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Medicaid Medically Needy: An Option Worth Revisiting?

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Medicaid medically needy programs allow states the option to expand Medicaid coverage to people with high medical expenses and who otherwise would be ineligible due to income or resource limits. To qualify, individuals "spend down" into Medicaid coverage by paying out-of-pocket medical expenses to lower their income to a predetermined level.

Currently, 33 states and the District of Columbia operate medically needy programs. In 2003, more than 3.4 million people – 6.3 percent of the Medicaid population – received coverage through a medically needy program at an annual cost of $27 billion -- 9 percent of total Medicaid expenditures.[1] These programs also allow states to expand Medicaid benefits to certain populations otherwise ineligible for Medicaid, notably young adults ages 19 to 21.

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State Health Policy Monitor provides an overview of how a particular state health policy issue, policy, or practice is implemented in select states and across the country.

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This *State Health Policy Monitor* describes Medicaid medically needy programs, who is eligible, and how the programs differ across states.

Overview

States use medically needy programs to provide Medicaid coverage to people in a range of situations. Many individuals become eligible because they have recurring medical expenses and spend down continually on services such as institutional care or prescription medication. Others become eligible because of significant one-time costs, such as accidents or catastrophic illnesses. Some people in states with medically needy income levels (MNIL) above certain categorical eligibility levels are eligible as medically needy without spending down if their income falls between the two levels and they do not qualify for coverage under any other circumstance.[2] This is especially true for those left out of the eligibility expansions of the 1980s and 1990s, such as parents.

Medically needy programs count income within one- to six-month time frames known as budget periods. When a person has incurred medical expenses equal to the difference between their income and the MNIL, he or she has qualified for coverage and will retain eligibility for the remainder of the budget period.[3] See 'Spending Down to Eligibility' for an example.

States can also allow people an alternative method of meeting the spend-down requirement, called "pay-in spend-down." Through pay-in spend-down, individuals satisfy the spend-down requirement by paying a monthly premium to the state that equals the difference between the family's income and the MNIL.[4]

States have considerable flexibility in deciding whom to cover in their programs. All states with medically needy

programs are mandated to cover children under 18 and pregnant women. States also have the option of covering young adults ages 19 to 21, parents and caretaker relatives, elderly, blind, and disabled people, and "reasonable subgroups" of these populations.[5] With the exception of Texas, all states with medically needy programs cover the aged, blind, and disabled, and this has become one of the primary pathways into coverage for long-term care. Most states also cover other optional groups.

States have some flexibility to modify the benefits packages for medically needy populations. They can restrict or reduce dental, vision, mental health, pharmacy, hospital and/or nursing home coverage. However, in practice most states offer medically needy individuals the full range of benefits available to the categorically needy. Notably, the Deficit Reduction Act of 2005 does not provide states additional flexibility to enroll medically needy individuals into alternative benefit plans.[6]

Spending Down to Eligibility

A 40 year old parent in a household of two has Crohn's disease. Her household income of $1,090 per month (after allowable deductions) is too high for her to qualify as categorically eligible for Medicaid and she does not have access to health insurance through her employer. Each month, she spends an average of $800 on doctor visits and medication. She lives in a state that covers parents under its medically needy program with a six month budget period and a MNIL of $5,818 (over six months) for two person households. Over six months, she earns $6,540. To qualify as medically needy, she is required to spend-down $722 (her income minus the MNIL). For each six month period, she is responsible for the first $722 of her health care costs. Once that requirement has been met, Medicaid pays all of her costs for the remainder of the budget period.

Variation across States

States can have expansive or narrow programs, based on whom they cover and what levels of spend down they require individuals to meet.[7] For example, in Louisiana a household of two would have to spend down to 20 percent of the federal poverty level (FPL) to become eligible for benefits. In Massachusetts a household of two would only have to spend down to 100 percent of the FPL – potentially a difference of several thousand dollars depending on the budget period and the duration of expenses.

States also differ on what optional groups they cover. While Texas is the only state not to expand coverage beyond mandatory pregnant women and children, five states (Georgia, Kansas, Montana, Utah, and Wisconsin) cover only the mandatory groups plus the aged, blind, and disabled. More than half of the states with medically needy programs cover all mandatory and optional groups (see Table 1).

Income and Resource Limits and Disregards

Federal regulations require that medically needy income limits be no higher than 133 percent of the maximum state Aid to Families with Dependent Children (AFDC) level as of July 16, 1996. While AFDC was eliminated and replaced with the Temporary Assistance for Needy Families (TANF) program in 1996, MNILs continue to be tied to old AFDC levels.[8]

As a result, MNILs differ substantially from state to state, from 14 percent of the FPL for an individual in Louisiana to 102 percent of the FPL for an individual in Vermont. However, states have significant flexibility in their methods for counting income when determining Medicaid eligibility through what is referred to as 1902 (r)(2) disregards. If a state uses this flexibility, it can effectively raise income limits, resulting in more people being categorically eligible for benefits. For a state's medically needy population, it could mean that many would have to incur fewer medical expenses before qualifying for Medicaid benefits.[9]

While states are not required to impose resource limits when determining eligibility, most medically needy programs use Supplemental Security Income (SSI) resource limits, which are $2,000 for individuals and $3,000 for couples.

