

Government-Sponsored Plans Guide

In General

There are several government-sponsored health care programs which are discussed. These programs are significant to the examiner because they may provide benefits similar to those of the employer-sponsored plans. These are the government-sponsored plans:

Federal

Medicare
CHAMPUS
Social Security Disability
Veteran's Administration

Federal-State Jointly Sponsored

Medicaid

State Sponsored

State Disability Benefits
Workers' Compensation Benefits

None of the above-named plans are deemed to be *private* plans within the meaning of the Medicare Secondary Program or COBRA. Nor are federal and other governmental employee plans deemed to be *private* plans for such purposes.

Medicare

In General

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people. It is administered by the CMS. The Social Security Administration takes applications for Medicare, assists beneficiaries in claiming Medicare payments, and provides information about the program.

Medicare has two parts: hospital insurance and medical insurance. Hospital insurance helps pay for inpatient hospital care and certain follow-up care. Medical insurance helps pay for doctor's services and many other medical services and items.

Hospital insurance is financed through part of the payroll (FICA) tax that also pays for Social Security. Voluntary medical insurance is financed from the monthly premiums paid by people who have enrolled for it and from general federal revenues.

Eligibility

A person is eligible for Medicare hospital insurance **at 65** if:

- Such person is entitled to monthly Social Security or railroad retirement benefits.
- Such person has worked long enough to be insured under Social security or the railroad retirement system.
- Such person would be entitled to monthly Social Security benefits based on his or her spouse's work record and such spouse is at least 62 (a spouse does not have to apply for benefit).
- Such person has worked long enough in federal, state, or local government employment to be insured for Medicare purposes.

A person is eligible **before age 65** if:

- Such person has been entitled to Social Security disability benefits for 24 months.
- Such person has worked long enough in government employment.

A wife, husband, or child may be eligible if she or he needs maintenance dialysis or a transplant. **Only** the family member who has permanent kidney failure is eligible for Medicare protection.

If a person is entitled to a railroad disability annuity or railroad retirement benefit based on disability such person may be eligible for Medicare.

Becoming Covered

Some people have to apply for hospital insurance protection before it can start. For others, hospital insurance protection starts automatically.

A person does not have to retire to have hospital insurance protection at 65. But if such person plans to keep working, such person will have to file an application for hospital insurance in order for your protection to begin. Such person should apply to Social Security about 3 months before age 65.

If a person is receiving Social Security or railroad retirement checks, hospital insurance protection will start automatically at 65.

If a person is a government retiree who is eligible for Medicare on the basis of government employment, such person will have to apply for hospital insurance in order for it to begin at 65. Such person should contact Social Security about 3 months before the 65th birthday to file an application.

If a person is not eligible for hospital insurance at 65, such person can buy it. To buy hospital insurance, such person also has to enroll and pay the monthly premium for

medical insurance. If an alien, such person must be a permanent resident and must reside in the U.S. for 5 years before Medicare may be purchased.

Being Disabled

If a person is under 65 and disabled, such person will have hospital insurance protection automatically after being entitled to Social Security disability benefits for 24 months.

If a person is a widow or widower between 50 and 65 and disabled – but has not applied for disability benefits because such person is already receiving other Social Security benefits – such person may be able to get hospital insurance. If disability is a possibility, it is advantageous to contact Social Security as soon as possible, because there is a waiting period before one is eligible for hospital insurance.

If a person is a government employee and becomes disabled before age 65, such person may be eligible for Medicare on the basis of government employment. Generally, there is a 29-month waiting period before hospital insurance protection can start. Such person should contact Social Security as soon as becoming disabled.

End Stage Renal Disease

End stage renal means permanent kidney failure. If a person, or a spouse or child of a person needs kidney dialysis or a kidney transplant, contact Social Security to apply for Medicare. Such person may apply by phone, or a representative can visit such person to take an application if such person is unable to go to the office.

If a person is eligible for Medicare, such protection will start with the third month after the month after such person actually begins maintenance dialysis treatment. Under certain conditions, coverage can start earlier.

Eligibility for Medical Insurance

Almost anyone who is 65 or older or who is eligible for hospital insurance can enroll for Medicare medical insurance. A person does not need any Social Security or government work credits to get medical insurance.

Aliens 65 or older who are not eligible for hospital insurance must be permanent residents and must reside in the U.S. for 5 years before they can enroll in medical insurance.

Obtaining Medical Insurance

A person may obtain medical insurance protection, by paying a monthly premium for it. Some people are automatically enrolled in medical insurance. Others must apply for it.

