Senator Day introduced--

S.F. No. 1198: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to professional firms; including marriage and
3 family therapy in the definition of professional
4 services; allowing marriage and family therapists to
5 practice professional services in combination;
6 amending Minnesota Statutes 2004, sections 319B.02,
7 subdivision 19; 319B.40.

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

9 Section 1. Minnesota Statutes 2004, section 319B.02,
10 subdivision 19, is amended to read:

11 Subd. 19. [PROFESSIONAL SERVICES.] "Professional services"
12 means services of the type required or permitted to be furnished
13 by a professional under a license, registration, or certificate
14 issued by the state of Minnesota to practice medicine and
15 surgery under sections 147.01 to 147.22, as a physician
16 assistant pursuant to sections 147A.01 to 147A.27, chiropractic
17 under sections 148.01 to 148.105, registered nursing under
18 sections 148.171 to 148.285, optometry under sections 148.52 to
19 148.62, psychology under sections 148.88 to 148.98, social work
20 under sections 148B.18 to 148B.289, marriage and family therapy
21 under sections 148B.29 to 148B.39, dentistry and dental hygiene
22 under sections 150A.01 to 150A.12, pharmacy under sections
23 151.01 to 151.40, podiatric medicine under sections 153.01 to
24 153.25, veterinary medicine under sections 156.001 to 156.14,
25 architecture, engineering, surveying, landscape architecture,
26 geoscience, and certified interior design under sections 326.02

1 to 326.15, accountancy under chapter 326A, or law under sections
2 481.01 to 481.17, or under a license or certificate issued by
3 another state under similar laws. Professional services
4 includes services of the type required to be furnished by a
5 professional pursuant to a license or other authority to
6 practice law under the laws of a foreign nation.

7 Sec. 2. Minnesota Statutes 2004, section 319B.40, is
8 amended to read:

9 319B.40 [PROFESSIONAL HEALTH SERVICES.]

10 (a) Individuals who furnish professional services pursuant
11 to a license, registration, or certificate issued by the state
12 of Minnesota to practice medicine pursuant to sections 147.01 to
13 147.22, as a physician assistant pursuant to sections 147A.01 to
14 147A.27, chiropractic pursuant to sections 148.01 to 148.106,
15 registered nursing pursuant to sections 148.171 to 148.285,
16 optometry pursuant to sections 148.52 to 148.62, psychology
17 pursuant to sections 148.88 to 148.98, social work pursuant to
18 sections 148B.18 to 148B.289, <u>marriage and family therapy</u>
19 <u>pursuant to sections 148B.29 to 148B.39,</u> dentistry pursuant to
20 sections 150A.01 to 150A.12, pharmacy pursuant to sections
21 151.01 to 151.40, or podiatric medicine pursuant to sections
22 153.01 to 153.26 are specifically authorized to practice any of
23 these categories of services in combination if the individuals
24 are organized under this chapter.

25 (b) This authorization does not authorize an individual to
26 practice any profession, or furnish a professional service, for
27 which the individual is not licensed, registered, or certified,
28 but otherwise applies regardless of any contrary provision of a
29 licensing statute or rules adopted pursuant to that statute,
30 related to practicing and organizing in combination with other
31 health services professionals.

32 Sec. 3. [EFFECTIVE DATE.]

33 <u>Sections 1 and 2 are effective the day following final</u>
34 <u>enactment.</u>

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Senate
State of Minnesota

S.F. No. 1726 - MinnesotaCare Enrollees in Active Military Service

Author: Senator Gary W. Kubly

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: April 4, 2005

S.F. No. 1726 permits MinnesotaCare enrollees in active military service to suspend MinnesotaCare enrollment without a lapse of coverage and provides premium calculations for those enrollees in active military service who choose to continue MinnesotaCare coverage and for their dependents.

Section 1 (256L.05, subdivision 6) permits enrollees who are ordered to active military service to suspend MinnesotaCare coverage upon the effective date of coverage provided by the federal government. Enrollees and their dependents are eligible for MinnesotaCare without reapplication or reenrollment and without lapse in coverage immediately upon termination of the coverage provided by the federal government provided that all MinnesotaCare eligibility criteria are met. These enrollees and their dependents are not subject to the four month "no insurance" waiting period.

Section 2 (256L.07, subdivision 5) for enrollees who are ordered to active military service who choose to continue MinnesotaCare coverage while in active service, and for their dependents, the commissioner shall consider the enrollee's income while in active service to be the lower of (1) enrollee gross income received before reporting for active service; or (2) enrollee gross income received while in active service, counting only the enrollee's base military pay.

Section 3 (256L.15, subdivision 4) states that when calculating premiums for enrollees ordered to active military service who choose to continue MinnesotaCare coverage, and for their dependents, the commissioner shall consider the income in accordance with section 2.

KC:ph

Senators Kubly, Wergin, Murphy, Vickerman and Kiscaden introduced--

S.F. No. 1726: Referred to the Committee on Agriculture, Veterans and Gaming.

1 A bill for an act

2 relating to health; allowing persons in active
3 military service to suspend MinnesotaCare enrollment
4 without a lapse in coverage; modifying MinnesotaCare
5 eligibility determinations and premium payment
6 calculations for persons in active military service;
7 amending Minnesota Statutes 2004, sections 256L.05, by
8 adding a subdivision; 256L.07, by adding a
9 subdivision; 256L.15, by adding a subdivision.

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

11 Section 1. Minnesota Statutes 2004, section 256L.05, is
12 amended by adding a subdivision to read:

13 Subd. 6. [ENROLLEES IN ACTIVE MILITARY SERVICE; OPTION TO
14 SUSPEND COVERAGE.] Enrollees who are ordered to active military
15 service and their dependents may suspend MinnesotaCare coverage
16 upon the effective date of health coverage under Tricare, the
17 Civilian Health and Medical Program of the Uniformed Service
18 (CHAMPUS), or other coverage provided under United States Code,
19 title 10, subtitle A, part II, chapter 55. These enrollees and
20 their dependents are eligible for MinnesotaCare without
21 reapplication or reenrollment and without any lapse in coverage,
22 immediately upon termination of health coverage under Tricare,
23 CHAMPUS, or other coverage provided under United States Code,
24 title 10, subtitle A, part II, chapter 55, provided that all
25 MinnesotaCare eligibility criteria are met. Enrollees who
26 suspend coverage under this subdivision remain MinnesotaCare
27 enrollees and are not subject to the four calendar month bar on

1 enrollment that applies to persons who voluntarily terminate
2 coverage under section 256L.06, subdivision 3, paragraph (d).
3 [EFFECTIVE DATE.] This section is effective the day
4 following final enactment.
5 Sec. 2. Minnesota Statutes 2004, section 256L.07, is
6 amended by adding a subdivision to read:
7 Subd. 5. [ENROLLEES IN ACTIVE MILITARY SERVICE.] When
8 determining eligibility for enrollees ordered to active military
9 service who choose to continue MinnesotaCare coverage while in
10 active service, and their dependents, the commissioner must
11 consider the enrollee's income while in active service to be the
12 lower of: (1) enrollee gross income received prior to reporting
13 for active service; or (2) enrollee gross income received while
14 in active service, counting only the enrollee's base military
15 pay.
16 [EFFECTIVE DATE.] This section is effective the day
17 following final enactment.
18 Sec. 3. Minnesota Statutes 2004, section 256L.15, is
19 amended by adding a subdivision to read:
20 Subd. 4. [PREMIUM CALCULATION FOR ENROLLEES IN ACTIVE
21 MILITARY SERVICE.] When calculating premiums for enrollees
22 ordered to active military service who choose to continue
23 MinnesotaCare coverage while in active service, and their
24 dependents, the commissioner shall consider the enrollee's
25 income while in active service to be the lower of: (1) enrollee
26 gross income received prior to reporting for active service; or
27 (2) enrollee gross income received while in active service,
28 counting only the enrollee's base military pay.
29 [EFFECTIVE DATE.] This section is effective the day
30 following final enactment.

1 Senator ..... moves to amend S.F. No. 1726 as follows:
2 Delete everything after the enacting clause and insert:
3 "Section 1. Minnesota Statutes 2004, section 256L.07, is
4 amended by adding a subdivision to read:
5 Subd. 5. [VOLUNTARY DISENROLLMENT FOR MEMBERS OF
6 MILITARY.] Notwithstanding section 256L.05, subdivision 3b,
7 MinnesotaCare enrollees who are members of the military and
8 their families, who choose to voluntarily disenroll from the
9 program when one or more family members are called to active
10 duty, may reenroll during or following that member's tour of
11 active duty. Those individuals and families shall be considered
12 to have good cause for voluntary termination under section
13 256L.06, subdivision 3, paragraph (d). Income and asset
14 increases reported at the time of reenrollment shall be
15 disregarded. All provisions of sections 256L.01 to 256L.18,
16 shall apply to individuals and families enrolled under this
17 subdivision upon six-month renewal.
18 **[EFFECTIVE DATE.]** This section is effective July 1, 2005."
19 Amend the title accordingly

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Senate
State of Minnesota

S.F. No. 1344 - Repealing MFIP Family Cap

Author: Senator Becky Lourey

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 4, 2005

S.F. No. 1344 repeals the provision in law that prohibits an increase in MFIP cash assistance for a child born while on assistance.

JW:rdr

Senators Lourey, Koering, Kiscaden, Berglin and Neuville introduced--

S.F. No. 1344: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to human services; repealing the Minnesota
3 family investment program family cap; repealing
4 Minnesota Statutes 2004, section 256J.24, subdivision
5 6.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

7 Section 1. [REPEALER.]

8 Minnesota Statutes 2004, section 256J.24, subdivision 6, is
9 repealed.

256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.

Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth; or

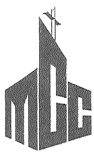
(5) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.



MINNESOTA CATHOLIC CONFERENCE

Archdiocese of St. Paul/Minneapolis ◆ Diocese of Crookston ◆ Diocese of Duluth
Diocese of New Ulm ◆ Diocese of St. Cloud ◆ Diocese of Winona

2005 Policy Brief

Repeal the Minnesota Family Investment Program Family Cap or Child Exclusion Policy

"God entrusts to every person the task of defending and promoting life."

Evangelium Vitae (The Gospel of Life), Pope John Paul II

Issue: During the 2003 legislative session, a number of changes were made to the Minnesota Family Investment Program (MFIP). Among these changes was the adoption of a family cap, or child exclusion policy, that "caps" the monthly cash grants awarded to MFIP participants based upon the existing number of family members in each family unit upon their enrollment in MFIP. In other words, newborn children conceived while their mothers are MFIP participants are excluded from the calculation of the family's cash grant. Evaluations of the impact of family caps on birth rates offer two scenarios; **it either fails to reduce the birth rate or it reduces the birth rate while increasing the abortion rate and denying a cash increment to newborns** (Center for Law and Social Policy, *Caps on Kids: Family Cap in the New Welfare Era,* 1998, revised January 24, 2002). For these reasons, many states have either repealed or revised their state's family cap policies in recent years (Center for Law and Social Policy, *Lifting the Lid Off the Family Cap: States Revisit Problematic Policy for Welfare Mothers,* December 2003).

Position: The Minnesota Catholic Conference opposed the adoption of the MFIP family cap during the in 2003 legislative session and we have been fighting actively for its repeal since it was enacted. We believe that the family cap, or child exclusion policy, is not only an economically unjust policy but it is also a direct threat to the sanctity and dignity of human life because this policy may force women to undergo abortions when they otherwise would not have made that choice. Moreover, this policy threatens the security of families who are already enduring difficult economic struggles by diminishing the means available to them to provide the fundamental necessities of life to their children who are born after such families enroll in MFIP.

Our first and most fundamental principle of Catholic Social Teaching, life and dignity of the human person, instructs us that every human person is made in the image and likeness of God. We believe, therefore, that every human life is sacred from conception through natural death and that the measure of every human institution is whether or not it protects and respects the life and dignity of every human person.

We further believe that the family is the central social institution in our society and that our public policies should support and strengthen families. We also believe that we are each members of one human family and therefore, as our Holy Father Pope John Paul II has taught us, "We are all really responsible for all."

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Because we believe that God has a special concern for our poor and vulnerable brothers and sisters, we believe that it is a fundamental moral obligation of a responsible society to provide an adequate safety net for these members of our human family. Moreover, as our United States Conference of Catholic Bishops explained in their 2002 statement *A Place at the Table,* faith and family life, food and shelter, education and employment and health care and housing are basic human rights.

Studies from other states with family caps have documented an increased rate of abortions among welfare-to-work program participants. Most notably, a four-year study conducted by Rutgers University for the New Jersey Department of Human Services documented a 14% increase in the rate of abortions **-- or a total of 1,429 abortions during the four years that were studied --** among their New Jersey Family Development Program participants (Rutgers University, *A Final Report on the Impact of New Jersey's Family Development Program: Results from a Pre-Post Analysis AFDC Case Heads from 1990-1996,* 1998).

In addition, the monthly cash grants paid to MFIP participants in Minnesota have remained stagnant for many years and the monthly cash grants that MFIP participants receive are very modest. For example, the maximum cash grant paid to a single mother with one child is $437 per month. Although the parent of a "capped" child does receive childcare assistance, medical care coverage and food support funds to partially off-set the additional expenses of caring for that child, the parent is responsible for co-payments for the "capped" child's childcare, any difference in the amount of childcare assistance paid and the fees charged by the child's childcare provider, co-payments for medical services received by the child as well as all other basic and necessary expenses related to providing for the child's daily needs. Consequently, the family cap results in more children being born into even greater poverty.

There are approximately 3,000 families per month in Minnesota who will not receive an increase in their monthly cash grants following the birth of a child under the now-existing family cap or child exclusion policy. The increase in a family's cash grant upon the birth of a child is estimated at approximately $79 per month **-- or less than $3 per day --** under the previous provisions of MFIP (Fiscal Note – 2003-04 Session, SF2615). The total cost of funding these cash grant increases is estimated at just $2.8 million per year or $5.6 million for each biennium *(Id.).*

Action: Because the family cap, or child exclusion policy, may very well result in an increase in the rate of abortions among MFIP participants and because it most certainly results in more children being born into even greater poverty, the family cap, or child exclusion policy, must be repealed.

Contact: For more information contact social concerns director, Kate Krisik at: 651.227.8777; or: kkrisik@mncc.org; or visit the Minnesota Catholic Conference website at: www.mncc.org.

February 2005

Caps On Kids

Family Cap in the New Welfare Era

A Fact Sheet

February 1999

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Traditionally, a family's welfare grant modestly increases when a baby is born; for example, the increment is 80 cents per day in Mississippi to $3.50 per day in California. In 1992, New Jersey became the first state to change this practice by "capping" the family's grant. Today, 23 states are implementing some type of "family cap" or "child exclusion" policy which typically precludes the family from receiving the incremental grant increase. By limiting families' access to this increment, policymakers have sought to reduce birth rates and encourage "personal responsibility."

The 1996 federal overhaul of welfare law creates an entirely new policy context. Previously, families could access assistance for as long as they qualified and many participants were not subject to work requirements. Today, federal welfare is restricted to a life-time limit of 60 months of assistance for the entire family; it also generally requires that the head of household work within 24 months. In other words, while family cap policies sought to *limit* a family's grant, the 1996 welfare law *eliminates* federal assistance for the entire family after 60 months of cumulative receipt. Thus, it is possible to view the family cap as a vestige of a defunct welfare law.

Evaluation data from early implementation states is mixed. New Jersey's final findings are the first and only to indicate that the family cap achieved the intended goal of decreasing births among welfare recipients; however, the decrease in births is accompanied by an increase in abortions and the denial of the traditional grant increase for many newborns.

DEFINING THE FAMILY CAP

- **"Family cap" and "child exclusion" typically refer to denial of the traditional grant increment that reflects the addition of an infant to the family**. Under the typical family cap,[1] if an additional child is conceived after the family begins to receive welfare, the family does not receive the traditional incremental increase; instead the family's grant is "capped" and the child "excluded" from the grant increase.[2] The typical cap exempts those children *conceived* before the mother became a recipient (children born during the first 10 months of receipt can receive benefits) as well as those who are conceived through rape or incest. Most states also exempt the firstborn children of minor parents.[3]

States with Family Cap Policies

Arizona	Florida	Maryland*	North Carolina	Virginia
Arkansa	Georgia	Massachusetts	North Dakota	Wisconsin**
California	Idaho**	Mississippi	Oklahoma*	Wyoming
Connecticut	Illinois	Nebraska	South Carolina*	
Delaware	Indiana*	New Jersey	Tennessee	

* Indiana, Oklahoma, and South Carolina provide capped families with vouchers to purchase goods and services for the newborn or reallocate the cash award to third parties (as in the state of Maryland).

** Idaho and Wisconsin provide "flat grants" under which the amount of assistance does not vary with individual family size.

- **"Family cap" and "child exclusion" also refer to other approaches to restrictions on the grant amount.** Connecticut and Florida allow the family to receive a part of the traditional incremental increase (about 50%). Georgia denies the traditional incremental increase but does permit benefits, under certain circumstances, to increase up to the maximum level of the family size prior to the birth of the child.[4] Vouchers are provided to families in lieu of the cash increment in three states--Indiana, Oklahoma, and South Carolina; Maryland provides the cash increment to a third party for administration.[5] Two states--Idaho and Wisconsin--have "flat grants," which typically provide the same grant amount to all families, regardless of family size.[6]

A NEW ERA OF POLICY DEVELOPMENTS

- **The federal law is silent on family cap**. The 1996 federal welfare law's block grant, the Temporary Assistance for Need Families (TANF), is silent on the subject of family cap. Prior to TANF, a state needed federal

approval to implement a family cap since the policy deviated from federal law; under the new block grant, however, a state may implement a family cap or may terminate a family cap without federal approval.[7]

- **Grants are now time-limited.** While family cap policies sought to *limit* a family's grant, the 1996 welfare law *eliminates* federal assistance for the entire family after 60 months of cumulative receipt. To the extent that a state views a limited grant as a means to influence the timing of childbearing, a state can now consider the elimination of federal grant assistance as having potentially greater impact.

- **Grants are now work-focused.** While family cap policies sought to send a "message" that women will not receive a grant increase that might enable them to stay home, states can now require mothers with very young children to participate in "work first" activities in order to receive assistance.[8]

- **Time-limited welfare led Kansas to end its family cap**. In light of the new federal time limits, the state of Kansas decided not to implement its family cap policy stating,

  > "Since the purpose of the family cap is to assure adults do not continue having children in order to receive increased public assistance, the 5-year time limit does an effective job curtailing such practice."

- **New legislation introduced in Congress would preclude federal TANF funding to states with a family cap policy.** In June 1998, Congressman Chris Smith (R-NJ) and cosponsors introduced H.R. 4066, "a bill to prohibit States from imposing a family cap under the program of Temporary Assistance to Needy Families." The Congressman will re-introduce the measure in 1999. Smith's interest is driven by research indicating the family cap increases abortion; the Congressman is also concerned about an increase in poverty.

- **New legislation filed in New Jersey would repeal the state's family cap policy.** The effort to repeal the family cap is being undertaken in the first state in the nation to experiment with a family cap policy.

A NEW ERA OF RESEARCH

- **Evaluations of the impact of the family cap on birth rates offer two scenarios:[9] It either fails to reduce the birth rate *or* it reduces the birth rate while increasing the abortion rate *and* denying a cash increment to newborns:**

  - Experimental research from Arkansas found no statistically significant difference in birth rates between the experimental and control groups.[10] The finding may be due

to the relatively small sample size (less than 400 participants).[11]

- A trend analysis[12] that considered multiple variables in New Jersey estimates that between October 1992 and December 1996 the family cap led to roughly:

    - 1,400 abortions incurred that otherwise would not have been performed.

    - 14,000 births averted that otherwise would have occurred.

- According to New Jersey state records, between May 1993 and June 1998 the family cap resulted in 28,000 newborns in poor families denied an incremental grant increase.

▪ **Research on the influence of the family cap on childbearing attitudes indicates a common belief that the policy has little attitudinal impact:**

- In Arizona, many of the interviewed caseworkers felt that few if any welfare recipients have more children just to increase their grants.

- In Delaware, most case workers felt that the cap would unlikely influence client's childbearing decisions. They believed the benefit of the cap would be to reduce government expenditures.

- In Indiana, welfare staff did not think that the cap policy was an effective deterrent to childbearing and did not feel that an average $60 decrease in recipients' cash grants would affect a behavior change.

