

How the New Welfare Reform Law Affects Medicaid

Leighton Ku and Teresa A. Coughlin

When the dust settled in the 104th Congress, the major changes to Medicaid came not from the highly visible proposals to block grant or cap the program, but from welfare reform legislation, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). Since attention focused on the ill-fated Medicaid block grant proposal, the welfare reform-related changes came as a surprise to many. While the welfare reform law does not change how Medicaid delivers health care nor alter its entitlement status, it reduces the number of people covered and lowers federal expenditures.

Medicaid is the joint federal-state health insurance program for low-income families, senior citizens, and people with disabilities. In 1995, 41 million people were insured by Medicaid at a cost of \$151 billion. The Congressional Budget Office (CBO) estimated that the new law would lower federal spending on Medicaid by about 1 percent in the year 2002 compared to previous projections, and save a total of \$4 billion over six years (1996 to 2002).¹ These savings will lower the federal deficit and reduce the pressure for further Medicaid spending cuts.

This policy brief discusses the four principal changes made to Medicaid eligibility by the welfare reform legislation:

- Decoupling welfare and Medicaid eligibility;
- Narrowing Medicaid eligibility for disabled children in the Supplemental Security Income (SSI) program;

- Terminating access to Medicaid for some legal immigrants because they lose SSI; and
- Barring most future legal immigrants from Medicaid.

It also reviews how the new provisions may potentially affect key parties—state and local governments, health care providers, and beneficiaries. Critical decisions will be made by state legislatures and executive agencies in the next several months as they implement the changes in federal rules.

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Welfare and Medicaid

The centerpiece of the welfare reform law is replacement of Aid to Families with Dependent Children (AFDC) by Temporary Assistance for Needy Families (TANF), a new federal block grant to states. (See brief no. 1 in this series for a broader description of the new welfare program.)

Before TANF, eligibility for AFDC and for Medicaid were closely linked: A person who received an AFDC check was *automatically* entitled to Medicaid. This link, however, was severed during the final stages of congressional debate on TANF. Policymakers feared that the tighter welfare eligibility criteria required by TANF might unintentionally cause many people to lose health insurance coverage. For example, if a person was disqualified from TANF because her five-year time limit expired, she might lose both welfare and Medicaid coverage. To prevent this, the new law requires

states to use the *AFDC eligibility criteria of July 1996* (just before the law changed) in determining Medicaid eligibility for families with children, regardless of how TANF eligibility changes. At their option, states instead may use more stringent AFDC criteria, as long as these were in place after 1988. To adjust for future inflation, states may update AFDC-related income and asset limits based on changes in the consumer price index.

A major consequence of the decoupling of Medicaid is that people may continue on Medicaid indefinitely, provided they are poor enough and meet other categorical qualifications, even though they cannot stay on TANF for more than five years. This is important because, even if welfare recipients are successful in finding work, as hoped under welfare reform, the jobs available to welfare recipients often lack private health insurance.²

The purpose of separating Medicaid and TANF eligibility was to *maintain* health insurance coverage for the former welfare population, but the decoupling may have other important consequences. Because welfare and Medicaid eligibility will use separate standards, new administrative procedures may be needed to determine TANF and Medicaid eligibility. The intertwined eligibility of AFDC and Medicaid made this simpler for clients and eligibility workers alike.

The CBO estimated that this aspect of the law would not reduce the number of people on Medicaid. Others have worried that it might have a dramatic effect.³ A reasonable fear is that, if the eligibility system becomes more complicated, or if clients misunderstand the new system, some people will fall through the cracks. For example, a family eligible for Medicaid but not TANF might not realize that health insurance is still available and, thus, never apply for benefits.

The number of those falling through the cracks depends on how states respond. For example, states could try to keep the application processes for Medicaid and welfare

closely tied. They could also spread the word that former welfare recipients may still be entitled to Medicaid. Another way to stem a possible decrease in Medicaid enrollment is that states could raise Medicaid AFDC-related income and asset standards to keep pace with inflation, as now permitted. In the past, some states have been interested in raising the income-eligibility standard for Medicaid but did not want to increase the number of people on welfare.

Unfortunately, it will be hard to disentangle the impact of all these factors, since Medicaid's AFDC-related caseloads were falling even *before* the new legislation. Between 1994 and 1995, the number of AFDC-related Medicaid enrollees declined by about 700,000 persons (4 percent), reversing a long trend of increasing levels. This

The separation of TANF and Medicaid eligibility, and the new requirements to verify immigrant status, make eligibility determination more complicated. State and local welfare offices will need to implement these new requirements at the same time they are sorting out other welfare reform-related changes.

reduction, and any that may follow, are caused both by broader economic changes that reduce the number of people in poverty and by state welfare reform policies.

