

# Better Managing New York State's Health Insurance Subsidy Programs

A Report of the  
Citizens Budget Commission



October 1, 2001



## FOREWORD

Founded in 1932, the Citizens Budget Commission (CBC) is a nonpartisan, nonprofit civic organization devoted to influencing constructive change in the finances and services of New York State and New York City governments. This report was prepared under the auspices of the CBC's Committee on Poverty, which we co-chair. The other members of the Committee are: Terry L. Andreas, Jeremiah Blitzer, Lawrence B. Bittenwieser, Bud H. Gibbs, Walter Harris, Alan M. Klein, Alexandra Lebenthal, William F. McCarthy, Frances Milberg, Felix A. Orbe, June E. Osborn, Lionel I. Pincus, Carol Raphael, Richard Ravitch, Duncan J. Stewart, Ronald Weiner, and Eugene J. Keilin, ex-officio.

The Committee on Poverty was established as a CBC research committee in 1993 following the unrest in the City of Los Angeles. The CBC Trustees believed it was important for the long-run future of New York to gain an understanding of the policy issues and fiscal pressures created by the presence of a large poverty population in New York City and other urban centers in New York State. The Committee's first report in 1994, *Poverty and Public Spending Related to Poverty in New York City*, calculated the amount of municipal spending for services to the indigent. The findings highlighted the fact that the largest expenditure item was medical care for the poor.

During the 1995-97 period many of the Trustees on this Committee were deeply involved in the CBC's *Budget 2000 Project*. As a part of that effort the CBC prepared a report on *Social Welfare Spending*. Among the themes stressed in the report was that more reliance on managed care and tighter eligibility for long-term care (combined with more affordable private long-term care insurance) could yield significant savings in state and municipal expenditures for health services.

Following the release of the *Budget 2000 Project*, this Committee turned its attention to the problem of the uninsured. In March of 1999 a Committee report on *Financing Medical Care for the Uninsured in New York State* found that current programs to help those without medical insurance were inadequate and wasteful. We recommended a new strategy with four elements: (1) Shift public spending for the uninsured from the current fragmented, hospital-oriented subsidies to a new, integrated program of subsidies for the purchase of private insurance. (2) Help make available reasonably priced insurance plans to those not now able to buy into large group insurance plans. (3) Target public subsidies to people with low incomes, and require those seeking subsidies to contribute towards premiums on an income-related basis. (4) Streamline administration of the programs in order to facilitate enrollment and to minimize administrative costs.

The State's Health Care Reform Act of 2000 pursued some of these policy directions and included a new program, Family Health Plus, that extends Medicaid coverage to many adults. In light of the expanded commitments, the Committee believed its most appropriate contribution could be identifying ways to strengthen the administration of the enlarged health insurance

subsidy programs. This report presents the CBC's recommendations for better managing these large and expensive subsidy programs.

A preliminary draft of this report was reviewed by public officials responsible for administering the current programs and leaders of advocacy groups concerned with these issues. The Commission thanks, in particular, each of the following for their helpful comments: Bridget Walsh and Karen Schimke of the Schuyler Center for Advocacy and Analysis; Denise Soffel of the Community Service Society; Deborah Bachrach and Anthony Tassi of the law firm Kalkines, Arky, Zall & Bernstein LLP; Judith Arnold and Kathryn Kuhmerker of the New York State Department of Health; Iris R. Jimenez-Hernandez of the New York City Human Resources Administration; Jane Preston of the New York State Senate staff; and Anne Heller of the Office of the Mayor of the City of New York. Their generosity in spending time reading the draft and their willingness to provide corrections and suggestions are deeply appreciated, but do not necessarily imply their endorsement of the report's recommendations.

Charles Brecher, CBC's Director of Research, and research consultant Sheila Spiezio, wrote this report. Nicolette Macdonald, CBC's Publications Coordinator, prepared the report for publication. An electronic version of the report is available on the CBC's website at [www.cbcny.org](http://www.cbcny.org).

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## **EXECUTIVE SUMMARY**

Most residents believe all fellow New Yorkers should have access to needed medical care. In order to promote this goal, the state's elected officials have authorized and funded multiple programs to make subsidized health insurance available to those with limited incomes. These include a large Medicaid program for the indigent, the Child Health Plus (CHP) program for children in low-income families, a new Family Health Plus (FHP) program for parents in low-income households, the Healthy New York program that makes reduced cost insurance available to low-wage workers at small firms, and the Elderly Pharmaceutical Insurance Coverage Program to assist seniors with drug costs. These programs already enroll nearly 4 million New Yorkers who otherwise would not have health insurance, and recent expansions in CHP and the new FHP are intended to increase significantly that number.

### **The Problem: Failure to Reach Many Who Qualify**

But the well-intentioned efforts face serious obstacles to realizing their potential. Despite growing numbers of newly uninsured, the Medicaid program saw its enrollment shrink dramatically—by more than one-quarter million in New York City in the last half of the 1990s. The CHP program quickly did reach many children, but it soon became apparent that they often were the wrong children. In 2000 it was estimated that more than one-third of the more than 500,000 CHP enrollees were eligible for Medicaid rather than CHP, and federal officials threatened to impose fiscal sanctions on the State if these children were not placed in the appropriate program. Implementation of the FHP program, originally scheduled to begin in January 2001, was delayed until October 2001 because the State and federal governments differed over the financing and administration arrangements for the program.

The programs suffer from a lack of coordination in eligibility rules and administrative practices. Adults seeking Medicaid are subject to relatively stringent limits on their assets, while the children in these same households might qualify for Medicaid or CHP despite their parents' assets. Medicaid and FHP exclude most immigrants, while CHP does not. The offices and agencies processing applications for the programs differ, with some community agencies and health plans able to accept children for CHP while local government social service departments must accept adults for Medicaid and FHP. The programs also vary in the interval at which individuals must be recertified as eligible, and whether or not recertification must include a "face-to-face" interview or can be accomplished via the mail.

As a consequence of these administrative complexities, many people do not receive health insurance benefits for which they could qualify. Individuals denied public assistance may be inappropriately denied Medicaid benefits because local social service agencies are relied upon to make the two decisions simultaneously. The growing number of people seeking Medicaid benefits outside the public assistance program have not been well served by the local social

service offices; in New York City, the "Medicaid-only" offices that serve these applicants suffered personnel reductions of one-third between 1995 and 2000, despite growing workloads.

The fragmented administrative structure generates high administrative costs. In New York City, the cost of "Medicaid-only" eligibility offices was \$68 million in fiscal year 2000 or about \$117 per recipient. For CHP, total administrative costs borne by the State and the health plans enrolling children likely approach 10 percent of the program's cost.

## **A Solution: Integrated Eligibility Determination**

New measures are needed to make New York State's health insurance subsidy programs work more effectively and efficiently. Several steps should be taken including better outreach and communication with uninsured families, but the analysis presented in this report highlights the need for better coordinated administration of the eligibility procedures for the programs. Moreover, the same changes that would enhance management of health insurance subsidy programs can be applied to yield similar benefits for a variety of other means-tested programs providing cash, food, daycare and other services. The eligibility processes for numerous public programs administered under State auspices should be linked to lower administrative costs and reach the target population more effectively.

Because responsibility is now divided between the State and local governments, and among agencies within State government, high level leadership is necessary to design and implement effective reforms. The Governor should take the lead in this effort. Since the State Department of Health (DOH) is the lead agency for insurance subsidy programs, the Health Commissioner should be given primary responsibility, and commensurate authority, by the Governor for redesigning the system and its supporting information systems.

The Governor and Health Commissioner should pursue a two-stage strategy. First, eligibility determination for the major health insurance programs should be integrated in a new system created independent of the current public assistance eligibility bureaucracy. This requires four steps: (1) defining common information requirements; (2) standardizing procedures relating to documentation requirements and recertification; (3) maintaining a statewide master eligibility file for all programs; (4) establishing multiple, common access points for eligibility and recertification with staff at these offices following uniform procedures across the state.

Determining eligibility for health insurance programs should no longer be viewed as a byproduct of public assistance program management. In the past, most beneficiaries got their health coverage this way. As recently as 1995, more than four of every five people with Medicaid coverage had qualified through public assistance or the federal Supplemental Security Income program; currently, the figure is barely one of two. Statewide about one million people are enrolled in a health insurance subsidy program without receiving cash benefits. This figure will grow as the new FHP program is implemented. This large, often working, population should be served by an eligibility determination system that is separate from local welfare offices.

The administration of this new system should be supported with a DOH-operated information system that includes a master eligibility file, but the line services of interviewing clients and reviewing the necessary documentation should rely on community-based organizations following the recently developed model of "facilitated enrollment." Local voluntary agencies should be reaching out to their constituents to promote enrollment; the county and New York City social service agencies should not be primarily responsible for determining eligibility for health insurance. The DOH should audit the decisions of the voluntary agencies and include performance criteria and financial incentives for accuracy in their contracts. In this way, the new system would promote efficiency of administration while improving outreach.

Second, the State should begin a longer-term process of integrating eligibility determination for all major means-tested programs including non-health programs. The families receiving health insurance subsidies often are eligible for other benefits, but must apply at separate offices and undergo eligibility checks requiring duplicative documentation and interviews. To illustrate, consider a family of three consisting of a preschool-age child, a school-age child, and a mother working at wages that bring the family an income just above the federal poverty threshold. With respect to health care benefits, each member could qualify for a different program—the mother for FHP, the older child for CHP, and the younger child for Medicaid. They would not qualify for public assistance, but could receive Food Stamps through a social service department office, school lunch and breakfast through the public school, an Earned Income Tax Credit through the State Department of Taxation and Finance, and housing aid from the local Housing Authority. Each form of assistance would require the working mother to submit applications and documentation of income and other household characteristics to separate government offices, probably taking time from work to meet the necessary eligibility determination steps.

The key to achieving an integrated eligibility system is an information system that creates a master eligibility file and supports diverse program applications. This information support system can start with health insurance subsidy programs, but should be planned as a backbone for broader applications. While this is a large task, the process can begin with three sensible and high-impact initial measures: (1) Integrate Food Stamp eligibility determination with health insurance program eligibility determination. (2) Test using school lunch program administrators as facilitated enrollers for health insurance programs. (3) Coordinate Earned Income Tax Credit benefit determination with health insurance subsidy eligibility determination.



## INTRODUCTION

Throughout the 1990s and into the new century, the United States has had a large and growing population without health insurance. This is a serious problem because it prevents many of these adults and children from obtaining needed medical care. The lack of insurance often impedes early intervention in the treatment of medical problems and results in higher costs as medical problems become more serious.

