Order Code RL31698

CRS Report for Congress

Transitional Medical Assistance (TMA) Under Medicaid

Updated January 8, 2008

April Grady
Analyst in Health Care Financing
Domestic Social Policy Division

Congressional Research Service

Prepared for Members and Committees of Congress

Transitional Medical Assistance (TMA) Under Medicaid

Summary

Medicaid, a means-tested federal/state program that provides health care coverage to certain groups of individuals, requires that states continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. Congress expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families who lose Medicaid for work-related reasons for at least six, and up to 12, months.

To qualify for TMA under Section 1925, a family must have received Medicaid in at least three of the six months preceding the month in which eligibility is lost and have a dependent child in the home. During the first six months of TMA, states must provide the same benefits the family was receiving, although this requirement may be met by paying a family's premiums, deductibles, coinsurance, and similar costs for employer-based health coverage. An additional six months of TMA (for a total of up to 12 months) is available for families who continue to have a dependent child in the home, who meet reporting requirements, and whose average gross monthly earnings (less work-related child care costs) are below 185% of the federal poverty line. States may impose a premium, limit the scope of benefits, and use an alternative service delivery system during the second six months of TMA.

Although federal statute outlines requirements for TMA, some states modify these requirements in practice. A survey of state Medicaid directors conducted by the Congressional Research Service (CRS) in July 2002 collected information on TMA programs in 46 states. Although not required by law, 12 states provide more than 12 months of TMA coverage. Many states also have policies that modify the "three of six months" requirement (17 states), change reporting requirements (19 states), or allow individuals to self-declare earnings and child care costs (20 states). None of the states have limited the scope of benefits provided during the second six months, and three states impose a premium. States are not required to report TMA participation and expenditures separately from other Medicaid data, but a number of states were able to provide these as part of the CRS survey.

Since 2001, Section 1925 TMA requirements have been funded by a series of short-term extensions, most recently through June 30, 2008 (P.L. 110-173). Although a State Children's Health Insurance Program (SCHIP) reauthorization bill passed by the House in 2007 (H.R. 3162) would have modified TMA and extended it for four years, the SCHIP bills vetoed by President Bush (H.R. 976 and H.R. 3963) would not. If Section 1925 were allowed to expire, states would still be required to provide four months of TMA to families who lose Medicaid eligibility because of an increase in earned income, hours of employment, or child or spousal support, but not to those who lose eligibility because of the loss of a time-limited earnings disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time).

Contents

List of Figures

List of Tables

Transitional Medical Assistance (TMA) Under Medicaid

Introduction

Medicaid, a means-tested federal/state program that provides health care coverage to certain groups of individuals, requires that states continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections. It also permanently requires four months of TMA for families who lose Medicaid eligibility due to an increase in earned income or hours of employment.

However, Congress expanded work-related TMA benefits as part of the Family Support Act of 1988 (P.L. 100-485), requiring states to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time).[1] An additional six months of TMA (for a total of up to 12 months) is required for families who meet certain conditions. These expanded TMA requirements are outlined in Section 1925 of the Social Security Act, and Congress has acted several times to extend them beyond their original sunset date of September 30, 1998. Most recently, TMA requirements under Section 1925 were extended through June 30, 2008, by P.L. 110-173.

This report provides an overview of TMA. While Section 1925 of the Social Security Act outlines the provisions requiring states to provide TMA for up to 12 months, states have considerable flexibility in designing and implementing their TMA programs. To better understand these programs, the Congressional Research Service (CRS) conducted a survey of state TMA policies in effect on July 1, 2002.

---

[1] Under the Aid to Families with Dependent Children (AFDC) program, the predecessor to the Temporary Assistance for Needy Families (TANF) program — which had a direct link to Medicaid eligibility — states were required to disregard the earnings of a recipient family for a limited time (special rules applied to applicants and child students). For the first four months of a job (less for part-time work), the disregard per month was $120, one-third of remaining earnings, and actual dependent child care costs up to $175 (up to $200 for a child under age 2). In months five through 12, the disregard per month was $120 plus dependent care costs. After 12 months, the disregard per month was $90 plus dependent care costs. The intent of these disregards was to allow individuals to remain on cash assistance (and Medicaid) for a limited period of time as they transitioned to work.

This report summarizes the results of the survey and discusses legislation introduced to extend, and in some instances to modify, TMA.

Family Medicaid Coverage and Cash Welfare

Medicaid is a health insurance program jointly funded by the federal government and the states. While states have considerable flexibility to design and administer their programs, certain groups of individuals must be covered for certain categories of services. Generally, eligibility is limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities. The federal government finances more than half of all Medicaid expenditures annually.

Medicaid Eligibility Under Section 1931. As described throughout this report, states are required to provide TMA to families who lose eligibility for Medicaid under Section 1931 of the Social Security Act. Following is a description of how Medicaid eligibility works for these families.

Prior to the creation of the Temporary Assistance for Needy Families (TANF) program, individuals qualifying for welfare under the Aid to Families with Dependent Children (AFDC) program were automatically eligible for and, in most states, automatically enrolled in Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, herein referred to as the welfare reform law) formally "de-linked" Medicaid and cash assistance and created a new Medicaid eligibility category for low-income families under Section 1931 of the Social Security Act.

Medicaid entitlement under Section 1931 was retained *only* for individuals who meet the income and resource eligibility standards of their state's former AFDC program in effect on July 16, 1996 (herein referred to as eligibility under Section 1931), *regardless* of whether they receive TANF or ever received AFDC. However, states were given flexibility to modify their income and resource eligibility standards for Medicaid in three ways: (1) states may lower their income standards, but not below those used for AFDC on May 1, 1988; (2) states may increase their income and resource standards by an amount that is no more than the percentage increase in the Consumer Price Index (CPI); or (3) states may use less restrictive income and resource methodologies than those in effect on July 16, 1996.

