



**CENTER ON DISABILITY STUDIES**  
UNIVERSITY OF HAWAII AT MĀNOA

# ***QUEST WINS – Work Incentives New Start, a Medicaid Work Incentive for Workers with Disabilities in Hawai'i***

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## **FORWARD**

The Ticket to Work and Work Incentives Improvement Act (TWWIIA) directed the Secretary of the Department of Health and Human Services (HHS) to establish the Medicaid Infrastructure Grant (MIG) program to support State efforts to enhance employment options for people with disabilities. The MIG project in Hawai'i, entitled Hire Abilities – Hawai'i, has been working toward a goal of supporting people with disabilities in securing and sustaining competitive employment in an integrated setting. The Centers for Medicare & Medicaid Services (CMS) is the designated federal agency with administrative responsibility for this grant program. This CMS grant program will achieve its goal of increasing employment opportunities for people with disabilities by providing money to the States to amend their health care delivery systems to meet the needs of people with disabilities who want to work.

The purpose of this paper is to:

- (1) offer information surrounding the challenges that people with disabilities face when maintaining their health and disability support benefits as they seek employment;
- (2) discuss alternatives that have been implemented by other states through Medicaid Work Incentive programs; and
- (3) present an analysis on how Hawai'i might offer such a program to working people with disabilities.

Any feedback from readers is appreciated. We hope that you find this informative.



**Medicaid Infrastructure Grant  
University of Hawai'i - Manoa**

## EXECUTIVE SUMMARY

### Persons with Disabilities in Hawai'i

In Hawai'i, there are approximately 18,000 adults receiving Social Security Disability Insurance (SSDI) benefits as "disabled workers"; the average benefit for a disabled worker is about \$963 per month. SSDI recipients get Medicare after a two-year wait, but many need medications and other assistance not covered by Medicare.

State of Hawai'i Disability Related Statistics	
Total Population (16-64)	781,052
SSDI disabled workers (18-64)	18,700
SSI (18-64)	12,578
SSI Working	893
With a disability (16-64)	72,790
Unemployment rate	61.4%
With a "go outside the home" disability (16-64)	18,909
With an employment-related disability	42,716

Sources: American Community Survey, 2005, U.S. Census;  
Social Security Administration, State Statistics – Hawai'i, 2005

More than 12,000 working age adults in Hawai'i receive Supplemental Security Income (SSI) benefits, with an average monthly payment of \$474. There are about 2,000 individuals who get both SSDI and SSI because their SSDI benefit is less than their monthly federal SSI payment. Their average monthly SSDI and SSI payments in the state of Hawai'i are \$497 and \$215, respectively.

### Medicaid and Adults with Disabilities

In Hawai'i, adults with disabilities typically are covered by Medicaid only if they:

- ✓ receive SSI;
- ✓ get Home and Community Based Services (HCBS) or facility care; or
- ✓ have enough medical bills to offset their income, or spend down, to qualify for short-term coverage through the state's Medically Needy Program

### Employment and Disability

According to the 2005 American Community Survey conducted by the U.S. Census Bureau, approximately 9.8% of the civilian, non-institutionalized working population (16 to 64 years of age) is reported as "with a disability" in Hawaii. Of this group of people with disabilities and of working age, roughly 61.4% are reported as "not employed." This is more than twice the rate of non-employment of those with "no disability."

Last year there were more than 6,000 adults with disabilities covered by Hawai'i Medicaid who were employed. Of these:

- ✓ 5,686 received SSI
- ✓ 545 got Home and Community Based Services

- ✓ 309 were certified through the Medically Needy Program

To keep Medicaid, workers with disabilities had to limit their income and assets to poverty levels, even though Medicaid costs for SSI recipients who worked were less than half of the costs for those who did not. In short, people who work have lower Medicaid costs due to a reverse correlation.

### **Problem: People with Disabilities Choose between Work and Healthcare**

From a survey conducted in 2005 by Hire Abilities using MIG funds, it was found that:

- ✓ 69.6% of respondents would sign up for a premium sharing program would allow for work without losing healthcare benefits
- ✓ 82.4% of respondents expressed interest in information about how to find and keep a job without losing healthcare benefits
- ✓ Lack of job supports, such as assistive technology and personal assistance, and the potential loss of benefits dissuade people with disabilities from working

### **Proposed Solution: A Medicaid Work Incentive Coverage**

Through greater flexibility provided by the federal government, Hawai'i can make adjustments its Medicaid program to accommodate people with disabilities to encourage work, as over 30 states have already done.

QUEST Work Incentive New Start Work (WINS) could:

- ✓ Reduce the number of uninsured or underinsured persons in Hawai'i
- ✓ Remove documented barriers to work, such as loss of benefits, lack of job supports and personal assistance services, and being told not to work by case workers
- ✓ Help working people with disabilities increase their economic independence and live above poverty by providing needed health care coverage and decreasing their reliance on SSDI or SSI benefits
- ✓ Enable some SSDI recipients to work and get Medicaid as a supplement to private or Medicare insurance
- ✓ Obtain federal funding for health care services for persons now served through state-funded mental health programs
- ✓ Allow persons with disabilities to work and pay state, federal and FICA taxes

The most tangible benefit to the state would be from the increase in taxes paid by those employed. A recent study entitled Medicaid: Good Medicine for State Economies – 2004 Update by Families USA Foundation determined that:

- ✓ For every \$1.00 that the state spends on Medicaid, there is a business activity return of up \$3.17
- ✓ In FY 2005, there were an estimated 11,000 jobs created due to Medicaid spending, with total spending on wages of \$466 million
- ✓ Every \$1 million spent on Medicaid results in \$3.2 million in new business activity, 29.34 jobs created; and \$1.2 million in new wages

### **QUEST WINS Eligibility**

Under the preliminary program design for Hawai'i's Medicaid Work Incentive Coverage,

a person must:

- ✓ Be employed
- ✓ Be age 16 through 64
- ✓ Be 'disabled' but for the earnings limit under SSA rules (Ticket to Work and Work Incentives Improvement Act, Title II, Section 201 (a)(1)(C), see Appendix A)
- ✓ Have net countable income less than 250% of the federal poverty level (FPL) under the Social Security counting methodology, which equals approximately \$4,981/mo.
- ✓ Have countable assets less than \$20,000
- ✓ Pay a premium

**QUEST WINS Coverage Groups**

Five broad types of individuals have been identified in the preliminary formulation of QUEST WINS:

- ✓ Former recipients of SSI cash benefits participating in section 1619(b) with earnings at or near the section 1619(b) income threshold
- ✓ People with disabilities enrolled in Medicaid under a medically needy or spend down category who, if enrolled in the program, could work more and retain more income and assets without losing Medicaid coverage
- ✓ People with disabilities who lack other sources of health insurance, including SSDI beneficiaries in the 24-month waiting period before receiving Medicare, and working SSDI beneficiaries nearing the end of an extended period of Medicare coverage who will experience a loss of Medicare
- ✓ People with disabilities whose premiums/cost sharing for other private or public insurance coverage (e.g., through private insurance, COBRA, spouses, or Medicare) exceed the cost of the QUEST WINS program
- ✓ People with disabilities whose private and/or public (Medicare) coverage does not provide needed medical supports, but which are covered by the QUEST WINS program

**Projected Enrollment and Cost**

The program's enrollment is expected to take approximately 5 years to mature and stabilize. By the fifth year, the program is expected to have between 580 and 1,040 participants, with an annual state budget of \$5.2 million to \$9.4 million and federal matching of \$7.5 million to \$13.4 million.

## **MIG RESEARCH**

During the past two years, the Hawai'i Hire Abilities project gathered the following facts and key findings regarding people with disabilities in the State of Hawai'i:

- ✓ There are persons with disabilities who could enter or re-enter the workforce, but who are reluctant to do so for fear of losing their Medicaid health care benefits.
- ✓ Health insurance is a major concern of persons with severe disabilities.
- ✓ Health insurance is not available through Medicaid or Medicare to many working people with disabilities.
- ✓ Persons with disabilities have special needs that require extra resources in order to enter or re-enter the workforce.
- ✓ Policy change is needed to provide people with disabilities:
  - Increased range of options to achieve higher levels of self-support that will reduce dependency on public assistance
  - Process for determining a gradual reduction in public support as need changes, rather than a precipitous loss currently experienced by many working SSDI recipients
  - Opportunities to increase financial security and independence by accumulating assets without losing healthcare

In developing recommendations for a Medicaid Work Incentive program for Hawai'i's Medicaid program, the Hawai'i Hire Abilities team considered four major sources of information:

- I. Focus groups on Oahu, the Island of Hawai'i, Maui and Kauai and with the Hire Abilities Advisory Board Advocacy
- II. A survey of individuals with disabilities who are Hawai'i residents
- III. Data from the Hawai'i Medicaid and SSA programs
- IV. A review of selected states with Medicaid Work Incentive programs

### **I. Focus Groups**

Focus groups were held statewide in 2005-2006. The purpose of the forums was to inform persons with disabilities, advocates, and other interested persons about the Medicaid Work Incentive options provided by the Balanced Budget Act (BBA) and the Ticket to Work and Work Incentives Act (TWWIIA) and to solicit public input regarding the need for, and desirable features of, such a program in Hawai'i. Advocates and organizations representing various disability groups were notified in advance of each forum and encouraged to attend and participate in the forums. It was also announced at each forum that written comment would be accepted.

Feedback received at the forums clearly indicates that there is strong support among persons with disabilities and their advocates for access to medical care under Medicaid for the disabled who work. Although not a focus of these forums, there are several other related issues of concern. Among them is the need for information about COBRA and the Health Insurance Portability and Accountability Act (HIPAA), access to help with insurance issues for people with disabilities such as how to combine private and public

health insurance, and a general information and referral service from which persons could obtain information on all programs available to disabled persons.

(A more detailed summary of the feedback from focus groups and consumer surveys is contained in Appendix B.)

## **II. Consumer Survey**

The federal Ticket to Work and Work Incentives Improvement Act (TWWIIA) provides a broad framework for program eligibility. This leaves the state with the responsibility to further define eligibility as it sees fit, should it choose to implement a program. In the absence of definitive eligibility criteria it seemed desirable to survey the two largest groups of disabled persons who are already receiving Medicaid/Medicare benefits. Those two groups are individuals with disabilities between the ages of 16 and 65 currently receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and those disabled individuals between the age of 16 and 64 within the Medically Needy population.

A review of the approaches taken by several other states that have already implemented Medicaid Work Incentive programs suggests that a consumer survey is instructive in making estimates regarding program participation. The survey enabled the team to gather demographic and anecdotal information from a random sample of selected groups of disabled persons within the state who would likely be eligible to participate in such a Medicaid program.

The following is a summary of the findings and observations taken from the survey responses:

- ✓ The respondents can be considered severely disabled with most (60%) having physical (e.g., deaf, blind, cardiovascular, orthopedic, neurological), 33% with mental (e.g., psychiatric) and 6% reporting developmental disabilities.
- ✓ The primary source/s of income for both groups is Social Security Disability Income or Supplemental Security Income. Not surprisingly, 72% reported being unemployed, however, 28% reported earned monthly income that averaged \$1,036 a month. Therefore about half of these individuals earn too much earned plus unearned income to qualify for Medicaid without a spend-down. This would potentially be a problem for the 36% who reported receiving SSDI benefits because they would have to spend down to get Medicaid coverage.
- ✓ Up to 15% said they were aware that services like Personal Assistance Services (PAS) could be used on the job, nonetheless, but 70% of respondents indicated that they would sign up for a premium sharing program to get Medicaid benefits while working.

