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Medicaid Eligibility for Adults and Children

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Summary

Medicaid is a means-tested entitlement program that is largely designed and administered by states under broad federal rules. The programs are jointly financed by federal and state funds. Federal contributions to each state are based on a state's willingness to finance covered medical services and a matching formula. The Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), is responsible for federal oversight of the program. In FY2003, preliminary federal and state spending on Medicaid reached $275.5 billion, exceeding Medicare payments, net of premiums, by over $15 billion.

Medicaid coverage for non-elderly, non-disabled adults and children is provided to people who qualify through a number of pathways, some of which are required under federal law, others are optional for states. State programs are required to provide coverage to families based on welfare program rules in effect in 1996. Coverage for children goes beyond those often very low financial criteria through a combination of other mandatory and optional pathways. Low income pregnant women can also receive Medicaid coverage through both mandatory and optional pathways. In addition, a number of other optional pathways exist for special groups of people who are not considered disabled because they do not have a disability as defined under the Supplemental Security Income (SSI) program rules. Some of those groups include, for example, certain women with breast or cervical cancer, uninsured individuals diagnosed with tuberculosis, people who become impoverished by their medical costs, and certain immigrants.

Variation across the state-based programs is the rule. Income eligibility levels and services covered vary, and the method for, and amount of, reimbursement for services differ from state to state. Medicaid is targeted to individuals with low-income, but not all of the poor are eligible, and not all of those who are covered are poor. For Medicaid-covered children and families, primary and acute care is often delivered through managed care organizations, while elderly enrollees and those with disabilities more often obtain such care on a fee-for-service basis. In recent years, more and more states have implemented a variety of major program changes using special waiver authority.

This report describes federal Medicaid eligibility rules for children and adults but does not address eligibility pathways for individuals qualifying on the basis of having a disability or for persons who are age 65 and over. This report is one of a number of CRS reports on Medicaid and will be updated periodically. Other reports include:

- CRS Report RL32977, Medicaid: Dual Eligibles;
- CRS Report RL32644, Medicaid Reimbursement Policy;
- CRS Report RL32277, How Medicaid Works: Program Basics; and
- CRS Report RL31413, Medicaid: Eligibility for the Aged and Disabled.

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Eligibility in General

Federal Medicaid law defines over 50 distinct population groups as being potentially eligible for states' programs. Some groups are mandatory, meaning that federal law requires all states and the District of Columbia that participate in Medicaid to cover them. Other groups are optional; that is, federal law allows states to choose to cover them.[1] Categories of eligible populations are found primarily in Section 1902(a)(10) of the Social Security Act. Prior to the 1980s, Medicaid eligibility was limited to poor families with dependent children, poor elderly and individuals with disabilities receiving Supplemental Security Income,[2] (these groups are known as Medicaid's traditional "categorical" groups) and the "medically needy"; almost all pathways were tied to the receipt of welfare payments. But beginning in the 1980s, additional eligibility pathways were added to the Medicaid statute to provide for the coverage of additional low-income children and pregnant women as well as other elderly and individuals with disabilities. Most recently, states were given options to provide Medicaid to additional select groups including certain women with breast or cervical cancer, uninsured individuals with tuberculosis, and working individuals with disabilities. Not all groups of Medicaid beneficiaries receive the same set of benefits. To understand more about the benefits offered under Medicaid see CRS Report RL32277, *How Medicaid Works: Program Basics*, by Herz, et al.

Medicaid programs have few federally required coverage groups for adults who do not have a disability. Groups that states must cover are: very low-income adults in families meeting welfare program rules in effect in 1996, and temporarily, those whose earnings rise above those levels due to increased work income;[3] and pregnant women with income at or below 133% of the federal poverty level. The mandatory routes to Medicaid are more numerous for children. All children whose families

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[1]All 50 states and the District of Columbia have Medicaid programs. In addition, five commonwealths and territories have Medicaid programs, although those programs do not operate under the same set of rules for eligibility and benefits as the states and D.C. In addition, territories' programs are funded through matching payments up to a ceiling.

[2]The SSI program provides monthly cash welfare benefits to individuals who are aged, blind or disabled and whose income and resources fall below certain thresholds. Federal Medicaid law requires states to provide Medicaid to most individuals who receive SSI benefits. For more information on the SSI program see CRS Report 94-486 EPW, *Supplemental Security Income (SSI): A Fact Sheet*, by April Grady.

[3]"Transitional medical assistance" is more fully described later in this report.

have income below the federal poverty level (FPL)[4] must be covered. But younger children, and in some states, older children are covered at much higher income levels through both optional coverage groups and through other mechanisms that make the programs more generous. **Table 1** summarizes the major Medicaid pathways for adults and children excluding those based on disability status. Each of those pathways is described in more detail in the pages to follow.

Medicaid eligibility is a two-tiered process. To qualify, first individuals must be a member of one of Medicaid's "categorical" groups. The major categorical groups include members of families with children; aged, blind or disabled individuals; and pregnant women. There are a number of additional optional coverage pathways. Once it is determined that an individual meets the categorical restrictions, financial tests are applied. Each eligibility pathway includes its own income and resource restrictions. The specific limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, those standards vary considerably among states.

Table 1. Major Medicaid Eligibility Pathways for Adults and Children

Mandatory coverage	Optional coverage
Low-income children: — Infants under age 1 with family income < or = 133% FPL — Children ages 1-5 with family income < or = 133% FPL — Children ages 6-18 with family income < or = 100% FPL — Section 1931 children (in very low-income families) — Children in welfare-to-work families — Title IV-E foster care children — Title IV-E adoption assistance children	— Infants under age one with family income over 133% FPL up to 185% FPL — Targeted low-income uninsured children — Ribicoff children — Medically needy — Independent foster care adolescents
Pregnant women: — Those with family income < or = 133% FPL	— Pregnant women with family income over 133% FPL up to 185% FPL — Medically needy
Low-income adults: — Adults in families with children eligible under Section 1931 — Adults in welfare-to-work families	— Medically needy adults in families

[4]The federal poverty guidelines are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). For 2005, the guidelines set the federal poverty level at $16,090 for a family of three in the contiguous 48 states.

Mandatory coverage	Optional coverage
Others:	
None	— COBRA continuation beneficiaries — Certain women diagnosed with breast and cervical cancer — Certain individuals with tuberculosis — Individuals qualifying under research and demonstration waivers — Certain immigrants

Sources: Title XIX of the Social Security Act (P.L. 74-271) and *Medicaid Eligibility for Families and Children*, Kaiser Commission on Medicaid and the Uninsured, Sept. 1998, by A. Schneider, K. Fennel, and P. Long.

Medicaid Coverage for Families

Low-income families can qualify for Medicaid coverage through four major pathways all of which are described below in more detail. The first two pathways — Section 1931 coverage and transitional medical assistance — are explicitly for families. The remaining two pathways — medically needy coverage and coverage under Section 1115 research and demonstration waivers — can be applied by states to other groups in addition to families. In addition, there are several other pathways covering smaller groups of mostly children. They are described below in the section "Other AFDC-Related Groups." The four major pathways for families include:

- Section 1931 of the Medicaid statute covers families whose income and resources are low enough to have qualified for cash welfare payments under the former Aid to Families with Dependent Children (AFDC) program rules;
- Transitional medical assistance (TMA), extends coverage, on a time-limited basis, to families that would otherwise lose Medicaid due to increased earnings or other income;
- The optional medically needy program covers families and/or individuals whose income is just above the Section 1931 thresholds, or whose medical expenses, when subtracted from income, impoverish them[5]; and
- Demonstration projects conducted by states and approved under Section 1115(c) of the Social Security Act[6] cover some families and/or individuals.

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[5]The medically needy pathway is also an important coverage group for the elderly and people with disabilities. For more information on coverage under medically needy for the elderly and people with disabilities, see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone.

[6]Section 1115(c) of the Social Security Act provides authority for states to waive a number of provisions of Medicaid statute for the purpose of conducting research and demonstrations, as long as those projects are consistent with the purpose of Title XIX. In many states, this authority has been used to undertake major program changes rather than to conduct time limited demonstrations for research purposes.

Family Coverage under Section 1931

Medicaid's Section 1931 preserves Medicaid entitlement for individuals who meet the requirements of the former AFDC programs that were in effect before welfare reform. This eligibility pathway was created as part of the reforms in 1996. Before 1996, all recipients of the AFDC program were automatically eligible for Medicaid coverage. The 1996 reforms replaced the AFDC program with a new program, Temporary Assistance for Needy Families (TANF). At the same time, the Section 1931 coverage group was established within Medicaid to ensure that low-income families would not lose Medicaid as a result of the reforms of the cash assistance programs.

Under Section 1931, states must ensure that, at a minimum, income and resources standards and methodologies for low-income families are no more restrictive than those in effect in 1988. Specifically, Section 1931 allows states to (1) reduce income standards below those in effect in 1996, but they cannot be lower than those used on May 1, 1988; (2) increase income and resource standards for any period after 1996, but by no more than the percentage increase in the Consumer Price Index (CPI) for the same period; and (3) use less restrictive methods for counting income and resources than those in effect on July 16, 1996. This last provision affords states the flexibility to make family coverage under Section 1931 more generous by disregarding various amounts of income or types of assets when compared against the 1996 standards.

The AFDC program in place in 1996 was similar to Medicaid in that states administered the program under broad federal guidelines. States determined eligibility and benefit levels based on "need standards," "payment standards," and "maximum payments." A number of the rules for counting income and resources for the former AFDC program remain in effect in many states today for determining eligibility for Medicaid under Section 1931. Some of those welfare program rules included:

- When determining financial eligibility, states were required to compare the family's income to a gross income limit set at 185% of the states' chosen need standard;
- States were to disregard certain amounts of income: a standard allowance of $90 per month, the first $30 of earnings during the first 12 months of enrollment, and one-third of remaining earning during the first four months of enrollment;
- When counting resources, states were required to compare the value of all resources against a federal upper limit of $1,000; and
- States were to exclude the family's home and the equity value of a car up to $1,500 (or a lower state limit).

Table 2 displays the income standards used to determine financial eligibility for families under Section 1931 expressed as a percentage of 2002 poverty levels (Column 3). These percentages are compared with the percentages used for AFDC eligibility in 1996 in Column 2 — these percentages serve as the floor for states under the provisions of Section 1931. In addition, the maximum percentages available to families through other eligibility pathways ("higher threshold for

families") are shown in Column 4. Most states have extended the generosity of Medicaid's coverage of families since 1996, often using the 1931 pathway. Some states use other means to extend Medicaid's coverage for families.