Since the welfare reform law of 1996, a number of states have aligned Section 1931 Medicaid eligibility with eligibility for TANF, and many use less restrictive methods for counting income and resources to allow individuals and families to qualify for Medicaid at higher income and resource levels than those in place on July 16, 1996. As part of their methodology for determining Medicaid eligibility, some states have policies in place to disregard a portion of earnings or income for a limited period of time. For example, a state might disregard the first $120 plus 90% of earnings during a family's first four months of Section 1931 Medicaid coverage. After month four, the disregard drops to $120. As a result, the amount a family can

earn and still qualify for Medicaid is reduced in the fifth month of coverage and beyond.[2]

As shown in **Figure 1**, the Medicaid income eligibility threshold for a working parent[3] applicant in a family of three ranged from $255 per month to $3,806 per month as of July 2006. In 14 states, a working parent applicant in a family of three needed income at or below 50% of the federal poverty line (FPL) to qualify for Medicaid.[4] The same parent could have income between 50% and 100% FPL in 23 states, and income above 100% FPL in 14 states (including DC).[5]

In addition to disregarding certain amounts or types of income, states may disregard some or all of the value of a parent's assets when determining eligibility for Medicaid. As of July 2006, 21 states (including DC) had eliminated their Medicaid asset test for parents. In contrast, 47 states (including DC) had done so for children.[6]

---

[2] In 2001, 36 states (including DC) did not have time-limited disregard policies for Section 1931 coverage, meaning that the amount a family could earn and still qualify for Medicaid would not vary from month to month. In the 15 states with these policies, the length of the disregard period ranged from four to 12 months. See Kaiser Commission on Medicaid and the Uninsured, *Can Medicaid Work for Low-Income Working Families?* (April 2002), available at [http://www.kff.org/medicaid/4032-index.cfm].

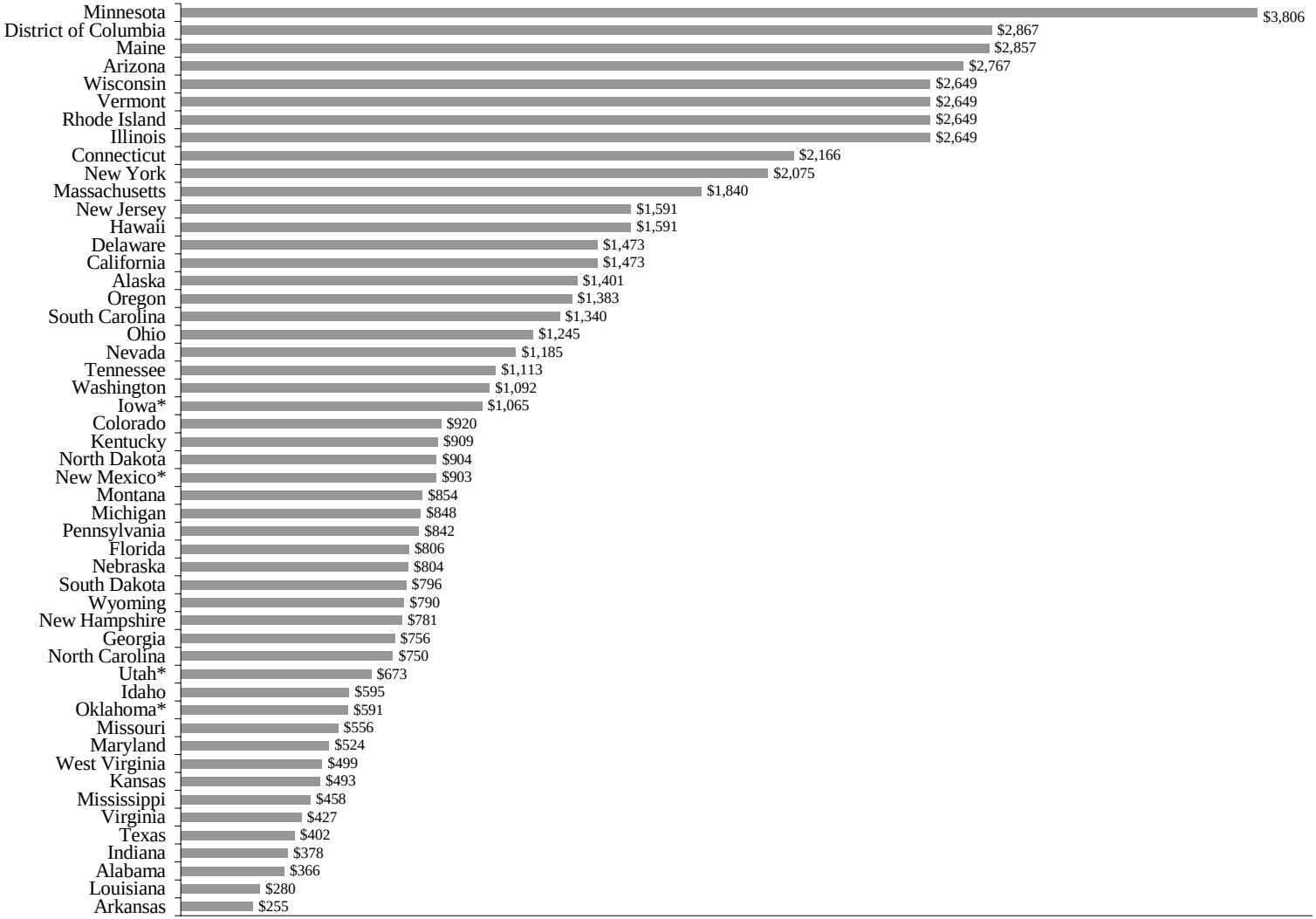
[3] Although parents *and* children are eligible for family Medicaid coverage under Section 1931, a number of eligibility pathways with higher income and asset thresholds (e.g., mandatory eligibility for ages 6 and under with family income less than or equal to 133% FPL) may be available for children. Depending on state practices, children may be enrolled via these other pathways, rather than Section 1931. In contrast, Section 1931 is one of the few Medicaid eligibility pathways available for parents (and more generally, adults) who are not pregnant, disabled, or elderly. States that wish to work outside of the regular Medicaid rules can do so under a waiver (see CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, by Evelyne P. Baumrucker).

[4] The 2007 federal poverty line for a family of three is $17,170 per year ($21,470 in Alaska and $19,750 in Hawaii). The 2006 federal poverty line for a family of three is $16,600 per year ($20,750 in Alaska and $19,090 in Hawaii).

