Chapter 10: A Description of Medicaid Eligibility

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Background

Legislation

Title XIX of the Social Security Act is an entitlement program that provides medical care for certain low-income individuals and families. The program, known as Medicaid, became law in 1965 as a jointly funded[1] cooperative venture between the Federal and State governments. The purpose of the program is to provide medical care for specific groups of low-income individuals: those who are aged, blind, or disabled; members of families with children; and pregnant women. Medicaid is the largest program providing medical and other health-related services to America's poorest people. In fiscal year 1991, Medicaid accounted for $90.5 billion[2] in Federal and State payments for medical services rendered to over 28.0 million[3] users. However, Medicaid was not designed to provide health insurance to all poor Americans. Originally, individuals became eligible for Medicaid because of their "categorical" relationship to two Federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s have resulted in dramatic changes in Medicaid eligibility provisions. Now, individuals in additional selected low-income groups are eligible for Medicaid solely on the relationship of their incomes to the Federal poverty level (FPL). (FPL is calculated by the U.S. Bureau of the Census, Department of Commerce. It is comprised of a matrix of threshold incomes on the basis of family size by number of related children under 18 years of age. It is annually adjusted by a factor of the Consumer Price Index.) Because of the variation in AFDC eligibility requirements from State to State, plus the recent Medicaid eligibility expansions, Medicaid eligibility has become a more complex and confusing topic for many. Although this chapter cannot remove the complexities of Medicaid eligibility policy, we hope to provide a better understanding of the basic eligibility provisions.

National estimates of Medicaid enrollment

United States

Figure 10.1 presents the percents of the U.S. population, within selected age groups, that were covered by Medicaid and the percent of the population without health insurance in 1990 based on the U.S. Census Bureau's *Current Population Survey*. It shows that Medicaid predominantly covers the very young and the very old. The highest proportion of Medicaid coverage is for the age group 0-5 years, with more than 20 percent of this group enrolled in Medicaid for some part of 1990. The youngest children are more likely to be covered by Medicaid than to be uninsured for health care, and those 6-19 years are almost equally likely to be uninsured as to be covered by Medicaid.

The aged are three times more likely to be covered by Medicaid than to be uninsured, due to the fact that almost all elderly persons are enrolled in the Medicare program. However, the working age population is three times more likely to be uninsured than to be covered by Medicaid.

Figure 10.2 presents the percent of the U.S. population enrolled in Medicaid by age group and income level. For persons with family incomes below FPL, 63 percent of children 0-5 years were covered by Medicaid in 1990.

Young children (up to age 6)

The high enrollment rate for these very young children is due to congressional efforts to expand Medicaid coverage of poor women and children, without enrolling them in cash assistance programs. There are several Medicaid eligibility groups through which children under 6 years of age can obtain Medicaid eligibility. The primary eligibility groups for children of these ages are:

- Children in AFDC families (either cash recipients or medically needy individuals).
- Children under 6 years of age in families with incomes up to 133 percent of the FPL.
- Children under 1 year of age in families with incomes up to 185 percent of the FPL, subject to State options.
- Children who meet SSI criteria for blindness or disability.
- Children, through the optional "Ribicoff" provisions adopted by 34 States, who are in families that meet AFDC income and resource standards but who do not qualify as dependent children, usually children in two-parent families where the primary breadwinner is employed.

Older children (ages 6-18)

The second largest Medicaid enrolled age group is 6-18 years, comprising 13 percent of all U.S. children in this group. It is more difficult for older children to qualify for Medicaid eligibility, because the options are more limited for them than for younger children. The primary ways to obtain Medicaid eligibility for this age group are:

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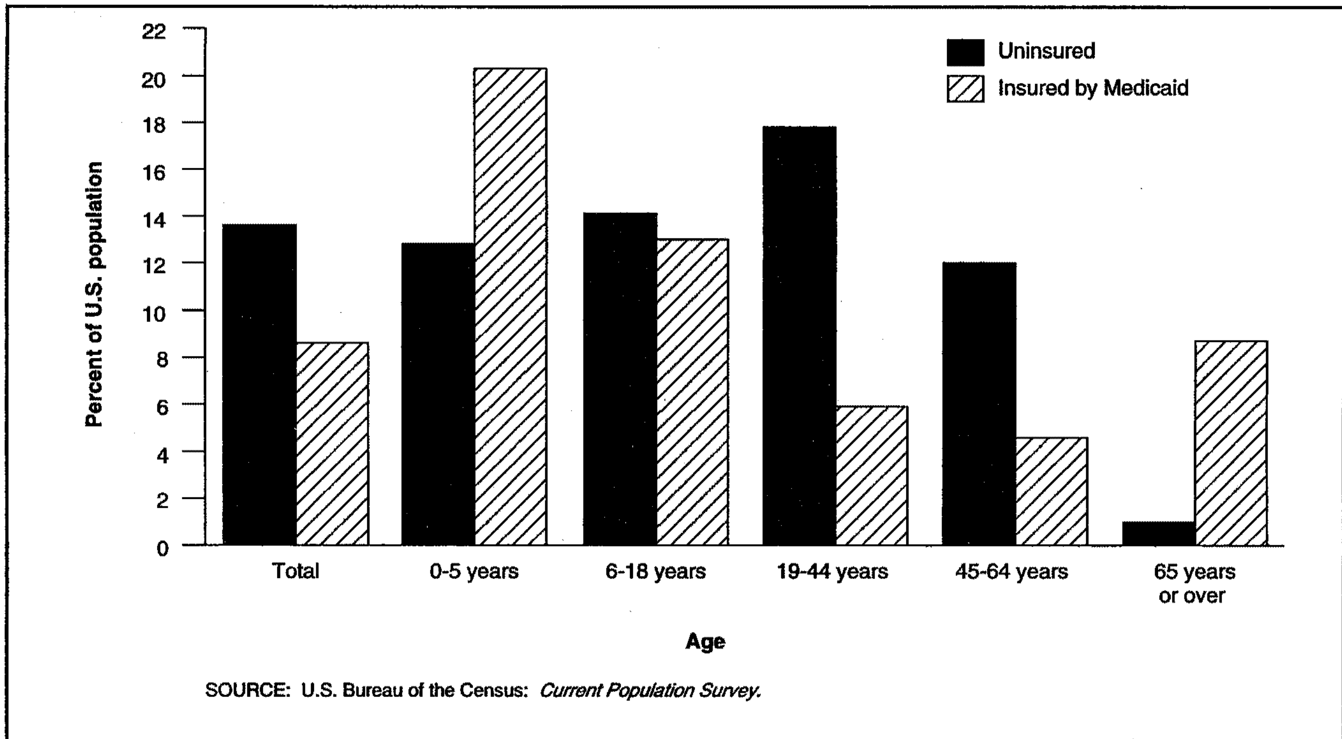
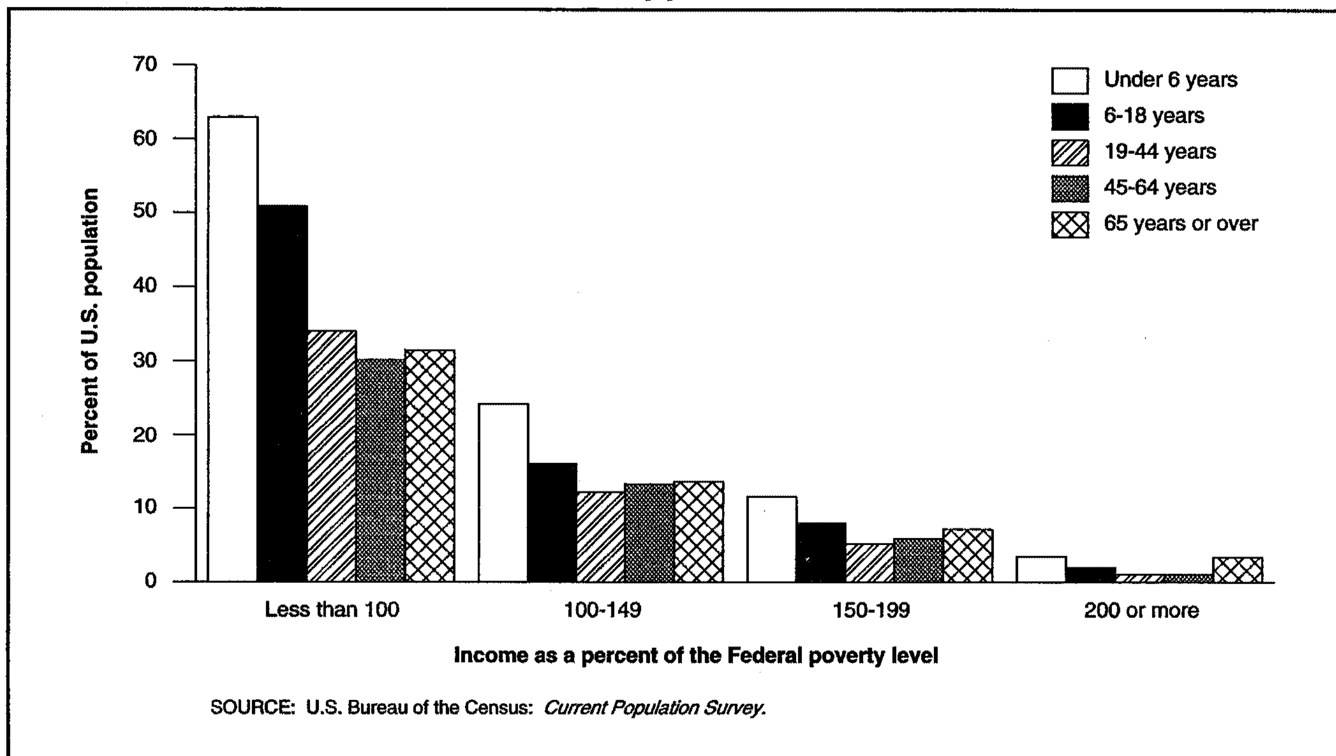
[1]Federal contributions to Medicaid vary with the States' per capita income. The proportion of the Federal contribution may range from 50 percent to 83 percent of vendor payments for covered services. Administrative costs are financed at other rates.
[2]As reported on HCFA Form-64, "Quarterly Medicaid Statement of Expenditure for the Medical Assistance Program."
[3]As reported on HCFA Form-2082, "Statistical Report on Medicaid: Eligibles, Recipients, Payments and Services."