Automatic Enrollment for Medical Benefits

If a person is receiving Social Security benefits or retirement benefits under the railroad retirement system, such person will be automatically enrolled for medical insurance - unless declined: at the same time such person becomes entitled to hospital insurance.

Applying For Medical Insurance

A person has to apply for medical insurance if such person:

- Plans to continue working past 65.
- Refuses medical insurance enrollment when first becoming entitled to hospital insurance.
- Is 65 but not eligible for hospital insurance.
- Has permanent kidney failure.
- Is a disabled widow or widower between 50 and 65 who isn't getting disability benefits.
- Has medical insurance but terminated such coverage.
- Is eligible for Medicare on the basis of government employment.
- Lives in Puerto Rico or outside the U.S.

Contact Social Security or the railroad retirement office for detailed information about medical insurance enrollment.

Home Health Care

If a person is home confined, and meets certain other conditions, hospital insurance can pay the full approved cost of home health visits from a participating home health agency. There is no limit to the number of covered visits.

Covered services include part-time skilled nursing care, physical therapy, and speech therapy. If such person needs one or more of those services, hospital insurance also covers part-time services of home health aids, occupational therapy, medical social services, and medical supplies and equipment.

Hospice Care

Under certain conditions, hospital insurance can help pay for hospice care for terminally ill beneficiaries, if the care is provided by a Medicare-certified hospice.

Special benefit periods apply to hospice care. Hospital insurance can pay for a maximum of two 90-day periods and one 30-day period.

Covered services include doctors' services, nursing services, medical appliances and supplies including out-patient drugs for pain relief, home health aide and homemaker services, therapies, medical social services, short-term inpatient care including respite care, and counseling.

Hospital insurance pays almost all of the cost of out-patient drugs and inpatient respite care. For all other covered services, hospital insurance pays the full cost.

Medical Insurance Benefits

Medicare medical insurance helps pay for doctor's services and a variety of other medical services and supplies that are not covered by hospital insurance. Many of the services needed by people with permanent kidney failure are covered only by medical insurance.

Each year, as soon as such person meets the annual medical insurance deductible, medical insurance generally will pay 80 percent of the approved charges for covered services received during the rest of the year.

Doctors' Services

Medical insurance covers doctors' services no matter where received in the U.S. Covered doctors' services include surgical services, diagnostic tests and X-rays that are part of the treatment, medical supplies furnished in a doctor's office, services of the office nurse, and drugs which are administered as part of treatment and cannot be self-administered.

Outpatient Hospital Services

Medical insurance covers outpatient hospital services received for diagnosis and treatment such as care in an emergency room or outpatient clinic of a hospital.

Home Health Visits

Medical insurance can cover an unlimited number of home health visits if all required conditions are met, and such person does not have Medicare hospital insurance.

Other Medical and Health Services

Under certain conditions or limitations, medical insurance covers other medical services and supplies. Some examples are: ambulance transportation,

home dialysis equipment, supplies, and periodic support services; independent laboratory tests; outpatient physical therapy and speech pathology services; and X-rays and radiation treatments.

Exclusions

Medicare provides basic protection against the high cost of illness, but it will not pay all health care expenses. Some of the services and supplies Medicare cannot pay for are: custodial care, such as help with bathing, eating, and taking medicine; dentures and routine dental care; eyeglasses, hearing aids, and examinations to prescribe or fit them; nursing home care except for care in a skilled nursing facility; personal comfort items, such as a phone or TV in the hospital room; prescription drugs and patient medicines; and most routine physical checkups and related tests.

In certain situations, Medicare can help pay for care in qualified Canadian or Mexican hospitals. Otherwise, Medicare cannot pay for hospital or medical services received outside the U.S. (Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands are considered part of the U.S.).

Employer Group Health Plans

Group health plans that cover at least one employer with 20 or more employees are required to offer their workers age 65 or older the same health benefits that are provided to younger employees. They also must offer the spouses age 65 or older of workers of an age the same health benefits given younger spouses.

If a person is 65 or older and continues working - or is the spouse 65 or older of a worker - and such person accepts the employer's health plan, Medicare will be the secondary health insurance payer. This means that the person or doctor should bill the other insurance plan first. Medicare ordinarily pays the part of the bill that the other plan does not pay.

If a person rejects the employer's health plan, Medicare will be the primary health insurance payer. The employer is not allowed to offer a Medicare supplemental coverage if his or her health plan is rejected.

If a person has reason to believe that his or her employer's plan is not providing the same benefits extended to younger workers, or if the employer's plan is paying benefits secondary to Medicare, such person should bring this to the attention of the insurance carrier that handles his or her Medicare claims.

