

ONE-YEAR REAUTHORIZATION OF TRANSITIONAL MEDICAL ASSISTANCE

MAY 14, 2002.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. TAUZIN, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 4584]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4584) to amend title XIX of the Social Security Act to extend the authorization of transitional medical assistance for 1 year, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

The purpose of H.R. 4584 is to reauthorize transitional medical assistance for one year.

BACKGROUND AND NEED FOR LEGISLATION

Transitional medical assistance—which is sometimes referred to as transitional Medicaid—was created to ensure that former welfare recipients have health care coverage after entering the workforce. These individuals typically enter low-wage jobs that do not offer private coverage or offer coverage with expensive premiums. Transitional medical assistance was created to fill this void and extends up to a year of Medicaid coverage to these individuals and their families.

Transitional medical assistance, as provided under section 1925 of the Social Security Act, was established in 1988, although a more limited provision dates back to 1972. It was extended in the 1996 welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act, P.L. 104–193. Families moving from welfare to work, who lose eligibility for Medicaid due to earnings from employment, are entitled to an initial six months of Medicaid coverage without regard to the amount of their earned income. These families are also entitled to an additional six months of coverage if family earnings, less childcare costs, do not exceed 185 percent of the federal poverty level. To qualify, a family must have received Medicaid in three of the six months immediately before becoming ineligible as a result of increased income. Families lose their eligibility for transitional medical assistance when there is no longer a dependent child in the home, when they fail to pay any premiums, when they fail to meet quarterly income reporting requirements, or when the caretaker recipient has no earnings.

The federal waiver process allows states to increase the duration of assistance, modify the income eligibility standards, or change the income reporting requirements to address the needs of their welfare population. However, budget neutrality requirements may limit the ability of states to use this process to pursue program expansions or administrative simplifications. In addition, because there are no state reporting requirements regarding transitional medical assistance, there is no nationwide data as to the extent to which eligible families obtain and keep coverage.

Transitional medical assistance is set to expire on September 30, 2002. H.R. 4584, introduced by Mr. Upton, Mr. Hall of Texas, Mr. Tauzin, and Mr. Bilirakis, provides a one-year reauthorization of transitional medical assistance.

HEARINGS

The Subcommittee on Health held a hearing on “Welfare Reform: A Review of Abstinence Education and Transitional Medical Assistance” on Tuesday, April 23, 2002. The Subcommittee received testimony from Jacqueline Del Rosario, Executive Director, ReCapturing the Vision International; Joe S. McIlhaney Jr., M.D., The Medical Institute for Sexual Health; David W. Kaplan, M.D., Head of Adolescent Medicine and Professor of Pediatrics, University of Colorado School of Medicine; Cindy Mann, J.D., Senior Fellow, Kaiser Commission on Medicaid and the Uninsured; and William J.

Scanlon, Ph.D., Director, Health Care Issues, U.S. General Accounting Office.

COMMITTEE CONSIDERATION

On Wednesday, April 24, 2002, the Full Committee met in open markup session and favorably ordered reported a Committee Print to amend title XIX of the Social Security Act to extend the authorization of transitional medical assistance for 1 year, without amendment, by a voice vote, a quorum being present. The Committee also agreed to a unanimous consent request by Chairman Tauzin that the Committee Print would be introduced as a bill, H.R. 4584, and to allow for this report to be filed on that bill.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. No record votes were taken in connection with ordering H.R. 4584 reported to the House. A motion by Mr. Tauzin to order H.R. 4584 reported, without amendment, to the House was agreed to by a voice vote.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held an oversight hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The objective of H.R. 4584 is to extend the authorization of transitional medical assistance for one year.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4584, to amend title XIX of the Social Security Act to extend the authorization of transitional medical assistance for 1 year, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 10, 2002.

Hon. W.J. "BILLY" TAUZIN,
*Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4584, a bill to amend title XIX of the Social Security Act to extend the authorization of transitional medical assistance for one year.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Eric Rollins and Jeanne De Sa.

Sincerely,

STEVEN LIEBERMAN
(For Dan L. Crippen, Director).

Enclosure.