There are a few caveats that must be considered in evaluating the information in **Table 2**. Most states use a complex combination of counting and disregarding various forms of income. Putting those amounts together to determine a single income standard relative to poverty can introduce some error. This difference may result in percentages in two columns that are close to each other, but actually reflect the same standards. For example in Alabama, the AFDC standard relative to poverty was calculated to be at 15% in 1996. Currently CRS calculates the 1931 standard to be at approximately 20% of poverty. This five percentage point difference may not reflect policy changes in the state of Alabama increasing the level of generosity of the program, but rather may be due to calculating errors introduced because of the complexity of states' income counting rules.

Table 2. AFDC 1996 Income Standard, Section 1931 Income Ceiling in 2002, and Higher Thresholds Applicable to Families All as a Percentage of Poverty

(by state)[a]

State	1996 AFDC eligibility threshold	1931 standard[b]	Higher threshold for families[c]
Alabama	15%	20%	
Alaska	68%	82%	
Arizona	32%	n/a[d]	100%
Arkansas	19%	20%	
California	56%	71%	
Colorado	39%	41%	
Connecticut	59%	107%	
Delaware	31%	82%	100%
District of Columbia	39%	200%	
Florida	28%	57%	
Georgia	26%	41%	
Hawaii	57%	52%	100%
Idaho	29%	29%	
Illinois	35%	35%	
Indiana	27%	30%	
Iowa	39%	113%	
Kansas	40%	39%	
Kentucky	24%	49%	
Louisiana	18%	21%	
Maine	39%	152%	
Maryland	34%	38%	
Massachusetts	52%	n/a[d]	133%
Michigan	42%-45%[e]	69%	
Minnesota	49%	49%	200%
Mississippi	11%	37%	
Missouri	27%	77%	Certain adults in families to 100%
Montana	39%	88%	
Nebraska	34%	36%	
Nevada	32%	87%	
New Hampshire	51%	57%	

State	1996 AFDC eligibility threshold	1931 standard[b]	Higher threshold for families[c]
New Jersey	39%	133%	
New Mexico	36%	82%	
New York	53%-65%[e]	No response	100%
North Carolina	25%	60%	
North Dakota	40%	40%	
Ohio	32%	100%	
Oklahoma	28%	185%	
Oregon	43%	No response	100%
Pennsylvania	39%	67%	
Rhode Island	51%	185%	185%
South Carolina	18%	58%	
South Dakota	40%	64%	
Tennessee	17%	88%	100%
Texas	17%	32%	
Utah	39%	54%	
Vermont	60%	84%	185%
Virginia	33%	29%	
Washington	50%	87%	
West Virginia	23%	43%	
Wisconsin	48%	103%	185% to 200%
Wyoming	33%	63%	

Sources: CRS tabulations of 1996 AFDC income thresholds as a percentage of 2002 poverty levels based on data from **Table 8-12**, *1996 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, WMCP 104-14

Section 1931 income levels as a percentage of 2002 poverty levels from CRS tabulations of data compiled based on a 50-state survey of state eligibility practices conducted by George Washington University Center for Health Services Research and Policy for CRS.

Higher threshholds from CMS-11024-03,
[http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp]; and *States that Have Expanded Family Coverage*,
[http://www.familiesusa.org/site/DocServer/States_that_have_expanded.pdf?docID=407, Families USA].

Notes:

a. For AFDC and Section 1931 columns, CRS tabulated states' income ceilings as a percentage of 2002 poverty levels for a family of three. For the higher thresholds in Column 4, CRS relied on other sources for the eligibility thresholds. In those states with higher thresholds, the eligibility threshold is generally defined as a percentage of poverty rather than an income level, so it would not automatically change year to year. Therefore comparisons to AFDC and Section 1931 columns can be made.
b. Effective income ceiling for 1931 eligibility calculated with income disregards at 12 months after enrollment; and earnings disregards for one adult per three-person family unit.
c. Coverage under these higher income thresholds are authorized under research and demonstration waiver projects defined in Section 1115 of the Social Security Act.
d. In Arizona and Massachusetts, Section 1931 eligibility is subsumed under the research and demonstration waiver eligibility groups.
e. Michigan and New York reported different income standards for different counties.

After a family is initially determined to be eligible for Medicaid, states may conduct re-determinations at intervals that are no longer than 12 months. Unless families report rising income or earnings to state agencies, they would remain eligible until the next re-determination. Most states conduct re-determinations for Section

1931-eligible families at 12-month intervals; a smaller number of states use shorter periods for re-determining eligibility. (See **Table 3** for re-determination periods.)

Counting Income. The Medicaid program is often criticized for being administratively complex and having confusing rules. The income eligibility rules for families qualifying under Section 1931 contribute to that impression. As described above, states have limited flexibility to reduce or increase income standards but they have considerably more flexibility in the way that countable income is defined. By excluding certain types of income from their definitions of countable income, states can effectively raise the generosity of the eligibility pathway without explicitly raising the income standards.

States are required to disregard certain amounts and types of income when determining eligibility, because those "income disregards" were part of the income counting methods in place in 1996. In almost all states, that means that the first $50 of child support payments is "disregarded" or not counted for the purpose of determining Medicaid eligibility. In addition, certain portions of a family's earned income is not counted and the portion is disregarded in decreasing amounts over time. During the first four months of employment, $120 plus one-third of remaining earnings per month are not counted. After four months of enrollment, $120 per month of earnings are disregarded. Finally, after a family is on the program for 12 months, $90 of earnings per month are disregarded. The earned income disregards are intended to lessen the immediate impact of the transition to work. Many states also disregard a child care allowance of $175 per month per child over age two and $200 per month for children under age two.

In addition to these minimum income disregards, many states have used the additional flexibility to define countable income to make this pathway considerably more generous than under the former AFDC program rules. **Table 3** shows the earned income disregards and the redetermination periods for Section 1931 families in 2002. In 2002, 18 states used more generous earned income disregards than the "90+30+one-third" rules in place under 1996 and described above. A survey conducted by the Center on Budget and Policies Priorities found that almost all states liberalized their standards by implementing either more generous earned income disregards or by eliminating various income and assets rules. The Center also found that no states are known to have reduced income standards below those in effect in 1996.[7]

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[7]M. Broaddus, S. Blaney, A. Dude, J. Guyer, L. Ku, J. Peterson, *Expanding Family Coverage: State Medicaid Eligibility Policies for Working Families in the Year 2000*, Center on Budget and Policy Priorities, Dec. 31, 2001.

Table 3. Income Disregards and Redetermination Periods for Family Coverage Under Section 1931 in 2002

State	Earned income disregards	Redetermination period
Alabama	$90+$30+1/3 of remaining earnings	12 months
Alaska	$90	6 months
Arizona	$90+$30+1/3 of remaining earnings for those under 36% of poverty level; otherwise, $90	12 months
Arkansas	20% of earnings	12 months
California	$90	12 months
Colorado	$90	12 months
Connecticut	All income up to 100% of FPL plus $90.	12 months
Delaware	$90+$30+1/3 of remaining earnings	12 months
District of Columbia	0	12 months
Florida	$90 per employed individual/ $110 plus 50% of remaining earnings for families.	6-12 months
Georgia	$90+$30+1/3 of remaining earnings	6 months
Hawaii	$30 and 1/3 of remaining earnings	12 months
Idaho	$30 and 1/3 of remaining earnings	12 months
Illinois	$90+$30+1/3 of remaining earnings	12 months
Indiana	$90	12 months
Iowa	20% plus 50% of remainder	12 months
Kansas	$90+40% of remaining earned income	12 months
Kentucky	$90+$30+1/3 of remaining earnings	12 months
Louisiana	$90	12 months
Maine	All income up to 150% FPL plus $90 earnings	12 months
Maryland	0	12 months
Massachusetts	0	6-12 months
Michigan	$200 +20%	12 months
Minnesota	0	12 months
Mississippi	90	12 months
Missouri	$90+$30+1/3 of remaining earnings	12 months
Montana	$200 + 25% of remaining earnings	12 months
Nebraska	20% of earnings	6 months[a]
Nevada	First three months of earnings	12 months
New Hampshire	20% of earnings	12 months
New Jersey	$90 per individual	12 months
New Mexico	$125+50% of remaining earnings	12 months
New York	$90	12 months
North Carolina	27.5% of earnings	12 months
North Dakota	$180 or 27% of earnings plus 50% of remainder	12 months
Ohio	$250 plus 50% of remainder	6 months
Oklahoma	$120	6 months
Oregon	No response	No response
Pennsylvania	50% of earnings or $90+$30+1/3 of remaining earnings	12 months
Rhode Island	Disregard all income up to 185% plus $90	12 months
South Carolina	50% during first four months of enrollment, thereafter $100	12 months
South Dakota	0	12 months
Tennessee	$150	6 months
Texas	$120	6 months

State	Earned income disregards	Redetermination period
Utah	$90+$30+1/3 of remaining earnings	6-12 months
Vermont	$150 +25% of remainder	6-12 months
Virginia	$90	12 months
Washington	50% of earnings	12 months
West Virginia	$90 per worker	12 months
Wisconsin	$90	12 months[b]
Wyoming	$200 per workers,$400 married couple	12 months

Source: CRS compilation of a 50-state survey of state eligibility practices conducted by George Washington University Center for Health Services Research and Policy for CRS.

Notes:

a. Effective November 1, 2003.
b. On July 1, 2003 changes to six months.

Contributing to the seeming impenetrability of the Medicaid rules, many states continue to count income using 1996 welfare program rules in addition to their new, more generous income counting methods. A fictional example of this is the case of State A. State A has a new income counting rule under Section 1931 that disregards all income between the former AFDC level and 100% of the federal poverty level. But State A continues to apply the "$90+$30+one-third" rule from the former AFDC program along with the new rule that allows considerably greater amounts of income to be disregarded for the purposes of determining eligibility under Section 1931. This illogical combination of income counting methods is conducted simply because it allows the state to prove to CMS that the Section 1931 eligibility pathway is meeting the statutory purpose of ensuring that anyone who would have qualified for the former AFDC program is still able to obtain Medicaid. The generosity of the new rules would most assuredly include at least those qualifying under the old and less generous rules; nonetheless, some states are hesitant to abandon those calculations for fear of being found to be out of compliance with requirements that ensure that those who were eligible under 1996 welfare program rules would be eligible under Section 1931.

A second example of how the rules of Section 1931 contribute to administrative complexity without clearly benefitting recipients is the fact that states generally conduct re-determinations for this population on an annual basis — so disregards intended for use after four and nine months of enrollment are rarely used — except when an enrollee self-reports an income change, triggering a redetermination before 12 months has elapsed.

