U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE MEDICAID BUY-IN PROGRAM:

LESSONS LEARNED FROM NINE "EARLY IMPLEMENTER" STATES

May 2002

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This report was prepared under contract #HHS-100-00-0018 between HHS's ASPE/DALTCP and George Washington University. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Andreas Frank.

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Lessons Learned From Nine "Early Implementer" States

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May 2002

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-100-00-0018

This policy paper was funded through a contract with the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation supporting a project entitled *"Case Studies and Technical Assistance for Medicaid Buy-Ins for People with Disabilities."* This paper was also funded by a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education supporting the Rehabilitation Research and Training Center on Workforce Investment and Employment Policy for Persons with Disabilities. In addition, this paper was supported by a grant from the Robert Wood Johnson Foundation.

The opinions Contained in this paper are those of the authors and do not necessarily reflect those of the U.S. Department of Health and Human Services, the U.S. Department of Education, or the Robert Wood Johnson Foundation.

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EXECUTIVE SUMMARY

For many individual Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) recipients, the risk of losing Medicaid coverage linked to their cash benefits is a powerful work disincentive. Eliminating barriers to health care and creating incentives to work can greatly improve financial independence and well being. To support this goal, Congress included a Medicaid Buy-In option in the Balanced Budget Act of 1997 and enacted the Ticket to Work and Work Incentives Improvement Act (TWWIIA) in 1999. These laws authorized states to create Medicaid Buy-In programs to extend Medicaid coverage to persons with disabilities who go to work.

This report discusses findings from case studies of nine states operating Medicaid Buy-In programs for working persons with disabilities. The nine states are **Alaska**, **Connecticut**, **Iowa**, **Maine**, **Minnesota**, **Nebraska**, **Oregon**, **Vermont**, and **Wisconsin**. At the time of the study, approximately 13,000 persons were enrolled in the programs in the nine states. The paper gives particular attention to the decisions made by states concerning program eligibility, their approaches to estimating program enrollment and costs, and the patterns of program enrollment to date. The report is designed to assist stakeholders (such as Medicaid directors, state legislators, and cross-disability coalitions) design and implement Medicaid Buy-In programs and related work incentive initiatives.

This report is the second in a series of three reports. The first report includes in-depth case studies of nine early implementer states entitled *Medicaid Buy-In Programs: Case Studies of Early Implementer States*. The final report, *Policy Frameworks for Designing Medicaid Buy-In Programs and Related State Work Incentive Initiatives*, provides policy frameworks describing the interrelationships between health entitlements (especially Medicaid) and cash assistance programs (particularly SSDI, SSI and state SSI supplementation programs).[1]

Major Findings

1. **Medicaid Buy-In programs typically are managed by state Medicaid agencies with significant input from consumers and assistance from other state agencies.**

    - **Stakeholder involvement was important in program design**. The input of persons with disabilities and other stakeholders had an impact in shaping

[1] The three reports were funded through a contract with the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation supporting a project entitled "*Case Studies and Technical Assistance for Medicaid Buy-Ins for People with Disabilities*." Additional support was provided from a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education supporting the Rehabilitation Research and Training Center on Workforce Investment and Employment Policy for Persons with Disabilities and a grant from the Robert Wood Johnson Foundation.

program design. In many states, persons with disabilities played a central role in planning the program and were heavily involved in surveys, field research, focus groups or other preliminary program design activities. Several states have formal mechanisms for involving persons with disabilities in program management.

- **The Medicaid Buy-In program is linked to other employment supports**. To address the multiple barriers facing persons with significant disabilities, most states linked their Medicaid Buy-In program to complementary employment supports for persons with disabilities. Benefits counseling, expanded vocational rehabilitation services, supports for employers, and collaboration with One-Stop centers are among the programs in place.

- **The state Medicaid agency usually works with other state agencies to support persons with disabilities in the workplace**. In general, states use existing Medicaid eligibility, reimbursement, service delivery and program management structures, both at the state and county level, to administer the Medicaid Buy-In program. In most states, the Medicaid agency has formal or informal relationship with other state agencies, particularly vocational rehabilitation programs, to carry out functions that are outside the scope of Medicaid.

2. **Eligibility standards and cost-sharing policies show considerable variation across the states and may have a significant impact on program enrollment.**

    - **Most Medicaid Buy-In programs have an upper income limit of 250% of Federal Poverty Level (FPL) and broadened asset standards, but vary considerably in how they "count" income and assets**. With the exception of **Connecticut** and **Minnesota**, the upper income limit for Medicaid Buy-In programs is 250% of FPL ($1,790 monthly net income after applying the standard SSI disregards or $3,665 gross income for a single person in 2001). **Connecticut**'s limit is 450% of poverty while **Minnesota** has no upper income limit. CoMost Medicaid Buy-In programs have an upper income limit of 250% of Federal Poverty Level (FPL) and broadened asset standards, but vary considerably in how they "count" income and assets. With the exception of **Connecticut** and **Minnesota**, and **Oregon** do not count the income of other household members, thus easing access to the program for certain married individuals. In every state except **Alaska** and **Nebraska**, applicants may retain more assets than persons in other Medicaid categories. In several states, retirement accounts, medical savings accounts, or approved employment accounts are not counted as assets and provide additional opportunities for individuals to save money.

    - **Limits on unearned income may be an important factor in restraining enrollment in several states**. In the states of **Alaska**, **Maine**, **Nebraska**,

and **Vermont**, in addition to gross income standards, applicants are subject to a separate dollar limit on their unearned income. This policy prevents enrollment of persons with significant income from non-work sources and may have the effect of reducing overall program enrollment.

- **Persons with incomes above specified levels must pay premiums**. The threshold level for premium liability ranges from 100% FPL to 200% FPL. Four states--**Iowa**, **Maine**, **Nebraska**, and **Vermont**--use a premium schedule based on income brackets. In three others--**Alaska**, **Connecticut**, and **Minnesota**--applicants pay a premium calculated as a variable percentage of individual or household income. The states of **Oregon** and **Wisconsin** calculate premiums separately for earned and unearned income with steeper schedules for unearned income. This approach may discourage persons with substantial income from non-work sources from enrolling in the program.

- **Several states provide enrollment protections for individuals who lose employment while in the Medicaid Buy-In program, but protections are not consistent across the states**. Such protections are designed to continue Medicaid eligibility for persons when they temporarily lose their ties to the workplace. **Connecticut**, **Iowa**, **Minnesota**, and **Wisconsin** provide an incentive for continued work effort by providing Medicaid Buy-In program coverage during temporary periods of unemployment and, in **Wisconsin**, before an individual finds a job as well. Without such protections, individuals risk losing Medicaid benefits if a job effort fails. Allowing persons returning to other Medicaid categories to retain accumulated assets is an additional protection available in **Connecticut** and **Minnesota**.

3. **Available data are insufficient to show whether the program is meeting its objectives.**

- **Before they began operating their Medicaid Buy-In programs, states developed enrollment and cost projections, often assuming considerable contributions from private insurance and premium payments**. States typically used existing Medicaid eligibility and claims data to estimate program enrollment and per capita costs. States typically relied on the estimates of other states when projecting private insurance offsets and premium payment amounts. Thus far, premium payments and private insurance offsets have been lower than expected, due in part to lower than expected levels of earned income and insufficient work hours to qualify for private insurance coverage. States with large state-funded personal care or pharmacy programs, such as **Connecticut** and **Wisconsin**, are offsetting some previous state expenditures with federal Medicaid funds.