Overall, the consumer survey corroborated the committee's observations and experience.

## **III. State of Hawai'i Statistics**

The ability to predict the number of persons who may participate in such a program is critical. However, there is no precedent for such a program in Hawai'i and thus, no



specific historical data upon which to draw. There are, however, related programs on certain Medicaid populations that offer health care coverage to pregnant women and children. In trying to project the number of individuals who may become eligible for a Medicaid Work Incentive program, the following data was considered:

STATE OF HAWAI'I DISABILITY RELATED STATISTICS		
	Number	Average Benefit
Total Population (16-64)	781,052	n/a
SSDI disabled workers (18-64)	18,700	\$963
SSI recipients(18-64)	12,578	\$474
SSI Working	893	n/a
With a disability (16-64)	72,790	n/a
With a "go outside the home" disability (16-64)	18,909	n/a
With an employment-related disability	42,716	n/a

Sources: American Community Survey, 2005, U.S. Census; Social Security Administration, State Statistics – Hawai'i, 2005

#### IV. Review of States' Experiences:

As of December 2010, 45 states have implemented Medicaid Buy-in programs with total nationwide enrollment of 76,679. It should be noted that a majority of the states' buy-in programs have less than 2,000 participants, while a few have high participation, such as Massachusetts with over 10,000 enrolled in 2004. On average, 66% of the participants reported earnings, and a majority of states with buy-in programs showed greater than 80% of participants with earnings.

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The Medicaid Buy-in first became an option for states after Congressional approval of the Balanced Budget Act (BBA), which afforded states the option of providing Medicaid coverage to working individuals with disabilities who, because of their earnings, cannot qualify for Medicaid under other statutory provisions. In the Ticket to Work and Work Incentives Improvement Act (TWWIIA) gives states the option to provide Medicaid coverage to persons with disabilities who work by creating two new optional Medicaid eligibility groups: the "Medicaid Buy-in Group" and the "Medical Improvement Group." States are not, however, required to cover both groups. TWWIIA offers states flexibility in providing this coverage so long as eligibility is not more strictly defined than the criteria used for Supplemental Security Income (SSI). Thus, it is up to individual states to select income and asset limits under the administrative rules of their programs.

#### Key Findings on Medical Expenditures of Other States

Medical expenditures of Medicaid Work Incentive participants vary across states. Key findings are summarized below:

- ✓ When Medicaid and Medicare expenditures are combined, total per participants per month (PPPM) expenditures in 2002 for Medicaid Buy-In participants in the analytic group averaged \$1,467 – ranging from \$833 in Washington to \$3,024 in Indiana – with 73 percent paid by Medicaid and 27 percent paid by Medicare.

- ✓ States vary in the proportion of Buy-In participants' expenditures paid by Medicaid and Medicare. Indiana, with the highest combined PPM expenditures, has the largest share paid by Medicaid (92%), while Illinois and Arkansas have the largest share paid by Medicare (46%).
- ✓ In the 22 states with a Buy-In program as of 2002, average PPM Medicaid expenditures among Buy-In participants in 2002 were \$1,076, slightly higher comparing with an average of \$1,046 PPM Medicaid expenditures for Blind and Disabled population in the regular Medicaid program.
- ✓ PPM Medicaid expenditures ranged from \$460 in Washington to \$2,771 in Indiana. In 7 of the 22 states, PPM Medicaid expenditures were more than \$1,000.
- ✓ PPM Medicare expenditures averaged \$391, ranging from \$156 in New Mexico to \$699 in Utah.

<b>Medicaid Expenditures per Participant per Month (PPM) for Buy-In Participants Relative to Average Monthly Earnings in 2004</b>	
<i>State</i>	<i>Average PPM Medicaid Expenditures</i>
Arizona	<i>n/a</i>
Minnesota	\$1,725
Missouri	\$1,045
Wisconsin	\$1,010
Vermont	\$982
Washington	\$589

Source: Mathematica State Annual Buy-In Report Form for 2004.

Note: Data above are for participants enrolled for the entire fourth quarter of the given year. States are sorted in descending order of the average PPM Medicaid expenditures in 2004. The correlation between average PPM Medicaid expenditures and average monthly earnings among all Buy-In participants for 2003 is -0.27. Correlation with overall Medicaid expenditures - 0.37.

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In comparing other states, one can consider the effectiveness of Medicaid Work Incentive program's design. Beyond general observations across buy-in programs, four states were reviewed in detail when developing options for Hawai'i's buy-in program: Arizona, Minnesota, Missouri, Vermont, Washington, and Wisconsin. These states were chosen given their variety of sizes and legislative approaches taken in implementing a buy-in program. (Additional information on each of these states' programs can be found in Appendix C.) Some general statistics regarding these states can be found below:

<b>State Medicaid Buy-in Program Data</b>				
	<b>Arizona</b>	<b>Minnesota</b>	<b>Vermont</b>	<b>Washington</b>
Population Ages 16 to 64 (2005 ACS data)	3,667,827	3,328,870	410,222	4,124,279
With any disability and % of pop.	424,516 (11.6%)	321,129 (9.6%)	52,875 (12.9%)	544,482 (13.2%)
Income Eligibility Limitation	250% FPL	No limit; must have gross earnings $\geq$ \$65/month	250% FPL; after disregards, net income	220% FPL
Asset Limitation	None	\$20,000	\$5,000	None
Federal Authority	TWWIIA - Basic / Medical Improvement	TWWIIA - Basic	Balanced Budget Act	TWWIIA - Basic / Medical Improvement
Implementation Date	12/16/2002	7/1/1999	1/1/2000	1/22/2002
Medicaid Buy-in Enrollment and % of pop. with any disability (2004 data, Mathematica) <sup>a</sup>	835 (0.26%)	8,094 (2.61%)	840 (1.64%)	545 (0.11%)
SSDI disabled workers and % of pop. (Social Security Statistical Supplement, 2006) <sup>b</sup>	121,280 (2.7%)	89,130 (2.7%)	16,020 (3.9%)	122,460 (3.0%)
SSI 18-64 and % of pop. (Social Security, 2006) <sup>b, c</sup>	73,128 (2.0%)	54,583 (1.6%)	10,421 (2.5%)	87,556 (2.1%)
SSI Employment rate (Social Security Statistical Supplement, 2006) <sup>b</sup>	4.9%	15.3%	9.8%	6.0%
<sup>a</sup> % of pop. with any disability calculated from 2004 ACS data to match the 2004 enrollment data <sup>b</sup> 2005 data taken from 2006 SSA publication <sup>c</sup> SSI figures have been reduced to account for blind and disabled persons aged 65 and older.				

Source: American Community Survey, 2005, U.S. Census

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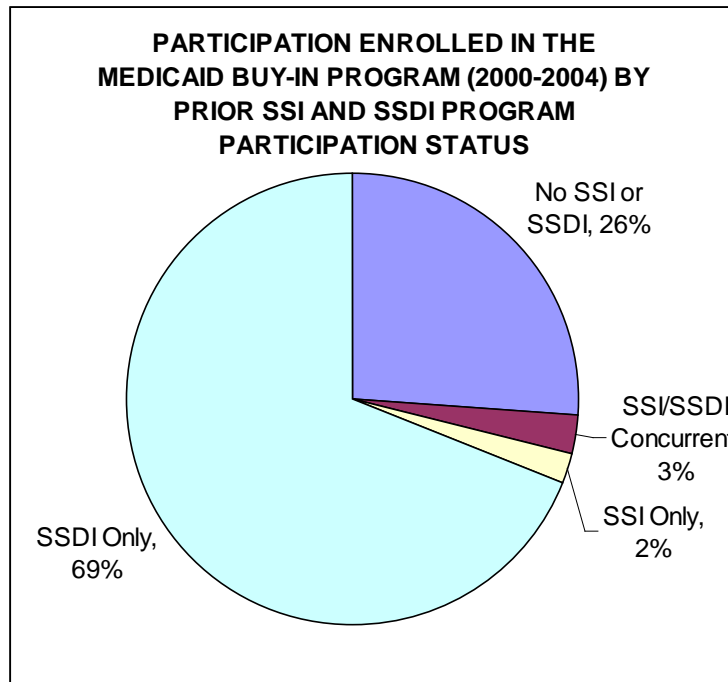
When considering Medicaid Work Incentives programs, there is often interest in statistics related to types of disabilities in a state and how a work incentive program could improve the employment outcomes for these groups. Data from several states, including Hawai'i, from the American Community Survey is summarized below:

<b>Population by Disability Type</b>							
	<b>Population 16 to 64 years</b>	<b>With any disability</b>	<b>With a sensory disability</b>	<b>With a physical disability</b>	<b>With a mental disability</b>	<b>With a self- care disability</b>	<b>With a go- outside- home disability</b>
<b>Arizona</b>	3,667,827	425,468	106,367	249,412	154,049	66,021	102,699
Percent	100.0	11.6	2.9	6.8	4.2	1.8	2.8
<b>Hawaii</b>	781,052	76,543	16,402	42,958	24,213	8,592	18,745
Percent	100.0	9.8	2.1	5.5	3.1	1.1	2.4
<b>Minnesota</b>	3,328,870	319,572	69,906	169,772	123,168	46,604	69,906
Percent	100.0	9.6	2.1	5.1	3.7	1.4	2.1
<b>Vermont</b>	410,222	52,919	12,307	29,946	21,742	6,974	11,896
Percent	100.0	12.9	3.0	7.3	5.3	1.7	2.9
<b>Washington</b>	4,124,279	544,405	140,225	309,321	218,587	78,361	119,604
Percent	100.0	13.2	3.4	7.5	5.3	1.9	2.9
<b>Wisconsin</b>	3,563,399	377,720	81,958	210,241	142,536	57,014	81,958
Percent	100.0	10.6	2.3	5.9	4.0	1.6	2.3

Source: American Community Survey, 2005, U.S. Census

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Although it is difficult to know the long-term impact of a buy-in program on each of these groups, early findings suggest that several of the groups benefits, particularly people with mental illness. There is often a misconception that enrollees in Medicaid Work Incentive plans would already be covered under other Medicaid programs. In fact, nearly 70% of other states' enrollees only participate in the SSDI program, while only 5% have participation history with SSI.