Figure 10.1
Percent of U.S. population insured by Medicaid and percent uninsured, by age groups: Survey year 1990



SOURCE: U.S. Bureau of the Census: *Current Population Survey.*

Figure 10.2
Percent of U.S. population in selected family income and age groups insured by Medicaid: Survey year 1990



SOURCE: U.S. Bureau of the Census: *Current Population Survey.*

- Children in AFDC families (either cash recipients or medically needy individuals).
- "Qualified children" under 19 years of age who were born after September 30, 1983, in families whose incomes do not exceed FPL. (This provision is being phased in. Currently children up to age 10 can be enrolled.)
- Children who meet SSI criteria for blindness and disability.
- Children under 21 years of age (20 States) or, at State option, under age 20 (1 State), under age 19 (4 States), or under age 18 (10 States)—the so-called "Ribicoff children" who are in families that meet AFDC income and resource standards but who do not qualify as dependent children, usually children in two-parent families where the primary breadwinner is employed.

In the 16 States that have not opted to provide "Ribicoff" eligibility, Medicaid eligibility for children 10 years of age or over who are not eligible for AFDC or SSI is limited to selected groups of children, such as those in foster homes, subsidized adoptions, intermediate care facilities, nursing facilities, or psychiatric institutions, and not all States cover all of these groups.

Aged (65 years or over)

The third most likely age group to be covered by Medicaid is the aged. Medicare covers more than 95 percent of the aged population for most health care services, with the exception of outpatient prescription drugs and long-term nursing home care. Less than 9 percent of the U.S. population 65 years of age or over has health care financed by Medicaid. The two principal ways that aged individuals become eligible for Medicaid are:

- Aged persons who qualify for SSI, either cash recipients or medically needy individuals.
- Under the Qualified Medicare Beneficiary (QMB) provisions of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (Public Law 100-360), poor Medicare beneficiaries might elect to have Medicaid pay their Medicare premiums, copayments, and deductibles. States have the option to enroll QMBs in Medicaid.

Working age persons (ages 19-64)

Those persons least likely to be covered by Medicaid are working age persons 19-64 years of age. Figure 10.1 shows that about 5 percent of this group is covered by Medicaid, predominantly through AFDC, SSI, and pregnant women eligibility groups. Only 5.9 percent of persons in the age cohort 19-44 years and 4.6 percent of those in the age cohort 45-64 years were eligible for Medicaid in 1990.

There is a difference in Medicaid enrollment by sex, with 8.4 percent of U.S. females and 3.2 percent of U.S. males enrolled in Medicaid, as shown in Figure 10.3. Figure 10.3 presents the Medicaid and uninsured status of those in the age group 19-44 years age group, by sex and income level, demonstrating the low proportion of poor working age males (19-44) covered by Medicaid and the high rates of no health insurance among males in that age group. For persons living in families with incomes below 100 percent of FPL, 43.7 percent of females are enrolled in Medicaid, whereas 18.0 percent of the males are enrolled. The female enrollment in Medicaid drops sharply as income increases. Less than 15 percent of females aged 19-44 years living in families with incomes between 100 and 149 percent of FPL were enrolled in Medicaid in 1990, and less than 10 percent of males in that age group were enrolled. More than one-half of males aged 19-44 who live in families with incomes below FPL are uninsured.

Individuals in these age groups who can qualify for Medicaid are:

- Adults in AFDC families (either cash recipients or medically needy individuals).
- Adults who meet SSI criteria for blindness or disability (either cash recipients or medically needy individuals).
- "Qualified pregnant women" in families with incomes up to 133 percent of FPL.
- "Qualified pregnant women" in families with incomes up to 185 percent of FPL, subject to State options.

Mandatory and optional Medicaid eligibility provisions are discussed in detail in the following sections.

Eligibility provisions

Overview

Except for Arizona, all the States and Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands each operate Medicaid programs according to State or territorial rules and criteria that vary widely within the broad framework of Federal guidelines. Arizona operates its Medicaid program under a waiver of some basic Medicaid requirements.

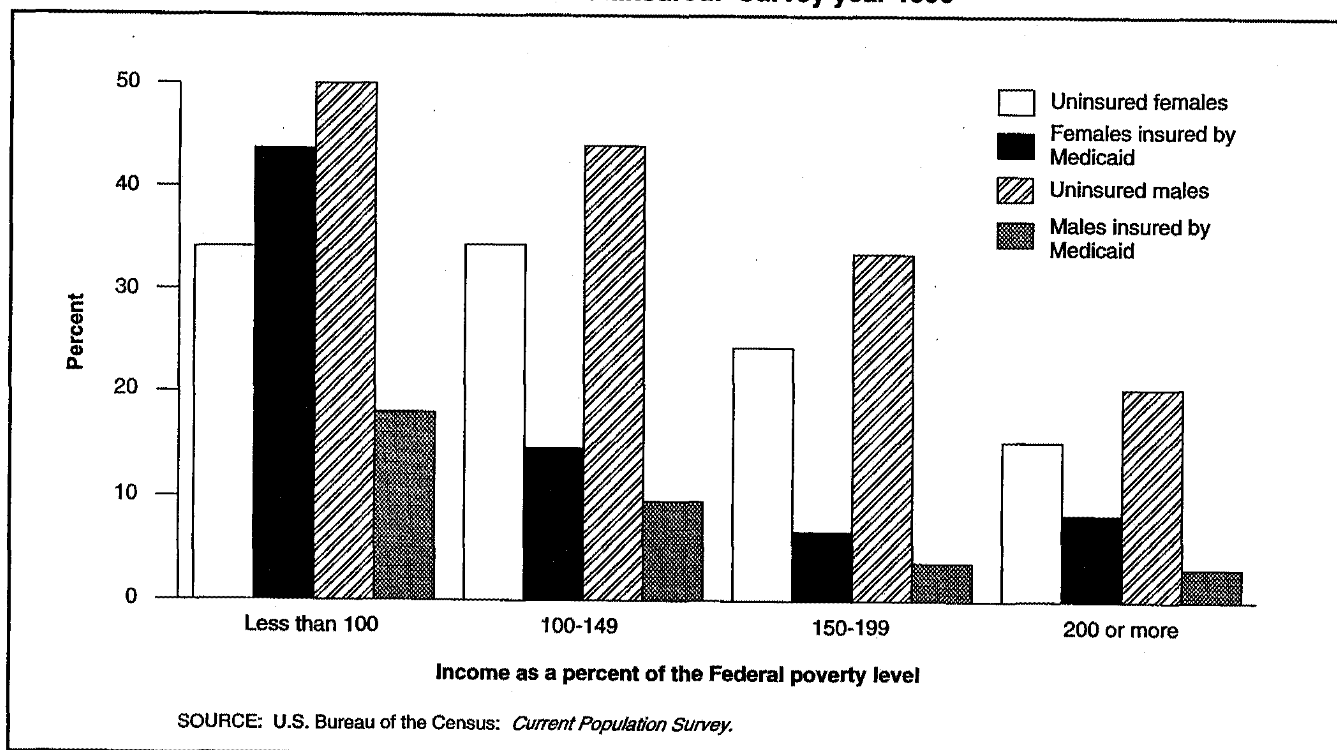
To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive federally assisted income-maintenance payments, as well as certain groups not receiving cash payments. The specific mandatory Medicaid eligibility groups are:

- Families receiving or linked in specific ways to assistance through the AFDC program.
- Aged, blind, and disabled individuals who receive SSI or who meet more restrictive State eligibility requirements.
- Infants, children under 6 years of age, and pregnant or postpartum women whose family incomes are at or below 133 percent of the FPL[4] or such higher level as the State had in effect when 133 percent was mandated. States are also required to extend

[4]FPL for a family of three in 1992 for the District of Columbia and all States, except Alaska and Hawaii, was $11,570 per year. In Alaska and Hawaii, it was $14,460 and $13,310, respectively.

Figure 10.3

Percent of males and females age 19-44 years in selected family income groups covered by Medicaid and uninsured: Survey year 1990



SOURCE: U.S. Bureau of the Census: *Current Population Survey.*

Medicaid eligibility until age 19 to all children born after September 30, 1983, in families at or below FPL.

- Medicare-eligible individuals whose incomes do not exceed a specified percent of FPL and whose resources are below twice the standard allowed under the SSI program.
- Special protected groups (these are usually individuals who lose cash assistance because of the cash program's rules but who may keep Medicaid for a period of time).

States also have the option to cover additional groups related to the mandatory coverage groups. The broadest optional groups that States may cover (and for which they will receive Federal matching funds) under the Medicaid program include:

- Infants up to 1 year of age and pregnant women not covered under the mandatory rules whose family incomes are more than 133 percent but not more than 185 percent of FPL (the percent to be set by each State).
- Certain aged or disabled adults who have incomes above those requiring mandatory coverage but below FPL.
- Children under 21, 20, 19, or 18 years of age, or reasonable groups of these children, who meet income and resources requirements for AFDC, but who are not otherwise eligible for AFDC or children under 19 years of age but born after a State-chosen date prior to September 30, 1983, who meet the income and resource requirements of AFDC.
- Institutionalized individuals with incomes and resources below specified limits.
- Caretaker relatives whose incomes and resources meet AFDC income and resource requirements.
- Persons receiving care under home and community-based waivers.
- Recipients of State supplementary payments.
- Pregnant women during a period of presumptive eligibility.
- Medically needy persons.

The option to have a medically needy program permits States to extend Medicaid eligibility to additional persons who would qualify under one of the mandatory or optional groups if they had less income or resources. The medically needy are individuals whose incomes or resources are above levels generally required for eligibility. For those with excess income and who have incurred large medical expenses, this option allows them to "spend down" to the State Medicaid eligibility level by incurring medical and/or remedial care expenses to offset their excess income. If a State elects to have a medically needy program, it must provide coverage to certain children under 18 years of age and pregnant women.