- **Program performance data are not available in a consistent format across the states**. The amount and types of administrative program data

available from the states varies considerably. While every state can report the number of participants, the availability of data on earnings, private insurance coverage, or client characteristics is not uniformly available. Thus, it is not possible to compare state experience across a broad range of variables.

- **Preliminary data show actual enrollment exceeding projections in two states, falling short of projections in one state, and matching projections in five states**. **Minnesota** and **Iowa** have exceeded projections, **Nebraska** has fallen short of projections, and **Alaska**, **Connecticut**, **Maine**, **Vermont**, and **Wisconsin** have matched projections. (**Oregon** did not provide information on projected enrollment.) Given the variation in state methods of projecting enrollment, it is not possible to identify with certainty the forecasting approaches that are most likely to result in accurate estimates.

- **Most Medicaid Buy-In program enrollees are persons who moved from another Medicaid eligibility category to the Medicaid Buy-In program**. Consistent with state expectations, most Medicaid Buy-In program enrollees are individuals who were already enrolled in Medicaid and who moved from another category to the Medicaid Buy-In category. Such persons include both individuals who moved from a "spend-down" category to the Medicaid Buy-In program and persons who moved from another category when their incomes increased.

4. **State policies on general Medicaid eligibility, SSI, and state SSI supplementation and federal policies on SSDI affect Medicaid access for working persons with disabilities.**

    - **A state's choices about SSI and state SSI supplementation affect Medicaid access for working persons with disabilities**. When states elect to provide automatic Medicaid eligibility for all SSI beneficiaries, SSI beneficiaries who go to work receive Medicaid coverage automatically through Section 1619 work incentives without submitting any additional documentation. Four study states--**Iowa**, **Maine**, **Vermont**, and **Wisconsin** --have automatic eligibility for federal SSI recipients. Five study states--**Alaska**, **Connecticut**, **Minnesota**, **Nebraska**, and **Oregon**--make retaining coverage somewhat more difficult by requiring a separate application to the state for continued Medicaid coverage. Similarly, states can adopt policies that help assure continued Medicaid coverage when persons eligible only for state SSI supplements without federal SSI enter the work force. **Connecticut**, **Vermont**, and **Wisconsin** have adopted such policies.

    - **A state's choices about income standards for persons with disabilities within its overall Medicaid program affect Medicaid access for working persons with disabilities**. In a state with relatively generous Medicaid

income standards in non-Buy-In categories, a greater proportion of working persons with disabilities can gain access to Medicaid through avenues other than a Medicaid Buy-In program. Income standards in traditional Medicaid eligibility categories vary greatly across the study states with **Alaska**, **Connecticut**, **Maine**, **Nebraska**, and **Vermont** having higher income standards than the other states.

- **Several states cite the Social Security Administration's (SSA) inability to grant demonstration waivers for SSDI beneficiaries as a barrier to increasing program enrollment and the earnings levels of participants**. Preliminary data suggest that significant numbers of persons participating in Medicaid Buy-In programs may increase their disposable incomes but are unwilling to earn more than $780 per month (Substantial Gainful Activity-SGA) because their eligibility for SSDI will be jeopardized by doing so. (In states collecting earnings data, only 14% of enrollees in Medicaid Buy-In programs had earnings over SGA.) States want to implement projects that would move from the "cash cliff" to a gradual phase-out of benefits, but have not received authority to do so.

I. INTRODUCTION

For individuals with disabilities receiving Medicaid, the fear of losing health care and related services is one of the barriers keeping such individuals from maximizing their employment, earnings potential, and independence. Too often persons with significant disabilities can not obtain private sector health insurance that provides coverage of the services and supports that enable them to live independently and enter, remain in, or rejoin the workforce. Thus, they need to rely on Medicaid for coverage of such necessary services as personal assistance, prescription drugs, and durable medical equipment.

Eliminating barriers to health care and other needed supports and creating financial incentives to work can greatly improve short and long-term financial independence and financial well being. So concluded Congress when it included a Medicaid Buy-In option in the Balanced Budget Act of 1997 and when it enacted the TWWIIA. By authorizing states to offer Medicaid Buy-In programs, these pieces of legislation opened a window of opportunity for states to develop work incentive initiatives that encourage people with disabilities to work or increase their level of work.

To date, **19 states**[2] have implemented Medicaid Buy-In programs for working persons with disabilities, several additional states have enacted legislation aimed at creating such programs,[3] and one state (Massachusetts) created a similar program under Section 1115 Demonstration Project authority. As states consider new policy initiatives, they need information from other states as to what has worked, what has not worked, and why. They need guidance on such issues as:

- Who needs the services and supports?
- How many people are likely to enroll?
- How much will it cost?
- What program design options are available?
- What kind of infrastructure maximizes effective and efficient implementation?

[2] Alaska, Arkansas, California, Connecticut, Iowa, Maine, Mississippi, Minnesota, Nebraska, New Hampshire, New Mexico, New Jersey, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, and Wisconsin.

[3] States enacting legislation include Arizona, Colorado, Illinois, Indiana, Kansas, Missouri, Oklahoma, New York, Texas, and West Virginia. The legislation is diverse and in some states is directed toward the creation of demonstration projects.

- What are the best strategies for involving persons with disabilities in the decision-making processes?

- What standards are appropriate for measuring outcomes?

To assist states as they seek answers to these questions, the Assistant Secretary for Planning and Evaluation, in coordination with the Center for Medicare and Medicaid Services, asked the Project Team to provide information on state experiences with the design and implementation of Medicaid Buy-In programs for workers with disabilities.

The overall project had several purposes.

- To examine and describe the early implementation experiences of nine states that opted for the Medicaid Buy-In program for working disabled persons.

- To use the descriptive information to inform and provide technical assistance to various state-level stakeholders about the lessons that can be learned from these states.

- To inform federal policymakers so that they can better understand the experiences of states implementing Medicaid Buy-In programs.

To accomplish the project purposes, the Project Team prepared:

- Case studies of each of nine states.

- A summary of the lessons learned from the nine state Case Study.

- A policy guide for developing health care and income assistance components of a state's comprehensive work incentive initiative for disabled workers.

- A summary of conclusions and recommendations for use by federal agencies to enhance employment and earnings for persons with significant disabilities.

The Case Study states are **Alaska**, **Connecticut**, **Iowa**, **Maine**, **Minnesota**, **Nebraska**, **Oregon**, **Vermont**, and **Wisconsin**. These nine states, with approximately 13,000 enrollees at the time of the study, are geographically dispersed and illustrate a variety of program design options and decision-making strategies.

This paper describes the lessons learned from the nine state case studies. The paper examines information gathering strategies, Medicaid Buy-In program design features, policy approaches and administrative systems, cost estimation methodologies, and program experience. Eligibility standards for calendar year 2001 are used in the report.

II. POLICY APPROACHES AND ADMINISTRATIVE STRUCTURE

In each state, the specific roles played by stakeholder groups, such as state officials, consumers, advocates, providers and employers, in the design and implementation of the Medicaid Buy-In program vary. In general, states use existing state Medicaid administrative structures to manage their Medicaid Buy-In programs, but each state charted its own path in creating a program that met the needs of that specific state.

In order to design their work incentives programs to meet the specific needs of their residents, states conducted surveys, held focus groups, carried out field research, and engaged in informal data gathering. They used these findings to refine their Medicaid Buy-In programs and to identify additional employment initiatives appropriate to support workers with disabilities.

In all of the states, consumers with disabilities and their advocates, working with other stakeholders, play a central role in shaping the design of the Medicaid Buy-In program and related employment initiatives. Several states established formal mechanisms for involving consumers with disabilities and disability organizations. Other states provide less formal approaches for securing consumer input.

