

State Usage of
Medicaid Coverage
Options for Aged,
Blind, and Disabled
People

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Assessing
the New
Federalism

An Urban Institute
Program to Assess
Changing Social Policies

Discussion
Papers

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Assessing the New Federalism

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states. It focuses primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. Alan Weil is the project director. In collaboration with Child Trends, the project studies changes in family well-being. The project provides timely, nonpartisan information to inform public debate and to help state and local decision makers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia. Publications and database are available free of charge on the Urban Institute's Web site: <http://www.urban.org>. This paper is one in a series of discussion papers analyzing information from these and other sources.

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Abstract

Medicaid is an important source of health insurance for low-income aged, blind, and disabled people, covering 10.9 million persons nationwide in 1997. Federal law requires that Medicaid programs cover certain aged, blind, and disabled persons, but states also have a variety of eligibility options. In contrast to Medicaid eligibility policy for pregnant women and children, coverage policy for these populations has remained virtually unchanged since the mid-1980s. This paper presents state-level data on Medicaid eligibility policy drawn from a 1998 Urban Institute survey of state Medicaid programs, as well as information collected by the National Academy for State Health Policy and Commerce Clearing House, Inc. Analysis of these data suggests that Medicaid eligibility for these groups is very complex, with multiple ways of covering the same population. Coverage of aged, blind, and disabled populations varies considerably by state, with many states not taking advantage of available options to extend coverage beyond that required by federal law. At the same time, federal rules limit state flexibility to expand or simplify coverage in some areas, most notably medically needy coverage.

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Introduction

Medicaid is an important source of health insurance for low-income aged, blind, and disabled people, covering 10.9 million people nationwide in federal fiscal year (FFY) 1997.¹ These groups often face barriers to private insurance coverage (e.g., limits due to preexisting conditions, unaffordable premiums) because they tend to require more health care, and often more expensive types of care, than other groups. Lack of Medicaid coverage can impose substantial financial burdens on low-income aged, blind, and disabled persons. One recent study found that noninstitutionalized elderly Medicare beneficiaries with incomes below 200 percent of the federal poverty level (FPL) and no other source of insurance spent between 22 and 35 percent of their incomes on out-of-pocket medical expenses, while “dual eligibles” (people covered by both Medicare and Medicaid) spent just 4 to 8 percent of their incomes on out-of-pocket medical expenses (AARP/Lewin, 1997).

For low-income aged, blind, and disabled people who are not eligible for Medicare, Medicaid provides a full range of acute and long-term care benefits at little or no cost to enrollees. For people eligible for both programs, Medicaid helps to pay Medicare’s cost-sharing requirements and covers prescription drugs, nursing homes, and other long-term care services—benefits that Medicare does not provide. Lastly, some low-income Medicare beneficiaries who are not eligible for full Medicaid benefits may be eligible to receive assistance from Medicaid with their Medicare premiums and cost-sharing requirements. In this manner, Medicaid helps to fill in gaps left by other public and private insurance plans.

Medicaid spending for aged, blind, and disabled people dominates the program. While just over one-quarter of Medicaid enrollees in 1997 were aged, blind, or disabled, they accounted for 72 percent (\$104.9 out of \$145.2 billion) of Medicaid spending on medical services. Long-term care,

particularly in institutional settings, is a significant contributor to these expenditures. States spent \$57.9 billion on long-term care for the aged, blind, and disabled in 1997, including \$42.6 billion for nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs). Other significant contributors to the high cost of coverage for these enrollees are inpatient hospital care (\$13.6 billion, mostly for the blind and disabled) and prescription drugs (\$8.5 billion).

Federal law requires that Medicaid programs cover certain low-income aged, blind, and disabled people, primarily recipients of Supplemental Security Income (SSI). In addition, most states use at least one of several optional categories of Medicaid eligibility to insure other aged, blind, and disabled people. Nonetheless, in 1995, only 42 percent of people age 65 and older with family incomes below 100 percent of the FPL were covered by Medicaid.² Although several changes to eligibility policies in the last decade were designed to increase coverage of the low-income, uninsured population, nearly all of these expansions have targeted children and pregnant women. Federal Medicaid eligibility policies for aged, blind, and disabled people have remained virtually unchanged since the mid-1980s.

This paper presents data on state Medicaid eligibility policy for aged, blind, and disabled people drawn from a 1998 Urban Institute survey of state Medicaid programs, as well as information collected by the National Academy for State Health Policy (Horvath, 1997) and Commerce Clearing House, Inc. (CCH, 1998). In brief, analysis of these data suggests that Medicaid eligibility for the aged, blind, and disabled is very complex and confusing, with multiple ways of covering the same population. Coverage of the aged, blind, and disabled populations varies considerably by state, with many states not taking advantage of available options to extend coverage beyond that required by federal law. At the same time, federal rules limit state flexibility to expand or simplify coverage in some areas. For example,

income requirements for medically needy coverage, which provide Medicaid to people with high medical expenses but incomes initially too high for Medicaid, tend to be very low, in part due to a federally imposed ceiling that links maximum income levels to the old Aid to Families with Dependent Children (AFDC) payment standards.

Medicaid Eligibility Policy for the Aged, Blind, and Disabled

Persons who are aged, blind, and disabled become eligible for Medicaid through several different pathways. The most common mechanism is by having income and assets below a given threshold, which is often associated with receipt of cash assistance (e.g., Supplemental Security Income or state supplementary payments). In addition, people with incomes too high to qualify for cash assistance may “spend down” to Medicaid by incurring medical expenses that, when deducted from their income, bring them below specified income eligibility levels. A closely related mechanism extends Medicaid coverage to people in high-cost institutional and other long-term care settings with incomes above normal cash assistance levels. This allows states to provide coverage to a limited group of people with very high medical expenses. In addition to these pathways to full Medicaid benefits, states must also offer premium and cost-sharing assistance to certain low-income people eligible for Medicare.

