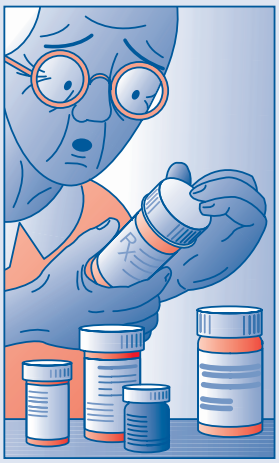

Could Your State Do More to Expand Medicaid for Seniors And Adults with Disabilities?

The federal government has given states several options to use when increasing Medicaid coverage for seniors and people with disabilities. Those options include the following:

1. Extending Medicaid to seniors and people with disabilities whose incomes are under 100 percent of the federal poverty level. States can also take steps that, in effect, raise income guidelines higher than the poverty level.

2. Augmenting federal Supplemental Security Income (SSI) with state payments and providing Medicaid to everyone receiving these state supplemental payments.

3. Establishing a "medically needy" program, which provides Medicaid coverage after medical expenses consume much of a person's income, or liberalizing eligibility for an existing medically needy program.

4. Including elderly and disabled people in Medicaid expansions under Section 1115 waivers.

In addition, states can expand Medicaid for working people with disabilities by:

5. Extending Medicaid to working people with disabilities whose incomes are less than 250 percent of the federal poverty level or are less than a higher, state-established threshold.

6. Continuing Medicaid coverage for working people with disabilities who would otherwise lose coverage when their medical conditions improve.

7. Providing Medicaid coverage to working people with severe physical or mental health conditions that could lead to disability.

Across the U.S., senior organizations and disability rights activists have successfully pressed for some of the options listed above to maximize Medicaid coverage for seniors and people with disabilities.[1] The chart on page 4 shows which states have taken advantage of some of these options. As the chart shows, however, all states could still do more to provide Medicaid coverage to seniors and people with disabilities.

Why Medicaid Coverage Is Crucial to Seniors and People with Disabilities

Most seniors and people with disabilities receive some health coverage through the federal Medicare program. Still, Medicaid is crucial to low-income seniors and people with disabilities because it pays their Medicare premiums, deductibles, and copayments, and it also pays for services that are not covered by the Medicare program. For example, all state Medicaid programs provide some coverage for prescription drugs. Many state Medicaid programs also provide coverage for personal care services (home care that assists with bathing, dressing, and other activities of daily living), podiatry, eye examinations, eyeglasses, and dental care (including dentures) — services that are not generally covered under Medicare. Studies have shown that Medicaid greatly improves access to health care: Low-income seniors with Medicaid are more likely to see doctors and have a usual source of care, and they are less likely to delay care due to costs, than are low-income seniors who have only Medicare.[2]

What Are the Minimum Medicaid Requirements for Seniors and People with Disabilities?

Who must be offered full Medicaid coverage?

Generally, under federal requirements, states must offer *full* Medicaid coverage to those who qualify for federal SSI payments.

- The federal income limits for SSI benefits in 2001 are $531 for an individual and $796 for a couple. (These levels are currently 74 percent and 82 percent of the federal poverty level, respectively.) However, the SSI program does not count the first $20 of income from another source (such as Social Security retirement). Therefore, most seniors and people with disabilities who are not in paid employment are generally eligible for Medicaid if their monthly incomes are below $551 for an individual or $816 for a couple and they meet resource requirements.[3]
- Seniors and people with disabilities who work can get Medicaid and SSI at higher income levels because the first $65 of earnings and half of the remaining earnings are not counted in calculating Medicaid and SSI eligibility. (Some other income is also not counted for people with disabilities applying

[1] The options listed in this paper apply to people living independently. You may also want to research your state's eligibility levels for people receiving nursing home care and home- and community-based care. For these people, states can establish Medicaid income eligibility levels at up to 300 percent of SSI payment levels and can offer a medically needy program. Many of the options discussed in this paper also extend coverage for children with disabilities, although children may also obtain Medicaid coverage under other provisions.