Data Source: Buy-In finder files from 27 states and Ticket Research File (TRF) Analytic Group: 126,606 ever-enrolled Buy-In participants from 2000 through 2004

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- ✓ **Many states have different approaches to income eligibility standards.** Eligibility standards and cost-sharing policies show considerable variation across the states and may have a significant impact on program enrollment. Most Medicaid Work Incentive programs have an upper income limit of 250% of FPL and broadened asset standards, but vary considerably in how they "count" income and assets. Limits on unearned income may be an important factor in restraining enrollment in several states. Generally, states' buy-in programs allow participants to keep more assets, such as retirement accounts, and medical savings accounts, than are permitted in traditional Medicaid programs.
- ✓ **Participation in programs is limited.** While there is great variation among the programs of the several states that have Medicaid Work Incentive programs, generally the participation is limited. Enrollment

participation by state is listed below:

NUMBER OF PARTICIPANTS EVER ENROLLED IN THE MEDICAID BUY-IN PROGRAM, BY YEAR AND STATE							
State	Implementation Date	2000-2004	2000	2001	2002	2003	2004
Massachusetts	7/1/1997	19,361	6,453	7,657	9,765	10,949	10,858
South Carolina	10/1/1998	155	90	103	104	76	66
Oregon	2/1/1999	1,509	380	648	800	981	782
Alaska	7/1/1999	613	103	186	260	307	347
Minnesota	7/1/1999	14,065	6,826	8,270	8,203	8,490	8,094
Nebraska	7/1/1999	317	132	176	156	151	134
Maine	8/1/1999	2,404	572	949	1,107	1,166	1,027
Vermont	1/1/2000	1,480	362	517	683	760	840
New Jersey	2/1/2000	1,911	3	323	723	1,161	1,626
Iowa	3/1/2000	11,348	2,427	4,153	5,947	7,586	9,246
Wisconsin	3/1/2000	10,789	968	1,996	4,478	6,734	9,113
California	4/1/2000	2,195	258	712	902	1,152	1,502
Connecticut	10/1/2000	6,389	1,008	2,654	3,511	3,838	4,318
New Mexico	1/1/2006	2,740	—	565	1,113	1,520	1,797
Arkansas	2/1/2006	263	—	213	218	122	107
Utah	7/1/2006	960	—	196	395	433	496
Illinois	1/2/2006	798	—	—	160	456	798
Pennsylvania	1/2/2006	6,203	—	—	1,511	3,148	5,463
Washington	1/2/2006	601	—	—	157	288	545
New Hampshire	2/2/2006	2,246	—	—	1,102	1,503	1,909
Indiana	7/2/2006	11,144	—	—	4,297	7,887	8,862
Kansas	7/2/2006	1,178	—	—	523	830	1,001
Missouri	7/2/2006	24,686	—	—	8,919	17,627	22,783
New York	7/3/2006	2,543	—	—	—	634	2,541
Louisiana	1/4/2006	499	—	—	—	—	499
Michigan	1/4/2006	123	—	—	—	—	123
West Virginia	5/4/2006	86	—	—	—	—	86
Total		126,606	19,582	29,318	55,034	77,799	94,963

Source: Black and Ireys. "Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy- In Program, 2003-2004." Washington, DC: Mathematica Policy Research, January 2006.

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✓ **States reported no difference in the utilization rate.**

The states reporting their experiences, to date, indicate that the disabled individuals in their Medicaid Work Incentive programs do not use Medicaid services at any greater or lesser rate than those in their standard coverage groups, i.e. SSI or Medically Needy groups.

✓ **There is a wide range of cost data across states that generally reflects the underlying Medicaid costs prior to program implementation.**

The average per member per month (PPPM) Medicaid expenditures in the fourth quarter of 2004 was \$1,176 and in a study of all the implementing states, states with high PPPM expenditures before the program had high PPPM expenditures after the program and states with low PPPM expenditures before the program, experienced low PPPM expenditures after the program as well.

✓ **Premiums are currently being charged in most states.**

Buy-In programs vary widely in their premium and cost-sharing structures. Under

federal law, states can require a premium or other means of cost sharing (that is, coinsurance or co-payment) from Buy-In participants. Nearly all states have established a premium structure tied to a sliding scale based on income. A premium structure can be an effective tool for states interested in influencing enrollment trends. Some states are instituting a mandatory one-time entry fee for participants who enroll in the program in lieu of or in addition to a premium payment. However, states are limited in their ability to use premiums and other cost sharing to raise revenue because they retain only the state's share of the returns and must turn over the remainder to CMS. For example, if a state has a 50 percent Medicaid match, it must return \$50 for every \$100 collected in premiums.

## **PROCESS OF DETERMINING GOALS**

### **National Support from the Centers for Medicare and Medicaid Services**

The Hire Abilities program was created through funding by the Centers for Medicare and Medicaid Services to facilitate the competitive employment of people with disabilities through: (a) Medicaid buy-in opportunities under the Medicaid State plan, (b) significant improvements to Medicaid services that support people with disabilities in their competitive employment efforts, and (c) providing comprehensive coordinated approaches across programs to removing barriers to employment for individuals with a disability.

### **National Observations Regarding Employment for People with Disabilities**

- *Low Expectations:* In general, society has low employment expectations for people with disabilities, in spite of example after example of individuals who have highly successful careers. We reinforce those low expectations by tying income and healthcare benefits to NOT working. Employment for many individuals is seen as a social-developmental activity, not as the primary defining role that it is for people without severe disabilities. Family members, friends, service providers, and the individuals themselves share and reinforce this attitude, leading to a self-fulfilling prophesy. These low expectations often begin early in life and are repeated and reinforced as individuals mature. Equally important is the message we send to potential employers: Why should they hire people with disabilities? They can only work a few hours; they cannot do certain tasks; they are unreliable; they are often sick; they have high absenteeism.
- *Segregation:* We force people into programmatic silos based on their age, their disability, or their education. This in turn leads to limited opportunities for employment based on the particular silo they are in. We build silos based on the services and supports that are provided by specialized agencies (mental health centers, vocational rehabilitation agencies, day care centers, and schools). Each has its own agenda and seeks a particular clientele. We segregate people with disabilities into day activity programs, sheltered workshops, enclaves, etc. and

much of this segregation is tied to funding streams.

- *Fragmentation*: Similarly, our employment support system for people, especially those with disabilities, is fragmented. It has many relatively autonomous parts. Our educational system works with children and young adults, preparing them for employment or higher education. The post-secondary education system is composed of colleges, universities, community colleges, and technical schools. The vocational rehabilitation system provides a variety of vocational services including counseling and training. Workforce Incentive Act, One-Stops provide access to job services and vocational services and supports. Mental health centers and organizations that serve people with developmental disabilities provide employment related services. All too often, these systems do not interact or interact ineffectively.
- *Contradictory Messages*: People with disabilities, their families and friends, and employers are being inundated with contradictory messages. To be eligible for assistance in going to work through the Social Security Administration a person must first prove he or she is so disabled that they cannot work. Congress, through this very legislation as well as other Federal statutes establishes employment goals for people with disabilities, but there are other statutes that penalize work attempts.
- *Complexity*: The Federal and State statutes, regulations, guidelines, and other legal documents represent a large amount of exceedingly complex material. The rules for getting on Medicaid, and then staying on, are complex. The Social Security disability rules and regulations are different and also very elaborate. When we combine these complexities with the multiple organizations that people with disabilities must navigate, it is amazing that as many people with disabilities work as do. Also because of this complex system of red tape and multiple organizations, prospective employers tend to avoid becoming involved.

### **Recommended Program Characteristics**

The Hire Abilities Advisory Board reviewed and discussed the information cited in this report. In addition, individual members of the team drew upon professional experience in working with persons with disabilities living in Hawai'i. After debate regarding the different features of a program design, there was consensus regarding the need for Hawai'i to implement a Medicaid Work Incentive Coverage program. In short, the team recommends that the development of the program conform to the following characteristics:

- ✓ *Simplicity*: The program should be a model of simplicity in order to reduce administrative procedures and costs and be user-friendly. This could be achieved by adding a program to the QUEST system, similar to those other programs that have been created for special class of individuals. For instance, people can currently receive coverage when losing Medicaid Fee-For-Service (FFS) or QUEST through the QUEST-Net program. In addition, special coverage

provisions are available for pregnant women and children. In this light, a new special class for Medicaid should be created for working people with disabilities.

- ✓ *Equal Treatment:* To overcome inequities in the current system, the program should give equal treatment to all working persons who are certified disabled by the Social Security Administration or by the State Medical Review Team. All qualified individuals deserve access to this work incentive regardless of whether they receive SSI, SSDI, both or neither. Currently, federal and State welfare policies that have separated eligibility for healthcare from eligibility for cash assistance, in order to encourage return to work for low-income individuals. The net result of this policy is that when people with disabilities enter the job market, those who have no or minimal work history are afforded greater access to healthcare than those with enough history to qualify for SSDI.
- ✓ *Delinking Healthcare for People with Disabilities and Federal Poverty Line:* Eligibility for the program should not be overly restricted by income, assets, or other resources of the individual or spouse. Eligibility should be determined primarily by an individual's certified disability and willingness to work. For people with disabilities, access to Medicaid is limited to those under 100% FPL (\$980/month in 2007) and strict asset limits, and access to Medicare is through SSDI eligibility which is limited to those under SGA (\$900/month in 2007), which is under 100% FPL in Hawai'i. These eligibility requirements leave several groups of people with disabilities with a difficult choice between work and healthcare. At present, the eligibility requirements make it difficult for people with disabilities to enter the job market. (For more information on potential beneficiaries, see the section on Potential Coverage Groups below.)
- ✓ *Second Tier Coverage for those with Employer-based Plans:* The program should be available as a second layer of coverage to those who have employer-based healthcare coverage. This would cover out-of-pocket expenses not otherwise covered by private insurance, and would function similar to a Medi-gap plan.
- ✓ *Premium and administrative setup linked with the state's QUEST program:* To simplify premium setup and administration of the buy-in program, it should be linked with the QUEST program as closely as possible. Since Hawai'i already provides coverage beyond basic Medicaid through QUEST-Net for people losing Medicaid FFS or QUEST, there is already an infrastructure to manage the administrative and premium collection needed for the QUEST WINS program.
- ✓ *Integration with the Department of Human Services' Section 1115 Project:* Hawai'i is currently working on a Section 1115 project with CMS that will, among other goals, seek to expand the QUEST program and move much of it into managed care. A Medicaid Work Incentive could be designed and implemented in the context of the Section 1115 project, as was done in Massachusetts and Arizona. Although eligibility for the Buy-In program requires that individuals be working, neither BBA nor TWWIIA establishes, or allows states to establish, a



minimum number of hours worked in a given period. For example, Massachusetts requires Buy-In participants to work at least 40 hours per month. Massachusetts was able to define work because it implemented its Buy-In program through an 1115 Medicaid demonstration waiver in 1997, freeing the state from the Buy-In guidelines in both BBA and TWWIIA. Section 1115 of the Social Security Act gives the federal Secretary of the Department of Health and Human Services authority to waive aspects of the federal Medicaid law to permit states to undertake special research and demonstration projects. QUEST WINS could be connected to the Section 1115 implementation of Medicaid into managed care with the permission of the federal Secretary of the Department of Health and Human Services.

### **Guiding Principles**

- ✓ People with disabilities are valuable human resources; there is a community expectation that they will participate in the labor force to the maximum extent possible.
- ✓ Anyone, regardless of disability, must have the opportunity to participate in the labor force and have the right to fair treatment in exercising that opportunity.
- ✓ Local labor market (employer) needs must be met.
- ✓ There must be a mutual benefit to the employee with a disability and the employer.
- ✓ Employment must be in typical integrated workplace settings appropriate to the type of work.
- ✓ All employment options must be available from entry-level jobs to the most advanced occupations.
- ✓ Individuals have the right to choose their employment and employer.
- ✓ Employers have the right to choose whom they hire.
- ✓ People have the right to take risks in the employment they choose.