Counting Assets. Under Section 1931, states can apply an assets test, as long as it is no more restrictive than the test in effect in 1996. States can also, under rule number three above, use "less restrictive" methods for counting assets. This has been interpreted in some states and by CMS as allowing for no assets test for the Section 1931 eligibility pathway. Dropping assets tests has a number of major benefits for states and for enrollees. It simplifies the onerous eligibility determination process considerably. In addition, it removes a significant barrier to access to health care for people at the bottom of the income scale. In 2002, 19 states had no assets tests for

Section 1931 families. Other states had liberalized their assets rules. Only 10 states[8] imposed a stringent assets standard. In those states in 2002, families with $1,000 or more in assets were unable to qualify for Medicaid.

Other Eligibility Rules for Families Qualifying under Section 1931. A number of other eligibility rules are applicable for families seeking Medicaid under Section1931. Some remain as vestiges of the AFDC program ended almost 10 years ago.

- *Gross income standard*. About half of the states report imposing a gross income standard. This is an income test that is applied before any income is disregarded or alternative methodologies for counting income are used. It is the sum of the total countable gross monthly earned income of all family members and the total countable monthly unearned income of family members. The family is able to proceed to the eligibility determination process only if its gross income is, at most, a certain percentage of the selected standard, often between 133% and 185% of the federal poverty level.
- *100-hour work rule*. Many states continue to require that employed parents in two-parent families work fewer than 100-hours per month to qualify under Section 1931. This "100-hour rule" was originally established by the Secretary as a standard for determining whether a family meets the "deprivation requirement" for the former AFDC program. In order for a family to qualify for assistance under the old program's rules, its children had to be deprived of parental support or care due to the death, absence, incapacity, or unemployment of a parent. Two-parent families generally qualified only under the "unemployment" criterion which was narrowly defined in the AFDC regulations. Forty one states responding to the CRS-funded survey confirmed that they continue to impose a 100-hour limit on work hours for working families. The rule remains popular even though regulations posted by CMS in 1998 (then called the Health Care Financing Administration — HCFA) removed this 100-hour limitation. The regulation allows states to adopt more flexible definitions of unemployment, to align their TANF, foster care, and Medicaid programs, and to simplify administration. Under the revised rule, states are not allowed to define unemployment in any way that is more restrictive than the definition of unemployment that existed when the rule was first published.

Certain individuals qualifying under the Section 1931 pathway may be denied Medicaid coverage if they refuse to cooperate with states' TANF work requirements. States are permitted to deny Medicaid benefits to nonpregnant adults and heads of households who lose TANF benefits because of refusal to work, but must continue to provide Medicaid coverage to their children.

Enrollment. In 2002, about 10.6 million family members were reported by states to have qualified for Medicaid through the Section 1931 pathway. That included about 3.6 million adults and 7.1 million children. Section 1931 eligibles as

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[8]Alabama, Arkansas, Georgia, Idaho, Indiana, Kentucky, New Hampshire, Virginia, Washington, and West Virginia.

a percentage of program eligibles ranged from a high of 37% in Delaware to under 1% in Virginia. It is not known how many children qualifying through more generous pathways as well as under Section 1931 are reported here or elsewhere. **Table 4** shows the number of children, adults and total individuals enrolled in Medicaid who qualify under Section 1931 as reported by states for FY 2002. It also provides total program enrollment and the percentage of total program enrollment that Section 1931 comprises for comparison purposes.

Table 4. Enrollment of Section 1931 Adults and Children by State, FY2002

State	Section 1931 adults	Section 1931 children	Total Section 1931 family members	Total Medicaid enrollment	Section 1931 enrollees as a percentage of total Medicaid
Alaska	15,330	18,881	34,211	121,400	28.2%
Alabama	24,858	75,501	24,858	845,125	11.9%
Arkansas	19,941	36,920	56,861	608,017	9.4%
Arizona	162,614	206,739	369,353	1,053,602	35.1%
California	986,487	2,051,417	3,037,904	9,336,447	32.5%
Colorado	57,104	82,011	139,115	438,670	31.7%
Connecticut	17,267	50,483	67,750	487,989	13.9%
District of Columbia	24,678	36,043	60,721	151,340	40.1%
Delaware	16,775	37,672	54,447	147,197	37.0%
Florida	211,497	434,520	646,017	2,691,502	24.0%
Georgia	105,621	203,814	309,435	1,459,631	21.2%
Hawaii	25,564	49,930	75,494	195,684	38.6%
Iowa	43,190	64,576	107,766	358,708	30.0%
Idaho	304	1,354	1,658	196,406	1.0%
Illinois	23,171	96,346	119,517	2,076,146	5.8%
Indiana	98,220	158,973	257,193	881,942	29.2%
Kansas	26,093	40,246	66,339	305,110	21.7%
Kentucky	51,042	93,009	144,051	769,826	18.7%
Louisiana	59,433	99,583	159,016	990,286	16.1%
Massachusetts	48,957	98,358	147,315	1,204,312	12.2%
Maryland	31,603	72,139	103,742	752,065	13.8%
Maine	23,710	14,757	38,467	346,449	11.1%
Michigan	61,541	153,552	215,093	1,527,627	14.1%
Minnesota	51,480	99,634	151,114	680,627	22.2%
Missouri	206,860	376,404	583,264	1,098,525	53.1%
Mississippi	53,691	106,477	160,168	707,986	22.6%
Montana	10,858	19,616	30,474	106,229	28.7%
North Carolina	164,298	215,422	379,720	1,389,455	27.3%
North Dakota	10,223	17,707	27,930	71,619	3.9%
Nebraska	13,247	27,530	40,777	266,245	15.3%
New Hampshire	5,834	12,305	18,139	115,517	15.7%
New Jersey	55,809	141,689	197,498	982,676	20.1%
New Mexico	44,478	82,075	126,553	462,878	27.3%
Nevada	13,488	33,253	46,741	203,251	23.0%
New York	169,645	451,287	620,932	4,139,898	15.0%
Ohio	44,739	150,938	195,677	1,754,379	11.2%
Oklahoma	4,375	13,393	17,768	677,788	2.6%
Oregon	26,279	57,128	83,407	637,140	13.1%
Pennsylvania	111,362	262,996	374,358	1,710,999	21.9%

State	Section 1931 adults	Section 1931 children	Total Section 1931 family members	Total Medicaid enrollment	Section 1931 enrollees as a percentage of total Medicaid
Rhode Island	15,662	32,657	48,319	204,789	23.6%
South Carolina	71,622	103,922	175,544	895,863	19.6%
South Dakota	9,622	16,397	26,019	113,925	22.8%
Tennessee	48,458	147,170	195,628	1,700,384	11.5%
Texas	136,145	312,586	448,731	3,202,171	14.0%
Utah	25,889	41,989	67,878	233,156	29.1%
Virginia	502	1,177	1,679	727,784	<1%
Vermont	5,339	11,296	16,635	156,958	10.6%
Washington	39,902	83,951	123,853	1,104,813	11.2%
Wisconsin	51,917	103,685	155,602	776,638	20.0%
West Virginia	38,313	616	38,929	362,264	10.8%
Wyoming	5,514	7,551	13,065	69,802	18.7%
National total	**3,570,551**	**7,107,675**	**10,602,725**	**51,499,240**	**21.0%**

Source: CRS tabulation of Medicaid MSIS data. Downloaded from the Center for Medicare and Medicaid (CMS) MSIS Datamart on August 3, 2005.

Note: Includes annual unduplicated eligibles reported as "receiving cash."

Transitional Medical Assistance

Transitional medical assistance (TMA) was established prior to the 1996 welfare reforms to address the concern that individuals receiving AFDC payments would be discouraged from seeking work or would turn down work opportunities for fear of losing Medicaid. The TMA provisions require states to continue providing Medicaid to members of families who would otherwise have lost such assistance due to increased work hours, increased earnings of the caretaker relative, or the loss of one of the time-limited earned income disregards.

There are several TMA requirements in statute today. The TMA provision that is currently in effect requires states to provide an additional six months of Medicaid coverage to families who were receiving Medicaid under Section 1931 in at least three of the last six months should income rise for any of the above reasons. In addition, states are required to extend Medicaid coverage for a second six months to families who were covered during the entire first six-month TMA period, and whose earnings are below 185% of poverty. These TMA provisions are due to sunset at the end of September 2005, although this date has been repeatedly extended. If these provisions were to expire, separate TMA provisions would become effective. Under the older and permanent TMA provisions, Medicaid would be required to be extended for families who would otherwise lose coverage due to the above reasons, for a period of four months. Families eligible for this four-month extension must have been receiving Medicaid under Section 1931 in at least three of the preceding six months.[9]

[9]For more information about TMA, see CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady.

Other AFDC-Related Groups

While the AFDC program no longer exists, a number of Medicaid eligibility groups remain tied to states' former AFDC rules.

Recipients of adoption assistance and foster care who are under age 18 and eligible for Title IV-E of the Social Security Act. States are required to provide Medicaid to recipients of adoption assistance and foster care assistance who are under age 18 and enrolled under Title IV-E of the Social Security Act.

Former foster care recipients who are ages 18, 19, or 20. In 1999, states were given the option to continue to provide Medicaid coverage to children who were aging out of the federal, Title IV-E foster care system. Responding to a survey on eligibility rules in place in 2003, 30 states and the District of Columbia indicated that they include such former foster children as Medicaid eligible. An additional eight states reported covering *all children* under age 21 through other pathways, so foster children would be covered via this broader pathway.[10]

"Ribicoff" children. States have the option to provide Medicaid coverage to "reasonable" categories of children who meet the former welfare program's financial criteria but do not qualify as a "dependent child." The Ribicoff pathway, named for the former Senator who sponsored legislation authorizing this group, applies to children under age 21 who do not meet the dependency requirement, often because they do not live with their families.

In the past, this pathway had been used for children residing in institutions or in state-based foster care or adoption assistance programs. But today, most of those children can qualify under other poverty-level eligibility pathways, since those pathways do not include a family dependency requirement. Ribicoff, as a result, has little meaning for most children under the age of 19.

For children who are 19 or 20 or are inpatients in psychiatric facilities, on the other hand, Ribicoff may still be a valuable pathway to Medicaid. Older children cannot qualify under the other poverty-level groups because those pathways define eligible children to be under the age of 19. Institutionalized children who are in families with income that exceeds the poverty level ceilings also cannot qualify as poverty-level children because their parent's income is deemed to be available to children under those pathways. Under Ribicoff, on the other hand, parental income is not considered to apply to children who do not reside in their parents' homes.

