June 9, 2003

Medicaid and Work Incentives for People with Disabilities: Background and Issues

Joshua M. Wiener, Ph.D.
Principal Research Associate
The Urban Institute
2100 M Street, NW
Washington, DC 20037
(202) 261-5652
(202) 223-1149 (fax)
jwiener@ui.urban.org

This paper was prepared for the Ticket to Work and Work Incentives Advisory Committee as part of a contract with the Urban Institute. Lisa Ekman was the project officer. Anat Grosfeld of the Urban Institute provided valuable research assistance. The author is grateful for the insights and information provided by state officials and consumer advocates in Iowa, New Hampshire, Pennsylvania, South Carolina, and Connecticut. Useful comments on an earlier draft were provided by Sheila Zedlewski, Marie Strahan, Jerome Kleckley and Gina Livermore. The views presented here are those of the author and do not necessarily represent those of the Ticket to Work and Work Incentives Advisory Committee or the Urban Institute.

Executive Summary

Medicaid and Work Incentives for People with Disabilities: Background and Issues

Joshua M. Wiener, Ph.D.
The Urban Institute
Washington, DC

The potential loss of health benefits under Medicare and Medicaid is a deterrent to people with disabilities entering or re-entering the labor force. Although people with disabilities are generally not "sick," they often have conditions that require greater than average use of medical and long-term care services. To address this problem, Medicaid includes several mandatory and optional provisions, including ones from the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act, that allow people with disabilities to work and retain coverage.

This paper describes the Medicaid work incentives and how they are being implemented at the state level. It explores the major issues involving Medicaid and work incentives, including the state fiscal crises, horizontal equity across states and groups, coverage of needed services, defining disability, and the interaction between Medicaid and Social Security Disability Insurance and Medicare. In addition, the article also analyzes more technical design issues related to the Ticket to Work and Work Incentives Improvement Act work incentives, including definition of employment, age restrictions, and use of premiums.

Introduction

Medicaid is a critical source of health and long-term care financing for low-income persons with disabilities. Over the course of fiscal year 2002, Medicaid covered an estimated 7.9 million individuals with blindness or disability.[1] It is estimated that Medicaid provides health coverage for approximately two-fifths of disabled persons with incomes below the federal poverty level (FPL) and 15 percent of disabled persons with incomes between 100 and 200 percent of the FPL.[2] Medicaid eligibility is consequential for blind and disabled persons because they often have serious medical and other conditions that require services that they cannot easily afford. Medicaid covers a wide range of medical and long-term care services that are often critical to enabling individuals with disabilities to work or to remain in the community. High health insurance premiums and pre-existing condition exclusions are significant barriers to private insurance for this group. Even when insurance is available, it almost never covers long-term care and other support services that people with disabilities often need.

Historically, Medicaid eligibility for persons with disabilities has been tied to an inability to work, which means that individuals had to choose between receiving the medical and long-term care services that they needed and participating in the workforce. Partly as a result of their physical and mental conditions, partly due to society's low expectations of people with disabilities and partly because of cash assistance and Medicaid policy, relatively few persons with disabilities who received public benefits worked.[3] For good reasons, people with disabilities were unwilling to risk losing their health coverage.

In more recent years, younger people with disabilities have demanded that they receive support to enable them to live normal lives in the community, including

participating in work. As part of the changing view of people with disabilities, the Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 contained provisions that enable lower-income people with disabilities to work and still retain Medicaid coverage. These provisions, often referred to as "Medicaid buy-ins" because higher income beneficiaries are required to pay premiums (thus "buying into" the program), are coverage options available to the states, but are not required.

The purpose of this paper is to analyze the role of Medicaid for working people with disabilities. The paper begins with an overview of Medicaid, especially as it relates to people with disabilities. The second section summarizes federal law regarding Medicaid work incentives for people with disabilities and describes on a national basis how states have used the flexibility available to them. In order to gain a more detailed understanding of how the Medicaid buy-in programs are working at the state level, the third section presents case studies of five states which have chosen either the BBA or TWWIIA Medicaid work incentives options. The fourth section analyzes some of the issues raised by the existing structure of work incentives. The paper concludes with policy implications for expanding work participation by people with disabilities.

I. Overview of Medicaid

A. Basic Features of Medicaid

Medicaid is the principal health and long-term care financing program for low income populations. It is a means-tested, open-ended entitlement program, jointly financed by the federal and state governments and administered by the states. Over fiscal year 2002, Medicaid programs enrolled an estimated 50.9 million persons—about one in

five Americans—and spent an approximately $216 billion in state and federal funds for services.[4]

While the federal government sets minimum standards, states have a number of options in how they implement the program. Consequently, Medicaid actually encompasses 56 separate programs (one in each state, the District of Columbia, the four U.S. Territories, and the Commonwealth of Puerto Rico).[5] Federal financial assistance is provided to states for coverage of specific categories of people and services through federal matching payments. The rates for these federal matching payments vary from 50 to 77 percent and are based on each state's per capita income; states with lower per capita income have higher federal matching rates.

Medicaid covers a very broad range of services with nominal cost sharing, which reflects the low-income of the covered population. Mandatory services include inpatient and outpatient hospital services; physician, midwife, and certified nurse practitioner services; laboratory and x-ray services; nursing home and home health care; early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21; family planning; and rural health clinics and qualified health centers. In addition, states have the option to cover a very wide range of additional services, including prescription drugs, clinic services, prosthetic devices, hearing aids, dental care, intermediate care facilities for the mentally retarded (ICF/MRs), and a wide range of nonmedical home and community-based services through waivers. Unlike Medicare, Medicaid is a major source of financing for long-term care services.

Covering people with disabilities is important for states because this group is relatively expensive to cover due to their high medical needs. The Congressional Budget

Office estimates that while 16 percent of Medicaid enrollees in 2002 were blind or disabled, these individuals accounted for 43 percent of federal Medicaid expenditures for services.[6] In 2002, average total (federal and state) per enrollee Medicaid expenditures for persons with disabilities were $11,770, compared to $1,999 per nondisabled adult, $1,514 per child, and $13,099 per elderly person.[7] People with disabilities have chronic medical conditions that lead to more physician visits, higher rates of hospitalization, greater use of prescription drugs, and increased need for long-term care. Given the high costs of serving this population, one way in which states limit their Medicaid financial exposure for these services is by limiting Medicaid eligibility for blind and disabled persons.

In 1998, the most recent year that detailed spending data are available, 57 percent of total Medicaid expenditures for people with disabilities were for acute care services (e.g., physicians services, hospital care, prescription drugs) and 43 percent were for long-term care services (e.g., home care, nursing facilities and intermediate care facilities for the mentally retarded).[8] Medicaid's prescription drug benefit is particularly important for disabled beneficiaries who accounted for 55 percent of total Medicaid spending on prescription drugs in 1998. Similarly, in that same year, people with disabilities accounted for 61 percent of spending on home and community-based services.

B. General Medicaid Eligibility Policy

Medicaid provides coverage for only certain "categories" of low-income people, such as children, parents, pregnant women, older people, persons with disabilities, and individuals who are blind. In general, nondisabled, childless adults are not eligible for Medicaid, regardless of their income and asset levels or their medical needs. Since the

welfare reforms of 1996, Medicaid coverage is no longer automatic for families with children who receive cash assistance.

Medicaid is a means-tested program under which people qualify based on financial need. Financial eligibility is subject to an extensive set of requirements that include income and financial resource (i.e., asset) criteria. These tests consist of two parts: the standard and the methodology. The standard is the dollar amount below which an individual or family qualifies for coverage. For example, an income standard might be $ 552 per month (the SSI payment level in 2003), while the resource or assets standards for older people and younger people with disabilities generally are $2,000 for individuals and $3,000 for couples.

The methodology is the way in which income or assets are counted for purposes of applying the standard. For example, states must disregard (that is, not count) some types or amounts of income, such as $20 of unearned income from any source and one-half of earned income, and they have the option to disregard additional amounts. They must also exclude some or all of the value of certain assets—for example, homes and vehicles up to as certain value—when calculating total resources. Under Section 1902(r)(2) of the Social Security Act, states may use “less restrictive” income and resource methodologies than those used by SSI.[9] Depending on the methodology used, the effective income and resource standards for Medicaid eligibility can be quite different from those embodied in the standard. States have widely used this flexibility in setting standards for eligibility options for working people with disabilities.

II. Medicaid Eligibility Rules Regarding Working People with Disabilities

The Medicaid program contains a number of rules that both facilitate and hinder work by people with disabilities. The major eligibility provisions affecting this issue involve the link to Supplemental Security Income, Section 1619(b) of the Social Security Act, the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999. A less widely used mechanism is a Section 1115 of the Social Security Act research and demonstration waiver. Massachusetts is the principal state using this option to provide Medicaid to working people with disabilities as part of a much larger demonstration project.

A. A Bird's Eye View of Medicaid Eligibility Policy for Aged, Blind and Disabled Persons

States must provide Medicaid coverage for certain groups of low-income aged, blind and disabled individuals, but they also have numerous options to cover additional groups. Medicaid eligibility requirements and options are briefly summarized on table 1.

Medicaid eligibility for older people and persons with disabilities is tightly connected to eligibility for the SSI program, and many of the Medicaid eligibility rules pertaining to these populations are derived from rules of the SSI program. For example, federal law generally requires Medicaid programs to cover elderly, blind and disabled individuals receiving cash assistance from the SSI program, as well as certain persons who lose SSI payments due to earnings from work or increased Social Security benefits.[10] An exception to this general rule is that federal law gives states the option to use eligibility criteria that are more restrictive than SSI, but only if those rules were in effect when SSI was enacted in 1972, the so-called "209(b)" option. In 2001, 39 states and the

District of Columbia provided Medicaid coverage to all SSI beneficiaries, while the remaining 11 states used alternative criteria for elderly and disabled beneficiaries.

States can also receive federal matching funds for certain optional populations. These optional populations include:

- Recipients of state supplementary payments (SSP) to SSI.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL. This pathway is often referred to as "poverty-level" coverage.
- Individuals who have incomes slightly above the SSI level or who have substantial medical expenses. This pathway is commonly referred to as "medically needy" coverage.
- Institutionalized individuals with income and resources below specified limits.
- Persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers.
- On a first come, first served basis, subject to the availability of federal funds, Medicaid also provides help paying part of the Medicare Part B premium for certain individuals with incomes between 120 and 135 of the FPL.[11]
- Working people with disabilities with family income up to 250 percent of the FPL (with earned income by the beneficiary being disregarded) or any state-designated income and resource level.

The type of coverage that people with disabilities receive from Medicaid varies depending on their financial status and eligibility for Medicare. Approximately 36 percent of younger people with disabilities who are eligible for Medicare (as a result of their receipt of Social Security Disability Insurance benefits) are also eligible for Medicaid.[12] Low-income aged, blind, and disabled people who are not eligible for Medicare usually are eligible for a full range of acute and long-term care benefits through Medicaid. Low-income persons who are eligible for both programs receive assistance from Medicaid with Medicare's cost-sharing requirements as well as coverage for some services that Medicare does not provide, including prescription drugs, nursing facility care beyond Medicare's 100-day limit, and other long-term care services. Federal law

also requires Medicaid programs to pay some or all Medicare cost-sharing expenses—including Medicare Part A and Part B premiums and deductibles and coinsurance—for Medicare services provided to Medicare beneficiaries with incomes up to 120 percent of poverty; these provisions are known as "Medicare savings programs."[13] Thus, Medicaid helps to fill in gaps left by Medicare and private insurance.

B. The Medicaid Starting Point: Supplemental Security Income (SSI)

As noted above, state Medicaid programs generally must cover SSI beneficiaries or a subset of them. To be eligible for SSI, a person must be age 65 or older, blind or disabled and have limited income and resources. Under SSI law, an individual is considered disabled if "he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[14] In 2003, earned income exceeding $800 per month for nonblind, disabled individuals and $1,330 for blind individuals is evidence of "substantial gainful activity" or SGA.[15]

Under section 1619(a) of the Social Security Act, however, people under age 65 who have already qualified for SSI benefits can have earned incomes that exceed the substantial gainful activity threshold and receive reduced cash payments. People who are age 65 and older, blind and younger people who meet the SSI disability requirements are eligible to receive SSI benefits if their "countable" incomes (which can include earned and unearned income) fall below maximum SSI benefit levels. Some income is not "countable." In determining eligibility for SSI, the Social Security Administration disregards $20 of income per month from any source and $65 per month of earned

income plus one-half of remaining earnings, and certain other public benefits such as food stamps and home energy or housing assistance. In 2003, once determined to be eligible, beneficiaries can increase their income up to $1,189 per month for individuals and $1,743 per month for couples and still receive SSI benefits.

From the beneficiaries' perspective, there are two advantages of these work incentives. First, there is no cash cliff as there is with Social Security Disability Insurance coverage where individuals are suddenly no longer eligible; individuals lose their SSI benefits gradually. Second, individuals may easily move back to regular SSI status if their earnings are significantly reduced or eliminated.

