THE EFFECTIVENESS OF MEDICAID BUY-IN PROGRAMS IN PROMOTING THE EMPLOYMENT OF PEOPLE WITH DISABILITIES

BRIEFING PAPER PREPARED FOR THE:

TICKET TO WORK AND WORK INCENTIVES ADVISORY PANEL

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Table of Contents

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EXECUTIVE SUMMARY

The 1999 Ticket to Work and Work Incentives Improvement Act (Ticket Act) expanded state authority originally granted under the 1997 Balanced Budget Act (BBA) to provide Medicaid coverage to working people with disabilities who, because of income and assets, would not otherwise qualify for Medicaid coverage. Both the BBA and the Ticket Act authorized states to charge premiums for this coverage, and thus, allow working individuals with disabilities to "buy in" to Medicaid. These programs are commonly referred to as Medicaid Buy-in programs. In addition to the expanded state authority, the Ticket Act also appropriated funds for Medicaid Infrastructure Grants (MIGs) to states for purposes of developing Buy-in program infrastructure and conducting a variety of activities designed to promote the employment of people with disabilities. As of May 2004, 29 states had implemented Buy-in programs. Collectively, these programs are serving approximately 64,000 people with significant disabilities. Of the 29 states that have implemented Buy-in programs, 15 have been implemented under the authority of the Ticket Act.

The purpose of this paper is to provide the Ticket to Work and Work Incentives Advisory Panel with information about the features of the existing Medicaid Buy-in programs, and the potential effectiveness of these programs in promoting the employment of people with disabilities. We base our assessment on information obtained from existing data and documents on the Buy-in programs, and on information collected through interviews with staff from: selected states with Buy-in programs; states considering adoption of Buy-in programs; the Centers for Medicare and Medicaid Services (CMS); and the two Technical Assistance centers serving Medicaid Infrastructure Grantees.

A. Findings

There is considerable variation across states in the eligibility criteria used by Buy-in programs. State rules regarding income (earned, unearned, and spousal income) vary dramatically. The maximum gross income permitted for Buy-in eligibility ranges from about $23,000 to no income limit at all. In most states, the maximum gross income for purposes of eligibility is about $48,000. State eligibility rules regarding assets also vary, but most Buy-in programs apply rules that are less restrictive than the SSI standard. Three states do not apply any limitations to assets.

Premiums charged by Buy-in programs also vary substantially. The percentage of Buy-in enrollees required to pay a premium ranges from 2% to 100% across states. Differences in the methods used by states to calculate premiums leads to significant differences across states in the premiums that would be paid by individuals in like circumstances. For example, an individual with gross income of $1,400 ($600 unearned and $800 earned) per month will be ineligible in three states, and will pay between $0 and $81 per month for coverage in the others. If more of the $1400 in gross income is unearned versus earned ($1,100 unearned and $300 earned), the individual would be ineligible in six states and pay between $0 and $536 per month for coverage in the others.

There is considerable variation in enrollment across states. Buy-in enrollment as of March 2004 ranged from 2 in Wyoming to 16,508 in Missouri. While state eligibility criteria and premium structures will affect the number and types of individuals who enroll, many other factors will also affect Buy-in enrollment: the procedures used by states to verify disability and work activity; whether the enrollment process is automated; the level of knowledge about the program on the part of eligibility workers; the amount and nature of outreach conducted; state eligibility criteria used for other categories of Medicaid; the general system of supports for people with disabilities in the state; and the general economy.

The majority of Buy-in participants in most programs are DI beneficiaries, and most participants were covered by Medicaid prior to Buy-in enrollment. While there are some inconsistency regarding how DI status is measured, it appears that about 75% of Buy-in enrollees in 21 of the Buy-in states are DI beneficiaries. It also appears that about 75% of Buy-in enrollees in these same states were enrolled in another Medicaid category prior to Buy-in enrollment.

Earnings of participants tend to be relatively low. In 19 states that reported Buy-in enrollee earnings for the year 2002, 52% of participants had earnings. This percentage ranged from 25% in New Mexico to 93% in Indiana. In six of the 19 states, fewer than 50% of Buy-in enrollees had earnings, and in four states over 80% of enrollees had earnings. Among Buy-in enrollees with some reported earnings, the earnings tended to be low. Over three-quarters of those with earnings had earnings of less than $800 per month. The low earnings may be due to the incentives inherent in the DI program. Despite the provision of health insurance, many DI beneficiaries are unable or unwilling to forgo all of their benefits for earnings. This was frequently cited by interviewees as a barrier to the effectiveness of the Buy-in programs.

Buy-in programs break the link between health insurance and SSI/DI eligibility and increase employment incentives for some. For those without health insurance coverage and not enrolled in the federal disability programs, Buy-in programs reduce incentives to stop working in order to qualify health insurance benefits via the disability programs. The higher the gross income eligibility limit, the more this type of incentive is reduced. In all but a few states, the Buy-in income eligibility threshold is substantially higher than the 1619(b) threshold, suggesting that the Buy-in successfully de-links health insurance from SSI eligibility and increases work incentives for some former SSI recipients in those states. Most Buy-in programs also increase work incentives among DI beneficiaries participating in Medicaid via spend down or poverty programs. For these individuals, the Buy-in reduces restrictions on earnings and allows them to earn at higher levels and maintain Medicaid coverage.

The treatment of unearned income for purposes of Buy-in eligibility and premium determinations has consequences for promoting employment among DI beneficiaries through Buy-ins. In states that use the SSI methodology for counting income and in states where unearned income limits are applied, DI beneficiaries with above average DI benefits will not be eligible for the Buy-in, or will be subject to stricter income limits than similar individuals without DI benefits. Some states are purposefully limiting Buy-in eligibility with these criteria. Others treat unearned income unfavorably in premium calculations in an effort to target Buy-in eligibility only to those willing and able to work, as demonstrated by their willingness to give up all or most of their DI benefits in the form of premiums and cost-sharing. In many states, it is likely that the implications of the treatment of unearned income for DI beneficiaries was not considered in the design of the program. The effect of these policies on the ability of a Buy-in to promote employment among DI beneficiaries is uncertain. These policies do, however, clearly restrict access to the Buy-in to only those with low DI benefits or low earnings.

Consumer awareness of Buy-in programs could be improved. Surveys and interviews conducted with Buy-in enrollees in several states indicate that there is confusion and lack of knowledge about the program among many enrollees. Lack of consumer awareness and/or trust that health insurance will be maintained under a Buy-in if earnings increase will significantly undermine any potential effects of Buy-in programs on employment.

Buy-ins appear to provide important and necessary supports for people with disabilities. Most notable are prescription drugs and personal assistance services. The need for prescription drug and

more complete outpatient mental health service coverage by Medicare beneficiaries with severe mental impairments may be one reason why a large proportion of Buy-in enrollees in a number of states are DI beneficiaries with mental health conditions. As Medicare assumes prescription drug coverage in the future, it is possible that the value of the Buy-in will decline for many and the composition of program enrollees could change substantially.

While a number of studies indicate that Buy-in enrollees increase their earnings, on average, after enrollment in the Buy-in, no strong evidence exists that these programs *caused* the increase in employment because of the absence of data on suitable comparison groups. The studies to date yield a number of interesting findings related to employment, however:

- Descriptive cross-state comparisons of enrollee earnings suggest that program design affects average enrollee earnings substantially, but this may reflect variation in who enrolls rather than induced changes to their earnings.
- Anecdotal evidence from consumer surveys, interviews, and focus groups indicate that many Buy-in enrollees view the Buy-in as critical to their own ability to work or sustain their earnings.
- Descriptive data from a number of states show that average earnings increase after enrollment, and this increase may reflect the Buy-in inducing increases in employment and earnings. These data also show that the earnings paths of enrollees vary substantially after enrollment.
- The most rigorous analysis of the impact on employment, one employing a comparison group design, shows no statistically significant effect, but may be limited by a short observation period, and the newness of the program at the time the evaluation was conducted.

Medicaid Infrastructure Grant (MIG) funding appears to have been instrumental in helping states to develop Buy-in programs, but also in helping states develop systems and cross-agency collaborations that represent, in many cases, a first attempt at addressing employment issues in a more comprehensive fashion. The funding has also made state-level policy analysis and program evaluation efforts possible.

B. Suggestions for Improvement

A number of ideas for improving the effectiveness of Buy-in programs were offered by state officials interviewed. Others arise out of our qualitative review of the programs. These are listed below by the entity(ies) authorized to pursue them:

States:

- Assess the Buy-in program to determine if program features are inhibiting the state's ability to meet the goals of its Buy-in, and the goals of the broader state system of supports for people with disabilities.
- Identify and address administrative and consumer awareness issues that might be inhibiting Buy-in effectiveness.

The Centers for Medicare and Medicaid Services (CMS):

- Provide guidance on the disability determination process, or guarantee states that they will not be penalized by CMS for incorrect decisions.
- Provide guidance to states on eligibility grace periods when employment is lost, and define grace periods in the State Plan Amendment template.

- Maintain flexibility in the use of MIG funding.
- Continue to support TA and information-sharing opportunities.
- Continue to engage in national-level evaluation efforts, and support more rigorous efforts to estimate Buy-in program impacts and determine the factors that contribute to effectiveness.

Other Federal Agencies:

- Provide leadership for interagency coordination at the federal level.
- Allow data sharing between programs for purposes of program evaluation.
- Increase funding for benefits counseling to consumers with disabilities participating in state and federal programs.

Congress:

- Allow states to define work.
- Remove the upper age limit (age 64) for Buy-in programs implemented under the Ticket Act.
- Give CMS more control over MIG eligibility requirements.
- Implement a benefit offset program for DI similar to SSI, and change the definition of disability.

C. Conclusions

It is likely too early to expect dramatic employment outcomes from Buy-in programs given the newness of the programs and the fact that many were implemented during a recession when jobs were hard to find. Many programs are still experiencing growing pains, and both participants and eligibility workers are still learning how to make use of them. The programs are clearly providing needed medical supports to many DI beneficiaries who do not have access to those supports under Medicare. As the Buy-in programs mature, we may see greater participation by individuals who want to increase their earnings significantly.

The Buy-in provisions of the BBA and the Ticket Act cannot be deemed a success or failure in isolation from other factors affecting the employment of people with disabilities. The Buy-in represents a relatively small, incremental change in policy occurring within a very complex system of supports for people with disabilities. Given the nature of the current system, with eligibility for federal disability benefits so closely tied to a definition of disability that precludes work, it is likely that the Buy-in is having a large impact on providing needed services, but a small impact on reducing work disincentives. Thus, even if states are successful in removing employment barriers and providing needed supports to people with disabilities, it is unclear whether this will be sufficient to significantly increase employment in the absence of more fundamental changes to the way in which we provide income support to people with disabilities.

I. INTRODUCTION

A. Purpose of the Paper

The 1999 Ticket to Work and Work Incentives Improvement Act (Ticket Act) expanded state authority originally granted under the 1997 Balanced Budget Act (BBA) to provide Medicaid coverage to working people with disabilities who, because of income and assets, would not otherwise qualify for Medicaid coverage. Both the BBA and the Ticket Act authorized states to charge premiums for this coverage, and thus, allow working individuals with disabilities to "buy in" to Medicaid. These programs are commonly referred to as Medicaid Buy-in programs. In addition to the expanded state authority, the Ticket Act also appropriated funds for Medicaid Infrastructure Grants (MIGs) to states for purposes of developing Buy-in program infrastructure and conducting a variety of activities designed to promote the employment of people with disabilities.

The purpose of this briefing paper is to provide the Ticket to Work and Work Incentives Advisory Panel with information about the effectiveness of the existing Medicaid Buy-in programs in promoting the employment of people with disabilities, based on a comprehensive assessment of information available to date. The primary focus of the assessment is on the following:

- features of state Buy-in programs likely to affect Buy-in enrollment and employment of people with disabilities, including specific strategies being used by states to target Buy-ins in ways that promote employment;
- evidence of the effectiveness of Buy-in programs in promoting employment of people with disabilities; and
- factors that potentially inhibit the effectiveness of Buy-in programs in promoting the employment of people with disabilities.

B. Sources of Information

We used data and information obtained from several sources in developing this paper:

Interviews with staff in selected Buy-in states. We conducted interviews with staff associated with the state's Buy-in program and/or activities conducted under the state's MIG from 14 of the 29 states that have implemented Buy-in programs.[1] In most cases, we interviewed the MIG director. The MIG director was selected because we believe that this individual would have the most general knowledge about the status of the Buy-in program and the factors that might affect enrollment and the employment of participants.

Interviews with staff in selected states without Buy-in programs. We conducted interviews with staff in six non-Buy-in states, including the District of Columbia (District of Columbia, Florida, Maryland, Michigan, North Dakota, and Virginia). These states were selected because: they have MIGs and were undertaking activities with the intention of implementing Buy-in programs (District of Columbia, Maryland, North Dakota, and Virginia); do not have a MIG but in the past, had intended to implement a Buy-in program (Florida); or do not have a MIG but plan to implement a Buy-in in the future (Michigan). In three of the four states with MIGs, the MIG

[1] These states include: Alaska, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Maine, Minnesota, Nebraska, New Hampshire, Utah, Washington, and Wisconsin.

directors were interviewed. In the other three states, advocates and consultants involved in the Buy-in related activities were interviewed.

Interview with Centers for Medicare and Medicaid Services (CMS) staff. We conducted an interview with the two staff persons most closely involved in the administration of the MIGs from the CMS Center for Medicaid and State Operations.

Interviews with staff of the MIG Technical Assistance Centers. We interviewed two staff from each of the two technical assistance (TA) centers supporting states in their MIG-related initiatives. The two TA centers are the Center for Workers with Disabilities within the National Association of State Medicaid Directors, and the National Consortium for Health Systems Development.

Existing data and documents with information about Medicaid Buy-in programs. We collected numerous documents and information on the Buy-in programs. Some of these are widely available reports, while others are less-widely available reports and analyses conducted by specific states that were identified and collected during our interviews with state and MIG-related officials.

C. Organization

The paper is organized into the following sections:

In ***Section II***, we briefly describe the relationship between health insurance and employment. We then discuss the intent of the Ticket Act, and provide a theoretical discussion of how Buy-in programs might or might not promote employment among various subgroups of people with disabilities to whom they are targeted.

In ***Section III***, we describe features of the Buy-in programs and other factors believed to affect the number and types of individuals who enroll.

In ***Section IV***, we describe what is known about the characteristics of Buy-in enrollees.

In ***Section V***, we present information about the effectiveness of the Buy-in programs. The discussion focuses on the effectiveness of these programs in terms of: de-linking health insurance from DI and SSI eligibility; providing needed supports for people with disabilities; and increasing employment.

In ***Section VI***, we conclude with a discussion of ideas for improving the effectiveness of Medicaid Buy-in programs. Some represent suggestions obtained during the interviews with state officials and other staff involved in implementing these programs, while others arise out of the qualitative assessment of Buy-in programs conducted for this paper. The discussion is organized around issues that might be addressed by states, CMS, other federal agencies, and Congress.

II. WHAT MEDICAID BUY-IN PROGRAMS ARE SUPPOSED TO DO

In this section, we briefly discuss the purpose of Medicaid Buy-in programs, and the rationale supporting their existence. We begin with a brief discussion of the relationship between health insurance and employment among people with disabilities. We then note the purpose of the Ticket Act with respect to the general issue of health insurance and employment, and the provisions related specifically to Buy-in programs. We conclude this section with a theoretical discussion of how, and for whom, Buy-in programs might promote employment.

A. Relationship between Health Insurance and Employment

Many people with chronic conditions and disabling impairments require a variety of medical services and supports. Health care expenditures for working-age people with disabilities are on the order of five times the expenditures of their counterparts without disabilities, averaging about $7,600 per year, compared to $1,500 per year (GAO 2003). Thus, health insurance coverage is extremely important to those with disabilities who might face substantial out-of-pocket costs, or risk not being able to afford needed care, in the absence of such coverage.

Because of the importance of health insurance, access to insurance coverage is likely to figure heavily in the employment decisions of people with disabilities. Employment-related health insurance has the potential to induce labor market entry by people with disabilities, as employment can potentially provide access to private insurance, often funded by the employer, at least in part. Public health insurance, however, may be a disincentive to employment. Many working-age people with disabilities are eligible to participate in the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) disability programs, which provide cash benefits to people with disabilities, but also provide public health insurance through Medicare and Medicaid. Because SSI and DI eligibility requires a participant's earnings to be below a certain, low threshold, employment can mean the potential loss of health benefits for many working-age people with disabilities covered by Medicare and/or Medicaid.

About half of working-age people with disabilities receive health insurance through the public programs, primarily, Medicare and Medicaid (GAO 2003). The likelihood of being covered by Medicare or Medicaid increases substantially among those with lower incomes and those with more severe disabilities (GAO 2003; Livermore et al. 2001). In all but a few states, SSI recipients are automatically eligible for Medicaid coverage. Further, they can maintain that coverage, even after cash benefits cease, if earnings increase up to a certain threshold, known as the section 1619(b) income threshold.[2] All DI beneficiaries that have been on the rolls for 24 months or longer are eligible for Medicare coverage and can maintain that coverage after cash benefits cease due to earnings for up to 96 months. After that point, some may be eligible to purchase Part A and Part B Medicare coverage. Additionally, states have the option to offer Medicaid to several other categories of people with disabilities including those with incomes up to 100% of the Federal Poverty Level (FPL) and those with incomes in excess of Medicaid eligibility levels who have substantial Medical expenses. These individuals "spend-down" to Medicaid eligibility levels by incurring high medical bills which reduce the individual's income below the state-determined income eligibility limit. [3]

[2] The 1619(b) threshold varies by state and is equal to: the annualized gross earned income amount which would reduce SSI cash benefits to zero for an individual with no other income (taking into account the state's supplementary payment level, if any) plus the state's average annual per capita Medicaid expenditures. When an individual who is otherwise eligible for 1619(b) has gross earnings which exceed the state threshold amount, the individual may be determined eligible under an individualized threshold calculation, which uses the individual's actual Medicaid expenditures if higher than the state Medicaid average.

[3] For example, assume the state's medically needy income level is $450 per month. An individual with a $650 monthly income would have a monthly "spend-down" of ($650-$450) or $200. Assuming the state has opted to use six months as the "budget period" for the program, the $200 is multiplied by the state's budget period of 6 months for a total spend-down requirement of $1,200. Once the individual has incurred medical bills totaling more than $1200, he or she is covered by the Medicaid program for the remainder of the budget period.

A substantial amount of anecdotal evidence exists on the importance of health insurance in the employment and program participation decisions of people with disabilities. Fear of losing health insurance, or inadequate employer-sponsored health insurance, is frequently cited as a barrier to work in focus groups and surveys conducted with people with disabilities (President's Committee 1994; Hanes 2000; Porter 2004).

A few empirical studies have also demonstrated that the availability of health insurance affects the employment decisions of people with disabilities. Kreider and Riphahn (2000) found that adults age 50 to 61 who had health insurance through their most recent employer were less likely to apply for DI, presumably because those with employment-related health insurance would be less likely to quit their jobs and become uninsured. Stapleton et al. (1998) found evidence that some employed SSI recipients substantially increase their earnings as the 1619(b) eligibility threshold increases, suggesting that some SSI recipients, in fact, keep earnings sufficiently low to maintain their Medicaid eligibility.

Two other studies focused on Medicaid benefit generosity, using mean health expenditures as a measure of benefit generosity. Yelowitz (1998) examined the effect of Medicaid benefit generosity on SSI participation among those with characteristics considered to make them among those most likely eligible for Medicaid by reason of disability. Yelowitz estimated that the effect of increases in Medicaid expenditures on this subpopulation explains 20 percent of the growth in SSI rolls over time. Stapleton et al. (1995) studied the number of applicants for SSI, which should be more sensitive than the SSI participation rates used by Yelowitz, but found that Medicaid had no effect on SSI participation rates (and hence, withdrawal from the labor force). Both studies had difficulty in detecting effects, perhaps because studies using mean expenditures as a measure of benefit generosity are biased toward finding no effect (Gruber and Madrian 2002).

B. Intent of the Ticket to Work and Work Incentives Improvement Act

Despite a dearth of "hard" evidence, policymakers and advocates for people with disabilities have generally agreed that the Medicare and Medicaid programs create substantial work disincentives for people with disabilities because of the programs' links to DI and SSI, where eligibility is contingent on insubstantial work activity. In recent years, the disability community and policymakers have developed a variety of options for de-linking health insurance benefits from disability benefits. This was the motivation behind several provisions of the Ticket Act, which includes the state option to eliminate income and asset restrictions in creating Medicaid Buy-in programs for people with disabilities. In the Ticket Act itself, Congress notes the following findings related to health insurance and people with disabilities:

> *(3) Health care is particularly important to individuals with disabilities and special health care needs who often cannot afford the insurance available to them through the private market, are uninsurable by the plans available in the private sector, and are at great risk of incurring very high and economically devastating health care costs.*
>
> *(4) Americans with significant disabilities often are unable to obtain health care insurance that provides coverage of the services and supports that enable them to live independently and enter or rejoin the workforce. Personal assistance services (such as attendant services, personal assistance with transportation to and from work, reader services, job coaches, and related assistance) remove many of the barriers between significant disability and work. Coverage for such services, as*

well as for prescription drugs, durable medical equipment, and basic health care are powerful and proven tools for individuals with significant disabilities to obtain and retain employment.

(5) For individuals with disabilities, the fear of losing health care and related services is one of the greatest barriers keeping the individuals from maximizing their employment, earning potential, and independence.

(6) Social Security Disability Insurance and Supplemental Security Income beneficiaries risk losing medicare or medicaid coverage that is linked to their cash benefits, a risk that is an equal, or greater, work disincentive than the loss of cash benefits associated with working. (Ticket Act, Section 2(a)).

The stated purposes of the Ticket Act provisions that specifically relate to Medicaid Buy-in programs include the following:

(1) To provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependency on cash benefit programs.

(2) To encourage States to adopt the option of allowing individuals with disabilities to purchase Medicaid coverage that is necessary to enable such individuals to maintain employment. (Ticket Act, Section 2(b)).

Section 201 of the Act loosened restrictions on states regarding who is eligible to buy into the Medicaid program. Medicaid Buy-in programs allow working people with disabilities, otherwise ineligible for Medicaid, to purchase Medicaid coverage. Under the Ticket Act, states have the option to eliminate all income, assets, and resource limitations for workers with disabilities who buy into Medicaid. States may also continue to offer the Medicaid Buy-in to workers with disabilities who participate in the Buy-in, even if they no longer meet SSA medical criteria for disability due to medical improvement. States are authorized to require individuals to pay premiums, or other cost-sharing charges, on a sliding scale.