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[10]Oregon did not respond to any survey questions, West Virginia and Vermont did not respond to this particular section of the survey. Connecticut, Delaware, Georgia, Indiana, Kentucky, Maine, Oklahoma, Pennsylvania, South Carolina all reported that these children are not covered. (CRS compilation of a 50-state survey of state eligibility practices conducted by George Washington University Center for Health Services Research and Policy.)

Forty-five states responded affirmatively to a question in the CRS survey about whether their Medicaid programs include any categories of Ribicoff children.[11]

Poverty-related Pregnant Women and Children

Between 1986 and 1991, Congress gradually extended Medicaid to additional groups of pregnant women and children (see **Table 5**). Under these provisions, states are required to cover pregnant women with family incomes equal to or below 133% of the federal poverty income guidelines.[12] Coverage for pregnant women qualifying through this pathway is limited to services related to pregnancy and complications of the pregnancy and extends to 60 days after pregnancy.

States are required to cover all children under age six (or alternately under age seven or eight) who are in families with income equal to or below 133% of the federal poverty level. In addition, states must cover all children in families with income equal to or below 100% of poverty. This requirement has been phased-in since July 1, 1991 and was fully implemented in 2002. All poverty-related children receive full Medicaid coverage.

States have the option to go beyond the above mandatory groups to include pregnant women and infants under one year of age whose family income is over 133% up to 185% of the FPL. In 2002, 36 states and the District of Columbia extended coverage to some or all pregnant women and infants in this category.

Table 5. Poverty-Related Pregnant Women and Child Pathways

	States required to cover	State can choose to cover
Pregnant women	Family income equal to or below 133% FPL	Family income no more than 185% FPL
Infants < age 1	Family income equal to or below 133% FPL	Family income no more than 185% FPL
Children < age 6, 7, or 8	Family income equal to or below 133% FPL	None*
Children < age 18	Family income equal to or below 100% FPL	None*

Source: Congressional Research Service

* While the federal statute only explicitly allows children's coverage up to 133% for children under age 6, and 100% of poverty for children under age 18, many states have extended coverage well beyond these income levels through the use of income disregards.

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[11]Oregon did not respond to any survey questions, West Virginia did not respond to this particular section of the survey. Oklahoma reported that these children are not covered. Hawaii, Arizona and Tennessee cover these children through other pathways. (CRS survey of state eligibility practices conducted by George Washington University Center for Health Services Research and Policy.)

[12]100% of FPL is equal to $16,090 and 133% of FPL is equal to $21,400 for a family of three in 2005.

As with the Section 1931 eligibility pathway, states have the ability to apply more generous income and assets disregards and methodologies to extend coverage beyond the statutory ceilings for poverty-related pregnant women and children. Many states have chosen to do so for some or all of their poverty-related groups of children and pregnant women. (see **Table 7** for more information on assets tests.)

A small but growing body of research supports the conclusion that when entire families have insurance coverage, the children experience health benefits such as increased access and use of health care services.[13] Nonetheless, policy makers at both the federal and state levels have met with less opposition when extending coverage to children in families and less success for coverage proposals for entire families. This reflects a consensus that children's health care is an important priority but no such consensus exists with respect to coverage for adults.

Table 6. Maximum Eligibility Thresholds for Pregnant Women and Children as a Percentage of Poverty, by State, July 2004

State	Pregnant women	Infants	Children ages 1 to 5	Children ages 6-19
Alabama	175%	133%	133%	100%
Alaska	175%	175%	175%	175%
Arizona	133%	140%	133%	100%
Arkansas	200%	200%	200%	200%
California	200%	200%	133%	100%
Colorado	133%	133%	133%	100%
Connecticut	185%	185%	185%	185%
Delaware	200%	200%	133%	100%
District of Columbia	200%	200%	200%	200%
Florida	185%	200%	133%	100%
Georgia[a]	200%	200%	133%	100%
Hawaii	185%	200%	200%	200%
Idaho	133%	150%	150%	150%
Illinois[a]	200%	200%	133%	133%
Indiana	150%	150%	150%	150%
Iowa	200%	200%	133%	133%
Kansas	150%	150%	133%	100%
Kentucky	185%	185%	150%	150%
Louisiana	200%	200%	200%	200%
Maine[a]	200%	185%	150%	150%
Maryland	250%	200%	200%	200%
Massachusetts	200%	200%	150%	150%
Michigan	185%	185%	150%	150%
Minnesota	275%	280%	275%	275%
Mississippi	185%	185%	133%	100%

[13]K.L. Hanson, "Is Insurance Enough? The Link between Parents' and Children's Health Care Use Revisited," *Inquiry*, vol. 35, no. 3, 1998, pp. 294-302; L. Ku, M, Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms*, Center on Budget and Policy Priorities, Sept. 2000; A. Davidoff, L. Dubay, G. Kenney, A. Yemane, "The Effect of Parents' Insurance Coverage on Access to Care for Low-income Children," *Inquiry*, vol. 40, no. 3, 2003, fall, pp. 254-68; S. Guendelman, M. Pearl, "Children's Ability to Access and Use Health Care," *Health Affairs*, Mar.-Apr., vol. 23 no. 2, 2004, pp. 235-44.

State	Pregnant women	Infants	Children ages 1 to 5	Children ages 6-19
Missouri	185%	300%	300%	300%
Montana	133%	133%	133%	100%
Nebraska	185%	185%	185%	185%
Nevada	133%	133%	133%	100%
New Hampshire	185%	300%	185%	185%
New Jersey[a]	200%	200%	133%	133%
New Mexico	185%	235%	235%	235%
New York	200%	200%	133%	100%
North Carolina	185%	185%	133%	100%
North Dakota	133%	133%	133%	100%
Ohio	150%	200%	200%	200%
Oklahoma	185%	185%	185%	185%
Oregon	185%	133%	133%	100%
Pennsylvania	185%	185%	133%	100%
Rhode Island	250%	250%	250%	250%
South Carolina	185%	185%	150%	150%
South Dakota	133%	140%	140%	140%
Tennessee [b]	185%	185/100%	133/100%	100/100%
Texas	185%	185%	133%	100%
Utah	133%	133%	133%	100%
Vermont [c]	200%	300%	300%	300%
Virginia	133%	133%	133%	133%
Washington	185%	200%	200%	200%
West Virginia	150%	150%	133%	100%
Wisconsin	185%	185%	185%	185%
Wyoming	133%	133%	133%	100%

Source: Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, Oct. 2004.

a. Illinois and Maine cover infants in families with income at or below 200% of the federal poverty level (FPL) who are born to mothers enrolled in Medicaid. Illinois covers infants not born to Medicaid enrolled mothers in families with income at or below 133% of the FPL. Maine covers infants not born to Medicaid enrolled mothers in families with income at or below 185% of the FPL. Georgia covers infants in families with income at or below 235% FPL who are born to mothers enrolled in Medicaid. Georgia covers infants not born to Medicaid enrolled mothers in families with income at or below 185% of the FPL. New Jersey covers infants in families with income at or below 200% FPL who are born to mothers enrolled in Medicaid. New Jersey covers infants not born to Medicaid enrolled mothers in families with income at or below 185% FPL.

b. In Tennessee, the first number represents the income eligibility guidelines under "regular" Medicaid. The second number represents the income eligibility guideline for new applicants to the TennCare waiver program. Enrollment is closed to some but not all children covered under the state's waiver.

c. In Vermont, Medicaid covers uninsured children in families with income at or below 225% FPL; and underinsured children up to 300% FPL.

Targeted Low-income Children. Section 4911 of the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) established an additional Medicaid coverage group for low-income children.[14] Targeted low-income children are those who are not

[14]This provision establishes a Medicaid coverage group that is parallel to the group of children eligible for health coverage under another provision of BBA 97, the State Children's Health Insurance Program (SCHIP) (Section 4901). The two provisions allowed (continued...)

otherwise eligible for Medicaid, are not covered under a group health plan or other insurance, and are living in families with income that is either: (1) above the state's Medicaid financial eligibility standard in effect in June 1997, but less than 200% of the FPL; or (2) in states with Medicaid income levels for children already at or above 200% of the poverty level as of June 1997, within 50 percentage points over this income standard. States can either establish a specific coverage pathway for such targeted low-income children or they can build upon other existing Medicaid coverage groups for children. In August 2004, 33 states reported covering targeted low-income children under Medicaid.[15]

Special Eligibility Rules for Families, Pregnant Women And/or Children

A number of special eligibility procedural rules and options apply to individuals qualifying under the above eligibility groups. Many of the provisions were developed for the purpose of streamlining Medicaid's eligibility and redetermination processes, to help improve coverage and health outcomes among pregnant women and newborns, and to better reach low-income children.

Deeming of Parent's Income. When determining whether an individual meets the financial eligibility rules for Medicaid, only the income of a spouse, or a parent of a dependent child under age 21 counts. The income, as well as other financial characteristics, of parents are "deemed" available to their children, but only if the children share the household. Regulations require that the income and resources of both parents with whom a child resides must be considered, regardless of whether or not both parents contribute toward that child's care.

Waiving Asset Requirements. States can choose to waive asset tests for families of certain women qualifying on the basis of pregnancy, infants, and children under age 19. The tests can be waived for all individuals in those groups whether the pregnant woman or child is in a mandatory coverage group or an optional coverage group. States may not, however, waive the asset tests for family members who are eligible under Section 1931, or for "qualified" pregnant women or children.[16] As of December 2003, 48 states reported having waived the asset test for one or more groups of pregnant women or children.

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[14](...continued)
states to choose, after the passage of BBA 97, to either extend Medicaid for targeted low-income children, to create a new SCHIP program for those children, or coordinate both programs to cover the target population.

[15]Two states, Arkansas and New York had not yet submitted enrollment data. All other states reported covering such children under separate SCHIP programs. At Centers for Medicare and Medicaid Services, see
[http://www.cms.hhs.gov/schip/enrollment/2004ever2qt.pdf].

[16]"Qualified" pregnant women are women who meet the income and resources to qualify for the former AFDC program and would be eligible if her child had been born and was living with her. Qualified children are those under age 19 who meet the income and resource requirements of the former AFDC program without regard to any other former AFDC program eligibility requirements.

