**In most states, Medicaid eligibility is automatic for SSI recipients.** SSI recipients automatically qualify for Medicaid in 39 states and the District of Columbia. If the SSI check is as little as $1, Medicaid eligibility is automatic. In most of these states, the SSI recipient does not need to take any action as their eligibility is automatically certified. In some of these states, eligibility is automatic, but the individual SSI recipient must file a Medicaid application to establish that eligibility. The states in which a separate Medicaid application must be filed include: Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, Utah, and the Northern Mariana Islands.

In 11 states, known as section 209(b) states, Medicaid eligibility is not automatic for SSI recipients. These states use their own Medicaid eligibility criteria, which differs from SSI criteria. The Medicaid eligibility employed by 209(b) states will vary greatly from state to state, and may be more restrictive or more liberal than SSI’s criteria. The states which exercise the 209(b) option include: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. If you reside in one of these states, you will need to find out how SSI recipients qualify for Medicaid in your state.

**Working with SSI’s income and resource rules will often ensure Medicaid eligibility.** The SSI income and resource rules are discussed in Chapter XX. Individuals, spouses and parents can often organize their finances to ensure SSI and Medicaid eligibility. For example, in a state that pays the 2003 SSI federal benefit rate (FBR) of $552, with no state supplement, a single parent living with two children including one with a disability would be able to maintain SSI eligibility for the child with a disability until the parent’s gross monthly income reaches $2,609 ($31,308 per year). If Medicaid is critical to the child, the parent may wish to work with his or her employer to keep their income below $2,609 per month. This could be done by accepting extra health benefits in lieu of cash; putting money into a cafeteria plan or flexible spending account (approved under section 125 of the Internal Revenue Code), if available; or by going to a part-time schedule.

If Medicaid is important to the child, the parent must be careful to keep the parents’ and child’s resources within SSI limits. For example, retaining exempt resources, such as the residential home or a vehicle for travel to medical appointments, will not affect SSI eligibility. On the other hand, accumulating more than $2,000 in a child’s savings account would result in a termination of SSI eligibility and, with it, the right to automatic Medicaid in most states. The considerations for adult SSI recipients will be the same or very similar.
The following provisions each allow a former SSI recipient to be treated as an SSI recipient for Medicaid purposes, allowing that person to continue eligibility for Medicaid.

**Recipients of Social Security Widow’s/Widower’s Benefits:** If a person loses SSI when he or she becomes entitled to Social Security widows or widowers’ benefits, the person remains automatically eligible for Medicaid if SSI eligibility would continue in the absence of the widow’s or widowers’ benefits. Eligibility continues only for so long as the person remains ineligible for Medicare, a period of 24 months following the first month of Social Security eligibility.

*Example:* Mary was receiving SSI benefits of $552 per month and was automatically eligible for Medicaid in her state. Upon the death of her husband, she qualifies for Social Security Widows’ Benefits of $600 per month, which makes her ineligible for continuing SSI benefits. She will continue to be eligible for Medicaid, as if she was still an SSI recipient, for the two-year waiting period for Medicare.

**Recipients of Social Security DAC Benefits:** A recipient of Social Security Child’s Insurance Benefits, often referred to as Disabled Adult Child’s (DAC) benefits, can continue eligibility for automatic Medicaid if, after July 1, 1987, the person lost SSI due to entitlement to or an increase in DAC benefits.

*Example:* Paul, age 33, was receiving SSI benefits in early 2003 at the FBR of $552. He was also automatically eligible for Medicaid in his state. During the spring of 2003, Paul’s father dies and Paul becomes eligible for Social Security DAC benefits of $750 per month and loses his SSI benefits because of excess income. Since Paul lost his benefits due to receipt of DAC benefits he will remain eligible for Medicaid so long as his resources and income other than DAC benefits remain within SSI limits.

