

June 2003

MEDICAID AND TICKET TO WORK

States' Early Efforts to Cover Working Individuals with Disabilities



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Highlights of [GAO-03-587](#), a report to the Senate Committee on Finance and the House Committee on Energy and Commerce

Why GAO Did This Study

Over 7 million individuals with disabilities rely on medical and supportive services covered by Medicaid. However, if working-age individuals with disabilities desire to increase their self-sufficiency through employment, they could jeopardize their eligibility for Medicaid coverage, possibly leaving them without an alternative for health insurance.

In an effort to help extend Medicaid coverage to certain individuals with disabilities who desire to work, the Congress passed the Ticket to Work and Work Incentives Improvement Act of 1999. This legislation authorizes states to raise their Medicaid income and asset eligibility limits for individuals with disabilities who work. States may require that working individuals with disabilities “buy in” to the program by sharing in the costs of their coverage—thus, these states’ programs are referred to as a Medicaid Buy-In.

The act also required that GAO report on states’ progress in designing and implementing the Medicaid Buy-In. GAO identified states that operated Buy-In programs as of December 2002 and analyzed the income eligibility limits and cost-sharing provisions established by those states. GAO also assessed the characteristics of the Buy-In participants in four states that were among the most experienced in implementing the program.

www.gao.gov/cgi-bin/getrpt?GAO-03-587.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

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What GAO Found

As of December 2002, 12 states had implemented Medicaid Buy-In programs under the authority of the Ticket to Work legislation, which was effective October 1, 2000, enrolling over 24,000 working individuals with disabilities. These states used the flexibility allowed by the legislation to raise income eligibility and asset limits as well as cost-sharing fees.

Across the 12 states, income eligibility levels ranged from 100 percent of the federal poverty level (FPL) in Wyoming to no income limit in Minnesota, with 11 states setting income eligibility limits at twice the FPL or higher. In addition to increasing income and asset levels, these states required participants to buy in to the program by charging premiums, ranging from \$26 to \$82 a month, and copayments, generally ranging from \$0.50 to \$3 for office visits and prescription drugs.

In detailed analysis of four states—Connecticut, Illinois, Minnesota, and New Jersey—GAO found that most Buy-In participants had prior insurance coverage by Medicaid and Medicare, few had prior coverage by private health insurance, and many earned low wages—most making less than \$800 per month.

In commenting on a draft of this report, the Centers for Medicare & Medicaid Services noted that it expects to report in 2004 on its current study of states’ experiences in 2001 and 2002 with the Medicaid Buy-In programs.

Enrollment and Income Eligibility Characteristics of 12 States with Ticket to Work Medicaid Buy-In Programs

State	Enrollment	Buy-In start date	Income limit as a percentage of FPL ^a
Missouri	8,461	July 2002	250%
Minnesota	6,178	July 2001	No limit
Indiana	3,318	July 2002	350%
Connecticut	2,433	Oct. 2000	\$75,000 per year ^b
Pennsylvania	1,325	Jan. 2002	250%
New Hampshire	968	Feb. 2002	450%
New Jersey	551	Feb. 2001	250% (earned) and 100% (unearned)
Kansas	489	July 2002	300%
Illinois	323	Jan. 2002	200%
Washington	144	Jan. 2002	220%
Arkansas	65	Feb. 2001	250%
Wyoming	3	July 2002	100%

Source: State-reported data as of December 2002.

^aThe FPL for an individual in 2002 was \$8,860 annually.

^bConnecticut’s income eligibility limit is not determined by the FPL.

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Abbreviations

ADL	activities of daily living
AHRQ	Agency for Healthcare Research and Quality
AWI	average wage index
BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare & Medicaid Services
DI	Social Security Disability Insurance
EPE	extended period of eligibility
FPL	federal poverty level
IADL	instrumental activities of daily living
MEPS	Medical Expenditure Panel Survey
NHIS	National Health Interview Survey
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income

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United States General Accounting Office
Washington, DC 20548

June 13, 2003

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable W.J. "Billy" Tauzin
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

During fiscal year 2000, over 7 million individuals with disabilities were enrolled in Medicaid, a federal-state program that finances health care for certain low-income Americans. For these individuals, Medicaid gives states the option to cover a wide array of medical and supportive services, including assistance with basic daily activities such as bathing, dressing, and eating. Depending on state Medicaid rules, individuals with disabilities who qualify for cash assistance from the Supplemental Security Income (SSI) or Social Security Disability Insurance (DI) programs may qualify for Medicaid. Nearly all individuals who qualify for SSI, which primarily covers low-income individuals who are disabled and have little or no work experience,¹ are assured eligibility for Medicaid coverage. Under DI, which assists people who worked but became disabled before their retirement age,² individuals are eligible for Medicare, a federal health insurance program for elderly individuals and some individuals with disabilities. Depending on their income and assets, individuals eligible for DI also may

¹SSI beneficiaries also include individuals who are blind or aged. References to the SSI program throughout this report address individuals who are disabled, not blind or aged, except where noted.

²DI beneficiaries also include certain other persons, including dependents and survivors of workers with disabilities. References to the DI program throughout this report address only workers with disabilities, not dependents or survivors.

qualify for Medicaid and thus receive coverage for some services not covered by Medicare, such as most outpatient prescription drugs.