Also, if a person works past 65 - or is a s 65 or older - and is covered under an employer health plan from an employer of any size, such person can wait to enroll in Medicare medical insurance during a 7 month special enrollment period. The special enrollment period begins with the month the plan coverage ends, or the month employment ends - whichever comes first. If a person meets certain requirements, such person won't have to wait for a general enrollment period, and won't have to pay the 10 percent premium surcharge for late enrollment.

If a person is under 65 and disabled, Medicare will be the secondary payer if such person chooses coverage under the employer's health plan or a family member's employer health plan. This provision applies only to large group health plans. A large group health plan is any plan that covers employees or at least one employer that has 100 or more workers. But, such person has special enrollment period and premium rights under Medicare medical insurance that are similar to those workers 65 or older have.

If a person is under 65, is entitled to Medicare solely on the basis of permanent kidney failure, and has an employer group health plan, Medicare will be the secondary payer for an initial period of up to 18 months. At the end of the 18-month period, Medicare becomes the primary payer.

If a person is under 65 and entitled to Medicare on the basis of disability or because such person has kidney failure and the employer's plan is denying coverage, offering different coverage, or paying benefits that are secondary to Medicare he or she should notify the insurance carrier that handles Medicare claims.

CHAMPUS

In General

CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services. CHAMPUS share most of the costs of care from civilian hospitals and doctors when the family members cant get care through a military hospital or clinic. But there are certain things the family members need to know about CHAMPUS before using it.

CHAMPUS is intended as a supplement to benefits from a military hospital or clinic, but it does not duplicate those benefits. The most comprehensive and lowest cost care is available from military medical facilities. Also CHAMPUS recognizes different categories on eligible persons, from whom available benefits and costs vary.

- Some people are not eligible for CHAMPUS, such as active-duty military, parents, parents-in-law, and most persons eligible for Medicare hospitalization insurance.
- CHAMPUS is not free. The family members must pay part of the medical costs, as well as everything CHAMPUS doesn't cover.

Covered Persons

CHAMPUS is a health benefits program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service and National Oceanic and Atmospheric Administration.

Here's a list of who's covered by CHAMPUS:

- Husbands, wives, and unmarried children of active-duty service members;
- Retirees, their husbands or wives, and unmarried children.
- Unmarried husbands and wives and unmarried children of active-duty or retired service members who have died.

- Husbands, wives and unmarried children of reservists who are ordered to active duty for more than 30 days (they are covered only during the reservist's active-duty tour) or reservists who die on active duty.
- Former spouses of active or retired military who were married to a service member or former member who had performed at least 20 years of creditable service for retirement purposes at the time the divorce or annulment occurred. The former spouse must also meet the following requirements:
 1. Must not have remarried.
 2. Must not be covered by an employer-sponsored health plan.
 3. Must not be eligible for Part A of Medicare.
 4. Must not be a NATO member's former spouse.

A divorced person to be covered must meet at least one of the following three situations:

- A. Must have been married to the SAME member or former member for at least 2- years, and at least 20 of those married years must have been creditable in determining the member's eligibility for retirement pay.
- B. Must have been married to the SAME member or former member for at least 20 years, and at least 15 – but less than 20 – of those married years must have been creditable in determining the member's eligibility for retirement pay.
- C. Must have been married to the SAME military member or former member for at least 20 years, and at least 15 – but less than 20 – of those married years must have been creditable in determining the member's eligibility for retirement pay.

Social Security Disability

Workers Benefits

For the purposes of Social Security, disability is a mental or physical impairment-expected to result in death or to last for a period of not less than 12 months that prohibits an individual from engaging in any substantial gainful activity.

Social Security disability benefits are payable after a five-month waiting period. Disability benefits end with the earliest of (a) the month in which the worker dies, (b) the month in which he attains age 65, or (c) the third month following the month in which disability ceases.

To be insured for disability benefits in any month, an individual must be fully insured, i.e., have one quarter of coverage for each year after the later of 1950 or year of attainment of age 21, up to the computation point. The computation point is the first of the year in which the earlier of disablement or age 62 occurs. The individual must also have had at least 20 quarters of coverage during the ten years prior to becoming disabled. Special exceptions apply in the case of an individual who becomes disabled prior to age 31 and in the case of blindness.

Age and work credits. Although the amount of earnings constituting a quarter of coverage will change each year, it is possible to provide general guidelines on the amount of credited employment needed to qualify for benefits. A current Social Security brochure summarizes by age the number of years of credit employment required.

Family Benefits

Benefits are also payable to the dependents of a disabled worker. The benefits are based on a certain percentage of the worker's benefit subject to a maximum limit referred to as the Maximum Family Benefit.

