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Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment

Appendix:

Methods for Modeling Public Insurance Eligibility for Adults

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Appendix:

Methods for Modeling Public Insurance Eligibility for Adults

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A. Overview of Simulation Model

The Public Insurance Eligibility Algorithm models 1999 eligibility for nonelderly adults age 18-64 using data from the National Survey of America's Families (NSAF). The algorithm parallels the eligibility determination process by calculating various income, asset and family structure measures and comparing them to the relevant thresholds and rules in the state where the person or family resides. The primary focus of the algorithm is adult eligibility for non-disabled Medicaid and other state public insurance programs. Eligibility can be established through the following mechanisms:

- Family Coverage Category programs established through Section 1931 of the Social Security Act in relation to the 1996 Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA) (also referred to as "Section 1931 programs"),
- Section 1115 Medicaid and SCHIP waiver programs,
- Medically Needy programs for parents and adult dependents age 18-20,
- Transitional Medical Assistance (TMA) programs for families that lose Medicaid eligibility due to an increase in income,
- Ribicoff and state child poverty expansion programs for adults age 18-20, and SCHIP programs for 18 year olds,
- Public insurance programs funded exclusively with state dollars (also referred to as "state-only programs").
- Adults who report receiving SSI and other selected adults with disabilities who may be eligible through Medically Needy programs that cover disabled populations are also included in the eligible population. However, SSI recipient eligible adults were not included in the analysis, because their characteristics and enrollment patterns differ significantly from other adults.

Eligibility for Medicaid for pregnant women was not modeled because there was no indicator for pregnancy in the 1999 NSAF data. We also did not model eligibility for public health insurance coverage offered through General Assistance programs. Below is a detailed description of the various Medicaid and public insurance eligibility pathways and methods we used to model the rules for each eligibility category.

B. Description of Medicaid and Other Public Insurance Eligibility Pathways

Section 1931 Programs

PRWORA established the Section 1931 Medicaid eligibility category that severed the relationship between welfare receipt and Medicaid coverage for low-income families. The

delinking of Medicaid and cash assistance was designed as a means to protect Medicaid coverage for those families that might lose their welfare benefits under federal welfare reform. PRWORA set minimum eligibility rules for Section 1931 programs at 1996 AFDC eligibility standards, but also gave states the option of rolling back their income and resource eligibility thresholds to their May 1988 levels or increasing them beyond their August 1996 levels. Any increase in threshold levels could not outpace the rate of increase in the Consumer Price Index. Section 1931 legislation, however, permitted states to implement expansions through the use of more generous income disregards or the elimination of asset tests and work history rules.

Our model of the Section 1931 eligibility pathway is divided into two categories: baseline eligibility and optional state-expansion eligibility. The baseline eligibility is a construct of our model that reflects federal laws that set minimum eligibility thresholds for Section 1931 programs at 1996 AFDC eligibility levels. The optional state-expansion category reflects the extent to which *actual* Section 1931 rules expanded categorical eligibility or raised effective income eligibility standards beyond the minimum levels established by the federal government. In 1999, seven states had not established a separate Section 1931 program. Instead, three of the states, Hawaii, Massachusetts and Rhode Island, used Section 1115 waiver programs, and four of the states, Illinois, Nebraska, Texas, and Utah used their Medically Needy programs to expand parent coverage. People in these states are modeled as having a baseline Section 1931 eligibility category, but any families that are eligible, beyond those in the baseline category, are assigned to the eligibility mechanism that is being used to provide family coverage (i.e. Section 1115 or medically needy), not to the optional Section 1931 category.

Our modeling of the baseline eligibility construct assumes that the 1996 AFDC rules are an absolute floor for eligibility standards, but if states chose to exercise the option to roll back the income and resource methodologies to 1988 levels, our modeling of the baseline categories using 1996 AFDC income and resource tests would artificially inflate the number of adults that are eligible through Section 1931. To address this problem, we identified adults who were only deemed eligible through the 1996 AFDC baseline category *and* who were ineligible for other family-related programs (i.e. Section 1931, Section 1115, and Medically Needy programs) because they failed the income and resource tests. These observations were then recoded as ineligible. Only 66 individuals met these conditions and these individuals lived in the following states: Alabama Florida, Illinois, Louisiana, Michigan, New Hampshire, New Jersey, Ohio, Texas[1].

