

**SOUTHERN REGIONAL INITIATIVE TO
IMPROVE ACCESS TO BENEFITS FOR
LOW INCOME FAMILIES WITH CHILDREN**

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EXECUTIVE SUMMARY

With the passage of welfare reform, the consolidation of child care programs, the attainment of more state options under Medicaid and the enactment of the State Children's Health Insurance Program (CHIP), states are now in the position to make significant changes in fundamental health and social policies related to children. As states move forward to design and implement public policies that support low income working families, it is critical that the perspective of families be included in their deliberations.

In studies conducted by the Southern Institute on Children and Families, a resounding message from families has been that they need assistance in paying for child health coverage, child care and other needs and they would like such assistance to be related to their income. They are frustrated by public programs that provide benefits based on arbitrary time limits and other rules that are not related to their ability to pay.

An economic reality check demonstrates the income versus expenses predicament faced by low wage families. Table 1 displays the annual income for a family of three earning at the minimum wage (80% of the federal poverty level), 100%, 150% and 200% of the federal poverty level.

TABLE 1			
VARIOUS LEVELS OF ANNUAL INCOME RELATED TO			
THE 1997 FEDERAL POVERTY LEVEL			
FOR A FAMILY SIZE OF THREE			
80% of Poverty (Full Time Minimum Wage)	100% of Poverty	150% of Poverty	200% of Poverty
\$10,712	\$13,330	\$19,995	\$26,660
Source: Southern Institute on Children and Families, 1997.			

Given these income levels, it is not difficult to understand how families earning these amounts are in a constant economic struggle to pay for housing, utilities, food, clothing, transportation, health care, child care and other basic

needs. And, it's not difficult to understand why they become discouraged when they encounter public policies and programs that fail to recognize simple economic realities.

In addition to implementing new strategies to assist low income families, states must move aggressively to utilize existing opportunities to bolster families who work in low wage jobs. The extent to which states take advantage of and promote available programs varies widely across the southern region.

Southern Regional Initiative to Improve Access to Benefits for Low Income Families With Children

In February 1997, the Southern Institute on Children and Families received support from The Robert Wood Johnson Foundation to launch a regional outreach initiative to help southern states identify ways to improve access to benefits for low income working families with children. Specific objectives of the project are:

- To identify specific actions needed to improve access to child health coverage and child care assistance;
- To assist and encourage states to implement aggressive outreach strategies, especially in the development of more effective communication with families about the availability of health coverage, child care and other benefits; and
- To make the eligibility process for child health coverage more accessible, dignified and user friendly.

Development of Information Outreach Materials

Public policy makers often assume that the passage of laws and/or the appropriation of funding will result in benefits reaching the citizens who are eligible to receive them. With programs for low income families, however, insufficient attention and resources have been devoted to the development of effective communication strategies to inform them about available benefits. Studies by the Southern Institute have shown that many families are not aware of government benefits that can help provide health coverage for their children, assist them in paying for child care, and allow them to keep more of what they earn.

This project builds on Southern Institute initiatives undertaken in cooperation with health and human service officials in **NORTH CAROLINA** and **GEORGIA** to develop effective information outreach materials. Through the use of 27 focus groups conducted in nine urban and rural counties with welfare and transitional benefits recipients, community organizations and employers, the Southern Institute developed easy to understand information outreach brochures to convey positive messages about the following benefits for low income working families:

- Medicaid benefits for children during and after the welfare related transition period;
- Medicaid benefits for children in low income working families who have no current or recent connection to the welfare system;
- Earned Income Tax Credit (EITC) benefits, especially the monthly advance which is available at no cost to the employer;
- Child care assistance for families leaving welfare for work and child care assistance for low income working families in general;
- Food stamps; and
- Child support enforcement.

The project provides technical assistance to states to replicate the information outreach brochures developed in Georgia and North Carolina and also produced videos to be used in conjunction with the dissemination of the information outreach brochures. All states and the District of Columbia have indicated that they will take advantage of the opportunity to produce the brochures for use in their outreach efforts.

At present, 10 southern states have completed production and are using the brochures statewide. The project also produced videos based on the brochures. (See Table 6 for state by state information.)

State Site Visits

From March through September 1997, the project sponsored site visits to the following 17 southern states and the District of Columbia:

Alabama	Louisiana	South Carolina
Arkansas	Maryland	Tennessee
Delaware	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

The Foundation for Child Development provided support with two of the state site visits.

The site visits were conducted in cooperation with governors' offices and state health and human service officials. A total of 445 persons participated in the site visit meetings. The site visit meetings identified policies and procedures that present access barriers for low income families and also identified strategies states are using to improve access to benefits, primarily child health coverage and child care subsidies.

On completion of the 18 site visits, the project sponsored the Southern Regional Forum on Improving Access to Benefits for Families With Children to promote dialogue on interagency and interdepartmental issues affecting low income families. The forum brought together state policy staff who work with health coverage, child care, eligibility and transportation issues. Persons attending the regional forum were designated by each of the 17 governors, as well as designees from the District of Columbia. Forum presentations are summarized in the relevant chapters of this report and contacts for further information are provided.

Actions That Can Improve Access to Benefits

This report outlines actions states are taking and actions that can be taken to improve access to benefits for low income families with children. The chapters include discussion of access issues related to the affordability of health coverage and child care in relation to family income, the categorical structure of

benefit programs for low income families with children, the complex and often counterproductive eligibility rules, inadequate transportation services and the need for aggressive state and community outreach. Additionally, state strategies to address needs are summarized and state-by-state data is presented where available. The recommended actions are presented below and appear at the end of the relevant chapters.

Child Health Coverage

- 1) To increase the number of low income children who have health coverage, states should utilize the opportunities presented by the Medicaid program, CHIP and state/local coverage programs to design a coordinated approach to child health coverage.
 - To assure health coverage for all children living in poverty, states should accelerate the federal Medicaid phase-in for all children 18 years old and younger.
 - To prevent inequity of health coverage across age groups, states should design coverage programs for low income children to achieve uniformity in age groups and income levels.
- 2) To allow states to efficiently provide Medicaid coverage for children and families who are eligible under the state welfare (TANF) program, the Medicaid law can be amended to give states the option to create a Medicaid eligibility category which mirrors TANF eligibility.
- 3) To assure that families applying for welfare (TANF) understand that they do not have to be on welfare to obtain Medicaid coverage for their children, states should fully inform and link applicant families to health coverage opportunities, such as Medicaid poverty related children coverage, Section 1931 coverage, state CHIP coverage and other state/local coverage programs.
- 4) To avoid denying Medicaid coverage to children in income eligible families who have resources that exceed state asset limits, states should exempt assets when determining eligibility for child health coverage.
- 5) In order to reduce the chances that reporting requirements could result in income eligible families losing Medicaid benefits during the first year after leaving welfare, the federal Medicaid law can be amended to give states the option to eliminate reporting requirements in the second six months of Transitional Medicaid.