MCCA required States to pay Medicare cost sharing for QMBs as of January 1, 1989. QMBs are elderly and disabled persons who are entitled to Medicare and whose incomes are at or below specified percents of FPL (100 percent of FPL in 1992). Medicaid cost sharing consists of premiums, deductibles, and coinsurance for Part B (supplementary medical

insurance) and, in some cases, Part A (hospital insurance) premiums, deductibles, and coinsurance. This provision was retained despite subsequent repeal of major portions of the legislation. All of the 50 State Medicaid programs have full or partial administrative "buy-in" agreements under which State Medicaid programs automatically enroll dually entitled persons and pay their Medicare premiums. For this dually enrolled population, Medicare pays the bills for services covered by the program, less the applicable deductibles and coinsurance which are paid by Medicaid.

Federal Medicaid law requires States to provide medical services for certain groups of individuals. In general, States must extend coverage to individuals who receive public assistance under the Social Security Act because they are poor and are either aged, blind, disabled, or specified members of families with children. In addition, States must extend coverage to other federally prescribed groups of low-income individuals, e.g., pregnant women, children, and those who could generally qualify for such public assistance, except for their slightly greater income and/or resources. Other such groups may be covered at the option of the State.

In addition, States may also provide coverage, at their option, to individuals known as the medically needy. These are individuals who would qualify under one of the mandatory groups if they had less income or resources. The medically needy are individuals whose incomes or resources are above levels generally required for eligibility. The medically needy program allows them to spend down to the State Medicaid eligibility level by incurring medical and/or remedial care expenses to offset their excess income. If a State elects to have a medically needy program, it must provide coverage to certain children under 18 years of age and pregnant women.

Federal matching payments are available to States for these mandatory and optional coverage groups. Finally, States can offer Medicaid eligibility to additional groups that are not included in the mandatory or optional groups, but they do not receive Federal matching payments for services rendered to those individuals. Such groups are referred to as "State-only coverage groups."

Medicaid eligibility: Mandatory coverage groups

As required by the Social Security Act (1902(a)(10)(A); Title 42 Code of Federal Regulations [hereafter abbreviated 42 CFR] 435.1-435.170 and 436.1-436.128), State Medicaid programs must cover the following groups of individuals:

- Families with children receiving AFDC assistance or meeting specific requirements under the AFDC program.
- Children (including infants), pregnant, and/or postpartum women whose incomes do not exceed standards related to FPL guidelines.
- Aged, blind, or disabled individuals receiving assistance under the Federal SSI program or whose eligibility is determined under State standards that are more restrictive than the standards for SSI.
- Medicare-eligible individuals whose incomes do not exceed standards related to FPL guidelines: Coverage is generally limited to payment of Medicare premiums, deductibles, and coinsurance.

AFDC and related groups

States must provide Medicaid to all families receiving cash payments through AFDC (42 CFR 435.1, 435.4, 435.110, 435.401, 436.110, and 436.401). When determining the Medicaid eligibility of families and children, the program cannot use eligibility requirements that are more restrictive than the requirements in the State's AFDC plan. Figure 10.4 represents the income limits for AFDC eligibility under the mandatory and optional provisions.

The groups able to receive AFDC cash payments and Medicaid include:

- Children who are deprived of the support of one or both parents up to age 18, and those up to age 19 who are full-time students and are expected to complete such schooling by age 19. Except for these 18-year-old students or trainees, AFDC children cannot be more than 17 years of age (42 CFR 435.1, 435.4, 435.110, 435.401, 436.110, 436.401, and 45 CFR 233.10(b)(2)).
- Families in which the principal wage earner is unemployed. Some States are required to make payments for only 6 months. This group is mandated until September 30, 1998, at which time the group becomes optional (Social Security Act 407(b), 1902(a)(10)(A)(i) and 1905(m)(1); Public Law 100-485, section 401(d), 45 CFR 233.100).
- Pregnant women with no other eligible children.

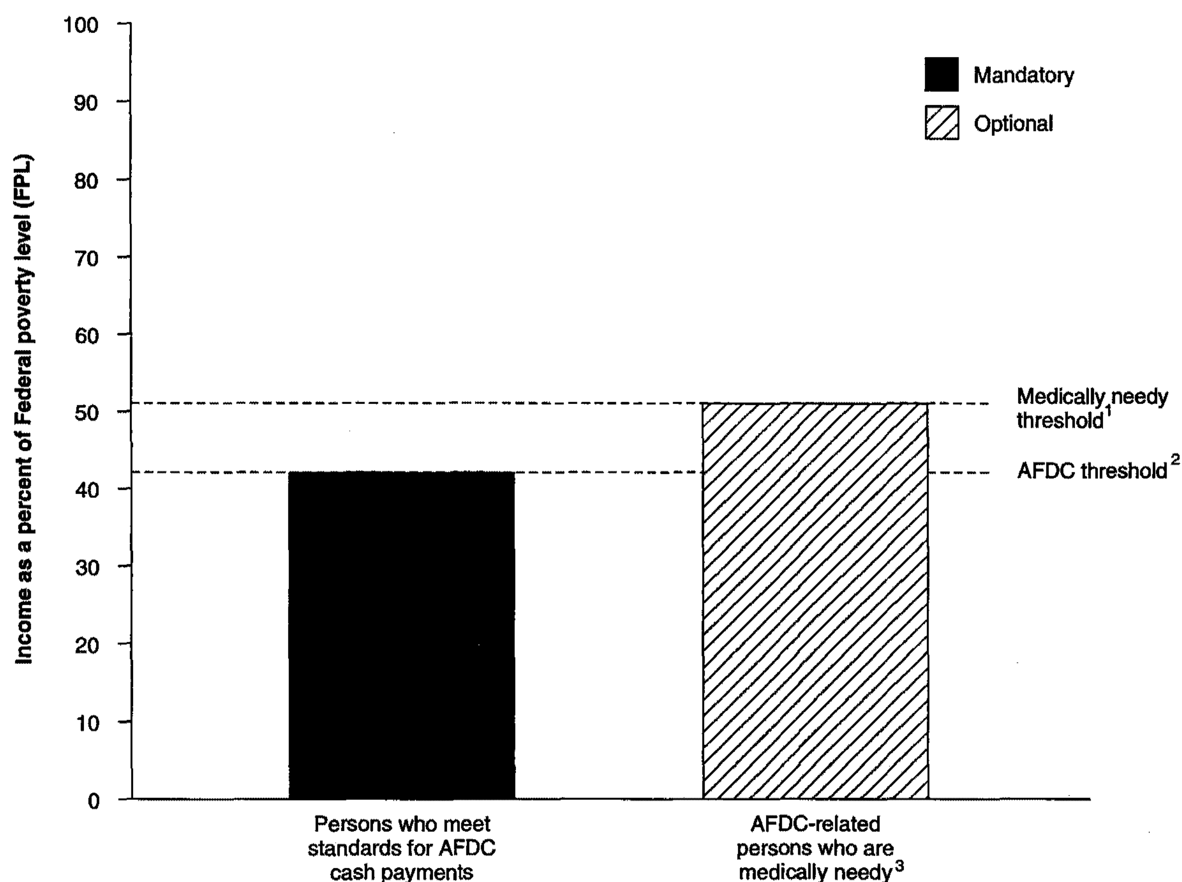
In order to be considered eligible for AFDC payments, and therefore also eligible for Medicaid, a family must pass specific tests regarding its income and assets. Each State establishes a "need standard" for determining AFDC eligibility. The need standard is the amount of income that the State decides is necessary for a family of a given size to purchase basic necessities such as food, clothing, shelter, household supplies, and personal care items.

The States also establish payment standards, which are generally the amount that would actually be paid to a family with no countable income. States often pay considerably less than the amount in the need standard and employ differing methods of limiting payments. Table 10.5 presents the AFDC need and payment standards by jurisdiction for families of one, two, three or four persons as of January 1992. As can be seen from this table, there is wide variation in the eligibility standards established by the States for AFDC payments and, therefore, for the related mandatory Medicaid coverage. For example, maximum payment standards for a family of four range from $144 per month in Mississippi to $1,025 in Alaska. State AFDC income levels are not increased automatically each year.

Besides providing Medicaid eligibility to recipients of cash assistance through AFDC, States must also extend

Figure 10.4

Aid to Families with Dependent Children (AFDC) related mandatory and optional Medicaid eligibility for adults and children as of September 30, 1992



[1]The medically needy threshold (income level) can be no higher than 133 1/3 percent of the State's comparable AFDC threshold (payment standard). The median medically needy threshold was 51 percent of FPL in 1992. States must allow individuals with incomes above this level to "spend down" to the medically needy threshold by incurring medical expenses.

[2]The AFDC threshold (payment standard) is set individually by each State. Although the AFDC threshold is not based on a percent of the FPL, it ranged from a high of 76.6 percent to a low of 15.5 percent of the FPL for a family of three in 1992. The median AFDC threshold among all States was 42 percent of the FPL in 1992.

[3]The medically needy are persons who would otherwise be eligible under AFDC provisions except that they have income and/or resources that are too high. In determining eligibility, resource (asset) limits apply.

SOURCE: Health Care Financing Administration: Data from the Office of Research and Demonstrations.

Medicaid coverage to additional persons. As of October 1, 1990[5], Medicaid eligibility is also mandatory for the following AFDC-related groups of persons:

- Individuals deemed to be receiving AFDC. This group includes individuals who are denied AFDC payments solely because the payments would be less than $10 (42 CFR 435.1, 435.115, and 436.114); individuals who would be receiving AFDC payments if they were not participating in a work supplementation program [42 CFR 435.1, 435.115, and 436.114); individuals who are denied AFDC payments solely because the State is recovering an overpayment (Social Security Act 402(a)(22)(A); Public Law 97-35 section 2318, 42 CFR 435.115 and 436.114); and families losing AFDC as a result of receiving child or spousal support (Medicaid is limited to 4 months after such loss). (Social Security Act 406(h) and 1902(a)(10)).
- Children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Social Security Act (473(b), 473(b)(1) and/or (2), 1902(a)(10)(A), 1902(b); 42 CFR 435.115).
- Individuals terminated from AFDC because of increased earnings or hours of employment. The State must continue to provide Medicaid coverage to such families for 6 to 12 months beyond the date of AFDC termination. For the final 6 months, the State may require families to pay premiums for continued

[5]Some of these provisions predate October 1, 1990.