[5] Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents* (January 2007), available at [http://www.kff.org/medicaid/7608a.cfm].

[6] Ibid.

Figure 1. Medicaid Income Eligibility Threshold for a Working Parent Applicant in a Family of Three, July 2006



Source: Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents* (January 2007).

Note: Amounts reflect earnings disregards (if any), which may be time-limited. Parents in 30 states must also meet an asset test to qualify. Depending on the state, coverage may be under Section 1931 of the Social Security Act or under a waiver. States marked with (*) cover parents at higher income levels under a waiver, but the coverage generally provides fewer benefits and has higher cost-sharing than is allowed under regular Medicaid. The 2006 federal poverty line for a family of three is $1,383 per month ($1,729 in Alaska and $1,591 in Hawaii).

Transitional Medical Assistance

States must provide TMA to families losing eligibility for Section 1931 Medicaid under two scenarios.[7] First, states are required to provide four months of TMA coverage to families who lose Medicaid eligibility under Section 1931 due to increased child or spousal support. This provision was included in the Child Support Amendments of 1984 (P.L. 98-378) and was made permanent by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

Second, under Section 1902(e)(1) and Section 1925 of the Social Security Act, states are required to provide TMA to families losing Section 1931 Medicaid eligibility for work-related reasons. States were originally required to provide four months of TMA to families losing eligibility due to an increase in hours of work or income from employment. However, the Family Support Act (FSA) of 1988 (P.L. 100-485) expanded state TMA requirements under Section 1925, requiring states to provide at least six, and up to 12, months of TMA coverage to families losing Section 1931 Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard.

FSA originally authorized Section 1925 to replace the four-month requirement in Section 1902(e)(1) through FY1998. However, the welfare reform law of 1996 (P.L. 104-193) extended Section 1925 thorough FY2001, and the provision has continued to exist under a series of short-term extensions (most recently, through June 30, 2008).[8]

If Section 1925 were allowed to expire,[9] states would still be required to provide four months of TMA to families who lose Medicaid eligibility due to an increase in earned income or hours of employment, but not to those who lose eligibility due to the loss of a time-limited earnings disregard. In addition, regardless of activity to extend Section 1925, states would still be required to provide four months of TMA to families who lose Section 1931 eligibility due to increased child or spousal support.

Initial Six-Month Period of Section 1925 TMA Coverage. Under Section 1925 of the Social Security Act, families losing Section 1931 Medicaid eligibility due to the loss of a time-limited earned income disregard or an increase in hours of work or income from employment must receive at least six months of TMA coverage. To be eligible, federal statute specifies that families must have received

---

[7] Section 1931(c) of the Social Security Act.

[8] P.L. 106-554, P.L. 107-229, P.L. 107-235, P.L. 107-240, P.L. 107-244, P.L. 107-294, P.L. 108-2, P.L. 108-40, P.L. 108-89, P.L. 108-210, P.L. 108-262, P.L. 108-308, P.L. 109-4, P.L. 109-19, P.L. 109-91, P.L. 109-171, P.L. 109-432, P.L. 110-48, P.L. 110-90, P.L. 110-173.

[9] Over the years, the provision has expired temporarily (for days or weeks) on three occasions. Before P.L. 109-91 was enacted in October 2005, Section 1925 had expired on September 30; before P.L. 109-171 was enacted in February 2006, Section 1925 had expired on December 31; and before P.L. 110-48 was enacted in July 2007, it had expired on June 30.

Medicaid under Section 1931 in at least three of the six months preceding their loss of eligibility and have a dependent child in the home.[10] During this initial six-month period of TMA, states must provide families with the same amount, duration, and scope of benefits offered under Section 1931 (that is, the Medicaid coverage the family was previously receiving). However, states may opt to meet this requirement by using Medicaid funds to pay a family's premiums, deductibles, coinsurance, and similar costs for employer-based health coverage (referred to in statute as "wrap-around"). TMA may not be terminated during this initial six-month period so long as the family continues to have a dependent child in the home.

Second Six-Month Period of Section 1925 TMA Coverage. During the initial six-month period, states must notify families of the availability of up to six additional months of TMA, for a total of up to 12 months of coverage. To maintain eligibility for the second six-month period of TMA, families must report their gross monthly earnings and child care costs in months four, seven, and 10 of their coverage (that is, on a quarterly basis). In addition, TMA coverage may be terminated during the second six-month period if any of the following apply:

- the family ceases to include a dependent child;
- the family's average gross monthly earnings (less child care costs necessary for employment) exceed 185% FPL (approximately $2,647 for a family of three in 2007);
- the caretaker relative had no earnings in one or more of the three previous months (unless the state determines that the lack of earnings was due to an involuntary loss of employment, illness, or other good cause);
- the family fails to file a quarterly report; or
- the family fails to pay any required premiums (should the state choose to impose them).

TMA Enrollment and Expenditures

While states are required to submit data on their Medicaid programs to the Department of Health and Human Services (HHS), they are not required to report TMA enrollment and expenditures separately from other Medicaid program data. In the summer of 2002, the Congressional Research Service (CRS) surveyed state Medicaid directors on their TMA policies. As part of this survey, states were asked to report, if available, monthly enrollment and expenditures for TMA for selected months in 2001. These data are provided in **Table 1**, below.

As **Table 1** illustrates, approximately 682,800 individuals in 32 states were enrolled in TMA in December 2001. More recent data indicate that as of June 2006, there were approximately 351,300 TMA enrollees in 15 states whose Medicaid

---

[10] Families losing eligibility due to increased child or spousal support are eligible for a total of four months of TMA if they received Medicaid under Section 1931 in at least three of the six months preceding their loss of eligibility and have a dependent child in the home. There are no additional eligibility requirements for support-related TMA.

enrollment accounted for about 18% of total U.S. Medicaid enrollment.[11] Using these figures, a very rough approximation of U.S. TMA enrollment in June 2006 would be 2.0 million. This rough estimate may be inaccurate if the states without TMA data differ systematically from the 15 states with TMA data (e.g., if they have a higher or lower percentage of TMA enrollees in their Medicaid populations).