Transitional Medical Assistance (TMA)

The TMA eligibility category was designed to extend Medicaid coverage for a minimum of 12 months to families who lose Section 1931 Medicaid eligibility due to increased earnings or child support income. For the first six months of TMA eligibility, there are no income limits, but individuals must have received Medicaid for three of the last six months prior to losing eligibility for Medicaid. For the second six months, eligibility for TMA also requires the gross income to be below 185% of the federal poverty guidelines. States have the option of expanding these

[1] Since our data do not reflect all the family structure and income combinations that would qualify for Medicaid, this list is not an exhaustive list of states that lowered eligibility levels below the 1996 AFDC eligibility standards. The list also does *not* imply that eligibility for all adults in these states has been set below the 1996 AFDC levels.

requirements by relaxing the "three out of six months" requirement or extending the length of TMA coverage (Center for Budget and Policy Priorities 2000).

The eligibility algorithm can only determine whether the adult is currently eligible for public coverage, not *when* an adult might have lost eligibility that eligibility. Thus it is not possible to model the "three out of six months" requirement or determine whether to use the 185% income requirement. To simulate TMA eligibility, our model assigns TMA eligibility to all parents who were ineligible for Section 1931, had Medicaid in at least one out of the past 12 months prior to the survey interview and whose income is below 185% FPL. For parents in states that did not have a Section 1931 program in place during 1999, we conditioned eligibility for TMA on being ineligible for whichever eligibility pathway is used to establish Family Coverage Category eligibility in the state (either Section 1115 or Medically Needy—both programs are discussed below).

This method of modeling TMA causes both upward and downward pressures on final estimates of TMA eligibility. In states that had the "three out of six months" requirement (35 states as of July 2000), our simulation of eligibility might overestimate the number of adults eligible through TMA. Our simulation of eligibility might understate eligibility through TMA for individuals who were in their first 6 months of TMA eligibility and had income above 185% *or* lost Medicaid 12 or more months prior to the survey, but lived in a state that extended TMA coverage beyond 12 months (14 states as of July 2000) and had income under 185% of poverty.

Section 1115 Waiver Programs

Section 1115 waivers allow states to use federal matching funds to cover populations that are otherwise ineligible for Medicaid under federal rules (e.g. non-disabled adults without dependent children and higher-income parents). States must receive prior approval from the Centers for Medicare and Medicaid Services before they can receive federal funds for these waiver programs.

As of 1999, ten states extended coverage to parents under Section 1115 waivers: Delaware, Hawaii, Massachusetts, Minnesota, Missouri, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin. Five of these states, Delaware, Hawaii, Oregon, Tennessee, and Vermont also extended coverage to adults without dependent children.

Under waivers, states may require adults who are eligible at a certain level of income to pay premiums to participate in the program. (States cannot otherwise charge premiums in Medicaid.) Our algorithm distinguishes between adults who face premium requirements for eligibility and adults who do not. Section 1115 waiver programs may also require applicants to be uninsured and have no ESI-offer. Due to data constraints on measurement of ESI offers, as well as a desire to simplify the eligibility algorithm, our model does not reflect such provisions, but we did create indicators to identify people who live in states with these insurance requirements.

Due to unsustainable enrollment increases in Section 1115 programs during the mid-1990's, some states were forced to implement enrollment caps (Hawaii) or to freeze enrollment

altogether (Tennessee). We did not model enrollment caps in our eligibility model since this would require obtaining administrative data on the number of people enrolled in Medicaid at the time individuals were interviewed for the NSAF survey. We did, however, model the 1995 enrollment freeze for Tennessee's 1115 program by conditioning Medicaid eligibility on currently receiving Medicaid, as well as meeting the categorical, income and resource requirements for the program.