Mandatory Coverage: SSI and Section 209(b) Eligibility Standards

Federal law requires that Medicaid programs cover certain “categorically needy” beneficiaries, with Supplemental Security Income (SSI) recipients representing the largest group of such people who are aged, blind, or disabled. SSI is a federal program that provides cash assistance to aged, blind, and disabled people who have low incomes and assets. To be eligible for SSI in 1998, “countable” monthly income had to be less than \$494 for individuals and \$741 for couples. These limits were 74 and 82

percent of the FPL, respectively. The actual income levels that SSI recipients may possess is somewhat higher than the aforementioned levels because some income is not “countable.” In determining eligibility, the Social Security Administration disregards \$20 of income per month from almost any source, \$65 per month of earned income plus one-half of remaining earnings, as well as certain other benefits, such as food stamps and home energy or housing assistance, to arrive at “countable” income. Including these disregards, the maximum income at which a person qualified for SSI benefits in 1998 was \$514 per month for one person and \$761 per month for two people—assuming the beneficiary received Social Security but no earned income. People with earned income could receive reduced SSI payments up to much higher incomes, \$1,073 per month for one person and \$1,567 per month for two people in 1998. Resource limits for SSI eligibility, which have not increased since the mid-1980s, are \$2,000 for individuals and \$3,000 for couples. These limits generally apply to “liquid assets” such as stocks and cash; they exclude (in whole or part) assets such as homes, cars, burial plots or funds, and the cash surrender value of life insurance.

Most states provide Medicaid to all SSI recipients, but 11 states use their own eligibility standards for aged, blind, and disabled people. Under Section 209(b) of the Social Security Amendments of 1972, state Medicaid programs may use narrower definitions of blindness or disability, lower income or resource standards, more restrictive methods to count income and resources, or any combination of the above (Horvath, 1997). For example, states using more restrictive income or resource standards may establish lower monthly income thresholds to qualify for Medicaid than are necessary to qualify for SSI, or they may allow beneficiaries to keep fewer assets. Likewise, states using more restrictive methods to count income or resources may define more income or assets as “countable” than SSI when determining eligibility. The purpose of Section 209(b) was to lessen the

financial impact on states of the national “floor” created by SSI. Consequently, Medicaid eligibility standards used by Section 209(b) states are mostly more restrictive than SSI standards, but they can be the same as or more liberal than SSI standards if they were in place as of January 1972.

In addition to those people who qualify through SSI or Section 209(b) standards, states must also cover a number of other categorically needy groups. These groups are mostly small, special protected groups who may lose cash assistance but retain Medicaid eligibility for a period of time, such as people who lose SSI due to increased earnings from work or increased Social Security benefits. For more information on these smaller categorically needy groups, see CCH (1998), Schneider, Fennel and Keenan (1999), and Schneider, Strohmeyer, and Ellberger (1999).

Optional Coverage: SSP and OBRA 86 Eligibility Standards

States also have several options to cover aged, blind, and disabled people who do not qualify for mandatory coverage. Many states provide state supplementary payments (SSP) to certain SSI recipients and people with incomes too high to qualify for SSI using state funds. In addition to providing cash assistance, as many as 37 states extend optional Medicaid coverage to SSP-only beneficiaries. Unlike the federal SSI program, which uses the same eligibility criteria nationwide, states establish their own maximum benefits and eligibility criteria for SSP. Consequently, income and resource eligibility standards for SSP—and SSP-related Medicaid coverage—vary considerably by state. SSP income eligibility standards are generally below 100 percent of the FPL, but they exceed the FPL in some cases. States may also provide Medicaid to people eligible for SSI or SSP but not receiving cash payments.

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) gave states an additional option to extend Medicaid benefits to aged and disabled individuals with incomes up to 100 percent of the

FPL (\$8,050 for individuals and \$10,850 for two people in 1998).³ Twelve states and the District of Columbia currently use this option. Except in Section 209(b) states, SSI rules determine what is counted as income. Resource standards and counting methods must be the same as SSI unless the state has a medically needy program with higher resource standards, in which case the state may use the higher standards. States must offer these enrollees the same services provided to the categorically needy.

Medically Needy Programs and Other Spend-Down Options

People whose incomes or resources initially exceed the limits for the groups mentioned above may still be able to get Medicaid coverage. Many states allow people to “spend down” to Medicaid, most commonly through a “medically needy” program. This coverage option allows people who meet categorical requirements—e.g., pregnant women, children, adults with dependent children, aged, blind, or disabled—to deduct incurred medical expenses from their income when determining eligibility for Medicaid. By federal law, the income level that people must spend down to in order to qualify for Medicaid cannot exceed 133 and 1/3 percent of each state’s Aid to Families with Dependent Children payment levels. People with incomes below the income threshold can also qualify for Medicaid even if they do not have large medical expenses.

If a state elects to have a medically needy option, it must cover pregnant women and children, but coverage of aged, blind, and disabled individuals is optional. One exception is that states using the Section 209(b) option must allow aged, blind, and disabled applicants to deduct medical expenses from income in determining eligibility. If a Section 209(b) state does not have a medically needy program, it must establish a separate spend-down option for aged, blind, and disabled people. The income level that these people must spend down to is the same as the income limit for Medicaid eligibility applied by

the state under its Section 209(b) option. This requirement is sometimes referred to as “209(b) spend down.”