- 6) To avoid requiring families to spend a specified time on welfare in order to obtain health coverage, the federal Medicaid law can be amended to give states the option to eliminate the rule that requires families to receive cash assistance for three out of the previous six months in order to be eligible for Transitional Medicaid.
- 7) To assist low income families to access health coverage for their children, states and communities should design and implement aggressive outreach strategies.
- 8) To improve access to child health coverage, states and communities should identify and implement actions needed to make the application process less burdensome for families.
- 9) In order to avoid erroneous or premature termination of Medicaid benefits for a child, states should develop and implement information systems which assure that children are automatically transferred from one eligibility category to another without disruption to their Medicaid benefits.
- 10) To assure that the eligibility system is regularly examined with the goal of reducing policy and procedural barriers, states and communities should establish a periodic review process of eligibility outcome data.

Child Care Assistance

- 1) To assist more low income families with the high cost of child care and to discourage welfare as an entry point for child care assistance, states should identify and implement actions to achieve an income based system of child care subsidies for low income working families with no requirement that a family be on welfare for any period of time in order to obtain assistance in paying for child care.
- 2) To avoid denying child care assistance to children in income eligible families who have resources that exceed state asset limits, states should exempt assets when determining eligibility for child care assistance.
- 3) To assure that the application and recertification process is not burdensome for low income families seeking child care assistance, states should review eligibility policies and procedures, including recertification periods and verification requirements.
- 4) In order to provide continuity of child care assistance, states should review policies regarding agency initiative in making category changes for low income families whose children remain eligible.

- 5) To assure that families know about available child care assistance, states and communities should design and implement outreach strategies to communicate the availability of child care assistance for low income working families.
- 6) To foster cooperation with Head Start, states should identify and disseminate information on successful Head Start collaboration strategies and document issues that need to be addressed at the federal level.

Transportation

- 1) To develop more efficient and responsive transportation solutions for poor and low income citizens, states should create state level or multi-state work groups composed of the various public and private agencies that purchase or provide transportation services. The objectives would be to:
 - Identify strategies to effectively and efficiently coordinate transportation services designed to assist low income citizens; and
 - To identify strategies to help low income families acquire personal automobiles.

Including advocacy groups and/or family representatives in the deliberations will provide needed input from user groups. The experience of local initiatives should be examined and information on state or federal demonstration projects should be reviewed. Federal technical assistance should be provided to avoid misinterpretation of federal policies and rules and to identify coordination and collaboration opportunities.

- 2) To avoid penalizing low income families who own an automobile, states should eliminate automobile asset testing for families applying for child health coverage, child care assistance and other benefits.

Earned Income Tax Credit

- 1) To assure that families learn about the EITC, states should conduct information outreach campaigns, with special efforts targeted to families on welfare, and provide EITC information and forms to eligibility workers.
- 2) To assure that children do not lose Medicaid because their family claimed the EITC and did not spend their refund quickly, states should exclude the cash received through the EITC, whether through the advance method or end of year tax refund, from the state definition of assets.
- 3) To avoid children losing Medicaid coverage, the federal government can enact the same policy it has for income and thus disallow the counting of EITC cash as an asset in determining Medicaid eligibility.

CHAPTER 1 INTRODUCTION

With the passage of welfare reform, the consolidation of child care programs, the attainment of more state options under Medicaid and the enactment of the State Children's Health Insurance Program (CHIP), states are now in the position to make significant changes in fundamental health and social policies related to children. While producing much controversy, welfare reform brought long overdue attention to the economic issues and incentives intertwined in welfare and health policy. Since its passage, states have made greater investments in benefits to help low wage families with high cost items like health coverage and child care.

As states move forward to design and implement public policies that support low income working families, it is critical that the perspective of families be included in their deliberations. Studies by the Southern Institute on Children and Families (hereinafter referred to as the Southern Institute) often involve personal interviews and focus groups with families where they are asked to share their views and are encouraged to make suggestions on what actions are needed to improve policies and operations. In Southern Institute studies on health and welfare issues, a resounding message from families has been that they need assistance in paying for child health coverage, child care and other needs and they would like such assistance to be related to their income. They are frustrated by public programs that provide benefits based on arbitrary time limits and other rules that are not related to their ability to pay.

An economic reality check demonstrates the income versus expenses predicament faced by low wage families. Table 1 displays the annual income for a family of three earning at the minimum wage (80% of the federal poverty level), 100%, 150% and 200% of the federal poverty level.

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Source: Southern Institute on Children and Families, 1997.			

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- To make the eligibility process for child health coverage more accessible, dignified and user friendly.

Development of Information Outreach Materials

The project builds on Southern Institute initiatives undertaken in cooperation with health and human service officials in **GEORGIA** and **NORTH CAROLINA**. Through the use of 27 focus groups in nine urban and rural counties with welfare and transitional benefits recipients, community organizations and employers, the Southern Institute developed and tested eye-catching, easy to understand information outreach brochures to convey positive messages about the following benefits for low income working families:

- Medicaid benefits for children during and after the welfare related transition period;
- Medicaid benefits for children in low income working families who have no current or recent connection to the welfare system;
- Earned Income Tax Credit (EITC) benefits, especially the monthly advance which is available at no cost to the employer;
- Child care assistance for families leaving welfare for work and child care assistance for low income working families in general;
- Food stamps; and
- Child support enforcement.

The project provides technical assistance to states to replicate the information outreach brochures initially developed in Georgia and North Carolina.

The project also produced videos to be used in conjunction with the dissemination of the information outreach brochures. Two videos were produced to inform families about available benefits and one video provides information for employers. The videos for viewing by families and community organizations were also produced in Spanish.

State Site Visits

From March through September 1997, the project sponsored site visits to the following 17 southern states and the District of Columbia:

Alabama	Louisiana	South Carolina
Arkansas	Maryland	Tennessee
Delaware	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

The Foundation for Child Development provided support to assist with two of the state site visits.

The site visits were conducted in cooperation with governors' offices and state health and human service officials. A total of 445 persons participated in the site visit meetings. The site visit discussions identified policies and procedures that present access barriers for low income families and also identified strategies states are using to improve access to benefits, primarily child health coverage and child care subsidies. The discussions were centered on four areas:

- Outreach strategies to both inform families about available health coverage, child care and other benefits and to assist them in enrollment;
- Eligibility policies related to Medicaid coverage for poverty related children and welfare families;
- Simplification of Medicaid eligibility procedures and requirements; and
- Eligibility policies and procedures related to child care assistance;

Appendix A provides information on state contacts who were responsible for handling arrangements for the site visits.

Southern Regional Forum

On completion of the 18 site visits, the project sponsored the Southern Regional Forum on Improving Access to Benefits for Families With Children. The forum brought together state policy staff who work with health coverage, child care, eligibility and transportation issues. Persons attending the regional

forum were designated by each of the 17 governors, as well as designees from the District of Columbia. Other guests attending the forum included representatives of the National Governors' Association, Administration on Children and Families, Health Care Financing Administration, advocacy groups, national policy researchers and foundation representatives

The regional forum was designed to share information gained on the state site visits and to promote dialogue on interagency and interdepartmental issues affecting low income families. The opportunity to learn about issues and strategies used in other states and in other program areas was well received by the attendees. A total of 120 individuals were in attendance. Five panels of state, federal and private sector representatives provided information on the following topics:

- Supporting work through child care subsidies;
- Making health coverage available to working families;
- Implementing state and community outreach;
- Removing health coverage eligibility barriers; and
- Reaching for transportation solutions

The forum presentations are summarized in the relevant chapters of this report and contacts for further information are provided. See Appendix B for the forum program.