Every child of an individual entitled to disability benefits is entitled to a monthly benefit of one-half the individual's Primary Insurance Amount (PIA). Payments cease with the month preceding the earliest of (a) the month in which the child dies or marries, (b) the month in which the child attains age 16 and is neither disabled nor a full-time student in an elementary or secondary school, (c) the earliest of a month during no part of which he was a full-time student in an elementary or secondary school, or the month he attains age 19 (under certain circumstances benefits may continue through the current semester in which he is enrolled.)

A spouse may receive full benefits-100% of the worker's PIA-at any age while caring for a child entitled to a child's benefit, provided the child is not receiving his benefit solely because he is a student. Payments will cease with the month before the month in which (a) either spouse dies, (b) they are divorced (a special rule applies if duration of marriage is greater than ten years), (c) the primary insured individual is not entitled to disability benefits or old-age benefits, or (d) there is not child entitled to benefits and the spouse is under age 62.

Impairment Test

To qualify for SS disability benefits, an individual must have a medically determinable physical or mental impairment so severe that it prevents the performance of any substantial work for at least 12 months, or is expected to result in death. In cases where a determination of disability cannot be made on the basis of medical evidence alone, an individual's impairment must be so severe that he not only is unable to do his previous work but also cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy.

Since 1956, when the Social Security Act was amended to provide for the payment of disability benefits, the determination as to whether disability exists has been made, in some cases, on factors such as these described in the regulations.

In determining whether an individual's impairment makes him unable to engage in substantial gainful activity primary consideration is given to the severity of his impairment. Consideration is also given to such other factors as the individual's education, training, and work experience.

It must be established by medical evidence, and where necessary by appropriate medical tests, that the applicant's impairment results in such a lack of ability to perform significant functions—such as moving about, handling objects, hearing or speaking, or, in a case of mental impairment, reasoning or understanding—that he cannot, with his training, education, and work experience, engage in any kind of substantial gainful activity.

Social Security Determines Disability

The COBRA participant may obtain 29 months of continuation if disabled on the Qualifying Parts as *determined by Social Security*. How does SS determine disability? Their rules follow:

- SS pays only for total, long-term disability, and not for partial disability or conditions that last less than 5 months. SS defines disability in terms of the ability to work. A person who cannot work for a year or more, or whose condition is likely to result in death, may qualify for benefits.
- Disability is determined by doctors and disability examiners at State agencies based on clinical evidence and examinations. The actual process of determining disability involves five basic questions. They are:
 1. Are you working? If you are and are earning at least \$500 a month, you will not be considered disabled.
 2. Is your condition severe? If your impairments do not singly or in combination interfere with the basic work-related activities, your claim will be denied.

3. Is the condition severe enough to meet the Listing of Impairments? SS maintains a list of impairments for each of the major body systems which are so severe they automatically mean you are disable. If your condition is not on the list, SS has to determine if it has the same effect as a condition on the listing with regard to your ability to perform work-related activities.
4. Can you do the work you did previously? If you cannot do the work you did previously, the SS looks to see if you can do any other type of work. Social Security considers your age, education, past experience and transferable skills and reviews the job demands of occupations as determined by the Department of Labor.
5. Can you do any other type of work? If you cannot do the work you did previously, SS then looks to see if you can do any other type of work. If you cannot do past or other work, you will be found disabled.

Under this process, one person may qualify for disability benefits while another person with the same condition may not, based on the difference in their ability to work.

Social Security Regulations

The SS regulations list criteria that are to be considered in appropriate sequence, the first of which is the determination of whether an individual is actually engaging in substantial gainful activity. It is in this area that the dollar amounts referred to above apparently come into play. To quote the regulations:

Determinations based on an individual engaging in substantial gainful activity. Where an individual is actually engaging in substantial gainful activity, a finding will be made that the individual is not under a disability without consideration of either medical or vocational factors.

Determinations based solely on the medical severity of impairments. Medical considerations alone can justify a finding that the individual is not under a disability where the medically determinable physical or mental impairment is not severe, e.g., does not significantly limit the individual's physical or mental capacity to perform basic work-related functions. On the other hand, medical considerations alone would justify a finding of disability where:

- The impairment meets the duration requirement (i.e., is expect to last at least 12 months or result in death).
- The impairment meets or equals the severity of a listed impairment published in the disability regulations.
- Other evidence does not rebut a Finding of disability, e.g., the individual is not actually engaging in substantial gainful activity.