A. Consumer Roles

In most Case Study states, consumers participated in program design through cross-disability coalitions. For example, in **Minnesota**, the Minnesota Work Incentives Coalition and the Minnesota Consortium of Citizens with Disabilities played critical roles by conducting and publishing a survey on work incentives in the state. In **Connecticut**, a coalition established in 1999 consisting of disability groups, consumers, and advocates was a major force. Several consumer-focused groups continue to provide advice on the Medicaid Buy-In program, including the state Committee for Persons with Disabilities.

In several states, a broad-based working group provided leadership for the creation of the Medicaid Buy-In program. In **Oregon**, for example, the state created a steering committee of advocates, consumers, researchers and state officials to design the original Medicaid Buy-In program. In **Maine**, the original Medicaid Buy-In Advisory Council included consumers, advocacy groups and service providers. This group was expanded and renamed CHOICES Advisory Group as part of the state's systems change work under the Medicaid Infrastructure grant.

Wisconsin contracted with Employment Resources, Inc. and the University of Wisconsin to research work incentives. The project's Consumer Advisory Panel

included individuals with disabilities who had personal experience with the long-term support system and had faced barriers to getting and keeping work. In addition to surveys, the state asked a community rehabilitation provider to test innovative approaches to person-centered approaches, including Vocational Futures Planning.

In **Alaska**, cross-disability groups, including the State Independent Living Council, the Governor's Committee on Employment and Rehabilitation of Persons with Disabilities, the Alaska Human Resources Investment Council and the Alaska Mental Health Trust Authority were involved in the initial planning of the Medicaid Buy-In program. The Governor of **Alaska** convened a Disability Summit where the high unemployment rate of persons with severe disabilities was discussed. In conjunction with consumer groups, **Alaska** conducted a survey and did field research to examine the efficacy of providing comprehensive vocational rehabilitation services and benefits counseling.

In **Iowa**, an association of employers played a major role. The Iowa Business Council, consisting of the 25 largest businesses in the state, identified persons with disabilities as an untapped pool of potential employees. The Council worked with Creative Employment Options, the employment policy arm of a university-affiliated program, to create a Medicaid Buy-In Program to foster economic development in the state.

States often use more informal approaches to gather information, including meetings with stakeholders and legislative and executive branch planning sessions. In **Nebraska**, the state convened a stakeholder group during the development of the Medicaid Buy-In program. In **Vermont**, several focus groups identified barriers faced by persons with disabilities and the need for benefits counseling. In **Iowa**, consumer groups are providing advice on an informal basis through the Personal Assistance and Comprehensive Family Support Services Council.

B. The Role of State Legislatures

State laws authorizing Medicaid Buy-In programs provided varying amounts of specificity about design issues. Laws in **Iowa** and **Nebraska** provide a general program framework with few design details. Laws in **Alaska**, **Connecticut**, **Minnesota**, **Vermont** and **Wisconsin** provide more detail on such design features as premium schedules, asset rules, and income standards. In these states, the executive branch was charged with operationalizing the design directives. In **Maine** and **Oregon**, the executive branch through Medicaid State Plan amendments without specific state legislation initiated Medicaid Buy-In programs. Subsequent legislative acts provided funding for the programs.

In some states, prior to authorizing a Medicaid Buy-In program, the state legislature mandated studies, surveys, or demonstration projects to gauge the need for the program. In these states, Medicaid Buy-In programs and related employment

initiatives were established subsequent to the completion of the studies and surveys. In **Connecticut**, the Chair of the Human Services Committee in the House of Representatives established the Work Incentives Working Group that was instrumental in crafting the state's program. The **Vermont** legislature included language in an appropriations bill requiring a study of potential methods to increase the number of employed disabled individuals in the state. Subsequent legislation authorized the Medicaid Buy-In program.

Similarly, the **Wisconsin** legislature, as part of an appropriations bill, created the Pathways to Independence Demonstration Project. The Pathways Project, established before the Medicaid Buy-In, was designed to provide coordinated vocational and health care advice to disabled individuals and provided a test of several elements of the state's system.

C. Management Structures

The Medicaid agency plays the lead role in most states on the development of policy and program implementation. In general, states use existing Medicaid management structures to administer the Medicaid Buy-In program. In some cases, program design features mirror those of other Medicaid-related programs.

To address the multiple barriers facing persons with significant disabilities, many states developed additional work incentives to complement the Medicaid Buy-In program. Benefits counseling, expanded vocational rehabilitation services, and collaboration with One-Stop centers established under the Workforce Investment Act are among the incentives in place. Generally, the Medicaid agency has formal or informal relationships with other state agencies, particularly vocational rehabilitation programs and One-Stop service delivery systems.

In **Alaska**, the Medicaid Buy-In program is part of "Alaska Works." Alaska Works is a cross-agency initiative spearheaded by the Governor's Council on Disabilities and Special Education which is designing and implementing reforms focusing on the role of One-Stop Centers, intake and referral procedures, and benefits counseling. The state Medicaid agency has worked extensively with the vocational rehabilitation program, One-Stop Centers and the State Workforce Investment Board.

In **Connecticut**, the Medicaid Buy-In program is integrated into a broader Employment Plan that includes benefits counseling. The Rehabilitation Services Agency is heavily involved in benefits counseling where advice about the Medicaid Buy-In program is integrated into a broader Employment Plan developed for persons with disabilities. The Department of Social Services (which includes both the Medicaid agency and the agency administering the vocational rehabilitation program) conducts outreach.

In **Iowa**, the Department of Human Services (which includes the Medicaid program) established a "charter group" to help draft the regulations implementing the Medicaid Buy-In program, which included, among others, the vocational rehabilitation program and Disability Determination Services. In **Maine**, the Medicaid Buy-In program is running parallel to a Medicaid infrastructure enhancement project that is charged with improving coordination of a range of policies and organizations. The Bureau of Vocational Rehabilitation within the Department of Labor is a partner on the Medicaid Buy-In as is the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

In **Minnesota**, the Department of Human Services assists county agencies in the implementation of the program. One-Stop Centers established under the Workforce Investment Act are involved in outreach and vocational rehabilitation training and counseling. In **Nebraska**, as part of its Medicaid Infrastructure grant, the state is seeking to integrate more effectively the operations and policies of the Medicaid Buy-In program with other services to support working persons with disabilities.

In **Oregon**, the Department of Human Resources runs the Oregon Employment Initiative, the state's comprehensive work incentive initiative, as well as the Medicaid Buy-In program. Various divisions within the Department of Human Resources sit on the Initiative Steering Committee. Employment Initiative Specialists work with employers and provide, among other things, benefits counseling, peer mentoring, assistance in writing PASS and Impairment-Related Work Expenses (IRWE) plans, interview preparation, and self-advocacy skills for interacting with employers.

In **Vermont**, the Division of Vocational Rehabilitation has lead responsibility for implementing the Vermont Work Incentives Initiative Project that includes benefits counseling, job training, and case management. The Division works closely with the Medicaid agency on the development of policy and implementation of the Medicaid Buy-In component. **Vermont**'s Medicaid Buy-In program design is modeled after and uses the same fees, premiums, collection efforts and sanctions as the state children's health insurance program.

In **Wisconsin**, the Pathways to Independence program, the state's demonstration project providing comprehensive programs integrating health care, vocational rehabilitation, benefits counseling, and other services and supports, is run jointly by the Department of Workforce Development and the Office of Strategic Finance of the Department of Health and Family Services. The program is coordinated with the Medicaid Buy-In program.