[2] Medicare Payment Advisory Commission, "Access to Care," *Report to Congress: Context for a Changing Medicare Program* (Washington: Medicare Payment Advisory Commission, June 1998); Ellen O'Brien, Diane Rowland, and Patricia Keenan, *Medicare and Medicaid for the Elderly and Disabled Poor* (Washington: The Henry J. Kaiser Family Foundation, May 1999).

[3] Generally, limits on resources (assets) are $2,000 for an individual, $3,000 for a couple. Resources include things like checking or savings accounts, stocks and bonds, real estate other than the beneficiaries' personal home, etc.

for Medicaid — for example, work-related expenses are deducted from their countable incomes).

Other eligibility requirements, not discussed in this issue brief, apply to seniors and people with disabilities who have dependent children.

In 11 states, called 209(b) states (after Section 209(b) of the Social Security Amendments of 1972), SSI eligibility does not guarantee Medicaid eligibility. Currently, 209(b) states are as follows: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

These states use different criteria than those of the SSI program to determine Medicaid eligibility for seniors, people with disabilities, and people who are blind. They may use more restrictive definitions of disability, or more restrictive income and resource requirements, than the SSI program. However, if a state elects to use this more restrictive option to determine Medicaid eligibility, it cannot use criteria that are more restrictive than the standards the state used in 1972, when SSI first became effective.

Who must be offered partial Medicaid coverage?

States must offer *partial* Medicaid coverage to four groups of low-income seniors and people with disabilities who meet income and resource tests that are more liberal than the regular Medicaid income and resource tests.[4]

- Those with incomes at or below the federal poverty level, known as **Qualified Medicare Beneficiaries (QMBs)**, are entitled to have Medicaid pay their Medicare premiums, deductibles, and copayments. The maximum incomes that an individual and a couple can have to qualify for QMB in 2001 are $736 and $988 per month, respectively. (These figures are the poverty level plus $20 of unearned income that is disregarded, or deducted from income, when eligibility is being determined. Working people with disabilities can take additional deductions.)

- People with incomes between 100 percent and 120 percent of the federal poverty level — up to $879 and $1,182 per month, respectively, for individuals and couples — are known as **Specified Low-Income Medicare Beneficiaries (SLMBs)**; they are entitled to Medicaid payment of their Medicare Part B premiums only.

- People with incomes between 120 percent and 135 percent of the federal poverty level, up to $987 and $1,327 per month for individuals and couples, respectively, are known as **Qualified Individuals (QIs)** and are eligible through a block grant program to apply for payment of their Medicare Part B premiums.

- Working people with disabilities, under provisions for **Qualified Working Disabled Individuals (QWDI)**, are entitled to full or partial Medicaid payment of their Medicare Part A premiums if they meet resource requirements and their incomes after deductions are less than 200 percent of poverty ($1,432 per month for individuals, $1,936 for couples). These deductions include $85, half of remaining earnings, and impairment-related work expenses.

[4] These more generous resource limits are $4,000 for an individual, $6,000 for a couple.