The SSI program also limits the amount of countable resources that beneficiaries may have in order to qualify. Resource limits for SSI eligibility, which have not increased since the mid-1980s, are $2,000 for individuals and $3,000 for couples. These limits generally apply to "liquid assets" such as stocks and bonds, mutual funds, and money in bank accounts; they exclude (in entirety or up to a limit) the value of assets such as homes, cars, burial plots or funds, personal effects, and the cash surrender value of life insurance.[16]

C. Mandatory Work Incentive: Section 1619(b) of the Social Security Act

States must provide Medicaid coverage to "qualified severely impaired individuals" who have already qualified for SSI and continue to have the disabling physical or mental impairment that initially qualified them but subsequently have more than $800 a month in earnings (e.g., "substantial gainful activity") in 2003.[17] These persons remain entitled to Medicaid as long as their gross earnings are determined to be less than the value of the sum of SSI, state supplemental payments, Medicaid benefits and

publicly-funded attendant care that they would be eligible to receive in absence of their wage earnings. To measure whether a person's earnings are high enough to replace these benefits, the Social Security Administration calculates state-specific thresholds, which range from a low of $17,348 in Alabama to a high of $41,514 in New Hampshire in 2003 (table 2). Five states—California, Iowa, Massachusetts, Nevada and Oregon—have higher thresholds for blind SSI beneficiaries. If an individual earns more than the state threshold amount, he or she can request an individualized upper limit, which considers the persons actual use of Medicaid, publicly-funded attendant care and work expenses. Beneficiaries can be reinstated to SSI payment status or SSI status under section 1619(b) without a new application if their income and resources are reduced to a level that they can once again meet the SSI criteria.

In addition, the income limits are made more flexible by deducting from gross earnings the cost of certain impairment-related items and services that an employed individual with disabilities needs to work. SSI beneficiaries also may save for items related to vocational goals and employment outcome under "Plans for Achieving Self-Sufficiency" (PASS) and have that money disregarded for eligibility purposes. However, beyond this, the provisions generally do not allow states to deviate from federal resource or assets guidelines, thus limiting efforts to encourage savings or to reward increased earnings by beneficiaries.

These provisions guarantee extended Medicaid coverage to people who have previously received SSI benefits, but they do not provide coverage for those who have not received this cash assistance.[18] Moreover, both the Medicaid and SSI provisions have been difficult for consumers to understand and for eligibility workers to implement. In

1999, only 1.9 percent of working age SSI beneficiaries were in the 1619(b) category.[19] After reviewing the evidence, Newcomb, Payne and Waid concluded that, "While the 1619 provisions have created more opportunity for work among SSI recipients, it does not appear that they have significantly helped move people off the rolls."[20]

A. Optional Work Incentives: Medicaid Buy-In Programs

While states must provide Medicaid to most SSI beneficiaries and to people who qualify under section 1619(b), coverage under the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) is optional for the states. The target populations for the Medicaid work incentives provisions of the BBA and the TWWIIA are primarily Social Security Disability Insurance (SSDI) beneficiaries who cannot utilize Section 1619 protections because they are not eligible for SSI, persons receiving SSI who have or could exceed state-established income or resource limits under 1619(b); and individuals with disabilities who have been working but have not or are not currently receiving cash benefits or Medicaid coverage. The BBA and TWWIIA provide states with more flexibility than the Section 1619 provisions. Table 3 compares the eligibility rules of the provisions of the Balanced Budget Act and the Ticket to Work and Work Incentives Improvement Act. Table 4 provides state-by-state information on the implementation of the BBA and TWWIIA provisions. As of June 2002, there were a total of 27,209 Medicaid beneficiaries in the BBA and TWWIIA work incentives in 25 states.

1. Balanced Budget Act of 1997

Section 4733 of the BBA established a new optional Medicaid coverage group, which allows states to provide Medicaid eligibility to working people with disabilities.

For people who meet the SSI definition of disability, states may offer Medicaid coverage to individuals with net family income below 250 percent of the federal poverty level and resources not exceeding the SSI resource standard. In calculating income, all earned income is disregarded, but unearned income may not exceed the SSI income standard (which is $552 for an individual and $829 for couples in 2003). There is no definition of an employed individual and states may not establish minimum standard for number of hours worked or minimum level of earnings. As in other parts of Medicaid, 209(b) states may use more restrictive eligibility criteria than are used by SSI. States may require payment of premiums and other cost-sharing charges on a sliding scale based on income. As of June 2002, 12 states covered working people with disabilities under the BBA provisions.[21]

2. Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA)

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) established two new Medicaid eligibility groups, the basic coverage group and the medical improvement group, as well as a new grant program to the states and a new Medicaid research and demonstration program.

Eligibility Options: Basic Coverage Group and Medical Improvement Group

Basic Coverage Group. The basic coverage group is similar to the BBA group, except that states are free to establish their own income and resource standards or to have no income and resource standards at all and there is an age limit (no persons under age 16 or 65 and older). There is no definition of an employed individual and states may not establish any minimum requirement for number of hours worked or earnings. Currently 13 states have adopted this option.

Medical Improvement Group. The medical improvement group targets individuals whose disabilities are cyclical or periodic.[22] The intent of this provision was to ensure continued medical coverage for those individuals when, due to treatment or support services, their condition improved to the point that they no longer met the disability criteria for SSI, SSDI, and Medicaid. Despite the finding of "medical improvement," these individuals must continue to have conditions that constitute a "severe medically determinable impairment." Some groups meeting this description include persons with AIDS/HIV, persons with severe and persistent mental illness who respond to psychotropic medications, persons with epilepsy, persons with certain types of multiple sclerosis, and persons with some cancers. As with the basic coverage group, eligibility is limited to persons between the ages of 16 and 64. Earned income is not automatically disregarded. There are no federally established income and resource standards.

Unlike the basic coverage and BBA groups, the medical improvement group does have a statutory definition of an "employed individual," which is a person who is earning at least the federal minimum wage and is working at least 40 hours a month, or is engaged in a work effort that meets an alternate definition as defined by the state and approved by the Secretary of the Department of Health and Human Services. Currently, three states have adopted this option.

Options Available to States under Basic Coverage and Medical Improvement Groups. States have some options under the TWWIIA provisions. First, as indicated above, states are free to establish their own income and resource standards, or to have no income and resource standards at all. Second, although SSI income and resource

methodologies are the default, states may use more liberal methodologies than are used by SSI as authorized by Section 1902(r)(2) of the Social Security Act. Third, as in other parts of Medicaid, 209(b) states may use more restrictive eligibility criteria than are used by SSI.

Fourth, states may impose premiums or other cost-sharing under both coverage groups. Any premium or cost-sharing must be imposed on a sliding scale based on income. For any individual whose annual family income is less than 450 percent of the federal poverty level, the premiums may not exceed 7.5 percent of the individual's income. In addition, states must charge the full premium for any individual whose adjusted annual gross income exceeds $78,027 annually in 2003 (an amount that increases annually by the consumer price index). States may subsidize payment of premiums for individuals whose incomes exceed this level, but any such subsidy must be made solely with state funds. According to the Centers for Medicare & Medicaid Services, a flat cost-sharing charge combined with a sliding scale premium would meet the requirement that such charges be on a sliding scale based on income.

If an individual could be covered under private health insurance at no cost to him or her, states may require the individual to enroll in the insurance plan. Where private group health insurance is available to the individual at some cost, states may enroll individuals in such plans provided doing so is cost-effective and the state pays the costs of enrolling in the plan, including premiums, deductibles and co-insurance.

Maintenance of Effort Requirement. The TWWIIA prohibits states from supplanting state funds for programs to help working individuals with disabilities with federal funds that provide Medicaid benefits under the basic coverage group or the

medical improvement group. If a state covers either or both of these Medicaid eligibility groups, federal Medicaid matching funds will not be available unless the state establishes, to the satisfaction of the Secretary of the Department of Health and Human Services, that its expenditures for those programs are not less than its expenditures for such programs for the fiscal year ending before December 17, 1999.

Infrastructure Grants and Medicaid Demonstrations

Beyond establishing new coverage options, the TWWIIA also establishes a Medicaid Infrastructure Grant Program and authorizes a new set of Medicaid demonstrations.

Medicaid Infrastructure Grant Program. The Medicaid Infrastructure Grant Program is an eleven year grant program which makes $150 million available to states over the first five years. The Centers for Medicare & Medicaid Services currently is preparing to issue the fourth round of the call for proposals. Appendix 1 summarizes state activity on the Medicaid Infrastructure Grants. The goal of the grants is to provide states with additional funds (and manpower) to design and implement Medicaid activities supporting working people with disabilities. In general, the programs are more focused than the Real Choice System Change grants that the Centers for Medicare & Medicaid Services are providing to states to help them expand home and community-based services. The Medicaid Infrastructure Grants help states to:

- Implement the Medicaid eligibility groups discussed above.
- Design and plan a Medicaid demonstration for employed individuals with potentially severe physical or mental impairments.
- Plan, design or evaluate improvements to the Medicaid State Plan for purposes of providing more effective employment support.

- Create a state-to-state Medicaid Infrastructure Center to serve as a regional technical assistance provider for health care improvements supporting employment.

Funds may also be used to conduct outreach campaigns to educate beneficiaries about the availability of Medicaid coverage for working people with disabilities. Subject to availability of the overall annual amount appropriated for this grant program, the minimum award to each state is $500,000 per fiscal year.

To be eligible for grant funds, a state must make personal assistance services available under its State Medicaid plan to the extent necessary to assist individuals with disabilities maintain employment. In order to disperse the funds in a timely fashion, the Centers for Medicare & Medicaid services have used fairly lenient criteria in determining whether states meet the requirement for personal assistance services.

Medicaid Demonstrations. The companion to the grant program is a mandated set of Medicaid demonstrations on providing Medicaid to "workers with potentially severe disabilities." At the time of their demonstration coverage, these individuals would not normally be considered "disabled" under the SSI definition and would not otherwise be Medicaid eligible. The purpose of the demonstration is to evaluate the effect of providing early intervention in the form of health and long-term care services on the ability of participants to retain employment and on their physical and mental status. In other words, can providing Medicaid coverage prevent the health and functional status of individuals from deteriorating to such an extent that they meet the SSI definition of disability? These demonstrations are funded at $250 million over six years.

The demonstrations have several other requirements. Participants must be at least 16 but less than 65 years old, and have a specific physical or mental impairment that can reasonably be expected to lead to blindness or disability as defined under the SSI

program if Medicaid services are not provided. Unlike the regular Medicaid program, which is an open-ended entitlement, demonstration states will be required to cap the number of people covered in the demonstrations. The law does not require that states impose any income or resource test. Since they are capping enrollment, states are permitted to operate the demonstrations on less than a statewide basis. Three states—Mississippi, Rhode Island and Texas--and the District of Columbia have been granted waivers. As of April 2003, Mississippi and the District of Columbia have begun enrolling beneficiaries, while Rhode Island and Texas have not. The maximum proposed enrollment in each of the four demonstration states is quite small, 500 enrollees or less (table 5).

III. State Case Studies

In order to obtain a better understanding of the implementation of the BBA and TWWIIA buy-in options for working people with disabilities, case studies were conducted of five states—Connecticut, Iowa, New Hampshire, Pennsylvania, and South Carolina—that provided Medicaid coverage to working people with disabilities under the BBA or the TWWIIA. In order to gather information, state websites were searched and telephone discussions held with state officials and consumer advocates from January to March 2003. Topics investigated included background history related to the state decision to provide coverage, a description of eligibility rules and the availability of long-term care services, experience with the coverage option, budget outlook and policy issues, and recommendations for change. In order to encourage candor on the part of respondents, persons interviewed were told that they would not be quoted or otherwise identified. Appendix 2 summarizes the case study results for each state.

A. Background History and Budgetary Outlook

Adoption of the Medicaid buy-in provisions had extremely broad, bipartisan support. For example, it unanimously passed the legislature in New Hampshire and Connecticut. Business groups, who saw these initiatives as a way of addressing the labor shortages of the late 1990s, were often involved. In Pennsylvania, the incremental cost was funded with tobacco settlement funds. Low cost estimates by the states aided the adoption of the eligibility expansions, as did the ideology of helping persons with disabilities work.

Although all of the case study states are projecting major budget deficits, none of the states will be eliminating the buy-in program, even though it is an optional rather than mandatory eligibility category. However, some states are tentatively considering increasing premiums. Some observers noted that several of the community-based services that people with disabilities heavily depend on, such as transportation, are at risk in the current budgetary environment. In addition, people with disabilities obtain Medicaid through other coverage options (e.g., medically needy programs) that are at greater risk of being cut.

B. Eligibility Requirements

The Medicaid buy-in provisions are relatively liberal by Medicaid standards, with states adopting the TWWIIA options being more generous than those states adopting the BBA provisions. In general, states using the BBA provisions adhere quite closely to the SSI methodologies for determining income and resources, while states using the TWWIIA options are more likely to disregard additional income and resources.

Most states limit income eligibility to 250 percent of the FPL, although New Hampshire covers person with income as high as 450 percent of the FPL (including the income of the spouse) and Connecticut covers individuals with income as high as $75,000 for an individual. However, additional disregards in some states, such as unearned income and Plans for Achieving Self-Support expenses (PASS), make the effective income levels higher than the nominal standards. In addition, New Hampshire, Connecticut and Iowa allow individuals who have lost their jobs and, therefore, have no earned income to retain their Medicaid eligibility for an extended period of time if they intend to return to work. None of the case study states opted to totally eliminate income and asset standards, partly because of concerns about the potential costs and partly because they did not want it to appear that "millionaires are getting free health insurance."

Similarly, resource standards vary substantially, but are generally much higher than standard SSI eligibility levels, which are $2,000 for an individual. For example, the resource standards for an individual are $20,000 in New Hampshire, $12,000 in Iowa, and $10,000 in Connecticut and Pennsylvania. Of the case study states, only South Carolina adhered to SSI resource standards. In addition, states commonly excluded retirement accounts, medical savings accounts, and accounts for employability-related expenses, making the effective resource standards higher. States do not count these assets because they want to encourage savings and because accumulating some resources is part of the normal work experience. In New Hampshire, liquid resources accumulated from earnings while Medicaid eligible under the buy-in and kept in a separate account will be excluded when determining future eligibility for non-buy-in Medicaid categories.

