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Medicaid Eligibility for Families and Children

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Introduction

Measured by enrollment, Medicaid is the largest health insurer in the country. According to the Urban Institute's estimates, Medicaid covered 41.3 million Americans in 1996; Medicare, in comparison, covered 38 million. Moreover, millions of low-income Americans without private health insurance coverage are eligible for Medicaid but are not enrolled in the program. For example, researchers at the Agency for Health Care Policy Research recently estimated that in 1996 about 4.7 million uninsured children were eligible for Medicaid but not enrolled.[1] If all of these children were enrolled in Medicaid, the number of children without some form of health insurance coverage would drop by 40 percent.

There are numerous reasons why Medicaid does not cover all of the children or adults who qualify. This Issue Paper focuses on one of those reasons: the complexity of Medicaid eligibility policy. This complexity makes the program difficult for low-income Americans to understand and for state Medicaid officials to administer. Yet within this complexity are options that enable states, if they so choose, to use their Medicaid programs as a policy tool to reduce -- potentially dramatically -- the number of children and adults without basic health care coverage.

This paper begins with an overview of Medicaid eligibility policy. It then turns to two groups of Americans -- low-income children and nondisabled adults under 65 -- and summarizes the statutory and regulatory Apathways≅ to Medicaid eligibility available to individuals to them.[2] The paper concludes with a discussion of policy options available to states under current law for increasing Medicaid eligibility for these two groups. It also reviews the policy options available to the federal government for altering current law to expand Medicaid eligibility.

The complexity of Medicaid eligibility policy is just one reason why Medicaid does not cover all of the children or adults who qualify. Other reasons include burdensome application forms and procedures, lack of outreach efforts, and negative perceptions of Medicaid among low-income families.[3] These issues are the subject of other analyses and are being explored in related Kaiser Commission projects.[4]

As CBO has recognized, states have Aa great deal of flexibility in operating the Medicaid program.≅[5] For this reason, Medicaid eligibility policy, like Medicaid coverage policy and Medicaid payment policy, varies from state to state. This paper does not

attempt to describe Medicaid eligibility policy in each state.[6] Instead, the focus is on the federal policies that structure the eligibility choices that states make.

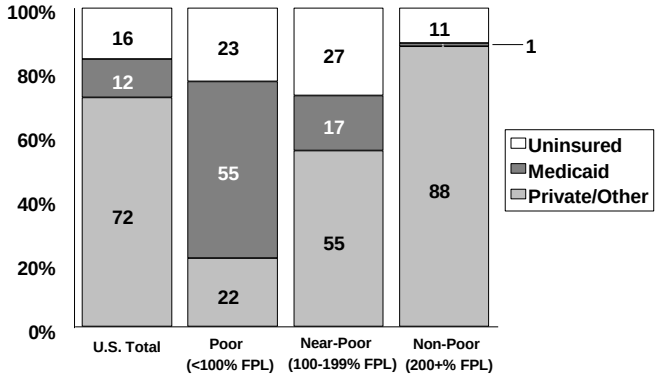
I. Overview of Medicaid Eligibility Policy

Medicaid eligibility policy reflects the basic structure of the program. Medicaid is a means-tested, federal-state, individual entitlement program with historical ties to the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) cash assistance programs. Medicaid=s policy premise of means-testing explains much about its income and resource rules. Medicaid=s association with AFDC and SSI has guided Medicaid=s historical eligibility categories. Finally, because Medicaid is an individual entitlement, both the states and the federal government have relied on eligibility policy as a tool for limiting their financial exposure for the cost of covered benefits.

Medicaid=s role is to cover basic health and long-term care services for low-income Americans. However, being poor does not assure Medicaid coverage. As shown in Figure 1, Medicaid in 1995 covered only about 55 percent of the nonelderly poor, earning less than $12,590 for a family of three. Medicaid's reach to individuals with incomes just above the poverty line is even more limited, covering only 17 percent of the near-poor. Despite Medicaid, low-income people are considerably more likely to be uninsured than those with higher incomes. While a portion of the low-income uninsured are eligible for Medicaid but not enrolled, a substantial share are excluded from Medicaid coverage by program eligibility rules that reflect policy choices at both the federal and state level.

Figure 1

Health Insurance Coverage by Poverty Level, 1995



SOURCE: Urban Institute estimates of the nonelderly population, 1997.

At the federal level, eligibility policy choices are reflected in the authorization of federal Medicaid matching funds (on an open-ended basis) for the costs incurred by a state in paying for covered services on behalf of certain low-income individuals. Federal Medicaid matching funds are available to states for the costs of covering some categories of individuals but not others. If federal matching funds are not available for a particular category, it is unlikely that a state will extend Medicaid coverage to those categories of individuals, because the state would then bear the costs of care entirely at its own expense.

At the state level, eligibility policy choices are reflected in state decisions as to which optional eligibility categories and which income and resource criteria to adopt. There are certain eligibility groups -- for example, pregnant women with family incomes at or below 133 percent of the federal poverty level ($1,513 per month for a family of three in 1998) -- that all states opting to participate in Medicaid must cover. In addition, there are other categories for which states may receive federal matching funds if they choose to extend Medicaid coverage. However, the availability of federal matching funds for a particular category of individuals does not necessarily mean that a state will cover that category, since the state must still contribute its own matching funds toward the costs of coverage.

The terms on which federal Medicaid matching funds are available to states include five broad requirements relating to eligibility: categorical; income; resources; immigration status; and residency. Two of these broad requirements -- income and resources -- are financial in nature. The other three -- categorical, immigration status, and residency -- are non-financial. In order to qualify for Medicaid, an individual must meet both its financial and non-financial requirements.

Within each of these five broad requirements are Amandatory≅ and Aoptional≅ elements. It is important to understand the context in which these terms are used. State participation in Medicaid is voluntary, not mandatory. The federal government makes Medicaid matching funds available on an open-ended, entitlement basis to states that elect to participate in the program. In order to participate, states must offer coverage for basic benefits to certain populations -- e.g., medically necessary physician and hospital services to certain low-income families and children.

States receive federal Medicaid matching funds for at least 50 percent and as much as 80 percent of the costs of this mandatory coverage, depending on the state. In exchange, states are also able to draw down federal Medicaid matching funds at the same rate for optional populations and services such as the low-income elderly and disabled at risk of nursing home and other expensive long-term care services. Similarly, within each of the five major eligibility requirements there are minimum policies states must follow and there are more expansive policies that states may adopt. According to the Health Care Financing Administration, 55 percent of all Medicaid spending paid for optional populations or optional services.[7]

A child or adult who establishes Medicaid eligibility is not, on the basis of that initial determination, entitled to maintain eligibility indefinitely. Federal Medicaid regulations require that states redetermine eligibility of a Medicaid beneficiary at least once every 12 months. This redetermination, like the original determination, is designed to ensure that a beneficiary continues to meet each of the financial and non-financial requirements for eligibility. Those beneficiaries, who due to a change in income, resources, or family composition no longer meet the eligibility requirements of their state through any pathway, lose their entitlement to Medicaid. There are some limited exceptions for certain categories such as pregnant women, who are entitled to continue Medicaid coverage for 60 days post-partum regardless of any change in financial or non-financial circumstances.

Fluctuations in monthly income are common among low-income families. These changes can lead to the loss of Medicaid coverage by a child or family whose income may spike during one part of the year but spends most of the year earning under the federal poverty level. This occurs commonly in states that use 1-month, 3-month, and 6-

month redetermination periods. To address eligibility "churning," the Balance Budget Act of 1997 gave states the option of extending Medicaid coverage with federal matching funds to children under 19 for a period of up to 12 months after the initial determination of eligibility regardless of any change in financial or non-financial circumstances that would otherwise make them ineligible. This option does not extend to low-income adults with dependent children.