Special Eligibility for Long-Term Care

People eligible for institutional (e.g., nursing home) care, home- and community-based waiver services, or hospice care often become eligible for Medicaid at higher income levels than non-institutionalized people. States extend coverage to these groups using optional eligibility criteria designed to provide Medicaid to people who have too much income to qualify for SSI, but not enough money to cover the high cost of long-term care, especially in institutions. For example, states may cover individuals living in a nursing home for at least 30 consecutive days under the “special income rule (or cap),” also known as the “300 percent rule (or cap).” While these people must meet resource eligibility standards for SSI (or other resource standards to which eligibility is linked), income standards for this group can be as high as 300 percent of the standard for SSI (\$1,482 per month for a single individual in 1998). Once eligible, individuals must contribute all of their income toward the cost of their institutional care, except for a small personal needs allowance. In states using the special income rule and not having a medically needy program, individuals with income above the threshold are ineligible for Medicaid even if they do not have enough income to pay the cost of the institution.

People who would be eligible for Medicaid if they were institutionalized may also be eligible through other optional categories. These groups include people receiving care through home- and community-based waiver service programs, certain non-institutionalized, severely disabled children age 18 or younger (e.g., Katie Beckett, “model” waivers), and recipients of hospice care. This enhanced eligibility for home and community-based services is designed to “level the playing field” between institutional and non-institutional care.

Assistance with Medicare Premium and Cost Sharing

The groups mentioned above are generally eligible for the full range of Medicaid benefits.⁴ Federal law also requires that states help finance Medicare premiums, deductibles, and coinsurance for other low-income elderly and disabled people. These are people who have incomes too high to qualify for full Medicaid benefits, but for whom Medicare premiums and cost-sharing requirements pose a significant financial burden.

The structure of Medicaid provisions to pay Medicare premiums and cost sharing is complex. There are four separate categories of individuals eligible for such assistance. The income levels of those eligible, scope of assistance, and entitlement status vary by category. In general, states must provide assistance with all Medicare premiums and cost sharing up to 100 percent of the FPL and assistance with part B premiums up to 175 percent of the FPL. This assistance is an entitlement up to 120 percent of the FPL; above that point it is subject to annual federal funding caps. For more information concerning Medicaid assistance with Medicare premiums and cost sharing, see Schneider, Strohmeyer, and Ellberger (1999), Schneider, Fennel, and Keenan (1999), and Rosenbach and Lamphere (1999).

States' Utilization of Optional Medicaid Eligibility Standards

States differ in their use of the various Medicaid coverage options for aged, blind, and disabled people. The remainder of this paper looks more closely at states' utilization of optional Medicaid coverage. We compare income and resource standards applied by the states that use the Section 209(b) option in place of SSI eligibility criteria; then we examine which states use SSP-related eligibility and the OBRA 86 option to establish standards above the mandatory levels. We also analyze spend-down levels for medically needy programs.

States Using the Section 209(b) Option

Thirty-nine states and the District of Columbia enroll all SSI recipients in Medicaid.⁵ The remaining 11 states—Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia—use the Section 209(b) option to apply state-specific Medicaid eligibility standards for aged, blind, and disabled people. Table 1 shows the income and resource standards used by these “Section 209(b)” states.

Typically, at least one eligibility standard (income, resource, or definition of disability) used by these 11 states is more restrictive than the comparable SSI standard. However, only Illinois has income levels dramatically below SSI standards and only Missouri has resource limits substantially below SSI levels (but only for individuals). Six of these states use the same (or higher) income limits as SSI, but they may count income differently. About half of the Section 209(b) states use more restrictive resource limits than SSI, and others that appear to use SSI limits (or something more generous) may count resources differently. For example, Oklahoma restricts the value of prepaid burial plans and Virginia counts more real property than SSI. Yet not all standards used by Section 209(b) states are more restrictive than SSI. New Hampshire uses a higher income limit than SSI, Minnesota and North Dakota use higher asset limits, and Virginia allows people to have a larger burial fund. Hawaii is unique in that the state maintains its Section 209(b) status, but the state covers all aged, blind, and disabled people to levels above SSI standards through other optional categories.

The number of states using the Section 209(b) option is declining over time. North Carolina stopped using more restrictive criteria in 1995 (see box 1, p.14), and state officials in Minnesota and Missouri mentioned in our survey that both states are considering a switch from their existing Section

209(b) criteria to SSI criteria. These officials suggested that such a switch would simplify the eligibility process and reduce their administrative burden (particularly if they rely on SSA to determine eligibility).

Table 1
Medicaid Income and Resource Limits in States Using the Section 209(b) Option, 1998

State	Section 209(b) Eligibility Standard (Monthly Income) ^a		Section 209(b) Eligibility Standard (Percent of FPL) ^b		Section 209(b) Resource Limit ^c	
	Individual	Couple	Individual	Couple	Individual	Couple
Federal SSI Standards	\$494	\$741	74%	82%	\$2,000	\$3,000
Connecticut	\$476	\$633	71%	70%	\$1,600	\$2,400
Hawaii ^d	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	\$283	\$375	42%	41%	\$2,000	\$3,000
Indiana	\$494	\$741	74%	82%	\$1,500	\$2,250
Minnesota	\$467	\$583	70%	64%	\$3,000	\$6,000
Missouri	\$494	\$741	74%	82%	\$999.99	\$2,000
New Hampshire	\$508	\$642	76%	71%	\$1,500	\$1,500
North Dakota	\$494	\$741	74%	82%	\$3,000	\$6,000
Ohio	\$427	\$741	64%	82%	\$1,500	\$2,250
Oklahoma	\$494	\$741	74%	82%	\$2,000	\$3,000
Virginia	\$494	\$741	74%	82%	\$2,000	\$3,000

