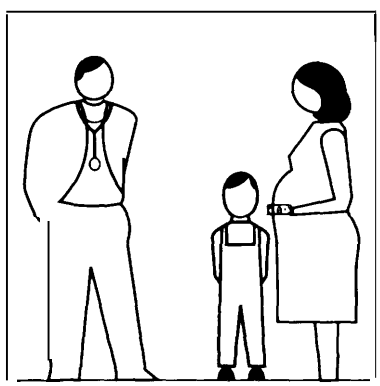
Background 2

Patient cost-sharing is common in health insurance and whether it should remain a feature of national health reform is a critical issue. What are the effects of patient cost-sharing? Do upfront copayments affect health outcomes because they discourage the use of health services? Does not having cost-sharing lead to unnecessary, frivolous care? Is there evidence that patients really do make better choices when they bear some of the costs of their care? Which cost- sharing mechanisms work best? If cost-sharing is warranted, should poor people, people with chronic illnesses, children, pregnant women, or others be shielded from it? These are some of the fundamental questions that relate to cost-sharing policy in all models of health reform, whether they be managed competition, single payer, or other approaches.

WHY COST-SHARING?

Patient cost-sharing has been increasingly viewed by many employers and health benefit managers as an essential deterrent to health services and as a way to minimize premium price increases (30,40). For those who believe that harnessing competitive forces is key to health care reform, requiring patients to share in the costs of their health care is based on perhaps one of the most fundamental concepts of competition: that consumers make better choices when they bear some of the financial cost of their decisions (56).



Patient cost-sharing has long been a standard feature of conventional fee-for-service (FFS) health care delivery,[1] but the

[1] In fee-for-service health care, physicians and other providers bill separately for each patient encounter or service rendered. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the practitioner does not change with the number of services actually rendered.

cost-sharing philosophy of health maintenance organizations (HMOS) has, until recently, been decidedly different.[2] In all HMOS, for example, health plan members must obtain care within the HMO system to be covered and HMO contract physicians are at financial risk for the care provided to enrolled members. In such a setting, extensive cost-sharing has typically been viewed as an unnecessary barrier to care because overall utilization and access to specialty care are so tightly controlled. Yet, recently, employers have demanded that even the most tightly structured HMOS require at least nominal copayments to futher reduce access to primary care providers and to help lessen premium requirements (14,59).

Advocates of increasing the number of people in HMOS and other managed care plans use *differntial* cost-sharing as a ''carrot and stick"; for example, some health plans structure nominal out-of-pocket payments to encourage consumers to ''sample" managed care with its more limited choice of providers, while relatively high cost-sharing requirements are used to persuade people to surrender their attachment to fee-for-service medicine and unlimited freedom of choice of providers (31,40). Many reform proposals also view cost-sharing as a way to encourage or discourage the use of specific health services; for example, by mandating little or no cost-sharing for some or all preventive services and requiring high out-of-pocket payments for inappropriate use of the emergency room (for example, in the 102d Congress H.R. 3205, H.R. 5514, and H.R. 5502; refs. 1 and 2).

Still others reject cost-sharing as an ill-advised financial obstacle to early diagnosis and treatment (for example, in the 102d Congress S. 2320, H.R. 1300; 34).

WHAT ARE THE OUT-OF-POCKET COSTS OF INSURED PEOPLE?

Today, almost all Americans with health insurance contribute to the premiums for their health insurance and have varying levels of out-of-pocket responsibility when they visit a physician, are hospitalized, or seek many other health care services (see box 2-A). In traditional indemnity[3] or FFS health care plans, cost-sharing beyond premiums typically consists of:

- an initial *dedictob;*[4]
- plus a percentage of covered expenses, referred to as *coinsurance;*[5]
- up to a *maximum* annual dollar amount.[6]

In addition, covered benefits are usually subject to a lifetime maximum after which the insured person is fully liable for any health care costs.

Members of health maintenance organizations (HMO) are rarely subject to deductibles or coinsurance but often must pay a flat *copayment7*

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[2] Health maintenance organizations are organizations that, in return for prospective per capita (cavitation) payments, act as both insurer and provider of specified health care services. Prepaid group practices and independent practice associations (IPAs) are types of HMOs.

[3] Traditional indemnity plans are fee-for-service health plans that typically reimburse health care providers on a ''reasonable and customary" basis or as billed.

