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Medicaid Eligibility for the Elderly

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Almost all of the nation's elderly -- over 34 million -- have health insurance coverage through Medicare.[1] However, Medicaid is a crucial source of coverage for 6 million of these elderly Medicare beneficiaries who are poor or low-income. The coverage that Medicaid provides takes two forms: (1) payment for health and long-term care services that Medicare does not cover, notably outpatient prescription drugs and long-term care; and (2) assistance with the costs of Medicare premiums and co-insurance requirements. Most poor Medicare beneficiaries are eligible for both forms of Medicaid coverage; the rest are eligible only for assistance in meeting Medicare premium and cost-sharing requirements.[2]

Qualifying for Medicaid -- whether for the broader coverage of health and long-term care benefits or for the narrower assistance with Medicare premiums and cost-sharing -- is a far more difficult undertaking than qualifying for Medicare. Medicare, like Social Security, is an entitlement program with automatic coverage based on eligibility. Medicaid is also an entitlement program but it is also means tested, with different levels of coverage based on income. Medicaid eligibility policy is complex, making the program difficult for elderly and other low-income Americans to understand and for state Medicaid officials to administer. Yet within this complexity are options that enable states to use their Medicaid programs as a policy tool for increasing financial protections for the low-income elderly against the cost of nursing home and other long-term care, as well as improving access to care for this population.

Significant numbers of low-income elderly people are eligible for Medicaid -- particularly Medicaid assistance with Medicare premiums and cost-sharing -- but are not enrolled.[3] The relatively low participation is explained in part by the complexity of Medicaid eligibility, but it is not the only explanation. Others include burdensome application forms and procedures, inadequate outreach efforts, and negative perceptions of

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Medicaid among elderly people and their families. These issues have been explored in related Kaiser Commission projects and are not the subject of this Issue Paper.[4]

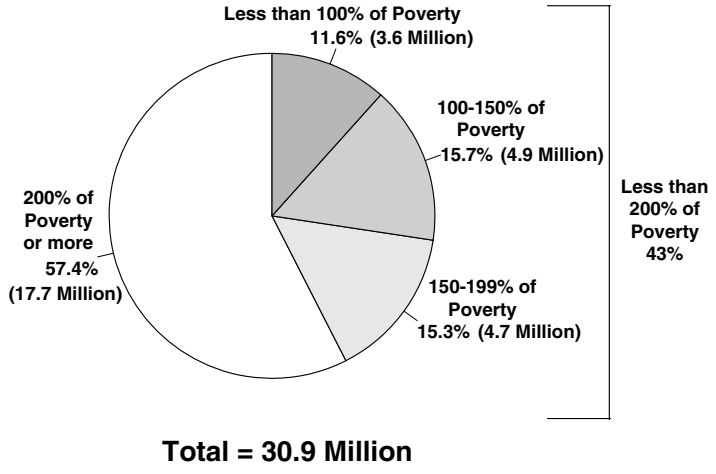
The purpose of this Issue Paper is to explain Medicaid eligibility policy for the low-income elderly population. The Paper begins with an explanation of the importance of Medicaid for low-income elderly people. After a brief overview of Medicaid eligibility policy generally, the Paper then reviews the major statutory and regulatory "pathways" available to the low-income elderly for full Medicaid coverage and for assistance with Medicare premiums and cost-sharing. As CBO has recognized, states have "a great deal of flexibility in operating the Medicaid program."[5] Medicaid eligibility policy, like Medicaid coverage policy and Medicaid payment policy, varies from state to state.[6] This Issue Paper does not attempt to describe Medicaid eligibility policy for the low-income elderly in each state.[7] Instead, the focus is on the federal policies that structure the eligibility choices that states make.

I. HEALTH CARE FOR THE LOW- INCOME ELDERLY

Two in five elderly people (43%) -- over 13 million people -- are low-income, living on incomes below 200% of the federal poverty level (Figure 1). Twelve percent of the elderly have an income below the federal poverty level. Another 31 percent live on incomes between 100 and 200 percent of the poverty level. Social Security income is the main source of support for over two-thirds of the elderly and accounts for over 90 percent of income for 3 out of 10 elderly beneficiaries. With an average annual Social Security benefit (in 1996) of $9,800 for men and $7,332 for women, it is not surprising that many of the elderly live on incomes at or near the poverty level.[8] Poverty rates increase with age, are higher for women than men, and are higher for elderly minority populations than whites.

Figure 1

The Elderly Population, by Income, 1996



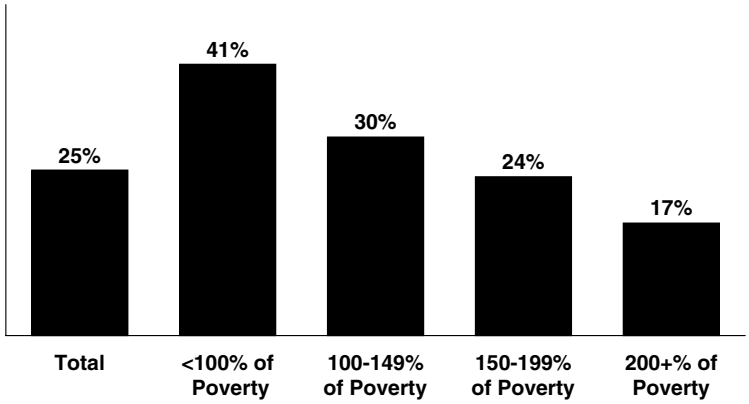
Total = 30.9 Million

Note: 1996 federal poverty level was $7,740 for individuals; $10,360 for couples.
SOURCE: Urban Institute estimates of non-institutionalized population based on analysis of March 1997 Current Population Survey.

Medicare is especially important to low-income elderly people because they are in poorer health than higher income elderly people (Figure 2). Forty-one percent of poor and near-poor elderly people perceive their health to be fair or poor compared to 17 percent of elderly people with incomes above 200 percent of the poverty level. Poor and near-poor elderly people are also more likely to suffer from chronic conditions, including arthritis, hypertension, and diabetes that require on-going medical treatment.[9]

Figure 2

Percent of Elderly Medicare Beneficiaries Reporting Fair or Poor Health, 1995



SOURCE: Urban Institute estimates from the 1995 MCBS, including institutionalized beneficiaries.

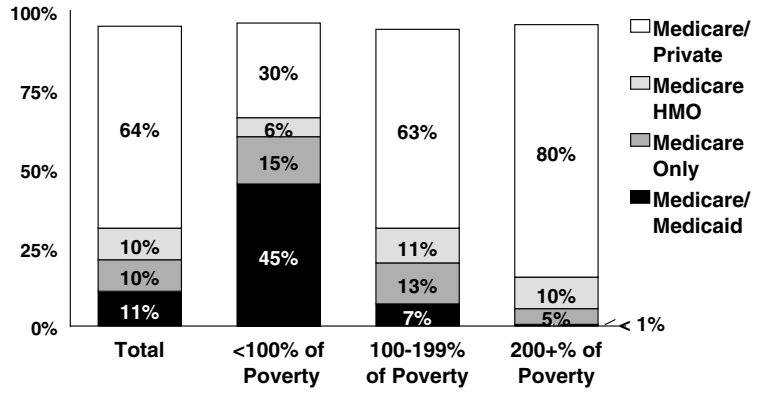
Although Medicare provides basic health coverage for hospital and physician visits, the cost of uncovered services, coupled with substantial cost sharing requirements and the Part B premium, impose a serious financial burden for many elderly people. Depending on the individual's income and resources, Medicaid may pay the beneficiary's Medicare Part B monthly premium ($45.50 in 1999), Medicare Part B annual deductible ($100), Medicare hospital deductible ($768 per benefit period in 1999), Part A coinsurance, and coinsurance and deductibles charged by health maintenance organizations. Because low-income Medicare beneficiaries have greater health needs than those with higher incomes, they spend a significant share of their incomes on health-related costs.[10] In 1997, poor Medicare beneficiaries without Medicaid coverage to supplement Medicare spent one-third (35%) of income on out-of-pocket health costs, while poor Medicare beneficiaries with full-year Medicaid coverage spent eight percent of income on out-of-pocket costs.[11]

