

# Improving Latina Health through Medicaid Advocacy: A Toolkit



## **Improving Latina Health Through Medicaid Advocacy: A Toolkit**

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# **Medicaid Access:**

*A Critical Source of Health Care  
for Low-Income Latinas*

*Judy Waxman, Vice President  
National Women's Law Center*

# Women & Health Coverage

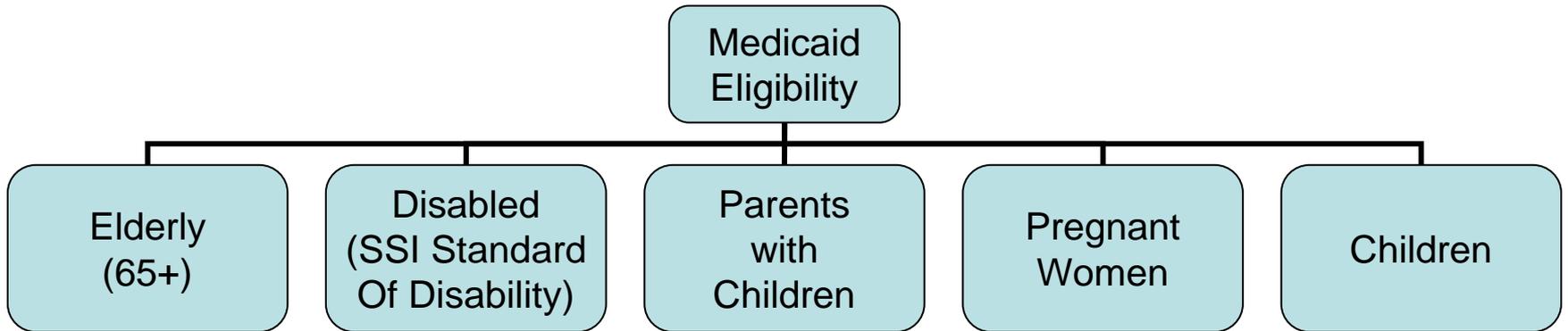
<b>Type of Health Coverage</b>	<b>All Women age 19-65</b>	<b>Latinas age 19-65</b>
Employer-Sponsored	63%	NA
Individual Coverage	6%	NA
Medicaid	9%	14%*
Uninsured	19%	38%
Other	3%	NA

\*Nearly one quarter of all women in Medicaid are Latinas.

# What is Medicaid?

- **The nation's major public health insurance program for low-income Americans**
- **Run jointly by the federal and state government**
- **An entitlement program that provides health and long-term care coverage for close to 53 million low-income people, of which 10 million are Latinos**

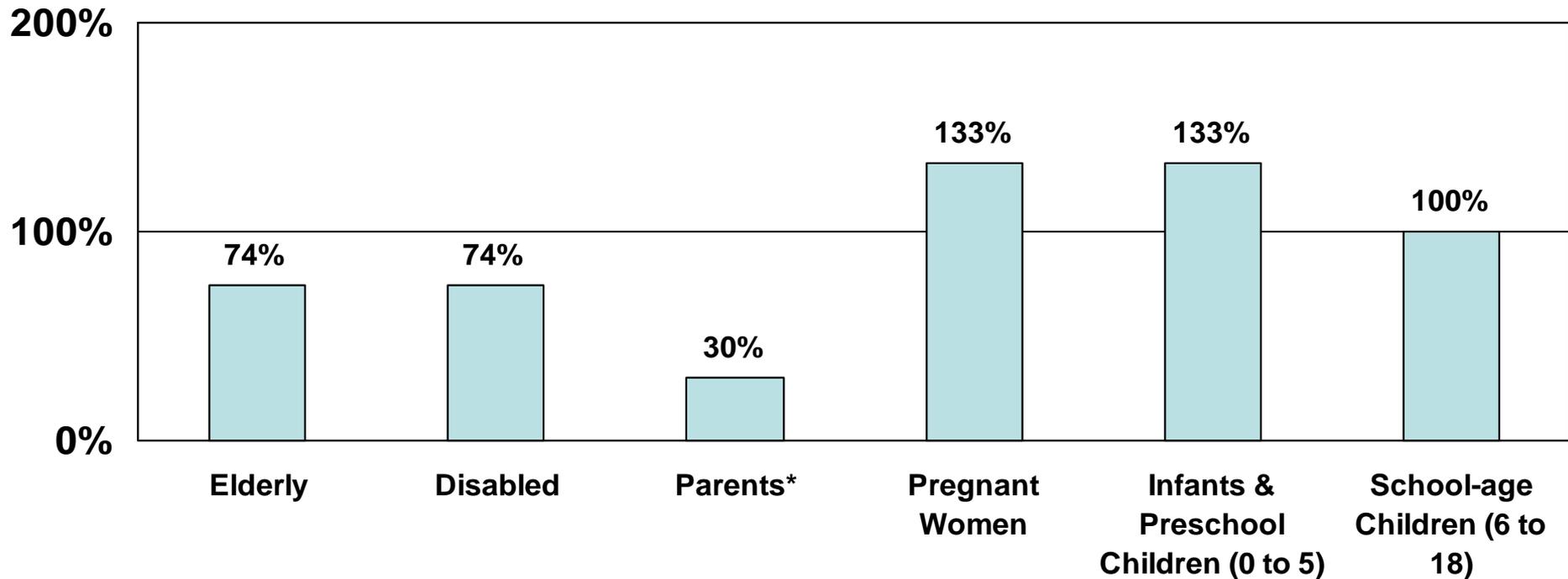
# Who Qualifies?



Individuals in each group must meet financial and other non-financial criteria.

# Medicaid Mandatory Income Eligibility, 2007

Percent of Federal Poverty Level



The Federal Poverty Level is \$17,170 for a family of three for 2007.

\* AFDC median for 1996, which is the minimum standard now used for mandatory eligibility. 30% of the Federal Poverty Level is \$326/month.

# Immigration Status Eligibility

- Citizens
- “Qualified Alien” after 5 years
  - Half of the states cover some “qualified aliens” in the first 5 years
- Documentation is required for all

# Benefits

- Comprehensive services, but...
- Low cost sharing, but...
- Over 40% of all births
- The largest source of public funding for family planning services

## **MEDICAID 101: The Federal-State Health Care Partnership**

### **What is Medicaid?**

*Medicaid is the largest source of health care funding for the poor in the U.S., serving one in six Americans or close to 53 million people,<sup>1</sup> including more than 10 million Latinos.<sup>2</sup> Twenty-five percent of Latinos are Medicaid beneficiaries, the largest minority group served by the program.<sup>3</sup>* Medicaid guarantees eligible individuals coverage for primary, acute and long-term care services. The program is run jointly by the federal and state governments, with each state administering its own Medicaid program under federal guidelines, and the federal government contributing more than half of the program's costs.<sup>4</sup>

Medicaid is an entitlement program, which means that *anyone who meets the stringent eligibility requirements can enroll in the program* and there is no limit on the number of people allowed into the program.

There are five main categories of eligible people: (1) Children, (2) Parents, (3) Pregnant Women, (4) People with Disabilities, and (5) the Elderly. Beyond these categories, eligibility is determined based on financial considerations, with a federally defined income threshold for each group and a limit on assets,<sup>5</sup> and immigration status requirements, limiting coverage to documented immigrants who are legally residing in the U.S., depending on the date of their arrival.<sup>6</sup> States may seek approval through an application to the federal government called a "waiver" if they want to alter their program in any way that would not meet federal Medicaid requirements.

### **What is Covered by Medicaid?**

Since its early years, the Medicaid program has guaranteed its beneficiaries access to key health services, including physician services, laboratory and x-ray services, inpatient and outpatient hospital care, nursing home care and family planning supplies and services.<sup>7</sup> Many states have opted to go beyond federal requirements and provide coverage of "optional" services, such as coverage for prescription drugs.<sup>8</sup> Unfortunately, the recently passed budget law called the Deficit Reduction Act (DRA) allows states to replace even the traditional Medicaid package with reduced benefit packages for certain groups.<sup>9</sup>

### **Who Pays for Medicaid?**

Medicaid was created in 1965 to serve as the primary health care program for the poor. A partnership was created between the state and federal governments to allow both to share the financial burden of the program and to provide health care to the most vulnerable Americans. *Because the federal government commits to paying at least half the cost of Medicaid, the*

*program has a fiscal incentive for states to extend health care coverage to their low-income residents.*

Costs for the program are divided between the federal and state governments based on a matching rate, called the federal medical assistance percentage or “*FMAP*.” The FMAP is calculated based on a formula that uses each state’s per capita income to account for varying degrees of poverty among the states.<sup>10</sup> Wealthier states, which have higher per capita incomes, receive less federal support than poorer states. Currently, FMAPs range from a minimum of 50% in states like California and New York to a maximum of 76% in Mississippi.<sup>11</sup>

States generally may charge a co-payment or insurance premium, known as *cost-sharing*, to beneficiaries for the care they receive, including prescription medication. However, traditionally, some groups and services were exempt from cost-sharing in order to ensure their use of needed health care.<sup>12</sup> Unfortunately, the DRA now allows states to impose new or higher cost sharing on most Medicaid beneficiaries. States may not require cost-sharing for services for mandatory children and pregnant women. Very significantly, the DRA grants providers the right to *deny* services or drugs if a beneficiary cannot pay the cost-sharing amount at the point of service. This individual then not only faces a loss of care for a particular health need, but also faces the loss of his/her health insurance all together.

### **Medicaid Covers More People (and Costs More) When the Economy Is Weak**

Medicaid is *counter-cyclical*, meaning that it expands to cover more people when weak economic times lead more individuals to become eligible for the program.<sup>13</sup> Therefore, as the need grows and more enter the program, federal financial support also grows. The fact that Medicaid is an entitlement program has ensured the program’s ability to cover more uninsured, low-income people when the economy suffers a downturn.<sup>14</sup> *If the federal government were to provide funding for Medicaid only through limited amounts of money rather than providing matching funds for all state expenditures as it does through the FMAP, states would come up short during hard times, and they would not be able to meet the growing demands during an economic slump.*<sup>15</sup>

### **Ways to Expand Medicaid Coverage**

States can expand Medicaid coverage in various ways. One way is to raise the income at which people are eligible.<sup>16</sup> States must cover eligible populations (known as mandatory populations) up to a certain percentage of the federal poverty level. But states can go beyond this level and cover individuals at higher incomes. Currently, all states go above some federal minimums to cover portions of these so-called “optional” populations. Another way to expand coverage is to streamline the enrollment process by eliminating the asset test. Even when their income meets eligibility criteria, many individuals do not enroll because they encounter barriers to enrollment. One such barrier is the asset test, which counts parents’ ownership of certain assets when determining the family’s eligibility for Medicaid. Removing this test eases the application process, streamlines and reduces administrative costs and increases the pool of eligible individuals. In 2004, 21 states had eliminated the asset test for parents.

States may also allow working individuals with disabilities the option of *buying into Medicaid*. Under this option, working individuals with disabilities, who because of their earnings cannot

qualify for Medicaid, can pay a monthly premium in an amount equal to the difference between their income and the maximum income eligibility level set by their state.<sup>17</sup> In total, 31 states allow certain populations to utilize the buy-in option to receive benefits.<sup>18</sup>

States also may seek permission through *a waiver* to use federal Medicaid funds to cover more categories of people than those required by federal law.<sup>19</sup> Waivers were designed to let states try “research and demonstration” to institute projects that “further the objectives of the [Medicaid] program.”<sup>20</sup> Unfortunately, in an attempt to contain costs, many states are now using these waivers to limit Medicaid enrollment and benefits while increasing the cost to recipients rather than using the waivers to expand coverage.

### **Cutting Medicaid Severs the Federal-State Partnership and Hurts Beneficiaries**

Recent efforts to cut federal funding to Medicaid could have dire consequences for the program’s beneficiaries, the majority of whom are women. An inadequate federal commitment exposes these women and their families to inevitable cuts in coverage or a reduction in benefits at the state level. As health care costs continue to rise and access to employer-sponsored insurance decreases, the federal government must continue to carry its fair share of the Medicaid financing burden and stay true to its historical commitment to this health insurance safety net.

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<sup>1</sup> IssuesPA, *Medicaid 101 – An Overview of a Federal-State Partnership*. at <http://www.issuespa.net/articles/10933/> (accessed June, 2005).

<sup>2</sup> Center for Medicare and Medicaid Services, National MSIS data, Table 07, Medicaid Eligibles by Race/Ethnicity January 26, 2006.

<sup>3</sup> The Henry J. Kaiser Family Foundation, *Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity*, states (2004-2005), U.S. (2005) [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Minority+Health&link\\_category=Health+Coverage+%26+Uninsured&link\\_subcategory=Nonelderly+With+Medicaid&link\\_topic=Distribution+by+Race%2fEthnicity](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Minority+Health&link_category=Health+Coverage+%26+Uninsured&link_subcategory=Nonelderly+With+Medicaid&link_topic=Distribution+by+Race%2fEthnicity) (accessed May 29, 2007).

<sup>4</sup> National Health Policy Forum, *The Basics: Medicaid Financing*. The George Washington University, September 14, 2004. at [http://www.nhpf.org/pdfs\\_basics/Basics\\_MedicaidFinancing.pdf](http://www.nhpf.org/pdfs_basics/Basics_MedicaidFinancing.pdf)

<sup>5</sup> Almanac of Policy Issues, *Medicaid: A Program Overview*. U.S. Department of Health and Human Services, Health Care Financing Administration – *A Profile of Medicaid: 2000 Chartbook*, Section 1, September 2000.

<sup>6</sup> The 1996 welfare law created two categories of legal immigrants for Medicaid eligibility purposes: those who arrived before 1996 are eligible for Medicaid and those who arrived after 1996 but have not yet resided in the U.S. for five years are ineligible. Undocumented immigrants are also ineligible. The Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*, 7 (July 2002).

<sup>7</sup> For a comprehensive list of all mandatory services, refer to Centers for Medicare & Medicaid Services, *Medicaid – A Brief Summary*, <http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp> (accessed August 29, 2005).

<sup>8</sup> “In addition to the mandated benefits packages, states may provide additional “optional” services. All fifty states do.” Anna Sommers, Ph.D., Arunabh Gosh, B.A., The Urban Institute and David Rousseau, M.P.H., The Kaiser Commission on Medicaid and the Uninsured. *Medicaid Enrollment and Spending by “Mandatory” and “Optional” Eligibility and Benefits Categories*. June 2005.

<sup>9</sup> For more information about what services could be lost under the DRA, please see *Medicaid Cuts: Benefits May Be Reduced for Women Under the DRA* at [http://www.nwlc.org/pdf/FSMedicaidandtheDRA\\_04.21.06.pdf](http://www.nwlc.org/pdf/FSMedicaidandtheDRA_04.21.06.pdf)

<sup>10</sup> Glossary of Home Health Care and Health Care Terms, “FMAP is a percentage of Federal matching dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capital income.” at [http://www.healthcarewebdesign.com/glossary\\_healthcare\\_homecare\\_terms/glossaryF.php](http://www.healthcarewebdesign.com/glossary_healthcare_homecare_terms/glossaryF.php) (accessed July 2005)

<sup>11</sup> *Federal Financial Participation in State Assistance Expenditures*, FY 2006 Federal Register: November 24, 2004 (Volume 69, Number 226).

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<sup>12</sup> For more information on the effects of cost-sharing on low-income populations, please see *Increased Cost-Sharing in Medicaid Hurts Women and their Families* at <http://www.nwlc.org/pdf/6-2005MedicaidCost-Sharing.pdf>.

<sup>13</sup> Leighton Ku, *CDC Data Show Medicaid and SCHIP Played A Critical Counter-Cyclical Role In Strengthening Health Insurance Coverage During Economic Downturn*. The Center on Budget and Policy Priorities, Revised October 8, 2003.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> 42 U.S.C. §§ 1396-1396v; 42 C.F.R. Ch. IV; 45 C.F.R. Subtitle A.

<sup>17</sup> *Medicaid Eligibility*, Centers for Medicare & Medicaid Services. at <http://www.cms.hhs.gov/eligibility/criteria.asp> (accessed June 2005)

<sup>18</sup> Allen Jensen, *Variables Impacting Participation in a State's Medicaid Buy-In Program: Medicaid Eligibility "Starting Points" and Restrictions in Medicaid Buy-In Program*. Draft, September 4, 2003. at [http://www.uiowa.edu/~lhpdc/work/III\\_Framework/2003\\_TablesA\\_B\\_StartPoints.doc](http://www.uiowa.edu/~lhpdc/work/III_Framework/2003_TablesA_B_StartPoints.doc)

<sup>19</sup> *Medicaid Section 1115 Waivers: Current Issues*, Kaiser Commission on Medicaid and the Uninsured. Key Facts, January 2005.

<sup>20</sup> *Id.*

## **The Efficiency of Medicaid**

Many misconceptions exist with respect to the cost and efficiency of the Medicaid program. Those who favor a massive overhaul of the system often paint a picture that Medicaid costs are “spiraling out of control” and must be stopped. Upon closer inspection, while there are ways to improve the program, as a whole, Medicaid is currently more efficient than even the private market.<sup>1</sup>

### **Medicaid Saw Increased Costs in Early 2000**

The Medicaid program underwent a severe period of fiscal stress from 2001 to 2004. During this period, state revenues were decreasing and Medicaid spending and enrollment growth was increasing. *The increase in Medicaid enrollment in those years was due to weak economic times and a decrease in the availability of employer-sponsored insurance.* Medicaid enrollment for families (non-disabled adults and children) grew by 11.6 percent between 2000 and 2002 and by another 7.1 percent between 2002 and 2003.<sup>2</sup> These enrollment increases, which occurred during a recession and slow economic recovery, are evidence that Medicaid worked as intended. The economic downturn that began in early 2001, combined with a double-digit increase in inflation, made many more people eligible for Medicaid.<sup>3</sup> Structured as an entitlement program, Medicaid is designed to work as a safety net that expands during weak economic times.<sup>4</sup> When the economy is in recession and states are short on money, unemployment figures rise.<sup>5</sup> As a result, a greater number of people become eligible for Medicaid benefits.<sup>6</sup> Studies have shown that in 2002, if Medicaid had not responded to the weak economy by providing coverage to the unemployed, the number of uninsured would have been several millions higher.<sup>7</sup>

### **Medicaid Costs Today**

As states' fiscal budgets have rebounded, the Medicaid program costs have also slowed. In fact, total Medicaid spending increased in state fiscal year 2006 by only 2.8% on average, which is slowest rate of growth in Medicaid since 1996.<sup>8</sup> The fiscal year 2006 is also the first year since 1998 that state revenues grew at a faster rate than total Medicaid spending.<sup>9</sup> Given the improved

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<sup>1</sup> Medical Study News, *Study explains reason behind recent Medicaid spending growth.* at [http://www.news-medical.net/print\\_article.asp?id=7537](http://www.news-medical.net/print_article.asp?id=7537)

<sup>2</sup> Kaiser Commission on Medicaid and the Uninsured. *Medicaid Enrollment and Spending Trends.* June 2005

<sup>3</sup> *The Uninsured: A Primer. Key Facts About Americans Without Health Insurance.* The Kaiser Commission on Medicaid and the Uninsured, November 2004.

<sup>4</sup> Leighton Ku, *CDC Data Show Medicaid and SCHIP Played Critical Counter-Cyclical Role In Strengthening Health Insurance Coverage During The Economic Downturn.* Center on Budget and Policy Priorities, October 8, 2002.

<sup>5</sup> David Shactman and Michael Doonan, *Reimagining Medicaid: Policy Brief.* Council on Health Care Economics and Policy, November 2002.

<sup>6</sup> Id.

<sup>7</sup> Leighton Ku. *CDC Data Show Medicaid and SCHIP Played a Critical Counter-Cyclical Role in Strengthening Health Insurance Coverage During the Economic Downturn.* Center on Budget and Policy Priorities, October 8, 2003.

<sup>8</sup> Vernon Smith et al., *Low Medicaid Spending Growth Amid Rebounding State Revenues.* The Kaiser Commission on Medicaid and the Uninsured, October 2006.