[4] A deductible is the amount of covered health care expenses (e.g., $200, $500, $1,000) that must be incurred by the health plan enrollee and his or her dependents before any health benefits become payable by the health plan. Deductible requirements apply to each individual in a family for a specific time period (usually a year). Some plans *specify family* deductibles after which no additional individual deductibles are required; family deductibles are typically equivalent to two or three times the individual deductible.

[5] Coinsurance refers to the freed percentage of covered expenses shared by a health plan and an enrollee after the deductible requirement has been met. For example, an 80-20 coinsurance arrangement means that, after the deductible is reached, 80 percent of covered expenses are paid by the plan and 20 percent are paid by the person covered by the plan.

[6] Such maximums are dollar limits on covered out-of-pocket expenses (e.g., $750 or $1,000) for deductible and coinsurance requirements incurred by the health plan enrollee. Not all health plans place limits on enrollees' out-of-pocket expenses.

[7] Copayments are fixed dollar amounts that a health plan enrollee is required to pay for a covered service (e.g., $10 per office visit, $3 per prescription drug).

Box 2-A—Health Insurance Premiums

This background paper focuses only on certain forms of patient cost-sharing-those such as deductibles and coinsurance that are based on a person's actual use of medical cam services and that are typically levied at the time services are received. Deductibles, coinsurance, and copayments are designed, in part, to make people 'think twice" before seeking care and to forgo the use of services that are expected to bring little benefit. Premium costs serve a different purpose; they do not directly affect how many services are purchased, but rather the amount and type of insurance purchased. Nevertheless these two types of cost-sharing are related. If a purchaser faces a choice between higher premiums with limited cost-sharing and lower premiums with high cost-sharing, he or she may choose to purchase the less expensive policy with higher deductibles and copayments or coinsurance.

Premiums are a major component of total consumer spending for health care. In 1990, it was estimated that U.S. households spent a total of $224.7 billion on health care expenses; 19 percent or $42.6 billion were payments by consumers for private health insurance premiums (42).

There is little agreement on the degree to which higher premiums reduce the purchase of insurance. Estimates range from a very low price responsiveness—where a 10 percent increase in premiums reduces the purchase of insurance by only 1.6 percent—to very high estimates, in which a 10 percent premium increase reduces insurance purchase by 28 percent (48).

SOURCE: Office of Technology Assessment 1993.

for primary care visits and sometimes for hospitalization (Group Health Association of America (28)).

In addition to cost-sharing for covered services, other health care costs are commonly borne by those with private and public health insurance (see table 1-1 presented earlier in this report). These include the difference between the provider's bill and the health plan's *approved* reimbursement for a covered service or ''balance billing" (see box 2-B); care received for uncovered preexisting conditions or during the waiting period before an employee or dependent becomes eligible for coverage; and frequently uncovered services such as preventive services, vision and hearing care, experimental treatments, and speech, physical, and occupational therapy.

The National Medical Expenditure Survey conducted by the Agency for Health Care Policy and Research provides estimates of *total* out-of-pocket spending by people under 65 with private health insurance, but the proportion of these dollars paid to meet health plan cost-sharing requirements is not known. In 1987, the privately insured population under age 65 spent in aggregate (excluding premium expenses) approximately $51.9 billion out-of-pocket for health care services; this equalled about 28 percent of their total cost of care (85).[8] On an individual basis, the proportion of health care expenses paid by insurers and the insured is split almost evenly: on average in 1987, people under 65 with private health insurance paid about one-half of their health expenses and their insurers paid most of the balance (86).[9]

Current Trends in Patient Cost-Sharing

Publicly and privately funded surveys of employment-based health plans are the principal

[8] This figure includes expenses for inpatient hospital and physician services, ambulatory physician and nonphysician services including vision care and telephone calls with a charge, prescribed medicines, home health care services, dental services, and medical equipment purchases and rentals (85). Over-the-counter medications are not included.

[9] In addition to payments by private health insurers, an unknown proportion of health care spending for privately insured people under age 65 is paid by other sources such as Medicare, Medicaid, other public programs, worker's compensation, and private charity care (86).

Box 2-B—Balance Billing

Balance billing is an important component of patient cost-sharing that is often overlooked in analyses of cost-sharing policy. There are no data estimating the dollar value of consumer payments for balance billing but the burden on individuals can be considerable.