Source: Urban Institute survey of state Medicaid programs, 1998.

a) States using the Section 209(b) option may use different methods of counting income than SSI.

b) The 1998 federal poverty level (FPL) in the 48 contiguous states and the District of Columbia was \$8,050 for one person and \$10,850 for two people. The FPL for Hawaii was \$9,620 for one person and \$12,480 for two people (Source: HHS Poverty

Guidelines, *Federal Register*, Vol. 63, No. 36, February 24, 1998, pp. 9235-9238).

c) States using the Section 209(b) option may use different methods of counting resources than SSI.

d) Hawaii maintains its Section 209(b) status, but all aged, blind, and disabled people are eligible under other coverage options with higher income standards and/or resource standards than SSI.

Optional Coverage for People Receiving State Supplementary Payments

Many states offer Medicaid to aged, blind, and disabled people with incomes above SSI/Section 209(b) standards. One common approach used by these states is to cover people receiving state supplementary payments (SSP) but not SSI. This category encompasses a wide range of income and resource standards, as SSP benefits tend to vary by living arrangement, type of eligible (e.g., aged, blind, or disabled), or cost of living in different geographic areas. Table 2 presents a

simplified picture of SSP-related Medicaid eligibility. Based on available sources (Horvath, 1997; CCH, 1998), we estimate that 29 states offer Medicaid to SSP-only recipients living independently. Maximum SSI/SSP benefits for these people appear in table 2.⁶ These benefit levels are roughly the income levels at which people are eligible to receive SSP (and therefore Medicaid), but they are not quite the same because states may disregard certain income when determining eligibility. As a result, people with incomes above the maximum SSP benefit may still be eligible for Medicaid. Many states also offer Medicaid to some SSP-only recipients living in group arrangements. Including these states, one survey (Horvath, 1997) reported that 37 states provided Medicaid to at least some SSP-only recipients as of September 1996.

The information in table 2 shows that many states can and do offer Medicaid to aged, blind, and disabled people with incomes above the mandatory (e.g., SSI) levels. Using the maximum SSI/SSP benefit as a proxy for the income level at which people become eligible for SSP-related Medicaid coverage, it appears that some states, such as Maine, South Dakota, and Washington, extend Medicaid eligibility just above the mandatory limits. Other states, such as Alaska, California, and Connecticut, offer Medicaid to SSP recipients with incomes as high as 100 to 140 percent of the federal poverty level, well above the required limits. Nevertheless, SSP-related Medicaid eligibility extends coverage to relatively few people. The Social Security Administration reported that roughly 290,000 people received only state supplements and no SSI in December 1996 (Committee on Ways and Means, 1998). Even if all of these people received Medicaid, they would account for just 3 percent of the 9.7 million aged, blind, and disabled people enrolled in Medicaid in the average month during federal fiscal years 1996 and 1997.

Table 2
Optional Medicaid Coverage of Non-Institutionalized Aged, Blind, and Disabled Persons, 1998

State	Maximum SSI/SSP Benefit for Persons Living Independently ^a (Monthly Payment)		Maximum SSI/SSP Benefit for Persons Living Independently ^a (Percent of FPL)		OBRA 86 Expansion for Aged & Disabled Persons (Percent of FPL)
	Individual	Couple	Individual	Couple	
Alabama	-	-	-	-	-
Alaska	\$856	\$1,269	102%	112%	-
Arizona	-	-	-	-	-
Arkansas	-	-	-	-	-
California - aged/disabled	\$650	\$1,156	97%	128%	-
California - blind	\$705	\$1,271	105%	141%	-
Colorado - aged	\$533	\$1,086	79%	120%	-
Colorado - disabled	\$494	\$979	74%	108%	-
Connecticut	\$747	\$1,094	111%	121%	-
Delaware	-	-	-	-	-
District of Columbia ^b	-	-	-	-	100%
Florida	-	-	-	-	90%
Georgia	-	-	-	-	-
Hawaii	\$499	\$750	65%	72%	100%
Idaho	\$542	\$758	81%	84%	-
Illinois ^c	N/A	N/A	N/A	N/A	-
Indiana	-	-	-	-	-
Iowa - aged & disabled ^b	-	-	-	-	-
Iowa - blind	\$516	\$763	77%	84%	-
Kansas	-	-	-	-	-
Kentucky ^b	-	-	-	-	-
Louisiana	-	-	-	-	-
Maine	\$504	\$756	75%	84%	100%
Maryland	-	-	-	-	-
Massachusetts - aged	\$623	\$943	93%	104%	100%
Massachusetts - blind ^d	\$644	\$1,287	96%	142%	133%
Massachusetts - disabled ^d	\$608	\$921	91%	102%	133%
Michigan	\$508	\$769	76%	85%	100%
Minnesota	\$575	\$852	86%	94%	-
Mississippi	-	-	-	-	100%
Missouri - aged & disabled	-	-	-	-	-
Missouri - blind ^e	N/A	N/A	N/A	N/A	-
Montana	-	-	-	-	-
Nebraska	\$502	\$839	75%	93%	100%
Nevada - aged	\$530	\$815	79%	90%	-
Nevada - blind	\$603	\$966	90%	107%	-
New Hampshire	\$521	\$762	78%	84%	-
New Jersey	\$525	\$766	78%	85%	100%
New Mexico	-	-	-	-	-
New York	\$580	\$844	86%	93%	-
North Carolina ^f	-	-	-	-	-

Table 2
Optional Medicaid Coverage of Non-Institutionalized Aged, Blind, and Disabled Persons, 1998