In the absence of a comprehensive national approach to solving this problem, state governments have been obliged to take the initiative. New York State has been one of the more active and innovative states in addressing the issue. Historically, its Medicaid program has been one of the most generous in the nation. In 1998, after new federal funding for this purpose became available, New York significantly expanded a pilot program called Child Health Plus (CHP) to provide health insurance for children from families with incomes above those qualified for Medicaid. Then the State's Health Care Reform Act of 2000 (HCRA) allocated substantial funding for a new Family Health Plus (FHP) program that provides benefits to adults with incomes above the Medicaid levels. Together the CHP and FHP programs are intended to reduce significantly the number of New Yorkers without insurance. Specifically, the new initiatives were estimated to provide insurance to about 1.1 million of the 3.1 million New Yorkers without insurance.<sup>1</sup>

But the well-intentioned efforts are not realizing their promise. Despite growing numbers of newly uninsured, the Medicaid program saw its enrollment shrink dramatically—by more than one-quarter million in New York City in the last half of the 1990s.<sup>2</sup> The CHP program did quickly reach many children, but initially they often were the wrong children. In 2000 it was estimated that more than one-third of the more than 500,000 CHP enrollees were eligible for Medicaid rather than CHP, and federal officials threatened fiscal sanctions on the State if these children were not placed in the appropriate program.<sup>3</sup> (Medicaid offers more generous benefits to the children, but less generous federal funding to the State.) Implementation of the FHP program, originally scheduled to begin in January 2001, was delayed until October 2001 because the State and federal governments differed over the financing and administration arrangements for the program.<sup>4</sup>

New measures are needed to make New York State's strategy work more effectively. These include better outreach and communication with uninsured families, but the analysis

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<sup>1</sup> Kenneth Thorpe and Curtis Florence, *Medicaid Eligible, But Uninsured: The New York Experience* (NY: United Hospital Fund, October 2000). The authors estimated that 147,200 children were eligible for CHP in addition to the 522,000 already enrolled, and that 378,300 adults would be eligible for FHP.

<sup>2</sup> City of New York, *Mayor's Management Report*, Volume II, Agency and Citywide Indicators, fiscal years 1995-2000.

<sup>3</sup> Jennifer Steinhauer, "Many Not Eligible in State Program to Insure Children," *The New York Times*, September 30, 2000, p. 1.

<sup>4</sup> Raymond Hernandez, "U.S. and Albany Agree to Provide Health Benefits to Uninsured Poor," *The New York Times*, May 30, 2001, p. A1.

presented in this report highlights the need for more efficient and better coordinated administration of the eligibility procedures for the multiple, subsidized health insurance programs. Moreover, the same changes that would enhance management of health insurance subsidy programs can be applied to yield similar benefits for a wide variety of means-tested programs providing cash, food, daycare and other services. The eligibility processes for numerous public programs administered under State auspices should be linked to save administrative costs and reach the target population more effectively.

The key to achieving this improved performance is new administrative practices supported by a comprehensive information system. Such a system does not now exist, and Governor George Pataki should authorize the Commissioner of Health to plan and begin implementation of the needed administrative and information system infrastructure. New technology should be deployed to make it possible for New York to reach its uninsured and indigent residents and to provide them with the medical care and other support services they need—care for which its elected officials have already authorized the funding.

The remainder of this report is organized into three sections. The first describes the major health insurance programs, their eligibility rules and procedures, and the lack of coordination among these programs. The second makes the case for an integrated eligibility system for these health insurance subsidy programs. It both documents the problems caused by current fragmentation and inconsistency, and describes the necessary elements of an integrated system. The final section indicates how the proposed integrated system could be extended to non-health programs that have means-tested eligibility criteria with the goals of reaching more uninsured and reducing administrative costs.

## **LACK OF COORDINATION AMONG HEALTH PROGRAMS**

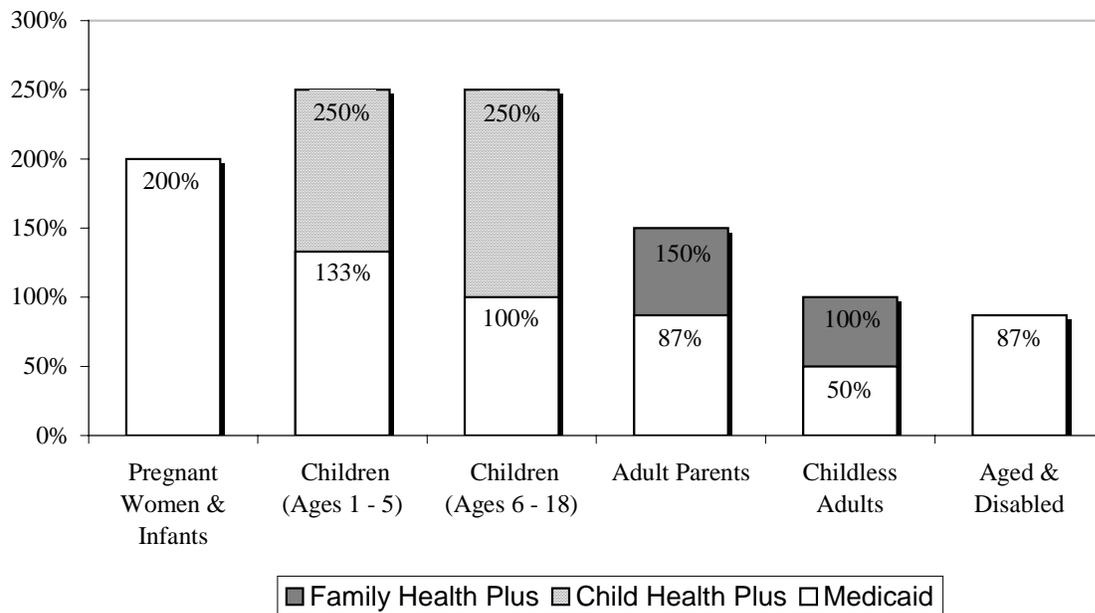
The State's three large health insurance programs are intended to complement each other to provide a comprehensive safety net for low-income households. Their income eligibility criteria are linked to extend coverage to the poor and near poor, with some cost sharing for those at the higher income range. However, the design breaks down for two major reasons. First, the eligibility rules relating to factors other than income are not coordinated, so people cannot move readily from one program to the next when their income changes. Second, the administrative procedures for establishing eligibility and enrolling people in health plans are not well-coordinated, often requiring people to "start over" at a new agency or office when they are rejected for one of the programs. In addition, the State has a smaller insurance subsidy program, called Healthy New York, with rules and administrative procedures that are not linked to any of the three larger programs.

## The Linked Income Eligibility Criteria

The State has coordinated income criteria among the major programs. At the core of the system is the Medicaid program, which conforms to complex federal guidelines. It provides comprehensive benefits to poor residents without requiring any payment from them for coverage.

The income limits for Medicaid eligibility vary among five categories of individuals—pregnant women and infants, children, parents, childless adults, and the disabled and aged. (See Figure 1.) The Medicaid standards are most generous for pregnant women and their newborn children (up to age one). They may have incomes up to 200 percent of the federally determined poverty threshold. This threshold is updated annually and varies with family size; in 2000 the threshold for a two-person family was \$11,869 annually and rose to \$23,009 for a family of six.<sup>5</sup>

**Figure 1**  
**Subsidized Health Insurance Income Eligibility Limits, 2001**  
*(Income as percent of federal poverty threshold)*



For children, the Medicaid income limits vary between those ages one to five, and those ages six to 18. For the younger group, the income limit is 133 percent of the federal poverty threshold, falling to 100 percent for the older children. For the parents in families with children, the income limit is set by the State legislature and is not linked to the federal poverty threshold nor necessarily updated periodically. The current standards set limits that vary with family size

<sup>5</sup> United States Census Bureau, <<http://www.census.gov/hhes/poverty/threshld.html>> (29 May 2001). Data for a family of two assumes a non-elderly parent and child, and a family of six assumes two parents and four children.

and range from \$10,800 for a mother and child to \$17,004 for a family of eight.<sup>6</sup> Since the income limits for parents are lower than for children, there are some households in which the children qualify for Medicaid but the parents do not.

The State legislature also sets the income limits for adults who do not have children; the current limit for a single, non-elderly, adult is \$4,793 annually and for a non-elderly childless couple is \$6,169.<sup>7</sup> The State legislature also sets the standard for the aged and disabled. These rules are quite complex, depending on the individual's living arrangements (such as in a nursing home or group home), as well as other factors, with the income limits generally well above those for childless adults who are not aged or disabled. For an aged or disabled individual living independently in the community, the income limit equals approximately 87 percent of the poverty threshold.

As shown in Table 1, the Medicaid program is expensive, requiring over \$21 billion annually in New York State. The federal government pays half the cost, and the remainder is divided between the State and localities, about 33 percent and 17 percent of the total, respectively. Just over one-quarter of the Medicaid enrollees are aged and disabled individuals, but this group has an average annual cost of nearly \$15,200 each and represents about two-thirds of the total spending. Children comprise nearly half of all Medicaid enrollees, but their average cost is a relatively low \$1,800 annually and they represent only about 13 percent of all Medicaid spending. The remaining 29 percent of Medicaid enrollees are adults, mostly parents, with an average annual cost of about \$5,000.<sup>8</sup>

The CHP program covers only children. The benefits include most basic medical and hospital care, but are somewhat less comprehensive than under Medicaid. For example, there is no coverage for long-term care or transportation costs. CHP's income limits begin where the Medicaid limits end and extend up to 250 percent of the federal poverty threshold. Premiums for children in families with incomes up to 160 percent of the poverty threshold are fully subsidized. The parents of children in families with incomes between 161 and 222 percent of the poverty threshold are required to pay \$9 monthly per child toward the premium. Parents of children in families with incomes between 223 and 250 percent of the poverty threshold must pay \$15 per month per child. Parents pay the premium for a maximum of three children. Parents with incomes above the maximum limit can enroll their children by paying the full premium. The premium varies by insurer and location, but averages about \$110 per month statewide. There are a large number of families in which the children qualify for CHP, but the parents are not eligible for subsidized coverage.

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<sup>6</sup> New York State Department of Health, <<http://www.health.state.ny.us/nysdoh/medicaid>> (29 May 2001). The State provides monthly income limits that have been converted to annual incomes by the authors.

<sup>7</sup> The Medicaid income eligibility standard for childless adults is related to the Standard of Needs for public assistance which varies by county, and is 53.5 percent of the federal poverty threshold in New York City.

<sup>8</sup> New York State Department of Health, <<http://www.health.state.ny.us/nysdoh/medicaid>> (29 May 2001). New York State pays 90 percent of nonfederal Medicaid long-term care costs and 25 percent of all other, nonfederal Medicaid expenditures. This represents 32.7 percent of total Medicaid spending of \$21.2 billion, as shown in Table 1.