Table 7. States That Waive Asset Tests As of December 2002

State	Pregnant women	Poverty level children	Optional children
Alabama	X	X	X
Alaska	X	X	
Arizona	X	X	N/A
Arkansas		X	
California	X	X	X[a]
Colorado	X		
Connecticut	X	X	
Delaware	X	X	X
DC	X	X[a]	X[b]
Florida	X	X	X
Georgia	X	X	
Hawaii	X	X	N/A
Idaho			
Illinois	X	X	X
Indiana	X	X	X
Iowa		X	X
Kansas	X	X	X
Kentucky	X	X	
Louisiana	X	X	X
Maine	X	X	X
Maryland	X	X	X
Massachusetts	X	X	X
Michigan	X	X	X
Minnesota	X	X	X
Mississippi	X	X	
Missouri	X	X	X
Montana			
Nebraska	X	X	X
Nevada			
New Hampshire	X	X	
New Jersey	X	X	X
New Mexico	X	X	X
New York	X	X	
North Carolina	X	X	
North Dakota	X	X	X
Ohio	X	X	
Oklahoma	X	X	N/A
Oregon	N/R	N/R	N/R
Pennsylvania	X	X	X
Rhode Island	X	X	X
South Carolina	X	X	X
South Dakota		X	X
Tennessee	X	X	N/A
Texas	X		
Utah			

State	Pregnant women	Poverty level children	Optional children
Vermont	X	X	X
Virginia	X	X	X[c]
Washington	X	X	X
West Virginia	X	X	
Wisconsin	X	X	X
Wyoming	X	X	X

Source: CRS compilation of a 50-state survey of state eligibility practices conducted by George Washington University Center for Health Services Research and Policy.

Notes: N/A — Not applicable. In these states, either optional groups of children have not been covered, or coverage for children that would otherwise fall into these groups has been achieved through other program expansions, such as through waiver programs.

N/R — Not Reported

a. Asset test applied to certain sub-groups of individuals in this category.
b. Asset test "on books," but rarely applied.
c. Asset test dropped after date of completion for survey.

Presumptive Eligibility. In some states certain new applicants can receive Medicaid coverage of ambulatory (non-institutional or inpatient) services while waiting for their applications for coverage to be processed by the Medicaid agency. States can choose to offer presumptive eligibility to pregnant women, children and to women qualifying under the breast and cervical cancer treatment pathway. (See description of this coverage group on page 20.)

Presumptive Eligibility for Pregnant Women. The purpose of the presumptive eligibility provision for pregnant women is to ensure that prenatal care is not delayed because a woman does not have a Medicaid card during the time it takes for a state to process an ordinary Medicaid application and make a final eligibility determination. Certain providers of care may make an interim determination, on the basis of preliminary information, that a pregnant woman seeking treatment may be financially eligible for Medicaid benefits. Providers permitted to make this determination include individual practitioners, clinics participating in a number of federally funded health-related programs or in state perinatal care programs, and Indian Health Service facilities. The provider must notify the Medicaid agency of the presumptive eligibility determination within five days, and must inform the woman that she is required to make a formal application for Medicaid by the last day of the month following the month in which the determination of presumptive eligibility was made.

Once the provider has established tentative eligibility, the woman may receive ambulatory prenatal care. If the woman fails to apply for Medicaid, her presumptive eligibility ends the last day of the month after the month she is determined presumptively eligible. If she applies for Medicaid, her presumptive eligibility period continues until the day on which the state makes a final eligibility determination. Even if the state should ultimately determine that the woman is not eligible, payment will still be made to the provider for services rendered during the presumptive eligibility period.

Payments made on behalf of applicants who are later found to be ineligible for the program are not counted as erroneous payments for the purposes of meeting administrative oversight thresholds.

Presumptive Eligibility for Children and Women with Breast or Cervical Cancer. Similarly, states can also choose to provide coverage for care and services offered under the state plan for medical assistance during a presumptive eligibility period for children under age 19 and for women who are eligible under the pathway specific to certain breast or cervical cancer patients (described below). The presumptive eligibility is the same as for pregnant women, although the care and services go beyond ambulatory care to include all Medicaid services offered under the state program.

States can determine which providers are to make determinations of presumptive eligibility for women with breast and cervical cancer. States can also determine which providers may make presumptive eligibility determinations for children, but in this case regulations offer additional guidance on the choice of providers. They must be providers that are:

- eligible to furnish health care items and services covered under the approved plan and to receive payments under the plan;
- authorized to determine eligibility of a child to participate in Head Start;
- authorized to determine eligibility of a child to receive child care services under the Child Care and Development Block Grant Act of 1990;
- authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC);
- authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or the State Children's Health Insurance Program; or
- an elementary or secondary school as defined under the Elementary and Secondary Education Act of 1965 or is operated or supported by the Bureau of Indian Affairs;
- a state or tribal child support enforcement agency;
- an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act; or
- a state or tribal office or entity involved in enrollment in the program under Part A of Title IV, Title XIX, or Title XXI of the Social Security Act; or
- authorized to determine eligibility for any assistance or benefits provided under any program of public or assisted housing that receives federal funds; or
- any other entity the state identifies, as approved by the Secretary of the Department of Health and Human Services (DHHS).

As of December 2003, presumptive eligibility was available for women qualifying on the basis of pregnancy in 33 states. Fewer states reported presumptive eligibility for children in 2003; 11 offered presumptive eligibility to children under one year, and only nine offered presumptive eligibility to older children.

Continuous Eligibility. Continuous eligibility occurs when states provide Medicaid coverage to an individual for a stated amount of time even if the family income of that person rises to levels that would otherwise disqualify them from such coverage. States are required to provide continuous eligibility to individuals

qualifying through certain eligibility pathways, and are given the option of providing continuous eligibility to individuals qualifying through other eligibility pathways. Continuous eligibility provides for more stable coverage for both the enrollees and for their service providers despite what may be frequent fluctuations in incomes.

Continuous Eligibility for Pregnant Women. States are required to continue Medicaid coverage for pregnant women who would otherwise lose eligibility because of a change in family income through the pregnancy and post-partum period. The post-partum period is defined as ending on the last day of the month during which the 60th day after the end of the pregnancy falls. Medicaid law requires continuous eligibility for pregnant women and infants regardless of changes in income. That is, a child born to a woman receiving medical assistance remains eligible for medical assistance for one year or up to one year of age so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for medical assistance.

Continuous Eligibility for Children. States have the option to provide poverty level children with a continuous eligibility period of no more than 12 months. The continuous eligibility period begins when the child is determined or redetermined to be eligible for coverage but is not available to children who are presumptively eligible during the presumptive eligibility period. Thirty states responded to CRS' eligibility survey that their Medicaid program offered some continuous eligibility period to children under age one in 2002. All but four states reported that infants' coverage is continued for a full 12 months. Several states reported offering the continuous eligibility period only to infants born to mothers who are enrolled in the program. Similar to presumptive eligibility, fewer states offer continuous coverage to older children. Twenty-two states offered continuous eligibility to some older groups of poverty level children.

Guaranteed Enrollment for Beneficiaries Enrolled in Managed Care Organizations. A related provision allows states the option of guaranteeing that Medicaid recipients enrolled in certain managed care organizations (MCOs) retain eligibility for the Medicaid services provided by the MCO even if the enrollee otherwise loses Medicaid eligibility. This "guaranteed enrollment period" is not limited to non-disabled adults or children and was not intended to improve access to Medicaid services for low-income children and pregnant women. Rather, its purpose was to improve Medicaid programs' attractiveness to MCOs that might otherwise be concerned that income fluctuations of Medicaid's population would lead to unstable and unpredictable funding. Guaranteed enrollment periods may be provided for a period not to exceed six months.

If a recipient loses Medicaid eligibility during a minimum guaranteed enrollment period, he/she is entitled to coverage (through the end of the enrollment period) only for services furnished or arranged by the MCO with which he or she is enrolled.

Medically Needy

States may extend Medicaid coverage to persons who are members of one or more of the broad categories of Medicaid covered groups (i.e., the aged, disabled, pregnant women or families with children), but do not meet the applicable income or resource requirements for eligibility. States have the option to establish "medically needy" coverage for those individuals whose income, and in some cases resources, are close to, but somewhat higher than, those for the above coverage groups. Most importantly, though, states are allowed to deduct medical expenses from countable income of applicants when determining financial eligibility for the medically needy program. In other words, individuals are allowed to "spend down" to eligibility through the medically needy pathway.[17] This makes medically needy programs important to individuals or families experiencing a medical crisis or whose routine medical costs are high relative to their modest income. In 2003, 35 states and the District of Columbia[18] covered the medically needy.

Any state that opts to include medically needy coverage for any group is required to extend that coverage to children under age 18, pregnant women, certain newborns, and certain protected persons who are blind or disabled and were eligible as of 1973. Other groups can be included as well, including the elderly and individuals with disabilities and children who under age 21, 20, or 19 and caretaker relatives of eligible children. States are also allowed to create "reasonable" categories of children to be eligible as medically needy, such as children under age 19 who are full-time students.

States that offer medically needy coverage can set a single income standard, called the medically needy income limit (MNIL) at any level up to $133^{1/3}$% of the maximum payment amount that could have been made to the same size family or individual under the states' former AFDC plan. The MNIL can be raised or lowered in accordance with the welfare reform provisions described above as they relate to Section 1931 family coverage. If raised, they can rise by no more than the annual increase in the consumer price index, or if lowered, they cannot fall below those in effect in May 1988. Methodologies for calculating income and resources must be the same as those used for the most closely related cash assistance program (for example, for low-income families the methodologies of the former AFDC program would be used, and for aged and disabled, the methodologies of the SSI program would be used).

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[17]Individuals may also "spend-down" to become eligible for Medicaid under a pathway expressly for individuals with disabilities known as the "209(b)" pathways. For more information about eligibility for people with disabilities under "209(b), see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone

[18]These include: Alaska, Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. All states except Texas cover aged and disabled medically needy groups.

For healthy children or other members of families without significant medical costs, the medically needy program has been all but overtaken by some of the other eligibility pathways. Coverage for families under Section 1931, waiver programs, and poverty-level child coverage often extend beyond those allowable ceilings for medically needy coverage. The medically needy pathway, however, remains an important part of the program for the elderly and individuals with disabilities who may have high medical and long-term care expenses. For more on eligibility rules for medically needy elderly and individuals with disabilities, see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone.

Individuals Qualifying Under Section 1115 Demonstration Waivers

States are able to experiment with new approaches for providing health care coverage by conducting demonstrations that promote the objectives of the Medicaid program using research and demonstration waivers authorized by Section 1115 of the Social Security Act. Section 1115 allows the Secretary of HHS to waive a number of Medicaid rules — including many of the federal rules relating to Medicaid eligibility and benefits.[19] The Health Insurance Flexibility and Accountability (HIFA) Initiative is an explicit effort of HHS to encourage states to seek Section 1115 waivers to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with incomes below 200% FPL. A number of states have used such waivers to enact broad-based, and sometimes statewide, health reforms although demonstrations under Section 1115 need not be statewide.