State	Maximum SSI/SSP Benefit for Persons Living Independently ^a (Monthly Payment)		Maximum SSI/SSP Benefit for Persons Living Independently ^a (Percent of FPL)		OBRA 86 Expansion for Aged & Disabled Persons (Percent of FPL)
	Individual	Couple	Individual	Couple	
North Dakota	-	-	-	-	-
Ohio	-	-	-	-	-
Oklahoma	\$547	\$847	82%	94%	-
Oregon - aged/disabled	\$496	\$741	74%	82%	-
Oregon - blind	\$521	\$767	78%	85%	-
Pennsylvania	\$521	\$785	78%	87%	100%
Rhode Island	\$558	\$862	83%	95%	-
South Carolina	-	-	-	-	100%
South Dakota	\$509	\$756	76%	84%	-
Tennessee	-	-	-	-	-
Texas	-	-	-	-	-
Utah	-	\$746	-	83%	100%
Vermont	\$549	\$844	82%	93%	-
Virginia	-	-	-	-	-
Washington	\$521	\$762	78%	84%	-
West Virginia	-	-	-	-	-
Wisconsin	\$578	\$873	86%	97%	-
Wyoming	-	-	-	-	-

Source: Urban Institute, 1999.

SSP payments from State Assistance Programs for SSI Recipients, Social Security Administration (Pub. No. 13-11975),

January 1998. Medicaid eligibility for SSP recipients based on "Medicaid Financial Eligibility for Aged, Blind, and Disabled: Survey of State Use of Selected Options," National Academy for State Health Policy, May 1997, and Commerce

Clearing House, Inc., Medicare and Medicaid Guide (CD-ROM version), November 1998. States using the OBRA 86

option based on Urban Institute survey of state Medicaid programs, 1998.

Note: The 1998 federal poverty level (FPL) in the 48 contiguous states and the District of Columbia is \$8,050 for one

person and \$10,850 for two people. The FPL for Alaska is \$10,070 for one person and \$13,570 for two people. The FPL

for Hawaii is \$9,260 for one person and \$12,480 for two people (Source: HHS Poverty Guidelines, Federal Register, Vol. 63, No. 36, February 24, 1998, pp. 9235-9238).

a) Payments are for persons living independently in their own homes, unless otherwise specified. In some cases, the state

may offer optional SSP coverage to people in other independent or group living arrangements. Payment levels may be

significantly higher (or lower) in these other arrangements. The maximum income limits for eligibility may differ from the

payment levels shown if states disregard income when determining eligibility.

b) These states do not specify "living independently" as a living arrangement; however, these states pay supplements to people

in some living arrangements that fall under the definition of "living independently" used by other states.

c) Illinois determines supplemental payment levels on a case-by-case basis.

d) Massachusetts covers blind and disabled people with incomes up to 133% of the FPL through MassHealth, the

Table 2
Optional Medicaid Coverage of Non-Institutionalized Aged, Blind, and Disabled Persons, 1998

State	Maximum SSI/SSP Benefit for Persons Living Independently^a (Monthly Payment)		Maximum SSI/SSP Benefit for Persons Living Independently^a (Percent of FPL)		OBRA 86 Expansion for Aged & Disabled Persons (Percent of FPL)
	Individual	Couple	Individual	Couple	

state's

Section 1115 Demonstration.

e) Missouri Aid to the Blind pays a supplement of \$373 for individuals and \$746 for couples. Only those recipients who

receive less than \$494 monthly in SSI and less than \$523 from other sources qualify for this supplement. The supplement

is reduced dollar-for-dollar by the SSI payment.

f) On January 1, 1999, North Carolina began covering aged and disabled people up to 100% of the federal poverty level using the OBRA 86 option.

Optional Poverty-Related Coverage

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) gave states the option to extend Medicaid benefits to aged and disabled individuals with incomes up to 100 percent of the FPL. Our survey found that 11 states and the District of Columbia used the OBRA 86 option in 1998 (table 2). North Carolina implemented coverage up to 100 percent of the FPL in January 1999, becoming the

Box 1

North Carolina Uses Existing Options to Expand Coverage

Prior to January 1, 1995, North Carolina used more restrictive Medicaid eligibility standards than SSI for aged, blind, and disabled people under authority of the Section 209(b) option. On that date, the state dropped its more restrictive standards and made all SSI recipients eligible for Medicaid. Four years later, the state took another step and extended coverage to aged and disabled people with incomes up to 100 percent of the federal poverty level using the OBRA 86 coverage option.

Prior to 1995, North Carolina's Section 209(b) income levels for Medicaid eligibility did not keep pace with inflation and therefore fell further below poverty levels each year. Those who did not qualify based on income had to spend down to the state's historically low medically needy income levels, which were about 35 to 40 percent of the federal poverty level. Many SSI recipients who did not qualify under the Section 209(b) eligibility criteria were upset that they had to spend down to such low medically needy levels to get Medicaid coverage when SSI recipients in most other states were automatically eligible for Medicaid. Fueled by letters and testimony from these individuals, the state legislature passed legislation to switch to automatic Medicaid eligibility for SSI recipients.

North Carolina's recent decision to expand coverage to 100 percent of poverty using the OBRA 86 option was in response to an intensive effort by advocates and legislators to expand coverage for the aged and disabled, particularly for prescription drugs. Advocates initially proposed a prescription drug benefit for aged and disabled people up to 200 percent of poverty. "The biggest need of this population is prescription drugs," said a state official, "[but] the proposed program was too expensive to pursue." The OBRA 86 option became the accepted compromise. Although the income limit is lower than the initial plan, recipients receive the full range of Medicaid benefits, which includes prescription drugs. The state official attributes the success of this effort to good timing, adding "the state's economy is strong... advocates got behind the plan... and the legislature responded." The state is ahead of its goals to enroll the newly eligible population, with an estimated 35,000 people already in the program according to one state official. "This change is making a big difference in people's lives," the official remarked.