Summary of Report

This report outlines actions states are taking and actions that can be taken to better support low income working families with children. Most of the information contained in the report was gathered on state site visits conducted during the project. Some additional surveying was required to collect updated information on issues discussed in the report. A brief review of the chapters is presented below.

Chapter 2 discusses the information outreach brochures and videos developed by the Southern Institute and provides the status of efforts to replicate the information outreach brochures throughout the southern region.

Chapter 3 discusses issues and strategies states can consider in providing health coverage for more low income children. The chapter also discusses federal policies that restrict access to Medicaid coverage, as identified on the state visits. The chapter outlines Medicaid issues related to families leaving welfare for work and low income families who have no connection to the welfare system. Information is also presented on state Medicaid eligibility levels for children as of September 1, 1997 and state Medicaid plan amendments submitted by southern states as part of the State Child Health Insurance Program (CHIP). And finally, the chapter contains a discussion of eligibility outreach and eligibility simplification issues.

Chapter 4 discusses issues, provides survey results and presents information on strategies states can consider when designing actions to improve access to child care assistance.

Chapter 5 discusses transportation issues and strategies.

Chapter 6 provides information and discusses issues related to the Earned Income Tax Credit (EITC).

Chapter 7 provides information on recent federal developments relevant to the project.

CHAPTER 2 INFORMATION OUTREACH

Most communication on benefits and services for families has been in the form of bureaucratically worded documents that advise of rights and responsibilities in connection with receipt of benefits. Rarely are there materials that communicate information on available benefits in an easy to understand, “user friendly” manner.

Public policy makers often assume that the passage of laws and/or the appropriation of funding will result in benefits reaching the citizens who are eligible to receive them. With programs for low income families, however, insufficient attention and resources have been devoted to the development of effective communication strategies to inform them about available benefits. Thus, many families are not aware of government benefits that can help provide health coverage for their children, assist them in paying for child care, and allow them to keep more of what they earn.

Initial Development of Information Outreach Brochures

In a study conducted by the Southern Institute in cooperation with the North Carolina Department of Human Resources and the Tennessee Department of Human Services, serious misconceptions about the availability of benefits were identified.¹ The findings showed that families on welfare and families receiving Transitional Medicaid, as well as community organizations who work to help them, lacked information or were misinformed about the availability of health coverage and other benefits.

As part of the study, personal interviews were conducted with randomly chosen recipients of Aid to Families With Dependent Children (AFDC) and Transitional Medicaid benefits. During the interviews, specific questions were

¹ Sarah C. Shuptrine, Vicki C. Grant and Genny G. McKenzie, A Study of the Relationship of Health Coverage to Welfare Dependency (Columbia, SC: Southern Institute on Children and Families, March 1994).

asked in order to determine the degree to which recipients understood how benefits changed when they left welfare for work. The questions related to AFDC (the cash assistance welfare program), Medicaid, food stamps, child care and housing.

Table 2 shows the findings from the recipient interviews. The program least understood was Medicaid, with 76% incorrect responses. Forty-seven percent (47%) of the responses related to child care assistance were incorrect. Responses indicated that many believed that families had to be on welfare to receive any assistance with health coverage and child care.

TABLE 2 PERCENTAGE OF RECIPIENTS PROVIDING INCORRECT RESPONSES TO THE IMPACT OF EARNINGS ON BENEFITS	
Benefit	Percentage Providing Incorrect Responses
AFDC	24%
Food Stamps	6%
Medicaid	76%
Child Care	47%
Housing	24%
Source: Southern Institute on Children and Families, 1994. Data collected from recipient interviews in Charlotte, North Carolina and Nashville, Tennessee.	

The Southern Institute published its report in March 1994 and recommended that state social services officials in the southern states develop “user friendly” materials to effectively communicate the benefits available through various programs. With support from the North Carolina Department of Human Resources, 18 focus groups were held in six counties to assist in the development and testing of information outreach brochures that communicated the availability of Medicaid benefits for children, the Earned Income Tax Credit (EITC), child care and food stamps. Subsequent to the **NORTH CAROLINA** information outreach project, nine additional focus groups were held in three

counties in **GEORGIA** with support provided by the Georgia Division of Family and Children Services.

In each state, focus groups were held in urban and rural counties with the following groups: 1) AFDC and Transitional Medicaid recipients (chosen randomly); 2) community organizations; and 3) employers. In North Carolina, 144 persons participated in the focus groups. In Georgia, 89 persons participated.

In both states, pretest and post test questions were administered to measure the knowledge of focus group participants regarding general Medicaid eligibility rules for children, Transitional Medicaid, the Earned Income Tax Credit and child care. The pretest results in both states clearly demonstrated the need for aggressive information outreach. The **GEORGIA** pretest results are summarized below.

Recipients

- **55%** did not understand that if parents get off welfare because of work, their children would be able to get Medicaid.
- **57%** did not understand that even if a child's parents live together, the child can get Medicaid.
- **59%** did not know about the availability of Transitional Medicaid Assistance for up to one year.
- **78%** did not understand that children under age six are eligible for Medicaid at higher income levels than older children.
- **53%** did not know that if parents get a job, they might qualify to get more take home pay from the EITC.
- **41%** did not know that a paycheck plus money from EITC is much greater than a welfare check.
- **82%** did not understand that the money a working parent gets from the EITC does not count against Medicaid, AFDC, food stamps, SSI or housing benefits.
- **39%** did not understand that if parents get off welfare because of work, they can get help with child care expenses for up to one year.

Community Organizations and Providers

- **31%** did not know about the availability of Transitional Medicaid coverage for up to one year.
- **92%** did not understand that children under age six are eligible for Medicaid at higher income levels than older children.
- **39%** did not know that a paycheck plus money from the EITC is much greater than a welfare check.
- **42%** did not understand that the EITC does not count against Medicaid, AFDC, food stamps, SSI or housing benefits.
- **16%** did not know about the availability of Transitional Child Care benefits for up to one year.

Employers

- **21%** did not know that children do not have to be on welfare to be eligible for Medicaid coverage.
- **43%** did not know about the availability of Transitional Medicaid coverage for up to one year.
- **78%** did not understand that children under age six are eligible for Medicaid at higher income levels than older children.
- **50%** did not understand that the EITC is available to low income working families regardless of whether or not they owe taxes.
- **86%** did not understand that they could add a portion of EITC to the employee's paycheck each pay period.
- **50%** did not know about the availability of Transitional Child Care benefits for up to one year.
- **50%** did not know that there are programs that supplement the wages of low income workers with children at no cost to the employer.

For illustration purposes, the first page of the three **GEORGIA** outreach brochures are displayed on page 12 and each brochure is included in its entirety in Appendix C.