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The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government.**NASHP resources available at: www.nashp.org**

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TABLE 1. MEDICALLY NEEDY PROGRAMS BY STATE

States with Medically Needy Programs	Covered Groups					Income Limit (as % FPL)[1]		Total Enrollment FFY 2003 (000s)	Total spending ($ millions) FFY 2003
	Pregnant Women	Children 0-18	Aged, Blind, Disabled	Young Adults 19-21	Caretaker Relatives[2]	Individual	Couple		
Arkansas[3]	✓	✓	✓	✓		15	22	14.3	$47.0
California	✓	✓	✓	✓	✓	83	97	976.4	$5,104.0
Connecticut	✓	✓	✓	✓	✓	80	76	41.2	$420.3
DC	✓	✓	✓	✓	✓	53	41	34.4	$357.5
Florida	✓	✓	✓	✓	✓	25	25	87.2	$278.7
Georgia	✓	✓	✓			44	39	14.3	$112.3
Hawaii	✓	✓	✓		✓	51	51	3.2	$87.7
Illinois	✓	✓	✓		✓	40	39	398.3	$2,638.0
Iowa	✓	✓	✓	✓	✓	67	50	11.1	$40.1
Kansas	✓	✓	✓			66	49	6.2	$42.5
Kentucky	✓	✓	✓		✓	30	28	34.3	$130.0
Louisiana	✓	✓	✓		✓	14	20	12.5	$59.8
Maine	✓	✓	✓	✓	✓	44	35	5.0	$72.1
Maryland	✓	✓	✓	✓	✓	49	41	91.6	$1,254.2
Massachusetts	✓	✓	✓		✓	100	100	23.0	$209.5
Michigan	✓	✓	✓	✓	✓	57	56	101.2	$292.7
Minnesota	✓	✓	✓	✓	✓	67	62	30.3	$501.8
Montana	✓	✓	✓			73	54	8.9	$133.8
Nebraska	✓	✓	✓		✓	55	41	36.7	$405.7
New Hampshire	✓	✓	✓		✓	76	70	12.1	$148.1
New Jersey	✓	✓	✓	✓		51	45	5.2	$106.8
New York	✓	✓	✓	✓	✓	87	93	935.8	$11,610.8
North Carolina	✓	✓	✓	✓		34	33	42.5	$571.1
North Dakota[4]	✓	✓	✓	✓		66	51	16.3	$223.8
Pennsylvania	✓	✓	✓	✓		59	46	115.1	$1,141.0
Rhode Island	✓	✓	✓		✓	87	69	4.4	$112.5
Tennessee	✓	✓	✓	✓		34	27	210.8	$509.6
Texas[5]	✓	✓				N/A***	N/A***	101.5	$289.4
Utah	✓	✓	✓			53	48	5.0	$25.0
Vermont	✓	✓	✓		✓	102	76	14.3	$53.8
Virginia	✓	✓	✓	✓		47	42	7.1	$68.4
Washington[6]	✓	✓	✓			78	61	19.3	$160.3
West Virginia	✓	✓	✓		✓	28	28	6.6	$36.5
Wisconsin	✓	✓	✓			83	61	40.5	$158.9
Totals	**34**	**34**	**33**	**17**	**20**			**3,471.0**	**$27,413.5**

Information gathered by the National Academy for State Health Policy, April 2007.

Income limit, enrollment, and spending data from Kaiser Family Foundation: statehealthfacts.org.

Footnotes

1 Medically needy income limits as a percent of federal poverty level, 2001.

2 Includes parents and other caretaker relatives. See 42 CFR 435.310 for more information.

3 Arkansas covers children up to 21 in foster homes, private institutions, or inpatient psychiatric facilities.

4 North Dakota covers children to age 20.

5 Texas has the only program that does not cover aged, blind, disabled. Its income limits are Medicaid eligibility levels (185% for infants/pregnant women, 133% for children ages 1 to 5, 100% for children ages 6 to 19).

6 Washington also covers eligible refugees with incomes over cash assistance levels.

Summary

While eligibility is limited to only certain groups, medically needy programs are important methods for strengthening overall Medicaid programs because:

- Medically needy programs can be used by states to expand Medicaid coverage without a waiver;
- By including optional groups in their medically needy programs, states can cover a wide range of individuals with high-cost medical conditions and some low-income uninsured who would otherwise have no prospect for coverage; and
- Through the use of 1902 (r)(2) income disregard flexibility, states have the potential to significantly expand coverage to targeted populations with incomes above categorical eligibility requirements.

However, medically needy programs can be vulnerable during tight budget years. In 2003, Oklahoma and Oregon both eliminated their programs due to shortfalls in their state budgets. When Oregon's program was discontinued, 8,750 people lost coverage.[10] When Oklahoma eliminated its medically needy program a few months later, an estimated 800 children, 6,500 parents, and 1,000 seniors lost coverage.[11]

Still, many states have successfully used medically needy programs to expand benefits to some individuals with high-cost conditions who would otherwise be ineligible for Medicaid coverage. Through medically needy programs, states also have a vehicle to expand Medicaid coverage to populations that may otherwise be ineligible for Medicaid, especially parents and young adults.

Notes

1 Calculated by NASHP from data obtained from Kaiser Family Foundation: statehealthfacts.org.

2 Jeff Crowley. "Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage," Kaiser Commission on Medicaid and the Uninsured. January 2003.

3 Health Alliance Partnership, "An Overview of Medicaid Spend-down and State Options," April 2004.

4 Crowley, 21.

5 CMS. "Medicaid at a Glance 2005: A Medicaid Information Source" Centers for Medicare and Medicaid Services, 2005.

6 Karen Tritz et al, "Side by Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005." CRS Report for Congress, January 2006.

7 NASMD. "Aged, Blind, and Disabled Medicaid Eligibility Survey," National Association of State Medicaid Directors, 2003.

8 Crowley, 4.

9 Crowley, 17.

10 Judy Zerzan. "Oregon's Medically Needy Program Survey," Office for Oregon Health Policy and Research, February 2004.

11 Leighton Ku and Sashi Nimalendran. "Losing Out: States are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs." Center on Budget and Policy Priorities. December 22, 2003.

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