Statewide the CHP program has over 500,000 enrollees, with nearly 60 percent in New York City. (See Table 1.) In federal fiscal year 1999, the annual CHP appropriation was about \$464 million, or an average of less than \$900 per child. Of this total, \$257 million is from the federal government and \$207 million from the State.

**Table 1**  
**Expenditures, Beneficiaries and Average Benefit**  
**Medicaid and Child Health Plus**  
**New York State and New York City, Federal Fiscal Year 1999**

	Expenditures		Beneficiaries		Cost per beneficiary
	Amount (millions)	Percent	Number	Percent	
<b>New York State</b>					
Medicaid <sup>(a)</sup>	\$21,248	100.0%	3,417,800	100.0%	\$6,217
Children	\$2,697	12.7%	1,527,849	44.7%	\$1,765
Adults	\$4,843	22.8%	986,266	28.9%	\$4,910
Aged and Disabled	\$13,709	64.5%	903,685	26.4%	\$15,170
Child Health Plus <sup>(b)</sup>	\$464		516,381		\$899
<b>New York City</b>					
Medicaid <sup>(a)</sup>	\$13,892	100.0%	2,208,962	100.0%	\$6,289
Children	\$1,883	13.6%	1,005,738	45.5%	\$1,872
Adults	\$3,326	23.9%	653,038	29.6%	\$5,093
Aged and Disabled	\$8,683	62.5%	550,186	24.9%	\$15,782
Child Health Plus <sup>(b)</sup>	\$272		303,108		\$899

Notes: <sup>(a)</sup> The New York State Department of Health, <<http://www.health.state.ny.us/nysdoh/medstat-profiles/99/demographics>> (29 May 2001). Data are for federal fiscal year 1998-1999.

<sup>(b)</sup> The New York State Department of Health, <<http://www.health.state.ny.us/nysdoh/chplus/childenr.htm>> (29 May 2001). Data are for February 2001. Expenditures are allocated funds, not actual expenditures. New York City expenditures estimated at 58.7 percent of state spending, or equal to the city share of enrollees.

The FHP program is intended to cover lower income adults who do not qualify for Medicaid. The benefit package is almost the same as under Medicaid, although, like CHP, there is no coverage for long-term care or transportation. The income limits begin where those of Medicaid end and extend up to 100 percent of the federal poverty threshold for childless adults and 150 percent of the federal poverty threshold for parents.<sup>9</sup> These income limits are to be phased in over a period beginning in 2001 and ending in October 2002. There are no requirements for contributions from enrollees toward the premium cost. Even when FHP is fully implemented, there will remain a substantial number of parents whose children qualify for CHP, but who do not qualify for a subsidized program themselves.

<sup>9</sup> There are, however, some differences in the way in which income is defined for eligibility purposes under Medicaid and FHP. Medicaid uses a "net" income concept that allows for expenses for medical care and enables people to qualify despite higher incomes if they have large medical bills; FHP uses a "gross" income concept.

The State's plan is to fund FHP with a waiver as part of the Medicaid program, with 50 percent federal matching, and the non-federal share divided between the State and localities. Projected costs are \$240 million in 2001, \$492 million in 2002, and \$696 million in the subsequent year. If the projected goal of 380,000 adults were reached in the last year, this would represent an average annual cost of about \$1,800.

Together these three programs have the potential to provide insurance coverage to a large number of low-income New Yorkers. The potential beneficiaries include all children in families with income up to 250 percent of the poverty threshold, all parents with incomes up to 150 percent of that level, and other adults up to 100 percent of the poverty threshold. In total, approximately 5.1 million New Yorkers are estimated to be eligible for one of the programs.<sup>10</sup>

The problem, in practice, has been extending the potential benefits to many of them. Two types of obstacles are inconsistent eligibility rules relating to factors other than income, and inconsistent and fragmented administrative practices across the programs.

## **Inconsistent Eligibility Rules**

While the income eligibility limits for the three programs are linked, other eligibility requirements are not consistent. The most significant of these differences are requirements relating to immigration status and to assets.

Asset Limits. A family's economic status depends on more than its income; they also may have assets such as a home, automobile, savings account or investments. Some programs may require individuals to exhaust all or part of these assets before they are eligible for a public subsidy. The limits on available assets vary among the health insurance programs.

Medicaid has the most stringent asset tests, which are based on State requirements. Excluding what is deemed essential personal property, a childless adult or couple seeking Medicaid can have no more than \$2,000 in assets; parents of children can have no more than \$5,100. Up to \$4,650 of the value of an automobile is excluded from this asset test. Less stringent, and highly complex, asset limits apply for the aged and disabled. Although FHP will be funded through Medicaid, the State will waive the asset test for FHP.

In contrast, the CHP program has no asset limit. Similarly, children may qualify for Medicaid despite their parents being ineligible due to assets above the prescribed limits. Children qualify based on their family's income, with no limits on parents' assets.

Immigration Status. Medicaid and FHP also differ from CHP in their exclusion from eligibility of certain immigrants. Federal law prohibits federal funding for Medicaid benefits for both

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<sup>10</sup> Thorpe, *op. cit.* (991,100 uninsured adults and children are eligible for Medicaid; 378,300 adults are eligible for FHP; and 147,200 children are eligible for CHP.) In addition, 3,073,241 are enrolled in Medicaid, and 516,381 are enrolled in CHP (refer to Table 1) for a total of 5,106,222.

undocumented aliens and for most people who entered the United States legally after August 22, 1996 (the date the relevant federal "welfare reform" law was enacted). Those in the second group can receive Medicaid only after being in the country for five years. In contrast, immigrant status (or lack thereof) is not a condition of eligibility for CHP.

Some states have dealt with the federal restrictions by creating "look alike" Medicaid programs for immigrants. These programs are identical to Medicaid in all other eligibility rules and benefits, but they are funded entirely with State funds. New York did not take this approach.<sup>11</sup> However, a recent New York State Court of Appeals decision held that the State must fund benefits equivalent to those under Medicaid for immigrants disqualified under the federal program by the 1996 welfare reform legislation.<sup>12</sup> This will require a new program category in New York supported by State funds.

## **Inconsistent and Fragmented Administrative Practices**

The programs not only have different eligibility rules, but they also have different procedures for enforcing the rules. The differences relate to program "gateways" or application portals, re-certification processes, and documentation requirements.

Application. The way in which a person initially becomes eligible for subsidized insurance varies with the program and the individual's circumstances. For Medicaid, there are four distinct application routes—through the Supplemental Security Income (SSI) program, through the State's public assistance program, through a "Medicaid-only" office operated by local social service departments, and through community-based organizations designated by the State as "facilitated enrollers." CHP and FHP rely on both local social service departments and facilitated enrollers, with CHP also accessible through its health plans.

The SSI program provides cash benefits to poor individuals who are aged or disabled. The monthly allowance includes a federally funded portion that is uniform nationally, and a State funded supplement that is determined by the State legislature. However, administration of the entire benefit is the responsibility of the federal Social Security Administration. Individuals apply to them, and federal employees determine eligibility. Applicants must document their residence, income, age, and, if applicable, medical disability. Anyone deemed eligible for SSI is automatically made eligible for Medicaid, since the income and other criteria for SSI are more stringent than for Medicaid. Non-citizens were denied SSI benefits as part of the 1996 federal welfare reform legislation, but those benefits were subsequently restored for most legal immigrants. The Social Security Administration provides the State Department of Family Services, Office of Temporary and Disability Assistance (OTDA), identifying information on all SSI beneficiaries monthly. This becomes part of the State Department of Health (DOH) Medicaid eligibility file.

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<sup>11</sup> Deborah Bachrach, Karen Lipson, and Anthony Tassi, *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State* (NY: The Commonwealth Fund, March 2001), p.19.

<sup>12</sup> *Mohamed Aliessa et al versus Antonia Novello*, June 5, 2001.

The OTDA has supervisory responsibility for the State's public assistance programs, but it delegates eligibility determination tasks to county and New York City social service departments. Families with children apply for the Family Assistance Program, and adults without children apply for the Safety Net program, at designated offices operated by these local governments. These programs have lower income criteria than Medicaid, and also impose various types of work or job search requirements that do not apply to Medicaid. Consequently, anyone found eligible for public assistance is automatically deemed eligible for Medicaid. (Although many found ineligible for public assistance may be eligible for Medicaid, they must apply separately via a Medicaid-only office, described below.) The OTDA uses the identifying information from its public assistance files as a part of its Medicaid eligibility files, and issues Medicaid cards to all public assistance recipients.<sup>13</sup>

Local social service departments also operate "Medicaid-only" eligibility offices. Persons who are not eligible for, or do not wish to receive, SSI or public assistance, apply for Medicaid coverage at these offices. Applicants must complete a lengthy application form and document their immigration status, age, income, assets, and other relevant information. For applicants who are hospitalized, in nursing homes or require extensive home care, third parties assist in the application process and eligibility workers are sometimes assigned to hospital sites. The local social service departments provide the State identifying information on those people they find eligible, and this becomes part of the State's Medicaid eligibility file.

State legislation passed in 1998 authorized designated nonprofit agencies to serve as "facilitated enrollers" to help make Medicaid eligibility more accessible. Employees of community-based agencies approved by the State can help applicants fill out the forms and assemble documentation, and can serve as the interviewer to verify information on behalf of the State. Applications approved by a facilitated enroller are sent to the local social service department for subsequent review, but the applicant need not appear in person at the local social service office. In the spring of 2001 the State allocated \$20 million to train more community-based enrollers.<sup>14</sup> At that time, statewide 33 community agencies had been designated as facilitated enrollers.<sup>15</sup> In addition, health insurance plans serving children under the CHP program and approved for this role by the State also can serve as facilitated enrollers for Medicaid. As of early 2001, statewide 18 such plans have been approved.

The CHP program is administered by the State DOH. Parents seeking CHP coverage for their children submit a DOH-approved application form, which also can be used for application for Medicaid coverage for children, to the specific health insurance plan in which they want their child enrolled. Employees of the plan are responsible for reviewing the application and its documentation, and plans retain these materials. The plans' workers approve applications and enroll eligible children in their plan. The plan submits bills for premiums for all its eligible

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<sup>13</sup> Although OTDA has a role in Medicaid eligibility, the State Department of Health is the "single state agency" responsible for Medicaid under federal rules. The Department of Health, among other functions, handles payment policies for Medicaid providers and monitors quality of care; the DOH also provides direction to OTDA in Medicaid eligibility determination.

<sup>14</sup> Judith Messina, "NY Child Health Loses Ground as Enrollment Falls," *Crain's New York Business*, May 7-13, p.1.