- In Arkansas, virtually all recipient mothers--95% of control group members and 100% of experimental group members--said that they would not have another child in order to get additional benefits.

- In New Jersey, less than 40% of respondents in a client survey cited a loss of additional incremental grant benefits as a reason for avoiding pregnancy.

▪ **Data on family cap and contraceptive use suggest two scenarios: the cap policy may have had relatively little impact or it may increase contraceptive utilization.**

- In New Jersey, the data suggest greater contraceptive use among the experimental than the controls. For example,

experimentals were 21% more likely to use contraceptives compared to controls (the comparison was among new cases).

- In Arkansas, nearly 80% of all fertile mothers who responded to a survey reported no changes in the type of birth control method used since the date when the cap policy was instituted.

- **New brain research has demonstrated that well-being during the first few years of life is essential for future growth and development.** These studies reveal that poor children are more likely to be exposed to the risk factors that can inhibit normal brain functioning and development during this critical period.[13] In part as a response to the brain research, the National Governors' Association is working to "convey the importance of investing in a child's first three years to legislators, parents, business, and other members of the [communities] who can become partners in our effort to give children a better start in life."[14]

FAMILY CAP AND CHILD WELL-BEING

- In 16 states, family cap policies have resulted in more than **83,000** children being capped. This figure which is already greater than the current combined total recipient caseloads of Arkansas, Delaware, North Dakota, and Wyoming, most likely significantly understates the number of capped children in the country because:
    - Some family cap states do not count the number of capped children;
    - Some family cap states do not report counts of capped children during the state's entire implementation period;
    - Some family cap states do not count capped children statewide but rather report data from their waiver demonstration, which was limited to certain families;
    - Some states--including California, the state with the largest TANF caseload--have only recently implemented a family cap policy;
    - Many family cap states do not report complete counts of affected children. In these states, capped children who leave welfare are lost to the count. That is, if 100 children were capped in a given year.

- **Evaluations have not yet measured the effect of the family cap on child well being.** While several of the early evaluations polled recipients regarding their perceptions of child well-being, none have offered

statistical findings regarding child well being. Future analysis may offer such insights.

- Over half of the recipients polled in New Jersey believe the family cap hurts children by withholding welfare benefits.

- Researchers in Delaware plan to examine indicators of children's health, education and development; and a report is expected on a client survey in Indiana that examined such measures of child well-being as rates of reported child abuse and neglect, and the proportion of children in good health.

FAMILY CAP AND STATE POLICY CHOICES

The new welfare era of life-time limits on assistance and work requirements should invite a review of existing family cap policies. They may merely be a vestige of the old order. While the final findings from New Jersey indicate the family cap reduced birth rates it did so while increasing abortions and denying a grant increment to 28,000 newborns. Other new research links poor developmental outcomes to early childhood poverty. Accordingly, we urge states to revisit their existing family cap policies. States can proceed in a number of ways:

- **Terminate an existing family cap.**

- **Evaluate the effects of the state's time limit policy on birth rates.**

- **Evaluate the effects of the state's work requirements on birth rates.**

- **Restrict the cap to a pilot population.**

- **Limit economic consequences through use of third party payments or vouchers.**

- **Invest in expanded family planning services.**

- **Invest in non-coercive family planning services outreach.**

EVALUATION RESOURCES

Arkansas Welfare Waiver Demonstration Project: Final Report. C. Turturro, B. Benda, and H. Turney. (Little Rock: University of Arkansas at Little Rock, School of Social Work, June 1997).

Evaluation of the Arizona EMPOWER Welfare Reform Demonstration: Interim Implementation Status Report. G. Mill, R. Kornfeld, L. Peck, and A. Werner (Cambridge, MA; ABT Associates, Inc., August 1997)

The A Better Chance Demonstration: Report on First Year Site Visits. D. Fein and T.S. Thompson. (Bethesda, MD: Abt Associates, Inc., August 1996)

An Interim Report on the Impact of New Jersey's Family Development Program (1996); The Recipient's Perspective: Welfare Mothers Assess New Jersey's Family Development Program and The Family Cap; The final research findings were issued in three reports: *Cost-Benefit Analysis of New Jersey's Family Development Program: Final Report; A Final Report on the Impact of New Jersey's Family Development Program: Results from a Pre-post Analysis of the AFDC Case Heads from 1990-1996* and *A Final Report on the Impact of New Jersey's Family Development Program Experimental-Control Group Analysis* (New Brunswick, NJ: Rutgers University, 1998).

NOTES

[1] The terminology itself is controversial. For example, some states prefer "family cap" but object to "child exclusion" because the child is not excluded from benefits available to the family—the family is simply ineligible for an incremental increase. Another state may object to both terms: such is the case with Maryland, which provides a "child specific benefit" administered through a third party. Back to text

[2] A family cap can also include a range of other related policy choices. For example, states can treat income from child support and earnings differently for families that are capped. Some states allow families to retain *all* child support income for the capped child and do not count this income in determining TANF eligibility or payments. A few states allow families to keep more earnings to cover some of the expenses for the capped child. States, however, are not to distinguish capped children for purposes of calculating assistance under such programs as Medicaid, WIC, or food stamps. With regards to work requirements, states may distinguish between capped and non-capped families. Since TANF (and prior to TANF under federal waiver), some states lowered the age-of-child criteria that triggers a work requirement for families with capped children. For example, in Massachusetts under TANF, the work program requirement is triggered at six years for families with non-capped children, but decreases to three months for families with children born subject to the cap. Back to text

[3] Four states—Arkansas, California, Mississippi, and Delaware—apply the family cap to newborns of minor teen parents who receive cash benefits as members of an assistance unit. As of January 1, 1999, Delaware plans to implement a provision that applies to the babies of all minor teen parents. Back to text

[4] "For example, if the TANF benefit for a caretaker and one child is reduced from $235 (family maximum for two) to $200 because of a child support payment, the birth of a second child under the cap policy may increase the benefit amount to $235. In this case example, the benefit cannot be greater than the family maximum for two even after the birth of the second child. However, the birth did result in an increase of benefits." (Georgia Department of Human Resources.) Back to text

[5] In Oklahoma, the voucher can only be used for items of necessity for newborns until the age of 36 months. Indiana has not yet implemented its voucher system, which would provide vouchers equal to 50% of the customary increment. Back to text

[6] The flat grant does not increase in amount when the family size increases. For this reason, some view a flat grant as having the same potential effect as a family cap. For example, a maximum grant of $276 is provided to all families in Idaho regardless of family size (though families are allowed to keep some income from any earnings as well). However, the purpose of a flat grant may be rooted more in administrative simplification or in accomplishing other policy objectives. For example, in Wisconsin, the amount of the flat grant is predetermined by the assigned work category (e.g., "community service jobs"or "transitional placements") rather than by the size of the family. Back to text

[7] States can continue or terminate their waivers. States that continue a family cap under waiver are no longer required to continue the evaluation that was a requirement of each approved waiver. Back to text

[8] A state has the ability to mandate participation in a work program as soon after childbirth as it chooses. A mother who fails to participate in mandated activities can be sanctioned. The 1996 law does not allow the state to sanction a mother who fails to participate if she can demonstrate that she was unable to secure child care for a child under the age of six. While she may not be sanctioned for this reason, the time-limit clock still ticks. Back to text

[9] CLASP compiled evaluations, other reports, and data from the original 14 states with federal waivers. Seven are conducting (or have completed) an evaluation of their family cap policy. Back to text

[10] In Arkansas, capped families had, on average, 0.16 births as compared to control group members, who averaged 0.14 births during the five-year waiver period. Back to text

[11] The smaller a study sample, the larger the difference must be between the control and experimental groups in order to reach statistical significance. In the Arkansas study, research on birthrates was limited to a 10% random sample of the full study group. Thus, for the birthrates analysis, the number studied was 184 in the experimental and 182 in the experimental group. Back to text

[12] The final evaluation report by Rutgers University provides dramatically different conclusions than a draft of the report which received wide press coverage. The draft report found the same trend as the final report: births decreased (not at a statistically significant level) and abortions increased; however, the draft found that abortions increased more than births decreased -- in other words, the decrease in births was achieved through abortions. The final report's trend analysis finds that for every abortion, 10 births were averted. For a review of some issues raised by the final report see CLASP's "Open Questions: New Jersey's Family Cap Evaluation" at www.CLASP.org. Back to text

[13] J.L. Aber, "Poverty and Brain Development in Early Childhood, " *Child Poverty News & Issues* 7(1), 1997. Back to text

[14] National Governor's Association, *The First Three Years: A Governor's Guide to Early Childhood* (Washington, DC: July 1997). Back to text

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CLASP POLICY BRIEF
CENTER FOR LAW AND SOCIAL POLICY

Childbearing and Reproductive Health Series
December 2003
Brief No. 1

Lifting the Lid Off the Family Cap:
States Revisit Problematic Policy for Welfare Mothers

By Jodie Levin-Epstein

In the early 1990s, a number of states began implementing "family cap" or "child exclusion" policies in their welfare programs to discourage welfare recipients from giving birth to children while receiving cash assistance. Essentially, these policies reversed the long-standing welfare practice of determining the size of a cash grant based on a family's size—that is, if a child was born into a family receiving welfare, the family's grant would be increased modestly. The family cap meant that each family's grant would be capped at a certain level, and no additional funds would be given if another child were born. Since 1992, 24 states have implemented some type of a family cap policy—15 before welfare reform in 1996 and nine since.

Not surprisingly, the family cap has been controversial, and a handful of states have made efforts to repeal their policies. While family cap policies have certainly reduced grant levels for needy families with newborns (likely to their detriment), the available research offers no compelling evidence that they have achieved the objective of reducing fertility. In fact, family cap policies may really be a vestige of the old welfare system, when cash assistance was available without time limits. The current welfare system, Temporary Assistance for Needy Families (TANF), limits federal cash assistance to 60 months in a lifetime. While family cap policies seek to limit cash assistance, TANF actually eliminates it after a set time.

This policy brief explains what family cap policies are, reviews some of the research on their effectiveness, explains how many families are affected by them, describes challenges that have been mounted against these policies, and recommends that states with family caps consider repealing these mistaken and potentially harmful policies.

What Is the Family Cap?

In states with "family cap" or "child exclusion" policies, newborn children conceived while their mothers receive welfare are excluded from the calculation of the family's cash grant.[1] This deviates from basic welfare policy in which a family's cash grant is typically based on the family's size, independent of when a child was conceived. States determine this incremental difference in benefits for families of different sizes. In 2003, for example, the benefit difference for families with one child versus two children ranged from 66 cents per day in Wyoming to $4.36 per day in part of California.[2] In a state with a family cap, the family's grant is capped, and the increment is not added when a child is born to a welfare recipient.

Family cap policies are controversial. For most proponents of

ABOUT THIS SERIES

This brief is the first in a series that will examine policies that seek to affect childbearing and reproductive health behavior, particularly among low-income families, including comprehensive sex education and abstinence education, provisions in welfare reform related to teen parents, and contraceptive and family planning services.

About the Author

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family caps, the goal is to diminish the fertility of welfare recipients. They argue that the policy creates an economic incentive for parents to abstain from intercourse or improve contraceptive practices, at least while they are receiving welfare. In addition, they note that the salaries of non-welfare families do not increase when a new child is born—so why should a welfare grant? Opponents generally cite three arguments against the family cap: that the policy may propel some women to seek abortions; that, while salaries do not respond to family size, tax policy often does; and, most importantly, that reducing grants compromises the well-being of children.

Most family cap polices were instituted prior to the restructuring of the nation's welfare program into the federal TANF block grant. Since then, new research and other developments have led some states to revisit the efficacy of their family cap policies.

Does the Family Cap Work?

Research regarding the effects of family cap policies has generally been negative or inconclusive. For example, a September 2001 General Accounting Office (GAO) review of the research concluded, "Due to limitations of the existing research, we cannot conclude that family cap policies reduce the incidence of out-of-wedlock births, affect the number of abortions, or change the size of the TANF caseload." However, some studies have shown that there is a possibility that the family cap affects births and abortions. A highly publicized 1998 study by Rutgers University showed that, between October 1992 and December 1996, roughly 14,000 births were averted in New Jersey due to the family cap policy; however, the report also estimated that 1,400 abortions were obtained by low-income women that would otherwise not have occurred. This study has since been criticized for potential flaws, however, including being described as having "weak evidence" by the GAO report.

Since 2001, a number of other studies and research reviews have sought to identify the role of family cap policies in fertility behavior.[4] A review of state level welfare policies to reduce subsequent non-marital births considered the role of family cap, earnings disregard, work exemptions, work requirements, and sanctions established prior to TANF. The researchers concluded that none of the policies influenced women's childbearing behavior—in fact, they noted that "even the family cap policy, which was designed for the sole purpose of reducing additional births, had no significant association with subsequent non-marital childbearing."[5] Another study looked at the effect of eight types of state welfare policies on marital and pregnancy transitions among those entering adulthood, including the family cap, and found "weak or nonexistent effects."[6] A study using a different data set found "no systematic effect of the family cap on fertility rates among women age 15 to 34." That researcher noted:

> If this empirical study result is correct, then the widespread adoption of the family cap as a state welfare policy appears ineffective at best and misguided at worst. Women are not responding by having fewer additional births, and consequently, fewer resources are being provided per child on welfare.[7]

A particularly startling research finding is that there's a possible link between a state's decision to institute a family cap policy and the racial make-up of the state's population. One analysis found that family cap policies are more likely in two types of states: "those with a higher percentage of African Americans in their [welfare] caseloads and those with higher percentages of Latinos in their [welfare] caseloads."[8]

Significantly, there has been surprisingly little research conducted on the impact of the family cap on children themselves.

Which States Have a Family Cap?

Under Aid to Families with Dependent Children (AFDC), the predecessor program to TANF, a state was required to apply for a waiver to implement a family cap policy. New Jersey was the first state to implement a family cap policy in 1992.[9] Since then, 23 have states implemented some form of family cap policy (see sidebar on page 3). Of the 24

states, 15 implemented their policy through a waiver and nine implemented their policy after TANF was passed in 1996.[10] TANF is silent on the issue of family cap, but the law's broad flexibility allows each state to decide for itself whether to establish such policies. In recent years, a number of states have eliminated their family cap policy or begun to phase it out.

How Many Families Are Affected by Family Cap Policies?

Because states were not required to collect data on the family cap until recently, the effect of family cap policies have been hard to gauge. However, they clearly affect a substantial number of families. For instance, according to the 2001 GAO report,[11] in an average *month* in FY 2000:

- Almost 10 percent of TANF families in states with family cap policies had their benefits affected. These TANF families received about 20 percent less in cash assistance per month due to the family cap.
- At least 108,000 families received less in cash benefits due to family cap policies in 20 states.

To put 108,000 families in perspective, that is more than the total number of families receiving TANF in the states of Alabama, Arkansas, Colorado, Idaho, Maine, Montana, Nebraska, Oregon, Utah, and Wyoming in December 2000.[12] And that figure is likely to underestimate the total affected. The GAO noted that 108,000 is "a minimum number of families who may have been affected during 2001," as more families may have been "capped" during the subsequent months.[13]

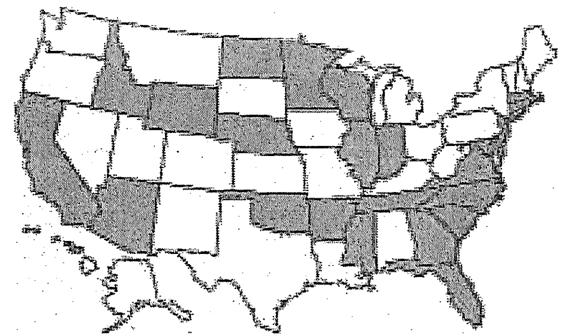
Beginning with FY 2000, the U.S. Department of Health and Human Services (DHHS) has reported to Congress on the percent of TANF families subject to grant reductions due to the family cap. Between FY 2000 and FY 2001, the percentage of families subject to family cap grant reductions rose from 4.1 to 4.5 percent—equaling more than 93,000 families in FY 2000 and nearly 95,500 families in FY 2001. These figures, too, likely underestimate the effect since five states with family cap policies (Maryland, Nebraska, North Carolina, Oklahoma, and Wyoming) reported *no* families as subject to the cap.[14] The annual DHHS report to Congress lists the family cap as the top known reason (after recoupment of previous grant overpayments) that family grants are reduced. For instance, in 2001, of the 2.1 million families receiving TANF, 4.5 percent had grants reduced because of the cap, while 3.9 percent were subject to work requirement reductions.

The percentage of families who have their grants reduced due to cap policies varies significantly from state to state—ranging from nearly 20 percent in Illinois to about 14 percent in Indiana, Massachusetts, and New Jersey, to under 5 percent in Arkansas, Florida, Nebraska, and South Carolina. It is not immediately apparent what accounts for this variation.

Challenges to Family Cap Policies

In many ways, family cap policies are a relic of a pre-welfare reform era. In fact, Kansas had planned to implement a family cap policy prior to enactment of TANF in

STATES WITH A FAMILY CAP



Arizona	**Illinois****	**N. Carolina**
Arkansas	**Indiana**	**N. Dakota**
California	**Maryland****	**Oklahoma**
Connecticut	**Massachusetts**	**S. Carolina**
Delaware	**Minnesota**	**Tennessee**
Florida	**Mississippi**	**Virginia**
Georgia	**Nebraska**	**Wisconsin***
Idaho*	**New Jersey**	**Wyoming**

Shaded areas indicate states with some type of family cap.

Sources: Minnesota Statutes, 2003, Chapter 256J.24, sub 6; U.S. Department of Health and Human Services. (2003, February). *Temporary Assistance for Needy Families Program Fifth Annual Report to Congress*. Washington, DC: Author, Table 12:13. Available at: http://www.acf.dhhs.gov/programs/ofa/annualreport5.

NOTE:
* Idaho and Wisconsin do not have family cap policies that try to influence the timing of conception; rather, TANF grants in Idaho are the same for families of all sizes, and Wisconsin grants for families are dependent on work status.

** Illinois is phasing out its family cap; Maryland is not continuing its family cap since every county has opted out of implementing the family cap since October 2002.

1996, but determined that the new 60-month lifetime limit for welfare sent a sufficient signal to families about the temporary nature of cash grants and the inadvisability of having additional children.[15]

Family cap policies have been challenged since the passage of TANF on both the state and national levels, and several states have revised or rescinded their family caps:

- In 2003, Illinois enacted a measure to phase out its child exclusion provision. Starting in 2004, the family cap does not apply to newborns, and the policy will terminate entirely by July 1, 2007. In the interim, the state agency, subject to appropriations, may stop applying the family cap to children born before 2004.
- In October 2002, Maryland began allowing counties to opt out of the family cap, and all counties have done so. The current state family cap policy expires in September 2004.
- In 2003, Arizona established that when child support is paid on behalf of a custodial parent receiving welfare, these monies should go to the capped child rather than to the state agency to recoup welfare costs.

In addition, a number of legal challenges have been mounted against family cap policies. In California and Indiana, for instance, plaintiffs successfully argued that capped children have rights to child support assignments. And, in Nebraska in December 2003, the state's highest court stopped implementation of a family cap policy on certain classes of parents with disabilities.[16]

On the national level, Rep. Dennis Kucinich (D-OH) introduced a welfare bill in 2003 that included a provision that would have imposed a 5 percent penalty on a state's TANF allocation if it decided to "penalize the birth of a child." (A similar bill was introduced in 2001 by the late Rep. Patsy Mink [D-HI]). In 1998, Rep. Chris Smith (R-NJ) introduced H.R. 4066, a bill that would have denied TANF funds to any state that had or planned to have a family cap policy. None of these federal provisions passed.

What Next?

States have the power to determine whether or not to implement a family cap, and a handful of them have recently decided to abandon this policy. These states are supported by most of the available research, which offers no compelling evidence that the family cap achieves its stated objective of reducing fertility. The evidence is clear, however, that family cap policies have reduced grants to needy families with newborns. If family caps are not achieving their stated aim *and* are potentially harming families, more states should consider repealing these mistaken policies.

Endnotes

1 For a detailed description of family cap policies, including exemptions, see Stark, S., & Levin-Epstein, J. (1999, February). *Excluded Children: Family Cap in a New Era.* Washington, DC: CLASP. Available at: http://www.clasp.org.

2 This compares the maximum monthly benefit available for a family of two and three as of January 1, 2003. The amount is $20 in Wyoming and $131 in region 1 of California. U.S. House Committee on Ways and Means. (Forthcoming). *2003 Green Book.* Washington, DC: Author, Table 11, TANF chapter. Available at: http://waysandmeans.house.gov.