The vast majority of TMA enrollees are eligible for work-related reasons, as nearly all states indicated in the CRS survey that less than 10% of their TMA population lost Medicaid eligibility under Section 1931 because of an increase in child or spousal support collections. **Table 1** also illustrates that expenditures for the 20 states reporting totaled $652.8 million in calendar year 2001.

Table 1. TMA Enrollment and Expenditures for Selected Months in 2001

State	Monthly enrollment (in thousands)			Total expenditures (federal and state share, in millions)			
	June 2001	Sept. 2001	Dec. 2001	June 2001	Sept. 2001	Dec. 2001	Calendar year 2001
Alabama	*No data provided*						
Alaska	1.7	2.0	1.9	$0.4	$0.3	$0.4	$4.9
Arizona[a]	43.3	16.9	27.2	NA	NA	NA	NA
Arkansas[b]	9.3	10.0	9.8	*No data provided*			
California[c]	38.3	41.5	43.4	$4.2	$3.9	$4.2	$49.8
Colorado	*No data provided*						
Connecticut	38.8	30.2	28.5	NA	NA	NA	NA
Delaware	12.8	14.4	16.1	$2.5	$2.7	$3.0	$36.6
District of Columbia	*No data provided*						
Florida	88.6	85.9	86.4	$9.6	$9.3	$9.4	$111.1
Georgia	*No data provided*						
Hawaii	4.4	4.3	4.6	$0.6	$0.6	$0.7	$1.9
Idaho[d]	8.4	8.6	9.4	$1.6	$1.2	$1.7	$17.6
Illinois	*No data provided*						
Indiana	26.8	28.1	30.1	NA	NA	NA	$61.4
Iowa	*No data provided*						
Kansas	9.8	9.9	9.6	$1.1	$1.1	$1.5	$14.2
Kentucky[e]	15.9	17.6	18.8	$3.2	$3.0	$3.2	$39.7
Louisiana[f]	3.3	3.1	3.8	NA	NA	NA	NA
Maine	*No data provided*						
Maryland	20.0	20.2	20.5	$3.7	$3.3	$3.6	$42.6
Massachusetts	*No data provided*						
Michigan[b]	69.1	66.2	63.5	*No data provided*			
Minnesota[g]	16.2	16.0	15.7	$0.9	$2.6	$2.8	$34.1
Mississippi	*No data provided*						
Missouri[d]	20.3	20.7	19.6	$3.4	$3.5	$3.0	NA
Montana	8.0	9.7	8.6	$1.2	$1.3	$1.2	$16.5

[11] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment in 50 States: June 2006 Data Update* (October 2007), available at [http://www.kff.org/medicaid/upload/7606_02.pdf].

State	Monthly enrollment (in thousands)			Total expenditures (federal and state share, in millions)			
	June 2001	Sept. 2001	Dec. 2001	June 2001	Sept. 2001	Dec. 2001	Calendar year 2001
Nebraska	16.9	15.0	14.6	$1.7	$2.1	$2.9	$30.4
Nevada	8.5	9.9	10.2	$1.2	$1.3	$1.3	$17.2
New Hampshire	1.1	1.1	1.1	NA	NA	NA	NA
New Jersey	27.5	31.3	25.5	$3.1	$3.4	$2.8	$44.0
New Mexico	12.3	13.8	11.6	$2.3	$2.8	$2.4	$28.8
New York	*No data provided*						
North Carolina	14.6	16.8	20.3	$1.5	$2.2	$2.2	$18.4
North Dakota	2.9	2.8	3.0	$0.3	NA	NA	NA
Ohio	*No data provided*						
Oklahoma	*No data provided*						
Oregon	28.4	28.1	28.2	$4.8	$4.4	$4.6	$56.1
Pennsylvania	66.8	67.6	68.4	NA	NA	NA	NA
Rhode Island	1.1	1.1	1.3	NA	NA	NA	NA
South Carolina[b]	48.4	57.3	62.2	*No data provided*			
South Dakota	*No data provided*						
Tennessee	*No data provided*						
Texas	*No data provided*						
Utah	14.2	11.7	8.9	$2.3	$2.1	$1.7	$24.2
Vermont	7.3	7.2	7.2	NA	NA	NA	NA
Virginia	*No data provided*						
Washington	*No data provided*						
West Virginia	*No data provided*						
Wisconsin	*No data provided*						
Wyoming	2.4	2.6	2.8	$0.3	$0.4	$0.3	$3.3
Total (number of states with data)	**687.4 (32)**	**671.7 (32)**	**682.8 (32)**	**$50.1 (21)**	**$51.5 (20)**	**$53.1 (20)**	**$652.8 (20)**

Source: July 2002 Congressional Research Service (CRS) survey of state TMA policies.

Note: NA indicates that a specific piece of information was not available for the state to provide as part of the CRS survey.

a. Arizona indicated in their survey response that, effective July 2001, they had increased their income eligibility standard for Medicaid under Section 1931 Medicaid. Since this allowed many families to retain Section 1931 coverage, TMA enrollment declined.

b. These states did not provide data as part of the CRS survey. June and September 2001 data for these states are from Kaiser Commission on Medicaid and the Uninsured, *Medicaid Program Enrollment Data Update: September 2001* (June 2002). December 2001 data are from Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment in 50 States: December 2001 Data Update* (Oct. 2002).

c. California indicated in its survey response that in 2000 it expanded its earnings disregards under Section 1931, allowing families to remain eligible for longer periods of time and thus keeping TMA enrollment low.

d. Monthly expenditure data are estimates provided by the state.

e. For Kentucky, Dec. enrollment represents 18,800 recipients (individuals) and 6,500 cases (families). Since data on cases but not recipients were available for June and Sept., enrollment is estimated using the ratio of recipients to cases in Dec.

f. For Louisiana, monthly enrollment numbers do not include child and spousal support cases.

g. Minnesota indicated that June 2001 expenditures are low due to the fact that capitation payments were not made in that month.

State TMA Program Policies

As **Table 1** illustrates, enrollment and expenditures for TMA vary tremendously by state, due both to differences in state characteristics (such as population size) and in Medicaid program design. As discussed above, Section 1925 of the Social Security Act requires states to provide up to 12 months of TMA to certain families. However, some states have made considerable efforts to expand and extend their TMA programs. Expansions and extensions of state TMA programs have occurred through a number of avenues within the states. These include waivers of federal requirements (also referred to as Section 1115 waivers), Medicaid state plan amendments that expand eligibility under Section 1931 through modified income and resource eligibility standards or other means, and the use of state-only funds.