Buy-in programs can offer people with disabilities the opportunity to increase their earnings and accumulate assets without losing their health insurance. The Ticket Act requires that Buy-ins be limited to *working* people ages 16-64 with *disabilities*.[4] Beyond this, the legislation gives states wide breadth in defining eligibility requirements and premium structures and, as a result, allows each state to define its own goals and priorities. Note also that the Buy-in program is an optional Medicaid category that can be exercised or eliminated at the state's discretion.

Section 203 of the Act established a mechanism by which states could receive grants from the Department of Health and Human Services (DHHS) that would provide support for states to develop Medicaid Buy-in programs and, more generally, develop the infrastructure necessary to address work incentive issues in their state systems. These grants for infrastructure and outreach, now called Medicaid Infrastructure Grants (MIG), would be awarded to states meeting certain criteria established by the DHHS. The Ticket Act specifically notes that no state may receive a MIG unless it demonstrates to the satisfaction of DHHS that it is making personal assistance

[4] The person must meet the same definition of disability used for SSI and DI eligibility determination, except for work requirements. States may also cover people who are no longer eligible for SSI or DI because of medical improvement.

services available to the extent necessary to enable individuals with disabilities to remain employed. The specific levels of personal assistance services necessary, and other criteria for receiving a MIG, have been established and are being administered by the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations.

C. How Buy-in Programs Might or Might Not Promote Employment

The Ticket Act gave states the ability to broaden access to health insurance for people with disabilities through a Medicaid Buy-in option in order to pursue two implicit goals:

- De-link eligibility for public health insurance from eligibility for SSI and DI to enable people with disabilities to reduce their dependence on cash benefit programs without the risk of losing health insurance; and
- Provide access to medical supports needed to maintain employment.

It is important to note that a state may have other objectives for implementing a Buy-in program. Most notably, even though every state pays a share of the Medicaid claims costs under the Buy-in program, it is possible that the state can obtain relief from other expenditures by introducing a Buy-in. Other state objectives might not conflict with the employment objectives of the legislation, but they might cause a state to implement a Buy-in in a way that does not optimize the employment objective.

If a Medicaid Buy-in program achieves the above goals, it should, in theory, create greater incentives for employment among *some* people with disabilities. The issue, however, is very complex. The effect of de-linking insurance from SSI/DI eligibility will depend on a variety of factors, including:

- the means of de-linking;
- the availability of insurance from other sources;
- the benefits provided by various types of insurance;
- the individual's current employment or disability program participation status;
- the individual's eligibility for other public programs that provide medical assistance;
- the individual's healthcare needs; and
- the individual's other characteristics, such as age, skills, work experience, and education.

The strength of the employment incentives created by a Medicaid Buy-in program will therefore vary depending on individual circumstances and the reasons why a person might be induced to participate in the Buy-in. In theory, five broad types of individuals might have incentives to enroll in a Buy-in. These 'types', and the associated incentives for employment potentially created by a Buy-in program, are as follows:

1. **Former recipients of SSI cash benefits participating in section 1619(b) with earnings at or near the section 1619(b) income threshold.** With a Buy-in, these individuals can increase their earnings without losing Medicaid coverage. The employment incentive is expected to be strong, but the increase in earnings for many might not be very large – they already have substantial earnings, and earnings increases might be limited by other factors.
2. **People with disabilities enrolled in Medicaid under a medically needy, spend down, or poverty level category** who, if enrolled in the Buy-in, could work more and/or retain more of their income and assets without losing Medicaid coverage. This group might include both

DI beneficiaries and non-beneficiary workers who meet the SSA medical disability criteria. The employment incentive for this group is mixed.

a. For those purposefully constraining earnings to maintain Medicaid coverage, the Buy-in will create strong employment incentives, although effects on earnings, like those for 1619(b) participants, could be small for many.

b. For those only seeking to avoid spend down requirements to retain more income and assets, the Buy-in creates weak or no employment incentives. The Buy-in simply represents a lower price and/or administratively simpler alternative to current coverage for those whose spend down is greater than the premium/cost sharing required under the Buy-in. Thus, the Buy-in might only induce those who are not working to begin working at very minimal levels in order to qualify for the lower-cost coverage.

The above categories of individuals will be most evident during the initial implementation of the program. Once a (presumably more expansive) Buy-in is implemented, there is no longer a reason for working individuals with disabilities requiring health insurance to enroll in the spend down or poverty categories. Thus, assuming that individuals and Medicaid eligibility staff have knowledge of the Buy-in and are working in the individuals' best interests, in the years after initial implementation, these individuals would fall into categories 3, 4, or 5 below, rather than being considered as former 'other Medicaid' covered individuals.

3. **People with disabilities who lack, or expect to lose, other sources of health insurance.** This group might include DI beneficiaries in the 24-month waiting period before receiving Medicare, working DI beneficiaries nearing the end of an extended period of Medicare coverage who will soon experience a loss of Medicare,[5] and non-beneficiaries who meet the SSA medical disability criteria who lack or expect to lose private or public health insurance coverage. The employment incentives for this group are mixed.

   a. A Buy-in might induce some working people with disabilities who lack (or expect to lose) health insurance to remain employed; that is, it reduces the value of leaving the workforce to go on SSI/DI benefits because it is no longer necessary to do so in order to obtain health insurance. Thus, for these individuals, the Buy-in creates a strong employment incentive.

   b. For DI beneficiaries in the 24-month waiting period for Medicare with no other insurance, the Buy-in might create an incentive to engage in some work activity for purposes of qualifying for the Buy-in, but that activity is likely to be minimal among those who do not wish to jeopardize their eligibility for DI (because of work activity) before completing the 24-month waiting period and qualifying for Medicare. In addition, many new DI beneficiaries may be unable to work at significant levels (or at all) if their disabling conditions are of recent onset and they are still in the process of adjustment. For these reasons, the Buy-in might only provide incentives to work at very minimal levels, to gain coverage during the 24-month waiting period for Medicare.

[5] DI beneficiaries who work can continue to receive at least 93 consecutive months of Medicare coverage, even though cash benefits have ceased due to work.

4. **People with disabilities whose premiums/cost sharing for other private or public insurance coverage** (e.g., through private insurance, COBRA, spouses, or Medicare)[6] **exceed the premiums/cost sharing required by the Buy-in program.** This group might include both DI beneficiaries and non-beneficiaries who meet the SSA medical disability criteria. For this group, the Buy-in creates weak or no employment incentives. The Buy-in represents a lower price alternative to current coverage. Thus, the Buy-in provides no additional work incentives among those already working, and might only provide incentives to work at very minimal levels in order to qualify for the lower-cost coverage among those who are not working. In essence, the Buy-in is "crowding" out other forms of insurance because it is a lower cost alternative.

5. **People with disabilities whose private and/or public (Medicare) coverage does not provide needed medical supports, but which are covered by the Buy-in.** Two primary examples of such supports are pharmaceuticals (not currently covered by Medicare) and long-term personal assistance services (not widely covered by any source except Medicaid). This group might include both DI beneficiaries and non-beneficiary workers who meet the SSA medical disability criteria. For these individuals, the Buy-in might create an incentive to engage in minimal work activity among those not working, for purposes of qualifying for the Buy-in, but provides no additional incentives to increase work activity among those already working, or to work at higher levels among those only seeking coverage.

The above discussion focuses on the likely effects of a Buy-in on employment behavior in terms of whether the Buy-in represents the creation of a "reward" that induces people to work, or the elimination of a "penalty" that punishes people for working. For non-working individuals with expensive or inadequate coverage, or lacking coverage altogether (groups 2b, 3b, 4, and 5), the Buy-in may be a reward that induces them to work, but only minimum levels are required to obtain the reward. Thus, we would not expect to see large increases in earnings due solely to the Buy-in. For those purposefully reducing or constraining earnings in order to obtain or maintain health insurance coverage (groups 1, 2a, and 3a), the Buy-in eliminates the penalty of losing (or not gaining) coverage due to work, leaving them free to work at high or increasing levels with no health insurance penalty. We would expect to see greater increases in earnings attributed to the Buy-in for this group.

In addition to the reward and penalty effects, a Buy-in might have an indirect effect on employment. The provision of needed medical supports to individuals who previously lacked them (groups 3b, 4, and 5) may lead to improvements in functioning and employment/earnings potential (i.e., an increase in human capital), and thereby increase the likelihood and value of working. For instance, this might be the case for DI beneficiaries whose Medicare coverage does not include prescription drugs, and whose symptoms and functioning can be greatly ameliorated by access to prescription drug treatments (e.g., treatments for psychiatric conditions, HIV, multiple sclerosis). It might also be the case for persons with severe physical disabilities who require personal assistance services to work, but do not have coverage for such services through their private insurance or Medicare.

[6] Some former DI beneficiaries that leave the rolls due to work and complete the Extended Period of Eligibility for Medicare are eligible to purchase Medicare coverage by paying a monthly premium. The premium in 2004 is $343 per month for Part A coverage and $66.60 per month for Part B coverage.

The discussion above is couched in very general terms, holds other factors that might affect employment or Buy-in participation constant, and assumes that individuals know about the programs well enough to make rational choices. These simplifications are intended to provide a basic framework for understanding the degree to which Buy-in programs are able to promote employment. In reality, the impact of the Buy-in on the employment outcomes for people with disabilities will depend on a number of factors. One important factor is the Buy-in program design. The design of the program will affect who enrolls and for what reasons. Other factors will also affect enrollment and employment outcomes of participants. In the next section, we discuss the nature of the state Buy-in programs and the many factors likely to affect the success of Buy-in programs in promoting the employment of people with disabilities.

III. BUY-IN PROGRAM DESIGN AND OTHER FACTORS AFFECTING ENROLLMENT AND OUTCOMES

A. Overview

States choose to develop and implement Buy-in programs because they provide a valuable social service to their populations. There may be other benefits to the state, such as offsetting costs from programs that are state funded (such as mental health, pharmacy programs, or subsidized high risk pools). In addition, there may be indirect economic benefits to the state associated with additional people working such as increased tax revenues and increased cash flow to the local economy. States have used these arguments to gain political support for the adoption of Buy-in programs. Fiscal considerations have, however, made it difficult in some states to gain political support to implement Buy-in programs. Several states are working on developing Buy-ins, but are trying to develop them in ways that are "budget neutral." This has proven difficult, if not impossible. Other states are trying to develop Buy-in demonstration waivers that would allow the state to define additional program parameters and set enrollment limits that would limit fiscal liability. CMS is, however, discouraging states from implementing Buy-in programs under Medicaid waivers.[7]

As of May 2004, 29 states had implemented Buy-in programs under an 1115 waiver (1), the BBA (12), or the Ticket Act (16). Another four states (Michigan, Nevada, North Dakota, and West Virginia) are expected to become operational in the near future.[8] As shown in ***Exhibit III.1***, about half of the Buy-in states began their programs after implementation funds became available through the Medicaid Infrastructure Grants (MIGs) following the passage of the Ticket Act. Three states with Buy-in programs do not have MIGs (Arizona, Arkansas, South Carolina) and of the 43 states with MIGs, 13 do not have Buy-in programs (Alabama, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Maryland, Rhode Island, South Dakota, Texas, and Virginia).

Each of the states with Buy-in programs has implemented the program in its own unique manner and within the context of other existing programs and the general state economy. While the

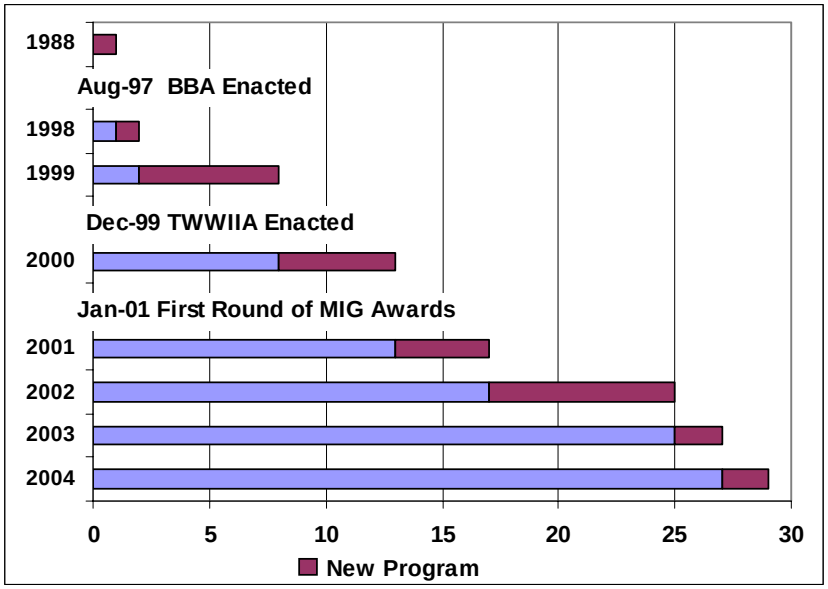
[7] CMS contends that the demonstration waiver process is designed to explore the outcome of an innovative program. Because there is a state plan option for a Buy-in, there is ample experience and opportunity for CMS to assess its value and therefore, a waiver for such programs is unnecessary. CMS views the waiver approach to implementing a Buy-in as merely a means for states to limit their fiscal liability, rather than as a means for testing an innovative approach.

[8] North Dakota implemented its Buy-in program in June 2004, during the final drafting of this paper.

intent of Buy-in programs is to improve the employment outcomes of people with disabilities, it is likely that a multitude of other political, fiscal, and philosophical considerations and compromises went into the actual selection of the design features of each state's program.

Most states have been facing a fiscal crisis since 2001. Because spending on Medicaid represents such a large portion of the state budget, legislatures have been looking at Medicaid cuts as a way to balance their budgets. Medicaid programs have reduced or frozen provider reimbursements, cut spending on pharmaceuticals,[9] and eliminated or limited some covered services. Despite fiscal pressures, many states have been able to implement Buy-in programs. Fiscal considerations have undoubtedly played a large role in the eligibility requirements and premium structures developed by states that have recently implemented programs. Moreover, some states with Buy-in programs have been forced to make or consider changes that would reduce program enrollment and/or costs, such as reducing asset limits, shortening grace periods for spells of unemployment, and increasing premiums.[10]

Exhibit III.1
Number of Medicaid Buy-in Programs by Year



Sources: CMS (2004), Carr et. al (2003).

In addition to fiscal considerations, a state's Buy-in eligibility requirements and premium structures will reflect different views of the intent of the BBA and Ticket Act. Who should be eligible? Should anyone who could benefit from the program be included, or should the program be used specifically to assist people engaged in a minimum level of work? Should it be available

[9] Actions include modifying formularies, subjecting more drugs to prior authorization, imposing limits on the number of prescription per month, and other policies to control utilization (Smith et al. 2004)

[10] One extreme example is Utah's Buy-in program, where state funding for the program was reduced from $600,000 to $200,000 for FY 2003. Program staff were forced to choose between further restricting eligibility (i.e., lower the income limit or impose an unearned income limit) or increasing premiums. In consultation with consumers, the program chose to increase premiums. Premiums were raised to almost 55% of countable income, creating significant hardships on enrollees. Funding for the program was reinstated the following year and premiums were subsequently reduced.

to people with very high incomes? Officials in different states answer these questions differently. A primary example of how views differ is with respect to the large number of people in Medicaid spend-down categories that move to the Buy-in after its implementation. Some administrators consider providing more stable access to health care to people who would otherwise be in a spend-down program a legitimate goal of their Buy-in programs. They argue that when people are in spend down, they lack consistent access to medications and treatment which can be so destabilizing that employment cannot be considered. Officials in other states reluctantly accept that this population meets the Buy-in eligibility criteria, but would like to impose eligibility requirements that would prevent people from using the Buy-in as "just a way to avoid spend down."[11] Above and beyond the intent of the federal of legislation authorizing Buy-in programs, are equity and political considerations with respect to other populations in the state that might or might not be covered by Medicaid. All of these factors will influence the specific Buy-in program design features selected by states.

As of March 2004, there were 63,867 Buy-in participants. Three-quarters of all Buy-in enrollees are concentrated in six states, with one-quarter in Missouri alone (***Exhibit III.2***). The variation in enrollment across states is driven to some degree by the size and characteristics of the state's population, but enrollment is also affected by a number of program-related factors (such as eligibility and premium features), as well as other factors that are external to the Buy-in programs. These factors will have important impacts on the number, characteristics, and employment outcomes of enrollees, and therefore, play a large role in determining how well Buy-in programs promote employment among people with disabilities.

In the sections below, we describe a number of program-related and other factors that will affect who and how many people enroll in the Buy-in programs, and potentially, their employment outcomes.

[11] Ten states exclude all or part of this group by imposing an unearned income limit. Three states allow DI beneficiaries to participate in the Buy-in, but require them to essentially "spend down" their unearned income via premiums and co-pays. In contrast, one state (Missouri) appears to be purposely shifting a large part of its spend down participants into the Buy-in.

Exhibit III.2
Medicaid Buy-in Enrollment by State, March 2004

State	Implementation Year	BBA or Ticket Act	Enrollment March 2004	Percent of Total	Cumulative Percent
Missouri	2002	Ticket Act	16,508	25.8%	25.8%
Massachusetts	1988	1115 waiver	6,947	10.9%	36.7%
Iowa	2000	BBA	6,520	10.2%	46.9%
Minnesota	1999	Ticket Act	6,221	9.7%	56.7%
Wisconsin	2000	BBA	6,096	9.5%	66.2%
Indiana	2002	Ticket Act	5,391	8.4%	74.7%
Connecticut	2000	Ticket Act	3,011	4.7%	79.4%
Pennsylvania	2002	Ticket Act	2,852	4.5%	83.8%
New Hampshire	2002	Ticket Act	1,294	2.0%	85.9%
New York	2003	Ticket Act	1,146	1.8%	87.7%
New Jersey	2001	Ticket Act	1,061	1.7%	89.3%
New Mexico	2001	BBA	977	1.5%	90.9%
California	2000	BBA	960	1.5%	92.4%
Kansas	2002	Ticket Act	704	1.1%	93.5%
Maine	1999	BBA	600	0.9%	94.4%
Oregon	1999	BBA	564	0.9%	95.3%
Illinois	2002	Ticket Act	556	0.9%	96.1%
Mississippi	1999	BBA	512	0.8%	97.0%
Vermont	2000	BBA	497	0.8%	97.7%
Arizona	2003	Ticket Act	432	0.7%	98.4%
Washington	2002	Ticket Act	312	0.5%	98.9%
Utah	2001	BBA	228	0.4%	99.3%
Alaska	1999	BBA	206	0.3%	99.6%
Nebraska	1999	BBA	111	0.2%	99.7%
Louisiana	2004	Ticket Act	64	0.1%	99.8%
South Carolina	1998	BBA	51	0.1%	99.9%
Arkansas	2001	Ticket Act	44	0.1%	100.0%
Wyoming	2002	Ticket Act	2	0.0%	100.0%
Total			63,867		100.0%

Source: CMS (2004).

B. Program Design Features

1. Implementation Authority

While a number of states implemented their Buy-in programs prior to the passage of the Ticket Act, states now have a choice of implementing a Buy-in program under either the authority of the BBA or the Ticket Act.[12] Depending on the choice of legislative authority, states will be subject to different restrictions with respect to the designs of their programs.

[12] Prior to the enactment of the BBA and the Ticket Act, Massachusetts developed a Medicaid Buy-in using 1115 demonstration waiver authority granted by what was then the Health Care Financing Administration (HCFA).

Income Restrictions. Under the BBA, states are required to limit Buy-in eligibility to those with "net family income" no higher than 250% of FPL for a given family size, and resources not exceeding the SSI resource limits ($2,000 for an individual/$3,000 couple). Section 1902(r)2 of the Social Security Act allows states to disregard additional kinds and amounts of income and assets beyond what is generally allowed.[13] As a result, the income and asset restrictions under the BBA are less restrictive than they may appear. In addition, states are required to use the SSI income counting methodology in determining eligibility for the program. That methodology defines income as equal to unearned income minus $20 plus one-half of all earned income above $65. In contrast, the Ticket Act puts no restrictions on income or assets for purposes of eligibility.

Definition of Disability. The Ticket Act allows states to establish up to two optional Medicaid eligibility categories. States may cover working individuals with disabilities, ages 16 to 64, who, except for earned income, would be eligible for SSI (Basic Coverage Group) and individuals whose medical conditions have improved and are determined to be no longer eligible for SSI or DI, but who still have a severe impairment (Medically Improved Group). The BBA restricts eligibility to those meeting the criteria for the Basic Coverage Group only.

Cost Sharing Restrictions. Both the BBA and the Ticket Act allow states to establish a mechanism to share the costs of the program with participants. States may charge participants premiums set on a sliding scale based on income. Under the Ticket Act, premiums may not exceed 7.5% of income. The BBA specifies no such restrictions on premiums.

Age Restrictions. The Ticket Act restricts enrollment in the Buy-in to people ages 16 to 64. There is no age restriction specified in the BBA.

The restrictions on Buy-in programs specified in the BBA and the Ticket Act are summarized in ***Exhibit III.3***.

Under the 1115 demonstration waiver, the state was able to define the eligibility group and develop a premium structure subject only to HCFA's approval.

[13] Under the general Medicaid rules for determining eligibility for Medicaid, states are required to follow the same rules and processes used by the most closely related cash assistance program to determine eligibility. For aged, blind or disabled individuals, those are the rules of the SSI program. Section 1902(r)(2) allows states to use less restrictive income and resource methodologies in determining eligibility for most Medicaid eligibility groups than are used by the associated cash assistance programs.

Exhibit III.3
Buy-in Restrictions under the BBA and the Ticket Act

Criteria	BBA Restrictions	Ticket Act Restrictions
Income	Family Net income up to 250% of FPL and unearned income must be less meet SSI test	No restrictions
Income Counting Methodology	SSI disregards*	No restrictions
Assets	SSI asset limits ($2,000 individual/$3000 couple)	No restrictions
Premium	No restriction	Maximum premium is 7.5% of income. States must charge 100% of premiums for any individual whose adjusted gross annual income exceeds $75,000
Age	No restrictions	16-64
Definition of Employment	Cannot define minimum earnings or hours	Same as BBA
Definition of Disability	Who, but for earnings" in excess of the limit established under section 905(q)(2)(B), would be considered to be receiving supplemental security income	Same as BBA
Medical Improvement Group	Not available	Optional to the States

*Based on HCFA Letter to State Medicaid Directors March 9, 1998.