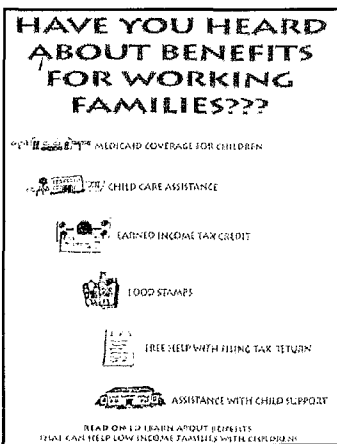
After reading through the outreach brochure, focus group participants were given a post test to measure gains in knowledge. No discussion was held prior to the post test. Results showed that the communication effectiveness of the outreach brochures was statistically significant in both states. Table 3, Table 4 and Table 5 display the **GEORGIA** post test results by target group.

INFORMATION OUTREACH BROCHURES



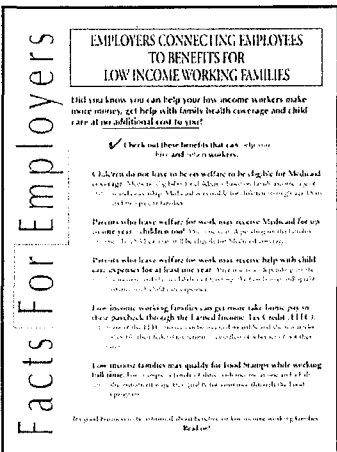
LEAVING WELFARE FOR WORK ISN'T AS SCARY AS IT SEEMS

This brochure is for use with families on cash assistance to help them understand that they do not have to be on welfare in order to receive benefits that can help them meet the needs of their children while working in low wage/no benefit jobs. It is ideal for review with welfare families at redetermination interviews and in job readiness classes. The brochure outlines benefits available to families during the transitional period, as well as benefits available beyond the transitional period. It provides information on Medicaid, the Earned Income Tax Credit, child care assistance and Food Stamps.



HAVE YOU HEARD ABOUT BENEFITS FOR WORKING FAMILIES???

This brochure is designed for general community outreach. It will help families who apply for cash assistance to understand that they can receive Medicaid and other benefits without having to be on welfare. It is also appropriate for distribution through schools, health providers, churches and other community organizations and to employers for dissemination in the workplace. The brochure provides information on Medicaid, the Earned Income Tax Credit, child care assistance, Food Stamps and Child Support Enforcement.



FACTS FOR EMPLOYERS

This brochure provides employers with information on how to link low income employees to benefits that basically supplement low wages at no cost to employers. The brochure is especially appropriate for employers who pay minimum wage or slightly above or employers who offer no or very limited benefits. It is an effective communication tool for use when making personal visits to employers and it is a valuable hand out at presentations to business groups. The brochure provides information on Medicaid, the Earned Income Tax Credit and child care assistance.

**TABLE 3
RECIPIENTS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM**

Program	Pretest	Post Test
Earned Income Tax Credit	41%	86%
Medicaid	38%	81%
Child Care	76%	93%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

**TABLE 4
COMMUNITY ORGANIZATIONS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM**

Program	Pretest	Post Test
Earned Income Tax Credit	71%	96%
Medicaid	61%	98%
Child Care	81%	100%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

**TABLE 5
EMPLOYERS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM**

Program	Pretest	Post Test
Earned Income Tax Credit	38%	100%
Medicaid	61%	96%
Child Care	50%	100%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

Replication of the Information Outreach Brochures in the Southern States

Following the development of the outreach brochures in Georgia and North Carolina, two states (**FLORIDA** and **TENNESSEE**) asked the Southern Institute to adapt the information outreach brochures for use by their states. Thus, when this project began, 13 states and the District of Columbia were not using the outreach brochures. On site visits to the remaining 13 southern states and the District of Columbia during this project, presentations on the information outreach brochures were made to those attending the state meetings.

States were informed that through this project the Southern Institute could provide technical assistance to adapt the information outreach brochures for use by their states. Printing and distribution costs would be the responsibility of each state.

The information outreach brochures were enthusiastically received by persons attending the site visit meetings. All states and the District of Columbia have indicated that they will take advantage of the opportunity to produce the brochures for use in their outreach efforts. At present, 10 southern states have completed production and are using the brochures statewide. Table 6 provides the status of replication of the information outreach brochures across the southern region.

TABLE 6
STATUS OF INFORMATION OUTREACH BROCHURES
JANUARY 1998

State	In Use	In Draft Stage	Planning To Use
Alabama			√
Arkansas			√
Delaware	√		
District of Columbia		√	
Florida	√		
Georgia	√		
Kentucky	√		
Louisiana			√
Maryland	√		
Mississippi	√		
Missouri		√	
North Carolina	√		
Oklahoma		√	
South Carolina	√		
Tennessee	√		
Texas			√
Virginia	√		
West Virginia			√

Note: Most states produced all three outreach brochures for use statewide. South Carolina and Tennessee did not produce the "Facts for Employers" brochure.
Source: Southern Institute on Children and Families, 1998.

Use of the information outreach brochures provides strong evidence that states in the South intend to be proactive in getting messages to low income families about the availability of health coverage and other benefits. While the outreach brochures are especially helpful to families leaving welfare for work, states indicate that the brochures will also be used in their efforts to reach out to families who have no connection with welfare and in their job development efforts with employers.

Information Outreach Videos

Six information outreach videos were developed through this project. The videos are designed to be used in conjunction with the information outreach brochures.

Each state that uses the information outreach brochures has been provided the following videos and has been advised that they can make additional videos or they can order them from the Southern Institute at cost:

- 5 training videos to educate local social services staff on the use of the brochures and the videos.
- 25 videos of the English version of *Leaving Welfare for Work Isn't As Scary As It Seems* and five of the Spanish version videos.
- 25 videos of the English version of *Have You Heard About Benefits for Working Families???* and five of the Spanish version videos.
- 25 *Facts for Employers* videos.

Two focus groups were held in South Carolina to test the video, *Have You Heard About Benefits for Working Families???* Focus group participants were parents of children who were income eligible for Medicaid, but not enrolled in Medicaid. Results indicated that the messages in the video effectively communicated that health coverage and other benefits are available to low income families and these benefits are available to working two parent families in addition to single parents. For many participants, these points were new information.

Participants suggested many possible viewing sites for the video. "Doctor's office" was the most frequent response. Other suggestions included hospitals or emergency room waiting areas, government offices such as social services agencies and health departments, libraries, schools, PTA meetings, women's shelters, churches, post offices, work break rooms and low income housing areas.

The video was positively associated with a feeling of encouragement. Many participants said they themselves could benefit from the new information and/or that they had friends who could benefit from the information.

CHAPTER 3 CHILD HEALTH COVERAGE

The majority of uninsured children live in families where at least one parent was employed full time at low wages.² Even if dependent health coverage is available through the workplace, which it often is not for low income workers, it is financially out of reach for these families.

Since the mid-1980s, public policy initiatives have been enacted to provide opportunities for poor and low income families to obtain Medicaid coverage for their children without requiring the families to be on welfare. The first major step was taken in 1986, when Congress passed an amendment to allow nonwelfare pregnant women and infants to age one to be eligible for Medicaid. Leadership for this significant and progressive change in national public policy emanated from the southern states as they sought ways to reduce the high number of infant deaths and disabilities occurring in the South.³

Since 1986, additional amendments have increased Medicaid age and income eligibility levels to allow more children in low income working families to be eligible for Medicaid. This group of children is often referred to as “poverty related” children because their Medicaid income eligibility levels are based on a specific percentage of the federal poverty level, rather than a relationship to welfare.