III. MEDICAID BUY-IN PROGRAM DESIGN FEATURES

Medicaid Buy-in program eligibility criteria, cost-sharing policies and other design features vary among the states. In seven of the states, 250% of the FPL is the upper income limit. **Connecticut**, adopted an upper level of 450% of FPL. **Minnesota**'s program has no upper income limit due to the state's decision to disregard all income when determining program eligibility. While program eligibility is limited to persons with disabilities with earnings, some states provide options that extend eligibility to unemployed persons who will soon go to work or return from a work absence.

A. General Eligibility

Eight states require participants to be working to enroll in the Medicaid Buy-In program. In **Wisconsin**, an unemployed individual participating in a Health and Employment Counseling (HEC) program can be eligible for the Medicaid Buy-In. Participants in HEC develop an employment plan and can participate in the in the Buy-In program for up to one year under their employment plan. Three states (**Maine**, **Minnesota** and **Vermont**) have a six-month eligibility period. The other states determine eligibility annually.

While states are constrained by federal law from directly requiring that Buy-In participants work a minimum number of hours, several states specify certain work-related requirements. **Connecticut** requires applicants to make contributions to FICA. **Oregon** specifies that an individual must have taxable income to participate. **Minnesota** requires income from work every 30 days to remain eligible for the Medicaid Buy-In program.

Connecticut is the only state extending coverage to those who are "medically improved." To qualify under the Medically Improved Group, a person must have been previously eligible for the Medicaid Buy-In under basic coverage and must be determined during a regularly scheduled medical review to no longer meet the program’s disability requirements due to medical improvement. Persons qualifying as medically improved must work at least 40 hours a month.

B. Income Eligibility

As permitted under federal law, each state established its own unique set of income eligibility standards for their Medicaid Buy-In programs and developed related policies on the use of individual or household income, additional income disregards, and unearned income limits. As part of their eligibility standards, the states of **Alaska**, **Maine**, **Nebraska**, and **Vermont** impose separate limits on the amounts of unearned

income (e.g., SSDI) qualifying individuals can receive. These limits restrain enrollment by limiting participation to persons whose unearned income falls below a set level. See Table 1 for details on income eligibility.

TABLE 1. Income Eligibility Criteria

	Whose Income is Counted?	What is the Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
Alaska	Individual and spouse for total income. Individual for unearned income.	Two part test: 1. Family net income less than 250% FPL. 2. Individual unearned income less than APA standard of need.	Standard SSI disregards.	Yes. Unearned income must be less than APA standard of need.
Connecticut	Individual.	450% FPL $6,250/mo (gross) or $3,082/mo (net) after SSI disregards.	Standard SSI disregards.	No.
Iowa	Individual and spouse.	250% FPL for family size.	Standard SSI disregards.	No.
Maine	Individual and spouse.	Two part test: 1. Countable unearned income less than 100% FPL. 2. Earned and unearned combined less than 250% FPL.	Standard SSI disregards, plus additional state disregard on unearned or earned income of $55.	Yes. Unearned income limit is 100% FPL plus $75.
Minnesota	Individual.	No income limit.	1902(r)(2) All earned and unearned income ignored.	No.
Nebraska	Individual and spouse.	Two part test: 1. 250% FPL for family size using standard SSI disregards. 2. Sum of all unearned and spouse's earned income less than SSI benefit level for family size.	Standard SSI disregards. Individual's earned income disregarded in part 2 of eligibility test. Individual's unearned income if from Trial Work Period.	Yes. Unless an individual is in a Trial Work Period or Extended Period of Eligibility, SSDI income (minus disregards) must be less than SSI income standard.
Oregon	Individual.	250% FPL for individual.	All unearned income, standard SSI disregards, and Employment and Independence Expenses.	No.
Vermont	Individual and spouse.	Two part test: 1. Family net income less than 250% FPL. 2. Family net income less earnings and $500 of SSDI at or below medically needy protected income level.	Standard SSI disregards. Disregard all earnings and $500 of SSDI for part 2 of eligibility test.	Yes. Unearned income limit is the medically needy program's protected income level plus $500.
Wisconsin	Individual and spouse.	250% net family.	Standard SSI disregards.	No.

Upper Income Level

Seven of the states included in the Case Study established an upper income eligibility limit at 250% of the FPL. Monthly income at 250% of poverty was approximately $1,790 net income after applying standard SSI income disregards or $3,665 gross income for a single individual ($43,980 annually) in 2001. **Connecticut** has opened its program to any individual with gross income of less than $6,250/month (equivalent to $75,000 annually) or net income of $3,082/month (approximately 450% FPL). **Minnesota** has no upper income limit. It has instead used its authority under Section 1902(r)(2) of the Social Security Act to disregard all income.

Individual or Household Income

When determining eligibility, six states--**Alaska**, **Iowa**, **Maine**, **Nebraska**, **Vermont**, and **Wisconsin**--count the income of both the medically eligible individual and his or her spouse (if any), while three, **Connecticut**, **Minnesota**, and **Oregon**, count only the income of the individual with a disability, regardless of household size.

Unearned Income Limits

In addition to total income criteria, the states of **Alaska**, **Maine**, **Nebraska**, and **Vermont** have established separate limits on unearned income. In **Alaska**, applicants must have individual unearned income less than the Alaska Public Assistance (APA) benefit standard. **Maine** restricts eligibility to individuals with unearned income less than 100% FPL plus $75. In **Nebraska**, the sum of all unearned income and the spouse's earned income must be less than the SSI benefit level for the appropriate family size but with an exemption from the limit if the individual has substantial earnings from a Trial Work Period or Extended Period of Eligibility. The unearned income limit in **Vermont** is the state's medically needy program's protected income level of $733 plus the $500 unearned income disregard.

Income Disregards

All states use standard SSI disregards to determine net income for purposes of eligibility.[4] Five states exclude additional types of income in determining eligibility. As noted earlier, **Minnesota** disregards all earned and unearned income in order to allow working persons with disabilities of any income level to qualify for entry into the program. In addition to the federal disregard of $20 per month, **Maine** has a separate $55 per month state disregard of unearned income when counting unearned income. **Nebraska** disregards the individual's unearned income if it is gained during an SSDI Trial Work Period or Extended Period of Eligibility. **Oregon** disregards all unearned income in determining eligibility. **Vermont** disregards $500 of the applicant's SSDI income in determining whether the individual meets unearned income requirements.

C. Resource Limitations

With the exception of **Alaska**, the Case Study states allow substantially higher levels of assets for Medicaid Buy-In program participants than are allowed for SSI beneficiaries. Moreover, several states encourage additional savings by disregarding assets held in retirement accounts, medical savings accounts, or other approved accounts created to pay employment or independence-related expenses. Several states provide considerable increases over previous levels, with **Connecticut** allowing

[4] Standard SSI disregards include the first $20 of any monthly income and the first $65 of monthly earned income plus one-half of the remaining earnings. IRWE and Blind Work Expenses are also disregarded when appropriate.

resources of $10,000 for an individual and $15,000 for a couple, **Wisconsin** providing for $15,000 for an individual (with no limit on spousal assets) and **Minnesota** setting a standard of $20,000 (and also putting no limits on spousal assets). See Table 2 for a complete list of asset standards.

Several states encourage specific kinds of saving by excluding additional amounts of specified types of assets from the Medicaid Buy-In resource limit. Four states (**Connecticut**, **Iowa**, **Minnesota**, and **Oregon**) specifically exclude retirement accounts and medical savings accounts from the calculation of countable assets. **Wisconsin** excludes retirement accounts initiated after enrolling in the Buy-In. In **Vermont**, all assets purchased with earnings accumulated through work after January 1, 2000 are exempt.