Balance billing works as folows. In fee-for-service health insurance, when someone submits a health claim, the insurer first determines the expenses on the claim that are "eligible" for reimbursement. The eligible expenses, often referred to as the ''usual or customary amount,' are those that are ultimely applied to coinsurance and deductible requirements to determine patients' out-of-pocket liabilities. The isured individual is responsible for *100 percent of balance* billing, i.e., provider charges that exceed the usual or customary amount regardless of any coinsurance or deductible requirements. The insurer compares the charges on each insurance claim with the amount it usually allows for the billed services. Each insurer determines the usual and customary charges based on local fees for services and procedures. The usual and customary proportion of physicians' charges accepted by insurers varies and is often unknown to patients (18). For example, some companies set reimbursement at the 90th percentile of the average charges for a particular service in the provider's geographic **area while others** use the 75th percentile.

Thus, as illustrated in the example below, if after meeting deductible requirements, the coinsurance rate is *80* percent and the health insurance plan reimburses physician charges at the *75th* percentile, the insured patient would actually be liable for 40 percent of the physician's fees.

Physician fee = $100

Usual and customary amount (at 75th percentile) = .75x $100= $75.00

Balance billing = $100- $75.00= $25.00

Insurer's total cost = $60.00
(.80 coinsurance x $75,00)

Patient's out-of-pocket cost = $40.00
(.20 coinsurance **X** $75.00) + $25 balance billing
Patient share of total cost= $40/$100=40 percent

T'here is no limit on balance billing in private health insurance. Under Medicare, physicians are prohibited from charging Medicare patients more than 115 percent of the approved Medicare fee schedule. Some reform proposals have argued for eliminating or limiting balance billing so that consumers are protected from excessive out-of-pocket expenses and are better able to predict the costs of their care (8,50).

SOURCE: Office of Technology Assessment, 1993.

sources of data on the cost-sharing features of private health insurance, but no one survey provides a wholly representative picture of the health coverage provided to the Nation's workforce. Further, the details of sampling and question construction in privately-funded surveys are typically proprietary (i.e., not open to public scrutiny) and have been criticized on methodological grounds. In addition, little is known about the extent of required cost-sharing in individual or nonemployment-sponsored health plans (25). Nonetheless, the available surveys clearly show that employer-sponsored health insurance plans are increasingly using deductibles, coinsurance, and copayments to deter utilization, minimize premium requirements, increase consumer cost-consciousness, and promote alternative delivery systems such as HMOS, preferred provider organ-

izations (PPOs), and point of service (POS) plans[10] (32,40,76,89).

This trend toward increasing reliance on patient cost-sharing is further reflected in a 1992 survey of business executives; it found that 61 percent of respondents reported that they *perceived* sharing costs with employees to be a very effective cost-control measure (30). A large proportion of respondents (i.e., up to 47 percent) also planned to have their company's employees bear the increasing costs of health benefits in 1991 and 1992. In light of these plans, it should also be pointed out that efforts by employers to shift costs to the employee are frequently a contentious issue in labor-management disputes (76).[11]

Fee-For-Service Coverage

Deductibles

In 1991, the average individual deductible in traditional FFS medium and large establishments was $198 per year (89). Although there appears to be a trend among some employers to base deductible requirements on wages, income-based arrangements are still relatively uncommon. In 1991,5 percent of participants in medium or large employer health plans were subject to deductibles that varied with their wages (89).

Coinsurance

Coinsurance rates of 80 percent insurance-financed and 20 percent employee-financed are the most prevalent in employer-based plans of all sizes and are typically applied to both ambulatory and inpatient care (72,88,89). The 80-20 combination has been the predominant coinsurance rate for some time, although not until the late 1980s did most plans also require cost-sharing for the entire portion of a hospital stay (87).

Annual Limits on Out-of-Pocket Expenses[12]

In FFS plans, coinsurance is typically required only up to some maximum annual limit after which allowed charges for covered benefits become fully reimbursable. Dollar limits on out-of-pocket expenses vary; in 1991, the most common individual limits ranged from $750 to $1,000 for participants in health plans sponsored by medium and large firms.[13] Still, as many as 11 percent of participants in these health plans had no limit at all on their out-of-pocket expenses (89).

The cost to insurers of including an annual out-of-pocket limit is minimal because most insureds' expenses do not reach their limit (73). The Congressional Research Service has, for example, calculated that in 1988 a typical annual premium would have increased by only 0.7 percent if it included a $1,000 annual out-of-pocket maximum as compared to no limit (73).

