,000 applications per month. The program has also expanded covered services. Children participating in this program were transferred to Medicaid on July 1, 1995, under the auspices of Minnesota’s 1115.
- Vermont began its “Dr. Dynasaur” program in 1990 to cover uninsured children up to age 6. Dr. Dynasaur was then integrated into the state’s Medicaid program in 1992 (through section 1902 (r)(2) options), and expanded the age limit to 18. This change provided the state with additional federal dollars to extend coverage to more children. The program also includes children who have some private insurance but who are “underinsured;” these children can use the state program to pay for copays and other services not covered under their private plan.
- New York’s Child Health Plus Program provides buy-in coverage for children under 15 at all income levels. Full subsidies are provided for families with incomes below 160 percent of the federal poverty level, and partial subsidies are provided for families between 160 percent and 222 percent of the federal poverty level (GAO 1996).
- Pennsylvania’s Children’s Health Insurance Program uses a combination of a 2-cent cigarette tax and privately funded programs to cover children through age 15 in families with incomes up to 185 percent of poverty, and children through age 6 up to 235 percent of poverty who are Medicaid ineligible. As of July 1995, 49,634 children were enrolled, 97 percent of whom had incomes at or below 185 percent of the federal poverty level (coverage is fully subsidized). Its Caring Program for Children, financed through donations and administered by Blue Cross of Western Pennsylvania, serves over 23,000 16-19 year-olds. A similar state program, BlueCHIP, financed through a 2-cent cigarette tax, serves younger children not eligible for Medicaid (GAO 1996).
- In 1992, the Florida Healthy Kids Corporation began enrolling children into a comprehensive, school-based health insurance program. Piloted in six Florida school districts, the program targets uninsured and underinsured children, although the coverage is also available to other family members when a child is enrolled. The schools provide the vehicle for establishing a group, administering the program, and marketing. The coverage is subsidized, with sliding scale premiums tied to family income (a similar model to the school lunch program). Early assessments are very favorable; findings from an evaluation of the program included
 - a dramatic decline in emergency room use of 70 percent;
 - a significant drop in the number of uninsured children; and
 - a decline in costs two years into the demonstration of over 20 percent from original estimates, as against the 24 percent increase that demonstration planners had originally expected (Abt Associates 1995)

Recommendation 5: With children’s health plans being less expensive and enjoying greater public support than programs for adults, these programs should be encouraged at the federal, state, and county levels. Once established, they can be used as stepping stones for expanded programs that cover uninsured adults.

Lesson 6: Employer-based coverage is the predominant way in which Americans get health coverage. In the absence of sweeping federal reform, efforts to cover the working poor will probably need to rely on employer-based coverage.

Most American families get health insurance as a benefit of employment. It seems quite unlikely for the foreseeable future that employer-sponsored coverage will be replaced by any other system for the employed population. This alone would be sufficient reason to look to expansions of employer-based coverage as a way of extending coverage for the working poor. It is also necessary to consider employer-sponsored health coverage as a policy option to address welfare reform's effect on health insurance coverage for three other reasons:

- employer-based insurance coverage has been declining;
- most uninsured people are in families with a working person; and
- most people entering the workforce as a result of welfare reform will be entering low-pay, low-skill jobs that often do not provide health coverage.

Clearly, many people who lack insurance could be helped by policies which either encourage or require employers to offer health coverage and finance at least a portion of the cost. Some states are using tax incentives or direct subsidies to encourage companies to provide insurance. Yet a review of state-sponsored premium subsidy programs for new insurance purchasers found no effect on coverage. One of the reasons cited for this poor performance was the failure to inform small employers of the available financial assistance. Another reason was that employers did not trust that the subsidy would be retained in the future (HCFO News & Progress 1995).

Traditional employer-sponsored group health insurance may not, in fact, be the best "fit" for the low-wage, former welfare population who tend to switch jobs frequently. Even if all employers were required to provide direct coverage, workers and their families would need to switch health plans, and most likely, their health care providers, whenever they change jobs.

If employers are to play a larger role, a more appropriate model is one in which they contribute to the purchase of insurance coverage that is portable—that is, individuals retain the same health plan even as they move from job to job. Similar to a "Health Insurance Purchasing Cooperative (HIPC)" model, some entity would contract with a health plan (or multiple plans) and make coverage available to participating individuals. Premiums would be paid through employer and employee contributions, with public subsidies to help cover the cost of part-time workers and short periods of unemployment. Consideration could be given to linking such a program to the Medicaid program.

This model would clearly be more effective if all employers were required to contribute to the insurance fund if they do not provide direct coverage. The disadvantage is that such a requirement increases the cost of labor—similar to an increase in the minimum wage—which could lead to layoffs, particularly among the kinds of (low-wage) jobs former welfare recipients are likely to get. Subsidies for low-wage companies could mitigate the potential negative impact on jobs.

The passage of the Health Insurance Reform Act of 1996 (Kassebaum-Kennedy bill), scheduled to go into effect in October 1996, promotes such access to health insurance by ensuring that health coverage is portable as workers switch jobs. Insurers cannot delay coverage or refuse to cover someone with a preexisting condition, provided that an individual has had health insurance coverage for twelve months. Workers can leave their jobs for another job without fear of losing health coverage, even if the worker or a family member suffers from a chronic illness. While the Kassebaum-Kennedy bill eases the hardship and difficulty affiliated with changing health insurance, the legislation does not help the millions of people who lose their jobs for longer than sixty-three days, nor does it affect the 40 million Americans who currently lack health insurance. The health legislation neglects the individuals who float in and out of the job market, caught in longer spells of unemployment. These are often the individuals who need health insurance most urgently. Finally, the bill cannot do anything to expand coverage to the employees who work for employers that offer no insurance or to employees who are too poor to pay the employee portion of the premium (even when the premium is not extraordinarily high).

State Efforts to Aggregate Purchasing for Small Employers

Some states have initiated programs to aggregate employer and employee purchasing power for purposes of buying health coverage. California formed a HIPC for small businesses (2-50 employees). The HIPC does not itself purchase coverage. Instead, it contracts with more than 20 health plans statewide, and employers that participate with the HIPC allow each employee to choose any health plan from those available in the area. Premiums are financed by employer (minimum 50 percent) and employee contributions. Similarly, Kentucky instituted a HIPC that is open to small businesses (up to 50 employees). The Kentucky purchasing arrangement also provides coverage for all state and school district employees and is open to municipalities and universities. The enabling legislation also requires that consideration be given to including Medicaid recipients at some future time.