Table 10.5

Aid to Families with Dependent Children monthly need and payment amounts, by State: January 1, 1992

State	Family of 1		Family of 2		Family of 3		Family of 4	
	Need standard	Maximum payment	Need standard	Maximum payment	Need standard	Maximum payment	Need standard	Maximum payment
Alabama	$441	$100	$537	$123	$637	$149	$747	$168
Alaska	515	515	821	821	923	923	1,025	1,025
Arizona	551	198	740	266	928	334	1,116	401
Arkansas	280	81	560	162	705	204	850	247
California	341	326	560	535	694	663	824	788
Colorado	253	214	331	280	421	356	510	432
Connecticut	356	356	473	473	581	581	683	683
Delaware	201	201	270	270	338	338	407	407
District of Columbia	450	258	560	321	712	409	870	499
Florida	552	180	740	241	928	303	1,117	364
Georgia	235	155	356	235	424	280	500	330
Hawaii	634	396	850	531	1,067	666	1,284	802
Idaho	365	208	446	254	554	315	627	357
Illinois	487	212	616	268	844	367	952	414
Indiana	155	139	255	229	320	288	385	346
Iowa	365	183	719	361	849	426	986	495
Kansas	239	239	321	321	396	396	462	462
Kentucky	394	162	460	196	526	228	592	285
Louisiana	245	72	472	138	658	190	809	234
Maine	271	214	427	337	573	453	720	569
Maryland	243	167	407	294	548	377	660	455
Massachusetts	392	392	486	486	579	579	668	668
Michigan	368	305	482	401	587	489	712	593
Minnesota	250	250	437	437	532	532	621	621
Mississippi	218	60	293	96	368	120	443	144
Missouri	145	136	250	234	312	292	365	342
Montana	285	232	381	311	478	390	575	469
Nebraska	222	222	293	293	364	364	435	435
Nevada	410	230	515	289	620	348	725	407
New Hampshire	388	388	451	451	516	516	575	575
New Jersey	162	162	322	322	424	424	488	488
New Mexico	192	192	258	258	324	324	389	389
New York	352	352	468	468	577	577	687	687
North Carolina	362	181	472	236	544	272	594	297
North Dakota	217	217	326	326	401	401	491	491
Ohio	487	199	670	274	817	334	1,010	413
Oklahoma	291	211	364	264	471	341	583	423
Oregon	310	310	395	395	460	460	565	565
Pennsylvania	313	215	481	330	614	421	749	514
Rhode Island	327	327	449	449	554	554	632	632
South Carolina	261	124	350	167	440	210	529	252
South Dakota	284	284	357	357	404	404	450	450
Tennessee	218	95	327	142	426	185	519	226
Texas	235	75	493	158	574	184	691	221
Utah	311	233	431	323	537	402	627	470
Vermont	768	465	937	567	1,112	673	1,246	755
Virginia	174	157	257	231	322	291	386	347
Washington	628	339	794	428	983	531	1,157	624
West Virginia	289	145	401	201	497	249	623	312
Wisconsin	311	249	550	440	647	518	772	618
Wyoming	414	195	585	320	674	360	753	390

NOTES: In a number of States, need and payment amounts vary depending on factors such as region and season and what components are included in the standard (e.g., rental allowance). In all such cases, the region with the highest concentration of recipients and/or the highest seasonal rate is displayed.

SOURCE: National Governors' Association, 1992.

Medicaid coverage, offer reduced benefits, or select alternative coverage options. This provision continues through September 30, 1998 (Social Security Act 402(a)(37), 1902(a)(52), 1902(e), and 1925; Public Law 100-485, section 303; 42 CFR 435.112 and 436.116).

- Individuals denied AFDC because the incomes and resources of persons other than a parent or spouse are used to determine eligibility, even though not actually made available, e.g., income and resources of siblings, stepparents, and grandparents (42 CFR 435.113 and 436.111).
- Individuals in the 1972 "pass-through" group. These are individuals who were entitled to or received Old Age Survivors and Disability Insurance (OASDI) benefits in 1972 and who would be eligible for AFDC, except for increased income resulting from the 1972 increase in OASDI. Few individuals should still be eligible under this provision (Social Security Act 1902(a); Public Law 99-603, section 249E; 42 CFR 435.114 and 436.112).
- Family members not receiving AFDC cash benefits solely because the State has chosen to limit the number of months during which benefits are provided to intact families on the basis of unemployment. This provision ceases after September 30, 1998 (Social Security Act 407(b)(2)(B)(i), 1902(a)(10)(A)(i)(V) and 1905(m)).
- Pregnant women whose pregnancies have been medically verified, given that the female:
  (a) Would be eligible for an AFDC cash payment (or would be eligible if the State had an AFDC-unemployed parents program) if the child had been born and was living with her.
  (b) Is a member of a family that would be eligible for AFDC if the State had an AFDC-unemployed parents program.
  (c) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's AFDC plan.
- States have the option to cover additional groups in their AFDC programs. However, if a State chooses to offer AFDC cash assistance to additional low-income families, it must also offer Medicaid coverage.

Pregnant women and children

During the past decade, Congress has enacted, almost annually, expansions to the eligibility groups under which low-income children and pregnant women could be enrolled in Medicaid. Pregnant women and children may be eligible for Medicaid if they are:

- Women who were eligible for, applied for, and received Medicaid while pregnant. These women continue to be eligible for pregnancy-related and postpartum services for a 60- to 90-day period after the pregnancy ends (Social Security Act 1902(e)(5) and (6), 1902(l)(1)).
- Poverty level pregnant women and infants under 1 year of age in families with incomes not exceeding 133 percent of FPL or such higher percent, up to 185 percent, as the State had in effect when this requirement was enacted. Pregnant women covered under this provision are eligible for all covered pregnancy-related and postpartum services until approximately 2 months after the child's birth (Social Security Act 1902(a)(10)(A)(i)(IV), 1902(e)(7), and 1902(l)(1)(A) and (B)).
- Newborn infants of women who are eligible for and are receiving Medicaid on the date of the child's birth. The child is automatically deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible up to 1 year as long as the mother would be eligible if still pregnant and the child is a member of the woman's household (Social Security Act 1902(e)(4); 42 CFR 435.3, 435.117, 436.2, and 436.124).
- Qualified children under 19 years of age, who were born after September 30, 1983 (or at an earlier date designated by the State), if those children would qualify for AFDC on the basis of income and resource requirements of the State's AFDC plan but are otherwise ineligible for AFDC, typically because they live in families with two able-bodied parents (Social Security Act 1902(a)(10)(A)(i)(III), 1902(e)(7), and 1905(n)(2); 42 CFR 435.3 and 436.2).
- Poverty level children aged 1-5 years in families with incomes not exceeding 133 percent of FPL along with children 6-18 years, who were born after September 30, 1983, in families with incomes not exceeding 100 percent of FPL. Coverage of any of these children who are hospitalized at the time that they would lose eligibility because of age continues to the end of their hospitalization (Social Security Act 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX)(C)(ii)(I).

Figure 10.6 presents the Medicaid eligibility coverage of children by age and income as a percent of FPL. Figure 10.7 presents the income coverage of the poverty-related mandatory and optional Medicaid eligibility of pregnant women as of September 1992.

Low-income aged, blind, and disabled

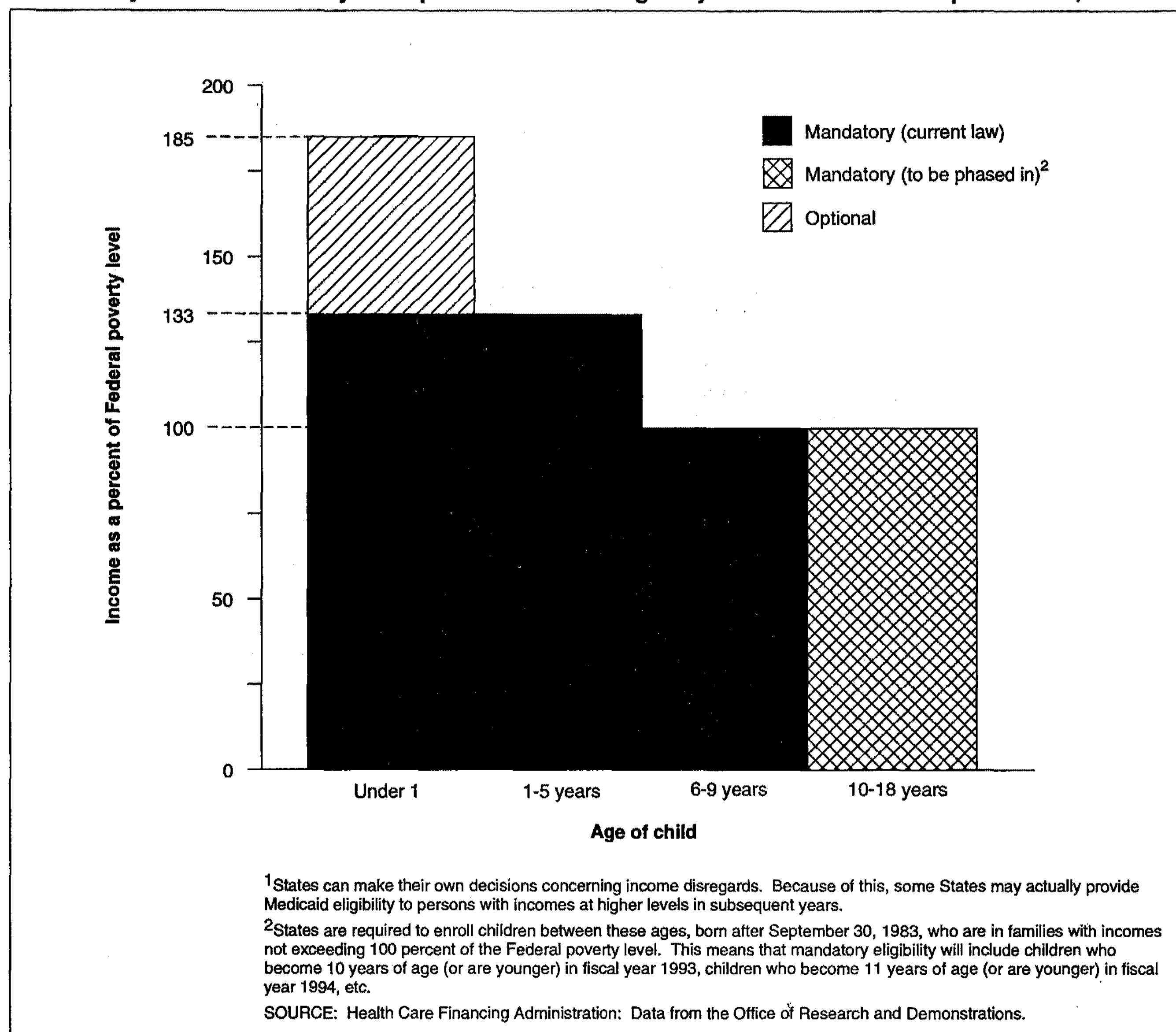
Prior to 1974, States were responsible for cash assistance to the low-income aged, blind, and disabled and thus had broad flexibility in setting eligibility requirements. However, in 1974, SSI was implemented and, for the most part, replaced the State programs. SSI was designed as a cash assistance program for low-income aged, blind, and disabled persons that has nationally uniform eligibility requirements. To be eligible for SSI[6], an aged, blind, or disabled individual must have countable income below benefit standards.[7] Applicants also must meet resource standards to be eligible for SSI and, thus, Medicaid. As of 1992,