3 United States General Accounting Office. (2001, September). *Welfare Reform: More Research Needed on TANF Family Caps and Other Policies for Reducing Out-of-Wedlock Births* (GAO-01-924). Washington, DC: Author, p. 20.

4 Most of the research on the family cap has examined its potential fertility effects—although the Urban Institute examined its relationship (and the relationship of a number of other welfare policies) to the living arrangement decisions of single mothers. See Acs, G., & Nelson, S. (2002, March). *Assessing the Relation-*

ship Between Welfare Policies and Changes in Living Arrangements of Low-Income Families and Children in the Late 1990s. Assessing the New Federalism Discussion Paper No. 02-25. Washington, DC: Urban Institute. Available at: http://www.urban.org.

5 Ryan, S., Manlove, J., & Hofferth, S. (2003, November). *State-Level Welfare Policies and Subsequent Non-Marital Childbearing*. Paper presented at the Annual Association for Public Policy Analysis and Management Research Conference, Washington, DC. Data are drawn from the Panel Study of Income Dynamics.

6 Harris, K.M., Guilkey, D., & Veliz, E. (2003, November). *Welfare Reform and Nonmarital Childbearing in the Transition to Adulthood.* Paper presented at the Annual Association for Public Policy Analysis and Management Research Conference, Washington, DC. Data are drawn from the National Longitudinal Study of Adolescent Health (known as Add Health).

7 Kearney, M.S. (2002, August). *Is There an Effect of Incremental Welfare Benefits on Fertility Behavior? A Look at the Family Cap*. Working Paper 9093. Cambridge, MA: National Bureau of Economic Research. Available at: http://www.nber.org.

8 Soss, J., Schram, S.F., Vartanian, T.P., & O'Brien, E. (2001). Setting the Terms of Relief: Explaining State Policy Choices in the Devolution Revolution. *American Journal of Political Science*, *45*(2), 378-403.

9 August 1993 was the first month a family's grant might be capped in New Jersey.

10 Kaiser Family Foundation. (1999, November). *Welfare Policy and Reproductive Health: 'Capping' a Family's Benefits.* Issue Brief. Menlo Park, CA: Author. Available at: http://www.kff.org.

11 United States General Accounting Office, 2001.

12 CLASP calculations using U.S. Department of Health and Human Services (DHHS) data, "Total Number of Families September 2000-March 2001" at http://www.acf.dhhs.gov/news/families.htm. The total number of TANF families for those 10 states was 91,992. The AFDC/TANF Families Monthly Average for FY 1999 for the same 10 states found the same results; the total of 105,000 families in those 10 states receiving TANF is still lower than the number of families impacted by the family cap. U.S. House Committee on Ways and Means. (2000). *The 2000 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means.* Washington, DC: U.S. Government Printing Office.

13 United States General Accounting Office, 2001.

14 U.S. Department of Health and Human Services. (2003, February). *Temporary Assistance for Needy Families Program Fifth Annual Report to Congress.* Washington, DC: Author. Available at: http://www.acf.dhhs.gov/programs/ofa/annualreport5.

15 Department of Social and Rehabilitation Services. (1997, January 27). *Family Cap Discussions.* Topeka, KS: Department of Social and Rehabilitation Services. Quoted in Stark, S., & Levin-Epstein, J. (1999, February). *Excluded Children: Family Cap in a New Era.* Washington, DC: CLASP. Available at: http://www.clasp.org.

16 Unpublished research by Paula Roberts, CLASP Senior Staff Attorney, 2003. For a summary list of family cap litigation, contact proberts@clasp.org.

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POLICY BRIEF

Childbearing and Reproductive Health Series

December 2003
Brief No. 1

The Center for Law and Social Policy (CLASP), a national nonprofit organization founded in 1968, conducts research, legal and policy analysis, technical assistance, and advocacy on issues related to economic security for low-income families with children.

The Childbearing and Reproductive Health Policy Brief Series examines policies that seek to affect childbearing and reproductive health behavior, particularly among low-income families, including comprehensive sex education and abstinence education, provisions in welfare reform related to teen parents, and contraceptive and family planning services.

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RUTGERS UNIVERSITY STUDY ON THE FAMILY DEVELOPMENT PROGRAM

A Final Report on the Impact of New Jersey's Family Development Program:

Results from a Pre-Post Analysis of AFDC Case Heads from 1990-1996

EXECUTIVE SUMMARY

The Family Development Program (FDP) was signed into law in New Jersey in January 1992 and officially implemented in October 1992. The ultimate objective of the Family Development Program was to reduce welfare dependency and to move clients from the welfare rolls and into employment. The Family Development Program included several provisions waivered under Section 1115 of the Social Security Act. The most well-known and the most controversial element of FDP was its "family cap" provision, which precluded an AFDC recipient from receiving additional cash benefits for a child that she conceived while on welfare.

The extraordinary amount of national attention focused on the family cap provision has drawn attention away from other important elements and provisions of the Family Development Program. While mothers on AFDC were denied cash benefits for additional children conceived while on welfare, they did qualify for an earned income disregard of up to 50 percent of their cash benefits. Any AFDC client who left the welfare rolls for employment also retained eligibility for Medicaid benefits for a full two years, instead of the single year of Medicaid eligibility provided by the Federal Family Support Act of 1988. To encourage and maintain family formation and high levels of family functioning, some of the financial penalties for (re)marriage were eliminated and benefits for two-parent households were equalized between those families eligible for cash assistance under Federal regulations (F-segment households) and those eligible under state regulations (N-segment households).

The Family Development Program was intended to enhance the sense of personal and familial responsibility among welfare recipients, and the family cap provision was integral to this objective. The family cap provision was intended to convey a distinct message of personal and family responsibility to welfare recipients. The message is that welfare recipients should base their family formation decisions on the same factors that influence these decisions among working families. In short, welfare recipients are required to assume some financial responsibility for their family formation decisions. Economic theory suggests that changes in the financial equation, all other things unchanged, can influence the childbearing decisions of women on welfare.

Like Section 1115 welfare waivers in other states, the Family Development Program was formally evaluated to detect and measure program impacts, costs, and benefits. This formal evaluation of the impacts, costs, and benefits of the Family Development Program relied on an experimental design, where evaluation subjects (AFDC cases) were selected at random into an experimental group (subject to all FDP provisions and waivers) and a control group (who were not subject to any FDP provisions or waivers). Comparisons between these two groups would

form the basis for conclusions about the impact of the Family Development Program. However, the intense national interest surrounding the family cap provision prompted calls for more detailed scrutiny of the impact of this provision on the family formation decisions of women on AFDC. There were fears that the publicity and controversy surrounding this provision may have resulted in some contamination of the formal evaluation's experimental design. In addition, difficulties in implementing the experimental design led to some confusion among evaluation subjects regarding their true experimental status.

The heightened public interest in the effects of a family cap provision on family formation decisions, coupled with concerns about the effectiveness of experimental design as a methodology for assessing the impact of a widely-publicized social policy, led project managers and staff from the U.S.DHHS Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation to request another look at family formation impacts associated with the Family Development Program, using an alternative methodology. In response to this request, a quasi-experimental research design was developed by the Rutgers research team and approved by both Federal offices and by the State of New Jersey Department of Human Services. The results on FDP impacts on the family formation decisions of women on AFDC using this alternative methodology are provided in this report.

OUR FINDINGS

The Family Development Program seems to have exerted some influence over the family formation decisions of women on AFDC. We found that, after the implementation of the Family Development Program, births declined over time, relative to projected births in the absence of FDP and its family cap. Over the same period, we find a marked increase in the utilization of family planning services among this population, again relative to projected utilization in the absence of FDP and its family cap. We also find that some women who became pregnant after FDP was implemented terminated their pregnancies. That is, abortion rates among AFDC women after the implementation of the Family Development Program were higher than those anticipated in the absence of this program. Although many women on AFDC did become pregnant and bear children after the implementation of the Family Development Program, the program had the decided effect of reducing pregnancies and births wrong the AFDC population.

Our best estimates of the magnitude of these impacts are given as follows:

> Between October 1992, the effective implementation of the Family Development Program (and the family cap), and the end of 1996, we estimate that there were 14,057 fewer births among AFDC female payees of childbearing age than would have occurred in the absence of the Family Development Program;
>
> Over this same period, we estimate that there were 1,429 more abortions among AFDC female payees than would have occurred in the absence of the Family Development Program; and
>
> We estimate that, following the implementation of the Family Development Program, there were 7,000 more family planning encounters per year than would have occurred in the absence of the Family Development Program.

These estimates fall somewhere between our highest and lowest estimates of birth, abortion, and family planning outcomes (based on different estimation methods). While the magnitudes of these impacts vary somewhat with model specification and estimation method, there is never any change in the general patterns described above.

METHODOLOGY

We arrived at these findings using a quasi-experimental methodology referred to as a pre-post analysis. Using administrative welfare data from the New Jersey Department of Human Services-Division of Family Development Program (FAMIS) and Medicaid Claims files from the Department of Human Services-Division of Medical Assistance and Health Services, we constructed statistical models to analyze four FDP impacts dealing with family formation decisions of AFDC payees (females) of children-bearing age: births, abortions, use of family planning services, and sterilizations.

Dichotomous dependent variables for these outcomes are defined on a quarterly basis for all AFDC female payees of childbearing age who are on the AFDC rolls between January 1991 and December 1996.[1, 2] Our statistical analyses incorporate the simultaneous impact of several measurable factors (including the Family Development Program) that may affect our various outcome measures; these include age, race, and education of the AFDC payee, the number of eligible children in the household, local -economic conditions, seasonal (quarterly) influences, and a time trend variable to capture the impact of unmeasurable external factors that exert a systematic effect over time on family formation outcomes. Estimated model coefficients always indicate statistically significant changes in each of our outcomes as of the effective date of the Family Development Program, with some evidence of an immediate post-FDP adjustment period followed by the resumption of a longer-term trend either above or below the pre-FDP trend.

We use our estimated coefficients to predict the probable course of the family formation outcomes of interest over the AFDC caseload in the absence of the Family Development Program and its family cap. This projection forms our counterfactual, or baseline, against which we measure the post-FDP impact. We then use these same coefficients, augmented by time coefficients measuring the FDP impact, to project outcomes as affected by FDP, while controlling for the impact of concurrent changes in the caseload composition on the outcomes of interest.

1 These dependent variables take a value of I if the outcome of interest (birth, abortion, and so on) occurred to that individual during the specified quarter, and 0 otherwise.

2 We exclude from this analysis 8,379 AFDC recipients who were used as evaluation subjects in the federally-mandated analysis of FDP impacts, costs and benefits. Otherwise, anyone who received AFDC cash benefits for more than one quarter between January 1991 and December 1996, and who was a female AFDC payee of child-bearing age, was included in our analysis. This provided us with a total of 2,330,551 quarterly observations for analysis.

CAVEATS AND COMMENTS

We have employed statistical methods to look for evidence of a connection between the implementation of the Family Development Program and its family cap, on the one hand, and various outcomes relating to the family formation decisions of women on AFDC, on the other. Statistical estimates, while illuminating, do not, by themselves, prove that the Family

Development Program and the family cap caused a reduction in births, an increase in abortions, or any other changes in family formation behavior. We need to examine the results further, and perhaps draw on other evidence, before we can make causal inferences with confidence.

One possible explanation for these results is the introduction of some other unidentified external influence, concurrent with the implementation of the Family Development Program. This influence may have directly affected our outcome measures (via, for example, changes in the way abortion or birth data are collected or reported), or it may simply be some other change in the external environment that occurred simultaneously with, but independently of, the Family Development Program. There were no changes in the managed care arrangements for AFDC recipients that would affect our abortion estimates, and we rely on welfare administrative records, rather than Medicaid claims files, for AFDC births. Given the increasing use of Medicaid managed care among AFDC recipients and its impacts on reporting of claims, we are not as confident about our measures of family planning utilization or sterilizations. We are not aware of any other external events over our observation period whose impact on family formation outcomes would coincide with the implementation of the Family Development Program.

Statistical models themselves provide no insights into the mechanisms and motivations that influence individual responses to a specific policy intervention like the Family Development Program. However, when we consider the probable impact of the Family Development Program on family formation outcomes within the framework of standard economic theory, we can develop some straightforward and testable predictions regarding the effect of a reduction in cash benefits on AFDC pregnancies. In general, economic theory predicts that, all other factors unchanged, at least some women on AFDC will respond by deciding against having an additional child when the financial resources available to raise a child are reduced (as is the case under the family cap). Indeed, statistical models using recipient-level data to test these hypotheses would look very much like those used to generate the results reported above. Our point here is simple: the results reported above are consistent with expectations developed from economic models of individual response to the FDP intervention.

Our findings here also agree, in direction and implication, with the results of another analysis of the family formation impacts of the Family Development Program. Findings from the formal federally-mandated evaluation of the Family Development Program, which utilizes a classical experimental design methodology, are consistent with the findings from our statistical pre-post analysis. Unlike our pre-post statistical methods, causal inferences can be drawn directly from results from these experimental designs based, as they are, on comparisons of the behavior of randomly-selected experimental and control group subjects (see Camasso, Harvey, Jagannathan, and Killingsworth, 1998). The results of our statistical analyses and the findings from the experimental design analyses both provide strong statistical evidence to support the conclusion that the Family Development Program and the family cap influenced births, abortions, and other family formation outcomes among women on AFDC.

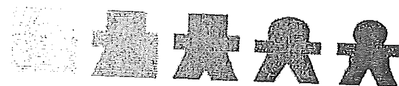
The estimates of birth, abortion, and other impacts provided above are somewhat conservative. The focus of this study was restricted to AFDC payees of childbearing age; the analysis did not include births, abortions, and other outcomes for daughters, siblings, and other non-payee women of childbearing age who reside in AFDC households and who are eligible for cash assistance. We also note that our analysis is restricted to the family formation behavior of women on AFDC. The family cap only applies to women on AFDC, and we cannot tell, from this

analysis, whether the implementation of FDP and the family cap has any continuing effect on the child-bearing decisions of AFDC recipients once they leave the rolls. Likewise, we do not know how the implementation of the Family Development Program and the family cap affects child-bearing among women who are potentially eligible for AFDC/TANF, but who do not choose to apply.

Governor's Task Force On Families First

November 2004

TENNESSEE DEPARTMENT OF
HUMAN SERVICES



Helping shape Tennessee lives.

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"We are very proud of Families First and all it has done for thousands of Tennessee families. We are confident this Task Force will look at our best practices, as well as those from other states, and make this an even stronger program."
--Commissioner Virginia T. Lodge
Task Force Member

Background

Riding a national wave of interest in welfare reform, the Tennessee General Assembly passed legislation creating the Families First program in the spring of 1996. In July of that year, the United States Department of Health and Human Services approved the waiver that allowed the Tennessee Department of Human Services (DHS) to implement work requirements, time limits and sanctions for non-compliance for recipients of public assistance and provide essential support services such as education, training, transportation and child care. Four goals were established by the State Legislature at the program's inception:

- Strengthen families by establishing firm, but fair, expectations of parents for work, responsible parenting and supporting their children.
- Permit adults to marry and retain benefits while on the Families First Program.
- Build a better workforce by requiring work, offering education and training opportunities and providing case management for families.
- Reduce poverty through work requirements, carefully planned benefit packages and transitional services.

Before the summer ended, the U.S. Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which eliminated the Aid to Families with Dependent Children (AFDC) welfare entitlement program and instituted a new program called Temporary Assistance to Needy Families (TANF).

TANF is a departure from AFDC in several ways. States are allocated a block grant to run their welfare programs but also must continue to meet a set minimum level of state funding, called the Maintenance of Effort (MOE). The federal funding does not adjust to changes in the number of families receiving benefits. In addition, states are required to meet minimum Work Participation Rates (WPR), an indicator of the number of participants engaged in work or other work-related activities, or face a reduction in the block grant amount.

"Child well-being should be a major focus of the program."
---Mai Bell Hurley
Task Force Member

TANF requirements are similar to those for Families First participants, but not identical (see Appendix). The key differences are related to what are allowable work activities in calculating the state's Work Participation Rate. Tennessee's waiver allows for more activities to be factored in the calculation of the rate – education in particular – and it allows participants to be exempted from inclusion in the rate due to a variety of "good cause" reasons. In addition, the waiver specifies a range of situations in which a month of Families First benefits does not count toward time limits on assistance.

Why Change Families First Now?

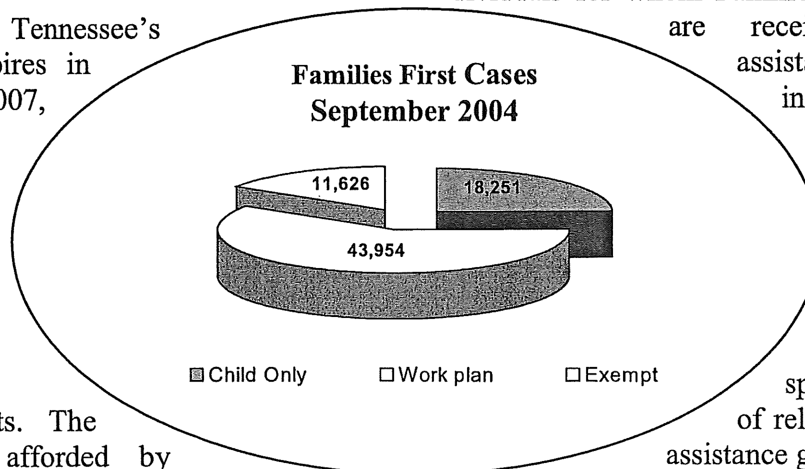
In January 2004, Governor Phil Bredesen named a group of business leaders, current and former clients, advocates, program contractors and senior DHS officials to a task force on Families First. They were charged with recommending ways to improve the program with the goal of "*enabling even more Tennesseans to become self-sufficient, tax-paying citizens*."

The logical question arising from that action was: Why bring this group together at this time?

- Eight years of experience with Families First has yielded a wealth of knowledge on program operations and client outcomes, providing the ability to suggest improvements with a basis in data and research. Welfare reform initiatives have been in place nationwide for more than a decade, and the diverse nature of these efforts provides an opportunity to evaluate the relative strengths of a variety of models aimed at fostering self-sufficiency.
- When Tennessee's waiver expires in June 2007, Families First will be required to conform to all federal TANF requirements. The flexibility afforded by the waiver with respect to calculation of the Work Participation Rate and determination of months countable toward time limits will be lost. Planning now is essential to ensure a smooth transition into compliance with all anticipated federal requirements.
- Congress was due to reauthorize TANF in September 2002. However, as of November 2004, it has not been reauthorized, but merely allowed to operate under a series of continuing resolutions, now extending until March 2005. Although the final version of reauthorization is not known, the Department must prepare for the changes that are likely to be a part of the final TANF bill, primarily: 1) scheduled and significant increases in the required Work Participation Rate (WPR); 2) modification or elimination of the credit that has allowed Tennessee and most states to more easily reach the required WPR; and 3) changes in the definitions of activities allowed in the calculation of the WPR.

Families First Assistance Group Demographics

In the Department's terminology, an assistance group is defined as a group of individuals for whom Families First benefits are received. The assistance group includes at least one child (individual under age 18) and at least one caretaker within a specified degree of relationship to the assistance group child.



In September 2004, 73,831 assistance groups received Families First benefits. Nearly 44,000 of those assistance groups had caretakers subject to the program's work requirements.

2003 Families First Case Characteristics Study

- **188,256 people (133,786 children and 54,470 adults) received benefits through the Families First program.**
- **The average assistance group included 2.7 persons (1.9 children), and it was headed by a 33 year-old female caretaker.**
- **74% of assistance groups had an adult caretaker receiving benefits; 26% of the assistance groups were child-only. Child-only cases are those in which the caretaker is not part of the assistance group. In these situations, the caretaker is typically either a Supplemental Security Income (SSI) recipient, who must be excluded, or a non-parental caretaker, who is not required to be included in the assistance group.**
- **61% of assistance groups lived in urban Tennessee counties (Davidson, Hamilton, Knox, and Shelby).**
- **53% of assistance groups reported having Internet access.**
- **42% of caretakers resided in a household that had a car.**
- **58% of all caretakers were black (non-Hispanic), and 75% of rural caretakers were white (non-Hispanic).**
- **57% of caretakers had never been married.**
- **60% of caretakers had a GED or high school diploma. The average highest grade completed for all caretakers was 11.2.**

***University of Tennessee Center for Business and Economic Research**

Task Force Process

The Governor's Task Force met six times between March and August 2004 for one- or two-day meetings. Members used many resources to advance discussions: research and experience of other states, nationally recognized experts in welfare policy, sub-committee work groups and focus groups. Written reports and research on a wide variety of pertinent topics were also disseminated.