These and other similar efforts—a number of which have been initiated by private employer coalitions rather than state government—have been able to make coverage available to a number of small businesses and their employees at rates that appear to be lower than what would otherwise be available. The lower rates can be attributed in part to aggressive negotiations with health plans regarding premiums and in part to lower administrative costs that result from centralized enrollment, premium collection and distribution, and lower marketing costs. But these programs' success in expanding access to *uninsured* workers has been quite limited. The result is not surprising, however, given that employer participation is voluntary, and many employees cannot afford coverage (employers choosing to participate in California are responsible for contributing only half of the lowest-cost premium).

Such efforts may be particularly helpful in bringing down the cost of coverage for the smaller businesses that are likely to employ many of the people coming off welfare. Such businesses have often faced high health insurance premiums, in part because of the high administrative costs health plans incur in marketing to and servicing small employers. Arrangements for aggregating purchase of coverage for such small firms, as in California

and Kentucky, can reduce costs for such firms because the purchasing cooperative takes over some of the administrative functions and realizes economies of scale. As noted, premiums costs may still be unaffordable for many small firms and their employees, which means that state subsidies may be the only way to extend coverage. But the subsidy dollars will go further if employers and employees are purchasing through the HIPC or a similar joint purchasing arrangement, since more of the dollars go to pay for medical care rather than for administrative costs.

It is important to note that efforts of this sort that pool the purchasing power of many small businesses can be successful only if legislative rules governing the conduct of insurers in the small-group market constrain the behavior of all insurers to prevent them from skimming off the low-risk people. Essentially, these HIPCs cannot survive if they agree to take on all applicants, regardless of medical condition, unless other insurers are required to do the same. Otherwise, the HIPC will become the insurer of last resort and will get all the high-risk people that other insurers wish to avoid because they incur high medical bills. The recently passed federal reform legislation provides much of the needed protection, particularly by mandating that insurers guarantee to issue coverage to all small-group applicants (after a waiting period for certain conditions for people who were not previously insured) and preventing insurers from dropping coverage for groups that have high-risk employees. But the federal legislation does nothing to prevent insurers from charging very high rates to higher-risk groups. If other groups can do this, HIPCs will be required to do so also to keep their rates competitive for lower-risk groups. States that have not already done so may need to pass legislation to address this issue if HIPCs are to be able to keep premium rates at reasonable levels for higher-risk groups.

Recommendation 6: In the short term, states could encourage small employers to contribute to workers' coverage directly or could offer subsidies to employers meeting specified criteria. States need to target small firms in a publicity campaign to inform them of this new option; they must offer enough of a subsidy to be attractive; and they should guarantee the continuation of the subsidy for a period of years.

In the long term, states should consider requiring employers that do not provide coverage directly to contribute to the cost of covering employees (with reduced contribution levels for part-time workers), through some kind of efficient pooling mechanism that would permit workers to retain coverage with the same plan if they change jobs.

Supply Side Strategies

Enhancing Access to Integrated, Comprehensive, and Efficient Health Care

The second set of options involves building up the supply side of the health care market to better meet the growing needs of former welfare recipients who either lose their Medicaid coverage or despite coverage, face barriers to timely access to health services. These policy options would also benefit a broader group of low-income individuals—whether they are uninsured, underinsured, live in underserved areas, or have a wide range of health and social service needs.

To meet the demands of a growing population in need will require some increase in resources, and this section of the report notes key areas where additional funding will be helpful. But more money alone will not solve the problem. The health care delivery system needs to be re-oriented and restructured to meet the special needs of the people trying to get off welfare and achieve self-sufficiency.

For example, an effort to meet the needs of people leaving welfare must address the mismatch between where lower-income families live and the location of the trained personnel and facilities that comprise the health care infrastructure. This will require strong efforts to bring the right kinds of providers to the right places, with active outreach strategies.

In addition, efforts to provide appropriate health care to this group must recognize that they often have a variety of risk factors beyond disease and illness that can adversely affect their health. These include substance abuse, mental illness, teenage pregnancy, and family violence. Barriers to receiving timely and appropriate care, such as a lack of transportation, language problems, and the lack of a regular source of primary and preventive care, complicate this picture.

To address these problems, health care will have to be effectively combined with social services through integrated delivery systems treating a cluster of problems that affect an individual's health. States should build these factors into their contracting with managed care organizations for their Medicaid populations. Communities also need to take such factors into account in helping people who lose Medicaid.

Lesson 1. To protect their ability to serve the indigent, public hospitals must adapt to market changes.

Public hospitals need to reshape themselves into more efficient providers of care in order to continue their mission to provide care to low-income populations.

The health care marketplace is rapidly changing, with payers placing greater pressure on all providers to control costs and better position themselves in a more competitive environment. Hospitals are acquiring each other, affiliating, merging—forming all kinds of alliances in an effort to share information systems, expensive equipment, and overhead. They are forming or entering managed care networks, and trying to be a part of more comprehensive systems serving broader geographic areas.

We have seen most of these changes occurring within the private hospital industry. Yet public hospitals are facing similar market pressures, plus others that make them particularly vulnerable and threaten their survival:

- Public hospitals have been steadily losing the private insurance revenues that in the past have cross-subsidized care for the indigent, as large private purchasers negotiate reimbursement methods that eliminate implicit subsidies.
- Proposed Medicaid reforms and a continuation of recent declines in employer-sponsored health coverage will increase the number of uninsured and, therefore, the demand for uncompensated care. Under the scenario envisioned in 1995 congressional Medicaid reform plans, uncompensated hospital care is projected to be 47 percent higher than under baseline estimates in 2002, reaching a projected \$43 billion (Thorpe et al. 1995). Welfare reforms leading to additional coverage loss would increase the demand even further.
- The future of the federal government's Disproportionate Share Hospital (DSH) payments, which have provided some \$17 billion annually to hospitals with a particularly large share of non-paying and low-paying patients, is in doubt.