[6]In 1992, the Federal SSI benefit standard was $422 per month for an individual and $633 per month for a couple.

[7]Countable income is defined to be gross income minus certain disregards, such as the first $20 of unearned income and a certain portion of earned income.

Figure 10.6

Poverty-related mandatory and optional Medicaid eligibility for children[1] as of September 30, 1992



[1]States can make their own decisions concerning income disregards. Because of this, some States may actually provide Medicaid eligibility to persons with incomes at higher levels in subsequent years.

[2]States are required to enroll children between these ages, born after September 30, 1983, who are in families with incomes not exceeding 100 percent of the Federal poverty level. This means that mandatory eligibility will include children who become 10 years of age (or are younger) in fiscal year 1993, children who become 11 years of age (or are younger) in fiscal year 1994, etc.

SOURCE: Health Care Financing Administration: Data from the Office of Research and Demonstrations.

countable resources[8] could not exceed $2,000 for an individual and $3,000 for a couple. Figure 10.8 presents the income levels for the mandatory and optional SSI eligibility groups.

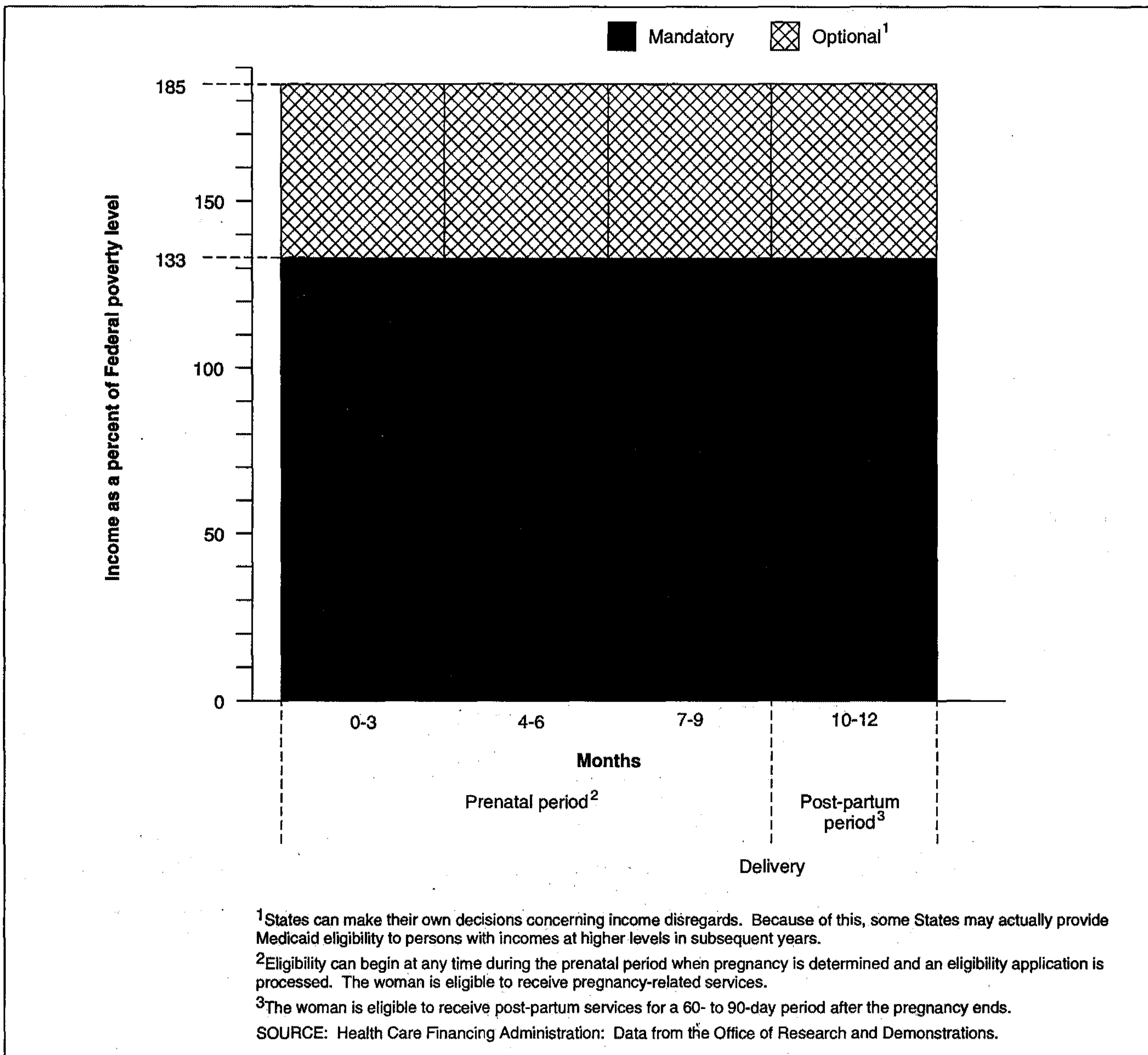
A State's Medicaid program must cover the aged, blind, and disabled who are either SSI recipients or individuals who meet eligibility criteria more restrictive than the requirements for SSI.[9] Because SSI requirements were more restrictive than those existing in some States and less restrictive than others, States were given two options in offering Medicaid eligibility to the aged, blind, and disabled receiving cash assistance. The first option, known as the "section 1634 option," allows a State to make all SSI recipients eligible for Medicaid. Under the second option, known as the "section 209(b) option," States can limit Medicaid eligibility to individuals who meet some or all of more restrictive requirements in the State aid program that preceded SSI. Table 10.9 shows, as of January 1992, that 39 States and the District of Columbia chose the first option—to offer Medicaid eligibility to all SSI recipients—and 12 States chose the second option—to use more restrictive criteria.

States choosing the section 1634 option must provide Medicaid coverage to all aged, blind, or disabled individuals or couples (eligible spouses) receiving cash assistance through SSI. This includes individuals receiving SSI pending final determination of blindness

[8]Examples of assets that are not considered countable resources for SSI eligibility include: the applicant's home, $2,000 equity value of household goods and personal effects, the equity of one automobile, and $1,500 for burial expenses.

[9]In the U.S. territories, Medicaid eligibility of the aged, blind, and disabled is determined according to standards related to each specific territory (42 CFR 435.1, 435.3, 435.4, 435.120, 435.121, 436.3, 436.110, and 436.401).

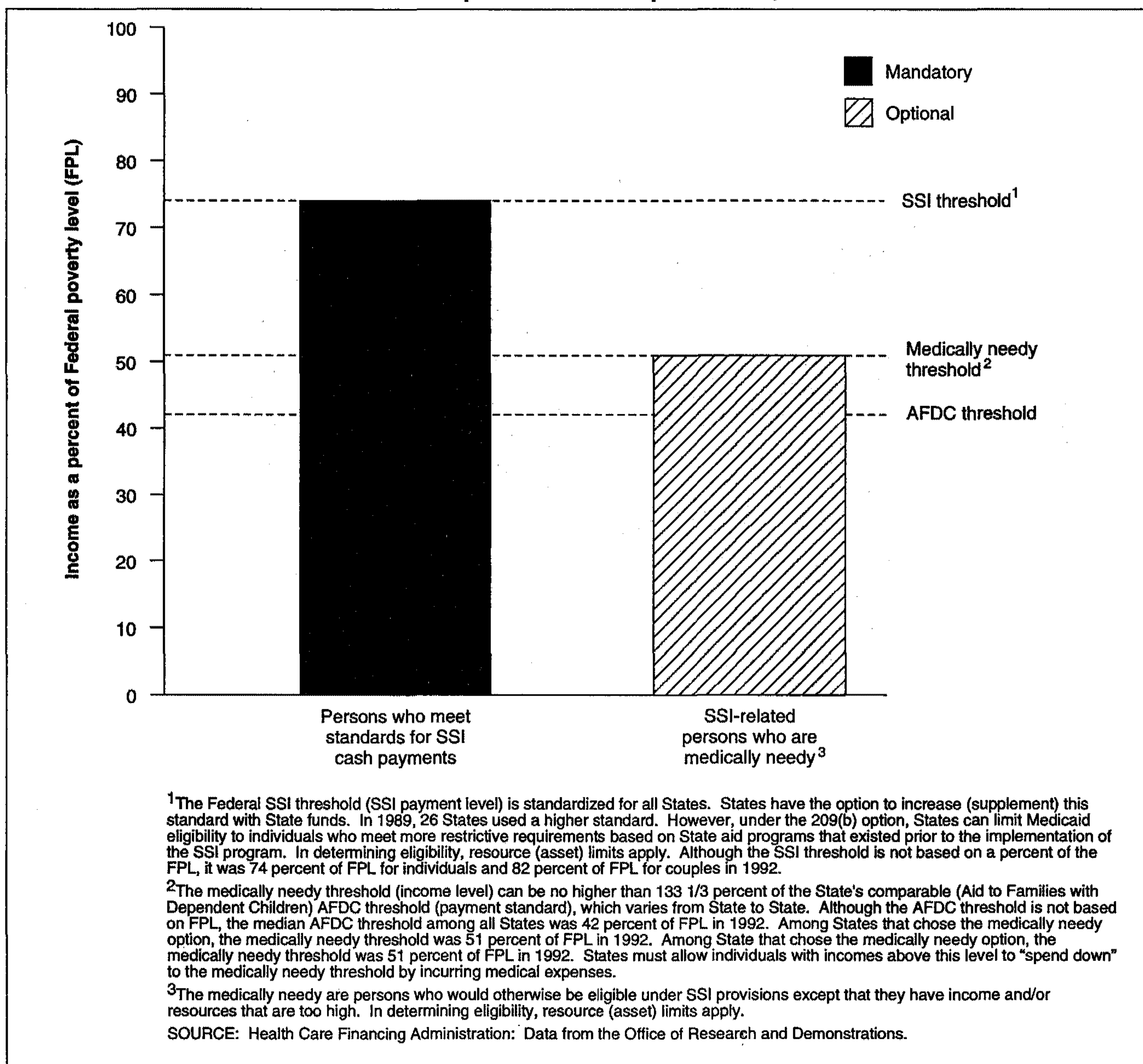
Figure 10.7
Poverty-related mandatory and optional Medicaid eligibility for pregnant women as of September 30, 1992