**The Pickle Amendment:** This protects certain persons who, after April 1977, were eligible for both SSI and SSDI and later lost eligibility for SSI because the receipt of SSDI, along with any other income, made the person ineligible for SSI. Automatic eligibility for Medicaid continues if the person would be presently eligible for SSI if SSDI cost of living increases since the person last received SSI are disregarded.

*Example:* In 1999, John was receiving $430 in monthly SSDI benefits and $90 in SSI benefits (the 1999 FBR was $500). That same year he started receiving a private pension of $125 per month, making his combined SSDI and private pension income more than allowed by SSI [i.e., his countable income of $535 (i.e., $555 - 20 general income exclusion) was now more than the SSI rate of $500]. Having lost SSI, John also lost his right to automatic Medicaid. Assume John’s pension will remain a constant $125 per month.
Because the Pickle Amendment allows John to disregard SSDI cost-of-living increases since 1999 (i.e., since he was last dually entitled to SSI and SSDI), his countable income for Pickle Amendment purposes will remain a constant $535 in future years. This was more than the FBR of $512 in 2000 and more than the FBR of $530 in 2001, meaning that he remained ineligible for Medicaid under Pickle. In 2002, with the FBR now up to $545, John’s countable income of $535 (after ignoring SSDI cost-of-living increases) is now less than the SSI rate for his state. Since John would now be eligible for a small SSI check ($10) if the post-1999 SSDI increases are ignored, John is now eligible for Medicaid under Pickle.

For a more detailed explanation, see Bonnyman, G., *Medicaid Eligibility in a Time Warp*, 22 Clearinghouse Rev. 120 (June 1988) and Bonnyman, G., *A Quick and Easy Method of Screening for Medicaid Eligibility under the Pickle Amendment* (updated and published annually in the Clearinghouse Review).

**Section 1619(b): Continued Medicaid for Persons Who Lose SSI Due to Wages:** This special work incentive is fully discussed in Chapter XX. It provides Medicaid for individuals who lose SSI benefits when earnings are too high. Under 1619(b), automatic Medicaid continues if the person would continue to be eligible for SSI if the wages were ignored and if annual income is less than a specified income threshold. In section 209(b) states, Medicaid continues, pursuant to the 1619(b) criteria, if the individual was eligible for Medicaid in the month prior to losing SSI and the other 1619(b) criteria is met.

The income threshold changes every calendar year and will be different in each state, based on the state’s unique SSI rate and Medicaid expenditures. These thresholds range from $15,000 to $39,000 per year. A higher, “individualized threshold” can be established if medical or other expenses are high enough.

**The Medically Needy Program, as Available to Persons with Disabilities, is an Option Exercised by Two-Thirds of the States:** Medically needy individuals are those who would qualify for Medicaid, including individuals who are disabled, but have income or resources above limits set by their state. Since Medicaid agencies often do not explain the spend down (or “share of cost”) program to applicants or recipients, you should find out if your state offers this option and take steps to educate yourself and your clients/consumers on how it works.

**How the Spend Down Works:** Each state sets its medically needy income levels based on family size. For example, New York set its 2002 level at $634 per month for a household of one. All individuals meeting the federal (i.e., SSI) definition of disability, who have income and resources below the medically needy level, automatically qualify for Medicaid. A state must establish a
uniform set of income and resource rules for determining income for the medically needy. The state’s methodology employed in determining income and resource eligibility “shall be no more restrictive than the methodology which would be employed under the [SSI] program in the case of ... blind, or disabled individuals ....”

Individuals with income above the medically needy level do not automatically qualify for Medicaid. They must first meet a “spend down” or “share of cost” test. The spend down is the amount by which income exceeds the medically needy level after subtracting allowable deductions.

For example, in New York, a single adult with a disability receives a monthly SSDI check of $754, which exceeds the state’s 2002 medically needy level of $634. The Medicaid agency will disregard the first $20 as an unearned income exclusion and the individual will face a $100 spend down (i.e., countable income exceeds the medically needy level by $100). The spend down acts like a deductible or insurance premium that must be paid or incurred before coverage begins.