Determinations based on vocational as well as medical considerations. Where an individual with a marginal education and long work experience (e.g., 34 to 40 years or more) which was limited to the performance of arduous unskilled physical labor, is not working and is no longer able to perform such labor because of a significant impairment or impairments, the individual may be found to be disabled. Where a finding of disability (or its absence) is not made under any of the foregoing steps, the individual's impairment is evaluated in terms of physical and mental demands of the individual's past relevant work. If the impairment does not prevent the performance of past relevant work, disability will be found not to exist. If an individual cannot perform his or her past relevant work but the individual's physical and mental capacities are consistent with his or her meeting the demands of a significant number of jobs in the national economy, and the individual has the vocational capabilities (considering his or her age, education, and past work experience) are not consistent with making an adjustment to work different from that which the individual has performed in the past, it will be determined that the individual is under a disability.

Mental Impairments

Medical criteria for evaluating mental impairments have been revised by the Social Security Administration, in consultation with the American Psychiatric Association, and other professionals.

Because the diagnosis, evaluation, and treatment of mental disorders are continually changing, the Department of Health and Human Services and the American Psychiatric Association will periodically review and update rules in these areas.

Dual Approach. In determining disability for Federal Old-Age, Survivors and Disability insurance, a dual approach is used in most instances. Both the presence of mental disorder (Part A) and its relevance to the ability to work (Part B) are evaluated to determine eligibility for mental health disability payments. The existence of mental impairments is decided according to medical evidence, just as the existence of physical impairments is decided. Psychiatric history is also considered when evaluating the severity of mental disorders.

Documentation. The presence of mental disorders is documented primarily on the basis of reports from individual providers, such as psychiatrists, psychologists, and mental health facilities. Psychiatric history, clinical signs, symptoms, and laboratory findings are considered.

Psychotic And Other Severe Disorders. Organic mental disorders are psychological and behavioral abnormalities associated with the dysfunction of the brain, determined by history and physical examination or laboratory tests. The new regulations add four requirements to Part A of the procedure for determining severity. Any one of the seven requirements must be medically proven for Part A, along with demonstration of a specific loss of cognitive abilities.

Nonpsychotic Disorders. Anxiety-related somatoform, personality, and substance-addiction disorders were previously grouped together. The new regulations considered each separately. Anxiety-related disorders now include disorders resulting from traumatic experiences. The new regulations also give significance to frequent panic attacks.

Veteran's Administration

Compensation For Disability

The Veteran's Administration (VA) pays compensation to the veteran who is disabled by injury or disease incurred in or aggravated by active service in line of duty. Payments are based on the degree of disability.

The VA pays additional money for dependents if service-connected disabilities are evaluated as thirty percent or more disabling. In addition, if the veteran is thirty percent or more disabling and the spouse is in need of regular aid and attendance, an increased dependency allowance is payable for such spouse.

Special monthly compensation rates may be authorized for veterans whose service-connected disabilities are very severe and meet certain statutory requirements. These special rates apply, for example, for blinded veterans and those who have lost limbs or the use of limbs.

VA Medical Care

The VA provides hospital or outpatient care when needed for all service-connected medical or compensated dental conditions. It will give treatment at one of the many VA medical centers or clinics. Also, under certain circumstances, it may pay for outpatient care by a hometown doctor or dentist. Generally, it will not authorize payment for services of hometown doctors or dentists not approved in advance.

Certain persons who were administratively discharged under other than honorable conditions may be furnished health care for any disability incurred or aggravated during active duty service in line of duty.

Hospital care in VA facilities is provided to any veteran who is rated service-connected; is retired from active duty for a disability incurred or aggravated while in military service; is in receipt of VA pension; is eligible for Medicaid; is a former POW; is in need of care for a condition possibly related to exposure to dioxin or other toxic substance (such as Agent Orange) while in Vietnam August 5, 1964, through May 7, 1975; is in need of care for a condition possibly related to exposure to ionizing radiation from participating in nuclear test or in the American occupation of Hiroshima or Nagasaki, Japan between September 11, 1945, and July 1, 1948; or an income below \$15,833 for additional dependent). Hospital care in VA facilities may

be provided on a space available basis to nonservice-connected veterans with incomes between \$15,833-\$21,110 for a veteran with no dependents and between \$18,999-\$26,388 for a veteran with a spouse (add \$1,055 for each additional dependent). Veterans with incomes in excess of these amounts may be furnished hospital care in VA facilities on a space available basis if they agree to pay the VA a copayment.

Note: Income amounts listed above will be adjusted January 1 of each year by the same percent VA pension rates a re increase. Amounts are for 1989.

The VA will furnish all necessary outpatient treatment, including drugs and medicines, for any medical disability if:

- The veteran is of the Spanish-American War, the Mexican border period or of World War I.
- The veteran is receiving an allowance for regular aid and attendance.
- The veteran is receiving an allowance because of being housebound.
- The disability is service-connected and rated at 50 percent or more.
- The veteran is a former prisoner of war.