or disability or pending final disposal of excess property under an agreement with the Social Security Administration (Social Security Act 1902(a)(10)(A); CFR 42 435.120). It must also include the working blind or disabled who receive SSI (Social Security Act 1619(a) and 1902(a)(10)(A)(i)(II); Public Law 99-643 section 2). States electing the 1634 option can either arrange to have the Social Security Administration determine which people are eligible for Medicaid as a byproduct of the SSI eligibility determination process, referred to as "1634 agreements," and automatically issue Medicaid identification cards to them, or the State can require SSI recipients to file a separate Medicaid application with the State.

States choosing the 209(b) option can have more restrictive eligibility requirements for Medicaid than those in effect for SSI. These more restrictive requirements can apply to the definition of blindness (42 CFR 435.530) or disability (CFR 42 435.540), or income or resources (42 CFR 435.731). However, any such requirement may be no more restrictive than those in effect under the State's Medicaid plan on January 1, 1972, and no more liberal than those applied under SSI or under an optional State supplemental program that meets Federal requirements. In addition, States electing this option must deduct from the individual's income any SSI payment, optional State supplements, and medical expenses incurred by the individual or the individual's financially responsible relatives not subject to third-party payment. This is often referred to as the "209(b) spend down."

Figure 10.8
Supplemental Security Income (SSI) related mandatory and optional Medicaid eligibility for aged, blind, and disabled persons as of September 30, 1992



[1]The Federal SSI threshold (SSI payment level) is standardized for all States. States have the option to increase (supplement) this standard with State funds. In 1989, 26 States used a higher standard. However, under the 209(b) option, States can limit Medicaid eligibility to individuals who meet more restrictive requirements based on State aid programs that existed prior to the implementation of the SSI program. In determining eligibility, resource (asset) limits apply. Although the SSI threshold is not based on a percent of the FPL, it was 74 percent of FPL for individuals and 82 percent of FPL for couples in 1992.

[2]The medically needy threshold (income level) can be no higher than 133 1/3 percent of the State's comparable (Aid to Families with Dependent Children) AFDC threshold (payment standard), which varies from State to State. Although the AFDC threshold is not based on FPL, the median AFDC threshold among all States was 42 percent of FPL in 1992. Among States that chose the medically needy option, the medically needy threshold was 51 percent of FPL in 1992. Among State that chose the medically needy option, the medically needy threshold was 51 percent of FPL in 1992. States must allow individuals with incomes above this level to "spend down" to the medically needy threshold by incurring medical expenses.

[3]The medically needy are persons who would otherwise be eligible under SSI provisions except that they have income and/or resources that are too high. In determining eligibility, resource (asset) limits apply.

SOURCE: Health Care Financing Administration: Data from the Office of Research and Demonstrations.

All States are also required to offer Medicaid eligibility to the following aged, blind, and disabled groups:

- QMBs are individuals who qualify for Medicare Part A and whose incomes do not exceed 100 percent of FPL[10] and whose resources do not exceed twice the SSI resource-eligibility standard. State Medicaid programs must provide coverage to QMBs that is limited to the payment of their Medicare cost-sharing charges; i.e., Part B premiums (including Part A premiums for individuals who do not qualify for Part A coverage based on their work history) along with Part A and Part B deductibles and coinsurance.[11] States may pay Part B premiums under a buy-in agreement with U.S. Department of Health and Human Services that can be modified to include payment of Medicare Part A premiums on behalf of QMBs.

[10]The 1992 FPLs for persons 65 years of age or over are $6,810 for an individual living alone and $9,190 for a couple. In Alaska, the FPLs for individuals and couples are $8,500 and $11,840, respectively; in Hawaii, they are $7,830 and $10,570, respectively (Social Security Act 1902(a)(10)(E)(i), 1902(a)(10) after (E), 1905(p), 1843, 1818(g), and 1843(i); 42 CFR 400.200, 406.26, 407.40, 407.42, and 431.625).

[11]QMB coverage is optional in territorial Medicaid programs. However, if territories choose to cover QMBs, they may do so at an income-eligibility level at or below FPL.

Table 10.9

State selection of Supplemental Security Income (SSI) criteria versus option 209(b) for Medicaid eligibility determination, by State: May 1992

State	SSI criteria	Option 209(b)
Alabama	X	
Alaska	X	
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut		X
Delaware	X	
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii		X
Idaho	X	
Illinois		X
Indiana		X
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota		X
Mississippi	X	
Missouri		X
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire		X
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina		X
North Dakota		X
Ohio		X
Oklahoma		X
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia		X
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	

NOTES: Under option 209(b), States can limit Medicaid eligibility to individuals who meet more restrictive requirements than those for SSI. Thirty-nine States offer Medicaid eligibility to all SSI recipients, and 12 States chose option 209(b).

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations, Medicaid Program Studies Branch.

- Qualified disabled and working individuals (QDWIs) are disabled but employed individuals who are entitled to Medicare Part A benefits through enrollment under section 1818A of the Social Security Act whose income does not exceed 200 percent of FPL and whose assets do not exceed 200 percent of the maximum amount allowed for SSI recipients. Their only Medicaid benefit is payment of their Part A premiums paid for by Medicaid. States may require QDWIs to share in paying their Part A premiums on a sliding scale based on the amount of income they receive between 150 percent and 200 percent of FPL; this coverage is optional in the U.S. territories. (Social Security Act 1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), and 1905(s); 42 CFR 400.200).
- Specified low-income Medicare beneficiaries (SLMBs): Beginning January 1, 1993, State Medicaid programs must pay, and territorial programs may pay, Medicare Part B premiums for this group. This group is comprised of individuals who would be QMBs except for the fact that their family incomes exceed QMB levels. Their incomes must not exceed 110 percent of FPL in 1993 and 1994 or 120 percent of FPL in subsequent years. SLMBs are retroactively eligible for benefits for a time period of 3 months (Social Security Act 1902(a)(10)(E)(ii) and 1904(p)).
- Disabled individuals who would continue to be eligible for cash assistance except for earned income (Social Security Act, section 1619(b)). As previously noted, Medicaid eligibility is typically linked to receipt of cash assistance through the SSI program. Disabled individuals with high medical expenses often cannot afford to lose their medical coverage through Medicaid, and thus SSI income limits could act as a deterrent for employment for those who are disabled and who are able to work. This provision is designed to reduce this deterrence (Social Security Act 1902(a)(10)(A)(i)(II) and 1905(q); Public Law 99-509, section 9404).
- Aged, blind, and disabled individuals who are ineligible for cash assistance or optional State supplements because of requirements that are prohibited under Medicaid (42 CFR 435.122, 436.111).
- Aged and disabled individuals in 1972 and 1977 "pass-through" groups. The 1972 group is made up of individuals who became ineligible for cash assistance because of the 1972 increase in their OASDI benefit and who would continue to be eligible but for that increase (Social Security Act 1902(a) and 42 CFR 435.134). The 1977 group is made up of individuals who would be eligible for cash assistance except for the OASDI cost-of-living increase of 1977. This requirement is known as the "Pickle Amendment." This amendment does not apply in Puerto Rico, Guam, the Virgin Islands, and American Samoa, where the SSI program is not in effect (Social Security Act 1902(a); Public Law 99-272, section 503; Public Law 92-603,

section 249E; Public Law 94-566, section 503; 42 CFR 435.134, 435.135, and 435.136).

- Individuals receiving mandatory State supplements. A mandatory State supplement is a cash payment that a State is required to make under Section 212 of Public Law 93-66 to an aged, blind, or disabled individual (Social Security Act 1618, 1905(j); Public Law 93-233, section 13(c); 20 CFR 416.2001, 42 CFR 435.1, 435.4, 435.130, 435.1010).
- Individuals who are at least 18 years of age if they lost SSI eligibility and SSI-linked Medicaid eligibility by becoming eligible for OASDI child's benefits or increases to those benefits because of blindness or a disability that began before they reached 22 years of age. Medicaid coverage would continue as long as the individual is eligible for SSI if it were not for their OASDI eligibility (Social Security Act 1634(c)).
- Disabled widows and widowers who lost cash assistance because of 1983 changes in the calculation of their Social Security OASDI benefits (Social Security Act 1634(b); Public Law 99-272, section 12202).
- Under the 1973 Medicaid provisions, Medicaid coverage was extended to individuals in groups that include: essential spouses, certain individuals who were institutionalized, and individuals who were eligible as disabled under the State plan in 1973 but did not meet SSI disability requirements (Social Security Act 1905(a) and 1611(e)(5); Public Law 93-66, section 230 and 232; 42 CFR 435.131, 435.132, 435.133).
- Disabled widows, widowers, and unmarried divorced spouses who meet specific conditions (Social Security Act 1634(d)).