If public hospitals are to continue to be the last resort for indigent patients, they cannot afford to sit passively on the sidelines as their revenues dry up and their uncompensated care demands expand. They need to become engaged in the market “revolution,” and work to become more efficient players.

One area ripe for improvement involves emergency rooms. Public hospital ERs often suffer from inefficiency, in large part due to great numbers of patients coming to emergency rooms for primary care and other non-emergency care needs. Many of these individuals are uninsured, or they have Medicaid coverage but lack a regular source of primary care in the community. The result is long waiting times and inappropriate use of expensive resources.

Some public hospitals strategies to reduce this problem

- Hennepin County Medical Center and Metropolitan Health Plan, a county HMO in Minnesota, have reduced inappropriate use of emergency services by instituting a telephone triage service, available after clinic hours and on weekends. The phone line is staffed by nurses, who provide medical information, make clinic appointments, and make referrals to appropriate providers including visits to Urgent Care or emergency department if necessary (Bluford and Johnson 1995).
- Santa Clara Valley Health and Hospital System of San Jose, California began a 24-hour pediatric advice telephone line in which nurses assess the situation, give parents advice, and arrange urgent care appointments when appropriate. In its first three months of operation, the advice line reduced inappropriate after-hours use of the Emergency Department by 52 percent and increased patient satisfaction. The health system plans to implement advice lines for geriatrics, adult medicine, and obstetrics/gynecology (Robitaille 1995).
- San Francisco General Hospital has implemented “Fast Track,” a new system for more efficient triage, registration, and treatment in the Emergency Department. It involves streamlining the registration process, designating specific hours and rooms for urgent care, and greater use of nurse practitioners and attending physicians to provide for patients’ urgent care needs. Patients are being treated more quickly, fewer patients are leaving without being seen, and staff morale is improved (Peri 1995).

For some public hospitals, emergency department reform is just one element of a comprehensive set of strategies aimed to strengthen their competitive position and hence their financial viability.

- The Maricopa Health System in Phoenix, Arizona recognized the need to retain its current health plan members, to market to new customers, to provide customer-friendly services closer to where members resided, and to begin developing partners to fill in services missing in the continuum of care or in geographical areas where the health system lacked facilities and providers. After developing a set of short-term and long-term goals, it embarked on an ambitious strategy including: promoting staff participation and recognition; enhancing communications with patients; improving member relations with health plan enrollees; and increasing presence/marketing in the community (Sapp 1995).
- Denver Health and Hospitals, a large integrated public health care system, responded to new market pressures with a major program called, “Excellence in Service Delivery - Being the Best.” It involved: identifying areas for improvement through patient and employee satisfaction surveys; developing goals and objective, measurable service delivery standards; training employees, with an emphasis on teamwork, good communications, and treating customers with respect; and monitoring the project to detect failures and celebrate successes (Meehan and Gabow 1995).

More public hospitals are moving in the direction of these leaders, but the process is slow and can be extremely difficult for those institutions that have never before seen themselves as “competitors” in a dynamic marketplace. These hospitals face numerous internal challenges that involve changing historical philosophies and attitudes about the role of a safety net provider.

A number of “competition tips” have been offered by Arizona’s Maricopa Health System to public hospitals trying to take a more proactive approach (Sapp 1995):

- Seek the commitment of and, if possible, a partnership with medical staff.
- Develop a strong primary care network.
- Assure that teaching programs support business goals.

- Integrate the delivery system, and integrate with your own health plan if one exists.
- Actively seek contracts with private and public third party payers.
- Market what you do well—i.e., promote “centers of excellence.”
- Assess geographic penetration, especially for primary care services.
- Never take existing patients for granted; if there is a payer source, there will be a competitor.
- Manage care—not just the services—of the patient.

Recommendation 1: States and counties should assist their public hospitals to become more aggressive and efficient providers of care. This could include technical assistance and training for management, which could be facilitated through such organizations and agencies as the National Association of Public Hospitals, or the U.S. Department of Health and Human Services’ Health Resources and Services Administration, which offers similar services to community health centers (discussed below).

Also, Medicaid reform should stipulate that states’ ability to reduce disproportionate share hospital payments is contingent on the development and implementation of new programs that provide health care services to the uninsured or direct health-related subsidies to low-income people.

Lesson 2: Community and migrant health centers should be helped to expand and compete in a managed care environment.

A critically important component of the health care delivery system for millions of lower-income people, and particularly those without insurance, is the network of community and migrant health centers (C/MHCs) around the country. In 1996, there were some 627 “federally qualified” (i.e., they meet specific criteria and receive federal grants) CHCs serving about 8 million people (HRSA Fact Sheet 1996). There are also numerous non-federally qualified health centers and clinics receiving support from state and local governments and/or private charities and religious institutions. These clinics often operate on very limited budgets and, like the federally qualified centers, serve as providers of last resort for many individuals. Unlike public hospitals, which are intended to provide primarily tertiary and emergency care, community health centers and clinics are geared toward providing neighborhood-based, primary and preventive care services in traditionally underserved areas. A majority of those served are poor racial/ethnic minorities. Forty-four percent are infants, children and adolescents, and thirty percent are women and children of childbearing years. Seventy-eight percent of those being served are either Medicaid recipients or uninsured (HRSA Fact Sheet 1996).

The demand for community health centers has been growing and may escalate in the future. For example, legal aliens who lose their SSI, Medicaid, and Food Stamp benefits

will often be left without any health care safety net. The large six-year cutbacks in Food Stamps and Supplemental Security Income (SSI) payments, along with cuts in Social Services Block Grant (see Figure 2 below), will likely augment the demand for community health centers and public hospitals. In cases where people's income drops because they lose cash assistance and do not find work, their access to necessities of life will diminish and, as a result, their health can be expected to deteriorate. For example, the Social Services Block grant is scheduled to absorb over \$2.4 billion in cuts from the anticipated growth in its budget over the next six years. These spending reductions could affect programs such as Meals-on-Wheels, which delivers meals to people who can't leave their residences. Though some of the former recipients of government assistance will be able to utilize private resources, others will go without meal services. Malnutrition, a probable result, will lead to poor health outcomes and yield higher health care costs. A decrease in general nutritional well-being in the present will inevitably lead to higher health care costs in the future.

