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

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EXECUTIVE SUMMARY

POLICY FRAMEWORKS FOR DESIGNING MEDICAID BUY-IN PROGRAMS AND RELATED STATE WORK INCENTIVE INITIATIVES

PURPOSE OF REPORT

This report provides policy frameworks to assist stakeholders (such as Medicaid directors, state legislators, and cross-disability coalitions) design and implement Medicaid Buy-In programs and related work incentive initiatives to enhance the level of economic self-sufficiency of persons with significant disabilities. Of particular focus of the paper are the design decisions affecting enrollment, costs, and a state's fiscal exposure.

The policy frameworks describe the interrelationships between federal and state cash assistance programs (particularly SSDI, SSI, and state SSI supplementation programs) and health entitlements (particularly the Medicaid program). The policy frameworks are derived from the experiences of the nine early implementation states included in the Case Study (Alaska, Connecticut, Iowa, Maine, Minnesota, Nebraska, Oregon, Vermont, and Wisconsin).

OTHER REPORTS PREPARED BY PROJECT

This is the third in a series of reports based on data collected from case studies documenting the early experience of nine states implementing Medicaid Buy-In programs and related work incentive initiatives. The three reports were funded through a contract with the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation supporting a project entitled "*Case Studies and Technical Assistance for Medicaid Buy-Ins for People with Disabilities.*" Additional support was provided from a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education supporting the Rehabilitation Research and Training Center on Workforce Investment and Employment Policy for Persons with Disabilities and a grant from the Robert Wood Johnson Foundation.

In addition to this policy paper, the study team prepared two other reports. The first report includes in-depth case studies of nine early implementer states entitled *Medicaid Buy-In Programs--Case Studies of Early Implementer States* (April 2002). The second report, *The Medicaid Buy-In Program: Lessons Learned from Early Implementer States (*(April 2002), compares the nine states included in the Case Study across the primary topic areas and themes addressed in the Case Study.

OVERALL PURPOSES OF THE STUDY

The overall project had several purposes.

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

- To use the descriptive information to inform and provide technical assistance to various state-level stakeholders about the lessons that can be learned from these states.
- To inform federal policymakers so that they can better understand the experiences of states implementing Medicaid Buy-In programs.

MAJOR FINDINGS

1. Preliminary Considerations by States in Designing Medicaid Buy-In Programs and Related Work Incentive Initiatives

- **Framing the issue.** Stakeholders are finding more interest in adopting Medicaid Buy-In programs when they characterize their efforts as part of an "employment initiative" (rather than as a health reform initiative) that includes, but is not limited to, the enactment of a Medicaid Buy-In program.

- **Devising a comprehensive, person-centered initiative.** In order to address the multiplicity of barriers to work facing persons with significant disabilities, states are adopting comprehensive, person-centered approaches. The health care component of a comprehensive initiative may include a Medicaid Buy-In program, but it may also include changes to the regular Medicaid program, changes to the state SSI supplementation program, and/or changes to the manner in which the Medicaid and state SSI supplementation programs are administered. In addition to a health care component, other components of a comprehensive initiative may include, benefits counseling, enhanced vocational rehabilitation services, seeking authority from SSA to continue the connection to cash assistance as earnings increase i.e., changing the rules governing eligibility for SSDI cash benefits to provide for gradual rather than precipitous loss of SSDI cash payments (demonstration authority required from SSA), housing and transportation components, and involvement by employers.

- **Understanding the "starting point" of state Medicaid Buy-in programs.** The design and implementation of the Medicaid Buy-In program cannot be viewed in isolation; rather, it must be viewed in the context of a state's overall Medicaid program and other state-specific initiatives (e.g., state SSI supplementation program). It is critical to understand a state's "starting point" i.e., the Medicaid standards and state SSI supplementation program standards prior to the enactment of the Medicaid Buy-In program. For example, the higher the percentage of SSDI recipients who are already eligible for Medicaid (and Section 1619 work incentives) in a state, the smaller the fiscal impact of the Medicaid Buy-In program on the state.

  Similarly, assessing the relative success of a Medicaid Buy-In program must be viewed in the context of the state's starting point. A person who becomes eligible to buy into Medicaid under a state's Medicaid Buy-In program in State a may already have been eligible for Medicaid in State B under its regular Medicaid program. In other words, a state's large enrollment in its Medicaid Buy-In program may be the result of its extensive outreach campaign and the progressive policies governing the Medicaid Buy-In program (e.g., using minimal premiums and no unearned income

limits). On the other hand, the large enrollment in the Medicaid Buy-In program may be because the state's regular Medicaid program is very restrictive (e.g., no medically needy program or the medically needy protected income level is less than the federal SSI benefit standard).