Medicaid covers 12 percent of elderly Medicare beneficiaries (Figure 3). The low-income Medicare beneficiaries who are also covered by Medicaid are in poorer health, and are more likely to be over age 85, female, and living without a spouse than other Medicare beneficiaries.[12] Although Medicaid can provide important assistance, the program does not cover all elderly low-income people. Medicaid covers 47% of the

poor and 7% of low-income (between 100-199% FAL) elderly Medicare beneficiaries. While many of those with higher incomes have private supplemental insurance to cover Medicare's gaps, the low-income elderly are less likely to have private supplemental coverage. As a result, 1 in 7 low-income elderly Medicare beneficiaries (14 to 15 percent) are without coverage to supplement Medicare. Those who rely solely on Medicare have poorer access to care than those with supplemental coverage.[13]

Figure 3

Health Insurance Coverage of Elderly Medicare Beneficiaries, 1995



SOURCE: Urban Institute estimates from the 1995 MCBS, including institutionalized beneficiaries, other public coverage excluded.

II. OVERVIEW OF MEDICAID ELIGIBILITY POLICY

Medicaid is a means-tested, federal-state, individual entitlement[14] program with historical ties to the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI)[15] cash assistance programs. Medicaid eligibility policy reflects this basic program structure. Because Medicaid is means-tested, it has extensive rules for determining income and resources. Because Medicaid is not a uniform federal program like Medicare, there are substantial variations in eligibility policy from state to state. Medicaid's historical links to AFDC and SSI are reflected in its coverage of certain categories of low-income individuals, such as the elderly. Finally, because Medicaid entitles eligible individuals to coverage for basic health and long-term care services, both the states and the federal government have historically relied on eligibility policy as a tool for limiting their financial exposure for the cost of covered benefits with respect to populations with high average per capita expenditures like the elderly and disabled.[16]

At the federal level, eligibility policy choices are reflected in the way in which the Medicaid statute allows federal matching funds to be used. More specifically, federal Medicaid matching funds are available to states for the costs of covering some

categories of low-income individuals -- e.g., the elderly -- but not other categories -- e.g., childless, non-disabled adults. Similarly, within a category, federal matching funds may be available to states for the costs of covering some individuals -- e.g., the elderly in nursing homes -- even if the state does not cover the elderly in the community who are in need of long-term care. If federal matching funds are not available, it is unlikely that a state will extend Medicaid coverage to that category of individuals, because the state would then bear the costs of care entirely at its own expense.

At the state level, eligibility policy choices are reflected in state decisions as to which optional eligibility categories and which income and resource criteria to adopt. There are certain categories of individuals that all states opting to participate in Medicaid must cover. There are other categories of individuals for which states may receive federal matching funds if they choose to extend Medicaid coverage. However, the availability of federal matching funds for a particular category of individuals does not necessarily mean that a state will cover that category, since the state must still contribute its own matching funds toward the costs of coverage.

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

Within each of these five broad requirements are “mandatory” and “optional” elements. It is important to understand the context in which these terms are used. State participation in Medicaid is voluntary, not mandatory. The federal government makes Medicaid matching funds available on an open-ended, entitlement basis to states that elect to participate in the program. In order to participate, states must offer coverage for basic benefits to certain populations. States receive federal Medicaid matching funds for at least 50 percent and as much as 80 percent of the costs of this mandatory coverage, depending on the state. In exchange, states are also able to draw down federal Medicaid matching funds for optional populations and services such as the low-income elderly and disabled at risk of nursing home and other costly long-term care services. According to the Health Care Financing Administration, over half -- about 55 percent -- of all Medicaid spending is for optional populations or optional services.[17]

Virtually all elderly Medicaid beneficiaries are also covered by Medicare. The fact that an elderly individual has Medicare coverage -- or supplemental private health insurance coverage -- does not bar the individual from Medicaid coverage if he or she is otherwise qualified. From the standpoint of the Medicaid program, Medicare is a type of “third party liability” -- a third party payer that is liable for some of the costs of care provided to the beneficiary that reduces the costs of coverage for Medicaid. When Medicare and Medicaid both cover the same services -- e.g., inpatient hospital care --

Medicare pays first. Medicaid pays only for the services it covers that Medicare does not -- e.g., outpatient prescription drugs.

An elderly individual who establishes Medicaid eligibility is not, on the basis of that initial determination, entitled to maintain eligibility indefinitely. Federal Medicaid regulations require that states redetermine the eligibility of a Medicaid beneficiary at least once every 12 months. This redetermination, like the initial eligibility determination, is designed to ensure that a beneficiary continues to meet each of the financial and non-financial requirements for eligibility. Those beneficiaries who no longer meet the eligibility requirements in their state lose their entitlement to Medicaid coverage. Such changes, however, are less likely for the elderly than for other Medicaid beneficiaries. While fluctuations in monthly income are common among low-income families, thereby compounding the complexity of Medicaid eligibility policy for this population, they are less frequent among the low-income elderly, who tend to be living on Social Security benefits and other fixed income streams.

Categorical Eligibility

Medicaid eligibility is limited to individuals who fall into specified categories. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. These statutory categories can be broadly classified into five broad coverage groups: children; pregnant women; adults in families with dependent children; individuals with disabilities; and the elderly. This Issue Paper focuses on the elderly -- individuals age 65 or above. Of course, many of the elderly also have disabilities and could potentially meet the categorical eligibility requirement for Medicaid on the basis of their disabilities. However, in order to avoid the administrative cost and burden associated with disability determinations, state Medicaid programs generally establish categorical eligibility for an elderly person based on age. Within each category, states may have sub-categories or pathways to eligibility based on level of income or services needed.

Income Eligibility

Being in a Medicaid eligibility category is essential to qualifying for Medicaid coverage. It is not, however, sufficient. Because Medicaid assistance is limited to those in financial need, the program also imposes financial eligibility requirements. These requirements take two basic forms: income tests and resource (or assets) tests. These financial requirements vary from category to category. For example, both the income eligibility thresholds and the resource tests for children differ in most states from the income and resource tests applicable to the disabled or the elderly.[18]

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

premiums and cost-sharing -- income eligibility standards are tied directly to specified percentages of the federal poverty level (e.g., 100 percent, 120 percent, 135 percent, 175 percent). In other cases -- e.g., individuals residing in nursing facilities -- income eligibility standards are tied to the federal cash assistance programs (e.g., 300 percent of the SSI payment standard).

There are two components of income eligibility: the standard and the methodology. An income *standard* is a dollar amount -- say, $687 per month (100 percent of the 1999 federal poverty level for an individual). An income *methodology* is the way in which an applicant's income is counted for purposes of applying the income standard. For example, an income methodology may count all income received from any source -- e.g., Social Security benefits, pensions, wages, interest payments, and dividends. Or it may disregard some types or amount of income -- e.g., the $20 unearned income monthly disregard and the $65 monthly earned income disregard (plus one-half of remaining earnings) that are basic to the SSI income methodology. The standard is meaningless without the methodology, and income methodologies vary from state to state. Indeed, the methodology is what converts the nominal dollar standard into an actual amount.