### **Systems Expectations**

- ✓ The system will maximize employment for people with disabilities.
- ✓ The system will provide a high quality workforce for employers.
- ✓ It will provide effective leadership at the State and local level.
- ✓ It works for all job seekers (not just persons with disabilities)
- ✓ It is responsive to the needs of employers and people with disabilities.
- ✓ It has both a local and a State structure; it is based in local communities.
- ✓ There is ease of access for employers and potential employees; simplicity of design.
- ✓ It effectively tracks employment and earnings (outcomes) and demonstrates clear measures of success.
- ✓ It is permanent—available to people whenever they need it. It must be built on a stable funding base, not competitive grant funds.
- ✓ It does not put the individual (with a disability) or the employer at risk.
- ✓ It puts a premium on communication and coordination among all the elements of the system.

**Service and Support Principles**

- ✓ It must be as transparent as possible to both the employer and employees.
- ✓ The individual's employment choices and resulting services and supports should be based on individual person-centered designs.
- ✓ Person-centered planning tools need to focus on employment.
- ✓ Services and supports should include "whatever it takes" to achieve successful employment outcomes.
- ✓ Public and post-secondary education are key ingredients to success in a changing business world.
- ✓ Service and support practices must be "evidence based" (tested).
- ✓ Assistive technology must be accessible, universal, flexible, and replaceable.
- ✓ Technology is a critical tool to the provision of services and supports.
- ✓ Quality healthcare coverage must be available to all.
- ✓ Other employment-related services and supports must be available on an as-needed basis (e.g., transportation, child care, personal assistance, assistive technology).

Note: Guiding Principles, Systems Expectations, and Service and Support Principles are referenced from the CMS Medicaid Infrastructure Grant proposal, 2008.

## **POTENTIAL COVERAGE GROUPS**

TWWIIA governs the provision of health care services to workers with severe disabilities by establishing a Medicaid state plan buy-in optional eligibility groups. The Balanced Budget Act originally provided optional Medicaid eligibility group for working individuals with disabilities. By the end of 2006, over 80,000 individuals in 32 states were covered under these two new eligibility groups.

The strength of employment incentives created by Medicaid Work Incentive programs vary depending on individual circumstances and the reasons why a person might be desire to participate in QUEST WINS. Broad types of individuals should be considered when designing QUEST WINS:

### **1. Former 1619(b) Recipients and Others with earnings too high for Medicaid**

One group that would be cover under the Medicaid Work Incentive would be former recipients of SSI cash benefits participating in Section 1619(b), *with earnings at or near the section 1619(b) income threshold*. Under Section 1619(b), individuals can earn up to \$28,263 in 2007. Under the proposal, a single individual could earn \$59,770, or 250% FPL using the SSI income calculation. With Medicaid Work Incentive Coverage, these individuals can increase their earnings without losing Medicaid coverage.

### **2. Medically Needy / Spend Down Categories**

The Medicaid Work Incentive Coverage, as proposed, would also cover people *with disabilities enrolled in Medicaid under a medically needy, spend down, or poverty level categories, who*, if enrolled in the buy-in, could work more and/or retain more of their income and assets without losing Medicaid coverage. Once a buy-in is implemented, there will no longer be a reason for working individuals with disabilities requiring health insurance to enroll in the spend-down categories. Currently, there are approximately 2,500 individuals that spend-down to receive Medicaid.

### **3. People who might otherwise qualify for Medicaid, but for asset limits**

This group might include *SSDI beneficiaries in the 24-month waiting period* before receiving Medicare, *working SSDI beneficiaries* nearing the end of an extended period of Medicare coverage who will soon experience a loss of Medicare, and non-beneficiaries who meet the SSA medical disability criteria who lack or expect to lose private or public health insurance coverage.

### **4. People whose other insurance alternatives are too expensive**

People with disabilities whose premiums/cost sharing for other private or public insurance coverage (e.g., through private insurance, COBRA, spouses, or Medicare) exceed the premiums/cost sharing required by QUEST WINS. This group might include both SSDI beneficiaries and non-beneficiaries who meet the SSA medical disability criteria. The buy-in represents a lower price alternative to current coverage.

**5. People whose insurance does not provide medical supports**

People with disabilities whose private and/or public (Medicare) coverage does not provide needed medical supports, but which are covered by the buy-in. This group might include both SSDI beneficiaries and non-beneficiary workers who meet the SSA medical disability criteria.

## ELIGIBILITY REQUIREMENTS

### *Index of Eligibility Restrictiveness*

Additional analysis has been performed utilizing a quantitative review of other states' buy-in policies. To assess the effects of these program features on enrollment, an index of eligibility restrictiveness was constructed to distinguish programs that are minimally restrictive from those that are maximally restrictive. States were scored based on their restrictiveness in each of the three categories.

Index of Eligibility Restrictiveness		
Threshold	Category	Score
Earned Income	No Limit	0
	450% to 800% FPL	1
	300% to 350% FPL	2
	250% FPL	3
	220% to 225% FPL	4
	200% FPL	5
	No Limit	0
Asset Limit	\$20,000 to \$25,000	1
	\$12,000 to \$15,000	2
	\$8,000 to \$10,000	3
	\$4,000 to \$5,000	4
	\$2,000	5
Separate Unearned Income Limit	No	0
	Yes	3

State Scenarios by Eligibility Levels							
State	Implementation Date	Buy-In Enrollment per 10,000 State Residents with a Disability (Age 16-64)		Earned Income Threshold	Individual Asset Limit	Unearned Income Limit	Index of Eligibility Restrictiveness
		December, 2005	Rank	(% of FPL)			
Wisconsin	March, 2000	257.7	2	250 <sup>a</sup>	15,000 <sup>c</sup>	No	5
Minnesota	July, 1999	206.8	4	No Limit	20,000	No	1
Vermont	January, 2000	114.6	7	250 <sup>a</sup>	5,000 <sup>ce</sup>	Yes	10
Arizona	December, 2001	24.4	15	250 <sup>b</sup>	No Limit	No	3
Washington	January, 2002	14.5	18	220 <sup>ad</sup>	No Limit	No	4

a Includes spousal income  
b Does not include spousal income  
c Includes spousal assets  
d Includes earned plus unearned income, after disregards and exclusions  
e Disregards assets accumulated since enrollment  
Sources: Participant-level data submitted by states (April 2006) and the Ticket to Work Medicaid Infrastructure Grant Reporting  
Note: Only states implementing Buy-In programs in 2002 and earlier are included in this table. This allows for more equal comparison on enrollment-related indicators because states that have recently implemented a program are still in the stage of rapid enrollment growth, which can hide or distort the effect of other indicators.

**See Appendix D for eligibility restrictiveness of other states with Medicaid buy-in programs.**

### Income Limits

*Recommendation: Increase the net earned income limitation.*

*Rationale:* The net income standard for Medicaid eligibility in Hawai'i is 100% of FPL, or \$980/month, which with current income disregards applied, equates to \$2,043/month in gross wages. This places a significant obstacle to people with disabilities that would otherwise seek employment but for the threat of losing

healthcare coverage.

Under the state's current Medicaid guidelines, an individual could not earn above the 100% FPL limit (\$980/month in 2007). Examples of individuals who would not be covered under the state's current Medicaid program, but would be covered under QUEST WINS are highlighted in the shaded scenarios listed below:

*Recommendation: Provide an unearned income disregard.*

*Rationale:* Under the current system, many with low levels of earned income are not eligible for Medicaid because there are no disregards for unearned income. For instance, under the current system, an individual with monthly a SSDI benefit is significantly limited in his/her ability to earn additional income without jeopardizing his/her healthcare.

***Examples of how changes in income can allow people with disabilities to work more and retain healthcare are found in Appendix E.***

#### Asset Exclusions

*Recommendation: Exclude higher asset levels above the \$2,000 limit currently in place for Medicaid.*

*Rationale:* Persons with disabilities have many expenses associated with employment not generally faced by non-disabled workers. For example, a modified vehicle may be required for transportation to and from work. Some individuals may require adaptive equipment, a communication augmentation device, work site modification, or other forms of assistive technology. It is also important for a person with a disability to have an emergency fund available to meet unexpected expenses such a loss of a hearing aid, repair and maintenance of a modified vehicle, etc. The committee reviewed asset limits established by other states and selected those recommended above.

*Recommendation: Exclude retirement plans and development accounts, such as 401(k)s, Individual Development Accounts (IDAs) and Individual Retirement Accounts (IRAs).*

*Rationale:* Persons with disabilities have the right and necessity of saving for retirement. By allowing people with disabilities who work build assets, there will be less strain put on state systems, allowing them to concentrate on those who truly need the assistance.

#### Premium & Enrollment Fees

*Recommendation: Require an enrollment fee and a monthly premium charge based on a sliding scale of countable income for earnings above 100% FPL (\$980/month in 2007).*

*Rationale:* Premium participation that can be linked to current QUEST systems to ease administration. Decisions about who pays a premium, how much each participant pays, and how premiums change across different income brackets can be used to shape enrollment patterns. An important feature of the premium structure is the income threshold above which all participants must pay a premium. Two other key features of a program's premium structure are the amount of the premium payment and the treatment of earned and unearned income for purposes of premium calculations.

#### Work Requirement

*Recommendation:* Proof of income should be required in the form of pay stubs, tax returns, or other official documentation.

*Rationale:* This program is designed to remove barriers to employment for persons with disabilities. Without a work requirement, the program will be used by consumers to shift additional costs onto the state, will prove burdensome on the QUEST system, and will ultimately fail like Missouri's program.

#### Medicaid Eligibility Review

*Recommendation:* A Medicaid Eligibility Review should be conducted every 12 months.

*Rationale:* It is important to the long-term viability of the system to periodically verify eligibility. This should not be burdensome to the participants, since they should, at a minimum, be seeing a physician once a year.

#### Basic Coverage & Medical Improvement

*Recommendation:* Hawai'i's Medicaid Work Incentive program should be created under the Ticket to Work and Work Incentives Improvement Act (TWWIIA), with both Basic Coverage and Medically Improved categories.

*Rationale:* Of the two federal laws that authorize Medicaid Buy-ins, TWWIIA provides the most robust work incentives. When a participant becomes ineligible for coverage under the Basic Group due to medical improvement, continued eligibility can be established using the Medically Improved Group. Individuals in this group cannot receive long-term care services, but can keep their Medicaid coverage.

## **PROGRAM OPTIONS**

Below are program options based on varying eligibility requirements modeled after existing Medicaid Buy-in programs in three other states. It should be noted that state programs vary mostly owing to eligibility requirements, and once an individual qualifies for Medicaid, he/she receives standard Medicaid services in that state, and that not all state Medicaid programs differ by state. That said, existing state Medicaid Buy-in programs provide the best data from which to understand how policy decisions may

impact enrollment.