Medicaid does not require that an individual who meets its categorical, income, resource, immigration status, and residency requirements also be uninsured. Medicaid treats insurance coverage as a payment source, not as an eligibility criterion. More specifically, private insurance coverage under Medicaid is a type of Athird party liability≅ that the program uses to reduce its costs of coverage. In most cases, when a Medicaid beneficiary also has private coverage, the private insurer must pay first. Then Medicaid will pay for Medicaid-covered services for which the private insurer is not obligated to pay. This policy stands in sharp contrast to the approach taken under the new Child Health Insurance Program (CHIP), under which states are expressly prohibited from using federal CHIP matching funds to pay for services to children with private health insurance.[8]

Unlike employer-based insurance coverage, Medicaid eligibility is not directly tied to employment for many of the Medicaid coverage categories. For example, a pregnant woman whose income is equal to or less than 133 percent of the federal poverty level is eligible for Medicaid coverage in every state whether or not she worked before or during her pregnancy. On the other hand, as a result of the 1996 welfare law, a state has the option to deny Medicaid eligibility to non-pregnant women with dependent children with respect to whom the state has terminated cash assistance for refusal to work (states are not permitted to terminate Medicaid coverage to children for this reason).

The earnings flowing to an individual or a family from work will affect income eligibility for Medicaid. At income levels near Medicaid eligibility thresholds, a small increase in earnings can result in a loss in Medicaid eligibility even though the increase in earnings may not be sufficient to enable the worker to afford private health insurance coverage. To mitigate this disincentive to work or to increase the hours worked, states are required to extend "transitional" Medicaid coverage for up to one year to women (and their dependent children) who lose cash assistance due to earnings.

Figure 2: Major Medicaid Eligibility Pathways for Selected Groups

MANDATORY COVERAGE	OPTIONAL COVERAGE
LOW-INCOME CHILDREN	
Primary Pathways	
Infants under age 1 with income ≤ 133% FPL	Infants under age 1 with income ≤ 185% FPL
Children age 1 to 6 with income ≤ 133% FPL	Children age 1 to 6 with income ≤ 185% FPL
Children age 6 to 15 with income ≤ 100% FPL	Children age 6 to 15 with income ≤ 133% or 185% FPL
Section 1931 children	Targeted low-income children (CHIP children)
Children in welfare-to-work families	Transitional coverage for children in welfare-to-work families
Title IV-E foster care children	Non-Title IV-E foster care children
Title IV-E adoption assistance children	Non-Title IV-E adoption assistance children

Other Pathways	
	Medically needy
	Ribicoff children
CHILDREN WITH DISABILITIES	
Primary Pathways	
Supplemental Security Income (SSI) recipients	Katie Beckett children
	Home or community-based waiver children
Other Pathways	
SSI recipients as of 8/22/96	Medically needy
PREGNANT WOMEN	
Primary Pathways	
Pregnant women with income ≤ 133% FPL	Pregnant women with income ≤ 185% FPL
Other Pathways	
	Medically needy
LOW-INCOME ADULTS	
Primary Pathways	
Certain adults in low-income families with children	Adults in two-parent households with dependent children
Other Pathways	
	Medically needy
	COBRA continuation beneficiaries

Categorical Eligibility

Medicaid eligibility is limited to individuals who fall into specified categories. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. Figure 2 shows the major "pathways≅ to Medicaid eligibility for children and for non-disabled adults under 65. Several of these pathways overlap one another, with the result that a child or an adult may qualify for Medicaid coverage under more than one eligibility category. For example, a child age 5 is potentially categorically eligible as (1) a Apoverty-related≅ child; (2) a dependent child in a family meeting July 16, 1996 state welfare eligibility standards; or (3) a child in a welfare-to-work family. If this child has a disabling condition, the child may also qualify for Medicaid as a child receiving Supplemental Security Income (SSI) benefits. The number of categories and the multiple pathways by which one may qualify for coverage add to the complexity of Medicaid eligibility policy.

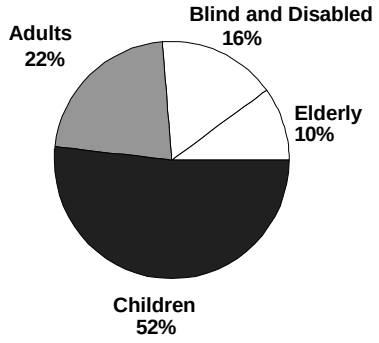
There are five broad coverage categories: children; pregnant women; adults in families with dependent children; disabled individuals; and the elderly. This paper focuses on three of these five broad coverage categories: children, pregnant women, and adults in families with dependent children.

Children. The Urban Institute estimates that of the 41.3 million individuals enrolled in Medicaid in 1996, just over half -- 21.3 million -- are children (Figure 3). The two primary eligibility pathways for children are (1) membership in a one-parent (and in

some cases two-parent) family with dependent children with income and resources sufficiently low to meet the July 16, 1996 AFDC standards in the state of residence; and (2) membership in a family (one-parent, two-parent, or no-parent) with an income below specified federal poverty level thresholds.

Figure 3

Distribution of Medicaid Enrollees by Category, 1996



Total = 41.3 Million People

SOURCE: Urban Institute estimates, 1998.

Pregnant Women. Medicaid pays for over 40 percent of the live births in the U.S.[9] One reason is that all pregnant women, regardless of age or family circumstances, are eligible for Medicaid if their incomes are at or below 133 percent of the federal poverty level ($1,513 per month for a family of three in 1998). Their entitlement to coverage extends throughout the pregnancy and for 60 days post-partum.

Adults in Families with Dependent Children. Unlike children and pregnant women, non-disabled adults do not have the benefit of a broad Medicaid eligibility category that is tied to the federal poverty level. Instead, adults who are neither disabled, pregnant, or elderly can only potentially qualify for Medicaid if they are an adult in a family with dependent children. This category is a remnant of Medicaid=s long association with the Aid to Families with Dependent Children (AFDC) program, which has been repealed and replaced with the Temporary Assistance to Needy Families (TANF) block grant.[10]

Prior to the repeal of AFDC in 1996, adults and children in families receiving AFDC cash assistance were automatically eligible for Medicaid. This is no longer the case: families receiving cash assistance under TANF are not eligible for Medicaid on the basis that they are receiving cash assistance. Instead, a new eligibility category, found at section 1931 of the Social Security Act, was created for these adults and children. Under section 1931, a state Medicaid program must cover families that meet the AFDC eligibility criteria that were in effect in a state as of July 16, 1996, whether or not the family receives cash assistance under the state=s TANF program.

Of particular relevance to adults are the non-financial eligibility criteria relating to family composition. These criteria derive from the pre-1996 welfare law “deprivation” requirements, under which “a child in a family must be deprived of parental support and care by reason of the death, absence, incapacity, or unemployment of a parent.” Section 1931 maintains the deprivation requirements by limiting Medicaid coverage to non-

disabled adults in single-parent households with a minor child or to non-disabled adults in two-parent households where the principal earner is unemployed.[11]