MEDICAID ELIGIBILITY AS OF APRIL 2001

STATE	MONTHLY INCOME GUIDELINES FOR INDIVIDUAL SENIORS: EXPANDING COVERAGE BASED ON PERCENTAGE OF POVERTY LEVEL	EXPANDING COVERAGE BASED ON STATE SUPPLEMENTAL PAYMENTS (2001 SSI + State Supp. Levels)	EXPANDING COVERAGE BASED ON MEDICALLY NEEDY OPTION (Income Retained After Spending Down)	EXPANDING COVERAGE THROUGH SECTION 1115 HEALTH REFORM DEMONSTRATION WAIVERS	WORKING DISABLED: IMPLEMENTED TWWIIA OR BBA EXPANSION
ALABAMA		$530.00			
ALASKA[1]		$984.00			✔
ARIZONA[2]		$530.00		$716/$279	
ARKANSAS		$530.00	$108.33		✔
CALIFORNIA	$946.00	$712.00	$600.00		✔
COLORADO		$567.00			
CONNECTICUT[3]		*$747.00*	*$477.06*		✔
DELAWARE		$530.00			
DISTRICT OF COLUMBIA	$716.00	$530.00	$377.00		
FLORIDA	$645.00	$530.00	$180.00		
GEORGIA		$530.00	$208.00		
HAWAII[4]	*$825.00*	*$534.90*	*$418.00*		
IDAHO		$583.00			
ILLINOIS[5]	*$501.00*	*individual determination*	*$283.00*		
INDIANA		*$530.00*			
IOWA		$530.00	$483.00		✔
KANSAS		$530.00	$475.00		
KENTUCKY		$530.00	$216.67		
LOUISIANA[3]		$530.00	$92.00		
MAINE	$716.00	$540.00	$416.00		✔
MARYLAND		$530.00	$350.00		
MASSACHUSETTS	$716.00	$658.82	$522.00		
MICHIGAN[3]	$716.00	$544.00	$341.00		
MINNESOTA[6]		*$611.00*	*$482.00*		✔
MISSISSIPPI	$1,017.00	$530.00			✔
MISSOURI		*$530.00*			
MONTANA		$530.00	$508.00		✔
NEBRASKA	$716.00	$537.00	$392.00		
NEVADA		$566.40			
NEW HAMPSHIRE		*$557.00*	*$544.00*		
NEW JERSEY	$716.00	$561.25	$367.00		✔
NEW MEXICO		$530.00			✔
NEW YORK		$617.00	$625.00		
NORTH CAROLINA	$716.00	$530.00	$242.00		
NORTH DAKOTA	*$716.00*	*$530.00*	*$475.00*		
OHIO		*$530.00*			
OKLAHOMA	*$716.00*	*$583.00*	*$259.00*		
OREGON		$531.70	$413.00	$716.00 (only applies to those without Medicare)	✔
PENNSYLVANIA	$716.00	$557.40	$425.00		
RHODE ISLAND	$715.83	$594.35	$625.00		
SOUTH CAROLINA	$716.00	$530.00			✔
SOUTH DAKOTA	$716.00	$545.00			
TENNESSEE		$530.00	$241.00	$2,863.00 (uninsurable only)[7]	
TEXAS		$530.00			
UTAH	$716.00	$530.00	$382.00		
VERMONT[3]		$589.04	$683.00	$1074 (uninsured only)[8]	✔
VIRGINIA[3,9]		*$530.00*	*$216.67*		
WASHINGTON		$555.90	$556.00		
WEST VIRGINIA		$530.00	$200.00		
WISCONSIN		$613.78	$591.67		✔
WYOMING		$539.90			

NOTES: In April 2001, federal SSI monthly payments were $530 for an individual. Subsequently, they were retroactively increased to $531.

209(b) states are italicized. These states have an additional 209(b) spend-down guideline that is not reflected in this chart. Furthermore, for seniors with income sources other than SSI and a state supplement, income guidelines may be more restrictive than those reflected in column 3.

The figures in this chart do not include income disregards.

1 The federal poverty level for Alaska is $894.

2 Arizona provides coverage up to 100 percent of poverty and allows a spend-down to $279 monthly through a Section 1115 waiver.

3 Higher income limits for Medically Needy apply in some areas of the state. Lowest figure for state shown.

4 The federal poverty level for Hawaii is $825.

5 Illinois's coverage based on percentage of poverty will gradually be raised to 100 percent of poverty by 2002.

6 Minnesota increased coverage to 100 percent of poverty beginning in July 2001.

7 In Tennessee, Medicare beneficiaries ineligible for Medigap coverage and other people without health insurance can qualify for Medicaid at this income level.