<sup>9</sup> Ibid.

economic picture that states face today, it is not surprising that enrollment in Medicaid also slowed to 1.6%, as an improved economy resulted in fewer people becoming eligible for the program. Another major contributing factor to slowed spending growth is the passage of the Medicare Modernization Act which transitioned over 6 million low-income seniors and individuals with disabilities from Medicaid drug coverage to the newly created Medicare Part D plans in January 2006.

**Medicaid is a Cost Efficient Program**

Critics of Medicaid often focus on so-called “fraud, waste and abuse” in the program. However, one study showed that fraud and abuse in Medicaid only accounted for .007% of the Medicaid budget.<sup>10</sup> It is also overlooked that Medicaid is more efficient than private insurance with much lower administrative costs. Overall, Medicaid costs have risen at *nearly half the rate* of private insurance costs.<sup>11</sup>

**The Medicaid Program is Good for States’ Economies**

For every dollar invested in Medicaid, three dollars of business activity is generated in the form of local jobs and wages, in revenues for hospitals and other providers, as well as in support of community health facilities.<sup>12</sup> The fact that states are required to pay half of all Medicaid costs also creates a strong incentive to run the program efficiently and keep costs down. The following chart demonstrates how cuts would harm state economies.<sup>13</sup>

State	Economic Impact
Arkansas <sup>14</sup>	\$100 million in state Medicaid funding generated \$533 million in economic activity, created over 10,000 jobs for Arkansas and produced nearly \$306 million in income. For every \$1 dollar spent by the state government on Medicaid, \$4 dollars gets added to the gross state product.
Maryland <sup>15</sup>	For every \$1 million in Medicaid cuts, the state would lose \$2.27 in lost business activity and \$800,000 in lost wages. Every \$1 million cut would also result in 22 lost jobs.
North Carolina <sup>16</sup>	Due to Medicaid budget cuts, the state has lost 9,700 jobs and \$706,257,420 in revenue.

<sup>10</sup> John Reichard, “Baucus Mounts Spirited Defense of Current Medicaid Spending Levels,” *CQ Health Affairs*, January 19, 2005 (citing recent CMS report).

<sup>11</sup> John Holahan and Arunabh, “Understanding the Recent Growth in Medicaid Spending, 2000-2003,” *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

<sup>12</sup> Alliance for Health Reform, *Sourcebook for Journalists*, 2004, pg 63.

<sup>13</sup> The individual state information was compiled by the National Mental Health Association, in a report entitled *Measuring the Economic Impact of State Medicaid Programs*. Links for each individual state will be provided in the corresponding footnote information.

<sup>14</sup> Economic and Fiscal Impact of Additional \$100 Million in State Funding for Medicaid Programs, University of Arkansas, Arkansas Business & Communities, Dr. Miller, Wayne; Dr. Pickett, John, March 24, 2003;

[http://www.arcommunities.org/econ\\_dev/Economic/economicimpact/medicaid.asp](http://www.arcommunities.org/econ_dev/Economic/economicimpact/medicaid.asp)

<sup>15</sup> Medicaid: Good Medicine for MD’s Economy, Advocates for Children and Youth Fiscal Facts;

[http://www.acy.org/web\\_data/good\\_medicine.pdf](http://www.acy.org/web_data/good_medicine.pdf).

<sup>16</sup> The Economic impact of Proposed Reduction in Medicaid Spending in North Carolina; Institute for Public Health, School of Public Health, University of North Carolina, Kilpatrick, Kerry; Olnick, Joshua; Lugar, Michael; Koo, Jun; Office of economic Development; Kenan Institute of Private enterprise; April 11, 2002;

<http://www.healthlaw.org/pubs/2002/NC.econimpact.doc>

West Virginia <sup>17</sup>	A 10% cut in federal Medicaid match funds will result in a \$188.1 million in business volume, 3,268 jobs and \$66.7 in employee compensation
Wisconsin <sup>18</sup>	A 10% cut in Medicaid and Badger care funding will have an accompanying loss of \$240 million in wages, salaries and other types of income. After initial impact, additional losses would total 9,100 jobs and \$394 million in income.

### **Proposals Seeking to Limit Federal Funding to States Will Hurt Beneficiaries**

Many reform proposals involve capping federal funds to the Medicaid program. If federal contributions to the Medicaid program are capped, the state will be left to shoulder the burden of increasing costs. Given the trend in health care costs, when these costs increase, the state will have to make up any differences without federal assistance, which will be near impossible under current state budget conditions. This will force the state to scale back their program, which often mean eligibility and/or benefit reductions.

### **Expanding Not Cutting, Medicaid Resources Are the Answer**

Reducing spending on Medicaid is fiscally unsound and would increase the numbers of uninsured, which costs taxpayers more in the long-run. Instead of searching for ways to cut the program, reform measures should focus on ways to reach even more people and relieve the program's burden of long term health services and rising health care costs.

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<sup>17</sup> Economic Impact of Medicaid Federal Match – Match on the West Virginia Economy; Dr. Christiadi; Dr. Witt, Tom, Bureau of Business and Economic Research College of Business and Economics; West Virginia University; January, 2003; c.2002, West Virginia Research Corporation.

<sup>18</sup> Economic Impact of Reducing Medicaid and Badger Care Expenditures; Wisconsin Council on Children & Families, Voices for Wisconsin's children, Prof. Deller Steven PhD, Madison, UW, February 11, 2003; <http://www.wccf.org/pdf/economicimpact.pdf>

## Health Care for the Poor: Who Is Eligible for Medicaid

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>1</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. In addition, beneficiaries must meet certain immigration status requirements to qualify for Medicaid, even if they would otherwise qualify for services.

### Income Eligible Groups under Medicaid:

- (1) **Children** – A child up to age six becomes eligible by residing in a family of three with an income at or below \$1,903/month or 133% of the federal poverty level (FPL). A child between six and 19 qualifies if their family income is \$1,431/month or 100% of FPL. Most states opt to cover children with family incomes up to \$2,647/month or 185%.
- (2) **Parents** – A parent becomes eligible for Medicaid if he or she has a dependent child and falls at or below the income standard used by the state for its welfare program in July of 1996. These income levels vary greatly by state and are considerably lower than those of other eligible categories. The median required income eligibility level for parents is only 31% of FPL, or \$444 per month (for a family of three). A state does have the option of covering parents above these minimum requirements. The median optional income eligibility level for working parents is \$930 per month, or 65% of FPL.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$1,903/month (or 133% of FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum. States can opt to cover women whose income is higher, and most do.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$630/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).<sup>2</sup> Many states go beyond this level and cover people with disabilities at or below \$1,431, or 100% of FPL (for a family of three).
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. Income levels vary depending on how the individual qualifies, but at minimum, these standards mirror those of the SSI program. Many states have chosen to cover people at or below \$1,431 or 100% of FPL (for a family of three).

### Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>3</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC)

and do not have other health care coverage may qualify for the basic Medicaid benefits package.

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage for family planning services for individuals whose incomes are over the eligibility level for parent coverage. The population served by waivers varies by state. Some states cover all women and men who meet the income eligibility level. Other states only cover women post-partum for a specified number of years. Other states cover only women over 19 years old.<sup>4</sup>

### **Immigration Status Eligibility Under Medicaid:**<sup>5</sup>

- (1) **Citizens** – Citizens who meet the program’s income-based and other non-financial eligibility requirements are entitled to Medicaid coverage, even if they live with someone who is not eligible because of their immigration status.
- (2) **Lawfully Residing Immigrants Who Arrived Before 1996** – Legal immigrants who were residing in the U.S. prior to 1996 are eligible to receive Medicaid, even if they obtained their qualified alien status after that date, as long as they remained “continuously present” in the United States from their last date of entry before August 22, 1996 until they obtained qualified status.
- (3) **Legally Residing Immigrants Who Arrived After 1996** – Legal immigrants who entered the U.S. after 1996 are eligible for regular Medicaid only if they have resided in the U.S. for at least five years and maintain a “qualified status.”<sup>6</sup> In addition, certain qualified immigrants are exempt from this five year residency requirement.<sup>7</sup> Otherwise, legal immigrants who have not yet resided in the U.S. for five years are eligible for coverage for emergency Medicaid services only.
- (4) **Undocumented Immigrants**<sup>8</sup> – Undocumented immigrants are not eligible for Medicaid benefits, although they are eligible for Medicaid coverage for emergency medical care if they meet all other Medicaid requirements such as income and asset tests.

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<sup>1</sup> There are other components to Medicaid eligibility, including a residency requirement as well as limits on resources and assets.

<sup>2</sup> There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

<sup>3</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, *The Medicaid Resource Book*, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>4</sup> The Alan Guttmacher Institute, “Medicaid Family Planning Waivers,” *State Policies in Brief* (June 1, 2007).

<sup>5</sup> From the Centers for Medicare and Medicaid Services, FAQ, “Qualified Aliens Part I and Part II,” available at: [http://www.cms.hhs.gov/MedicaidEligibility/05a\\_Immigrants.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidEligibility/05a_Immigrants.asp#TopOfPage).

<sup>6</sup> Qualified aliens include: LPRs (“green card” holders), refugees, aliens granted asylum, aliens whose deportation is being withheld, Cuban and Haitian entrants, aliens granted parole for at least one year, certain battered aliens, and victims of a severe form of trafficking. For additional information, please see: Centers for Medicare and Medicaid

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Services, FAQ, “Qualified Aliens Part I and Part II,” available at:  
[http://www.cms.hhs.gov/MedicaidEligibility/05a\\_Immigrants.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidEligibility/05a_Immigrants.asp#TopOfPage).

<sup>7</sup> The following groups are exempt from the five year bar rule: Amerasians with LPR status, immigrants with LPR status who are honorably discharged veterans or on active duty or whose spouse or parent has LPR status and has been honorably discharged or is on active duty, refugees, asylees, Cuban/Haitian entrants, aliens whose deportation is being withheld, victims of a severe form of trafficking, and members of Federally-recognized Indian tribes as well as some American Indians born in Canada. Further, aliens who arrive in one of the above listed categories but later convert to LPR status remain exempt from the bar. For more information, please see Centers for Medicare and Medicaid Services, FAQ, “Qualified Aliens Part I and Part II,” available at:  
[http://www.cms.hhs.gov/MedicaidEligibility/05a\\_Immigrants.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidEligibility/05a_Immigrants.asp#TopOfPage).

<sup>8</sup> Note that some states may also choose to provide some form of state-only funded coverage for additional immigrant groups such as PRUCOLs (persons residing under color of law but who do not have LPR status), undocumented immigrants, immigrant children, and others, regardless of whether they meet the five year bar.

## **The Federal Poverty Level: What Is It and Why Does It Matter?**

The Federal Poverty Level (FPL) is meant to define the monetary level under which an individual or family is considered to be “living in poverty.” However, the FPL is too low to represent a realistic household budget and is thus not an appropriate indication of poverty. Nonetheless, the FPL is the primary determinant of who does and does not qualify for many government aid programs. For the Latino Community, 30% of whom have incomes below 100% of FPL,<sup>1</sup> this standard is especially troubling. Since many states use eligibility levels for adults in assistance programs that are far below even 100% of FPL, there will be many more Latinos in need of assistance who will not be able to receive it.

### **Poverty in the Latino Community**

Racial and ethnic minorities are more likely than non-Hispanic whites to have family incomes that are less than 200 percent of the federal poverty level (\$34,340 per year for a family of three in 2007).<sup>2</sup> The high rate of poverty for Latinos creates many hardships including lack of adequate housing, food insecurity, and lack of needed medical care. For instance, nearly one in three families with children headed by a Latino citizen experienced at least one of these three hardships, and nearly half of families with children headed by a Latino non-citizen experienced one or more.<sup>3</sup> Latinas are more likely to be poor than their non-Hispanic peers; 21.2% of all Latinas live in poverty, compared to 8.8 % of non-Hispanic white women.<sup>4</sup>

### **How is the Federal Poverty Level determined?**

The FPL was originally determined in 1963 by taking the cost of the Department of Agriculture’s “economy food plan” and multiplying it by three. According to information available at the time, one-third of a family’s post-tax income was spent on food with the remainder spent on other goods and services.<sup>5</sup>

Adjusted annually to reflect inflation, the FPL for 2007 is \$17,170 per year for a family of three with income including general earnings, unemployment compensation, worker’s compensation, income from Social Security payments, alimony or child support, financial assistance from outside sources, and many other things. (See chart below) If a family’s annual income falls below this number, they are considered to have income below the poverty level.<sup>6</sup>

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<sup>1</sup> The Henry J. Kaiser Family Foundation, *Poverty Rate by Race/Ethnicity, states (2004-2005), U.S. (2005)*, [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?previewid=1107&action=compare&category=Minority+Health&link\\_category=Demographics+and+the+Economy&link\\_subcategory=People+in+Poverty&link\\_topic=Poverty+Rate+by+Race%2fEthnicity](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?previewid=1107&action=compare&category=Minority+Health&link_category=Demographics+and+the+Economy&link_subcategory=People+in+Poverty&link_topic=Poverty+Rate+by+Race%2fEthnicity) (accessed May 31, 2007).

<sup>2</sup> Families USA, *Minority Health—Quick Facts about Disparities*, <http://www.familiesusa.org/issues/minority-health/facts/#Medicaid> (accessed June 12, 2007).

<sup>3</sup> Arloc Sherman, *African American and Latino Families Face High Rates of Hardship*, The Center on Budget and Policy Priorities, Nov. 21, 2006.

<sup>4</sup> National Women’s Law Center, “Fact Sheet: Racial and Ethnic Disparities among U.S. Women,” *Making the Grade on Women’s Health: A National and State-by-State Report Card*, 2004.

<sup>5</sup> Gordon M. Fisher, *The Development and History of the U.S. Poverty Thresholds – A Brief Overview*.

<sup>6</sup> United States Department of Health and Human Services, “The 2007 HHS Poverty Guidelines”

### **FPL: Not an Accurate Measure of Poverty**

Use of the FPL is often criticized for its failure to reflect a typical family in the modern world, as it has not changed since its inception more than four decades ago. Of critical importance is the outdated assumption that one-third of a family's income is spent on food. Recent estimates have determined food to account for closer to one-fifth of a family's budget.<sup>7</sup> However, even if food did account for one-third of a family's budget, the economy, or thrifty food plan (TFP) is described by the Department of Agriculture as being "designed for temporary or emergency use when funds are low."<sup>8</sup> Thus, paying such a small amount for food consumption is not considered sustainable for a significant amount of time.

In addition, the FPL calculation does not take into account such factors as child care because when it was created, policymakers assumed that families had one wage-earner and one person who stayed at home.<sup>9</sup> It also fails to address new changes in the standard of living as well as the fact that health care coverage and costs vary for different population groups.

Perhaps most crucially, the FPL does nothing to address the fact that the cost of living changes dramatically depending on where a family is located. High housing costs in large cities are especially burdensome for poor families. If adjustments were made to the poverty level based on variants in housing rental costs across geographic regions, the highest poverty rates would not be in Mississippi, New Mexico, and Arkansas as previously understood, but rather in Washington, D.C., followed by New York City and the entire state of California. This indicates that poverty programs such as Medicaid are inadvertently providing inequitable services to people facing significantly different costs of living.<sup>10</sup>

<b>2007 FPL Guidelines</b> (Valid In the 48 connected states and D.C.)		
<b>Number of Persons in Family or Household</b>	<b>100% FPL Income per Year</b>	<b>100% FPL Income per Month</b>
1	\$10,210	\$851
2	\$13,690	\$1,141
3	\$17,170	\$1,431
4	\$20,650	\$1,721
5	\$24,130	\$2,011
For each additional person, add	(about) + \$3,480	(about) + \$290

<sup>7</sup> International Union, United Automobile, Aerospace and Agricultural Implement Workers. uaw.org

<sup>8</sup> Fisher, Gordon M. "The Development and History of the U.S. Poverty Thresholds – A Brief Overview"

<sup>9</sup> Willis, Jessie. "How We Measure Poverty: A History and Brief Overview" Oregon Center for Public Policy. www.ocpp.org.

<sup>10</sup> Reed, Deborah. "Poverty in California: Moving Beyond the Federal Measure," *California Counts: Population Trends and Profiles*. Vol. 7, #4. May 2006.

## Poor Parents on Medicaid Targeted for Cuts

Medicaid is the largest source of health insurance for poor and low-income Americans and provides a safety net for those with the greatest need. Parents are among Medicaid's neediest population, and yet current Medicaid reform proposals seek to remove many of them from Medicaid's protections.

### Coverage for Low Income Parents is in Jeopardy

As states review their financial situations, some of the neediest beneficiaries, like parents, may face benefit reductions and increased cost-sharing. As a result, many parents, already on painfully tight budgets, may be unable to secure necessary health coverage.

### Medicaid is an Important Source of Health Insurance for Parents

Medicaid is often the only possible source of health insurance coverage for low-income parents, who are unlikely to have employer-based or other health insurance.<sup>1</sup> More than one-third of low-income parents, whose incomes were below 200% of the federal poverty level (FPL), lacked health insurance in 2005.<sup>2</sup> Without Medicaid, far more of these parents would be uninsured.

### Coverage for Parents Matters

Medicaid coverage has ensured that parents have access to many important health services, including acute care, hospital care, preventive screenings, pregnancy-related care, mental health services and family planning services.<sup>3</sup> Research shows that Medicaid coverage is essential not only to the health of parents but also to the health of their children, who are more likely to be enrolled in health insurance and get services if their parents are also enrolled.<sup>4</sup>

### Only the Lowest-Income Parents Qualify for Medicaid

To qualify for Medicaid, an individual must have a low enough income to meet the federally set "mandatory" income eligibility standard, or the higher "optional" level set by the state. While the numbers vary by state, the mandatory income level for parents is much lower than for other categories of eligible individuals, as can be seen in the chart at right.

Eligibility category	Mandatory Level of Coverage
Parents (family of 3)	12%-63% <sup>5</sup>
Aged and Disabled	74%
Pregnant Women	133%
Children	133%

Women are more likely to qualify as beneficiary parents under Medicaid than are men. This is because women tend to be poorer; they are more likely to meet the stringent income eligibility level for parents; and they are more likely to head single parent households.

States must provide Medicaid coverage to parents who meet the income, resource and family composition rules<sup>6</sup> that were in place on July 16, 1996 in their individual state welfare programs. All of these eligibility levels are well below the current FPL and range from \$164 to \$872 a month for a family of three. **The median required income eligibility level for parents is only 31% of FPL, or \$426 per month, and leaves two thirds of poor parents without health care assistance.**

### Even Expanded Coverage for Parents is Very Low in Most States

Prior to 1996, anyone receiving cash assistance through welfare automatically became eligible for Medicaid. However, welfare reform in 1996 required people to apply separately for welfare and Medicaid. States can cover more parents by expanding Medicaid coverage beyond the required income eligibility standard. Although all states currently provide coverage to parents above the lowest federal minimum standard, only **15 states** have raised their eligibility levels above the FPL. **The median income level for "optional" parents who are working is only 65% of FPL, or \$904 per month for a family of three.** (See Chart 1, over.)