2. Program Eligibility Criteria

States have considerable flexibility in determining the eligibility criteria for their Buy-in programs. It is through these eligibility criteria that a state can, to some degree, target the program to certain groups. It is also through these criteria that states can provide very expansive programs, or limit enrollment by imposing very restrictive eligibility criteria. Below, we briefly describe the Buy-in eligibility criteria selected by states, and discuss their implications for enrollment and the employment outcomes of participants. These criteria include those related to income, assets, and the inclusion of the "medical improvement" category available under the Ticket Act. The eligibility criteria used by each of the Buy-in states is summarized in ***Exhibit III.4***. A more detailed description of the criteria used by each state is provided in ***Appendix A***.

Exhibit III.4
Eligibility Criteria Used by Medicaid Buy-in Programs

Feature	BBA	Ticket Act	Total
Income limit			
100% or 200% of FPL	0	1	1
250% of FPL	12	7	19
300% or 350% of FPL	0	2	2
450% of FPL	0	2	2
Income limits not tied to the FPL	0	2	2
Unlimited	0	1	2*
Treatment of Spousal Income			
Spousal income not counted	2	8	10
Spousal income counted	10	4	14
Spousal Income counted only under certain circumstances	0	2	2
Not applicable (unlimited income)	0	1	2*
Income Counting Methodology			
Standard SSI	10	10	20
Gross Income	1	2	3
Other (including unlimited income)	1	3	5*
Treatment of Unearned Income			
No separate unearned income limit	5	12	18*
Less than 100% of FPL	2	2	4
Over 100% of FPL	4	1	5
Unearned income limit imposed under certain circumstances	1	0	1
Asset limit (Individual)			
SSI standard ($2,000) or less	3	2	5
$4,000-$9,999	2	2	4
$10,000-19,999	5	5	10
$20,000-25,000	2	4	6
Unlimited	0	2	3*
Coverage of Medically Improved Group	0	7	7

* Total includes Massachusetts (the only state implementing a Buy-in under an 1115 waiver). Wyoming is not included in the table. Eligibility criteria for that state are not yet finalized.

a. Income

There are a number of Buy-in program eligibility criteria that relate to income. All affect the maximum level of earnings a participant may have and remain eligible for the Buy-in, and thus, will affect both the number of enrollees and the observed earnings of participants. All else constant, one would expect that less restrictive income eligibility criteria would lead to greater enrollment and higher earnings observed among enrollees. In reality, however, all else is not constant and the many factors that affect enrollment and the observed earnings of participants are difficult to disentangle and attribute to the income eligibility criteria alone. But one can say with certainty that with less restrictive income eligibility criteria, more people will be eligible to

participate in the program, and participants will be permitted to earn higher amounts without losing Medicaid coverage.

The income eligibility criteria used by the Buy-in programs include the following:

Income Limits: Although the Ticket Act allows states to offer a broad-based program, most of the Buy-in states limit income to 250% of FPL. MIG directors in several of these states report that they were trying to develop low-cost programs with limited enrollment in order to garner political support. Others indicate that their states were "just following the lead" of the early implementers who developed programs under the BBA. A few states have set relatively high income limits, and two states do not impose any limit at all.

Treatment of Spousal Income: States have choices regarding how to treat spousal income. The BBA defines the income limit in terms of net *family* income, but two BBA states have used the flexibility offered by Section 1902(r)(2) of the Medicaid statute to disregard spousal income in the eligibility determination. The Ticket Act makes no reference to spousal income. Eight states do not count it in determining Buy-in eligibility. Although counting spousal income can be a confounding factor in determining whether it makes sense for an individual to work, four states count it in order to remain consistent with other Medicaid eligibility categories. Two states count spousal income only if it is above a certain threshold ($100,000 in Missouri, and half of the SSI standard in Washington). In general, counting spousal income in the eligibility determination will serve to restrict eligibility for the Buy-in, and limit the maximum earnings permissible among Buy-in enrollees with working spouses relative to other participants.

Income Counting Methodology: The BBA requires that states count income using the SSI income counting methodology. As noted previously, that methodology calculates countable income as unearned income minus $20 plus one-half of all earned income above $65. Most of the states that implemented programs under the Ticket Act authority also use this approach in order to be consistent with their other Medicaid eligibility groups. Use of the SSI income counting methodology will restrict Buy-in eligibility among DI beneficiaries. Those with high DI benefits will, in some cases, not be eligible for the Buy-in or will not be able to earn at higher levels and remain eligible for the Buy-in if they retain their DI benefits. In addition, excluding from participation in the Buy-in those with high DI benefits may also exclude those with the highest earnings potential if past earnings are any indicator of an individual's current earnings potential, because DI benefits are a function of an individual's earnings history. Three states have chosen to disregard federal disability income in determining eligibility in an effort to allow a broader range of DI beneficiaries to have access to the program.[14] In an attempt to make their programs less confusing for participants, three states have opted to define their income limits in terms of gross income.

Treatment of Unearned Income: Nine states specify an unearned income limit that is separate from and in addition to other income eligibility criteria. By setting an unearned income limit, states can limit enrollment, particularly among DI beneficiaries. By setting the unearned limit at the level allowed by other Medicaid eligibility groups, the state can severely limit the number of Buy-in enrollees who are new to the Medicaid program and would therefore cause Medicaid to incur new costs. One state with an unearned income limit (Nebraska) is unique in that it

[14] In one state (Oregon) any unearned income in excess SSI standard will be given to the state as a client contribution.

disregards unearned income if the individual is in a Trial Work Period. This permits DI beneficiaries attempting to return to work to participate in the program and earn at higher levels than would otherwise be permissible.

The net impact of the above criteria on eligibility, the maximum allowable gross income, and the maximum allowable earnings, can be seen in ***Exhibit III.5*** for individuals with different income-related characteristics in each of the Buy-in states. While the SSI counting methodology has a large impact on the maximum income and earnings of DI beneficiaries (and others with unearned income) in most states, the states with separate unearned income limits that are set below the poverty level (Arkansas, Nebraska, South Carolina, and West Virginia) appear to have the most restrictive programs. In those states, even a lower-than-average monthly DI benefit of $600 per month would make an individual ineligible for the Buy-in program.[15]

Exhibit III.5
Buy-in Program Gross Income and Earnings Limits for Persons with Selected Income-Related Characteristics, by State

	No unearned income	With $600/mo. in unearned income		With $1200/mo. in unearned income		Married with $600/mo. in unearned income	
State	Annual Gross Income Limit	Annual Earnings Limit	Annual Gross Income Limit	Annual Earnings Limit	Annual Gross Income Limit	Annual Earnings Limit:Spouse with $1000/mo. countable income	Annual Earnings Limit:Spouse with $1500/mo. countable income
Alaska	$59,170	$44,770	$51,970	not eligible	not eligible	$40,670	$28,670
Arizona	$47,570	$47,570	$54,770	$47,570	$61,970	$47,570	$47,570
Arkansas	$47,570	not eligible	not eligible	not eligible	not eligible	not eligible	not eligible
California	$47,570	$47,570	$54,770	$47,570	$61,970	$25,070	$13,070
Connecticut	$75,000	$67,800	$75,000	$60,600	$75,000	$67,800	$67,800
Illinois	$38,260	$23,860	$31,060	$9,460	$23,860	$12,580	$580
Indiana	$66,190	$51,790	$58,990	$37,390	$51,790	$51,790	$51,790
Iowa	$47,570	$33,170	$40,370	$18,770	$33,170	$25,070	$13,070
Kansas	$56,880	$42,480	$49,680	$28,080	$42,480	$37,560	$25,560
Louisiana	$47,570	$33,170	$40,370	$18,770	$33,170	$33,170	$33,170
Maine	$47,625	$33,170	$40,370	not eligible	not eligible	not eligible	not eligible
Massachusetts	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited
Minnesota	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited
Mississippi	$47,340	$40,140	$47,340	$32,940	$47,340	$44,052	$38,052
Missouri	$23,275	$16,075	$23,275	$11,275	$25,675	$16,075	$16,075
Nebraska	$48,230	not eligible*	not eligible*	not eligible*	not eligible*	not eligible*	not eligible*
New Hampshire	$84,810	$70,410	$77,610	$60,810	$75,210	$75,030	$63,030
New Jersey	$47,570	$33,170	$40,370	$23,570	$37,970	$25,070	$13,070
New Mexico	$47,570	$33,170	$40,370	$23,570	$37,970	$33,170	$33,170
New York	$47,570	$33,170	$40,370	$23,570	$37,970	$33,170	$33,170
Oregon	$47,570	$47,570	$54,770	$47,570	$61,970	$47,570	$47,570
Pennsylvania	$47,570	$33,170	$40,370	$23,570	$37,970	$33,170	$33,170
South Carolina	$47,570	not eligible	not eligible	not eligible	not eligible	not eligible	not eligible
Utah	$47,570	$33,170	$40,370	$23,570	$37,970	$25,070	$13,070
Vermont	$47,570	$33,170	$40,370	not eligible	not eligible	$25,070	$13,070
Washington	$41,895	$34,695	$41,895	$29,895	$44,295	$75,030	$63,030
West Virginia	$47,625	not eligible	not eligible	not eligible	not eligible	not eligible	not eligible
Wisconsin	$47,625	$33,170	$40,370	$23,570	$37,970	$25,070	$13,070

*Unless in a Trial Work Period.

Source: Authors' calculations based on information contained in ***Appendix A***.

[15] The average monthly DI benefit was $834 in December 2002 (SSA 2004).

b. Asset Limits

SSI and most Medicaid programs require that participants have less than $2,000 in assets (with certain exclusions).[16] While asset limits will restrict enrollment in the program, they may also restrict the ability of participants to achieve self-sufficiency. An often-cited barrier to independence for people who rely on Medicaid is the inability to accumulate sufficient assets for a down payment on a house, a vehicle, or to pay for education. Perhaps for these reasons, all but five Buy-in programs allow participants to accumulate assets at levels higher than the SSI standard. Ten states allow individuals to accumulate additional assets in state-approved accounts, the details of which vary by state.

c. Medical Improvement

Under the Ticket Act, states have the option to continue Buy-in coverage for enrollees who lose DI eligibility as a result of a continuing disability review finding that they are "medically improved." To continue to be eligible for the Buy-in, these individuals must continue to have a "severe, medically determinable impairment."

Seven states have opted to cover this group but to date, there have been no enrollees in this category. Although several state officials expressed confusion over how to interpret the Ticket Act eligibility criteria for this category, it has not been viewed as a large issue because no one has applied for the category. It may remain a small issue if Buy-in enrollees who go to work participate in SSA's Ticket to Work program. The Ticket Act prohibits the initiation of a continuing disability review for any SSI or DI beneficiary using a Ticket and making timely progress toward their employment goals.

3. Premiums and Cost Sharing

Both the BBA and the Ticket Act allow states to share the cost of the program with enrollees. Most states require some or all enrollees to pay a premium.[17] Individuals will only enroll in the Buy-in if the cost of doing so is less than their expected out-of-pocket health care expenditures in the absence of the program. In general, the higher the premium, the less likely individuals will enroll in the program, and at very high premium levels, only those with very high health care expenses would be expected to enroll. There are three aspects of the premium calculation that can affect program enrollment: the income level below which the participant does not pay any premium; the treatment of earned and unearned income; and the amount of the premium.

Income level below which the participant does not pay any premium: Several states charge a premium to all enrollees regardless of income. Most states, however, exempt individuals with incomes below some level (usually between 100% and 200% of FPL). As shown in ***Exhibit III.6***, the percentage of participants required to pay premiums varies widely across states, from 2% in Oregon to 100% in California.

Amount of premium: Most states have developed a sliding scale based on income for premiums, but the range of those premiums varies dramatically. The average monthly premium

[16] The SSI asset test excludes the recipient's home, car, household goods, burial plots, term life insurance, and income considered part of a Plan for Achieving Self Support (PASS).

[17] Two states (Arizona and New Mexico) have opted to have enrollees pay a co-payment to the provider for each service they receive instead of collecting premiums.

for those required to pay premiums varies from $12 per month in Maine to $321 per month in Utah (***Exhibit III.6***).

Treatment of earned and unearned income in premium determination: In states that calculate premiums based on countable income as defined by the SSI income counting methodology, all else equal, those with DI benefits or other unearned income will pay higher premiums relative to others. Three states (Oregon, Washington and Wisconsin) further distinguish between earned and unearned income by requiring those with unearned income to give up, in the form of a premium, all or part of their unearned income in excess of either the SSI level or a basic living allowance. The effect of this is that DI beneficiaries with above average benefits are required to pay substantially higher premiums relative to others.

A description of each state's cost-sharing provisions is provided in ***Appendix A***.

Exhibit III.6
Percent of Buy-in Enrollees Required to Pay Premiums and Average Monthly Premium, by State

State	Percent of Participants Required to Pay Premiums	Average Monthly Premium
California	100%	$35
Washington	100%	$81
Illinois	99%	$48
Pennsylvania	93%	$43
Minnesota	83%	$40
Utah	82%	$321
Massachusetts	74%	$44
Kansas	59%	$67
Alaska	49%	$43
Indiana	44%	$64
Iowa	29%	$35
Connecticut	17%	$40
Maine	16%	$12
Wisconsin	13%	$131
Vermont	12%	$18
Missouri	11%	$65
New Hampshire	11%	$34
Nebraska	3%	$72
Oregon	2%	$30
Total	44%	$64

Source: Ireys et al. (2003). Average monthly premiums calculated for participants who paid premiums.

The premiums charged to individuals in identical circumstances can vary substantially across states. ***Exhibit III.7*** illustrates eligibility and premiums for four hypothetical Buy-in enrollees. For simplicity, we have assumed that all four are unmarried, have no children, meet the asset limits set by the state and have no unearned income except SSI or DI benefits.

Alfred has $600 in DI benefits (unearned income) and earns $300 per month. His unearned income precludes him from participation in several states and his monthly premium ranges from

$0 to $56 depending on where he lives. Bonnie and Carla have the same gross income ($1,400 per month) but for Bonnie, more of the income is from earnings rather than DI benefits. Depending on the state, this distinction could have a large impact on eligibility and premiums. Bonnie (with a $600 DI benefit and $800 earnings) will pay between $0 and $81 per month while Carla (with a $1,100 DI benefit and $300 in earnings) will pay between $0 and $536.

Exhibit III.7
Eligibility and Premiums for Four Hypothetical Buy-in Enrollees, by State

	Alfred	Bonnie	Carla	Dwayne
Unearned Income	$600	$600	$1,100	$1,100
Earned Income	$300	$800	$300	$800
Total Gross Income	$900	$1,400	$1,400	$1,900
Income with SSI disregards	$698	$948	$1,198	$1,448
Premiums				
Alaska	$0	$10	Not eligible	Not eligible
Arkansas	Not eligible	Not eligible	Not eligible	Not eligible
Arizona	Co-pay	Co-pay	Co-pay	Co-pay
California	$20	$20	$20	$35
Connecticut	$0	$0	$0	$0
Illinois	$38	$44	$75	$81
Indiana	$0	$0	$48	$69
Iowa	$0	$38	$38	$92
Kansas	$0	$69	$83	$110
Louisiana	$0	$0	$80	$80
Maine	$0	$0	Not eligible	Not eligible
Massachusetts	$0	$37	$37	$77
Minnesota	$12	$62	$62	$112
Missouri	$0	$71	$71	$130
New Hampshire	$0	$0	$80	$80
New Jersey	$0	$0	$25	$25
New Mexico	Co-pay	Co-pay	Co-pay	Not eligible
New York	$0	$0	$85	$92
Oregon	$36	$36	$536	$536
Pennsylvania	$35	$48	$60	$73
South Carolina	Not eligible	Not eligible	Not eligible	Not eligible
Utah	$0	$27	$65	$102
Vermont	$0	$0	Not eligible	Not eligible
Washington	$56	$81	$105	$142
West Virginia	Not eligible	Not eligible	Not eligible	Not eligible
Wisconsin	$0	$0	$454	$469

Source: Authors' calculations based on state premium structure information presented in ***Appendix A***.

C. Administrative Factors

1. Operational Definition of Work

With the exception of Massachusetts, states are not allowed to define "work" for purposes of Buy-in eligibility. But some of the administrative rules and procedures implemented by states

can constitute a defacto eligibility requirement. A few states have implemented rules that intentionally include populations who are not currently working in their programs (e.g., New Mexico covers non-working DI beneficiaries in the two-year waiting period for Medicare eligibility, and Wisconsin covers people enrolled in the Health and Employment Counseling program who are preparing to work). Officials in many states, however, would like to define work in a manner that would allow them to target their programs to people engaged in significant work efforts. Officials in several states report that they have people who are "walking the neighbor's dog" or "doing a little yardwork" and claiming that they are working based on those activities. One disability advocacy website touts the absence of a definition of work as a "huge loophole" that can "get Medicaid for just about any person with a disability."[18] States have responded to this predicament is several ways:

- **Requiring proof of employment.** While in some states the applicant must simply attest that they are working, in others they must verify that they are working and paying Federal Insurance Contributions Act (FICA) taxes by presenting a pay stub, tax return, or a letter from an employer (the requirements for each state are described in ***Appendix A***). Verifying legitimate self-employment has been problematic for many states.
- **"Pushing the envelope" on defining employment.** One state (Minnesota) is in the process of establishing a $65 per month earnings minimum by requiring participants to have earned income, and then disregarding the first $65 in earnings in the eligibility determination. As noted previously, Nebraska has a low unearned income limit but waives the limit if the applicant has earnings sufficient to be in a Trial Work Period ($580 per month in 2004). In other words, many DI beneficiaries will be eligible for the Buy-in only if they have earnings over $580 per month.
- **Using administrative rules to set parameters.** Rather than defining work, one state (New Hampshire) is in the process of defining what employment is NOT in its administrative rules.

Several MIG directors view the inability to set a work requirement as a major flaw in their Buy-in programs. They argue that it is difficult to control the size of enrollment and to target the program as a work incentive. In addition, they believe that the political support for the program is based on its pro-work approach. The Buy-in risks losing this support if the program is viewed as a way to avoid spend down or "just another poverty program." Others regard the lack of a work definition as an opportunity because it provides them the flexibility to offer consistent and affordable Medicaid coverage to a wider range of people with disabilities who need it, and to offer the program to people who are taking "baby steps" into the workforce.

Although most MIG directors interviewed indicated that they would like the states to have the ability to define employment, few want the definition to be dictated by CMS. States envision defining employment in a variety of ways including, for example: working at least 40 hours per month and earning at least minimum wage (the definition specified in the Ticket Act for the medical improvement group, and used by Massachusetts under its 1115 waiver); or a tiered system where earnings can be very low in the first year of eligibility, but must increase in subsequent years.

[18] http://www12.inetba.com/barrierbreakers/index2.ivnu.

2. Operational Definition of Disability

Another defacto eligibility requirement that varies by state is how accessible the program is to people who have not had their disabilities determined for purposes of SSI or DI eligibility. This population includes people with significant disabilities who do not qualify for SSI or DI because they are working above SGA.

The Ticket Act defines disability for purposes of Buy-in eligibility as:

> *"..who, but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving Supplemental Security Income…"* (the Ticket Act, Title II, Section 201 (a)(1)(C)).

Although the Ticket Act requires that the programs be available to people who meet the SSA definition of disability "but for earnings," the way a state interprets and applies this definition can affect enrollment. Because the SSA definition of disability is based on the inability to work, states struggle with the inherent contradiction in making a disability determination if the individual is working. Most Buy-in applicants are DI beneficiaries so there is no need to assess their disability status. But Buy-in applicants who have not participated in the DI or SSI programs must go through a determination process, and the entity that makes the determination and how that entity interprets the law will affect whether the applicant is found to be eligible for the program.

Most states use either the Disability Determination Service (DDS) or the Medical Review Team (MRT) to conduct disability determinations for the Buy-in. Both groups have experience performing disability determinations. The DDS is the state entity that determines disability for the SSA disability programs. State MRTs perform interim disability determinations while individuals are awaiting DDS review, as well as determinations for some Medicaid Medically Needy programs. There is some evidence that non-DDS adjudicators making disability determinations specifically for the Buy-in apply somewhat looser standards of disability than when DDS adjudicators are used to make these determinations (Fishman and Cooper 2002).

In either case, the disability standard can be difficult to establish. Many states interpreted the "but for earnings" language to mean that they should apply SSA's five-step disability determination process, but ignore earnings. The five sequential steps of the process are:

1. Is the applicant working and earning over SGA?
2. Is the applicant's condition "severe?"
3. Is the condition found in the list of disabling conditions?
4. Does the applicant have the residual functional capacity to do the work he or she did previously?
5. Does he or she have residual functional capacity to do any other type of work?

State officials report that it is straightforward to ignore the first step in the process, but believe that the last two steps create confusion when the applicant is working.

Because the number of applicants requiring disability determinations specifically for the Buy-in is relatively small, most can be adjudicated on a case-by-case basis. States are not completely comfortable with what they are doing, however. As one MIG director explained "We'd like some sort of guidance, but we're muddling through." There are potential downsides to "muddling through." First, it is likely that there are significant inconsistencies across states. Second, states

worry that their interpretations and processes will not hold up under appeal. Third, these determinations are not portable across states or across programs.

3. Grace Periods

About half of the Buy-in programs allow participants who lose their jobs to continue participating in the program for a period of time. This "grace period" is usually defined as lasting from six to 12 months. For a population that might be highly prone to spells of unemployment, the length of the grace period can be an important factor affecting both the total number of people enrolled in the program and the proportion of enrollees with no earnings.

4. Automation

State Medicaid agencies use a computerized eligibility system that needs to be modified to fully automate a Buy-in program. The automated system allows the eligibility worker to input relevant client data, and based on that data, the software will return information on the programs for which the client is eligible. State officials report that modifying their automated systems to include the Buy-in can cost upwards of $250,000. Because of cost and other considerations, some states have had to implement their Buy-in programs without updating the systems. In the absence of an automated system, enrollment in the Buy-in requires the local eligibility worker to manually determine eligibility, compute premium payments, and forward the paper work to the state Medicaid agency.