For example, assume an elderly individual living alone with no earned income and no pension income other than a monthly Social Security check. If the individual lives in a state with an income standard of $500 per month, he or she may receive a Social Security check of up to $520 per month and still qualify for Medicaid because the methodology used to calculate income disregards the first $20 each month.[19] However, a Social Security check in an amount greater than $520 per month would disqualify the individual from Medicaid coverage on this basis. (Note that he or she might be able to qualify under some other eligibility pathway, depending on the state and the individual's medical expenses and other circumstances).

There are some Medicaid eligibility categories for which individuals may qualify by "spending down" -- that is, the costs of health care that an individual has incurred are deducted from the income that an individual receives in determining whether he or she qualifies for Medicaid. The most commonly known eligibility category to which the spend-down approach applies is the "medically needy." These are individuals who fall into one of the required eligibility categories -- e.g., pregnant woman, child, adult with dependent children, elderly, or disabled -- but whose income is greater than the applicable income threshold for cash assistance. Many elderly Medicaid beneficiaries may qualify as "medically needy" due to high long-term care or other medical expenses.

Resource Eligibility

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

As in the case of income eligibility requirements, resource requirements include both standards and methodologies. A resource *standard* is a dollar amount -- typically $2,000 in the case of an elderly individual and $3,000 in the case of an elderly couple. In contrast to the Medicaid income standards, some of which are tied to the federal poverty level, Medicaid resource standards are generally not indexed to inflation or otherwise adjusted on a regular basis. As a result, resource standards have become more and more restrictive over time.

A resource *methodology* determines which resources are counted and how those counted resources are valued. For example, the home in which an individual lives is generally not a countable resource, regardless of its value. Similarly, a wedding ring or engagement ring is generally not a countable resource. Most other resources tend to be countable, although the resource methodology that applies to the eligibility category in question -- e.g., children, the disabled, the elderly -- may not count the entire value of the resource. For the elderly, the resource methodology used by the SSI program is the methodology most often used for Medicaid eligibility purposes.

The SSI resource methodology does not count the first $2,000 of household goods or personal effects or the first $4,500 in current market value of a car. In some cases, such as if the car is used to obtain medical treatment or for employment, its entire value is excluded for the calculation of resources. Similarly, SSI resource methodology does not count the first $1500 in burial funds; however, this amount is reduced by the face value of any irrevocable burial contracts, trusts, or other arrangements.[20]

Immigration Status

The fourth broad Medicaid eligibility requirement is immigration status. Citizens who meet the program's financial and other non-financial eligibility requirements are entitled to Medicaid coverage. Immigrants who have entered the U.S. *illegally* can not qualify for basic Medicaid benefits, although they are (if they meet all other financial and non-financial requirements) eligible for Medicaid coverage for emergency care. Immigrants who are *legally* residing in the U.S. who meet all other financial and non-financial requirements are eligible for Medicaid coverage for emergency care, but they are not necessarily eligible for the full range of Medicaid services.

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

Most immigrants entering the country legally on or after August 22, 1996, are ineligible for non-emergency Medicaid coverage for five years from their date of entry into the U.S.[21] After the 5-year period has expired, states may, at their option, extend Medicaid coverage to these legal immigrants (if they meet the other financial and non-financial requirements) or they may continue to deny them benefits until they become citizens. In those states that elect to extend Medicaid coverage to legal immigrants after 5 years, the income and resources of the sponsor of the immigrant must be attributed to the immigrant in determining Medicaid eligibility. The 1997 Balanced Budget Act created an exception to this general 5-year bar for immigrants who are receiving SSI benefits on the basis of age (or disability). In states that grant Medicaid eligibility to SSI recipients, these immigrants are eligible for Medicaid; in states that use more restrictive eligibility rules for SSI recipients generally, these immigrants are eligible if they meet the state's more restrictive rules.[22]

Residency

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

When an elderly individual enters a nursing home which is in a state other than where the family residence is located or where the spouse (if any) resides, the individual's state of residence for Medicaid purposes is typically the state in which the nursing home is located. The state where the nursing home is located, not the state where the family residence or spouse resides, determines the individual's eligibility for Medicaid under its rules and pays for the services covered under its Medicaid program.[23]

III. ELIGIBILITY PATHWAYS FOR THE ELDERLY

As noted above, Medicaid offers two types of coverage for the low-income elderly: (1) coverage for the basic Medicaid benefit package (e.g., physician, hospital, nursing facility, prescription drug, and other services, as well as assistance with Medicare premiums and cost-sharing; and (2) assistance with the costs of Medicare premiums, deductibles, and co-insurance requirements only. As shown in Figure 4, some Medicare beneficiaries qualify for both types of coverage (eg, SSI-related), while others qualify only for coverage for Medicare premiums and cost-sharing.

Figure 4

Medicaid Eligibility Pathways for the Elderly

Full Medicaid Coverage

SSI-Related

Medically Needy

Nursing Facility

Assistance with Medicare Premiums and Cost-Sharing

Qualified Medicare Beneficiaries

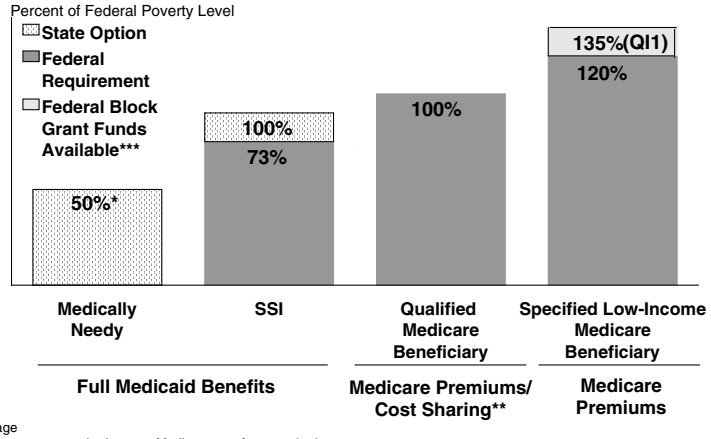
Specified Low-Income Medicare Beneficiaries

Other Categories (Qualified Individuals)

Furthermore, as shown in Figure 5, eligibility for different benefits is based on relatively small differences in income. In addition, there is considerable state variation in coverage levels for the elderly due to differences in use of optional coverage categories (Table 1).

Figure 5

Medicaid Income Eligibility Levels for Elderly and Disabled Beneficiaries, 1998



*Average
**States are not required to pay Medicare rate for cost-sharing
***Block grant funds for Part B premium; funds may also be used for a small portion of the premium for those with incomes between 135-175% of poverty (QI2).