The only source of health care for many people in such situations is likely to be neighborhood clinics. Such clinics could be overwhelmed by a deluge of both AFDC recipients hitting their benefit time limits and eventually losing Medicaid and people with disabilities losing Medicaid as a result of losing SSI.

Figure 2: Outlay and Revenue Effects of Welfare Reconciliation Bill of 1996 (millions of dollars)

Program	1996	1997	1998	1999	2000	2001	2002	Total
Family Support Payments	0	868	882	897	762	456	-146	3,720
Food Stamp Program	0	-2,093	-3,939	-4,129	-4,194	-4,334	-4,568	-23,260
Supplemental Security Income	0	-6793	-3,526	-4,280	-4,824	-4,344	-4,958	-22,725
Medicaid	0	-38	-514	-567	-581	-948	-1,433	-4,082
Child Nutrition	0	-128	-403	-494	-553	-605	-670	-2,853
Old Age, Survivors, & Disability Insurance	0	-5	-10	-15	-15	-20	-20	-85
Foster Care	0	68	25	16	31	41	51	232
Social Services Block Grant	0	-375	-420	-420	-420	-420	-420	-2,475
Earned Income Tax Credit	0	-445	-456	-463	-480	-493	-515	-2,852
Maternal and Child Health	0	18	35	50	50	50	50	253

Source: Congressional Budget Office

Funding for other public programs that have traditionally supported the underprivileged community have also not kept pace with inflation in recent years. For example, funding to attract physicians into practicing in low-income areas through the National Health Service Corps is following a path of frozen or declining monetary allocation. Because of inflation, these numbers translate into a real budget cut. Similarly, funding for Maternal and Child Health Block Grant, a program which covers a wide array of health screening, preventive, and prenatal care services, faced a budget reduction of \$5.8 million in fiscal

year 1996. However, the recent welfare legislation did designate \$18 million in mandatory appropriations in 1997, rising to \$50 million in 1999, for Maternal and Child Health, a program which until now has been subject to annual review for discretionary funds.

Figure 3: Recent Funding Level of Major Program Components (millions of dollars)

Program	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997*
Primary Care Health Centers	683.1	734.6	756.5	758.1	757.1
Maternal and Child Health Block Grant	664.5	687.0	684.0	678.2	681.1
National Health Service Corps	116.2	124.0	117.2	109.5	113.0

* Administration's 1997 budget request

Source: Health Resources and Services Administration

According to the National Association of Community Health Centers, four out of five patients that receive health care at CHCs are already either uninsured or Medicaid-insured. Although health centers could be a final safety net for millions of additional uninsured individuals, the amount of resources available to health centers to meet the swelling demand is declining: For example, federal funding for primary health care centers, already diminishing through inflation since fiscal year 1994, is facing even deeper cutbacks in fiscal year 1997. Other changes are also likely to have a negative effect:

- CHCs' revenue base is likely to be diminished because proposed welfare and Medicaid reforms are projected to reduce the number of Medicaid recipients; the cuts will affect many of the 3.6 million current Medicaid-eligible users of health centers.
- States are making a major effort to move the majority of their Medicaid enrollees into managed care plans. Medicaid patients (along with the revenue they represent) are being siphoned off from many centers as managed care organizations develop networks of providers that do not include health centers. (Under Medicaid 1115 waivers, states are not required to include federally qualified health centers as managed care providers, although some states have included such a requirement.) Under proposed block grants, there is no federal mechanism to ensure that states include the health centers as managed care providers, and community health centers would likely lose even more of their paying patients.
- For CHCs' remaining Medicaid patients, the reimbursement rates will likely decline because expected reforms would eliminate the provision that requires Medicaid (and Medicare) programs to pay 100 percent of reasonable cost for services provided by federally qualified health centers.

This is not a call for clinging to cost-based reimbursement, which creates incentives to inflate costs and has been largely eliminated. Instead, we encourage CHC *integration* into the health care market through temporary fiscal measures that keep them afloat during a difficult transition period. This is not inconsistent with our disapproval of "any willing

provider” laws, for a functioning market favors its most efficient suppliers. However, there are positive externalities associated with the survival of community health centers, such as a decrease in unnecessary utilization of emergency rooms, that are unaccounted for and warrant greater federal support.

Health centers will be under pressure to serve a larger proportion of uninsured patients with a smaller revenue base. One way the federal government’s Health Resources and Services Administration (HRSA) is trying to address this problem is through HRSA’s Center for Managed Care, which provides training and technical assistance to health centers so that they are better equipped to participate in managed care networks. The Center for Managed Care provides training to hundreds of health center grantees to help them learn managed care techniques including management information systems, contract negotiations, rate setting, quality assurance, and marketing. HRSA also works on site with health centers to help them develop integrated services networks, which link hospital care with other health care and social services providers such as physicians, nurse practitioners, and therapists. As a result, there are 429 Community and Migrant Health Centers currently involved in developing or operating 147 C/MHC managed care networks in 41 states, and over 100 health centers are involved in managed care contracting, in most cases as part of an HMO’s network of primary care providers (HRSA Profile 1995).

These kinds of efforts must be expanded so that health centers avoid being left behind in the managed care revolution. Helping the centers make the transition to managed care is preferable to *requiring* managed care plans to contract with C/MHCs and other “essential community providers” (practitioners serving in low-income and underserved areas) or to reimbursing them for services provided to plan enrollees even if the C/MCH is not officially in the plan’s networks. Managed care plans would certainly oppose such regulatory influence in network determination, understandably fearing that they would lose control over the composition of their networks. If a decision were nevertheless to be made to require that health centers be automatically included in a network, the requirement would have to be carefully structured to avoid underwriting inefficiency. A better alternative to mandating inclusion of health centers would be to provide them with training in managed care techniques that would help them *qualify* for the networks that health plans establish.