H.R. 4584—A bill to amend title XIX of the Social Security Act to extend the authorization of transitional medical assistance for one year

Summary: This bill would extend by one year the requirement that state Medicaid programs provide up to 12 months of eligibility, known as transitional medical assistance (TMA), to certain Medicaid beneficiaries (usually former welfare recipients) who would otherwise be ineligible because they have returned to work and have increased earnings. Under current law, the requirement will expire on September 30, 2002.

CBO estimates that H.R. 4584 would increase direct spending by \$355 million over the 2003–2007 period. Within that total, CBO anticipates that federal Medicaid spending would rise by \$365 million and that federal spending in the State Children's Health Insurance Program (SCHIP) would decline by \$10 million. Because this bill would affect direct spending, pay-as-you-go procedures would apply.

This bill does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill's one-year extension of transitional medical assistance would result in additional state spending of \$265 million over the 2003–2007 period.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 4584 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—				
	2003	2004	2005	2006	2007
CHANGES IN DIRECT SPENDING					
Medicaid:					
Estimated Budget Authority	130	200	25	10	0
Estimated Outlays	130	200	25	10	0
SCHIP:					
Estimated Budget Authority	0	0	0	0	0
Estimated Outlays	-5	-10	5	0	0
Total cost of H.R. 4584:					
Estimated Budget Authority	130	200	25	10	0

	By fiscal year, in millions of dollars—				
	2003	2004	2005	2006	2007
Estimated Outlays	125	190	30	10	0

Note.—SCHIP is the State Children's Health Insurance Program.

Basis of estimate

Medicaid

State Medicaid programs are required by section 1931 of the Social Security Act to cover individuals who meet the eligibility requirements for the state's Aid to Families with Dependent Children (AFDC) program that were in effect on July 16, 1996. AFDC has since been replaced by the Temporary Assistance for Needy Families (TANF) program. States that wish to expand eligibility beyond this minimum requirement may do so by disregarding a portion of an applicant's income and assets. Although there is no formal link between Medicaid and TANF eligibility, many states have aligned the two programs' eligibility standards. As a result, most of the individuals who receive Medicaid under section 1931 are welfare recipients.

Under current law, states are required to temporarily continue Medicaid coverage for certain individuals (and their dependents) whose earnings increase above the state's eligibility levels. This transitional medical assistance is available for individuals who have received Medicaid under section 1931 for at least three of the previous six months and would otherwise lose their eligibility because their earnings have increased. TMA recipients are guaranteed to remain eligible for Medicaid for six months; after that, they may remain eligible for another six months if they report their income on a periodic basis and have incomes below 185 percent of the poverty level. Some states have opted to soften the three-out-of-six requirement (by disregarding some of a recipient's income when determining eligibility) or provide TMA for longer periods (under a waiver).

The requirement for states to provide TMA currently applies to individuals who lose their eligibility under section 1931 prior to September 30, 2002. H.R. 4584 would extend the requirement through September 30, 2003. CBO estimates that this bill would increase federal Medicaid spending by \$130 million in 2003 and a total of \$365 million over the 2003–2007 period.

Number of Beneficiaries. Many families move on and off the Medicaid and TANF rolls as their family and employment circumstances change. Under current law, CBO anticipates that about 1.4 million families enrolled under section 1931 will lose their Medicaid eligibility in 2003. Based in part on experience with welfare case closures, CBO projects that slightly more than one million families will leave the TANF rolls in 2003. As noted earlier, many of those families will also lose their Medicaid eligibility. The remaining families will be Medicaid recipients who were not enrolled in TANF.

Based on research on families leaving welfare, CBO anticipates that about 500,000 families would meet the basic requirements for TMA in 2003. Recent TANF data on the number of recipients in each family suggest that there are about 500,000 adults and

900,000 children in those families. (Virtually all families that receive TANF and have an adult recipient are single-parent families.)

From this eligible population, CBO estimates that the extension of TMA would enroll an additional 300,000 adults and 360,000 children in Medicaid. Those estimates account for individuals who would remain enrolled in Medicaid under other eligibility categories after losing their section 1931 eligibility (and thus not receive TMA). Based on studies of families leaving welfare, CBO also assumed only moderate participation in TMA. As noted earlier, many children in families that lose their section 1931 eligibility remain eligible for Medicaid under other eligibility rules. However, studies suggest that many children drop off the rolls once their parents lose eligibility. By extending TMA, the bill would therefore keep some of those children enrolled in Medicaid.