<sup>15</sup> Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, *Creating a Seamless Health Insurance System for New York's Children* (NY: The Commonwealth Fund, February 2001), p. 7.

enrollees to the DOH. Identifying information for each enrolled child is submitted at the time of enrollment and with each billing cycle. The DOH maintains a master file of children enrolled in CHP. The State DOH periodically audits the plan's eligibility determinations, and the State Comptroller audits the DOH's performance of this function. Early in the program's implementation, the Comptroller found that many children were inappropriately enrolled in CHP when they should have been covered under Medicaid.<sup>16</sup>

The State plans to administer the FHP program in a manner that incorporates some features of CHP, but is more similar to Medicaid. That is, applications can be submitted through insurance plans, community-based facilitated enrollers or local social service departments, but only local social service departments can determine eligibility. The State DOH plans to make available a single application form for Medicaid, CHP and FHP.

Recertification. Once deemed eligible for a health insurance subsidy, adult beneficiaries are obliged to report any changes in their income or status that change their eligibility. In addition, for those eligible through public assistance benefits, there are periodic automated checks with wage and income databases available to the State OTDA to detect unreported income and other potential fraud. People not reporting income may have their benefits ended and even be prosecuted for fraud.

Unlike adults, children in the Medicaid program are assured of at least one year of coverage. That is, even if their family's income changes, children remain covered by Medicaid for one year. In contrast, adults in the Medicaid program lose benefits whenever their income or other conditions change in a way that violates the initial eligibility criteria.<sup>17</sup>

In order to enforce the eligibility rules and detect changes in beneficiaries' status, the programs each have recertification procedures. These recertifications vary in their frequency and nature among the programs. The Medicaid program requires an initial three-month and subsequent six-month recertification for adults qualifying through public assistance, and annual recertifications for adults in the Medicaid-only program and for all children. The CHP program requires annual recertification, and the FHP program also anticipates annual recertification.

The recertifications differ in terms of whether they require a personal ("face-to-face") interview or whether it can be completed through the mail. Medicaid recertifications require a face-to-face interview with each client, both adults and children. This means an appearance at a local social service department office at a designated time. (The community-based organizations designated as facilitated enrollers for Medicaid eligibility also may conduct face-to-face interviews for Medicaid recertification of children.) The CHP program mails recertification forms to clients, and they may be returned by mail to the CHP plan. The FHP program anticipates mail recertifications similar to the CHP process. While mail recertification often requires

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<sup>16</sup> See Jennifer Steinhauer, *op. cit.*; and Office of the State Comptroller, *Department of Health's Management of the Child Health Plus Program*, Report 97-2-10 (NY: Office of the State Comptroller, April 1998).

<sup>17</sup> Adults participating in the mandatory Medicaid managed care program, which is being phased-in statewide, are guaranteed six months of eligibility regardless of income changes.

additional outreach to gain responses from clients, it is widely regarded as less burdensome for clients than face-to-face interviews.

The Medicaid requirement for face-to-face interviews for recertification is based on State, not federal, law. One study found that 40 states permit mail recertification of children in their Medicaid program, although face-to-face interview requirements are more common for adults.<sup>18</sup> New York State has permitted mail recertification for the disabled Medicaid-only population and for nursing home residents, and it has begun a demonstration program to test mail recertification for children in the Medicaid-only program and has granted waivers to some local social service departments for semi-annual (but not annual) face-to-face recertification interviews for Medicaid beneficiaries receiving public assistance.

Documentation. At the time of both initial application and recertification, individuals are asked to complete appropriate forms and submit documentation of their answers. The programs vary in the scope of information sought and the means accepted for documentation.

Since the Medicaid program has eligibility criteria relating to immigration status and assets, its eligibility procedures seek documentation of these factors. Citizens must provide proof of this status through passports, birth certificates or naturalization papers; non-citizens must provide documentation of their immigration status. Assets are documented through bank statements, deeds and other instruments.

For factors that are common to programs, such as proof of residence and incomes, the same standards of documentation are applied to CHP and to children and pregnant women seeking Medicaid, but these standards differ from those for other adults seeking Medicaid. Generally, the CHP and Medicaid childrens' standards are less stringent. For example, residence can be documented with a magazine label or an ID card for CHP, but for adults Medicaid requires rent receipts or a lease; earnings verification requires four weeks of pay stubs for CHP, but eight weeks for Medicaid adults.

While for adults the Medicaid forms and documentation rules are more detailed than those for CHP and Medicaid children, all have been subject to two types of criticism. First, they seek information that is not relevant to eligibility determination. For example, questions about the veteran status of household members and about home heating costs have been questioned as not relevant to any eligibility criterion. Second, documentation is sought from applicants for information that the State can verify through external means. As a part of its fraud detection efforts, the State has cooperative relationships with multiple agencies to cross-check information on wages (but not all other sources of income) reported by applicants. Requiring verification in the form of paper documents for information that the State can and does verify electronically by independent means can be an unnecessary obstacle to eligibility.<sup>19</sup>

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<sup>18</sup> Deborah Bachrach, Robert Belfort, Karen Lipson, *Closing Coverage Gaps: Improving Retention Rates in New York's Medicaid and Child Health Plus Programs* (NY: Kalkines, Arky, Zall and Bernstein, December 2000), p. 16.

<sup>19</sup> The sources available for electronic verification of wages generally contain data that is one or more months old. It may be appropriate to seek other forms of documentation for more recent earnings, if these earnings have declined significantly from the time for which electronic data are available.

## Two Smaller, Isolated Programs

Medicaid, CHP and FHP are the major programs by which New York State seeks to aid the uninsured, but it also has two smaller efforts. The HCRA expanded earlier pilot programs to create the Healthy New York program, which provides subsidized commercial health insurance for employees of small businesses and for individual purchasers. Since 1987 the State has subsidized prescription drugs for the elderly under the Elderly Pharmaceutical Insurance Coverage Program (EPIC).

Healthy New York. The Healthy New York program mandates that insurance companies selling unsubsidized managed care plans also offer a standardized benefit package to eligible employees and individuals which is made more affordable by limiting some otherwise mandated benefits (such as chiropractic care) and by a State subsidy.<sup>20</sup> The State subsidy is provided to insurance companies in the form of two "stop-loss funds" (one for small business employees and one for individuals). The stop-loss funds reimburse insurers for 90 percent of claims paid on behalf of Healthy New York enrollees who incur costs between \$20,000 and \$100,000 in a given year. According to the State Insurance Department, premiums for employers should be about 15 percent lower and for individuals about 50 percent lower, than what would otherwise be available in the marketplace.<sup>21</sup> There has been some criticism by small employers, however, that the premiums are only marginally less expensive than existing managed care plan policies with better benefits.<sup>22</sup>

Employers are eligible for the subsidized small business plan if they meet these conditions: (a) not offered insurance to employees in the past 12 months; (b) have fewer than 50 employees, of whom at least 30 percent earned less than \$30,000 annually; (c) pay at least half the cost of the premium. The HCRA authorizes \$34 million in fiscal year 2001, \$77 million in 2002 and \$104 million annually thereafter for the stop-loss fund for this group.

Given the nature of the program, it is employers (corporations, partnerships or proprietors) rather than individuals who apply to managed care plans and are determined eligible. The New York State Insurance Department administers the programs. It does not maintain any identifying information or eligibility file relating to the workers covered by the subsidized insurance program.

Individuals who wish to purchase a Healthy New York policy from an insurer must have a household income no more than 250 percent of the federal poverty threshold. They apply

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<sup>20</sup> Neil D. Levin, "States Program a Worthy Effort," letter to the editor, *Crain's New York Business*, February 26, 2001.

<sup>21</sup> As of March 2001, individual monthly premiums in New York City vary by plan ranging from \$193.48 to \$260.30. For a family, monthly premiums range from \$572.25 to \$755.65. See the New York State Department of Insurance website, <[www.state.ny.us/nysdoi/](http://www.state.ny.us/nysdoi/)> (29 May 2001).

<sup>22</sup> "Insurance Department will Re-Evaluate Rates For Healthy New York," *Crain's New York Business*, <[www.crainsny.com](http://www.crainsny.com/)> (25 April 2001).

directly to a managed care plan that the State Insurance Department has approved to sell Healthy New York policies. The HCRA authorized \$6 million for the stop-loss fund for this group in fiscal year 2001, growing to \$24 million annually in fiscal year 2003.

After reviewing and accepting applications to their plans, insurers are not required to provide the State with any identifying information relating to the individuals covered by the subsidized insurance program. There are no standardized documentation requirements imposed on insurance plans by the State Insurance Department.

The EPIC Program. The EPIC program is operated by the State Department of Health and is aimed at elderly people, most of whom enjoy federal Medicare benefits, rather than at the uninsured. However, Medicare does not cover prescription drugs outside the hospital, and in recent years paying for such drugs has placed a financial hardship on many elderly residents.

Enrollment in EPIC increased sharply from 112,000 in 1999 to over 200,000 in 2000 (about a quarter of beneficiaries live in New York City) due to expanded income limits and lower cost-sharing fees. In 1999, the program provided \$148 million in benefits (payments to pharmacies on behalf of enrollees) or \$1,270 on average per beneficiary. Nearly 4,000 pharmacies statewide participate in the program. The net state costs of the program (less manufacturers' rebates and participant fees) are estimated to be \$165 million in fiscal year 2001.<sup>23</sup>

New York State residents over age 65 with an annual income less than \$35,000 for single adults or \$50,000 for married couples, who do not receive full Medicaid benefits (or do not have private prescription coverage that is better than Medicaid) are eligible for EPIC. There are two program options: a Fee Plan for low and moderate-income seniors and a Deductible Plan for higher-income seniors. Those enrolled in the Fee Plan pay an annual fee ranging from \$8 to \$230 for a single adult with an income of less than \$6,000 and \$20,000, respectively; the fees for a married couple are \$8 to \$300, for incomes of less than \$6,000 to \$26,000, respectively. Fee plan members also pay a co-pay at the pharmacy based on the cost of the prescription, ranging from \$3 for prescriptions less than \$15 to \$20 for prescriptions costing more than \$55. The Deductible Plan is for single adults with incomes between \$20,001 and \$35,000 and married couples with incomes between \$26,001 and \$50,000. There is no fee to join the Deductible Plan, but enrollees are liable for the full costs of their prescriptions until they meet their deductible, ranging from \$530 to \$1,230 for a single adult with an income of under \$21,000 to less than \$35,000, respectively. For married couples, deductibles range from \$650 to \$1,715 for incomes of less than \$27,000 and \$50,000, respectively. Deductible Plan members are also liable for the same co-pays as Fee Plan members, once they have met their deductible.

The First Health Services Corporation holds a contract with the State through September 2002 to enroll seniors, conduct outreach, process claims and reimbursements, and develop information systems. The contractor accepts applications at outreach sites, as well as those

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<sup>23</sup> New York State Department of Health, <<http://www.health.state.ny.us>> (28 August 2001).

mailed to the State. Applicants file a two-page form, along with proof of age. Income and insurance status are verified through existing State data systems.