Children Receiving SSI

The new law also modifies how childhood disability will be assessed in the SSI program. Like AFDC, SSI participation generally automatically granted Medicaid eligibility. And children could qualify for SSI (and thereby Medicaid) if an "individual functional assessment" determined that the child was disabled. The individual assessment was given if the child's impairment did not match one of the qualifying medical diagnoses listed by the federal government. This was most relevant for children with moderate mental or behavioral impairments,

although sometimes it also applied to physical health problems. About a quarter of the children in SSI gained eligibility through individual assessments.

The new legislation ends the use of individual assessments; children now must demonstrate one of the "listed" medical impairments to qualify for SSI benefits. The Social Security Administration estimates 135,000 children will lose SSI grants because of these changes. However, most of these children (an estimated 80 percent) will still be eligible for Medicaid through other criteria, such as those for children under the poverty level.⁴

Immigrants

Among the most important health-related measures in the new law are those affecting immigrants. Previously, noncitizen immigrants legally admitted to the United States were entitled to Medicaid coverage on the same terms as native and naturalized citizens. The new law limits the eligibility of noncitizen immigrants for Medicaid and other public assistance programs.⁵ Policies for immigrants who were in the United States when the law was passed differ from policies for those who arrive in the future.

Current Immigrants. Under the new law, most noncitizen immigrants, including those who legally entered the country before August 1996, will be disqualified from SSI.⁶ Many of the immigrants who lose SSI would still qualify for Medicaid through other criteria, such as the medically needy provisions. Immigrants in states such as Texas, which have very stringent medically needy provisions or which lack them altogether, will be more likely to lose Medicaid coverage. The CBO estimated that many current noncitizens—about 200,000—who are terminated from SSI would requalify for Medicaid. However, more (about 300,000) would lose their Medicaid eligibility by 1998. These changes will affect more elderly SSI recipients than disabled. Immigrants receiving SSI are more likely to be aged, and the aged are less likely to requalify through other criteria than are the disabled.

In addition, the new legislation permits states to exclude current non-citizen immigrants from all but emergency Medicaid services, regardless of their categorical need or income. However, we are not aware of any states that are currently planning to exercise this option. If any state implemented such a provision, current immigrants would be much more strongly affected.

Future Immigrants. Among the Medicaid-related provisions, those affecting future noncitizens are the most far reaching.

Immigrants legally entering the United States after August 1996 are barred from Medicaid for all but emergency care for their first five years in the country.⁷ (States, at their option, may extend this bar until citizenship.)

Further, the new law makes it much harder to qualify after the five years have passed. In determining if an immigrant is poor enough to qualify, the new law stipulates that the income and assets of the immigrant's sponsors (those who sponsored admission to the United States and signed affidavits of support) must be "deemed" available.⁸ For example, if a man who is a citizen sponsors his sister's entry to the U.S., his income and savings would be counted in determining her eligibility, even if she lived independently and did not actually receive any support from the brother. The CBO estimated that by 2002, the bar coupled with the tighter resource standards will exclude about 600,000 future immigrants from full Medicaid coverage.

Similar to the TANF provisions, the precise impact of the immigrant measures on Medicaid enrollment and spending depends upon decisions to be made by states. The two chief issues are the method of assessing eligibility and the breadth of the emergency benefit.

Some insights as to how states might respond can be gained by examining how states interpreted emergency benefits for undocumented aliens under earlier legislation. California, for example, let undocumented aliens apply in welfare offices and issued Medicaid cards that indi-

cated that the person was entitled to a narrow benefit package. Even so, California's emergency benefits were relatively broad and included most outpatient services. By contrast, some other states did not certify the undocumented aliens or issue a Medicaid card, but determined eligibility *only after* the alien was admitted for emergency room or hospital services, thereby narrowing benefits to those services only.

The restrictions on all but emergency services might not correspond with the most accepted or cost-effective medical practices. For example, it might be less expensive to serve a diabetic by providing ongoing preventive and primary care, rather than waiting until emergency treatment is needed for a coma or kidney failure caused by

services with federal matching funds. The TANF-related changes lock states into basing Medicaid eligibility for families with children on AFDC criteria in place in July 1996 or earlier.

A number of state officials have said they want to use state funds to continue some Medicaid coverage for immigrants. The fact that they cannot receive federal matching funds for this has effectively reduced their flexibility. In the states that "protect" immigrants, the reduction in federal funding would require additional state outlays. If states do not use their own funds to cover the disenfranchised clients, then both state and federal outlays could decline.

States' decisions will also directly affect local governments. Counties and cities (and state governments as well) often maintain public hospitals or clinics that serve indigent and uninsured patients. The loss of Medicaid funding means that other local or state revenue sources must be tapped to cover the uncompensated care costs. Although the new law gives states the option to deny state-funded benefits to noncitizens, this will be difficult to reconcile with many hospitals' and clinics' charters that require them to serve the indigent.