Many states eventually are able to automate their Buy-in programs, some using MIG funding to make the changes, and others because they were already in the process of updating their systems, making the additional cost of adding the Buy-in negligible. Automating the Buy-in eligibility process can lead to an increase in program enrollment. Wisconsin provides a dramatic example. The state initially implemented the Buy-in prior to changing the system, then made the modifications the following year. A formal process evaluation found that, prior to automation, eligibility workers were hesitant to enroll participants because of the complexity of the manual enrollment process (APS 2002). After automation, Buy-in enrollment tripled during the two years following the change.[19]

5. Staff Knowledge and Outreach Efforts

Buy-in enrollment, and the employment outcomes of participants, will be affected by the amount and nature of outreach conducted, and the level of knowledge eligibility workers have about the program. States have taken very different approaches to promoting their programs and educating potential enrollees and eligibility workers. Some states are purposefully limiting their outreach activities in order to keep their Buy-in programs small. Others are using MIG funds to market their Buy-in programs to potential enrollees through a variety of means, including:

- Collaborations with local Social Security Administration field offices, the State Vocational Rehabilitation Agency, and the SSA-funded Benefits Planning, Assistance and Outreach (BPAO) programs to reach out directly to DI beneficiaries;
- Written information sent to individuals with earned income who participated in the state's spend-down program during the past year;

[19] Authors' calculation based on CMS Buy-in enrollment data and Medicaid Purchase Plan Annual Report 2002.

- Written materials and workshops developed for disability stakeholder groups (e.g., Developmental Disability Councils, Centers for Independent Living);
- Training for state agencies, employment service providers and employers;
- Public awareness campaigns implemented via radio advertising and brochure distribution;
- Videos, brochures and interactive CDs created by professional media firms; and
- Small grants to community organizations to develop outreach activities.

No state has evaluated the impact of specific outreach activities on Buy-in enrollment, but several states have surveyed program participants and asked where they learned about the Buy-in.[20] Each survey of Buy-in participants offered a different set of options to answer the question so it is difficult to compare findings across states. Nonetheless, there are a few notable findings. In one state, 33% of enrollees cited the state Vocational Rehabilitation agency as the source of information, compared to less than 10% in two other states. Community organizations accounted for 20% of responses in one state compared to only 1% in another.

Generally, between one-third and two-thirds of Buy-in enrollees learn about the program from their Medicaid eligibility worker, but training these workers and convincing them to promote the program has proven to be a significant challenge in many states for a variety of reasons:

- The Buy-in is a new aid category and there will be a learning period.
- Buy-in participants make up a tiny proportion of Medicaid enrollees (one-quarter of one percent of all Medicaid enrollees in states with Buy-in programs),[21] so it is easy for eligibility workers to overlook the program.
- Buy-in eligibility rules are often complex and difficult to grasp.
- In some states, enrollment in the Buy-in requires additional forms, which may intimidate some eligibility workers (Jee and Menges 2003).
- Eligibility workers are focused on determining eligibility, rather than promoting employment and thus, may not see the value of the program and/or are unable to offer advice on how best to use the program.

In some states, eligibility worker training for the Buy-in is performed in the same way as training for other Medicaid programs—dissemination of written materials. In other states, MIG staff members provide in-person training and ongoing technical assistance to eligibility workers.

When the onus of marketing the program is left to the eligibility worker or to an automated system, clients may be automatically enrolled in the Buy-in when it is the best available option. The downside of providing this "seamless" coverage is that people do not know that they are in the program, and therefore do not take advantage of the work incentives it offers.

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[20] California, Connecticut, Maine, Vermont and Utah surveyed program participants and included questions about their sources of information about the Buy-in (Jee and Menges 2003, Porter 2003, Salley and Glantz 2002, Vermont Division of Vocational Rehabilitation 2003a, and Julnes et al. 2003).

[21] Authors' calculation using 2003 Medicaid enrollment data. http://www.cms.hhs.gov/medicaid/managedcare/mcsten03.pdf. Buy-in participants as a percent of total Medicaid enrollees ranges from 2.4% in Iowa to less than 0.10% in 11 states.

D. Other Factors

1. Other Medicaid Categories for People with Disabilities

Aside from the Buy-in programs, eligibility for Medicaid varies considerably by state. The eligibility requirements of the state's other disability-related Medicaid categories will affect the number and characteristics of people enrolling in the Buy-in.

Federal law requires states to provide coverage to SSI recipients and four groups of former SSI recipients: 1619(b) participants, and three groups who lose their SSI because of increases in DI payments (Cost of Living increases in DI, entitlement to disabled widow(er) or entitlement or increase in Childhood Disability Benefits). In addition, states have the option to cover the following groups:

- State Supplementary Payment Group: In some states, anyone receiving a state SSI supplemental payment is eligible for Medicaid.
- Poverty Level Group: States may provide Medicaid to people with disabilities with incomes up to 100% FPL.
- Medically Needy or Spend down: Individuals with incomes above other Medicaid eligibility groups can "spend down" to a state determined income eligibility limit. In addition, the eleven 209(b) states are required to allow all aged, blind, and disabled residents to spend-down to Medicaid eligibility levels. In some states, the medically needy group is not eligible for the full range of Medicaid services.
- People in long-term care settings or participating in home and community based waiver programs and who have incomes below 300% of the SSI standard.

Because the Buy-in serves people with disabilities who do not qualify for a "free" Medicaid category, the state's highest income standard for Medicaid eligibility in other disability-related categories will influence enrollment in the Buy-in; all else equal, the higher the value, the fewer individuals who would potentially use the Buy-in program. As shown in ***Exhibit III.8*** (column C), the highest income eligibility standard for other Medicaid varies considerably across the Buy-in states.

2. Other Supports

Enrollment in the Buy-in will also be a function of the number of people with disabilities who work, and therefore, will be affected by other available state supports for employment. Some states have better disability beneficiary employment statistics than others. For example, 17% of SSI recipients in Iowa work, compared to 3% in Mississippi (***Exhibit III.8***, column G). While many factors will influence the employment rates of a given state's disability beneficiary population, the state's overall environment and system of supports is likely to play a large role. In fact, there appears to be a strong correlation between the Buy-in participation of DI beneficiaries and the employment rate of SSI beneficiaries.[22] It seems likely that this positive

[22] Although we cannot determine how many people in each state are eligible for the Buy-in, or would be if they were working, we assume that the number is roughly proportional to the number of DI beneficiaries who would not be eligible for Medicaid via another disability-related Medicaid category. We estimate this number to be the number of DI beneficiaries in the state with DI benefits that are greater than the highest Medicaid income eligibility standard. This figure is shown in column (E) of Exhibit III.8.

correlation reflects a wide range of immeasurable state attributes that affect employment (e.g., attitudes towards people with disabilities, the job market and employment opportunities, employment supports).[23]

Exhibit III.8
Buy-in Enrollees and Factors Affecting Enrollment

State	Buy-in Enrollees (A)	DI Beneficiaries (B)	Highest monthly income level to receive other Medicaid (C)	% of DI beneficiaries with DI benefits over highest Medicaid level (D)	DI beneficiaries not eligible for Medicaid without a spend down (E)	Buy-in enrollees as a % of (E) (F)	% of SSI beneficiaries who work (proxy for other work-related factors in the state) (G)
Iowa	6,520	53,210	$574	72%	38,386	17%	17%
Missouri	16,508	137,200	$574	74%	100,933	16%	7%
Minnesota	6,221	74,630	$737	53%	39,223	16%	15%
Connecticut	3,011	56,890	$747	56%	32,036	9%	9%
Wisconsin	6,096	91,260	$591	71%	65,240	9%	12%
Alaska	206	8,110	$984	28%	2,257	9%	7%
Massachusetts	6,947	133,310	$678	61%	81,500	9%	8%
New Hampshire	1,294	25,450	$601	74%	18,731	7%	10%
Vermont	497	13,780	$733	53%	7,268	7%	9%
Indiana	5,391	119,440	$574	74%	88,844	6%	6%
New Mexico	977	35,460	$574	73%	25,753	4%	5%
Maine	600	38,580	$776	42%	16,318	4%	8%
Pennsylvania	2,852	242,990	$776	52%	127,249	2%	6%
Kansas	704	45,290	$574	73%	32,969	2%	11%
Utah	228	24,050	$776	48%	11,507	2%	11%
New Jersey	1,061	134,980	$776	57%	77,133	1%	7%
Oregon	564	65,490	$576	73%	47,831	1%	8%
Nebraska	111	28,230	$776	44%	12,467	1%	15%
Arizona	432	97,760	$776	53%	52,219	1%	4%
Mississippi	512	94,250	$574	73%	68,746	1%	3%
New York	1,146	355,400	$661	67%	237,631	0%	6%
Illinois	556	189,620	$660	66%	125,566	0%	6%
Washington	312	100,830	$574	74%	74,923	0%	6%
California	960	474,520	$790	50%	238,921	0%	5%
South Carolina	51	111,370	$776	50%	55,957	0%	5%
Louisiana	64	97,970	$574	74%	72,151	0%	4%
Arkansas	44	84,890	$574	73%	61,712	0%	5%

Sources: (A)CMS 2004; (B) SSA 2003 Table 5.J2; (C) Authors' computations based on information from http://www.nasmd.org/eligibility/; (D) Computed based on DI benefit levels SSA 2003 Table 5,J8; (E.F) Computed. (G) SSA 2003.

[23] The correlation coefficient between columns F and G is .58, meaning that 33% ($.58^2$) of the variation in enrollment can be explained by the proxy for other work supports in the state. The correlation is statistically significant (p=.001). In interpreting this correlation, it is important to keep in mind that SSI recipients are not Buy-in enrollees.

3. The Economy

Enrollment, and the ultimate success of the Buy-in, is predicated on the ability of people with disabilities to find jobs. The Ticket Act was passed in 1999 when the economy and state budgets were strong. By 2001, the country was in a recession. Even as the economy started to grow in late 2001, it was dubbed the "jobless recovery" as the unemployment rate hovered at 6.4%--a nine-year high—and total employment did not increase. As a result, the traditional difficulties that people with disabilities face when finding employment were compounded by the lack of jobs and increased competition for those that were available. In fact, the employment rate of working-age people with disabilities fell from 33% in 2000 to 31% in 2002.[24]

IV. CHARACTERISTICS OF BUY-IN ENROLLEES

As the discussion of ***Section III*** points out, there are numerous factors that influence the number and types of individuals who will enroll in a Buy-in, and these factors appear to vary considerably across states. Here, we briefly describe what is known about the characteristics of the individuals participating in Buy-in programs.

A. Disability Benefit Categories of Enrollees

As discussed in ***Section II***, Buy-in enrollees are likely to fall into one of several categories of people with disabilities, depending on their program participation and health insurance status prior to enrollment. Buy-in participants may be former recipients of SSI cash payments, DI-only beneficiaries, or working non-SSI/DI beneficiaries. Of the latter two groups, some will be former members of other Medicaid enrollment categories (e.g., medically needy and spend down), and others will not.

Complete information on the benefit status of Buy-in enrollees across states is not available. But 2002 enrollment data from 21 Buy-in states provide some indication. These data indicate that three-quarters of Buy-in participants are DI beneficiaries (Ireys et al. 2003). These data also show substantial variation across states in the percentage of enrollees who are DI beneficiaries. In 10 states, over 80% of Buy-in participants were DI beneficiaries at enrollment, and in four states, fewer than 50% were DI beneficiaries. Some of this reflects true variation in the proportion of DI beneficiaries who enroll in the Buy-in, and some of it reflects differences across states in data availability and the ways in which DI beneficiaries are identified among Buy-in enrollees.

The high proportion of DI beneficiaries among Buy-in enrollees is not surprising. The programs are limited to people who meet SSA's medical disability criteria. Given that current SSI recipients and former SSI recipients who exceed eligibility limits because of earnings can qualify for Medicaid though other pathways (categorical eligibility and section 1619(b)), only DI beneficiaries and people not participating in either SSI or DI would potentially enroll. Former SSI recipients exceeding 1619(b) income thresholds represent another potential group. States do

[24]Employment rate: The percentage of working-age men and women with a work limitation who are employed, based on the Current Population Survey. Accessed 6/14/04 http://www.disabilitystatistics.com.

not report information on the numbers of former 1619(b) participants in their Buy-in programs to CMS, but this group is likely to be very small. [25]

It is difficult to measure the number of people who would meet the disability criteria but do not participate in either federal disability benefit program. Although states were initially worried that there may be a large number of these potential enrollees who would "come out of the woodwork" when Buy-in programs were implemented, this has not been the case.[26] Although there is no generally available data source that accurately captures the number of people who were neither DI nor Medicaid participants prior to enrolling in the Buy-in, it appears that they make up roughly 10% of the Buy-in participants.[27]

B. Health Insurance Status of Enrollees

Three-quarters of Buy-in participants were covered by Medicaid prior to enrolling in the Buy-in (Ireys et al. 2003). While anecdotal evidence suggests that a large proportion of these participants were spending down to receive Medicaid services prior to the Buy-in, the only available empirical evidence suggestions that only 39% of Buy-in enrollees previously covered by Medicaid were in a spend down category.[28]

Over three-quarters of Buy-in participants in 21 states have some insurance in addition to Medicaid—usually Medicare (***Exhibit IV.1***). Given the large percentage of enrollees who are DI beneficiaries, it is not surprising that a large portion of Buy-in enrollees have Medicare coverage. In the 21 states collectively, 7% have private insurance but the percentage varies dramatically by state. In Indiana, 25% of enrollees have private coverage compared to less than 1% in New Mexico, Washington, and Missouri. It is important to note that the 7% of Buy-in enrollees with private coverage do not all receive full employer-based coverage. The figure includes people with private medigap policies, dental insurance, or coverage through a spouse.

[25] Gross income thresholds for continued Medicaid coverage under section 1619(b) are rather high, ranging from $21,145 to $42,390 in the Buy-in states. According to national data on 1619(b) participants, only 28,705 (39%) have incomes exceeding $14,400 per year (SSA 2003).

[26] Initially, some were concerned that the Buy-in would "crowd-out" private insurance. That is, that people would reject employer-sponsored insurance in favor of a less expensive, more comprehensive Medicaid program. This does not appear to be a significant issue given the small number of enrollees in most programs, and the large proportion of participants that come from other Medicaid categories (noted in the next section). One MIG director interviewed regards the issue of crowd-out differently, suggesting that Buy-in programs should "embrace crowd-out" and market beneficiaries to employers as "already insured" workers.

[27] This should equal the number of Buy-in participants who were neither DI nor other Medicaid at the time of enrollment. The Ireys et al. (2003) report seems to indicate irregularities in the reporting of the DI status of enrollees. Several states report a much larger number of Buy-in participants with Medicare coverage than the number of DI beneficiaries. CMS and state staff have suggested that this must be in error.

[28] Ireys et al. found that 39% in Medically Needy (spend down), 21% of enrollees with previous Medicaid coverage were in cash assistance categories, 27% in poverty-related categories, and 14% in other categories. It is difficult to interpret these findings because of apparent variation across states in how prior Medicaid eligibility categories are reported.

Exhibit IV.1
Buy-In Enrollees with Medicaid Coverage Prior to Enrollment and Other Health Insurance Coverage

State	Medicaid prior to enrollment	Medicare	Private Insurance	Other Insurance
Alaska	100%	51%	7%	17%
California	98%	85%	5%	6%
Connecticut	*	83%	4%	0%
Illinois	78%	86%	16%	0%
Indiana	95%	35%	25%	0%
Iowa	68%	83%	2%	0%
Kansas	81%	90%	13%	0%
Maine	61%	80%	8%	0%
Massachusetts	81%	54%	8%	0%
Minnesota	64%	90%	12%	1%
Missouri	90%	80%	0%	0%
Nebraska	94%	91%	3%	4%
New Hampshire	74%	82%	3%	3%
New Jersey	7%	79%	16%	0%
New Mexico	56%	29%	1%	4%
Oregon	77%	80%	15%	23%
Pennsylvania	21%	84%	20%	0%
Utah	69%	74%	2%	4%
Vermont	91%	87%	7%**	0%
Washington	67%	86%	1%	1%
Wisconsin	74%	83%	2%	0%
Total	74%	75%	7%	1%

Source: Ireys et al. 2003.
*Prior Medicaid status was undetermined for 40% of enrollees.
**Ireys et al. 2003 reports 44%. In private communication, the a state official indicated that the published number was an error on the part of the state.

C. Demographic and Disability Characteristics of Enrollees

Several states have analyzed administrative or participant survey data and described the demographic characteristics of Buy-in enrollees. Drawing on this information, it appears that, relative to the average DI beneficiary, Buy-in participants tend to be younger, more likely to have at least a high school education, less likely to be married, and more likely to have a psychiatric disability (more detailed demographic information by state is presented in ***Appendix B***).

It is likely that the Buy-in attracts a large number of people with psychiatric disabilities because Medicaid provides more comprehensive coverage for mental health services and pharmaceuticals than either Medicare or private insurance. For example, a study of Buy-in enrollees in California that used SSA administrative data to determine the primary reason for disability reports that 45% of Buy-in enrollees had a primary diagnosis (for purposes of DI eligibility) of mental illness, compared to 28% of DI beneficiaries in the state overall. In contrast, individuals with musculoskeletal impairments comprised a disproportionately low percentage of Buy-in

participants - 11.2% of Buy-in participants compared to 25% of DI beneficiaries (Salahuddin 2003).

Aside from the study noted above that had access to SSA administrative data, it is difficult to develop a profile of Buy-in participants by disability type for purposes of comparing them to all DI beneficiaries in the state, and making comparisons across states. This is because states do not have access to the SSA administrative data, and must develop their own ways of identifying, classifying and reporting disability type. The methods for doing this differ greatly across states.[29] Despite the limited comparability of the disability measures reported across states and those reported by SSA,[30] it is interesting to note that in seven states that have reported the primary disabilities of enrollees in their program evaluations, the data indicate that the Buy-in attracts a disproportionately high number of people with psychiatric disabilities compared to the DI population generally. The data also indicate wide variation across the seven states: between 30% and 53% of Buy-in enrollees had a psychiatric disability compared to 28% of DI beneficiaries;[31] between 7% and 17% had mental retardation compared to 5% of DI beneficiaries;[32] and between 40% and 60% of Buy-in enrollees have physical disabilities, chronic conditions and sensory conditions compared to two-thirds of DI beneficiaries.[33]

D. Earnings

In the 19 states that have reported enrollee earnings data, 52% of Buy-in participants had earnings (Ireys et al. 2003). This percentage ranged from 25% in New Mexico to 93% in Indiana. In six of the 19 states, fewer than 50% of Buy-in enrollees had earnings, and in four states over 80% of enrollees had earnings.[34] Although some of this variation can be explained by program eligibility-related factors, most cannot. For example, New Mexico has a relatively low percentage of Buy-in participants who are working because the program is targeted to DI beneficiaries in the two-year waiting period for Medicare. Some of the variation may be caused by the operational definition of work, the administrative ability to remove people from the program when they are no longer eligible, and the length of the grace period where, the longer

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[29] Several states are, however, currently working together to develop a methodology that would allow states to determine and report disability type using diagnostic codes available on the Medicaid data system.

[30] Wisconsin data is from a sample of participants based on their most recent disability determination (APS 2003). Minnesota reports disability type based on categories of claims and services (Minnesota MIG 2004). The numbers reported by Vermont, Connecticut and Kansas are self-reports from participant surveys. (Vermont Division of Vocational Rehabilitation 2003a, Porter 2004, Hall 2003)

[31] Vermont, 30.1%; Connecticut, 36.7%; Minnesota 47.7%, Wisconsin 50.3%, Kansas 53.2% (Vermont Division of Vocational Rehabilitation 2003a, Porter 2003, Minnesota MIG 2004, APS 2003, Hall 2003).

[32] Kansas, 7.3%; Wisconsin 12.7%, Minnesota 15.7% (Hall 2003, APS 2003, Minnesota MIG 2004).

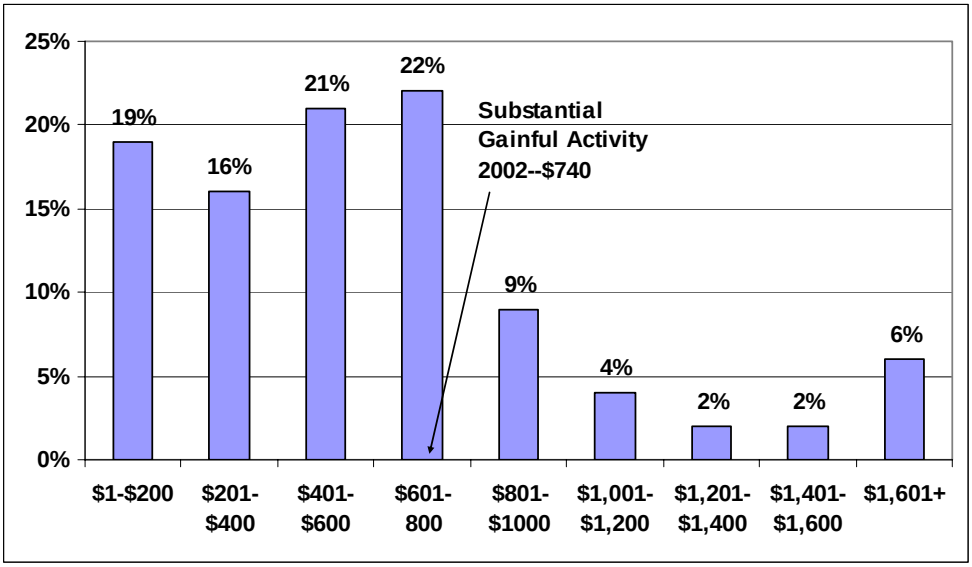
[33] Wisconsin 37%, Minnesota 40%, Kansas 40%, Vermont 62%. (APS 2003, Minnesota MIG 2004, Hall 2003, Vermont Division of Vocational Rehabilitation 2003a).

[34] Although this number is important because it gives a sense of who is in the Buy-in, it is likely to be an understatement of the actual percent of people who have earnings because of the data source. Most states use their Unemployment Insurance data system to track earnings. Although Unemployment Insurance data capture 99.7% of wages and salaries from civilian employment, they do not reflect, among other small classes of workers, two categories that may be significant for Buy-in enrollees--self employment and casual employment. It is interesting to note that only two states, Pennsylvania and Indiana, use eligibility system data to report earnings. Indiana has the highest percentage of people with earnings and Pennsylvania has the highest percent of enrollees with earnings over $1,600.

the grace period, the more opportunity there is for individuals with no earnings to remain on the program.