Nearly any medical expense that is paid or incurred can be used to meet a spend down requirement, even if it is for goods or services not covered by your state plan. The following is a list of typical expenses that may be used: health insurance premiums and co-payments; doctor bills; mental health bills (including a psychiatrist’s services and mental health counseling services); dental bills; home health care; prescriptions drugs; eyeglasses and optometry bills; and over-the-counter drugs or purchases related to health care.

These provisions allow states, with approval of the federal Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, to waive (or not follow) specific requirements of the Medicaid Act. These are often referred to as “section 1915(c) waivers.” All states participate in these optional waivers to varying degrees.

Waiver of “Statewidedness:” Ordinarily, the state’s Medicaid plan must offer comparable coverage in all regions of a state. It would be illegal, under regular Medicaid rules, to offer a Medicaid-funded service to some individuals that is not offered to Medicaid recipients statewide. A waiver can be approved to offer a level of Medicaid coverage in one or more sections of the state, or to a limited number of recipients, that is not available to all recipients statewide.

Waiver of Comparability: Ordinarily, the state’s Medicaid plan must treat all similarly situated recipients equally. It would be illegal, under regular Medicaid rules, to offer a Medicaid-funded service to one individual with a disability and not offer it to others with a different disability. A waiver could select a targeted group of recipients (such as persons with traumatic brain injury or persons with AIDS) and offer them a scope of services not available to persons who have different disabilities but similar needs.
Waiver of Certain Income and Resource Rules: A waiver can be implemented which exempts certain populations from the general income and resource requirements. For example, the Katie Becket waiver allows a Medicaid program to disregard parental income and resources for certain children.

These waiver programs are structured to provide an alternative to institutional care and often provide greater access to a range of services and equipment (often referred to as durable medical equipment or assistive technology) than available under other covered services within the state plan. A number of other services may be available under your state’s unique waiver program or programs, such as case management, job coaching, homemaker services, home health aide services, adult day health, habilitation, respite, home modifications, partial hospitalization and psycho-social rehabilitation for persons with psychiatric diagnoses. Some of these are optional services that a state may not cover in its regular state plan. Others are services that are not otherwise available as either required or optional services.

This optional program, created by the Balanced Budget Act amendments of 1997, is designed to provide health insurance to working people with disabilities who, because of relatively high earnings, cannot qualify for Medicaid under another provision. These provisions were specifically targeted to those SSDI recipients who, because they were not also eligible for SSI, could not qualify for Medicaid under the 1619(b) provisions. Subject to federal criteria, a state can structure the buy-in as it sees fit.

The original 1997 buy-in included several key eligibility components:

- Individuals are not required to have been on SSI.
- Eligibility was set at net income of less than 250 percent of the federal poverty level, with all SSI exclusions applied. For a household of one, this meant a state could provide Medicaid to an individual who has $40,000 or more in annual wages.
- Except for their earnings, the person with a disability would be eligible for SSI.
- Substantial gainful activity (i.e., earnings in excess of $800 monthly in 2003, and adjusted in later years) is not an eligibility consideration. A person could be eligible for the buy-in despite earning in excess of the substantial gainful activity amount.
- States could increase the Medicaid resource limits to as high as $14,000.
- States could charge premiums or other cost-sharing charges.
Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 included several key provisions to make the Buy-in program more attractive:

- It allows states to offer a buy-in to persons with earnings up to 450 percent of the poverty level. For a household of one, this means a state could provide Medicaid to an individual who has $70,000 or more in annual wages.

- States are now allowed to set income limits and require cost sharing and premiums, based on income, on a sliding scale. A state could require some individuals to pay the full premium as long as the premiums do not exceed 7.5 percent of the individual’s total income.