An alternative to explicit mandates on managed care networks to include neighborhood health centers is for states to require that managed care plans have formal provisions for enrolling and serving vulnerable populations. The 1994 MinnesotaCare Law, for example, requires health plans to file annual action plans with the state that provide information about a number of access and quality-related issues. The plans must submit policies and procedures for enrolling and serving high-risk and special needs populations, which include but are not limited to people receiving Medical Assistance, General Assistance Medical Care, and MinnesotaCare; low-income people; those within certain racial, cultural and ethnic communities; chemically dependent persons; people with serious and persistent mental illness; the elderly; and others who are at high risk of requiring treatment (Minnesota Department of Health 1994).

Recommendation 2: Efforts should be enhanced to help both federally qualified and non-federally qualified community and migrant health centers adapt to the increasingly competitive managed care environment, and bring them into managed care networks. States should encourage managed care plans to team up with health centers and other essential community providers by requiring health plans, as a condition of licensing, to develop action plans for serving high-risk and special needs populations.

Lesson 3. Enhancing the supply of appropriate health care practitioners and services and expanding outreach efforts in underserved areas are critical steps toward improving access for millions of Americans.

An estimated 43 million people in the U.S. are without access to a primary care provider, and an estimated 72 million individuals live in designated “medically underserved and health professional shortage areas” (Health Resources & Services Administration 1996). These numbers will likely rise as welfare and Medicaid reforms lead to additional loss of Medicaid coverage. Getting primary care physicians to shortage areas is one part of the solution. But individual providers also need the support and outreach services to best meet the needs of the underserved populations.

Despite the excess overall supply of physicians, the more affluent parts of metropolitan areas continue to support a relatively large supply of doctors, and inner-city and rural areas continue to experience shortfalls in needed physicians. In addition, underserved areas often experience shortages of allied medical personnel such as nurse practitioners and physician assistants. The National Health Service Corps (NHSC) is the main government program aimed at bringing health personnel to underserved communities. NHSC extends loans and scholarships to these professionals in return for their commitment to practice for a time in underserved areas. In FY 1995, the program awarded 220 scholarships, 548 loan repayment plans, and 29 grants to states covering about 200 providers, for an addition of about 1,000 practitioners (Health Resources and Services Administration 1995). This assistance is helpful to community health centers, as well as to the Indian Health Service. Yet, funding still falls far short of meeting needs.

The *cultural sensitivity and training* of the physicians and allied medical personnel is important, over and above the size of the supply. Placing Spanish speaking nurses and physicians in Hispanic neighborhoods, for example, reduces language barriers that otherwise reduce patients’ true access to the health care system. In general, the training of minority health care practitioners should be given additional support, since minority providers are more likely to practice in neighborhoods with significant concentrations of minority, indigent patients.

Examples of programs to deal with cultural and language barriers.

- An innovative project at the Harborview Medical Center in Seattle, Washington called Community House Calls, is helping to foster communication, trust and understanding between health care professionals and the Ethiopians, Cambodians, and other immigrants and refugees in the area. The project uses Interpreter Case Managers—bilingual and bicultural members of the health care team trained as interpreters, outreach workers and home visitors to families served by the medical center’s clinics. Community Advisors, trusted elders of the cultural groups, help educate the case managers, clinic staff, and resident physicians about the culture-specific social needs of their community. In addition, the project is involved in providing cross-cultural training to medical residents from the University of Washington. These activities help both providers and patients to share responsibility for bridging cultural gaps, and promote more effective use of the health care system (The Safety Net 1995).
- One promising program for improving access for minority patients is the Research Center in Minority Institutions Program of the National Center for Research Resources at the National Institute of Health. The program provides grant support to institutions offering doctorate degrees in health professions/health sciences that have predominantly minority student enrollments. While the program is intended to promote biomedical and behavioral research, a by-product could be the training of more minority medical personnel who may someday practice in underserved areas.

Placing medical professionals who have the expertise to serve the specific needs of target populations is also important. People leaving welfare who lose Medicaid coverage will include a significant number of young women in child-bearing years, including teenagers. It will be important to staff clinics with gynecologists, pediatricians, and family practice physicians who can properly serve such patients.

Access to family planning services is a crucial element in an overall strategy for improving health for lower-income Americans, and the new welfare law encourages investment in family planning services in two ways. While the legislation restricts states from transferring funding from cash welfare grants to health care, it makes an exception for family planning services. Also, the proposal would make states eligible for “bonuses” to augment their federal block grants for reducing out-of-wedlock births. If more than five states qualify, the grant will be \$20 million to the states with the five largest decreases. If less than five states qualify, those that do will each receive \$25 million. These provisions should create strong incentives for states to invest in family planning services, perhaps redeploying funds from cash assistance to family planning in an effort to help break the cycle of teenage pregnancy, unemployment, and long-term welfare dependence.

Another critical aspect of improving health care delivery involves *outreach*. Health care services must get to where people in need are located. Efforts in this area include tertiary care centers opening satellite clinics in neighborhoods, or sending nurses for home visits with new mothers.

Innovative approaches to effective outreach

- The District of Columbia Healthy Start Project features Maternity Outreach Mobile Units. The project deploys two mobile clinics to provide access to early prenatal care for women in two low-income sections of the city. The mobile units target areas with the highest infant mortality rates and large numbers of women of childbearing age. They stop at various sites such as public housing complexes and community and recreational centers. The mobile units provide such services as pregnancy testing, physical and risk assessments, fetal monitoring, health/nutrition/parenting education and counseling, referral and assistance with Medicaid and WIC applications. The federal grant that has funded this project is scheduled to end during 1996, and the project's future is uncertain.
- Minnesota's Metropolitan Health Plan has implemented a set of programs which facilitate access to appropriate services. This county managed care plan provides:
 - free transportation to clinic appointments for eligible enrollees;
 - cellular phones for "at-risk" patients without access to telephones, programmed for primary care providers, emergency numbers, and a family member;
 - outreach counselors that help coordinate services for enrollees with multiple needs; and two additional primary care clinics in underserved neighborhoods (Bluford and Johnson 1995).

Recommendation 3: The federal and state governments should enhance the supply of appropriate health care practitioners, and expand outreach efforts in underserved areas. The federal government could increase funding for the NHSC to help meet critical shortages.

States and communities should make special efforts to invest in preventive health, family planning, and support services tailored to high-risk people in the community. Communities should also invest in innovative outreach efforts to bring services to where the patients are.