Following an initial Task Force meeting on March 15, four sub-committees, consisting of program participants, employers, community members and Department staff were convened. Sub-committees on laws, rules, regulations and policies; participant opportunities; service delivery; and research each met multiple times during April and May. Focus groups with program stakeholders took place in each of the eight DHS districts across the state in May. Over five hundred people participated in the various groups. In June, the Task Force met and heard reports on the sub-committee and focus group discussions.

Expert Consultants

The Task Force then heard and discussed the findings of several well-known experts. **Dana Reichart**, the TANF director from Louisiana, presented results from a research project on family stability conducted there and discussed her experiences with making changes to Louisiana's TANF program.

Gordon Berlin, Senior Vice President of Manpower Demonstration Research Corporation (MDRC), provided an overview of the most conclusive research to date on successful welfare reform efforts nationally and reviewed the related policy implications of those approaches for Tennessee.

Julie Strawn, Senior Policy Analyst with the Center for Law and Social Policy (CLASP), presented research on employment-focused education and the positive employment outcomes of post-secondary education at the community college level.

Consultant **Deborah Chassman**, who assisted the state in writing the Families First waiver, discussed specific Families

First policies in light of research from other states.

Elaine Ryan, Deputy Executive Director with the American Public Human Services Association (APHSA), updated the Task Force on the status of federal legislation and how it may impact Tennessee's program.

Don Bruce of the University of Tennessee Center for Business and Economic Research summarized evaluations of Families First, including reports on car access and employment outcomes, interactions between local labor markets and Families First caseloads and results from an ongoing longitudinal study of program participants.

Before Families First, only 50% of AFDC participants completed high school. By 2003, almost 60% of Families First participants had completed high school.

Tennessee Department of Children's Services Commissioner **Viola Miller** described successful diversion policies in Kentucky's TANF program.

General Themes

The Task Force examined all major aspects of the Families First program. The group was not asked to achieve consensus on the many issues it addressed, but rather to conduct a thorough review of the program and think creatively about potential changes. The following general themes broadly summarize those discussions:

- The focus of the program should be to help families achieve economic independence and improve their children's well-being.
- Assuming personal responsibility is essential for attaining self-sufficiency and enhancing family and children's well-being.
- Research consistently demonstrates "mixed strategies" models that include work, education and training are the most effective ways to achieve client self-sufficiency.
- A solid educational foundation is a prerequisite for long-term economic success. The Department's policies and practices should continue to support educational attainment, from quality child care through post-secondary opportunities.
- Support services are essential to client employment and employment retention, especially child care and transportation.
- Many state and community services, both public and private, can be better coordinated to enhance participants' work, education and training achievements.
- To improve results for clients, the Department should encourage client-focused services, professional development of employees, accountability and the use of technological enhancements.
- Strategic planning is best informed and developed through current research, best practices, expert advice and input from stakeholders.

Program Strengths

By many indicators, the Families First program has been successful. There is, however, a need to build on success to continue to improve the program. For example, High Performance Bonus Awards announced by the federal Department of Health and Human Services in October 2004 provide a clear illustration of both program strengths and weaknesses. In measures of

employment success, Tennessee ranked third in the nation in both new job placements and in employment retention. However, Tennessee ranked 49th in the nation on wage increases among employed clients and former clients. These significantly different results suggest the program excels in finding stable employment for clients but struggles with fostering career advancement. It is through career advancement and/or wage progression that most clients will be able to become self-sufficient. Further research is needed to better understand the effects of program operation, labor market conditions and educational levels of participants on career advancement.

Tennessee has won a high performance bonus in one or more of the following categories in five of the past six years: job entry, improvement in job entry, Food Stamp retention, Medicaid retention and child care access.

The Task Force recognized several aspects of Families First that should be retained and expanded. First, the program needs to focus on enhancing its "mixed strategies" approach. While the program includes more educational activities than are available under TANF, it is not clear that activities are always appropriately combined for individual clients. Random selection studies conducted by the Manpower Demonstration Research Corporation in eight U.S. cities showed that the impact on the annual income of participants in the "mixed strategies" model exceeded that of those taking part in either the "job search/work first" or "education first" models (see Appendix for details).

Second, although Tennessee will be losing the federal waiver, the waiver currently provides flexibility in the types of activities counted toward the Work Participation Rate and the length of time participants may remain in activities. As a result, Tennessee has been able to test and learn from a wider variety of approaches to assisting clients than have most states.

Third, Families First has had success in achieving outcomes that generate federally-awarded bonus payments. These have earned the state $36.8 million since the program's inception. Bonuses have been awarded for employment entry and for continuing transitional services. In federal fiscal year 2002, Tennessee had the highest average rank among all states in the five high performance categories (Job Entry, Success in the Workforce, Medicaid and SCHIP Enrollment, Food Stamp Participation and Child Care Subsidies). Efforts should be made to continue policies conducive to these achievements.

"The fundamental goal of the program is to give people the skills they need to get out of poverty."
---Dr. Judith Hammond
Task Force Member

Finally, one of the program's most innovative services, Family Services Counseling (FSC), has received national attention as an effective short-term intervention model for serving participants facing barriers to self-sufficiency, including mental health problems, domestic violence, substance abuse, learning disabilities, and children's physical, mental, and behavioral health. FSC counselors also have introduced creative approaches to problem resolution by working with the non-custodial parents of Families First children. Although FSC is not currently countable toward the Work Participation Rate, it is expected that

TANF will be amended in reauthorization to credit states for some limited period of time when TANF participants are active in "barrier removal activities."

Task Force Recommendations

The following Task Force recommendations are purposely stated broadly in most cases. For those recommendations supported by the Governor and General Assembly, the Department will need to develop an overarching implementation plan to include the numerous specific actions that will need to be taken to carry out each recommendation.

Also underlying these recommendations is the recognition that implementing any one or all of the recommendations may require additional resources and that, further, such funds at any level – federal, state or local – are not available now. In view of this fiscal reality, the Task Force encourages the Department, in addition to developing its implementation plan, to begin addressing the recommendations to the extent possible by restructuring current funding, using available non-recurring funds and/or conducting pilot programs to test the ideas and further inform its strategic planning and implementation efforts.

1 – Change the DHS Organizational Environment

Effective case management is essential to client success.

A central theme of the Task Force's deliberations was that improving the organizational environment at DHS is critical to the program's success. The first step to reaching this goal is implementation of intensive case management for Families First participants. For example, Department staff must develop a specific, individualized service plan for each participant promoting salary, career and educational advancement. The participant should be informed of opportunities available and fully involved in the development of the plan. To provide the necessary case management, the Department should consider establishing a new job classification for case managers, with higher pay and qualifications, to manage much smaller Families First caseloads (50-70 clients) and provide a level of quality and intensity in service that is not possible today.

"Changing the Department's organizational culture will be critical to Families First achieving its full potential."
--Dr. Pearl Sims
Task Force Member

In addition, the organizational environment can be improved by developing a climate in DHS that is conducive to client-focused services. Particularly in large urban areas, offices have a "warehouse" atmosphere – one in which any possibility for personal attention and service is lost, due to the volume of clients being served. By creating neighborhood-based satellite offices, participants could receive personalized attention in a location closer to their homes and community resources.

Over the past two years, Families First cases have increased by 10.8% without a corresponding increase in the number of case managers available to work with clients.

Experienced, well-trained front-line staff are essential to improving the organizational environment. Unfortunately, turnover is an on-going problem. New training curricula and training delivery approaches are needed. In addition, on-going encouragement of professional development and creation of career tracks for

employees would improve organizational culture and employee performance.

2 – Streamline Inefficient Policy and Statutory Requirements

Achieving results, not processes, should be emphasized.

Some Families First statutory requirements appear to play little or no role in fostering self-sufficiency, are costly to administer and contribute to a level of complexity that makes navigating the program exceedingly difficult for participants. Consequently, the Task Force recommends elimination of interim time limits, which are imposed when Families First participants have received cash assistance for 18 months. While the original intent of this policy was to reinforce the concept of Families First as a time-limited program, in practice this time limit has been a hindrance to many participants, serving as a barrier to the successful completion of educational and training programs.

15,643 Families First participants have accrued 60 total months on the program. However, only 4 individual participants accrued 60 countable months on the program and were terminated.

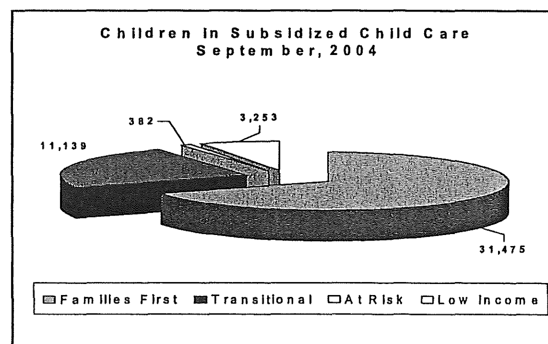
In addition, the Task Force recommends elimination of the "family cap" provision. If the child was born 10 months or more after the initial Personal Responsibility Plan was signed, the cash grant does not increase. The rationale behind this policy is that women should not be rewarded for having additional children who are supported by public funds. However, the Task Force identified no evidence that the policy has had any effect on recipient behavior – average family size is essentially the same as in 1996.

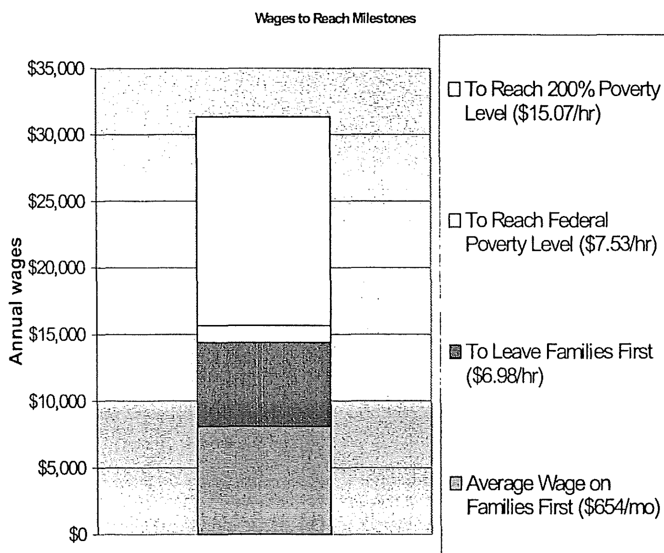
3 – Expand Child Care Eligibility

Affordable, quality child care is a prerequisite for self-sufficiency.

National experts, program participants and Task Force members repeatedly stressed the importance of child care assistance to achieving self-sufficiency. Knowing that there are not enough funds currently to adequately address these needs, the Task Force recommends that the Department make child care availability a priority, targeting current funding as available and as new funding permits.

The Task Force identified three key groups that could be served by an expansion of subsidies. For non-parental caretakers caring for children in danger of being placed in foster care, access to child care assistance may be the difference between a stable home environment and placement in Department of Children's Services' custody. Without child care, teen parents in high school are also at very high risk of dropping out and becoming long-term recipients of public assistance. For working families with no connection to the Families First program, help with child care expenses may be the surest path to avoid reliance on cash assistance.





4 – Improve Career Advancement

Participants need jobs with increasing wage potential.

Client outcomes can be improved by increasing attention to long-term employment planning. Many Families First clients have difficulty moving to higher paying work from entry-level jobs. Case managers can facilitate better career planning through education about labor market conditions, high-demand occupations and non-traditional job opportunities. Continuing education also offers a route to better paying positions in a client's chosen field. It is a case manager's responsibility to research and present a range of opportunities and to assist the client to make choices leading to long-term self-sufficiency.

" I attribute my success to a positive attitude, determination, and willingness to take advantage of each and every opportunity presented to me through the Families First Program."

--Bonita Payne
Task Force Member

5 – Integrate the Mixed Strategies Approach into Adult Education

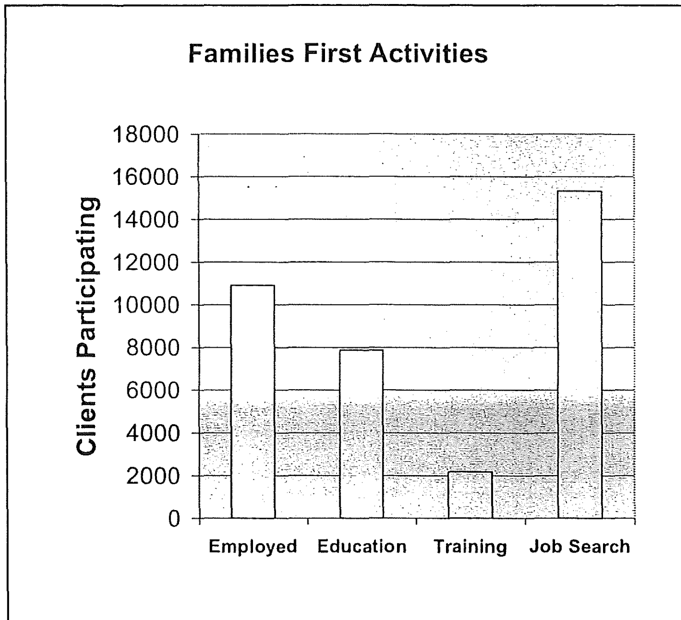
Work and education combined generate the most positive outcomes for clients.

The Task Force recommends changes be made to the Adult Education (AE) services provided through Families First to improve the experiences for, and performance of, participants and reinforce the goal of self-sufficiency.

Although the average educational levels of clients have improved through the program, too many clients have languished in AE without making significant strides towards a GED or employment. Many clients require AE (or continue to struggle in AE) because of repeated negative experiences in traditional school settings.

To address these problems, the AE curriculum should be revamped incorporating research–tested adult learning concepts and stressing skills needed in the workplace. Although AE should encourage academic achievement when it is a realistic goal, the Department should improve its screening and assessment of those participants who may not have the ability to complete a GED.

The Task Force further recommends reinstating some of the achievement incentive payments targeted for clients who make progress in Adult Education and other activities. Recent research indicates that completion bonuses, which were eliminated in 2003 due to budget constraints, motivated AE participants to advance. After bonuses were instituted, the rate of advancement to the 9th grade level increased by 356% over pre-bonus rates. However, bonuses did not increase the speed of academic advancement for adult learners, suggesting that incentive payments are most effective in encouraging perseverance.



6 – Improve Post-Secondary Education and Training

More education significantly reduces dependence on public assistance.

The Task Force makes a number of recommendations to improve post-secondary education and training: 1) Policies should allow participants to pursue education and training, including AE and post-secondary training. 2) Education and training activities should be coupled with work-study opportunities that align with career goals. "Mixed strategies" can make it easier to balance work, family and school by keeping the overall number of required work hours at an attainable level and by clarifying that student work-study is a countable activity toward work participation rates. 3) Use on-campus (site) case managers where the number of clients justifies it to facilitate access to child care, work-study and job placement services that ensure student participants receive the kind of support and employment-related education that pays off in higher-paying employment.

While research documents that Families First participants face daunting obstacles in moving from the welfare rolls to private-sector payrolls, post-secondary education and training can play a vital role in improving their economic outcomes. Employment-focused, post-secondary education and training, together with the supportive services that enable parents to succeed in school, are essential to improving the lives of many low-income parents and their children.

7 – Develop More Effective Partnerships with Agencies and Organizations at all Levels

Existing resources can be leveraged on behalf of clients.

Local community partnerships are critical to the continuing effectiveness of the Families First Program. However, the state must take the lead in initiating, fostering and guiding relationships with organizations that have a statewide presence, while also providing encouragement and assistance to local partnerships. Collaboration with agencies may include the goals of advancing employment, supporting work through service provision or addressing family social and economic stability.

Unfortunately, Families First participants sometimes have difficulty accessing available programs and services. To promote client access to these existing programs, the Task Force makes two recommendations: 1) Develop structured partnerships with post-secondary education and training institutions including the Tennessee Technology Centers, community colleges, other colleges and universities, and the Department of Labor and Workforce Development and its career centers. These institu-

tions have established career and job placement services for adult learners and can be instrumental in facilitating career advancement. 2) Develop a pay-for-performance system that compensates these entities for key client outcomes such as job placement, job retention and salary progression.

The Task Force found many examples of collaborative opportunities beyond direct employment services such as partnering with local Housing Authorities in their asset development programs. Collaborating with a wide variety of state agencies such as the Departments of Transportation, Children's Services, Mental Health and Developmental Disabilities, Education, Health, Financial Institutions, Correction and Agriculture to creatively develop ways to assist participants with multiple service needs should also be undertaken.

Community-based non-profit and social service agencies are another vital resource. The Department should consider redirecting some of its area managers' time to improving local partnership development and collaboration with these agencies.

8 – Implement an On-the-Job Training Program

Employer-provided training leads directly to jobs for clients.

The Task Force recommends implementing an on-the-job training (OJT) program, in which the Department would enter into contracts with employers to provide training and a guaranteed job for a client in return for partial payment of the trainee's wages. These programs have proven successful in other states, and are used by Tennessee's Department of Labor and Workforce Development, but are prohibited for Families First clients under current Tennessee law. A program such as this would render obsolete the criticisms that training programs do not teach skills needed to gain employment, because it is the employers themselves that are providing the training.

9 – Implement a Diversion Program

Many clients do not need the full range of program services.

Current state law requires participation in the full Families First program in order to access services. However, some crises may be resolved without ongoing cash assistance, particularly for families facing short-term needs. The Task Force, therefore, recommends changing program policy and state statute to allow families to choose some combination of time-limited cash payments, child care, transportation, or other services in lieu of full program benefits depending on their situation. This concept known nationally as "diversion" is used in some form in at least 30 states.

"All I needed was a job."
---Elizabeth Newton
Task Force Member

Prime candidates for diversion are individuals with strong work histories who are currently unemployed and have specific needs that, when filled, will allow them to re-enter the workforce in a reasonable period of time. Before approval for a diversion service, applicants should be screened to ensure they do not face barriers that would be best addressed through receipt of the entire package of Families First benefits and services.

10 – Promote Access to Transportation

Ensuring reliable transportation promotes employment and job-retention.

Access to transportation was identified as a major factor in whether program participants have successful outcomes. Families First should form stronger partnerships with the Tennessee Department of Transportation (TDOT), Tennessee Department of Education, community providers, and employers to ensure transportation is provided to areas where jobs are located.

74% of Families First participants receive transportation assistance.

In addition, Families First already has a program called First Wheels that provides no-interest car loans to qualified participants. Expanding eligibility to a larger range of applicants, such as those who are not yet employed, initiating outreach programs for potential participants and implementing an online application process are all ways that were identified to help make First Wheels a self-sustaining program that provides a vital resource. Awareness of programs such as First Wheels will be greatly increased by establishing a client-friendly orientation with a consistent message.

While gas prices have soared over the last several years, the gas reimbursement paid to Families First participants who provide their own transportation has been reduced. Budget restrictions also eliminated transportation assistance for clients who leave the program due to employment. Seeking ways to better fund these services should be considered to give clients greater opportunities to get to work or school during and immediately after their time on Families First.

4,063 Families First participants' work programs were interrupted and 880 participants were exempted from work program requirements due to a disability. (September 2004)

11 – Encourage Family Stability

Restrictive program requirements unfairly exclude many two-parent families.

The Task Force recommends changes to state statute and Families First policy to eliminate deprivation as an eligibility requirement. The deprivation requirement is both complicated to implement and acts as a disincentive to the development of two-parent families. In practice, deprivation rules restrict access to Families First for most two-parent families. Policies and initiatives that encourage family stability have received a great deal of attention in the TANF reauthorization debate. Under current state statute, unless children are deprived of parental support through the absence of one or both parents, therefore, it is currently very difficult for married couples with children to qualify for assistance. The alternative to the deprivation policy is to determine eligibility for all families on income and resources alone, and the Task Force recommends this change.

12 – Assist in Disability Application Process

Some clients may be failing in the program because of a disability.