<b>3 Eligibility Options</b>			
	<u>Option A - MN Model</u>	<u>Option B - VT Model</u>	<u>Option C - AZ Model</u>
Buy-In Enrollment (State Residents with a Disability, Age 16-64)	1,505	835	180
Earned Income Threshold (% of FPL)	No Limit	250 <sup>c</sup>	250 <sup>ab</sup>
Unearned Income Limit	No	No	No
Individual Asset Exclusions	\$20,000	\$10,000 <sup>d</sup>	\$10,000 <sup>d</sup>
Monthly Premium	\$35 to 7.5% of gross income	5% of monthly countable income	5% of monthly countable income
Coverage Groups	Basic + Medically Improved	Basic + Medically Improved	Basic
a Includes spousal income b Includes earned plus unearned income, after disregards and exclusions c Does not include spousal income d Includes spousal assets			

<C:\Documents and Settings\Bill Mihalke\Desktop\Medicaid Buy-in\DRAFTS\DRAFTS - Working Docs\Analysis\MBI 3 Option CBA - v1.1 - Buy-in Participants.xls>

## Cost

As previously pointed out in the report, of the states that have implemented a Medicaid Work Incentive program, the participation rate among the disabled population in those states has been low, approximately one percent.

### *Participation Estimate*

Participation has been estimated based on models 3 models of varying levels of restrictiveness.

### *Medicaid Cost per Participant*

The cost per participant per buy-in program, as estimated by the Med-QUEST division, is approximately \$15,000 per year beginning in Year 1, with an assumed increase of 10% per year.

## Benefits/Savings

The most tangible benefit to the state would be from the increase in taxes paid by those employed. In fact, a recent study entitled *Medicaid: Good Medicine for State Economies - 2004 Update* by Families USA Foundation determined that:

- ✓ For every \$1.00 that the state spends on Medicaid, there is a business activity return of up \$3.17.
- ✓ In FY 2005, there were an estimated 11,000 jobs created due to Medicaid spending, with total spending on wages of \$466 million.



- ✓ For every \$1 million spent on Medicaid, there are the following results: \$3.2 million in new business activity; 29.34 jobs created; and \$1.2 million in new wages.

A December 1999 study commissioned by the Able Trust reported that 23% of earned income from people with disabilities would be returned to the state and federal governments in taxes. That study further concluded that there are other intangible or non-monetary outcomes that can be seen as benefits. In addition to employment and tax revenues, those benefits can include:

- ✓ Increased educational attainment
- ✓ Access to equipment or resources needed for independence
- ✓ Improved self-image and greater self-esteem
- ✓ Improved communication and interpersonal skills
- ✓ Improved job-related skills
- ✓ Improved self-sufficiency and decreased dependency upon other forms of support
- ✓ Overall increased quality of life

## **ADDITIONAL POINTS OF CONSIDERATION AROUND IMPLEMENTATION**

The Hire Abilities project is committed to assisting the Department of Human Services with the following elements of development and implementation:

1. Broad involvement of relevant interest groups with policy-makers seeking consensus on program development issues
2. Creation of education and outreach materials
3. Outreach, education and supports to employers, providers, and consumers
4. Development of a benefits information network to support work incentive planners, such as Hawai'i Protection and Advocacy and the Department of Labor One-stop Navigators
5. Measurement of buy-in participation levels once a program is implemented

Since the overall goal of the MIG grant is to maximize employment opportunities for people with disabilities who want to work or work more, upon the implementation of a Medicaid Work Incentive by DHS, the MIG team will adjust its focus toward comprehensive employment. This will include collecting data and measuring results of the Buy-in program and then comparing results with other states' programs. Working with national technical support organizations, continuing support will be provided to DHS by the MIG team.

### **Legislative Authority**

A number of states implemented their buy-in programs through the Balanced Budget Act (BBA). Due to the passage of the Ticket to Work and Work Incentives Improvement Act (TWWIIA), states now have a choice of implementing a buy-in program under either

the authority of the BBA or TWWIIA.

Depending on the choice of legislative authority, there are different restrictions with respect to the program design. The BBA allows states to provide Medicaid coverage to working individuals with disabilities whose family's net income does not exceed 250% of the FPL. Two additional provisions were added under TWWIIA (P.L. 106-170). The first allows states to further expand Medicaid coverage to working individuals with disabilities, between the ages of 16 and 64, with incomes and resources as defined by the state, and allows states to impose premiums and other cost-sharing on individuals who qualify. The second allows states, under certain circumstances, to provide coverage to persons whose medical conditions have improved and who have therefore become ineligible for SSI on the basis of disability.

Additional details on the BBA and TWWIIA are listed below:

- ✓ Income Restrictions – Under the BBA, states are required to limit buy-in eligibility to those with “net family income” no higher than 250% of FPL for a given family size, and resources not exceeding the SSI resource limits (\$2,000 for an individual/\$3,000 couple). Section 1902 of the Social Security Act allows states to disregard additional kinds and amounts of income and assets beyond what is generally allowed. As a result, the income and asset restrictions under the BBA are less restrictive than they may appear. In addition, states are required to use the SSI income counting methodology in determining eligibility for the program. That methodology defines income as equal to unearned income minus \$20 plus one-half of all earned income above \$65. In contrast, TWWIIA puts no restrictions on income or assets for purposes of eligibility. (See Appendix E)
- ✓ Definition of Disability – TWWIIA allows states to establish up to two optional Medicaid eligibility categories. States may cover working individuals with disabilities, ages 16 to 64, who, except for earned income, would be eligible for SSI (Basic Coverage/Medicaid Buy-in Group) and individuals whose medical conditions have improved and are determined to be no longer eligible for SSI or SSDI, but who still have a severe impairment (Medically Improved Group). The BBA restricts eligibility to those meeting the criteria for the Medicaid Buy-in Group only.
- ✓ Cost Sharing Restrictions – Both BBA and TWWIIA allow states to establish a mechanism to share the costs of the program with participants. States may charge participants premiums set on a sliding scale based on income. Under TWWIIA, premiums may not exceed 7.5% of income. BBA specifies no such restrictions on premiums.
- ✓ Age Restrictions – TWWIIA restricts enrollment in the buy-in to people ages 16 to 64. There is no age restriction specified in BBA.

The chart below highlights key differences between BBA and TWWIIA authorizations that enable the states to implement Medicaid Buy-in program. It should be noted that Hawai'i has an additional consideration for QUEST WINS implementation given its Section 1115 project that is broadly implementing managed care for its Medicaid

populations, including the Aged, Blind, and Disabled group currently in the state plan.

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

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

Source: Goodman and Livermore. "The Effectiveness of Medicaid Buy-in Programs in Promoting the Employment of People with Disabilities." Washington, DC: Cornell University Institute for Policy Research, July 2004.

Concurrent to Hawai'i's MIG, the state's Department of Health and Human Services is participating in a demonstration project, called QUEST Expanded, under Section 1115 of the Social Security Act. Hawai'i's Section 1115 demonstration gives Hawai'i broad flexibility in offering Medicaid to additional coverage groups, such as:

- ✓ Adult TANF recipients not Medicaid eligible
- ✓ Childless adult GA recipients not Medicaid eligible
- ✓ Adults who have lost QUEST or Medicaid Fee-for-Service (QUEST-Net adults)
- ✓ Adults with incomes at or below 100% FPL and who meet Medicaid asset limits, but are not otherwise Medicaid eligible (QUEST-Adult-Coverage-Expansion)
- ✓ Children not SCHIP/Medicaid eligible

Given the similarity of the buy-in program's goals with those of the Section 1115 demonstration, QUEST Expanded should be considered when framing Hawai'i's buy-in program for people with disabilities. If QUEST WINS is to be integrated with Hawai'i's Section 1115 demonstration, the context of the state's managed care integration should also be considered.

A chart in Appendix E summarizes various paths that are currently used by states as means of establishing eligibility to Medicaid coverage to recipients. Hawai'i is a Section 209(b) state, which gives the Department of Human Services flexibility in its administration of its Medicaid program. Hawai'i uses the same eligibility criteria as Social Security, and since Medicaid is not directly tied to Supplemental Security Income, Medicaid is often awarded more quickly than Social Security benefits.

## **APPENDIX A – DEFINITION OF DISABILITY UNDER THE TICKET TO WORK AND WORK INCENTIVES ACT (TWWIIA)**

### **TITLE II--EXPANDED AVAILABILITY OF HEALTH CARE SERVICES**

#### **SEC. 201. EXPANDING STATE OPTIONS UNDER THE MEDICAID PROGRAM FOR WORKERS WITH DISABILITIES.**

***(a) In General.--***

***(1) State option to eliminate income, assets, and resource limitations for workers with disabilities buying into medicaid.--Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396(a)(10)(A)(ii)) is amended--***

***(A) in subclause (XIII), by striking ``or" at the end;***

***(B) in subclause (XIV), by adding ``or" at the end;***  
***and***

***(C) by adding at the end the following new subclause:***

***``(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;"***

# APPENDIX B – FOCUS GROUP AND CONSUMER SURVEY RESULTS

## MEDICAID INFRASTRUCTURE GRANT – HAWAII

### 2005 CONSUMER AWARENESS AND UTILIZATION OF WORK INCENTIVE PROGRAMS

#### BACKGROUND

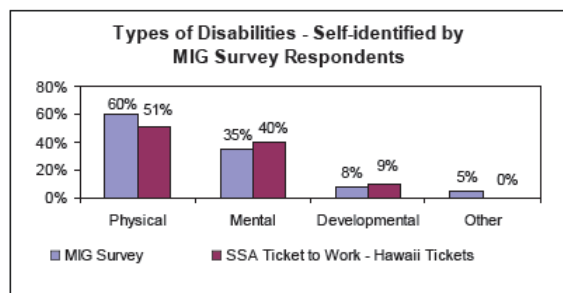
Medicaid offers critical protections to people with disabilities, particularly those with chronic conditions that have no cure or solution. Some people with disabilities qualify for Medicaid by a disability designation similar to that used by Social Security for SSI, while others qualify through Home and Community based waivers.

Many with disabilities aspire to go back to work, yet find themselves in a “Catch 22” position of losing critical benefits that improve their health and keep them on a positive path toward a productive life. Ironically, when people with disabilities are able to manage significant health problems, they are often experience a financial barrier that prevents them from growing their earnings and joining the general, tax-paying public.

Many work incentives exist around the country, and different states have different models to improve employment levels for people with disabilities. An important first-year milestone for the Medicaid Infrastructure Grant (MIG) was the gathering of data related to public awareness and utilization of government programs through primary research.

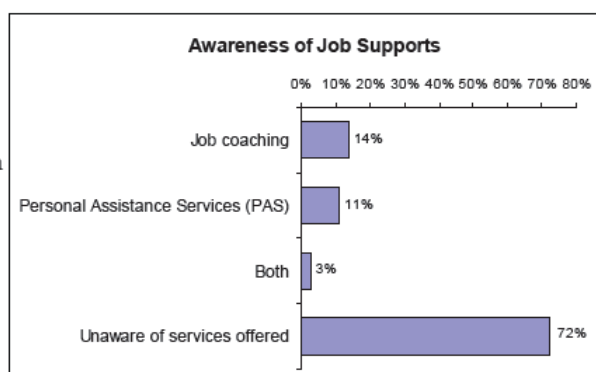
#### STUDY METHODOLOGY

In order to gather base-line information about levels of awareness and programming needs among those with disabilities, the MIG team performed both a survey and series of focus groups in 2005. *The survey yielded 105 valid participants.*

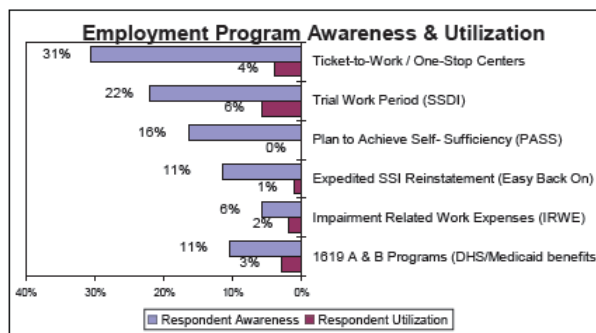


#### SURVEY FINDINGS

- 72% of the sample was unemployed; 28% reported earned monthly income that averaged \$1,036.
- Low levels of knowledge by survey respondents regarding job supports.