C. Medicaid Buy-in Premiums and Private Insurance

All of the case study states, except for South Carolina (which also does not impose premiums for the State Children's Health Insurance Program), impose premiums on higher income beneficiaries. Premiums are between 5 and 10 percent of income. States typically include spousal income in determining family income, but may count only "net" income, which includes only about half of earned income by the person with disabilities. Individuals with incomes above $78,027 are charged the "full premium." While this is true for Iowa, the maximum premium is assessed when income is above $35,028. All of the case study states except Iowa credit private health insurance premiums against the Medicaid-buy in premiums. In addition, the states will pay the private health insurance premium of individuals if it is cost effective to do so.

D. Long-Term Care Services

None of the case study states cover a broad personal care benefit through the regular Medicaid program. New Hampshire has a narrowly-focused benefit for people in wheelchairs. Instead, all of the states rely on Medicaid home and community-based services waivers as a financing mechanism for noninstitutional long-term care services for the Medicaid buy-in population. Connecticut used to have a state-funded program of personal care, but cases have been transferred to a home and community-based services waiver. Although participants in the waivers must need nursing home level of care, state officials did not report that access to long-term care services was a problem.

E. Outreach and Education

States have engaged in a number of outreach and education initiatives to increase enrollment, although the extent of these efforts vary. In New Hampshire, for example,

they made a major outreach effort using the Medicaid infrastructure grant. These initiatives have included radio spots, brochures and posters and the state plans to involve local Chambers of Commerce. Benefit specialists provide counseling services on the Medicaid buy-in and offer education and outreach other services. Grant contracts have been made to independent living centers to provide outreach. Training and outreach efforts have included SSA offices, area agencies serving consumers with developmental disabilities and acquired brain disorders, mental health agencies, one-stop centers (offering employment related services to both employees and employers), advocacy groups, and other local and state agencies.

In Connecticut, the Connect to Work program encourages persons with disabilities to return to work utilizing Medicaid to address their medical and long-term care needs. Marketing the coverage options has included mailings to disabled people on SSI with earned income and disabled individuals who have lost Medicaid eligibility within the last two years. They target people earning less than the SGA, educating them that they can earn more and still maintain Medicaid eligibility. The state has five benefits counselors in the field who work with individuals with disabilities. State officials have given talks to groups providing services to people with disabilities, such as the Multiple Sclerosis Society.

F. Experience to Date

The number of beneficiaries in the Medicaid buy-in programs is not large in absolute terms, varying from 770 participants in South Carolina to 5,048 participants in Iowa. As expected by state officials, the substantial majority of beneficiaries in the buy-in option had previously been Medicaid eligibles. Generally, only about 20 percent or

less of buy-in participants are new Medicaid beneficiaries. Often, buy-in beneficiaries were previously eligible for Medicaid through the medically needy option. The majority of beneficiaries are dually eligible for Medicare and Medicaid, most likely meaning that they are receiving SSDI benefits. For example, in Connecticut, 82 percent of beneficiaries are dually eligible for Medicare and Medicaid. In Pennsylvania, about half of buy-in participants are dually eligible. State officials speculated that purely SSI beneficiaries were mostly covered under Section 1619(b) provisions rather than through the BBA and TWWIIA Medicaid buy-ins.

The BBA and TWWIIA programs in each state are designed to accommodate individuals with fairly significant earnings by Medicaid and SSI standards. However, although all participants in the states have earnings or had earnings and are looking for work, the level of income is generally modest. In states with income information, most individuals are earning less than the SGA. For example, in Iowa, 4 percent of beneficiaries earn $750 per month or more; 57 percent earn $100 per month or less. In Iowa, approximately 42 percent of beneficiaries work 10 hours per month or less; 10 percent of beneficiaries work 80 hours a month or more. In Connecticut, 27 percent of beneficiaries are earning $5,000 a year or less and 43 percent are earning between $5,000 and $9,999; thus, roughly 70 percent of beneficiaries earn less than the SGA. In Pennsylvania, although they do not track earnings, half of all buy-in beneficiaries worked 100 hours a month or less.

Consistent with the relatively modest earnings of participants, a substantial majority of beneficiaries do not pay premiums, except in Pennsylvania where almost all beneficiaries are required to contribute to the cost of their health coverage. The

percentage of beneficiaries who are paying premiums generally ranges from about 10 to 25 percent. In New Hampshire, 18 percent of beneficiaries pay premiums and 75 percent of those paying premiums have net incomes (i.e., disregarding half of earned income) between 150 and 200 percent of the FPL. In Iowa, 27 percent of buy-in beneficiaries paid premiums, while in Connecticut 12 percent pay premiums. Although some officials noted that charging premiums created some administrative complexities for the states, these respondents did not believe that premium levels were high enough to deter program participation.

IV. Key Policy Issues

The current relationship between Medicaid and persons with disabilities who want to work raises a number of policy concerns, including both broad policy issues and more technical questions raised by TWWIIA.

A. Broad Policy Issues

The broad policy issues include the current fiscal difficulties of the states and its implications for Medicaid, the variation in coverage across states and eligibility groups, the availability of needed Medicaid services, the use of a work rather than a functional definition of disability to determine eligibility, and the interactions between SSDI and Medicaid.

1. Fiscal Crisis of the States and Medicaid

Battered by declining revenues and sharply rising Medicaid costs, states are now facing one of the most severe fiscal crises of the last fifty years.[23] States face budget shortfalls of more than $80 billion in fiscal year 2004.[24] In part because Medicaid is designed to be a counter-cyclical program (i.e., as unemployment rises and incomes drop

in an economic downturn, more people become eligible for Medicaid), its spending has been growing much faster than overall state spending.[25] Because of the fiscal pressures that they face, most states are considering cutting Medicaid, which accounts for about a fifth of state spending.[26] As noted above, our case study states indicate that the Medicaid work incentives have very broad and bipartisan support and are not currently targets for budget cuts, although there are some discussions of increasing premiums under the BBA and TWWIIA options. One state, Florida, is not implementing its planned coverage of work incentives for persons with disabilities. If state finances continue to decline, however, more states may eliminate this optional coverage. Over the long run, it will be difficult for states to sustain the projected expenditures growth rate for Medicaid, over 40 percent of which is due to persons with disabilities. The fiscal problems of the states may also reduce the interest of states not currently participating in the BBA or TWWIIA buy-in options from doing so.

2. Horizontal Equity Across States and Groups

The Medicaid program is a mixture of federal requirements and state options. The relative balance of those two features is a matter of dispute. National observers tend to emphasize the great variation across states in Medicaid coverage and other factors, while states tend to emphasize (and chafe under) the uniform federal requirements.[27] State flexibility is usually justified as a way of better matching local preferences with program design. While states must provide Medicaid coverage to working persons with disabilities mandated under Section 1619(b) of the Social Security Act, eligibility under the BBA and TWWIIA is optional and states have great flexibility in how they implement the statutory provisions. As a result, while 27 states have implemented either

the BBA or TWWIIA optional categories (or a Medicaid section 1115 research and demonstration waiver), 23 states and the District of Columbia have adopted neither. Even within states that have elected to cover these groups, there is variation in income and resource standards and methodologies and in premiums charged. As a result, identical individuals will be eligible for Medicaid in some states, but not in others, raising issues of horizontal equity (i.e., are similar individuals treated the same?). The key question is whether Americans believe that there is enough of a national interest in providing health and long-term care to working people with disabilities to mandate uniform national coverage or is the current state discretion acceptable. In the current policy environment, federal mandates are in disfavor, but it is unlikely that all (or even additional) states will adopt these eligibility options without it being made a federal requirement.[28] Many states adopted these coverage options when state coffers were full; the state fiscal crisis means that money is not available for eligibility expansions. Some states are also fearful of their fiscal liability of providing Medicaid eligibility to a potentially large population of working people with disabilities.

A different but related issue is that of equity across eligibility groups covered by Medicaid. There is substantial variation across groups in the Medicaid financial eligibility standards within states as well as across states. For example, income eligibility standards for nondisabled parents (generally covered under Temporary Assistance for Needy Families or related groups) are far below that for people who are aged, blind and disabled. For example, in order to qualify for Medicaid in the median state, a working parent can only earn 66 percent of the FPL.[29] The Medicaid work incentives add to that differential, both by setting higher income and resource standards and by using much

more liberal methodologies to calculate financial status. The expanded Medicaid eligibility for disabilities is justifiable as a way to encourage individuals to work or to return to work, but people of all incomes and disability status need health insurance coverage. The key policy question is whether it is equitable only to provide the more generous eligibility to working people with disabilities. As states consider cutting their Medicaid programs in order to balance their budgets, issues of equity across eligibility groups may become more prominent.

3. Coverage of Needed Services, Especially Home and Community-Based Services

People with disabilities need a wide range of medical and long-term care services, which states do not always cover as part of their Medicaid program. This is particularly an issue for noninstitutional long-term care services. While home health is a mandatory service, personal care services and services available under Medicaid home and community-based services waivers are optional to the states. In 1998-1999, 25 states and the District of Columbia covered personal care as an optional benefit.[30] In addition, 44 states and the District of Columbia offered personal care as part of a home and community-based services waiver; all of the remaining states offered personal care as an optional benefit as part of the regular Medicaid program. In some cases, these services may only be provided in an individual's home and not in the workplace or the community, reducing their utility for working people with disabilities.[31]

States and persons with disabilities are drawn to home and community-based services waivers, in part, because they allow Medicaid coverage of an exceptionally broad range of services, including many non-medical services not normally covered by Medicaid. Services that may be covered under the waivers include case management,

homemaker/home health aide services, personal care services, adult day health, habilitation, respite care, non-medical transportation, home modifications, adult day care, and other services approved by the Secretary of the Department of Health and Human Services. In 2003, all 50 states and the District of Columbia had a Medicaid home and community services waiver for older people and younger persons with disabilities and for persons with developmental disabilities (principally mental retardation). However, like other aspects of Medicaid, states vary in the degree to which they used waivers to fund home and community services. States may provide home and community-based services waivers to the BBA and TWWIIA coverage groups by amending an existing waiver or establishing a new one.

The waivers have three major constraints that limit their utility for working people with disabilities. First, because the waivers are intended to substitute home and community-based services for institutional care, states must limit these waiver programs to beneficiaries meeting the state's level of care criteria for nursing homes, intermediate care facilities for the mentally retarded, or hospital services.[32] For the older population and younger adults with physical disabilities, the comparison institution is almost always a nursing home. Thus, persons with disabilities who do not need that level of care, but still have significant needs, are ineligible for the waiver.

Second, a related problem affects persons with mental illness. Federal law and regulation require that average Medicaid expenditures for waiver beneficiaries must be the same or less than they would have been without the waiver. Under current regulations, this is determined by comparison to the average Medicaid costs of the relevant institutional providers. Since Medicaid does not cover "institutions for mental

diseases" (e.g., psychiatric hospitals) for persons aged 22-64, it is extremely difficult for states to meet this standard for working age persons with mental illness since there are few expenditures. As a result, there are not many waiver programs that focus on persons with this disability.

Third, home health and personal care services offered under the regular Medicaid program must be offered as an open-ended entitlement—a legal obligation on the part of government to provide services to individuals who meet pre-established criteria regardless of the cost to the government. This characteristic makes states potentially vulnerable to large expenditure increases due to increased demand by the high percentage of people with disabilities in the community who are not receiving paid services.[33] In contrast to the regular Medicaid program, home and community-based services wavers are not individual entitlements and states must limit in advance how many people they will serve during the course of a year. Since waiver programs are not entitlements, states may and do establish waiting lists and may establish programs on less than a statewide basis.[34] Thus, even in states with home and community-based services waivers, people with disabilities may not be able to access needed services.

4. Defining Disability: Inability to Work vs. Functional Impairment

Eligibility for Medicaid, including the BBA and TWWIIA provisions, is tightly linked to SSI (and SDDI) rules defining disability. Under SSI law, an individual is considered to be disabled if he or she is unable to work. As a result, there is an inherent contradiction in determining that a person is disabled (i.e., meets the SSI disability standard) while the individual is working. State disability determination agencies and SSA must use a standard intended to prove a person cannot work while ignoring the fact

that individuals are, in fact, working. These eligibility standards are contradictory and act as a work disincentive. While an inability to work standard may make sense for a program that provides a cash substitute for earned income, it is a less useful measure of need for medical and long-term care services, where functional and diagnostic measures are more commonly used to establish eligibility.

5. Interaction with Social Security Disability Insurance (SSDI) and Medicare

While Medicaid policy is dominated by its link to SSI, many people obtaining Medicaid eligibility under the BBA and TWWIIAA are SSDI beneficiaries, most of whom are eligible for Medicare. Social Security Disability Insurance (SSDI) is a federal, nonmeans-tested disability insurance program for workers who have a substantial Social Security-covered work history and have become disabled or blind before retirement age. To ease the transition off cash benefits, SSDI beneficiaries have a "trial work period" of nine months during which a person may work and continue to receive SSDI cash benefits and an "extended eligibility period" of 36 months during which a person may work, and if necessary, return to their SSDI status if employment fails without having to reapply.

SSDI beneficiaries are entitled to Medicare benefits after a two-year waiting period. SSDI beneficiaries who lose cash benefits due to increased work effort, but still have a disabling condition, are covered by Medicare for at least 93 months after they have completed the 9 month trial work period. The Medicare hospital insurance (Part A) is free, while beneficiaries have to pay the normal premium for medical insurance (Part B).