**CHART 1: A Comparison of the Mandatory and Optional Income Eligibility Levels for Parents**

STATE	Mandatory minimum level <sup>7</sup> (1996 AFDC level in monthly \$ amount for a family of 3)	% of FPL (2006) <sup>8</sup>	Optional Medicaid level for Working Parents <sup>9</sup> (monthly \$ amount for a family of 3)	% of FPL (2006)
<b>US Median</b>	<b>\$426</b>	<b>31%</b>	<b>\$904</b>	<b>65%</b>
Alabama	\$164	12%	\$366	26%
Alaska*	\$1028	60%	\$1401	81%
Arizona	\$347	25%	\$2767	200%
Arkansas	\$204	15%	\$255	18%
California	\$730	53%	\$1473	107%
Colorado	\$421	30%	\$920	67%
Connecticut	\$872	63%	\$2166	157%
Delaware	\$338	24%	\$1473	107%
District of Columbia	\$420	30%	\$2867	207%
Florida	\$303	22%	\$806	58%
Georgia	\$424	31%	\$756	55%
Hawaii*	\$712	45%	\$1591	100%
Idaho	\$317	23%	\$595	43%
Illinois	\$377	27%	\$2649	192%
Indiana	\$288	21%	\$378	27%
Iowa	\$426	31%	\$1065	77%
Kansas	\$429	31%	\$493	36%
Kentucky	\$526	38%	\$909	66%
Louisiana	\$190	14%	\$280	20%
Maine	\$553	40%	\$2857	207%
Maryland	\$373	27%	\$524	38%
Massachusetts	\$565	41%	\$1840	133%
Michigan	\$459 <sup>10</sup>	33%	\$848	61%
Minnesota	\$532	38%	\$3806	275%
Mississippi	\$368	27%	\$458	33%
Missouri	\$292	21%	\$556	40%
Montana	\$541	39%	\$854	62%
Nebraska	\$364	26%	\$804	58%
Nevada	\$348	25%	\$1185	86%
New Hampshire	\$550	40%	\$781	56%
New Jersey	\$443	32%	\$1591	115%
New Mexico	\$389	28%	\$903	65%
New York	\$577 <sup>11</sup>	42%	\$2075	150%
North Carolina	\$544	39%	\$750	54%
North Dakota	\$431	31%	\$904	65%
Ohio	\$341	25%	\$1245	90%
Oklahoma	\$307	22%	\$591	43%
Oregon	\$460	33%	\$1383	100%
Pennsylvania	\$421	30%	\$842	61%
Rhode Island	\$554	40%	\$2649	192%
South Carolina	\$200	14%	\$1340	97%
South Dakota	\$507	37%	\$796	58%
Tennessee	\$583	42%	\$1113	80%
Texas	\$188	14%	\$402	29%
Utah <sup>12</sup>	\$568	41%	\$673	49%
Vermont	\$650	47%	\$2649	192%
Virginia	\$240	17%	\$427	31%
Washington	\$546	39%	\$1092	79%
West Virginia	\$253	18%	\$499	36%
Wisconsin	\$517	37%	\$2649	192%
Wyoming	\$590	43%	\$790	57%

Note: Some states have, since July 2006, changed their income eligibility levels for parents.

\* Note that Hawaii and Alaska each have separate FPL levels that are different from the 48 contiguous states.

**Mandatory Level for Parents:**

48 states are at or below 50% FPL (\$692 per month for a family of 3)  
3 states are above 50% FPL  
No state is above 63% FPL (\$872 per month for family of 3)  
family of 3)

**Optional Levels for Parents:**

13 states at or below 50% FPL (\$692 per month for a family of 3)  
36 states at or below 100% (\$1383 per month for a family of 3)  
15 states above 100% FPL  
10 states at or above 150% (\$2075 per month for a family of 3)

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***References***

<sup>1</sup> Sixty-four percent of employers of the working poor do not offer health insurance and, even when they do, workers often can't afford to enroll. Stan Dorn, "Medicaid Coverage for Poor Adults: A Potential Building Block for Bipartisan Health Reform," Economic and Social Research Institute, November, 2004.

<sup>2</sup> Matthew Broaddus and Leighton Ku, "Coverage for Parents Helps Children, Too," Center on Budget and Policy Priorities, Oct. 20, 2006.

<sup>3</sup> Unfortunately, this year's Deficit Reduction Act threatens all mandatory services by allowing states to create reduced benefit packages for certain beneficiaries. To learn more about the potential effects of this new law, please see *Medicaid Cuts: Benefits May Be Reduced for Women Under the DRA* at [http://www.nwlc.org/pdf/FSMedicaidandtheDRA\\_04.21.06.pdf](http://www.nwlc.org/pdf/FSMedicaidandtheDRA_04.21.06.pdf)

<sup>4</sup> Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2004).

<sup>5</sup> See Chart 1 for a list of current mandatory eligibility levels in all 50 states and the District of Columbia.

<sup>6</sup> Family composition rules refer to the requirement that the family be either a single parent family or a two parent family in which the principal earner is unemployed (i.e. does not work more than 100 hours a month).

<sup>7</sup> House Ways and Means Committee, *The 1996 Green Book Overview of Entitlement Programs*, Washington, DC, 1996 available at <http://aspe.hhs.gov/96gb/contents.htm#toc>

<sup>8</sup> The Federal Poverty Level in 2006 is \$16,600 for a family of three in the 48 contiguous states, \$20,750 in Alaska and \$19,090 in Hawaii.

<sup>9</sup> The income level for parent eligibility was obtained from Table 3, "Income Threshold for Parents Applying for Medicaid," Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, December 2006, unpublished data. Calculations for percent of the federal poverty level were determined using 2006 federal poverty guidelines.

<sup>10</sup> Michigan has different payment schedules by region. The standard chosen is the lowest.

<sup>11</sup> New York has different payment schedules by region. The standard chosen is the lowest.

<sup>12</sup> Utah's expanded Medicaid program – known as the Primary Care Network – provides a limited benefits package with enrollment fees and co-payments and is subject to enrollment cap.

## **Medicaid and Latinas: Why Medicaid is So Important**

Racial and ethnic minorities make up a substantial number of people living in the U.S. and experts project that their numbers will grow rapidly, comprising almost half of the U.S. population by the year 2050. Despite their strong presence, there are significant health disparities for minority populations in the U.S. Although there are many different reasons for these health disparities, access to insurance is one of the most important pieces of the puzzle. The landmark Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care* provides compelling evidence that *access to care* is the real key to closing the gap in health outcomes for all racial and ethnic groups. Public programs that can provide health coverage to many low-income families hold the greatest promise for mitigating health disparities for racial and ethnic minorities. According to the report, *the single most effective way to reduce racial and ethnic disparities in health is through the expansion and preservation of public programs like Medicaid.*

Medicaid, the national health insurance program for poor and low-income people, plays a critical role in providing health coverage for low-income women, especially Latinas. Women are the majority of the adult Medicaid population, comprising nearly 71 % of beneficiaries ages 19 and older.<sup>1</sup> Women are twice as likely as men to qualify for Medicaid (8 and 4% respectively) because they tend to be poorer and are more likely to meet the stringent eligibility criteria.<sup>2</sup> Women are also more likely to be in low-paying jobs that do not offer employer-sponsored insurance. Therefore Medicaid is often the only possible source of health insurance coverage for this population. Despite efforts to expand Medicaid access to more low-income women, millions still remain uninsured and that number is increasing.

### **Nearly one in ten women in the U.S. receives health care coverage through Medicaid.**

- 14% of Latinas receive Medicaid<sup>3</sup> and they comprise 21% of all women in Medicaid.<sup>4</sup>
- One in five low-income women is covered by Medicaid.<sup>5</sup>
- Medicaid is the largest source of health insurance for single mothers and covers almost 40% of this population.<sup>6</sup>

### **Medicaid ensures that women have access to many important health care services.**

- Mandatory services include acute care, physician and hospital care, preventive screenings, pregnancy-related care, mental health services and family planning services.<sup>7</sup>
- Medicaid provides diagnosis and treatment of chronic illnesses including breast and cervical cancer and HIV/AIDS. Latinas have the second-highest rate of HIV/AIDS and fare worse than other groups of women in cervical cancer incidence and deaths,<sup>8</sup> making access to prevention and treatment services a vital component of reducing such disparities.

**Medicaid is important for low-income women of *all* ages.**

- For elderly women, the program covers nursing-home and long-term care services. 16% of Latinos are “dual eligibles” and rely on both Medicaid *and* Medicare, the health care program for the elderly.<sup>9</sup>
- More than 6 million low-income reproductive-age women rely on Medicaid for their basic health care.<sup>10</sup>

**Reproductive health services in particular are vital to women in Medicaid.**

- Nearly one-quarter of Latinas do not receive prenatal care during the first trimester,<sup>11</sup> about twice the rate of white women lacking care, making Medicaid expansions an important tool in providing more care to Latinas to ensure healthier births.
- Medicaid covers over one-third (37%) of all births in the U.S.<sup>12</sup>
- The program contributed \$770 million toward family planning in 2001, making it the largest source of public funding for family planning in the U.S.<sup>13</sup>
- Family planning, a mandatory service under Medicaid, generally covers gynecological care, testing for and treatment of sexually transmitted diseases, and major prescription contraceptive methods. Twenty-six states have waivers that expand coverage of family planning only to low-income women who would not otherwise qualify for Medicaid.<sup>14</sup>

**While Medicaid provides health care coverage for a substantial number of low-income women, many go without coverage.**

- Despite efforts to provide coverage to low-income women through state expansions, 38% of Latinas are uninsured, the highest rate of any racial or ethnic minority group lacking health insurance.<sup>15</sup>
- Latinas are also more likely to experience gaps in their insurance coverage and they are least likely to have dental or vision coverage. Half of all Latinas experienced a period without health insurance during one year.<sup>16</sup>
- Expanded access to comprehensive health care and insurance is particularly important to low-income women because of their higher rate of health problems and inadequate resources.<sup>17</sup>

The Medicaid program has faced severe challenges in the last few years. The federal Deficit Reduction Act of 2005 cut Medicaid funding and also allowed for changes to the program that have already resulted in decreased benefits and higher costs for some beneficiaries.<sup>18</sup> States, on their own, have reduced benefits to enrollees and even cut thousands of individuals from the program altogether.

Medicaid has the potential to do even more to keep and expand health care coverage for minorities in the U.S. It is estimated that 74% of the 23 million uninsured minority Americans could be covered using Medicaid and the State Children’s Health Insurance Program (SCHIP).<sup>19</sup> It is important to halt cuts and, ideally, to restore benefits to this federal-state program as Medicaid provides vital health care to millions of individuals and has the potential to greatly reduce health disparities for minorities.

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- <sup>1</sup> Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data, 2004.
- <sup>2</sup> National Women's Law Center and The Henry J. Kaiser Family Foundation, *Women's Access to Care: A State-Level Analysis of Key Health Policies* (Menlo Park: The Henry J. Kaiser Family Foundation, July 2003), 41, available at <http://www.nwlc.org/pdf/KaiserFinal.pdf>, accessed July 10, 2007.
- <sup>3</sup> The Henry J. Kaiser Family Foundation, *Key Facts: Race, Ethnicity & Medical Care*, January 2007, available at <http://kff.org/minorityhealth/upload/6069-02.pdf>, accessed July 5, 2007.
- <sup>4</sup> The Henry J. Kaiser Family Foundation, *Issue Brief: Medicaid's Role for Women*, May 2006, available at <http://www.kff.org/womenshealth/upload/Medicaid-s-Role-for-Women-May-2006.pdf>, accessed July 5, 2007.
- <sup>5</sup> *Id.*
- <sup>6</sup> Roberta Wyn and others, *Falling Through the Cracks: Health Insurance Coverage of Low-Income Women* (Washington: The Henry J Kaiser Family Foundation, February 2001), 23.
- <sup>7</sup> Unfortunately, the budget law called the Deficit Reduction Act of 2005 (DRA) allows states to replace the traditional Medicaid package with reduced benefit packages for certain groups. For more information about what services could be lost under the DRA, please see *Medicaid Cuts: Benefits May Be Reduced for Women* at [http://www.nwlc.org/pdf/FSMedicaidandtheDRA\\_04.21.06.pdf](http://www.nwlc.org/pdf/FSMedicaidandtheDRA_04.21.06.pdf), accessed July 10, 2007.
- <sup>8</sup> National Women's Law Center, "Fact Sheet: Racial and Ethnic Disparities among U.S. Women," *Making the Grade on Women's Health: A National and State-by-State Report Card*, 2004.
- <sup>9</sup> *Supra* note 1.
- <sup>10</sup> The Henry J. Kaiser Family Foundation and The Alan Guttmacher Institute, "Medicaid: A Critical Source of Support for Family Planning in the United States," *Issue Brief* (April 2004) [hereinafter Kaiser April 2004 Issue Brief], 2.
- <sup>11</sup> Kaiser statehealthfacts.org, *Percentage of Mothers Beginning Prenatal Care in the First Trimester by Race/Ethnicity*, 2004, available at [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Women%27s+Health&link\\_category=Health+Status&link\\_subcategory=Prenatal+Care&link\\_topic=Prenatal+Care+by+Race%2fEthnicity](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Women%27s+Health&link_category=Health+Status&link_subcategory=Prenatal+Care&link_topic=Prenatal+Care+by+Race%2fEthnicity), accessed July 10, 2007.
- <sup>12</sup> National Governors' Association, *MCH Update 2005: States Make Modest Expansions to Health Coverage*, June 2006.
- <sup>13</sup> Kaiser April 2004 Issue Brief, *supra* note 4, at 5.
- <sup>14</sup> Some states may also cover services for men and teens under age 19. Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief*, July 2007.
- <sup>15</sup> The Henry J. Kaiser Family Foundation, *Women's Health Insurance Coverage*, February 2007, available at [http://www.kff.org/womenshealth/upload/6000\\_05.pdf](http://www.kff.org/womenshealth/upload/6000_05.pdf), accessed June 1, 2007.
- <sup>16</sup> *Id.*
- <sup>17</sup> For more information on the unique barriers women face in accessing health care see The Commonwealth Fund & National Women's Law Center, *Issue Brief: Women and Health Coverage: The Affordability Gap*, April 2007, available at [http://www.nwlc.org/pdf/1020\\_Patchias\\_women\\_hlt\\_coverage\\_affordability\\_gap.pdf](http://www.nwlc.org/pdf/1020_Patchias_women_hlt_coverage_affordability_gap.pdf), accessed July 10, 2007.
- <sup>18</sup> See *supra* note 7.
- <sup>19</sup> FamiliesUSA, *Improve Public Programs Improve Minority Health*, January 2006, available at <http://www.familiesusa.org/assets/pdfs/minority-health-tool-kit/Improve-Programs.pdf>, accessed July 10, 2007.

## **Health Care for Low-Income Pregnant Women: Focus on Latinas**

### **Prenatal Care is Essential to Latinas and Their Families**

Women who see health care providers regularly during pregnancy have healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems related to pregnancy. Babies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care.<sup>1</sup>

*Nearly one-quarter of Latinas do not receive prenatal care during the first trimester, about twice the rate of white women.*<sup>2</sup> However, research indicates that Latinas often have healthy birth outcomes due to cultural factors such as strong community support during pregnancy. Despite evidence of this “prenatal paradox,” some studies have shown differences among subgroups of the Latina population. For instance, undocumented immigrant women without prenatal care have higher rates of lower birth weight babies than those with prenatal care, and Latinas from Puerto Rico suffer from higher rates of low birth weight babies caused in some part by delayed prenatal care. Prenatal care also reduces the risk of maternal death, which is relatively high among all Latinas.<sup>3</sup>

Expanding Medicaid and the State Children’s Health Insurance Program (SCHIP) to cover more Latinas’ health care during pregnancy and enrolling more Latinas who are already eligible are critical to ensuring even better health outcomes for pregnant Latinas and their babies.

### **Low-income pregnant women may be eligible for health care in one of the following ways:**

- **Medicaid**, the federal-state program that provides health care coverage to the poor, provides low-income pregnant women with full coverage, including prenatal and postpartum care, if they meet certain income and immigration status qualifications. The income level varies by state, but at minimum, every state must cover pregnant women whose income is at or below 133% of the Federal Poverty Level (FPL). States may cover women at higher levels and still receive a federal match. Many states provide coverage for pregnant women whose income is up to 200% FPL and a few go even higher.<sup>4</sup> However, federal dollars cannot be used to provide coverage to “legal immigrants”<sup>5</sup> who arrived in the U.S. after 1997 and have lived here less than 5 years or to those who are otherwise ineligible for the program, including the undocumented.
- **State-funded programs** use only state dollars to provide coverage to populations the federal Medicaid program does not cover, primarily due to immigration status.
- **State Children’s Health Insurance Program (SCHIP)**
  - States may obtain *SCHIP waivers* to provide full coverage for pregnant women who meet certain immigration status and income eligibility requirements. Five states currently cover pregnant women under this program, raising the income eligibility status above the Medicaid level in these states.

- States may amend their SCHIP programs via state plan amendment to implement the *SCHIP “unborn child” regulation*,<sup>6</sup> enabling states to cover pregnant women who would not otherwise qualify for Medicaid because of their immigration status. In a few states, pregnant women whose income is too high to qualify for Medicaid may also receive coverage under this option. Unfortunately, because the regulation focuses on providing health care for the woman’s fetus and not the woman herself, states are not required to provide the full range of services covered by Medicaid, including postpartum care, which is contrary to standard medical practice. Eleven states are currently implementing this option and most do provide postpartum care through state funded programs.
- **Emergency Medicaid** provides limited coverage for labor and delivery services *only* for undocumented immigrant women but does not include coverage for routine prenatal, postpartum, or other vital health care services. It does cover emergency care should its need arise after the pregnancy.
- **Other federal programs**, e.g. the Maternal/Child Health Services Block Grant, Community and Migrant Health Centers, the Supplemental Food Program for Women, Infants and Children (WIC)<sup>7</sup> may provide various nutritional and health supports or prenatal care to poor women but do not provide full health care coverage. These programs vary by state.

### **Federal Legislative Proposals to Expand Coverage for Latinas**

There are several legislative vehicles currently being debated at the federal level that would provide an opportunity to increase access to comprehensive prenatal care for low-income Latinas. Congress must reauthorize SCHIP this year and will decide whether or not to continue funding coverage for pregnant women in states that choose to use their SCHIP money for this purpose. Current law allows states to submit a waiver to expand SCHIP coverage to pregnant women who meet immigration eligibility standards and whose income level is greater than the state’s income eligibility level for Medicaid. Allowing states the option to amend their SCHIP programs without undergoing the burdensome waiver process is one way to ensure that more states expand coverage for pregnant women. However, this action would only increase coverage for pregnant women who meet certain immigration status requirements. It is therefore imperative that when lawmakers consider SCHIP reauthorization legislation, they also include the Legal Immigrant Children’s Health Improvement Act (Legal ICHIA), which would restore Medicaid and SCHIP coverage to legal immigrant children and pregnant women who have resided in the U.S. for less than 5 years.

### **Pathways to Expansion at the State Level**

At the state level, advocates can work toward implementing waivers that expand coverage to more pregnant women on the basis of income level and convince their states to provide prenatal care to pregnant women regardless of immigration status. Eliminating barriers to a state’s public health programs and ensuring linguistically appropriate and culturally competent care are also essential to ensuring that more Latinas are able to get health care during their pregnancies. States can also adopt presumptive eligibility for pregnant women enrolling in Medicaid or

SCHIP so that they can receive care as soon as possible. Presumptive eligibility allows health care providers, on site, to grant temporary program eligibility coverage and to provide immediate care while an enrollment application is being processed.<sup>8</sup>

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<sup>1</sup> National Women's Health Information Center, *Frequently Asked Questions: Prenatal Care*, Apr. 2006, available at <http://www.4women.gov/faq/prenatal.pdf>, accessed June 15, 2007.

<sup>2</sup> Kaiser statehealthfacts.org, *Percentage of Mothers Beginning Prenatal Care in the First Trimester by Race/Ethnicity*, 2004, available at [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Women%27s+Health&link\\_category=Health+Status&link\\_subcategory=Prenatal+Care&link\\_topic=Prenatal+Care+by+Race%2fEthnicity](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Women%27s+Health&link_category=Health+Status&link_subcategory=Prenatal+Care&link_topic=Prenatal+Care+by+Race%2fEthnicity), accessed July 10, 2007.

<sup>3</sup> National Latina Institute for Reproductive Health, *Prenatal Care Access Among Immigrant Latinas*, Dec. 2005, at <http://www.latinainstitute.org/pdf/PrenatalCare-2.pdf>, accessed July 10, 2007.

<sup>4</sup> For state-by-state data of income eligibility for pregnant women see Kaiser statehealthfacts.org, *Income Eligibility Levels for Pregnant Women Applying for Medicaid by Annual Income and as a Percent of Federal Poverty Level (FPL)*, 2006 available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=Income+Eligibility%2d%2d+Pregnant+in+Medicaid>, accessed July 10, 2007.