8 In Vermont, Medicare beneficiaries and other people with insurance are not eligible for Medicaid at this income level.

9 Virginia increased coverage to 80 percent of poverty beginning in July 2001.

SOURCES: Guidelines for individual seniors are from a Families USA survey of states, April 2001. States with implemented TWWIIA and BBA expansions are listed at (www.uoia.edu/~lhpdc/work/map.html).

What kinds of care does Medicaid cover?

In every state, Medicaid *must* cover hospital care, clinic services, x-ray and lab services, physicians' services, and nursing facility and home health services.

States *may* cover other services at their option:

- although it is an optional benefit, every state covers prescription drugs; and
- states may also cover podiatry, optometry, physical therapy, personal care or attendant services, other home- and community-based care, and a number of other services.

WHAT QUALIFIES AS A DISABILITY UNDER MEDICAID?

Medicaid uses the SSI program's definition of disability, which requires adults to have a severe "medically determinable physical or mental impairment" that renders the person unable to engage in any "substantial gainful activity." In 2001, substantial gainful activity is defined as a job that pays more than $740 per month (after any impairment-related work expenses and employment subsidies).

However, the substantial gainful activity test is lifted after a person initially qualifies for Medicaid. If someone begins working despite the impairment that qualified him or her for Medicaid and his or her earnings rise above $740 per month, the state must continue to provide Medicaid coverage until the person has sufficient earnings to provide a "reasonable equivalent" of SSI, Medicaid, and publicly-funded attendant care services.

WHAT OPTIONS DO STATES HAVE WHEN EXPANDING MEDICAID COVERAGE?

1) Providing coverage to those with incomes up to or beyond 100 percent of poverty

States have the option of providing full Medicaid coverage to seniors and people with disabilities who have incomes up to 100 percent of poverty. (States must disregard the same amount of income that they disregard in calculating SSI eligibility.) This means that, in 2001, states can cover individuals with incomes up to $736 per month and couples with incomes up to $988 per month (the poverty level plus $20 of unearned income that is disregarded). Only 17 states currently provide coverage up to or beyond 100 percent of poverty. In addition, Illinois has passed legislation that will phase in coverage up to 100 percent of poverty by 2002. Florida covers seniors and people with disabilities who have incomes up to 90 percent of poverty.

States can also provide coverage of seniors and people with disabilities living above the poverty level by disregarding more of their income in determining Medicaid eligibility. Under Section 1902(r)(2) of the Social Security Act, states can liberalize methods of counting income and resources for certain groups of Medicaid beneficiaries.[5] If, for example, a state disregarded $80 of monthly income, it could, in effect, raise the eligibility level for seniors to $80 above the poverty line. California and Mississippi are examples of states that do this, with monthly income guidelines (for individuals) of $946 and $1,017, respectively. Similarly, states can liberalize resource limits (currently $2,000 for individuals, $4,000 for couples) by disregarding some resources.

[5] States can use Section 1902(r)(2), for example, to liberalize income and resource tests for seniors and people with disabilities living independently, but not for people receiving care in nursing homes or under a home and community-based care waiver.

ILLINOIS

The AIDS Legal Council of Chicago and the SSI Coalition for a Responsible Safety Net jointly embarked on a "100% Campaign" in 1998 to urge Illinois to expand its Medicaid income guidelines for seniors and people with disabilities to 100 percent of poverty. "Particularly effective," says Barbara Otto, executive director of the SSI Coalition, "were charts showing the huge disparities in Illinois's Medicaid eligibility guidelines for different populations." For example, at the time, pregnant women were eligible for Medicaid if they had monthly incomes up to $1,373, and children were eligible if they had family incomes up to $913, but aged, blind, and disabled people had to have incomes below $308 per month to get Medicaid.

The 100% Campaign put together fact sheets, charts, and county-by-county estimates of the number of elderly and disabled people who would benefit from a Medicaid expansion.

When the Illinois Department of Public Assistance estimated a high cost for the expansion, the 100% Campaign countered by showing that savings in existing programs had been understated and the participating population overstated.