The Department should consider providing specialized assistance for disabled individuals to navigate the Social Security or SSI disability application processes. Physical and mental disabilities create barriers to self-sufficiency for many Families First participants. A successful exit from the program through employment

may not be a realistic outcome for these individuals. Their quality of life, however, could be improved significantly by income from Social Security and/or SSI benefits. The application process for these programs can be complex and lengthy. Assisting clients through the process should help more people qualify for benefits for which they are eligible.

Other Changes/Issues Considered

National experts and the Task Force members recognized that lifetime limits on assistance have not served as a motivating factor for Families First participants to advance towards self-sufficiency. Due to the numerous clock-stoppages, exemptions, and interruptions, as well as the unintended consequence of interim time limits, relatively few months are counted toward the lifetime 60-month limit. Despite these problems, the Task Force felt good cause reasons for clock stoppages should remain in the program until the expiration of the waiver, when some of them probably will not be countable under federal TANF rules. In the interim, the introduction of true case management should significantly reduce the number of months that are not counted toward time limits due to the Department's failure to act timely to provide activities and services for participants.

"If the Department can institute an intensive case management system, these recommendations will become a reality and dramatically improve the services provided to clients."

--Linda Moynihan
Task Force Member

Partial sanctions, amounting to 20% of the cash grant, are applied when parents fail to provide proof of immunizations and health checks for the children in the family and when children do not attend school. Many Task Force members strongly believe that an essential goal of the program is to improve the well-being of children, and that the intent of these sanctions is appropriate. However, the Task Force notes that there are other state agencies with primary responsibility for providing and monitoring health and education services. The threat or imposition of a Families First grant reduction may not be the best mechanism to encourage parental responsibility. Furthermore, partial sanctions are inconsistently administered across the state, and it is extremely difficult to determine whether or not a situation warrants such action. The general sense of the Task Force is that eliminating partial sanctions should be considered, but only if commitment to the health and educational success of Families First children remains a vital focus of the program and the Department's case management efforts.

"Among the many ideas for improving Families First that the Task Force received and discussed, two particularly compelling messages emerged that merit the Department's continuing attention as we work to reach the full potential of Families First:

- ***Every Families First family is unique, therefore, so too should be the plans and services to help them.***
- ***Helping families become truly self-sufficient takes the combined efforts of all of our communities – human and social service, education, health and business."***

--Ed Lake
Task Force Member

Families First Advisory Councils have been a mandated component of the program since its inception but have been underutilized in many areas of the state. Community and private sector involvement in Families First would be advantageous to the program, and fostering this involvement should be a goal. The role and functions of the Councils should be re-evaluated in light of that goal.

The Task Force also discussed the potential merits of instituting mandatory drug testing. However, research revealed that in the few states requiring some type of drug testing the constitutionality of the requirement is in question. Other barriers include the significant additional costs involved, the fact that drug testing fails to differentiate between occasional and ongoing abuse of drugs, and that the tests do not identify alcohol use or abuse, the most common drug-related barrier to employment.

On the positive side, testing could increase the likelihood that training dollars would be spent on participants who could pass the employer drug tests. Nevertheless, the Task Force concludes that a more effective tool to ameliorate drug-related issues could be more effective case management and client-education by the Department and its contract partners.

"The Families First Program has served Tennessee for almost ten years. We are excited to embark on making meaningful changes that will improve the lives of Tennesseans over the next decade and years to come."

--- Commissioner Virginia T. Lodge
Task Force Member

Acknowledgments

The Task Force wishes to acknowledge the many behind-the-scenes contributions of the dedicated Department of Human Services staff who so capably supported its work.

Thanks go to the Department's Family Assistance directors Susan Cowden, Paul Lefkowitz, Lori Shinton, Cresa Bailey and research coordinator Kerry Mullins. Their work with the Task Force subcommittees, focus groups and expert consultants and in providing the Task Force with high quality research and background materials was invaluable.

Special thanks are in order for Brenda Tucker for her attention to detail in organizing the Task Force meetings and to Natalie Marler and Cheryl Booker for their efforts in constructing and formatting this report.

This document and supplemental materials are located at the DHS website: http://www.state.tn.us/humanserv. Supplemental materials include summaries of the sub-committee and focus group processes, summaries of the expert consultants' research, and further suggested reading.

Appendix

Media Release for Announcement of Task Force

March 2, 2004

GOVERNOR NAMES TASK FORCE TO STUDY FAMILIES FIRST PROGRAM
STATE'S "WELFARE TO WORK" PROGRAM WORKING TOWARDS GREATER SUCCESS

NASHVILLE, Tenn.— Governor Phil Bredesen today announced the creation of a task force to study Tennessee's welfare-to-work program, Families First. The 2004 Families First Task Force is made up of social services experts, service providers and former clients.

In 1996, the federal government replaced the welfare entitlement program Aid to Families with Dependent Children (AFDC) with the Temporary Assistance to Needy Families (TANF) program. Just prior to the TANF legislation's passage, Tennessee was granted a waiver and allowed to create its own unique welfare reform program called Families First. The program fits the needs of individual citizens with its focus on
education, training and personal responsibility. Families First, like "welfare" programs in all the states, provides a cash benefit with supportive services to families with children who are experiencing financial difficulties.

"Families First has enabled thousands of Tennesseans to become self-sufficient," said Governor Bredesen. "However, we have been in the program seven years, and the time has come to see where we can make some changes and help even more Tennesseans become self-sufficient, tax-paying citizens. In addition, we are facing the upcoming reauthorization of the TANF legislation and the end of our waiver in 2007. We need to begin preparing now to be ready to conform to the federal program's requirements when the time comes."

The Department has received national recognition for its work in moving people to employment, finding them child care and offering specialized programs that help clients overcome barriers. "We are very proud of Families First and all it has done for thousands of Tennessee families," said Human Services Commissioner Virginia T. Lodge. "We are confident this task force will look at our best practices, as well as those from other states, and make this an even stronger program."

Since its creation, Families First has served more than 200,000 families. The program is currently serving more than 70,000 families and 140,000 children.

Families First Task Force Participant List

Virginia Lodge	Commissioner, Department of Human Services
Ed Lake	Deputy Commissioner, Department of Human Services, Chairperson
Glenda Shearon	Assistant Commissioner, Department of Human Services
Linda Moynihan	Executive Director, Tennessee Conference on Social Welfare, Nashville
Regina Walker	Senior Vice President for Community Initiatives, United Way of The Mid-South, Memphis
Reverend Herbert Lester, Jr.	Senior Minister, Centenary United Methodist, Memphis
Jacqueline Holloway	Families First Council, Oak Ridge
Elizabeth Newton	Employment Career Specialist, University of Tennessee Wave, Knoxville and former participant
Dr. Judith Hammond	Assistant Vice President for Community Outreach, East Tennessee State University, Johnson City
Lafayette McKinnie	WIA Director, Southwest Human Resources Agency, Jackson
Luz Belleza-Binns	Social Worker, Metro Social Services Family Services Program, Nashville
Dr. Pearl Sims	Director of Leadership Development Center at Peabody College of Vanderbilt University, Nashville
Bonita Payne	Current participant, Nashville
Dixie Taylor-Huff	Owner, Quality Care Health Center, Lebanon
Mai Bell Hurley	Chair of the Statewide Families First Advisory Council, Chattanooga

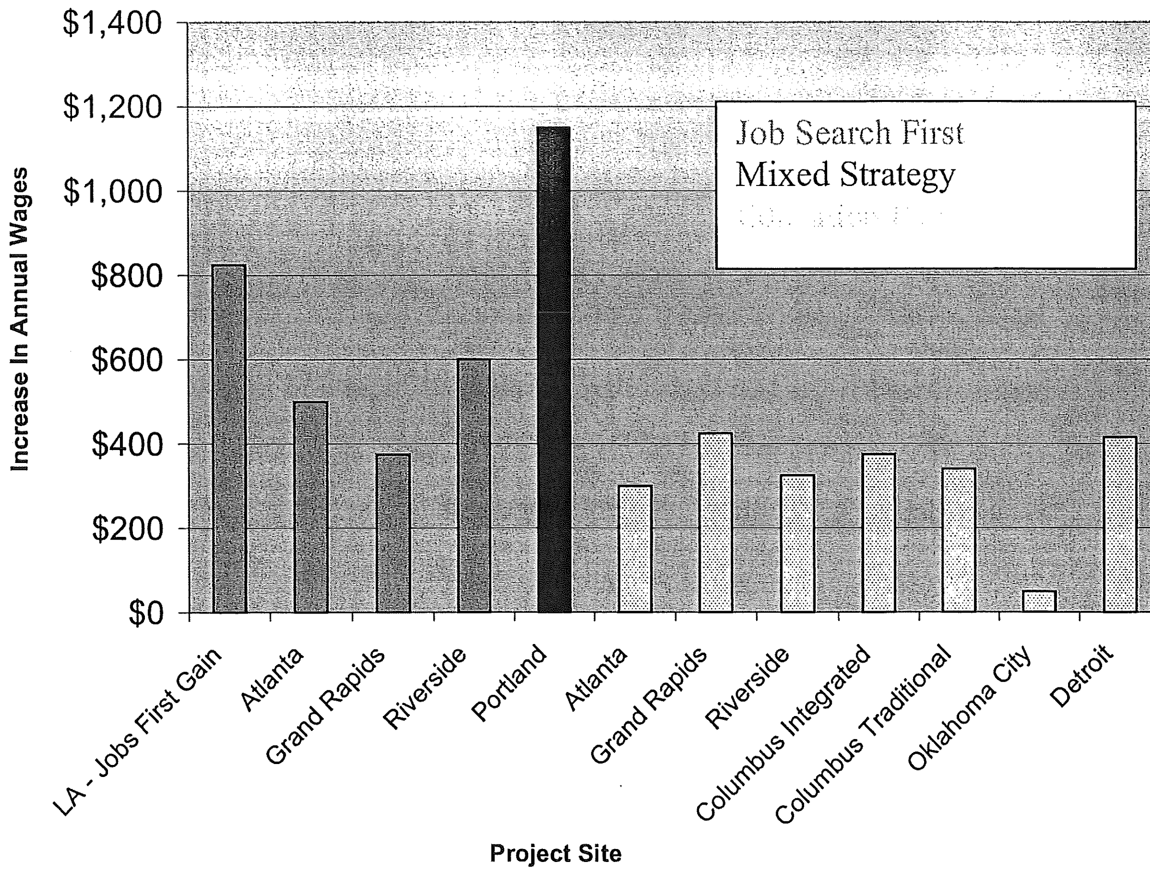
Comparison of Families First & TANF

	Families First	TANF
Required Activity Hours (for non-exempt participants)	40 hours/wk Exception: 20 hrs/wk for participant who tests < 9th grade and enrolls in Adult Education	30 hours/wk Exception: 20 hours/wk for families w/ children < 6
Universal Engagement	All participants must sign a PRP upon eligibility determination Non-exempt participants must have work activities in their PRP	No universal engagement provision - Parents are not required to work until the state determines they are ready for the workplace or they have received assistance for 24 months, whichever is earlier (They are included in the WPR but cannot be sanctioned for non-compliance with work activities)
Child Care Funding	FY 2002 Federal Funding for TN: Discretionary: $44.2m Mandatory, no state match: $37.7m. Federal share of matching fund: $28.7m Total = $110.6 million (does not include TANF transfers)	Federal CCDBG funding for FY 2002: Mandatory (including matching) - $2.71 b. Discretionary - $2.08 b.
TANF Block Grant Funding	Tennessee receives $191.5 million annually	$16.5 billion a year through FY 2002
Supplemental Grants	Tennessee currently receives $21.6 million	$319 million in FY 2002 to states with historically low spending levels or high population growth
Waivers	Tennessee's waiver expires 6/30/07	Allows states operating under waivers to continue using those policies until expiration
Contingency Fund	Tennessee has not accessed the contingency fund since its inception	$2 billion in matching grants in case of recession. To qualify, states must: Spend 100% of its MOE; Have a seasonally adjusted unemployment rate of 6.5% that is up 10% or more from at least 1 of the preceding 2 years; **or** Food Stamps average monthly caseload must be up 10% compared to what enrollment would have been in the corresponding period of FY 94 or 95
Family Formation Funding	(Fatherhood initiative eliminated).	No specified amount of TANF funds are earmarked to achieve the family formation-related goals listed in the legislation. Some non-TANF funding streams exist that address abstinence (Child Health Block Grant, Adolescent Family Life Act)

Comparison of Families First & TANF (continued)

Work Activities **Bold indicates activities in which waiver gives TN more flexibility in meeting the WPR (can count for more hours/months, or can be counted at all)** *Italics indicates not countable toward the Federal work participation rate, but a countable Families First work activity*	Countable for 40 hours: • Unsubsidized work • **Employment Career Services (can be 40 hrs for 10 weeks, then must be part-time)** • **Work Experience** • Community Service • **High School for teen parents (no other activity needed)** • *Family Services Counseling (FSC generally not a stand-alone activity* • **VISTA volunteers** **Participants at < 9th grade level have only a 20 hr work requirement - fulfilled by Adult Ed** Must be combined with 1 of the above to meet the 40 hours requirement: • **Skills training** • **Adult Education (unless participant is below 9th grade, in which case it can stand alone)** • Vocational Education (12 months max) • **Work Prep (includes options such as Fresh Start/ PACE) 20 hours max)** • **Post-secondary education**	Countable for 20 or more hours: • Unsubsidized work • Subsidized work • Work experience if private sector work is not available • On-the-job training • Job search and job readiness assistance (for 6 weeks max/yr.) • Community Service • Vocational Education (12 months max) • Providing child care for a community service participant Countable for 10 additional hours in conjunction with the activities above: • Job skills training related to employment • Education directly related to employment, or GED/secondary school for participant w/o GED or HS diploma
Who is exempt from work activities *and* work participation rates **Bold indicates groups that will have work requirements when waiver expires**	• Child-only cases • **Disabled (non-SSI)** • **Incapacitated** • **Elderly (60+)** • **Caring full-time for a disabled family member in the home** • 2-parent Families with an infant < 16 weeks (stricter that TANF law – for reporting purposes, the more flexible federal rules apply) • Single parent families with a child <1 year	• Child-only cases • Single mothers with child < 1 (state option)
Time Limits	• 18 months consecutively (3 month minimum period of ineligibility before re-approval) • 60 months lifetime TN is able to "stop the clock" on time limits for several groups – those for whom appropriate education or job training services cannot be provided, child care and/or transportation cannot be obtained, and those testing <9th grade and in Adult Ed.	• 60 months lifetime 20% of caseload may be exempted from the lifetime limit, but **not** from work requirements (So they are still subject to sanctions)
Fatherhood Initiatives	(Fatherhood initiative eliminated)	No dedicated funding stream for fatherhood programs
Transitional Medicaid (TM)	Participants leaving cash assistance are eligible for 18 months of TennCare unless they have left the state or failed to cooperate with child support enforcement (children in the latter case remain eligible)	Participants are eligible for 12 months if termination is due to earnings; for 4 months if assistance is lost due to receipt of child support

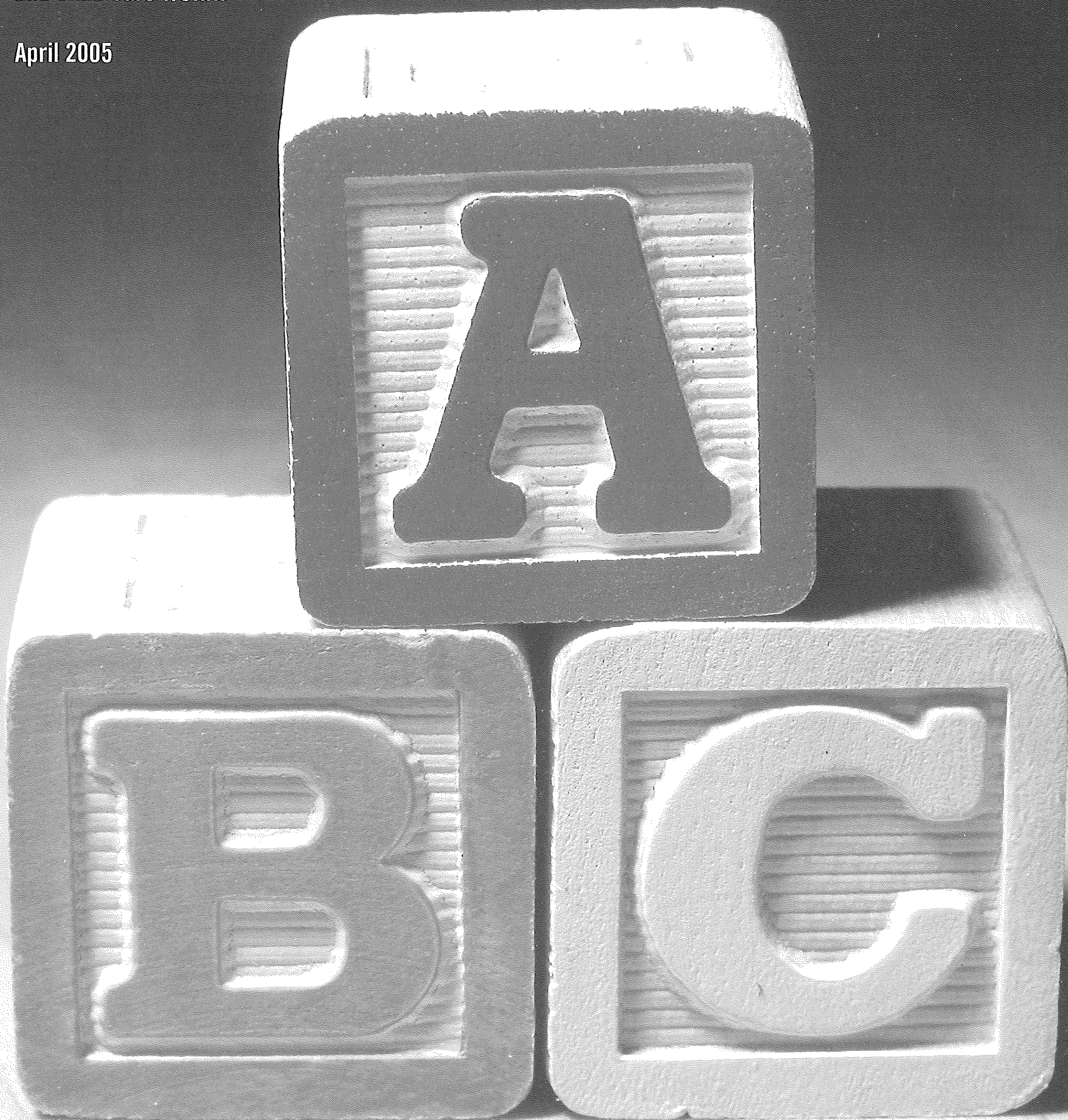
Impact on Annual Earnings of Three Strategies



Source: Gorden Berlin, MDRC

By Children's Defense Fund Minnesota
and Child Care WORKS

April 2005



Missed Opportunities Produce Costly Outcomes

"Environmental changes, educational shortcomings, economic benefits and ethical imperatives all underline the value of preparing kids better for success in school, work, and life."

—Minnesota School Readiness Business Advisory Council

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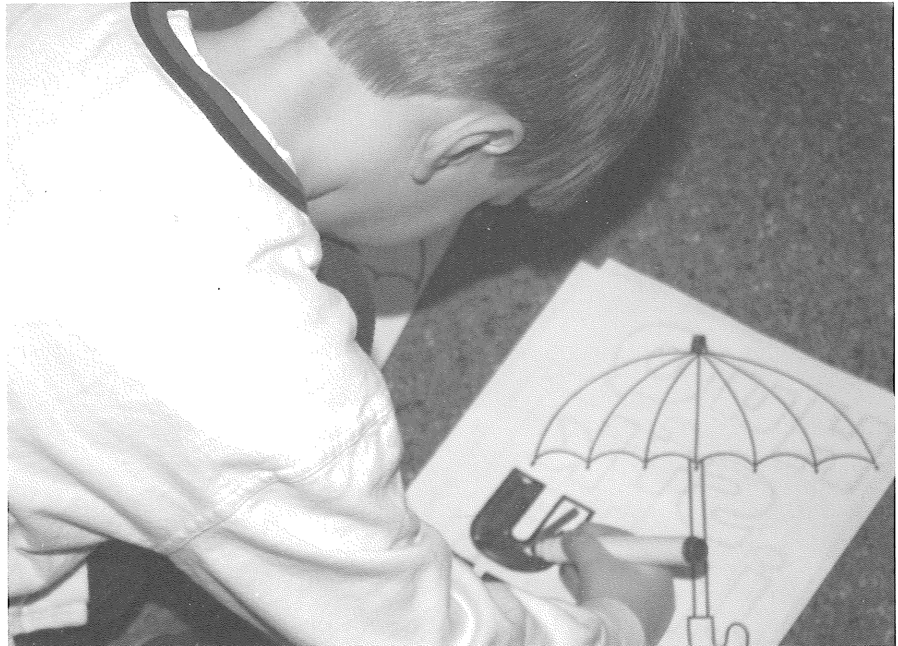
Childcare in Minnesota

Successful children become successful adults, so investing in Minnesota's children is good for all of Minnesota. Experts in many different fields—including primary school teachers, police officers, economists, and early brain development researchers—agree that investing in quality early care and education produces good outcomes for children and significant benefits to the broader community. **Yet, public resources that support working Minnesota families' access to quality early care and education for their children continue to diminish.**



Courtney Cushing Kiernat

This report focuses on Minnesota's Child Care Assistance Program (CCAP), which provides low-income working families with financial assistance to access early care and education for their children. The most dramatic policy and funding shifts in early care and education in recent years have been to CCAP. The report analyzes the impact of the changes and makes recommendations for future policy-making. The report uses the terms "early care and education" and "child care" interchangeably—because, in fact, they are one and the same.