Table 1. Medicaid Eligibility for the Elderly, by State, 1998

State	SSI or 209(b) Income Levels Percent of FPL [a]	SSI/SSP Benefit Percent of FPL [b]*	Medicaid Coverage Up to 100% FPL Percent of FPL [c]	Medically Needy Income Levels for Individuals Percent of FPL [d]**	300% Rule In Effect (as of 1996) [e]
Number of States with Optional Coverage	11	23	12	35	33
Alabama	74				X
Alaska	74	102			X
Arizona	74				X
Arkansas	74			16	X
California	74	97		89	
Colorado	74	79			X
Connecticut(1)	71	111		71	X
Delaware	74				X
District of Columbia	74		100	56	
Florida	74		90	27	X
Georgia	74			31	X
Hawaii(1)	N/A	65	100	54	
Idaho	74	81			X
Illinois(1)	42	N/A		42	
Indiana(1)	74				
Iowa	74			72	X
Kansas	74			71	
Kentucky	74			32	X
Louisiana	74			15	X
Maine	74	75	100	47	X
Maryland	74			52	
Massachusetts	74	93	100	78	
Michigan	74	76	100	61	X
Minnesota(1)	70	86		70	
Mississippi	74		100		X
Missouri(1)	74				
Montana	74			73	
Nebraska	74	75	100	58	
Nevada	74	79			X
New Hampshire(1)	76	78		76	X
New Jersey	74	78	100	55	X
New Mexico	74				X
New York	74	86		87	
North Carolina	74			36	
North Dakota(1)	74			60	
Ohio(1)	64				X
Oklahoma(1)	74	82		39	X
Oregon	74	74		100	X
Pennsylvania	74	78	100	63	X
Rhode Island	74	83		83	X
South Carolina	74		100		X
South Dakota	74	76			X
Tennessee	74			26	X
Texas	74			***	X
Utah	74		100	55	
Vermont	74	82		110	
Virginia(1)	74			37	X
Washington	74	78		78	X
West Virginia	74			30	X
Wisconsin	74	86		86	
Wyoming	74				X

N/A: not applicable in Hawaii, data not available in Illinois.

(1) 209(b) state. Income levels for individuals. Resource limits and methods of counting resources may also differ from SSI.

* For individuals living independently.

** Level varies by region in CT, MI, VA, and VT. *** TX program only covers pregnant women and infants.

Source: Bruen et al., The Urban Institute, 1999; [a], [b], [c], [d]; Horvath 1997 [e].

A. Full Medicaid Coverage

This section reviews the main eligibility pathways that a low-income elderly individual may use to establish an entitlement to coverage for Medicaid benefits. These pathways are summarized in Table 2.

SSI-Related Pathways

Subject to one important exception, states are required to cover elderly individuals receiving cash assistance under the Supplemental Security Income (SSI) program.[24] In 1999, to qualify for SSI, an elderly individual must have an income of no more than $520 per month ($771 per month for a couple) and countable resources of not more than $2,000 ($3,000 for a couple). These figures include the $20 monthly income disregard. There were just over 2 million elderly SSI recipients in 1998.[25]

Not all of these SSI recipients automatically qualified for Medicaid, however. That is because of the exception to the SSI coverage requirement for elderly individuals residing in those states that have elected the so-called "209(b)" option. This option, named for the section of the 1972 Social Security Act Amendments in which the SSI program was enacted, allows states to use their 1972 state assistance eligibility rules in determining eligibility for the elderly instead of the federal SSI rules, which adjust income standards for inflation each year. However, if a state uses its more restrictive 1972 standards, it must also allow individuals to "spend down" into Medicaid eligibility by deducting incurred medical expenses from income. (Elderly individuals generally cannot deduct their medical expenses in calculating their income in order to qualify for SSI). As of 1998, 11 states had elected the "209(b)" option, applying income standards, resource standards, and/or resource methodologies more restrictive than those applicable under SSI: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.[26]

States have the option of extending Medicaid coverage to elderly individuals who are receiving State Supplementation Payments (SSP) but not SSI payments. Under SSI law, states have the option of providing a cash payment to supplement the basic federal SSI payment. In 1997, all but 7 states provided some amount of supplementary payment, ranging from $2 per month (Oregon) to $243 per month (Connecticut); the median SSP payment that year was $36 per month.[27] Under the SSP-only eligibility option, states may make Medicaid available to elderly individuals receiving these payments. In 1998, 28 states reported making Medicaid coverage available to elderly individuals living independently and receiving state supplementation payments but not SSI benefits (see Table 1).[28]

Table 2. Medicaid Eligibility Pathways for Elderly Individuals: Full Medicaid Benefits Package

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	**Resource Test**
Primary Pathways		
SSI Recipients*	≤ $500 per month for an individual; ≤ $751 per month for a couple	≤ $2,000 for an individual; ≤ $3,000 for a couple; may not dispose of resources to qualify
Or		
Individuals in "209(b)" states	No more restrictive than 1972 state standard; individual may "spend down" to eligibility by deducting incurred medical expenses from income	No more restrictive than 1972 state standard and methodology; individual may not dispose of resources to qualify
Other Pathways		
Individuals who lose SSI ("Pickle Amendment")	Would meet SSI standard but for Social Security cost-of-living increase	Same as SSI
Disabled widows and widowers ineligible for SSI due to increase in benefits	Would meet SSI standard but for Social Security disability benefit increase	Same as SSI
OPTIONAL COVERAGE	**Eligibility Criteria**	
	Income Test	**Resource Test**
Primary Pathways		
Medically needy	State sets income standard; individual may "spend down" to qualify by deducting incurred medical expenses from income	State sets resource standard; individual may not "spend down" or dispose of resources to qualify
Institutionalized individuals under special income level	Income standard no higher than 300% of SSI standard ($1500 per month in 1999)	Same as SSI
Individuals receiving state supplementation payments (SSPs)	SSI-eligible but for increased income	Same as SSI
Other Pathways		
Individuals receiving Home- and Community-based services	Would be eligible if institutionalized	Would be eligible if institutionalized
Poverty-level individuals age 65 or older	≤ 100% FAL [a] (In 1999, $687 per month for an individual)	Same as SSI [a]

* Federal SSI benefit standard in 1999. Does not include $20 per month income disregard.

[a] States may use "less restrictive" income and resource methodologies under section 1902(r)(2) of the Social Security Act.

Many elderly individuals receiving SSI also receive Social Security benefits. In some cases, cost-of-living increases in the Social Security benefit may cause an individual to lose his or her SSI (or SSP) benefits. Although these individuals may lose their SSI or SSP payments, they remain eligible for Medicaid in those states that cover elderly individuals receiving SSI or SSP benefits. That is because under the so-called "Pickle" amendment, these states are required to disregard the Social Security cost-of-living increases received by the individual for Medicaid purposes.

"Medically Needy" Pathway

Many low-income elderly individuals and couples have incomes that exceed the SSI eligibility level (73 percent of the 1999 federal poverty level for an individual, not including the $20 per month disregard) and have medical expenses that Medicare does not cover. States that want to offer Medicaid coverage to assist these individuals or couples with their medical expenses have the option of covering them with federal matching funds through the "medically needy" pathway. In 1998, 35 states and the District of Columbia had elected to offer coverage to the "medically needy."[29] This eligibility pathway is often used by elderly individuals residing in nursing facilities or by individuals living in the community with high prescription drug or medical equipment expenses.

Under the "medically needy" option, a state establishes an income standard, as well as a resource standard. In counting income or resources for the elderly, a state must apply methodologies no more restrictive than those under the SSI program. In determining income -- but not resource -- eligibility, the state deducts the medical expenses an individual has incurred over a budget period (not more than 6 months) from the individual's countable income. If the individual's income less incurred medical expenses is less than the state's medically needy income standard, and if the individual's countable resources are less than the state's medically needy resource standard, then the individual is eligible for Medicaid coverage for the remainder of the budget period.[30] At the end of the budget period, the individual's "medically needy" eligibility must be redetermined for a new budget period.[31]

Nursing Facility Pathway

Under the "medically needy" pathway, there is no upper limit on the amount of monthly income an individual can receive and still qualify for Medicaid coverage. So long as the individual's incurred medical expenses are sufficiently high to reduce the individual's income to the state medically needy income standard during the budget period, the individual will qualify for Medicaid. In states with medically needy coverage, many individuals in nursing homes qualify this way. However, states that wish to provide Medicaid coverage for the elderly in nursing facilities but want to set an upper limit on the beneficiary's income have another option: the so-called "special income rule" for individuals in nursing facilities and other institutions. As of September 1996, 33

states had elected to cover this group; 14 of these states did not cover the "medically needy."[32]

Hypothetical Medically Needy Eligibility Determination

Assume a hypothetical state with an income standard for the SSI recipients of $550 per month in 1998 ($494 federal SSI payment, $36 median state supplementation payment, and $20 income disregard). Assume further that this state offers a medically needy program and sets its medically needy income standard at $470 per month, its medically needy resource standard at $2,000, and uses a 1-month accounting period. Finally, assume that an elderly individual living alone in this state receives a monthly Social Security check of $600, making her ineligible for Medicaid through the SSI pathway because her monthly income is $50 higher than the $550 per month income standard.