As ***Exhibit IV.2*** indicates, even among Buy-in enrollees with some reported earnings, the earnings tend to be low. Over three-quarters in the 19 states reporting earnings had earnings of less than $800 per month. Many MIG directors attributed this to the DI "cash cliff." In a survey of Connecticut Buy-in enrollees, over 20% of individuals reported that they did not work more hours, 26% had turned down a raise and 16% had turned down a job because they were afraid they would lose cash benefits (Porter 2004).

Exhibit IV.2
Distribution of Earnings of Buy-In Enrollees, 2002*



Source: Ireys et al. 2003.
*Based on Individuals fourth-quarter 2002 enrollees with earnings.

E. Service Utilization and Costs

In 2002, average per member per month (PMPM) costs for Buy-in programs ranged from $260 in Pennsylvania to $2,250 in Indiana (***Exhibit IV.3***). The large variation across states may stem from several factors:

Underlying health conditions of the participants. Programs may be attracting more or less costly participants depending on other available avenues of Medicaid eligibility, or due to the design of the Buy-in program. For example, the average premium in Utah was $321, so the state's Buy-in would likely attract only people with high expected medical care costs. In Indiana, the program attracts a large number of Buy-in enrollees who need high-cost waiver services (including sheltered workshops), thus increasing the state's average Buy-in costs.

Overall generosity of the state's Medicaid program. Because Buy-in participants are eligible for the same set of services as the other Medicaid enrollees, costs vary based on reimbursement rates and the number and types of optional services that a state offers.

Proportion of Buy-in participants who have other health insurance coverage. Medicaid is the payer of last resort so, for enrollees with other insurance, Medicaid pays only those costs not covered by the other insurance.

We can control for some of the variation in Buy-in expenditures that is due to differences in the generosity of state programs by looking at the ratio of average per member per month (PMPM) Medicaid costs for Buy-in participants to the average PMPM for disabled SSI recipients (excluding costs for nursing homes and intermediate care facilities for people with mental retardation).[35] The substantial variation across states in this ratio suggests that other factors play a role.

Exhibit IV.3
Average PMPM Medicaid Costs of Buy-In Participants and SSI Recipients

State	Total Buy-In Participants 2002 (A)	Average PMPM Medicaid Expenditures 2002 (B)	Average PMPM Medicaid Expenditures for SSI Recipients* (C)	Ratio of Buy-in PMPM to SSI Recipient PMPM (D)
Maine	617	$505	$1,301	0.39
Alaska	186	$572	$1,377	0.42
Pennsylvania	888	$260	$550**	0.47
Massachusetts	5,918	$441	$886	0.50
Nebraska	91	$605	$1,021	0.59
Kansas	384	$609	$890	0.68
Illinois	177	$575	$767	0.75
California	651	$559	$661	0.85
New Hampshire	880	$1,602	$1,893	0.85
Vermont	336	$980	$986	0.96
Connecticut	2,075	$1,616	$1,601	1.01
Minnesota	5,932	$1,467	$1,447	1.01
New Mexico	712	$854	$842	1.01
Iowa	4,811	$722	$623	1.16
Wisconsin	3,339	$919	$751	1.19
Missouri	4,736	$950	$791	1.20
New Jersey	516	$1,128	$768	1.47
Utah	138	$1,372	$679	1.96
Indiana	2,344	$2,260	$841	2.69

Sources: (A, B)--Ireys et al. 2003; (C)--CMS MSIS report 2001 for each state. (D) Authors computation based on previous columns.

*Excludes Nursing Home and ICF/MR expenditures. Expenditures are from 2001, inflated to 2002 dollars.

**2001 MSIS data was not available for Pennsylvania. Values reported are 2000 values inflated by 3% per year for 2 years.

[35] It is unlikely that a substantial number people with disabilities living in institutions would participate in the Buy-in. Medicaid expenditures associated with institutionalization are therefore excluded for purposes of the comparison.

As noted previously, about 75% of Buy-in participants are dually enrolled in Medicare. Medicare has relatively comprehensive coverage of inpatient hospital care and physician services, but has limited coverage of outpatient mental health services and no coverage for pharmaceuticals or community-based long term care. We would expect Medicaid costs for the Buy-in participants to be concentrated in the categories of services not covered by Medicare. Based on information from a small number of states that have analyzed their Buy-in costs, spending on inpatient care is indeed lower for Buy-in participants than for other Medicaid disability groups, while spending on prescription drugs is higher ***(Exhibit IV.4)***. Pharmaceuticals account for between 22% and 74% of Buy-in costs compared to 20% of Medicaid costs for other Medicaid disability groups. Home health and personal support account for a relatively small portion of Buy-in costs.

Exhibit IV.4
Distribution of Buy-In Costs by Type of Service

	Pharmaceuticals	Inpatient	Home health/ Personal support
SSI National*	20%	18%	15%
California	74%	10%	5%
Wisconsin	46%	9%	6%
New Hampshire	31%	2%	13%
Vermont	31%	2%	
Minnesota	22%		

Sources: CMS-MSIS (2000), Jee and Menges (2003), APS (2003), Clark et al. (2003), Vermont Division of Vocational Rehabilitation (2003b), Minnesota MIG (2004).

V. EVIDENCE OF EFFECTIVENESS

In this section, we review available studies and information on the existing Medicaid Buy-in programs in search of evidence of program effectiveness. We focus on the following three areas, reflecting the primary purposes of the legislation:

- Evidence that Buy-in programs have effectively de-linked health insurance access from DI/SSI eligibility;
- Evidence that Buy-in programs provide needed services and supports; and
- Evidence that Buy-in programs affect the employment of people with disabilities.

A. Evidence of De-Linking Health Insurance and SSI/DI Eligibility

Breaking the link between public health insurance and eligibility for SSI/DI is one of the primary goals of the health insurance-related provisions in the Ticket Act, including the Buy-in. As discussed above, that link is believed to greatly influence the employment decisions of people with disabilities in ways that make work an unviable proposition because health insurance eligibility is contingent on low levels of work activity and earnings. A Buy-in can break or weaken the link between health insurance and DI/SSI eligibility for people with disabilities, however, the way in which the Buy-in program is designed will inherently target and exclude some people with disabilities.

In this section, we focus on the design features related to income eligibility criteria and premiums that states have adopted. In assessing these features, we develop a better understanding of who the Buy-in programs are targeting, and thus, for whom the link between

health insurance and SSI/DI eligibility is most likely to be broken. We also discuss the issue of consumer awareness and trust of Buy-in programs, and the potential effect on the de-linking of health insurance from SSI/DI eligibility and employment decisions.

1. Income Eligibility Criteria

The Medicaid Buy-in has the potential of breaking the link between eligibility for federal disability benefits and health insurance coverage. How the Buy-in does this will differ depending on the program participation status of the individual.

Former SSI cash recipients maintaining Medicaid coverage through section 1619(b). It is commonly believed, and one empirical study has demonstrated (Stapleton et al. 1998), that some 1619(b) participants constrain their earnings to remain below the 1619(b) income threshold to retain their Medicaid eligibility. If the income eligibility threshold for the Buy-in is set much higher than the state's 1619(b) threshold, then it will effectively break the link between SSI and Medicaid, permitting former SSI cash recipients to earn more and retain Medicaid coverage.

As noted in ***Section III*** and ***Appendix A***, a range of income thresholds is used by states for determining eligibility for the Buy-in, from 100% FPL up to no income limit at all. Most states use 250% FPL as the cut-off. In 2004, 250% FPL for an individual is $23,275. Given that most of the Buy-in states have 1619(b) thresholds in the $21,000 to $30,000 range, at first glance, it would appear that the Buy-ins would do little to encourage higher earnings among former SSI recipients by guaranteeing continued health insurance coverage because the income limits are set low relative to 1619(b) income limits. But the gross FPL limits are misleading because of the income counting and adjustment procedures used by states. Taking into account the income counting methodologies employed, ***Exhibit V.1*** shows the dollar cut-offs by state for a single individual with no unearned income or impairment-related work expenses. The exhibit also shows the 1619(b) thresholds for each state.

In all but a few states, the Buy-in income eligibility threshold is substantially higher than the 1619(b) threshold, suggesting that the Buy-in successfully de-links health insurance from SSI eligibility for some former SSI recipients, or potential SSI recipients, in those states. That is, former SSI recipients working at or near 1619(b) levels can work and earn at higher levels without losing health insurance coverage by enrolling in the Buy-in. In only one state (Missouri) is the Buy-in threshold *lower* than the 1619(b) threshold. While nearly all Buy-in programs still impose an upper limit to income, with a few exceptions, the additional amount that can be earned beyond the 1619(b) threshold is about $20,000 per year or more.

DI beneficiaries seeking to retain or obtain Medicaid coverage. DI beneficiaries are covered by Medicare, and can keep that coverage for up to about nine years after leaving the DI program due to earnings. But because of significant gaps in Medicare coverage (discussed further in the next section), many DI beneficiaries seek and obtain Medicaid coverage via spend down, medically needy, or other poverty provisions in the state Medicaid program. For these DI beneficiaries in all but a few states,[36] the Buy-in will allow them to work and earn more than

[36] In states that set the unearned income limit for the Buy-in at the same level as the limit for their other disability-related poverty categories under Medicaid, DI beneficiaries in these Medicaid categories will generally not be eligible for the Buy-in. These states include Alaska, Arkansas, Nebraska (except if in a trial work period), South Carolina, and West Virginia. Note that these states have very low enrollment in general, and as measured as a percentage of the potentially eligible DI population, as shown in Exhibit III.8. Enrollment in West Virginia is not shown because the state had not begun enrollment at the time that the data in Exhibit III.8 were reported.

would otherwise be permissible to maintain Medicaid. As discussed previously, however, the majority of Buy-in states use the SSI income counting methodology when determining income for purposes of Buy-in program eligibility. Its preferential treatment of earned income has implications for DI beneficiaries whose DI benefits will be counted as unearned income for purposes of Buy-in eligibility. The practical effect of this is that DI beneficiaries will be subject to more restrictive income eligibility thresholds under many Buy-in programs. For example, an individual with $600 per month in DI benefits will be subject to a Buy-in income threshold that is $14,400 less than an equivalent individual without such benefits in states that use the SSI income counting methodology.[37] In general, the greater the DI benefit, the more restrictive the Buy-in income limit because it reduces the maximum Buy-in income eligibility limit by two times the level of the DI benefit.[38] Because of the treatment of DI benefits in calculating Buy-in eligibility in most states, one could argue that, in these states, health insurance is not de-linked from DI eligibility. In fact, it is linked in just the opposite manner from the traditional linkage that public policy has been attempting to eliminate. Instead of losing health insurance when benefits are lost, DI-only recipients must give up DI benefits before health insurance can be gained.

While the use of the SSI income counting methodology seems reasonable in the context of the SSI program, it may not make sense in the context of a Buy-in program with respect to DI beneficiaries because DI benefits are not reduced with earnings.[39] For those with very high DI benefits, the Buy-in will provide little or no incentive to work – too much may have to be given up in order to obtain Medicaid coverage. It will also not allow those who might have high earnings potential (i.e., those with high past earnings and high DI benefits) from accessing services through the Buy-in that might improve their ability to work. Given the DI program rules and realities of how DI benefits are adjusted in response to earnings, even beneficiaries willing to work at earnings levels high enough to give up DI benefits will find it difficult to obtain Buy-in coverage unless the nine-month Trial Work Period is completed and SSA has appropriately discontinued cash benefits.

The fact that the majority of Buy-in enrollees are DI beneficiaries and the fact that the income counting methods in many states serve to more severely restrict the gross level of earnings and income permitted for Buy-in eligibility among DI beneficiaries relative to others, suggest that many Buy-in programs will create weak incentives for DI beneficiaries to work at substantial levels, and overall, lead to only small impacts on employment.

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[37] All but nine states use a variant of the SSI income counting methodology in determining Buy-in eligibility.

[38] See Exhibit III.5 for specific examples.

[39] It is important to note that the SSI counting methodology is used in Buy-in and other programs that define income limits in terms of FPL percentages, rather than in terms of gross income. The methodology's preferential treatment of earnings allows participants to earn higher incomes and retain eligibility than would be permitted if the gross FPL percentage alone were used to determine the income limit. Buy-in programs implemented under the BBA were required to define income limits in terms of FPL percentages and to use the SSI income counting methodology. Although Buy-in programs implemented under the Ticket Act are not required to use this methodology, most have chosen to do so.

Exhibit V.1
Annual 1619(b) and Buy-in Income Eligibility Limits

State	1619(b) Threshold 2004	Annual Gross Income Limit for Buy-in Participant with No Unearned Income	Difference (Buy-in Limit - 1619(b) Limit)
Alaska	$41,058	$59,170	$18,112
Arizona	$23,209	$47,570	$24,361
Arkansas	$21,592	$47,570	$25,978
California	$29,040	$47,570	$18,530
Connecticut	$42,390	$75,000	$32,610
Illinois	$25,641	$38,260	$12,619
Indiana	$28,341	$66,190	$37,849
Iowa	$22,688	$47,570	$24,882
Kansas	$27,330	$56,880	$29,550
Louisiana	$22,510	$47,570	$25,060
Maine	$31,213	$47,625	$16,412
Massachusetts	$30,452	unlimited	unlimited
Minnesota	$36,180	unlimited	unlimited
Mississippi	$21,227	$47,340	$26,113
Missouri	$25,655	$23,275	-$2,380
Nebraska	$27,851	$48,230	$20,379
New Hampshire	$39,510	$84,810	$45,300
New Jersey	$27,021	$47,570	$20,549
New Mexico	$25,430	$47,570	$22,140
New York	$34,765	$47,570	$12,805
Oregon	$23,045	$47,570	$24,525
Pennsylvania	$22,448	$47,570	$25,122
South Carolina	$23,568	$47,570	$24,002
Utah	$23,815	$47,570	$23,755
Vermont	$27,989	$47,570	$19,581
Washington	$21,145	$41,895	$20,750
West Virginia	$22,988	$47,625	$24,637
Wisconsin	$27,645	$47,625	$19,980

Sources: http://policy.ssa.gov/poms.nsf/lnx/0502302200 and authors' calculations based on information contained in ***Appendix A***.

Others seeking to obtain health insurance coverage. For those without health insurance coverage and not enrolled in the federal disability programs, the Buy-in will eliminate incentives to stop working in order to qualify health insurance benefits via the disability programs for some. In states where the gross income limit for the Buy-in are set very low (e.g., Missouri, see ***Exhibit V.1***), individuals may have to reduce earnings to qualify for coverage. Even in states where the gross income limits are more generous, for those with potentially high DI benefits, the trade-offs

between work and going on disability benefits may not be substantially affected by the Buy-in once taxes and other factors (such as asset limits and the treatment of spousal income) are taken into account. In general, the higher the gross income limit, the more likely the Buy-in will delink health insurance coverage from the decision to leave the labor force to apply for disability benefits among those without health insurance.

2. Premiums

The treatment of unearned income and the potential effects on enrollment and earnings is also an issue with respect to the calculation of premiums. As discussed in ***Section III***, states use a variety of criteria for determining the premiums individuals must pay for coverage. In most cases, the premium is tied to income overall (either personal or family income), and therefore, not linked in any direct way to SSI/DI eligibility. In a few states, however, the premium formula includes a component that treats unearned income separately from earned income. In these cases, those with unearned income are charged higher premiums than similar individuals without unearned income.

As DI benefits are considered unearned income, the Buy-in premiums in these states are directly linked to DI eligibility, and are generally much higher than for similar individuals without unearned income. For example, in Oregon, Buy-in participants must forgo in the form of a monthly premium payment any unearned income in excess of the state's SSI standard ($564 in 2004). In Washington, a component of the premium calculation is a “monthly enrollment fee” equal to 50% of unearned above the State of Washington's Medically Needy program's Protected Income level ($571). In Wisconsin, individuals pay 100% of unearned income minus a living allowance ($655 per month in 2003) and specified deductions plus 3% of the individual's earned income. The large variation in premiums paid by persons in similar circumstances except for unearned income were noted previously in ***Exhibit III.6***. The implication is that Buy-in coverage is again linked to DI but in a manner that is different from the traditional idea of linking: those on DI are required to pay more for coverage than those who are not.

3. Consumer Awareness

For Buy-in programs to de-link health insurance from SSI/DI eligibility and eliminate the fear of losing health insurance if a beneficiary goes to work, it is necessary for consumers to be aware of the program rules and trust the system. A Buy-in program with a generous income limit will have no effect on the employment of people with disabilities if participants and members of the target population are unaware of the fact that they are permitted to earn higher levels of income without losing coverage, or if they are distrustful of the program. Lack of consumer awareness and/or trust that health insurance will be maintained under a Buy-in if earnings increase will significantly undermine any potential effects of Buy-in programs on employment. Buy-in enrollees in several states have expressed beliefs about the programs that are likely to undermine the effectiveness of these programs in promoting employment.

Confused: Numerous enrollees in several states expressed concern that the eligibility criteria and enrollment process are too complex and confusing. Adding to this confusion is the inaccurate and conflicting information that enrollees report they get from eligibility workers. One state found that its program actually got more confusing as time went on. In an initial survey, 44% of respondents to an enrollee survey said they did not fully understand their financial options, and in a follow-up survey a year later, 57% didn’t understand. (APS 2002)

"Medicaid and Medicare and SSI all fall into the same bureaucratic bowl of soup. The rules are impossible to understand. I think they give the rules to lawyers to pass the bar exam." --Maine Buy-in enrollee (Salley and Glantz 2002).

"I'm a social worker and I'm a professional, so I have a better understanding of SSI and DI and Medicaid than a lot of people do, but even I was nervous, because there's so many, there's so many complexities, there's so many ins and outs. I mean, you really have to think very carefully about what the implications are for you."-- Connecticut Buy-in enrollee (Porter 2004).

Unaware: A number of Buy-in states have conducted surveys of participants and asked questions to determine whether or not program participants were aware that they were in a special Medicaid program that permitted them to earn more money and remain eligible, and to assess their beliefs about losing health insurance if they increased their work effort. Findings related to consumer awareness include:

- A survey of 266 Vermont Buy-in enrollees found that 20% of respondents were unaware that they were enrolled in the state's Buy-in program. Although a large percentage of respondents were aware of enrollment, only 62% somewhat or strongly agreed that they understood the basic rules of the Buy-in program (Vermont Division of Vocational Rehabilitation, 2003a; 2003b).
- A survey of 733 Connecticut Buy-in enrollees found that 33% of respondents were unaware that they were enrolled in the state's Buy-in program. Among those surveyed, about 45% said that they wanted to work more in the previous 12 months, and of these 41% indicated that fear of losing health insurance was a reason why they did not work more. Across all respondents, 52% agreed or strongly agreed that, if they worked more, they might lose their health insurance (Porter 2004). Connecticut has a $75,000 income limit for its Buy-in.
- Among 660 working respondents to a survey of Buy-in enrollees in Massachusetts, 47% believed they would lose their Medicaid or Medicare benefits if they worked more (Center for Health Policy Research 2004). Massachusetts has no income limit for its Buy-in.

Although the majority of Buy-in respondents in Connecticut and Vermont are aware that they are enrolled in the program, a rather large percentage of enrollees in these and other states appear to be unaware of program eligibility rules, either through their own admission or as indicated by their fear of losing health insurance benefits if they increase work. Somewhat surprising, and perhaps indicative of lack of consumer awareness, is the large percentages of enrollees who report a fear of losing health insurance due to work in states like Connecticut and Massachusetts, that have relatively high or no limits on income for purposes of Buy-in eligibility.

Fearful: There is a lot at stake for consumers when they go to work, and many are fully aware that they are still tied to DI eligibility rules. Some feel overwhelmed with the complexity of the whole system and are fearful of working and losing their cash benefits and health insurance. Fear of working and losing health insurance among Buy-in enrollees has been frequently cited among survey respondents in a number of states (Salley and Glantz 2002; APS Healthcare 2003; Hanes 2002). This fear may be due to lack of awareness of program rules, but might also be based on consumer experiences and due to a number of real factors. Examples of real factors leading to the loss of Buy-in coverage include: earnings exceeding eligibility limits; eligibility determination errors by the Medicaid agency; and consumer errors in submitting required paperwork. Among survey respondents enrolled in the Maine Buy-in program, 16% indicated that they had lost their Medicaid coverage at least once during the previous 12 months, and of

these, the primary reasons were errors or paperwork problems (27%) and earnings being too high (27%) (Salley and Glantz 2002).

"The fear of getting arrested- I mean I was like, even coming to you today was like ok, is there something wrong? Did I do something wrong with my paperwork, or you know, even when I send my paperwork in every year when I do my evaluation its that fear until you get that paper back, am I over limit, or are they going to deny me for something and how am I going to survive without medical benefits?"-- Connecticut Buy-In enrollee (Porter 2004).

"I would like to do more, but I'm afraid to do more, too, because of this income. I mean the boss is willing to have me come in there and do a little extra, but she knows I have those guidelines there. And you're even afraid to get a raise, you know. I just got a raise, and she said "Is that going to put you over the limit?", and I said no. It was only 22 cents. If it does, it does. I mean, what could I do?" –Connecticut Buy-in enrollee (Porter 2004).

"*If I lose the benefits, I lose the medications. If I lose the medications, I lose my life*"—Maine Buy-in enrollee (Salley and Glantz 2002).

Compounding the problem is that in most states, if individuals participate in the Buy-in, accumulate assets and then need to return to regular Medicaid either because they lose their jobs or turn age 65, they may not be eligible because their assets are too high.

"I can have more assets, but, you know, at what price to me on down the road when I may not be earning what I'm earning, if I should become more disabled? Then, what do I do? I've really, can I say, screwed myself? Because I won't be eligible for any subsidies or supports, and the savings that I will have put away will be quickly eaten up by my personal assistance needs. So, I won't have income to live on, and . . . that could potentially put me in the need for being back on benefits again, and being a cost to the system rather than paying into it."—Connecticut Buy-in enrollee (Porter 2004).

B. Evidence of Providing Needed Supports

One goal of the Buy-in is to provide access to the medical supports needed to maintain employment. These supports include stable and consistent access to health care and pharmaceuticals, as well as "supports that enable [people with disabilities] to live independently and enter or rejoin the workforce… such as attendant services, assistance with transportation to and from work, reader services, job coaches, and related assistance." (Ticket Act, sec 2(a)4).

In the absence of the Buy-in, people with disabilities are often left without comprehensive medical coverage or are forced into poverty to obtain it, either by limiting their work efforts or spending-down to qualify for Medicaid. Under these circumstances, individuals often have sporadic access to needed services compounded by limited funds for anything except basic survival. This situation makes it difficult to even consider employment and self-sufficiency.