Maximum Lifetime Benefit

Most indemnity plans place a limit on the amount they will reimburse an insured person for medical expenses over a lifetime. In 1991, three-

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lo The term preferred provider organization (PPO) refers to a variety of different insurance arrangements under which plan enrollees who choose to obtain medical care from a specified group of 'preferred' providers receive certain advantages, such as reduced cost-sharing charges. PPO providers typically furnish services at lower than usual fees in return for prompt payment by the health insurance plan and a certain assured volume of patients. Point-of-service (POS) plans are a hybrid form of managed-care plan based on a mixture of cavitation and fee-for-service (FFS) payment arrangements. POS plans permit health plan enrollees to choose a FFS, PPO, or HMO provider at the time he or she seeks services (rather than at the time they choose [o enroll in a health plan).

1 1 In 1989, the leading strike issue was health benefits, accounting for 60 percent of work stoppages and 78 percent of striking workers (76).

12 Limits on out-of-pocket expenses usually apply to the sum of deductible and coinsurance (e.g., 20 percent of allowed charges) payments incurred by the insured for *allowed* charges for covered benefits; balance billing payments are never limited in private health plans. Dental and mental health benefits are usually subject to separate limitations. Individual and family limits may be separate.

13 These dollars limits apply only to out-of-pocket *coinsurance* payments.

quarters of participants in medium and large firms' health plans that required cost-sharing had a lifetime maximum, most commonly set at $1 million (89).

Health Maintenance Organizations (HMOS)

The cost-sharing features of HMOs mirror both industry philosophy and government mandates established in the HMO Act of 1973 (Public Law 93-222) and its amendments in 1988 (Public Law 100-51) (28). The HMO Act of 1973 established guidelines that set limits on the type and extent of patient cost-sharing in health maintenance organizations. Although Federal HMO requirements do not apply to all HMOs, they determine the cost-sharing burden of the three out of four HMO enrollees who belong to federally qualified HMOs (29).[14] Among federally qualified HMOs, copayments may not exceed 50 percent of the total cost of any individual service and, in the aggregate, copayments may not exceed more than 20 percent of the cost of providing all "basic health services" as defined by Federal regulations (42 CFR 417.104(4)(i); 42 USCA S300e-1(1)).[15] In addition, an individual's total copayment charges may not exceed 200 percent of the total annual premium cost that would be required for coverage with no copayments. Deductibles for basic benefits are prohibited except for open-ended arrangements such as point-of-service plans (42 USCA S300e(b)(l)).

Copayments are the most common cost-sharing feature of HMO coverage and are used most often by Independent Practice Associations (IPAs) (28).[16] Overall, in 1991, 72 percent of HMO enrollees were required to pay a fixed copayment for primary care visits. Among the best-selling packages[17] offered by HMO, primary care visit copayments ranged from $2 to $15 in 1991 (28). Because access to physician specialists in HMOs is typically controlled by ''gatekeeper" primary care providers, copayments for specialty care are usually not required (53).

In 1991, three-quarters of HMO enrollees were not subject to cost-sharing when hospitalized, according to a survey of HMOs by the Group Health Association of America (28). Copayments for hospital care were used most often in IPA-model HMOs but are also used in some staff-model HMOs.[18]

Some reform proposals apparently leave the door open to types and levels of cost-sharing that have traditionally been associated with fee-for-service, indemnity health insurance. For example, Sheils and his colleagues analyzed various impacts of high-and low-cost-sharing for managed care under a managed competition model of reform (69). In their high-cost-sharing scenario, individuals would face a $250 deductible ($500 per family) with 20 percent coinsurance up to a maximum out-of-pocket of $2,000 ($3,000 per family).

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14 A Federally qualified HMO is one that has&en determined by the U.S. Department of Health and Human Services to meet the standards set forth in Title XIII of the Public Health Service Act, in such areas as financial and administrative stability, quality, scope of services covered, and rate-setting practices.

15 Federal statute and regulations define HMO basic health services to include: physician services (including consultant and referral services by physicians); inpatient and outpatient hospital services; short-term rehabilitation if it is expected to result in significant improvement of the member's condition within two months; medically necessary emergency services; at least 20 necessary and appropriate evaluative and/or crisis intervention mental health visits; diagnosis, medical treatment and referral services for abuse of or addiction to alcohol and drugs; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; and certain preventive health services.