- States must require a 100 percent premium payment for individuals with adjusted gross incomes greater than $75,000 unless states choose to subsidize the premium using their own funds.

At the time this document was written, more than 26 states had adopted and were implementing buy-in programs, with many additional states at various stages of pre-implementation (including several that had been adopted and were awaiting federal approval, and several pending in state legislatures). You should check the status of the buy-in program in your state as it may offer the only means of accessing continuing Medicaid for those SSDI recipients who are unable to access continuing Medicaid through the 1619(b) program.

Under federal Medicaid law, a Medicaid applicant or recipient is entitled to an administrative hearing any time a decision is made which affects his or her right to Medicaid or to any service for which Medicaid funding is sought. This is known as a “fair hearing” and will be available in all states.

A person whose Medicaid benefits or right to services funded by Medicaid are either denied or terminated is entitled to a written notice of that decision. The notice must explain: the action that is being taken, the reason for the action, the right to a hearing to appeal the decision, and the availability of free services from a Legal Services, Legal Aid or similar program (such as a Protection and Advocacy program). States are permitted to establish their own time limits for requesting hearings. Typically, the Medicaid recipient will be permitted a time limit (30 - 60 days) for requesting the hearing. However, if the notice indicates that an ongoing benefit, such as funding for home health care services, is to be terminated on a certain date, the recipient will need to request the hearing before the termination date if continued services are going to be requested pending the appeal. Federal Medicaid law provides that benefits are to be continued pending the appeal (a concept often referred to as “aid continuing”) if the hearing is requested before the effective termination date and the recipient (or advocate working on his or her behalf) specifically requests the continuation of benefits.
In an effort to improve outreach to children who may be eligible but who have not yet enrolled in the program, the Agricultural Risk Protection Act of 2000 “established a critical link between the National School Lunch Program, Medicaid and [SCHIP].” States may now share information with SCHIP and Medicaid “agencies about families who participate in the school lunch program in an effort to help identify eligible children.” Almost every state has taken advantage of this opportunity to “enlist the support of schools in its outreach and enrollment strategies.” Sign Them Up: A Quarterly Newsletter about the Children’s Health Insurance Program (CHIP), p. 5 (Fall 2001, Children’s Defense Fund).

SCHIP Eligibility Criteria

As noted above, states are given a wide degree of latitude in establishing eligibility criteria, including ages, geographic areas, income and resource rules, and duration of eligibility. Again, however, there are certain mandatory guidelines. Generally, coverage must be limited to children who are under 19 years of age, who are not eligible for Medicaid or other health insurance, and whose family income is below 200 percent of the federal poverty level for their size of family (which is up to $34,100 per year for a family of four). See www.insurekidsnow.gov/questions.htm. However, children enrolled in a state-created insurance program, which was in place prior to July 1, 1997, and did not utilize any federal funds, will still be eligible for SCHIP. Effective November 1, 2002, the definition of child has been amended to include “the period from conception to birth.” This will allow a state, if it chooses, to cover prenatal care and delivery.

If a state has raised its Medicaid eligibility level above 150 percent of the poverty level before June 1, 1997, the state may raise the eligibility standards for SCHIP to 50 percent above the current Medicaid income level. However, the State cannot lower its Medicaid income and resource limits in an effort to make children ineligible for Medicaid and thereby eligible for SCHIP.

Any financial eligibility criteria must not operate to cover children in families with higher incomes without covering children in families with lower incomes. Nor can the eligibility criteria deny coverage to children with pre-existing medical conditions. Finally, children who are inmates in a public institution or who are patients in an institution for “mental diseases” are not eligible for coverage.