Five states created separate "approved accounts" for the purposes of paying employment or independence-related expenses. **Iowa** disregards funds in an assistive technology account in the calculation of assets. **Wisconsin** allows participants to register retirement and other savings accounts as Independence Accounts; up to 50% of earned income can be placed in an Independence Account. **Oregon**, **Vermont** and **Connecticut** also offer some form of approved accounts.

TABLE 2. Resources Limits and Exclusions

	What is the Resource Limit?	Are Retirement Accounts Excluded from Countable Assets?	Are Medical Savings Accounts Excluded from Countable Assets?	Are Approved Accounts for Employment or Independence Excluded?
Alaska	$2,000 Individual $3,000 Couple	No.	No.	No.
Connecticut	$10,000 Individual $15,000 Couple	Yes.	Yes.	Yes.
Iowa	$12,000 Individual $13,000 Couple	Yes.	Yes.	Yes, Assistive Technology Accounts.
Maine	$8,000 Individual $12,000 Couple	No.	No.	No.
Minnesota	$20,000 (Only count individual assets)	Yes.	Yes.	No.
Nebraska	$4,000 Individual $6,000 Couple	No.	No.	No.
Oregon	$12,000 (Only count individual assets)	Yes.	Yes.	Yes.
Vermont	$2,000 Individual $3,000 Couple Plus assets accumulated from earnings since 1/1/00.	Yes, if from earnings after 1/1/00.	Yes, if from earnings after 1/1/00.	Yes, if from earnings after 1/1/00.
Wisconsin	$15,000 (Only count individual assets)	Yes. Retirement accounts initiated after Buy-In enrollment are not counted. Retirement accounts existing prior to Buy-In enrollment are counted.	No.	Yes, Independence Accounts.

D. Cost-Sharing Policies

In every state, enrollees with incomes exceeding specified levels--ranging between 100% and 200% FPL--are assessed premiums. States differ as to whether they assess premiums based on family income or individual income and on whether they use net or gross income as the cost-sharing base. For purposes of cost-sharing, states may make different decisions about income disregards and treatment of household income than they made during the eligibility process. Their decisions reflect differing priorities about relative ease of entry to the program and equitable allocation of program costs. Some states have crafted their cost-sharing strategies to be similar to those in other Medicaid programs such as waiver programs or SCHIP. The approaches require varying amounts of administrative time and expertise.

Every state has established a minimum income level at which eligible persons begin to share in program costs. The minimum level for payment of a premium ranges from 100% FPL (**Minnesota** [after December 2001] and **Alaska**) to 200% FPL (**Connecticut** and **Nebraska**). **Iowa**, **Maine**, and **Wisconsin** begin assessing premiums at 150% FPL and **Vermont** at 185% FPL. In **Oregon**, individuals pay a premium if they meet one of two conditions: either individual earned income is greater than 200% FPL or unearned income exceeds the SSI income standard plus state supplement. Table 3 details the options states have chosen in setting premiums.

Design decisions made in the eligibility phase, such as counting household income, income disregards, or the treatment of unearned income, may or may not be used in determining cost-sharing. For example, **Iowa** and **Wisconsin** use family income to determine eligibility, but individual income to determine premiums. **Connecticut** does just the opposite, using individual income to determine eligibility and family income to determine premiums.

Some states have special provisions designed to reduce premium liability. **Wisconsin** collects a premium if individual gross income is above 150% FPL for the enrollee's family size. That is, an eligible individual with a spouse would have his individual income applied against a two-person poverty level standard. **Minnesota** has a similar approach, collecting a premium only if an individual's income exceeds 100% FPL for the appropriate family size. (Prior to December 1, 2001, premiums began at 200% FPL.)

Several programs reduce premiums if individuals are paying for private insurance or Medicare. In **Vermont**, individuals in the 225-250% FPL bracket are eligible for a discounted Medicaid Buy-In premium if they secure employer-sponsored coverage. In **Connecticut**, premiums paid for private insurance reduce an individual's liability for Buy-In premium payments. In **Maine**, a premium is due if net family income is above 150% FPL; however, there is no premium at any income level if the individual with a disability is paying a Medicare Part B premium.

Alaska, **Connecticut**, **Maine**, and **Oregon** deduct IRWE to determine countable income for cost-sharing. **Oregon** also deducts "Employment and Independence expenses" and **Wisconsin** has a special deduction for medical and remedial expenses. Medicaid Buy-In programs in **Connecticut**, **Iowa**, **Minnesota**, **Oregon**, and **Wisconsin** have explicit links to employer-sponsored health insurance coverage. Those states require Medicaid payment for employer-sponsored coverage for which individuals are eligible if such coverage is less costly than Medicaid.

Setting Premiums

States use one of three methods to set premiums:

- A percentage of all income,
- A fixed amount based on income brackets, or
- Separate payments schedules for earned and unearned income.

Percentage of Income

Alaska, **Connecticut** and **Minnesota** calculate premiums as a percentage of total income. **Alaska** charges a varying percentage based on income and family size up to a maximum of 10%. Initially, **Minnesota** charged 10% of individual income above 200% FPL for the family size. As of December 1, 2001, the premium is based on a sliding scale between 1-7.5% beginning at 100% FPL. **Connecticut** calculates 10% of family net income above 200% FPL, minus any income paid toward the cost of health insurance.

Fixed Premium Based on Income Brackets

Iowa, **Maine**, **Nebraska**, and **Vermont** assess a fixed dollar premium that varies according to income brackets. In **Maine**, for example, the premium is $10 per month if monthly income is 150-200% FPL or $20 per month if monthly income is 200-250% FPL. **Nebraska** uses a steeper premium schedule, with individuals paying $29 per month at 200% FPL and $175 per month at 249% FPL. In **Vermont**, the monthly premium, assessed only on persons whose incomes are at least 185% of poverty, is $10 up to 225% of poverty and $25 between 225% and 250% of poverty but is reduced to $12 if the individual secures employer-sponsored coverage. **Iowa** has eleven payment brackets, ranging from $20 to $207 monthly.

Separate Payments for Earned and Unearned Income

Oregon and **Wisconsin** calculate separate payment obligations for earned and unearned income with proportionately smaller premiums assessed on income derived from work. In **Oregon**, unearned income in excess of the SSI income standard ($533) is paid to the state. In addition, individuals pay a percentage of their earned income over 200% FPL but with disregards for work and disability-related expenses. For persons liable for premiums, **Wisconsin** deducts the SSI income standard, IRWE, and medical

and remedial expenses, and then collects the remainder of the unearned income as part of the premium. The individual pays 3% of his earned income, in increments of $25, as a premium.

TABLE 3. Cost-Sharing Policies: Minimum Income Level and Premium Method				
	Income Level at Which Premiums Start	**Premium is a "Percent of Income"**	**"Payment" based on "Income Brackets"**	**Separate Premiums of "Earned" and "Unearned" Income**
Alaska	100% FPL net family income.	Yes. Varying percent by income with 10% maximum.	No.	No.
Connecticut	200% FPL net family income.	Yes. 10% of family income minus any payments for private health insurance.	No.	No.
Iowa	150% FPL gross individual income.	No.	Yes. Eleven brackets with monthly range from $20 to $207.	No.
Maine	150% FPL net family income; no premium if paying Medicare Part B.	No.	Yes. 150<200% FPL=$10 monthly. 200<250% FPL=$20 monthly.	No.
Minnesota	Gross individual income of 100% FPL for family size. (Before 12/1/01, 200% FPL for family size.)	Yes. Scale 1-7.5% of income above 100% FPL. (Before 12/1/01, 10% of income above 200% FPL.)	No.	No.
Nebraska	200% FPL net family income.	No.	Yes. Five income bands with premiums from 2% to 10%.	No.
Oregon	Two part test: 1. Individual unearned income above SSI level. 2. Individual's earned income above 200% FPL after work and disability related disregards.	No.	No.	Yes. All unearned income in excess of SSI income standard. Between 2% and 10% of individual's adjusted earned income and remaining unearned income.
Vermont	185% FPL net family income	No.	Yes. 185-225% FPL=$10 225-250% FPL=$12 (if have private insurance) or $25 (if no private insurance)	No.
Wisconsin	Gross individual income below 150% FPL for enrollee's family size.	No.	No.	Yes. 100% of unearned income minus standard living allowance, work expenses, and medical and remedial expenses. 3% of individual earned income.