16 Independent Practice Associations (IPAs) are a form of HMO in which participating physicians remain in their independent office settings, seeing both enrollees of the IPA and patients covered by other health insurance plans. Participating physicians may be reimbursed by the IPA on a fee-for-service or a cavitation basis.

17 The Group Health Insurance Association of America uses ''best-selling package'' in its industry analyses to describe the features of the typical HMO benefit package. On average, 69 percent of total HMO enrollment is represented in the best-selling packages (28).

18 In staff model HMOs, the majority of health plan enrollees are cared for by physicians who are typically salaried staff of the HMO.

Other Private Health Insurance Arrangements

In recent years, many employment-based health plans have initiated various hybrid insurance arrangements. For example, preferred provider organizations (PPOs) selectively contract with providers for discounted services but pay them on a traditional fee-for-service basis. Employees who enroll in PPOs are often exempt from deductibles or have reduced cost-sharing compared with those who choose more traditional health plans with unrestricted choice of providers (31,40). Point of Service (POS) plans combine the features of FFS and HMO health plans and are among the fastest growing of ''hybrid' delivery systems (22). POS plans allow enrollees considerable freedom of choice in selecting a provider but the choice is made in the context of cost-sharing requirements that promote HMOS over PPOs and discourage traditional FFS care overall. In a typical POS arrangement, HMO care is available at little or no cost at the point of service, PPO care is offered at reduced cost-sharing rates, and traditional FFS care is subject to standard or even higher than average deductible and coinsurance requirements.

Yet the reductions in out-of-pocket cost- sharing offered to PPO health plan members who use preferred providers may not be cost saving to the insurer and employer. Although controlled studies are lacking, reports are increasing that, despite negotiated discounts with preferred providers, little or no savings can be found when coinsurance requirements are waived or reduced for the use of FFS preferred providers (20,26,33,92).

Publicly Funded Plans

Medicare

Cost-sharing is a basic feature of Medicare coverage. In addition, unlike most health plans, Medicare has no maximum liability on out-of-pocket expenses (61). However, only 20 percent of Medicare beneficiaries actually have to pay deductibles and coinsurance because they are either covered by a supplemental Medigap plan or are dually eligible for Medicaid benefits[19] (47).

As of 1992, Medicare beneficiaries were required to pay a $652 deductible on the frost hospital admission in a benefit period[20] and $163 daily copayment for hospitilal stays of 61 to 90 days (84). A $326 daily copayment is also required if, during the course of a benefit period, total hospital stays exceed 90 days. The Medicare inpatient hospital deductible is updated annually.

Medicare coverage for physician services is optional under Part B coverage and requires a separate premium. For those who purchase Part B benefits, Medicare requires 20 percent coinsurance after a $100 annual deductible. Balance billing is limited in the Medicare program; Federal law does not allow physicians to charge Medicare patients more than 115 percent of the Medicare fee schedule.

Unlike private insurance plans which have steadily increased cost-sharing in recent years, Medicare has implemented few changes in cost-sharing requirements (61). During the 1990 budget reconciliation hearings, major increases in Medicare premiums and cost-sharing were dropped as a result of the much publicized opposition by elderly people.

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19 Federal Medicaid law requires States to pay the coinsurance for Medicare participants with family incomes under 100 percent of the Federal poverty level (74).

20 Medicare Part A benefits are paid on the basis of benefit periods. A Medicare benefit period is defined as beginning with the first day a beneficiary receives Medicare covered inpatient hospital services (84). It ends when the beneficiary has been out of a hospital or skilled nursing facility (SNF) for 60 days in a row. It also ends if the beneficiary remains in a SNF but does not receive skilled care there for 60 days in a row. A new benefit period starts when inpatient hospital services are again required. The number of benefit periods is unlimited.

Table 2-l-State Medicaid Programs Requiring Copayments for Basic Physician, Clinic and Hospital Services, as of Jan. 1, 1991