The Buy-in offers access to the full range of Medicaid-covered services in each state. This is relatively comprehensive coverage and for the many Buy-in participants who are Medicare-eligible DI beneficiaries, Medicaid covers many of the services that Medicare excludes. In this section, we discuss the types of supports that the Buy-in offers (standard Medicaid services, personal assistance services, and waiver services) as well as the limitations of these supports. In addition, we discuss the types of supports being developed by the Medicaid Infrastructure Grantees.

As noted in ***Section III***, in some states prescription drugs make up a large portion of the cost of the Buy-in program. This is not surprising given the large percentage of participants who have most of their inpatient and outpatient care covered by Medicare. In 2006, Medicare will begin full implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108-173). We conclude this section with a discussion of the implications of the prescription drug benefit for the Buy-in programs.

1. Filling Medicare's Gaps and Other Medicaid-Covered Services

As noted previously, a large percentage of Buy-in participants are covered by Medicare. Thus, it appears that a large role of the Buy-in at this point is to fill Medicare's coverage gaps. Medicare lacks coverage for some services that might be necessary for work, including:

- pharmaceuticals;
- home health for people who are not confined to the home;
- durable medical equipment for out-of-home use;
- assistive devices that compensate for sensory or neurological deficits (e.g., hearing aides);
- rehabilitation services intended to maintain or slow the deterioration of functioning; and
- full coverage for outpatient mental health treatment.[40]

In addition to filling the above gaps in Medicare coverage, Medicaid in some states provides some types of employment supports. For example, states offer some or all the following:

- personal assistance services both in and out of the home;
- targeted case management to assist individuals in gaining access to needed medical, social, educational and other services;
- supported employment services for people with mental illness;[41]
- supported employment and supported housing for people with mental retardation as waiver services;[42] and
- additional types of assistive technology and durable medical equipment.

For a substantial percentage of Buy-in participants, the value of Medicaid services is so significant that, prior to the Buy-in, they were willing to spend down to qualify for Medicaid. The benefit of the Buy-in compared to a spend down category of eligibility is echoed throughout enrollee surveys, focus groups and interviews. In Illinois, 73% of Buy-in participants previously enrolled in a spend down category are paying a premium that is less than 25% of what their spend-down would have been (Illinois Department of Public Aid 2003). In Kansas, participants attributed to the Buy-in an ability to pay off outstanding pharmacy bills or make purchases that increased their ability to work, such as fixing a car or Buy-in a used one (Hall 2003).

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[40] Medicare requires a 50% co-payment for outpatient mental health services.

[41] Some states include employment-related supports in the Mental Health Rehabilitation Option.

[42] Supported employment is often included as a service in Mental Retardation /Developmental Disabilities waiver programs.

Four Buy-in states do not have spend-down provisions so the Buy-in offers the only access to Medicaid for people with incomes that exceed Medicaid eligibility limits.[43]

Despite its breadth of coverage, Medicaid is not a panacea. The drawbacks of Medicaid have been expressed by Buy-in enrollees and are well articulated in the literature.

Coordination of benefits is difficult. Medicaid programs have extensive experience coordinating with Medicare for people who are eligible for both programs.[44] Medicaid is the payer of last resort so each state has a third-party liability system that tracks information on Medicare payments and uses Medicaid funds to pay only for services, or portions of services, not covered by Medicare. This is a complex process, but from the perspective of state staff implementing and operating the Buy-in, the third-party liability system is well established and does not require modifications to accommodate Buy-in participants.[45]

Consumers, on the other hand, have a very different perspective. Medicare and Medicaid have different coverage rules and often limit where beneficiaries can receive care. The burden usually falls on beneficiaries to understand their coverage and advocate for appropriate coordination (Ryan and Super 2003). Coordination with private insurance can be difficult as well. One interviewee gave the following example: If a private insurance company denies a claim for durable medical equipment because it is "not medically necessary," it requires advocacy to make Medicaid rethink the decision.

Coordinating benefits with private insurers is much more difficult for Medicaid agencies than is coordination with Medicare. Some Medicaid programs have Health Insurance Premium Payment (HIPP) options where the state will pay the private insurance premiums and co-payments for Medicaid enrollees who have access to other insurance if it is "cost effective." Some states offer this HIPP option to Buy-in enrollees, while others, such as Massachusetts and Vermont, offer a lower Buy-in premium to enrollees with private insurance. The ability to coordinate with other insurers varies by state and the Buy-in programs are generally tied to whatever processes the state's Medicaid program has already established.

Insurance coverage doesn't mean access. Medicaid reimbursements are very low and as a result, many providers, particularly specialists, do not participate in the program. This can make finding a provider difficult (Santerre 2002). In addition, there are often significant administrative hassles.

"*Medicare and Medicaid do not pay doctors enough. The doctor didn't treat me and passed me off to the other doctors. It took me 15 months to be properly diagnosed and treated*"—Vermont Buy-in enrollee (Vermont Division of Vocational Rehabilitation 2003a).

[43]Four states (Mississippi, New Mexico, South Carolina and Wyoming) do not have a Medically Needy eligibility group and are not 209(b) states which are required to allow people with disabilities to spend down to the SSI level.

[44] Including for example, SSI/DI dual enrollees, spend down participants, certain Qualified low income Medicare Beneficiaries (QMB), and Specified Low income Medicare Beneficiaries (SLMB).

[45] This process is more complex when the beneficiary is enrolled in either a Medicaid managed care plan or a Medicare+Choice plan. In these cases it can be more difficult to determine the services or portion of services that should be covered by Medicare versus Medicaid.

"They're getting very fussy. My medications need prior authorization, it makes it very awkward for a re-fill. Faxing back and forth between different parties."—Maine Buy-in enrollee (Salley and Glantz 2002).

Medicaid has a "welfare stigma." Some Medicaid recipients are embarrassed or feel that they are treated with less respect because they must rely on the program.

"And when I go to the doctor, or to any provider, I have to tell you I feel a little embarrassed about using that card. And I always have this, I always feel compelled to say 'I just want you to know I pay for this. I pay $430 a month for this' because it seems like I'm, like I'm on the state. And, you know, I don't have anything against people who are, but I feel a stigma that shouldn't be there, but I feel it." -- Connecticut Buy-in enrollee (Porter 2004).

"*[It was a] degrading experience to get Medicaid. DHS makes you feel like you are lying to get the benefits"*—Maine Buy-in enrollee (Salley and Glantz 2002).

There are significant gaps in services. The services covered by Medicaid vary by state: All states offer pharmaceutical coverage but some have limits on the number of prescriptions an individual can fill per month, and others have restrictive formularies. Few Medicaid programs provide vision and dental care and coverage of durable medical equipment is inconsistent across states.

"Medicaid just sent people a letter that they're not doing eyeglasses anymore. Eye exams, I can't afford this."--Vermont Buy-in enrollee (Vermont Division of Vocational Rehabilitation 2003a).

2. Personal Assistance Services (PAS)

The Ticket Act provides states an incentive to implement or expand personal assistance services (PAS) provided both in and outside of the home (including the workplace) and make those services available to Buy-in participants. States providing adequate PAS are eligible for MIG funding. As noted in ***Section II***, the Act specifies that PAS be available under the Medicaid state plan (i.e., the services are available statewide and across eligibility groups) in order for states to be eligible for the MIG funding. Faced with fiscal constraints, many states were unable to add or expand services under their state plans, but were able to implement more limited PAS programs under waivers. CMS has established a process to deem states "conditionally eligible" if their waivers meet a minimum standard (PAS must be statewide, available to people with physical disabilities and MR/DD who are working at least 40 hours per month, and allow services outside the home). Conditionally eligible states can receive MIG funding for a limited number of years.

Generally, enrollee eligibility for PAS is based on the physical inability to perform activities of daily living. Several states, most notably Utah and Oregon, have expanded PAS to include people with psychiatric disabilities and mental retardation that need assistance with cognition and behavior.

Given the emphasis placed on PAS in the Ticket Act, it is important to note that relatively few Buy-in participants use PAS. For example, in Minnesota and Maine 5%-7% of Buy-in participants use Medicaid-provided PAS (private communication; Salley and Glantz 2002). This seemingly low usage is not surprising given that state criteria for PAS eligibility is generally geared towards people with severe physical disabilities, and these individuals make up a relatively small portion of Buy-in participants. Nevertheless, for those individuals, PAS is a critical support for work.

3. Medicaid Infrastructure Grants

While the focus of the discussion in this section is the effectiveness of the Buy-in programs in providing needed supports, in the words of one MIG director, "It's hard to separate success of the Buy-in from success of the MIG." The Medicaid Infrastructure Grants have undertaken a variety of efforts to address employment barriers that go beyond the issue of access to medical supports. Many people we interviewed reminded us that "the Buy-in is a necessary, but not sufficient condition" for employment. The MIG funds have allowed states to undertake a variety of complementary activities intended to promote the employment of people with disabilities. Examples include:

- Increasing access to benefits information by developing web-based benefits planning tools and providing training for benefit specialists;
- Developing statewide interagency advisory groups and formed coalitions with transportation and housing authorities, mental health agencies and groups working with youth-in-transition in order to create an integrated system of services.
- Assisting One-Stop centers in making their facilities and programs more accessible to people with disabilities;
- Providing outreach and education about the types of assistive technology (AT) devices that are available to assist consumers with disabilities; and
- Surveying consumers to identify unmet needs.

4. Medicare Drug Benefit

The Medicare Modernization Act of 2003 created a Medicare drug benefit that will go into effect in January 2006. The Act requires that any Medicare beneficiary (including those who are also eligible for Medicaid) receive their prescription drugs through the new Medicare program. As a result, the role of the Buy-in programs in providing needed pharmacy benefits will change.

The Medicare drug benefit is voluntary and, for a monthly premium, beneficiaries will be able to purchase a drug plan with the following features (O'Sullivan et al. 2003):

- a $250 deductible;
- 25% coinsurance for costs between $251 and $2,250;
- no coverage for drug costs between $2,250 and $5,100;
- full coverage for catastrophic costs (those exceeding $5,100 annually);[46] and
- the coverage will be provided through prescription drug plans that meet minimum requirements set by Medicare.

The Act specifies that Medicare is the primary payer and Medicaid coverage is NOT available for drugs or cost sharing. It provides three levels of premium and cost-sharing subsidies for individuals with incomes below 150% of FPL or who are dually eligible for Medicare and Medicaid.

[46] The $5,100 in total costs would represent $3,662 in out-of-pocket costs after Medicare deductibles and co-payments are applied to the expenditures below $2,250.

1. Individuals dually eligible for Medicare and Medicaid with incomes up to 100% of FPL will pay no premium, no deductible, and will pay up to $1 for generic drugs and $3 for others.
2. Other individuals with incomes below 135% of FPL and other "full-benefit" dual eligibles with income over 100% of FPL will pay no premium, no deductible, and will pay no more than $2 for generic drugs and $5 for others.
3. Other individuals with incomes between 135% and 150% of FPL will have a $50 deductible, 15% cost sharing for costs up to the out-of-pocket limit and cost-sharing for costs above the out-of-pocket threshold of $2 for a generic drug and $5 for others.

It appears that Buy-in participants will qualify for the second type of subsidy as a "full-benefit dual eligible." Nevertheless, According to a CMS official who spoke at a recent conference on Medicaid Buy-in programs,[47] it is unlikely that the soon-to-be released regulations will directly address the special situation of Buy-in participants unless it is raised during the comment period for the regulations.

Regardless of how the Medicare prescription drug benefit is ultimately implemented, it will reduce the value of the Medicaid Buy-in for Medicare beneficiaries, especially for those who enroll in the Buy-in predominantly to obtain prescription drugs. For participants with incomes below 150% of FPL, they will be eligible for a subsidy regardless of whether they enroll in the Buy-in. For people with incomes over 150% of FPL, participation in the Buy-in will likely qualify them for a subsidy, but this subsidy is less valuable than current Medicaid pharmacy benefit because it requires a copayment and the breadth of available drugs may be more restrictive than under the current system (Crowley 2004). As a result, we would expect a reduction in the number of Buy-in enrollees, especially in states with high premiums.

C. Evidence of Increasing Employment

To date, there is only weak evidence that Buy-in programs promote the employment of some people with disabilities. Four general types of analyses of Buy-in participant earnings have been conducted, but none provide definitive evidence that Buy-in programs promote employment. The four types of analyses include: comparisons of earnings among participants across states, primarily for descriptive purposes, and to qualitatively assess correlations between earnings levels and program design features; survey findings regarding respondent opinions about the effect of the Buy-in on employment; empirical studies of Buy-in enrollee earnings before and after Buy-in participation; and empirical studies of enrollee earnings that use a comparison group. We briefly describe these studies and their findings below.

1. Descriptive Studies of Earnings Levels across State Buy-in Programs

Two recent studies provide descriptive comparisons of the earnings of Buy-in participants across states. Neither attempts to estimate the effect of Buy-in programs on employment, rather, the intent is to provide descriptive information about earnings, to provoke further consideration of the issues surrounding Buy-in programs, and, in one case, to provide a qualitative assessment of the likely effect of particular program design features on enrollee earnings.

[47] National Council of State and Local Human Service Administrators conference sponsored by American Public Human Services Association and the Center for Workers with Disabilities convened in Washington, DC on July 19, 2004.

Ireys et al. (2003) provides descriptive information about Buy-in enrollee earnings in 19 states as reported to CMS by states on their 2002 State Annual Buy-In Report Form. These data, described previously in ***Section III***, provide a useful overview of the earnings experiences of enrollees in different states and raise questions for further research about the observed variation across states in earnings, as well as other enrollee characteristics.

Hanes and Folkman (2003) examine the implementation experiences of Buy-in programs in seven states to make inferences about the relationships between program design and enrollment. One of the issues considered is the earnings levels of Buy-in participants, and how observed differences across states might be tied to program design. Focusing on the percentage of enrollees who work and earn more than $780 (the level of substantial gainful activity (SGA) as defined by SSA in 2002, the time period for the data presented) the authors find wide variation in the percentage of enrollees working above SGA – from below 10% of enrollees in Iowa to more than 60% in Massachusetts. In attempting to attribute the observed variation to program design features, the authors conclude that there appears to be no definitive trend or consistent interpretation that would lead one to believe that there is one program model that serves as a "true" work incentive relative to others. Programs that attempt to target enrollment to those most likely to work at high levels (e.g., Oregon) perform as well or even less well, in terms of the percentage of enrollees working above SGA, as programs with no income limits, and thus no targeting (e.g., Massachusetts). The authors conclude that, while program design will influence enrollment patterns, and thus, the observed earnings of enrollees, a host of other factors, both internal and external to state Medicaid programs, will influence the extent to which Buy-in enrollees work at substantial levels.

2. Survey and Focus Group Findings

Findings from a few recent surveys conducted with Buy-in enrollees in different states provide anecdotal evidence that Buy-in programs promote and enable employment among some Buy-in participants:

- Among the 31% of survey respondents who were working and enrolled in the Vermont Buy-in, 80% indicated that the Buy-in program was very important in helping them keep working (Vermont Division of Vocational Rehabilitation 2003a);
- In a survey of Buy-in enrollees in Utah, most respondents (percentage not reported) indicated that the Buy-in program had helped them become employed or increase their hours of work (Julnes et al. 2003);
- Among working Buy-in enrollees surveyed in Connecticut, about 60% indicated that the Buy-in program made work or increased earnings possible (Porter 2004).

The survey findings imply that a large proportion of Buy-in participants in some states believe that the Buy-in is key to helping them go to work. Focus group and interview findings from several states, while less representative of the Buy-in populations in those states in general, provide additional evidence that the Buy-in promotes employment among some enrollees. For some, access to health insurance via the Buy-in is the main reason for going to work; for others, the Buy-in is necessary to enable employment:

"The primary reason I went to work was to get the medical benefits. I'd go down the tubes if it weren't for MWD." --Vermont Buy-in enrollee (Vermont Division of Vocational Rehabilitation 2003a).

"I keep the job to get the benefit (MWD). It is a priority – physically it sometimes is a struggle (to work), but keeping this benefit is a priority." --Vermont Buy-in enrollee (Vermont Division of Vocational Rehabilitation 2003a).

"I think its [the Buy-in program] wonderful. I'm really happy its there. I really probably would have a lot more difficulty working, especially once I lose my private insurance, if I didn't have it…I'm not usually the mushy type, but I'm, grateful for it, I guess you could say. Even with all the administrative crap, I am. I would gladly jump through even more hoops." --Connecticut Buy-in enrollee (Porter 2004).

3. Comparisons of Earnings Pre and Post Buy-in Enrollment

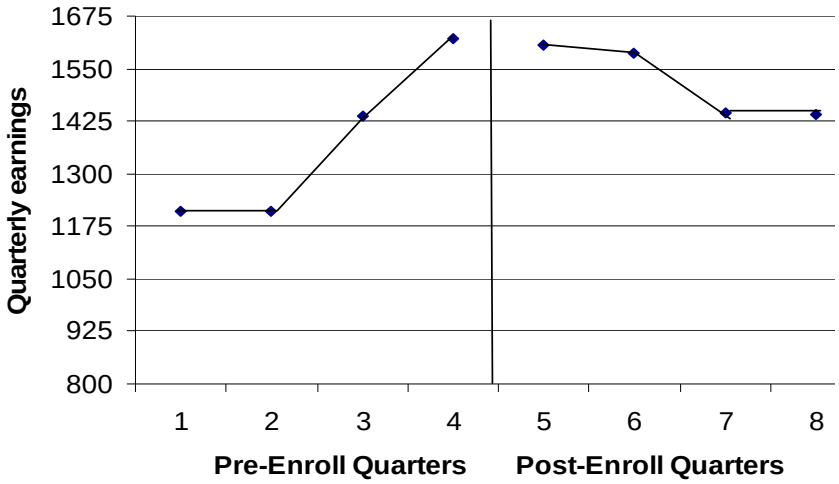
Pre-post analyses of enrollee earnings have been conducted for Buy-in participants in a number of states (Porter 2004; Julnes 2004; Clark et al. 2003; Hanes et al. 2002). These analyses track average earnings of Buy-in participants, comparing earnings before and after Buy-in enrollment. A common finding of these analyses is that, on average, earnings tend to increase significantly just prior to and during the quarter of enrollment, then stabilize or fall somewhat after enrollment, but remain at levels somewhat higher than during the pre-enrollment periods.

The increase in average earnings post-enrollment does not, alone, constitute evidence that the Buy-in is promoting employment. All Buy-in programs have a work requirement for enrollment. Thus, one would expect average earnings to be higher post-enrollment due to selection. The increase in earnings among participants might also be due to a host of factors that are unrelated to the Buy-in (e.g., the economy and changes in other programs that affect who enrolls in the Buy-in). Enrollment in the Buy-in for many might simply be an incidental outcome of an increase in earnings that was driven by some other factor.

The pre-post enrollment earnings trends are of interest, however, because they provide a first look at the earnings experiences of enrollees and raise questions for further consideration. In one such study, Porter (2004) uses quarterly earnings data obtained from the state Unemployment Insurance program to examine pre- and post-enrollment earnings for a cohort of Connecticut Buy-in enrollees, focusing on the four quarters prior to the quarter of enrollment, the quarter of enrollment, and the four quarters following the quarter of enrollment. These data indicate a marked and statistically significant increase in earnings from pre-enrollment to the quarter of enrollment, with a slight (statistically insignificant) decline in earnings thereafter (***Exhibit IV.2***).

A question raised by this pattern (a pattern common to other programs that have conducted similar analyses, though perhaps not as dramatic) is to what extent is this pattern due to the Buy-in *inducing* individuals to go to work in order to obtain coverage, versus other factors inducing individuals to go to work, as they might have done without the Buy-in, but incidentally enroll in the Buy-in. Pre-post changes in means are likely to reflect both types of changes. It is also possible, however, that increases in earnings prior to Buy-in enrollment partially reflect employment increases induced by the Buy-in prior to formal Buy-in enrollment. Without a suitable comparison group, however, it is not possible to determine whether pre-post earnings changes overstate or understate the effects of the Buy-in on earnings.

Exhibit IV.2
Connecticut Buy-in Enrollee Earnings, Pre- and Post-Enrollment



Source: Porter (2004).

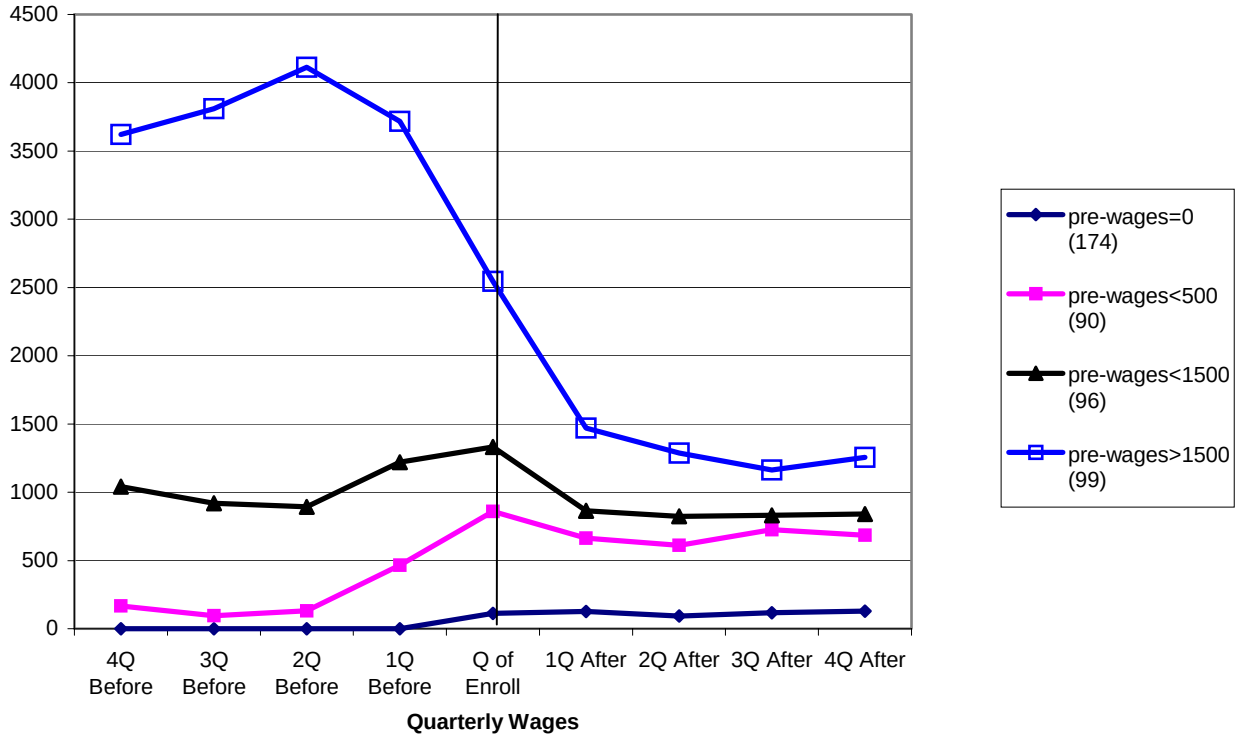
In other analyses, Julnes et al. (2004) divides Utah Buy-in enrollees into groups based on: 1) the *level* of pre-enrollment earnings; and 2) the magnitude of the *changes* between pre- and post-enrollment earnings. This analysis of subgroups demonstrates the heterogeneity of Buy-in enrollees, and how that heterogeneity is masked if one focuses only on overall average earnings.