If this individual has high medical expenses, she may be able to qualify for Medicaid if her countable resources do not exceed $2,000. Assume she has prescription drug expenses of $300 per month. After incurring expenses of $130, she will have met her "spend-down" obligation of $130 ($600 less $470) for the month. Medicaid would pay for her remaining prescription drug expenses of $170, plus any other medical costs that Medicaid covers, incurred during the remainder of the month. This process would then be repeated the following month. If the state were to use a 6-month accounting period, then she would have to meet a "spend-down" obligation of $780 (6 times $130). In this case, it would take about 2 ½ months for her to incur $780 in prescription drug costs. After incurring these expenses, however, she would receive a Medicaid card that would pay her prescription drug and other covered medical expenses for the remainder of the 6-month period.

Under the "special income rule" option, a state may set an income standard at up to 300 percent of the SSI benefit ($1,500 per month in 1999) for individuals in nursing facilities and other institutions. Institutionalized individuals with Social Security, pension, and other income of more than this amount may not qualify for Medicaid, even if their monthly costs of care in the nursing facility exceed their income. If their countable income is under the state-established limit, these individuals must also meet the SSI resource test in order to qualify for Medicaid. Individuals who qualify through this pathway must apply all of their income, except for a small personal needs allowance, towards the cost of nursing home care.

The high cost of nursing facility services -- on average, $41,000 in 1995[33] -- makes Medicaid an important benefit for the elderly at risk of nursing facility care. It also makes nursing facility residents a high-cost beneficiary population for state Medicaid programs. The tension between beneficiary need for financial protection and state concerns about costs has led to the development of Medicaid eligibility policies specific to the coverage of nursing facility services for the elderly (and disabled).

Transfer of Resources

Federal Medicaid law attempts to discourage individuals from transferring savings and other countable resources to adult children or siblings or others in order to satisfy the Medicaid resource test and qualify for nursing facility coverage. It does so by imposing, for a specified period time, an exclusion of nursing facility coverage upon those individuals who engage in such transfers. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child.

More specifically, if an elderly individual who is living at home (or the individual's spouse) disposes of resources for less than fair market value within 36 months of applying for Medicaid, then the individual is subject to a period of exclusion from coverage for nursing facility services (or home- and community-based care). The 36-month "look-back" period is extended to 60 months in the case of transfers into a trust.

The period of exclusion from Medicaid coverage is related to the amount of resources transferred, the average monthly cost of nursing facility care in the state, and the date on which the transfer was made. For example, assume that 12 months before applying for Medicaid, an elderly individual transferred $25,000 in savings to her granddaughter. On average, the monthly cost to a private (i.e., non-Medicaid) resident in a nursing facility is a little over $3400 per month ($41,000 divided by 12). Under the statutory formula, the amount transferred is divided by the average monthly cost to yield a number that represents the number of months of exclusion from coverage. In this case, she would be excluded for over 7 months ($25,000 divided by $3400). However, because the exclusion begins to run from the date of the transfer, and because in this case the transfer occurred 12 months before application, there would be no exclusion from coverage in this case. If she had transferred $100,000 to her granddaughter 12 months prior to application, she would be excluded from coverage for 17 months ($100,000 divided by $3400 equals 29 months less 12 months).

Spousal Impoverishment Methodologies

Federal Medicaid law requires states to apply a special set of income and resource methodologies in determining eligibility when one spouse is in a nursing facility and the other remains in the community. States may, but are not required to use them when one member of a couple receives home and community based services under Medicaid. The purpose of these methodologies is to enable the institutionalized spouse to receive Medicaid coverage for nursing facility care while leaving the community spouse with sufficient resources and monthly income to avoid hardship. These methodologies apply to any eligibility pathway that a state uses under its Medicaid program in determining Medicaid eligibility for nursing facility residents, including the medically needy and special income rule options. Once Medicaid eligibility has been established, these methodologies also govern the calculation of the

amount of the couple's monthly income that must be applied toward the cost of nursing facility care for the institutionalized spouse.

The spousal impoverishment methodologies are triggered when one spouse enters a nursing facility (or hospital) and is likely to be there for at least 30 days, whether the spouse applies for Medicaid at the time of institutionalization or after. At that point, the value of all of the couple's countable resources is calculated, and the community spouse is allowed to keep one-half of the resources, subject to a minimum and maximum amount. As shown in Table 3, the minimum amount which a state must allow the community spouse to retain is $16,152 in 1998; the maximum, $80,760 (these figures are adjusted each year for inflation). Once the community spouse's protected resource amount has been determined, the institutionalized spouse must reduce the remaining resources to $2,000 before qualifying for Medicaid in most states.

Table 3. Spousal Impoverishment: 1999 Federal Income and Resource Standards

	Income Standards (indexed to the federal poverty level)	Resource Standards
Minimum	$1,356.25 per month; $1,382.50 per month (as of 7/1/99)	$16,392
Maximum	$2,049 per month	$81,960

With respect to income, the spousal impoverishment methodologies require states to allow the community spouse to retain a certain amount of monthly income. Again, there is a minimum amount that states must allow the community spouse to keep ($1,356 per month in 1999) and a maximum ($2,049) (these figures are adjusted each year for inflation). If the Social Security or pension income in the community spouse's name is not sufficient to reach the state-specified level, income in the institutionalized spouse's name is reserved for the community spouse in an amount necessary to make up the shortfall. Any remaining income of the institutionalized spouse (other than a small personal needs allowance) is applied toward the cost of the institutionalized spouse's care. In the case of both the income and resource protections, the law allows for exceptions to the general formulas in individual cases through both administrative and judicial procedures.

Home and Community-Based Services Pathway

Under the "section 1915(c)" waiver authority, states have the option of receiving federal Medicaid matching funds for covering home- and community-based services to elderly individuals at risk of nursing facility care. One purpose of this benefit's flexibility is to enable states to eliminate the institutional bias inherent in a benefits package that covers only nursing facility care. Benefits design is only part of the solution to institutional bias, however. If eligibility criteria for nursing facility residents are more generous than those for individuals who live at home, many of the low-income elderly in

need of long-term care may be precluded from Medicaid eligibility, and therefore home- and community-based services, so long as they remain at home.

To enable states to avoid this anomalous result, the federal Medicaid statute allows states to apply the same eligibility rules to individuals in need of home- and community-based services as they would apply to individuals in nursing facilities. For example, a state that has elected the option of covering institutionalized individuals under the special income rule may apply this same income rule (up to 300 percent of the SSI benefit level) to individuals in the community. Similarly, states with "medically needy" coverage could apply their "spend down" to individuals needing home-and community-based services as well as those in nursing facilities. As of September 1996, 34 of the 50 states offering home- and community-based waiver services reported using a special income rule of 300 percent of SSI, 15 reported using "medically needy" spend-down rules, and 34 applied spousal impoverishment rules.[34]

Poverty-Level Pathway

SSI benefits without state supplementation are about 73 percent of the federal poverty level for an individual and 81 percent of poverty for a couple (not counting $20 disregard).[35] States have the option of extending full Medicaid coverage to elderly individuals at higher poverty thresholds. Specifically, states may cover elderly individuals whose income does not exceed 100 percent of the federal poverty level and whose countable resources do not exceed the SSI threshold of $2,000 for an individual, $3,000 for a couple. In counting income or resources, states may use the SSI methodology, or they may use any methodology that is "less restrictive" than the SSI methodology. This flexibility enables states to effectively raise the poverty-level income standards or resource standards for this population beyond 100 percent of poverty or $2,000 if they choose. Under this option, elderly individuals are not permitted to "spend down" into Medicaid eligibility by incurring large medical expenses as they are able to do through the "medically needy" pathway.