Table 7 displays the federal minimum Medicaid age and income eligibility levels for poverty related children as of October 1997. Each year, federal law requires that the age level for children under poverty be increased by one year. Currently, all children through age 13 in families with income below poverty are eligible for Medicaid. By year 2002, all children 18 and younger under poverty will be Medicaid eligible. However, states are not prohibited from taking action

² General Accounting Office, New Strategies to Insure Children, (Washington, DC: US General Accounting Office, GAO/HEHS-96-35, January 1996) p. 4.

³ Southern Regional Task Force on Infant Mortality, Final Report for the Children of Tomorrow, (Washington, DC: Southern Governors' Association, November 1985).

immediately to accelerate the phase in of coverage for children ages 14 through 18 so as to provide Medicaid coverage for all children under poverty. States can accelerate the phase in and even establish higher eligibility levels for children by simply amending their State Medicaid Plan. A federal waiver is not required.

**TABLE 7
FEDERAL MINIMUM MEDICAID AGE AND INCOME
ELIGIBILITY LEVELS, 1997
(Expressed As a Percentage of the 1997 Federal Poverty Level)**

Age	Federal Poverty Level	Annual Income (Family of Three)
Birth to Age 1	133%	\$17,729
Age 1 - 5	133%	\$17,729
Age 6 - 13*	100%	\$13,330
*On October 1 of each year, federal law requires that the age limit advance by one year until 18 year old children are included in the year 2002.		

Research has shown that health insurance makes a difference when it comes to children having access to needed health care. Children without health coverage are less likely to have access to a regular source of medical care or to seek care for injuries, and are more likely to receive care in a clinic or emergency room and less likely to be appropriately immunized.⁴ A Families USA report cited the following:

Uninsured children frequently go without annual doctor visits. Almost two out of five long-term uninsured children (37 percent) have no doctor visits throughout the year -- more than two-and-one-quarter times the rate for insured children. Even young children age five years and under, who should receive annual doctor visits to monitor their growth and development, go without such care at three times the rate of insured children. When they do see doctors, long-term uninsured children are twice as likely as insured children to get care in emergency rooms.⁵

⁴ General Accounting Office, New Strategies to Insure Children, 3; Linda J. Blumberg and David W. Liska, The Uninsured in the United States: A Status Report, (Washington, DC: The Urban Institute, April 1996); and Ron Pollack, Cheryl Fish-Parcham, and Barbara Hoenig, Unmet Needs: The Large Differences in Health Care Between Uninsured and Insured Children, (Washington, DC: Families USA, 1997).

⁵Pollack, Fish-Parcham, and Hoenig, 1.

Studies have also shown that children with public health coverage such as Medicaid have comparable access to children who have private coverage.⁶

For low income families, affordability of child health coverage is a major impediment to their children having access to preventive and primary health care. As shown in Table 8, in the South, 65% of all uninsured children live in families with income at or below 200% of the federal poverty level.⁷

⁶ U.S. Congress, Office of Technology Assessment, Healthy Children: Investing in the Future, OTA-H-345 (Washington, DC: U.S. Government Printing Office, February 1988), 17; Alan C. Monheit and Peter J. Cunningham, "Children Without Health Insurance," The Future of Children vol. 2 no. 2 (Winter 1992): 154-170; The Uninsured in the United States: A Status Report, 5.

⁷ Sarah C. Shuptrine and Vicki C. Grant, Uninsured Children in the South, Second Report, (Columbia, SC: Southern Institute on Children and Families, November 1996) p. 10.

**TABLE 8
DISTRIBUTION OF UNINSURED CHILDREN BY FAMILY INCOME
AS RELATED TO THE 1993 FEDERAL POVERTY LEVEL**

Area	Less Than or Equal to 100%	101% - 200%	Greater Than or Equal to 201%
Alabama	38%	29%	33%
Arkansas	28%	46%	25%
Delaware	8%	53%	38%
District of Columbia	47%	38%	14%
Florida	25%	37%	38%
Georgia	18%	32%	50%
Kentucky	34%	19%	47%
Louisiana	53%	26%	21%
Maryland	10%	39%	51%
Mississippi	28%	37%	34%
Missouri	21%	45%	34%
North Carolina	14%	33%	54%
Oklahoma	34%	43%	23%
South Carolina	35%	30%	35%
Tennessee	20%	34%	47%
Texas	29%	43%	28%
Virginia	8%	49%	43%
West Virginia	28%	26%	46%
SOUTHERN STATES	28%	37%	35%
UNITED STATES	25%	35%	40%

Source: Southern Institute on Children and Families (1994 CPS).

This chapter presents a discussion of issues that impede access to health coverage for low income children. Although the focus is on Medicaid, the issues are relevant to the design of other state health coverage programs for children. Every effort has been made to simplify the discussion of some very technical issues. Reading about it is difficult enough, but for families trying to navigate

the complicated eligibility system with minimal assistance, it can be overwhelming. The emphasis is on the critical need to implement effective outreach and also to simplify the application process. Even if families are better informed about their options, difficult application procedures will still impede their access to health care programs for which they are qualified.

Medicaid Income Eligibility Levels for Children

Whether provided through Medicaid or another method, the first decision is to determine the income eligibility level at which the state will assist low income working families to obtain child health coverage. Tying eligibility to some percentage of the federal poverty level has been the usual method of setting income eligibility levels. Table 9 provides percentage categories based on the 1997 federal poverty level by family size.

TABLE 9 1997 FEDERAL POVERTY LEVEL BY FAMILY SIZE					
Family Size	100%	133%	150%	185%	200%
One	\$7,890	\$10,494	\$11,835	\$14,597	\$15,780
Two	\$10,610	\$14,111	\$15,915	\$19,629	\$21,220
Three	\$13,330	\$17,729	\$19,995	\$24,661	\$26,660
Four	\$16,050	\$21,347	\$24,075	\$29,693	\$32,100

Note: Income guidelines are adjusted upward annually to reflect increases in the poverty level.
Source: Southern Institute on Children and Families.

In order for state policy makers to make informed decisions on the establishment of child health coverage eligibility levels, state data on the characteristics of uninsured children are needed, although such data are not readily available. To assist states, the Southern Institute analyzed data on uninsured children using the 1994 Current Population Survey (CPS).⁸ Uninsured children in the CPS are children uninsured all year. From a regional

⁸ Ibid., p. v.

perspective, it was found that in 1993, 43% of the nation's uninsured children resided in 17 southern states and the District of Columbia. The analysis found that age and income ranges which had the lowest percentages of uninsured children coincided with Medicaid age and income ranges. Some of the other findings are presented below:

- Uninsured children as a percentage of a state's population of children age 18 and younger ranged from a high of 25% in LOUISIANA to a low of 10% in MISSOURI and NORTH CAROLINA. More than one million (25%) of all uninsured children in the South lived in TEXAS.
- In 12 southern states, less than one third of uninsured children lived in families with income at or below the poverty level.
- Older children in the South were much more likely to be uninsured than children age five and younger.