The work incentives for SSDI are different than for SSI, which raises at least three Medicaid and work effort issues. First, unlike SSI beneficiaries who have a gradual

reduction in benefits and extended eligibility for Medicaid when they have significant earnings, SSDI beneficiaries face a "cash cliff," a precipitous loss of cash assistance when they earn more than the "substantial gainful activity" level. They also face an eventual loss of Medicare benefits. As noted above, preliminary data from the case study states suggest that significant numbers of persons participating in Medicaid buy-in programs may increase their disposable incomes but are unwilling to earn more than the SGA, perhaps because their eligibility for SSDI will be jeopardized by doing so. In one study, only 14 percent of Medicaid buy-in programs had earnings over the SGA.[35] Thus, the existing rules may limit the work effort of SSDI beneficiaries who participate in the Medicaid buy-in program. To address this issue, the TWWIIA mandated a demonstration that would reduce SSDI by $1 in benefits for every $2 earned, making SSDI more like SSI in its cash work incentives.

Second, a major effect of the Medicaid buy-in program is likely to be to increase the disposable income of SSDI recipients. SSDI-only beneficiaries will be able to obtain Medicaid without having to "spend down" under the medically needy or 209(b) coverage options.[36] Without having to spend as much on medical care, the disposable income of these individuals is likely to be higher than before.

Third, in contrast to Medicaid, where an individual receives coverage so long as he or she meets the eligibility standards, the continuing Medicare coverage for working people with disabilities is time limited. Thus, in deciding whether to work and how much, SSDI beneficiaries must consider whether they believe they will ultimately be able to obtain private health insurance to replace their Medicare coverage and, if not, whether they believe they will be able to qualify for Medicaid under the buy-in or some other

pathway. For state Medicaid agencies, the end of Medicare coverage means that they will have to pay for the hospital, physician and other services that Medicare would otherwise cover, which can be expensive.

B. TWWIIA Design Issues

In addition to the broad, macro policy issues, there are a number of more technical issues affecting the Medicaid buy-in options and work incentives for people with disabilities. These include the definition of employment, the age restriction under TWWIIA, and the required premium payments.

1. Definition of Employment

As discussed above, states are prohibited from setting minimum number of hours or earnings in defining whether an individual with disabilities is employed and therefore eligible for the Medicaid buy-in options. Some state officials have expressed a concern that persons with only nominal work activity or earnings may be qualifying for Medicaid under these provisions, which they believe is inconsistent with the intent of the statute. These officials view this low level of work as problematic because the financial eligibility criteria for working people with disabilities are considerably more liberal than they are for other categories of individuals and they believe it is unfair to grant eligibility to persons who are not "really working." On the other hand, more strictly defining eligibility would eliminate medical and long-term care coverage for some individuals, who most likely would become uninsured or would reduce their work effort. In addition, some people with disabilities may need to "walk" before they can "run," and a low initial level of work effort may be part of a process which may eventually lead to a greater level of labor force involvement.

2. Age Restriction Under TWWIIA

Under TWWIIA, eligibility for the basic coverage group and the medical improvement group is limited to persons aged 16-64; there is no age restriction under the BBA group. Under the TWWIIA options, working people with disabilities who are or who become age 65 or older are ineligible for Medicaid coverage under the TWWIIA options. Thus, individuals with disabilities who are working with the aid of the Medicaid services will no longer be able to be employed until or unless they qualify for Medicaid through other eligibility categories (e.g., BBA, medically needy or poverty level coverage for persons aged 65 and older). In general, individuals will have to qualify under much stricter income and resource rules than are available under TWWIIA, and it is likely that some individuals will have to significantly deplete their resources before they can qualify. While this issue is likely to affect only a small number of people for the foreseeable future, the age restriction creates long-term disincentives for people with disabilities to return to work because they know that they may be unable to retain coverage beyond age 65. In addition, the provision limits their incentives to accumulate assets since they may have to deplete those resources to qualify for Medicaid under other coverage rules.

3. Premiums

Most states impose premiums on higher income beneficiaries participating in BBA and TWWIIA Medicaid work incentives. The rationale for doing so is to make Medicaid more like regular health insurance, where most workers have to pay a premium, and to impose some personal responsibility for health care coverage on working people

with disabilities.[37] Premiums also offset the state costs to some extent. State staff believe that the premiums are modest and that the financial requirements have not deterred program participation. However, in the case study states, it is also true that the vast majority of beneficiaries have earnings below the level for which premiums are required. It should be noted that studies of the nondisabled population have found that out-of-pocket premiums can deter people from enrolling in health insurance programs.[38] Arguably, however, health and long-term care coverage is more important to people with disabilities than people without disabilities and, therefore, cost less of an impediment to participation.

V. Conclusions

It has long been recognized that the potential loss of health benefits under Medicare and Medicaid is a deterrent to people with disabilities entering or re-entering the labor force. Although people with disabilities are generally not "sick," they often have conditions that require substantial use of medical and long-term care services. Thus, the potential consequences of loss of medical benefits can be significant and have prevented individuals on SSI and SSDI from working.

Even though there have been work incentives in Medicaid through Section 1619(b) of the Social Security Act for many years, the BBA and the TWWIIA added greatly to the ability of younger persons with disabilities to work and still retain Medicaid coverage. In general, states adopting these options have been relatively liberal in setting income and resource standards and methodologies (at least compared to regular Medicaid eligibility requirements), allowing persons with income well beyond the "significant gainful employment" level to receive Medicaid coverage. In general, state officials and

consumer advocates interviewed for the case studies in this report were satisfied with federal rules and options and did not have proposals for major changes.

An assessment of how well the incentives are working depends on whether one views the current experience as the beginning or the end of the process of integrating people with disabilities into the labor force. On the one hand, state enrollment levels are generally modest as are the earnings and work efforts of beneficiaries. Only a small minority of buy-in beneficiaries appear to be engaged in full-time employment or something close to it. Most beneficiaries appear to be working at much below the SGA level, which may indicate a fear of loosing cash benefits, especially SSDI payments.

On the other hand, states and people with disabilities are just beginning to gain experience with the TWWIIA work incentives and with an overall change in attitudes towards work by people with disabilities and by society as a whole. State respondents emphasized that the Medicaid eligibility expansions in many states have been in place for less than 18 months and are just beginning to mature. Moreover, there may be a generational divide in attitudes towards work between people who have been on SSI or SSDI for long periods of time and persons who are just coming on the rolls.

The interaction between Medicaid and work incentives have raised a number of broad policy issues:

- Almost all states are experiencing severe budget shortfalls. In order to close these gaps, they are almost certain to cut Medicaid. While the Medicaid buy-in programs appear to be protected for the short-term, a major consideration is whether states will require additional federal revenues in order to retain current coverage, let alone to expand it.

- While about half of the states have adopted either the BBA or TWWIIA provisions, half have not. Because the work incentive coverage provisions are not mandatory, it seems unlikely, especially in the current fiscal environment, that all states will cover these Medicaid eligibility options unless required to do so or receive significant

additional funding. This state variation raises questions of horizontal equity across the states.

- An issue similar to the coverage of eligibility groups concerns the coverage of services needed by persons with disabilities. States have broad discretion in what services they cover. Some states cover a lot; others cover relatively little. This again raises questions of horizontal equity.

- For work incentives programs, there is a fundamental inconsistency in measuring disability by an inability to work. Inability to work has a logical relationship to cash benefits, but it does not distinguish who most needs medical and long-term care benefits. A more functional definition of disability might do a better job of identifying people who most need these services, without pushing individuals to stop working.

- While Medicaid has the most experience interacting with SSI, Medicaid involvement with SSDI and Medicare is also consequential for work incentives. It would appear that the abrupt ending of SSDI cash benefits when earnings reach a specific level has a deterrent effect on the amount of work in which beneficiaries are willing to engage under the Medicaid options. Advocates of change would like SSDI to be closer to the SSI model of gradual loss of cash benefits, while opponents contend that doing so could be costly.

As policymakers review the experience with BBA and TWWIIA Medicaid options, there are also a number of specific issues that should be considered.

- While states are not actively seeking to trim persons from the rolls, many observers noted that the minimum level of employment for the basic coverage group was so low that it ended up including a significant proportion of people who did not have "real jobs." Advocates of tightening the definition of employment contend that coverage of persons with minor levels of employment is inconsistent with the goals of the program and unfair to other groups who do not enjoy such generous Medicaid eligibility criteria. On the other hand, opponents of tightening the definition of employment argue that many persons may need to start employment slowly before they are able to work more extensively.

- Under the TWWIIA eligibility options, Medicaid coverage cannot be offered to persons age 65 or older. Advocates of eliminating the restriction contend that society needs to encourage older people to work. Opponents note that people generally do not work after age 65 and that Medicaid has numerous other eligibility options for older people, albeit not as generous as those offered under TWWIIA.

- Most states impose premiums on higher-income Medicaid beneficiaries who are eligible under BBA and TWWIIA. To some observers, it is only fair that higher

income beneficiaries help contribute to the cost of their care. However, some policy analysts worry that the premiums are a barrier to participation.

People with disabilities are increasingly entering the workforce as people with disabilities demand new opportunities and society changes its conceptions about what persons with disabilities can and should do. A key component of helping working people with disabilities is providing the health and long-term care services that they need. Federal Medicaid law sets a framework to help people work, but that structure has not yet resulted in a large movement from SSI and SSDI to work.

Endnotes

[1] Congressional Budget Office, "Fact Sheet for CBO's March 2003 Baselines: Medicaid and State Children's Health Insurance Program," (Washington, DC: Congressional Budget Office, March 2003).

[2] Kaiser Family Foundation, "Medicaid's Role for the Disabled Population Under Age 65," (Washington, DC: Kaiser Family Foundation, 2001).

[3] Chad Newcomb, Suzanne Payne, and Mikki Waid, "What Do We Know About Disability Beneficiaries' Work and Use of Work Incentives Prior to Ticket," in Kalman Rupp and Stephen H. Bell, *Paying for Results in Vocational Rehabilitation*, (Washington, DC: The Urban Institute, 2003), pp. 31-69.

[4] Enrollment estimates from Congressional Budget Office, *op. cit.*; expenditure estimates from the Urban Institute (unpublished), based on data from the Centers for Medicare and Medicaid Services (Form 64).

[5] The U.S. Territories (American Samoa, Guam, Northern Mariana Islands and U.S. Virgin Islands) and the Commonwealth of Puerto Rico are not included in this analysis.

[6] Congressional Budget Office, *op. cit.*

[7] Author's calculations based on Congressional Budget Office data.

[8] Kaiser Family Foundation, "Medicaid's Role for the Disabled Population Under Age 65," (Washington, DC: Kaiser Family Foundation, 2001).

[9] Centers for Medicare & Medicaid Services, *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Income and Resources: Questions and Answers*, May 11, 2001, available at: http://cms.hhs.gov/medicaid/eligiblity/elig0501.pdf., accessed February 11, 2003.

[10] 42 U.S.C. 1396a(a)(10)(A)(i)(II); 42 U.S.C. 1396v(a)(2).

[11] The provisions in federal law [42 U.S.C. 1396a(a)(10)(E)(ii)] authorizing premium assistance up to 135% of the FPL (the QI-1 program) and 175% of the FPL (the QI-2 program) expired on December 31, 2002. Congress extended the QI-1 program as part of an Omnibus appropriations act passed in January 2003 (P.L. 108-7). At the time of this writing, legislative staffers believe that the QI-1 program likely will be reauthorized for five years sometime during the 108th Congress. The QI-2 program was allowed to expire at the end of 2002 and is unlikely to be reauthorized.

[12] Ellen O'Brien and Diane Rowland, *Medicare and Medicaid for the Elderly and Disabled Poor*, (Kaiser Family Foundation, 1999).

[13] 42 U.S.C. 1396a(a)(10)(E)(i) and 1396a(a)(10)(E)(iii); states are required to pay only premiums (not deductibles and co-payments) for those individuals between 100 and 120 percent of the FPL.

[14] 42 U.S.C. 1382c(3).

[15] The substantial gainful activity level for 2003 is $1,330 per month for blind individuals.

[16] 20 CFR 416.1201 to 416.1266 (Subpart L).

[17] 42 U.S.C 1382h(b); 42 U.S.C. 1396d(q).

[18] Julie Scales, Donna Folkemer and Alan Jensen, *Ticket to Work: Medicaid Buy-In Options for Working People with Disabilities,* (Washington, DC: National Conference of State Legislatures, undated), available at http://204.131.235.67/programs/health/Forum/tickettowork.htm.

[19] Chad Newcomb, Suzanne Payne, and Mikki D. Waid, "What Do We Know About Disability Beneficiaries Work and Use of Work Incentives Prior to Ticket?," *Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work?,* Kalman Rupp and Stephen H. Bell, editors, (Washington, DC: The Urban Institute, 2003), pp. 31-69.

[20] Ibid, p. 46.

[21] Unpublished data, Centers for Medicare & Medicaid Services.

[22] Center for Workers with Disabilities, *Working for Tomorrow,* (Washington, DC: Center for Workers with Disabilities, July/August 2001).

[23] Greg Von Brehen and Nick Samuels, "The Fiscal Survey of States, November 2002," (Washington, DC: National Association of State Budget Officers, 2002); National Governors' Association, "Governors to Meet with President, Cabinet Officials and Congressional Leaders During NGA Winter Meeting," February 22, 2003, available at: http://www.nga.org/nga/newsRoom/1,1169,C_PRESS_RELEASE^D_5079,00.html.

[24] NGA, ibid.

[25] National Association of State Budget Officers, "NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal 2003," (Washington, DC: National Association of State Budget Officers, 2002).

[26] Vernon Smith, Kathy Gifford, Rekha Ramesh and Victoria Wachino, *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003,* (Washington, DC: Kaiser Family Foundation, 2003); and, John Holahan, Joshua M. Wiener, Randall R. Bovbjerg,

Barbara A. Ormond and Stephen Zuckerman, *The State Fiscal Crisis and Medicaid: Will Health Programs Be Major Budget Targets?* (Washington, DC: Kaiser Family Foundation, 2003).