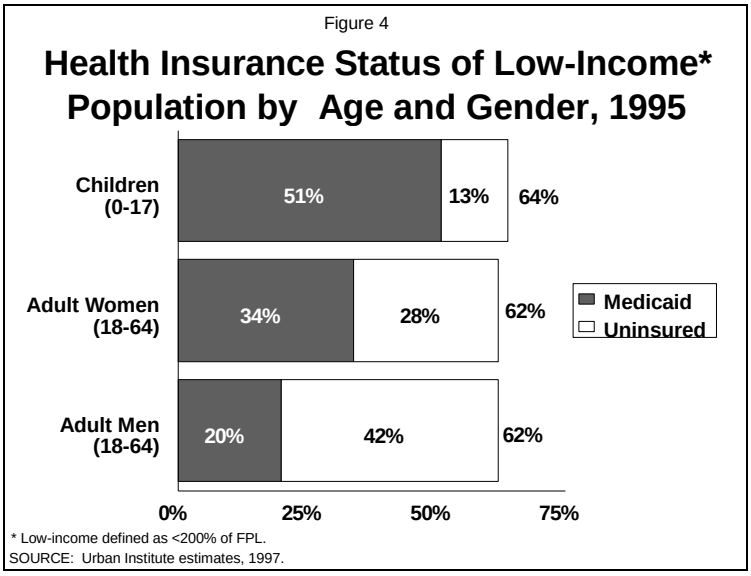
Under a recent regulation issued by the Department of Health and Human Services, states have the option of defining unemployment for this purpose, although they cannot be more restrictive than the pre-1996 welfare law standard, which generally prohibited the principal earner from working more than 100 hours per month. This new flexibility allows states to treat two-parent families as they treat single parent families, by simply applying an income test in determining Medicaid eligibility and ignoring the number of hours worked.[12]

Adults without Categorical Eligibility. The Medicaid eligibility categories described above have the effect of excluding millions of poor men and women from Medicaid, regardless of their degree of impoverishment or medical need. Women who are not pregnant, not disabled, not elderly, or do not have dependent children are ineligible for Medicaid. The same applies to men living in poverty. The effects of these categorical exclusions can be seen in Figure 4. Compared to children, low-income adult women and men are two to three times more likely to be uninsured.

Income Eligibility

Being in a Medicaid eligibility category is essential to qualifying for Medicaid coverage. It is not, however, sufficient. Because Medicaid assistance is limited to those in financial need, the program also imposes financial eligibility requirements. These requirements take two basic forms: income tests and resource (or assets) tests. These financial requirements vary from category to category. For example, both the income eligibility thresholds and the resource tests for children differ in most states from the income and resource tests applicable to the disabled or the elderly.

Figure 4



There are some eligibility categories for which states are not required to apply a resource test. However, all Medicaid eligibility categories are subject to an income test. Many of these tests vary from category to category (and from state to state). In some cases -- notably children, pregnant women, and Medicare beneficiaries -- income

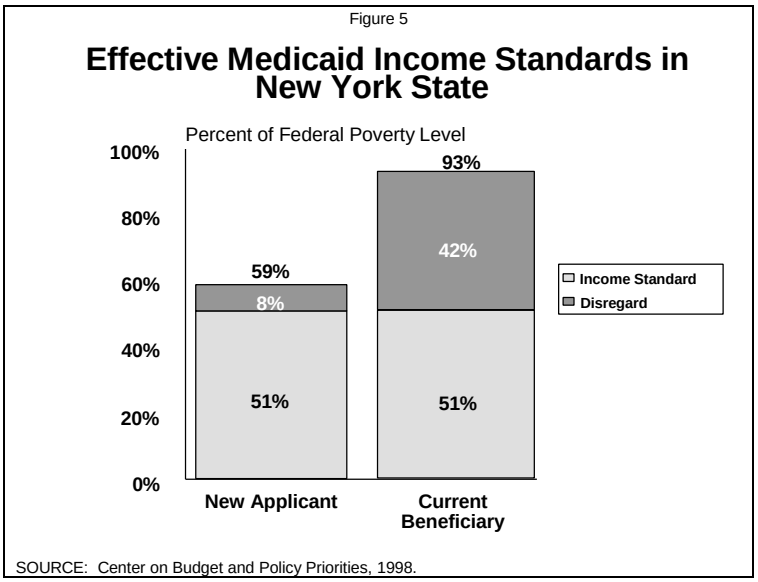
eligibility standards are tied directly to specified percentages of the federal poverty level (e.g., 100 percent, 120 percent, 133 percent, 185 percent). In other cases -- notably the disabled and the elderly -- income eligibility standards are those of the federal cash assistance programs or are a multiple of them (e.g., 300 percent of the SSI payment standard).

There are two components of income eligibility: the standard and the methodology. An income *standard* is a dollar amount -- say, $1,138 per month (100 percent of the 1998 federal poverty level for a family of three). An income *methodology* is the way in which an applicant=s income is counted for purposes of applying the income standard. For example, an income methodology may count all income received from any source, or it may disregard certain kinds of income, such as earned income. The standard is meaningless without the methodology. Indeed, the methodology converts the nominal income standard into the actual income level required to qualify for the program.

Consider a state with a nominal Medicaid income standard of 100 percent of poverty in 1998, or $1,138 per month for a family of three. If such a family earned $1,300 per month and had no other income, and if the state=s Medicaid income methodology disregards the first $200 of earned income each month, the family would qualify for Medicaid under an income standard set at $1,138 per month because under this methodology only $1,100 of the family=s income would be counted. Looked at another way, the income methodology in this example would allow a family with a gross income equal to 118 percent of the federal poverty level to qualify for Medicaid under an income standard set at 100 percent of poverty. If the state uses an income methodology that disregards, for example, the first $1,200 of earned income each month ($300 per week), the family could earn 200 percent of poverty, or $2,276 per month, and still qualify for Medicaid under a nominal 100 percent of poverty standard ($2,276 minus $1,200 equals $1,076).

Figure 5 shows how income methodologies significantly impact who is eligible for Medicaid. In New York state, income disregards are applied differently for families with dependent children applying for Medicaid than for those attempting to continue their Medicaid eligibility. The state's Medicaid income standard is 51 percent of the federal poverty level, about $580 per month for a family of three. New applicants are permitted to disregard $90 per month of income, the minimum AFDC level, creating an effective income standard of 59 percent of the federal poverty level. Continuing beneficiaries, however, can disregard 45 percent of their income raising the effective income level to 93 percent of the federal poverty level or $1,047 per month.

Figure 5



SOURCE: Center on Budget and Policy Priorities, 1998.

There are some Medicaid eligibility categories for which individuals may qualify by Aspending down≅ -- that is the costs of health care that an individual has incurred are deducted from the income that an individual receives in determining whether he or she qualifies for Medicaid. The most commonly known category to which the spend-down approach applies is the Amedically needy.≅ These are individuals who fall into one of the required eligibility categories -- e.g., pregnant woman or a family with dependent children -- but whose income is greater than the applicable income standard for cash assistance in the state.

Children and pregnant women eligible for Medicaid based on federal poverty level criteria may not spend down to qualify on this basis. In states that elect to cover the medically needy, however, pregnant women and children whose incomes are higher than the poverty level criteria may still qualify for Medicaid if their medical expenses are sufficiently high.

Resource Eligibility

For most eligibility categories in most states, individuals must have resources of less than a specified amount in order to qualify for Medicaid. Resources include items such as cars, savings accounts, and savings bonds.

As in the case of income eligibility requirements, resource requirements encompass both standards and methodologies. A resource *standard* is a dollar amount -- typically $1,000 in the case of an adult with one or more dependent children, or $2,000 in the case of an aged or disabled individual. In contrast to the Medicaid income standards, some of which are tied to the federal poverty level, Medicaid resource standards are generally not indexed to inflation or otherwise adjusted on a regular basis. As a result, resource standards have become more restrictive over time.

A resource *methodology* determines which resources are counted and how those counted resources are valued. For example, the home in which an individual lives is generally not a countable resource, regardless of its value. Similarly, a wedding ring or engagement ring is generally not a countable resource. Most other resources tend to be

countable, although the resource methodology that applies to the eligibility category in question may not count the entire value of the resource. For example, the resource methodology applicable to AFDC-like families with children does not count up to $1,500 in equity value of the first car. A state can make a resource standard less restrictive without changing the standard simply by adjusting its resource methodology. It could disregard more of the value of certain countable resources or exclude them from counting altogether. To continue with the above example, a state seeking to promote work could exclude the first $10,000 in market value of a car that is used primarily for commuting to employment from counting toward the resource standard, or it could disregard the car altogether regardless of its value.