Exhibit IV.3 shows the pre-post earnings patterns by level of pre-enrollment earnings.[48] The exhibit illustrates how pre-post earnings patterns can be very different for enrollees depending on their pre-enrollment earnings. While the earnings of most Utah enrollees remained fairly constant, or increased slightly after enrollment, for the 20% of enrollees with the highest pre-enrollment earnings, average post-enrollment earnings decline markedly.

The variation in these patterns might reflect the varying reasons why people with disabilities enroll in the Buy-in. For many, the Buy-in might induce employment at minimal levels in order to qualify for coverage. For others already working enough to meet eligibility criteria, the Buy-in may have no effect on earnings. For some, the Buy-in may reduce work disincentives associated with a previous Medicaid category, and thus, induce at least small increases in employment and earnings. Finally, the Buy-in might represent for some, access to needed coverage as health worsens and/or as other sources of coverage are lost, perhaps following disability onset. These scenarios represent pure speculation based on the earnings patterns observed. Further investigation of the characteristics of members of these subgroups, and the reasons behind the interesting differences in earnings patterns might substantiate or discredit this speculation. It is possible that the results simply reflect the well-known statistical phenomenon of "regression toward the mean." Among those with initially high earnings, very few will achieve significant earnings growth, but many are susceptible to earnings decline for reasons unrelated to the Buy-in. Symmetrically, none of those with the lowest initial earnings can experience a significant decline, but some might experience significant gains, again for reasons unrelated to the Buy-in.

[48] Pre-enrollment earnings are measured as the average of earnings during the four quarters prior to the quarter of enrollment, based on state Unemployment Insurance wage data.

Exhibit IV.3
Pre-Post Earnings Patterns by Level of Pre-enrollment Earnings, Utah Buy-in Participants



Source: Julnes et al. (2004).

In another disaggregation of Utah Buy-in enrollees by earnings characteristics, enrollees are grouped by the magnitude of the *changes* in earnings that occur from before to after enrollment in the Buy-in.[49] The researchers find that: for about 70% of Buy-in enrollees, earnings remain relatively unchanged; for about 10% of enrollees, earnings increase substantially after enrollment; and for the remaining 20%, earnings decline markedly (Julnes et al. 2004).

Another study of pre- and post-enrollment earnings of Buy-in participants in New Hampshire (Clark et al. 2003) takes the findings of the estimated increases in earnings, and compares them to the estimated additional costs to the state of covering these individuals via the Buy-in. The authors find that the post-enrollment earnings of Buy-in participants increased relative to earnings in the prior year by $3.28 per every additional state dollar spent on the program. This study suffers the same limitation as other pre-post analyses noted above, that is, in the absence of evidence from a comparison group, one cannot definitively attribute all of the increase in earnings among enrollees to the Buy-in program. There is reason to believe, however, that much of the increase in earnings could indeed be due to the Buy-in program. The vast majority of the New Hampshire Buy-in participants (88%) had been enrolled in Medicaid (via medically needy, spend down, and other categories) immediately prior to enrolling in the Buy-in. For these individuals, the Buy-in eliminated rather significant restrictions on income imposed by the

[49] Earnings changes are measured as the difference between the first quarter after enrollment and the average of the following: the fourth quarter before enrollment, the third quarter before enrollment, and the second quarter before enrollment, based on state Unemployment Insurance wage data.

eligibility criteria of their previous Medicaid category. If other factors affecting employment did not change significantly over the relatively short study period, it is reasonable to believe that much of the increase in earnings observed was due to the Buy-in eliminating the income restrictions imposed by the Medicaid categories previously used by Buy-in enrollees.

The attempt to quantify the costs and benefits of the Buy-in undertaken by Clark et al. highlights an important tradeoff that states face in designing their programs. On the one hand, if the state is going to be covering many of these individuals in their Medicaid programs anyway, the state might as well allow them to earn more by offering a Buy-in program. On the other hand, the Buy-in will lead to additional state costs incurring both from the costs that would have previously been paid by individuals via spend down, and from the costs of new people to the Medicaid program.

4. Evaluating Earnings Changes Over Time Using Comparison Groups

A few studies have examined the pre-post earnings changes of Buy-in participants, and compared them to the changes in earnings of a non-participant comparison group in an effort to assess the effect of Buy-ins on employment.

Hanes et al. (2002) analyze the pre- and post-enrollment earnings of Buy-in participants in Oregon, Vermont, and Wisconsin. The authors also track the earnings over the same time period for two comparison groups of people with disabilities: non-participants in Oregon and people with disabilities in Washington state. The study notes the large difference in the earnings of Oregon enrollees relative to others, and hypothesizes that this is due to Oregon's efforts to target the Buy-in to those most ready to work , but who are unable to increase earnings for lack of health insurance coverage.[50] The study is limited in terms of evaluating whether a Buy-in has an effect on employment, however, because it focuses on differences in the *levels* of earnings, rather than differences in *changes* in earnings, across study and comparison groups. Both study and comparison groups appear to exhibit similar increases in earnings over time. Though no statistical (difference-in-difference) tests of significance are reported, from the earnings patterns presented, it appears that the Buy-in programs have little or no effect on earnings.

A study by Salahuddin (2003) examines the impact of the California Buy-in on the employment of people with disabilities using a comparison group of people with disabilities in the state of Washington. The focus of the analysis is on the earnings of DI beneficiaries. The author uses Social Security administrative data on individual characteristics, including earnings. DI beneficiaries in Washington state are selected for a comparison group because of similarities to California in terms of the pre-Buy-in earnings and other characteristics of DI beneficiaries, and other factors related to state programs and economies. The SSA data are matched to California Buy-in data to identify Buy-in enrollees among California DI beneficiaries. Multivariate techniques are used to control for observed differences in characteristics between the treatment and comparison group members and to estimate the impact of participation in the California Buy-in on earnings.

Salahuddin (2003) finds no significant effect of the Buy-in on earnings in several different specifications estimating the determinants of changes in earnings. The lack of a measured effect

[50]Oregon requires participants to give up any unearned income in excess of the state's SSI standard in order to participate in the Buy-in and thus, will likely attract only those who can work at levels high enough to justify the loss of unearned income (SSI and DI benefits).

may be due to a number of factors. The program was new at the time of the study. Many participants had been enrolled in the Buy-in for only a short period of time (21% of the sample had been enrolled for two months or less), so few may have had opportunities to increase earnings. It might also be that a large number of enrollees were just switching Medicaid categories with a goal of obtaining lower cost coverage, rather than a goal of increasing earnings (77% of Buy-in participants had been receiving Medicaid through another program in the month prior to Buy-in enrollment).

VI. SUGGESTIONS FOR INCREASING THE EFFECTIVENESS OF BUY-IN PROGRAMS

In our collection and review of information on Medicaid Buy-in programs, a number of factors affecting Buy-in effectiveness were raised by interviewees and in the literature. In the sections below, we discuss some ideas for improving the effectiveness of Medicaid Buy-in programs. Some of these are ideas obtained from state staff involved in implementing these programs, while others arise out of the qualitative assessment of Buy-in programs conducted for this report. We organize the discussion around issues that might be addressed by states, CMS, other federal agencies, and Congress.

A. States

Assess the Buy-in program to determine if program features are inhibiting the state's ability to meet the goals of its Buy-in, and the goals of the broader state system of supports for people with disabilities. As discussed throughout this paper, a number of program features will determine who is eligible for the Buy-in, and among these individuals, for whom the program represents an increase in work incentives. How states design their programs should depend on their specific goals. Representatives from several states indicated that some of the features of their Buy-in programs were determined based simply on what other states were doing, rather than on thoughtful consideration and analysis of the likely impact of the programs on the employment of people with disabilities.

One specific example of a program feature that appears to affect Buy-in participation and potential effectiveness is the treatment of unearned income. As discussed previously, the differential treatment of unearned income causes those with high DI benefits (and thus, those with substantial work histories) to be ineligible for the Buy-in program in several states, or severely limits the amount of income that can be earned and still retain eligibility for the Buy-in. The use of the SSI income counting methodology and treatment of unearned income in this manner was required under the BBA, but states need not use the SSI methodology under the Ticket Act. States may be adhering to this methodology to maintain consistency with income accounting methods used for other Medicaid categories, or just because it's what they have always done, without considering the potential consequences for DI beneficiaries who may need certain services provided by Medicaid programs in order to work. Alternatively, states may be using the criteria to purposefully limit their programs. When asked if the Buy-in program would be more successful without the unearned income limit, one MIG director responded "It depends on who you ask. The advocates would like to have no limit on unearned income, but from Medicaid's perspective the program is working perfectly as is."

Low asset limits have also been cited as a program feature potentially inhibiting Buy-in effectiveness. Strict limits prevent working people with disabilities from saving and working towards self-sufficiency. Implementing asset criteria utilized for other programs without

consideration of the goals of the Buy-in program and the potential effect on work incentives for Buy-in participants could limit the success of these programs.

Even if states thoughtfully evaluate their program features in the context of broader goals for the system, it can be difficult to make program changes. As several interviewees explained, once the program is in place it is politically very difficult to change because there are always winners and losers.

Identify and address administrative and consumer awareness issues that might be inhibiting Buy-in effectiveness. Fear of losing health insurance appears to remain an issue among Buy-in participants. This may be partly due to a lack of awareness of program rules, and partly due to administrative features of programs that make them complex and difficult to navigate, and/or that increase the likelihood that coverage will be interrupted. Examples include short grace periods for continued eligibility when employment is interrupted, paperwork errors, and eligibility workers not informing beneficiaries of their enrollment in the Buy-in and its special rules. Outreach and education campaigns also appear to be important and necessary components of implementing Buy-in programs, especially in light of the complexity of these programs, their potential interaction with other programs, and the fact that most programs are new and unfamiliar to consumers and Medicaid eligibility staff. Staff from a few states indicated that they purposefully have not embarked on large-scale marketing of the programs in order to "keep a low profile" and not draw any attention (e.g., due to high enrollment growth) that might get the program cut from next year's budget.

B. CMS

Provide guidance on the disability determination process or guarantee states that they will not be penalized by CMS for incorrect decisions. The ability of people with disabilities who are working and not currently attached to the disability system to enroll in the Buy-in may be hampered in some states. While some states have developed processes to determine disability for this population, in others the determination is haphazard. Many states are nervous that the determinations will not hold up under CMS audit, and that claims will be denied. This insecurity about the determination process may lead states to err on the side of not enrolling individuals who might be eligible for the program. It may be particularly important to include this group in the Buy-in, as it is a population that, with adequate access to health care, may be able to maintain their attachment to the workforce.

Provide guidance to states on grace periods, and define grace periods in the State Plan Amendment template. Currently many states defined in their administrative rules grace periods for continued eligibility in circumstances where employment is terminated, but these rules are not reviewed or approved by CMS. Some states offer no grace periods at all when employment is lost, making the program unduly harsh on people with intermittent work experiences. Recognizing that employment may be intermittent for many people with severe disabilities, and that extremely short or no grace periods for temporary unemployment may not be conducive to the goals of a Buy-in program, CMS should provide some guidance to states on this issue, allow states wide latitude in defining the grace period for unemployment so that any state can develop a process that would minimize the ability to game the program, and make whatever rules developed be subject to approval via the state plan amendment process. Advocates of short or no grace periods argue that other Medicaid eligibility categories do not have eligibility grace periods for income, assets, or any other eligibility criteria. The employment requirement of Buy-in programs, and their underlying goal of promoting and supporting the employment of people

with disabilities through the provision of health insurance, may, however, provide a compelling reason for grace periods.

Maintain flexibility in the use of MIG funding. The effectiveness of the Buy-in is closely tied to the effectiveness of the variety of activities conducted by states under their MIGs. MIGs have been key to both promoting Buy-in programs to consumers and state agency staff, and developing other employment supports. To date, CMS has allowed a great deal of flexibility on how MIG funds can be spent and states generally believe that this flexibility is a great strength of the program. Among the many useful activities that states are able to conduct under their MIGs is evaluation and assessment of their program's performance. It is unlikely that much of the information on the Buy-in programs presented in this report would even be available were it not for the MIG resources. Through the MIGs, CMS has encouraged and given states the resources to engage in program evaluation and policy analysis activities.

Continue to support and offer TA and information sharing opportunities. The two TA centers have sponsored a number of conferences and forums for information sharing across states on the issue of Buy-in programs and employment supports for people with disabilities. CMS has also sponsored its own forums, most recently, one devoted to issues related to using state data for purposes of policy research and evaluation. It is important for CMS to continue to support these activities. Though states are required to obtain TA from some source, states are free to specify the nature of the TA and the source, and are not confined to using one or both of the two TA centers. While there are numerous advantages to this flexibility and decentralization, it could be the case in the future that the TA centers receive insufficient funding to be able to sponsor the conferences and forums that they have been able to convene in the past. If this is the case, then CMS will need to take the lead in sponsoring such activities. MIG staff find these forums extremely useful for: developing an understanding of the federal rules and regulations governing Buy-ins; developing and refining program and administrative procedures; understanding factors affecting the success of their programs; and developing ideas about how to improve the employment support systems in their states, in general.

Continue to engage in national-level evaluation efforts. CMS, through its contractor, Mathematica Policy Research, has been tracking the experiences of Buy-in programs. The first report from this effort (Ireys et al. 2003) is a useful resource on information about the range of Buy-in programs across the country. CMS should continue to support these, and more in-depth analyses, of state Buy-in programs. CMS is in a position to conduct a national level evaluation of these programs that would potentially be much more rigorous than any evaluation that could be conducted by an individual state. CMS staff indicate that they are in the process of developing a data-sharing arrangement with SSA. The SSA data are critical to conducting any rigorous evaluation of the Buy-ins. These data will provide large sample sizes and allow the construction of comparison groups (e.g., in a manner similar to that employed in Salahuddin 2003) that will permit the empirical estimation of impacts of the Buy-in on employment and provide more definitive evidence on the effectiveness of Buy-in programs in promoting employment. There is clearly a large degree of variation in how the Buy-in programs have been implemented. A rigorous, national evaluation of these programs would provide useful information to states about the factors that appear to increase or decrease effectiveness that could be used to refine their programs, and might provide evidence on the benefits of Buy-in programs that would attract greater support for these programs, and for employment initiatives targeted to people with disabilities in general.

C. Other Federal Agencies

Provide leadership for interagency coordination at the federal level. States are attempting to break down the service and funding "silos" within their states. Many report difficulty "getting people to the table" and would like to see more leadership at the federal level to encourage staff at the state level to cooperate with other agencies. In addition, the federal government could develop integrated and flexible funding streams.[51] In the absence of this leadership, state agencies are left wondering whose job it is to provide such things as supported employment, supportive housing, assistive technology, and other supports.

Allow data sharing between programs. Evaluation of the Buy-in programs is severely hampered by the inability of CMS and states to gain access to SSA data. As noted above, CMS staff have indicated that they are in the process of working with Social Security to gain access to these data for research purposes, but to date that access has not been granted.

Increase funding for benefits counseling. The effectiveness of Buy-in programs is contingent on the ability of people with disabilities to make informed choices. The Ticket Act recognized the complexity of the system and directed SSA to fund the Benefits Planning, Assistance and Outreach (BPAO) projects. The BPAO grants fund only about 500 specialists nationwide, and many states report that this is wholly inadequate to meet their needs. In addition, BPAO-funded benefit specialists are only permitted to serve Social Security beneficiaries. Some states have funded additional specialists through their MIGs or other sources, but others have been unable to identify another funding stream. The Buy-in has added another dimension of complexity to the already complex employment decisions of people with disabilities. Unless the employment support system for people with disabilities is markedly simplified in the future, the need for benefit specialists will continue to increase, along with the federal and state initiatives attempting to promote the employment of people with disabilities.

D. Congress

Allow states to define work. Although some states would like the legislation amended to define work, most want the ability to define work themselves within certain parameters. It is likely that the lack of this ability has had important impacts on Buy-in programs. In an effort to contain costs, states have made decisions in designing their programs that they may have made differently if they had been able to target enrollment by defining employment.

Remove the age limit for Buy-in programs in the Ticket Act. The Ticket Act limits Buy-in eligibility to those ages 16 to 64. In theory, the age limit creates a disincentive for older people to enter the program because they know it will end when they turn age 65. In addition, it may dissuade people from saving because they know they will deplete their resources when they turn 65 in order to qualify for Medicaid in another eligibility category.

As the workforce ages and as the Social Security full retirement age increases,[52] there is a conceptual justification for extending the program to people over age 65. Further, there is no reason to expect Buy-in participants to exit employment at age 65. Several states interviewed

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[51] In addition to the MIG, CMS provides several Real Systems Change Grants to address the integration of services at the state level.

[52] The full retirement age for Social Security is increasing 2 years (from 65 to 67) over a 22 year period beginning with people born in 1938. The age increases 2 months per year with an 11-year hiatus when the retirement age will be 66 (for people born 1943-1954) (http://www.ssa.gov/pubs/retirechart.htm).

indicated that this restriction should be lifted. From CMS' perspective, lifting the age restriction could create a whole new set of eligibility issues because SSA does not define disability for individuals age 65 and over. It is important to note however, that several BBA states have enrolled people over age 65 in the Buy-in (most of whom had disability determinations before they turned 65). In addition, the 1619(b) provision in SSI applies to people over 65 and, according to SSA's Program Operations Manual, the disability determination can be made after the individual turns 65.[53]

Give CMS more control over MIG eligibility requirements. The Ticket Act is clear that the standard for MIG eligibility is the provision of adequate PAS as included in the state Medicaid plan. To accommodate states that do not meet the PAS criteria, CMS has established a "conditionally eligible" category that allows states time to develop the option. CMS has also established a process to determine if PAS established under state waivers meets the intent of the Ticket Act. Nevertheless, a number of states are at risk of losing MIG funding because they cannot (either fiscally or politically) expand PAS to the required minimum level. Given that a relatively small proportion of Buy-in participants use PAS, some MIG directors question whether PAS availability should be the sole criterion for granting states resources to develop Buy-in programs and other broad-based employment supports. A few MIG directors have expressed frustration that states with strong systems are able to get funding to make those systems stronger, while states with weak systems are penalized. Eliminating the PAS requirement and allowing CMS greater flexibility in developing criteria for awarding MIG funding to states would address this.

Implement a benefit offset program for DI similar to SSI and change the definition of disability. These suggestions have broad implications that go well beyond the Buy-in. Nevertheless, we mention them here because so many interviewees believe that these two aspects of the disability system are having major impacts on the success of the Buy-in in promoting employment. The DI cash cliff is perceived to be a significant work disincentive, one that a Buy-in alone cannot address. In addition, many state interviewees believe that defining disability in terms of work for purposes of federal program eligibility is in direct conflict with initiatives that attempt to increase the employment of those that participate in such programs.

[53]The relevant section of the Program Operation Manual is at http://policy.ssa.gov/poms.nsf/lnx/0502302030 (accessed 6/20/2004).

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APPENDIX A
BUY-IN PROGRAM DESIGN FEATURES BY STATE

This Appendix briefly summarizes the characteristics of the Buy-In program in each state. The information is derived from a variety of sources including: The Center for the Study and Advancement of Disability Policy at George Washington University (http://www.medicaidbuyin.org), State Medicaid Agency Websites, and Medicaid Infrastructure Grant Websites.

Alaska

Authorizing Legislation: BBA
Implementation date: July 1999
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: Individual unearned income less than Alaska Public Assistance (APA) standard of need.
Resource Limit: $2,000/$3,000
Excluded Assets: None
Work Requirement: Must have earned income.
Grace Period: None
Premium Threshold: 100% of FPL
Individual or family income: Net family income
Premium Structure:
If family income is more than 100% of the FPL, the individual is assessed an income-based premium of up to 10% of net income beginning in the third month of eligibility. The formula for calculating the payment is Y=(X-100)/15-0.75(N-1) where Y is the percentage payment required, X is the percentage of poverty represented by the person's family income, and N is the number of persons in the household.

Arizona

Authorizing Legislation: Ticket Act Basic Coverage/Medical Improvement
Implementation date: January 2003
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual
Income Disregard: Disregard unearned income/ Standard SSI disregards
Separate Unearned Income Limit: No (unearned income is disregarded)
Resource Limit: No resource limit
Excluded Assets: Retirement Accounts, Other approved accounts
Work Requirement: Paid for working and paying FICA taxes
Grace Period: Guaranteed six months of eligibility the first time approved for program unless in institutional living arrangement.
Premium Threshold: n/a
Individual or family income: n/a
Premium Structure: No premiums are charged. Co-payments are required.

Arkansas

Authorizing Legislation: Ticket Act Basic Coverage
Implementation date: February 2001
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: Unearned income must be less than SSI standard plus $20
Resource Limit: $4,000/$6,000
Excluded Assets: Up to $10,000 in approved account
Work Requirement: Employed in any ongoing work activity for which income is reported to the IRS. Employment must be verifiable with paycheck stubs, tax returns, 1099 forms or proof of Quarterly Estimated tax.
Grace Period: Up to six months if enrollee intends to return to work
Premium Threshold: n/a
Individual or family income: n/a
Premium Structure:
No premiums are charged, however cost sharing/co-payments apply.