- **Understanding the value and limitations of relying on the experiences of other states.** There is a wealth of knowledge that can be gleaned from reviewing the experiences of other states that have implemented Medicaid Buy-In programs. It is critical, however, to understand whether other states are comparable in terms of such considerations as: the existing regular Medicaid eligibility categories; the existence of and policies governing the state SSI supplementation program; the design of the Medicaid Buy-In program (including the fiscal assumptions, policy objectives, policy tradeoffs, eligibility categories and cost sharing); and the administration of the Medicaid program and its state SSI supplementation program.

- **Understanding the Impact of federal policies on state options.** In designing Medicaid Buy-In programs, State policy makers and other stakeholders need to recognize that significant numbers of persons participating in Medicaid Buy-In programs are increasing their disposable income but are unwilling to earn more than $780 per month (Substantial Gainful Activity-SGA) because of the "cash cliff" under the SSDI program (a person who earns more than SGA for more than 12 months will lose eligibility for SSDI). In states collecting earnings data, only 14 percent of enrollees in Medicaid Buy-In programs had earnings over SGA.

2. Designing Medicaid Buy-In Programs

- **Focus of the program.** The focus of the Medicaid Buy-In program depends on the relative emphasis placed on enabling disabled persons with substantial employment and earnings to buy into Medicaid and/or enabling disabled persons who have modest employment and earnings to increase their disposable income. The focus of a Medicaid Buy-In program can have a significant effect on how many people are enrolled in the program. The greater the relative focus on disabled persons with modest employment and earnings, the greater the potential enrollment and fiscal exposure of the state.

- **Policy objectives.** Policy objectives may include increasing the percentage of Medicaid Buy-In participants who have earnings from employment and/or increased disposable income; increasing the percentage of enrollees that have some of their health care needs paid for by private insurance; and/or increasing the percentage of persons who have reduced dependency or are no longer dependent on cash benefits or health care entitlement services.

- **Using eligibility criteria to affect enrollment and fiscal exposure.** In order to control costs, the state may limit eligibility into the Medicaid Buy-In program through various means including by using unearned income eligibility limits or indirectly, through unearned income limits by requiring minimal earnings levels. The

higher the earnings level eligibility requirement and the lower the unearned income limit for eligibility, the lower the participation rate in the Medicaid Buy-In program and the lower the costs of the program to the state.

- **Using premiums and premium levels to affect enrollment and fiscal exposure.** The state may restrict access to the Medicaid Buy-In program by prescribing the circumstances under which an individual is required to pay a premium and the size of the premium (including, for example, applying a different premium against unearned income (SSDI benefits) than against earned income). The higher the premium amount based on level of unearned income, the lower the participation rate and the lower the net cost to the program per participant. A high premium on unearned income has the effect of limiting the program to individuals with higher earnings.

3. Redesigning the State's SSI Supplementation Program and the Medicaid Program to Increase Access to Work Incentives

- **State SSI supplementation programs.** State decisions regarding the design of state SSI supplementation programs can have a major impact on Medicaid eligibility levels in states and access to work incentives under Section 1619 (i.e., increase a disabled worker's disposable income with significant earnings; continue Medicaid when they have such earnings; and enjoy income security under the SSI program by being able to return to cash payment status if their ability to work ceases or is significantly reduced). For example, to enable persons with significant disabilities to take advantage of these work incentives, the state can increase the income standard for the state SSI supplementation program or increase the earned and unearned income disregards.

- **Regular Medicaid program.** States may use various Medicaid eligibility categories (such as the federal poverty level option or the medically needy option) to increase the number of disabled workers who qualify for regular Medicaid.

4. Redesigning the Methods of Administration for the Medicaid and State SSI Supplementation Programs to Improve Access to Work Incentives

- **In general.** The state has the discretion to adopt methods for administering the state SSI supplementation program and the Medicaid program that facilitate access to and use of work incentives designed to increase the level of economic self-sufficiency of persons with significant disabilities.

- **Underutilization of Section 1619.** The work incentives made available under Section 1619 continue to be underutilized resulting in persons with disabilities not earning commensurate with their abilities and/or not benefiting from health-related services and supports to which they are entitled. Underutilization and access to Section 1619 work incentives is particularly a problem in those 17 states that do not provide automatic eligibility for Medicaid for SSI recipients.

- **Automatic Medicaid eligibility for federal SSI recipients.** A state may permit a federal SSI recipient to be automatically eligible for Medicaid.

- **Single application for SSI and Medicaid.** A state may permit a federal SSI recipient to make a single application for SSI and Medicaid. A single application will most likely result in more Medicaid eligible individuals who actually use the benefits made available under the Medicaid program.

- **State SSI supplementation program rules relating to eligibility for Medicaid.** A state has the authority to make persons not eligible for federal SSI but who are eligible for the state SSI supplementation program entitled to protections offered to federal SSI beneficiaries, including the right to maintain eligibility for Medicaid even when they are no longer eligible for cash assistance under the state SSI supplementation program.

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