Many of the demonstrations extend comprehensive health insurance coverage to individuals who would not otherwise be eligible for Medicaid. As of September 2003, CMS reports 18 states and the District of Columbia have used the waiver demonstration authority to expand coverage opportunities statewide.[20] Not all of those states, however, have current approval to operate those programs. Some waiver approvals have expired and other states have chosen to discontinue their demonstrations. **Table 7** provides additional detail on the states with comprehensive demonstrations as reported by CMS in 2003.

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[19]See also the discussion of Section 1115 waivers below.

[20]They include Arizona, Arkansas, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, and Wisconsin. *Medicaid At-a-Glance, 2003*, Publication number CMS-11024-03.

Table 8. States with Expanded Eligibility under Medicaid Section 1115 Waivers

(as of 2003)

	Extended eligibility groups	Waiver expired or demonstration discontinued
AZ	All individuals under 100% FPL; children under 200% FPL	
AR	Children under 200%	
DE	All individuals under 100% FPL	Expired December 2003
DC	All adults ages 50 to 64 under 50% FPL	
HI	All individuals under 100% FPL, certain children and adults with income under 300% FPL	
IL	Parents of SCHIP children with income under 185% FPL	
MD	Children with income under 200% FPL.	
MA	Pregnant women and infants with income under 200% FPL; children 1-18 under 150% FPL; parents under 133% FPL; other disabled individuals and long-term unemployed individuals	
MI	Childless adults with income under 35% FPL	
MN	Parents and caretaker adults with income under 200% FPL; children and pregnant women under 275%	
MO	Children under 300% FPL; certain post-partum women and parents transitioning off TANF	
NY	Adults under 100% FPL; children under 150% FPL	
OK	Not clear how eligibility was extended beyond current law	Expired December 2003
OR	All individuals under 100% FPL; uninsured children under 200% FPL; certain adults under 170% and 200% FPL	
RI	Families under 185% FPL	
TN	Uninsured children under 200% FPL; uninsured adults under 100% FPL; certain uninsurable individuals	Task force developing plans to significantly reduce scope or discontinue
UT	Adults with income under 150% FPL; certain high risk pregnant women.	
VT	Uninsured adults under 150% FPL; parents and caretaker relatives under 185% FPL; under-insured children between 225% and 300% FPL.	Expired December 2003
WI	Children under age 19, under 200% FPL; parents under 200% FPL	

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *State Waiver Programs and Demonstrations*, CMS-11024-03, at [http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp].

Other Eligibility Pathways for Individuals Without Disabilities

In recent years, some new groups have been added to Medicaid that move the program further away from its traditional links to cash assistance programs. Two new pathways were added to Medicaid for individuals with specific medical diagnoses — for low-income women diagnosed with breast and cervical cancer, and for people with tuberculosis. In addition, Medicaid is available to individuals or families qualifying for continued employer-based coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and to unauthorized aliens seeking medical treatment in emergency rooms.[21]

Women with Breast and Cervical Cancer

Woman who are eligible for Medicaid under this optional coverage group are those who are identified as needing treatment for breast or cervical cancer (including precancerous conditions) through the Center for Disease Control's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Women who qualify must be under age 65, uninsured, and otherwise not eligible for Medicaid. Benefits are limited to the period in which the beneficiary requires breast or cervical cancer treatment. States' spending for the benefits is matched at an enhanced federal matching rate.[22] As of 2004, all states and the District of Columbia have chosen to cover women who meet these requirements.[23]

Persons with Tuberculosis

States may choose to offer Medicaid to people with tuberculosis (TB) who are uninsured. Individuals qualifying under this pathway are entitled only to those services related to the treatment of tuberculosis. In 2003, 13 states[24] and the District of Columbia covered such persons with TB.

COBRA Continuation Beneficiaries

States have the option of providing a limited benefit to certain individuals who are entitled to continue health insurance offered by former employers under the

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[21]Legally immigrating aliens participating in Medicaid do so through the standard pathways described throughout this document, although some limitations may apply. Those rules are discussed on page 28.

[22]States receive federal matching money for most Medicaid services at an average rate of 57%. The enhanced matching rate for services for women qualifying through this pathway is equivalent to the matching rate provided under the SCHIP program. It is calculated to be the basic Medicaid FMAP increased by 30% of the difference between the state's basic Medicaid FMAP and 100% with a minimum of 65% and a maximum of 85%.

[23]Personal communication, CMS Office of Legislation, Dec. 21, 2004.

[24]These include California, Florida, Louisiana, Minnesota, New York, Ohio, Oklahoma, Oregon, Rhode Island, Utah, Washington, Wisconsin, and Wyoming (CMS Publication, CMS-11024-03).

provisions of the Consolidated Omnibus Budget Reconciliation Act of 1984 (COBRA). That Act requires employers with 20 or more employees to continue to offer health insurance benefits to employees who would otherwise lose the coverage due to a change in their work status. The Medicaid option allows states to pay the former employees' premiums but only under the following circumstances:

- The employee or family member worked for a firm with 75 or more employees;
- The premium payment is "cost effective" i.e., the premium paid for the employer based coverage is below the amount Medicaid would have otherwise spent on Medicaid services for the individual;
- The employee entitled to elect COBRA coverage is in a family with income that does not exceed 100% of FPL; and
- The individual or family's resources do not exceed twice the SSI resource limit. (The SSI resource limit is $2,000 for an individual and $3,000 for a couple.)

Emergency Services for Illegal Aliens

A states's Medicaid plan is required to cover treatment for emergency conditions for illegal aliens and for persons in lawful temporary resident status who otherwise meet the program's eligibility criteria.[25] An emergency medical condition is defined as a "medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."[26] Coverage provided to these individuals, on the other hand, may exclude organ transplants.

General Eligibility Principles and Requirements

Wide Variation in State Programs

Federal requirements and options combine with state choices and definitions to ensure wide variation in the characteristics of state Medicaid programs. This variation across state programs makes generalizations about Medicaid eligibility policies difficult.

Federal law describes more than 50 eligibility pathways. Some of those pathways describe mandatory coverage groups; others are optional for states. Some of those coverage groups defined in federal law are described precisely, such as women diagnosed with breast or cervical cancer identified through the Center for Disease Control's National Breast and Cervical Cancer Early Detection Program.

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[25]Persons legally residing in the U.S. would qualify for Medicaid through general Medicaid eligibility pathways as described in this report, with some restrictions. See a discussion of those restrictions on page 27.

[26]Section 1903(v)(3) of the Social Security Act.

Other pathways are only generally described with the specifics left to states' discretion.

Where federal law identifies optional coverage groups, states have a great deal of flexibility in defining and specifying the pathways they choose to implement as described above. For example, federal law provides an option for states to cover children who are between the ages of six and eight and whose family income is between 100% and 133% of the federal poverty level (FPL). States can choose any combination of income level and age within those parameters. Another example is an eligibility pathway referred to as Ribicoff children. This pathway allows states to identify "reasonable classifications" of children whose income is very low and who do not otherwise qualify under welfare-related pathways. Under that category, states can define one, two, 10, or any number of classes of children to be offered Medicaid coverage. Most states cover multiple classifications of Ribicoff children.

For almost all Medicaid eligibility groups, mandatory and optional alike, federal law also leaves the precise definitions of financial eligibility criteria — countable income and resources — up to states. States can define what counts as income and resources for most coverage groups. A few exceptions to this rule include individuals eligible for Medicaid because of receipt of SSI payments, or through SSI-related eligibility pathways. For those individuals, definitions of income and resources come directly from SSI statute and regulations. A few other eligibility pathways place limits on states' ability to define income and resources. For example, a Medicaid regulation pertaining to optional families and children prohibits states from using any requirements for determining eligibility that are more restrictive than those used under the state AFDC plan (that existed in 1996). Similarly, states cannot use more restrictive definitions for optional aged, blind, and disabled individuals, than those used under SSI.[27] And in the Medicaid tradition, there are exceptions to those rules as well.

All of this variation contributes to the overwhelming level of diversity and complexity of the states' Medicaid programs. Many people have said that if you know one Medicaid program, you know one Medicaid program. This is because every rule or definition that applies in one state could be quite different in another. This immense variation also makes reforming the Medicaid program exceedingly difficult. A minor federal law change could have multiple ripple effects in each state.

Retroactive Eligibility

Under federal law, persons who are determined to be eligible for Medicaid must be provided with coverage for any care and services under the plan during the three months before he or she made application if that person would have been eligible for such assistance during that time. States are directed to determine if applicants have unpaid bills during the three calendar months before application and to pay for those services that are included in the state's Medicaid plan.

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[27] 42 CFR Section 435.01.

Citizenship

Medicaid programs are required to cover all U.S. citizens who meet the states' financial and categorical restrictions. States are also required to cover certain groups of legal permanent resident immigrants. Those groups are:

- refugees for the first seven years after entry into the United States;
- asylees for the first seven years after asylum is granted;
- certain other individuals whose deportation is being withheld for humanitarian reasons under the provisions of the Immigration and Nationality Act[28], for seven years after the deportation is first withheld;
- lawful permanent aliens after they have been credited with 40 quarters of coverage under Social Security; and
- immigrants who are honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children who otherwise meet the state's financial eligibility criteria.

For all other aliens lawfully admitted for permanent residence or permanently residing in the U.S. under color of law (e.g., certain aliens admitted pursuant to the discretionary authority of the Attorney General), states have the option to provide Medicaid coverage once any applicable waiting period has been met. Waiting periods of five years are applied to legal immigrants arriving in the United States after August 22, 1996[29] and to legal immigrants already residing in the country as of that date who become disabled in the future.

All Medicaid applicants are required to declare in writing, under penalty of perjury, that they are a citizen or national of the U.S., or an alien in a satisfactory immigration status. In addition, states are required to verify with the Bureau of Citizenship, the immigration status of all aliens applying for Medicaid through the Systematic Alien Verification for Eligibility (SAVE) system. This requirement does not apply to aliens seeking treatment for emergency medical conditions.

Eligibility Verification. States are required to have an income and eligibility verification system in administering Medicaid. States are required to request and make use of Internal Revenue Service (IRS) unearned income and quarterly wage information. The Omnibus Budget Reconciliation Act of 1986 clarified that the use of such information be targeted toward the most productive cases, and did not require states to use the information to verify the eligibility of *all* beneficiaries (e.g., states can verify samples of beneficiaries.)