B. Assistance with Medicare Premiums and Cost-sharing

The eligibility pathways discussed in the previous section lead to coverage for the full Medicaid benefits package. This package includes not just nursing home care and prescription drugs, but also assistance with Medicare premiums and cost-sharing requirements. For low-income Medicare beneficiaries, Medicaid's assistance with Medicare premium and cost-sharing obligations can make a substantial difference in the amount of financial burden imposed by Medicare and in the accessibility of covered services.[36]

Table 4. Medicare Premiums and Cost-Sharing Obligations, 1999

Premiums and Services	Cost
Part A Hospital	Deductible: $768 per benefit period Coinsurance: (days 61-90): $192/day (reserve days): $384/day
Part B Premium	$45.50/month
Physician and other ambulatory services	$100 deductible and 20% coinsurance

Federal Medicaid law recognizes that there are substantial numbers of elderly Medicare beneficiaries who are not sufficiently poor to qualify for full Medicaid benefits but who need assistance with Medicare premium and cost-sharing requirements if Medicare coverage is to be affordable for them. Thus, states participating in Medicaid are required to offer assistance for Medicare premiums and cost-sharing -- but not any other Medicaid benefits -- to certain categories of low-income Medicare beneficiaries. The federal government matches the costs of this assistance at the same rate that it matches the costs of the full benefits package (between 50 and 80 percent depending on the state). This section reviews each of these pathways to eligibility for cost-sharing assistance, which vary with respect to income levels, scope of assistance, and entitlement status. These pathways are summarized in Table 5.

Medicaid assistance for Medicare cost-sharing varies from state to state. This is because under the Balanced Budget Act of 1997, states have the flexibility to avoid paying Medicare deductibles and co-insurance if their Medicaid payment rates for the service in question are sufficiently lower than those under Medicare. For example, if Medicare will allow $100 for a physician visit, the coinsurance requirement is 20 percent of this amount, or $20. However, if the state Medicaid program only allows $60 for the physician visit, the state does not have to pay any of the $20 coinsurance requirement. Even prior to the Balanced Budget Act, at least 12 states did not pay the full amount of Medicare cost-sharing for eligible Medicaid beneficiaries.[37]

The Balanced Budget Act prohibits physicians and other Medicare providers from charging the beneficiary for the amount of the cost-sharing that the state Medicaid program does not pay. To continue the previous example, the physician may not charge the beneficiary the $20 coinsurance amount that the state Medicaid program does not pay. This protects the beneficiary from an out-of-pocket burden but reduces the provider's income, creating a disincentive for the provider to treat the beneficiary. The more low-income beneficiaries a provider treats, the greater the financial impact.

Qualified Medicare Beneficiaries (QMBs)

States are required to provide assistance for Medicare premiums and cost-sharing to Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level and countable resources at or below twice the allowable resource level under SSI. In 1999, the federal poverty level is $687 per month for an individual and $922 per month for a couple; twice the SSI resource level is $4,000 for an individual and $6,000 for a couple. In counting income and resources for these individuals, known as Qualified Medicare Beneficiaries, or QMBs, states must use methodologies that are no more restrictive than those under SSI. Thus, in applying the federal poverty level, states must disregard the first $20 per month in income, raising the effective standard to $707 per month for an individual and $942 per month for a couple in 1999. States also have the flexibility to use "less restrictive" methodologies than those under SSI, allowing them to disregard any amount of income or resources they choose.[38]

Table 5. Medicaid Eligibility Pathways for Elderly Individuals: Medicaid Assistance with Medicare Cost-Sharing*

Category	Income Test**	Resource Test	Medicaid Pays:	Entitlement
Qualified Medicare Beneficiaries (QMBs)	≤ 100%of FAL (per month, $687 for individual, $922 for couple in 1999) [a]	≤ 200% of SSI limit ($4,000 for individual, $6,000 for couple) [a]	All Medicare premiums and cost-sharing* charges	Yes
Specified Low-Income Medicare Beneficiaries (SLMBs)	Between 100 and 120% of FAL (per month, less than $824 for individual and $1,106 for couple in 1999) [a]	≤ 200% of SSI limit ($4,000 for individual, $6,000 for couple) [a]	Medicare Part B monthly premium	Yes
Qualifying Individuals 1 (QI1s)	Between 120 and 135% of FAL on a first come, first served basis (***per month, less than $927 for individual and $1,244 for couple in 1999)	≤ 200% of SSI limit ($4,000 for individual, $6,000 for couple)	Medicare Part B monthly premium. This benefit is subject to annual federal funding cap.	No
Qualifying Individuals 2 (QI2s)	Between 135 and 175% of FAL on a first come, first served basis (***per month, less than $1,202 for individual and $1,613 for couple in 1999)	≤ 200% of SSI limit ($4,000 for individual, $6,000 for couple)	Portion of Medicare Part B monthly Premium (2.5%, or $1.14 per month in 1999). This benefit is subject to annual federal funding cap.	No

* States are not required to pay for Medicare cost-sharing if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.

** The $20 per month income disregard is not included.

***Persons selected to receive assistance in a calendar year are entitled to receive assistance for the remainder of the year, but not beyond, as long as they continue to qualify.[39]

[a] States may use "less restrictive" income and resource methodologies under section 1902(r)(2) of the Social Security Act.

Specified Low-Income Medicare Beneficiaries (SLMBs)

States are also required to provide assistance with Medicare premiums to Medicare beneficiaries with income between 100 and 120 percent of the federal poverty level ($824 per month in 1999 for an individual) and resources that do not exceed twice the SSI resource level ($4,000 for an individual, $6,000 for a couple). In determining income and resources for these individuals, known as Specified Low-Income Medicare Beneficiaries (SLMBs), states must use the SSI methodologies, including the $20 income disregard. As in the case of QMBs, states have the flexibility to use "less restrictive" methodologies with respect to SLMBs.

In contrast to QMBs, SLMBs are not entitled to Medicaid assistance for all forms of Medicare cost-sharing. Instead, their protection is limited to the monthly Part B premium. For elderly individuals at this income level, this is still a significant benefit: $45.50 per month (or $546 per year in 1999) that would otherwise be deducted from the beneficiary's Social Security check.

Qualified Individuals

The Balanced Budget Act of 1997 established two new categories of Medicare beneficiaries who may receive Medicaid assistance with all or a portion of their monthly Part B premiums. Unlike QMBs or SLMBs, these Medicare beneficiaries, referred to as Qualified Individuals (QIs), do not have an individual entitlement to this assistance. In addition, the federal funding for this assistance is capped each year and expires in FY 2002. Within this annual cap, each State is allocated a fixed amount of federal funds each year; no state match is required each year.[40] States are required to limit the number of beneficiaries receiving such assistance so that the federal cost (there is no state share) does not exceed the state's allocation. States must select among eligible Medicare beneficiaries on a first-come, first-served basis. The benefit is paid in all federal dollars; states do not match the payment as they do for other Medicaid programs.