Stakeholders of Child Care: Everyone Shares the Outcomes

Affordable and accessible quality child care helps parents to work while providing early education opportunities for Minnesota's youngest citizens. Using public resources to support these families reflects Minnesota's community values—work and education. Rather than fund and administer a bureaucratic child care "system," public resources in Minnesota help parents access the private early care and education market. Consequently, child care has many stakeholders:

- Children
- Parents
- Child Care Providers
- Businesses
- Communities

These interconnected stakeholders are each affected by changes in the system. **And each bears a cost if children are left in low quality or unstable child care arrangements.**

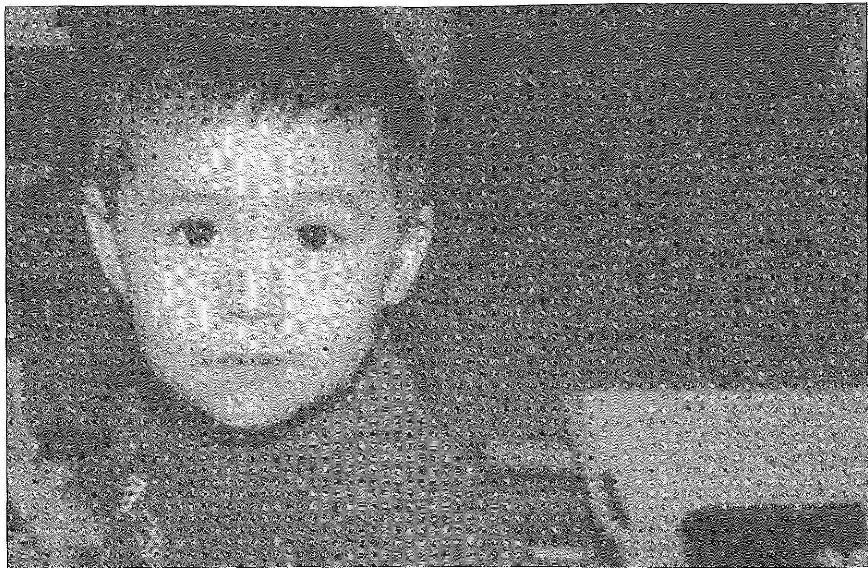
The Public's Role in Early Childhood Care and Education

Federal, state and local governments have an important role in ensuring the stability and accessibility of the early care and education infrastructure—much in the same way government supports other community infrastructures, like roads and public safety.

In Minnesota, less than one percent of the entire state budget is spent on early care and education programs. The Minnesota Child Care Assistance Program (CCAP) is only one of these programs.

Using public funds to pay for child care assistance is highly effective at helping low-income families work and succeed. A study found that former **welfare-to-work recipients with young children are 60 percent more likely to still be working after two years if they receive child care assistance.** As welfare reform progresses and fewer public funds are spent on providing cash assistance to families moving from Minnesota's welfare-to-

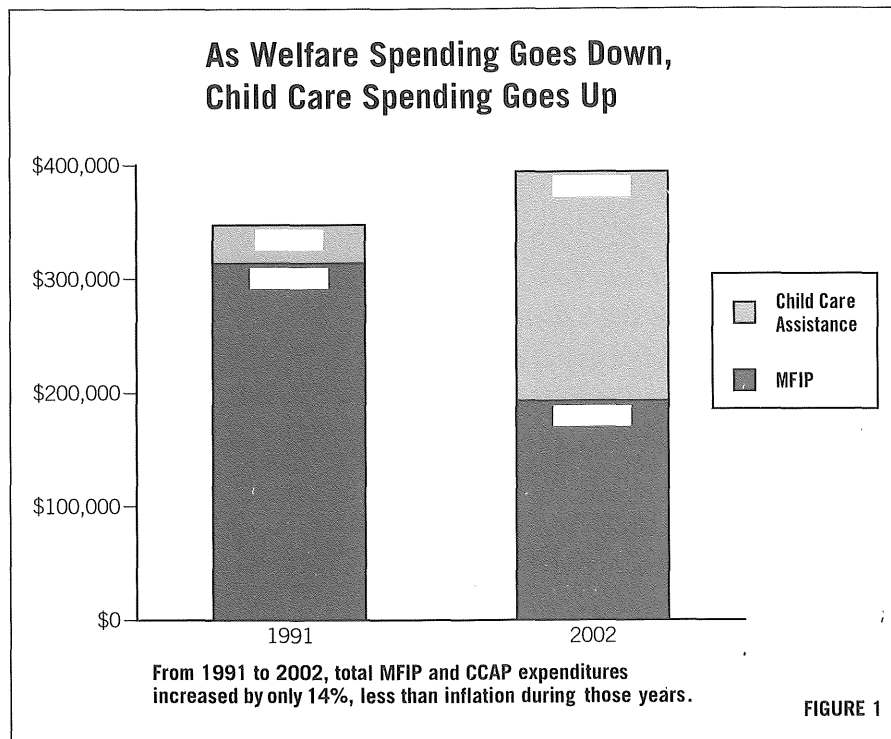
work program (the Minnesota Family Investment Program, or MFIP), there is an increased demand for child care assistance (see Figure 1). But estimates suggest that only 16 percent of eligible Minnesota families used child care assistance in 2000. At the same time, 7,300 families on average were on a waiting list for the assistance.


Courtney Cushing Kiernat

Child Care Policy & Funding in Minnesota

In Minnesota, a combination of federal, state and county resources help all working families pay for child care. Income tax breaks for a limited portion of parents' child care costs are available under both state and federal tax codes. In addition, Minnesota uses the federal Child Care Development Block Grant (CCDBG) and Temporary Assistance to Needy Families (TANF) funds, state general funds and special revenue funds to fund Minnesota's Child Care Assistance Program (CCAP).

Federal CCDBG and TANF funding for child care remains stagnant. Consequently, because actual child care costs continue to rise, the federal funding for assistance shrinks over time. For fiscal year 2006, President Bush recommends cuts that will result in a loss of assistance for 300,000 children nationwide—5,000 in Minnesota. This is of great concern, as CCAP relies heavily on federal funding. It accounted for almost 45 percent of CCAP funds in the 2004–2005 state biennium.



From 1991 to 2002, total MFIP and CCAP expenditures increased by only 14%, less than inflation during those years.

FIGURE 1

Child Care Policy Changes in Minnesota

Despite the emerging evidence-based arguments for investing more public resources into early childhood programs, Minnesota significantly decreased its commitment to helping working families access quality early care and education in recent years.

Reduced State Funding for Child Care by $86 Million in 2004-2005 Biennium

In 2003, the state legislature cut funding for CCAP by $86 million, or about one third, for the 2004-2005 biennium. This included a 48 percent decrease of state funds for BSF (see box "Overview of Key CCAP Components" on next page). The policy changes lowered the program eligibility level, increased family co-payments and temporarily froze provider reimbursement rates. (For a detailed explanation of 2003 legislative changes, see Appendix A.) Many providers had to pass more costs onto

families in order to stay afloat. The changes have made stable, quality care unavailable or unaffordable for thousands of families in need of assistance. **An estimated 10,000 children are no longer accessing child care assistance as a result of these changes, although their parents are still working and need assistance.**

Many of the 2003 policy changes in CCAP were permanent. Therefore, projected CCAP funds for the 2006-07 biennium also were reduced by $51 million, or almost 20 percent. However, the freeze on the maximum reimbursement rates paid to child care providers was supposed to be a temporary cost-savings measure, not a permanent policy change. The freeze was scheduled to be lifted in July 2005.

Governor Pawlenty Proposes Cutting Additional $70 Million—Total $121 Million Reduction for 2006-2007 Biennium

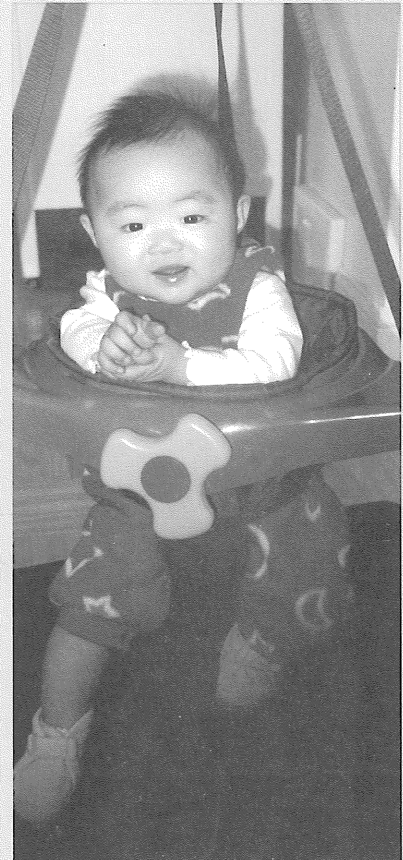
A new proposal in the governor's budget would reduce the state's commitment by an additional $70 million for the 2006-2007 biennium by maintaining the temporary freeze for three more years. **Under this proposal, reimbursement rates for private providers would be based on 2001 private market rates until July 2007.**

Costly Outcome

Cutting public investment in child care does not contain the cost of providing care; it only hurts families and businesses and shifts costs to local Minnesota communities. Access and quality were greatly compromised by the 2003 changes; neither working Minnesota families nor private providers can financially afford more cuts. The governor's proposal

Overview of Key CCAP Components

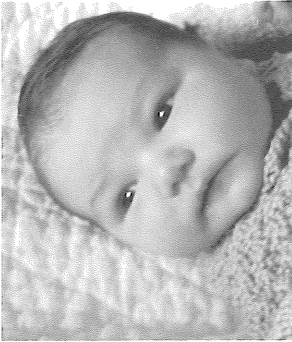
Resources: The state allocates CCAP funds to counties; counties add their own funds for program administration—including determining family eligibility, and registering and reimbursing providers.



Families: CCAP helps Minnesota families that participate in the state's welfare-to-work program—the Minnesota Family Investment Program (MFIP), those who have left MFIP within the past year and are part of Minnesota's Transition Year (TY) program, and families with incomes under 175 percent of the poverty guidelines (about $27,000 for a family of three) through the Basic Sliding Fee (BSF) program. BSF families receive assistance until their income rises to 250 percent of poverty (about $39,000 for a family of three). Child care for MFIP and TY families is forecasted so every eligible family who applies is guaranteed assistance. BSF is funded with a capped appropriation, so a limited number of eligible families receive assistance. Others who are eligible and apply are put onto a waiting list.

Parent Choice: Under federal law, CCAP parents must be able choose any provider who is willing to be reimbursed by CCAP up to a maximum reimbursement rate set by the state. Families choose from both informal care (families, friends or neighbors) and licensed options (center- or family-based).

Parent Responsibility: Families are responsible for a monthly co-payment that increases as the family's income increases. Families who earn less than 75 percent of the poverty guidelines are exempt from the monthly parent co-payment. In addition, families may be required by their provider to pay the difference between the state reimbursement rate and the provider's actual rate, as well as any special fees charged by the provider.

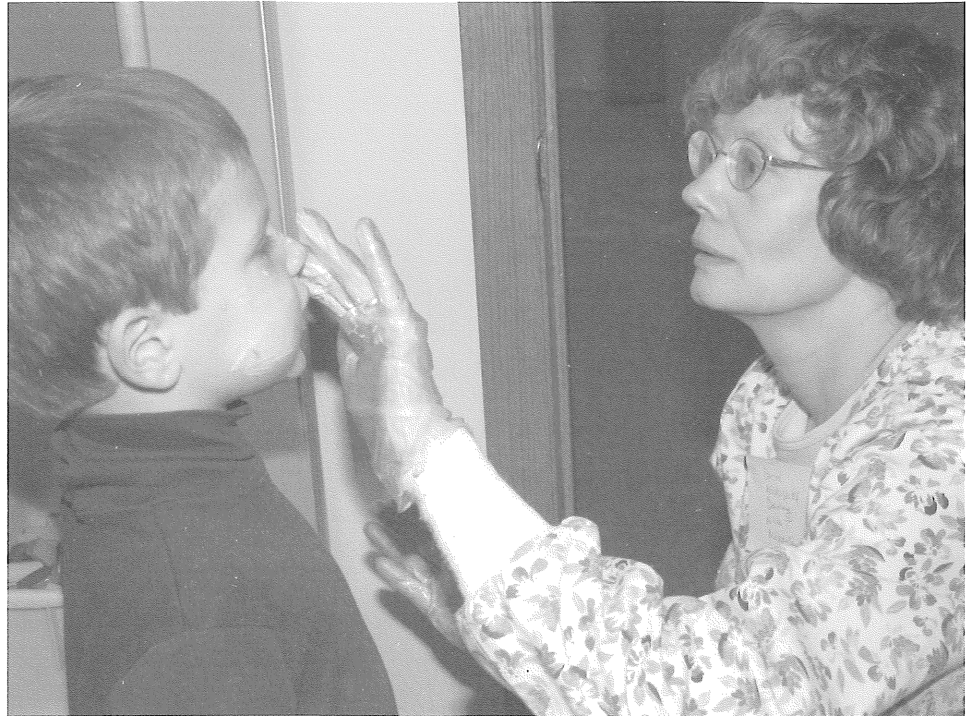


Family Faced 500% Increase in Child Care Costs

Mary,* a single mother of twin toddlers who worked full-time as a hotel clerk in Greater Minnesota, earned just over $2,000 per month. Prior to the 2003 cuts, she paid a $58 co-payment for child care utilizing CCAP.

In 2003, her monthly co-payment doubled to $119. In addition, the rate at which her child care center was reimbursed for her children was frozen. The center started charging her an additional $240 per month to make up the difference. Paying $359 per month for child care—a 500 percent increase—was more than Mary could handle. She pulled her children from the center.

**name has been changed*



Courtney Cushing Kiernat

will make their situations worse. Private providers, many of whom (according to the Department of Human Services) are operating with no profit margin, confirm that the continued reimbursement freeze will force them to:

- Pass the rate difference on to CCAP families;
- Stop taking CCAP families; or
- Lower quality by reducing staff.

The Departments of Finance and Human Services estimate that a continued rate freeze will prevent thousands of the lowest-income working families from accessing help to pay for child care.

What Cost Does Each Stakeholder Bear?

Each stakeholder in the child care system will experience costly outcomes if Minnesota does not strengthen its commitment to early childhood and increase investments in the child care infrastructure. Ultimately, taxpayers and lawmakers need to decide if the *cost of not investing* in quality child care is too great, creating life-long impacts on future generations.

Children: Missed Opportunity to Get Ready for Learning and Success

To thrive and succeed, children need nurturing opportunities to develop—cognitively, physically, spiritually, socially and emotionally. Families are the primary influence on their children's development, but most Minnesota parents work outside the home. As a result, two-thirds of young Minnesota children spend time in early care and education settings.

Child care is more than "babysitting"; it establishes the foundation for children's development. Brain research studies consistently find that the first five years of a child's life are the most critical for development. Physical, emotional, social and cognitive growth is occurring rapidly. During this critical time, young brains are shaped by the quality of their interactions with adults. High quality interactions can enhance healthy development; poor ones can impede it.

Good quality child care includes:

- Parent involvement;
- Qualified, responsive, nurturing, and reliable caregivers; and
- A stimulating, age-appropriate, safe learning environment.

***Every* Minnesota child deserves the highest quality early childhood experiences, but research shows that high quality early care and education programs have the greatest impact on children from low-income families.** Investing in these children's early education and helping their parents give them the right start can make an enormous difference in getting them ready to learn in Minnesota's schools.

Courtney Cushing Kiernat

Impact on Minnesota's Youngest Learners

Approximately 670,000 Minnesota children ages 12 and under spend some of their time in non-parental care during a typical week. In 2004, the state provided financial assistance for child care to about 56,000 children through Minnesota's Child Care Assistance Program (CCAP).

After the 2003 budget cuts, many Minnesota children lost assistance to access child care. Between July 2003 and November 2004, more than 10,000 Minnesota children dropped out of CCAP. More than 40 percent of these children live in families accessing CCAP through the state's welfare-to-work program, the Minnesota Family Investment Program (MFIP). Department of Human Services data suggests the vast majority of these families are still working, and thus, their children still need care. However, **where the children now spend their days, and the quality of those settings, is mostly unknown.**

Where young children, particularly low-income, at-risk children, spend their days while their parents work is important. The Department of Education reports that less than 50 percent of Minnesota kindergarteners are fully prepared for kindergarten. But, a Department of Human Services study of children in accredited, or higher quality, child care centers illustrates how quality care can make a difference. Although the study has some limitations, the results are profound. Over 80 percent

Where Are the Children?

"Out of the 15 CCAP families we had, 10 families dropped out of care because of changes to the CCAP program—eligibility or co-pays.

I don't know where most of those children spend their days. Three of the families have relatives or friends watching the children. One family used a teenage cousin to watch the children, and suffered a fire. Two of the families were single mothers who no longer are at their place of employment."

—Child Care Center Director
Austin, Minnesota

of the children in the sample from accredited centers were assessed as "fully proficient," or ready for kindergarten.

Results from low-income children matched those of their fellow students from higher income, more educated households. In addition, there were no differences based on race. This is in stark contrast to the racial disparities for Minnesota children that exist in most other domains, including primary and secondary education, health, child welfare, and criminal justice.

The findings are bittersweet, since the 2003 Legislature eliminated incentives for accredited child care providers to care for CCAP children. Over the past two years, fewer low-income children had access to child care that would make the difference for them as they start school. Quality early education can even the playing field for low-income children, giving them a fair start.

Fewer CCAP Resources Affects ALL Minnesota Children

There are fewer licensed child care providers statewide from which all Minnesota working families can choose. From December 2003 to December 2004, the number of licensed providers statewide decreased by 550. **The impact is particularly acute in Greater Minnesota where families in higher income brackets use the same providers as CCAP families and providers are operating at a zero percent profit margin or at a loss.** When a child care provider shuts down, every child in that program, not just the low-income children, experiences a disruption.

Access to quality care has suffered. Providers across the state report being in financial crisis and having to take sharp measures to contain costs. For example, 26 percent of a sample of Hennepin County centers reduced staff benefits and salaries and 45 percent laid off staff. **These actions increase staff turnover and student-teacher ratios, which negatively impacts the quality of care for all children in these programs.**

Finally, when children reach elementary school, students who are not able to follow directions and pay attention divert resources from their classmates. In a national poll, 86 percent of kindergarten teachers said poorly prepared students in the classroom negatively affect the progress of all children, even the best prepared.

What Does "School Readiness" Look Like in Young Children?

A recent national survey of kindergarten teachers found that school readiness has less to do with mastering the ABCs and counting to 20, and much more to do with being emotionally and socially ready to learn academic material.

Kindergarten teachers want five- and six-year-olds who enter school to be able to:

- Follow directions;
- Pay attention; and
- Get along well with others.

Quality early care and education settings reinforce families' efforts to teach young children these skills.

Parents: Missed Opportunity to Support Working Parents

For most parents, working outside the home is not a choice. In Minnesota today, 21 percent of children live with only one parent. Many two-parent households must have both parents in the workforce to make ends meet. Working parents want the best for their children—nurturing, safe environments in which the children can grow and learn. Sometimes neighbors and grandparents can help out, but many grandparents do not live close by or are in the workforce themselves and not available as consistently as working parents' schedules require. Consequently, many Minnesota families rely on early care and education programs.