[27] John Holahan, Alan Weil and Joshua M. Wiener, editors, *Health Policy and Federalism,* (Washington, DC: The Urban Institute, in press).

[28] National Association of State Budget Officers, *NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal Year 2003,* (Washington, DC: National Association of State Budget Officers, 2002); Holahan et al., op. cit.; and, Smith et al., op. cit.

[29] Matthew Broaddus, Shannon Blaney, Annie Dude, Jocelyn Guyer, Leighton Ku, and Jaia Peterson, *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000,* (Washington, DC: Center on Budget and Policy Priorities, 2002).

[30] Allen J. LeBlanc, M. Christine Tonner and Charlene Harrington, "State Medicaid Programs Offering Personal Care Services," *Health Care Financing Review,* 22(4): 155-73, 2001.

[31] Joshua M. Wiener, Jane Tilly and Lisa Maria B. Alecxih, "Home and Community-Based Services for Older Persons and Younger Adults with Disabilities in Seven States," *Health Care Financing Review,* 23(3): 89-114, 2002.

[32] Janet O'Keeffe Janet, *Determining the Need for Long-Term Care Services: An Analysis of Health and Functional Eligibility Criteria in Medicaid Home and Community Based Waiver Programs*, (Washington, DC: AARP, 1996); and, Janet O'Keeffe, *People with Dementia: Can They Meet Medicaid Level-of-Care Criteria for Admission to Nursing Homes and Home and Community-Based Waiver Programs*? (Washington, DC: AARP, 1999).

[32] Pat Johnson, "Issue Brief on Medicaid Provider Reimbursement," National Conference of State Legislatures.http://www.hpts.org/hpts97/issueb2001.nsf., 2000, accessed January 30, 2001.

[33] Liu, Korbin, Kenneth G. Manton, and Cynthia Aragon, "Changes in Home Care Use by Disabled Elderly Persons: 1982-1994," *Journal of Gerontology:Social Sciences,* 55B(4):S245-S253, 2000.

[34] Joshua M. Wiener, Jane Tilly and Lisa Maria B. Alecxih, "Home and Community-Based Services for Older Persons and Younger Adults with Disabilities in Seven States," *Health Care Financing Review,* 23(3): 89-114, 2002; and, Allen J. LeBlanc, M. Christine Tonner, and Charlene Harrington, "Medicaid 1915(c) Home and Community-Based Services Waivers Across the States," *Health Care Financing Review,* 22(2): 159-174, 2000.

[35] Donna Folkemer, Allen Jensen, Robert Silverstein, and Tara Straw, *The Medicaid Buy-In Program: Lessons Learned from Nine "Early Implementer" States*, (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2002), available at: http://aspe.hhs.gov/daltcp/reports/EIlesson.htm.

[36] The medically needy option allows states to set slightly higher income limits—called the medically needy income level (MNIL)—than were allowed under the Aid to Families with Dependent Children (AFDC) program. In addition to meeting the income standard, individuals can also qualify under the medically needy option by incurring out-of-pocket medical expenses that, when subtracted from regular income, put them below the MNIL, a process known as "spending down," or depleting their incomes paying for medical care. In addition, as a condition of electing to use more restrictive eligibility criteria, states using the section 209(b) option also must allow applicants to qualify for Medicaid by "spending down." These mechanisms make it possible for applicants with incomes that are too high to qualify for Medicaid, but who have significant medical expenses, to become eligible by deducting incurred medical expenses from their incomes.

[37] Larry Levitt, Erin Holve, and Jain Wang, "Employer Health Benefits: 2001 Annual Survey," (Menlo Park, CA and Chicago: Kaiser Family Foundation and Health Research and Educational Trust, 2001).

[38] Leighton Ku and Teresa A. Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, 36(4): 471-80, 1999-2000; M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-group Market," *Journal of Health Economics*, 14(1): 47-63, 1995; and, Peter J. Cunningham, Elizabeth Schaefer, Christopher Hogan, "Who Declines Employer-Sponsored Health Insurance and is Uninsured?" *Issue Brief 22*, (Washington, DC: Center for Studying Health Systems Change, 1999); Elizabeth Shenkman, Donna Hope Wegener, Jane Pendergast, and Traci Hartzel, *Premium Subsidies and 'Adverse Retention' in a Children's Managed Care Program*, (Gainesville, FL: Institute for Child Health Policy, 1996).

Table 1: Overview of Common Medicaid Eligibility Pathways

Mandatory Coverage	**Eligibility Criteria**	
	Income Test	**Resource Test**
SSI Recipients[1]	? $552/mo. for individual, ? $829/mo. for couple; earnings may not exceed $800/mo.	? $2,000 for individual, ? $3,000 for couple
Individuals in 209(b) states	State sets income standard; individuals may spend down to qualify by deducting incurred medical expenses from income.	State sets resource standard; individuals may not "spend down" or dispose of resources to qualify.
Certain individuals who lose SSI[2]	Would meet SSI standard but for increase other benefits.	Same as SSI.
Qualified severely impaired individuals	But for earnings, income under SSI level; earnings may not exceed state-specific thresholds.[3]	Same as SSI.
Optional Coverage	**Eligibility Criteria**	
	Income Test	**Resource Test**
Medically needy[4]	State sets income standard; individuals may spend down to qualify by deducting incurred medical expenses from income.	State sets resource standard; individuals may not "spend down" or dispose of resources to qualify.
Individuals receiving state supplemental payments[4]	State sets income standard.	Same as SSI.
Poverty-level individuals age 65 or older[4]	Up to 100% of FPL.	Same as SSI.
Institutionalized individuals under special income level	Income standard no higher than 300% of SSI benefit.	Same as SSI.
Individuals receiving home- and community-based services	Would be eligible if institutionalized (though not all states apply the special income rule to home- and community-based services).	Would be eligible if institutionalized.
Working disabled under 250 percent of poverty, BBA rules[4]	But for earnings, would be eligible for Medicaid as qualified severely impaired individuals; family income ? 250% of FPL. All earned income from the beneficiary is disregarded.	Same as SSI.
Working disabled, TWIIAA rules[4]	But for earnings, would be eligible for Medicaid as qualified severely impaired individuals; any income level chosen by the state.	Any resource level chosen by the state.
Partial Coverage for Medicare Beneficiaries	**Eligibility Criteria**	
	Income Test	**Resource Test**
Assistance with Medicare premiums and cost-sharing	Standards range from ? 100% of FPL up to 135% of FPL for most beneficiaries; ? 200% of FPL for Qualified Disabled Working Individuals	? $4,000 for individual, ? $6,000 for couple

1) Does not include $20 per month income disregard.

2) This category includes individuals who lose SSI due to Social Security cost-of-living increases; disabled widows and widowers who lost SSI due to an increase disability benefits from the Social Security Amendments of 1983 (P.L. 98-21), and individuals who would lose SSI as a result of receiving child's, early widow's or early widower's benefits under Social Security.

3) The Social Security Administration publishes state-specific income thresholds above which these individuals are no longer eligible for Medicaid because it is assumed they can buy "reasonably equivalent" coverage.

4) Section 1902(r)(2) of the Social Security Act allows states to use "less restrictive" income and resource methodologies for these pathways.

Table 2: 1619(b) Thresholds by State, 2003

Persons with Disabilities

Alabama:	$17,348.00
Alaska:	$36,310.00
Arizona:	$21,586.00
Arkansas:	$20,682.00
California:	$26,837.00
Colorado:	$30,728.00
Connecticut:	$39,727.00
Delaware:	$24,654.00
District of Columbia:	$31,765.00
Florida:	$20,234.00
Georgia:	$19,555.00
Hawaii:	$20,886.00
Idaho:	$25,162.00
Illinois:	$26,001.00
Indiana:	$28,346.00
Iowa:	$21,146.00
Kansas:	$25,546.00
Kentucky:	$21,307.00
Louisiana:	$20,762.00
Maine:	$22,454.00
Maryland:	$25,205.00
Massachusetts:	$28,766.00
Michigan:	$22,265.00
Minnesota:	$31,389.00
Mississippi:	$19,575.00
Missouri:	$25,559.00
Montana:	$20,537.00
Nebraska:	$25,303.00
Nevada:	$29,067.00
New Hampshire:	$41,514.00
New Jersey:	$27,144.00
New Mexico:	$22,785.00
New York:	$34,136.00
North Carolina:	$25,795.00
North Dakota:	$28,410.00
Ohio:	$26,424.00
Oklahoma:	$21,200.00
Oregon:	$25,508.00
Pennsylvania:	$21,796.00
Rhode Island:	$31,632.00
South Carolina:	$21,591.00

South Dakota:	$24,977.00
Tennessee:	$17,787.00
Texas:	$22,452.00
Utah:	$19,612.00
Vermont:	$23,756.00
Virginia:	$21,778.00
Washington:	$20,345.00
West Virginia:	$20,862.00
Wisconsin:	$23,151.00
Wyoming:	$18,990.00
North Mariana Island:	$14,268.00

Blind

California:	$28,325.00
Iowa:	$21,674.00
Massachusetts:	$29,615.00
Nevada:	$31,690.00
Oregon:	$26,108.00

Source: Social Security Administration.

Table 3: Basic Rules of Medicaid Work Incentives Under Balanced Budget Act and Ticket to Work and Work Incentives Improvement Act of 1999

	BBA	TWWIIA Basic Coverage Group	TWWIIA Medical Improvement Group
Who Can Be Covered?	Disabled individuals	Disabled individuals age 16 through 64	Employed individuals with a medically determinable severe impairment who lose eligibility under the XV group because they are no longer disabled.
Income standard	**1.** 250 percent of the Federal poverty level for family. **2.** If (1) is met, the applicant's unearned income is less than SSI FBR (currently $512 a month for an individual, $769 for a couple). All earned income is disregarded.	State establishes its own standard. All earned income disregarded. State can choose not to have an income standard.	State establishes its own standard. All earned income disregarded. State can choose not to have an income standard.
Resource standard	SSI resource standard ($2,000 for individual, $3,000 for couple).	State establishes its own standard. State can choose not to have a resource standard.	State establishes its own standard. State can choose not to have a resource standard.
Rules for determining eligibility	SSI rules and methodologies	If State establishes income and/or resource standards, SSI rules and methodologies apply. If State chooses not to establish income and resource standards, no rules or methodologies apply.	If State establishes income and/or resource standards, SSI rules and methodologies apply. If State chooses not to establish income and resource standards, no rules or methodologies apply.
Use of more restrictive eligibility rules than SSI (209(b) States)	Yes	Yes	Yes
Use of more liberal income and resource methodologies than SSI (section	Yes. States can disregard additional income (earned or unearned) and/or	Yes. States that establish an income and/or resource standard can disregard additional income and/or	Yes. States that establish an income and/or resource standard can disregard additional income and/or

	BBA	**TWWIIA** **Basic Coverage Group**	**TWWIIA Medical Improvement Group**
1902(r)(2)).	resources in either/both the 250 percent family income test and the individual eligibility determination. States can disregard all income and resources if they choose to do so. FFP limits do not apply to income disregards.	resources if they choose to do so. FFP limits do not apply to income disregards.	resources if they choose to do so. FFP limits do not apply to income disregards.
Premiums and cost-sharing charges	States may require payment of premiums and other cost-sharing charges on a sliding scale based on income. States are not required to collect premiums or cost-sharing charges.	**1.** States may (but are not required to) require payment of premiums and other cost-sharing charges on a sliding scale based on income. **2.** For individuals with income over 250percent of the poverty level, States may (but are not required to) charge 100 percent of premiums. If the State chooses to charge100 percent of premiums for these individuals, there is a limit on the total amount of premiums of 7.5 percent of their income if their income is less than 450 percent of the poverty level. **3.** States must charge 100 percent of premiums for any individual whose adjusted gross annual income (as defined under IRS rules) exceeds $75,000.	**1.** States may (but are not required to) require payment of premiums and other cost-sharing charges on a sliding scale based on income. **2.** For individuals with income over 250percent of the poverty level, States may (but are not required to) charge 100 percent of premiums. If the State chooses to charge100 percent of premiums for these individuals, there is a limit on the total amount of premiums of 7.5 percent of their income if their income is less than 450 percent of the poverty level. **3.** States must charge 100 percent of premiums for any individual whose adjusted gross annual income (as defined under IRS rules) exceeds $75,000.

	BBA	TWWIIA Basic Coverage Group	TWWIIA Medical Improvement Group
		This requirement applies regardless of whether a State charges premiums and cost-sharing under (1) or (2) above.	This requirement applies regardless of whether a State charges premiums and cost-sharing under (1) or (2) above.
Maintenance of effort - States must demonstrate that they are maintaining funding for programs (other than Medicaid) to assist disabled individuals who want to work.	No requirement	Required	Required

Source: Centers for Medicare & Medicaid Services, http://cms.hhs.gov/twwiaa/comchart.asp, accessed January 6, 2003.