Medically Needy Program

Prior to PRWORA, Medically Needy programs provided Medicaid coverage for those individuals who were categorically eligible for AFDC but did not pass the AFDC income or asset tests. Medically Needy programs generally had higher income thresholds than AFDC programs, but if a family's income still did not meet the income requirements, they could also "spend down" into eligibility by incurring out-of pocket medical expenses that put their net income below Medically Needy income eligibility levels. Post-PRWORA, federal regulations state that eligibility for Medically Needy programs is measured in relation to the 1996 AFDC minimum eligibility standards for the Section 1931 programs. The more generous income and resource methods allowed for Section 1931 family coverage do not extend to the Medically Needy program. PRWORA did not create substantial changes for the Medically Needy program, except for the four states that used their Medically Needy program as a vehicle for family coverage, instead of establishing a separate Section 1931 program.

States are not required to have a Medically Needy program, but if states implement this program they are required to cover children age 0-17. Other populations such as caretakers, adult dependent children age 18-20, the elderly, and persons with disabilities are covered at the states' discretion.

For the adult Medicaid eligibility model, we simulated eligibility for caretakers, dependent adult children and persons with disabilities. Constraints on our ability to identify dependent adult children limited our ability to model eligibility for 19 through 20 year olds. To model disabled Medically Needy eligibility, we used an indicator on the NSAF that identifies people who have an activity limitation that limits their ability to work. This indicator is too general to capture state criteria for disability in most states. To minimize the incongruity between specific state definitions of disability and the broad measure of disability on the NSAF, only people who reported a work-limiting disability and who were currently not in the labor force were considered for eligibility through Medically Needy programs that covered the disabled. In general, we could not model "spend down" eligibility for the Medically Needy program since we did not have measures of out-of pocket medical expenses on the NSAF.

Eligibility for Adult "Children"

There are three pathways of eligibility for adult children age 18-20: 1.) Ribicoff programs 2.) state poverty expansions, and 3.) State Children Health Insurance Programs (SCHIP). From the perspective of adults age 18-20, all of these eligibility pathways represent optional state expansions for Medicaid.

Pre-PRWORA, the Ribicoff program was created as a child expansion program for children who did not meet the categorical requirements of the AFDC program, but did meet the income and resource requirements. As with the Medically Needy program, post-PRWORA Ribicoff eligibility is determined relative to the 1996 AFDC income and resource eligibility standards. If states wanted to extend eligibility for all young adults age 18-20 beyond AFDC income levels, they could choose to expand beyond the minimum age limits for the federal poverty expansion categories.[2]

The Balanced Budget Act of 1997 gave states an additional option of extending eligibility for 18 year olds through the State Children's Health Insurance Program (SCHIP,) a separate federally financed public insurance program. In 1999, only two states, Hawaii and Washington, did not have an SCHIP program. States can establish an SCHIP program by either creating a Medicaid expansion program or a separate SCHIP program. States may require children who are at a certain level of income to pay premiums to participate in the program. Our model distinguished between 18-year-olds who have premium requirements for eligibility and 18-year-olds who did not.

State-Only Programs

These programs represent public insurance programs that are funded entirely by the state. While several states have medical insurance programs associated with state General Assistance programs, we only captured broader state programs. Specifically, we modeled the state-only portion of Minnesota's MinnesotaCare, which extends eligibility for public insurance to parents between 175% and 275% of poverty and adults without dependent children under 175% of poverty. We also modeled eligibility for Washington's Basic Health Plan program for adults with income that is above Section 1931 eligibility levels but below 200% of poverty.

C. Description of Inputs to Eligibility Model

This section describes the data sources that were used to build the adult eligibility model as well as the input variables needed in order to evaluate an adult's eligibility for public insurance.

Data

The eligibility algorithm was created using the 1999 National Survey of America's Families, which is administered under the Urban Institute's Assessing the New Federalism (ANF) project. The NSAF is a household survey that collects demographic, economic, social, and health information for over 100,000 adults and children that represent the non-institutionalized civilian population under age 65 nationally and in 13 states study states. The NSAF over-samples households with incomes under 200% of FPL so as to enable analyses on policy issues that affect the low-income population.