In May 2000, the governor signed legislation to gradually increase Illinois's Medicaid income guidelines from 41 percent of poverty to 100 percent over a three-year transition period. The federal government pays 50 percent of Medicaid expenses in Illinois; tobacco settlement funds were the primary funding source for the state's share of the expansion.

July 2001 marked the second year of implementation for this expansion, and Illinois's Medicaid income guidelines increased to 85 percent of poverty. So far, the costs of the expansion have been quite close to those projected by the 100% Campaign.

Source: Barbara Otto, SSI Coalition for a Responsible Safety Net, Chicago, July 2001.

2) Providing coverage to people receiving state SSI supplemental payments

In 2001, federal SSI limits are $531 for an individual and $796 for a couple. (Some income is disregarded.) Many states augment the incomes of SSI recipients with state supplemental payments (SSPs). In these states, people who do not receive SSI may still receive SSP if they have incomes that fall between the federal SSI limit and the higher limits established by states for supplemental payments.

As noted on page 2, states must generally provide Medicaid coverage to those who qualify for federal SSI payments. At their option, states may also provide Medicaid to people who receive state supplemental payments, including those who receive SSP but not SSI. Providing coverage to SSP-only recipients is one way to expand Medicaid coverage to more aged, blind, and disabled people.

Some states pay supplements to all people eligible for SSI benefits, while others limit supplements to SSI recipients in group-living facilities. As shown in the table on page 4, in 2001, 25 states supplement SSI for seniors living independently and provide Medicaid coverage to all people receiving the supplements. Monthly supplements for individuals vary from $1.70 in Oregon to $454 in Alaska.

Advocates can raise Medicaid income eligibility levels and expand the number of seniors and people with disabilities covered by Medicaid by persuading their states to increase the amount of an existing SSP supplement or to establish a new SSP program.

3) Providing medically needy coverage

Seniors and people with disabilities who have limited resources and whose incomes are above SSI payment levels may be helped under the state option to serve the medically needy — people whose high medical expenses consume much of their income. As long as their medical expenses are high enough and they meet a resource test, seniors of any income level may qualify for Medicaid coverage.

Under this option, incurred medical expenses are deducted from income. If the remainder is below the state's medically needy income limit, and if other program requirements are met, the person may obtain health coverage through Medicaid. This process is known as spending down. After people spend down to their states' medically needy income level, Medicaid pays any additional medical expenses. (In a few states, such as New York and Utah, consumers can opt to pay the state the amount they would need to spend down each month, rather than submitting proof of medical expenses, in order to qualify for Medicaid.)

States have new options in 2001 to raise income standards for the medically needy. Previously, federal regulations linked these standards to old welfare payment levels.[6] Generally, this resulted in medically needy levels that were well below SSI payment levels. Under regulations that became effective on March 12, 2001 (changes in Federal Financial Participation limits) and Section 1902(r)(2) of the Social Security Act, states can now increase medically needy income guidelines by disregarding income.[7] By not counting income that falls between the state's former medically needy level and some higher amount set by the state, the state can allow consumers to retain much more income than before and still qualify for Medicaid.

Sixteen states do not have medically needy programs, and even states that do provide coverage often fail to update their eligibility thresholds.

4) Section 1115 health reform demonstration waivers

States can provide coverage to virtually any group of people who would not ordinarily be eligible for Medicaid benefits by launching a demonstration project under Section 1115 of the Social Security

USING DISREGARDS TO LIBERALIZE MEDICALLY NEEDY PROGRAMS

As shown in the chart on page 4, four states currently have medically needy levels of $200 per month or less. This means that a senior in those states who has income just $1 above the monthly individual SSI limit of $531 — $532— must spend at least $332 per month on medical care before Medicaid will pay any remaining expenses ($532 in income minus the $200 medically needy level equals $332 to be spent on medical care). This would leave only $200 or less for food, shelter, and all other personal expenses.