Another implication for states is that program administration will become more difficult. The separation of TANF and Medicaid eligibility, and the new requirements to verify immigration status, make eligibility determination more complicated. Those states that completely restructure their TANF eligibility to be far different from what it was under AFDC will need to run two separate eligibility systems—a dramatic increase in complexity. In addition, state and local welfare offices will need to implement these new requirements at the same time they are sorting out other welfare reform-related changes. The legislation does make additional federal funding available for this purpose, but state and local governments often face other barriers (such as personnel caps and computer system problems) that limit their ability to cope with chang-

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untreated diabetes. Similarly, while the legislation explicitly covers the costs of delivering a child, the coverage of prenatal care appears more doubtful.

Implications for State and Local Governments

A major policy goal of the 104th Congress was to provide more flexibility to states in both welfare and Medicaid, albeit with fewer federal dollars than would be available without reform. But passage of the welfare reform bill without a Medicaid bill effectively reduced both state flexibility and federal funding in Medicaid.

The immigration provisions, and to a lesser extent the other changes, curtail states' ability to serve certain groups under Medicaid and to pay for these

ing administrative procedures.

Lastly, most states are increasingly using managed care programs for Medicaid. The emphasis on emergency benefits for immigrants is somewhat at odds with managed care's emphasis on the use of primary care to help avoid emergency room use or hospitalizations.

Implications for Health Care Providers

For most health care providers, welfare reform will have modest effects. Medicaid's entitlement nature and the form of health care delivery is not altered by the new legislation. "Safety net providers" (hospitals and clinics that serve a large number of Medicaid and uninsured patients) will face more serious consequences. Safety net providers include public and nonprofit hospitals, community health centers, and related public and charitable facilities that offer free or reduced-price medical care to the poor and uninsured. The most strongly affected will be hospitals and clinics located in high-immigrant areas, such as Miami, southern California, south Texas, or New York City.

The loss of Medicaid coverage will mean that low-income people will increasingly turn to safety net providers for free or reduced-price health care. Thus, these safety net providers must bear losses in Medicaid funding at the same time that more people are seeking care. Unless they are able to get additional revenue from state or local sources, the safety net providers may face financial hardships.

Implications for Beneficiaries: A Summing Up

The effects for beneficiaries will vary. Eligibility changes affecting children and immigrants on SSI and affecting TANF recipients mean that many will completely lose Medicaid coverage. An earlier study indicated that a majority of those who lost Medicaid failed to gain private insur-

ance and became uninsured.⁹ The loss of health insurance will reduce the access of such persons to medical care and could impair their health status. In light of their low incomes, the newly uninsured will have to make difficult choices between paying for medical care and paying for other basic needs.

A larger category of people, immigrants entering the United States after August 1996, will no longer be eligible for full Medicaid coverage, although they remain entitled to emergency care coverage. Differences in state implementation policies will shape the extent to which immigrants can actually

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obtain these services. It will become more difficult for them to get preventive and primary health care, however.

Most beneficiaries will find it harder to get onto Medicaid, because of changes in the administrative procedures. For example, though most disabled children who lose SSI will be able to qualify for Medicaid through other eligibility criteria, they may have to apply at a different office and complete a new set of application forms. These changes increase the risk that some will fall through the cracks.

While the changes wrought by the welfare reform legislation narrow Medicaid coverage somewhat, states still have the flexibility to fine-tune or expand Medicaid health insurance coverage in many ways, using a combination of regular program options and federal waivers. States may want to offset the federal restrictions, or they may see the new law as an opportunity to save state as well as federal tax dollars. For example, some states may use their own funds to serve needy people who will no longer be

eligible under the new federal rules, while other states may pass on health coverage issues for these groups to local communities. Which of these options states exercise will be determined by a complex set of political and budgetary forces, independent of the new welfare reform legislation.

Notes

1. Congressional Budget Office (1996), "Federal Budgetary Implications of H.R. 3734, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996," August 9.

2. The legislation also reauthorized transitional Medicaid benefits, which offer an extra one to two years of Medicaid coverage to those who leave welfare because they find a job or earn more. This just extended prior policies.

3. Rosenbaum, S., and Darnell, J. (1996), "An Analysis of the Medicaid and Health-Related Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996," Washington, D.C.: Kaiser Commission on the Future of Medicaid.

4. A future brief in this series will discuss the SSI changes and their implications for children in detail.

5. The new legislation did not greatly alter provisions for undocumented aliens—that is, those who entered the U.S. illegally. They continue to be eligible only for Medicaid emergency care services.

6. Some current immigrants are exempt from the exclusions, including refugees, asylees, veterans and their dependents, and those who have worked in the U.S. for 10 years.

7. Groups exempted from this bar include refugees, asylees (for their first five years), and military personnel.

8. These provisions are also affected by the immigration bill that was passed by Congress soon after the welfare reform law.

9. Short, P., Cantor, J., and Monheit, A. (1988), "The Dynamics of Medicaid Enrollment," *Inquiry*, 25:504-16.

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