

THE BASICS

Medicaid Eligibility and Benefits

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The Medicaid program provides health coverage to poor or disabled individuals. It was enacted in 1965, the same year as Medicare, under Title XIX of the Social Security Act. Medicaid is administered by the states according to broad federal guidelines and is jointly funded by states and the federal government.¹ The Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health and Human Services oversees states' administration of their Medicaid programs. Although Medicaid is optional, all states, the District of Columbia, and the territories have a program. In 2014, Medicaid provided coverage to an estimated 64.6 million people at a cost of \$498.9 billion in combined state and federal spending.²

Each state operates its Medicaid program according to federal statutes and regulations that define mandatory eligibility categories and the benefits that must be provided. States have flexibility to extend eligibility to additional optional eligibility categories and to offer optional benefits. In addition to establishing eligibility criteria and benefit packages, states may exercise policy preferences in other areas of program administration, such as processes for determining eligibility, setting provider payment rates, and operating demonstration programs, within the broad federal guidelines and subject to federal approval. As a result of each state's ability to vary eligibility, benefits, and other aspects of their programs, state programs differ. Each state has a federally approved Medicaid Plan that outlines eligibility and benefit categories, as well as other aspects of its Medicaid program.

WHO IS ELIGIBLE?

The Medicaid program has often been considered three programs in one because of the distinct populations eligible for the program and the services they use. The three populations

are (i) low-income families, children, and pregnant women; (ii) low-income elders; and (iii) low-income disabled persons. The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-48 as amended) added a fourth population: working-age adults without children. Medicaid eligibility is generally based on an individual's family income and assets. The rules for counting income and assets vary by state and eligibility group. In addition, only U.S. citizens and some categories of lawfully residing immigrants are eligible for Medicaid.

Families and Children

State programs *must* cover the following groups of children, families, and pregnant women:

- Infants born to Medicaid-eligible pregnant women
- Children up to age 19 and pregnant women with family incomes at or below 133 percent of the federal poverty level (FPL) (\$26,719.70 for a family of three in 2016)
- Children and certain adults who would be eligible for cash assistance under pre-welfare reform rules in effect in July 1996
- Children and certain adults with incomes below 185 percent of the FPL (\$37,166.50 for a family of three in 2016) in families that are leaving welfare for work as transitional medical assistance
- Children in foster care or an adoption assistance program

States have the option of making children, families, and pregnant women with incomes above the mandatory coverage limits eligible for Medicaid. For example, most states cover children with incomes up to 200 percent of the FPL under their Medicaid programs or through Medicaid and the Children's Health Insurance Program (CHIP).³

Elderly and Disabled

State programs *must* cover elderly and disabled individuals receiving cash benefits under the Supplemental Security Income (SSI) program (or aged, blind, or disabled individuals who meet state criteria that were in place in a state as of January 1972 and are more restrictive than SSI's eligibility criteria).

States have the option of making eligible for Medicaid certain elderly or disabled individuals with incomes above the mandatory coverage limits but below the FPL.

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Certain severely impaired individuals who are working and have earnings above the SSI eligibility limits are permitted to continue receiving Medicaid benefits, despite the loss of SSI coverage.

States have the option of allowing individuals with disabilities with incomes up to 250 percent of the FPL (\$29,425 for an individual in 2016) to continue receiving Medicaid while working.

Working-Age Adults without Children

The ACA would have extended Medicaid eligibility to all individuals under age 65 living in families with incomes under 133 percent⁴ of the FPL starting in 2014. But in June 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius* that held that the federal government cannot make all federal Medicaid funding for a state's Medicaid program contingent on a state implementing the ACA Medicaid expansion.⁵ As a result of this decision, states may opt not to expand the program to newly eligible adults without losing their federal Medicaid funding for other eligible populations. As of this writing, 30 states and the District of Columbia have opted to expand Medicaid to include this population. Several additional states are considering whether to expand.⁶

The ACA provided special funding for states that expand eligibility to adults under age 65 with incomes up to 133 percent of the FPL. The federal government is to pay 100 percent of the costs through 2016, 95 percent of the costs in 2017, 94 percent of the costs in 2018, 93 percent of the costs in 2019, and 90 percent of the costs in 2020 and thereafter for those newly eligible for Medicaid as a result of the ACA. In a document released in December 2012, CMS announced that states cannot expand to less than 133 percent of FPL and receive 100 percent federal payment for this group. CMS stated that the law does not provide for a phased-in or partial expansion, and that the higher federal matching rate will not be available to states that partially expand coverage (such as up to 100 percent of FPL) through 2016.⁷

Medically Needy

“Medically needy” is an optional eligibility category. States who allow medically needy individuals to qualify for Medicaid deduct the cost of the person's medical care from his or her income when determining eligibility. This concept of “spending down” to Medicaid eligibility often applies to elderly individuals who have high medical expenses and are

often in nursing facilities. Thirty-four states and the District of Columbia provided eligibility to medically needy individuals in 2014.⁸

Beneficiaries Eligible for Medicare Savings Programs

Under the Medicare Savings Programs, Medicaid programs are required to pay the premiums and cost sharing for eligible Medicare beneficiaries with low incomes that are too high for them to qualify for full Medicaid benefits. As shown in the table below, the four mandatory Medicare Savings Programs vary by the income eligibility limits and covered premiums and cost sharing.