CBO anticipates that the bill's effect on Medicaid enrollment would be much smaller when measured on a full-year equivalent basis. Under current law, families losing their section 1931 eligibility would receive four months of eligibility—even without TMA—under a separate provision of Medicaid law. The bill would therefore provide most families with another eight months of eligibility instead of 12. Even then, research on TMA recipients indicates that many people do not remain eligible for a full 12 months because they fail to report their incomes on a periodic basis.

After accounting for these factors, CBO estimates that H.R. 4584 would increase Medicaid enrollment on a full-year-equivalent basis by about 115,000 in 2003, 160,000 in 2004, and smaller amounts in 2005 and 2006. The bill's effects would extend beyond 2003 because families who qualify for TMA at any point in that year would be entitled to as many as 12 months of additional eligibility, even if that period of eligibility runs beyond 2003. (Families living in states that provide more than 12 months of TMA through a waiver could remain eligible into 2005 or 2006.)

Per Capita Costs. CBO estimates that the federal share of costs in 2003 per full-year equivalent would be about \$1,350 for an adult and \$975 for a child. Those figures are lower than CBO's baseline figures for adults and children (by about 30 percent and 10 percent, respectively) because of a number of adjustments. First, CBO excluded pregnancy-related costs for adults. Pregnant women are typically eligible for Medicaid at much higher income levels than under section 1931, so they would be unlikely to receive TMA. Second, CBO assumed that adults and children in families receiving TMA would be somewhat healthier than other Medicaid recipients and thus have lower costs, on average. Finally, CBO assumed that some TMA recipients would receive a more limited set of benefits than Medicaid usually provides because states do not have to provide non-acute care services to TMA recipients in their second six-month period of eligibility.

State Children's Health Insurance Program

CBO anticipates that under current law about 10 percent of the families leaving welfare in 2003 because of higher earnings would have incomes high enough to make their children ineligible for Medicaid, and that some of the children in these families would enroll in SCHIP instead. By extending TMA, the bill would make those children eligible for Medicaid. Since children who are eligible

for Medicaid cannot receive SCHIP, the bill would lead to savings in SCHIP.

CBO estimates that the bill would reduce federal SCHIP outlays by \$5 million in 2003 and \$10 million in 2004. Since states generally have three years to spend their SCHIP allotments, those savings would free up funds that could be spent on benefits in later years, and CBO estimates that spending would increase by \$5 million in 2005.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through fiscal year 2006 are counted.

	By fiscal year, in millions of dollars—											
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
Changes in outlays	0	125	190	30	10	0	0	5	0	0	0	
Changes in receipts	Not applicable											

Intergovernmental and private-sector impact: This bill does not contain any intergovernmental or private-sector mandates as defined in UMRA. The bill's one-year extension of transitional medical assistance would result in additional state spending of \$265 million over the 2003–2007 period.

Estimate prepared by: Federal Costs: Eric Rollins and Jeanne De Sa; Impact on State, Local, or Tribal Governments: Leo Lex; and Impact on the Private Sector: Amy Fedigan.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. One-year reauthorization of transitional medical assistance

Under current law, transitional medical assistance sunsets after September 30, 2002.

This section reauthorizes transitional medical assistance for an additional year, extending the sunset date to September 30, 2003.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) * * *

* * * * *

(e)(1)(A) * * *

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of title IV during the period beginning on April 1, 1990, and ending on September 30, **[2002]** *2003*. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.

* * * * *

EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE

SEC. 1925. (a) * * *

* * * * *

(f) SUNSET.—This section shall not apply with respect to families that cease to be eligible for aid under part A of title IV after September 30, **[2002]** *2003*.

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ADDITIONAL VIEWS

We support this legislation, which extends the sunset of transitional medical assistance (TMA) for an additional year. Our strong preference, however, is that Congress eliminate the sunset entirely, making the program more dependable for the beneficiaries who depend on it and the states that administer it. At a minimum, the Committee should have reauthorized TMA for five years, consistent with the reauthorization of Temporary Assistance for Needy Families (TANF).