<sup>5</sup> For purposes of Medicaid eligibility, the term "legal immigrants" refers to the following categories of immigrants: lawful permanent residents; refugees, asylees, and other "humanitarian" immigrants; and other "lawfully present" or "lawfully residing" immigrants often referred to as "persons residing under the color of law" (PRUCOL).

<sup>6</sup> For further discussion and analysis see National Women's Law Center, *The SCHIP Unborn Child Regulation*, March 2007, at <http://www.nwlc.org/pdf/SCHIPUnbornChildRegulation2007.pdf>, accessed June 15, 2007.

<sup>7</sup> *Supra* note 3.

<sup>8</sup> For state-by-state data on which states currently allow presumptive eligibility see Kaiser statehealthfacts.org, *Has Presumptive Eligibility Under Medicaid for Pregnant Women*, 2006, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Enrollment+Practices+for+Pregnant+Women&topic=Presumptive+Eligibility>, accessed July 10, 2007.

## **Medicaid Cuts: Benefits May Be Reduced for Women**

The Deficit Reduction Act of 2005 (DRA) allows states to avoid federal requirements governing which services certain groups of beneficiaries receive through Medicaid. This could have some especially troubling effects for women's health as they face the possibility of losing key benefits, including family planning services.

### **Medicaid Eligibility**

Only certain, limited groups, subject to particular income and resource eligibility levels, are eligible for Medicaid insurance. These are: (1) Children, (2) Parents, (3) Pregnant Women, (4) People with Disabilities, and (5) the Elderly. Women make up 71% of adult Medicaid beneficiaries, and 11.5% of U.S. women of reproductive age (15-44) are covered by the program.<sup>1</sup>

### **Before the DRA: Certain Benefits Were Required for Everyone**

Before the DRA, there were certain federal Medicaid requirements, known as **mandatory services**, that had to be provided, when medically necessary, to all Medicaid beneficiaries. These included: *physician and hospital services, laboratory and x-rays, early and periodic screening, diagnostic, and treatment (EPSDT) services for defined children, federally-qualified health center services, family planning, pediatric and family nurse practitioner services, nursing facility services for individuals 21 and older and home health care*. Although the states had discretion in the amount, duration and scope of this coverage,<sup>2</sup> coverage for these mandatory services had to be provided.

States also could receive federal funds to cover certain non-mandatory services. These **optional benefits** have included important services such as prescription drugs, dental treatment and physical therapy and currently represent 60% of all Medicaid expenditures. *Notably, once a state decides to cover a service, it generally must offer the service to all Medicaid beneficiaries regardless of eligibility group.*

### **After the DRA: Parents and Children May Be Enrolled in Reduced Benefit Plans**

Under the DRA, states can replace their traditional Medicaid plans with so-called "benchmark" plans, which are reduced benefit packages. However, states cannot require certain groups to use a benchmark plan rather than a traditional Medicaid plan. These exempted populations include pregnant women at or below 133% of FPL, elderly, blind and disabled individuals and women battling breast or cervical cancer, leaving *parents<sup>3</sup> and children<sup>4</sup>* as the only Medicaid-eligible

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<sup>1</sup> Adam Sonfield and Rachel Benson Gold, "Conservatives' Agenda Threaten Public Funding for Family Planning." *The Guttmacher Report* February 2005.

<sup>2</sup> For example, they can limit the number of physician visits per year or the length of stay for a hospital visit.

<sup>3</sup> Because of confusing guidance issued by CMS about the DRA, it is uncertain whether any parents will be exempted.

populations who can be required to use the new state benchmark plans rather than traditional Medicaid.

Unfortunately, CMS, the agency responsible for overseeing Medicaid, has interpreted the DRA to allow states to enroll *all Medicaid beneficiaries* in benchmark plans, so long as the enrollment is voluntary and the exempt groups may “opt out” at any time and go back to traditional Medicaid coverage. Of course, ***“opting out” requires that beneficiaries know that their participation is voluntary and that they understand how to opt out if they choose to do so.***

### **Reduced Benefit Plans are a Big Step Backward from Traditional Medicaid**

Benchmark plans are not subject to traditional Medicaid requirements. Instead, they are only required to offer benefits equivalent to those offered in either (1) the Federal Employee Health Benefits Program<sup>5</sup>, (2) the state’s own state employee health benefits plan<sup>6</sup>, (3) the HMO with the largest non-Medicaid enrollment in the state,<sup>7</sup> (4) the actuarial equivalent of one of these plans,<sup>8</sup> or (5) whatever package the state designs that would be “appropriate for the population” so long as it is approved by the Secretary of Health and Human Services.

States opting for a benchmark plan will do so in order to cut costs by reducing benefits below the requirements of traditional Medicaid. In fact, ***the Congressional Budget Office (CBO) estimates that benefit reductions resulting from the benchmark option will reduce spending on parents by one-third.***

Under the DRA, in addition to avoiding coverage requirements, states may now ignore the long-standing requirement under Medicaid law that benefit packages be “comparable” across groups of eligible people, and states can now design different packages for different groups of people. Thus, a parent in a benchmark plan could be offered a different benefit packages than his/her child, and a state could even vary packages across different regions in the state.

### **The DRA Compromises Family Planning Services for Women**

Given the leeway to ignore longstanding Medicaid benefit requirements as well as the ability to create different coverage for different groups, the benchmark plans may result in a ***significant reduction in services for parents and children.***

It is hard to know exactly which benefits will be lost, but states have already had the “flexibility” to design packages for SCHIP based on the same benchmark options now given to states for their Medicaid plans under the DRA. In designing the SCHIP plans, ***four states*** - Montana, North Dakota, Pennsylvania and Texas - ***chose packages that do not include coverage of family planning.*** Also, North Dakota, and Wyoming do not cover contraceptives in their state

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<sup>4</sup> In an effort to preserve EPSDT, the DRA requires that children in benchmark plans also have a “wrap-around” plan to cover additional services when the benchmark plan doesn’t cover all of the EPSDT services. Unfortunately, this is likely to create an administrative hurdle that will make it harder for children to get the comprehensive care to which they are entitled.

<sup>5</sup> The standard Blue Cross/Blue Shield preferred provider plan that the federal government offers its employees.

<sup>6</sup> Any health benefit plan that a state provides its employees.

<sup>7</sup> States can also determine the value of the benefits offered in these plans and offer a plan with the same value (known as an actuarial equivalent plan).

<sup>8</sup> This is referred to in the DRA as “benchmark equivalent coverage.”

employee health plan, and North Dakota's largest HMO does not cover family planning in its benefit packages. Taking this information together, it is clear that *the DRA puts key family planning services at risk*.

Birth control is the main component of family planning coverage under Medicaid and a vital health care service. It is the most effective way to prevent unwanted pregnancies and safely space pregnancies in the interest of the mother's and child's health. Other services important to women are potentially at risk, including the very few abortions that are allowed to be covered under Medicaid.<sup>9</sup>

### **Conclusion**

Ultimately, the DRA gives states unprecedented flexibility to the states through so-called "benchmark" plans to cut any benefit. The primary target of these reduced benefit packages will be low-income parents, the majority of whom are women. Parents who qualify for Medicaid are among the poorest individuals; the average income of such a beneficiary is under \$11,000 a year for a family of three. Limiting benefits to this population will surely result in a loss of care for many low-income women and their families.

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<sup>9</sup> Coverage of abortion under Medicaid is very limited. Federal law - known as the Hyde amendment - requires that Medicaid dollars be used to cover abortions only in cases of rape or incest or if the woman's life is endangered. States can, and many do, cover more abortions without federal dollars.

## **Increased Cost-Sharing in Medicaid Hurts Women and Their Families**

New flexibility granted to the states under the Deficit Reduction Act of 2005 (DRA) allows for increased cost-sharing as a way to contain program costs. This has real implications for the access to care and health status of low-income populations. *A working mother with two children is eligible for Medicaid only if she makes, on average, \$309 or less a week.* On this sort of budget, a family would be hard-pressed to find the resources to pay a co-payment if in need of medical care. *Thus, cost-sharing measures reduce costs by making necessary health care unaffordable.*<sup>1</sup> Also, cost-sharing policies ultimately increase financial burdens on other parts of the health care system by forcing beneficiaries to delay care until they are sicker and wind up in the emergency room.

### **What is Cost-Sharing?**

*Cost-sharing* refers to the out-of-pocket payments, usually in the form of co-payments, that beneficiaries are required to make in connection with the receipt of a covered service under their health insurance plan. The majority of states use co-payments – fixed amounts that must be paid by the beneficiary at the time the service is received – as their primary cost-sharing device. Some states also impose premiums, which are prepaid payments made to a health plan by beneficiaries.<sup>2</sup>

### **Before the DRA, Cost-Sharing in Medicaid Was Limited**

Prior to the DRA, Medicaid law forbade cost-sharing for certain populations and for select services. No co-payments were allowed for children under age 18, terminally ill individuals in hospices, inpatients in nursing facilities<sup>3</sup>, services for pregnant women and family planning, or for emergency services. For all other populations and services, states were allowed to impose “nominal” cost-sharing.<sup>4</sup>

Also, federal law prohibited participating physicians, hospitals, and other providers from collecting additional payments from their patients. Thus, providers had to serve a Medicaid patient, even if the person cannot pay the required cost-sharing.<sup>5</sup>

### **After the DRA: Most Beneficiaries Face Cost-Sharing**

The DRA allows states to impose new or higher cost sharing on most Medicaid beneficiaries. Cost-sharing can be imposed in the following ways:

- Children and parents over 150% of FPL can be charged unlimited premiums and co-payments of up to 20% of the cost of the service.
- Children and parents between 100% of FPL and 150% of FPL can be charged co-payments up to 10% of the cost of the service.
- Total cost sharing (including both co-payments and premiums) can be up to 5% of an individual's income determined on a quarterly or monthly basis.

- No eligible individual is exempt from co-payments on non-preferred prescription drugs
- Mandatory children and pregnant women<sup>6</sup> are prohibited from cost-sharing except for co-payments for non-preferred prescription drugs.

The DRA also allows states to adjust the “nominal” amount annually according to medical inflation. More significantly, the DRA grants providers the right to *deny* services or drugs if a beneficiary cannot pay the cost-sharing amount at the point of service. This individual not only faces a loss of care for a particular health need, but also faces the loss of his/her health insurance all together. The DRA states that if a person does not pay his/her premium within 60 days of the due date, the state can terminate the person’s enrollment. Beginning in January 2007, states can also allow hospitals to impose cost-sharing on non-emergency use of the ER.

### **Cost-Sharing Hurts Low-Income Populations**

Co-payments are intended to limit the overuse of health care. However, particularly with low-income populations, the result of imposing co-payments goes beyond limiting overuse. ***Research shows that co-payments cause patients to avoid or delay essential medical care, and premiums lead many to drop out of publicly funded health insurance programs all together.*** One comprehensive study found that low-income adults and children reduced their use of *appropriate* medical care services by 44% when they were forced to make co-payments.<sup>7</sup> This study also found that co-payments lead to poorer health among low-income adults as compared to those not subject to this form of cost-sharing.

Similarly, premiums reduce low-income people’s access to care. One multi-state study showed that ***premiums set as low as 1% of family income led to a 15% reduction in participation in publicly funded health insurance programs, while a 3% premium led to almost a 50% decrease in enrollment.***<sup>8</sup>

The consequences of all types of cost-sharing can be especially serious for Medicaid beneficiaries because they have severely limited financial means and already bear a large out-of-pocket burden for their health expenses. On average, non-elderly, non-disabled adults on Medicaid with incomes below the federal poverty level spend ***three times*** as much (by percentage of income) on out-of-pocket payments than the amount spent by middle-class adults with private coverage.<sup>9</sup> Also out-of-pocket medical expenses for non-elderly, non-disabled adult Medicaid beneficiaries grew ***twice as fast*** as their income.<sup>10</sup>

### **Cost-Sharing Will Hurt the Health of Women and their Families**

The findings from Oregon and Utah along with an abundance of other studies<sup>11</sup> on the effects of co-payments and premiums on low-income populations point to the fact that increased cost-sharing in Medicaid:

- makes participation in publicly-funded health coverage like Medicaid unaffordable;
- prevents access to primary and preventive care;
- leads to poorer health outcomes for low-income families;
- leads to more complicated health conditions that require more expensive care and greater inappropriate use of the emergency room; and
- increases both the rate of uncompensated care and the pressure on safety-net providers.

Women and their families do not fare well when costs for Medicaid coverage and care exceed their ability to pay, leaving many uninsured and with unmet medical needs. Although cost-sharing rates have not increased since the 1980s, neither has the amount of income that a family is allowed to have in order to qualify for the Medicaid program in many states. In fact, in most states, Medicaid covers only the very poorest parents. Imposing more cost-sharing on these populations simply would force many to go without care.

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<sup>1</sup> Cindy Mann and Samantha Artiga, “The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program.” Kaiser Commission on Medicaid and the Uninsured, June 2004.

<sup>2</sup> Like traditional cost-sharing, premiums require an out-of-pocket cost to beneficiaries and therefore have many of the same effects of cost-sharing. Andy Schneider et al. “The Medicaid Resource Book.” Kaiser Commission on Medicaid and the Uninsured, July 2002, p 62.

<sup>3</sup> This restriction applies to those inpatients in hospitals and nursing homes that are required to apply most of their income to the cost of their care. *Id.*, p 64.

<sup>4</sup> *Id.*, p64. (Nominal cost-sharing is defined as \$2 per month per family for a deductible, between \$.50 to \$3.00 for co-payments, and a five percent coinsurance of the state’s payment rate for the item or service.)

<sup>5</sup> Even though the provider can’t withhold the service, the patient is still liable to the provider for the allowable cost-sharing amount.

<sup>6</sup> Mandatory children are those ages 0-5 at or below 133% of FPL and ages 6-19 at or below 100% of FPL.

Mandatory pregnant women are women at or below 133% of FPL.

<sup>7</sup> Leighton Ku, “Charging the Poor More for Health Care: Cost-Sharing in Medicaid.” Center on Budget and Policy Priorities, May, 7, 2003 (citing the 1992 The Rand Health Insurance Experiment, <http://www.rand.org/health/hiedescription.html>).

<sup>8</sup> Leighton Ku, “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings.” Center on Budget and Policy Priorities, May 31, 2005.

<sup>9</sup> Leighton Ku and Matthew Broaddus, “Out-of-Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing.” Center on Budget and Policy Priorities, May 31, 2005.

<sup>10</sup> For those below the poverty line, out-of-pocket payments grew by an average of 9.4% per year from 1997 to 2002, while over the same period of time, income grew only 4.6% annually. Ku and Broaddus.

<sup>11</sup> For a review of the research, see Julie Hudman and Molly O’Malley, “Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations.” Kaiser Commission on Medicaid and the Uninsured, March 2003.

## **The DRA's Citizenship Documentation Requirement Impedes Medicaid Access for U.S. Citizens**

The Deficit Reduction Act of 2005 (DRA) imposed a new citizenship documentation requirement for Medicaid enrollment that has led to significant delays, denials or loss of Medicaid coverage for U.S. citizens and increased administrative costs for states. A recent study examining the impact of the new requirement confirms that Medicaid enrollment is down, particularly among low-income children. In Virginia, for example, enrollment in the state's Medicaid program has declined by 13,279 children since the new law went into effect.<sup>1</sup>

### **Before the DRA: Documentation Not Required to Verify Citizenship for Eligibility**

All U.S. citizens who meet Medicaid's financial and non-financial eligibility criteria are entitled to Medicaid, though certain legal immigrants are also eligible.<sup>2</sup> The federal government has long required states to establish that Medicaid applicants are U.S. citizens or satisfy the immigration restrictions. Prior to the DRA, states could determine citizenship by allowing applicants to attest to their citizenship in writing. All states except Montana, New Hampshire, New York and Georgia used this self-declaration option to establish U.S. citizenship.

### **After the DRA: Strict Documentation Requirement Enacted**

The DRA added a new documentation requirement for establishing eligibility. Effective July 1, 2006, citizens applying for or renewing their Medicaid coverage must prove their citizenship and identity by providing documents such as birth certificates or U.S. passports. Individuals are required to provide originals or certified copies of these documents which may be time-consuming and costly. Although some states may be able to utilize electronic matches of vital records for individuals who lack paper citizenship documents and who still reside in the state in which they were born, coordinating these new systems may be prolonged and there are no interstate vital records databases yet. Because states are not permitted to provide applicants with coverage while they attempt to obtain the necessary documents, individuals may experience serious delays while securing these documents.

### **Who Is Affected?**

- Since the new documentation requirement was enacted, in the seven states for which data is available, enrollment has dropped significantly, which state officials attribute primarily or entirely to the new law.<sup>3</sup>
- In Wisconsin, more than 19,000 Medicaid-eligible individuals were either denied coverage or lost coverage because of the new law. In Kansas, between 18,000 and 20,000 applications and previous beneficiaries, mostly children and parents, have gone without health insurance since the new law went into effect.<sup>4</sup>

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<sup>1</sup> Donna Cohen Ross, Center on Budget and Policy Priorities, "New Medicaid Citizenship Documentation Requirement Is Taking A Toll." March 13, 2007.

<sup>2</sup> For purposes of Medicaid eligibility, the term "legal immigrants" refers to the following categories of immigrants: lawful permanent residents; refugees, asylees, and other "humanitarian" immigrants; and other "lawfully present" or "lawfully residing" immigrants often referred to as "persons residing under the color of law" (PRUCOL).

<sup>3</sup> See *supra* note 1.

<sup>4</sup> *Id.*

- Between 1.2 and 2.3 million U.S.-born citizens may have serious problems getting or retaining Medicaid coverage because they lack a birth certificate or passport.<sup>5</sup>
- Those most likely to be affected are low-income children and parents who are citizens and otherwise eligible for Medicaid, but who lack a birth certificate or passport.
- This provision will likely have a negative impact on people of color and the rural poor. For example, during much of the 20<sup>th</sup> Century in the South, access to hospitals for births were limited to African-American and poor white families. As a result, members of these groups were born at home and do not have birth certificates.<sup>6</sup>

### **Family Planning Expansion Populations**

Individuals who receive family planning services under Medicaid waivers may be significantly impacted by the new documentation provision. Twenty-six states have obtained waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy.<sup>7</sup> Because these individuals become Medicaid beneficiaries for coverage of family planning services and supplies only, they typically enroll on site at family planning clinics instead of applying at public assistance offices. Clinics are not equipped to deal with the burdensome documentation requirements which may lead to confusion, delays and even denials of care. In addition, the time-sensitive nature of family planning services make the DRA's impact particularly troublesome for this population. The potential roadblocks are especially acute for teens who may need to obtain documentation records from their parents which may ultimately prevent them from seeking critical reproductive health care services at all.

It is imperative that the DRA's citizenship documentation requirement be repealed so that no one loses Medicaid coverage or has to wait to receive health care. There are already numerous barriers for low-income persons seeking Medicaid. Advocates are currently working toward a fix that would allow states to opt out of the rigorous verification requirement at their discretion.

To date, the following groups are exempt from the requirement due in large part to advocates' success in raising the harmful consequences of the new law on the most vulnerable populations:

- Children in foster care;<sup>8</sup>
- Newborns whose mothers received Medicaid on their date of birth, regardless of the mothers' immigration status will be "deemed" Medicaid eligible during their first year of life (however, this will not eliminate the potential barrier these babies may face in proving citizenship after one year); and
- Elderly and disabled citizens who receive both Medicare and Medicaid or are enrolled in Medicaid because they receive SSI benefits.

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<sup>5</sup> Leighton Ku, Center on Budget and Policy Priorities, "Revised Medicaid Documentation Requirement Jeopardizes Coverage for 1 to 2 Million Citizens," July 13, 2006.

<sup>6</sup> Jane Perkins, National Health Law Program, "The Deficit Reduction Act of 2005: Implications for Advocacy," Apr. 27, 2006.

<sup>7</sup> AL, AZ, AR, CA, DE, FL, IL, IA, LA, MD, MI, MN, MO, NM, NY, NC, OK, OR, PA, RI, SC, TX, VA, WA, & WI currently have family planning waivers. "State Medicaid Family Planning Eligibility Expansions" *State Policies in Brief*, The Guttmacher Institute, July 2007.