Under the new regulations, a state with a $200 per month medically needy income limit could raise that income limit from $200 per month to $531 per month by disregarding $331 of monthly income. This would put the medically needy on a par with those who qualify for Medicaid because they receive SSI.

[6] Maximum medically needy income standards were 133⅓ percent of the state's 1996 Aid to Families With Dependent Children (AFDC) payment levels, updated by the consumer price index.

[7] Section 1902(r)(2) of the Social Security Act allows states to not count a portion of an individual's earned income when determining that person's eligibility for Medicaid, thereby allowing individuals to retain more income without resorting to a medically needy spend-down or putting them at risk of losing Medicaid altogether.

GETTING AROUND 209(b) RESTRICTIONS

As discussed earlier, 209(b) states use different criteria from those used by the SSI program in determining Medicaid eligibility for seniors, people with disabilities, and people who are blind. This can present several problems for beneficiaries. First, by definition, income, resource, or disability criteria are more restrictive in 209(b) states than in other states. Second, use of a special 209(b) spend-down (discussed below) may result in inequities in Medicaid eligibility. Third, people in 209(b) states cannot apply for SSI and Medicaid simultaneously at the Social Security office, so they are less likely to find out about, and apply for, Medicaid.

Whether or not they've elected to provide a medically needy spend-down, 209(b) states must allow another type of spend-down. For any population whose 209(b) eligibility requirements are more restrictive than those in the SSI program, states must disregard SSI income and state supplemental payments, and deduct medical expenses, in calculating Medicaid eligibility. If their medical expenses are high enough, people of any income level can qualify for coverage in a 209(b) state.

In many 209(b) states, eligibility standards are close to SSI payment levels. However, states such as Ohio have lower 209(b) eligibility levels that result in inequities. In Ohio, the 209(b) eligibility level for an individual in 2001 is $480 ($460 plus $20 that is disregarded). Since all SSI income is disregarded, an Ohioan with total monthly income of $551 will immediately qualify for Medicaid if at least $71 of that income is from SSI and less than $480 is from another source (such as Social Security retirement). If, on the other hand, more than $480 is from some other source, the person will have to incur medical expenses equaling the difference between that income and $480 before qualifying for Medicaid.

Seniors, people with disabilities, and blind people must file separate applications for Medicaid and SSI in 209(b) states, compounding Medicaid outreach problems. This cumbersome application system also results in higher administrative expenses for states. However, if a state opts out of 209(b) status and provides Medicaid coverage for everyone receiving SSI, it can rely on the Social Security Administration to make Medicaid eligibility determinations for SSI recipients rather than making its own.

States can take one of two different approaches to resolving these problems for beneficiaries in 209(b) states. First, they can opt out of 209(b) status, as noted above. Second, even if they remain 209(b) states, they can exercise the option to cover people with incomes up to or beyond the federal poverty level discussed on page 5. This has the effect of lifting 209(b) restrictions because, for those seeking coverage under this category, states cannot apply the more restrictive criteria that they use to determine 209(b) eligibility.

Act that will "promote the objectives" of the Medicaid program. One of these objectives is making medical assistance available to people who are aged, are blind, or have disabilities and whose "income and resources are insufficient to meet the costs of necessary medical services." Another objective is furnishing "rehabilitation and other services to help such families and individuals attain or retain capacity for independence or self-care." Some states have used Section 1115 waivers to cover people with serious health conditions that will lead to disability, such as HIV. Other states have used the waivers for more comprehensive expansions of coverage to the low-income uninsured. However, whether those expansions assist people over age 65 and people with disabilities — and whether they assist or harm other current Medicaid beneficiaries — will depend on a number of

VIRGINIA

Seniors and people with disabilities faced two major obstacles to gaining Medicaid coverage in Virginia: First, the state has very low medically needy income levels that vary by geographical area. In some localities, people with incomes slightly above SSI limits had to spend all but about $216 of their monthly incomes on medical care to get coverage. Second, Virginia is a 209(b) state and used more restrictive resource tests for Medicaid than for the SSI program. Many seniors were excluded from Medicaid coverage because land around their homes or their unprobated estates were counted as resources. In rural Virginia, it is not unusual for very low-income people to live in dilapidated houses or trailers on ten or more acres of land.