## THE CASE FOR AN INTEGRATED ELIGIBILITY SYSTEM

Under current policies, New York State is making some progress in extending coverage to its large uninsured population. However, more could be done, in a more efficient way, by integrating the eligibility systems created under the current programs. This section describes the ways in which a lack of integration prevents those who are eligible from gaining coverage, and it presents the key elements in the design of an integrated system.

### The Problems

New York's current eligibility system is seriously deficient. In recent years it has a record of denying coverage to large numbers of people who are eligible, deterring many others who are entitled from seeking coverage, enrolling some children in the wrong program thereby jeopardizing federal funding, and generating high administrative costs for these questionable accomplishments.

**Table 2**  
**Participation in Selected Subsidy Programs**  
**New York City, Fiscal Years 1995-2000**

<b>Program</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
<b>Public Assistance Recipients</b>	1,119,400	1,008,000	880,100	763,300	675,500	572,900
FAP (Formerly AFDC)	850,700	798,100	700,400	610,600	562,300	479,600
SNA (Formerly Home Relief)	268,700	209,900	179,700	152,700	113,200	93,300
<b>SSI Recipients</b> <sup>(a)</sup>	356,597	371,504	379,961	386,259	385,452	389,664
<b>Food Stamp Recipients</b>	1,442,100	1,372,300	1,238,700	1,073,100	991,300	896,700
PA Recipients	1,131,400	1,031,300	906,900	742,700	648,200	552,700
Non-PA Recipients	310,700	341,000	331,800	330,400	343,100	344,100
<b>Medicaid Enrollees</b>	1,822,100	1,800,400	1,709,200	1,644,600	1,629,200	1,593,500
Public Assistance	1,119,400	1,008,000	880,100	763,300	675,500	572,900
Medicaid-Only	344,400	387,100	414,300	462,700	524,700	585,500
SSI	358,300	405,300	414,800	418,600	429,000	435,100
<b>CHP Enrollment</b> <sup>(b)</sup>	NA	NA	86,425	147,499	240,424	307,816

Sources: City of New York, *Mayor's Management Report*, Volume II, Agency and Citywide Indicators, fiscal years 1995-2000.

Notes: <sup>(a)</sup> Data are from Social Statistics, Yearly Summary Data, New York State Office of Temporary and Disability Assistance.

<sup>(b)</sup> Data from the New York State Coalition of Prepaid Health Services Plans, *Managed Care Enrollment Trends, 1999 and 2000, Year End Reports* (NY: New York State Coalition of Prepaid Health Services Plans, 1999 and 2000).

NA - Not Applicable.

**Inappropriate Denials.** Many people who are eligible for coverage have been denied benefits. This injustice results from the close connection between public assistance and Medicaid eligibility, and from the cumbersome process required for Medicaid-only eligibility.

Prior to the federal welfare reforms of 1996, the large majority of people eligible for Medicaid qualified through application for public assistance. As previously described, those qualifying for public assistance are automatically made eligible for Medicaid. As shown in Table 2, in 1995 fully 1.1 million or 61 percent of the 1.8 million Medicaid enrollees had gained coverage as a consequence of also receiving public assistance. Another 20 percent were automatically eligible as a result of receiving SSI. Only 344,000 or 19 percent had separately applied for Medicaid.

The federal changes, accompanied by local administrative changes designed by the Giuliani Administration in New York City, made it much more difficult for adults to qualify for, and remain eligible for, public assistance. Applicants were subject to more rigorous job search requirements, and current beneficiaries were subject to more stringent recertification procedures. The percent of public assistance applicants rejected increased from just above one-quarter in the early 1990s to more than half in 1996 and remained above 50 percent throughout the late 1990s. (See Table 3.) These administrative changes, together with an improving local economy, reduced the number of public assistance recipients in New York City from more than 1.1 million in 1995 to under 573,000 in 2000.

**Table 3**  
**Employees, Personal Service Costs, and Applications for Public Assistance and Medicaid**  
**New York City, Fiscal Years 1995-2000**

Indicator	1995	1996	1997	1998	1999	2000
<b>Full-Time Employees</b> <sup>(a)</sup>						
Public Assistance program	10,378	10,143	8,961	8,085	7,707	7,542
Medicaid program	2,625	2,256	2,137	1,955	1,867	1,740
<b>Personal Service Expenditures</b> <sup>(b)</sup>						
Public Assistance program	\$291,210,074	\$286,565,588	\$266,883,114	\$248,675,526	\$247,165,835	\$247,830,194
Medicaid program	\$80,050,005	\$60,692,248	\$60,623,618	\$65,449,089	\$66,671,139	\$68,499,538
<b>Number of PA Applications (000s)</b> <sup>(c)</sup>	277.6	258.8	212.2	200.2	197.2	203.2
Rejection Rate <sup>(d)</sup>	43.3%	55.8%	54.5%	56.7%	51.8%	51.6%

Sources: <sup>(a)</sup> Data are from City of New York, *Adopted Budget, Expense, Revenue, Contract*, fiscal years, 1996-2001. <sup>(b)</sup> Data are from City of New York, *Comprehensive Annual Financial Report of the Comptroller for Fiscal Year Ended June 30, 2000*. <sup>(c)</sup> Data are from City of New York, *Mayor's Management Report*, Volume II, Agency and Citywide Indicators, fiscal years 1995-2000. <sup>(d)</sup> Rejection rates include rejections, withdrawals, and grant reductions.

Many of those denied, or terminated from, public assistance were nonetheless eligible for Medicaid. However, the administrative procedures did not make this connection for them. Instead, those not receiving public assistance were obliged to go to a Medicaid-only center and apply separately for Medicaid. Many did; the number of Medicaid-only recipients increased from 344,000 to 586,000 from 1995 to 2000, but this did not fully compensate for the decline in public assistance recipients. (Refer to Table 2). The net decline in Medicaid enrollment over this period,

reaching nearly 229,000, can be attributed entirely to the decline in those qualifying through public assistance.

In New York City, the Medicaid-only eligibility centers were not well-equipped to handle the growing workload. As shown in Table 3, the personnel budget for Medicaid-only offices was cut 14 percent between 1995 and 2000, and the number of full-time employees was reduced by over a third—from 2,625 to 1,740.

Limited or Late Outreach. Traditionally the county and New York City officials administering Medicaid were not oriented to conducting outreach efforts. At a time when more people were becoming eligible for Medicaid, there were few initiatives to inform people of this. This remains the case in many counties, and in New York City significant outreach was initiated only recently.

It was not until early 2000 that Mayor Giuliani launched the HealthStat program, in a separate division of the Mayor's Office (Mayor's Office of Health Insurance Access), rather than New York City's local social service agency (the Human Resources Administration).

HealthStat is a citywide initiative to expand health insurance enrollment. Over 20 municipal agencies are active in outreach efforts to identify uninsured residents and to refer them to an appropriate health plan. For example, the Department of Health includes CHP and Medicaid enrollment information in each newborn birth certificate mailing, and has hired 50 public health advisors to enroll children at city schools, where school nurses are generating about 1,000 referrals per week. The Department of Corrections generates about 200 referrals a week from information booths at all correctional facilities, and the Parks Department generates about 100 referrals per week from outreach efforts at recreation centers.<sup>24</sup> Through HealthStat the Fire Department and Housing Authority have also been enlisted to help boost enrollment, and the Mayor has granted cash awards to public schools that generate substantial new health insurance enrollment. However, while HealthStat makes information about Medicaid and CHP widely available and generates many outreach activities, it has not changed the eligibility requirements or processes.

The Wrong Children in CHP. As noted earlier, when federal funding became available in 1998, New York State initiated a major expansion of its CHP program. This program is designed for children in families with incomes above the Medicaid eligibility levels. However, it is administered by the Department of Health rather than delegated to the local social services departments, and its procedures are different. As a result, it initially enrolled many children who should have been in Medicaid.

The federal government has two reasons to object to its funds being used to enroll these children in CHP. First, the benefit package for Medicaid is somewhat more generous than for CHP, so children are better served if they can be in Medicaid rather than CHP. Second, the federal matching share is higher for CHP (65 percent) than for Medicaid (50 percent), so federal agents have a fiscal incentive to shift eligible children from CHP to Medicaid. For both these

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<sup>24</sup> New York City Mayor's Press Office, "Mayor Giuliani Launches HealthStat Public Awareness Campaign," press release, November 27, 2000; New York City HealthStat, <<http://www.ci.nyc.ny.us/>> (29 May 2001).

reasons, federal officials may seek to impose penalties on New York State for improperly enrolling Medicaid-eligible children in CHP.

The State Comptroller was the first to point out that inappropriate CHP enrollment was a serious problem. In 1998, the Comptroller reviewed the administration of the program and found that at least 40 percent of the children enrolled were likely to be Medicaid eligible.<sup>25</sup> The problem continued as enrollment expanded quickly in 1999 and 2000. In the fall of 2000 the Health Department acknowledged about one-in-five children were inappropriately in CHP, but many health plan administrators were reporting the figure was close to half.<sup>26</sup> Many families were sent letters notifying them that their children were no longer eligible for CHP and that they would have to go through a separate Medicaid eligibility process.

Since the fall of 2000 an interagency task force has dealt with the problem of children inappropriately enrolled in CHP. A joint application form for CHP and Medicaid coverage for children was designed and put into practice, permitting the information to be used to enroll the child in the appropriate program. A State Comptroller's audit conducted in the last quarter of 2000 and released in mid-2001 indicated that the proportion of CHP enrollees who should be enrolled in Medicaid had dropped from over 40 percent to between 20 and 24 percent, and that procedures were being implemented to continue to reduce this figure.<sup>27</sup> As of July 2001 the State DOH believes that few or no Medicaid eligible children are enrolled in CHP.<sup>28</sup>

High Administrative Costs. The faulty administration of health insurance subsidies does not come cheaply. The fragmented approach makes it impossible to identify all the associated administrative costs, but the available figures suggest they are substantial.

For the large group that qualifies for Medicaid through public assistance, the marginal cost of Medicaid eligibility arguably is zero. The expense is necessary for public assistance, and there is no added cost for Medicaid. However, it is worth noting that the administrative costs of public assistance are relatively high. In New York City in fiscal year 2000, the administrative costs of public assistance were nearly \$248 million. This sum represented about 13 percent of the total amount spent for cash benefits and represented an administrative cost of \$432 per recipient and \$929 per case. This compares to an average benefit payment of \$7,293 per case.<sup>29</sup>

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<sup>25</sup> Office of the State Comptroller, *Department of Health's Management of the Child Health Plus Program*, Report 97-2-10 (April 1998).

<sup>26</sup> Jennifer Steinhauer, "Many Not Eligible in State Program to Insure Children," *The New York Times*, September 30, 2000, p. 1.

<sup>27</sup> Office of the State Comptroller, *Department of Health: Management of Child Health Plus B*, Report 2000-S-28, July 18, 2001.