[2] In 1999, federal poverty expansion included pregnant women and children age 0-5 with family incomes under 133% of FPL, and children older than 5 but born after September 30, 1983 with family incomes under 100% of poverty. Since 1999 NSAF data does identify pregnant women, we do not model Medicaid eligibility for this population.

The survey was administered to adults in households that contained children and that identified themselves to be the adults with the most knowledge about the children in the household that were selected for the survey. The survey also collected information on randomly selected adults in households without children. Different levels of detail were obtained for different adults in the sample. As a result, there are two data files available on the 1999 NSAF that contain information on adults: one dataset that collects general information on all adult respondents and their spouses/partners, and a smaller dataset that collects more detailed information on all single adults and one adult that is randomly chosen from each spouse/partner pair. We used the second dataset for this model since it contained the data on past-year Medicaid participation that was needed for the TMA eligibility determination. There are 52,587 observations in the dataset, but 349 observations were dropped because they were either under the age of 18 or because one adult or both adults in the family had missing values for the earnings variable, leaving us with 52,238 observations for the model.

Specifying Family Units

To collect information about sampled adults' family structure, income and resources, we created an algorithm that defined the Health Insurance Unit (HIU) for adults. HIUs consist of the sampled adult, their married spouse and their dependent children. Information on the type of relationship that exists between parent-child pairs (e.g., biological, adoptive, step, foster or partner's child) was only available for sampled children. The absence of complete information for non-sampled children may result in incorrectly linking the child of an unmarried partner to a sampled adult.

To model Section 1931 eligibility for families with an unmarried full-time student, we used the 1996 AFDC rule that defined the maximum age at which these students can be considered dependents of their parent(s). Some states permit 18 year olds who are full time students to be considered dependent children. We cannot identify full-time students on the NSAF data, so we used "living with a parent" as a proxy for being a full-time student. If a dependent 18 year old has a child, both the child and the 18 year old were included in the HIU of the teenager's parent. The NSAF may also include unmarried full time college students who are living away from home, but receive financial support, and would be considered dependents of their parents. These young adults appear as single person families in the NSAF and are evaluated by the algorithm using rules that apply to adults, based on their own income and assets.

To define HIUs for unmarried parents, one of the parents was selected at random and attached to their children; the other parent was captured in a separate HIU. We did not link unmarried parents because the income from one adult cannot be deemed to the other adult, for purposes of eligibility determination. However, this choice may have resulted in our assigning the children to the adult who does not have official custody.

Income and Asset Measurement

Income was divided into earned and unearned income. Earned income was measured using current month earnings for sampled adults. Current unearned income was approximated

using income reported from the prior calendar year. We only included those types of income that would be included for Medicaid eligibility determination: interest and dividend income from investments, rental property income, income from friends or relatives, pension income, Social Security payments, and unemployment compensation payments. To approximate current unearned income, prior year unemployment compensation payments were only attributed to those currently unemployed and looking for work.

We did not have direct information on the value of an HIU's assets. To approximate the value of assets, we assumed a 6 percent return on the reported rental, interest and dividend income. All personal income and assets for adults in the HIU were summed and assigned to each member of the HIU. Child income, including child support payments, was not included in the total HIU income because this income is usually not considered when evaluating parents' eligibility for public insurance. Although unearned income for 18 year old dependents would be considered when determining their own eligibility for Medicaid, CPS estimates suggest that only 18 percent of low-income 18 year olds have unearned income, therefore, we ignored it in our analysis.

When income is used to evaluate an individual's eligibility for public insurance, most states will typically disregard a portion of the individual's HIU income and use the income net of these disregards for eligibility determinations. Disregards for the net income tests include deductions for work-related expenses, childcare expenses, and additional earnings disregards. Although different eligibility pathways vary in the degree to which states allow certain disregards for eligibility determinations, prior to PRWORA, the disregard formula for applicants typically included deductions for work-related expenses that were usually set at $90 per worker and child care expense deductions that were usually capped at $200 per HIU per child under age 2 and $175 per HIU per child age 2 and over. The redetermination process for recipients would also allow an earnings disregard for each worker, which was usually calculated to be $30 and one-third of gross income net of the fixed $30 earnings disregard, work-expense deductions, and child-care expense deductions.