<sup>8</sup> Specifically, children who receive either Title IV-B services or Title IV-E adoption assistance or foster care payments are exempt.

## **Barriers to Medicaid for Latinas and Latina Immigrants**

Many barriers exist for uninsured low-income persons seeking health coverage through Medicaid or other sources, particularly for Latino communities. Further, immigrants and non-citizen (61% of whom are Hispanic)<sup>1</sup> face additional obstacles.

### **Lack of Employer Coverage Makes Medicaid Even More Important**

Though most uninsured Latinos come from working families, many do not have access to employer sponsored insurance, increasing the potential importance of public health coverage for these communities.<sup>2</sup> Overall, in 2000, Medicaid covered approximately four in ten low-income Latinos.<sup>3</sup> More recently, among non-elderly women, 14% of Hispanics have coverage through Medicaid, comprising 21% of non-elderly women on the program.<sup>4</sup> In addition, 39% of Hispanic children are also enrolled in the program.<sup>5</sup> However, the legal barriers erected through 1996 welfare reform legislation coupled with cultural and linguistic barriers can make it difficult for Latinas (both citizens and non-citizens) to access Medicaid. For example, based on a 2002 survey, among the 4.9 million uninsured Hispanic children, at least 1.8 million were eligible for but not enrolled in Medicaid (and/or the State Children's Health Insurance Program, SCHIP).<sup>6</sup>

### **Barriers to Coverage v. Barriers to Care**

It is important to keep in mind that in thinking about health care issues, there are at least two different aspects to consider. One is access to health *insurance* programs, and the other is access to health *care* (actually getting to see a doctor).

### ***Having Health Coverage Is Not the End of the Story***

Although most studies show that access to health coverage significantly improves access to health care, the two are not necessarily the same. Particularly for non-citizens, some studies have shown for example that even insured non-citizen adults were three times less likely to have seen a doctor in the past two years than insured citizens, suggesting that non-citizens may face additional obstacles to accessing care providers even when they have insurance.<sup>7</sup> Among women, even Latinas who have Medicaid and are in fair to poor health are much less likely to have seen a doctor in the past year than non-Hispanic white women (7% of Latinas v. 3% of non-Hispanic white women).<sup>8</sup> While the barriers to care and coverage often overlap, this fact sheet focuses mostly on access to Medicaid coverage.

### **Language Barriers**

Linguistic and cultural barriers play a fundamental role in the ability of Latinas to access Medicaid, particularly for Latinas that primarily speak Spanish. For example, many persons with limited English proficiency are erroneously categorized as ineligible for Medicaid coverage because of communication hardships.<sup>9</sup> In one study, 46% of Spanish-speaking parents said they did not finish the application procedures because the materials were not in their language. Further, 50% of these parents reported that the lack of Spanish-language application materials discouraged them from even trying to apply for Medicaid for their children.<sup>10</sup> Finally, another

survey found that three out of ten Latinos had trouble communicating with their health care providers, while two out of ten said they had faced hardships obtaining care based on their race or ethnic background.<sup>11</sup> However, by federal law, all Medicaid agencies are required to provide “meaningful language services” to LEP persons, and prohibit discrimination based on national origin.<sup>12</sup>

### **Cultural Competency Issues**

There are also additional cultural competency barriers to care. For example, one study in Texas found that Hispanic women were much less likely than non-Hispanic black or non-Hispanic white women to have obtained a routine mammogram over the past year, even though breast cancer is one of the leading causes of death for Hispanics. One researcher suggested that in addition to language barriers and low insurance rates, one reason for this disparity might be that Hispanics tend to utilize health services only when they are actually ill. Further, women in Hispanic families are often the main care-givers, putting their families first and their own health care needs last as a result.<sup>13</sup>

Finally, new immigrants may lack familiarity with the U.S. system of health insurance and the concept of coverage, and may come from countries and cultures with different systems for health care and understandings of medicine.<sup>14</sup>

### **Geographic Barriers**

Hispanics in new “growth communities” (smaller rural and urban areas which previously had few Latino residents that are now experiencing population increases) are likely to live further from community health centers or a safety-net hospitals than those who live in major Hispanic centers.<sup>15</sup> These physical barriers might inhibit Latinas’ ability to access health care and/or enroll in public coverage programs like Medicaid. Further, doctors in these new growth areas reported more language and communication barriers than doctors in major Hispanic centers.<sup>16</sup>

### ***Eligibility and Immigration Status are Connected***

Complex eligibility requirements can make enrollment in Medicaid confusing for anyone, but it can be especially difficult for immigrant families.<sup>17</sup> In general, immigrants are not eligible for full Medicaid unless they have legal status and have been in the country for at least five years. (Note that all immigrants, regardless of status, are eligible for emergency Medicaid). However, differing citizenship statuses among family members (such as immigrant parents of U.S.-born children) means that some family members could be eligible for Medicaid while other members of the same family are not.

Even when families understand this distinction, fear is a powerful barrier to enrollment. One study found that some Latino families were concerned that enrolling an eligible child might still jeopardize the citizenship status of other family members.<sup>18</sup> (See also, information below on public charge and sponsorship). Further, many state Medicaid applications erroneously request immigration status information of family members who are not applying for Medicaid, which surely deters potential applicants. In fact, states are prohibited from requiring Social Security numbers or other immigration status information about persons in the family who are not seeking Medicaid benefits themselves.<sup>19</sup>

## **DRA Citizenship Documentation Requirements**

New requirements implemented by the Centers for Medicaid and Medicare Services (part of the Deficit Reduction Act, DRA) require extensive documentation verification for enrollment, often including original birth certificates, passports, and other forms of identification, which can make it even more difficult to apply. (For more information on this requirement, see the enclosed fact sheet on Citizen Documentation). Although this requirement did not apply to non-citizens (who have always had to provide documentation of status to receive benefits) and has had less effect on Latinos, misrepresentation in the media and from other sources may deter many otherwise eligible immigrants from applying.<sup>20</sup>

In addition, many states have family planning waivers which allow some women to obtain family planning services through Medicaid even if they are not eligible for other Medicaid services. However, persons in family planning services are not exempt from the documentation requirement. This may have an especially burdensome effect on younger Latinas wishing to apply for family planning services, as it may be necessary for them to ask their parents for such documentation.<sup>21</sup>

## **Additional Issues for Non-Citizens**

### ***Fear of Public Charge***

Many immigrants may be worried that use of Medicaid will cause the government consider them “public charges,” or a burden to the country which could affect their status as potential citizens or LPRs.<sup>22</sup> However, enrollment in Medicaid, unlike the use of federal cash assistance benefits, does *not* contribute to status as a public charge (with the exception of immigrants in need of long-term care).

### ***Sponsorship Concerns***

Fear that use of benefits will have a negative impact on their sponsors can also be a barrier for immigrants. In some states, sponsors who have filled out an enforceable affidavit of support (INS form 1-864) can be held responsible for paying back the sponsored immigrant’s use of non-emergency Medicaid services (regular Medicaid benefits that have extensive eligibility requirements regarding residency and citizenship) and other public benefits while that immigrant maintains LPR status. Further, sponsors are not held liable for benefits used after the immigrant becomes a citizen or used after the immigrant achieves 40 quarters of work in the U.S.,<sup>23</sup> though liability for benefits used prior to these status changes may continue for some time. However, states have limited abilities to pursue this liability.

In addition, immigrants may fear that enrolling in Medicaid will hurt their abilities to sponsor relatives who may wish to join them in the United States. However, as long as their household income is at least 125% FPL, use of public benefits will not affect their abilities to sponsor relatives.<sup>24</sup>

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<sup>1</sup> Hispanics make up 61% of non-citizen adults, and 59% of non-citizen children. Kaiser Commission on Medicaid and the Uninsured: “Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Adults,” June 2007, p. 2, available at <http://www.kff.org/uninsured/upload/7651.pdf>; Kaiser Commission on Medicaid and the Uninsured: “Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Children,” May 2007, p. 2, available at <http://www.kff.org/medicaid/upload/7643.pdf>

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<sup>2</sup>Kaiser Commission on Medicaid and the Uninsured: “Health Insurance Coverage and Access to Care Among Latinos,” June 2000, p. 1, available at <http://www.kff.org/uninsured/upload/Health-Insurance-Coverage-and-Access-to-Care-Among-Latinos.pdf>.

<sup>3</sup> Kaiser Commission on Medicaid and the Uninsured: “Health Insurance Coverage and Access to Care Among Latinos,” June 2000, p. 1, available at <http://www.kff.org/uninsured/upload/Health-Insurance-Coverage-and-Access-to-Care-Among-Latinos.pdf>

<sup>4</sup>The Kaiser Family Foundation, “Key Facts: Race, Ethnicity and Medical Care,” January 2007, p. 16, available at <http://kff.org/minorityhealth/upload/6069-02.pdf>; The Kaiser Family Foundation, Women’s Issue Brief: “Medicaid’s Role for Women,” May 2006, available at: <http://www.kff.org/womenshealth/upload/Medicaid-s-Role-for-Women-May-2006.pdf>

<sup>5</sup> The Kaiser Family Foundation, “Key Facts: Race, Ethnicity and Medical Care,” January 2007, p. 16, available at <http://kff.org/minorityhealth/upload/6069-02.pdf>;

<sup>6</sup> Covering Kids and Families, “Questions and Answers: Outreach, Enrollment and Immigration Issues,” October 2003, p. 1, available at <http://coveringkidsandfamilies.org/resources/docs/ImmigrantQA.pdf>

<sup>7</sup>Kaiser Commission on Medicaid and the Uninsured: “Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Adults,” June 2007, p. 5, available at <http://www.kff.org/uninsured/upload/7651.pdf>.

<sup>8</sup> Kaiser Commission on Medicaid and the Uninsured: “Health Insurance Coverage and Access to Care Among Latinos,” June 2000, p. 2, available at <http://www.kff.org/uninsured/upload/Health-Insurance-Coverage-and-Access-to-Care-Among-Latinos.pdf>.

<sup>9</sup> Jennifer Ng’andu, National Council of La Raza, “Immigrants, Refugees, Asylees, and the Undocumented: Understanding Laws that Impact Their Health and Well Being,” (2006), p. 1.

<sup>10</sup> Kaiser Commission on Medicaid and the Uninsured, “Medicaid and Children, Overcoming Barriers to Enrollment,” January 2000, p. 14, available at: <http://www.kff.org/medicaid/upload/Medicaid-and-Children-Overcoming-Barriers-to-Enrollment-Report.pdf>.

<sup>11</sup> Pew Hispanic Center and the Kaiser Family Foundation, “Survey Brief,” March 2004.

<sup>12</sup> Ng’andu, at p. 2: Executive Order 13166, as well as The Civil Rights Act of 1964 (P.L. 88-352).

<sup>13</sup> Kaisernetwork.org, Daily, “Public Health & Education: Numerous Factors Including Language Barriers, Lack of Insurance Prevent Hispanic Women in Texas From Receiving Mammograms,” June 19, 2007, available at: [http://kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=45655](http://kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=45655)

<sup>14</sup> National Immigration Law Center, “Immigrant Friendly Outreach and Enrollment,” June 2002, p. 4 available at [http://www.nilc.org/immspbs/health/Issue\\_Briefs/Immigrant-Friendly\\_App\\_Enrllmnt.PDF](http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly_App_Enrllmnt.PDF)

<sup>15</sup> Kaiser Commission On Medicaid and the Uninsured, “Health Coverage and Access to Care for Hispanics in “New Growth Communities and “Major Hispanic Centers,” September 2006, p. 3 available at: <http://www.kff.org/uninsured/upload/7551.pdf>.

<sup>16</sup> Id.

<sup>17</sup>National Immigration Law Center, “Immigrant Friendly Outreach and Enrollment,” June 2002, p. 1, available at [http://www.nilc.org/immspbs/health/Issue\\_Briefs/Immigrant-Friendly\\_App\\_Enrllmnt.PDF](http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly_App_Enrllmnt.PDF)

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<sup>18</sup> From the Kaiser Commission on Medicaid and the Uninsured, “Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low Income Parents,” May 2007, p. 14, available at: <http://www.kff.org/medicaid/upload/7640.pdf>

<sup>19</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004), p. 25. Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>

<sup>20</sup> National Immigration Law Center, “2006 Annual Report,” p. 10, available at [http://www.nilc.org/nilcinfo/2006\\_nilc\\_annualreport.pdf](http://www.nilc.org/nilcinfo/2006_nilc_annualreport.pdf)

<sup>21</sup> See also the accompanying fact sheet, “The DRA Imposes Burdensome Documentation Requirements on US Citizens” included in this toolkit.

<sup>22</sup> National Immigration Law Center, “Immigrant Friendly Outreach and Enrollment,” June 2002, p. 2, available at [http://www.nilc.org/immspbs/health/Issue\\_Briefs/Immigrant-Friendly\\_App\\_Enrllmnt.PDF](http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly_App_Enrllmnt.PDF)

<sup>23</sup> Id.

<sup>24</sup> Id.

## **Moving Forward: Advocacy to Reduce Barriers**

### **Success: Improving the DRA Citizenship Documentation Requirements**

Prior to the Deficit Reduction Act of 2005 (DRA), babies born in the U.S. to immigrant mothers who were receiving emergency Medicaid were automatically eligible for regular Medicaid. However, when the Centers for Medicare and Medicaid Services (CMS) issued their original regulations as part of the DRA, CMS enacted a requirement for all those eligible for Medicaid to verify their citizenship status. Thanks to the tireless efforts of health advocates this new rule has since been changed and Medicaid coverage for newborns has been restored.

### **On the Horizon- Pending Legislation**

While Medicaid remains a crucial program for Latinas and their families, new initiatives to improve the program and aim to eliminate disparities are being considered:<sup>1</sup>

#### ***Making the New Citizen Documentation Requirements a State Option Only***

New legislation, S. 909, has been introduced by Senator Bingaman (D-NM) and others which would make the new citizenship documentation requirement *optional* (instead of mandatory) for states. Reducing the number of states that require citizenship documentation is critical for reducing a major barrier to Medicaid for low-income families, especially children.

#### ***The Legal Immigrant Children's Health Improvement Act (ICHIA)***

The Legal Immigrant Children's Health Improvement Act, "ICHIA," S.764/ H.R.1308, would eliminate the five year bar requirement for children and pregnant women seeking Medicaid and SCHIP who are Legal Permanent Residents (LPRs). For more information, please visit the National Council of La Raza's website: <http://nclr.org/content/policy/detail/30216/>

### **Other Legislative Initiatives**

Below are some examples of pending legislation which seek to address health disparities in the Latino community, including increased funding for language access programs and community health workers who serve limited-English speaking populations.

- *Community Health Workers Act of 2007*, H.R. 1968 (Solis D-CA);
- *Health Equity and Accountability Act of 2007*;
  - The Congressional Hispanic Caucus, the Congressional Asian Pacific Islanders Caucus, and the Congressional Black Caucus are working on this bill to eliminate health disparities and increase health care access. The text of this bill is not yet available.
- *Minority Health Improvement and Health Disparity Elimination Act*, S. 1576, (Kennedy D-MA).

### **Resources on Language Access and Medicaid**

- For more information on language access and Medicaid, please visit the National Health Law Program (NHeLP)'s website:  
<http://www.healthlaw.org/library.cfm?fa=detail&id=71227&appView=folder>

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<sup>1</sup> For a summary and status of all bills visit: <http://thomas.loc.gov/>

## **Medicaid, Family Planning and Women's Health**

Medicaid is the joint federal/state health insurance program for certain categories of the poorest among us. The program is of particular importance to women, who make up 71% of the program's adult insured. Within this group, approximately 7 million women of reproductive age rely on Medicaid for their health insurance.<sup>1</sup>

### **Why Does Family Planning Matter to Women?**

*Family Planning improves women's health by (1) allowing for the early detection of disease by getting women into doctor's offices for regular health screenings, (2) allowing women to space out the birth of multiple children, which improves health care outcomes for both mothers and children, (3) preventing unintended and high-risk pregnancies, (4) allowing women the opportunity to stay in the workforce, and (5) enabling them to lead healthy and productive lives.*

Latinas account for approximately one in every seven U.S. women of reproductive age.<sup>2</sup> Women of reproductive age are in a particularly vulnerable position because they are more likely than other population groups to lack health insurance. In 2006, 19% of all women ages 18-64 were uninsured and 38% of Latinas ages 18-64 were uninsured, the highest rate of any racial or ethnic minority group.<sup>3</sup> Unfortunately, due to significant budget cuts, the proportion of reproductive age women covered by Medicaid has been dwindling for several years.<sup>4</sup> Efforts on the state and federal level to cut or cap Medicaid will further reduce this number and undermine this important source of health care for many low-income women.

### **Family Planning in the Latino Community**

There are unique barriers to accessing family planning in the Latino community, which is concerned with potential emotional and physical side effects and long-term safety of hormonal contraception, like birth control pills. There are also socioeconomic, cultural and structural factors such as immigration status, poverty, lack of health insurance, and inadequate culturally and linguistically appropriate care, that make access to reproductive health services not only difficult but virtually impossible for some Latinas.<sup>5</sup>

*The rate of unintended pregnancy for Latinas is nearly twice that of white women.*<sup>6</sup> The disparity for Latina teens is especially troubling. The teen pregnancy rate for Latinas is nearly twice the national average: Fifty-one percent of Latina teens get pregnant at least once before age 20, the highest of any racial or ethnic group.<sup>7</sup> Latinas are also disproportionately affected by HIV/AIDS and cervical cancer,<sup>8</sup> making improved access to services that address their reproductive health needs critically important.

### **Medicaid Covers Essential Family Planning**

Medicaid provides vital contraceptive coverage to the millions of low-income women of reproductive age that depend on the program for their health care. Currently, 11.5% of U.S. women of reproductive age (15-44) are covered by Medicaid.<sup>9</sup> Even those women who are not

insured by the Medicaid program can have access to family planning services only through state family planning Medicaid expansions. (See below.)

Medicaid law, within certain guidelines, leaves it to each state to decide what services to include under “family planning.” These services can include a range of reproductive health care. Most states generally cover gynecological exams, testing for and treatment of sexually transmitted diseases, and major forms of prescription contraceptives. In addition, 32 states and the District of Columbia also cover over-the-counter contraceptive methods such as condoms.<sup>10</sup>

### **Medicaid Is the Main Source of Funding for Family Planning and Needs to Be Preserved**

The Guttmacher Institute estimates that in 2002, about 17 million women were in need of publicly funded contraceptive coverage.<sup>11</sup> While other sources of family planning services for these women, such as Title X, have stagnated since the 1980s, Medicaid has grown. *Today, the Medicaid program accounts for two-thirds of all federal and state family planning funding nationwide.*<sup>12</sup>

### **Many States Have Expanded Family Planning in Medicaid**

There is a significant financial benefit to providing contraceptive coverage. Every \$1 spent on family planning saves \$3 in Medicaid costs that otherwise would have gone for prenatal and newborn care. Currently, the Medicaid program finances almost 40% of all births in the U.S.<sup>13</sup> Since the early 1990s, **26 states** have been granted special permission (known as “waivers” of federal policy) to expand Medicaid’s family planning coverage to low-income women who would not otherwise qualify for Medicaid’s full insurance program.<sup>14</sup> An evaluation of these expansions by the Centers for Medicare and Medicaid Services found that the programs studied not only met the federal requirement that they be budget neutral, but in fact have *saved money for both the states and the federal government.*<sup>15</sup> As the federal and state governments consider changes to Medicaid in the name of saving money, important preventive services like family planning must be maintained, or even expanded.

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<sup>1</sup> The Alan Guttmacher Institute, *Medicaid Turns 40. What You Didn’t Know About This Vital Source of Family Planning Funding*, July 29, 2005, available at <http://www.guttmacher.org/media/inthenews/2005/07/29/index.html>, accessed July 10, 2007.

<sup>2</sup> The Alan Guttmacher Institute, *Opportunities for Action: Addressing Latina Sexual and Reproductive Health*, March 2005, available at <http://www.guttmacher.org/pubs/psrh/full/3703905.pdf>, accessed July 3, 2007.