The VA may provide certain outpatient medical services to prepare for hospital care and to complete treatment furnished VA hospital care.

The VA may furnish ambulatory care to the veteran eligible for hospitalization who meets the following conditions:

- Hospital care is necessary but may be avoided by ambulatory care.
- Hospital care would be necessary if the condition remains untreated.

The VA may furnish outpatient and ambulatory care within available resources on a priority basis. Veterans with a service-connected disability are in the top priority group.

As part of outpatient medical treatment, the veteran may be eligible for home health services necessary or appropriate for the effective and economical treatment of disabilities. These services include some home improvements and structural alterations.

If Vietnam era veteran readjustment counseling and follow-up mental health services to facilitate adjustment to civilian life is available.

If the veteran needs a prosthetic appliance, and if receiving hospital or domiciliary care or meeting the basic requirements for outpatient treatment, it may be provided.

Medicaid

In General

Medicaid is a program of medical assistance, funded by the federal government and the states, for impoverished individuals who are aged, blind, or disabled, or members of families with dependent children. The states operate Medicaid programs according to state rules and criteria that vary widely within a broad framework of federal guidelines.

The original Social Security Act, made no direct provision for medical assistance. However, it did establish a system of categorical public assistance that allowed the federal government to share with states the cost of providing maintenance payments to the needy aged and blind, and to needy families with dependent children. This assistance, which was subsequently extended to the permanently and totally disabled, could include the cost of some medical care in monthly assistance payments to recipients.

In 1950, public assistance under the Act was broadened to include federal sharing in vendor payments, i.e., direct payments by a state to doctors, nurses, and health care institutions, rather than to the welfare recipient himself. Although federal sharing in vendor payments created an administrative framework for a welfare medical program, federal funding was so small that only a few states participated. Subsequent amendments to the Act made more federal funds available so that, by 1965, all of the states provided medical vendor payments in their federally aided categorical assistance programs. Many states also offered an allowance for some items of medical care in welfare payments to categorical assistance recipients.

The need for medical assistance became so great that most states could finance only a few services. To help satisfy this need Medicaid was enacted in the Social Security Amendments of 1965 providing grants to states for medical assistance programs beginning January 1, 1966.

Financing

Medicaid is jointly funded by the states and the federal government, with the federal share of expenditures determined by a formula based on state per capita income. States with relatively low per capita income of \$8,088 had a match of 79.9% in fiscal year 1991, while Connecticut, with a per capita income of \$16,094, received a 50% match. Since 1987 this matching rate has been recalculated annually.

Program administration costs are matched at 50%, and higher matching rates are provided for data systems operations and quality monitoring efforts. States failing to meet administrative performance standards may have either their medical services or administration match reduced by specified percentages. Overall, federal funds account for approximately 57% of the total Medicaid expenditures.

Federal payments to the states are appropriated annually from general revenues to meet expenditures submitted by the states. There is no limit on federal payment. States may finance their share entirely from state funds or require local governments to finance up to 60% of program costs. Only 14 states exercise the latter option and local dollars account for a small proportion of state financing in all but three of these states.

Eligibility By State

Persons qualify for coverage because they are either categorically needy or medically needy. All persons receiving Aid to Families with Dependent Children (AFDC) and most persons on Supplemental Security Income (SSI) are considered categorically needy and are covered in all states. Certain groups that do not receive cash assistance are also defined as categorically needy. States also have the option of treating other groups as categorically needy.

These include children (those younger than a maximum state age limit and poor enough to meet AFDC income standards but who do not qualify for cash assistance for other reasons), institutionalized persons meeting state financial standards, and disabled children living in the community who would be eligible if institutionalized.

Thirty-seven states provide benefits to the medically needy: individuals whose income or resources exceed standards for cash assistance but who meet a separate state-determined income standard and are also aged, disabled, or a member of a family with dependent children. Persons who *spend down* income and assets due to large health care expenses may qualify as medically needy.

Reimbursement

State Medicaid plans must provide payment rates that are consistent with efficiency, economy, and quality of care, for practitioners, laboratories, suppliers, and other health care providers. Payment must be sufficient to enlist enough providers so that Medicaid services are available to the general population, and providers must accept Medicaid payment as payment in full as a condition of Medicaid participation.

For inpatient hospital and nursing home services, a state's Medicaid agency must offer the HHS Secretary assurances that the rates are reasonable and adequate, after which the Secretary either disapproves the rates, accepts them, or accepts them by default by failing to review them within a specified time.

