Medicaid Reform Module: Eligible Populations

Author	Page	Summary
Flexibility		
National Governor's Association	6	Increase flexibility to tailor benefits to beneficiary health care needs. This flexibility includes the ability to choose to provide the set Medicaid benefit package or to provide a tailored benefit package with four options for coverage: 1. Benchmark coverage: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state. 2. Benchmark equivalent coverage: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, include age-appropriate immunizations.
National Governor's Association	6	3. Existing state-based comprehensive coverage: In the states where existing state-based comprehensive coverage exists (e.g. state-only funded programs; or waiver populations), the existing health benefits package is deemed to be meeting the coverage requirements. 4. Secretary approved coverage: This may include coverage that is the same as the state's Medicaid program; coverage provided in a Medicaid demonstration project approved by the Secretary; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison. SCHIP benefits flexibility is not being proposed for certain categories.
National Academy for State Health Policy	13	The NASHP workgroup recommended that states should have full flexibility to expand Medicaid eligibility to income levels above the eligibility floor.
US Department of Health & Human Services 2003	6-7	States electing a "State Health Care Partnership Allotment" would have to continue providing current mandatory services for mandatory populations. For optional populations and optional services, the increased flexibility of these allotments will allow each State to innovatively tailor its provision of health benefit packages for its low-income residents. For example, States could provide premium assistance to help families buy employer-based insurance.

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US Department of Health & Human Services 2003	8	The FY 2003 President's Budget proposed to give States the option to extend Medicaid coverage for spouses of disabled individuals who return to work and are themselves eligible for supplemental security benefits. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse's Medicaid eligibility. This proposal would extend to the spouse the same Medicaid
Health Management Associates March 2002	21	To improve coordination, continuity of coverage and to simplify the relationship between Medicaid and the State Children's Health Insurance Program (SCHIP), change federal SCHIP law to allow the parents of children who apply for SCHIP and are found eligible for Medicaid to choose enrollment in SCHIP.
Simplifying Eligibility		
Roundtable on Indian Health (Urban Institute)	10	Reform should simplify and improve American Indian/Alaskan Native outreach, eligibility and enrollment (allow for self-declaration).
National Conference of State Legislatures 2005	4	There should be greater flexibility with the eligibility process based solely on income.
Health Affairs, Change in Challenging Times	W5-122	Simplify and extend Medicaid coverage to everyone below a certain poverty level (e.g. 100 or 150 % FPL).
Health Management Associates February 2006	15	Allow states to eliminate categorical eligibility and base eligibility simply on income.
National Conference of State Legislatures 2004	2	States should be allowed to give families and individuals eligibility for the program based on their low-income status even if they do not otherwise fit the categorical eligibility. This will make the program a more explicit program for low-income people and greatly simplify the eligibility process. This reform coupled with work requirements and enhanced deductibles and copayments would reinforce the provisions of welfare reform. States should have the flexibility to use restricted TANF funds to finance any additional state costs incurred by this provision.
Health Management Associates March 2002	19	Allow states the option to define eligibility for Medicaid, based only on state-defined income levels, without regard to arbitrary eligibility categories.
Promoting other Forms of Coverage		
Center for Health Transformation	7	Integrate the healthy poor into private health insurance.
Health Management Associates February 2005	17	Allow states to test innovative approaches within Medicaid that incorporate health savings accounts or tax credits as strategies to increase coverage for the uninsured.
Expanding Enrollment		
National Conference of State Legislatures 2005	1	Promote private initiatives to expand access to health care and ancillary services to support people with challenging health care needs.

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National Conference of State Legislatures 2005	2	Medicaid benefits in the territories should be similar to those in states.
National Academy for State Health Policy	14	Establish a national minimum Medicaid eligibility threshold that would require states to cover all individuals with household incomes up to 100 percent of the FPL, as well as continuing the current requirements to cover children under age six and pregnant women up to 133 percent of the FPL or higher. The workgroup further recommended that these new requirements be phased in over four years and that the Federal government offer an enhanced match for new eligibles.
National Academy for State Health Policy	52	The workgroup recommended that legal immigrants should be eligible for Medicaid on the same terms as U.S. citizens regardless of their date of entry into the country or length of residence.
Capping Enrollment		
United Hospital Fund	4	Repeal the entitlement of services to beneficiaries.
Cato Institute	2	Discourage program expansions by freezing payments at the 2005 level.
Other		
Partnership for Medicaid	1	The Partnership believes that individual and provider protections, including a private right of action to enforce those protections, should be maintained, and access to culturally appropriate care should be promoted. They also advocate that reform efforts should not eliminate current federal coverage guarantees, nor should they result in reducing or eliminating coverage for currently eligible individuals.
National Association of Public Hospitals and Health Systems	1	NAPHHS promotes ensuring the availability of comprehensive benefits to covered individuals. States currently provide essential health benefits to both mandatory and optional populations through their Medicaid programs. They advocate that Medicaid reform efforts should not result in reducing or eliminating the entitlement of our most vulnerable populations to coverage.
National Conference of State Legislatures 2004	2	States should be allowed to set minimum work requirements for program recipients with incomes above the minimum federal requirements for eligibility, as a condition of participating in the program, for those able to work.
US Department of Health & Human Services 2003	9	Under current law, Medicaid programs pay Medicare Part B Premiums for qualifying individuals (QI-1s), who are defined as Medicare beneficiaries with incomes of 120% to 135% of poverty and minimal assets. The Budget would continue this premium assistance for five years.

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US Department of Health & Human Services 2003	9	Transitional Medicaid Assistance (TMA) provides health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare related Medicaid eligibility due to earnings from work. The Administration proposed modifications to TMA provisions to simplify it and make it work better with private insurance. These provisions include: States would be given the option to offer 12 months of continuous care to eligible participants; States could waive income-reporting requirements for beneficiaries; States that have Medicaid eligibility for children and families with incomes up to 185 percent of poverty could waive their TMA program requirements; States would have the option of offering TMA recipients "Health Coupons" to purchase private health insurance instead of offering traditional Medicaid benefits.
Health Management Associates March 2002	22	To improve the availability of needed medical, hearing, vision and dental coverage for low-income children who qualify for SCHIP, remove the prohibition on SCHIP enrollment for children who are covered by employer sponsored health coverage that is not as comprehensive as SCHIP, and allow SCHIP to "wrap-around" the employer-sponsored coverage, just as Medicaid does.