For certain eligibility categories, states have discretion to liberalize or eliminate resource tests altogether. Since 1986 states have had the option of not imposing a resource test on low-income pregnant women and children. Appendix Table 1 shows that, as of May 1998, forty states had elected to drop the resource test for all poverty-level children and two others have dropped it for certain categories of children. The effect of dropping the resource test is Ato lessen barriers to eligibility for this high priority population.≅[13]

The identification and valuation of resources for purposes of Medicaid eligibility is intrusive for the applicant, presents a labor-intensive task for the state Medicaid agency, and adds substantial complexity to the program. In part, these results are the intended outcomes of a welfare-based resource test: to screen out those applicants who are not considered sufficiently needy to warrant public subsidies for health or long-term care coverage, and to discourage individuals from applying for Medicaid benefits in the first instance. Figure 6 highlights the disparity in two states' approaches to applying resource tests for children. Texas' comprehensive resource requirements stand in sharp contrast to South Carolina's, which has dropped its resource test for children.

Identifying and valuing applicants' resources, however, is administratively costly, and raises the question of whether resource tests justify their high administrative costs. A 1993 Urban Institute analysis found that fewer than 10 percent of families with children meeting Medicaid=s income eligibility requirements would be denied Medicaid coverage on the grounds of excess resources. Not surprisingly, most families with children whose incomes are sufficiently low to qualify for Medicaid are unable to afford to obtain or retain significant amounts of resources. The analysis concluded that Medicaid resource tests are Aprobably not cost effective, particularly for nonelderly groups of the population≅ unless they can be administered Avery inexpensively.≅[14]

Figure 6

Examples of Items Included in Medicaid Resource Tests for Children in Two States

Texas	South Carolina
Car, Truck, Motorcycle, or Boat	
Equipment of Any Kind	
Houses, Land, or Lots	No Resource Test
Livestock or Cattle	
Life or Burial Insurance	
Real Estate	
Rental Properties	
Checking or Savings Accounts	
Retirement Accounts	
Money Market Accounts	
Trust Funds	
Stock, Bonds, or Mutual Funds	
Savings Bonds	
Oil or Mineral Rights	
Any cash not in a bank	
Any item not listed above	

SOURCE: Texas and South Carolina Medicaid Application Forms as of June 1998.

Immigration Status

The fourth broad Medicaid eligibility requirement is immigration status. Citizens who meet the program=s financial and non-financial eligibility requirements -- including the U.S.-born children of illegal immigrants -- are entitled to Medicaid coverage. Immigrants who are *legally* residing in the U.S. may qualify for Medicaid coverage for emergency care if they meet all other financial and non-financial eligibility requirements, however, these legal immigrants may not qualify for Medicaid coverage for non-emergency care. Immigrants living illegally in the country are not eligible for Medicaid coverage other than for emergency care.

The 1996 welfare law created two categories of legal immigrants for Medicaid eligibility purposes: those who were residing in the U.S. prior to August 22, 1996, and those who entered the U.S. on or after that date. Those legal immigrants who were residing in the U.S. before August 22, 1996 are, at state option, eligible for Medicaid if they are otherwise qualified, whether or not they were receiving Medicaid coverage prior to that date. All states except Wyoming have elected to continue eligibility for this population.

Most immigrants entering the country legally on or after August 22, 1996 are ineligible for Medicaid (and other federal benefits) for five years from their date of entry into the U.S. The only exceptions to this five-year bar for most legal immigrants is coverage for emergency care services. After the five-year period has expired, States may, at their option, extend Medicaid coverage to these otherwise qualified immigrants or continue to deny them benefits until they become citizens.[15] Medicaid eligibility for immigrants is summarized in Figure 7.

Figure 7

Summary of Immigration Requirements Related to Medicaid Eligibility

Even if an individual meets Medicaid's categorical, income, resource, and residency requirements, they are subject to further immigration criteria.

- Immigrants entering the US legally on or after August 22, 1996 are barred from receiving Medicaid for five years.
- States have the option to continue Medicaid eligibility for legal immigrants entering before August 22, 1996.
- All immigrants, legal and illegal, remain eligible for emergency services under Medicaid.
- States can use state funds to provide health services to both legal and illegal immigrants.
- Immigrant children born in the US are eligible for Medicaid even if their parents are not eligible.

SOURCE: Center on Budget and Policy Priorities, 1998.

Residency

Being a citizen of the U.S. (or a legal immigrant in the U.S. prior to August 22, 1996) is not sufficient to qualify for Medicaid, even if an individual meets the other categorical, income, and resource requirements. An individual must also be a resident of the state offering the Medicaid coverage for which the individual is applying. In general, an individual is considered a resident of a state if the individual is living there with the intention of remaining indefinitely. States are prohibited by federal law from denying Medicaid coverage because an individual has not resided in a state for a specified minimum period. Medicaid has developed special eligibility policies to address the circumstances of migrant and seasonal farmworker families and homeless individuals.[16]

II. Medicaid Eligibility Pathways

There are many different eligibility pathways that a child or family may use to establish an entitlement to Medicaid coverage. As noted above, individuals may potentially qualify for Medicaid under more than one pathway. This section reviews the main pathways under federal Medicaid law for children, pregnant women, and non-disabled adults.

Children. The federal statutory pathways through which a low-income child may qualify for Medicaid are summarized in Figure 8. The pathways are divided into mandatory and optional groupings. For each pathway, the basic income and resource standards are set forth.

Figure 8: Medicaid Eligibility Pathways for Low-Income Children

Mandatory Coverage	Eligibility Criteria		Optional Coverage	Eligibility Criteria	
	Family Income	Resource Test		Family Income	Resource Test
Primary Pathways			**Primary Pathways**		
Infants under age 1	≤ 133% FPL[a]	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)	**Infants under age 1**	≤ 185% FPL[b]	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)
Children age 1 to 6	≤ 133% FPL	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)	**Children age 1 to 6**	≤ 185% FPL	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)
Children age 6 to 15[c]	≤ 100% FPL[d]	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)	**Children age 6 to 15**	≤ 133% FPL or ≤ 185% FPL	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)
			Targeted low-income children age 15-19 (CHIP children) born before 10/1/83	≤ 100% FPL	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)
Section 1931 children	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96			
Children in welfare-to-work families (12 month transitional coverage)	Family receives cash assistance in 3 of 6 months prior to ineligibility due to increased earnings up to 185% FPL	No resource test during coverage period			
Title IV-E foster care children	State AFDC income level as of 7/16/86	State AFDC level as of 7/16/96	**Non-Title IV-E foster care children**	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96
Title IV-E adoption assistance children[f]	State AFDC level as of 7/16/96, or SSI level (≤ $494/month for individual, ≤ $741/month for couple)	State AFDC level as of 7/16/96, or SSI level (≤ $3,000 for couple, ≤ $2,000 for individual)	**Non-Title IV-E adoption assistance children**	Title IV-E foster care level	Title IV-E foster care level
			Medically needy children under age 18	Spend down to eligibility by incurring medical expenses	No more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)

Other Pathways	Other Pathways		
	Ribicoff children	AFDC level as of 7/16/96	AFDC level as of 7/16/96
Mandatory and optional pathway thresholds are subject to expansion in states using section 1902(r)(2) "less restrictive" methodologies.[g]			

a. In 1998, 133 percent of the federal poverty level (FPL) for a family of three was $18,155/year, or $1,513/month. 63 Fed. Reg. 9235 (1998).
b. In 1998, 185 percent of the FPL for a family of three was $25,253/year, or $2,105/month. Id.
c. Social Security Act requires coverage of children to age 19 at or under 100 percent of the FPL born after September 1983. Under this provision, coverage is being phased in one year at a time. By September 2002, all of these children under 19 will be covered.
d. In 1998, 100 percent of the FPL for a family of three was $13,650/year, or $1,138/month. Id.
e. Section 1931(b) allows states to use income and resource methodologies that are "less restrictive" than those used under the state AFDC program as of July 16, 1996, effectively expanding Medicaid eligibility. This flexibility does not allow states to liberalize the AFDC family composition rules.
f. Children covered under Title IV-E adoption assistance agreements are defined as "special needs" children, with respect to whom the state determines there is a specific condition or situation (such as disability, age, or membership in a minority group) that prevents placement without special assistance.
g. For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are "less restrictive" than those used under the state AFDC programs as of July 16, 1996, effectively expanding Medicaid eligibility without changing the income and resource standards. This provision applies to the mandatory and optional poverty-level categories, qualified children, medically needy children, and Ribicoff children.