TABLE 1: Medicare Savings Programs

Program	Income Limit	Pays For
Qualified Medicare Beneficiary (QMB)	100 percent FPL	Part A premiums, Part B premiums, deductibles, coinsurance, and copayments
Specified Low-Income Medicare Beneficiary (SLMB)	120 percent FPL	Part B premiums
Qualified Individual (QI)	135 percent FPL	Part B premiums
Qualified Disabled Working Individual*	200 percent FPL	Part A premiums

** Qualified Disabled Working Individuals are working disabled individuals under 65 who no longer qualify for premium-free Medicare Part A after returning to work and are not eligible for Medicaid.*

Note: The Medicare Savings Programs have asset limits of \$7,280 for an individual and \$10,930 for a married couple in 2015. These limits are indexed and change annually. States have the option of setting less restrictive income and asset limits.

WHAT SERVICES ARE REQUIRED?

Subject to medical necessity, Medicaid programs must cover the following services for categorically eligible populations:

- Hospital services (inpatient and outpatient)
- Physicians’ services
- Medical and surgical dental services
- Nursing facility (NF) services for individuals aged 21 or older
- Home health care for persons eligible for NF services
- Family planning services and supplies

- Federally qualified health center and rural health clinic services
- Laboratory and X-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services (to the extent authorized under state law)
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under age 21

WHAT SERVICES ARE OPTIONAL?

States may also receive federal funding if they elect to provide other optional services. Commonly covered optional services under the Medicaid program include: prescription drugs (which all states cover), clinic services, NF services for those under age 21, intermediate care facilities for individuals with intellectual disabilities (ICF/IID) services, optometrist services and eyeglasses, and dental services. States also have the option of providing home- and community-based services to certain individuals who are eligible for Medicaid, including case management, personal care services, respite care services, adult day health services, and home health services.

SERVICES FOR ACA ELIGIBLES

The ACA made changes to Medicaid benefits for newly eligible groups. Specifically, the law requires states to provide “benchmark” benefits to most of those who are newly eligible for coverage under the Medicaid expansion. Benchmark benefits, first introduced in the Deficit Reduction Act of 2005 (DRA), give states the option to provide a benefit package that is equivalent to a benchmark commercial insurance product.⁹ The ACA requires that the benchmark benefit package provide essential health benefits and other services, which were also required in new individual and small group insurance products beginning in 2014.

COST SHARING IN MEDICAID

Because of the limited income of most individuals eligible for Medicaid, Medicaid’s laws and regulations place strict limits on cost sharing. Premium charges are prohibited under traditional Medicaid for most eligibility groups. Similarly, service-related cost sharing (for example, copayments and coinsurance) is prohibited for certain eligibility groups and services. The DRA provided states with greater latitude to require

beneficiary cost sharing in some circumstances and simplified the process that states go through to have their cost-sharing plan approved. The DRA cost-sharing options vary by beneficiary category, income level, and the type of service. For example, mandatory eligible children under 19 are exempt from premiums and cost sharing for mandatory and preventive services. States may not require beneficiaries to pay more than 5 percent of their income for medical care.

ENDNOTES

1. For more detail, see “The Basics: Medicaid Financing,” National Health Policy Forum, January 5, 2016, www.nhpf.org/library/details.cfm/2528.
2. Enrollment can be measured in two ways that differ because an individual’s Medicaid eligibility status can change during the course of the year. The average number of enrollees at a point in time, or “person year equivalents” was 58.9 million in 2013, as estimated by the CMS Office of the Actuary. An estimated 72.5 million people were enrolled in Medicaid for at least one month in 2013. Christopher J. Truffer et al., “2014 Actuarial Report on the Financial Outlook for Medicaid,” U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, 2014, p. ii-iii, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf>.
3. Tricia Brooks *et al.*, “Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015,” January 20, 2015, <http://files.kff.org/attachment/report-modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015>.
4. The ACA sets the upper income limit at 133 percent of the FPL, but allows states to “disregard” 5 percent of income potentially making the income limit 138 percent of the FPL.
5. Alison Mitchell, “Medicaid Financing and Expenditures,” Congressional Research Service, Report R42640, July 30, 2012.
6. National Academy for State Health Policy, StateReform.org, “Map: Where States Stand Now on Medicaid Expansion Decisions, updated December 29, 2015, www.statereform.org/Medicaid-Expansion-Decisions-Map.
7. Centers for Medicare & Medicaid Services (CMS), “Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid,” December 10, 2012, p. 12, www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.
8. Medicaid and CHIP Payment and Access Commission, “Medically Needy Program Thresholds as a Percent of FPL, 2014,” August 2015, www.macpac.gov/medically-needy-program-thresholds-2014/.
9. Some populations, such as pregnant women and people with disabilities, were exempted from benchmark benefits under the DRA, and the ACA continues those exemptions.