Benefits Provided

All states must provide a standard benefit package to the categorically needy that includes inpatient and outpatient hospital services; physician services; laboratory and X-ray services; family planning; skilled nursing facility (SNF) services for adults; home health care for persons entitled to SNF services; rural health care clinic services; nurses-midwife services; and Early and Periodic Screening, Diagnosis, and Treatment for children.

The required benefit package for the medically needy is less comprehensive than that for the categorically needy. States opting to cover the medically needy must, at a minimum, provide ambulatory care for children and prenatal care and delivery

services for pregnant. Almost all states that have medically needy programs; however, provide the same services to both medically and categorically needy recipients.

States must also provide (and receive federal matching payments for) 32 other service categories. Among these are prescription drugs; dental care; eyeglasses; services provided by optometrists, podiatrists, and chiropractors; intermediate care facility (ICF) services; and services to the mentally retarded in ICFs. There is considerable variation among states in optional services offered. Virtually all cover prescription drugs, ICF services, and optometrists' services. Regardless of the services a state chooses to offer, it must do uniformly throughout the state, providing comparable coverage to all categorically needy beneficiaries and allowing beneficiaries to obtain services from any qualified provider.

The three requirements of uniformity, comparability, and freedom of choice may be waived under certain conditions if approved by the Health Care Financing Administration (HCFA). For example, HCFA has authority to grant waivers for four different types of managed care options: promotion of voluntary enrollment in health maintenance organizations (HMOs), voluntary or mandatory enrollment in health maintenance organizations (HMOs), voluntary or mandatory enrollment in partial capitation or fee-for-service primary care case management systems, voluntary or mandatory enrollment in health insuring organizations (HIOs), and mandatory enrollment in multiple HMO systems under which beneficiaries may voluntarily disenroll from one organization in order to enroll in another.

Managed care arrangements affect only a small percentage of Medicaid beneficiaries. About 2.8 million beneficiaries (slightly more than 10% of all Medicaid beneficiaries) residing in 30 states are enrolled in Medicaid managed care programs, with only Arizona's program covering all beneficiaries statewide.

Benefits Limitations

States have broad discretion in defining coverage of both mandatory and optional services. They may impose durational limits on coverage such as ceilings on inpatient days or physician visits. They may also establish utilization controls such as medical necessity reviews, prior authorization for certain services, or second surgical opinion programs. Most deny coverage for experimental services.

With respect to physician's services, states have placed limits on specific services (such as organ transplants, cosmetic surgery, and routine physicals); the frequency of visits; and the frequency of visits by practice setting. In 1987, 11 states limited inpatient physician visits, and 12 states limited physician visits in long-term care facilities. Five states (Arkansas, Kansas, Nevada, Oklahoma, and Tennessee) limited office visits; three (Arkansas, Ohio and Oklahoma) limited home visits; six limited visits for all settings other than inpatient hospital; and one (Missouri) limited emergency room visits made for nonemergency reasons. States may also apply limits to the number of times specific services may be provided. These services typically include psychiatric visits, consultations with specialists, family planning, comprehensive physical exams; and eye exams.

In addition, 22 states require prior authorization for specific procedures such as hemodialysis, sterilization, and organ transplants. Eleven require prior authorization for all elective procedures. States may also require authorization for certain service sites or for care outside the state. In 1987, only five states (Colorado, Maine, New York, North Dakota, and West Virginia) placed no limits on physicians' services.

Ten states have instituted beneficiary cost sharing as a form of utilization control. Federal statute constrains the use of this strategy, however, permitting only nominal copayments (for example, \$1 per physician visit) and only for certain group beneficiaries. Certain services, such as pregnancy and emergency care, are also statutorily exempt from copayment requirements. In addition, providers may not deny services if a beneficiary cannot pay the cost sharing amount.

Cost Sharing By Recipients

State Medicaid plans may impose deductibles, coinsurance, or copayments on Medicaid recipients, except for certain children, hospital or nursing home inpatients.

Requirements for Institutions

The institution used by a Medicaid patient must be licensed or formally approved by an officially designated state standard-setting authority. It must also be certified to provide care under the Medicare program or be determined currently to meet the requirements, certification, and it must have in effect a utilization review plan applicable for all patients who receive medical assistance.

Administration

At the federal level, the Secretary of Health and Human Services is responsible for administration of federal grants-in-aid for the state programs. Immediate responsibility at the federal level has been assigned to the CMS.

Medicaid Third Party Recovery

New Medicaid third-party liability regulations require states to integrate pursuit of third-party liability payments with the mechanized claims processing and information retrieval systems used to administer their Medicaid programs. States must generally refuse to make Medicaid payments when third-party liability is known, but the regulations specify when states must pay and then attempt to collect certain claims involving young children and pregnant women.