Because eligibility for Medicaid is generally linked to individuals' income and assets, working-age individuals—aged 16 to 64—with disabilities who live in the community and work may jeopardize their Medicaid coverage due to earnings from work, possibly leaving them without an adequate health insurance alternative. The loss of Medicaid may be of particular concern for working-age individuals with disabilities because some benefits—including personal assistance with daily activities and adaptive equipment (such as household items modified for use by those with disabilities)—may not be available through other sources of health insurance. For example, private health insurance, such as that offered by employers, often does not cover personal assistance with basic daily activities or adaptive equipment. As a result, working-age individuals with disabilities may forgo employment and associated earnings in order to ensure their continued financial eligibility for Medicaid coverage of their health care needs.

In an effort to help extend Medicaid coverage to certain individuals with disabilities who desire to work, the Congress passed the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170, 113 Stat. 1860). This legislation, effective October 1, 2000, authorizes states to raise their Medicaid income and asset limits for individuals with disabilities who work. States may require that working individuals with disabilities “buy in” to the Medicaid program by sharing in the costs of their coverage—therefore, such states' programs are referred to as a Medicaid Buy-In. A Medicaid Buy-In program is intended to assist individuals by allowing them to work and thereby increase their independence and self-sufficiency, while at the same time enabling them to obtain or maintain health care coverage. The act directed that we report to the Congress on characteristics of individuals with disabilities, including their health care costs and health insurance coverage, as well as states' progress in designing and implementing the Medicaid Buy-In program. Accordingly, as agreed with the committees of jurisdiction, we examined

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1. characteristics of working-age individuals with disabilities compared with the rest of the working-age U.S. population with regard to employment, education, income, health insurance status, and health care expenditures,
 2. how states that have chosen to establish a Ticket to Work Medicaid Buy-In program have designed their programs, including income eligibility limits and any cost-sharing provisions, and
 3. characteristics of selected states' Ticket to Work Medicaid Buy-In participants, including previous health insurance coverage and income from employment.

To compare characteristics of working-age individuals with disabilities to individuals in the rest of the working-age population, we analyzed data available from the Agency for Healthcare Research and Quality's (AHRQ) Medical Expenditure Panel Survey (MEPS)—the survey of individuals' demographics, employment, health characteristics, and medical spending (household component) for 1997 and 1998, the most recent years for which relevant data were available. We analyzed data from MEPS because such data provided both a way to identify working-age individuals with disabilities and details on their health care expenditures. Our estimates based on MEPS resulted in a relatively broad definition of disability for individuals aged 16 to 64 because it included individuals who reported one or both of the following conditions: (1) needing help or supervision in performing activities of daily living (ADL) (such as bathing or dressing) or instrumental activities of daily living (IADL) (such as taking medications or preparing meals) because of an impairment or a physical or mental health problem,³ or (2) being completely unable to work at a job, do housework, or go to school. For individuals meeting this definition of disability, we compared characteristics such as income level, insurance status, and health care expenditures to those of the rest of the U.S. population aged 16 to 64. AHRQ collected these data prior to

³MEPS identifies ADLs as basic physical activities such as bathing, dressing, or getting around the house and identifies IADLs as cognitive or social functions such as using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping. MEPS offers a relatively expansive definition of disability in that it does not distinguish the number of ADLs or IADLs with which an individual may require assistance. Other national surveys that provided details on the number of ADLs and IADLs with which an individual required assistance—such as the National Health Interview Survey (NHIS) Disability Supplement—were based on older data—1994 and 1995. As of March 2003, the NHIS Disability Supplement had not been updated.

implementation of Ticket to Work Medicaid Buy-In programs and thus the data do not reflect any effects of states' Buy-In programs. (App. I provides detailed information on our methodology for developing estimates and characteristics of working-age individuals with disabilities.) To examine the designs of the Buy-In programs for states that had chosen to establish a Buy-In program and whose programs were in effect as of December 2002, we reviewed state Medicaid plan amendments describing the Buy-Ins, analyzed published state documents, and conducted telephone interviews with state Medicaid officials. Additionally, we analyzed the Buy-In implementation experience of four states—Connecticut, Illinois, Minnesota, and New Jersey—that were among the most experienced in implementing the program. At the federal level, we interviewed officials at the Centers for Medicare & Medicaid Services (CMS), which oversees states' Medicaid programs, to gather information about states' programs. We reviewed documents, including federal laws and reports, related to the state Buy-In programs. We conducted our work from May 2002 through June 2003 in accordance with generally accepted government auditing standards.

Results in Brief

Compared with the rest of the working-age U.S. population, the estimated 6.7 million working-age individuals with disabilities were more likely to be not working, have less education, and have incomes below the federal poverty level (FPL). However, they were less likely to be uninsured than the rest of the working-age U.S. population—just 9 percent of those with disabilities reported being uninsured, compared with 15 percent of the rest of the working-age population. Nearly half of individuals with disabilities who reported having health insurance obtained coverage through public sources, such as Medicare and Medicaid. Annual average health care expenditures for working-age individuals with disabilities were about five times the expenditures for other working-age individuals.