- Only low to moderate awareness of work-related programs, with low levels of utilization.



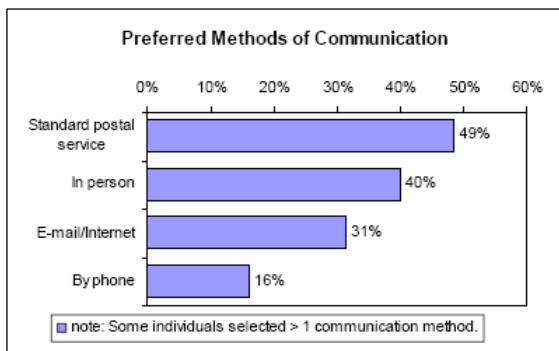
Note: Per Social Security Administration reporting (2005), 2.54% of all blind and disabled SSI recipients in Hawaii participate in Section 1619 work incentives.

- A high level of interest in additional work incentives exists in the disability community.

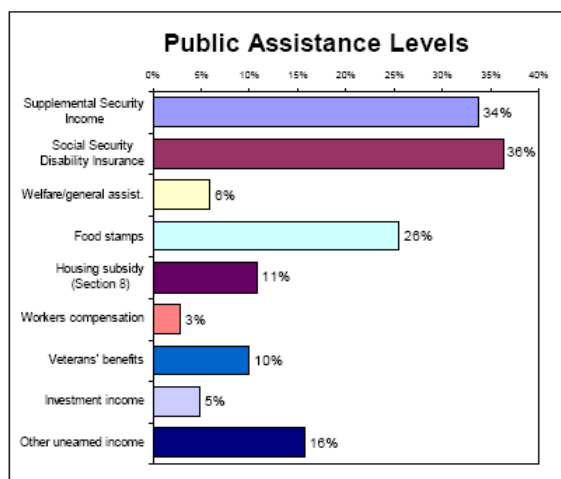
69.6% of survey respondents would sign up for a premium sharing program that would let them increase their earnings without losing their Medicaid benefits.

82.4% of survey respondents expressed interest in additional information about how to find and keep a job that would allow them to increase earned income without losing their Medicaid benefits.

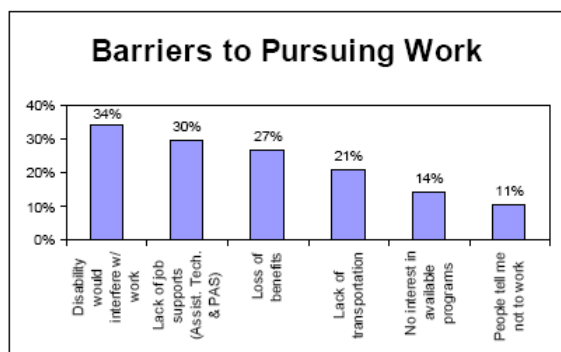
5. Preferences indicate several methods of communication are needed to effectively raise awareness, with standard post and in-person communication the most preferred.



6. Respondents receive supplemental income from several sources.



7. A variety of factors are perceived as barriers to work for those with disabilities.



### FOCUS GROUP FINDINGS

Thirteen focus groups were held on the islands of Oahu, Maui, Kauai, and the Island of Hawaii. The general consensus of focus group participants was that they would like to work and develop a career so long as they did not have to endure the stress of losing benefits, particularly Medicaid.

1. Participants were asked if they had a “dream job,” and they described a wide variety of responses, totaling 58 “dream jobs”. The following are among the most frequent responses:

- Teacher / Professor
- Social Worker
- Forest Ranger
- Entrepreneur / Self-Employment
- Artist / Writer
- Deaf Daycare
- Auto Body Shop Mechanic
- Doctor / RN / Cert. Nurse’s Assistant
- Lobbyist / Advocate
- Accountant

2. A variety of job supports were discussed by focus group participants when asked to identify job supports that help their ability to find work and build a career. These include the following:

- Dept. of Vocational Rehabilitation
- Family support
- United Way
- Hawaii Center for Independent Living
- Churches
- Goodwill
- Steadfast
- Clubhouse
- PASS Program
- Assistive Technology

3. To the contrary, the following were identified as hindrances to finding work and building a career:

- Lack of funds to undergo training
- Lack of transportation
- Insufficient access to vocational rehabilitation
- Lack of opportunity matching education
- People with disabilities being pigeon-holed into low paying service jobs
- Lack of personal assistance in workplace
- Need for additional child care
- Lack of information on available services
- Case managers not equipped with information to assist clients
- Long, stressful & time consuming process

## **APPENDIX C – FIVE STATES’ MEDICAID WORK INCENTIVE PROGRAMS**

(see Black and Ireys, “Understanding Enrollment Trends,” 2006)

### **ARIZONA**

**Overview** – Arizona’s Medicaid Work Incentive program, entitled Freedom to Work (FTW), was implemented in December 2002, under the TWWIIA. Arizona, like Massachusetts, is operating its Medicaid Work Incentive program within a broad, statewide Section 1115 Demonstration Waiver. FTW provides Medicaid services to qualified individuals with disabilities who are determined ineligible for Arizona’s regular Medicaid program due to earnings. Individuals who qualify for FTW may also receive services; Arizona has specific elements for review before an FTW participant may access services. Arizona is implemented both the Basic Coverage Group and the Medical Improvement Group.

**Eligibility Criteria and Program Context** – This program is for disabled individuals of ages 16 to 65 who work and whose own monthly countable income from work is \$2,042 or less. This income limit is 250% FPL which is readjusted each year – usually upward - at the beginning of April. There is no limit on resources. An applicant must be a U.S. citizen or qualified immigrant and an Arizona resident. A Social Security number is required.

For the Basic Coverage Group, the individual must be age 16 to 64, have a disability, and must be employed (see description below). When a FTW participant becomes ineligible for coverage under the Basic Group because he or she no longer meets the disability definition, FTW eligibility can be “redetermined” using the Medically Improved Group. Individuals in this group cannot receive long-term care services.

To qualify for continued FTW under the Medical Improvement Group, the participant must be employed (see below) and earning at least the federal minimum wage (i.e., \$5.15 / hour) working at least 40 hours per month (i.e., \$206 / month). “Employed” for the Medical Improvement Group may also be defined as “gross monthly earnings at least equal to those earned by an individual who is earning the federal minimum wage and working 40 hours per month. Also, to continue coverage under the Medical Improvement Group, a participant must have a “severe medically determinable impairment.” This determination will be made on a case-by-case basis by the Disability Determination Services Agency (DDSA), the same entity in Arizona that determines disability for the Social Security Administration.

**Premium Structure** – A FTW premium is assessed for all participants and is based on earned income after allowable deductions. State law specifies that the amount of the premium cannot exceed 2% of the customer’s countable income. The premium schedule is arranged in earned income tiers beginning at \$500 of earned income with a premium of \$10 and increasing by \$5 for every additional \$250 earned. FTW

participants residing in institutions will not incur a premium because they are already meeting other cost sharing requirements by contributing to the cost of their long term care services (based on post eligibility treatment of income).

**Other Policies** – Monthly earned income, after deductions, must be under 250 percent of the Federal Poverty Level (\$1,846 in 2002). Income deductions are applied in the following order as appropriate: a) student child income deduction; b) a general disregard of \$20; c) a \$65 work expense deduction; d) Impairment Related Work Expenses (IRWE); e) one half of the amount remaining after the four preceding deductions; and f) blind work expenses. Resources and unearned income are not considered in the FTW eligibility determination process.

FTW participants must be working. For the Basic Coverage Group, the beneficiary must provide verification of payment for work and payment of Social Security and Medicare taxes. Acceptable documentation includes AHCCCS Verification of Employment Form, pay stubs, a letter from an employer, or direct contact with an employer. Self-employed individual must provide either a copy of the previous year's tax return or copies of current business records such as a business ledger. Individuals in the Medical Improvement Group must provide documentation that they are earning at the wage amount required.

#### Note

Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services to waive certain requirements of the law. Regarding Title XIX, Section 1115 Research and Demonstration waivers essentially allow the Secretary to provide federal Medicaid matching funds to a state that is providing Medicaid-financed coverage that does not meet federal minimum standards or that extends beyond available federal options. While this waiver authority is broad, it is limited in a variety of ways: 1) there must be "an experimental pilot or demonstration project;" and 2) the project must be "in the judgment of the Secretary, likely to assist in promoting the objectives of the program." States may reREQUEST the following provisions of Title XIX to be waived: a) waiver of "Stateness" of service availability; b) waiver in "Amount, Duration, and Scope" of services, to permit the provision of different benefit packages to different populations in the demonstration; and c) "Freedom of Choice" to enable states to restrict the choice of providers of services.

Section 1115 also allows certain expenditures to be regarded as costs under the states Title XIX plan which are not otherwise considered Medicaid or SCHIP expenditures. These include: 1) expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan; 2) expenditures relating to providing a certain number of months of guaranteed eligibility to demonstration participants; and 3) expenditures related to the coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply. Section 1115 waivers also must be cost neutral.

## MINNESOTA

**Overview** – Minnesota's Medicaid Work Incentive program, Medical Assistance for Employed Persons with Disabilities (MA-EPD), was implemented in July 1999 under the authority of the Balanced Budget Act and, in October 2000, was converted to the TWWIIA. Building on work they had done educating the disabled community about work incentives in the early 1990's, the Minnesota Consortium for Citizens with Disabilities



provided the main impetus behind enactment of the MA-EPD program.

The program grew quickly, with approximately 5,000 enrollees within a year of the program's inception and 6,165 as of December 2004, making it one of the largest Buy-In programs. The rapid enrollment and growth of the program was a direct result of extensive outreach done by the disability community and advocacy groups. State officials also noted that the transfer of individuals from other Medicaid programs into the Buy-In was, and continues to be, an important factor fueling the program's rapid growth—at least 64 percent of new Buy-In participants in 2002 through 2004 were in Medicaid for at least one month during the year prior to enrollment. State officials also noted that enrollment grew early on because Medicaid served a large number of individuals in day training and habilitation facilities that subsequently transferred into MA-EPD.

Following its rapid growth initially, enrollment in Minnesota's Buy-In program actually decreased slightly in late 2001. This drop is most likely associated with changes to Minnesota's Medicaid eligibility policy in July 2001, raising eligibility for regular Medicaid to 100 percent of the FPL (that is, the monthly threshold was raised from \$612 to \$716 for individuals) and eligibility for the medically needy program protected income level to 70 percent of the FPL (that is, to \$501 from \$482). The state raised the medically needy protected income level again in July 2002 to 75 percent of the FPL. These increases in the regular Medicaid thresholds allowed more people to qualify for regular Medicaid rather than the Buy-In, thus reducing the number of MA-EPD enrollees and stabilizing the level of program enrollment.