Additionally, even though TMA is a vital route to coverage for parents leaving welfare for work, a significant number of parents miss out on TMA coverage. According to the latest Urban Institute data, two-thirds of parents lose Medicaid after leaving welfare, even though the vast majority are likely to be eligible for TMA, suggesting that simplifications to TMA are needed to assure that eligible families secure the coverage. In particular, there are four administrative simplifications that we wish to see enacted:

(1) A waiver of reporting requirements for families who qualify for TMA: Families can be eligible for TMA for up to 12 months; however, they must meet prescriptive reporting requirements to keep their eligibility. To receive the first six months of TMA, families must notify the state of their employment and income status (even though there is no income eligibility limit during this period). They then must report income to the state by the 21st day of the 4th month. In order to maintain eligibility for the second six months, the family must report again to the redetermination office after six months even if their income has not changed. In the second six months of TMA, families must report income to the state by the 21st day of the first and fourth month. A trip to the redetermination office can entail an entire day off from work, and if all paperwork is not correct, the family must make another trip. Often, a day off from work means a day of no pay. If the family does not show up as required, coverage is terminated.

(2) The elimination of TMA requirements for the subset of states that already provide health insurance to families at or above 185% of poverty. If states already meet TMA requirements through their regular Medicaid program, compliance with administrative rules of TMA is unnecessary and duplicative.

(3) A state option to waive requirement that families have been on Medicaid for three of the previous six months to qualify for TMA: Currently, in order to be eligible for TMA, a family must have had Medicaid coverage for three of the previous six months. This requirement excludes families who, for one reason or another, decided not to seek medical assistance even when they were eligible for it.

(4) A state option to expand TMA coverage above 185% of poverty: Currently, the income limit for TMA is 185% of poverty. Some

states, however, would like the option to expand their TMA programs to individuals above that income level in order to make the transition from welfare to work rewarding.

While states could potentially use section 1115 of the Social Security Act to waive these administrative requirements, budget neutrality makes this an unattractive option for states, because they would be forced to reduce program spending in other areas, such as benefits or eligibility. We have long supported enacting these simplifications, and two of the four were included in H.R. 5291, the "Beneficiary Improvement and Protection Act of 2000," reported by the Committee in October of 2000.

In addition, we would like to see the Committee take action on the issue of health insurance coverage for pregnant women and children in Medicaid and the Children's Health Insurance Program who are legal immigrants. Until the passage of the 1996 welfare reform law, legal immigrants were generally eligible for public benefits on the same basis as citizens. The welfare law eliminated the ability of most legal immigrants to receive any federal benefits, because it conditioned eligibility on citizenship status rather than legal status, extending to most legal immigrants the eligibility restrictions that had traditionally applied only to undocumented immigrants. Since passage of welfare reform, Congress has acted in some instances to reinstate eligibility for public benefits. In 1997, Congress restored Supplemental Security Income (SSI) to most immigrants who were already in the United States when the welfare law was enacted, and in 1998, it restored food stamp eligibility for immigrant children and for elderly and disabled persons who were here before August of 1996.

As a result, the eligibility of legal immigrants for public benefits varies among federal programs and depends on a variety of factors, including date of entry to the United States, type of immigration status, work history, age, and state of residence. Welfare reauthorization provides an opportunity to reconsider the restrictions and other immigrant provisions in the welfare law in a more comprehensive manner than has been undertaken to date. Therefore, we believe it would have been appropriate to address the issue of legal immigrants when the TANF was reauthorized.

There has been significant interest in giving states the option to provide Medicaid (and CHIP) coverage for legal immigrants and eliminating the five-year deeming requirement that accompanies the ban. Congressmen Diaz-Balart and Waxman are the lead sponsors of a bill, H.R. 1143, which would allow states to provide Medicaid coverage for legal immigrant children and pregnant women under Medicaid and CHIP and not require sponsor deeming for the first five years of residency. In 2000, the Committee reported out the Beneficiary Improvement and Protection Act (H.R. 5291) which allowed states the option to cover legal immigrant children and pregnant women under Medicaid and CHIP after they lawfully resided in the country for two years. This prohibition on coverage of legal immigrants is bad health policy as individuals who lack insurance tend to forgo or delay needed treatment and later on tax the health system as preventable illnesses turn into serious conditions requiring more expensive care. We believe the Committee should act to rectify this problem quickly.

JOHN D. DINGELL.
PETER DEUTSCH.
ED TOWNS.
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LOIS CAPPS.
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