Lesson 4. To effectively treat the people making the transition from welfare to work, medical services must be more effectively integrated with mental health care and critical social services.

In addition to getting the right health care providers to the right places, there is a need to integrate medical services with both mental health services and a variety of social services to more effectively serve people. Former welfare recipients will be dealing with a range of "adjustments" related to job training and child care issues as they lose both cash and Medicaid benefits. Many have been suffering from depression and other mental health problems. They may also need assistance related to family planning, housing, nutrition, substance abuse, violence, crime, and other poverty-related problems.

Despite the fact that most of these problems are inter-related and exacerbate each other, they are generally dealt with separately. Because they fall under a variety of “jurisdictions,” efforts to address them tend to be piecemeal, with separate agencies (federal, state, county, charitable institutions, etc.) in different locations targeting specific problems.

There are some innovative efforts, however, that attempt to integrate many of these services to better serve the “whole” individual or family. One example is the Hillsborough County Health Care Plan (HCHCP). HCHCP is a managed care insurance program targeting uninsured residents of Hillsborough County, Florida, whose family income net of medical expenses is at or below the federal poverty level. HCHCP is trying to improve access to health care services, emphasizing prevention and early intervention, and improve the integration of medical, mental health, substance abuse, and social services. This is accomplished largely through co-location of services. County social workers are placed at each of the community health clinics to assess the needs of individuals who seek care, enroll those eligible for the managed care program, and coordinate social services. For example, the social workers would enroll eligible individuals for food stamps, rent subsidies, or utility subsidies, etc. In addition, HCHCP contracts for a number of “ancillary” services, including mental health and substance abuse counseling (Alpha Center 1995).

Another example of integration of health and social services is in Hennepin County’s Metropolitan Health Plan, a county HMO serving primarily Medicaid enrollees in Minnesota. The plan works with a number of community programs and agencies that address problems of teen-age pregnancy, chemical abuse, and school readiness (Bluford and Johnson 1995).

Recommendation 4: States should promote programs at the state and community levels that integrate health and social services. In this way, limited funds could be targeted toward special high-risk segments of the population leaving welfare and help assure access to relatively low-cost health and social services that are likely to help achieve the long-term goals of welfare reform.

Summary and Conclusions

Moving large numbers of people from welfare to work is a major goal of U.S. public policy, a goal which underlies many of the provisions in the welfare reform bill that became law in August, 1996. This report has examined a range of options for mitigating the adverse impact of welfare reform on access to health care. The strategies outlined here can help facilitate the long-range goals of independence and self-sufficiency for people currently receiving AFDC.

This report has developed realistic options for states as they attempt to move welfare recipients into permanent jobs. We outline both “demand-side” strategies that provide financial assistance to people so that affordable health coverage is available and “supply-side” strategies that make an appropriately targeted delivery system available. People leaving welfare need the resources to obtain health coverage, but they also need a system of care that is readily accessible and provides a range of health and social services matching their often complex needs.

Options for empowering people to maintain health coverage include expanding transitional Medicaid assistance, using 1115 waivers in a cost-effective fashion to extend coverage to the working poor and near-poor, covering low-income teenagers regardless of the welfare status of the family, establishing children’s health insurance programs, and developing ways for employers to contribute to state-wide purchasing arrangements that could provide continuous coverage to people who are likely to experience frequent job changes and spells of unemployment.

A basic theme of this paper is to help institutional providers serving large numbers of low-income families survive and become more efficient in a rapidly changing health care marketplace. It is more sensible to provide the training needed to help providers link into integrated managed care networks than to freeze them in place and pour subsidies into organizations that have trouble competing in the new environment.

Finally, we stress the importance of cross-cutting initiatives that address overlapping problems facing many people trying to leave welfare. There is a need to combine health and social services in a coordinated fashion to deal with the many risk factors that can lead to rising costs and poor health outcomes.

Appendix I

There is some evidence that the prospect of losing Medicaid coverage has been a factor keeping people on welfare or causing them to return to welfare. Several studies have found that the availability of Medicaid is associated with the size of the AFDC caseload and a reduction in the proportion of female heads of household who work (Moffitt 1992; Moffitt and Wolfe 1990; Winkler, 1990). To put it another way, severing the link between eligibility for cash assistance and eligibility for Medicaid would reduce the number of people staying on cash assistance.

The literature, however, reveals some important qualifications. First the effect of Medicaid on work efforts appears to emerge entirely from the decision of whether to work, and not from the decision of whether to increase hours of work. In addition, Winkler found that the effect on employment, though statistically significant, was small. A 10 percent increase in Medicaid is expected to reduce an average female head's probability of being employed by 0.9 to 1.3 percentage points (Winkler 1990).

Another study found larger negative effects of Medicaid on employment, but disclosed that most of this effect emerged from the behavioral responses of the relatively small proportion of AFDC recipients who have serious health conditions and understandably fear the loss of Medicaid's comprehensive health coverage. This study also found that for the AFDC caseload as a whole, the potential availability of employer-sponsored group health insurance was a critical factor in a recipient's decision to work (Moffitt and Wolfe 1990).

The most recent study on this subject found that much of the anticipated deterrent effect of Medicaid on labor force participation is now mitigated by the expansions of Medicaid that cover children up to age 12 living in poverty, regardless of the AFDC eligibility of their parents (Yelowitz 1996). The "notch" problem associated with the loss of in-kind benefits as earnings rise is limited by the fact that in many cases, the parent is risking her own coverage but not her children's coverage. Of course, this is only as long as household income remains below the poverty line. In any event, this literature is only relevant to the issue analyzed here because it relates to the impact of the potential loss of Medicaid on voluntary departures from welfare to take a job. Under the new law, large numbers of welfare recipients will be terminated from AFDC. For this group, the challenge is to assure that such people have access to health care.

Appendix II

Summary of Select Provisions of HR 3734 “Personal Responsibility and Work Opportunity Reconciliation Act of 1996”

General

Five-year lifetime cap for all individuals on cash assistance from Federal block grant funds.

After two years of cash assistance, individuals not exempt must be participating in work or work training. A period of job search may count as work and for teenagers, school attendance can be used to satisfy this requirement.

Those subject to the work requirement who unsuccessfully search for a job for two months must participate in community service jobs as defined by states.