The July 2002 CRS survey asked states to respond to a number of questions designed to determine the extent to which states have extended or expanded TMA coverage. For example, several states lengthen the period of Medicaid coverage by providing a 12-month disregard of *all* earned income at the point when an increase in income jeopardizes their Medicaid eligibility under Section 1931. This disregard allows the family to retain Section 1931 Medicaid eligibility for 12 months. After the disregard is exhausted at the end of this 12-month period, families are then eligible for up to 12 months of TMA. Other states extend TMA coverage through the use of state-only funds.

States also use various options to modify the "three of six months" requirement for TMA. As previously discussed, federal statute requires that individuals receive Medicaid under Section 1931 in three of the six months immediately preceding their loss of eligibility in order to qualify for TMA. However, some states will effectively bypass this rule by using earned income disregards. For example, a family whose earnings are low enough to qualify for Section 1931 Medicaid may see an increase in earnings immediately (in months two or three) after receiving coverage. This increase in earnings may mean that they no longer qualify for Section 1931 Medicaid, and they would not qualify for TMA because they did not receive Medicaid in three of the immediately preceding six months. Some states would allow this family to remain eligible for Medicaid by disregarding all earnings for two months, and as a result, also meet the "three of six months" requirement for TMA. Other states conduct "look-back" reviews to provide retroactively coverage to low-income families who would have qualified under Section 1931 Medicaid had they applied.

Table 2, below, summarizes state responses to the CRS TMA survey, which reflects state policies in effect as of July 1, 2002. Detailed state-by-state information is available in **Appendix A**.

Table 2. Overview of State TMA Policies

Policy	Number of states
Allows self-declaration of earnings and/or child care costs	20 (out of 51)
Does not require reporting of earnings or child care costs on a quarterly basis (in months four, seven, and 10)[a]	19 (out of 46)
Modifies the "three of six months" requirement	17 (out of 51)
Provides Medicaid "wrap-around" coverage[a b]	13 (out of 46)
Provides more than 12 months of TMA coverage	12 (out of 51)
Imposes a premium in the second six-month period of TMA[a]	3 (out of 46)
Limits benefits provided in the second six-month period of TMA[a]	0 (out of 46)

Source: July 2002 Congressional Research Service (CRS) survey of state TMA policies and Kaiser Commission on Medicaid and the Uninsured, *Can Medicaid Work for Low-Income Working Families*? (Apr. 2002).

Note: Five states (Arkansas, Michigan, Ohio, Oklahoma, and West Virginia) did not respond to the CRS survey. Information for these states was taken from the Kaiser report, reflecting policies in place as of June 2001. Policies in the remaining states are those as of July 1, 2002. For state-specific information, see **Table A-1**, below.

a. Based on responses from the District of Columbia and 45 states that completed the CRS survey, as comparable information for the remaining five states was not available from the Kaiser report.
b. "Wrap-around" refers to the state option to use Medicaid funds to pay a family's premiums, deductibles, coinsurance, and similar costs for employer-based health coverage.

Legislative Developments

Since 2001, Section TMA requirements under Section 1925 of the Social Security Act have been funded by a series of short-term extensions, most recently through June 30, 2008 (P.L. 110-173). In the 109th Congress, a provision to modify Section 1925 TMA was included in a welfare reauthorization bill that saw action, but was not adopted. In the 110th Congress, a provision to modify and extend Section 1925 TMA for four years was included in a State Children's Health Insurance Program (SCHIP) reauthorization bill passed by the House (H.R. 3162), but not in the SCHIP bills vetoed by President Bush (H.R. 976 and H.R. 3963).

TMA and Welfare Reauthorization. Early in the 109th Congress, the House Ways and Means Subcommittee on Human Resources favorably reported H.R. 240, a welfare reauthorization bill that would have extended TMA under Section 1925 through FY2006 with no statutory changes. The Senate Finance Committee approved its own welfare reauthorization measure (S. 667, discussed below) that would have modified and extended TMA through FY2010. Ultimately, the Deficit Reduction Act of 2005 (P.L. 109-171) extended TMA through calendar year 2006 and provided a scaled-back version of welfare reauthorization through FY2010.[12]

[12] See CRS Report RL33418, *Welfare Reauthorization in the 109th Congress: An Overview*, by Gene Falk, Melinda Gish, and Carmen Solomon-Fears.

Although welfare reauthorization was achieved through other means, S. 667 is noteworthy in that it would have provided a five-year extension of Section 1925 TMA and given states statutory options for modifying their TMA policies (as described earlier and shown in **Table 2**, a number of states have already implemented changes through other avenues). Under S. 667, states could have opted to:

- provide continuous eligibility for TMA for 12 months by waiving quarterly reporting requirements;
- extend coverage for an additional 12 months (for a total of up to 24 months of TMA) so long as a family's gross monthly earnings (less necessary child care costs) remained below 185% FPL;
- waive the requirement that a family must have received Section 1931 Medicaid in three of the previous six months to qualify for TMA.

S. 667 also would have allowed states to meet Section 1925 TMA requirements by extending Medicaid coverage under Section 1931 to families whose gross monthly earnings (less necessary child care costs) are at or below a level that is at least 185% FPL. In a state choosing this option, families whose earnings exceed the eligibility standard for Section 1931 Medicaid would receive no further medical assistance. Families whose earnings remain at or below the state's eligibility standard (at least 185% FPL) would continue to receive Section 1931 Medicaid.

In effect, this provision would have prevented states with relatively high Section 1931 eligibility standards from having to provide the automatic six months of TMA coverage outlined in Section 1925 to families whose earnings exceed those relatively high standards. It would not have allowed states with lower (less than 185% FPL) Section 1931 eligibility standards to opt out of providing the automatic six months of TMA (even in cases where family earnings exceed 185% FPL), and it still would have required them to provide up to six additional months of TMA to families whose earnings remain at or below 185% FPL.