Table 4: Medicaid Buy-In Policies and Enrollments as of June 30, 2002						
State	**Type**	**Effective Date**	**Date of 1st Enrollment**	**June 30,2002 Enrollment**	**Income Disregards and Policies**	**Resource Disregards and Policies**
Alaska	BBA 1997	04/01/99	07/01/99	143	Payments received from the Alaska Longevity Bonus Program are disregarded to the extent the payment does not cause total gross income to exceed 300 percent of the SSI FBR. All earned income of a spouse or other family member of the disabled individual is excluded.	Up to $2,000 per individual per year in distributions from Alaska Native Claims Settlement Act corporations is excluded. Dividends and benefit payments from the Alaska Permanent Fund Dividend Program are excluded.
Arkansas	TWWIIA Basic Coverage	02/01/01	N/A	70	An applicant's income cannot exceed 250% of the federal poverty level for a family.	$10,000 in savings for special purposes are disregarded that is approved by Human Services. Countable assets may be increase up to $6000 for an individual and up to $6400 for a family of four.
California	BBA 1997	04/01/01	N/A	500	All disability income of the disabled individual is disregarded (e.g., federal and state disability income and private disability income such as indemnity payment from an insurance company based on the individual's disability.)	There are no resource disregards.
Connecticut	TWWIIA Basic Coverage /Medical Improvement	10/01/00	10/01/00	2,306	An applicant's yearly income must be less than $75,000 per year. Assets of $10,000 for and individual and $15,000 for a couple are disregarded.	An individual's retirement accounts, Medical savings accounts and employability accounts are all disregarded.
Florida	TWWIIA Basic Coverage	04/01/02	N/A	*	No Info on CMS website.	
Illinois	TWWIIA Basic Coverage	12/01/01	N/A	82	No Info on CMS website.	
Indiana	TWWIIA Basic Coverage/ Medical Improvement	07/01/02	N/A	*	No Info on CMS website.	
Iowa	BBA 1997	03/01/00	03/01/00	4,092	In order to be eligible, an applicant's income cannot exceed 250% of the federal poverty limit. Unearned income is disregarded	A resource disregard of $12,000 applies to individuals and a disregard of $13,000 applies to couples. Medical savings accounts are allowable if they are IRS exempt. Retirement and Assistive technology savings accounts are disregarded.

State	Type	Effective Date	Date of 1st Enrollment	June 30,2002 Enrollment	Income Disregards and Policies	Resource Disregards and Policies
Kansas	TWWIIA Basic Coverage	07/01/02	N/A	*	Coverage group: Working individuals with disabilities, ages 16-64. Family incomes up to 300 percent of the federal poverty level.	Assets of up to $15,000
Maine	BBA 1997	08/01/99	08/01/99	755	Disregard unearned income exceeding the SSI/SSP income standard that is up to and including 100 percent of the FPL.	Disregard all assets less than $8,000 for an individual or $12,000 for a couple.
Massachusetts	1115 Waiver	07/01/97	N/A	6,227	No Info on CMS website.	
Minnesota	TWWIIA Basic Coverage**	07/01/99	07/01/99	5,840	The state will offer Medicaid to anyone working with a disability age 18 through 64 with family income up to 250 percent of the federal poverty level (FPL).	Allowable resources up to $20,000 for an individual.
Mississippi	BBA 1997	07/01/99	N/A	345	In order to be eligible, an applicant's income cannot exceed 250$ of the federal poverty limit	A resource disregard of $4,000 applies to individuals and a disregard of $6,000 applies to couples. Retirement accounts are disregarded if they are through an employer
Missouri	TWWIIA Basic Coverage/ Medical Improvement	07/01/02	N/A	*	No Info on CMS website.	
Nebraska	BBA 1997	06/06/00	07/01/99	88	In determining eligibility under the individual income test, disregard all earnings, plus unearned income contingent upon a trial work period (such as a Social Security Trial Work Period).	Disregard an additional $2,000 in resources for an individual and an additional $3,000 in resources for a couple.
New Hampshire	TWWIIA Basic Coverage	02/01/02	02/01/02	640	The state will offer Medicaid to anyone working with a disability age 18 through 64 with a family income up to 450 percent of the federal poverty level (FPL).	Allowable resources up to $20,000 for an individual and $30,000 for a couple.
New Jersey	TWWIIA Basic Coverage	10/01/00	N/A	405		
New Mexico	BBA 1997	01/01/01	01/01/01	621	An applicant's yearly income must be less than 250% of the federal poverty limit.	An individual's retirement accounts are disregarded

State	Type	Effective Date	Date of 1st Enrollment	June 30,2002 Enrollment	Income Disregards and Policies	Resource Disregards and Policies
Vermont	BBA 1997	10/01/00	01/01/00	365	An applicant's yearly income must be less than 250% of the federal poverty limit.	Disregard and additional $12,000 in resources. An 'earnings for working' savings account can be established. This money and interest are disregarded.
Washington	TWWIIA Basic Coverage	01/01/02	N/A	*	The state will offer Medicaid to anyone working with a disability age 18 through 64 with countable income up to 220 percent of the federal poverty level.	
Wisconsin	BBA 1997	03/15/00	N/A	2,660	All of the applicant's unearned income, and any unearned income deemed available from an ineligible spouse, is disregarded in determining whether the 250 percent of the federal poverty income test is met.	$13,000 in resources is excluded. Resources of an ineligible spouse are excluded. Funds held in an Independent Account are excluded. 1) Only deposits made after the individual is eligible for Medicaid under the BBA group are excluded. 2) Deposits cannot exceed 50 percent of earned income in any calendar year. 3) Accounts must be separate from non-exempt resources and are subject to prior approval by the State. 4) Amounts deposited and all gains, dividends and interest earned in an employer's retirement fund and an individual's IRA account after becoming eligible for Medicaid qualify as part of an Independence Account if properly registered with the State.
Wyoming	TWWIIA Basic Coverage	N/A	N/A	*	Working Individuals with a disability ages 16-64 with incomes up to 100% of the Federal Poverty Level (FPL)	
Total				27,209		
*State was not actively enrolling on 6/30/02						
** Initially approved under BBA 1997						
Source: Centers for Medicare and Medicaid Services.						

Table 5: Demonstration to Maintain Independence

State	Population	Proposed Enrollment
District of Columbia	HIV/AIDS	500
Mississippi	HIV/AIDS	500
Rhode Island	Multiple Sclerosis	100
Texas	Bi-polar/Schizophrenia	500

Source: Centers for Medicare and Medicaid Services.

Appendix 1: Demonstration and Infrastructure Grant Activities Related to TWWIIA
State Program Descriptions

State	Agency	Medicaid Buy-in Activities	Medicaid Services Improvements
Alaska	Governor's Council on Disabilities and Special Education	· Assess why people do not join the Medicaid buy-in. · Assess the impact and cost-effectiveness of covering the medically improved. · Conduct outreach to people with disabilities, service providers, employers and state and federal agencies about the Medicaid buy-in and personal assistance services.	· Training and technical assistance for staff members on the buy-in, personal assistance services and TWWIIA. · Link job center staff and the Adult Public Assistance staff through co-location, outreach and electronic resources. · Work with trade associations, training programs, and planning and advocacy groups to disseminate information about infrastructure improvements. · Build the capacity of personal assistance service providers. · Change independent personal assistance services programs to self-directed approach.
Alabama	Alabama Medicaid Agency	· Exercise BBA Medicaid coverage option for income below 250% FPL. · Design program to people who have a potentially severe physical impairment. · Design a Medicaid buy-in for the eligibility groups described in section 1902 (a)(10)(A)(ii)(XIII)(XV)(XVI) of the Social Security Act.	· Create a workgroup of individuals with disabilities, consumer and advocacy groups, potential employers, and other stakeholders. · Through the Homeward Bound Waiver Services, provide personal assistance service benefits for daily living on and off the job. · Assist in identifying solutions to problems related to employed disabled individuals in integrated working environments. · Hold public forums with employers describing outcomes that encourage the employment of disabled individuals in integrated work settings. · Educate disabled individuals and the general public about the TWWIIA provisions and how they are being utilized in Alabama. · Develop a focus group of disabled working individuals to identify services needed to maintain employment.
California	Department of Health Services	· Conduct outreach to individuals with disabilities and provide training for consumers, employers, service providers and State and local agency staff on the California Working Disabled program and other work incentives and employment supports.	· Create a project steering committee to oversee the Health Incentive Improvement Project · Evaluate the adequacy of personal assistance services to support competitive employment. The project will authorize Medicaid services to be used in the workplace.
Colorado	Department of Health Care Policy and Financing	· Plan and implement a Medicaid Buy-In program. · Appoint a Medicaid Buy-In ombudsman.	· Improve personal assistance services. · Train staff professionals about work-incentive programs. · Conduct outreach and training for disability community on work incentives.

Connecticut	Department of Health and Human Services	· Conduct outreach. · Report on status of Medicaid buy-in program, including utilization data.	· Explore the programmatic and fiscal impact of expanding personal assistance services within Medicaid waiver program and state plan to individuals who have chronic mental illness, mental retardation, or developmental disabilities. · Explore options for developing a competent, flexible, culturally sensitive, adequately compensated long-term care workforce. · Establish Connect to Work Center at the Department of Social Services to research and evaluate mechanisms to increase competitive employment. · Train individuals and agency staff on services and programs. · Explore methods of peer support networks and benefit counseling.
Delaware	Health and Social Services	· Assess the need for recruitment and retention strategies for the buy-in and develop elements for a buy-in program.	· Analyze agency policy to determine personal assistance services related disincentives to employment and ways to extend PAS benefits. · Design a service delivery system around consumer needs. · Develop an emergency back-up system of qualified attendants. · Form an Infrastructure Advisory Committee to examine safety and medical issues and solutions.
District of Columbia	Medical Assistance Administration	· Design a Medicaid buy-in program that includes broad range of needed services. · Assess a range of options for the implementation of a buy-in program.	· Establish a leadership council to develop an integrated system for disabled residents to access care and services under the Medicaid program. · Develop informational materials. · Expand personal assistance services that are provided under the State plan to include services provided outside the home. · Amend existing Elderly Waiver to include the under 65 years of age population. · Analyze data related to persons with disabilities in need of personal assistance services and supports that would enable them to work. · Develop strategy to collect and monitor the number of disabled residents willing and able to work.
	*Medical Assistance Administration	· Expand Medicaid for demonstration-eligible District residents with HIV. · Assess the effectiveness of an "early intervention" Medicaid model in maintaining the health and well-being. . Evaluate the feasibility of wider implementation of early intervention model for persons with other potentially disabling conditions.	

Georgia	Department of Community Health	· Design a Medicaid buy-in for the working disabled.	· Survey potential workers for their knowledge and satisfaction of the current work incentives. · Design outreach and training programs using a peer support model. · Determine how frequently current Medicaid Waiver recipients use personal support services for employment. · Survey Medicaid Waiver recipients to assess desire for employment. · Analyze agency policies to determine disincentives to employment. · Amend policies to offer providers greater incentives for employment outcomes. · Develop incentives for providers to use waiver-funded personal support services for employment. · Conduct focus groups to determine the effectiveness of the current personal assistance services provided. · Create a jobs hot line, peer support networks, and marketing material. · Design and develop a data base to track outcomes for workers. · Expand personal assistance services through a State plan amendment..
Idaho	Department of Health and Welfare	· Hire and train benefit representatives. · Develop, design and seek legislative approval for a Medicaid buy-in program with wrap-around coverage. · Create steering committees, public input forums, and educational materials. · Enhance Medicaid data systems to track, report and evaluate individuals in the Basic Coverage Group.	· Issue State Plan and HCBS Waiver Amendments to increase the availability of personal assistance services. · Bring together a steering committee to address transportation. · Strengthen inter-agency and intra-governmental cooperation. · Hold employer symposiums statewide to discuss concerns/issues. Disabilities.
Illinois	Department of *Public Aid	· Enable persons with disabilities to buy into Medicaid coverage. · Design and implement a Medicaid buy-in administrative process. · Design and implement an educational and informational dissemination system.	
Iowa	Department of Human Services	· Assure that the State's Medicaid Buy-in program is efficient and accessible.	· Add personal care as an option under the State Medicaid Plan. · Revise the State's waiver to be more supportive of people with disabilities who are working.

Kansas	Department of Social and Rehabilitation Services	· Design, develop, and seek legislative approval for a Medicaid buy-in program. · Provide personal assistance services within the State plan.	· Draft person/family of choice centered standards for a wrap-around service approach and a voucher program that allows the consumer to purchase services. . Initiate advisory and interagency groups to help aid in policy development. · Initiate communication with private sector employers. · Design a software program for managing premium collection and necessary changes in the State's information systems.
Louisiana	Department of Health and Hospitals	· Review the feasibility and fiscal impact of a Medicaid Buy-in program, in order to seek legislative approval. · Identify infrastructure improvements/modifications needed to support a Medicaid Buy-in program.. · Design a system for managing premium billings and collections. · Enhance information systems to track key enrollee data, evaluate outcomes and impact of the buy-in.	· Create advisory groups to assist in the development, delivery and modification of Medicaid benefits and services needed. · Develop informational materials on services and supports. · Provide outreach and training about TWWIIA Medicaid provisions.
Maine	Medicaid Buy-In Activities	· Improve existing Medicaid buy-in program. · Conduct survey of (1) workers with disabilities participating in Medicaid buy-in program, (2) workers with disabilities not participating in the buy-in program, and (3) SSDI beneficiaries whose earned income is too high to qualify for buy-in program. · Expand Medicaid Buy-In Advisory Group.	· Review long-term care assessment tool to ensure that it captures the service needs of employed persons. · Conduct time study of people with disabilities who work, or are likely to work, to gain greater understanding about service needs. · Implement an action plan to increase consumer participation via the Internet. · Disseminate information.. · Conduct key informant interviews with employers. · Coordinate outreach with SSA.
Massachusetts	*Division of Medical Assistance	. Conduct evaluation and research projects of the Medicaid buy-in program. . Evaluate the advantages and disadvantages of continuing the CommonHealth program as it is versus taking advantage of Medicaid buy-in options. . Assess the impact of the health care services on participants' ability to seek and sustain competitive employment .	