Federal mandatory income thresholds for children vary by age. The minimum income standard for children up to (but not including) age 6 is 133 percent of the federal poverty level. For children ages 6 and older and born after September 30 1983, the minimum income standard is 100 percent of the federal poverty level. This differential has the effect of dividing families into those children eligible for Medicaid and those not. Consider a single-parent family with two children age 5 and age 16 and an income at 50 percent of the poverty level. In Texas, the 5-year old would be eligible for Medicaid, while the mother and 16-year-old would be ineligible. In Oregon, all three members of the family would be covered.

As discussed above, these income standards can effectively be modified through the adjustments to the methodologies used by states for counting family income or resources. Section 1902(r)(2) of the Social Security Act allows states to use more liberal methodologies than those which apply under the former AFDC program. For example, Pennsylvania disregards 50 percent of a parent=s earned income in determining Medicaid eligibility, thereby enabling a single parent with two children with earnings below 74 percent of the federal poverty level to remain on Medicaid. North Carolina exempts the first $5,000 in fair market value of a car.[17]

Children with disabilities may qualify for Medicaid under any of the statutory pathways described in Figure 8 if applicable to that child's circumstances. In some cases, however, none of these pathways is adequate to enable a disabled child to qualify due to income or resource limitations. Medicaid policy has developed some additional pathways targeted to children with disabilities that address these circumstances, which are also summarized in Figure 9.

This matrix of mandatory and optional eligibility pathways, combined with different policy decisions made by different states, has resulted in the variation from state to state in Medicaid eligibility thresholds for children that is reflected in Appendix Table 1. This variation may increase with the implementation of the new Child Health Insurance

Program (CHIP) enacted by Congress in 1997. As of September 1998, the Department of Health and Human Services has approved 34 state CHIP programs. In 25 of these states, federal CHIP matching funds are being used to finance Medicaid eligibility expansions for children.[18]

Figure 9: Medicaid Eligibility Pathways for Children with Disabilities

Mandatory Coverage	Eligibility Criteria		Optional Coverage	Eligibility Criteria	
	Family Income[a]	Resource Test[b]		Family Income	Resource Test
Primary Pathways			**Primary Pathways**		
Supplemental Security Income (SSI) recipients	≤ $494/month for individual, ≤ $741/month for couple	≤ $3,000 for couple, ≤ $2,000 for individual	**Katie Beckett children[c]**	Would meet Medicaid/SSI eligibility standard if institutionalized and parents' income not attributed	Would meet Medicaid/SSI eligibility standard if institutionalized and parents' resources not attributed
Title IV-E Adoption Assistance Children[d]	AFDC level as of 7/16/96, or SSI level (≤ $494/month for individual, ≤ $741/month for couple)	AFDC level as of 7/16/96, or SSI level (≤ $3,000 for couple, ≤ $2,000 for individual)	**Home or community-based waiver children[e]**	Would meet Medicaid eligibility standard if institutionalized and parents' income not attributed	Would meet Medicaid eligibility standard if institutionalized and parents' resources not attributed
Other Pathways			**Other Pathways**		
SSI recipients as of 8/22/96	≤ $494/month for individual, ≤ $741/month for couple	≤ $3,000 for couple, ≤ $2,000 for individual	**Medically needy**	Spend down to eligibility by incurring medical expenses	No more restrictive than state AFDC level as of 7/16/96 (≤ $1,000 in countable resources per family)

a. SSI income level is adjusted annually based on the 12-month change in the Consumer Price Index (CPI). Parents' income is attributed to children under age 18, but the needs of the parent and other children in the household are taken into account.
b. Parents' resources are deemed to children under age 18, but only to the extent that they exceed the applicable limits.
c. States electing this option must cover, on a statewide basis, all children in this category.
d. Children covered under Title IV-E adoption assistance agreements are defined as "special needs" children, with respect to whom the state determines there is a specific condition or situation (such as disability, age, or membership in a minority group) that prevents placement without special assistance. (1998 Green Book p. 750).
e. The home and community-based services option does not require a state to extend coverage to all such children throughout the state.

Pregnant Women. While pregnant women can, depending on their individual circumstances, qualify for Medicaid as non-disabled adults or as children, the primary eligibility pathway is the condition of pregnancy combined with a family income at or below 133 percent of the federal poverty level ($1,513 per month for a family of three in 1998)(Figure 10). Some states have raised their income standards for pregnant women to 185 percent of the federal poverty level ($2,105 per month for a family of three in 1998) or above. In states with Amedically needy≅ programs, pregnant women with incomes above these poverty-level thresholds may Aspend down≅ into Medicaid eligibility if their medical expenses are sufficiently high. Pregnant women are eligible for all services related to pregnancy.

Figure 10: Medicaid Pathways for Pregnant Women

Mandatory Coverage	Eligibility Criteria		Optional Coverage	Eligibility Criteria	
	Family Income	Resource Test		Family Income	Resource Test
Primary Pathways			**Primary Pathways**		

Mandatory Coverage	Eligibility Criteria		Optional Coverage	Eligibility Criteria	
	Family Income	Resource Test		Family Income	Resource Test
Pregnant Women	≤ 133% FPL[a]	Optional; if used, no more restrictive than SSI test (≤ $2,000 in countable resources for individual)	**Pregnant women**	≤ 185% FPL[b]	Optional; if used, no more restrictive than SSI test (≤ $2,000 in countable resources for individual)
Other Pathways			**Other Pathways**		
			Medically needy	Spend down to eligibility by incurring medical expenses	No more restrictive than state AFDC test as of 7/16/96 (≤ $1,000 in countable resources per family)

a. In 1998, 133 percent of the federal poverty level (FPL) for a family of three was $18,155/year, or $1,513/month. 63 Fed. Reg. 9235 (1998).
b. In 1998, 185 percent of the FPL for a family of three was $25,253/year, or $2,105/month. Id.

Figure 11: Medicaid Eligibility Pathways for Other Adults

Mandatory Coverage	Eligibility Criteria		Optional Coverage	Eligibility Criteria	
	Family Income	Resource Test		Family Income	Resource Test
Primary Pathways			**Primary Pathways**		
Certain adults in low-income families with dependent children[a]	AFDC level as of 7/16/96	Optional; if used, no more restrictive than AFDC level as of 7/16/96 (≤ $1,000 in countable resources)	**Adults in two-parent households with dependent children**	State discretion under section 1931(b) -- A less restrictive income methodology than state plan as of 7/16/96	State discretion under section 1931(b) -- A less restrictive resource methodology than state plan as of 7/16/96
Welfare-to-work families (12 month transitional coverage)	Family receives cash assistance in 3 of 6 months prior to ineligibility due to increased earnings up to 185% FPL	No resource test during coverage period			
Other Pathways			**Other Pathways**		
			COBRA continuation beneficiaries	≤ 100% FPL[b]	≤ $4,000 per individual, ≤ $6,000 per family
			Medically needy	Would qualify via another pathway after medical expense spend down	Would qualify via another pathway after medical expense spend down

a. Covered adults include single parents and adults in two-parent households where the principal wage earner is unemployed. Section 1931(b) of the Social Security Act allows states to use income and resource methodologies that are "less restrictive" than those used under the state AFDC program as of July 16, 1996, effectively expanding Medicaid eligibility. This flexibility does not allow states to liberalize the AFDC family composition rules.
b. In 1998, 100 percent of the federal poverty level (FPL) for a family of three was $13,650/year, or $1,138 month. 63 Fed. Reg. 9235 (1998).