During the Southern Institute state site visits in the spring and summer of 1997, attention was focused on the magnitude of the problem of uninsured children in the southern states. At that time, three southern states (**ARKANSAS, OKLAHOMA and SOUTH CAROLINA**) had recently initiated Medicaid expansions for children in low income working families. A few additional states were looking at expanding Medicaid or creating other opportunities for child health coverage. Nine states (**DELAWARE, KENTUCKY, MISSOURI, NORTH CAROLINA, OKLAHOMA, SOUTH CAROLINA, TENNESSEE, TEXAS and WEST VIRGINIA**) and the **DISTRICT OF COLUMBIA** had expanded or were considering expansions of Transitional Medicaid programs to provide longer periods of Medicaid coverage for families leaving welfare for work.

A survey was conducted to collect information on Medicaid age and income levels for children in the 17 southern states and the District of Columbia as of September 1997. The results are displayed in Table 10 and are summarized as follows:

- Two southern states (**ARKANSAS and SOUTH CAROLINA**) had implemented significant Medicaid expansions to provide health coverage for more children through the age of 18 in low income working families.

- Five states (**GEORGIA, MISSOURI, NORTH CAROLINA, VIRGINIA** and **WEST VIRGINIA**) had accelerated the federal phase in of children so as to provide Medicaid coverage for all children under 100% of the federal poverty level.
- Nine states (**ALABAMA, FLORIDA, KENTUCKY, LOUISIANA, MARYLAND, MISSISSIPPI, OKLAHOMA, TENNESSEE** and **TEXAS**) and the **DISTRICT OF COLUMBIA** had not accelerated the federal phase in of children under 100% of the federal poverty level. Thus, the Medicaid eligibility level for children ages 14 through 18 in these states was the welfare income eligibility level in effect on July 16, 1996.
- **TENNESSEE** allowed specified uninsured children who were not Medicaid eligible to buy into the TennCare program based on a sliding scale.

TABLE 10
MEDICAID ELIGIBILITY LEVELS FOR CHILDREN
SOUTHERN REGION, SEPTEMBER 1997
(Displayed as a Percentage of the 1997 Federal Poverty Level)

Area	Birth to 1	Ages 1-5	Ages 6-13	Ages 14-18 ^b
Federal Minimum	133%	133%	100%	None
Alabama	133%	133%	100%	15.2%
Arkansas ^c	200%	200%	200%	200%
Delaware	185%	133%	100%	100%
District of Columbia	185%	133%	100%	38%
Florida	185%	133%	100%	28%
Georgia	185%	133%	100%	100%
Kentucky	185%	133%	100%	48.6%
Louisiana	133%	133%	100%	17.6%
Maryland	185%	133% ^d	100% ^d	34.5%
Mississippi	185%	133%	100%	34%
Missouri	185%	133%	100%	100%
North Carolina	185%	133%	100%	100%
Oklahoma	150%	133%	100%	47.7%
South Carolina	185%	150%	150%	150%
Tennessee ^e	185%	133%	100%	53.2%
Texas	185%	133%	100%	17%
Virginia	133%	133%	100%	100%
West Virginia	150%	133%	100%	100%

Notes:

- a) The shaded areas indicate income levels or ages higher than the federal minimum.
- b) For ages 14-18, percentages below 100% of the federal poverty level are state Aid for Families with Dependent Children (AFDC) eligibility levels as of July 16, 1996.
- c) Arkansas has a Medicaid waiver to provide benefits to uninsured children with incomes below 200% who are not Medicaid eligible. Covered services for the expanded group differ from the regular Medicaid program.
- d) Maryland has a Medicaid waiver to provide primary care benefits only to children in these age groups with incomes in excess of these percentages, but no higher than 185%.
- e) Tennessee has a Medicaid waiver which allows specified uninsured adults and children who are not Medicaid eligible to buy TennCare coverage on a sliding scale.

Source: Southern Institute on Children and Families, Southern State Survey, October 1997.

Effective October 1997, the new Title XXI State Children's Health Insurance Program (CHIP) was implemented. The enactment of this new federal initiative gives states enhanced federal matching dollars to provide health coverage for low income, uninsured children through Medicaid expansions or a state health coverage program.

According to the National Governors' Association, as of January 12, 1998, four southern states (**ALABAMA, FLORIDA, MISSOURI** and **SOUTH CAROLINA**) had submitted CHIP implementation plans to HCFA. Listed below is information on these expansions in health coverage for children.

- **ALABAMA** plans to expand Medicaid to all children through age 18 below the federal poverty level. (Effective February 1, 1998.)
- **FLORIDA** plans to expand Medicaid to all children through age 18 below the federal poverty level. The Healthy Kids program will subsidize premiums for Healthy Kids benefits for children at or below 185% of the poverty level. (Effective January 1, 1998.)
- **MISSOURI** plans to expand Medicaid to children through age 18 up to 300% of the federal poverty level. (Effective July 1, 1998.)
- **SOUTH CAROLINA** expanded Medicaid coverage to all children through age 18 at or below 150% of the poverty level. (Effective August 1, 1997.)

Medicaid Age Groups for Children

As shown in Table 10 above, state Medicaid income eligibility levels vary by children's ages. The major reason for the age and income differences is the piecemeal manner in which the federal expansions were created. The differing age and income levels create a confusing and often disheartening situation for families with children of multiple ages. States must decide whether children's ages will matter when it comes to health coverage.

It is difficult for both families and providers to understand why Medicaid income eligibility levels for children vary by age. Age makes no difference in children's need for health coverage. For providers, having health coverage differences among children in the same family poses problems related to charging for care for uninsured siblings. Some physicians have indicated that

they were hesitant to become the primary care provider for a family where some children had health coverage and others did not have coverage.

To achieve equity among children in the same family, to reduce confusion about coverage groups and to foster good provider relationships, Medicaid expansions or state health coverage programs need to be designed to achieve uniformity across age groups and income levels. In doing so, states must be cautious not to adversely affect children in the younger age groups who are Medicaid eligible at higher income levels. **ARKANSAS** has achieved uniformity across all age groups. **SOUTH CAROLINA** has achieved uniformity for children ages one through 18 and maintained 185% of the federal poverty level for infants to age one.

Section 1931 Medicaid Eligibility

Prior to welfare reform, families who were eligible for welfare were automatically eligible for Medicaid. The passage of welfare reform severed this automatic link.

During the welfare reform debate, concern was expressed regarding the need to maintain Medicaid coverage for families receiving AFDC at the time welfare reform was enacted. There was also a desire to give states an additional opportunity to provide Medicaid coverage for both children and parents in low income families. As a result, Section 1931 of the Medicaid law created a new Medicaid eligibility category to provide Medicaid coverage for families who meet a state's AFDC eligibility requirements in effect on July 16, 1996, shortly before welfare reform legislation passed Congress.

States must now determine how to deal with two separate eligibility determinations, one for welfare and another for Medicaid. This does not mean that states have to use a separate application process and no southern state indicated the desire to do so. However, when the eligibility criteria differs between the Section 1931 rules and the new state welfare rules, administrative complexity is added to an already complicated process.