Table 5 shows that the QI category is divided into two subcategories. The first subcategory (QI1's) is composed of Medicare beneficiaries with incomes of at least 120 percent of the federal poverty level and less than 135 percent of the federal poverty level ($927 per month in 1999 for an individual, $1,244 for a couple) and resources of no greater than twice the SSI resource level ($4,000 for an individual, $6,000 for a couple). In counting income and resources, states must use SSI methodologies, including the $20 income disregard. If a QI1 individual is selected by the state on a first-come, first-served basis in a given year, he or she receives Medicaid assistance with the cost of the full Medicare Part B premium.

In contrast, Medicare beneficiaries who fall into the other subcategory of Qualifying Individuals (QI2's) do not receive the assistance with the full amount of the Part B premium. Instead, they receive assistance with only the portion of the premium attributable to the increases related to home health benefits enacted in the Medicare savings provisions of the Balanced Budget Act. For 1999, this amount is $1.14 per month, or 2.5 percent of the monthly premium of $45.50. States must make this benefit available to Medicare beneficiaries with incomes of at least 135 percent of the federal poverty level and less than 175 percent of the poverty level. (In 1999,175 percent of the federal poverty level was $1,202 per month for an individual and $1,613 per month for a couple). A state must impose the same resource test that applies to Medicare beneficiaries with incomes of under 100 percent of the federal poverty level: $4,000 for an individual and $6,000 for a couple. However, the state may not use "less restrictive" methodologies in determining either income or resources.

VI. Policy Options

State Policy Options

As the previous discussion makes clear, federal Medicaid law allows states substantial flexibility to extend Medicaid coverage to various categories of elderly individuals. States can exercise these eligibility options and receive federal Medicaid matching funds for the costs of such coverage without obtaining a section 1115 waiver from the Secretary of HHS.[41]

Wrap-Around Coverage. A state may wish to extend the comprehensive Medicaid benefits package, including prescription drug and long-term care services, to more of its low-income elderly residents in order to fill in many of the gaps in their Medicare coverage. A state could accomplish this by implementing one or more of several options available.

A state could automatically grant Medicaid eligibility to the elderly receiving SSI cash assistance rather than imposing its more restrictive 1972 income and resource standards. In the alternative, a state could cover all elderly individuals with incomes at or below 100 percent of the federal poverty level and resources at or below the SSI level of $2,000 per individual and $3,000 per couple. A state could further expand coverage under this option by adopting "less restrictive" income or resource methodologies (for example, by disregarding all resources, thereby eliminating the cost and burden associated with determining and verifying resources).

Another eligibility pathway a state could consider using is the "medically needy" option. This would enable it to provide Medicaid coverage to those low-income elderly who are ineligible for SSI benefits but whose income is insufficient to pay their high, recurring medical expenses.

Long-Term Care Coverage. A state may wish to focus on assisting those elderly in need of long-term care services. A number of eligibility options (with federal matching funds) are available to states pursing this objective in addition to the "medically needy" coverage option discussed above.

A state could cover the elderly in nursing facilities whose income falls below 300 percent of the SSI benefit and whose resources are at or below the SSI level. A state could also cover the elderly who, but for the receipt of home- and community-based services, would require the level of care provided in a hospital or nursing facility, and whose income falls below 300 percent of the SSI benefit and whose resources are at or below the SSI level.

Finally, a state could liberalize eligibility for low-income elderly couples with one spouse placed in a nursing facility (or receiving home- and community-based services) by raising the levels of income and resources protected for the community spouse to the highest amounts allowed under federal law (income of $2,049 per month in 1999, resources of $81,960 in 1999).

Assistance with Medicare Premiums and Cost-Sharing. A state may wish to expand assistance to low-income elderly residents in paying their Medicare premiums and other cost-sharing obligations. States have the following federally-matched options in this regard.

A state could liberalize eligibility for elderly Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level and resources of less than twice the SSI level (QMBs) by adopting "less restrictive" income and resource methodologies. For example, a state could dramatically streamline the eligibility process for this group by disregarding all resources and focusing just on income.

Similarly, by adopting "less restrictive" income and resource methodologies, a state could expand eligibility for elderly Medicare beneficiaries with incomes between 100 and 120 percent of the federal poverty level and resources of less than twice the SSI level (SLMBs). Again, a state could effectively eliminate the need to identify and verify assets by disregarding all resources for purposes of determining eligibility for the Medicare premium subsidy. It could also raise the effective income level beyond 120 percent of the federal poverty level by disregarding certain types or amounts of income.

Finally, a state that does not wish to liberalize eligibility criteria for assistance with Medicare cost-sharing may wish to pay the full Medicare cost-sharing amount even if its Medicaid payment for the item or service in question is substantially below the Medicare payment amount. This might have the effect of reducing the disincentive for physicians and other providers to treat low-income Medicare beneficiaries arising from the non-payment of cost-sharing amounts.

Federal Policy Options

As is evident, state options for expanding Medicaid coverage to the elderly are numerous. They are not, however, unlimited. Most notably, states are not able, without a section 1115 waiver, to target Medicaid coverage on the one benefit that is, for many low-income elderly, the single largest gap in the Medicare benefits package: outpatient prescription drug coverage.

To address this, the federal government could consider enacting a new optional eligibility group whose Medicaid entitlement would be the same as that of any dually eligible individual with one exception: covered items and services would be limited to the state Medicaid program's prescription drug benefit. Under this option, states could extend Medicaid prescription drug coverage to individuals with incomes at or below a state-established level up to a specified percent of the federal poverty level. States could (but would not be required to) impose a resource test; if a state chose to do so, the standard and methodologies could be no more restrictive than those applicable to QMBs and SLMBs (twice the SSI levels). As in the case of QMBs and SLMBs, states would have the option to use "less restrictive" income or resource methodologies in determining eligibility under this category.

Another option the federal government could consider is to increase the federal matching payments towards the cost of Medicare premiums on behalf of QMBs and SLMBs. The federal share of these costs, which currently averages 57 percent, could be gradually phased up to 100 percent over a period of time. States argue that the cost of subsidizing Medicare premiums and cost-sharing for the low-income elderly should be borne entirely by the federal government, which designs and operates the Medicare program. Federal officials point out that, as a result of "Medicare maximization" by the states, the Medicare program already provides significant assistance to states in financing nursing facility and home health services for the low-income elderly.[42] In either event, participation rates by the low-income elderly in the QMB and SLMB benefits are low. States have implemented the benefit differently and federalizing the benefits could lead to greater standardization in coverage.

VII. Summary

Medicaid serves as essential supplemental coverage for low-income elderly Medicare beneficiaries. Eligibility pathways lead to assistance with services particularly needed by the elderly but not covered by Medicare – long-term care and prescription drugs – and to assistance with Medicare premiums and cost-sharing. Due to its complexity, Medicaid eligibility for the elderly is difficult for beneficiaries to understand and for eligibility workers to administer. States could pursue a number of options to facilitate eligibility for the low-income elderly, including expanding criteria for full Medicaid, targeting those who need long-term care, and improving Medicaid assistance with Medicare premiums and cost-sharing. Currently, there are significant gaps in who Medicaid reaches and what is covered. The low-income elderly people who qualify for Medicaid supplemental coverage are the most vulnerable of Medicare beneficiaries with respect to social supports as well as health needs. The challenge for Medicaid will be to ensure that eligible elderly individuals enroll and receive assistance.

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Endnotes

1. See Kaiser Medicare Policy Project, *Medicare at a Glance*, July 1998, http://www.kff.org; *Medicare Chart Book*, June 1997.

2. Ellen O'Brien, Diane Rowland, and Patricia Keenan, *Medicare and Medicaid for the Elderly and Disabled Poor,* prepared for The Kaiser Commission On Medicaid and the Uninsured, May 1999.