On July 1, 2000, HCFA (now CMS) announced criteria for special demonstration projects under SCHIP. States that have had at least one year of experience implementing SCHIP and have submitted all of their required reports are eligible. In addition, the state will have “to provide assurances that it has met the primary purpose of SCHIP by expanding eligibility to low-income children” and “demonstrate that it is successfully reaching and enrolling eligible children.” In such cases, one of the possible demonstration projects can be to extend coverage “to low-income parents of the children they are enrolling in Medicaid and SCHIP.”
As noted above, states may choose to deliver services in one of three basic ways. They may simply choose to extend basic Medicaid coverage to those children determined to be eligible for SCHIP. In those cases, the state must apply, to SCHIP-eligible children, the full range of Medicaid services available to all other Medicaid eligible children in the state. This would include all the services available under Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program mandates that states provide all medically necessary mandatory and optional Medicaid services. See English, Abigail and Madlyn Morreale, *The New Children’s Health Insurance Program: Major Provisions and Early Lessons*, ABA Center on Children and the Law, www.abanet.org/child/chipfinal.html.

If a state chooses to create its own separate SCHIP program, it has a large degree of flexibility in choosing the scope of services to cover. There are four basic options available to states: benchmark coverage, benchmark-equivalent coverage, the preexisting state-based program in New York, Florida or Pennsylvania, or any other coverage package which is approved by CMS (formerly HCFA) as “appropriate.” Benchmark coverage must be equivalent to the coverage available to federal employees, state employees, or members of the largest commercial, non-Medicaid health maintenance organization in the state.

Benchmark-equivalent coverage must be the “actuarial equivalent” of one of the benchmark packages. They must include, at a minimum, the following categories of services:

- Inpatient and outpatient hospital services
- Physicians’ surgical and medical services
- Laboratory and x-ray services
- Well-baby and well-child care, including age-appropriate immunizations

The state must also include the following optional services, if the benchmark package used by the state to determine “actuarial equivalence” includes them:

- Coverage of prescription drugs
- Mental health services
- Vision services
- Hearing services

States are free to provide coverage for benefits that are not listed in either of these categories. In fact, the scope of permissive services is extremely comprehensive. Covered services may include the following:
Chapter 18

Benefits Planning, Assistance and Outreach

Cost Sharing

a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by state law,
b. performed under the general supervision or at the direction of a physician, or
c. furnished by a health care facility that is operated by a state or local government or is licensed under state law and operating within the scope of the license.

- Premiums for private health care insurance coverage
- Medical transportation
- Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals
- Any other health care services or items specified by the Secretary of HHS and not otherwise excluded

States are permitted to impose cost sharing charges, including premiums, deductibles and coinsurance, but the schedule for any of these charges must be made public. Any cost-sharing income received by the state will reduce the state’s appropriation under the program. Furthermore, any cost-sharing requirements must not favor children of higher income families over lower income families. No cost-sharing may be imposed for the preventive services of well-baby and well-child care, and age-appropriate immunizations. Finally, if the state is operating a Medicaid expansion program, the Medicaid rules for any cost sharing will apply.

There are additional limitations on the use of cost sharing based on the income of the family. For families above 150 percent of the federal poverty level, cost-sharing requirements may be imposed on a sliding scale, based on income, but the total amount of cost sharing cannot exceed five percent of the family’s income per year. For families below 150 percent of the federal poverty level, cost-sharing charges are limited to the Medicaid levels for non-categorically eligible individuals. Under applicable Medicaid requirements, the maximum permissible enrollment fees or premiums must be based on income and will vary from $1 to $19 per month. Additionally, the maximum permissible deductible is $2 per month. See English, Abigail and Madlyn Morreale, *The New Children’s Health Insurance Program: Major Provisions and Early Lessons, ABA Center on Children and the Law*, www.abanet.org/child/chipfinal.html.

Conclusion

Although states are given a broad degree of discretion in implementing SCHIP, its basic purpose and scope of coverage make it an important program to extend health insurance coverage to low-income children who are not otherwise eligible for Medicaid. For those parents with disabilities contemplating a return to work, the SCHIP in your state may ensure that health insurance will be available to those children.