During the site visits discussions, it was apparent that states were struggling to find an efficient way to provide Medicaid coverage for families who receive welfare. Many states were experiencing difficulty in doing so because they had enacted or were preparing to enact more liberal eligibility criteria for welfare families than the state's welfare criteria in effect on July 16, 1996, particularly in the area of allowed assets and the deprivation requirement.

All but a few states provided assurances that when families applied for welfare, they were being informed of Medicaid coverage opportunities without welfare. Those that could not make such assurances at the time indicated that plans to inform families were underway.

As discussed in Chapter 2, it is essential that families applying for welfare and those receiving welfare understand that they do not have to receive cash assistance to receive Medicaid coverage. In particular, for children ages 14 through 18 in the nine southern states that have not accelerated the Medicaid age related phase in for children under poverty (see Table 10 above), coverage under Section 1931 may be the only way they can obtain Medicaid coverage without being on welfare unless a state also has a Medically Needy program.

While the southern states did not want to return to automatic eligibility, all states indicated that they would like to have the option to create a Medicaid category that is a mirror image of their state's welfare criteria under the TANF block grant so that they would be able to link welfare families to Medicaid eligibility without the need for a separate eligibility determination.

Asset Testing

An additional state decision regarding eligibility for child health coverage is whether to disallow assistance to income eligible families who have assets such as a savings account and automobile. Federal law gives states the option to not impose an asset test in determining Medicaid eligibility for children.

Most states do not conduct an asset test for children. In the South, only **ARKANSAS** and **TEXAS** conduct asset tests for children's Medicaid. **OKLAHOMA** recently took action to eliminate asset testing effective December 1, 1997.

Transitional Medicaid

Transitional Medicaid benefits are provided to families who leave welfare due to increased earnings. Federal law states that families are entitled to Transitional Medicaid coverage for six months regardless of income and for an additional six months if their income does not exceed 185% of the federal poverty level.

Discussions during the site visits indicated that when families lose Transitional Medicaid in the second six months, it is usually not because their income exceeded 185% of the poverty level. The major reason for loss of Transitional Medicaid benefits is because families did not comply with reporting requirements related to verification of income. These reporting requirements are burdensome for families, employers and eligibility agencies and have little merit with regard to quality control. During site visit discussions, all states indicated that they would like to have the option to provide Transitional Medicaid benefits for 12 months without interim reporting requirements.

Federal law also requires as a condition of eligibility for Transitional Medicaid that families actually receive cash assistance for at least three months of the preceding six months. In effect, this rule encourages families to apply for welfare in order to obtain Medicaid coverage for their family. All states indicated that they would like to have the option of eliminating this rule.

States recognize that providing Medicaid coverage during a transitional period is an important strategy for welfare reform. However, an issue related to Transitional Medicaid is that it is time limited rather than income based. Benefits are terminated at a specific time regardless of the family's ability to pay for health coverage at that point.

As reported above, at the time of the site visits, nine southern states and the District of Columbia had increased or were giving consideration to increasing the time period for receipt of Transitional Medicaid. However, Southern Institute interviews and focus groups with families have identified time limited benefits as discouraging to families leaving welfare for work. Their clear message is that they would like to see benefits of all types available on a sliding

income scale so that they earn out of the range of eligibility rather than having benefits expire due to an arbitrary time limit.

After the expiration of Transitional Medicaid, it is likely that the children will still be eligible for Medicaid, especially if they are in the younger age groups where income eligibility levels are higher. For very low wage workers, however, having coverage for parents as well as children is important for the family's well being.

Two southern states have created programs to provide health coverage for adults. **DELAWARE** provides health coverage through the Diamond State Health Plan to uninsured individuals with incomes below the poverty level. **TENNESSEE** allows both children and adults in low income families to buy into Medicaid. Both states had to obtain federal 1115 waivers to enact their programs.

During site visit discussions, several states indicated a desire to be able to provide Medicaid benefits on a sliding income scale without having to go through what they consider to be an ordeal to obtain a federal Medicaid waiver.

State Child Health Coverage Strategies

During the site visit discussions, strategies implemented by southern states to expand health coverage for children in low income families were identified. Summaries of five state approaches are outlined below and state contacts are provided for further information.

Arkansas

An initiative of Governor Mike Huckabee, the ARKids First program was implemented in September 1997 to provide health coverage to working families who earn too much to be eligible for Medicaid, but cannot afford to purchase their own health insurance. ARKids is available to children through age 18 with income at or below 200% of the poverty level.

ARKids required a Medicaid 1115 waiver since it provides a limited benefits package and families are charged a small copayment for services. There is no resource test under ARKids.

Funding for ARKids is provided by \$11 million in state Medicaid dollars and \$33 million in federal Medicaid matching funds.

An aggressive marketing campaign is underway to reach out to eligible families. (See the Outreach program summary below for more information.) As of January 1998, 10,000 children were enrolled in the program.

Contact: William Freeburn
Arkansas Department of Human Services
PO Box 1437
Little Rock, AR 72203
501/682-8303
bill.freeburn@medicaid.state.ar.us

Florida

Healthy Kids is a non-Medicaid health insurance program offered through public schools. Currently, Healthy Kids is operating in 19 of Florida's 67 counties with over 47,000 children enrolled in the program. Children enrolled in the National School Lunch Program are deemed eligible for subsidized coverage. Those eligible for the program are uninsured children ages five through 18 who are enrolled in school and who are not eligible for Medicaid. Some counties have extended eligibility to pre-school children or younger siblings.

To reach children who are eligible for the program, Healthy Kids relies on the school system. On the first day of an open enrollment period, an application is sent home with the children. Applications are also sent home with report cards, with PTO meeting announcements and other materials that the school uses to communicate with the families. Included with the application is a self addressed envelope that families send directly to the Healthy Kids corporate office in Tallahassee.

All applications are forwarded to a Third Party Administrator (TPA) who creates an electronic record for the account. Electronic matches are made with the school systems and the State of Florida to verify age, school enrollment, and lack of Medicaid enrollment. Current efforts are underway to coordinate more closely with Medicaid to assure that children are appropriately referred. Matches are also made with the school system to verify participation in the National School Lunch Program. Children who are determined eligible for Healthy Kids are sent a letter from the TPA announcing the effective date of health coverage.

Healthy Kids is also promoted through radio and television public service announcements that can be utilized by counties during an open enrollment period. In addition, counties may elect to create a marketing program that includes billboards, newspaper advertisements, flyers and tray liners for fast food restaurants.

Contact : Jana Key
Florida Healthy Kids Corporation
223 S. Gadsden Street
Tallahassee, Florida 32301
850/224-5437
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South Carolina

In September 1997, Governor David Beasley announced the Partners for Healthy Children initiative which increased the income eligibility level for Medicaid to 150% of the poverty level for children ages one through 18. It is anticipated that the initiative will provide Medicaid coverage to an additional 75,000 children in South Carolina.

Funding for Partners for Healthy Children is being provided by a public-private partnership. State Medicaid match of \$3 million was contributed by three children's hospitals in South Carolina (Greenville Hospital System, Medical University of South Carolina and Richland Memorial Hospital). The South Carolina Department of Health and Human Services allocated \$1 million and \$2 million was appropriated by the South Carolina General Assembly. The state contributions will draw down federal Medicaid matching funds to provide a total program of over \$31 million. (See the Outreach program summary below for more information.)