The Virginia Poverty Law Center and various mental health advocacy organizations worked quietly to rectify these problems. Through testimony, flyers, fact sheets, and letters, they informed the state's Joint Commission on Health Care (a committee of legislators) and other legislators of options to expand health insurance coverage of senior citizens and people with disabilities. In particular, they called attention to unmet needs for prescription drug coverage of people with incomes just above SSI limits.

Through budget amendments, the Virginia legislature opted to cover seniors and people with disabilities with incomes up to 80 percent of poverty, effective June 2001. Federal SSI resource rules, instead of Virginia's more restrictive 209(b) limits, apply to this group.

Source: Jill Hanken, Virginia Poverty Law Center, Richmond, July 2001.

choices the state makes.

States must get approval from the U.S. Department of Health and Human Services (HHS) for a Section 1115 waiver. Under guidelines for approval, states must show that they are achieving savings elsewhere in their state Medicaid program so that the federal expenditures for the state's expanded Medicaid program will be no greater than federal expenditures would be in the absence of the proposed demonstration project.

Currently, several states use Section 1115 waivers to extend Medicaid coverage to low-income adults without dependent children. Some of these states limit coverage to people who are uninsured, while others allow some Medicare beneficiaries to participate. Since Medicaid pays for prescription drugs and Medicare generally does not, Medicaid is an important secondary coverage source for people with disabilities.

As of 2001, Arizona, Oregon, Tennessee, and Vermont included seniors and people with disabilities in general Medicaid expansions under Section 1115 waivers. In Arizona, eligibility guidelines for seniors are similar to guidelines many other states have used in their regular Medicaid programs. However, the expanded programs in Oregon and Vermont provide comprehensive coverage only to people who do not receive Medicare. In Tennessee, Medicare beneficiaries must be ineligible for Medicare supplemental coverage (Medigap) to receive coverage through the expanded Medicaid program, called TennCare.

In August 2001, HHS announced changes in its guidelines for approval of Section 1115 waivers that may harm some elderly and disabled Medicaid beneficiaries: Under the new guidelines, when

expanding Medicaid coverage to uninsured people under a demonstration waiver, states may (1) require optional Medicaid beneficiaries and others newly covered under an expansion to pay a higher share of the cost of care (premiums and copayments); and (2) help optional Medicaid beneficiaries and others newly covered under an expansion pay premiums for private insurance coverage, rather than providing them with full Medicaid benefits. Optional Medicaid beneficiaries include elderly and disabled people whose incomes are higher than SSI limits, as described in this issue brief. In addition, the new waiver guidelines provide new incentives for states to reduce the benefits to optional Medicaid beneficiaries that it is not required to cover under federal law. There are still many unresolved questions about how this waiver policy will be implemented.

Additional Options for Providing Coverage to Working People with Disabilities

5) Coverage up to or beyond 250 percent of poverty

Under both the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA, pronounced ("tweeah"), states can opt to provide coverage to working people with disabilities under age 65 even if they have earnings above the $740 allowable under the "substantial gainful activity" test. (This test was described on page 5.) Under the Balanced Budget Act, states can opt to provide Medicaid coverage to working people with disabilities whose incomes are under 250 percent of poverty. (States can charge premiums to this group of people on a sliding-fee scale and can require them to share other medical costs.) Furthermore, by using both the Balanced Budget Act option and Section 1902(r)(2) of the Social Security Act (which allows states to disregard income or resources in calculating Medicaid eligibility), states can, in effect, raise income guidelines above 250 percent of poverty by disregarding income. States can similarly disregard resources to raise Medicaid resource limits for working disabled people.