<sup>3</sup> The Henry J. Kaiser Family Foundation, *Women’s Health Insurance Coverage*, February 2007, available at [http://www.kff.org/womenshealth/upload/6000\\_05.pdf](http://www.kff.org/womenshealth/upload/6000_05.pdf), accessed June 13, 2007.

<sup>4</sup> The Alan Guttmacher Institute, “New Medicaid Initiative, State Budget Woes Collide,” *Issues in Brief* 2002(5).

<sup>5</sup> National Council of La Raza, *Entre Parejas: An Exploration of Latino Perspectives Regarding Family Planning and Contraception*, 2006.

<sup>6</sup> National Latina Institute for Reproductive Health, *Issue Brief: The Reproductive Health of Latinas in the U.S.*, March 2002, available at <http://www.latinainstitute.org/pdf/ReproHealth.pdf>, accessed July 9, 2007.

<sup>7</sup> The National Campaign to Prevent Teen Pregnancy, *A Look at Latinos: An Overview of Latina Teen Pregnancy*, March 2007, available at [http://www.teenpregnancy.org/espanol/PDF/latino\\_overview.pdf](http://www.teenpregnancy.org/espanol/PDF/latino_overview.pdf), accessed June 13, 2007.

<sup>8</sup> See *supra* note 6.

<sup>9</sup> Adam Sonfield and Rachel Benson Gold, “Conservatives’ Agenda Threaten Public Funding for Family Planning.” *The Guttmacher Report*, February 2005.

<sup>10</sup> Renee Schwalberg et al., *Medicaid Coverage of Family Planning Services: Results of a National Survey*. The Henry J. Kaiser Family Foundation, Washington, DC: 2001.

<sup>11</sup> Adam Sonfield and Rachel Benson Gold, “Conservatives’ Agenda Threaten Public Funding for Family Planning.” *The Guttmacher Report* February 2005.

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<sup>12</sup> Using AGI State-level data available at <http://www.guttmacher.org/pubs/2005/03/01/memo030105.pdf>

<sup>13</sup> Emily V. Cornell, “MCH Update 2002: States’ Health Coverage for Low-Income Pregnant Women, Children, and parents,” *National Governors’ Association Issue Brief* (June 9, 2003).

<sup>14</sup> In seven states—CA, MN, NC, NY, OK, OR, WA—men are also eligible to receive these services. The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief*, July 1, 2007.

<sup>15</sup> Rachel Benson Gold, “Doing More for Less: Study Says State Medicaid Family Planning Expansions are Cost-Effective,” *The Guttmacher Report* March 2004, 1.

## **State Medicaid Family Planning Waiver-A Model from Minnesota**

Minnesota has a Medicaid Section 1115 waiver to provide family planning services for low-income adults who would not otherwise qualify for Medicaid. The following waiver project can serve as a model for developing a family planning waiver in your state.

### **MINNESOTA FAMILY PLANNING DEMONSTRATION FACT SHEET**

**State:** Minnesota

**Name of Proposed Program:** *Minnesota Family Planning Project*

**Date Proposal Submitted:** July 3, 2002

**Date Proposal Approved:** July 20, 2004

**Date of Implementation:** July 1, 2006

**Expiration Date:** June 30, 2011

#### **ELIGIBILITY:**

The Minnesota Family Planning Demonstration extends Medicaid eligibility for family planning services to women and men, between 15 and 50, with family income at or below 200 percent Federal poverty level (FPL), who are not otherwise eligible for Medicaid, SCHIP, Medicare, or any other creditable health insurance coverage.

#### **FAMILY PLANNING SERVICES:**

Family planning services include a contraceptive counseling, contraceptive supplies, devices, implants and prescriptions, office visits, laboratory examinations and tests, voluntary sterilization, HIV/STI testing in conjunction with a family planning encounter, and referrals to other health care providers for primary care.

#### **COST SHARING:**

There is no cost sharing (premiums or copayments) for enrollees covered under the family planning demonstration.

#### **PRIMARY CARE REFERRAL SYSTEM:**

All enrollees of the Family Planning Program will also receive information about Minnesota's other health care programs, which cover primary care services. Enrollees who apply for the Family Planning Program via a medical provider will receive a Minnesota Health Care Programs Brochure upon application. This brochure contains a description of each Minnesota public health program, a list of covered services, basic eligibility criteria and contact phone numbers. Training on this program will be made available to providers, and they will be kept informed of program changes over time through the Provider Updates that the Minnesota Department of Human Services.

**EVALUATION:**

## Project objectives:

- Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.
- Increase the number of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.
- Reduce the number of unintended pregnancies among women and teens enrolled in Minnesota Health Care Programs.
- Reduce the proportion of pregnancies of Minnesota Health Care Programs enrollees that are spaced less than two years apart.
- Expand provision of family planning services to adolescents and other Minnesotans who do not traditionally access public health programs.

**ESTIMATED ENROLLMENT AND COST OF DEMONSTRATION:**

- The Minnesota Family Planning Project will serve approximately 30,000 enrollees when fully operational.
- Savings of \$2,179,563 (Federal share) are projected for the 5-year demonstration period.

To view and download Minnesota's entire waiver proposal, please visit the CMS website:  
<http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=Minnesota&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS060773&intNumPerPage=10>

## **Medicaid Family Planning Waivers: Providing Parity for Reproductive Health Services and Achieving Fiscal Savings for States**

Recent studies suggest a growing and disturbing disparity between poor and affluent women that has a substantial impact on their health and lives. Between 1994 and 2001, the rate of unintended pregnancies for affluent women fell by 20%, while the rate of unintended pregnancies for women living below poverty rose by 29%. A poor woman in the United States is now nearly four times as likely as a more affluent woman to have an unplanned pregnancy.<sup>1</sup>

Expanding access to family planning services through Medicaid is a cost-effective way to reduce the number of unintended pregnancies and improve the health and lives of low-income women. Over the past decade, states have been experimenting with Medicaid family planning expansions by seeking what are known as “family planning waivers” to achieve these goals.

### **What are Family Planning Waivers?**

Since the early 1990s, 26 states<sup>2</sup> have been granted special permission (known as a “waiver” of federal law) from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program, to expand Medicaid’s family planning coverage to low-income women who would not otherwise qualify for Medicaid’s full insurance program.<sup>3</sup>

There are two types of family planning waivers: the first, an income-based waiver, expands eligibility for family planning services to all women of reproductive age<sup>4</sup> (and sometimes men) up to a certain income level. Most of these income-based waivers expand eligibility for family planning services to the same income-level at which women are eligible for pregnancy-related services, should they choose to become pregnant. This type of income-based waiver is sometimes known as a “parity waiver,” because it creates parity between the income level at which women are eligible for family planning services and the income level at which women are eligible for pregnancy-related care.

Some states have opted for a second type of family planning waiver, a more limited family planning waiver that extends family planning services only to certain women who have been Medicaid enrollees due to their status as pregnant women or parents. Typically these waivers extend coverage for one or two years. Income-based parity waivers are preferable because they provide family planning services to significantly more women and have been shown to provide significant cost savings to states.

### **What are the Goals of Family Planning Waivers?**

Minnesota<sup>5</sup> cited the following objectives and purposes for its income-based family planning waiver in its proposal:

- Increase the number of individuals who have access to family planning services through the state’s Medicaid program;
- Increase the number of individuals enrolled in the state’s Medicaid program who utilize family planning services;
- Reduce the number of unintended pregnancies among women enrolled in the state’s Medicaid program;

- Reduce the number of unintended pregnancies among teens enrolled in the state’s Medicaid program;
- Reduce the proportion of Medicaid pregnancies that are spaced less than two years apart;
- Expand provision of family planning services to individuals who do not traditionally access public health programs.

**Why are Family Planning Waivers Important?**

Medicaid family planning waivers help meet the need for subsidized family planning services. A recent study found that publicly-funded clinics in the seven states with income-based waivers in 2001 were able to meet more of the need for subsidized contraceptive services than clinics in other states.<sup>6</sup>

Evidence suggests that Medicaid family planning waivers reduce the number of unintended pregnancies. Based on a review of the FamilyPACT program in California, researchers estimate that FamilyPACT prevented 213,000 unintended pregnancies, 45,000 which would have been to teenagers, in 2002.<sup>7</sup>

Medicaid family planning waivers save states money. Each dollar spent to provide publicly-funded family planning services saves the Medicaid program more than \$3 in pregnancy-related care alone.<sup>8</sup>

**What are the Cost Benefits of Family Planning Waivers?**

An evaluation of income-based family planning waivers commissioned by the Centers for Medicare and Medicaid Services (CMS) found that the programs studied not only met the federal requirement that they achieve budget neutrality, but in fact have saved money for both the states and the federal government.<sup>9</sup>

**State-by-State Analysis of Cost Savings Associated with Medicaid Family Planning Waivers<sup>10</sup>**

State	Year	Decrease in # of Births	Total Savings	State Savings	Federal Savings
Alabama	2000-2001	3,162	\$19,028,783	\$6,981,721	\$12,047,062
Arkansas	1997-1998	2,748	\$15,524,056	\$5,199,426	\$10,324,630
	1998-1999	4,486	\$29,748,208	\$9,411,954	\$20,336,254
California	1999-2000	21,335	\$76,182,694	\$64,314,302	\$11,868,392
New Mexico	1998-1999	507	\$1,334,435	\$652,918	\$681,517
	1999-2000	1,358	\$5,009,165	\$2,037,590	\$2,971,575
	2000-2001	1,528	\$6,510,909	\$2,650,439	\$3,860,470
Oregon	2000	5,414	\$19,756,294	\$11,077,646	\$8,678,648
South Carolina	1994-1995	2,228	\$13, 634,174	\$4,135,453	\$9,498,721
	1995-1996	3,151	\$19,615,968	\$6,201,946	\$13,414,022
	1996-1997	3,769	\$23,066,926	\$7,403,462	\$15,633,464

**Which States Currently Have Income-Based Family Planning Waivers?**

Nineteen states have income-based family planning waivers. Eligibility levels vary from 133% of the Federal Poverty Level (FPL) to 200% FPL.<sup>11</sup>

## Income Eligibility Levels for Family Planning Services under Medicaid Waivers

State	Income Level (as % of FPL)
Alabama	133
Arkansas	200
California	200
Illinois	200
Iowa	200
Louisiana	200
Michigan	185
Minnesota <sup>12</sup>	200
Mississippi	185
New Mexico	185
New York	200
North Carolina	185
Oklahoma	185
Oregon	185
Pennsylvania	185
South Carolina	185
Texas	185
Washington	200
Wisconsin	185

### Conclusion

At a time when states are struggling to reduce the number of unintended pregnancies and find ways to reduce Medicaid expenses, income-based family planning waivers are not only good health policy, but good fiscal policy, as well.

<sup>1</sup> Gold RB. “Rekindling Efforts to Prevent Unplanned Pregnancy: A Matter of ‘Equity and Common Sense.’” *Guttmacher Policy Review*, Volume 9, Number 3, Summer 2006.

<sup>2</sup> Several states are currently in the process of applying for income-based waivers: ME, MA, NJ, & WV.

<sup>3</sup> In seven states—CA, MN, NC, NY, OK, OR, WA—men are also eligible to receive these services. See The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief*, July 2007.

<sup>4</sup> In eight states—AL, IL, LA, MI, NM, NC, OK, TX—services are available for individuals aged 19 years and older and in PA services are available for individuals aged 18 and older.

<sup>5</sup> To view Minnesota’s waiver application in its entirety, see

<http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp?filtertype=dual&datefiltertype=1&datefilterinterval=&filtertype=data&atafiltertype=2&datafiltervalue=Minnesota&filtertype=keyword&keyword=family+planning&intNumPerPage=10&cmdFilterList=Show+Items>

<sup>6</sup> Frost, J, Frohwirth, L. and Purcell, A. “The Availability and Use of Publicly Funded Family Planning Clinics: U.S. Trends, 1994-2001,” *Perspectives in Sexual and Reproductive Health*, Sept./October 2004.

<sup>7</sup> The Henry J Kaiser Family Foundation and The Alan Guttmacher Institute, “Medicaid: A Critical Source of Support for Family Planning in the United States,” Issue Brief (April 2005).

<sup>8</sup> Ibid.

<sup>9</sup> Gold, RB. “Doing More for Less: Study Says State Medicaid Family Planning Expansions are Cost-Effective,” *The Guttmacher Report*, March 2004.

<sup>10</sup> Edwards, J., Bronstein, J. and Adams, K., “Evaluation of Medicaid Family Planning Demonstrations,” The CNA Corporation, CMS Contract No. 752-2-415921, November 2003. State calculations estimated by The Alan Guttmacher Institute based on the total savings and the CNA Corporation’s analysis of the federal share of savings in the final report.

<sup>11</sup> An additional 7 states have more limited family planning waivers that extend coverage only to certain women who have been Medicaid enrollees due to their status as pregnant women or parents: AZ, DE, FL, MD, MO, RI, VA.

<sup>12</sup> Minnesota proposed eligibility coverage for men and women up to 250% FPL in its waiver application but CMS approved coverage up to 200% FPL only.

## **Health Care for The Poor: Who Is Eligible for Medicaid in Alabama?**

In Alabama, there are 327,800 non-elderly women (of all races) on Medicaid, and they comprise 52% of the total non-elderly Medicaid population. Across the state, 16% of non-elderly women (of all races) living in Alabama are on Medicaid.<sup>1</sup> (Currently a breakdown of the number of Latinos on Alabama Medicaid is unavailable).

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Currently, Alabama has not elected higher optional levels for any beneficiary groups, including children and pregnant women.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – A child up through age five becomes eligible by residing in a family of three with an income at or below \$1,903/month (133% of the FPL). Children ages six to 19 qualify if their family income is at or below \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – In Alabama, a working parent becomes eligible for Medicaid if he or she has a dependent child and has an income level that falls at or below \$366/month (26% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$1,903/month (133% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities**<sup>4</sup> – An individual with a disability generally qualifies for Medicaid if his/her individual income is at or below \$630/month (74% FPL), the income standard used to determine eligibility for Supplemental Security Income.
- (5) **Elderly Populations** – Individuals over age 65 can qualify for full Medicaid (as well as Medicare), if their individual income is at or below \$630/month (74% FPL – mirroring the SSI levels).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** – In Alabama, any uninsured or underinsured woman between the ages of 50 and 65 with breast or cervical cancer who has been screened by the Centers for Disease Control and Prevention (CDC) may qualify for the basic Medicaid benefits package if her income is up to roughly \$1,702/month for an individual (200% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** – States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. In Alabama, a woman is eligible for family planning services if she has an income at or below \$1,122/month (133% FPL) and is 19 years of age or older.<sup>7</sup>

## **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In Alabama, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and to unqualified individuals who are otherwise eligible.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute, A Consumer’s Guide to Getting and Keeping Health Insurance in Alabama, December 2004, <http://www.healthinsuranceinfo.net/al05.html>. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007). Income level is based on the 2007 FPL guidelines and is calculated for an individual (family of 1).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>, accessed July 13, 2007.

## **Health Care for the Poor: Who Is Eligible for Medicaid in Arizona?**

Medicaid in Arizona is also referred to as the Health Care Cost Containment System (AHCCCS).

In Arizona, there are 481,869 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 54% of the total (non-elderly) Medicaid population. Across the state, 28% of non-elderly Hispanics (men, women and children) living in Arizona are on Medicaid.<sup>1</sup> Overall, there are 467,190 women (non-elderly, of all races) enrolled in Medicaid, comprising 52% of all Medicaid (non-elderly) enrollees, while 18% of women (non-elderly, of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only specific categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Currently, Arizona has elected slightly higher optional levels for children up to age one, but meets only minimum requirements for children ages one to 19, pregnant women, persons with disabilities, and the elderly.

### **Income Eligible Groups Under Medicaid:**

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of three with an income at or below \$2,003/month (140% of the Federal Poverty Level). A child up to age six becomes eligible with an income at or below \$1,903/month (133% FPL). A child between ages six and 19 qualifies if their family income is \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$2,767/month (200% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$1,903/month (133% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$630/month (74% FPL), the income standard used to determine eligibility for Supplemental Security Income (SSI).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$630/month (74% FPL- mirroring the SSI levels).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** – In Arizona, women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) may qualify for the basic Medicaid benefits package if their individual

income is up to roughly \$2,127/month for an individual (250% FPL) and they do not have other insurance.<sup>6</sup>

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. In Arizona, a woman who received Medicaid during her pregnancy and would have lost coverage 60 days postpartum is eligible to receive family planning services for up to two years.<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In Arizona, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and unqualified individuals who are otherwise eligible.<sup>8</sup>

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<sup>1</sup>Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, "Statehealthfacts.org." Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children's Health Insurance Program (CHIP), and may provide further coverage through state-only funded health insurance programs.

<sup>3</sup>Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Learn more about the Breast and Cervical Cancer Treatment Program (BCCTP) on the Arizona Health Care Containment System's official website: <http://www.ahcccs.state.az.us/Services/CoverageGroups/AdultNoChildren.asp#BCCTP>. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> From the The Alan Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief* (July 1, 2007), available at: [http://www.guttmacher.org/statecenter/spibs/spib\\_SMFPE.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf)

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance." (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>

## **Health Care for the Poor: Who Is Eligible for Arkansas Medicaid?**

In Arkansas, there are 21,170 non-elderly Hispanics (including men, women and children) on Arkansas Medicaid and they comprise 5% of the total non-elderly Medicaid population. Across the state, 20% of non-elderly Hispanics (including men, women and children) living in Arkansas are on Medicaid.<sup>1</sup> Overall, there are 212,350 non-elderly women (of all races) enrolled in Medicaid, comprising 55% of all non-elderly Medicaid enrollees in the state, while 18% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Currently Arkansas meets only minimum levels of coverage for the elderly and disabled.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – Children (up through age 19) are eligible for Medicaid if they reside in a family of three with an income at or below \$2,862/month (200% of the FPL).
- (2) **Parents**<sup>3</sup> – In Arkansas, a working parent becomes eligible for Medicaid if he or she has a dependent child and has an income level that falls at or below \$255/month (18% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid in Arkansas if her income is at or below \$2,862/month (200% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – In Arkansas, an individual with a disability generally qualifies for Medicaid if his/her income is at or below \$630/month (74% FPL), the income standard used to determine eligibility for Supplemental Security Income (SSI).
- (5) **Elderly Populations**<sup>4</sup> – In Arkansas, individuals over age 65 can qualify for full Medicaid (as well as Medicare) if their incomes are at or below \$630/month (74% FPL-mirroring the SSI levels).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** -In Arkansas, women (between the ages of 40 and 65) with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$1,702/month.<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. In

Arkansas, a woman is eligible for family planning services if she as an income at or below \$1,702/month (200% FPL).<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants:** In Arkansas, under Medicaid only emergency medical care (which includes labor/delivery) is available to legal immigrants who are subject to, but have not yet met, the five year bar and to unqualified individuals who are otherwise eligible. However, Arkansas provides prenatal care regardless of the woman's immigration status under its State Children's Health Insurance Program (SCHIP).<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, "Statehealthfacts.org." Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on income for a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children's Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute A Consumer's Guide to Getting and Keeping Health Insurance in Arkansas, January 2006, pp. 27-28, <http://www.healthinsuranceinfo.net/ar.pdf>; and conversation with State Medicaid Office on July 2, 2007. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> The Alan Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief* (July 1, 2007). Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance." (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>

## **Health Care for the Poor: Who Is Eligible for Medicaid in California?**

Medicaid in California is also referred to as Medi-Cal.