California

Authorizing Legislation: BBA
Implementation date: April 2000
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: No
Resource Limit: $2,000/$3,000
Excluded Assets: Retirement Accounts
Work Requirement: Provide proof of employment (e.g., pay stubs or written verification from the employer.
Grace Period: None
Premium Threshold: All pay premium
Individual or family income: Individual (unless spouse is also eligible)
Premium Structure:
Income is calculated by disregarding DI income for the individual, and then applying standard SSI methodology for the earned income plus any remaining unearned income if it is not DI. Premiums range from $20-$250 for an individual and are based on the following sliding scale:

COUNTABLE INCOME RANGE	PREMIUM INDIVIDUAL	PREMIUM COUPLE
$0-$600	$20	$30
$601-$700	$25	$40
$701-$900	$50	$75
$901-$1,100	$75	$100

$1,101-$1,300	$100	$150
$1,301-$1,500	$125	$200
$1,501-$1,700	$150	$225
$1,701-$1,900	$175	$275
$1,901-$2,100	$200	$300
$2,101-250%FPL	$250	$375

Connecticut

Authorizing Legislation: Ticket Act Basic Coverage/Medical Improvement
Implementation date: October 2000
Countable Income Eligibility: $75,000
Whose Income is Counted? Individual
Income Disregard: IRS deductions. (Income is counted as Adjusted Gross Income according to IRS rules)
Separate Unearned Income Limit: No
Resource Limit: $10,000/$15,000
Excluded Assets: Retirement Accounts, Other approved accounts
Work Requirement: Must make FICA contributions
Grace Period: Can continue for one year after losing employment
Premium Threshold: 200% of FPL
Individual or family income: Family
Premium Structure:
Premium is 10% of net *family* income in excess of 200% of FPL. Net family income includes income of spouse but not of dependent children and excludes standard SSI deductions, impairment-related work expenses and self-employment expenses. For individuals with net family incomes in excess of 250% of the FPL but not greater than 450% of the FPL, the amount of the monthly premium cannot exceed 7.5% of net family income. Fees paid for private insurance are deducted from the individual's Medicaid Buy-In premium liability.

Illinois

Authorizing Legislation: Ticket Act Basic Coverage
Implementation date: January 2002
Countable Income Eligibility: 200% of FPL (net after taxes)
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: No
Resource Limit: $15,000
Excluded Assets:
Work Requirement: Employment must be verifiable by pay stubs and employer documents that income is subject to income tax and FICA.
Grace Period No
Premium Threshold: $250
Individual or family income: Individual
Premium Structure:

Premiums assess according to the following chart based on the applicant's monthly income:

Countable Earned Income	Gross Unearned Income				
	$0-$250	$251-$500	$501-$750	$750-$1000	$1001+
$0-$250	$0	$19	$38	$56	$75
$251-$500	$6	$25	$44	$63	$81
$501-$750	$13	$31	$50	$69	$88
$750-$1000	$19	$38	$56	$75	$94
$1001+	$25	$44	$63	$81	$100

Indiana

Authorizing Legislation: Ticket Act Basic Coverage/Medical Improvement
Implementation date: July 2002
Countable Income Eligibility: 350% of FPL
Whose Income is Counted? Individual
Income Disregard: Standard Medicaid Disregards
Separate Unearned Income Limit: No
Resource Limit: $2,000/$3,000
Excluded Assets: Retirement Accounts, Up to $20,000 in approved accounts
Work Requirement: Employment must be verifiable by pay stubs and employer documents that income is subject to income tax and FICA.
Grace Period: Can continue for one year after losing employment
Premium Threshold: 150% of FPL
Individual or family income: Individual
Premium Structure:
Premiums range from $0 to $254 per month according to the following:

Income as a Pct of FPL	Individual	Couple
Less than 150%	None	None
150%-175%	$48	$65
175%-200%	$69	$93
200%-250%	$107	$145
250%-300%	$134	$182
300%-350%	$161	$218
More than 350%	$187	$254

Iowa

Authorizing Legislation: BBA
Implementation date: March 2000
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: No
Resource Limit: $12,000/$13,000

Excluded Assets: Retirement Accounts, Assistive Technology Accounts
Work Requirement: Must have earned income.
Grace Period: May continue for six months after work stoppage.
Premium Threshold: 150% of FPL
Individual or family income: Individual
Premium Structure:
Premiums are assessed if an *individual's* gross income is at or above 150% of the FPL. There are eleven different premium brackets depending on income level. At 150% of the FPL ($1,074/month), the monthly premium is $20. Individuals with incomes at or above 390% of the FPL pay the maximum premium of $201 per month.

Kansas

Authorizing Legislation: Ticket Act Basic Coverage
Implementation date: July 2002
Countable Income Eligibility: 300% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards and IRWEs
Separate Unearned Income Limit: No
Resource Limit: $15,000
Excluded Assets: Retirement Accounts, Independence Accounts
Work Requirement: Employment must be verifiable by pay stubs and employer documents that income is subject to income tax and FICA.
Grace Period: May continue for six months after work stoppage.
Premium Threshold: $750
Individual or family income: Family
Premium Structure:
Premiums are based on net income (unearned -$20 + half of earned income - IRWE) according to the following:

SINGLE		TWO/THREE PERSON	
Monthly Net Income	Monthly Premium	Monthly Net Income	Monthly Premium
$0.00-$749	$0	$0.00-$1,010	$0
$749.01-$936	$55	$1,010.01-$1,263	$74
$936.01-$1,123	$69	$1,263.01-$1,515	$93
$1,123.01-$1,310	$83	$1,515.01-$1,768	$112
$1,310.01-$1,497	$97	$1,768.01-$2,020	$130
$1,497.01-$1,684	$110	$2,020.01-$2,273	$149
$1,684.01-$1,871	$124	$2,273.01-$2,525	$168
$1,871.01-$2,060	$138	$2,525.01-$2,778	$186
$2,060.01-$2,245	$152	$2,778.01-$3,030	$205
greater than $2,245	Not eligible	2 person greater than $3,030	Not eligible
		$3,030.01-$3,815 (3 person)	$205
		3 person greater than $3,815	Not eligible

Louisiana

Authorizing Legislation: Ticket Act Basic Coverage
Implementation date: 2004
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual
Income Disregard: Standard SSI disregards and IRWEs
Separate Unearned Income Limit: No
Resource Limit: $25,000
Excluded Assets:
Work Requirement: Employed
Grace Period: None
Premium Threshold: 150% of FPL
Individual or family income: Individual
Premium Structure:
Premiums are assessed according to the following:

Countable income	Premium
Less than $1,123	$0
$1,124-$1,497	$80
$1,148-$1,871	$110

Maine

Authorizing Legislation: BBA
Implementation date: August 1999
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual and spouse
Income Disregard: Standard SSI disregards plus $55
Separate Unearned Income Limit: 100% of FPL plus $75
Resource Limit: $8,000/$10,000
Excluded Assets:
Work Requirement: Must have earned income
Grace Period: None
Premium Threshold: 150% of FPL
Individual or family income: Individual and spouse
Premium Structure:
$10 if monthly countable income is between 150% and 200% of the FPL and $20 if monthly countable income is over 200% of the FPL. There is no premium for individuals with monthly countable income under 150% of the FPL or paying a Medicare Part B premium.

Massachusetts

Authorizing Legislation: 1115 Waiver
Implementation date: 1988
Countable Income Eligibility: No limit
Whose Income is Counted? n/a

Income Disregard: n/a
Separate Unearned Income Limit: No
Resource Limit: None
Excluded Assets: n/a
Work Requirement: 40 hours per month for common health-working. No work requirement for common health non working but premiums are much higher
Grace Period: None
Premium Threshold: 150% of FPL
Individual or family income: Family income
Premium Structure:
Premiums are assessed on a sliding scale according to the following:

Income	Premium without other insurance	Premium with other insurance
0%-150% of FPL	$0	$0
150%-200% of FPL	$15 plus $5 for each additional 10% of FPL between 150% and 200%	60% of full premium
200%-400% of FPL	$40 plus $8 for each additional 10% of FPL between 200% to 400%	65% of full premium
400%-600% of FPL	$202 plus $10 for each 10% of FPL between 400 and 600%	70% of full premium
600%-800% of FPL	$404 plus $12 for each 10% of FPL between 600 and 800%	75% of full premium
800% - 1000% of FPL	$646 plus $14 for each 10% of FPL between 800 and 1000%	80% of full premium
Above 1000% of FPL	$928 plus $16 for each 10% of FPL above 1000%	85% of full premium

Minnesota

Authorizing Legislation: Ticket Act Basic Coverage (initially approved under BBA)
Implementation date: July 1999
Countable Income Eligibility: no limit
Whose Income is Counted? n/a
Income Disregard: n/a
Separate Unearned Income Limit: No
Resource Limit: $20,000 individual assets
Excluded Assets: Retirement Accounts
Work Requirement: Effective Jan. 1, 2004, must document earned income tax withholding and FICA tax withheld
Grace Period: Effective Jan. 1, 2004, if loss of employment not attributable to enrollee, may continue for 4 months
Premium Threshold: All pay a premium
Individual or family income: Family
Premium Structure:

Enrollees pay 10% of the difference between the individual's gross income (all earned and unearned income--excluding spousal and family income) and 200% of FPL for appropriate family size.

Mississippi

Authorizing Legislation: BBA
Implementation date: July 1999
Countable Income Eligibility: $3,945/individual or $5,271/couple
Whose Income is Counted? Individual and spouse
Income Disregard: None (Gross income is measured)
Separate Unearned Income Limit: $1,098 individual/$1,456 couple (135% of FPL)
Resource Limit: $24,000/$26,000
Excluded Assets: Retirement Accounts
Work Requirement: 40 hours per month (according to website)
Grace Period: No
Premium Threshold: 150% of FPL
Individual or family income: Individual and Spouse
Premium Structure:
$51-$85 per month if income is above 150% of FPL

Missouri

Authorizing Legislation: Ticket Act Basic Coverage/Medical Improvement Group
Implementation date: July 2002
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual (spouse's income counted only if it is over $100,000)
Income Disregard: None (Gross income is measured)
Separate Unearned Income Limit: no
Resource Limit: $1,000
Excluded Assets: Retirement Accounts, Independent Living Accounts from earnings while participating in Buy-In
Work Requirement: Employed
Grace Period: None
Premium Threshold: 150% of FPL
Individual or family income: Individual
Premium Structure:
Premiums are calculated according to the following:

Income as a percent of FPL	Premium
150%-175%	4% of income at 163%
175%-200%	5% of income at 183%
201%-225%	6% of income at 213%
226%-250%	7% of income at 238%

Nebraska

Authorizing Legislation: BBA
Implementation date: July 1999
Countable Income Eligibility: 1. Countable income less than 250% of FPL and 2. Sum of all unearned and spouse's earned income less than SSI benefit level for family size
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: Yes. Unless an individual is in a Trial Work Period or Extended Period of Eligibility, DI income (minus disregards must be less than SSI income standard.
Resource Limit: $4,000
Excluded Assets:
Work Requirement: Must have earned income
Grace Period: No
Premium Threshold: 200% of FPL
Individual or family income: Family
Premium Structure:
Persons with family incomes of between 200% and 249% of the FPL are assessed monthly fees ranging from 2% to 10% of income.

New Hampshire

Authorizing Legislation: Ticket Act Basic Coverage
Implementation date: February 2002
Countable Income Eligibility: 450% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: No
Resource Limit: $20,889/31,334 (indexed annually)
Excluded Assets: Independence Accounts
Work Requirement: Be working (proven with a pay stub or 1099 Estimated Tax statement if the individual is self-employed)
Grace Period: If an enrollee loses his/her job, there is a 12-month period during which time he/she can continue as long as the person: intends to go back to work in the next 12 months, and job loss was due to a good reason.
Premium Threshold: 150% of FPL
Individual or family income: Family
Premium Structure:
Premiums are assessed according to the following table based on family net income:

Monthly net income range	Monthly premium
< $1,108	$0
>$1,108 and <$1,477	$80
>$1,477 and <$1,846	$110

>$1,846 and <$2,215	$135
>$2,215 and <$2,585	$165
>$2,585 and <$2,954	$190
>$2,954 and <$3,323	$220

New Jersey

Authorizing Legislation: Ticket Act Basic Coverage
Implementation date: February 2001
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: Unearned income other than DI or SSI (pension, private disability etc) has limit of 100% of FPL
Resource Limit: $20,000/$30,000
Excluded Assets: Retirement Accounts
Work Requirement: Be employed
Grace Period: No
Premium Threshold: 150% of FPL
Individual or family income: Individuals
Premium Structure:
Individuals with income (after disregards) in excess of 150% of the federal poverty level are required to pay a monthly premium of $25 ($50 for a married couple). Currently, New Jersey is not collecting premiums because the cost of collecting them exceeded their value.

New Mexico

Authorizing Legislation: BBA
Implementation date: January 2001
Countable Income Eligibility: Earned income less than 250% of FPL
Whose Income is Counted? Individual
Income Disregard: Standard SSI disregards (including IRWE and cost of health insurance)
Separate Unearned Income Limit: Unearned income less than $1,090/month
Resource Limit: $10,000
Excluded Assets: Retirement Accounts
Work Requirement: (1) have enough gross earnings in a quarter to meet Social Security Administration's definition of a qualifying quarter, or
(2) lost SSI and Medicaid due to the initial receipt of DI benefits, until Medicare entitlement.
Grace Period: None
Premium Threshold: n/a
Individual or family income: n/a
Premium Structure:

No premium, co-payments apply:

- $5 per outpatient visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health sessions
- $5 per dental visit
- $15 per emergency visit
- $25 per inpatient hospital admission
- $2 per prescription, applies to prescription and non-prescription drug items

New York

Authorizing Legislation:	Ticket Act Basic Coverage
Implementation date:	April 2003
Countable Income Eligibility:	250% of FPL
Whose Income is Counted?	Individual
Income Disregard:	Standard SSI disregards
Separate Unearned Income Limit:	No
Resource Limit:	$10,000
Excluded Assets:	
Work Requirement:	Be employed
Grace Period:	May Buy-in continuously if employed for at least 6 months in a 12 month period
Premium Threshold:	150% of FPL
Individual or family income:	Individual

Premium Structure:

Individuals with incomes between 150% and 250% of FPL pay 3% of net earned income plus 7.5% of net unearned income.

Oregon

Authorizing Legislation:	BBA
Implementation date:	February 1999
Countable Income Eligibility:	250% of FPL
Whose Income is Counted?	Individual
Income Disregard:	All unearned income/Standard SSI disregards/Employment and Independence Expenses
Separate Unearned Income Limit:	no (see premium)
Resource Limit:	$12,000
Excluded Assets:	Retirement Accounts, Other approved accounts
Work Requirement:	Must have taxable income.
Grace Period:	No
Premium Threshold:	200% of FPL
Individual or family income:	Individual

Premium Structure:

Two parts

- Any unearned income in excess of the state's SSI standard. "Special need" SSI state supplements can increase the applicable SSI standard for certain purposes, reducing their payment liability.
- If adjusted individual income (unearned income not contributed as part of the cost share and all earned income minus state and federal taxes and Employment and Independence Expenses) exceeds 200% of the FPL. The premium is a percentage of adjusted income, ranging from 2%-10%.

Pennsylvania

Authorizing Legislation: Ticket Basic Coverage and Medical Improvement
Implementation date: January 2002
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: no
Resource Limit: $10,000
Excluded Assets:
Work Requirement: Employed and receiving compensation
Grace Period: 2 months
Premium Threshold: All pay premiums
Individual or family income: Individual
Premium Structure:
Monthly premium is 5% of *individual* countable monthly income

South Carolina

Authorizing Legislation: BBA
Implementation date: October 1998
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: Individual unearned income less than $552/month
Resource Limit: 2,000
Excluded Assets:
Work Requirement: Website says one needs to be earning more than $780/month
Grace Period: No
Premium Threshold: n/a
Individual or family income: n/a
Premium Structure:
No premiums

Utah

Authorizing Legislation: BBA

Implementation date: July 2001
Countable Income Eligibility: 250% of FPL
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards
Separate Unearned Income Limit: No
Resource Limit: $15,000
Excluded Assets: Retirement accounts
Work Requirement: Pay stubs or a business plan is needed to verify employment
Grace Period: May continue to Buy-in for 12 months after job loss
Premium Threshold: 100% of FPL
Individual or family income: Family
Premium Structure:
20% of the family's net countable income that above 100% of FPL.

Vermont

Authorizing Legislation: BBA
Implementation date: January 2000
Countable Income Eligibility: 1) Family net income less than 250% of FPL
2) Family net income less earnings and $500 of DI at or below medically needy protected income level
Whose Income is Counted? Individual and Spouse
Income Disregard: Standard SSI disregards. Disregard all earnings and $500 of DI for part 2 of eligibility test.
Separate Unearned Income Limit: Yes. Unearned income limit is the Medically Needy program's Protected Income Level plus $500.
Resource Limit: $20,000
Excluded Assets: Accounts with earnings after 1/1/00
Work Requirement: Must have earned income.
Grace Period: No
Premium Threshold: 185% of FPL
Individual or family income: Family
Premium Structure:
No premium is charged if family income is at or below 185% of the FPL.
185%-225% of FPL -- $10/month
225%-250% of FPL -- $25 (reduced to $12 if enrollee has private insurance)

Washington

Authorizing Legislation: Ticket Act Basic Coverage/Medical Improvement
Implementation date: January 2002
Countable Income Eligibility: 450% of FPL based on gross income for single individual or 450% of FPL for couple if married and spouse had income greater than ½ of Federal SSI standard.
Whose Income is Counted? Individual and spouse (But only individual income if

	spouse's income is less than ½ of the SSI standard)
Income Disregard:	Standard SSI disregards and IRWEs
Separate Unearned Income Limit:	No
Resource Limit:	No resource test
Excluded Assets:	n/a
Work Requirement:	Must have payroll taxes taken out of wages, unless self employed. If self-employed, must provide tax forms or legitimate business records
Grace Period:	Unspecified, but must be intending to return to work
Premium Threshold:	All pay premiums
Individual or family income:	Family

Premium Structure:

The assessed premium is the lesser of

(1) 7.5% of your total income; or

(2) The sum of 50% of any unearned income in excess of the medically needy income level (MNIL) - the current MNIL is $571; plus 5% of your total unearned income; plus 2.5% of your earned income after deducting $65.

West Virginia

Authorizing Legislation:	Ticket Act Basic Coverage
Implementation date:	Pending
Countable Income Eligibility:	250% of FPL
Whose Income is Counted?	Individual
Income Disregard:	Standard SSI disregards
Separate Unearned Income Limit:	Unearned income cannot exceed federal benefit standard plus $20
Resource Limit:	$5,000/$10,000
Excluded Assets:	Retirement Accounts, Independence Accounts from Participants earnings
Work Requirement:	Must be working
Grace Period:	No
Premium Threshold:	All pay premium
Individual or family income:	Individual

Premium Structure:

All participants pay a $50 enrollment fee and upon payment the first month's premium payment is waived. There is a sliding scale of premiums based on the annual gross income of the individual with a minimum monthly premium of $15 and a maximum of 3.5% of individual's gross monthly income.

Wisconsin

Authorizing Legislation:	BBA
Implementation date:	January 2000
Countable Income Eligibility:	250% of FPL
Whose Income is Counted?	Individual and Spouse
Income Disregard:	Standard SSI disregards
Separate Unearned Income Limit:	no (see premium)

Resource Limit:	$15,000 (only count individual assets
Excluded Assets:	Retirement Accounts initiated after Buy-in, Independence Accounts
Work Requirement:	Must be working or enrolled in an employment counseling program. Can remain in employment counseling for up to one year.
Grace Period:	Can enroll in Health Employment Counseling for up to a year. Additional grace period 6 months for a health setback.
Premium Threshold:	150% of FPL
Individual or family income:	Individual

Premium Structure:

Premiums are assessed when an individual's income is at or above 150% of the FPL for his family size.

- 100% of unearned income minus a living allowance ($655/month in 2003) and specified deductions (IRWE and medical deduction) plus
- 3% of the individual's earned income. If unearned income deductions exceed actual unearned income, the difference is subtracted from earned income before assessing the 3% premium.

Wyoming

Authorizing Legislation:	Ticket Act Basic Coverage
Implementation date:	Pending
Countable Income Eligibility:	100% of FPL
Whose Income is Counted?	Individual and Spouse
Income Disregard:	Standard SSI disregards. Additionally, first $600 per year of unearned income ($50 per month) is disregarded from income calculation.
Separate Unearned Income Limit:	No
Resource Limit:	None
Excluded Assets:	n/a
Work Requirement:	Must be employed
Grace Period:	No
Premium Threshold:	All pay premium
Individual or family income:	Individual

Premium

- The individual pays a premium of 7.5% of total gross monthly earnings from work; and
- The individual also pays a premium of 7.5% of her/his annual unearned income in excess of $600, provided
- The total paid in premiums, and the total premium amount liable does not exceed 7.5% of total family income.

APPENDIX B
DEMOGRAPHIC CHARACTERISTICS OF BUY-IN ENROLLEES IN SELECTED STATES

Several States have developed reports that provide demographic information on Buy-In participants. In this Appendix, we present this data and compare it to the demographics of the DI program nationally.

Exhibit B1: Age

State	Ages 20-44	Ages 45-64	65 or over**
DI National	25.0%	75.0%	
California	34.0%	55.5%	11%
Wisconsin	38.4%	61.6%	0%
Vermont	39.1%	59.3%	1.6%
Maine	45.0%	49.0%	6.0%
Kansas*	47.0%	53.0%	
Connecticut	51.8%	48.4%	
Illinois*	55.0%	45.0%	

* Estimated based on state data reported in different categories
**Applicable for BBA states only

Exhibit B2: Education

State	Less than High School Graduate	High school Graduate	Some college (includes 2-year degrees)	College graduate or more
National DI	31.0%	35.0%	23.0%	11.0%
Kansas	10.2%	39.8%	39.1%	10.9%
Minnesota*	12.7%	63.2%	15.8%	8.3%
Vermont	20.3%	47.3%	11.8%	17.3%
Connecticut	23.7%	42.6%	22.7%	10.9%

Exhibit B3: Marital Status

	Married	Single*
DI National	50%	50%
Connecticut	7.0%	92.9%
Minnesota	14.5%	85.5%
Wisconsin	22.0%	78.0%
Vermont	24.1%	74.9%
Maine	25.0%	75.0%

Sources of Information:

DI National, Social Security Supplement 2003, Table 5d6
California: Jee and Menges 2003
Connecticut: Porter 2004
Kansas: Hall 2003
Maine: Salley and Glantz 2002
Minnesota: Minnesota MIG 2004
Vermont: Vermont Department of Rehabilitation Services 2003a
Wisconsin: APS 2003