E. Protections and Assurances

In some states, individuals who must leave the work force temporarily are able to remain in the Medicaid Buy-In program temporarily. A few states allow individuals who have acquired assets to retain them if they transfer to another Medicaid eligibility category. See Table 4 for details.

Continued Eligibility During Unemployment

In **Connecticut**, to protect persons who have temporary health problems or are involuntarily terminated, an individual can continue to meet the employment test for a period of up to one year from the date of employment loss. To do so, the individual must profess an intention to return to employment. If employment ends for medical or other reasons, the **Iowa** Buy-In program participant may remain eligible for up to six months after the month of job loss if he or she intends to return to work.

Participants in **Minnesota**'s Medicaid Buy-In program are required to have income from work every 30 days, but special allowances are made for those who switch jobs. Also, as of December 1, 2001, recipients are allowed up to 4 months of medical leave--approved by a physician--without losing eligibility.

In **Wisconsin**, if a Medicaid Buy-In program participant has been in the program for at least six months and has a health setback that makes him unable to work, the work requirement may be exempted for up to 6 months. The individual may also participate in the Health and Counseling program for up to a year. However, individuals may only participate in the Health and Counseling program twice in a two-year period with at least six months between each period of participation.

TABLE 4. Work-Related Policies and Protections

	Work Requirements	Protections for Temporary Loss of Employment	Protections When Returning to Other Eligibility Categories
Alaska	Must have earned income.	None.	None.
Connecticut	Must make FICA contributions.	Can continue Buy-In for one year after losing employment.	Assets in retirement, Medical Savings Accounts, and approved accounts not counted during the individual's lifetime.
Iowa	Must have earned income.	Yes. May remain eligible for 6 months after work stoppage.	None.
Maine	Must have earned income.	None.	None.
Minnesota	Some income from work every 30 days.	Previously, up to 2 months of medical leave and allowances for switching jobs. After 12/1/01, up to 4 months of leave.	As of 12/1/01, up to $20,000 in assets protected for one year.
Nebraska	Must have earned income.	None.	None.
Oregon	Must have taxable income.	None.	None.
Vermont	Must have earned income.	None.	None.
Wisconsin	Must be working or enrolled in an employment counseling program. Can remain in employment counseling for up to 1 year.	Can enroll in HEC (time limited and restricted to twice in 5-year period). Can waive work requirement for 6 months due to a health setback.	None.

Exclusion of Assets

In **Connecticut**, an individual's assets in retirement, medical savings, and designated accounts are excluded from consideration during his lifetime if he reapplies for Medicaid under another eligibility category. As of December 1, 2001, **Minnesota** allows up to $20,000 in assets to be protected for one year if a person moves from the Medicaid Buy-In program to another Medicaid eligibility category.

SSI Demonstrations

Several states secured authority from the SSA to operate demonstrations involving specified SSI recipients participating in Medicaid Buy-In programs. **Wisconsin** received approval to count as income $1 out of every $4 earned by specified SSI recipients participating in Medicaid Buy-In programs (and the Pathways to Independence Program), rather than the standard $1 for $2 calculation. The waiver also allows SSI recipients to save up to 50% of their earnings in an approved account. **Vermont** has also received approval to conduct a demonstration for specified SSI recipients participating in Medicaid Buy-In programs.

F. Design Changes

Minnesota made significant changes to its Medicaid program in 2001. The state adopted a poverty level program and increased the protected income level for their medically needy program to 80% of FPL. By allowing individuals additional Medicaid eligibility options, these changes are likely to reduce enrollment in the Medicaid Buy-In program. Several states are considering changes to their Medicaid Buy-In program. **Alaska** is considering changes to resource levels and income disregards to encourage additional enrollment, while **Iowa** is considering a provision limiting eligibility to those disabled workers who pay FICA taxes.

IV. COST ESTIMATES AND BUDGET MODELING

When preparing budget estimates, states relied primarily on existing state Medicaid data, especially eligibility and claims data for current and former Medicaid clients, and SSA data on SSI and SSDI recipients. Some states used surveys and studies from state vocational rehabilitation, state mental health or developmental disabilities agencies. States often considered the data sources available to them inadequate.

Each of the eight states providing budget assumptions (**Oregon** did not provide assumptions) expected Medicaid Buy-In program enrollees generally would be existing Medicaid beneficiaries and estimated some offsets in program costs from premium payments. **Connecticut** and **Wisconsin** assumed cost offsets from converting individuals in state-funded pharmacy or home care programs to Medicaid. Some states estimated savings from private insurance coverage, while others did not attempt to quantity private insurance dollars. **Alaska**'s cost estimates assumed all individuals enrolled in the Buy-In would leave public insurance coverage after a short period of time.

Several states based their budget modeling on the enrollment and cost experience of other states. For example, **Minnesota** based its cost estimate on Massachusetts' experience implementing its Section 1115 waiver; **Wisconsin** based its cost estimate on the experiences of **Oregon** and Massachusetts; and **Connecticut** based its cost estimate on the experiences of states such as **Minnesota**, **Oregon**, and **Wisconsin**.

In preparing fiscal estimates for their Medicaid Buy-In programs, analysts developed models that estimated the number and characteristics of Buy-In Program enrollees. Major variables influencing estimates were:

- Number of persons expected to enroll.
- Proportion of enrollees transferring from another Medicaid category.
- Proportion of enrollees transferring from a state-funded program.
- Amount of premium dollars.
- Proportion of enrollees with private insurance coverage.
- Length of time each person would remain enrolled.

Based on their analysis of the interactions among these variables, six of the nine states predicted relatively modest budget increases relative to the size of their Medicaid

program and two (**Alaska** and **Wisconsin**) predicted cost savings over time. As noted, **Oregon** did not report budget estimates or assumptions.

Every state reporting information suggested that all or most potential enrollees would consist of existing Medicaid enrollees. Analysts in **Connecticut** likely conveyed the view of other Case Study states when they noted that "Medicaid is such an essential service that almost every disabled person would have been willing to forego earnings previously if that is what was necessary to meet the requirements for the Medicaid program." These individuals were predicted to result in no new net costs to the state because they were already on the Medicaid rolls.

Connecticut and **Wisconsin** adjusted their cost estimates to account for new federal revenue to supplant state funds. **Connecticut** has a state-funded prescription program (ConnPACE) and a state-funded personal assistance program. When enrollees in those programs convert to Medicaid through Medicaid Buy-In program participation, federal revenues become available for their personal assistance and prescription drug costs. The state budget estimate included these new revenues. In **Wisconsin**, analysts assumed some persons enrolled in the state-funded Community Options program, a community-based long-term care program, would transfer to the federally matched Medicaid Buy-In program.

Every state assumed some offsets from premium payments. Some states assumed large savings from increased private insurance coverage. In **Minnesota**, for example, the estimate assumed 16% of enrollees would gain employer-based coverage with estimated annual savings to the state of at least $3,500 per person depending on the individual's need for personal assistance services.