Medicaid eligibility: Optional coverage groups

As explained earlier, Medicaid must cover certain groups of individuals. In addition to the groups that must be covered, other individuals may be covered if the State wishes. These other individuals are generally referred to as the "optional groups."

The medically needy are one of the most significant of the optional groups, consisting of those who would be otherwise covered except for their slightly higher income and/or resources. Income may not be the only factor, i.e., pregnancy and dependency are also factors used in State decisions to cover optional groups. Federal funds are available to cover mandatory and optional eligibility groups. Funds are available for optional eligibility groups, regardless of whether they receive cash payments or are medically needy (Social Security Act 1902(a)(10)(A), 1905(a); 42 CFR 435.200 et seq., 436.200 et seq., 435.300 et seq., and 436.300). Unless regulations stipulate otherwise, a Medicaid agency that chooses to cover an optional group must provide Medicaid to all eligible individuals in that group (42 CFR 435.201 and 436.201).

States have the option to offer Medicaid eligibility to the following low-income families with children as well as to low-income aged, blind, and disabled individuals or groups of such individuals. Tables 10.10, 10.11, and 10.12 present the States choosing some of these options. These options are subject to change; and, therefore, State Medicaid plans should be consulted to determine which options are currently being provided.

AFDC related

- Individuals under 21 years of age (or at State option under age 20, 19, or 18)—the so-called Ribicoff children—who are in families that meet AFDC income and resource standards but who do not qualify as dependent children. Usually this refers to children in two-parent families where the primary breadwinner is employed. States may offer coverage to all such individuals or limit it to reasonable classifications (reasonable classifications include children in foster homes, subsidized adoptions, intermediate care facilities, nursing facilities, or psychiatric institutions) (Social Security Act 1902(a)(10)(A)(ii) and 1905(a)(i); 42 CFR 435.220 and 436.220).
- Individuals who are caretaker relatives of dependent children who live in families with incomes and resources that meet the AFDC eligibility limit but do not apply for AFDC (Social Security Act 1902(a)(10)(A)(ii) and 1905(a); 42 CFR 436.210, 435.510, and 436.510).
- Individuals who would be eligible for AFDC or SSI if they were not in an institution (42 CFR 435.211 and 436.211).
- Individuals who would be eligible for AFDC if child care costs were paid from earnings. In some States child care costs are paid by a State agency rather than by the applicant and are not deducted when calculating countable income for AFDC eligibility. This provision allows the State to offer Medicaid eligibility to individuals who would be eligible for AFDC if child care costs were paid by the applicant (Social Security Act 1902(a)(A)(ii) and 1905(a); 42 CFR 435.220 and 436.220).
- Individuals who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under the Federal AFDC law; i.e., Title IV-A of the Social Security Act. This provision gives the State the option to offer Medicaid coverage to such families (Social Security Act 1902(a)(10)(A)(ii)(III) and 1905(a); 42 CFR 435.223, and 436.212).

Pregnant women and children

- Infants under 1 year of age and pregnant or postpartum women in families whose incomes are above 133 percent and no more than 185 percent of FPL for a family of comparable size. States that extend Medicaid to infants and women with incomes of more than 150 percent of the poverty line may impose a monthly premium for such coverage (Social Security Act 1902(a)(10)(A)(i)(IX), 1902(a)(10) after (E), 1902(e), 1902(l), and 1916(c)).
- Pregnant women who meet, on the basis of preliminary information, the highest applicable income-eligibility criteria in the State's Medicaid plan

Table 10.10

Optional Medicaid eligibility groups: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) related, by State

State	Individuals who would be eligible for AFDC if:			Aged and disabled individuals	
	(1) Not in an institution	(2) Child care costs were paid from earnings	(3) State eligibility broad as allowed under title IV-A	(4) Whose income is above SSI standards but below FPL	(5) Who receive only State supplemental payments
Total with option	41	12	11	11	37
Alabama	X				X
Alaska	X		X		X
Arizona	X				
Arkansas	X				
California					X
Colorado	X	X			X
Connecticut	X	X			X
Delaware	X				X
District of Columbia	X	X		X	X
Florida	X		X	X	
Georgia	X				
Hawaii	X	X		X	X
Idaho	X		X		X
Illinois					X
Indiana					X
Iowa	X				X
Kansas	X				
Kentucky	X		X		X
Louisiana	X				
Maine	X		X	X	X
Maryland	X				X
Massachusetts	X			X	X
Michigan					X
Minnesota	X			X	X
Mississippi	X			X	
Missouri					X
Montana	X	X			X
Nebraska				X	X
Nevada					X
New Hampshire	X				X
New Jersey	X		X	X	X
New Mexico	X				
New York	X	X	X		X
North Carolina					X
North Dakota					
Ohio	X				X
Oklahoma	X	X	X		X
Oregon	X				X
Pennsylvania	X	X	X	X	X
Rhode Island	X	X			X
South Carolina	X			X	X
South Dakota	X				X
Tennessee	X				
Texas	X				
Utah	X	X			
Vermont	X	X	X		X
Virginia	X		X		X
Washington	X				X
West Virginia					
Wisconsin	X	X			X
Wyoming	X				

SOURCE: Health Care Financing Administration (HCFA), Office of Research and Demonstrations, Medicaid Program Studies Branch, June 1992, telephone survey of HCFA Regional Offices, and Medicaid State Plans.

Table 10.11
Optional Medicaid eligibility groups: Pregnant women and children, by State

State	Pregnant women and children with income below specified percent of the Federal poverty level	Presumptively eligible pregnant women	Ribicoff children under the age of:	Children under adoptive assistance agreements under the age of:	Disabled children
Total with option	19	25	51	35	19
Alabama			21	19	
Alaska			21		
Arizona	140		18		
Arkansas		X	18	18	X
California	185		21	21	
Colorado		X	21	21	
Connecticut	185		21		
Delaware			21	21	X
District of Columbia	185	X	21	21	X
Florida	150	X	21	18	
Georgia			18	18	X
Hawaii	185	X	19	21	
Idaho		X	21	18	X
Illinois		X	18		
Indiana		X	21	18	
Iowa	185	X	21	21	
Kansas	185		21	21	
Kentucky	185		18	19	
Louisiana		X	18	18	
Maine	185	X	21		X
Maryland	185	X	21	21	
Massachusetts	185	X	21	18	X
Michigan	185		21		X
Minnesota			21	21	X
Mississippi	185		18	18	X
Missouri		X	21	21	
Montana			21		
Nebraska		X	21	21	X
Nevada			19	19	X
New Hampshire			19	19	X
New Jersey		X	21		
New Mexico	185	X	18		
New York	185	X	21	21	
North Carolina		X	21		
North Dakota			21	21	
Ohio			21	21	
Oklahoma		X	21	21	
Oregon			21	18	
Pennsylvania		X	21	18	X
Rhode Island	185		19		X
South Carolina			18		
South Dakota			18		X
Tennessee	150	X	21	21	
Texas		X	18		
Utah		X	18		
Vermont			21		X
Virginia			21	21	
Washington	185		21	21	
West Virginia			21	21	X
Wisconsin		X	21	21	X
Wyoming			19	21	

SOURCES: Health Care Financing Administration (HCFA), Office of Research and Demonstrations, Medicaid Program Studies Branch, June 1992, telephone survey of HCFA Regional Offices and Medicaid State Plans.

Table 10.12

Optional Medicaid eligibility groups and other individuals, by State

State	Eligible for AFDC, SSI, or State supplemental payments but are not receiving them	Lost eligibility while enrolled in an HMO or a CMP	Receive home and community-based waiver services	Terminally ill hospice patients	Institutionalized for at least 30 consecutive days	Enrolled in employer-based group health plans	Enrolled in State-funded programs
Total with option	32	11	45	8	43	1	17
Alabama			X		X		
Alaska	X				X		X
Arizona	X	X	X		X		
Arkansas			X		X		
California			X	X			X
Colorado	X		X				
Connecticut	X	X	X		X		
Delaware			X		X		
District of Columbia	X	X			X		
Florida	X		X		X		
Georgia			X	X	X		
Hawaii	X		X	X	X		
Idaho	X		X		X	X	
Illinois			X				X
Indiana		X					
Iowa	X		X		X		
Kansas			X		X		
Kentucky	X		X	X	X		
Louisiana	X		X		X		X
Maine	X		X		X		
Maryland	X	X	X		X		X
Massachusetts	X	X	X		X		X
Michigan			X		X		
Minnesota	X		X		X		X
Mississippi					X		
Missouri							X
Montana	X		X		X		
Nebraska			X				
Nevada	X		X		X		
New Hampshire	X	X	X		X		
New Jersey	X	X	X		X		X
New Mexico			X		X		
New York	X	X	X	X	X		X
North Carolina	X	X	X				
North Dakota		X					
Ohio			X	X	X		X
Oklahoma	X		X		X		
Oregon	X		X		X		X
Pennsylvania	X		X		X		X
Rhode Island	X		X		X		X
South Carolina			X		X		
South Dakota			X		X		
Tennessee	X		X		X		
Texas			X		X		X
Utah	X		X		X		
Vermont	X		X	X			
Virginia	X		X		X		X
Washington	X		X		X		X
West Virginia	X		X		X		
Wisconsin	X		X	X	X		
Wyoming			X		X		

NOTES: AFDC is Aid to Families with Dependent Children. SSI is Supplemental Security Income. HMO is health maintenance organization. CMP is competitive medical plan.

SOURCE: Health Care Financing Administration (HCFA), Office of Research and Demonstrations, Medicaid Program Studies Branch, June 1992, telephone survey of HCFA Regional Offices, and Medicaid State Plans.

and who are therefore determined by a "qualified provider" to be presumptively eligible on a temporary basis (Social Security Act 1902(a)(47) and 1920).