Source: Interviews with North Carolina officials, February 1999.

twelfth state to use this option (box 1).

Although the OBRA 86 option allows states to use any income limit up to 100 percent of the FPL, Florida is the only state using a lower threshold (90 percent of FPL). Perhaps more striking is the diversity of states using the OBRA 86 option, consisting of both small and large states and both poor and rich states. They dot the country, exhibiting no distinct regional pattern. Some of these states have reputations as having generous public programs, while others tend to be thought of as being more restrictive.

Medically Needy Programs

Thirty-five states and the District of Columbia offer medically needy programs that give people a spend-down option for Medicaid coverage. The medically needy income limit (MNIL)—the income level (net of incurred medical costs) where people qualify through spend down—and resource standards for these programs appear in table 3. The table does not include standards for Texas because the state’s medically needy program does not cover the aged, blind, or disabled. Financial eligibility for medically needy programs varies considerably across the states. The medically needy income limits for individuals in Arkansas and Louisiana are under 20 percent of the federal poverty level, but other states, such as Oregon and Vermont, have limits of 100 percent of the federal poverty level or higher for certain groups. In many cases, a state’s MNIL is much lower than SSI or Section 209(b) income limits for the same family size. In 23 states the MNIL for individuals is below the federal SSI or state 209(b) income standard; in 26 states the MNIL for couples is below the federal SSI or state 209(b) income standard. Twenty of the 35 medically needy programs for aged, blind, and disabled people use at least one MNIL below 60 percent of the federal poverty level for one- or two-person families.

Table 3
**Medically Needy Income Limits (MNIL) and Resource Limits for Aged, Blind,
and Disabled People, October 1998**

State	MNIL (monthly income) and Resource Limit				MNIL as a Percent of the FPL		MNIL Last Changed
	Individual		Couple		Individual	Couple	
Alabama	-	-	-	-	-	-	-
Alaska	-	-	-	-	-	-	-
Arizona	-	-	-	-	-	-	-
Arkansas	\$108	\$2,000	\$217	\$3,000	16%	24%	1988
California ^a	\$600	\$2,000	\$943	\$3,000	89%	104%	1989
Colorado	-	-	-	-	-	-	-
Connecticut ^b	\$476	\$1,600	\$633	\$2,400	71%	70%	1995
Delaware	-	-	-	-	-	-	-
District of Columbia	\$377	\$2,600	\$397	\$3,000	56%	44%	1994
Florida	\$180	\$5,000	\$241	\$6,000	27%	27%	1993
Georgia	\$208	\$2,000	\$317	\$4,000	31%	35%	1991
Hawaii	\$418	\$2,000	\$565	\$3,000	54%	54%	1993
Idaho	-	-	-	-	-	-	-
Illinois ^c	\$283	\$2,000	\$375	\$3,000	42%	41%	1998
Indiana ^d	-	-	-	-	-	-	-
Iowa	\$483	\$10,000	\$483	\$10,000	72%	53%	1991
Kansas	\$475	\$2,000	\$475	\$3,000	71%	53%	1997
Kentucky	\$217	\$2,000	\$267	\$4,000	32%	30%	1992
Louisiana	\$100	\$2,000	\$192	\$3,000	15%	21%	1991
Maine	\$315	\$2,000	\$341	\$3,000	47%	38%	1993
Maryland	\$350	\$2,500	\$392	\$3,000	52%	43%	1994
Massachusetts	\$522	\$2,000	\$650	\$3,000	78%	72%	1998
Michigan ^e	\$408	\$2,000	\$541	\$3,000	61%	60%	1996
Minnesota	\$467	\$3,000	\$583	\$6,000	70%	64%	1998
Mississippi ^d	-	-	-	-	-	-	-
Missouri ^d	-	-	-	-	-	-	-
Montana ^f	\$491	\$2,000	\$491	\$3,000	73%	54%	1998
Nebraska	\$392	\$4,000	\$392	\$6,000	58%	43%	1991
Nevada	-	-	-	-	-	-	-
New Hampshire ^c	\$508	\$2,500	\$642	\$4,000	76%	71%	1998
New Jersey	\$367	\$4,000	\$434	\$6,000	55%	48%	1995
New Mexico	-	-	-	-	-	-	-
New York ^f	\$584	\$3,500	\$850	\$5,100	87%	94%	1998
North Carolina	\$242	\$1,500	\$317	\$2,250	36%	35%	1992
North Dakota	\$405	\$3,000	\$450	\$6,000	60%	50%	1996
Ohio ^d	-	-	-	-	-	-	-
Oklahoma	\$259	\$2,000	\$325	\$3,000	39%	36%	1995
Oregon ^f	\$671	\$5,000	\$904	\$5,000	100%	100%	1998
Pennsylvania	\$425	\$2,400	\$442	\$3,200	63%	49%	1990

Table 3
Medically Needy Income Limits (MNIL) and Resource Limits for Aged, Blind, and Disabled People, October 1998