The states of **Alaska** and **Wisconsin** assumed cost savings over time as a result of the Medicaid Buy-In program. The fiscal note in **Alaska** assumed net savings to the state after the third year based on working individuals leaving the SSI state supplement program and then leaving the Medicaid rolls for workplace coverage after a year of continued Medicaid coverage. The **Wisconsin** estimate assumed net savings over time as a result of a high level of premium payments combined with new federal funds for previously state-funded programs.

V. PROGRAM EXPERIENCE AND OUTCOMES

As of the end of 2001, approximately 13,000 persons were enrolled in the Medicaid Buy-In program in the nine Case Study states. Consistent program data are not available across the states. In most of the states, enrollment data thus far show enrollment consistent with estimates. The percentage of persons previously enrolled in Medicaid programs is generally consistent with estimates.

There is considerable variation in the percentage of enrollees paying premiums, with as few as 11% in **Maine** to 58% in **Alaska**. Most states are finding that significant numbers of persons on SSDI enrolled in the Medicaid Buy-In program (in the 86% range) are earning below the SGA level ($740 monthly in 2001). In general, both earnings levels and private insurance participation are lower than expected.

A. Data Sources

Medicaid Buy-In program data are often piecemeal and categorized by states as preliminary. Some of the data may not be reliable because the experience base is too short and the numbers are relatively small. **Alaska**, **Oregon**, **Vermont**, and **Wisconsin** are among the states analyzing data from their comprehensive work incentive initiatives. This analysis is ongoing and official findings have not yet been reported.

Several states are using their Medicaid Infrastructure grant funds to strengthen data collection capacity, including the establishment of databases, the development of research designs, and the hiring of experts. For example, **Alaska**, **Maine**, and **Nebraska** are using their Medicaid Infrastructure grants to, among other things, develop and implement a research plan focusing on program features such as eligibility, enrollment, and costs. **Connecticut** is gathering data on enrollees through its Medicaid information system and expects to publish utilization and cost data for the Medicaid Buy-In program group after automated eligibility is instituted.

B. Program Experience

The categories used by states to report program experience and outcomes include:

- Age
- Persons paying premiums
- Persons with private health insurance
- Persons previously enrolled in Medicaid, including SSI and SSDI recipients
- Earned income amounts

- Unearned income amounts
- Persons earning over the SGA Level.

Based on point-in-time reporting from all nine states, there were approximately 13,000 enrollees in the Medicaid Buy-In programs as of the end of 2001. (For enrollment details for each state, see the individual case studies.) In most of the states, data thus far show enrollment consistent with estimates. However, the states of **Iowa** and **Minnesota** have enrolled substantially more persons than forecast, while **Nebraska** has enrolled fewer persons than expected.

Previous Medicaid Enrollment

The percentage of persons previously enrolled in Medicaid programs was relatively high and generally consistent with estimates. Examples of state reports are 88% in **Maine**, 75% in **Minnesota**, and 90% in **Vermont**. States incur higher costs when an individual transfers from the state's medically needy program with a spend-down to a Medicaid Buy-In program without a spend-down. **Alaska** reported that persons enrolled in the Medicaid Buy-In program incur lower monthly costs than they did when enrolled in other Medicaid eligibility categories.

Private Health Insurance

Data available from **Alaska** and **Minnesota** show 12% of Medicaid Buy-In program participants enrolled in private health insurance, a smaller number than predicted.

Premium Payments

The proportion of persons paying premiums or other cost-sharing varied significantly among the states. With six states reporting, the percentage of enrollees paying premiums was 58% in **Alaska**, 40% in **Oregon**, 30% in **Iowa**, 17% in **Minnesota**, 16% in **Wisconsin**, 15% in **Connecticut**, and 11% in **Maine**.

Earned Income

Significant numbers of persons on SSDI enrolled in the Medicaid Buy-In program are earning below the SGA level. With the states of **Connecticut**, **Minnesota**, **Wisconsin**, **Iowa** and **Oregon** reporting earnings data, approximately 14% of enrollees had monthly earnings exceeding the SGA test for disability under the SSDI program ($740 in 2001). Nine percent of total enrollees had earnings over $1,000 a month.

Oregon reported that 51% of its Medicaid Buy-In program participants had earnings over the SGA level. As described in the **Oregon** Case Study, **Oregon** requires participants to pay as a cost-share any unearned income in excess of the state's SSI standard. Thus, persons who choose the Medicaid Buy-In program in **Oregon** must have sufficient earnings to compensate for the unearned income premium.

Unearned Income

Connecticut, **Iowa** and **Minnesota** provided information on unearned income. Monthly unearned income exceeded $600 in nearly two-thirds of the cases.

TABLE 5. Monthly Unearned Income of Medicaid Buy-In Enrollees					
	None	**$1-$600**	**$600-$799**	**$800-$999**	**$1,000 & more**
Reported by Connecticut, Minnesota and Iowa	7.9%	26.5%	37.4%	18.7%	9.3%

Age

Wisconsin, **Oregon** and **Minnesota** provided information on the ages of participants. In each of the three states, at least two-thirds of the Medicaid Buy-In program enrollees were aged 40 or older. Based on these data, Medicaid Buy-In program participants are substantially older than participants in SSI work incentive programs. Two-thirds of Section 1619 recipients nationally are under the age of 40.

VI. EFFECT OF THE MEDICAID BUY-IN ON ACCESS TO COVERAGE

Based on their design decisions, three of the nine Case Study states--**Iowa**, **Connecticut**, and **Minnesota**--have minimal restrictions on enrollment in their Medicaid Buy-In program. These states do not distinguish between earned and unearned income at the time of eligibility nor treat earned and unearned income differently when assessing premiums.

Vermont, **Alaska** and **Maine** impose upper limits on unearned income for qualifying persons, thus restraining enrollment of persons with significant income from sources other than work. **Oregon** and **Wisconsin** use separate premium schedules for earned and unearned income that assess higher premiums on unearned income than on earned income. These provisions have the effect of encouraging participation from persons with significant earnings from work and discouraging participation from those with small amounts of work earnings.

Nebraska links the level of earnings to the amount of unearned income counted towards eligibility. In order to disregard any of his unearned income, an individual in **Nebraska** must have sufficient income from work to trigger a Trial Work Period (at least $560 monthly as of January 2002). Without that level of earnings, individuals in **Nebraska** must have unearned incomes at or below the SSI level to qualify for the program.

A. Variation in Access to Medicaid

Demand for and enrollment in the Medicaid Buy-In program are likely to be affected by how easily workers with disabilities can gain access to Medicaid through other eligibility categories. Medicaid eligibility standards provide a different eligibility baseline in each state. The effect of the variation in Medicaid eligibility standards is that each state had a different "maximum income level" through which persons with disabilities, including workers with disabilities, could gain access to Medicaid prior to the Medicaid Buy-In program. The highest income standard in each state's Medicaid program prior to the Medicaid Buy-In program is shown in Table 6.[5]

[5] Variation can occur in each of the following programs: (1) **The income standard for the combined SSI and state SSI supplement**. This standard governs Medicaid eligibility determination for persons receiving cash benefits through SSI and/or state SSI supplementation. (2) **The "poverty level" or "standard of need" Medicaid eligibility category**. If a state chooses a poverty level option, this standard governs Medicaid eligibility for persons who do not receive cash benefits from SSI and/or state SSI supplementation. (3) **The amount of the protected income level under the "medically needy" Medicaid eligibility category**. In states without a poverty level category, the protected income level determines how much money an individual not on SSI has to "spend-down" before qualifying for Medicaid. In states with a poverty level category, it provides an alternative eligibility mechanism for persons whose incomes exceed the poverty level standard.