As states' began to take advantage of the Section 1931 flexibility PRWORA provided, variation in the formulas for income disregards increased. Some states increased the fixed dollar amounts for the work expense deduction and/or the earnings disregard so that the total fixed dollar amount deduction totaled up to $250 (up from the combined total of $120 from the typical formula described above). Some states also chose to increase or decrease the fraction of income that is used to calculate the earnings disregard and/or chose to extend earnings disregards to applicants as well as recipients. Other states altered the structure of the formula by only allowing a fixed dollar amount disregard or disregards that are calculated as a flat percentage of gross income.

For simplicity, we only assigned applicant disregards to all adults in the sample. Since we did not have information on work-related expenses, we assumed that individuals received the maximum work-expense deduction allowed by the state. The NSAF does, however, collect information on child care expenses. The child care expense measure captures the total child care expenses incurred by adult respondents for all children under age 13 in the family, but only if there is at least one sampled child under age 13 in the family. We used a simple imputation

method to impute child care expenses to parents in HIUs that have no sampled child under age 13 in the HIU, but do have non-sampled children under age 13. Although child care expenses are collected for all caretakers that are working, looking for work, or are in school, we only imputed child care expenses to HIUs with at least one parent working (N=2,130) in order to minimize the potential for imputing child care expenses to HIUs that did not use child care. This restriction does not affect our use of the child care expense measure because child care expenses are only deducted from working parents' earnings when evaluating income eligibility.

D. Description of Eligibility Criteria

While all programs have different eligibility requirements, the structure of the rules is essentially the same across all eligibility pathways. This section gives a general description of the eligibility criteria used to establish public insurance eligibility

Categorical Eligibility

For most programs, categorical eligibility is defined as meeting the family structure requirements for a particular eligibility pathway, i.e. identifying parents, adults without dependent children, age-eligible dependent adult children, and adults with disabilities. Some state Section 1931 programs, however, also have additional categorical criteria for two parent families that require the primary earner of the family to be unemployed but looking for work, or under-employed (i.e. working less than 100 hours per month). We define the primary earner of the family to be the father.

In addition to family structure related criteria, immigration status is a major categorical requirement affecting all federally funded public insurance programs. With the enactment of PRWORA, states can no longer use federal dollars to cover any illegal immigrants or any legal immigrants who arrived in the U.S. after August 1996 for the first five years they reside in the U.S.

To model this eligibility restriction, we create a post-1996 immigration indicator for all non-citizens. NSAF measures whether someone reports being a U.S. citizen. Since NSAF measures time of immigration in years, this indicator uses 1997 as the cut-off year since the August 1996 cut-off specified in PRWORA is not the majority of the year. All legal non-citizens that came before 1997 are potentially eligible for public insurance. For those that came in 1997 - 1999, only those who live in states that extend eligibility to more recent immigrants through state-only programs can be considered potentially eligible for public insurance. Immigrants who qualify for public insurance under these state expansions, are categorized as eligible for state-only programs, since the state receives no federal support for their coverage.

Income and Resource Eligibility

The income eligibility tests for the various eligibility pathways generally consist of a gross income test, where total gross HIU income is measured against a particular threshold and/or a net income test, where the HIU's gross income net of the various disregards is compared to the threshold. The income thresholds are adjusted for family size either explicitly with dollar

thresholds specific to each family size, or implicitly through thresholds that are expressed as a percent of the Department of Health and Human Services federal poverty guidelines. All of the income eligibility tests exclude the income of any SSI recipient from total HIU income and the SSI recipient is excluded from the count of total HIU size. When modeling net income, we calculate HIU disregards relative to the earnings of non-SSI adult workers.