State	MNIL (monthly income) and Resource Limit				MNIL as a Percent of the FPL		MNIL Last Changed
	Individual	Couple	Individual	Couple	Individual	Couple	
Rhode Island	\$558	\$4,000	\$600	\$6,000	83%	66%	1992
South Carolina	-	-	-	-	-	-	-
South Dakota	-	-	-	-	-	-	-
Tennessee	\$175	\$2,000	\$192	\$3,000	26%	21%	1992
Texas ^g	N/A	N/A	N/A	N/A	N/A	N/A	1994
Utah	\$372	\$2,000	\$456	\$3,000	55%	50%	1995
Vermont ^h	\$741	\$2,000	\$741	\$3,000	110%	82%	1996
Virginia ⁱ	\$250	\$2,000	\$308	\$3,000	37%	34%	1989
Washington ^f	\$521	\$2,000	\$592	\$3,000	78%	65%	1998
West Virginia	\$200	\$2,000	\$275	\$3,000	30%	30%	1986
Wisconsin ^f	\$578	\$2,000	\$592	\$3,000	86%	65%	1998
Wyoming	-	-	-	-	-	-	-

Sources: Urban Institute survey of state Medicaid programs, 1998. Date of last change to MNIL based on Commerce Clearing

House, Inc., Medicare and Medicaid Guide (CD-ROM version), November 1998.

Note: The 1998 federal poverty level (FPL) in the 48 contiguous states and the District of Columbia is \$8,050 for one person

and \$10,850 for two people. The FPL for Alaska is \$10,070 for one person and \$13,570 for two people. The FPL for Hawaii

is \$9,260 for one person and \$12,480 for two people (Source: HHS Poverty Guidelines, Federal Register, Vol. 63, No. 36,

February 24, 1998, pp. 9235-9238).

a) Federal regulations allow California to use the AFDC payment for one adult and two children as the MNIL for couples where

at least one individual is aged, blind, or disabled. The standard limit for one adult and one child is \$750 per month.

b) Connecticut uses two sets of income limits by region. The limits shown cover the most people. The other limits are \$575

(1 person) and \$734 (2 people).

c) CCH reports that these income limits are effective as of 3/98 (Illinois) and 1/98 (New Hampshire), but both states reported in

our survey that the same income limits applied as early as 1996 (the first point in time for which we requested information).

d) Section 209(b) spend down applies for aged, blind, and disabled people.

e) A separate scale applies to each of six different groups of counties in Michigan; the highest level is shown here.

f) These states appear to update their income limits annually during the period of our survey (1996-98).

g) Texas's medically needy program does not cover the aged, blind, or disabled.

h) The limits outside of Chittenden County in Vermont are \$683 per month.

i) Virginia uses three sets of income limits by region; the limits shown apply to the area with the largest population; the other

two sets are \$217 (1 person) and \$283 (2 people), and \$325 (1 person) and \$400 (2 people).

Medically needy income limits tend to be low because of federal rules and state choices.

Federal regulations specify that states may only receive federal funds to cover medically needy recipients with incomes up to 133 and 1/3 percent of the maximum payment for a family of the same size, with no income or resources, under the state's Aid to Families with Dependent Children (AFDC) plan as of July 16, 1996. The only major exception to this limitation is that states can set the MNIL for single individuals at an amount reasonably related to 133 and 1/3 percent of the highest AFDC payment for a two-person family, as long as a similar relationship existed in the state plan as of June 1, 1989.⁷

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 added another limitation that states may only increase the MNIL by the percentage increase in the Consumer Price Index (CPI) subsequent to July 16, 1996. Many states have a low MNIL because their AFDC benefit levels are low—the median AFDC benefit level for a family of two people was about 37 percent of the federal poverty level in 1996.⁸ Many states also held AFDC benefit levels constant for several years leading up to welfare reform, further restricting their ability to raise the MNIL. According to Commerce Clearing House's summaries of state Medicaid plans, Arkansas, California, Virginia, and West Virginia have not changed their MNIL since the 1980s. Several other states last changed their MNIL in the early 1990s. Our findings suggest that only a few states adjust the MNIL annually; Montana, New York, Oregon, Washington, and Wisconsin changed their MNIL in 1996, 1997, and 1998.

States are not required to provide the same benefit package to medically needy enrollees that they offer to other enrollees. Notably, federal law allows states to exclude nursing facilities and some optional services from their medically needy programs. Five states' medically needy programs do not cover nursing facility services: Arkansas, Florida, Iowa, New Jersey, and Oklahoma. All five of these states use the 300 percent rule for institutional eligibility, so there are other eligibility options available.⁹

However, other states restrict access to, or even exclude altogether, optional services such as podiatrists' care and dental services. Consequently, people who spend down to medically needy levels can be eligible for fewer services than people whose incomes were originally low enough to qualify for Medicaid through other pathways. These people become, in effect, a separate class of Medicaid recipient.

Conclusion

This analysis shows that there is considerable variation in Medicaid eligibility for aged, blind, and disabled people across states. Some of this variation comes from the federal-state structure of the program. Other variation comes from states' choices pertaining to available options. The federal government requires states to cover certain mandatory groups, but states have significant discretion over optional eligibility criteria. This autonomy leads to differences in Medicaid programs across states, as each state uses its own blend of mandatory and optional eligibility categories. Some states provide optional coverage well above the mandatory levels; others provide very little optional coverage.

Even within a single state, Medicaid may use several income and resource criteria to determine eligibility for aged, blind, and disabled people. This variation is partly a result of the piecemeal evolution of Medicaid and its historical linkage to the cash welfare programs. As it evolved, Medicaid took on different roles. For some low-income aged, blind, and disabled people, Medicaid functions as their regular health insurance, providing coverage for a comprehensive range of acute care benefits. For others, Medicaid covers home- and community-based services and is the primary payer for nursing home care. For those eligible for both Medicare and Medicaid, Medicaid provides financial assistance for Medicare premiums and cost-sharing requirements. Each of these new roles brought with it new

eligibility criteria, and often multiple layers of eligibility criteria, leading to the tangle of rules that apply today. This complexity stands in sharp contrast to efforts to simplify eligibility for adults and children in Medicaid and the Children’s Health Insurance Program (CHIP). Developing more coherent Medicaid standards could reduce confusion regarding eligibility and conceivably decrease administrative costs.