Nondisabled Adults Under 65. Federal Medicaid eligibility policy toward low-income adults who are not disabled and not elderly is far more restrictive than toward low-income children or pregnant women. As seen in Figure 11, there are relatively few mandatory or optional pathways for these adults, and the pathways that do exist are almost all limited to adults in single-parent households or in two-parent households. As discussed above, these family composition rules reflect Medicaid=s longstanding linkage to the recently-repealed AFDC program, which targeted cash assistance primarily to single mothers with children under 18.

In addition, the financial eligibility standards that apply to these adults are generally much lower than those that apply to children. The Center on Budget and Policy Priorities calculates that the median state income standard that represents the threshold under the section 1931 eligibility category is 45 percent of the federal poverty level, or $512 per month for a family of three in 1998.[19] This compares with 100 percent of poverty, or $1,138 per month for a family of three, in the case of children from age 6 through age 15.

III. Waivers

The categorical, income, and resource requirements described above are, like many other requirements in the federal Medicaid statute, subject to waiver by the Secretary of Health and Human Resources under section 1115 of the Social Security Act. These Ademonstration" waivers may enable states to receive federal Medicaid matching funds for the cost of covering populations or services for which matching funds would otherwise not be available.[20]

As Appendix Table 2 indicates, the Secretary of HHS has granted waivers allowing a number of states to expand Medicaid eligibility beyond the statutory categories. Arizona, Delaware, Hawaii, Massachusetts, Oregon, New Jersey, New York, Tennessee, and Vermont all operate statewide section 1115 demonstration programs in which adults who would otherwise be excluded for family composition reasons may qualify for Medicaid coverage. In some cases, states had previously covered some or all of these adults under their General Relief or General Assistance programs entirely at state or local expense; the section 1115 waiver enables these states to draw down federal Medicaid matching funds for part of the cost of this coverage.[21] Recent analysis of the Kaiser/Commonwealth Five-State Survey shows that the proportion of low-income uninsured adults in the waiver states is two to three times higher than in states that have not expanded Medicaid eligibility levels beyond AFDC levels.[22]

IV. Policy Options

State Policy Options

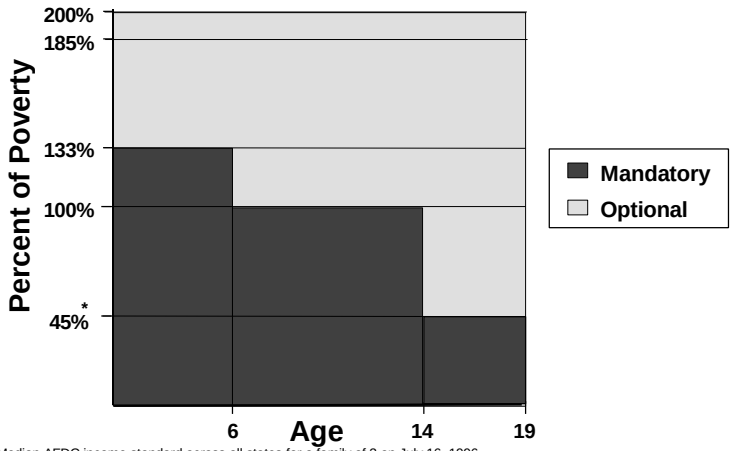
Because Medicaid is a federal-state partnership, many opportunities to expand Medicaid coverage fall within the states' discretion. Under current law, states have the flexibility to extend Medicaid coverage to certain categories of individuals. They can cover children, pregnant women, nondisabled adults in single-parent and certain two-parent families and receive federal Medicaid matching funds without obtaining a section 1115 waiver from the Secretary of HHS.

Under federal law, states must cover all children ages 6 and older and born after September 30, 1983 in families with incomes below 100 percent of the federal poverty level ($1,138 per month for a family of three in 1998). This mandatory coverage continues to be phased in over the next few years so that by 2002, states will be required to cover all children up to age 19 below poverty. Until full phase-in, the minimum income standard for children between the cut-off date and age 19 drops to the AFDC standard in effect as of July 16, 1996, about 45 percent of poverty nationally (Figure 12). Researchers estimate that these federal expansions have extended Medicaid coverage to 7.5 million children.[23]

States have the option to move beyond federal law. A number of states have already exercised their options to extend Medicaid coverage to older, low-income children. Thirty-four states have accelerated this phase-in and already cover children between 14 and 19 with incomes below 100 percent of poverty. Of these, six states have raised income eligibility levels to 200 percent of poverty or greater for teenagers as well as younger children.

Figure 12

State Options for Extending Medicaid Coverage Without a Waiver to Low-Income Children



* Median AFDC income standard across all states for a family of 3 on July 16, 1996.
SOURCE: HCFA and CBPP, 1998.

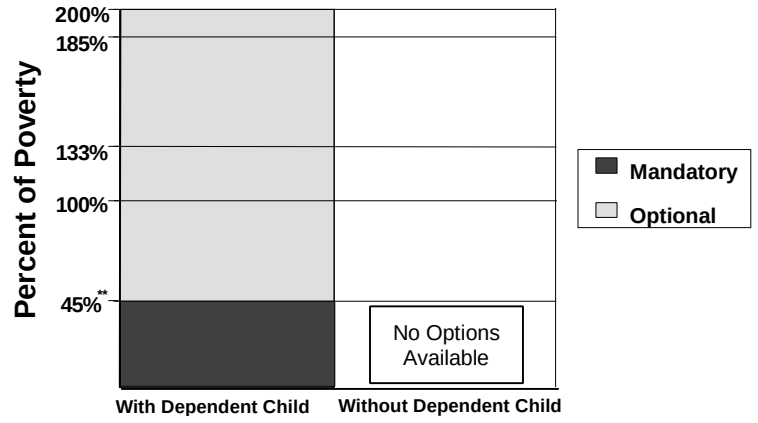
To illustrate this point, every state could potentially, if it contributed its share of the cost, extend Medicaid coverage to children under age 19 in families with incomes at or below 200 percent of the poverty level. The 200 percent of poverty level is for illustrative purposes only. The federal Medicaid statute imposes no upper limit on the eligibility threshold a state may establish. The principal eligibility pathway for such an expansion is the flexibility states have to use “less restrictive” methodologies for counting income under section 1902(r)(2) of the Social Security Act. The same approach could be applied to pregnant women. With the enactment of the Child Health Insurance Program (CHIP) in 1997, states have additional coverage options for children, some of which involve Medicaid.[24]

States= policy options with respect to non-disabled adults are more limited because they must meet all of Medicaid’s non-financial requirements in addition to the

state's income standards. Despite these limitations, all adults meeting Medicaid=s non-financial requirements, principally adults with dependent children, with incomes at or below 200 percent of the federal poverty level could be eligible for coverage (Figure 13). Again, states would have to contribute their share of the cost of this expanded coverage. Like the potential to expand coverage for children, this potential for expansion is based on the ability of states to use Aless restrictive≅ methodologies for counting income in determining Medicaid eligibility under section 1931 of the Social Security Act.

Figure 13

State Options for Extending Medicaid Coverage Without A Waiver to Non-Disabled Low-Income* Adults under 65



* Low-income is defined as 200% of poverty

****** Median AFDC income standard across all states for a family of 3 on July 16, 1996.

Source: HCFA and CBPP, 1998

Beyond increasing income standards for certain groups of individuals, states can take other measures to expand Medicaid eligibility. As mentioned earlier, they can eliminate the resource test for children or use less restrictive methodologies to count resources for adults.