In addition, S. 667 would have required states to collect information on average monthly TMA enrollment and participation rates for adults and children, to make the information publicly available, and to and submit the information to the Secretary of HHS. In turn, the Secretary of HHS would submit annual reports to Congress concerning these rates. The bill also would have required administrators within HHS to work together to develop guidance or other technical assistance for states regarding best practices in guaranteeing access to TMA. Finally, the bill would have required states to notify all families whose TANF benefits are terminated of their ongoing eligibility for Medicaid benefits or, if a family is no longer eligible for Medicaid, to supply a one-page notification describing eligibility and how to apply for Medicaid and SCHIP coverage.

Recent Action. Legislation to temporarily extend Section 1925 TMA through June 30, 2008, was enacted at the end of 2007 (P.L. 110-173). Although a reserve

fund for extending TMA was included in the FY2008 budget resolution,[13] its deficit-neutral status meant that offsets (or a waiver of budget rules) might be required.[14]

Although a provision to modify and extend TMA for four years was included in an SCHIP reauthorization bill passed by the House in 2007 (H.R. 3162),[15] it was not included in the SCHIP bills vetoed by President Bush (H.R. 976 and H.R. 3963). Under H.R. 3162, states could opt to treat any reference to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months) for purposes of the initial eligibility period for TMA, in which case the additional 6-month extension would not apply; could opt to waive the requirement that a family have received Medicaid in at least 3 of the last 6 months in order to qualify; and would be required to collect and submit to the Secretary of HHS (and make publicly available) information on average monthly enrollment and participation rates for adults and children under work-related TMA, and on the number and percentage of children who become ineligible for work-related TMA and whose eligibility is continued under another Medicaid eligibility category or who are enrolled in SCHIP (in turn, the Secretary would submit annual reports to Congress concerning these rates).

Discussion

Research shows that low-income individuals are more likely to be without health insurance than those with higher incomes. In 2006, 34% of people under age 65 with family incomes below the federal poverty threshold went without health insurance, compared to 12% of individuals with incomes at least two times the poverty threshold. Among low-income individuals who are working, health care coverage is not always available or affordable. Only 18% of people under age 65 with incomes below the poverty threshold received health care coverage through employment in 2006, compared to 79% of people with incomes of at least two times the poverty threshold.[16]

For low-income families, TMA continues health care coverage on a temporary basis when they might otherwise lose eligibility for Medicaid due to their earned income, hours of work, or child or spousal support. This continuation is especially valuable for parents, since income eligibility limits for Medicaid coverage of adults who are not pregnant, disabled, or elderly are quite low in some states (as shown in **Figure 1**), and since private health insurance may be unavailable or unaffordable. Although Congress has not yet reached consensus on the future of TMA under

---

[13] CRS Report RL33866, *Medicaid, SCHIP, and Health Insurance: FY2008 Budget Issues*, by April Grady et al.

[14] Until 2005 (ending with P.L. 109-19), short-term extensions of Section 1925 TMA were packaged with TANF and related programs and did not include offsets. Since then, extensions have sometimes included offsets (P.L. 109-91, P.L. 110-48, P.L. 110-90) and sometimes been packaged in broader legislation (P.L. 109-171, P.L. 109-432, P.L. 110-173).

[15] See CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162, S. 1893/H.R. 976, and Agreement*, by Evelyne P. Baumrucker et al.

[16] See CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2006*, by Chris L. Peterson and April Grady.

Section 1925, the Government Accountability Office (GAO) and others assert that TMA can play an important role in supporting low-income families, especially those who are transitioning from welfare to work.[17]

However, some have expressed concern that there are families eligible for TMA who do not enroll, and that programmatic aspects of TMA create barriers that prevent individuals from continuing to receive TMA once they become eligible. For example, GAO noted in 1999 that quarterly income reporting requirements for TMA could pose barriers to family receipt of TMA and recommended that the Congress consider allowing states to lessen or eliminate these requirements.[18]

---

[17] See U.S. Government Accountability Office, *Medicaid: Transitional Coverage Can Help Families Move from Welfare to Work*, testimony of David M. Walker before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives, GAO-02-679T (April 23, 2002).

[18] U.S. Government Accountability Office, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary*, GAO/HEHS-99-163 (September 1999).

Appendix A

Table A-1, below, provides state responses to the CRS survey on state TMA policies in effect as of July 1, 2002. This information was collected using a survey distributed by CRS to state Medicaid directors. Five states did not respond to the CRS survey. When available, information obtained elsewhere for these states (Arkansas, Michigan, Ohio, Oklahoma, and West Virginia) reflects policies in place as of June 2001.[19]

Table A-1 provides information by state on the following:

- length of TMA coverage;
- does the state modify the "three of six months" requirement;
- has the state changed the reporting requirements;
- does the state allow self-declaration of earnings and child care costs;
- does the state impose a premium in the second six-month period of TMA coverage;
- does the state limit benefits provided in the second six-month period of TMA coverage;
- does the state provide Medicaid "wrap-around" coverage;
- any state-specific notes.

Because this information was collected using a survey administered to the states, there are limitations to the data. Where possible, state-specific notes were included to provide more detail on how the state has implemented its TMA policies. However, aspects of the state's TMA program may be not represented in the table given the variation in how states have implemented these policies and the flexibility states have to design their programs.

[19] See Kaiser, *Can Medicaid Work?* (April 2002).