<sup>28</sup> Letter from Deputy Commissioners Judith Arnold and Kathryn Kuhmerker to Charles Brecher, dated July 23, 2001.

<sup>29</sup> City of New York, *Comprehensive Annual Financial Report of the Comptroller for the Fiscal Year Ended June 30, 2000*. Personal Services spending for public assistance totaled \$247,830,194, and Other Than Personal Services spending totaled \$1,946,547,205. The number of PA cases (266,900) is from the *Mayor's Management Report, op. cit.*

For the Medicaid-only enrollees, the City's administrative expenses in fiscal year 2000 totaled about \$68 million. This represents about \$117 per recipient, compared to per enrollee medical benefit costs of about \$1,872 per child and \$5,093 per adult. The City's figure does not include the costs to the State for its oversight of Medicaid program eligibility.

For the CHP program, administrative costs are not shown directly in the State's budget. There are two components of this cost—oversight by the State and eligibility determination by the private health plans. The State provided federal authorities with some estimates of its administrative costs in its CHP application.<sup>30</sup> For State fiscal year 2000-2001, administration costs are estimated to total \$31.7 million (4.6 percent of total premium costs of \$689.6 million), or \$61 for each of the 516,381 CHP enrollees in 2001. These costs relate primarily to oversight and outreach, because the State relies on the private health plans to determine who is eligible.

The plans finance the administrative costs of eligibility determinations through the CHP premiums paid by the State. If the CHP plans incurred administrative costs equal to those incurred by the City for eligibility determinations for Medicaid-only enrollees, then these costs (about \$117 annually) would represent about 9 percent of the premium the State pays to the plans.<sup>31</sup>

## **Requirements for an Integrated Eligibility System**

In order for New York State to manage its health insurance subsidy programs more efficiently and more effectively, it must integrate the current fragmented eligibility systems. Moving to a streamlined system requires leadership from the Governor so that the multiple agencies now involved can accomplish four basic steps.

Define common information requirements. The applications for each of the programs should seek the same information. Defining this common information base may require some compromises, but the standard must accommodate federal requirements. This means that the new standard may reflect the requirements of the more stringent program, notably Medicaid. While this would mean seeking more information from those initially applying only for CHP, it will have the long-run benefit of establishing a database that permits people to move easily from CHP or another program to Medicaid.

The State already has made some progress in this area by developing a combined application form for CHP and Medicaid, so that Medicaid-eligible children applying for CHP can be assigned to the appropriate program without a new application. For the implementation of FHP in the fall of 2001, the State is designing a common application for Medicaid, CHP and FHP. This requires seeking information about all applicants' immigration status. This creates a potential deterrent for those concerned about their status, but there is no realistic alternative.

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<sup>30</sup> New York State, *State Child Health Plan*, <<http://www.health.state.ny.us/nysdoh/child/schip99a.pdf>> (29 May 2001).

<sup>31</sup> CHP premiums vary by plan and by county. In May 2000, CHP premiums in Manhattan ranged between \$90 and \$130 per month, or \$110 on average, to equal \$1,320 annually.

Until Congress redefines the requirements for Medicaid, it will be necessary to include some basic questions about immigration status as part of an integrated eligibility system. This requirement should be accompanied by public information efforts that inform people that this information will not be used to harm them and that it is used only for purposes of determining eligibility for health insurance coverage.

Standardize Procedures. The elements of the eligibility process that now vary among programs should be standardized. These include the type of documentation required, the frequency of recertification, and whether or not a face-to-face interview is required for recertification. In this instance, it is not necessary to impose the currently most restrictive requirements to all the programs. Some procedures now required for Medicaid can be made less stringent within federal mandates, and this may be desirable.

The most difficult aspect of standardization relates to the procedures for those qualifying for Medicaid through applications for public assistance. The rules and procedures for public assistance are far more stringent than for Medicaid, so some of those rejected for (or terminated from) public assistance may be eligible for Medicaid. The best way to maintain stringent rules for public assistance but grant health coverage to all who qualify for Medicaid is to separate eligibility decisions for the two programs. Those seeking assistance initially should be able to use a common application form (as is now the case), but those denied cash assistance should be considered for Medicaid and FHP with their less stringent criteria applied to the information on the combined application (which is *not* now automatically the case).<sup>32</sup> Once an individual is eligible for Medicaid, that program's recertification procedures should apply for continued eligibility. No public assistance recipient should be automatically terminated from Medicaid when they lose their cash benefits; instead, they should be presumed to be still eligible for Medicaid until a separate Medicaid review is completed. There is an automated process for accomplishing this separation of termination decisions, and now it is being used more frequently and accurately than was the case in the early period of TANF implementation.<sup>33</sup>

This same principle should be applied for the 61,000 families statewide (about half live in New York City) who will be reaching their five-year time limit for federal TANF benefits at the end of 2001. Both the Giuliani and Pataki Administrations are considering requiring these families to apply separately for the State's Safety Net program, rather than automatically moving into the program when their federal benefits expire.<sup>34</sup> Those leaving TANF due to time limits should be presumed eligible for Medicaid, until a separate Medicaid recertification is necessary.

Authorize Multiple Common Access Points. If common information requirements and eligibility procedures are established, then agencies performing one type of eligibility review could perform

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<sup>32</sup> Social service districts are supposed to do this separate Medicaid review manually, because it is not part of an automated process. A State Comptrollers' audit found that counties varied widely in their capacity to conduct such reviews with an average of 10 percent of all cash benefit denials having no separate Medicaid review among upstate counties. See Office of the State Comptroller, *Department of Health and Office of Temporary Disability Assistance: Medicaid Eligibility Under TANF Assistance*, Report 2000-S-22, July 11, 2001.

<sup>33</sup> *Ibid.*

<sup>34</sup> Somini Sengupta, "Pataki Supports City's Welfare Plan: When U.S. Benefits End, Apply to State," *The New York Times*, May 16, 2001, p. B5.

the review for all programs. The entry and recertification points for all programs should be integrated, and the number of such access points should be expanded following the current model of facilitated enrollment.

Involving voluntary, community agencies in eligibility processes can make them both more accessible and more efficient. Access is improved when applicants can go to offices that are close to home or work and that are staffed by people who know their culture. This can be particularly important when immigration status is one factor in eligibility.

Efficiency can be improved when there are multiple agencies at work, and their performance is used to compare and set targets. Performance contracts with facilitated enrollers could set the payments at levels that reflect the cost among agencies with the best records. Budgets for local government agencies, such as New York City's Medicaid-only offices, could be set using similar standards.

Maintain a Statewide Eligibility File. If individuals are to be able to move easily, even automatically, between programs, when their income or other conditions change, then the State must have an integrated eligibility file for these programs. All individuals participating in any of the relevant programs should be included in a master file maintained by the State.

Such a file already exists for Medicaid, based on information assembled from the public assistance, SSI and Medicaid-only programs. A separate file for children in CHP is maintained by the DOH. New steps should be taken to integrate the CHP and Medicaid files and to insure that FHP eligibles are included in a new master file. This would permit enrollees in CHP or FHP to be shifted to Medicaid when their income falls. Similarly, Medicaid enrollees who gain employment or otherwise change their status could be shifted to CHP or FHP using a master eligibility file. The current system of separate eligibility files hampers this goal.<sup>35</sup>

The State's eligibility file should be hospitable to the electronic transfer of information from multiple sources. Documentation should be accepted in an electronic format, such as scanned documents, and information should be received in electronic, rather than paper, form from insurance plans, community-based facilitated enrollers and local social service departments.

## **EXPANDING INTEGRATED ELIGIBILITY TO OTHER PROGRAMS**

The four steps identified above would establish an integrated eligibility system for health insurance programs, but the approach need not be limited to these programs. Many other social welfare programs also are "means-tested;" that is, they have income eligibility requirements that require documentation. Integrating the enforcement of eligibility rules for these programs with

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<sup>35</sup> Another obstacle to such automatic transitions is that health plans participating in CHP are not required to participate in the Medicaid managed care program. Thus, the parents of children moving from CHP to Medicaid might have to select a new plan for their children.

that of health insurance programs could provide substantial benefits in the form of lower administrative costs and greater reach in serving those who are eligible.

## Scope of Means-Tested Programs

A recent national study by Congress' Ways and Means Committee found that in 1998 there were almost 80 different means-tested programs with annual expenditures of \$392 billion.<sup>36</sup> (See Table 4.) About half this total was accounted for by medical subsidy programs, notably Medicaid, CHP and others discussed above.<sup>37</sup> However, the other half is spent by programs providing other types of assistance. This includes cash assistance programs such as TANF and SSI, food and nutrition programs such as food stamps and school lunches, housing assistance programs, and a variety of others. Among all means-tested programs, the cash assistance programs account for about one-quarter of the expenditures, food and nutrition programs about one-tenth, housing about 8 percent, and the rest is divided among numerous other programs.

<b>Form of Benefit</b>	<b>Amount (millions)</b>	<b>Percent of Total</b>	<b>Intergovernmental Distribution</b>	
			<b>Federal Share</b>	<b>State/Local Share</b>
Medical	\$196,389	50.1%	57.9%	42.1%
Cash	\$94,562	24.1%	78.1%	21.9%
Food	\$35,511	9.1%	94.2%	5.8%
Housing	\$29,511	7.5%	91.1%	8.9%
Education	\$18,126	4.6%	93.7%	6.3%
Jobs/Training	\$3,856	1.0%	98.2%	1.8%
Services	\$12,453	3.2%	58.6%	41.4%
Energy Aid	\$1,321	0.3%	95.2%	4.8%
<b>Total</b>	<b>\$391,729</b>	<b>100.0%</b>	<b>70.8%</b>	<b>29.2%</b>

Source: U.S. House of Representatives, Committee on Ways and Means, *2000 Green Book*, <<http://frwebgate.access.gpo.gov/cgi-bin/multidb.cgi>> (29 May 2001).

Virtually all of these programs are available in New York State. Table 5 identifies the dozen largest non-health programs in the state. These programs are divided into two categories—entitlements and rationed benefits. Entitlements refer to programs where there are no restrictions on funding, and hence the total number of beneficiaries. Rationed benefits refer to those with

<sup>36</sup> U.S. House of Representatives, Committee on Ways and Means, *2000 Green Book*, <<http://frwebgate.access.gpo.gov/cgi-bin/multidb.cgi>> (29 May 2001).

<sup>37</sup> *Ibid.* Additional medical programs and their share of total medical care expenditures are: Medical care for veterans without service-connected disability (5 percent); General Assistance (2.5 percent); the Indian Health Service (1 percent); the Maternal and Child Health Services Block Grant (0.6 percent); Consolidated Health Centers (0.4 percent); Title X Family Planning Services (0.1 percent); and Medical Assistance to Refugees and Cuban/Haitian Entrants (less than one half of 1 percent). Medicaid represents 90.3 percent of total medical expenditures and CHP represents 0.1 percent of the total.

limited funding, so that all who are eligible might not receive benefits. Daycare is an example where long waiting lists for "slots" are common, especially in New York City.