Of the 12 states that had opted to implement Medicaid Buy-In programs under the Ticket to Work authority, all expanded eligibility to include working individuals with higher incomes or more assets than generally allowed under the states' traditional Medicaid programs. As of December 2002, the 12 states had enrolled over 24,000 working individuals with disabilities. Enrollment ranged from a low of 3 individuals in Wyoming to 8,461 in Missouri. Eleven of the 12 states set Buy-In eligibility limits for income at twice the FPL or higher—\$17,720 per year for an individual in 2002. Additionally, the states' Buy-In programs generally allowed participants to keep more assets, such as retirement accounts and medical savings accounts, than allowed in states' traditional Medicaid programs.

The higher income eligibility and asset levels set by states for the Buy-In programs provided additional opportunities—particularly for DI-eligible individuals, who had prior working experience before becoming disabled—to secure and maintain Medicaid coverage. In addition to increasing income and asset levels, all states took advantage of the statute’s flexibility by requiring participants to buy in to the program by paying premiums or copayments. Generally, states assessed premiums for individuals with incomes above the FPL and adjusted premiums upward as income increased. Across the 10 states that charged premiums in 2002, the average monthly premiums paid ranged from \$26 in New Hampshire to \$82 in Indiana. Additionally, the percentage of participants who were charged premiums varied significantly across the states, from 12 percent of participants in Connecticut to all or nearly all participants in Illinois, Pennsylvania, Washington, and Wyoming.

Our more detailed analysis of four states that were among the most experienced in implementing this program found that most Buy-In participants had prior insurance coverage by Medicaid and Medicare, few had prior coverage by private health insurance, and many earned low wages while participating in the Buy-In. More than half of the Buy-In participants in these four states had previous Medicaid coverage. Those Buy-In participants who had switched from another Medicaid eligibility category generally did so because they were able to increase their income and assets and maintain their Medicaid eligibility. Many Buy-In participants in these states were eligible for health care coverage through the Medicare program. However, Medicaid eligibility gave these individuals additional benefits that were not offered under Medicare, such as outpatient prescription drugs and personal care services. Few participants—less than 10 percent of participants in any of the four states—reported having employer-sponsored coverage at the time of their enrollment into the Medicaid Buy-In programs. Available employment data showed that participants generally were working in low-wage jobs—most making less than \$800 per month—although they could earn more and still retain Buy-In Medicaid benefits. These four states, however, had little information regarding the extent to which the Buy-In programs fostered employment among individuals with disabilities.

In its comments on a draft of this report, CMS noted it is conducting an extensive study of states’ experiences with the Medicaid Buy-In programs and expects to issue a report in 2004. CMS and 11 of the 12 states in our sample also provided technical comments, which we incorporated as appropriate.

Background

Eligibility for benefits under SSI, DI, Medicare, and Medicaid programs for individuals with disabilities is determined in part on whether an individual has a disability as defined in the Social Security Act.⁴ For purposes of these programs, a person is disabled if he or she has a medically determined physical or mental impairment that (1) has lasted or is expected to last at least 1 year or result in death and (2) prevents the person from engaging in substantial gainful activity (SGA). As of January 2003, SGA is defined as countable earnings—generally gross earnings less the cost of items that, because of the impairment, a person needs to work—of more than \$800 per month.⁵ The Social Security Administration’s (SSA) interpretation of disability specifies that for a person to be determined to be disabled, the impairment must be of such severity that the person not only is unable to do his or her previous work but, considering the person’s age, education, and work experience, is unable to do any other kind of substantial work that exists in the national economy.⁶

The Ticket to Work and Work Incentives Improvement Act of 1999 allowed states to expand the availability of Medicaid coverage for individuals with

⁴The DI program and SSI program are authorized under titles II and XVI, respectively, of the Social Security Act. The definition of disability for the DI program is in section 223(d) of the Social Security Act. The definition of disability for the SSI program is in section 1614(A)(3). In all material respects, the two definitions are similar and have been interpreted by the Social Security Administration (SSA) similarly.

⁵Under the Social Security Act, the Commissioner of Social Security has the authority to set the SGA level for individuals who have disabilities other than blindness. SSA has increased the SGA level several times over the past decade, to \$500 per month in 1990 and to \$700 per month in July 1999. In December 2000, SSA finalized a rule calling for the annual indexing of the nonblind SGA income limit to the average wage index (AWI) and on this basis increased the SGA income limit to \$780 in January 2002. The SGA income limit for individuals who are blind is set by statute and indexed to the AWI. For 2002, the SGA income limit for blind individuals was \$1,300 of countable earnings. In January 2003, the SGA limit increased to \$800 per month for nonblind individuals and to \$1,330 per month for blind individuals. To calculate countable earnings for SGA, SSA deducts from gross earnings the cost of items that, because of the impairment, a person needs to work (for example, attendant care services performed in a work setting, wheelchairs, or Braille devices).