But, child care is expensive—both for the providers who run programs and the parents who pay for them. In October 2004, the average annual cost of care ranged from $5,000 and $12,000, depending upon the child's age, type of care, and geographic location.

Working Minnesota families struggle with the costs. A May 2004 survey of people applying for Minnesota's welfare-to-work program showed that **child care was the number one reason parents with young children were applying for cash assistance.**

Figure 2 (see next page) illustrates the financial dilemma many parents face. The chart details a "no frills" monthly budget of a single parent with two young children needing full-time care. **Even at two and a half times the federal poverty line, this family cannot afford child care and all of their other basic needs in the metro area. They are doing slightly better than breaking even in Greater Minnesota.** Although they also would be eligible for limited assistance with health care, they would not be eligible for other forms of assistance, like housing or food support.

Impact on Minnesota's Working Parents

The 2003 budget cuts to CCAP shifted significant child care costs to working parents.

Many parents are no longer eligible for CCAP

The Department of Human Services estimates that 800 working Minnesota families were immediately cut off from child care assistance in July 2003 due to the CCAP eligibility changes. There is no way to estimate how many more families who would have been eligible for CCAP prior to the 2003 changes currently need financial assistance for child care.

"Our neighborhood child care program, operated out of a church in Richfield, has been an asset and a support for working families across all income levels in our community for over 30 years.

About one-third of the children served in our center receive Child Care Assistance payments.

Since 2003, the center lost its accreditation bonus, has struggled to retain and recruit enough families who can afford their co-pays, slashed staff, gave those remaining only a one percent pay raise (which was more than offset by the increase in health care premiums that was passed on to them), and cut the program's budget to the core.

Tuition went up almost ten percent and still the program is operating at a significant deficit.

Even now, I don't know how families are able to afford it—people are just barely hanging on. I am worried that the center will just go out of business. Then where will all the families go?"

—Non-CCAP Working Parent of Five- and Three-Year-Old Children

Many eligible CCAP parents can no longer afford to access the assistance

In 2003, the monthly amount parents pay in co-payments increased by as much as 100 percent for some families. Many CCAP families can no longer afford the co-payments. Child care subsidy workers across the state have seen many families suspend their CCAP cases since 2003—even though the families were still eligible—because they cannot afford the co-payment.

In addition, many CCAP parents are now required by their providers to pay a monthly "differential"—the difference in the rate between what the provider charges private pay families and what the state will pay for CCAP children. A recent survey of Minnesota child care providers indicated that a typical differential is $100-$200 per month. As one center director in Fergus Falls commented, "A hundred dollars a month is a lot for a single mom working at Taco Bell."

Higher costs for parents mean less access to the provider of their choice

According to federal regulations for CCAP, parents must be able to choose from the same options of child care settings that are available to other families, from informal care by relatives or neighbors, to family child care homes, to child care centers, as long as those providers accept CCAP families. Parents who cannot afford the co-payment plus the differential must find a cheaper alternative. But there are fewer and fewer alternatives available. According to Department of Human Services' estimates, if the state used *current* market rates to set reimbursement rates, CCAP families could choose from 82 percent of the providers statewide, as their rates would be at or below the rate the state will pay. **Instead, only 68 percent of the family child care market and 56 percent of the center-based providers are in this category and thus available to CCAP families who cannot afford more than their monthly**

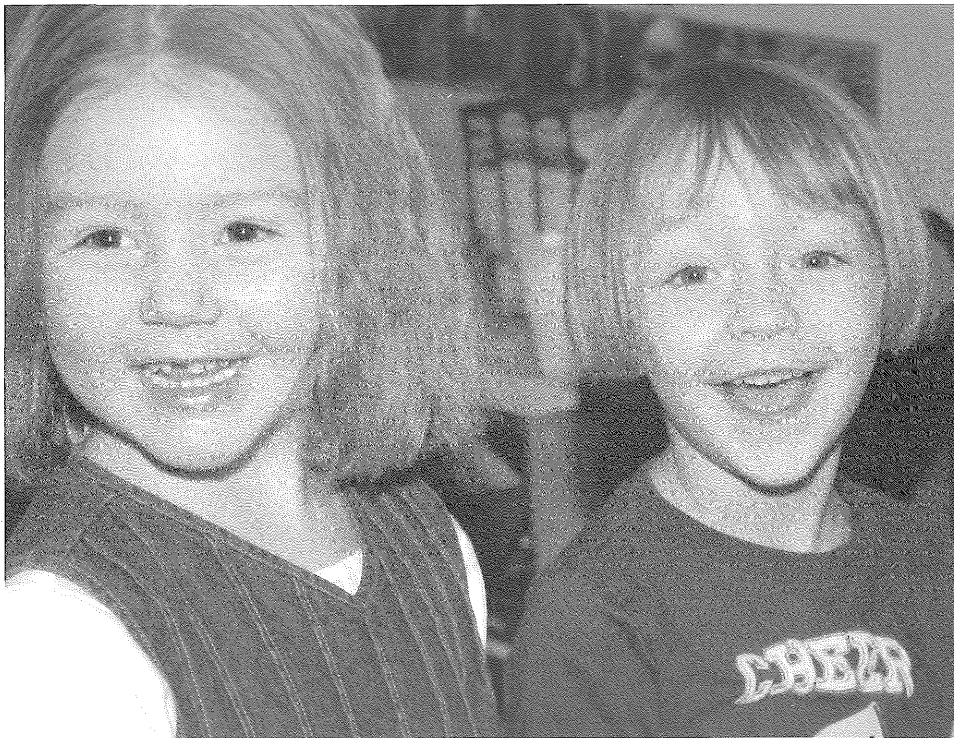
Monthly Budget for a Single Working Parent of a Toddler and Infant in Minnesota in 2002

Monthly Costs (2002)	Metro Area	Greater Minnesota
Food	$365	$365
Housing	$912	$564
Health Care	$275	$275
Transportation	$344	$445
Clothing/other	$249	$249
Net Taxes	$455	$290
Licensed Child Care	*$1,133*	*$877*
Total Monthly Costs	**$3,733**	**$3,065**

2002 Poverty Levels (Gross Monthly Income)	Net Monthly Income Metro Area	Net Monthly Income Greater Minnesota
175% ($2,190)	-$1,543	-$875
200% ($2,503)	-$1,230	-$562
250% ($3,129)	-$604	$64

SOURCE: JOBS NOW Coalition

FIGURE 2



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"...A rate freeze is the strategy most likely to restrict access to both licensed family child care and center-based care."

—Minnesota Department of Human Services

co-payments. Figure 3 (see next page) illustrates the loss across Minnesota between 2001 and 2004 of affordable child care for families of toddlers. A similar pattern exists across age groups and types of care.

Working CCAP parents have difficult budget choices

Child care costs have increased substantially over the past two years for CCAP families, but so have other necessities. Rising health care costs, fuel prices, and housing costs have also squeezed their budgets. Child care choices can be more flexible than other line items. Unfortunately, quality can be sacrificed for affordability.

Governor Pawlenty's 2005 Proposal

Governor Pawlenty's proposal to cut an additional $70 million over the next two years by continuing the rate freeze **will directly impact the ability of Minnesota parents with the least resources to access child care for their children.** The Minnesota Department of Human Services was asked to evaluate the impact of various ways to contain the state's child care expenditures. They concluded, ***"...a rate freeze is the strategy most likely to restrict access to both licensed family child care and center-based care."***

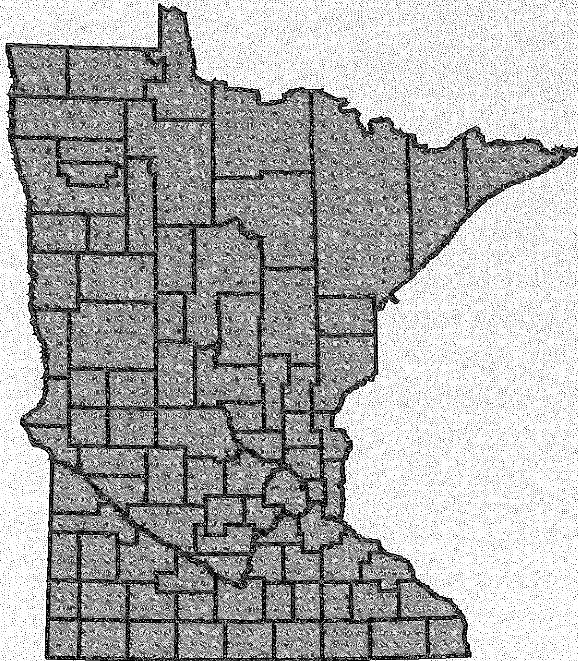
The state will realize savings because CCAP families will have less "purchase power" in the private market, and because fewer families will participate in CCAP as it will be out of reach financially for them. In fact, CCAP is now so restrictive that the program cannot find enough families who are eligible or who can afford to use the program, which has resulted in unused funds that are double the amount that is typical. The Governor's proposal relies on approximately 1,200 children from eligible MFIP families not accessing CCAP funds every month due to the freeze.

Accessibility Decreases

In 2001, in every county in Minnesota, 75–100 percent of family care providers were affordable to CCAP families with toddlers, i.e. the cost of this care did not exceed the monthly co-payment plus the state reimbursement. By 2004, that was true in only 13 counties.

Figure 3

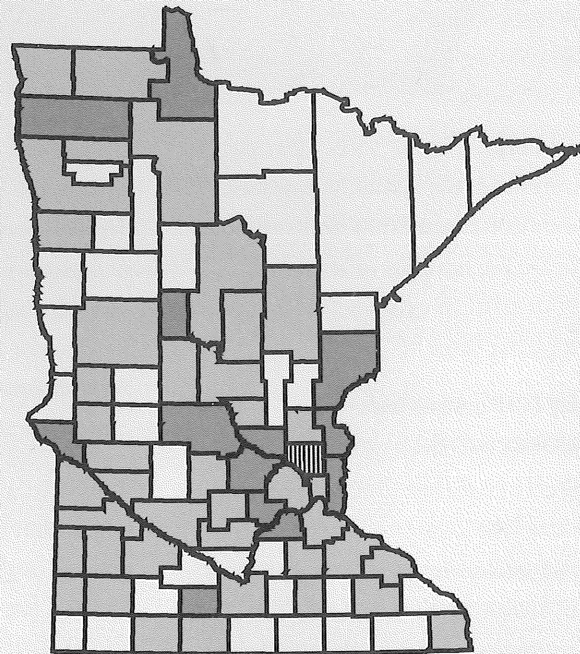
Percent of Family Care Providers Whose Rates Are Below the Maximum State Reimbursement Level for Toddlers



2001

Percent of Family Care Providers (for toddlers)

75–100%



2004

Percent of Family Care Providers (for toddlers)

75–100%
50–75%
less than 50%
no data

Data source: Department of Human Services. Map and analysis by CDF Minnesota

Providers: Missed Opportunity to Support Small Businesses

Licensed child care providers are small private business owners that employ more than 28,000 full-time equivalents and have gross receipts totaling $962 million annually in Minnesota. They set their own rates and find their own clients. Some choose to accept children whose families receive financial assistance from CCAP. Of the licensed slots available for Minnesota children, only 10 percent of those in center care and 6 percent of those in family care are filled by CCAP children.

Courtney Cushing Kiernat

If providers accept CCAP children, they are reimbursed for the costs of those children's care up to a maximum set by the state. This maximum is determined as the 75th percentile of the private market rate in that provider's geographic region. Providers of most CCAP children receive a portion of their reimbursement directly from family's co-payments and the rest from their county of residence. Unlicensed providers are paid 80 percent of the licensed family child care rate.

Current reimbursement rates for CCAP children have no relation to rates in the current private market. Due to a freeze on reimbursement rates imposed by the 2003 Minnesota legislature, the current reimbursement rates are based on the private market rates from 2001. On average statewide, current maximum reimbursement rates are at the 56th percentile for licensed family care and 48th percentile for centers.

If a provider's rate is greater than the maximum reimbursement rate, the provider has several choices—all of them detrimental to the provider's current clients and thus the business. They can:

- Stop caring for CCAP children;
- Charge CCAP families the difference in the rate, which these families can ill afford; or
- Lower the quality of care to contain costs and meet their monthly budgets.

Impact on Minnesota's Child Care Providers

"The average center is [financially] operating on the edge."
—DHS *Cost of Child Care* report

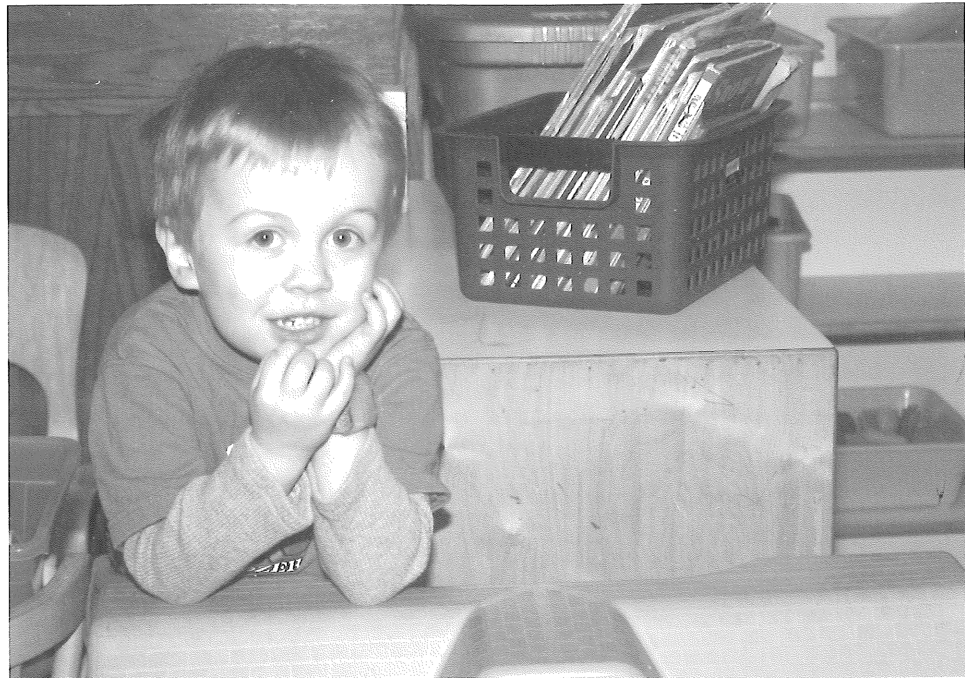
According to a recent report by the Minnesota Department of Human Services, the statewide average profit for child care centers is 3 cents per child per hour—less than 1 percent. When in-kind services are taken into account, child care centers are losing 12 cents per child per hour, on average.

Between July 2003 and January 2005, the number of providers Ramsey County reimburses for CCAP children decreased by 55 percent.

The sharpest decline was in the unlicensed providers who are often referred to as "family, friends, or neighbors."

These providers are not licensed, but are able to be reimbursed for CCAP families so the CCAP parents can afford to work.

The current reimbursement rate for these providers in Ramsey County is about $2 per hour. In July 2003, Ramsey County reimbursed more than 730 of them; by January 2005 that had shrunk to approximately 210.


Courtney Cushing Kiernat

Family child care providers are not doing much better

DHS estimates that the annual taxable income for a family provider working more than full-time is $8,500 in Greater Minnesota and $15,500 in the metro area.

Providers were also hit by the 2003 Minnesota legislature with high fee changes

Licensing fees for child care centers were increased as much as 300 percent, on average, and licensing fees of $150 were imposed on family child care providers for the first time. In addition, many providers are now being charged up to $100 annually by their county for performing criminal background checks. While fees, and even increased fees, may be reasonable, the timing of so many changes at one time was a disaster for child care providers.

Providers cannot contain costs any further

The primary costs for child care centers are labor, facility costs, and food. Reducing any of these costs puts children's safety and care at risk. The average child care center worker earns just $16,410. These are some of the lowest wages in the state—just slightly above the wages of dishwashers.

Because of the 2003 freeze, the difference between what providers are being paid and what their actual costs are has grown. Child care businesses have no ability to absorb more financial loss.

Child care providers have gone out of business. Licensed family providers were already suffering in 2003, and Minnesota saw an increased trend in family provider closings following the 2003 budget cuts. From December 2003 to December 2004, the number of providers statewide decreased by 550. **The impact is particularly acute in Greater Minnesota.** For example, the southwestern part of Minnesota saw a seven percent decline in the availability of licensed family providers in that one year.

Businesses and Communities: Missed Opportunity to Improve Minnesota's Prosperity

Whether considering the stability, reliability, and quality of either the current or future workforce, competitive businesses and Minnesota communities must focus on the role of quality early care and education.

A strong child care infrastructure benefits businesses—large and small—as well as Minnesota's economy. The infrastructure enables employers to:

- Recruit employees;
- Reduce turnover and absenteeism; and
- Increase productivity.

Courtney Cushing Kiernat

Working parents are a critical sector of Minnesota's labor force, but their dual roles as workers and parents require them to constantly juggle schedules and obligations.

- Almost 25 percent Minnesota's working parents with young children report that child care problems have prevented them from taking or keeping a job.
- About 22 percent of Minnesota's working parents say they have been late for work, left early, or missed work in the past six months due to child care problems.

The costs of unstable child care to Minnesota's businesses are real. Employers bear costs when parents' child care arrangements are not accessible and reliable. According to a national survey of human resource executives, unscheduled absenteeism cost small businesses an average of $60,000 and large companies an average of $3.6 million per year. Employee turnover is estimated to cost U.S. businesses 1.5 times the annual salary of a salaried employee and .75 times the annual wage of an hourly employee.

Certain sectors of Minnesota's economy rely heavily on working CCAP parents for their labor force. Specifically, health care and social assistance, retail trade, accommodation and food services, and the administrative and support services industries are more likely to employ parents who access CCAP funds.

Quality early care and education for the lowest income children improves the quality of the future workforce and is consequently one of the most efficient uses of today's tax dollars. Economists Art Rolnick and Rob Grunewald of the Minneapolis Federal Reserve Bank assert that putting public resources into high quality early childhood programs for the lowest income children is one of the best returns on public investment—an overall 18 percent rate of return on investment, 17 percent of which is a public rate of return. They rely on two scientific findings:

- The development of young children's brains is shaped by the quality of their interactions with adults. While it is possible to

"Whether it is a lack of transportation, *reliable child care,* or recurring personal problems, 'we are not seeing the same number of good, solid candidates in our worker pool.'"

—Branch manager from temporary employment services agency

As cited in article on labor shortage in the Federal Reserve Bank of Minneapolis' January 2005 fedgazette, emphasis added.

"The early care and education structure currently in place is not up to the task, either in physical capacity or educational quality."

—Minnesota School Readiness Business Advisory Council

have a positive influence on a child's development later in life, it is much less difficult and costly to create a healthy foundation early on.

- At-risk children who were in high quality early childhood programs have significantly better behavioral, social, and cognitive outcomes throughout their lives than their peers who were not in such programs.

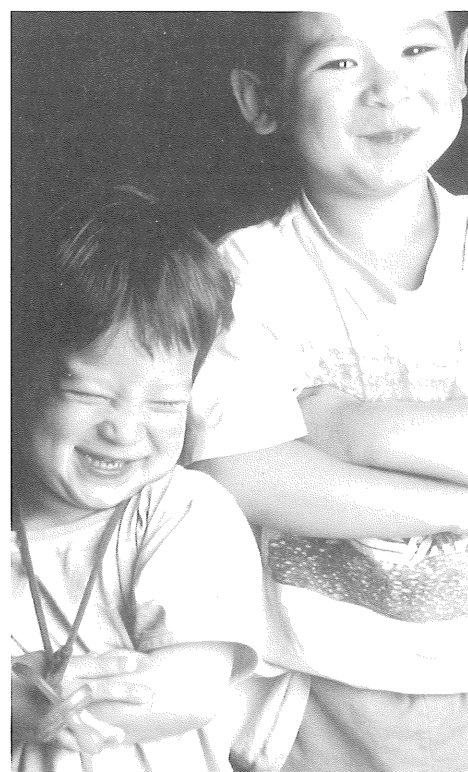
The economic analyses show that public investments produce public cost savings because of reduced incidence of:

- Grade repetition and special education;
- Criminal behavior and punishment;
- Welfare and related poverty costs.