In terms of dollars, the single largest program is SSI, which provides cash assistance totaling over \$3.2 billion to over 600,000 aged and disabled individuals. The TANF cash assistance program, FAP, and the State's Safety Net program together account for another nearly \$2 billion, reaching about 800,000 adults and children.

**Table 5**  
**Expenditures, Beneficiaries, and Average Benefit**  
**Selected Means-Tested Programs**  
**New York State**

<b>Program</b>	<b>Expenditures</b> <i>(millions)</i>	<b>Beneficiaries</b>	<b>Average Benefit</b>
<b>Entitlement Programs</b>			
Cash/Public Assistance <sup>(a)</sup>	\$5,203.8	1,410,698	\$3,689
Family Assistance Program (Formerly AFDC)	\$1,498.3	667,756	\$2,244
Safety Net Assistance (Formerly Home Relief)	\$456.4	126,747	\$3,601
Supplemental Security Income	\$3,249.1	616,195	\$5,273
LIHEAP <sup>(b)</sup>	\$80.3	600,834	\$135
New York State Earned Income Tax Credit (EITC) <sup>(c)</sup>	\$360.8	1,159,320	\$311
Food Stamps <sup>(a)</sup>	\$1,353.0	1,376,034	\$983
School Lunch Program <sup>(d)</sup>	\$392.3	1,168,691	\$336
School Breakfast Program	\$91.4	412,826	\$221
WIC <sup>(d)</sup>	\$273.5	476,564	\$574
<b>Rationed Benefit Programs</b>			
Head Start <sup>(e)</sup>	\$304.3	45,040	\$6,756
Day Care <sup>(f)</sup>	\$393.3	158,605	\$2,479
Housing Authority <sup>(g)</sup>			
Direct Operations	\$745.0	181,000	\$4,116
Section 8	\$534.0	75,589	\$7,065

Sources: <sup>(a)</sup> Data from New York State Department of Disability and Temporary Assistance, Statistics 2000 Summary, Volume LXII, No.12, March 16, 2001. <sup>(b)</sup> Data are for 1996, and represent households, not beneficiaries. <sup>(c)</sup> Schuyler Center for Analysis and Advocacy, *Background Paper on New York State's Earned Income Tax Credit (EITC)*, May 2001, <[http://www.scaanyorg/web\\_page\\_EITC.pdf](http://www.scaanyorg/web_page_EITC.pdf)> (29 May 2001). <sup>(d)</sup> *State of the States: Food and Nutrition Programs Across the Nation* (DC: Food Research and Action Center, December 2000). Represents Federal FY 1999 expenditures in NYS for WIC, School Lunch and School Breakfast programs. School Lunch and Breakfast beneficiaries are average daily number of students receiving a free or reduced price meal. <sup>(e)</sup> U.S. Department of Health and Human Services, Administration for Children and Families, <<http://www2.acf.dhhs.gov/programs/hsb/index.htm>> (29 May 2001), FFY 1999. <sup>(f)</sup> U.S. House of Representatives, Committee on Ways and Means, *2000 Green Book*; data are for 1998. <sup>(g)</sup> New York City Housing Authority, expenditures include administration, and are for New York City only. Beneficiaries represent units. Data from City of New York, *Mayor's Management Report*, fiscal year 2000, Volume II, p. 67.

Both the federal government and New York State provide payments to low-income workers through an Earned Income Tax Credit (EITC). The size of the refund varies by earnings and family size. New York tax filers without children may make a claim if their income is less than \$12,000, while those with one child must have an income below \$27,000 and those with two

or more children an income of less than \$30,580.<sup>38</sup> In 2000, the maximum benefit for a family with two or more children was \$4,674, consisting of \$3,816 in a federal payment and \$858 in a State payment.<sup>39</sup> In 1998, nearly 1.2 million state residents, more than half of whom resided in New York City, received a refund from the State, averaging \$311.<sup>40</sup> The State refund represented 20 percent of the total federal refund, estimated at \$1.8 billion or \$1,556 per recipient. The State EITC is scheduled to increase to 25 percent of the federal credit in 2001, 27 percent in 2002, and 30 percent in 2003.

Nutrition programs comprise another major investment. The Food Stamp program reaches nearly 1.4 million New Yorkers at an annual cost of nearly \$1.4 billion. School lunches and breakfasts are provided to nearly 1.2 million children at a cost of nearly \$500 million annually. The Supplemental Nutrition Program for Women, Infants and Children (WIC) provides food and services to more than 475,000 children, pregnant women and mothers at an annual cost of nearly \$275 million. In each case the income eligibility criteria differ from those of Medicaid; while it is possible to apply for WIC along with Medicaid, the Food Stamp program is administered separately and school lunch programs are administered by local school districts.

Preschool programs such as Head Start and multiple subsidized daycare programs are another major type of means-tested benefit in New York. Statewide about 45,000 children are enrolled in Head Start at a cost of more than \$300 million. Multiple other daycare programs reach about 159,000 children at a cost of nearly \$394 million. Eligibility for Head Start is limited to families with incomes below the federal poverty threshold or receiving public assistance and is determined by the agency running the program.

There are multiple housing programs run by the federal, state and local governments which subsidize both developers and tenants. Table 5 provides information on the two major programs operated by the New York City Housing Authority. First, buildings owned and operated by the Authority house 181,000 households. Families with incomes up to 80 percent of the median in the area are eligible for apartments with the rent charged varying with income. Application is made to the Housing Authority at one of its five borough offices, and eligibility is determined by the Authority. As shown in Table 5, the average annual subsidy per household is \$4,116 and the total amounts to \$745 million.

The second major housing program is known as Section 8. It subsidizes families in private rental units. Eligibility is limited to families with incomes less than 50 percent of the area median, with priority to those with incomes less than 30 percent of that level. Eligibility is determined by the Housing Authority. The total annual subsidies available are \$534 million, averaging \$7,065 per assisted household.

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<sup>38</sup> Citizens Committee for Children of New York, Inc., *Resource Guide for Working Families in New York City* (NY: Citizens Committee for Children of New York, Inc., November 2000).

<sup>39</sup> *Ibid.*

<sup>40</sup> Schuyler Center for Analysis and Advocacy, *Background Paper on New York State's Earned Income Tax Credit (EITC)*, May 2001, <[http://www.scaanyorg/web\\_page\\_EITC.pdf](http://www.scaanyorg/web_page_EITC.pdf)> (29 May 2001).

Perhaps the most meaningful way to describe the multiple means-tested programs is from the vantage of an indigent family. Table 6 shows the value of the major benefits a family consisting of a mother and two children might receive, under three different scenarios. In the first, the family has no earned income; in the second, the mother works full-time at minimum wage; in the third, the mother earns just enough to bring the family above the poverty threshold. In all cases, one child is a preschooler and the other is enrolled in public school.

**Table 6**  
**Annual Value of Selected Means-Tested Benefits**  
**For a Single Parent with Two Children in New York City <sup>(a)</sup>**

<b>Program</b>	<b>Unemployed Parent</b>	<b>Parent Employed Full-Time at \$5.15/hour</b>	<b>Parent Employed Full-Time at \$7.05/hour</b>
<b>Earned Income</b>	<b>\$0</b>	<b>\$10,712</b>	<b>\$14,664</b>
<b>Means-Tested Benefits</b>	<b>\$30,216</b>	<b>\$27,074</b>	<b>\$15,051</b>
<b>Entitlement Programs</b>	<b>\$20,173</b>	<b>\$18,445</b>	<b>\$11,251</b>
FAP/Cash <sup>(b)</sup>	\$6,924	\$2,016	\$0
LIHEAP	\$135	\$135	\$135
Earned Income Tax Credit <sup>(c)</sup>	NA	\$4,272	\$3,708
Food Stamps <sup>(d)</sup>	\$3,720	\$2,628	\$2,280
School Lunch	\$336	\$336	\$336
School Breakfast	\$221	\$221	\$221
Medicaid <sup>(e)</sup>	\$8,837	\$8,837	\$1,872
CHP	NA	NA	\$899
FHP	NA	NA	\$1,800
<b>Rationed Benefit Programs</b>	<b>\$10,043</b>	<b>\$8,629</b>	<b>\$3,800</b>
Head Start	\$6,756	\$6,756	\$0
Child Care	NA	NA	\$2,400
Section 8 Housing Credit <sup>(f)</sup>	\$3,287	\$1,873	\$1,400

Sources: Benefits from U.S. House of Representatives, Committee on Ways and Means, 2000 *Green Book*, < <http://frwebgate.access.gpo.gov/cgi-bin/multidb.cgi> > (29 May 2001). See Table 5.

Notes: <sup>(a)</sup> Estimates assume one child attends Head Start and one attends elementary school. <sup>(b)</sup> Based on Standard of Need Maximum of \$577 monthly. Earned income subtracted from grant in accord with FAP rules. <sup>(c)</sup> EITC data from NYS Department of Taxation and Finance website, < [www.tax.state.ny.us/stat\\_pit/eitc98](http://www.tax.state.ny.us/stat_pit/eitc98) > (29 May 2001). Payments based on NYC average payments (\$712 and \$618) for single filer with more than one child and incomes between \$8,000 and \$12,000, and between \$12,001 and \$16,000, respectively. The State benefit equals 20 percent of the federal benefit. <sup>(d)</sup> Based on a monthly benefit of \$310 monthly for the FAP family, \$219 for the family with minimum wage earnings, and \$190 for the family with earnings of \$7.05/hour, assuming a monthly rent of \$540 and a Standard Utility Allowance Level 1. <sup>(e)</sup> Based on average expenditures per child of \$1,872, and \$5,093 for an adult, refer to Table 1. <sup>(f)</sup> New York City Housing Authority, Section 8 Housing Credit based on assumed monthly rent of \$540 and voucher value of that amount less 30 percent of applicable income.  
 NA - Not Applicable.

In the first scenario, the total value of the means-tested benefits exceeds \$30,000 annually, with the largest component of nearly \$9,000 being Medicaid benefits. The monthly cash payment under the TANF program represents about \$7,000 and is the second largest component. If the preschool child were enrolled in Head Start, this would represent another \$6,700. Food Stamps would provide another \$3,700, and the school nutrition programs for the school age child represents nearly \$600 annually. If the family were fortunate enough to receive a

Section 8 voucher, the benefits would be worth nearly \$3,300 based on the family's assumed income and rent.<sup>41</sup>

Under the second scenario, earnings at minimum wage would provide the family \$10,712 in gross annual income, with a federal payroll tax liability of \$819. Medicaid would remain the largest benefit, followed by Head Start. This family would be eligible for \$4,272 in combined State and federal EITC benefits. The Section 8 Housing Credit would decline to \$1,873 due to the earnings. The remaining benefits have similar value to that under the previous scenario. Thus, the combined value of means-tested benefits for this family would be about \$27,000.