**Eligibility Criteria and Program Context** – MA-EPD extended Medicaid coverage to employed Minnesotans with disabilities age 16 through 64. Minnesota is unique in that its MA-EPD program has no upper limit for income eligibility and has an individual asset limit of \$20,000, both of which are high relative to other Buy-In programs. Beginning July 2004, the first \$65 of earned income is disregarded when determining eligibility for the program, which implies that a participant needs monthly earnings of greater than \$65 to be eligible for the program. In addition, Buy-In participants need to have Medicare and Social Security taxes withheld from wages or paid from self-employment earnings in order to provide proof of employment. Prior to July 2004, participants were exempt from this policy if their employer was not required to withhold these taxes.

Minnesota elected the Medicaid poverty level option for disabled individuals, providing these individuals with Medicaid eligibility if their monthly countable income is below the federal poverty line (that is, \$776 in 2004). Both the medically needy protected income level in Minnesota (\$582 in 2004, or 75 percent of the FPL) and state SSI benefit (\$645 in 2004) are higher than in most other Buy-In states.

**Premium Structure** – All MA-EPD participants must pay a monthly premium that is based on a sliding fee scale with a minimum of \$35. There is no maximum income limit or maximum premium amount. Buy-In participants who have incomes at or above 300 percent of the FPL are charged 7.5 percent of their gross income. In addition, the state made two changes to its premium policies in November 2003: (1) participants who have

unearned income pay an additional premium equal to 0.5 percent of their gross unearned income; and (2) the state ceased paying Medicare Part B premiums for MA-EPD enrollees with countable income above 200 percent of the FPL and now only these premiums for enrollees below this level.

**Other Policies** – Beginning in January 2004, MA-EPD participants may remain enrolled for up to four months without earnings if they become unable to work due to either medical reasons that are verified by a physician or an involuntary job loss. Prior to this change, the program allowed participants to remain on the program if they were unemployed due to a verifiable medical condition.

Note

All Medicaid enrollees in Minnesota are subject to a disregard, which the state terms “Method B” budgeting. Prior to 2003, the state’s Buy-In program was exempt from this policy.

Prior to January 2004, only MA-EPD participants with incomes over 100% FPL paid a premium based on a sliding fee scale (that is, the minimum premium of \$35 was not required).

## VERMONT

**Overview** – Medicaid for Working People with Disabilities (WPWD), Vermont’s Medicaid Work Incentive program, was implemented in January 1, 2000 under the authority of the Balanced Budget Act (BBA). WPWD was implemented as part of the Vermont Work Incentives Initiative (VWII), a broader initiative seeking to implement and advocate system-wide reforms to support people with disabilities in employment. The VWII, in addition to implementing a Medicaid Work Incentive program, provides benefit counseling for individuals with disabilities.

As of December 2004, Vermont had 520 enrollees in the WPWD program. This enrollment may be limited by a number of factors (described below), including the separate unearned income limit, the lack of work stoppage protection, and the availability of an array of other public options for health care coverage.

**Eligibility Criteria and Program Context** – WPWD has a two-step income test: 1) employed persons with disabilities must have a family net income less than 250 percent of FPL, and 2) income does not exceed either the Medicaid protected income level or the SSI payment level, whichever is higher, after disregarding the earnings and up to \$500 of SSDI benefits of the individual. The program’s resource limit is set at \$2,000 per individual and \$3,000 per couple at enrollment. After enrollment, there is no limit on the amount of assets that may be accumulated from the earnings of the person with disabilities, provided liquid assets from such earnings are kept in a separate bank account. The separate unearned income eligibility may prevent many SSDI beneficiaries from meeting income eligibility criteria. This, combined with the low asset limit of \$2,000 at enrollment, may contribute to the program’s low enrollment. In addition, the WPWD program may be intended to fill a narrow eligibility gap, as Vermont residents with low incomes already have access to a wide array of health care coverage options, most notably the Vermont Health Access Plan (VHAP), a Section 1115 waiver.

Vermont has a high medically needy protected income level of \$800 per month compared to other states, which makes it easier for eligible persons to meet the spend-down amount and lessens the relative advantage of enrolling in the Buy-In to avoid a large spend-down.

**Premium Structure** – Buy-In participants with income levels below 185% of the FPL are not required to pay premiums. The WPWD program has two income brackets that require a premium: before July 2003, those earning between 185-225 percent of FPL paid \$20, and those earning between 225-250 percent of FPL paid \$24 per month. Starting in July 2003, the monthly premium rose to \$50 and \$60, respectively. Only 8 percent of Buy-In participants paid a premium in the fourth quarter of 2003, and the average monthly premium for these participants for that quarter was \$27. The state eliminated the premium requirement in June 2004 to reduce its administrative burden. However, WPWD participants continue to be required to pay nominal cost sharing in the form of co-payments and coinsurance that is required of all Medicaid beneficiaries.

**Program Experience** – Vermont eligibility staff and benefit counselors are trained specifically on the WPWD program. The state also has disseminated pamphlets and other educational materials about the program. While the state covers personal assistance services (PAS), only a small handful of program participants receive these services, possibly because the approval process is extensive and lengthy, and possibly because the majority of consumers who would meet the activities-of-daily-living or institutional-level-of-care eligibility criteria for PAS have already acquired health coverage under an alternative program and are not currently seeking the earnings protection of the Buy-In.

In an effort to more clearly define the types of income that considered valid for eligibility determination purposes, the state, beginning September 15, 2005, began requiring that participants demonstrate that their earnings were subject to Federal Insurance Contributions Act (FICA) taxes. Self-employed individuals will be required to show evidence of Self-employment Contributions Act (SECA) taxes or a business plan supported by a third-party investor or funding source.

#### Notes

Beginning September 15, 2005, the state will disregard all unearned income from SSDI and veteran's benefits.

The asset limit at enrollment was increased as of September 15, 2005 to \$5,000 per individual and \$6,000 per couple.

This provision was eliminated as of September 15, 2005.

The average SSDI benefit nationally was \$862 in December 2003 (Social Security Administration 2004). Thus, it is likely that many SSDI beneficiaries would not be eligible for the Buy-In program.

## WASHINGTON

**Overview** – Washington adopted its Buy-In program, Healthcare for Workers with Disabilities (HWD), in January 2002 under the authority of TWWIIA. It is one of a few states that elected to cover both the Medicaid Buy-in Group and the Medical Improvement Group. No one has enrolled in the Medical Improvement Group as of yet because this group has not been defined at the federal level. As of December 2004, enrollment in the program had reached 448. Although this number almost doubled that of the previous year, enrollment remained relatively low compared to most other Buy-In programs. An economic downturn, the short program history, and some program features (highlighted below) may have contributed to the slow growth of HWD.

**Program Context and Eligibility Criteria** – Washington's general Medicaid eligibility is typical among states with a Buy-In program – its combined federal and state SSI benefit and medically needy protected income level are relatively generous compared to many other states with Buy-In programs. However, Washington has not chosen to provide categorical Medicaid eligibility for persons with disabilities, and the state's low 1619(b) earning threshold (\$1,762 in 2004) relative to other Buy-In states suggests that a large number of people may be eligible for HWD.

HWD has at least one distinctive eligibility criterion that may facilitate enrollment. Individuals do not have to meet any asset test to be eligible for HWD, in addition to having net income less than 220% of the FPL. The absence of an asset test enlarges the pool of potential Buy-In participants and encourages existing enrollees to accumulate assets.

**Premium Structure** – All HWD participants enrolled during the entire fourth quarter of 2004 paid a premium based on both unearned and earned income. The premium level is the lesser of 7.5 percent of total income or the sum of the following: 50% unearned income above the Medically Needy Income Level (MNIL), plus 5% of total unearned income, plus 2.5% earned income after a \$65 deduction. Premiums among Buy-In participants averaged \$86 per month in 2004. This amount is higher than most states with Buy-In programs, and may act as a disincentive for some eligible individuals to enroll in the Buy-In program.

**Other Policies** – Participants in the Medicaid Work Incentive Group must have earnings subject to federal income taxes, and self-employed participants must provide tax forms or business license/records. Participants in the Medical Improvement Group must work at least 40 hours per month and earn at least minimum wage. If HWD participants lose their job, they can choose to continue enrollment through the end of their current 12-month certification period, as long as (1) the job loss is due to a health crisis or involuntary dismissal; (2) they intend to return to work; and (3) they continue to pay monthly premiums based on their remaining income.

**Program Experience** – Because of state budgetary pressures, rescinding the HWD program was proposed in 2003. The program survived, partly due to strong support for it among the disability community. Outreach activities in 2003 were temporarily scaled

down but became more intensive in 2004.

## **WISCONSIN**

**Overview** – Wisconsin established its Medicaid Purchase Plan (MAPP) in March 2000 under the authority of the Balanced Budget Act as a program designed to increase work incentives for persons with disabilities. Enrollment was “modest” during the program’s first year of implementation (Innovative Resource Group 2002). Since then, however, enrollment has grown more quickly, and the MAPP has become the second largest Buy-In program in the nation with 7,713 participants as of December 2004.

**Eligibility Criteria and Program Context** – Wisconsin’s MAPP program is available to persons with disabilities age 18 and over with net countable income up to 250 percent of the FPL and resources up to \$15,000. In addition, MAPP participants are allowed once enrolled, to accumulate assets above the resource limit (APS Healthcare 2003). Compared to other states with Buy-In programs, MAPP has an above-average combined federal and state SSI supplement (\$683) and protected income level for its medically needy program (\$592). These factors, in conjunction with a relatively high monthly 1619(b) threshold of \$2,304, suggest that a large proportion of individuals with disabilities in Wisconsin may already be eligible for Medicaid through other pathways.

**Premium Structure** – MAPP participants with countable income from 150 to 250 percent of the FPL pay a premium equal to the sum of: (1) 3% of an individual’s earned income, and (2) 100% of unearned income less the standard living allowance and exclusions. The vast majority of MAPP participants (90%) enrolled in the fourth quarter of 2004 did not pay a premium, suggesting that the countable income among these individuals was below 150% of the FPL. Premiums among the 10% of participants who paid a premium averaged \$143.

**Other Policies** – If MAPP participants do not have earnings from work, they may participate in health and employment counseling (HEC) for up to a year, after which earnings from employment are required. Based on the most recent evaluation report, few MAPP participants take advantage of the option to participate in HEC - 68 individuals were actively doing so in July 2002. For MAPP participants with health problems that prevent them from working, Wisconsin waives the work requirement for up to 6 months. However, information from a focus group suggests that this work protection feature may be less attractive in practice than initially expected because: (1) it requires participants to have been enrolled in the Buy-In program for at least six months, and (2) it only can be used twice every three years.

**Program Experience** – The slower than expected enrollment growth early in the program may have been due in part to the following factors:

- Enrollment was initially cumbersome because MAPP county workers conducted the eligibility determination process manually until fall 2001, when this process was automated.

- Training of county economic support (ES) workers did not begin until after MAPP was implemented, and a survey of ES workers found that only one in four workers felt that their MAPP training was sufficient.
- Comments from program participants suggest that information about the program could be disseminated more effectively.