⁶SSA uses a series of steps to evaluate the applicant’s level of disability. As part of the steps, SSA compares the applicant’s condition to a Listing of Impairments that describes medical conditions that are severe enough to prevent a person from engaging in SGA. If an applicant’s impairment is cited in the Listing of Impairments or the applicant’s impairment is as severe as or more severe than those impairments in the Listing of Impairments, then the applicant would be considered disabled and awarded benefits without any further evaluation to determine whether he or she has vocational limitations that, when combined with the medical impairment, prevents work.

disabilities who work, even though they earn more than the SGA level. States that implement Ticket to Work Buy-In programs may consider as disabled those individuals who, except for the fact that they are earning more than the SGA \$800 monthly amount, otherwise would meet the Social Security Act definition of disabled.

Individuals with Disabilities Qualify for Medicaid Primarily through SSI or DI Eligibility

Individuals with disabilities become eligible for Medicaid in a variety of ways but primarily through SSI or DI eligibility (see table 1). Individuals with disabilities, however, must also meet Medicaid income and asset requirements in order to obtain Medicaid coverage. Both the SSI and DI programs contain work incentive provisions designed to assist individuals with disabilities to achieve gainful employment while retaining some eligibility for health care coverage.⁷

SSI

Individuals receiving SSI also are assured eligibility for Medicaid in 39 states and the District of Columbia. The remaining 11 states (known as 209(b) states) may use different standards for disability, income, or assets; thus, SSI beneficiaries in these 11 states may not have assured eligibility for Medicaid.⁸ Work incentives under SSI allow individuals to (1) have their SSI cash benefits gradually reduced as earnings increase, rather than having cash benefits removed entirely once earnings exceed the SGA limit, and (2) maintain their Medicaid coverage up to an income limit that varies

⁷These work incentive provisions can help individuals pay for services or items that they need in order to work or enable individuals to maintain or increase their cash benefits until they are stable in employment. Other work incentives allow individuals with disabilities to recover impairment-related work expenses, such as attendant care services and transportation costs.

⁸Under Section 1902(f) of the Social Security Act, 42 U.S.C. 1396a(f), states may use their 1972 state assistance eligibility rules in determining Medicaid eligibility for individuals with disabilities, rather than SSI eligibility rules, and 11 states do so. The 11 states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. These states are often referred to as 209(b) states because the origin of this authority is §209(b) of the Social Security Amendments of 1972. The 209(b) states' definitions of disability or their income/resource standards for Medicaid eligibility tend to be more restrictive than those for SSI but can be the same as or more liberal. If a state's 209(b) rules are more restrictive, it must also allow individuals to spend down into Medicaid eligibility by deducting incurred medical care expenses from income.

across the states (from \$15,049 (170 percent of the FPL) in Arizona to \$39,228 (443 percent of the FPL) in New Hampshire as of 2002).⁹

DI

Individuals receiving DI also may become eligible for Medicaid under certain circumstances. By virtue of their DI disability determination, they meet one of the categorical eligibility requirements for Medicaid.¹⁰ However, they must also meet Medicaid's income and asset requirements as defined by each state. DI beneficiaries can "spend down" their income on medical expenses in order to meet state-determined income limits for the medically needy eligibility category, if a state provides this optional coverage.¹¹ While DI beneficiaries receive health care coverage through Medicare,¹² eligibility for the medically needy category provides Medicaid-covered services that are not covered by Medicare, such as most outpatient prescription drugs. Work incentives under DI are structured such that if an individual's work activity increases to a level where he or she is no longer deemed disabled, the individual loses DI eligibility, and in turn, Medicaid eligibility.

⁹In contrast to other Medicaid income eligibility thresholds, which are usually set by the state within federal guidelines, SSA sets the income threshold for SSI-related Medicaid eligibility annually. The income threshold for a particular state is based on the current SSI cash benefit in each state and a state's per capita Medicaid expenditures. If an SSI beneficiary has gross earnings higher than the threshold amount for his or her state, SSA can calculate an individual threshold amount if he or she has medical or impairment-related work expenses above the state amount.

¹⁰States receive federal Medicaid matching funds for health care provided to certain individuals meeting broad federal requirements for eligibility, including categorical, income, resource, immigration status, and residency requirements. The categorical requirement includes individuals who fall into specified categories, which can be classified into five broad coverage groups: individuals with disabilities, children, pregnant women, individuals in families with dependent children, and the elderly.

¹¹The medically needy category refers to individuals who meet certain categorical requirements for Medicaid eligibility—for example, children, individuals with dependent children, and individuals who are aged, disabled, or pregnant—and have incurred medical expenses to the point where their income, less the medical expenses incurred, makes them eligible for Medicaid. As of November 2002, 35 states and the District of Columbia opted to cover Medicaid beneficiaries under the medically needy eligibility category.

¹²After they have received DI cash benefits for 24 months, DI beneficiaries are entitled to Medicare part A coverage and are eligible to enroll in part B. Medicare part A helps cover inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. Medicare part B helps cover physician services and outpatient hospital care.