Table A-1. State TMA Policies

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Alabama	12 months	No	No	No	No	No	No	
Alaska	12 months	No	No	No	No	No	No	Caseworkers may issue retroactively coverage under Section 1931 Medicaid (to meet the three out of six months requirement for TMA) to families who would have been eligible for Medicaid had they applied, although this practice is not common among caseworkers.
Arizona	24 months	No	Yes	No	No	No	No	The state conducts eligibility reviews every six months for TMA under a federal waiver (which expired 10/31/02). Until April 2002, Arizona had a state plan amendment in place to drop the three out of six months requirement.
Arkansas	*12 months*	*No*	*Not available*	*Income*	*Not available*	*Not available*	*Not available*	*Arkansas uses retroactive Medicaid eligibility to ensure that families meet the "three of six months" requirement for TMA. AR also allows self-declaration of income upon redetermination to ensure that families leaving cash assistance for work can more easily access continued Medicaid coverage or TMA.*

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
California	24 months	No	No	No	No	No	No	California provides the additional 12 months (for a total of 24 months) of TMA to persons 19 and older using state-only funds. There are no reporting requirements imposed by the state for the additional 12 months (children are covered by the state's Child Health Insurance Program).
Colorado	12 months	No	No	Child care	No	No	No	
Connecticut	24 months	Yes	No	Yes	No	No	No	Connecticut, through a Medicaid state plan amendment, extends TMA coverage to 24 months by disregarding all income for 12 months from the date a family would have become ineligible for Section 1931 Medicaid (provided the family has earnings at that time or becomes employed within six months of ineligibility). For families receiving benefits under Section 1931 that do not have earned income and become ineligible due to increased child support, all income is disregarded for 20 months. These disregards have the effect of "dropping" the three out of six months requirement for TMA. Connecticut allows self-declaration of earnings and child care costs unless there is reason to believe a report is inaccurate or incomplete.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Delaware	24 months	Yes	Yes	Child care	No	No	No	Until 10/01/02, Delaware had a waiver to provide an additional 12 months of TMA. Delaware has a state plan amendment in place to "drop" the three out of six months requirement by disregarding earned income in the 2nd and 3rd months of Section 1931 Medicaid coverage. Delaware has an 1115 waiver (which expires 12/03) in place to drop TMA reporting requirements (families are instead required to report changes within 10 days of occurrence).
District of Columbia	12 months	No	Yes	NA	Does not apply.	No	No	Since D.C. covers families up to 200% FPL under their SCHIP and Medicaid expansion programs, those who qualify for the second six months of TMA are certified for continuing benefits through those programs. Therefore, the column related to premium imposed does not apply to D.C. as the state does not enroll families in the second six months of TMA.
Florida	12 months	No	No	Yes	No	No	No	
Georgia	12 months	No	No	Yes	No	No	No	Until 7/02, Georgia had a state plan amendment in place to provide an additional 12 months of coverage with an income disregard under Section 1931 Medicaid.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Hawaii	12 months	No	No	No	No	No	No	Hawaii implemented its Section 1931 Medicaid category in November 2001. Prior to that date, only families leaving cash assistance qualified for TMA.
Idaho	12 months	No	Yes	Yes	No	No	Yes	Idaho requires families to report changes in their income and child care costs. However, if the state does not receive a response to a request for quarterly information and it has no other indication of a change, TMA is continued.
Illinois	12 months	Yes	No	Yes	No	No	No	Illinois provides eight months of TMA (as opposed to four months) to families who lose Section 1931 Medicaid eligibility due to increased child or spousal support with state-only funds. Illinois also uses state-only funds to provide TMA coverage to families who do not meet the three out six months requirement.
Indiana	12 months	No	No	No	No	No	No	
Iowa	12 months	No	No	No	No	No	No	
Kansas	12 months	No	Yes	NA	No	No	No	Kansas has a state plan amendment to disregard all income in excess of 185% FPL to allow families to receive 12 months of continuous TMA coverage with no reporting requirements.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Kentucky	12 months	Yes	No	No	No	No	No	Kentucky provides an earned income disregard for up to two months under Section 1931 Medicaid for families that do not meet the three out of six months requirement for TMA.
Louisiana	12 months	No	No	No	No	No	No	
Maine	12 months	Yes	No	No	Yes	No	Yes	Premium imposed after initial six months is 3% of net family monthly income.
Maryland	12 months	No	Yes	Yes	No	No	No	For Medicaid-only families, Maryland has a state plan amendment in place to drop the three out of six months requirement for TMA by disregarding earned income in the 2nd and 3rd months of Section 1931 coverage. There are no formal reporting requirements for TMA families. The local department of social services (whose workers have access to various databases to verify earnings) decides what is necessary to verify continuing eligibility.
Massachusetts	12 months	Yes	Yes	NA	No	No	No	The state implemented an 1115 waiver in 1997 (renewed for three additional years effective July 2002) to provide 12 months of continuous TMA coverage with no reporting requirements to families who lose Section 1931 Medicaid eligibility due to an increase in earned income. The waiver also allows Massachusetts to drop the three out of six months requirement for TMA.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Michigan	*12 months*	*Yes*	*Not available*	*No*	*Not available*	*Not available*	*Not available*	*State-funded transitional coverage is available for 12 months for Section 1931 families who find work quickly and do not meet the "three of six months" rule.*
Minnesota	12 months	No	No	Yes	No	No	No	
Mississippi	12 months	No	Yes	NA	No	No	Yes	Mississippi has a state plan amendment in place to provide 12 months of continuous TMA coverage with no reporting requirements. The state also disregards earnings in the month in which a family becomes ineligible for Section 1931 Medicaid to ensure a full 12 months of TMA (for families losing eligibility in their 3rd month of Section 1931 coverage, this disregard also helps to meet the three out of six months requirement for TMA). Although Medicaid wrap-around coverage is available in Mississippi, no TMA families were covered under the option at the time of the survey.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Missouri	24 months	No	No	Yes	No	No	Yes	Under an 1115 waiver (which expires 12/31/02), Missouri provides the additional 12 months of TMA to uninsured caretakers who meet eligibility requirements (net income less than 100% FPL and a child covered by Medicaid or SCHIP) when the initial 12 months of TMA is exhausted. They must report changes in income and employment as they occur, but quarterly reports are not required during the additional 12-month period. Prior to 7/02, the state provided 24 additional months of TMA to uninsured caretakers with gross incomes below 300% FPL. Although Missouri has not officially dropped the three out of six months requirement for TMA, caseworkers may issue retroactive Section 1931 coverage to families who would have been eligible had they applied.
Montana	12 months	No	No	No	No	No	No	Until July 2002, Montana had a federal waiver to drop the three out of six months requirement and allow 12 months of coverage for families receiving TMA due to increased child or spousal support.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Nebraska	24 months	No	No	Child care	Yes	No	No	Nebraska's 1115 waiver (which allowed the state to provide an additional 12 months of TMA) expired 7/1/02. The state did not apply for renewal and is considering other ways to continue the extended coverage. After the initial six months of TMA, families with income from 100% to 185% FPL must pay a monthly premium that ranges from $30 to $137 per month.
Nevada	12 months	No	No	Yes	No	No	Yes	
New Hampshire	12 months	No	No	No	No	No	No	
New Jersey	24 months	Yes	Yes	No	No	No	No	
New Mexico	12 months	Yes	Yes	NA	No	No	No	New Mexico has a state plan amendment in place to allow 12 months of continuous TMA coverage with no reporting requirements and to disregard all earned income in the 2nd and 3rd months of Section 1931 Medicaid coverage if a family exceeds the eligibility standard.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
New York	12 months	No	Yes	Child care	No	No	Yes	Two quarterly reports ("mailers") are sent, one in the 3rd month and one in the 6th month. If a family qualifies based on the first report, TMA is extended until the end of month 10 (if they report but do not qualify, TMA is extended to the end of month seven). If the family qualifies based on the second report, TMA is extended until the end of month 12. Proof of earnings in the previous four weeks is required with each report.
North Carolina	24 months	Yes	No	Yes	No	No	No	North Carolina has a state plan amendment in place to provide additional coverage by disregarding earned income for 12 months for families that would otherwise become ineligible for Section 1931 Medicaid due to earnings. This has the effect of dropping the three out of six months requirement for TMA for families receiving the disregard.
North Dakota	12 months	No	Yes	No	No	No	Yes	Reports are required only in months seven and 10, and this effectively extends the initial period of TMA through month seven.
Ohio	*12 months*	*No*	*Not available*	*No*	*Not available*	*Not available*	*Not available*	
Oklahoma	*12 months*	*No*	*Not available*	*Income*	*Not available*	*Not available*	*Not available*	
Oregon	12 months	Yes	Yes	NA	No	No	Yes	CMS is currently advising Oregon on how to modify its Medicaid state plan to reflect the state's TMA policies.