## APPENDIX D – STATE ELIGIBILITY LEVELS

State Scenarios by Eligibility Levels								
State	Implementation Date	Buy-In Enrollment per 10,000 State Residents with a Disability (Age 16-64)		Earned Income Threshold (% of FPL)	Individual Asset Limit	Unearned Income Limit	Index of Eligibility Restrictiveness	
		December, 2005	Rank					
Iowa	March, 2000	457.2	1	250 <sup>a</sup>	12,000 <sup>c</sup>	No	5	
Wisconsin	March, 2000	257.7	2	250 <sup>a</sup>	15,000 <sup>c</sup>	No	5	
Massachusetts	July, 1997	228.7	3	No Limit	No Limit	No	0	
<b>Minnesota</b>	<b>July, 1999</b>	<b>206.8</b>	<b>4</b>	<b>No Limit</b>	<b>20,000</b>	<b>No</b>	<b>1</b>	
Connecticut	October, 2000	185.1	5	783 <sup>f</sup>	10,000	No	4	
New Hampshire	February, 2002	148.6	6	450	22,694 <sup>dh</sup>	No	2	
<b>Vermont</b>	<b>January, 2000</b>	<b>114.6</b>	<b>7</b>	<b>250<sup>a</sup></b>	<b>5,000<sup>ch</sup></b>	<b>Yes</b>	<b>10</b>	
Indiana	July, 2002	113.7	8	350	2,000	No	7	
<b>Average<sup>k</sup></b>								<b>4.0</b>
New Mexico	January, 2001	87.2	9	250 <sup>ag</sup>	10,000	Yes	9	
Pennsylvania	January, 2002	59.1	10	250 <sup>af</sup>	10,000 <sup>c</sup>	No	6	
Maine	August, 1999	55.1	11	250 <sup>af</sup>	8,000 <sup>c</sup>	Yes	4	
Kansas	July, 2002	51.4	12	250 <sup>af</sup>	15,000 <sup>c</sup>	No	4	
New Jersey	February, 2000	38.0	13	250 <sup>a</sup>	20,000	Yes	7	
Alaska	July, 1999	36.0	14	250 <sup>a</sup>	2,000 <sup>c</sup>	Yes	11	
<b>Arizona</b>	<b>December, 2001</b>	<b>24.4</b>	<b>15</b>	<b>250<sup>b</sup></b>	<b>No Limit</b>	<b>No</b>	<b>3</b>	
Utah	July, 2001	22.3	16	250 <sup>af</sup>	15,000 <sup>c</sup>	No	5	
<b>Average<sup>k</sup></b>								<b>5.8</b>
Oregon	February, 1999	18.8	17	250 <sup>g</sup>	5,000	No	7	
Washington	January, 2002	14.5	18	220 <sup>af</sup>	No Limit	No	4	
Illinois	January, 2002	10.0	19	200 <sup>af</sup>	10,000 <sup>c</sup>	No	8	
Nebraska	July, 1999	9.3	20	250 <sup>ag</sup>	4,000 <sup>c</sup>	Yes	10	
California	April, 2000	7.5	21	250 <sup>af</sup>	2,000	Yes	11	
Arkansas	February, 2001	3.6	22	250 <sup>af</sup>	4,000	Yes	4	
Wyoming	July, 2002	1.9	23	225 <sup>ai</sup>	2,000 <sup>c</sup>	Yes	12	
South Carolina	October, 1998	1.0	24	250 <sup>af</sup>	2,000	Yes	11	
<b>Average<sup>k</sup></b>								<b>8.5</b>
<b>Median:</b>		<b>55.1</b>		<b>250</b>	<b>10,000</b>	<b>No</b>	<b>5.5</b>	
<p>a Includes spousal income</p> <p>b Does not include spousal income</p> <p>c Includes spousal assets</p> <p>d For a married couple, NH's asset limit is \$34,041</p> <p>e West Virginia has an additional \$5,000 liquid asset exclusion</p> <p>f Includes earned plus unearned income, after disregards and exclusions</p> <p>g Nebraska has a two-part income test- (1) The sum of the spouse's earned income and all unearned income must be less than SSI standard; (2) Countable income up to 250% FPL.</p> <p>h Disregards assets accumulated since enrollment</p> <p>i Wyoming's income and asset limit is 300% of the SSI income standard, approximately 225% of the federal poverty level, for both income and assets combined.</p> <p>j Vermont has a two-part income test: (1) Family net income less than medically needy protected income level after disregarding earnings, SSDI benefits, and veteran's benefits (2) Family net income less than 250% FPL.</p> <p>k Averages remove high and low outliers for each group.</p> <p>Sources: Participant-level data submitted by states (April 2006) and the Ticket to Work Medicaid Infrastructure Grant Reporting</p> <p>Note: Only states implementing Buy-In programs in 2002 and earlier are included in this table. This allows for more equal comparison on enrollment-related indicators because states that have recently implemented a program are still in the stage of rapid enrollment growth, which can hide or distort the effect of other indicators.</p>								

## APPENDIX E – EXAMPLES

The following examples illustrate how the income limit would be applied to determine eligibility under the current Medicaid methodology and, for comparison, under the proposed program. For Examples 1a and 1b, the person receives \$2,085 each month in earned income from work and \$700 a month in unearned income from SSDI. In the first example, eligibility is calculated based upon the current Med-QUEST income limit of 100% of the FPL.

Example 1a illustrates how the current system works. The countable monthly net income of \$1,700 is above the existing income limit of 100% of the federal poverty level (\$980/month in 2007). Therefore, the individual would be eligible for Medicaid coverage only with a spend-down of \$1,154 per month (\$1,700 – 546) in incurred medical costs.

### Example 1a

\$ 2,085 (gross earned income)  
 - 85 (earned income disregard)  
 \$ 2,000 / 2 =  
 \$ 1,000

\$1,000 (countable earned income)  
 + 700 (unearned income)  
 \$1,700 (total countable income)

In Example 1b, under the eligibility rules of the proposed program (Option B – VT Model), the same individual would be covered without a spend down because the proposed buy-in program sets the net income limit at 250% of FPL or \$2,450 per month of countable income and excludes unearned income.

### Example 1b

\$ 2,085 (gross earned income)  
 - 85 (standard earned income disregard)  
 \$2,000 / 2 =

\$1,000 (countable/net earned income excluding \$700 of unearned income; which is less than the countable net income limit of \$2,450 per month)



Example 2 demonstrates that any working individual with a disability earning a gross earned income under \$4,981 per month (\$59,770 annual income) and unearned income.

Example 2

\$3,025 (total gross earned income)

- 85 (standard earned income disregard)

\$2,940

\$2,940 / 2

= \$1,470 (countable earned income limit; also equal to 150% FPL in 2006)

## APPENDIX F – MEDICAID ELIGIBILITY

Summary of Means of Obtaining Medicaid Eligibility	
Category of Coverage	Summary of Eligibility Criteria
<b>Mandatory Coverage</b>	
SSI recipients	In 39 states and the District of Columbia, SSI recipients are automatically eligible for Medicaid. <sup>a</sup>
209(b) category <sup>b</sup>	States can use eligibility criteria for individuals who are aged, blind, and disabled that are more restrictive than the SSI program. State establishes a definition of disability and income and asset standards. These “209(b)” states are required to allow persons with disabilities to “spend down” to Medicaid eligibility by deducting incurred medical expenses from their income. A spend down program is operationally similar to the medically needy program described below.
SSI 1619(b) provision	Persons with disabilities who were receiving SSI cash benefits and continue to meet all SSI eligibility requirements, except for excess earnings, and whose income is insufficient to replace SSI, Medicaid benefits, and other social services they would have received in the absence of their earnings.
Welfare and poverty provisions	Pregnant women and low-income families with children who satisfy state-specific financial eligibility requirements.
Coverage for certain Medicare beneficiaries	States are required to extend limited Medicaid benefits (i.e., paying part or all of a person’s cost-sharing obligation to Medicare) to low-income individuals who also qualify for Medicare. <sup>c</sup>
<b>Optional Coverage<sup>d</sup></b>	
Medicaid Buy-In	Working persons with disabilities with income and asset eligibility criteria set by the state.
State supplementary payments recipients	Persons with disabilities receiving state supplementary payments to the federal SSI benefit.
Medically needy	Individuals whose income either falls below a state-specified threshold or have sufficient medical expenses that allow them to “spend down” to the state-specific income threshold. Assets also must be within the state-specific limit for the medically needy program.
Poverty-level coverage <sup>e</sup>	Persons with disabilities with income above that required for mandatory coverage but below the federal poverty line.
<p><sup>a</sup> The 1619(a) provision of the Social Security Act allows SSI recipients to continue receiving cash benefits at a reduced level when their countable earned income exceeds the substantial gainful activity (SGA) level (\$810, \$830, and \$860 for the years 2004, 2005, and 2006 respectively) until earnings reach a level where the SSI benefit is reduced to zero. Medicaid eligibility continues until SSI cash benefits cease. In this report, the term “SSI recipients” includes individuals receiving Medicaid benefits under the 1619(a) provision.</p> <p><sup>b</sup> States may set their own Medicaid eligibility criteria and definition of disability for individuals with disabilities as long as these criteria are not more restrictive than those in effect as of January 1, 1972. These states are often called “209(b)” states. The following states included in this study have opted to use 209(b) provisions: Connecticut, Illinois, Indiana, Minnesota, Missouri, North Dakota and New Hampshire (GAO 2003).</p> <p><sup>c</sup> States are required to cover these groups with limited benefits but QMBs and SLMBs (see below) may also receive full benefits if they qualify under some other eligibility group. These groups include: (1) a Qualified Medicare Beneficiary (QMB), for whom Medicaid will pay all of Medicare Part A and Part B expenses if the individual has income equal to or less than 100 percent of the FPL and assets less than \$4,000 (\$6,000 for a couple); (2) a Specified Low-Income Beneficiary (SLMB), for whom Medicaid will pay the Medicare Part B premium if the individual has income between 100 and 120 percent of the FPL and assets less than \$4,000 (\$6,000 for a couple); (3) a Qualifying Individual (QI) with assets less than \$4,000 (\$6,000 for a couple), for whom Medicaid will pay all of the Medicare Part B premium if the individual has income between 120 and 135 percent of the FPL and part of the Medicare Part B premium if the individual has between 135 and 175 percent of the FPL; and (4) a Qualified Disabled and Working Individual (QDWI), for whom Medicaid will cover a portion of the Medicare Part A premium if a person with disabilities has income less than 200 percent of the FPL and assets less than \$4,000 (\$6,000 for a couple) (Schneider et al. 2002). A person cannot be eligible for QI or QDWI if he or she is otherwise eligible for full Medicaid benefits.</p> <p><sup>d</sup> In addition to the optional coverage groups listed in this table, states may choose to provide coverage to low-income individuals with tuberculosis or who are uninsured and have been determined to need treatment for breast or cervical cancer.</p> <p><sup>e</sup> Section 1902(r)(2) of the Medicaid statute allows states to use less restrictive income and resource methodologies when determining Medicaid eligibility to cover aged or disabled individuals with income below the FPL.</p>	

Source: Black and Ireys. “Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy- In Program, 2003-2004.” Washington, DC: Mathematica Policy Research, January 2006.

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