Table 1: Highlights of SSI and DI and Their Links to Medicare and Medicaid

Program	SSI	DI
General description	<ul style="list-style-type: none"> Means-tested income assistance program for disabled, blind, or aged individuals with or without prior participation in the labor force. Federal income limit of \$545 in countable income per month for an individual (\$817 for a couple) and \$2,000 in assets for a single adult (\$3,000 for a couple) as of 2002.^a SSI cash benefits are based on a beneficiary's countable income, living arrangements, and state of residence. Most states pay some beneficiaries an additional amount referred to as a "state supplement." The amounts and qualifications for these state supplements vary by state. 	<ul style="list-style-type: none"> Income assistance program for individuals who have lost their ability to work as a result of a severe, long-term disability and have worked long enough in Social Security-covered employment and during a specified time period to meet program requirements.^b No federal income or asset limit for participation in the DI program, other than meeting the SGA earnings limit to be determined disabled (\$800 per month in 2003). The DI cash benefits are based on a beneficiary's lifetime average earnings that were covered by Social Security. The payment amount is adjusted each year to account for changes in the cost of living.
Number of working-age individuals covered	<ul style="list-style-type: none"> In 2001, 3.8 million individuals aged 18-64 received SSI benefits. 	<ul style="list-style-type: none"> In 2001, 5.3 million individuals through age 64 received DI benefits because of a disability they incurred.
Link to Medicaid and Medicare	<ul style="list-style-type: none"> In 39 states and the District of Columbia, SSI eligibility assures an individual's eligibility for Medicaid benefits. Eleven states use more restrictive disability, income, or asset requirements than SSI for Medicaid eligibility.^c No direct link to Medicare. 	<ul style="list-style-type: none"> Individuals eligible for DI meet the Medicaid categorical designation for disability, but they also must meet the Medicaid income and asset requirements as defined by the state. DI individuals may spend down their income and assets and thus become eligible for Medicaid under the medically needy eligibility category, if a state uses this optional coverage category. Entitled to part A Medicare coverage after they have received DI cash benefits for 24 months.^d
Program work incentives and effect on health coverage	<p>Under section 1619 (a),(b) of the Social Security Act, 42 U.S.C. 1382h(a),(b), disabled SSI beneficiaries who work may be eligible for continued Medicaid coverage through two work incentive programs:</p> <ul style="list-style-type: none"> <u>Section 1619(a)</u>: Allows disabled beneficiaries to continue to receive SSI cash payments even when earnings exceed the SGA (\$800 per month in 2003). However, as earnings increase, the SSI cash payment decreases until earnings completely replace cash benefits. There is no effect on Medicaid coverage as long as an individual receives SSI cash benefits. <u>Section 1619(b)</u>—SSI work incentive:^e Allows disabled beneficiaries to continue to receive Medicaid coverage even when they no longer qualify for SSI cash benefits. Medicaid coverage continues until earnings reach a threshold amount that varies by state. In contrast to other Medicaid income eligibility thresholds, which are usually set by the state within broad federal parameters, SSA sets the income threshold for SSI-related Medicaid eligibility, which varies from state to state on the basis of each state's current SSI cash benefit (the 	<p>DI beneficiaries who work may retain eligibility for Medicaid as long as their medical disability continues and they continue to meet a state's Medicaid income and asset requirements.</p> <p>Medicare coverage for DI beneficiaries who work may be retained under the following circumstances:</p> <ul style="list-style-type: none"> <u>Trial work period</u>: Allows DI beneficiaries to have a trial work period of 9 months (not necessarily consecutive) within a 60-month rolling period during which they can earn any amount without affecting their DI benefits. Medicare part A coverage continues for the 9-month period. <u>Extended period of eligibility (EPE)</u>: Immediately after the trial work period, DI beneficiaries enter a 36-month EPE as long as medical disability continues. Cash benefits continue for the first 3 months of this period regardless of the earnings level. For the remaining 33 months, DI cash benefits are paid only in months in which countable earnings were less than SGA (\$800 per month in 2003). For those who earn at or above SGA level after the 36-month EPE, part A Medicare coverage continues for at least 7 years and 9 months

Program	SSI	DI
	federal benefit and any state supplement) and a state's per capita Medicaid expenditures. ⁷ Across the 50 states and the District of Columbia, Medicaid eligibility for SSI-related individuals in 2002 ranged from 170 percent of the FPL in Arizona to 443 percent of the FPL in New Hampshire.	(including the 36 months of the EPE), unless the person is determined to be not disabled for a reason other than earning the SGA level. With the trial work period and the EPE, DI beneficiaries who work, and continue to have a medical disability, are entitled to at least 8-1/2 years of Medicare part A coverage following the start of a trial work period. ⁹

Source: SSA.

Note: GAO analysis of SSA documents, as of December 2002.

⁷Not all income or assets are counted in order to calculate "countable" income or assets. Income exclusions include \$20 per month of most income, \$65 per month of wages and one-half of wages over \$65, food stamps, and home energy and housing assistance. Assets excluded are the home a person lives in; a car, depending on its use or value; certain burial spaces and burial funds up to \$1,500; and life insurance with a face value of up to \$1,500.

⁸To be eligible for DI benefits, workers (except those who are blind) also must meet a test of substantial recent covered work, which means that workers aged 31 and older must have been in Social Security covered employment for at least 20 quarters of the 40 calendar quarters ending with the quarter in which the disability began. Workers disabled before age 31 may qualify for benefits under a special insured status requirement.