State	Service category	Copayment amount[a,b]
Alabama	Federally qualified health centers	$1.00
	Inpatient hospital	50.00/admksion
	Outpatient hospitat[c]	3.00
	Physician off ice visits (excluding optometric)	1.00
	Rural health ciinics[c]	1.00
Arizona	office visits	1.00
	Elective surgery	5.00
	Nonemergency use of emergency room	5.00
California	Emergency room (inappropriate use)	5.00
	Outpatient hospital	1.00
Colorado[d]	Physician services	2.00
	Inpatient hospital	15.oo/stay
	Outpatient hospital	3.00
	Physician visits	2.00
	Rural health clinics	2.00
Illinois	Inpatient hospital	Variese
Kansas	Ambulatory surgery center services	3.00
	Hospital:	25.00/admission
	inpatient	
	nonemergency outpatient	1.00
	outpatient surgery	3.00
	Physician office visit	1,00
Mississippi	Hospital:	
	emergency room	*2.00*
	inpatient	*5.00*
	Rural health clinic-office visit	1.00
Missouri	Hospital:	
	Inpatient	1 O.00/admission
	outpatient	*3.00*
Montana	Clinic Services	1.00
	Hospital:	
	inpatient	3.00/day[f]
	outpatient	1.00
	Physician	1.00
North Carolina	Hospital-outpatient	1.00
	Physician	*0.50*
Pennsylvania	Hospital:	
	inpatient	3.00/da~
	nonemergency service in a hospital	Varies[h]
	emergency room	Varies[h]
South Dakota	Ambulatory surgical center	Varles[i]
	Hospital-outpatient (except lab)	Varles[i]
	Physician	3.00
Virginia	Clinic	1 .Ooj'k
	Hospital:	
	inpatient	30.00/admission
	outpatient, nonemergency	*2.00*
	Physician	1.00

Table 2-l-State Medicaid Programs Requiring Copayments for Basic Physician, Clinic and Hospital Services, as of Jan. 1, 1991-Continued

State	Service category	Copayment amount
Wisconsin	Hospital:	
	inpatient, general	3.00/da~
	outpatient	3.00
	surgery	3.00
	Physician visits:[m]	
	cunsultaion	3.00
	diagnostic procedure in office	1.00
	office	1.00
	outpatient hospital	1.00

a Unless otherwise specified, copayment amounts are paid per service visit. They apply to all population groups allowed under the law except where otherwise noted.
b States may not impose these fees on categorically or medically needy persons under a variety of circumstances, including: services provided to children; pregnancy-related, emergency, family planning and hospice care; and services provided to categorically needy persons in health maintenance organizations.
c For these services the State requires the copayment be paid per claim for all Medicaid beneficiaries who are also Medicare eligible. All other Medicaid beneficiary-the copayment is per visit.
d Applies to persons age 19 and over.
e $2 for per diem of $275 to $325; $3 per diem over $325.
f Maximum copayment charge of $66 per stay.
9 Maximum copayment charge of $21 per stay.
h In Pennsylvania the copayment for services range from $1 t. $6 based on the Medicaid fee for the services provided. If the Medicaid fee is: $1.00-10.00 the copay is $1; $10.01-25.00 the copay is $2; $25.01-50.00 the copay is $4; $50.01 or more the copay is $6.
i Copayment is 5 percent of reimbursement for these services.
j Applies to pregnant women for nonpregnancy-related services.
k Applies to persons age 21 and over.
l Maximum copayment Of $75 per stay.
m A cap of $30 cumulative limit per calendar year per physician for all physician services (physician visits, surgery, lab and X-ray services, and diagnostic tests) applies.

SOURCE: U.S. Congress, Library of Congress, Congressional Research Service, Medicaid *Source Book: Background Data and Analysis* (Washington, DC: U.S. Government Printing Office, January 1993).

Medicaid

Although Federal rules permit State Medicaid programs to impose flat copayments for selected beneficiaries under certain circumstances, only 10 States require them for basic physician or hospital care (see table 2-1) (74). States are prohibited from imposing deductible or coinsurance charges on categorically needy persons (e.g., recipients of Aid-to-Families With Dependent Children [AFDC] cash assistance) or medically needy persons under a variety of circumstances, including: services provided to children; pregancy-related, emergency, family planning, and hospice care; and services provided to categorically needy enrollees in HMOS (74).[21] If cost-sharing charges are used, they must be ''nominal' that is, the maximum deductible for noninstitutional services cannot exceed $2.00 per month, coinsurance may range from $.50 to $3.00 (depending on the Medicaid payment amount). Providers are prohibited from denying care to those who are unable to or who do not pay their cost-sharing charges.

21 ''Categorically needy'' refers to those who are Medicaid-eligible by belonging to certain categories of poor people, such as those who are members of families with dependent children where one parent is absent, incapacitated, or unemployed. States have the option to offer Medicaid to medically needy persons when their family income and resources lie above the AFDC need standards *if* they meet the categorical requirements of the program (e.g., an absent parent or disability).