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[28] For more information on immigrant eligibility for Medicaid see Appendix A of CRS Report RL31114, *Noncitizen Eligibility for Major Federal Public Assistance Programs: Policies and Legislation*, by R. Wasem.

[29] At publication, all states except for Colorado and Wyoming have opted to cover this group, referred to as "optional qualified aliens." Press reports suggest that Colorado may re-institute coverage for this group.

Residence

State Medicaid agencies must provide Medicaid coverage to otherwise eligible residents of the state, including residents who are temporarily absent from the state. An individual is generally considered a resident of a state if he or she is living in it with the intention of remaining there permanently or indefinitely. Eligibility may not be denied because an individual has not resided in the state for a specified period or because the individual is temporarily absent from the state. A state is also prohibited from denying coverage to an individual who satisfied the residency rules but who did not establish residence in the state before entering a medical institution.

A state is required to reimburse providers for services provided to its residents in another state under the following circumstances:

- Medical services are needed because of a medical emergency;
- Medicaid services are needed and the beneficiary's health would be endangered if he or she were required to travel to their state of residence;
- The state determines, on the basis of medical advice, that the needed medical services or necessary supplementary resources are more readily available in another state; or
- It is general practice for beneficiaries in a particular locality to use medical resources in another state.

Homelessness

Homelessness does not automatically qualify an individual for Medicaid. A homeless person must still meet his or her state program's eligibility criteria. However, a state may not exclude from coverage any otherwise eligible individual who resides in the state, regardless of whether or not the residence is maintained permanently or at a fixed address. States are required to establish a method of making eligibility cards available to eligible individuals who do not reside in a permanent dwelling or do not have a permanent home or mailing address.

Rules for Medicaid Benefits

There are a number of general rules that apply to the benefits offered under state programs. Although the rules are primarily about benefits, they are important to consider for a complete understanding of Medicaid eligibility. This is because these rules contribute to states complaints about the inflexibility of the Medicaid program. In addition, it is often the effect of these rules on state programs that have encouraged the proliferation of waivers and experimentation in providing health benefits to selected Medicaid enrollees in different ways. The requirements are often waived as a part of the research and demonstration waivers described above.

Amount, duration, and scope. Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The state may not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the type of illness or condition. The state may place appropriate limits on a service based on such criteria as medical necessity.

Statewideness. Generally, a state plan must be in effect throughout an entire state; that is, the amount, duration, and scope of services covered must be the same statewide.

Comparability. The comparability rule requires that the benefits offered be the same for all individuals qualifying within each eligibility pathway. This rule is often a major source of states' concerns regarding inflexibility. It prohibits states from changing the benefits offered to individuals within one pathway as their family income rises. It also prohibits states from offering some groups trimmed down benefit packages.

Current Eligibility Issues

Medicaid eligibility rules and policies raise a number of issues that generate both debate about the program as well as many questions for legislators. A first issue relates to achieving the optimum amount of program enrollment among those who are eligible. Ensuring that people who are eligible for Medicaid enroll is important to those involved in Medicaid policy issues for a number of reasons. Reaching full enrollment is a way to minimize the number of people who are uninsured without requiring additional programs or changing current program rules.

A second important issue is how to account for the counter-cyclical impact of the economy on Medicaid eligibility and enrollment. That is, when the economy improves, Medicaid benefits are needed by fewer individuals. When the economy suffers, Medicaid benefits are needed by more people. This counter-cyclical effect is consistent with the notion that Medicaid is a safety net for people losing jobs and financial security. Moreover, when the economy suffers, states' revenues are impacted as is their ability to fund the program.

A final issue, the changing nature of Medicaid enrollment, describes the recent transformation of the program to cover new groups of individuals and to play a greater role in addressing the needs of citizens with moderate incomes and who have stronger ties to the workforce. These issues are discussed below.

Managing and Monitoring Enrollment

For a number of years, researchers have found that state Medicaid programs do not enroll all of the eligible population. Most research findings suggest that between 65% and 80% of individuals eligible for Medicaid enroll in the programs. Much of this research has focused on only two Medicaid populations: children and the elderly eligible for Medicare cost sharing assistance[30] as shown in **Table 9** below.

In 1998 Seldon, et al., found that children over age twelve had significantly lower rates of enrollment, or take-up rates, than those who were younger. The authors speculate that this could reflect continuous Medicaid coverage for some

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[30]For dual Medicaid/Medicare individuals eligible for limited benefits, primarily assistance with Medicare cost sharing amounts, Medicaid has undergone similar scrutiny. See [http://www.cms.hhs.gov/dualeligibles/outreach.asp].

children since birth. It may also be related to need and use of health care services. Children under age 12 are known to have more medical encounters than those over age 12. In addition, children who became eligible for Medicaid because they were in families qualifying through a welfare-related pathway had higher take-up rates than those qualifying through the poverty-level expansions. This could be because many states automatically enroll individuals who are receiving welfare benefits into Medicaid, but do not automatically do so for those qualifying through the poverty-related pathways.

Other factors can play a role in the persistent enrollment gap. Unlike private insurance, there is no open enrollment period for Medicaid coverage. Individuals do not "lose out" on Medicaid coverage for the year if they do not enroll at the beginning of the year. So people can enroll at any time, or whenever they find they need medical services. There has not, however, been any systematic review or evidence of this playing a role in the enrollment gap.

The presence of the enrollment gap raises a number of concerns. First, much analytic evidence shows that insurance coverage leads to improved health outcomes.[31] On the other hand, with the inadequacy of available data to measure the problem, we may never know what the true gap in enrollment is.[32] The surveys that probe insurance coverage have universally under-represented public program enrollment. Some researchers have attempted to adjust the survey responses for this under count, although others have not. To the extent that public program enrollment is under-represented in the national surveys used to calculate the enrollment gaps, the take-up rates presented in **Table 9** could be too low — and the enrollment gap could be smaller than estimated.

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[31]B.C. Strunk, P.J. Cunningham, *Trends in Americans' Access to Needed Medical Care,* 2001-2003, Center for Studying Health System Change, Aug. 2004; C. Williams, *From Coverage to Care: Exploring Links Between Health Insurance, a Usual Source of Care, and Access*, The Synthesis Project of the Robert Wood Johnson Foundation, Sept. 2002; J.D. Kasper, T.A. Giovannini, C. Hoffman, "Gaining and Losing Health Insurance: Strengthening the Evidence for Effects on Access to Care and Health Outcomes," *Medical Care Research and Review,* vol. 57, no. 3, pp. 298-318.

[32]For more information on the surveys and the public program undercount, see CRS Report RL31275, *Health Insurance: Federal Data Sources for Analyses of the Uninsured,* by Chris Peterson and Christine Devere.

Table 9. Findings on Medicaid Take-up Rates (Expressed as Percentages of Eligibles) Among Children and Adults

(selected years)*

	1996	1998/ 1999	2000	2002
Government Accounting Office, "Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies" (GAO/HEHS-98-93, Mar. 1998)				
Children, age 18 and under, eligible for Medicaid —	77%	n/a	n/a	n/a
J. Holahan, L. Dubay, and G.M. Kenney, "Which Children are Still Uninsured and Why?" (The Future of Children, vol. 13, no. 1, 2003)				
Children, age 18 and under, eligible for Medicaid or SCHIP and who do not have private insurance —	n/a	1999 66%	n/a	n/a
— Eligible under welfare-related criteria		79%		
— Eligible under poverty-related groups		64%		
T.M. Seldon, J.L. Hudson, J.S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002" (Health Affairs, vol. 23, no. 5, Sept./Oct. 2004)				
Children, age 18 and under, eligible for Medicaid —	71.9%	1998 72.2%	73.9%	79.1%
T.M. Seldon, J.S. Banthin, J.W. Cohen, "Medicaid's Problem Children: Eligible But Not Enrolled" (Health Affairs, vol. 17, no. 3, May/June 1998)				
All children, age 18 and under, eligible for Medicaid	70%	n/a	n/a	n/a
— Children ages 0-12	73.2%			
— Children ages 13-18	59.1%			

Source: Congressional Research Service.

* Excludes adults qualifying on the basis of disability status.

Efforts to Reduce the Enrollment Gap. State Medicaid agencies have often taken the lead in efforts to reduce the enrollment gap. The aggressiveness with which states have attempted to reduce the gap, however, has waxed and waned depending on the budgetary conditions that states face. The additional budgetary costs of covering people who are not currently enrolled has, at times, acted as a barrier to aggressive outreach. During particularly difficult fiscal times, states sometimes do the opposite of outreach; that is, they may create administrative hurdles intended to impede enrollment or hasten disenrollment.[33]

The federal government has also played a major role in encouraging states to reach out to potentially eligible individuals. A major force behind the liberalization of Medicaid in the 1980's allowing states to cover many more pregnant women and

[33]Thomas P. McCormack, "State Medicaid Eligibility Cutbacks & Exclusions — Proposed and Recently Enacted, 2003," Title II Community AIDS National Network, Oct. 22, 2003.

children was the realization that national infant mortality rates compared poorly with those of other industrialized nations. The Medicaid coverage expansions for pregnant women and children began slowly, and enrollment rates among the newly eligible populations seemed at times stuck at about 60%.[34] Since reducing infant mortality and improving coverage among children had become an important priority, Congress responded quickly by adding new eligibility pathways in new laws intended to encourage states to improve outreach. **Table 10** shows the major federal legislative actions in this area.

Table 10. Outreach and Enrollment Provisions Included in Major Federal Laws Since 1986

OBRA 1986	(P.L. 99-509)	— Allowed states to make ambulatory prenatal care available to pregnant women for a presumptive period of eligibility. — Established that the application of a resource test was optional for pregnant women and infants with income below poverty. (Subsequent modification to this section currently allows states to choose whether or not to apply a resource test to all poverty-related pregnant women, infants and children.)
MCCA 1988	(P.L. 100-360)	— Allowed states to continue eligibility for certain pregnant women for 60 days after delivery, regardless of changes in income that would otherwise make them ineligible based on the financial requirements.
Family Support Act of 1988	(P.L. 100-485)	— Established Transitional Medical Assistance for families leaving welfare who would otherwise lose Medicaid due to increased earnings and certain other income.
OBRA 1990	(101-508)	— Made rules regarding presumptive eligibility for pregnant women more generous. — Required states to allow processing of Medicaid applications for pregnant women and children at locations other than welfare offices. — Established demonstration projects for up to four states to test the effect of eliminating categorical eligibility requirements for individuals with family income below 150% FPL.
BBA 97	(105-33)	— Allowed states to continue eligibility for children for 12 months regardless of changes in family income that would otherwise make them ineligible based on financial requirements. — Allowed states to offer presumptive eligibility to children.