TABLE 6. Medicaid "Starting Points" Year 2001		
	Starting Point	**Source**
Alaska	$984	Standard of need
Connecticut	$748	State SSI supplementation
Iowa	$531	Federal SSI standard
Maine	$791	Poverty level with disregards
Minnesota	$716	Poverty level
Nebraska	$716	Poverty level
Oregon	$533	State SSI supplementation
Vermont	$733	Medically needy protected income level
Wisconsin	$615	State SSI supplementation

In **Connecticut**, **Maine**, **Alaska** and **Nebraska**, the Case Study states with the most expansive coverage, the highest Medicaid eligibility standard was at or above the FPL. In these four states, individuals with disabilities could qualify for Medicaid if their total incomes fell below a specified dollar figure. In **Vermont**, the highest Medicaid standard was a medically needy protected income level that is above the FPL. After July 1, 2001, **Minnesota** established a poverty level Medicaid eligibility standard.

As shown on Table 6, the highest Medicaid eligibility standard in **Wisconsin** was a state SSI supplementation level between the federal SSI standard and the FPL. **Iowa** and **Oregon**, the two states with the least expansive coverage, had no Medicaid eligibility standard above the federal SSI standard. In these two states, individuals with disabilities who were not on SSI could qualify for Medicaid only if they "spent down" to a level below the SSI level.

Thus, the new eligibility rules created by the Medicaid Buy-In program have a greater or lesser effect on overall eligibility standards depending on the state's baseline or "starting point." In a state with relatively generous Medicaid income standards in non-Buy-In categories, a greater proportion of working persons with disabilities can gain access to Medicaid through avenues other than a Buy-In program. **Alaska**, **Connecticut**, **Maine**, **Minnesota**, **Nebraska**, and **Vermont** have relatively generous non-Buy-In eligibility standards for persons with disabilities, **Wisconsin** has less generous standards, and **Iowa** and **Oregon** have the most restrictive standards.

B. Access to SSI Work Incentives

Medicaid Buy-In program enrollment may be influenced by the access of persons with disabilities to existing SSI work incentives. The ease with which SSI beneficiaries and persons receiving SSI state supplements can access Medicaid through SSI work incentives is another factor where there is great variation among states. If gaining access to continued Medicaid coverage is relatively easy for SSI beneficiaries who are working, such persons are more likely to secure continued Medicaid coverage through SSI work incentive provisions than if access is more difficult.

As shown on Table 7, ease of access to Medicaid for SSI beneficiaries--and thus access to continued coverage when beneficiaries goes to work--varies across the states. Four of the states--**Wisconsin**, **Vermont**, **Maine**, and **Iowa**--provide automatic Medicaid eligibility for federal SSI beneficiaries and thus automatic eligibility for continued Medicaid for SSI workers under the provisions of Section 1619(b). Three states--**Alaska**, **Nebraska** and **Oregon**--employ a more complex process by using federal SSI criteria for Medicaid eligibility but requiring a separate Medicaid application. The remaining two states--**Connecticut** and **Minnesota**--separate the two eligibility processes even more by using state-specific criteria for Medicaid eligibility.

When federal SSI beneficiaries have earnings that affect their eligibility for cash benefits, they automatically maintain Medicaid benefits in the states of **Iowa**, **Maine**, **Vermont**, and **Wisconsin**. Federal SSI officials send the names of eligible persons to the state and the beneficiary is not required to complete any additional forms. In the remaining five states, state Medicaid agencies are responsible for using federal data to secure continued eligibility for SSI beneficiaries who go to work. The administrative processes involved are often challenging for states to carry out and for Medicaid beneficiaries to understand.

Access to SSI work incentives for persons who receive a state SSI supplement but no SSI cash benefits is often even more complex. Only one of the eight states with a state SSI supplement--**Vermont**--has chosen federal administration of the benefit. In **Vermont**, recipients of state SSI supplements receive the same Medicaid coverage protection as SSI beneficiaries due to federal administration of the state SSI supplement. In the other seven states with state SSI supplementation programs, SSI recipients must apply for the state supplement and Medicaid at the state level. Of the seven states, only **Connecticut** and **Wisconsin** grant continued Medicaid coverage to state supplement-only recipients who lose their state SSI supplement due to earnings.

TABLE 7. Administration of Medicaid Eligibility Criteria and State SSI Supplementation

State	Automatic Medicaid for Federal SSI Recipient	Federal SSI Criteria, but Separate Medicaid Application Required	State Criteria for Medicaid (209(b) option) Separate Medicaid Application Required	Federally Administered State SSI Supplement	State Administered State SSI Supplement
Alaska		X			X
Connecticut			X		X
Iowa	X				
Maine	X				X
Minnesota			X		X
Nebraska		X			X
Oregon		X			X
Vermont	X			X	
Wisconsin	X				X

C. Federal Barriers Affecting State Initiatives

Minnesota, **Vermont** and **Wisconsin** have submitted to the SSA requests for demonstration authority for specified SSDI recipients participating in the Medicaid Buy-In program. (**Connecticut** has authority under its state law to seek similar

demonstration authority). In general, the demonstration authority would permit the states to "stop the clock" for specified participants regarding the Trial Work Period and the Extended Period of Eligibility, cessation month, grace months, and other related timelines. Additionally, the states wish to disregard some earned income to prevent precipitous declines in SSDI payments, such as reducing SSDI payments by $1 for every $2 above the SGA level. These states perceive the failure of the SSA to grant demonstration authority as adversely affecting their ability to enroll people in the program and increase earnings of enrollees above SGA. Additional barriers include the component of the definition of "disability" used for SSI and SSDI that includes the inability of an individual to engage in work (**Wisconsin** and **Nebraska**).

VII. CONCLUSION

The Balanced Budget Act of 1997 and the TWWIIA authorized states to enact Medicaid Buy-In programs for disabled workers. These laws provided state policymakers and other stakeholders an opportunity to focus on issues associated with employment of persons with significant disabilities. As these case studies in nine states illustrate, the experiences of states that have implemented Medicaid Buy-In programs and related employment initiatives provide a wealth of information for other states.

At the same time, a state should recognize the limitations of the experience of other states. Every state starts from a different baseline as it relates to Medicaid eligibility rules, the relationship between SSI eligibility and Medicaid, SSI state supplementation, and the implementation of existing SSI work incentives. The purpose, function, and size of a state's Medicaid Buy-In program vary depending on its policies governing eligibility for cash benefits, work incentives, and health coverage through Medicaid. Thus, the design of a Medicaid Buy-In program must be viewed in the context of a state's overall Medicaid program, other state-specific initiatives, and fiscal considerations.

CASE STUDIES AND TECHNICAL ASSISTANCE FOR MEDICAID BUY-INS FOR PEOPLE WITH DISABILITIES

Reports Available

Medicaid Buy-In Programs: Case Studies of Early Implementer States

HTML	http://aspe.hhs.gov/daltcp/reports/EIcasest.htm
PDF	http://aspe.hhs.gov/daltcp/reports/EIcasest.pdf

Policy Frameworks for Designing Medicaid Buy-In Programs and Related State Work Incentive Initiatives

Executive Summary	http://aspe.hhs.gov/daltcp/reports/polfrmes.htm
HTML	http://aspe.hhs.gov/daltcp/reports/polframe.htm
PDF	.

The Medicaid Buy-In Program: Lessons Learned From Nine "Early Implementer" States

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2002/EIlesses.htm
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