Recognizing the public good that can result, the Minnesota School Readiness Business Advisory Council (MSRBAC), a group of executives from more than 100 of Minnesota's leading companies, advocates for more investments in early childhood. Their 2004 task force report concludes that as the trend toward global competition increases, lagging early childhood preparation threatens the continued competitiveness of Minnesota businesses as well as Minnesota's quality of life.

Impact on Minnesota

It is difficult to assess how the 2003 changes to CCAP have affected Minnesota's businesses and communities. What we do know is that the current child care infrastructure is precarious, providers are operating on the edge, and many parents can no longer access affordable care. As the Department of Human Services notes in their recent report, "... we don't know at what point this [loss of access to child care] will have an effect on job stability for families or school readiness for children."



Analyses of demographic and employment trends suggest Minnesota's workforce will have an increased need over time for a strong early care and education infrastructure. Two trends are particularly relevant:

- The working parent workforce is expected to continue growing.
- Significant job growth will occur in the sectors that currently employ the majority of CCAP families.

The increasingly competitive knowledge-based global economy will demand more of tomorrow's workforce. Economists and businesses have made it clear: To invest public funds efficiently and wisely and get Minnesota's future workforce ready to compete, Minnesota needs a strong early childhood infrastructure *now.* The state must help sustain that infrastructure.

Conclusion: Opportunities for ALL Minnesotans

Children, parents, child care providers, businesses, and the broader community—all Minnesotans are impacted when the infrastructure that supports our youngest children is dismantled. Minnesotans must take action to stop the erosion of that infrastructure. We propose the following actions during the 2005 legislative session.

Allow More Low-Income Working Families Access to Child Care Assistance

1. Eligibility and Parent Co-Payment

Increase family income eligibility to allow families earning up to 250 percent of the federal poverty guidelines to enter CCAP. Make low-income working parents' contributions (including the CCAP co-payments as well as any differential rate costs providers need to require) affordable.

2. Provider Reimbursement

Thaw the freeze and reimburse child care providers at a rate at or below the 75th percentile of *current* private market rates. The rate freeze imposed in 2003 has wreaked havoc for child care businesses and weakened the quality and viability of the child care industry.

Increase Access to Quality

3. Accreditation Incentive

Research shows that providers are more likely to seek accreditation when they are able to realize a rate increase of 15 percent or more, based on obtaining that accreditation. Reimburse accredited child care programs at a rate that is at least 15 percent higher than the maximum child care assistance reimbursement rate. This supports quality programs and, in turn, improves the school readiness of all of the children served by those programs.

4. Minnesota Early Learning Fund

Research shows that at-risk children who attend high quality early childhood programs are better prepared for school and life. The State should match private funds to create the Minnesota Early Learning Fund to implement a voluntary quality rating system for early childhood programs and demonstrate successful approaches for serving low-income children and increasing quality of programs for all children.

Provide Relief to Struggling Small Businesses

5. Provider Fees

During the past two years, child care reimbursement rates have been frozen, while fees have increased exponentially. This has added to the financial strain felt by child care businesses, further limiting families' access to quality child care options. Suspend child care license and background study fees for the next biennium and take responsibility for defraying the cost of any licensing revenue lost by counties.

Appendix A: 2003 CCAP Budget Cuts and Program Changes

The 2003 Minnesota Legislature made the following policy changes to the Child Care Assistance Program (CCAP). These changes resulted in the elimination of $86 million in resources for child care assistance in the 2004-2005 biennium and the elimination of $51 million in resources in the 2006-2007 biennium.

Entrance income eligibility lowered from approximately 290 percent of the poverty guidelines to 175 percent

In other words, eligibility went from 75 percent to 44 percent of Minnesota's median income. The nationwide average income eligibility is 59 percent of a state's median income. Prior to 2003, Minnesota ranked 4th amongst states for income eligibility for child care assistance. **Minnesota now ranks 33rd for entrance levels, below Mississippi. Mississippi is the lowest-ranking state for overall child well-being.** Family income eligibility to exit CCAP was also reduced to 250 percent of the poverty guidelines; Minnesota ranks 7th in the nation for exit levels.

Family co-payments increased

Families experienced a steep increase in co-payments—by as much as 100 percent for some. Current co-payments for all other families range from 3-22 percent of the family's gross income. Families who earn less than 75 percent of the poverty line have no monthly co-payment.

Reimbursement rates to providers were temporarily frozen at 2001 rates

Current reimbursement rates for private providers of CCAP children are not related to current private market rates. In fact, the state freeze did nothing to contain child care providers' costs—child care business costs grow as their rents increase and their employees need cost-of-living increases. The freeze only reduced the state's commitment to helping Minnesota children access care.

Provider fees increased

Licensing fees for child care centers were increased as much as 300 percent, on average, and licensing fees of $150 were imposed on family child care providers for the first time. At the same time, counties may now charge up to $100 annually for performing criminal background checks for providers.

Quality incentives eliminated

A key indicator of quality is "accreditation" by the National Association for the Education of Young Children and other accrediting bodies. Prior to 2003, state policy encouraged child care providers to attain this level of quality and serve CCAP children by giving accredited providers a slightly higher reimbursement rate. This increased quality for all Minnesota children in accredited care since accredited programs serve non-CCAP children as well. But in 2003, Minnesota withdrew its commitment to encouraging high quality care—the accreditation incentive was eliminated.

Key Findings

1) The 2003 legislative changes put Minnesota in the bottom third nationwide in terms of child care assistance eligibility. This, combined with dramatic increases in out-of-pocket costs for families and frozen payments for providers, has made the program so restrictive that working families are finding it extremely difficult to access child care assistance.

- 10,000 fewer Minnesota children accessed child care assistance between 2003 and 2004; data indicate that their parents are still working and financially in need of assistance.
- From December 2003 to December 2004, the number of licensed providers statewide showed a net decrease of 550.
- In 2001, more than 75 percent of child care programs in all 87 Minnesota counties charged rates at or below the maximum rate paid by the state—in other words, child care assistance families had access to more than 75 percent of all child care programs without paying an additional fee on top of their co-payment. This met the guidelines suggested by the federal government. In 2004, only 13 counties were left with more than 75 percent of child care providers in that county charging rates financially accessible to child care assistance families.
- Child care assistance has become so restrictive that the unused funds are double the amount that is typical.

2) Governor Pawlenty proposes $70 million in child care cuts for the 2006-07 biennium. This is on top of $51 million in child care cuts for 2006–2007 biennium as a result of the 2003 changes. The governor's proposal highlights yet a further retreat from Minnesota's commitment to young children and takes the most harmful path for families in terms of spending reduction options.

- The Department of Human Service's recent "Cost of Care" report states that "*...a rate freeze is the strategy most likely to restrict access to both licensed family child care and center-based care.*"

3) Economists at the Federal Reserve Bank of Minneapolis view investment in high quality early care and education programs for low-income children as one of the most efficient uses of tax dollars, citing a 17 percent public return. A consortium of 100 leading Minnesota businesses (the Minnesota School Readiness Business Advisory Council) agree, highlighting the close correlation between quality early childhood programs and the future of Minnesota's workforce, economy and quality of life.

4) Quality child care reinforces families' efforts to provide the foundation for children's development, prepares children for kindergarten, and can level the playing field for low-income children.

- A recent study by the Department of Human Services that evaluated the school readiness of children who attended 22 accredited child care centers in Minnesota found that more than 80 percent of children in the sample were "fully ready for kindergarten"—compared to less than 50 percent in the general Minnesota population.
- Brain research studies consistently find that the first five years of life are some of the most critical for development. During this time, high quality interactions with adults enhance healthy development; poor ones impede it.

5) Parents need affordable, quality child care to work.

- Recent studies found that child care was the number one reason Minnesota families with children under the age of six applied for MFIP.
- Child care problems have prevented 25 percent of Minnesota's working parents from taking or keeping a job.

6) Investing in child care assistance positively correlates with reducing the need for cash assistance.

- One of the goals of welfare reform was to move families from welfare to work. As families make this transition, MFIP expenditures decrease, while child care expenditures naturally increase. Child care is a key component to keeping parents in the work force.

7) Licensed child care providers—a private industry comprised mostly of small businesses—are barely staying afloat.

- The average child care center in Minnesota is operating at a zero percent profit margin or at a loss, while the average family provider is making less than $15,500 in the metro and $8,500 in Greater Minnesota.

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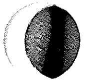
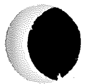
Notes





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Senate
State of Minnesota

S.F. No. 1162 - Provider Payment Disclosure and Limitation

Author: Senator Linda Berglin

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: April 4, 2005

S.F. No. 1162 requires health care providers to disclose the payments received from Medicare and medical assistance and limits the amount the provider can charge to uninsured individuals.

Section 1 (62J.82) requires provider payment disclosure and limits the amount a provider can charge to uninsured individuals.

Subdivision 1 defines the following terms: "covered individuals," "CPT code," "dependent," "health care service," "health plan company," "person," "provider," "third-party payer," and "uninsured individual."

Subdivision 2, paragraph (a), requires a provider to make available upon request at no cost the following information:

(1) by CPT code or other billing identifier the amount the provider receives as payment for health care services from the federal Medicare program; and

(2) by CPT code or other billing identifier the amount the provider receives as payment for health care services from the medical assistance program.

Paragraph (b) requires the provider to provide this information as soon as reasonably practicable, but no later than ten business days.

Paragraph (c) states that the information shall be revised quarterly as necessary to reflect any changes to the amounts received under paragraph (a).

Subdivision 3, paragraph (a), authorizes a provider to attempt to obtain information about whether any third-party payer may fully or partially cover the charges for health care services rendered by the provider.

Paragraph (b) requires the provider to inform each person, both orally and in writing, that uninsured individuals will be charged or billed for health care services in amounts that do not exceed the amounts described in subdivision 4.

Paragraph (c) requires the provider as part of any billing to any person who has not provided proof of coverage by a third-party payer or the provider determines that the person is uninsured a clear and conspicuous notice that includes:

(1) a statement of charges for health care services rendered by the provider;

(2) for each service rendered, the amounts required to be disclosed under subdivision 2; and

(3) a statement that uninsured individuals will be charged or billed for services in amounts that do not exceed the amounts described in subdivision 4.

Paragraph (d) permits the provider to incorporate the items into the provider's existing billing statements. States that all required communications under this subdivision must be language appropriate.

Subdivision 4 prohibits a provider from billing or charging an uninsured individual more than the higher of the Medicare or medical assistance payment required to be disclosed under subdivision 2 at the time the bill or charge is issued, plus five percent. States that once the bill or charge is issued, the provider may not increase the bill or charge even if the amount disclosed under subdivision 2 has increased.

Subdivision 5 states that the amounts paid by uninsured individuals do not constitute a provider's uniform, published, prevailing, or customary charges or its usual fees to the general public for purposes of any payment limit under the Medicare or medical assistance programs or any other federal or state financed health care program.

Subdivision 6, paragraph (a), states that providers under agreement with a health plan company or public health care program shall not have recourse against covered individuals for the amounts above those specified in the evidence of coverage or other document as cost sharing for health care services.

Paragraph (b) states that this does not limit a provider's ability to seek payment from any person other than the covered individual, the covered individual's guardian or conservator, immediate family members, or legal representative in the event of nonpayment by a health plan company.

Subdivision 7 states that a person may file an action in district court seeking injunctive relief and damages for violations of this section. States that a person may also recover costs and disbursements and reasonable attorney fees.

Subdivision 8 states that violations of this section by a provider are grounds for disciplinary or regulatory action by the appropriate licensing board or agency.

Subdivision 9 authorizes the attorney general to investigate violations of this section and to file an action or pursue other remedies available to the attorney general.

KC:ph

Senators Berglin, Lourey, Wergin and Foley introduced--

S.F. No. 1162: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to health; requiring disclosures of certain
3 payments; requiring disclosure of and limiting certain
4 charges to the uninsured; limiting provider recourse;
5 providing remedies; proposing coding for new law in
6 Minnesota Statutes, chapter 62J.

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

8 Section 1. [62J.82] [PROVIDER PAYMENT DISCLOSURE; CHARGES
9 TO UNINSURED; PROVIDER RECOURSE.]

10 Subdivision 1. [DEFINITIONS.] (a) For purposes of this
11 section, the terms defined in this subdivision have the meanings
12 given them.

13 (b) "Covered individual" means an individual who has health
14 plan company or public health care program coverage for health
15 care services.

16 (c) "CPT code" means a code contained in the most current
17 edition of the Physician's Current Procedural Terminology (CPT)
18 manual published by the American Medical Association and
19 available for purchase through the American Medical Association,
20 Order Department: OP054193, P.O. Box 10950, Chicago, Illinois
21 60610.

22 (d) "Dependent" has the meaning given under section 62L.02,
23 subdivision 11.

24 (e) "Health care service" has the meaning given under
25 section 62J.17, subdivision 2.

26 (f) "Health plan company" has the meaning given under

1 section 62Q.01, subdivision 4.
2 (g) "Person" means an individual, corporation, firm,
3 partnership, incorporated or unincorporated association, or any
4 other legal or commercial entity.
5 (h) "Provider" has the meaning given under section 62J.03,
6 subdivision 8.
7 (i) "Third-party payer" means a health plan company or a
8 public health care plan or program.
9 (j) "Uninsured individual" means a person or dependent who
10 does not have health plan company coverage or who is not
11 otherwise covered by a third-party payer.
12 Subd. 2. [PROVIDER PAYMENT DISCLOSURES.] (a) A provider
13 shall make available and, to the extent possible, immediately
14 provide to any person who requests it, at no cost, the following
15 information:
16 (1) by CPT code, or other billing identifier as may be
17 required to be used in billing for health care services, and
18 narrative description, the amount the provider receives as
19 payment for health care services from the federal Medicare
20 program; and
21 (2) by CPT code, or other billing identifier as may be
22 required to be used in billing for health care services, and
23 narrative description, the amount the provider receives as
24 payment for health care services from the medical assistance
25 program administered by the commissioner of human services.
26 (b) If a provider is unable to immediately provide the
27 amount it receives as payment for health care services in
28 response to a request made under this subdivision, the provider
29 shall make available and provide the information to the person
30 who requested it as soon as reasonably practicable, but in no
31 event shall the time for disclosure be delayed by more than ten
32 business days.
33 (c) The information required under this subdivision shall
34 be revised quarterly as necessary to reflect any changes to the
35 amounts the provider receives under paragraph (a).
36 Subd. 3. [NOTICE TO UNINSURED.] (a) A provider may attempt

1 to obtain from a person or the person's representative
2 information about whether any third-party payer may fully or
3 partially cover the charges for health care services rendered by
4 the provider to the person.
5 (b) A provider shall inform each person, both orally and in
6 writing, immediately upon first meeting with that person, or as
7 soon as practicable thereafter, that uninsured individuals will
8 be charged or billed for health care services in amounts that do
9 not exceed the amounts described in subdivision 4.
10 (c) If, at the time health care services are provided, a
11 person has not provided proof of coverage by a third-party payer
12 or a provider otherwise determines that the person is an
13 uninsured individual, the provider, as part of any billing to
14 the person, shall provide the person with a clear and
15 conspicuous notice that includes:
16 (1) a statement of charges for health care services
17 rendered by the provider;
18 (2) for each of the health care services rendered by the
19 provider, the amounts required to be disclosed under subdivision
20 2; and
21 (3) a statement that uninsured individuals will be charged
22 or billed for health care services in amounts that do not exceed
23 the amounts described in subdivision 4.
24 (d) For purposes of the notice required under paragraph
25 (c), a provider may incorporate the items into the provider's
26 existing billing statements and is not required to develop a
27 separate notice. All communications to a person required by
28 this subdivision must be language appropriate.
29 Subd. 4. [PROVIDER CHARGES TO UNINSURED.] In billing or
30 charging an uninsured individual or the individual's
31 representative for health care services, a provider shall not
32 bill or charge more than the higher of the Medicare or medical
33 assistance payment required to be disclosed under subdivision 2
34 at the time the bill or charge is issued, plus five percent.
35 After a bill or charge is issued under this subdivision, a
36 provider may not increase the bill or charge, even if the amount

1 disclosed under subdivision 2 has increased.
2 Subd. 5. [LIMITATIONS.] Notwithstanding any other
3 provision of law, the amounts paid by uninsured individuals for
4 health care services according to subdivision 4 does not
5 constitute a provider's uniform, published, prevailing, or
6 customary charges, or its usual fees to the general public, for
7 purposes of any payment limit under the Medicare or medical
8 assistance programs or any other federal or state financed
9 health care program.
10 Subd. 6. [RECOURSE LIMITED.] (a) Providers under agreement
11 with a health plan company or public health care plan or program
12 to provide health care services shall not have recourse against
13 covered individuals, or persons acting on their behalf, for
14 amounts above those specified in the evidence of coverage or
15 other plan or program document as co-payments or coinsurance for
16 health care services. This subdivision applies but is not
17 limited to the following events:
18 (1) nonpayment by the health plan company;
19 (2) insolvency of the health plan company; and
20 (3) breach of the agreement between the health plan company
21 and the provider.
22 (b) This subdivision does not limit a provider's ability to
23 seek payment from any person other than the covered individual,
24 the covered individual's guardian or conservator, the covered
25 individual's immediate family members, or the covered
26 individual's legal representative in the event of nonpayment by
27 a health plan company.
28 Subd. 7. [REMEDIES.] A person may file an action in
29 district court seeking injunctive relief and damages for
30 violations of this section. In any such action, a person may
31 also recover costs and disbursements and reasonable attorney
32 fees.
33 Subd. 8. [GROUNDS FOR DISCIPLINARY ACTION.] Violations of
34 this section may be grounds for disciplinary or regulatory
35 action against a provider by the appropriate licensing board or
36 agency.

1 Subd. 9. [AUTHORITY OF ATTORNEY GENERAL.] The attorney
2 general may investigate violations of this section under section
3 8.31. The attorney general may file an action for violations of
4 this section according to section 8.31 or may pursue other
5 remedies available to the attorney general.

1 Senator ..... moves to amend S.F. No. 1162 as follows:

2 Page 5, after line 5, insert:

3 "Subd. 10. [INCOME AND ASSET LIMITATIONS.] The provisions
4 of this section shall not apply to uninsured individuals with an
5 annual family income above $50,000."

1 Senator ..... moves to amend S.F. No. 1162 as follows:

2 Page 2, delete lines 12 to 35

3 Renumber the subdivisions in sequence

4 Page 3, line 17, after the semicolon, insert "and"

5 Page 3, delete lines 18 to 20

6 Page 3, line 21, delete "(3)" and insert "(2)"

7 Page 3, delete lines 29 to 36

8 Page 4, delete line 1 and insert:

9 "Subd. 3. [PROVIDER CHARGES TO THE UNINSURED.] In billing
10 or charging an uninsured individual or the individual's
11 representative for health care services, a provider must bill by
12 CPT code, or other billing identifier as may be routinely used
13 for billing that health care service. A provider shall not bill
14 or charge an uninsured individual or the individual's
15 representative more than the provider is paid for that service
16 by the third-party payer that provided the most revenue to the
17 provider during the previous calendar year. After a bill or
18 charge is issued under this subdivision, a provider may not
19 increase the bill or charge."

1 Senator ..... moves to amend S.F. No. 1162 as follows:

2 Page 2, line 5, delete "62J.03" and insert "144.50"

3 Page 2, line 6, delete "8" and insert "2"

1 Senator ..... moves to amend S.F. No. 1162 as follows:
2 Page 5, after line 5, insert:
3 "Sec. 2. [62J.83] [HOSPITAL COST DISCLOSURE.]
4 Subdivision 1. [IDENTIFICATION OF HOSPITAL
5 PROCEDURES.] Based on state or national data, the commissioner
6 of health shall select the following:
7 (1) the 25 most frequently performed hospital inpatient
8 procedures;
9 (2) the 25 most frequently performed hospital outpatient
10 procedures; and/or
11 (3) the 50 most frequently administered drugs in a hospital
12 inpatient setting.
13 Subd. 2. [REPORT.] Not later than 45 days after the end of
14 each calendar quarter, a hospital shall report to the
15 commissioner of health the average and the median allowable
16 charge by the hospital or outpatient surgical center for the
17 procedures and drugs identified in subdivision 1.
18 Subd. 3. [COMPUTATION.] For purposes of subdivision 2, the
19 computation of an average and median price for a procedure or a
20 drug shall be in accordance with a methodology prescribed by the
21 commissioner of health.
22 Subd. 4. [DISCLOSURE.] This information shall be available
23 to the public on a comparative basis."
24 Amend the title accordingly