⁹In identifying eligible individuals with disabilities, states generally are required to use the SSI eligibility requirements; however, they also have the option to use their January 1972 state assistance eligibility rules under section 1902(f) of the Social Security Act, which tend to be more restrictive than SSI rules. If a state's 209(b) rules are more restrictive, it must also allow individuals to spend down into Medicaid eligibility by deducting incurred medical care expenses from income. As of 2002, 11 states had elected this option: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

⁹Medicare part A helps cover inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. Medicare part B helps cover physician services and outpatient hospital care. DI beneficiaries are eligible to enroll in part B Medicare coverage after they have received DI cash benefits for 24 months.

⁹Throughout this report, we refer to individuals who qualify for Medicaid under 1619(b) as participants in the SSI work incentive program.

⁹If an SSI beneficiary has gross earnings higher than the threshold amount for his or her state, SSA can calculate an individual threshold amount if he or she has medical or impairment-related work expenses above the state amount.

⁹Under section 1818A of the Social Security Act, a disabled individual who has lost entitlement to premium-free Medicare part A solely because of SGA may be able to enroll in part A as long as the disability continues. The individual is responsible for paying the premiums.

Medicaid Buy-In Program Designed to Expand Coverage for Working Individuals with Disabilities

The Ticket to Work Medicaid Buy-In builds on an earlier effort to expand Medicaid eligibility for individuals with disabilities who desire to work. Through the Balanced Budget Act of 1997 (BBA) (Pub. L. No. 105-33, 111 Stat. 251), the Congress gave states the option of implementing a coverage category for working individuals with disabilities. For these individuals, the BBA authorized states to extend Medicaid coverage to those who meet the SSI definition of disability and exceed the SSI income eligibility limit but whose income remains under 250 percent of the FPL. States electing the BBA option may require beneficiaries to pay premiums or may use other cost-sharing provisions as long as they are set on a sliding scale based on income. As of December 2002, 12 states had implemented a BBA option for working individuals with disabilities.¹³

The Ticket to Work Medicaid Buy-In legislation expands the availability of Medicaid coverage for individuals with disabilities who desire to work by allowing them to gain or maintain Medicaid eligibility as they enter the workforce or to increase their earnings if they are in the workforce. The Ticket to Work Buy-In builds on the BBA option by giving states unlimited flexibility to set higher income and asset levels for two new eligibility groups—Basic Coverage Group and Medical Improvement Group—for working individuals with disabilities. (For a comparison of the two programs, see table 2.)

¹³States with the BBA option as of December 2002 included Alaska, California, Iowa, Maine, Mississippi, Nebraska, New Mexico, Oregon, South Carolina, Utah, Vermont, and Wisconsin.

Table 2: Comparison of Criteria for the Ticket to Work Buy-In and the BBA Option

Criteria	Ticket to Work Buy-In	BBA Option
Who can be covered	Basic Coverage Group: Working disabled individuals, aged 16–64 (SSI disability definition). ^a Medical Improvement Group: Employed Individuals losing Basic Coverage because they no longer meet the SSI disability definition, but still have severe impairment.	Working disabled individuals of any age (SSI disability definition). ^a
Income standard	For both the Basic Coverage and Medical Improvement groups , the state establishes its own standard or chooses not to have an income standard.	Up to 250 percent of the FPL, and unearned income must meet SSI income test. ^b
Asset standard	For both the Basic Coverage and Medical Improvement groups , the state establishes its own standard or chooses not to have one.	SSI asset standard (\$2,000/person, \$3,000/couple). ^b
Premiums and cost sharing	For both the Basic Coverage and Medical Improvement groups , the state may require premiums and other cost-sharing mechanisms on an income-based sliding scale. For annual incomes less than 450 percent of the FPL, state may charge premiums and use other cost-sharing mechanisms of up to 7.5 percent of income. States must charge the highest amount of premium under the states' premium structure for those with adjusted gross annual incomes exceeding \$75,000.	State may require premiums and other cost-sharing mechanisms on an income-based sliding scale.
States using this option as of December 2002 ^c	Basic Coverage Group: Arkansas, Connecticut, Illinois, Indiana, Kansas, Minnesota, Missouri, New Hampshire, New Jersey, Pennsylvania, Washington, Wyoming Medical Improvement Group: Connecticut, Indiana, Missouri, Pennsylvania, Washington	Alaska, California, Iowa, Maine, Mississippi, Nebraska, New Mexico, Oregon, South Carolina, Utah, Vermont, Wisconsin

Source: CMS.

Note: GAO analysis of CMS documents, as of December 2002.

^aFor those individuals who have not been determined disabled by SSA, the state must do a disability determination to ensure that the individual would meet the definition of disability under the SSI program. The disability test must be identical to the SSI or DI disability test except that employment activity, earnings, and SGA cannot be considered in determining whether the individual meets the definition of disability.

^bUnder usual eligibility rules, states are required to use the processes used by SSI and the former Aid to Families with Dependent Children program in determining eligibility for Medicaid. However, section 1902(r)(2) of the Social Security Act, 42 U.S.C. 1396a(r)(2), allows states to disregard (not include) additional kinds and amounts of income and assets beyond what is allowed under these programs. For example, a state could disregard a select amount of earned or unearned income or income used for home maintenance or repair.