States receive bonus grant for each year in which they demonstrate a net decrease in illegitimate births. If greater than 5 states qualify, the grant is \$20 million to the states with the five largest decreases; if less than 5 states qualify, the grant is \$25 million to those states who do qualify.

Bonus awards for other high performance states, as defined in bill, through 2003.

Exemption provisions for states that are deemed especially needy, such as those with above-national-average unemployment rates.

Prohibitions (Section 408)

No part of grant may be used to provide assistance to a family that includes an adult who has received assistance under any state program which receives federal funding for more than 60 months.

No assistance for families without a minor child.

No assistance for teenage parents not in school.

Teenagers are required to live with their parent or guardian unless they obtain an exemption for reasons such as exposure to physical or emotional harm. They must, however, live in an adult-supervised setting.

No part of grant may be used for medical assistance except for pre-pregnancy planning services. The bill allocates \$400 million to states to teach abstinence.

Exemptions may be made at the discretion of the state for minor children, unusual hardship, and American Indian and Alaskan peoples. Those exempted may not exceed 20% of the average monthly number of families to which assistance is provided.

States must deny assistance to (1) those who fraudulently misused welfare funds, (2) fugitives and felons, and (3) minor children who are absent from the home for significant periods of time.

Medicaid Coverage (Section 114)

Single parents and children will be guaranteed health coverage under Medicaid as long as they would qualify for welfare under current law.

A state may not lower its income standard applicable below federal standards in effect as of July 1, 1996. States whose standards are currently more generous may become more restrictive, but no more restrictive than income standards applicable on May 1, 1988.

A state may raise its current income standards, but by a percentage no greater than the annual percentage increase in the consumer price index (CPI).

A state has the option to terminate medical coverage for refusal to meet the work requirement, but it may not terminate assistance to a minor child who is receiving assistance and not head of a household.

States may continue waivers at their own discretion.

Work Requirement (Section 407)

A state which receives federal block grants must achieve minimum work participation rates of single-parent families on cash assistance as follows:

1997 = 25% 2000 = 40%

1998 = 30% 2001 = 45%

1999 = 35% 2002 = 50%

Work participation rates for two-parent families are:

1997 = 75%

1998 = 75%

1999 and after = 90%

Work participation is defined by 30 hours of work per week for purposes of meeting federal participation rates, but can be defined differently at the state's discretion.

A penalty of 5% is applied to the basic block grant amount for noncompliance with the required work participation rates. Penalties rise by 2% each year with a cap at 21% after the ninth year.

Refusal to engage in work may result in reduction or termination of assistance at the option of the state (with a mandated exception for single parents with children under the age of six who prove they cannot find suitable, affordable child care). Single parents with children under the age of one are exempt from the work requirement.

SSI Benefits (Section 211)

Methods for determining whether children are eligible to receive SSI disability benefits are tightened. The standard stipulates that an individual child must have a physical or mental impairment, which results in marked and severe functional limitations, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. The "individualized functional assessment" is repealed. Maladaptive behavior is eliminated as a symptom of a disabling mental impairment.

For a period of one year, all SSI recipients whose eligibility may be terminated under the provisions of this bill will be individually reviewed and their eligibility status redetermined. All new applicants on the date of enactment will be subject to the new criteria.

Illegal Alien Provisions (Section 401)

Illegal aliens are not qualified for any public benefits except:

treatment of emergency medical conditions.

short-term, non-cash, in-kind emergency disaster relief

immunization with respect to immunizable diseases and for testing/treatment of symptoms of such diseases.

programs and assistance (soup kitchens, crisis counseling) specified by the Attorney General. These services i) should deliver in-kind services at the community level ii) do not condition assistance on recipient's income iii) are necessary for the protection of life and safety.

programs for housing or community development assistance and other financial assistance by the Secretary of the Housing and Urban Development (HUD) provided that the alien is already receiving such a benefit on the date of the enactment of this bill.

Legal Alien Provisions (Section 402)

Legal aliens already in the U.S. do not qualify for most Federal benefits; exceptions include:

Medicaid benefits, at state option.

aliens who are admitted for permanent residences under the Immigration and Nationality Act.

veterans and immediate family thereof.

individuals who have worked for 40 qualifying quarters of coverage under Title II of the Social Security Act and did not receive any Federal means-tested public benefit during this period.

time-limited exceptions for refugees and asylees.

Five-Year Eligibility of Qualified Aliens for Federal Means-tested Public Benefits (Section 403)

An alien who enters US on or after the date of enactment of this act is not eligible for any means-tested public benefit for the first five years of their residency here except:

aliens who are admitted for permanent residences under the Immigration and Nationality Act

veterans and their immediate family.

time-limited exceptions for refugees and asylees.

for the following services:

- ❖ treatment of emergency medical condition
- ❖ short-term, non-cash, in-kind emergency disaster relief
- ❖ immunization with respect to immunizable diseases and for testing/treatment of symptoms of such disease, regardless of whether they are actually manifestations of the disease itself
- ❖ programs and assistance (soup kitchens, crisis counseling) specified by the Attorney General. These services i) should deliver in-kind services at the community level ii)do not condition assistance on recipient's income iii)are necessary for the protection of life and safety
- ❖ assistance/benefits under National School Lunch Act and Child Nutrition Act
- ❖ public health assistance for immunizations

- ❖ payments for foster care/adoption
- ❖ benefits under the Head Start Act
- ❖ benefits under Job Training Partnership Act

Transition for Aliens currently receiving Benefits (Section 402 D)

With different recertification processes for different programs, states will be allowed, but not required, to cut off cash assistance to those currently receiving benefits who have, by the provisions of the welfare legislation, become ineligible for benefits.

SSI: Commissioner of SSI shall redetermine the eligibility of any individual who is currently receiving benefits and no longer, according to the provisions of this Act, eligible to receive benefits.

Food Stamps: For a period of 1 year after the date of enactment of this Act, state agencies are responsible for recertifying the eligibility of those currently receiving food stamps who may, due to the provisions of this act, become ineligible. Until such time, aliens may receive benefits provided they were lawfully residing in the said state and currently receiving benefits.

