Options for Improving Medicaid Eligibility

Current Policies
Because Medicaid is a federal-state partnership, each state sets its own eligibility policies within broad federal guidelines which identify population groups eligible for federal funds. As a result, policy objectives and economic realities in each state play a significant role in determining the following key elements of Medicaid eligibility:

1. Which groups of people can be covered
Federal rules currently define almost 50 groups of people that states either must cover (e.g., children under age six from families with incomes of no more than 133% of the federal poverty level (FPL)) or may choose to cover (e.g., people over 65 who require nursing home care and have incomes at or below

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300% of the Federal SSI benefit) in their Medicaid programs. These groups, or eligibility categories, are defined by both financial criteria (income and resource standards) and non-financial criteria (age, disability, the presence of children in the home, receipt of another type of assistance, the need for certain services, etc.). If an individual does not belong to one of these groups, a state may not use federal matching funds to cover that person under Medicaid without a federally approved Section 1115 waiver. In effect, these rules exclude from coverage all childless adults who are not sick enough to qualify for disability coverage or old enough to qualify for Medicare.

2. How income is calculated
Eligibility categories are defined in part by income standards. People with incomes above the standards (e.g., 100% FPL) do not typically qualify for Medicaid. Federal rules allow states flexibility in how they calculate income for the purpose of determining eligibility, as long as the method used is at least as generous as the federal minimum standards that apply to each eligibility category and disregards some types of federal benefits, such as Agent Orange payments. Having met those standards, states may choose to disregard or deduct certain income when determining program eligibility and may establish different income disregard policies for different eligibility groups.

3. How assets are treated
The federal government allows states to establish an asset standard for most Medicaid eligibility categories (e.g., $2,000 cash on hand for an individual) and requires states to do so for some others. Where a standard exists, those with assets (e.g., car, retirement account) that exceed it do not qualify for Medicaid. But here, too, states have considerable flexibility in how they calculate available resources, as long as the method they adopt conforms to certain federal rules. For example, when determining whether a low-income family qualifies for Medicaid, the Medicaid agency may use any method of calculating resources that is less restrictive than the method that was in effect in 1996 as part of the state’s AFDC (Aid for Families with Dependent Children) program.

4. Beneficiary contributions to the cost of care
Current Medicaid eligibility policies enable states to require some beneficiaries to contribute to the cost of their care. Some beneficiaries, such as the working disabled, may be required to pay premiums. Some must “spend down” on health care enough of their income to reduce it to a state-established income standard before they can qualify for Medicaid. Beneficiaries who receive long term care may retain only a small amount of income to cover their own and their spouse’s personal needs. They must contribute the remainder of their income to the cost of their care in order to maintain eligibility. These beneficiaries must also allow the Medicaid agency to recover the cost of care from the individual’s estate.

What Works Well and What Doesn’t
Participants in the Medicaid workgroup agree that current eligibility policies achieve several important goals. Among them:

- Medicaid provides health coverage to millions of poor and low-income Americans, about 46 percent of them children.

- States can tailor their eligibility policies to their budget and policy priorities. Within federal guidelines, a state may choose to target more funding to children or to parents, the working disabled, or any of the other eligibility categories.

- States can modify the method used to calculate income or assets to encourage specific beneficiary behavior. For example, disregarding the income from job training programs may encourage beneficiaries to work.

- Only those with the greatest need receive Medicaid coverage. Non-financial criteria assure that only adults with children to support, who are over 65, or whose health status meets the level of disability required for participation in the SSI or SSDI (Social Security Disability Insurance) programs receive publicly funded coverage. Income limits ensure that only those who have a significant need for assistance in affording health insurance coverage access publicly funded coverage.

At the same time, workgroup participants identified several troubling aspects of the current Medicaid program.

- Policies can be inequitable. Because states have considerable flexibility in determining who is and is not eligible, a person may be eligible for Medicaid in one state and not in another. At the same time, within a
state program people with the same level of income may be required to pay different amounts toward their cost of care based upon their eligibility category.

• Asset and income limits for some groups of individuals do not automatically change as income and cost of living indices change.

• Current Medicaid policies do not support some widely held objectives, such as the preference of many policy makers and consumers for community-based, long term care services rather than institutional care. For example, some states are interested in encouraging the use of community-based long term care services by establishing lower functional criteria for people applying to Medicaid for community-based services than for those entering a nursing home. Current law prohibits this.

• Medicaid is a needs based program that systematically excludes certain groups of people. These exclusions often result in policies that are complex to administer and difficult to understand. Further, covering poor adults only when their health has deteriorated enough to qualify for SSI or institutional long term care services may increase costs. Providing up-front coverage might prevent or delay the deterioration, and the need to provide SSI cash benefits.

How the Current System Can Be Improved

Although the number of people who participate in the Medicaid program is affirmation that the program’s current eligibility policies are effective, workgroup members agree that there is room (and need) for improvement. To address the concerns and achieve the goals spelled out by the workgroup (above), group members are now exploring a range of options for improving eligibility policies. These include the following:

**Collapsing many of the current categories and expanding eligibility to more poor people.** One option under consideration by the group is to allow states to pull down the federal match to cover all who live in poverty (i.e., have an income of 100% FPL or less) as well as all pregnant women and children under age six who live in families with incomes of 133% FPL or less. Poor, working-age adults would be the major group added under this option which would reduce the complexity of Medicaid policies by removing all non-financial criteria except age, pregnancy status, and, possibly, immigrant status. This policy change would enable all who live in poverty in the U.S. to obtain the services they need to maintain health, identify serious illness at an early stage (when it is often easier and less expensive to treat), and treat serious and chronic illness. Recognizing that this option would add many adults to the program, the group is now examining its potential cost.
Enabling states to cover all adults up to a lower income limit, such as 75% FPL. This option would leave the income limits for pregnant women and children as they are now (133% FPL for pregnant women and children under six; 100% FPL for children six to eighteen). While this option might be less costly than the one above, states adopting it would need to retain more of the existing eligibility categories in order to prevent some people who are currently eligible for Medicaid from losing that eligibility. In particular, states that have already chosen to cover people with disabilities up to 100% FPL would need to retain that category in order to continue to cover that population.

Allowing states to extend Medicaid beyond these levels. If a state chooses to extend coverage beyond the income levels described in the options listed above, it would have the flexibility to design a program for the higher income group consistent with the state’s particular policy priorities. As a result, the program for the higher income group could be different than the program for the lower income group.

Establishing federal incentives to encourage states to expand eligibility. Such incentives might include paying a state a higher percentage of the cost of serving new eligibles than the federal government pays for serving current eligibles.

Allowing states more flexibility to determine eligibility for long term care. One option is to allow states to establish different functional eligibility criteria for those seeking community-based long term care services than for those seeking coverage of nursing home services. This would enable Medicaid to start serving people while they live in the community instead of waiting until their condition deteriorates enough to require more expensive nursing home care. However, such a strategy could raise state costs because the number of those applying for these services would likely be greater than the number of those applying to Medicaid for help in paying for nursing home care.

In exploring the pros and cons of the options outlined above, the Making Medicaid Work for the 21st Century advisory group is concerned with four key questions: 1) How much will the options under consideration cost, and can states and the federal government afford them? 2) What is the best way to implement these changes so that no current beneficiary is harmed? 3) What might be the unintended consequences of the proposed changes? 4) Which options, if any, should the group recommend?

For updates on this project and a list of advisory group participants and staff, visit the NASHP website at www.nashp.org.