Asset eligibility tests are usually not family-size specific; one threshold is used for all adults. As with income, we exclude the value of SSI recipients' assets from the measure of HIU assets that is used in resource eligibility tests.

E. Description of Hierarchical Eligibility Indicators

We created hierarchical eligibility indicators that collapse the various eligibility pathways into broader categories. Table 1 describes the collapsed categories for the three eligibility indicators (in the order that they appear in the hierarchy) and the specific eligibility pathways that are included in each category.

Table 1. Description of Eligibility Indicator 1

Collapsed Categories	Definition of Collapsed Categories	Eligibility Pathways
Mandatory Medicaid Eligibility	Captures eligibility pathways that states are federally mandated to provide if they choose to participate in Medicaid.	Eligibility for citizens and federally qualified immigrants through the following pathways: • Section 1931 Baseline Eligibility (1996 AFDC) • TMA
Optional and Waiver Medicaid Eligibility	Captures eligibility pathways that states have the option of providing, and for which they receive federal matching funds.	Eligibility for citizens and federally qualified immigrants through the following pathways: • Section 1931 State Expansion; • Section 1115 waivers; • Ribicoff; • Poverty Expansion; • SCHIP • Medically Needy.
State-Only Eligibility	Describes eligibility pathways financed exclusively by states.	Eligibility through state-only programs • MinnesotaCare • Washington State's Basic Health Plan Eligibility for NON-federally qualified immigrants through the following pathways: • Section 1931 Baseline Eligibility (1996 AFDC); • TMA • Section 1931 State Expansion; • Section 1115; • Ribicoff; • Poverty Expansion; • SCHIP • Medically Needy.

F. Validation of Algorithm

As a means to validate our algorithm and to identify subgroups of the population where eligibles are under-reported, we characterize adults who report receiving Medicaid, SCHIP or other state-sponsored coverage, but are not deemed eligible through the algorithm. We deem these adults to be "ineligible reporters." Table 3 details the extent to which our eligibility model captures the adults that report public insurance coverage on the NSAF and the characteristics of ineligible reporters. The table presents this information separately for parents and adults without dependent children since these two groups have very different eligibility pathways.

Among all adults who report public insurance, 32.2% are not deemed eligible through our 1999 algorithm. The algorithm does a better job of capturing parent reporters—90% are deemed eligible, compared with adults without dependent children reporting Medicaid, among whom only 49% are deemed eligible. The ineligible reporter rate drops for both groups when the analysis is restricted to public insurance reporters under 200% and 100% of poverty, but the childless adult rate is still considerably higher than the rate for parents.

Among parents who are ineligible reporters, 85% are in states that have general assistance programs that extend medical coverage to participants. This suggests that the exclusion of this category of public health insurance from the model may explain a good proportion of the ineligible reporters in this group. Our inability to model poverty expansions for pregnant women may also explain the patterns of ineligible reporters among parents, given the high percentage of non-disabled females among this group (61%) and the fact that pregnant women are eligible at higher levels than parents.

As previously stated, we could not model Medicaid poverty expansions for pregnant women because there was no indicator for pregnancy on the 1999 NSAF data. We used the pregnancy indicator available on the 1997 NSAF to estimate how many additional adults would be identified as eligible if an indicator for pregnancy were included on the 1999 NSAF. The 1997 NSAF pregnancy indicator, however, does not reflect published national estimates of pregnancy rates (1997 NSAF estimates 39 pregnancies per 1000 women age 15-44 whereas published estimates from the CDC report 104.7 pregnancies per 1000 women age 15-44 for 1996[3].) The NSAF appears to underreport pregnancies in this age group by 63 percent. With an adjustment for under-reporting pregnancies, we estimate that an additional 0.64 percent of adults would be made eligible by modeling the pregnancy related poverty expansions. These results from 1997 suggest that if we were able to model the pregnancy related poverty expansion programs, this would explain as many as 17% of all adult ineligible reporters.