TWWIIA provides another mechanism for achieving the same result. Under TWWIIA, states can set Medicaid income and resource standards as high as they wish for working disabled people, or elect not to impose any income and resource tests on working disabled people. (States can charge this group premiums based on income.) Under TWWIIA (but not under the Balanced Budget Act), states must charge full premiums to people with gross incomes exceeding $75,000.

As of August 2001, fifteen states have implemented Medicaid expansions to the working disabled using options afforded by the Balanced Budget Act of 1997 or options under TWWIIA. These states are Alaska, Arkansas, California, Connecticut, Iowa, Maine, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, Oregon, South Carolina, Vermont, and Wisconsin. For details, see (http://www.uiowa.edu/~lhpdc/work/map.html).

Washington is the most recent state to enact legislation expanding coverage to working people with disabilities. Under a law signed on July 11, 2000 implementing TWWIIA, Washington will allow residents with disabilities to earn up to 450 percent of the federal poverty level while retaining Medicaid coverage.

MISSISSIPPI

In 1998, the Mississippi Human Services Coalition, the Mississippi HIV/AIDS Assembly, the Coalition for Citizens with Disabilities, and 37 groups concerned with chronic illness campaigned for Medicaid coverage of the working disabled. They informed Mississippi legislators of the options available under the Balanced Budget Act, explained the importance of prescription drug coverage for people with chronic illnesses, signed petitions, provided cost estimates, and met with legislators.

Using tobacco settlement money to fund the state's share of the expansions, the state legislature voted not only to provide Medicaid coverage to the working disabled, but also to raise Medicaid income eligibility levels to 135 percent of the federal poverty level for all disabled and elderly people. When the governor vetoed the legislation, Medicaid coverage became an election campaign issue. In 2000, a newly elected legislature overrode the governor's veto, making Mississippi the first state to provide Medicaid coverage to seniors and people with disabilities with incomes up to 135 percent of poverty. In addition, Mississippi offered coverage to working people with disabilities on a sliding-fee scale, and it started a pilot program to cover people with conditions that could become severely disabling.

Source: Judy Barber, Mississippi Human Services Coalition, Jackson, July 2001.

6) Coverage when medical conditions improve

States that provide coverage under the TWWIIA option can also elect to continue Medicaid coverage for working people whose medical condition improves to the extent that they are no longer eligible for SSI or Social Security Disability Income (SSDI). This is especially important, for example, to people with HIV whose condition improves through the use of medications. States can continue to charge premiums to the medically improved population.

7) Other provisions

A number of other provisions also afford states opportunities to cover some groups of people with disabilities or with potentially disabling conditions. Examples of three such provisions are:

- Under TWWIIA, the federal government gives grants to some states to cover working people who are not yet disabled but have severe conditions or impairments — such as HIV, multiple sclerosis, or schizophrenia — that will likely lead to disability. States and advocates can consult with the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, regarding available grant opportunities.
- Under a law passed in 1993, states can provide limited Medicaid coverage to people diagnosed with tuberculosis who meet financial eligibility requirements.
- Under a law passed in 2000, states can provide full Medicaid coverage to uninsured women under age 65 who are diagnosed with breast or cervical cancer.

Overall Medicaid expansions, such as expansions of coverage to parents and children, also assist many people with disabilities. Studies show that many low-income families include adults or children with disabilities.

For further information about options available to states when expanding Medicaid to seniors and adults with disabilities, see:

Thomas McCormack, *Returning to Work and Keeping Medicare and Medicaid* (Washington: Ryan White Title II Community AIDS National Network, Inc., February 2001).

Thomas McCormack, *Many More Eligible: A Survey Of Eligibility Rules of Public and Semi-Public Health Coverage Programs* (Washington: Ryan White Title II Community AIDS National Network, Inc., July 2001).

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Credits:

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FamiliesUSA
The Voice for Health Care Consumers

1334 G Street, NW ◆ Washington, DC 20005
Phone: (202) 628-3030 ◆ Fax: (202) 347-2417
E-Mail: info@familiesusa.org