Federal Policy Options

State options for Medicaid eligibility expansion under current law are not unlimited. Most significantly, states cannot, without a section 1115 waiver, extend Medicaid coverage to low-income adults under age 65 without a disability unless those individuals have dependent children. The federal government could give the states additional flexibility by allowing them to receive federal Medicaid matching funds without a waiver for the coverage of adults who do not meet the current Medicaid family composition requirements. Depending on state response, this flexibility could result in significant reductions in the number of uninsured adults, particularly working poor adults without children, who do not have health coverage through their employers. The federal government could allow states, at their option, to extend the current 12-month transitional Medicaid coverage for welfare-to-work families an additional 24 months in order to reduce the number of working uninsured low-income parents.

To address the problem of eligibility churning due to income fluctuations among adults, the federal government could build on the flexibility it recently gave to states with respect to children. Under the Balanced Budget Act, a state can guarantee Medicaid coverage to a child for a period of up to 12 months regardless of changes in the child's

circumstances. The federal government could extend this same flexibility to states with respect to low-income parents with dependent children and parents in welfare-to-work families.

V. Conclusion

Medicaid serves as the nation's primary source of health insurance coverage for the poor. Medicaid eligibility policy is complex. Recent federal and state eligibility policy changes to promote Medicaid coverage of low-income pregnant women and children have resulted in greater coverage of these groups within the low-income population. However, Medicaid eligibility policy remains complicated and confusing for program administrators and for potential enrollees. Options are available for states that choose to simplify and broaden eligibility criteria to reach a greater share of the low-income population. However, many low-income individuals fall outside the program's eligibility categories and are precluded from coverage no matter how poor they are. While some of the 1115 waivers have expanded coverage to individuals not meeting Medicaid's categorical eligibility requirements, current federal rules limit states' choices in this area.

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This Issue Paper draws from a chapter on Medicaid eligibility in the Medicaid Resource Book being prepared for the Kaiser Commission on Medicaid and the Uninsured. The authors would like to thank Andrew Brown for his research assistance.

Appendix Table 1: Medicaid Eligibility Levels for Pregnant Women and Children

State	Pregnant Women and Infants	Children Under Age 6	Children Ages 6 to 14	Children Ages 14 to 19	Asset Test Required for Children (4)	Max. AFDC Payments (7/16/96) (5)	Medically Needy, 1996
	Pregnant Women, Infants and Children (as of May 20, 1998)					Other Eligibility Categories	
	(percent of Federal Poverty Level)						
United States	**133**	**133**	**100**			**45**	**49**
Alabama	133	133	100	100	No	15	N/A
Alaska	133	133	100	90	No	76	N/A
Arizona	140	133	100	30	No	32	N/A
Arkansas (2,3,4)	(133) (200)	200	200	200	Yes	19	25
California (1)	200	133	100	100	No	56	86
Colorado (1,4)	133	133	100	37	Yes	39	N/A
Connecticut	185	185	185	185	No	81	71
Delaware	185	133	100	100	No	31	N/A
District of Columbia	185	133	100	37	No	37	N/A
Florida (1)	185	133	100	100	No	28	28
Georgia	185	133	100	100	No	39	35
Hawaii	185	133	100	100	No	57	57
Idaho (4)	160	160	160	160	Yes	29	N/A
Illinois	200	133	130	133	No	35	45
Indiana	150	133	100	100	No	27	N/A
Iowa (4)	185	133	100	37	Yes	39	52
Kansas	150	133	100	100	No	40	44
Kentucky	185	133	100	46	No	49	28
Louisiana	133	133	100	17	No	18	N/A
Maine	185	133	125	125	No	51	42
Maryland (2)	185	185	185	33	No	34	40
Massachusetts (1)	185	133	133	133	No	52	72
Michigan	185	150	150	150	No	45	52
Minnesota (3)	275	275	275	275	No	49	66
Mississippi	185	133	100	32	No	34	N/A
Missouri	185	133	100	100	No	27	N/A
Montana (4)	133	133	100	48	Yes	41	46
Nebraska	150	133	100	100	No	34	45
Nevada (4)	133	133	100	31	Yes	32	N/A
New Hampshire	300	185	185	185	No	51	60
New Jersey (1)	185	133	133	133	No	41	52
New Mexico	185	185	185	185	No	36	N/A
New York (1)	185	133	100	51	No	61	76
North Carolina	185	133	100	100	No	50	34
North Dakota (4)	133	133	100	100	Yes	40	47
Ohio	150	150	150	30	No	32	N/A
Oklahoma	185	185	185	185	No	28	42
Oregon (4)	133	133	100	100	Yes	43	57
Pennsylvania (1)	185	133	100	37	No	39	43
Rhode Island (3,4)	250	250	250	250	Yes	51	69
South Carolina	185	150	150	150	No	18	N/A
South Dakota	133	133	100	100	No	47	N/A
Tennessee (3)	400	400	400	400	No	54	23
Texas (4)	185	133	100	17	Yes	17	25
Utah (4)	133	133	100	100	Yes	53	53
Vermont (3)	(200) (225)	225	225	225	No	59	81
Virginia	133	133	100	100	No	22	33
Washington	(185) (200)	200	200	200	No	50	62
West Virginia	150	133	100	100	No	24	27
Wisconsin	185	185	100	45	No	48	64
Wyoming (4)	133	133	100	52	Yes	55	N/A

SOURCE: Center on Budget and Policy Priorities. 1998 and National Governors' Association. 1996 and 1997.

N/A: No medically needy program

Note: The 1998 Federal poverty guideline for a family of three was $13,650; for Alaska $17,070 and Hawaii $15,700.

(1) The state operates separate child health insurance programs for children not eligible for Medicaid. Such Programs may provide benefits similar to Medicaid or they may provide a limited benefits package and may include premiums a sharing.

(2) Children covered under Medicaid expansion programs in Arkansas and Maryland receive reduced benefits package pursuant to fe waivers.

(3) The Medicaid programs in AR, MN, RI, TN, and VT may impose some cost-sharing—premiums and/or co-payments for some chi pursuant to federal waivers.

(4) The states noted count assets, in addition to income, in determining Medicaid eligibility for children; Utah does not consider assets for young children. An assets test in NOT required in Arkansas for its Medicaid expansion program.

(5) The United States figure represents the median maximum AFDC payment level.

Appendix Table 2: Expansion Population Eligibility in State Medicaid Programs Operating Under Statewide Section 1115 Demonstration Waivers*

State	Expansion Population	Family Income Requirement	Resource Requirement	Categorical Requirement Waived	Premium/Cost-Sharing	Enrollment Cap
Alabama	Children aged 6-19	< 133% FPL	N/A	Change in income requirement	No premium/cost-sharing	No
	Women for 24 months post-partum[a]	< 133% FPL		Pregnancy		
Arizona	Children up to age 14	≤ 100% FPL	N/A	Change in income requirement	$1-5 copay, depending on service. No copay for prescription drugs, prenatal care, EPSDT care, nursing facility services, and primary care visits not scheduled by the patient.	No
	Pregnant women and infants	≤ 140% FPL	N/A	Change in income requirement		
Arkansas	Children up to age 19	≤ 200% FPL	No resource test	Change in income requirement	$5 copay for prescriptions, $10 copay for outpatient services, percentage copay for hospital per diem	No
Delaware	Low-income children and adults	< 100% FPL	N/A	Changes income requirement for children, waives requirement of pregnancy, disability, or dependent children	No premium/cost-sharing	No
Hawaii	Low-income children and adults	< 300% FPL	< $2,000 for single person, < $3,000 for couple	Changes income requirement for children, waives requirement of pregnancy, disability, or dependent children	All persons (except pregnant women) making over 100% FPL pay 100% of medical, dental, and catastrophic care premiums. Sliding payment scale for children under 200% FPL.	No
Kentucky	No eligibility expansion					
Maryland	No eligibility expansion					
Massachusetts	Low-income employed	< 200% FPL	No resource test	Dependent child, pregnancy, disability	Cost-sharing on a sliding scale based on income	No
	Low-income unemployed	< 133% FPL	No resource test	Dependent child, pregnancy, disability		
	Unemployed persons receiving state or federal unemployment benefits	< 400% FPL	No resource test	Dependent child, pregnancy, disability		