Minnesota	Department of Human Services	· Evaluate the personal outcomes, funding impacts, and the integrated database of the Medicaid buy-in option. · Create a web-based tool kit for potential users and buy-in recipients	· Revamp the State Medicaid website and establish a disability phone link to enhance employment -related information resources. · Issue mini-grants to local organizations to train them on incorporating consumer assistance activities into web technologies. · Develop in-person and web-based training materials, and conduct training and other educational opportunities. · Identify, develop, and implement a strategic outreach plan to educate employers on accommodations and assistive technologies. · Interact with the business community and grantees of local infrastructure grants to address assistive technology devices and services. · Train local workers, consumers, job counselors, case managers, businesses, and vocational counselors on work incentives
Mississippi	*Division of Medicaid	. Use the grant award, in conjunction with State funds, to cover 500 persons with a diagnosis of HIV/AIDS who work. . Offer full Medicaid benefits and services as well as case management to the demonstration participants . Implement the project in nine counties in the Mississippi Delta. . Measure the participants' reliance on cash benefits, employment status, changes in health status, and quality of life.	
Missouri	Department of Social Services	· Research potential costs of a Medicaid buy-in. · Develop the legislation and fiscal note [justification] for a Medicaid Buy-in option.	· Develop training material and resources for consumers and others. · Build a resource base, which directs information to employers regarding available supports for persons with disabilities. · Develop a workgroup of persons to remove/reduce barriers to employment. · Assure the system meets the needs of consumers through use of consumers as advocates and by conducting focus groups and surveys. · Develop a report of "lessons learned" based on Missouri's experience.
Nebraska	Department of Health and Human Services	· Improve the Medicaid Buy-in program.	· Develop and actively utilize the information capacity of the Nebraska's Statewide Consumer Network. · Undertake a goal-setting process. · Improve the provision of personal assistance services. · Improve services for youth transitioning to work. · Improve integration with existing employment services and other programs. · Improve communication to stakeholders about the opportunities for competitive employment. · Investigate improvement to State's internal capabilities to manage data.

Nevada	Department of Human Resources	· Analyze the cost effectiveness of a Medicaid buy-in. · Hire and train staff and form an advisory board to review other state's buy-in structures. · Develop a request for including the buy-in program into the Executive budget. · Design and develop the buy-in program. · Establish a strategy for consumer/provider involvement in educating key legislators. · Make computer programming changes to fully implement buy-in enrollment. · Formalize partnerships needed to implement outreach, referral/information, service delivery, case management, and early intervention. · Provide education on Medicaid guidelines, eligibility, buy-in process, procedures and access. . Improve Medicaid services.	· Provide Personal Assistance Services provider education and workplace assistance training. · Develop and distribute pamphlets, brochures, and other informational materials on available Medicaid programs.
New Hampshire	Department of Health and Human Services	· Complete the design for the Medicaid buy-in program, get legislative authorization and implement the program. . Support One-Stop Centers so that they can counsel people with disabilities about the buy-in program. . Contribute the presence of a health insurance expert at each One-Stop location. . Develop system for premium billing and collection services, including tracking premium data. . Make improvements to facilitate personal assistance services for consumers.	· Develop rules to implement new personal assistance services legislation and provide seed money to local communities to create the infrastructure, including intermediary functions, to support enhanced personal assistance services with a consumer-directed option. · Provide supports to consumers that will allow them to participate fully in all aspects of grant implementation. · Develop and implement outreach strategies to train and educate the public, persons with disabilities, their families, businesses, providers and state staff on buy-in and TWWIIA programs. · Provide education and training to all field staff working with consumers, key stakeholders and local and state agencies. . Coordinate efforts of CMS, Dollars and Sense, Department of Labor, and SSA grantees on work incentives under the Governor’s Task Force for Employment and Economic Opportunity for People with Disabilities.
New Jersey	Department of Human Services	· Develop regulations to provide Medicaid coverage to working individuals with disabilities. · Develop a system for case management to assist individuals and professionals in understanding the buy-in program.	· Develop more effective public transportation services. · Modify and expand existing personal assistance services. · Undergo a public relations campaign to assist individuals with disabilities in understanding the existing and new work incentives programs. · Disseminate information about Personal Care Services. · Hold educational forums as part of outreach to consumers with disabilities. · Develop a management information system to monitor Medicaid infrastructure.

New Mexico	Health and Human Services Department	· Design, administer and monitor the infrastructure for an effective Medicaid buy-in program. · Conduct outreach and educational efforts on the Medicaid buy-in using peer presenters with disabilities. · Create a data collection upgrade and reporting system for implementation of the Medicaid buy-in.	· Form consumer groups to assist in the development, delivery and fine-tuning of work incentives activities. · Create advisory groups comprised of consumers, service providers, parents, advocates, and state agency personnel to oversee the project. · Provide training and technical. · Expand linkages between Medical Assistance Division of Human Services Department and the Comprehensive Health Insurance Pool (CHIP) a private health insurance plan for individuals with pre-existing disabling conditions. ·
New York	Department of Health	· Implementation of the State's proposed Buy-in program. · Development of an automated Medicaid Buy-in premium payment and data collection system.	· Implement outreach, education and training programs for State staff. · Develop a program evaluation component.
North Dakota		· Develop a Medicaid buy-in program.	· Assess existing Medicaid systems. · Perform a outreach activities to employers, consumers and Medicaid staff. · Establish a stakeholder network to guide development, consideration, implementation, and evaluation of grant projects.
Ohio	Job and Family Services	· A Study administrative changes required to Implement the Medicaid buy-in program.	· Study the Implications of adding "personal care" as an optional Medicaid state plan service. · Convene a consumer advisory group to provide input on these studies.
Oklahoma	Health Care Authority	· Work with advocacy groups to educate the State legislature on a Medicaid buy-in. · Research and evaluate premium collection and tracking systems used by other states.	· Review personal assistance services policies, availability, service delivery mechanisms. Survey stakeholders to determine how to expand personal assistance services outside of the home. · Study the positive and negative impacts of using non-emergency transportation programs for job transportation.

Oregon	Department of Human Services	· Develop a data tracking mechanism for the Medicaid buy-in program. · Improve Medicaid services.	· Initiate opportunities to enhance social support services. · Initiate information dissemination opportunities through website links and clearinghouse. · Expand consumer involvement by increasing consumer participation, developing training activities, and increasing advocacy group involvement. · Improve consumer choices and benefits counseling networks, develop outreach programs and strengthen links to employers. · Identify new methods to enhance and expand personal assistance services. · Develop options for effective medical transportation. · Develop access to emergency backup services for needs of workers. · Develop monitoring plan for infrastructure. · Develop a research component for infrastructure building efforts. · Design and develop an enhanced Medicaid benefit/services packages.
Pennsylvania	Department of Public Welfare	· Support consumer input into the implementation of the buy-in program. · Develop educational and outreach efforts for the new program.	· Establish a one-stop service model for persons with disabilities to learn about and obtain information on services related to finding employment. · Develop a back-up delivery system for attendant care services. · Establish Statewide Advisory Council on Employment.
Rhode Island	Department of Human Services	· Convene workgroups to develop action plans for the passage of Medicaid buy-in legislation. · Develop a policy to more closely mimic 1619(b) rules for the medically needy.	· Improve dissemination about programs currently available to consumers. · Provide benefit counselors to one-stops, train Medicaid eligibility workers, and develop a web site and linkages to relevant sites. · Facilitate a joint planning effort with stakeholders to bring together the work on developing one-stop career systems and the feasibility of replicating this effort on the health benefits side. · Work with employers to encourage hiring people with disabilities.
South Dakota	Department of Human Services	· Conduct a survey of states which have buy-in programs. · Determine the systems considerations, requirements, and costs associated with a buy-in program.	· Determining the costs associated with expanding personal assistance service programs. · Engage the disability community across the state. · Develop training materials for consumers, providers, employers and state and local staff.
Texas	Health and Human Service Commission	· Plan, design, and model the costs of a Medicaid buy-in program.	· Plan, design and model the costs of expanding personal assistance services.

	*State Agency: Health and Human Services Commission	· Target working individuals with schizophrenia, bipolar disorder or major depression, ages 18 to 64, who are not yet able to meet the SSI disability test.	
Utah	Department of Health	· Evaluate the impact of the State's Medicaid Buy-in program.	· Expand personal care services under the State Medicaid Plan. · Continue to conduct outreach and training to service workers and individuals with disabilities about work incentive programs. · Provide education to employers about hiring persons with disabilities.
Vermont	Department of Aging and Disabilities	· Study the Medicaid buy-in. · Support Medicaid systems programming and administrative structures necessary to allow for the administration of the buy-in and new personal assistance services option. · Conduct outreach to consumers, providers and employers on the Medicaid buy-in and personal assistance services option.	· Develop a new Medicaid State Plan option for consumer-directed personal assistance services. · Provide training for consumers of personal assistance services. · Fund an evaluation and planning unit.. · Disseminate information on data analysis, research and best practices. · Engage in activities to raise employment rates for people with disabilities statewide.
Virginia	Department of Medical Assistance Services	· Develop and implement a Medicaid buy-in program.	· Involve stakeholders in the direction of grant projects. · Expand personal assistance programs to provide more expansive services. · Participate in technical assistance partnership activities to disseminate information and learn from other states.
Washington	Department of Social and Health Services	· Design and implement a buy-in. · Change information systems.	· Pilot, in two areas, the State Personal Assistance Recruitment and · Retention program for personal assistance providers. · Allow the state to contract with vendors who would actively recruit and develop a network of personal assistance service providers. · Support a state budget request that would support state-wide implementation of the provider network program. · Design and implement a monitoring system of specialized programs and changes in the services delivery system for assisting hard to serve individuals. · Train case managers, social workers, service providers and administrators on new programs. · Ensure utilization of other work incentives programs. · Improve the utilization of community employment and training resources.

West Virginia	Division of Rehabilitation Services	· Design, implement and evaluate a Medicaid buy-In program.	· Improve, expand and evaluate the State's personal assistance service program. · Develop comprehensive, collaborative systems among state programs. · Design, train and provide follow-up assistance to all Medicaid stakeholders. · Evaluate the process, products and impacts of changes to Medicaid.
Wisconsin	Department of Health and Family Services	· Evaluate the disability determination process to assess the outcomes of case adjudication. · Automate the Medicaid purchase plan eligibility system.	· Hire staff person who will be responsible for networking with existing community resources and refer consumers to potential community supports. · Establish an 800 number to improve access by consumers. · Maintain and update the Department of Health and Family Services web-site. · Develop a computer model that will allow case managers and policy-makers to simulate effect of health and long-term care options in an integrated model. · Evaluate coordination and integration of employment related service provisions. · Collaborate with employers to share costs of personal assistance at the workplace.
Wyoming	Wyoming Department of Health	· Revise existing State statute in order to meet federal criteria.	· Design a comprehensive database for all people with disabilities who receive services. · Establish a community care model approach to service provision. · Provide training to resource professionals. · Integrate employers into the service provider network through the creation of community-based organizations.

Source: Center for Medicare and Medicaid Services, Demonstration and Infrastructure Grant Activities, http://www.cms.hhs.gov/twwiia/inf_dmap.asp <Accessed April 1, 2003.>

Note: Stars (*) Indicates a demonstration description. Nonstarred programs refer to Medicaid Infrastructure related grant activity. The District of Columbia and Texas are the only entities with both grants and demonstrations.

APPENDIX 2:

STATE CASE STUDIES

NEW HAMPSHIRE

BBA or TWWIIA Basic Coverage Group

TWWIIA. The state wanted a higher income cut off than is available under the BBA.

Medical Improvement Group:

No. The state wanted to see how the basic coverage group worked out first.

Background

Governor's Task Force on Employment and Economic Opportunity argued that TWWIIA coverage would support economic development. Federal grants helped with the design work. The governor was very supportive and the Medicaid coverage expansion unanimously passed the legislature. The fiscal impact was estimated to be small.

Eligibility Requirements

- General: One-year grace period if beneficiary loses employment and intends to return to work. Individual must meet New Hampshire's definition of disability.

- Income levels: Net income may not exceed 450 percent of FPL. Spousal income is included. Unearned income, impairment-related work expenses, and PASS disregarded. (Net income is approximately half of gross income.)

- Resource levels: $20,000 for individual and $30,000 for a married couple. These amounts excludes retirement accounts, medical savings accounts, individual development accounts, and accounts to enhance employability. Liquid resources accumulated from earnings while eligible and kept in a separate account will be excluded when determining future eligibility for non-buy-in Medicaid categories.

Premiums

There is no monthly premium if the net income is below 150 percent of the FPL. Premiums ranging from $80 to $210 per month in FY 2001 are charged if net income is between 150 percent and 450 percent of FPL. 7.5% of income is charged for persons with income over $75,000. Spousal income is included in the premium calculation.

Private Insurance

Employer-sponsored insurance premiums are deducted from the buy-in premiums, as are Medicare premiums.

Long-Term Care

Noninstitutional long-term care services are covered through three home and community-based services waivers. The Medicaid state plan covers personal care for people who must use wheelchairs.

Outreach and Education

The state has made a major outreach effort, including radio spots, brochures and posters. They plan to connect with Chambers of Commerce. Benefit specialists provide counseling services. Grants to independent living centers provide outreach. The Governor's Task Force for Employment and Economic Opportunity provides a forum for state and local agencies, advocacy organizations, and consumers to coordinate Medicaid infrastructure grant activities with other grantees (Dollars and Sense, Department of Labor, SSA). Training and outreach efforts have included statewide district offices, SSA offices, area agencies serving consumers with developmental disabilities and acquired brain disorders, mental health agencies, One-Stop centers (offering employment-related services to both employees and employers), advocacy groups, and other local and state agencies.

Experience

- Participants: 1,017 beneficiaries, only a few of which were not previously eligible for Medicaid. Approximately 70 percent of participants are dually eligible for Medicare and Medicaid.