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Pennsylvania	12 months	No	No	No	No	No	Yes	
Rhode Island	18 months	Yes	Yes	No	No	No	No	Under Rhode Island's waiver, the additional six months of TMA (for a total of 18 months) is provided to former cash assistance families on TMA due to employment- related loss of Section 1931 Medicaid eligibility. Families report earnings and child care costs in months seven and 13.
South Carolina	12 months	Yes	Yes	No	No	No	No	For families losing Section 1931 Medicaid eligibility due to employment, coverage is extended by disregarding earned income for 12 months from the date a family would have become ineligible. This has the effect of dropping the three out of six months requirement for TMA for families receiving the disregard. The state currently requires families to report earnings and child care costs only in month four. If they meet eligibility requirements, they are granted the second six months of TMA. When the state's ongoing departmental and systems reorganization is complete, SC plans to send out reports in months seven and 10 as well.
South Dakota	12 months	No	No	No	No	No	No	

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Tennessee	18 months	Yes	Yes	NA	No	No	No	The extension of TMA to 18 months is part of a federal waiver which expires 8/2007. TMA coverage is extended to anyone who has at least one month of TANF eligibility and individuals who lose Medicaid eligibility under Section 1931.
Texas	12 months	Yes	No	Yes	No	No	Yes	Currently, only TANF families receive Section 1931 Medicaid and a four-month earned income disregard designed to meet the three out of six months requirement for TMA. Medicaid-only families receive coverage under the state's medically needy program and are eligible for up to 12 months of transitional coverage if they become ineligible due to earnings. These families will also receive the four-month disregard when the state computer system is updated to include them in the Section 1931 category (this change should be in place by November 2002, with state-wide implementation taking up to a year and a half).

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Utah	24 months	Yes	Yes	No	No	No	Yes	Utah has a state plan amendment in place to extend coverage by disregarding earned income for up to 12 months (two six-month periods, conditioned on total gross earned income remaining below 185% FPL) from the date a family would have become ineligible for Section 1931 Medicaid due to earnings. This has the effect of dropping the three out of six months requirement for TMA for families receiving the disregard. Reports are required in months seven and 10 of TMA. Although a month 4 report is sent out, TMA is not terminated if the family does not respond (this effectively extends the initial period of coverage through month seven).
Vermont	36 months	No	No	Yes	No	No	No	Vermont provides an additional 24 months (for a total of 36 months). This was originally provided under a federal waiver (expired 7/1/01), but continued under their state plan by making changes to eligibility under Section 1931. TMA coverage is extended to pregnant women, children under 18 and their caretaker relatives, so long as these groups meet the income requirements.
Virginia	12 months	No	No	No	No	No	Yes	

State	Length of TMA coverage	Modifies the three out of six months require-ment	Changed reporting require-ments	Allows self-declaration of earnings and/or child care costs	Premium imposed in the second six-month period	Limits benefits provided in the second six month period	Provides Medicaid "wrap-around" coverage	State-specific notes
Washington	12 months	Yes	Yes	Yes	Yes	No	Yes	Washington has a state plan amendment in place to drop the month 10 reporting requirement and to disregard an income increase in the 2nd and 3rd months of Section 1931 Medicaid coverage to help families meet the three out of six months requirement for TMA. After the initial six months of TMA, families whose three-month average earnings (less child care) exceed 100% FPL must pay a monthly premium equal to 1% of that amount. Premiums for month seven of TMA are due by the end of month five.
West Virginia	*12 months*	*No*	*Not available*	*No*	*Not available*	*Not available*	*Not available*	
Wisconsin	12 months	No	Yes	No	No	No	No	
Wyoming	12 months	No	No	Yes	No	No	No	

Source: July 2002 CRS survey of state TMA policies and Kaiser Commission on Medicaid and the Uninsured, *Can Medicaid Work for Low-Income Working Families*? (Apr. 2002).

Note: NA for self-declaration of earnings and child care costs indicates that this column is not applicable because the state does not require families to report earnings and child care costs (that is, the state has changed its reporting requirements). States in italics (Arkansas, Michigan, Ohio, Oklahoma, and West Virginia) did not respond to the CRS survey. Information for these states was taken from the Kaiser report, reflecting policies in place as of June 2001. Policies in the remaining states are those as of July 1, 2002.