State	Expansion Population	Family Income Requirement	Resource Requirement	Categorical Requirement Waived	Premium/Cost-Sharing	Enrollment Cap
Minnesota	Pregnant women and children up to age 19	≤ 275% FPL	No resource test	Changes income requirement	Premiums range from 1.5 to 8.8% gross income, $4/month premium for families with children < 150% FPL, non-pregnant adults pay 10% of inpatient hospital costs with $1,000 maximum	No
	Planned extension to low-income adults	N/A	N/A	Dependent child, pregnancy, disability		
New Jersey	Low-income individuals	< 200% FPL	< $7,500 for individual, < $15,000 per family	Dependent child, pregnancy, disability	Individuals with income below 200% FPL receive fully subsidized care; individuals with income below 300% FPL receive partially subsidized care.	No
	Low-income individuals	< 300% FPL	< $7,500 resources for individual, < $15,000 per family			
New York	Home Relief population		N/A	Dependent child, pregnancy, disability	No premium/cost-sharing	No
	Women for 24 months post-partum[a]	≤ 185% FPL		Pregnancy		
Ohio	No eligibility expansion					
Oklahoma	No eligibility expansion					
Oregon	Low-income children and adults	< 100% FPL	< $5,000	Dependent child, pregnancy, disability	Cost-sharing on sliding scale for adult, non-pregnant new eligibles.	No
Rhode Island	Pregnant women and children under age 8	< 250% FPL	N/A	Change in income requirement	Individuals with family incomes between 185-250% FPL subject to cost-sharing requirements.	No
	Women for 24 months post-partum[a]	< 250% FPL		Pregnancy		
Tennessee	Uninsurable individuals	N/A	No resource test	Dependent child, pregnancy	Individuals with family incomes > 100% FPL subject to cost-sharing requirements on sliding scale based on income.	Enrollment capped at 1,775,000[b]
	Persons ineligible for employer- or government-sponsored health plans		No resource test	Dependent child, pregnancy, disability		
Vermont	Low-income children and adults	< 150% FPL	N/A	Dependent child, pregnancy, disability	No premium/cost-sharing	

*Based on data collected by the George Washington University Center for Health Policy Research. N/A indicates that this information was not clear based on the information reviewed.
a. Only family planning services are covered under this extension.
b. Tennessee does not cap enrollment of traditional eligibles meeting the state's 1993 Medicaid eligibility criteria and uninsurable persons. The enrollment of uninsured persons is limited by the difference between 1,775,000 and the sum of traditional eligibles and uninsurable persons.

Notes

[1] Thomas Selden, Jessica Banthin, and Joel Cohen, “Medicaid’s Problem Children: Eligible but not Enrolled,” *Health Affairs.* May/June 1998: 192-200.

[2] Medicaid eligibility policy vis-a-vis the disabled and the elderly will be the focus of subsequent analyses.

[3] See Lake Snell Perry & Associates, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups with Parents of Potentially Eligible Children.* Kaiser Family Foundation, September 1998. [link to item# 1436]

[4] See Kaiser Commission on Medicaid and the Uninsured, "Medicaid Eligibility and Enrollment Projects," September 1998; Donna Cohen Ross, *Child Health Outreach Handbook* , Center on Budget and Policy Priorities, July, 1998; Sarah Shuptrine, Vicki Grant, and Genny McKenzie, *Southern Regional Initiative to Improve Access to Benefits for Low-income Families with Children,* Southern Institute on Children and Families, February 1998.

[5] Congressional Budget Office, *Behind the Numbers: An Explanation of CBO’s January 1997 Medicaid Baseline,* April 1997, p. 7.

[6] For detailed state-by-state data on the number and type of beneficiaries covered, see David Liska, Brian Bruen, Alina Salganicoff, Peter Long, and Bethany Kessler, *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990-1995*, Third Edition, Kaiser Commission on the Future of Medicaid, November 1997.

[7] Statement of Bruce C. Vladeck, Administrator, Health Care Financing Administration, “1998 Budget for Medicaid and Medicare Part B” presented to the House Commerce Committee, Subcommittee on Health and Environment, February 12, 1997.

[8] *Choices Under the New State Child Health Insurance Program: What Factors Shape Cost and Coverage?* Kaiser Commission on Medicaid and the Uninsured, January 1998 [link to item# 2104].

[9] *MCH Update: State Medicaid Coverage of Pregnant Women and Children*, National Governors' Association, September 1997, www.nga.org.

[10] See David Super, Sharon Parrott, Susan Steinmetz, Cindy Mann, *The New Welfare Law*, Center on Budget and Policy Priorities, August 14, 1996, www.cbpp.org.

[11] For a discussion of eligibility rules relating to two-parent families, see Jocelyn Guyer and Cindy Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents*, Center on Budget and Policy Priorities, July 1998, www.cbpp.org.

[12] 63 Fed. Reg. 42270 (August 7, 1998.)

[13] Jeff Harris and Jane Horvath, *The Administrative Impact of the Medicaid Eligibility Resource Test*, Kaiser Commission on the Future of Medicaid, April 1993.

[14] Marilyn Moon, The Urban Institute, *Asset Limits and Medicaid*, Kaiser Commission on the Future of Medicaid, April 1993.

[15] See Leighton Ku and Bethany Kessler, *The Number and Cost of Immigrants on Medicaid: National and State Estimates,* Urban Institute, December 1997. For a discussion of the impact of the welfare law changes on elderly legal immigrants, see Robert B. Friedland and Veena Pankaj, *Welfare Reform and Elderly Legal Immigrants*, Henry J. Kaiser Family Foundation, July, 1997. For a review of the options remaining to states with respect to coverage of this population through either federally-funded or state-funded programs, see Kelly Carmody, *State Options to Assist Legal Immigrants Ineligible for Federal Benefits*, Center on Budget and Policy Priorities, February 1998, www.cbpp.org.

[16] Sara Rosenbaum, *Medicaid and Migrant Farmworker Families: Analysis of Barriers and Recommendations for Change,* National Association of Community Health Centers, 1991.

[17] Guyer and Mann. July 1998.

[18] www.hcfa.gov/init/chip-map.htm

[19] Guyer and Mann. July 1998.

[20] For a summary of the expansion populations covered by some states under section 1115 waivers, see Sara Rosenbaum and Julie Darnell, *Statewide Medicaid Managed Care Demonstrations under Section 1115 of the Social Security Act: A Review of the Waiver Applications, Letters of Approval, and Special Terms and Conditions,* Kaiser Commission on the Future of Medicaid, May 1997.

[21] Under section 1931 of the Social Security Act, States have the option of liberalizing their financial eligibility standards for adults in one-parent and certain two-parent families by adopting “less restrictive” income or resource methodologies. They do not, however, have the option to liberalize the non-financial eligibility rules. In order to receive federal Medicaid matching funds for the coverage of childless non-disabled adults who do not meet these family composition requirements, states must obtain a waiver from the Secretary of HHS under section 1115.

[22] Schoen, C., B. Lyons, D. Rowland et al, "Insurance Matters for Low-Income Adults: Results from a Five-State Survey" *Health Affairs*, Sept/Oct 1997.

[23] Selden, Banthin, and Cohen, May/June 1998.

[24] See Alina Salganicoff and Patricia Seliger Keenan, *Child Health Facts: National and State Profiles of Coverage,* Kaiser Commission on Medicaid and Uninsured, January 1998.

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