- Premiums: The state has the State Children's Health Insurance Program collect the premiums for the buy-in program. Premium collection has gone smoothly. Premiums are not believed to be a significant bar to participation. About 18 percent of beneficiaries pay premiums. Of those paying premiums, 75 percent have net incomes between 150-200 percent of FPL. In addition, of those paying premiums, 90 percent are eligible for Medicare.

Outlook and Issues

- The program benefits the state because it encourages people to work. Consumer advocates argue that there would be considerable opposition if the state tried to cut the Medicaid buy-in coverage. Community-based services may be at risk in the current budget environment.

- The state believes that improvements could be made to the TWWIIA legislation regarding the definition of work and the age limitation. The definition of work is problematic, as it does not allow the states to specify the number of hours worked or minimum level of earnings. Some people on the buy-in program may work for only a few hours. In addition, the state believes that people age 65 and over should be able to participate in the buy-in program.

- Consumer advocates argue that there needs to be more home and community-based services, perhaps with a higher Medicaid match. Personal care workers are said to be underpaid and typically do not have health insurance. Workforce issues need to be addressed.

- The Medicaid Infrastructure Grant is overseen by the Governor's Task Force for Employment and Economic Opportunity for People with Disabilities. Representation from the Governor's Office allows recommendations to be made to the Governor to promote the advancement of employment for adults with disabilities.

IOWA

BBA or TWWIIA Basic Coverage Group

Chose BBA because it was the first legislation that provided for this coverage group.

Medical Improvement Group

Not applicable.

Background

The Department of Human Services approached business groups to support work incentives for people with disabilities as a way to address the personnel shortage. The Iowa Business Council, consisting of the 25 largest businesses in the state, perceived people with disabilities as an untapped pool of potential employees. Business groups were heavily involved in helping get the legislation enacted.

Eligibility Requirements

- General: Limited to people under age 65.

- Income levels: Iowa has a two-step test. First, monthly net income levels must be less than 250 percent of FPL for family size. The second step is to determine if the individual meets the disability, assets and unearned income standards to receive an SSI benefit. Iowa disregards all unearned income at this step. Eligible individuals who end their employment for any reason may remain eligible for six months if she or he intends to return to work.

- Resource levels: Resources must be less than $12,000 for individuals and $13,000 for couples. Retirement accounts, assistive technology accounts and medical savings accounts are disregarded.

Premiums

Premiums are required when gross monthly income is above 150 percent of the FPL. The highest premium is the average full cost of health insurance for state employees. Maximum premium is 7.5 percent of gross income. Above $35,028, premium is constant and there is no state subsidy.

Private Insurance

If an individual has employer-sponsored health insurance and it is cost effective, the state will pay the premium. Thee are 26 persons in this category.

Long-Term Care

Noninstitutional long-term care services are available through a home and community-based services waiver. A total of 59 people in the Medicaid buy-in receive waiver services. Personal care is not available as an optional service under Medicaid.

Outreach and Education

The state has provided outreach efforts through Medicaid. They have provided informational meetings throughout the state.

Experience

- Participants: 5,048 individuals. This enrollment is about 10 percent of population with disabilities on Medicaid. Approximately 20 percent are new Medicaid enrollees. Early data suggested that participants generally were coming from the medically needy coverage group.

- Average earned income is $210 per month; average unearned income is $779 per month; average total income is $956 per month.

- Not including persons who are unemployed, 42 percent of participants work less than 10 hours per month; 10 percent work 80 hours a month or more. A total of about 4 percent of participants earn $750 a month or more; 57 percent earned $100 a month or less.

- Premium collection: Approximately 27 percent of beneficiaries pay premiums. Failure to pay premiums has not been a significant problem.

Outlook and Issues

- Despite a sluggish economy, the number of enrollees continues to increase at about 100 Medicaid beneficiaries a month.

- Many people are working for just a few hours a month for individuals. State officials would like to require more hours of work.

- Given the state fiscal problems, the legislature is looking at the Medicaid program as a whole for possible savings. Nothing specific has been proposed that would affect the Medicaid buy-in program.

- The ability to provide prescription drug coverage for persons with mental illnesses is particularly important.

CONNECTICUT

BBA or TWWIIA Basic Coverage Group

TWWIIA. The state chose TWWIIA because it allowed higher income thresholds.

Medical Improvement Group

Yes. The state saw this as a logical extension of the basic coverage group. However, there are no "medically improved" people in the program. It seems that people have stable disabilities.

Background

Although the state agency had been working with disability advocacy groups for a number of years, enactment of legislation was largely the result of a few committed state legislators who worked with consumer advocates. There is broad political support for initiatives to help people to work. The law passed unanimously in the legislature.

Eligibility Requirements

- Income levels: Individual may have income up to $75,000 per year. Earned and unearned income considered. Spouse's income is not considered. Impairment related work expenses are disregarded. While the state wanted a high level of eligibility, they did not want the perception that "millionaires" could get free health care.

- Resource levels: Individual may have resources up to $10,000 and couples may have resources up to $15,000. Retirement accounts, medical savings accounts, and accounts for employability-related expenses are also excluded for this as well as other eligibility categories. The state did not want to discourage savings. Liquid resources accumulated from earnings while eligible will be excluded when determining future eligibility for non-buy-in Medicaid eligibility categories.

- Persons receiving benefits who temporarily lose employment may continue Medicaid eligibility as an employed person for up to one year if the loss of employment is due to involuntary dismissal or temporary health problem, and the individual intends to return to work or is looking for new employment.

Premiums

Premiums are imposed on persons with income above 200 percent of the FPL based on family size. The premium is 10 percent of income above 200 percent of the FPL based on family size. For persons between 250 percent and 450 percent of the FPL, the premium may not exceed 7.5 percent of income. Spouse's income is considered when determining the premium charge. A credit is given for other health insurance premiums paid.

Private Insurance

If it is cost-effective, Medicaid will pay employer-sponsored health insurance premiums.

Long-Term Care

Personal care services are available through the home and community-based services waiver. It is a consumer-directed model and services can be provided at work. Many people receive home health benefits, which are available outside of the waiver. There was a state-funded personal care program, but beneficiaries have been transferred to the Medicaid waivers. The state program has basically been eliminated. Despite the requirement that people have a nursing home level of care in order to qualify for the waivers, the state has not had a problem getting people onto the waivers.

Outreach and Education

The Medicaid buy-in program is integrated into a broader employment plan that includes benefits counseling. The Connect to Work program in the Division of Rehabilitation Services tries to encourage disabled persons to return to work, utilizing Medicaid. There has been heavy marketing, including mailings to disabled people on SSI with earned income and disabled individuals who have ended Medicaid eligibility within the last two years. The state provides information to people earning less than the SGA that they can earn more and still maintain Medicaid. The state has five benefits counselors in the field. There have been talks to groups providing services to people with disabilities, such as the Multiple Sclerosis Society.

Experience

- Participants: Connecticut has 2,512 beneficiaries in the Medicaid buy-in program, almost half of whom are aged 30-44. Approximately 16 people have excluded retirement accounts. Approximately 27 percent of beneficiaries are earning $5,000 a year or less; 43 percent are earning $5,000 to $9,999 a year. Thus, approximately 70 percent of beneficiaries are earning less than the SGA. Approximately 9 percent of the caseload is involuntarily unemployed and seeking work. Fully 82 percent of beneficiaries are dually eligible for Medicare and Medicaid, primarily SSDI only. In percentage terms, the program has grown rapidly, from 651 beneficiaries in 2001 to 2513 beneficiaries in 2003. State officials are uncertain if the program is topping out.

- Premium collection: 12% of beneficiaries pay premiums, of which the average amount is $52 a month. The state does not believe that premiums have been a barrier to participation. The state sends a bill, which is supposed to be paid by the end of the month. If the client is more than 30 days in arrears, then the case is closed. Payment of premiums has not been a major issue. Programming the computers for the premium payment was more of the issue.

- The Medicaid infrastructure grant from CMS is combined with the benefits and outreach planning grant from SSA. The grants are housed within Vocational Rehabilitation, which is part of the Department of Social Services. State officials believe that having Medicaid and

Vocational Rehabilitation in the same agency greatly improves coordination. Changing attitudes regarding work for people with disabilities is a major task.

Outlook and Issues

- The state was originally going to have a more restrictive definition of employment, but CMS did not allow states to do that. However, there is also a view that many people need to start working a little before they can work a lot.

- With the current downturn in the economy, the caseload has not grown, but it has not shrunk. So far, the economy does not seem to be a major factor in the size of the program.

- With the current state fiscal crisis, there is some possibility that the premiums may increase. However, the basics of the program are not being considered for budget cuts.

- State officials would propose removing the limitation in eligibility to the population under the age of 65.

- The Medicaid buy-in is most effective when it is well integrated with other work programs for people with disabilities.

- Press releases about the program emphasize that the Medicaid buy-in program can also benefit Connecticut employers by helping them attract and retain workers. The state recognizes that many employers do not provide the comprehensive health insurance that people with disabilities need and Medicaid is, therefore, needed.

SOUTH CAROLINA

BBA or TWWIIA

BBA

Medical Improvement Group

Not applicable.

Background

The South Carolina Department of Health and Human Services made the push for this legislation. Given the small enrollment, there has been no particular push to switch to TWWIIA.

Eligibility Requirements

- Income: An individual's income must be below 250 percent of the FPL. South Carolina uses SSI methodologies in determining income.

- Resources: Resources must be below $2,000 for individuals and $3,000 for couples. South Carolina uses SSI methodologies in determining resources.

Premiums

South Carolina does not charge premiums for its Medicaid buy-in program. It also does not charge premiums for its State Children's Health Insurance Program.

Private Insurance

The Medicaid program will pay private health insurance premiums if it is cost effective.

Long-Term Care Benefits

Personal care is covered through home and community-based services waivers, which have more exclusions from resources. Personal care is not covered as a state plan benefit.

Outreach

The state provides an overview of Medicaid to all prospective beneficiaries. There are linkages with the Department of Vocational Rehabilitation.

Experience

- Participants: Approximately 770 beneficiaries are participating. Most beneficiaries were previously on Medicaid.

Outlook

- Despite the state's fiscal crisis, there are no plans for cutting the Medicaid buy-in program.

PENNSYLVANIA

BBA or TWWIIA

TWWIIA

Medical Improvement Group

Yes. It seemed to be the logical next step beyond covering the basic coverage group. It was also felt that if this group was not covered, then individuals could have a recurrence of their disabilities due to a lack of health coverage.

Background

The state liked the flexibility available in TWWIIA. The expanded eligibility was funded with funds from the tobacco settlement, as part of "Pennsylvania's Health Investment Plan." Medical Assistance for Workers with Disabilities was implemented in January 2002. They expect short-term costs, but savings in the long run because people will stay healthier longer. The initial cost estimate was nearly $25 million, which was based on an initial estimate of 10,000 enrollees, far more than currently enrolled.

Eligibility Requirements

- Income: Net countable income must be less than 250 percent of the FPL. The income of children and siblings is excluded.

- Resources: Countable resources must be less than $10,000. This resource level allows individuals to save and still maintain their Medicaid coverage. Family Savings Accounts (established by the Department of Community and Economic Development) are excluded.

Premiums

All participants must pay a monthly premium based on 5% of their net countable income. Premiums of less than $10 per month are waived. This level was established as a fair and reasonable payment for coverage.

Private Insurance

The Medicaid program will pay private insurance premiums if it is cost effective.

Long-Term Care

Noninstitutional long-term care services are available through home and community-based services waivers. Personal care is not an optional benefit for the Medicaid program.

Outreach and Education

Pennsylvania received a Ticket to Work infrastructure grant. It has used that funding to establish an advisory committee on employment. It has also developed outreach programs and CareerLink, a pilot job information and training program, which provides information on the Medicaid buy-in program.

Experience

Participants: There are 1,374 beneficiaries, less than the 10,000 originally budgeted. State officials believe that the SSA Ticket to Work initiative (which is slated to begin in Pennsylvania in late 2003) has the potential to have a positive impact on enrollment. Fully 73 percent of individuals in the buy-in program were enrolled in a different Medicaid eligibility group within the past year. Approximately 24 percent of people with some other Medicaid coverage were enrolled in a state-funded general assistance category. By using the buy-in program, the state moved working people with disabilities from a state-funded eligibility group to a federally-funded eligibility group. Over half of participants are between the ages of 30 and 49. A third of beneficiaries worked either part time or part-time for more than 100 hours per month; half worked 100 hours per month or less; and, one-seventh were self-employed. Higher income working people with disabilities may receive employer-paid health insurance and do not feel the need to obtain insurance through Medicaid. Many disabled individuals may feel that if they work too many hours, they will lose their benefits and therefore limit what they earn. Average monthly Medicaid costs are $529. A little over half of beneficiaries are dually eligible for Medicare and Medicaid.

Private insurance: Approximately 13 percent of participants had private insurance. The general lack of private insurance may reflect the broader Medicaid benefits, the failure of employers to offer insurance, and the high cost of private coverage.

Premiums: All but one percent of beneficiaries are required to pay premiums. Approximately a quarter of premium-paying beneficiaries are delinquent in their premium payments, at least temporarily. Many individuals are unable to pay the premiums due to layoffs and other reasons beyond their control. Under these circumstances, they are allowed to claim “good cause,” which is granted for up to two months when the problems are reported and verified in a timely manner. The premium is waived during the good cause period.

Outlook

- If the economy worsens, the state expects jobs generally to become less available, including those for persons with disabilities.

- The state expects to cut Medicaid this year. Despite the state's fiscal crisis, the Medicaid buy-in program is unlikely to be cut.

- Some state officials would like a clearer definition of "work."