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Tennessee

The TennCare Program has been operating under an 1115 waiver since January 1, 1994. Initially TennCare provided health coverage to all uninsured who did not have access to health insurance. In January 1995, enrollment was closed to the uninsured but remained open to the Medicaid population and uninsurables.

Effective April 1, 1997, TennCare opened enrollment for children under age 18 who did not have access to insurance through their parents' or guardians' employers. It was estimated that as many as 50,000 children would qualify under the open enrollment. As of December 7, 1997, 24,916 children had enrolled.

On January 1, 1998 an expansion occurred to include all children under 19, regardless of access to insurance, if the family's total income is below 200% of poverty. The open enrollment period for children below 200% of poverty will remain in effect until March 30, 1998. Open enrollment for children without access to health coverage will continue indefinitely.

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Virginia

In order to make health care coverage available to working families, Virginia offers a Health Insurance Premium Payment (HIPP) program. It was established in 1991 within the Department of Medical Assistance Services (Medicaid). Through HIPP, Medicaid funding is used to pay the health insurance premiums. After being approved for Medicaid and determined eligible for HIPP according to state regulations, the entire family may be covered. This program is allowed under Medicaid as long as it is cost effective and in accordance with Health Care Financing Administration regulations.

Every application for Medicaid is accompanied by an application for HIPP, providing there is evidence of insurability. Applications, employer verification forms and the medical history questionnaire are checked for accuracy at the Department of Social Services level. They are sent to the HIPP Unit at Medicaid. HIPP staff verify all necessary information with the employer. This may include but is not limited to types of plans, availability, premium amounts, eligibility and dates.

The cost of the group health insurance package is compared with the cost of the Medicaid managed care capitation plan. If the cost of the group health insurance package demonstrates savings on an annual basis, then the applicant is requested to enroll in HIPP. Medical utilization review and health insurance costs are taken into consideration when calculating cost effectiveness.

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Medicaid Eligibility Outreach

Despite state initiatives to provide Medicaid coverage opportunities for more low income children, there are approximately three million children who are eligible for Medicaid, but are not enrolled.⁹ Therefore, state policy makers should not consider the job done when they raise Medicaid eligibility levels or create a state child health insurance program. Special attention must be given to outreach and eligibility simplification if the intent of expansions is to be realized. Outreach issues and strategies are discussed below.

State Outreach Strategies

State outreach initiatives were a major topic of discussion on the state site visits. While there are some exemplary programs that have been implemented in the South, outreach initiatives were not underway in most states. Five statewide eligibility outreach initiatives are summarized below and contact information is provided.

Arkansas

On September 1, 1997, ARKids First was implemented to provide health coverage to working families who earn too much to be eligible for Medicaid, but cannot afford to purchase their own health insurance. ARKids is available to children through age 18 with income at or below 200% of the poverty level. Outreach efforts to promote the new program include the following:

- Providers, such as physicians, dentists, hospitals, school systems, rural health clinics and federally qualified health care centers, assist in promoting the program.
- An advertising campaign was developed for TV, radio and newspaper.
- Information was placed in Arkansas Department of Human Services (DHS) county offices, libraries, and on food trays in McDonald's restaurants and in their carry out meals.
- Speaker bureaus were established to provide local community contact through organizations such as the Lions Club, Rotary Clubs and other community interest groups.

⁹ General Accounting Office, Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate, HEHS-96-129, June 17, 1996.

- Toll free numbers were established and staff was hired to receive requests for materials and applications.
- Applications that are easy to read and understand were developed.

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Georgia

The Right from the Start Medicaid (RSM) Project began in July 1993 as Governor Zell Miller's response to Georgia's high infant mortality rate. The project was created to address the need to improve health care access for all children and pregnant women.

Through an agreement with the Georgia Department of Medical Assistance and the Georgia Department of Human Resources, eligibility workers are placed in health departments, hospitals, clinics, schools, day care centers, community action agencies and other locations in local communities. A major feature of the program is availability of staff during non-traditional hours so that applicants can apply for RSM without having to lose time from their jobs or from school. Non-traditional hours are defined as any time other than 8:00 AM to 5:00 PM, Monday through Friday.

The application process for RSM is quick and easy. Verification requirements are limited and RSM workers are trained to assist applicants in obtaining the verification they need to become enrolled in RSM.

Workers and supervisory staff make presentations regularly to community groups, medical providers and employers. Since 1994, RSM staff have made over 33,000 presentations. RSM staff have utilized creative techniques for distributing information to the public. Some examples include: flyers sent home with school children, program information in women's and children's shoe boxes, visits to day care centers, and brochures on pizza boxes delivered to homes. Employer contacts have resulted in opportunities to distribute literature through personnel offices and at employee forums, and to accept applications at job sites.

Additionally, Georgia is using the Southern Institute information outreach brochures statewide.

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South Carolina

To assure that eligible children become enrolled in South Carolina's Medicaid expansion program, Partners for Healthy Children, the South Carolina Department of Health and Human Services created a centralized eligibility system to give applicants new opportunities for filing applications. Parents can obtain applications from schools, doctors' offices, neighborhood pharmacies, local health clinics, child care centers and nearby hospitals, as well as typical governmental sources such as the county Department of Social Services. Applications are mailed to a central location, where eligibility is quickly determined.

A simplified application, which includes a straightforward income eligibility chart, was designed especially for children's Medicaid. McLeod Regional Medical Center participated in the printing of approximately 500,000 applications. (See Appendix D for a copy of the application.)

Additionally, South Carolina is using the Southern Institute information outreach brochures statewide.

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Tennessee

Effective April 1, 1997, the TennCare program opened enrollment to uninsured children up to age 18 who do not have access to insurance through parents' or guardians' employers. It was estimated that as many as 50,000 children would be eligible. The following outreach efforts were launched to enroll as many of the 50,000 children as possible:

- Letters and applications were sent to children on Food Stamps who were not enrolled in TennCare.

- Letters and applications were sent to families with children under age 18 who had previously been denied for TennCare due to closed enrollment for the uninsured.
- A letter and flyer were sent to all school boards, every school superintendent, school principals, school nurses, all Head Start programs, licensed day care centers, and Medicaid providers on file.
- Local health departments sponsored county meetings where a video on open enrollment for children was presented.
- A letter and flyer were sent to all employers on file with the Department of Labor. (Federal, state and large corporate employers were excluded.)
- The American Association of Retired Persons agreed to put an article in their newsletter asking members to get the word out to their families, neighbors, and friends that might have or know of children who would be eligible.

Additionally, Tennessee is using the Southern Institute information outreach brochures statewide.

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West Virginia

West Virginia is taking the following actions to improve access to Medicaid for children and families.

- At the beginning of each school year, each child is provided an enrollment form for their school lunch program. Through a cooperative effort with the Department of Health and Human Resources (DHHR), the form also provides a check off which gives the county school system permission to refer the parent or guardian to the county DHHR office. The county office in turn contacts the family, providing information on Medicaid coverage for all family members. Additionally, school based speech, occupational and physical therapists and school psychologists are oriented to the Medicaid eligibility process. They can make direct referrals to the county DHHR office for children whose parents desire such a referral.