Possible explanations of the childless adult ineligible reporter rate are less clear. For all income levels, only 29% live in a state that extends general assistance medical coverage to adults without dependent children. Non-disabled males, a group that is typically not eligible for public insurance, represent the largest group among all childless adult ineligible reporters (41%). One explanation could be that the HIU algorithm may be separating adults without dependent children from units that are considered eligible (e.g. 18-20 year old dependents or unmarried

[3] National Vital Statistics Report, Vol 47, No. 29, Dec 15, 1999

parents of children that did not have their children assigned to their HIU), but only 8% of childless adult ineligible reporters have an eligible adult in the NSAF social family.

Table 2. Ineligible Reporter Analysis (Weighted)

	All		Under 200% of Poverty	
	Childless Adults	**Parents**	**Childless Adults**	**Parents**
All Public Insurance Reporters				
Eligible Reporters	49.1	90.0	57.4	96.9
Ineligible Reporters	50.9	10.0	42.6	3.1
Percent of Ineligible Public Insurance Reporters:				
Age 18-20	16.6	30.1	16.7	0.5
Age 21-24	18.9	13.6	18.8	21.6
Age 25-34	16.4	26.9	16.8	38.3
Age 35-44	16.6	20.2	18.3	21.9
Age 45-54	15.3	8.7	12.3	17.7
Age 55-64	16.2	0.5	17.1	0.0
Disabled	35.3	21.6	40.6	20.8
Non-Disabled Female	23.5	60.9	23.7	74.2
Non-Disabled Male	41.2	17.5	35.7	4.9
Married	17.0	48.5	10.8	62.7
State has General Assistance with Medical Coverage (Parents only)	--	84.8	--	89.7
State has General Assistance with Medical Coverage (Childless Adults)	29.2	--	29.6	--
Has eligible adult in Social Family	8.0	5.7	9.8	4.5
Has eligible adult reporter in Social Family	6.2	4.3	7.7	0.8

G. Sources for Eligibility Rules

The primary source of data for Section 1931 rules is a report entitled *States' Implementation of Selected Medicaid Provisions of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996* published by the State Policy Documentation Project (SPDP), January 2000 (SPDP is a joint project of the Center for Law and Social Policy and the Center on Budget and Policy Priorities http://www.spdp.org/). According to the report, survey information was collected during late 1998-early 1999, and verified through the summer of 1999-November 1999. For the purpose of collecting data on 1999 rules, the time frame of this survey is appropriate. Nonetheless, in some states, the rules were adjusted from the 1999 report to reconcile more recent information on the dates of implementation for certain rules. Other sources used to collect the 1999 rules include: *Expanding Family Coverage: State's Medicaid*

Eligibility Policies for Working Families in the Year 2000, Dec. 2001 from the CBPP and a 2002 Kaiser Commission on Medicaid and the Uninsured report entitled *Can Medicaid Work for Low-Income Working Families?* by Kathleen Maloy et al.

The information obtained for the Section 1931 gross and countable (or net) income thresholds only had the rules for family size of three. To create thresholds for the full complement of family sizes, we compared Section 1931 rules to 1996-1999 AFDC/TANF rules. Where the Section 1931 threshold for a family size of three matched the comparable TANF/AFDC threshold, we used the TANF/AFDC thresholds for the other family sizes. Where the two sets of rules did not match, we calculated the percentage difference between the Section 1931 threshold and the AFDC/TANF threshold and applied the percentage difference to the other AFDC/TANF thresholds in order to create a full set of Section 1931 thresholds. For the Gross Income Test, only two states did not have a match between the Section 1931 rules and the AFDC/TANF rules (South Dakota and Wyoming); for the Countable Income Test 12 states did not match up (Connecticut, Indiana, Kansas, Maryland, Montana, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Vermont, Wyoming), but for 10 of these 12 states, the percentage difference between the Section 1931 threshold and the closest matching TANF/AFDC threshold was less than or equal to 10%.

TANF/AFDC rules came from the Urban Institute's Welfare Reform Database. Section 1115 rules came from a March 2002 Urban Institute telephone survey of state Medicaid administrators. Additional rules came from Urban Institute's TRIM and a 1999 survey of state Medicaid administrators.

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