3. A recent estimate is that between 3.3 and 3.9 million low-income elderly and disabled Medicare beneficiaries are eligible for Medicaid assistance with Medicare premiums and cost-sharing but are not receiving these benefits. Families USA Foundation, *Shortchanged: Billions Withheld from Medicare Beneficiaries*, July 1998, www.familiesusa.org. As part of the FY 1999 Performance Plan, under the Government Performance and Results Act (GIPRA) HCFA is "committed to finding and enrolling more dual eligible." See State Medicaid Director letter, http://www.hcfa.gov/medicaid/wrl10168.htm.

4. Patricia B. Nemore, National Senior Citizens Law Center, *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries*, Henry J. Kaiser Family Foundation, November 1997.

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

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

7. See Jane Horvath, National Academy for State Health Policy, *Medicaid Financial Eligibility for Aged, Blind and Disabled: Survey of State Use of Selected Options*, May 1997.

8. Social Security Administration, "Fast Facts about Social Security." 1997.

9. Diane Rowland and Barbara Lyons, Henry J. Kaiser Family Foundation, Medicare, Medicaid, and the Elderly Poor, *Health Care Financing Review*, Winter 1996, pp. 61-69.

10. AAUP Public Policy Institute and The Legin Group, *Out of Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, December 1997.

11. AAUP/Legin Group analysis of 1993 Medicare Current Beneficiary Survey Cost and Use Files, projected to 1997.

12. Ellen O'Brien, Diane Rowland, and Patricia Keenan, *Medicare and Medicaid for the Elderly and Disabled Poor*, prepared for The Kaiser Commission On Medicaid and the Uninsured, May 1999.

13. Diane Rowland and Barbara Lyons, 1996.

14. For an overview of Medicaid as "mandatory" federal spending, see Michael Hash and John Fermat, Health Policy Alternatives, *Primer on the Federal Budget*, Henry J. Kaiser Family Foundation, July 1997, www.kff.org.

15. The SSI program is a federally-administered, means-tested cash assistance program that provides monthly payments to eligible aged, blind, and disabled individuals who need assistance, generally because they are minimally covered under the Social Security program. See Committee on Ways and Means, *1998 Green Book*, May 19, 1998, pp. 261-326.

16. In 1996, Medicaid expenditures per elderly enrollee were $10,336, in contrast to an expenditure of $1,837 per non-elderly, non-disabled adult. Holahan et al., Kaiser Commission on Medicaid and the Uninsured, September 1998, Table 2.

17. Only 45 percent of Medicaid expenditures are for services that are required to be provided or to beneficiary groups that states participating in Medicaid are required to cover. Statement of Bruce C. Vladeck, Administrator, Health Care Financing Administration, on the 1998 Budget for Medicaid and Medicare Part B, presented to the House Commerce Committee, Subcommittee on Health and Environment, February 12, 1997.

18. For an overview of the income and resource tests applicable to children, see Andy Schneider, Kristen Fennel, and Peter Long, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility for Families and Children*, September 1998.

19. The monthly Social Security benefit in 1997 for low earners, defined as those who earned 45% of average wages, was $565 for those who retire at age 65. Committee on Ways and Means, 1998 *Green Book*, May 19, 1998, p. 4, p. 23.

20. For a discussion of SSI income and resource standards and methodologies, see Committee on Ways and Means, *1998 Green Book*, May 19, 1998, pp. 267-272.

21. There are some categories of legal immigrants to whom this five-year bar on Medicaid eligibility does not apply, including refugees, asylees, permanent resident aliens with 40 qualifying Social Security quarters, veterans, active duty members of the Armed Forces. For a discussion of the impact of the welfare law changes on elderly legal immigrants, see Robert B. Friedland and Veena Jankaj, National Academy on Aging, *Welfare Reform and Elderly Legal Immigrants*, Henry J. Kaiser Family Foundation, July 1997, www.kff.org.

22. Section 5305(b) of P.L. 105-33.

23. Conversations with Roy Trudel, Letty Carpenter, Health Care Financing Administration, September 11 and October 5, 1998.

24. In covering SSI recipients under Medicaid, states may elect, under section 1634 of the Social Security Act, to rely on the Social Security Administration (SSA), which processes applications for SSI cash assistance, to make the Medicaid eligibility determination for the individual on behalf of the state. As of January 1, 1996, 33 states had entered into such "section 1634 agreements" with SSA. Seven of the states that cover SSI recipients (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah) do not have a "section 1634 agreement" with SSI; instead, they require SSI recipients to file a separate application with their Medicaid agencies, which in turn make the final eligibility determinations.

25. Of the 6.5 million SSI recipients in 1998, 31 percent were elderly, www.ssa.gov/statistics/highssi.htm.

26. Bruen et al., *State Medicaid Coverage Options for Low-Income Aged, Blind, and Disabled People*. The Urban Institute, forthcoming 1999.

27. The seven states that did not provide SSP in 1998 are: Arkansas, Georgia, Kansas, Mississippi, Tennessee, Texas, and West Virginia. Committee on Ways and Means, *1998 Green Book*, Table 3-5, p.284, www.house.gov/ways_means/publica.htm.

28. Bruen et al., *State Medicaid Coverage Options for Low-Income Aged, Blind, and Disabled People*. The Urban Institute, forthcoming 1999.

29. Bruen et al., *State Medicaid Coverage Options for Low-Income Aged, Blind, and Disabled People*. The Urban Institute, forthcoming 1999.

30. The term "spend-down" is often applied to resources as well as income, most commonly when an individual is said to have "spent down" his or her countable resources to $2,000 in order to qualify for Medicaid coverage of nursing home care. Note, however, that this use of the term "spend down" is not technically correct. An individual cannot "spend-down" resources to qualify for medically needy eligibility in the same way as an individual can "spend-down" monthly income -- that is, by applying countable resources above the $2,000 or other eligibility threshold toward the cost of care with Medicaid paying the remainder of the cost. An individual with excess countable resources is simply ineligible for Medicaid "medically needy" coverage regardless of the cost of nursing home care.

31. States have the option of allowing medically needy individuals to pay their "spend down" liability to the state in advance each month, in a manner comparable to an income-related premium. Conversation with Letty Carpenter, Health Care Financing Administration, October 5, 1998.

32. Ibid.

33. Joshua Wiener and David Stevenson, Urban Institute, *Long-Term Care for the Elderly and State Health Policy*, November 1997, Series A, No. A-17, p. 1.

34. Jane Horvath, May, 1997, chart 4.

35. SSA, 1999. Http://www.ssa.gov/pubs/10003.html

36. Diane Rowland and Barbara Lyons, Medicare, Medicaid, and the Elderly Poor, *Health Care Financing Review*, Winter 1996, pp. 61-69.

37. Patricia Nemore, *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries*, The Henry J. Kaiser Family Foundation, November 1997, pp. 13-14.

38. Section 1902(r)(2) of the Social Security Act.

39. Federal Register 1999, vol. 64 no.59, p. 14932.

40. HCFA has published an allocation table for FY 1998. Federal Register March 29, 1999 (v64 no. 59), pp. (14931-14934). http://www.access.gpo.gov/su_docs/aces140.html

41. Minnesota has received a section 1115 waiver to demonstrate the voluntary enrollment of dually eligible elderly into managed care organizations. See Joshua Wiener and David Stevenson, *Long-Term Care for the Elderly: Profiles of Thirteen States*, Urban Institute, August 1998, pp. 49-50.

42. See Joshua Wiener and David Stevenson, August 1998, at p. 36.