^cFlorida received approval for a Ticket to Work Medicaid Buy-In program in June 2002; however, the state had not implemented the program as of December 31, 2002. Arizona received approval for a Ticket to Work Medicaid Buy-In program in December 2002. The program was implemented in January 2003, which was after the cut-off date of December 2002 for inclusion in this study.

The Basic Coverage Group allows states to cover people aged 16 to 64 who, except for the amount of their earned income, would be eligible to receive SSI benefits. States may establish their own income and asset standards or elect to have no standards at all.¹⁴ As with the BBA option, states electing the Basic Coverage Group may require participants to pay monthly premiums or may impose other cost-sharing mechanisms if they are set on an income-based sliding scale. However, for individuals with annual incomes less than 450 percent of the FPL, states may not impose premiums that exceed 7.5 percent of income. Additionally, if the individual's adjusted gross income for federal income tax purposes exceeds \$75,000, the state must require the individual to pay the highest amount of premiums that an individual would be required to pay under the state's premium structure, although a state is allowed to subsidize this cost with its own funds. While the Basic Coverage Group Buy-In participants must have earnings, the Ticket to Work legislation does not specify a minimum level of employment for this group. Since states cannot adopt rules defining employment for this group that are more restrictive than those in federal law, states cannot establish requirements such as minimum earnings or hours worked.

The Medical Improvement Group allows states to cover working individuals who lose Medicaid eligibility under the Basic Coverage Group because their conditions have improved to the point that they no longer meet the SSI definition of disability but still have "a severe, medically determinable impairment." The same premium requirements apply as for the Basic Coverage Group. If a state elects to cover the Medical Improvement Group, it must also cover the Basic Coverage Group. While the Ticket to Work legislation does not set an employment standard for the Basic Coverage Group, it provides a definition and also allows a state to define employment for the Medical Improvement Group. According to the legislation, an individual qualifying for the Medical Improvement Group is considered employed if the individual is earning at least the minimum wage and working at least 40 hours per month. Alternatively, a state may

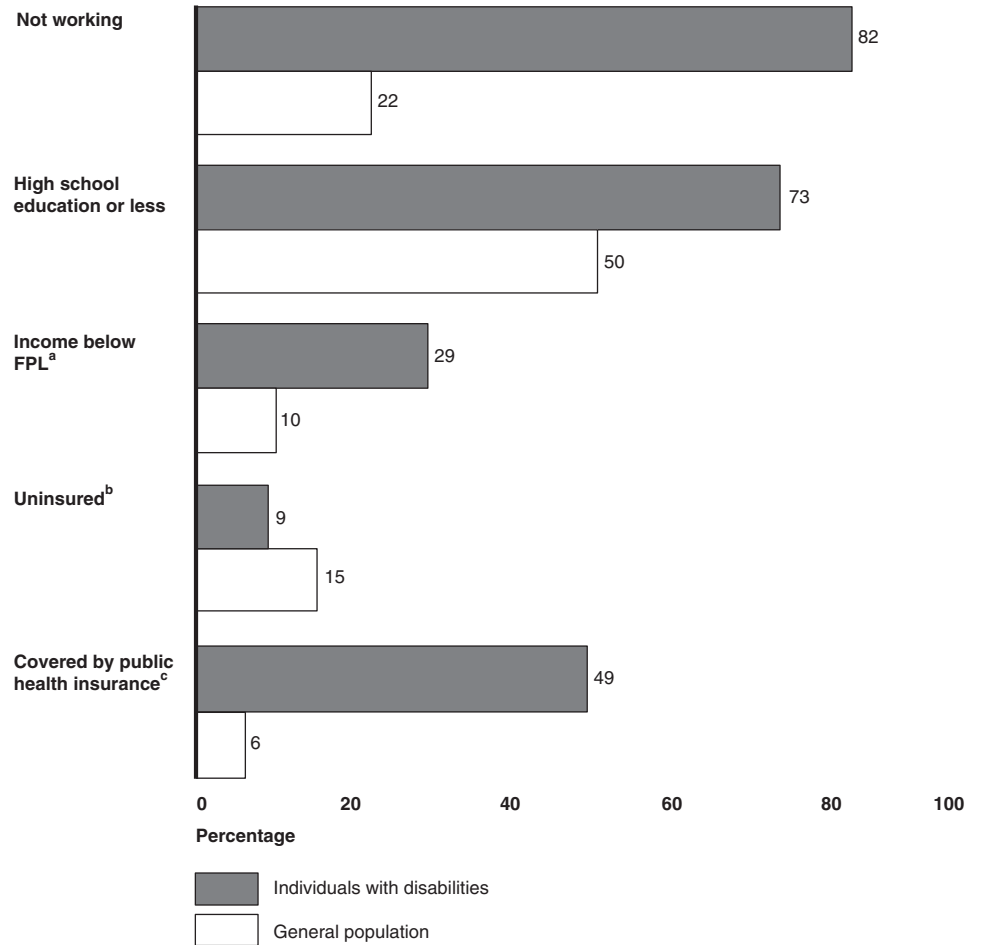
¹⁴If states establish income and asset standards, SSI income and asset methodologies are used to determine eligibility, including the SSI earned income disregard of \$65, plus one-half of remaining earnings. Other income disregards include \$20 of unearned income, and certain impairment-related work expenses, such as certain attendant care services, transportation costs, and medical devices. The SSI asset methodology allows for exclusion of such things as the home a person lives in, a car depending on its use or value, and life insurance valued up to \$1,500.

use hours of work, wage levels, or other measures to define employment if the Secretary of Health and Human Services approves the definition.