In California, there are 2,945,650 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 56% of the total non-elderly Medicaid population. Across the state, 25% of non-elderly Hispanics (including men, women and children) living in California are on Medicaid.<sup>1</sup> Overall, there are 2,784,110 non-elderly women (of all races) enrolled in Medicaid, comprising 53% of all non-elderly Medicaid enrollees, while 18% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. California currently meets only minimum levels of eligibility for children between the ages of one and 19.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – A child up to age one becomes eligible by residing in a family of three with an income at or below \$2,862/month (200% of the FPL). A child between ages one and five qualifies if their family income is at or below \$1,903/month (133% FPL). Children ages six to 19 qualify if their family income is at or below \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she has a dependent child and has an income level that falls at or below \$1,473/month (107% FPL).  
**Pregnant Women** – A pregnant woman is eligible for Medicaid in California if her income is at or below \$2,862/month (200% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (3) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$851/month (100% FPL).
- (4) **Elderly Populations**<sup>4</sup> - Individuals over age 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$851/month (100% FPL).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - In California, any uninsured woman who is at least 40 years old for breast cancer, or 25 years old for cervical cancer, who has been screened by the Centers for Disease Control and Prevention (CDC) may qualify for the basic Medicaid benefits package if their individual income up to roughly \$1,702/month (200% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility

level for parent coverage but under the state's income eligibility for pregnancy. In California, an individual is eligible for family planning services if she has an income at or below \$1,702/month (200% FPL).<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

(1) **Immigrants** – In California, under Medicaid only emergency medical care (which includes labor and delivery) is available to legal immigrants who are subject to, but have not yet met the five year bar requirement and to unqualified individuals who are otherwise eligible. However, California provides some state-funded health coverage to qualified immigrants and PRUCOL status immigrants who meet income and other eligibility criteria. Further, California provides prenatal care (through its State Children's Health Insurance Program), and state-funded long-term care, breast and cervical treatment, and other specified services regardless of immigration status. All of these programs may require that income and other eligibility criteria be met.<sup>8</sup>

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<sup>1</sup>Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, "Statehealthfacts.org." Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including a residency requirement as well as limits on resources and assets.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute, A Consumer's Guide to Getting and Keeping Health Insurance in California, January 2006, <http://www.healthinsuranceinfo.net/ca.pdf>, as well as the Northern California Cancer Center, Cancer Detection: Every Woman Counts website, [http://www.nccc.org/cancer\\_detection\\_programs.html](http://www.nccc.org/cancer_detection_programs.html). Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> The Alan Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief* (July 1, 2007). Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance." (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, "Table 10, State Funded Medical Assistance Programs," (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf)

### **Health Care for the Poor: Who Is Eligible for Medicaid in Colorado?**

In Colorado, there are 131,570 non-elderly Hispanics (including men, women and children) on Medicaid and they comprise 43% of the total non-elderly Medicaid population. Across the state, 15% of non-elderly Hispanics (including men, women and children) living in Colorado are on Medicaid.<sup>1</sup> Overall, there are 165,030 non-elderly women (of all races) enrolled in Medicaid, comprising 54% of all non-elderly Medicaid enrollees in the state, while 8% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Currently, Colorado provides coverage at only the minimum eligibility levels for children, people with disabilities, and the elderly.

#### **Income Eligible Groups under Medicaid:**

- (1) **Children** – Infants and children up to age six are eligible if their income for a family of three is at or below \$1,903/month (133% FPL). A child between the ages of six and 19 qualifies if their family income is at or below \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she has an income at or below \$920/month (67% FPL) for a family of three.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,862/month (200% FPL) for a family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$630/month (74% FPL), the income standard used to determine eligibility for Supplemental Security Income (SSI).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over age 65 can qualify for full Medicaid (as well as Medicare) if their incomes are at or below \$630/month (74% FPL-mirroring the SSI levels).

#### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 40 and 64 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$2,127/month (250% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. Colorado does not have a family planning waiver.<sup>7</sup>

## **Immigration Status Eligibility Under Medicaid:**

(1) **Immigrants-** In Colorado, under Medicaid only emergency medical care (which includes labor/delivery) is available to legal immigrants who are subject to, but have not yet met, the five year bar and to unqualified individuals who are otherwise eligible. However, Colorado does provide prenatal care to pregnant immigrant women who are lawfully present (regardless of the five year bar). Further, Colorado offers long-term care for persons who were receiving certain Medicaid- reimbursed services on July 1, 1997. Finally, some “Medicaid-like” services are available for lawfully residing immigrants over age 60 who are otherwise not eligible for Medicaid and are part of the Old Age Pension Program. All of these programs may require that income and other eligibility criteria be met.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute “A Consumer’s Guide to Getting and Keeping Health Insurance in Colorado,” January 2006, p. 29, <http://www.healthinsuranceinfo.net/co00.html>. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, “Table 10, State Funded Medical Assistance Programs,” (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf).

## **Health Care for the Poor: Who Is Eligible for Medicaid in Florida?**

In Florida, there are 419,690 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 25% of the total non-elderly Medicaid population. Across the state, 13% of non-elderly Hispanics (including men, women and children) living in Florida are on Medicaid.<sup>1</sup> Overall, there are 866,420 non-elderly women (of all races) enrolled in Medicaid, comprising 51% of all non-elderly Medicaid enrollees, while 12% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Florida meets only minimum levels for children ages one to 19.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of three with an income at or below \$2,862/month (200% FPL). A child up to age six becomes eligible with an income at or below \$1,903/month (133% FPL). A child between six and 19 qualifies if their family income is \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$806/month (58% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,647/month (185% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$766/month (90% FPL).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over age 65 can qualify for full Medicaid (as well as Medicare) if their individual income is at or below \$766/month (90% FPL).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women under between the ages of 50 and 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$1,702/month (200% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. In

Florida, a woman who received Medicaid during her pregnancy and would have lost coverage 60 days postpartum is eligible for family planning services for up to two years.<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In Florida, under Medicaid only emergency medical care (which includes labor/delivery) is available to legal immigrants who are subject to, but have not yet met, the five year bar and to unqualified individuals who are otherwise eligible. However, some children who were enrolled in and have remained on Florida’s State Children’s Health Insurance Program since January 31, of 2004 are still covered, regardless of immigrations status, if certain conditions are satisfied. However, enrollment of children who are not federally eligible has been frozen for some years. All of these programs may require that income and other eligibility criteria be met.<sup>8</sup>

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<sup>1</sup>Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute “A Consumer’s Guide to Getting and Keeping Health Insurance in Florida,” January 2007, <http://www.healthinsuranceinfo.net/fl.pdf>. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, “Table 10, State Funded Medical Assistance Programs,” (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf)

## **Health Care for the Poor: Who Is Eligible for Georgia Medicaid?**

In Georgia, there are 146,650 non-elderly Hispanics (including men, women, and children) on Medicaid, and they comprise 13% of the total non-elderly Medicaid population. Across the state, 21% of Hispanics (including men, women, and children) living in Georgia are on Medicaid.<sup>1</sup> Overall, there are 628,530 non-elderly women (of all races) enrolled in Medicaid, comprising 54% of all non-elderly Medicaid enrollees, while 15% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Georgia meets only the minimum eligibility levels for children ages one to 19, people with disabilities, and the elderly.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – A child up to age one becomes eligible by residing in a family of three with an income at or below \$2,862/month (200% of the FPL). A child ages one to five qualifies if their family income is at or below \$1,903/month (133% FPL). Children ages six to 19 qualify if their family income is at or below \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – In Georgia, a working parent becomes eligible for Medicaid if he or she has a dependent child and has an income level that falls at or below \$756/month (55% FPL) for a family of three.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid in Georgia if her income is at or below \$2,862/month (200% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her individual income is at or below \$630/month (74% FPL), the income standard used to determine eligibility for Supplemental Security Income (SSI).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over age 65 can qualify for full Medicaid (as well as Medicare) if their individual income is at or below \$630/month (74% FPL- mirroring the SSI levels).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** -In Georgia, any uninsured woman between the ages of 40 and 65 for breast cancer, or between the ages of 18 and 65 for cervical cancer, who has been screened by the Centers for Disease Control and Prevention (CDC) may qualify for the basic Medicaid benefits package if her individual income is up to roughly \$1,702/month for an individual (200% FPL).<sup>6</sup>

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. Georgia does not have a Family Planning expansion waiver.<sup>7</sup>

**Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants**- In Georgia, under Medicaid only emergency medical care (which includes labor/delivery) is available to legal immigrants who are subject to, but have not yet met, the five year bar and to unqualified individuals who otherwise meet the eligibility standards.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, "Statehealthfacts.org." Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children's Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute, A Consumer's Guide to Getting and Keeping Health Insurance in Georgia, January 2006, p. 25, <http://www.healthinsuranceinfo.net/ga.pdf>. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> The Alan Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance." (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>

## **Health Care for the Poor: Who Is Eligible for Illinois Medicaid?**

In Illinois, there are 239,390 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 20% of the total non-elderly Medicaid population. Across the state, 17% of non-elderly Hispanics (including men, women and children) living in Illinois are on Medicaid.<sup>1</sup> Overall, there are 664,600 non-elderly women (of all races) enrolled in Medicaid, comprising 55% of all non-elderly Medicaid enrollees, while 12% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Illinois meets only the minimum standards for children ages one to five.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – A child up to age one becomes eligible by residing in a family of three with an income at or below \$2,862/month (200% of the FPL). All other children, ages one to 19 qualify if their family income is at or below \$1,903/month (133% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she has a dependent child and has an income level that falls at or below \$2,649/month (192% FPL) for a family of three.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid in Illinois if her income is at or below \$2,862/month (200% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$723/month (85% FPL).
- (5) **Elderly Populations**<sup>4</sup> – In Illinois, persons over age 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$723/month (85% FPL).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - In Illinois, any uninsured woman between the ages of 40 and 65 with breast cancer or between the ages of 35 and 65 for cervical cancer who has been screened by the Centers for Disease Control and Prevention (CDC) may qualify for the basic Medicaid benefits package if her individual income is up to roughly \$1,702/month for an individual (200% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. In Illinois, a woman is eligible for family planning services if she has an income at or below

\$1,702/month (200% FPL) and is 19 years of age or older. Family Planning services are also available to women who have Medicaid-funded deliveries.<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

(1) **Immigrants** – In Illinois, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and unqualified individuals who are otherwise eligible. However, Illinois provides state funded coverage for all children regardless of immigration status and to other qualified immigrants who are victims of abuse. In addition, Illinois provides prenatal care regardless of immigration status through its State Children’s Health Insurance Program (SCHIP). All of these programs may require that income and other eligibility criteria be met.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute, A Consumer’s Guide to Getting and Keeping Health Insurance in Illinois, January 2006, pp. 28-29, <http://www.healthinsuranceinfo.net/il.pdf>. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, “Table 10, State Funded Medical Assistance Programs,” (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf)

## **Health Care for the Poor: Who Is Eligible for Massachusetts Medicaid<sup>1</sup>?**

Medicaid in Massachusetts is part of the program known as MassHealth.

In Massachusetts, there are 215,160 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 26% of the total non-elderly Medicaid population. Across the state, 44% of non-elderly Hispanics (including men, women and children) living in Massachusetts are on Medicaid.<sup>2</sup> Overall, there are 436,590 non-elderly women (of all races) enrolled in Medicaid, comprising 52% of all Medicaid non-elderly enrollees, while 16% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>3</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – A child up to age one becomes eligible by residing in a family of three with an income at or below \$2,862/month (200% of the FPL). All other children, ages one to 19 qualify if their family income is at or below \$2,146/month (150% FPL).
- (2) **A Parent<sup>4</sup>** - A working parent becomes eligible for Medicaid if he or she has a dependent child and has an income level that falls at or below \$1,840/month (133% FPL) for a family of three.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid in Massachusetts if her income is at or below \$2,862/month (200% FPL) for her family of three. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for full Medicaid (as well as Medicare) if his/her individual income is at or below \$851/month (100% FPL).
- (5) **Elderly Populations<sup>5</sup>** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their individual income is at or below \$851/month (100% FPL).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>6</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** – Women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is at or below \$1,702/month (250% FPL).<sup>7</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. Massachusetts’ Family Planning Waiver is pending review.<sup>8</sup>

### **Immigration Status Eligibility Under Medicaid:**

(1) **Immigrants**- In Massachusetts, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and unqualified individuals who are otherwise eligible. However, Massachusetts provides prenatal care regardless of immigration status through its State Children's Health Insurance Program, and provides some type of state funded coverage for all children regardless of immigration status. Some forms of coverage may also be available for certain elderly and disabled qualified immigrants or PRUCOLs with incomes below 100% FPL. Finally, some coverage may be available to qualified immigrants and PRUCOLs with incomes below 300% of FPL through the Commonwealth Care Health Insurance Program. All of these programs may require that income and other eligibility criteria be met.<sup>9</sup>

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<sup>1</sup> Massachusetts is currently implementing extensive health reform plans, including a type of individual health coverage mandate. Additional coverage options may exist for persons who have not had access to employer insurance for the past six months and have income levels below 300% of FPL through the Commonwealth Care Health Insurance Program. For more information, please visit: <http://www.mahealthconnector.org/portal/site/connector/>.

<sup>2</sup>Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, "Statehealthfacts.org." Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>3</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may also provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children's Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>4</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>5</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>6</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>7</sup> Massachusetts Women's Health Network website, available at <http://www.mass.gov/dph/fch/whn/>. Income level is based on the 2007 FPL guidelines and calculated for an individual (family of 1).

<sup>8</sup> Centers for Medicaid and Medicare Services available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=ascending&itemID=CMS1186404&intNumPerPage=2000>

<sup>9</sup> From The Kaiser Commission on Medicaid and the Uninsured, "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance." (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, "Table 10, State Funded Medical Assistance Programs," (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf).

## **Health Care for the Poor: Who Is Eligible for Medicaid in New Jersey?**

In New Jersey, there are 199,000 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 33% of the total non-elderly Medicaid population. Across the state, 15% of Hispanics (including men, women and children) living in New Jersey are on Medicaid.<sup>1</sup> Overall, there are 308,830 non-elderly women (of all races) enrolled in Medicaid, comprising 51% of all non-elderly Medicaid enrollees, while 8% of women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Currently New Jersey meets only minimum levels of coverage for children ages one to five.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of three with an income at or below \$2,862/month (200% of the FPL). Children ages one to 19 are eligible if their family income is at or below \$1,903/month (133% FPL)
- (2) **Parents**<sup>3</sup> – A parent (either working or non-working) becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$1,591/month (115% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,862/month for her family of 3 (200% FPL). Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$851/month (100% FPL).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$851/month (100% FPL)

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** -Women between the ages of 17 and 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and have no or limited health care coverage may qualify for the basic Medicaid benefits package if their individual income is below \$2,127/month (250% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. New Jersey does not have a family planning waiver.<sup>7</sup>

## **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In New Jersey, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and unqualified individuals who are otherwise eligible. However, New Jersey uses state funds to offer coverage to qualified immigrant children and parents through its New Jersey FamilyCare. Certain qualified immigrants and PRUCOLs may continue to be eligible for nursing home care if they were in “Medicaid – certified nursing homes” before January 29, 1997. New Jersey also offers prenatal care regardless of immigration status for pregnant women with incomes under 200% of FPL, but the program may be limited by availability of funds. All of these programs may require that income and other eligibility criteria be met.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute A Consumer’s Guide to Getting and Keeping Health Insurance in New Jersey, January 2006, p. 34 <http://www.healthinsuranceinfo.net/nj00.html>

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, “Table 10, State Funded Medical Assistance Programs,” (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf).

## **Health Care for the Poor: Who Is Eligible for Medicaid in New York?**

In New York, there are 928,210 non-elderly Hispanics (including men, women, and children) on Medicaid, and they comprise 30% of the total non-elderly Medicaid population. Across the state, 34% of non-elderly Hispanics (including women and children) living in New York are on Medicaid.<sup>1</sup> Overall, there are 1,674,070 non-elderly women (of all races) enrolled in Medicaid, comprising 53% of all non-elderly Medicaid enrollees, while 20% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. New York meets only the minimum levels for children ages one to 19, people with disabilities and elderly populations.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of three with an income at or below \$2,862/month (200% of the FPL). Children ages one to five are eligible if their family income is at or below \$1,903/month (133% FPL). Children ages six to 19 are eligible if their family income is at or below \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$2075/month (150% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,862/month for her family of 3 (200% FPL). Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$630/month (74% FPL), the income standard used to determine eligibility for Supplemental Security Income (SSI).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$630/month (74% FPL- mirroring the SSI levels).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** -Women with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and have no or limited health care coverage may receive treatment for their illness if their individual income is below \$2,127/month (250% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility

level for parent coverage but under the state's income eligibility for pregnancy. New York offers family planning services to anyone whose individual income level is under \$1,702/month (200% FPL) and to women following a Medicaid-funded delivery.<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In New York, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and unqualified individuals who are otherwise eligible.. However, New York uses state funds to offer coverage to qualified legal immigrants and PRUCOL status immigrants who meet the income and other eligibility criteria. In New York, there is no immigration test for children or women seeking prenatal care. All of these programs may require that income and other eligibility criteria be met.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, "Statehealthfacts.org." Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children's Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute A Consumer's Guide to Getting and Keeping Health Insurance in New York, January 2006, p. 28, available at <http://www.healthinsuranceinfo.net/ny00.html>

<sup>7</sup> The Alan Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance." (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, "Table 10, State Funded Medical Assistance Programs," (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf).

## **Health Care for the Poor: Who Is Eligible for Medicaid in North Carolina?**

In North Carolina, there are 77,640 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 8% of the total non-elderly Medicaid population. Across the state, 14% of non-elderly Hispanics (men, women and children) living in North Carolina are on Medicaid.<sup>1</sup> Overall, there are 543,220 non-elderly women (of all races) enrolled in Medicaid, comprising 55% of all non-elderly Medicaid enrollees, while 14% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. North Carolina meets only the minimum requirements for children ages six to 19, people with disabilities and elderly populations.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – Children up to age five are eligible for Medicaid if they reside in a family of three with an income at or below \$2,862/month (200% of the FPL). Children ages six to 19 are eligible if their family income is at or below \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$750/month (54% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,647/month for her family of three (185% FPL). Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$851/month (100% FPL).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$851/month (100% FPL).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** -Women between the ages of 18 and 64 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and have no or limited health care coverage may receive treatment for their illness if their individual income is below \$1,702/month (200% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. North Carolina offers family planning services to persons over the age of 19 whose individual income level is under \$1,574/month (185% FPL).<sup>7</sup>

## **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In North Carolina, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and unqualified individuals who are otherwise eligible.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute A Consumer’s Guide to Getting and Keeping Health Insurance in North Carolina, January 2006, p. 28, available at <http://www.healthinsuranceinfo.net/nc00.html>

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>

## **Health Care for the Poor: Who Is Eligible for Medicaid in South Carolina?**

In South Carolina, there are 301,220 non-elderly women (of all races) enrolled in Medicaid, comprising 54% of all non-elderly Medicaid enrollees, while 16% of non-elderly women (of all races) statewide are on the program.<sup>1</sup> Data for the number of Hispanics were not available.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

### **Income Eligible Groups under Medicaid:**

- (1) **Children** – Children up to age one are eligible for Medicaid if they reside in a family of three with an income at or below \$2,647/month (185% of the FPL). Children ages one to 19 are eligible if their family income is at or below \$2,146/month (150% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$1,340/month (97% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,647/month for her family of three (185% FPL). Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$851/month (100% FPL).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$851/month (100% FPL).

### **Service Eligible Groups Under Medicaid:**

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 47 and 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and have no or limited health care coverage may receive treatment for their illness if their individual income is below \$1,702/month (200% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. South Carolina offers family planning services to persons whose individual income level is at or below \$1,574/month (185% FPL).<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In South Carolina, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but

have not yet met, the five year bar, and unqualified individuals who are otherwise eligible.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute A Consumer’s Guide to Getting and Keeping Health Insurance in South Carolina, June 2007, p. 31, available at <http://www.healthinsuranceinfo.net/sc00.html>; as well as South Carolina’s Breast and Cervical Cancer Early Detection Program website, available at: <http://www.scdhec.gov/health/chcdp/cancer/bcn.htm>

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>.

## Health Care for the Poor: Who Is Eligible for Medicaid in Texas?

In Texas, there are 1,448,800 non-elderly Hispanics (including men, women and children) on Medicaid, and they comprise 57% of the total non-elderly Medicaid population. Across the state, 19% of non-elderly Hispanics (men, women and children) living in Texas are on Medicaid.<sup>1</sup> Overall, there are 1,309,910 non-elderly women (of all races) enrolled in Medicaid, comprising 52% of all non-elderly Medicaid enrollees, while 13% of non-elderly women (of all races) statewide are on the program.