The scenario is most complex for a family with earnings just above the poverty level, or nearly \$14,700 annually. They would qualify for an EITC of more than \$3,700, but would not be eligible for FAP payments. Their Food Stamps and Section 8 credit would be reduced due to the higher earnings. The younger child would no longer be eligible for Head Start, although the mother could receive a child care voucher, if space is available. With respect to health care benefits, the entire family would not be eligible for Medicaid, but each member could qualify for a separate program—the mother for FHP, the older child for CHP, and the younger child for Medicaid.

Troubling aspects of this complex benefit package are the fragmented eligibility system and the relatively high administrative costs. To obtain the set of benefits summarized in Table 6, the illustrative mother would have gone to a local public assistance office to obtain the TANF, Food Stamp and Medicaid benefits, separately applied to the local school for the school lunch and breakfast program, filled out another set of forms to qualify the younger child for Head Start, and applied separately to the Housing Authority for Section 8 assistance. Application for the EITC would be through State and federal income tax forms. In each case the documentation required to prove eligibility and the period for recertification would be different.

As noted earlier, the cost of ascertaining eligibility is about \$929 per case for public assistance. The separate administrative cost for the school lunch program equals about 10 percent of benefit value or \$34. The administrative cost of Head Start adds another \$676 per child, and NYCHA assistance another \$636, assuming administration costs also represent 10 percent of the total, for each. Thus, delivering about \$30,000 of benefits costs in excess of \$2,200 to determine eligibility. Moreover, this excludes the cost imposed on the mother, who would be obliged to take time from work to submit the applications and documentation and be recertified at the multiple program offices.

The administration of the multiple means-tested programs would be more efficient and would bring benefits to more of the target population if the separate eligibility processes were better integrated. While first priority should be given to integrating the health insurance subsidy programs, as described in the previous section, a long-run strategy should also be developed for integrating other means-tested programs. This is a complex task that should be phased-in over

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<sup>41</sup> There is an extensive waiting list for Section 8 benefits. According to the *Mayor's Management Report*, fully 219,000 families were on the Housing Authority's waiting list in fiscal year 2000.

several years, but some priority steps should be taken to integrate some of the programs with the health insurance programs as the eligibility process for the health programs is revamped.

## **Priority Steps for Integration**

Three measures are feasible as the health insurance programs are integrated and would provide substantial gains in reaching the needy population.

### *1. Integrate Food Stamp eligibility determination with health insurance subsidy eligibility determination.*

There already is some integration of Food Stamp eligibility with that of other programs. Persons applying for cash assistance under TANF may qualify for Food Stamps as part of their cash assistance applications. However, the income limits are more stringent for TANF than for Food Stamps, so many people qualify for Food Stamps without also receiving cash assistance. This requires a separate application process. As shown in Table 2, about 344,000 people in 2000 received Food Stamps while not receiving cash benefits.

People in this situation also may qualify for Medicaid. However, this requires a separate application from Food Stamps. While more people currently receive Medicaid only (without cash benefits) than receive Food Stamps only, they are not necessarily the same families. (Refer to Table 2.)

The applications for Food Stamps should be integrated with those for health insurance subsidies. The information required and other features of Food Stamps already overlap considerably with the requirements for Medicaid and other subsidy programs. The Food Stamps eligibles list should be integrated with a master list of eligibles for health insurance, and the recertification processes also should be integrated.

Significant progress toward this form of integration has been made in New York City. The local Human Resources Administration, which administers Medicaid and Food Stamps, makes Medicaid eligibility decisions based on information submitted on Food Stamp applications. It also conducted an outreach effort during November 2000 to February 2001 to enroll children in families receiving Food Stamps who were not enrolled in Medicaid through expedited mail applications.<sup>42</sup> These measures indicate the feasibility and effectiveness of more closely integrating these two programs.

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<sup>42</sup> Letter from Executive Deputy Commissioner Iris J. Jimenez-Hernandez to Charles Brecher, dated July 5, 2001.

2. *Experiment with using school lunch program administrators as facilitated enrollers for health insurance programs.*

The school lunch (and breakfast) program serves a population that overlaps substantially with the child population targeted by health insurance subsidy programs. Children in households with incomes up to 130 percent of the poverty threshold receive free lunches, and those in households with incomes up to 185 percent receive lunches at reduced cost. These thresholds are higher than those for Medicaid, but lower than for CHP. However, the number of children receiving free or subsidized school lunches exceeds the number of school age children enrolled in subsidized health insurance programs, perhaps by as many as 80,000 children.<sup>43</sup> In brief, the school lunch program appears to be better at enrolling eligible children than are the health insurance programs.

However, there are formidable obstacles to integrating school lunch and health insurance eligibility determination. Unlike health insurance, school lunches are available regardless of immigration status, require no documentation of income (income eligibility is self-declared), and have a recertification period that is at least one-year and may be several years.<sup>44</sup> Moreover, there is no computerized list of children eligible for school lunches; records are kept manually in each school. Thus, integration of the two systems would require adding requirements and information collection to the school lunch eligibility process that might deter enrollment in an undesirable manner.

A better short-run strategy would be to use those school personnel who now enroll children in school lunch programs as facilitated enrollers for Medicaid and CHP. They should be augmented by community agency staff and local Department of Health public health advisors who are already enrolling children at schools in New York City through HealthStat. For those parents willing to do so, supplementary information could be gathered for health insurance eligibility determination. If sufficient information and documentation is provided to school-based staff, then a complete application could be sent by them to the local social service agency for approval and inclusion in the master file of health insurance eligibles. Recertification would then become the responsibility of the integrated health insurance agency.

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<sup>43</sup> Thorpe, *op. cit.* There are 751,000 children between the ages of 6 and 21 enrolled in Medicaid, representing about 65 percent of all children in Medicaid. If the same percent of CHP enrollees are school-aged, this represents 335,648 children—for a total of 1,086,648 school-aged children in subsidized insurance programs. Currently 1,168,691 children receive the school lunch program. An estimated 82,043 children could be receiving free lunch and not be enrolled in a subsidized insurance program.

<sup>44</sup> Schools meeting certain requirements can participate in a program that only requires applications to be collected from students every four to five years, rather than every year, with the first year's data used as a basis for reimbursement. See Deborah Bachrach, Katherine Lee Yang, Clarke Bruno, and Anthony Tassi, *Implementing Express Lane Eligibility in New York State* (NY: United Hospital Fund, May 2000), p. 15.

3. *Coordinate EITC benefit eligibility with health insurance benefit eligibility.*

The EITC reaches many more working poor families than do the current health insurance subsidy programs, yet this group is a major target of the FHP and CHP programs. Over 1.1 million state residents, most of whom earned under \$28,000, received a state tax refund in 1998. However, as with school lunches, there are serious obstacles to integrating eligibility determination for the EITC and health insurance subsidies. The EITC is administered through the Internal Revenue Service and the State Tax Department via personal income tax returns, and current confidentiality laws prohibit using this information for other purposes. Moreover, the requirements are different, with the EITC considering only earned incomes (rather than total income), not dependent on immigration status, and paid annually based on the filing of tax returns. Nonetheless, in the long run, integration of the programs is possible by permitting people voluntarily to authorize their tax returns to be used for health insurance determination purposes, and they might also be asked to supplement the return with additional information needed for this process. The filing of a tax return, with the supplemental information, could be the basis for health insurance eligibility determination.

Until such procedures are developed, EITC beneficiaries could be targeted for health insurance outreach efforts. Those receiving the credit could be sent an application for Medicaid or FHP (based on gross income and number of dependents indicated on their return) with the overlapping information already filled in based on the return, and the missing information highlighted. This application could then be submitted to the local office or community agency authorized to make eligibility determinations. In this way, eligibility for the EITC is not changed, but the tax return could be used as a way to identify likely eligibles and expedite their applications.

## CONCLUSION

The large-scale health insurance subsidy programs authorized by New York State's elected leaders will not realize fully the intended benefit of helping the medically needy unless the management of these programs is improved. The current administrative practices and structures prevent many who are eligible from obtaining coverage, disqualify many others who ought to remain covered, and add to the overall costs of the programs.

Because responsibility is now divided between the State and local governments, and among agencies within State government, high level leadership is necessary to design and implement effective reforms. Since the State is primarily responsible for health and welfare programs, the Governor should take the lead. Because the State Department of Health is the lead agency for insurance subsidy programs, the Health Commissioner should be given primary responsibility, and commensurate authority, by the Governor for redesigning eligibility procedures and their supporting information systems.

The Governor and Health Commissioner should pursue a two-stage strategy. First, eligibility determination for the major health insurance programs should be integrated in a new system independent of the current public assistance eligibility bureaucracy. This requires four steps: (1) Define common information requirements. (2) Standardize procedures relating to documentation requirements and recertification. (3) Maintain a statewide master eligibility file for all programs. (4) Establish multiple, common access points for eligibility and recertification with staff at these offices following uniform procedures across the state.

Determining eligibility for health insurance programs should no longer be viewed as a byproduct of public assistance program management. In the past, most beneficiaries got their health coverage this way. As recently as 1995, more than four of every five people with Medicaid coverage had qualified through public assistance or SSI; currently, the figure is barely one of two. Statewide about one million people are enrolled in a health program without receiving cash benefits. This figure will grow as the new FHP program is implemented. This large, often working, population should be served by an eligibility determination system that is separate from, and more accessible and hospitable than, local welfare offices.

The administration of this new system should be supported with a DOH operated information system that includes a master eligibility file, but the line services of interviewing clients and reviewing the necessary documentation should rely on community-based organizations following the model of "facilitated enrollment." Local voluntary agencies should be reaching out to their constituents to promote enrollment; the county and New York City social service agencies should not be primarily responsible for determining eligibility for health insurance. The DOH should audit the decisions of the voluntary agencies and include performance criteria and financial incentives for accuracy in their contracts. In this way, the new system would promote efficiency of administration while improving outreach.

Second, the State should begin a longer-term process of integrating eligibility determination for all major means-tested programs including non-health programs. The key to achieving this is designing an information system that creates a master eligibility file and supports diverse program applications. This information support system can start with health insurance subsidy programs, but should be planned as a backbone for broader applications. While this is a large task, the process can begin with three sensible and high-impact initial measures: (1) Integrate Food Stamp eligibility determination with health insurance program eligibility determination. (2) Test using school lunch program administrators as facilitated enrollers for health insurance programs. (3) Coordinate EITC benefit determination with health insurance subsidy eligibility determination.