As noted above, one of the principal reasons why eligibility varies across states is that states make many different choices in regard to coverage options. Many states have options to cover low-income aged, blind, and disabled people that they do not use. For example, the OBRA 86 option to cover aged and disabled people with incomes below 100 percent of the FPL has the potential to both expand coverage and establish more consistent income standards, but only 12 states and the District of Columbia currently use this option. Other states use options that generally restrict eligibility, such as the 10 states that continue to use the Section 209(b) option rather than making all SSI recipients eligible for Medicaid. This option likely prevents some SSI recipients from obtaining Medicaid who would be eligible for coverage in most other states.

At the same time, some popular state options are not very effective means of expanding or simplifying coverage. Although 37 states offer some type of SSP-related Medicaid eligibility, the effect on total Medicaid enrollment is minimal. Most SSP recipients also receive SSI and therefore are already eligible for Medicaid in most states. SSP-related eligibility also introduces some of the greatest variation in eligibility criteria. For example, maximum allowable income levels for SSP vary considerably from state to state—and may even vary within states depending on location or individual circumstances. Likewise, there are only 11 states with no spend-down option for aged, blind, or disabled people (either medically needy or Section 209(b) spend down), but many of the existing programs use very low spend-down thresholds. These thresholds also vary considerably due to

variation in states' choices in such areas as AFDC payment rates and regularity of updates to the MNIL. By using the broader options available to them, or by dropping more restrictive options, states have the ability to increase Medicaid coverage of low-income aged and disabled individuals and set more consistent eligibility standards both across and within states.

Nevertheless, although states could choose to cover more people and/or simplify their eligibility criteria, they face some federal barriers, particularly for medically needy programs. Along these lines, the federal government may wish to reconsider the connection between states' MNILs and AFDC payment levels. Although federal welfare reform delinked Medicaid and welfare (i.e., AFDC and its successor, Temporary Assistance for Needy Families (TANF)), federal law still ties medically needy income levels to 133 and 1/3 percent of the AFDC payment levels from 1996. These payment levels tend to be much lower than SSI or Section 209(b) standards. After spend down, these higher-income individuals are left with less income than lower-income people who do not have to spend down to qualify.

Lastly, it should be noted that extending Medicaid benefits to more aged, blind, and disabled people is not always politically feasible. Despite recent budget surpluses, many states continue to face pressure to cut costs and lower taxes. A common argument against expanding coverage for the aged, blind, and disabled is that it is expensive—average Medicaid expenditures per enrollee were about \$10,800 for aged enrollees and \$8,840 for blind and disabled enrollees in 1997. The cost of covering new enrollees may not be as high as these figures suggest because they are unlikely to use expensive institutional long-term care services, but costs are important considerations.¹⁰ Moreover, states may have other priorities for their health care spending. Many aged, blind, and disabled people are already eligible for Medicare. Expanding Medicaid coverage to a population with at least some form of

insurance may not be a priority in states faced with growing numbers of uninsured adults and children. Nevertheless, Medicaid coverage options are powerful tools available to states to fill gaps in insurance for aged, blind, and disabled people, who often have considerable unmet medical needs.

Notes

1. All Medicaid expenditure and enrollment statistics presented in this paper are the authors' estimates based on state reports to the Health Care Financing Administration (HCFA).
2. The percentage of elderly individuals enrolled in Medicaid is the authors' calculation based on revised Current Population Survey (CPS) data from the Urban Institute's TRIM2 micro-simulation model, which imputes Medicaid coverage to some individuals on the CPS to better reflect Medicaid's administrative records. By contrast, original CPS data show only 30 percent of elderly people with incomes under 100 percent of the federal poverty level (FPL) covered by Medicaid in 1995 (Committee on Ways and Means, 1998). The number of Medicaid recipients shown by the CPS is lower than the number in Medicaid administrative data due to underreporting by CPS respondents. Note that the percentages given do not include younger persons with disabilities. The percentage of younger disabled people with incomes under 100 percent of the FPL covered by Medicaid is around 80 percent using data from the TRIM2 model. Comparable data are not available from the original CPS.
3. The legislation and subsequent HCFA guidelines for optional coverage of the elderly and disabled poor specifically require that the Department of Health and Human Services poverty guidelines be used as the measure of poverty.
4. States can exclude certain services from the benefit package available to medically needy people, notably care in nursing facilities.
5. Some states may require a separate application for Medicaid.
6. The definition of "living independently" (as applied to SSP) varies from state to state, so even this simplified approach encompasses a variety of living arrangements.
7. A special exception in the regulations allows California to use 133 and 1/3 percent of the 3-person AFDC payment level for 2-person families if one person is aged, blind, or disabled.
8. The median monthly AFDC payment for a 2-person family as a percent of poverty is the authors' calculation based on maximum AFDC payment levels from the Administration for Children and Families, U.S. Department of Health and Human Services (HHS), and HHS poverty guidelines for each state printed in the Federal Register, Vol. 63, No. 36, February 24, 1998, pp. 9235-9238.
9. According to Horvath (1997), these states use much higher income standards for institutionalized people and recipients of home- and community-based care.
10. This argument assumes that most people who would be eligible for care under an expansion up to 100 percent of poverty are already eligible under the special income rule or they can spend down to coverage under medically needy programs very quickly.

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