- Children for whom the State has adoption assistance agreements and has determined that the child has special needs for medical or remedial care and cannot be placed for adoption without Medicaid coverage. Such children may be under 21, 20, 19, or 18 years of age as determined by the State (Social Security Act 1902(a)(10)(A)(ii)(VIII)).
- Children of 18 years of age or younger who qualify as disabled individuals under section 1614(a) of the Social Security Act, live at home, and would qualify for Medicaid if they were in a medical institution. In addition, the child must require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded; it must be appropriate to provide such care at home; and the cost of such care must not exceed the estimated cost of institutional care. This provision is often referred to as the "Katie Beckett provision" (Social Security Act 1902(e)(3)).

Aged, blind, and disabled

States also have the option, but are not required, to offer Medicaid coverage to the following aged and disabled groups. Table 10.11 presents States selecting some of these options.

- Aged (65 years of age or over) and disabled individuals whose income is higher than SSI standards but lower than 100 percent of FPL. Disability must be determined by SSI standards or the more restrictive State standards (Social Security Act 1902(a)(10)(A)(ii)(X) and 1902(m)).
- Aged and disabled individuals receiving only State supplemental payments. This provision gives the States the option to offer Medicaid coverage to individuals who receive these State supplements but not SSI. This option is also available to States who use eligibility standards more restrictive than SSI standards; i.e., 209(b) States (Social Security Act 1902(a)(10)(A)(ii)(XI); 42 CFR 435.230 and 435.1006).

Other groups

- Individuals who lose their eligibility while enrolled in a health maintenance organization (HMO) or a competitive medical plan (CMP). States can deem such individuals as eligible for Medicaid for up to 6 months from the date of enrollment. Only family planning services and those provided by the HMO or CMP are covered (Social Security Act 1902(a)(52), 1902(e)(2) and 1903(m)(2)(F) and (H); Public Law 98-369, section 2364; Public Law 99-272, section 9517; Public Law 101-508, section 4732; 42 CFR 435.212).
- Individuals receiving services through home- and community-based waivers. This group is made up of individuals who would require institutionalization in the absence of services provided through home- and community-based waivers and who would be eligible for Medicaid if in an institution (Social Security Act 1902(a)(10)(A)(ii)(VI); 42 CFR 435.217).
- Terminally ill individuals who elect to receive hospice care, provided that they would be eligible for Medicaid if they were in a medical institution. A State or territory also has the option to cover specific groups of these individuals. The groups include: the aged; the blind; the disabled; individuals under 21, 20, 19, or 18 years of age; caretaker relatives; and pregnant women (Social Security Act 1902(a)(10)(A)(ii)(VII); Public Law 99-272, section 9505).
- Individuals who are in medical institutions for at least 30 consecutive days and whose income does not exceed a special State-set income limit for Medicaid eligibility for individuals in medical institutions. This limit may be no more than 300 percent of the maximum SSI benefit. A State or territory also has the option to cover specific groups of these individuals. The groups include: the aged; the blind; the disabled; individuals under 21, 20, 19, or 18 years of age; caretaker relatives; and pregnant women (Social Security Act 1902(a)(10)(A)(ii)(V) and 1905(a); 42 CFR 435.231).
- As a condition of Medicaid enrollment, a State may require and pay for enrollment of certain Medicaid-eligible individuals in cost-effective, employer-based group health plans. Enrolled individuals remain eligible for a minimum number of months as specified by the State (Social Security Act 1906).
- A State may opt to make medical assistance available for Consolidated Omnibus Budget Reconciliation Act (COBRA) 1985 (Public Law 99-272, title V) premiums[12] for qualified COBRA continuation beneficiaries. To qualify, the income of the qualified COBRA continuation beneficiaries can not exceed 100 percent of FPL and their resources cannot exceed twice the maximum amount of resources that an individual may have under the SSI program. In addition, the cost of COBRA premiums must be lower than the cost of equivalent Medicaid services (Social Security Act 1902(a)(10)(F) and 1902(u)).

Medically needy

Coverage of the medically needy is one of the most important eligibility options available to the States and territories for inclusion in their Medicaid programs. The medically needy are aged, blind, or disabled individuals or families and children whose income

[12]COBRA provides that persons laid off from jobs in which the employee had health insurance coverage may continue that coverage by paying monthly premiums, for a period of up to 18 months after termination of employment or severance period. COBRA premium refers to the applicable premium imposed with respect to COBRA continuation coverage. In the referenced subsection, COBRA continuation coverage means coverage under a group health plan provided by an employer with 75 employees or more provided pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

Table 10.13

Medicaid medically needy programs and their monthly protected income levels, by State: January 1992

State	Medically needy program	Monthly protected income level			
		Family of 1	Family of 2	Family of 3	Family of 4
Alabama	No	NA	NA	NA	NA
Alaska	No	NA	NA	NA	NA
Arizona	No	NA	NA	NA	NA
Arkansas	Yes	$108	$217	$275	$333
California	Yes	600	750	934	1,110
Colorado	No	NA	NA	NA	NA
Connecticut	Yes	473	629	773	908
Delaware	No	NA	NA	NA	NA
District of Columbia	Yes	407	428	545	665
Florida[1]	Yes	180	241	303	364
Georgia	Yes	208	317	375	442
Hawaii	Yes	396	531	666	802
Idaho	No	NA	NA	NA	NA
Illinois	Yes	283	358	492	558
Indiana	No	NA	NA	NA	NA
Iowa	Yes	483	483	566	666
Kansas	Yes	422	466	470	488
Kentucky	Yes	217	267	308	383
Louisiana	Yes	100	192	258	317
Maine	Yes	315	341	458	575
Maryland	Yes	359	400	442	484
Massachusetts	Yes	522	650	775	891
Michigan	Yes	408	541	567	593
Minnesota	Yes	467	583	709	828
Mississippi	No	NA	NA	NA	NA
Missouri	No	NA	NA	NA	NA
Montana	Yes	407	417	443	469
Nebraska	Yes	392	392	492	584
Nevada	No	NA	NA	NA	NA
New Hampshire	Yes	436	608	616	623
New Jersey	Yes	350	433	566	658
New Mexico	No	NA	NA	NA	NA
New York	Yes	509	742	750	850
North Carolina	Yes	242	317	367	400
North Dakota	Yes	345	400	435	530
Ohio	No	NA	NA	NA	NA
Oklahoma	Yes	284	359	459	567
Oregon	Yes	413	526	613	753
Pennsylvania	Yes	425	442	467	567
Rhode Island	Yes	558	600	741	850
South Carolina	Yes	225	225	283	341
South Dakota	No	NA	NA	NA	NA
Tennessee	Yes	175	192	250	308
Texas	Yes	100	211	267	301
Utah	Yes	350	430	536	626
Vermont	Yes	758	758	900	1,008
Virginia	Yes	250	308	358	400
Washington	Yes	458	575	650	725
West Virginia	Yes	200	275	290	312
Wisconsin	Yes	514	592	689	823
Wyoming	No	NA	NA	NA	NA

[1]Eliminated program April 1992.

NOTES: In a number of States, need and payment amounts vary depending on such factors as region and season and what components are included in the standard (e.g., rental allowance). In all such cases, the region with the highest concentration of recipients and/or the highest seasonal rate is displayed. NA is not applicable.

SOURCE: National Governor's Association, 1992.

and/or resources may be too high to qualify for cash assistance or under other optional groups. However, in the States' and territories' views, these individuals cannot afford to pay their medical bills. When a State's Medicaid program covers any individual in a medically needy group, it must cover all of the individuals who are eligible to be members of that group (Social Security Act 1902(a)(10)(C); 42 CFR 435.300).

States and territories electing this option may set income and resource eligibility levels for the medically needy that are no lower than those groups receiving cash assistance and no higher than that allowed by Federal regulations. The income standard cannot be higher than 133 1/3 percent of the highest amount that would ordinarily be paid under AFDC to a family of the same size. Table 10.12 presents the States electing this option and the medically needy income standards in effect during 1991.

Applicants with incomes in excess of eligibility standards must be allowed to spend down to the medically needy income eligibility level by incurring medical expenses. This is referred to as the medically needy income spend-down provision. Examples of deductible medical expenses include Medicare and other health insurance premiums, deductibles and coinsurance charges, and expenses incurred for medical services included in the State's Medicaid plan or recognized under State law. This spend-down provision is especially important for granting Medicaid eligibility to the institutionalized who incur very large medical expenses.

A review of personal resources is also conducted prior to granting Medicaid eligibility to medically needy individuals. In determining the resources of an individual (and his/her eligible spouse, if any) certain resources are excluded. Resource exclusions include the individual's home and specified limits for household goods, personal effects, an automobile, a burial space, and other defined items.

In the case of institutionalized medically needy, as well as any other persons who reside in a medical institution (e.g., a nursing facility), States must count resources that a person no longer owns if the person gave them away for less than fair market value within the previous 24 months (Social Security Act 1613; 42 CFR 435.841).

If the State chooses the medically needy option, it must offer coverage to pregnant women, including at least 60 days of postpartum care, and children under 18 years of age (Social Security Act 1902(a)(10)(C), 1902(e) and 1902(e)(4); 42 CFR 35.301, 435.301, and 435.340). States can also select a number of other specified groups. In doing so, the State may offer different benefits to different groups under the medically needy option (Social Security Act 1902(a)(47); 42 CFR 435.1, 435.300-435.340 and 436.300-436.322). As of January 1992, more than one-half of the States and Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands have exercised their option of covering the medically needy under Medicaid.

As previously stated, the Federal Government provides matching funds for services provided to the mandatory and optional groups delineated earlier. At its own expense, a State may extend Medicaid coverage to individuals who are not in the preceding groups. The Federal Government, however, will not provide matching assistance in such cases. Persons covered fully at a State's expense need not meet any of the Federal requirements for categorical eligibility. For example, a young single male 21 years of age or over and living alone could, at a State's option, receive Medicaid benefits as a State-only eligible. As of January 1992, 17 States (presented in Table 10.13) operate other medical service programs for which there are no Federal matching funds.