Exceptions:

aliens who are admitted for permanent residences under the Immigration and Nationality Act

veterans and immediate family thereof

individuals who have worked for 40 qualifying quarters of coverage under Title II of the Social Security Act and did not receive any Federal means-tested public benefit during this period

time-limited exceptions for refugees and asylees.

Eligibility of Aliens for State/Local Public Benefits (Section 411)

Aliens, except (those exceptions already mentioned) qualified aliens, are also not eligible for state-local public benefits except:

treatment of emergency medical condition

short-term, non-cash, in-kind emergency disaster relief

immunization with respect to immunizable diseases and for testing/treatment of symptoms of such disease, regardless of whether they are actually manifestations of the disease itself

programs and assistance (soup kitchens, crisis counseling) specified by the Attorney General

A state has the authority to provide for eligibility of illegal aliens for state and local public benefits for which they would otherwise be ineligible by enacting a law which affirmatively provides such eligibility

States have the authority to limit eligibility for state public benefits except:

veterans and immediate family thereof

individuals who have worked for 40 qualifying quarters of coverage under Title II of the Social Security Act and did not receive any Federal means-tested public benefit during this period

time-limited exceptions for refugees and asylees

Child Support (Section 382)

Procedures under which child support orders are enforced will include a provision for health care coverage of the child and in the case that a noncustodial parent provides such coverage and subsequently switches employers, the new employer will be mandated to provide coverage for that child, assuming health care is provided.

Limitations on Grants (Section 403)

States cannot expend more than 15% of grant on administrative costs. May spend no more than 30% of amount of any grant on one specific state program.

[NOTE: All Appendix II information from Congressional Record, July 30, 1996]

Sources

- Abt Associates, Inc. 1995. "Evaluation of the Medicaid Extension Demonstrations." Contract No. HCFA 500-87-0030(1). Florida Healthy Kids Demonstration: Final Report. May 1.
- Acs, Gregory, Pamela Loprest and Keith Watson. 1993. "Medicaid and Health System Reform: The Potential for Integration into an Employer-Based System" The Urban Institute. March.
- Alpha Center. 1995. "Hillsborough County Health Care Plan." Technical Assistance Memorandum #8. Washington, DC. December.
- Bluford, John W. and Monette Johnson. 1995. "The Ethics of Managed Care." The Safety Net. Summer.
- Congressional Budget Office. 1993. "In Pursuit of Higher Wages and Employment-Based Health Insurance." CBO Staff Memorandum. February.
- CRS Report for Congress: State Welfare Initiatives. 1995. Congressional Research Service, The Library of Congress. Updated September 1.
- CRS Report for Congress: Medicaid: Program and Demonstration Waivers. 1994. Congressional Research Service, The Library of Congress. December 23.
- Danziger, Sandra and Sheldon Danziger. 1995. "Will Welfare Recipients Find Work When Welfare Ends"? Welfare Reform Briefs. Urban Institute Number 12. June.
- Gage, Larry S. 1995. "Managed Care or Managed Costs? A Concept (and an Industry) at the Crossroads." The Safety Net. National Association of Public Hospitals. Summer.
- Health Care Financing & Organization: News & Progress. 1995. The Alpha Center. July.
- Health Care Resources and Services Administration. 1994. Public Health Service, U.S. Department of Health and Human Services. Profile FY 1995.
- Health Resources and Services Administration. 1996. Public Health Service, U.S. Department of Health and Human Services. Fact Sheet.
- Loprest, Pamela and Gregory Acs. 1996. "Profile of Disability Among Families on AFDC." Report prepared for the Kaiser Family Foundation. August.
- Medicaid Letter. 1995. Vol. 1 No. 2. Health Care Press, Skaneateles, N.Y. August.
- Meehan, Margorie and Patricia Gabow. 1995. "Service Delivery Excellence in a Public Hospital." The Safety Net. Winter.
- Meyer, Jack A., Nancy Bagby, and Marilyn Klotz, 1996. "Welfare-to-Work in Indianapolis: A Preliminary Evaluation." Economic and Social Research Institute, November.
- Minnesota Department of Health. 1994. "1994 Action Plans for Minnesota Health Plan Companies." Minnesota Health Information Clearinghouse. September.

- Moffitt, Robert. 1992. "The Effect of the Medicaid Program on Welfare Participation and Labor Supply." *Review of Economics and Statistics*. 74:2. November.
- Moffitt, Robert and Barbara Wolfe. 1990. "The Effects of Medicaid on Welfare Dependency and Work." University of Wisconsin-Madison, Institute for Research on Poverty, Special Report No. 49. March.
- Pavetti, LaDonna. 1995. "Who is Affected by Time Limits?" *Welfare Reform Briefs*, No. 7. The Urban Institute. Washington, DC.
- Peri, Camille. 1995. "Emergency Fast Track in San Francisco." *The Safety Net*. Fall.
- Robitaille, Steve. 1995. "Santa Clara Valley Health and Hospital Systems." *The Safety Net*. Summer.
- Sapp, Barbara A. 1995. "A Public Hospital's Response to a Dynamic Marketplace." *The Safety Net*. National Association of Public Hospitals. Winter.
- State Initiatives in Health Care Reform. 1995. No. 11, The Alpha Center. Washington, DC. March/April.
- The Annie E. Casey Foundation. 1995. *Kids Count Data Book*. Baltimore, MD.
- Thorpe, Kenneth E., et al. 1995. "Anticipating the Number of Uninsured Americans and the Demand for Uncompensated Care. The Combined Impact of Proposed Medicaid Reductions and the Erosion of Employer-Sponsored Insurance." Council on the Economic Impact of Health Care Reform. November.
- United States Department of Commerce, Bureau of the Census. 1996. Unpublished data.
- United States General Accounting Office. 1995a. "Tennessee's Program Broadens Coverage but Faces Uncertain Future." September.
- United States General Accounting Office. 1995b. "Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion." July.
- United States General Accounting Office. 1996. "Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children." January.
- United States Government Printing Office. 1996. Congressional Record. July 30.
- Winkler, Anne E. 1990. "The Incentive Effects of Medicaid on Women's Labor Supply." *Journal of Human Resources*. July.
- Yelowitz, Aaron S. 1996. "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions." Institute for Research on Poverty, DP#108-96.

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