Notes:

OBRA: Omnibus Budget Reconciliation Act

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[34]"Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion," GAO/HEHS-95-175, July 19, 1995; "Health Insurance for Children: Private Coverage Continues to Deteriorate," GAO/HEHS-96-129.

MCCA: Medicare Catastrophic Coverage Act
BBA: Balanced Budget Act

The welfare program reforms of 1996 saw Medicaid participation rates dipping again, this time among low-income families. The problem was considered to be an unanticipated consequence of welfare reform's success and provisions delinking Medicaid coverage from receipt of cash welfare benefits. At the same time that families were being lost in the transition off of AFDC, consensus was building to extend federally-sponsored health care to cover all poor and near poor children in the U.S. It became widely recognized that in order to achieve universal or near universal coverage of children, Medicaid's reach among children already eligible must be improved.

In 1998, the States Children's Health Insurance Program (SCHIP) was enacted.[35] The program provides grants to states to extend health coverage to children in families with low and modest income who are not eligible for Medicaid. A portion of the SCHIP grant was identified for outreach activities and the DHHS and the Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid Services, or CMS) encouraged outreach activities. In addition, HCFA established the Outreach Information Clearinghouse[36] which provided outreach information and a forum for information exchange among states, providers, schools and school districts, and children's groups, among others. HCFA also produced two "guides" or reports on Medicaid eligibility, enrollment and outreach activities, identifying when practices and procedures were federally required and which state activities were highly successful.[37] Finally, HCFA provided funds for five states to conduct pilot projects to remove barriers in states' application, enrollment, and renewal process.[38]

Removing administrative barriers. Much has been written about the complexity of the application and eligibility determination processes and how those processes have, in the past, raised considerable barriers to enrollment for many of Medicaid's target populations. Applications have been notoriously long and sometimes have questions that are difficult to understand. After the passage of SCHIP, many states worked to ensure "transparency," so that children making application for either Medicaid or SCHIP were placed in the appropriate program without having to undergo separate processes or applications. States made changes such as reducing the number of pages of applications, minimizing documentation requirements, and eliminating asset tests.

Nonetheless, during periods of heavily strained state budgets, erecting indirect barriers to enrollment — such as increasing the documentation requirements,

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[35]See CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview* by Elicia Herz, Bernadette Fernandez and Chris Peterson.

[36][http://www.cms.hhs.gov/schip/outreach].

[37]U.S. Department of Health and Human Services, Health Care Financing Administration, *Supporting Families in Transition*, Mar. 1999 and *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*, July 2001.

[38]States that were awarded these grant funds included Florida, Massachusetts, Ohio, Pennsylvania, and Washington.

establishing intrusive verification procedures such as fingerprinting, or reducing the number of days in a week or hours in a day during which applications may be accepted — effectively restrain Medicaid program participation and thus spending. In the recent period of strained state budgets, a number of states are reported to be considering establishing such "red tape barriers" to deter enrollment in response to budget pressures.[39]

The Impact of the Economy on Enrollment

The nation's economic condition during any given period has a direct impact on states' Medicaid programs. First, when depressions or recessions occur, citizens often lose jobs. Job loss can drive up Medicaid enrollment for two reasons: because people lose their job-based income, and because people lose their job-based health care coverage. The number of people qualifying on a financial basis swells at the same time that the perceived need for Medicaid to play its safety-net role swells. The same forces that raise the number of low-income people in need of Medicaid benefits concomitantly reduce states' ability to fund Medicaid. Rising joblessness reduces states' tax revenues.

Federal statute provides states with considerable flexibility to choose whether to cover certain eligibility groups and to define other eligibility groups in ways that would allow more or fewer individuals to qualify for benefits. This means that eligibility policy could, in theory, be used as a tool to reduce Medicaid spending when states' budgets are tight or to extend the generosity of the program in other times. But this much control over the program's size and cost is often elusive for state-level policy makers. Instead, Medicaid's size and spending levels are largely driven by the nation's general economic fluctuations, the size and needs of the states' population, and by other political concerns.

Cutting eligibility to reduce costs is difficult (but not impossible). There are three reasons for this. Eligibility and enrollment trends are driven by economic conditions, making the impact of any policy changes at the state level either dulled or accentuated by the changes driven by the economy. For example, if a state eliminated coverage for medically needy people during a time when incomes are generally high and fewer people are qualifying for such coverage, there is less objection. But if the eligibility pathway were eliminated during a recession — at just the time when large numbers of individuals and families are finding their income dipping into the range for medically needy coverage, the cutback has a considerably stronger impact. This situation leads to the second problem with cutting eligibility — eliminating individuals' ability to rely on Medicaid, at exactly the time when such need for assistance is climbing, may be politically unpopular. Many states seek to avoid this unappealing tool for fiscal restraint by instead restricting benefits, reducing provider payments, and/or raising copayments for services.

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[39]D.C. Ross, L. Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, Oct. 2004; T.P. McCormack, *State Medicaid Eligibility Cutbacks and Exclusions — Proposed and Recently Enacted, 2003*, Title II Community AIDS National Network, Oct. 2003.

Finally, there is a cyclical problem with reducing the size of the Medicaid program during a recession. When states budgets are flush with revenues, improving access to medical care for those in need is a very popular use of state funds. During such periods, many states add eligibility coverage groups to Medicaid or modify the definitions of existing groups to include additional people, thereby increasing the program's generosity. Such eligibility expansions raise the fiscal stress on the states during the next recession.

In the late 1990's, the nation's economy surged, largely spurred on by the technology stock boom. States' revenues improved and Medicaid programs in many states became more generous. But during the next few years, 2001 to 2003, states were unable to keep up with the program's rising costs. In response, states appealed to the U.S. Congress for fiscal relief. In 2003, states received that relief with a provision passed as part of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-027) that temporarily raised the share of Medicaid paid by the federal government.[40]

Beside fiscal relief, there are few other proposals that directly provide additional funding for the program when the economy drives such periodic increases in eligibility and enrollment. Such proposals would modify the federal-state funding relationship to shift costs from states to the federal government in recessionary periods.[41]

Changing Nature of Medicaid Enrollment

Medicaid's target populations have undergone major changes over the years. Early in the program's history, eligibility for Medicaid was tied to the receipt of cash assistance. When enacted, Medicaid was offered only to families and individuals who qualified to receive payments under two programs: the former AFDC program, which provided cash assistance to very low-income families with children; and the SSI program, which provides cash assistance to very low income individuals who are aged or meet certain federally prescribed definitions of blindness or disability. The program's close link to cash welfare programs began to erode when Congress enacted a series of eligibility expansions in the 1980's targeted primarily to children and pregnant women. These new groups were in families whose income was too high to qualify for cash welfare payments, but was still at or near poverty.

Later, changes in Medicaid continued to move the program further from its cash assistance roots. In 1996, the AFDC program was replaced with a program of grants to states for various low-income assistance efforts. The TANF program was passed as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (TANF, P.L. 104-193). With this change to federal welfare policy, Medicaid's link to cash welfare assistance for poor families was formally broken. Instead, the

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[40]For a more complete description of this provision and the circumstances surrounding its passage, see CRS Report RL31773, *Medicaid and the Current State Fiscal Crisis* by Christine Scott.

[41]For more information on financing Medicaid see CRS Report RS21262, *Federal Medical Assistance Percentage (FMAP) for Medicaid*, and CRS Report RL31773, *Medicaid and the Current State Fiscal Crisis*, by Christine Scott.

eligibility rules for families applying for Medicaid were liberalized to allow states the flexibility to specify new rules, as long as states continue to provide Medicaid coverage to individuals who would have been eligible to receive AFDC payments under old program rules.[42] The automatic eligibility for Medicaid for recipients of SSI payments, however has remained.

Over the last decade, many states have continued to make changes that move Medicaid programs further away from its historical coverage groups. States are able to apply to the Secretary of HHS for waivers of certain federal Medicaid rules. These waivers, authorized under Section 1115 of the Social Security Act, allow states to conduct demonstrations, the goals of which must be consistent with the purpose of the Medicaid statute. Under these demonstrations, some states have extended coverage to higher income individuals and to individuals who otherwise do not fit into Medicaid's traditional categorical coverage groups (the elderly, blind and disabled individuals, and members of families with dependent children).[43]

The number of approved demonstration waivers has increased over the last decade, encouraged by both the Clinton and G.W. Bush Administrations. State officials have identified a lack of flexibility in eligibility policies as one of the reasons waivers have such appeal. Notwithstanding the program's flexibility that allows states to choose which optional groups to cover, and to define income and resources tests and methodologies for many groups, other rules constrain states. One program rule meant to achieve "fairness" within and across states is a predominant issue for states. This "comparability"[44] rule states that all individuals within a single eligibility category must be offered the same set of benefits. For example, a poverty-related child qualifying in Maryland's Anne Arundel County must receive the same set of Medicaid benefits as a child qualifying for Medicaid but residing in Queen Anne's County. This rule also prevents states from offering a particular population a trimmed down benefits package — so for example, if a state chooses to cover all pregnant women who are in families with income below 185% of poverty, the state could not offer reduced benefits to those with income over 150% or charge larger co-pays to this somewhat higher income group than charged to those below 150% of poverty. States argue that they must, as a consequence of this rule, offer nothing to anyone in a particular coverage group or income range, when they could otherwise offer some additional individuals a limited set of benefits. Because of this "all or nothing" inflexibility, some states claim they could be more generous to certain groups than they are today.

Skeptics question whether states' complaints about lack of "flexibility" disguise less benevolent goals. Detractors of policies to enhance the states' design flexibility worry that advocates of increasing flexibility are primarily those who would prefer to reduce Medicaid's assistance for poor people, and are prevented from doing so because of existing mandates and the comparability rule.

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[42]The law includes minimum eligibility standards to ensure that families who had formerly qualified for Medicaid through their receipt of AFDC would continue to be eligible for coverage (Section 1931(b)).

[43]See CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, by Evelyne Baumrucker.

[44]General rule at Section 1902(a)(10)(B) of the Social Security Act.

Putting arguments about what flexibility means aside, Medicaid's role as insurer of last resort has undergone a transition from covering only those eligible for cash assistance to having a much larger role for a broader range of low-income uninsured individuals. The debate about Medicaid's role is likely to intensify as private insurance coverage continues to decline, and as aging baby boomers demand more long-term care services that are typically not covered under private health insurance plans.