The regulations penalize providers for seeking payment from a Medicaid-eligible individual, or from the individual's relative or representative, of any amount for which a third party is liable. Providers may not refuse Medicaid-covered services to eligible individuals, however, on the basis of a third party's liability. See Attachment A - Medicaid Last Payer Program - Prescription Drugs

Recent Federal Legislation

Since 1986, the Congress has broadened the number of poor persons eligible for the Medicaid by weakening this link between Medicaid and cash benefits. Expanded Medicaid eligibility has been targeted to specific populations, especially pregnant women and children. Recent measures include:

- The Omnibus Budget Reconciliation Act of 1986 (Pub. L. No. 99-509, OBARA86), which permitted states to cover, first, pregnant women and young children, and second, the aged and disabled with incomes up to 100% of the federal poverty level.
- The Omnibus Budget Reconciliation Act of 1987(Pub. L. No. 100-203, OBRA87), which created a state option to cover pregnant women and infants with incomes up to 185% of the federal poverty level.
- The Medicare Catastrophic Coverage Act of 1988 (Pub. L. No. 100-360), which converted OBRA86 opinions to mandates for pregnant women, infants, and Medicare eligible with family incomes below 100% of poverty, and allowed states to cover poor children up to their eighth birthday.
- The Omnibus Budget Reconciliation Act of 1989 (Pub. L. No. 101-239, OBRAA89), which required states to cover all pregnant women and infants in families with incomes up to 133% of the federal poverty level effective April 1, 1990, and phased in mandatory coverage of all children born after September 30, 1990, up to their sixth birthday in families below 133% of poverty.
- The Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508, OBRA90), which requires states to cover poor children born after September 30, 1983, who are over six years old, up to their 19th birthday.

State Disability

In General

State temporary disability statutes are another approach to the problem of the worker who is cut off from earnings by a non-job illness or accident. California, Hawaii, New Jersey, New York, Puerto Rico and Rhode Island already have these temporary disability laws. The New Jersey statute's statement of purpose is a good example of the objectives of all six--to make comprehensive and systematic provision for the protection of working people against loss of earnings due to nonoccupational sickness or accident.

Thus, workers in these six jurisdictions now have protection that goes well beyond the benefits provided by workers' or unemployment compensation. Workmen's compensation, while protecting workers who are forced into unemployment because of sickness or accident; protects them only if the cause is in some way connected with their work. Likewise, unemployment compensation protects workers who become unemployed through no fault of their own, but only if they are able to work, and are available for work. The temporary disability statutes go further--they protect workers who are involuntarily forced into unemployment or who are forced to remain unemployed, because of a nonoccupational sickness or accident.

Plan Administration

To accomplish this protection, state-administered funds have been created as a source from which eligible employees may receive temporary benefits while suffering from a qualifying disability. The financing of these funds is achieved in most part through required contributions of covered employees. Employers are also required to contribute in Hawaii, New Jersey, New York, and Puerto Rico, however.

In all of the six states the amount of the contributions from covered employees is based on the employee's individual earnings. In Rhode Island, for example, a covered employee must contribute an amount equal to 1.5% of the first \$4,800 in wages paid to him by his employer during a calendar year. Employees who rely upon prayer or other spiritual means for restoration of health to the exclusion of medical methods may be exempted from making these required contributions. (In California and Rhode Island, employee contributions for unemployment insurance have been ended, either in whole or in part, on enactment of the Temporary Disability Benefit States.) In most cases, the contributions are withheld from the employees' wages and later transmitted by the employer to the state agency or, if the employer has a private plan, to the plan insurer. It should be noted at this point that all of the states provide severe penalties for violation of this requirement.

Benefits

Benefits from these funds vary both in amount and duration in the different states. Generally speaking, they range in amount from a minimum of seven dollars a week to a maximum of \$154.00 a week for a period of not more than 39 weeks in California, 26 weeks elsewhere. As in the case of contributions, the benefits are computed on the basis of the workers' past earnings; a direct relationship is therefore established between how much the worker has contributed and how much he may receive. Payments of the benefits are made in cash, and employees, of course, must file notice and proof of claims as required by their respective states.

Length Of Disability Payments

Temporary disability benefit statutes are just that –temporary. They offer no safeguard to the worker who becomes permanently disabled due to a non-job illness or accident. He must look for help, if any, to the provisions of his employer's pension plan which deal with permanent and total disability. The duration of benefit payments under the disability laws of four states and Puerto Rico is fixed at 26 weeks. California's maximum duration is 39 weeks.