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.<sup>2</sup> Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels. Texas covers only the minimum levels for children ages one to 19, people with disabilities, and the elderly.

### Income Eligible Groups under Medicaid:

- (1) **Children** – Children up to age one are eligible for Medicaid if they reside in a family of three with an income at or below \$2,647/month (185% of the FPL). Children ages one to six are eligible if their family income is at or below \$1,903/month (133% FPL) Children ages six to 19 are eligible if their family income is at or below \$1,431/month (100% FPL).
- (2) **Parents**<sup>3</sup> – A working parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$402/month (29% FPL).
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,647/month for her family of three (185% FPL). Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$630/month (74% FPL), the income standard used to determine eligibility for Supplemental Security Income (SSI).
- (5) **Elderly Populations**<sup>4</sup> – Individuals over 65 can qualify for full Medicaid (as well as Medicare) if their income is at or below \$630/month (74% FPL- mirroring the SSI levels).

### Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.<sup>5</sup> Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between with breast cancer (priority going to women between the ages of 50 to 64) or cervical cancer (priority going to women between the ages of 18-64 who have not had a pap smear in the past five years) who have been screened by the Centers for Disease Control and Prevention (CDC) and have no or limited health care coverage may receive treatment for their illness if their individual income is below \$1,702/month (200% FPL).<sup>6</sup>
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state’s income eligibility for pregnancy. Texas offers family planning

services to women over the age of 18 whose individual income level is under \$1,574/month (185% FPL).<sup>7</sup>

### **Immigration Status Eligibility Under Medicaid:**

- (1) **Immigrants** – In Texas, under Medicaid only emergency medical services (which include labor/delivery) are available to legal immigrants who are subject to, but have not yet met, the five year bar, and unqualified individuals who are otherwise eligible. However, Texas provides state funded coverage for qualified immigrant children and provides prenatal care regardless of immigration status through its State Children’s Health Insurance Program. All of these programs may require that income and other eligibility criteria be met. In addition, Texas does not always grant Medicaid eligibility (beyond emergency services) even for qualified immigrants who have met the five year bar.<sup>8</sup>

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<sup>1</sup> Unless otherwise noted all data provided is from the Henry J. Kaiser Family Foundation, “Statehealthfacts.org.” Categories examined were: Medicaid Eligibility, Income Eligibility- Children; Pregnant Women; and Other groups under Medicaid. Note that FPL amounts are current with the 2007 guidelines. All calculations are based on a family of three unless otherwise noted.

<sup>2</sup> There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets. In addition, these eligibility levels reflect those used for Medicaid only. States may provide coverage to additional children (and sometimes parents) through combined or separate programs through the State Children’s Health Insurance Program (SCHIP), and may provide further coverage through state-only funded health insurance.

<sup>3</sup> Income levels at which parents are eligible can vary greatly within states, and are more likely to have changed since the Kaiser fact sheets have been updated. Further, parental levels may be subject to change in dollar amounts (beyond just an FPL percentage). Therefore, income eligibility levels for parents is reflected as a dollar amount for working parents as of 2006 (e.g.- this number does not reflect the 2007 FPL guidelines).

<sup>4</sup> Both elderly individuals and people with disabilities may have to meet additional resource tests beyond just their income levels in order to qualify; certain other groups of elderly and/or disabled persons may also be eligible for partial Medicaid to assist with varying levels of cost sharing in their Medicare plans.

<sup>5</sup> To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

<sup>6</sup> Georgetown University Health Policy Institute A Consumer’s Guide to Getting and Keeping Health Insurance in Texas, January 2006, p 29, available at <http://www.healthinsuranceinfo.net/nc00.html>

<sup>7</sup> The Alan Guttmacher Institute, “State Medicaid Family Planning Eligibility Expansions,” *State Policies in Brief* (July 1, 2007).

<sup>8</sup> From The Kaiser Commission on Medicaid and the Uninsured, “Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance.” (November 2004). Available at: <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>; See also the National Immigration Law Center, “Table 10, State Funded Medical Assistance Programs,” (Updated July 2007), excerpt from the National Immigration Law Center, Guide to Immigrant Eligibility for Federal Programs (2002). Available at: [http://www.nilc.org/pubs/guideupdates/tbl10\\_state-med-asst\\_2007-07.pdf](http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07.pdf)

## **Lobbying 101: Communicating Effectively with Your Government**

*Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that can. -- Margaret Mead*

“Lobbying” is simply persuading legislators or other government officials to act in favor of a specific cause. It is one of the most important things an advocate can do.

### **Basic Ways to Lobby: Letters, Calls & Meetings**

#### Letters

Personal letters are extremely effective because they show legislators that the author is knowledgeable, interested, and committed to the matter at hand. Sending a personal letter also alerts the legislator to the fact that the author is politically active. Legislators keep close track of how their mail is running on particular issues, and personal letters are given great weight.

The letter should be short and to the point. Try to address only one issue in each letter. Start the letter by stating what it is you want the legislator to do, e.g. "Please vote in favor of House Bill 000." Explain the reason(s) that you care about this issue, including ways in which the issue touches you personally. Where relevant, emphasize the specific impact of the issue within the legislator's district.

Be sure to find out what happened on the issue you wrote about and let your legislators know that you are following their action on this issue. It is great to write a "thank you" note if they voted the way you wanted on an issue. Send a note of regret if they voted against your wishes.

*If you can, faxing your letter is probably the most effective delivery method. E-mails seem less personal and, therefore, are less persuasive. Regular mail is slow due to enhanced security measures.*

#### Telephone Calls

Call your representatives. Federal representatives can be reached at their offices in Washington, DC or at their state offices, or just call the U.S. Capitol switchboard at 1-202-224-3121 and ask for the Member by name. Explain that you are a constituent and ask to speak to the staffer who follows your issue. Make the call short, polite and to the point.

Follow-up on the call. Be sure to call back and thank the legislator for their support or very politely express regret at their vote.

## Meetings

*Public Meetings*-- Officials often host “town hall meetings” open to the public where you can ask questions about specific issues. Call your member's district office (check the blue section of the telephone book) to see if any are scheduled.

*Private Meetings*—If you arrange a private meeting, it is useful to remember that you are there to exchange ideas. It is sometimes just as important to know why a legislator opposes your position as it is to know that the legislator supports your position.

Leave literature for the legislator summarizing your points. This will serve as a reminder of your visit and the issue.

Follow up the visit with a thank you note and perhaps more information on your issue. If the legislator asked for certain information be sure you get back to the legislator with that information. Remember that the main objective of your contact is to establish an ongoing relationship with your legislator and establish yourself (and any organization you represent) as a reliable source of information.

### **The Best Times to Lobby**

There are special times in the legislative process when letters, calls and meetings can be especially productive:

- When a bill is introduced and assigned to a committee, you can contact your legislators to request that they become official supporters of the bill by “cosponsoring” the bill. Obviously, the more cosponsors a bill has, the more likely it is to gain support and move through the legislative process.
- If the bill is bottled up in committee and appears unlikely to ever emerge, you might contact your Members of Congress and urge them to get the bill moving.
- In the Senate, a minority of Senators can stop passage of a bill by launching a “filibuster,” essentially an endless debate. Many campaign finance efforts over the years have fallen victim to Senate filibusters. The votes of 60 Senators are needed to end a filibuster and allow action on a bill. You might contact your Senators and urge them to fight these tactics used to block action on important legislation.
- When legislation is about to come up on the floor of the House or Senate, you could contact your legislators and urge support for the position you advocate.

You can learn the federal status of a bill by going to <http://thomas.loc.gov/> and searching the bill by name or number.

## General Lobbying Advice:

- **Know Your Legislator** Be sure to do some basic research in order to help you understand how a legislator might approach an issue. This should include: an examination of his/her record on related legislation; any prior favorable commitment to your cause, party, or position; and what kind of influence the legislator will have over the issue, e.g. will the issue come before a Committee your legislator sits on?
- **Know Your Issue** Know the status of the legislation and be sure to know the bill's name and number. Buttress your arguments with the most salient and persuasive facts available. Anticipate arguments against your position, and be prepared to respond to these arguments.
- **Be accurate.** To build a working relationship and get action, you need to be a credible source of information. Never bluff. If you don't know something, just say so. Tell them you will find out and get back to them.
- **Make It Personal (and Local)** Establish your own credentials or expertise on the subject of legislation under consideration. Make a personal connection to the issue you are discussing. Do not be afraid to speak from personal experience. Whenever possible, speak locally. Connect the position you support to the people the official represents.
- **Be brief.** Members of Congress and their staffs are incredibly busy and so are you. Most members of Congress represent over 600,000 people. They appreciate it when you get to the point and respect their time. Because your meeting or call might be interrupted, get to your request in the first few minutes.
- **Have an Objective and an "Ask"** Have a clear objective for any call, letter or meeting. This should include a very specific request: "Vote for Bill No. 103 to provide health care to 1000 of your constituents" not "Support health care for all Americans."
- **Be specific.** In your communications with Members of Congress, make a point to mention the bill by number, give reasons why you support the bill, and let them know that you are a constituent.
- **Be courteous.** If you meet with the legislator's staff, treat this meeting as though it is with the legislator. The legislator depends on this staff person's advice, and this staff person serves as your gateway to the legislator. Treat him or her with respect. Try to persuade, but never argue with him or her.
- **Be persistent.** If you find that the staff people you need to speak with are out of the office, leave a message for them with your name and number. If they don't return your call within two to three days, then call again. Keep track of your calls, but remember that they are very busy.

## **Lobbying Law Basics**

It is legal for both individuals and organizations to lobby.

Even organizations recognized by the Internal Revenue Service as non-profit 501(c)(3) organizations can legally lobby Congress on issues they care about. There are limitations on the expenditure of organizational funds, but it is not illegal as many in the international development community have believed. In fact, lobbying by non-profit organizations is encouraged by a 1976 tax law and its accompanying regulations.

It is important to understand the limitations so the organizations to which we belong are able to maximize their ability to influence legislation without jeopardizing their legal status. This section offers only basic information, but you are encouraged to learn more so that you and your organizations take advantage of your rights. \*

While there are limitations on how much of an organization's budget can be spent on lobbying, there is NO limitation on individual citizens and constituents. It is a First Amendment right and one of the privileges and responsibilities of living in a democracy to be able to exercise the right to meet with politicians, tell them how we want them to vote and then let them know on election day if we thought they did a good job.

### **What can non-profit organizations do legally?**

It is important to remember that any non-profit organization is permitted to lobby and that it will never jeopardize its 501(c)(3) tax status as long as it abides by the Internal Revenue Service regulations. Regarding lobbying, there are two facts to understand:

1. Lobbying is defined by the IRS as expenditure of an organization's resources to promote particular legislation. Direct lobbying is when money is spent for communication to a legislator or government employee who may participate in the formation of the legislation and both (1) refers to the legislation and (2) expresses a view on the legislation. Grass Roots lobbying is an attempt to influence specific legislation by encouraging the public to contact legislators about that legislation. Such grass roots lobbying (1) refers to specific legislation, (2) reflects a view about the legislation, and (3) encourages people to communicate with Members of Congress about that legislation. If the group doesn't spend funds for these purposes, according to the IRS, it has not lobbied. IRS lobbying laws do not limit the education of legislators. Organizations can inform their members about the legislative process and how citizens can influence the process. Lobbying simply refers to the allocation of an organization's funds for the purpose of influencing specific legislation.

2. A 501(c)(3) organization can spend an "insubstantial" amount (usually interpreted as 5%) of its budget on lobbying, or an organization can opt to spend up to 20% by filing IRS form 5768 and electing to come under the provisions of a 1976 law. Education and research expenditures are not reported as lobbying.

In addition to educating and lobbying Congress, a non-profit organization can educate its individual members, contributors and supporters about the importance of educating and lobbying Congress. Congress is usually more impressed by an informed district constituency (voters) who regularly visit their district offices than they are by visits paid by lobbyists in Washington, D.C. They are impressed if they have both visits from paid lobbyists in D.C. where they are their legislative assistants are kept well informed AND by constituents back home who demonstrate that citizens care about the developing world.

### **What can one person do?**

As a constituent, you can call, write and visit your Members of Congress. As an individual YOU CAN lobby for or against specific legislation, urge passage or defeat of a bill and try to directly influence the laws that govern our lives. Whenever you are in Washington, D.C., you can visit congressional offices, but Congresspeople are regularly in their district offices, and you can visit with them there. The key to being an effective advocate is to develop an on-going relationship, provide reliable information and understand the basics of the legislative process. (Refer to the section on the decision making process for a summary.)

As a citizen advocate, you can promote specific legislation while informing elected officials about health care issues. You can bring others with you to represent a diverse group of constituents and demonstrate the breadth of support for the expansion of the Medicaid system. If you have worked on programs that benefit from developmental assistance, you may know more than the legislator or his/her legislative assistant, and you can be an asset by providing this information. This information can be given by mail, visits, fax or phone. If you are involved in one or more organizations, ask the organizations to send their materials to your member of Congress and his/her legislative assistant.

As an effective advocate, you should use your time with your legislators wisely and efficiently. They are busy people, and you should come prepared. It is important for you to know his/her party affiliation, past voting record (if any), committee assignments and the characteristics of the district. If possible, work with representatives of other organizations to determine how many groups in the district support Medicaid and how many people that represents. It is also important to develop a relationship with the Legislative Assistant who works on the issues. S/he may be better informed on specific issues and often turns to effective and reliable advocates for information.

\* For more information about IRS regulations, refer to *Being a Player: A Guide to the IRS Lobbying Regulations for Advocacy Charities*, prepared in 1991 for the Advocacy Forum, a project of the Alliance for Justice, 1601 Connecticut Ave., N.W., Washington, D.C. 20009. Also refer to *The NonProfit Lobbying Guide*; Jossey-Bass Publishers, 1991.

## **Tips for Effectively Using the Media**

You can engage the media in Medicaid through letters to the editor, talking to reporters, issuing press releases, or by organizing press events to generate media coverage. This will allow your story to reach a wider audience and educate the broader public about Medicaid in your state.

Whatever media outreach option you choose, you will need to convey a message.

**TIP 1:** Hone your message. Keep it as straightforward as possible. Remember that your initial goal is not to thoroughly educate reporters about the program. Once you capture their attention, you can give more detail.

Messages are the overarching points that your organization wants to convey about an issue.

- Messages should support your main goals.
- Messages take time to create. You shouldn't rush the process.
- Messages should not change frequently. To have impact, they must be repeated over and over again. Stay on point.
- Less is more. Within a single campaign, don't have more than 3 or 4 messages. More is too confusing and won't get heard.
- Keep it short. Messages should be conveyed in a sentence or two. If it takes a paragraph, keep working.
- Make it understandable. Use plain language and avoid specialized vocabulary or acronyms.
- Make it memorable. Use sound bites, statistics and anecdotes. Real people stories are ideal. Have people available who receive Medicaid benefits prepared to talk to the press about why the program is important to them.

**TIP 2:** Once you establish your message, reach out to reporters and writers at local newspapers to discuss Medicaid and its importance to women and families.

### Pitch Call

*Purpose is to propose a story idea, an interview or coverage of an event.*

- Be succinct and persuasive – you have one or two minutes.
- Make your calls in the morning.
  - Print media deadlines can be as early as 4 pm.
  - For television, pitch two days ahead when possible. Decisions to send crews made night before a story appears on air.
- Begin with reporters you know.
- Offer a hook – even if you spark the reporters' interest, they may still need to sell it to their editors.
- Find ways to localize.
- Follow up with written information, if needed.
- Use pitch calls to build relationships:
  - Get to know journalists who cover your field.

- Call them with response to breaking news and with good, quotable quotes.
- Suggest interview “experts” or “real people.”
- Suggest getting together to discuss additional story ideas.

**TIP 3:** Use media advisories to announce an event, and use press releases to announce or respond to breaking news

#### Press Release

*Announces or Reacts to Breaking News and is Written Like a News Story*

- **Headline:** grab reporters’ attention.
- **Lead sentence:** summarize what’s most newsworthy.
- **Next:** facts and supporting quotes.
- **End of statement:** paragraph mission statement from organization.
- If reporters need substantial time to prepare story, send an embargoed release ahead of the release date.
- If e-mailing, subject line must grab the reporter – and never send attachments.

#### Media Advisory

*Alerts Reporters to an Upcoming News Event.*

- **Keep it short (one-page)**
  - List event and its participants, date and location.
  - Briefly identify the purpose of the event.
- **Offer a compelling preview**
  - Strong headline and lead sentence to peak reporters’ interest.
  - Don’t reveal your news but provide a reason for them to attend.
- Fax or e-mail to reporters who cover the issue, editors, news directors, bureau chiefs, TV/radio producers, and daybooks.
- Follow up with a phone call (pitch call).

**TIP 4:** Once you have successfully garnered media attention, you will do over the telephone or in person interviews with reporters. You can prepare for the interview by knowing all sides of the issue and thinking in advance about what kinds of questions the reporter will ask

#### Preparing for a Media Interview

- Remember the audience ... readers, listeners, viewers, not the reporter.
- What questions will the reporter likely ask?
- Have your message points and soundbites ready.
- Know your opponents’ viewpoints and have counterpoints ready.
- Don’t make things up and never lie.

#### The Interview

- In the presence of the media, you are always “on.” Be careful what you say –reporters have a job to do.
- Set ground rules – Don’t say anything you wouldn’t want to see in the paper.
  - On the Record
  - Off the Record

- On Background
- Stay on message!
- Don't use jargon or acronyms.
- It's okay to say you'll get back to them with additional information.
- When reporters ask incendiary questions or something you may not be comfortable asking, use these "off message," questions to bridge your point. E.g.:
  - The best way to answer that is to look at the broader issue...
  - What's really at issue here...
  - That's a good question. But first let me go back to an earlier point...
- Be concise. For TV, your interview will be edited to a 10-20 second clip.

**TIP 5:** Letters to the editor and op-eds provide outlets to concisely discuss your organization's view and control the message.

Letter to the Editor -- *A Short Rebuttal to an Article or Commentary, Usually 150-200 Words.* If you get a story about Medicaid placed in the newspaper, or if a newspaper runs a story on Medicaid, ask the families or individuals you work with to follow up with letters to the editor about how Medicaid has helped them.

- Keep it short and be factual but not dull.
- Timing is everything. Getting a letter the same day will increase your chances of publication. If a whole week has gone by, don't bother.
- Send it by e-mail in the body of the text, not as an attachment.

Op-Ed

*A Column or Guest Essay, Typically 500-700 Words in Length.*

- Should be timely, lively, forceful, and well written.
  - Unusual or provocative opinion on a current issue, a call-to-arms, or an expert take on an issue by a well-known name.
  - Not event announcements or generic ideas; want readers to say, "Wow, did you see that op-ed today?"
- Determine your goal and audience, then determine the news outlet that can best deliver your op-ed to your target audience.
- Figure out what you want to say and who can say it.
- Make your points compelling – first sentence should grab the readers' attention and everything that follows should keep it.

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The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including economic security, education, employment and health, with special attention given to the concerns of low-income women. For more information on the Center visit: [www.nwlc.org](http://www.nwlc.org).

**SAMPLE LTE**

To the Editor:

Gardiner Harris's June 19 article (Gee, Fixing Welfare Seemed Like a Snap) repeated the National Governor's Association erroneous claim that Medicaid accounts for 22 percent of state budgets, and that states pay more for Medicaid than elementary and secondary education. In fact, state spending on Medicaid accounts for an average 12.7 percent of state budgets, which is far below K-12 and higher education costs, according to the Congressional Research Service.

The governors' singular focus on Medicaid as a percentage of state budgets ignores larger issues: states are paying more for Medicaid today than five years ago because overall health care costs have risen and program enrollment has increased. Slashing Medicaid spending is a quick fix for curbing public expenditures but will not solve these underlying issues.

By dealing with budget woes through scaling down public health insurance programs, we are merely borrowing time. In the end, the public will pay more as the poor forego routine and needed medical care and require more expensive care when they become even sicker. And still, we will not have addressed the growing ranks of uninsured Americans.

Marcia D. Greenberger  
Co-president  
National Women's Law Center