Individuals with Disabilities Had Lower Employment, Education, and Income—and More Insurance Coverage—than the General Population

Compared with the rest of the working-age population, the estimated 6.7 million working-age individuals with disabilities nationwide were more likely to be not working, have less education, and have incomes below the FPL. Specifically, 82 percent of working-age individuals with disabilities, or about 5.5 million individuals, reported that they were not working. (See fig. 1.) Nearly three-fourths of working-age individuals with disabilities reported they had a high school education or less. Furthermore, these individuals were nearly three times more likely than individuals without disabilities to have incomes below the FPL. At the same time, individuals with disabilities were less likely to be uninsured compared with the rest of the working-age U.S. population, with just 9 percent of those with disabilities reporting being uninsured, compared with 15 percent for the rest of the working-age population. Nearly half of individuals with disabilities who reported having health insurance obtained coverage through public sources, such as Medicaid and Medicare.

Figure 1: Selected Characteristics of Working-Age Individuals with Disabilities Compared with the Rest of the General Working-Age Population



Source: AHRQ.

Note: GAO analysis of AHRQ’s MEPS household component, 1997 and 1998.

^aIndividuals reported income levels from either 1997 or 1998. The FPL in 1997 was \$7,890 for an individual; the FPL in 1998 was \$8,050 for an individual.

^bIndividuals reported being uninsured during the entire year for 1 of the 2 years.

^cPublic health insurance coverage primarily includes Medicaid and Medicare.

Working-age individuals with disabilities were far more likely to have public health coverage than working-age individuals in the general population. Specifically, working-age individuals with disabilities were about eight times more likely to have public health insurance coverage than other working-age individuals. Generally, the lower the income level, the more likely an individual with disabilities was to have public health insurance coverage. For example, 75 percent of individuals with disabilities who had incomes below the FPL had public health insurance, while fewer than 20 percent of those with incomes at or exceeding 400 percent of the FPL had public coverage.

The extent of their health care costs underscores the need for individuals with disabilities to maintain some type of health insurance coverage to help cover the costs of their care. Health care expenditures for working-age individuals with disabilities were about five times the expenditures for other working-age individuals, annually averaging about \$7,600 and \$1,500, respectively.¹⁵

States' Buy-In Programs Expanded Eligibility and Increased Cost Sharing for More Workers with Disabilities

The 12 states that opted to implement the Ticket to Work Medicaid Buy-In program as of December 2002 set income and asset levels for eligibility that provided new opportunities for working individuals with disabilities to secure and maintain Medicaid coverage. DI-eligible individuals benefited particularly because states' broader eligibility categories under the Buy-In allowed individuals to become eligible for Medicaid without spending down their incomes and to remain eligible when their incomes rose to higher levels. In addition to expanding income eligibility and asset limits, all states took advantage of the flexibility of the statute to charge premiums or copayments to ensure that Buy-In participants shared in the cost of their health care coverage.

Twelve States Expanded Medicaid Eligibility Levels for Working Individuals with Disabilities

Across the 12 states that opted to implement Ticket to Work Medicaid Buy-In programs, all set eligibility requirements that expanded eligibility for working individuals with higher incomes or more assets than usually allowed under their Medicaid programs. As of December 2002, the number of Buy-In participants for the 12 states totaled 24,258, ranging from 3 participants in Wyoming to almost 8,500 participants in Missouri. (See

¹⁵In our MEPS analysis of health care expenditures of individuals with disabilities, we did not find a difference in average expenditures between those in and out of the workforce.

table 3.) Eleven of the 12 states set Buy-In eligibility limits for income at twice the FPL or higher—or \$17,720 per year for an individual in 2002—thereby expanding opportunities for individuals to secure and maintain Medicaid coverage. Buy-In programs also allowed participants to retain more assets than usually allowed in states’ Medicaid programs. Of the 12 states, 7 states set asset limits that ranged from \$10,000 to \$30,000 for individuals, couples, or both. Three states— Missouri, Indiana, and Arkansas—opted for asset requirements of \$4,000 or less for an individual,¹⁶ while the remaining two states—Washington and Wyoming—imposed no asset limits.

Table 3: Enrollment and Eligibility Characteristics of 12 States With Ticket to Work Medicaid Buy-In Programs

State	Enrollment ^a	Buy-In start date	Income limit as a percentage of FPL ^b	Asset limits ^c
Missouri	8,461	July 2002	250%	\$999.99 individual ^d
Minnesota	6,178	July 2001 ^e	No limit	\$20,000 individual
Indiana	3,318	July 2002	350%	\$2,000 individual; \$3,000 couple
Connecticut	2,433	Oct. 2000	\$6,250 monthly gross income, or \$3,082 monthly net income ^f	\$10,000 individual; \$15,000 couple
Pennsylvania	1,325	Jan. 2002	250%	\$10,000 couple
New Hampshire	968	Feb. 2002	450%	\$20,000 individual; \$30,000 couple
New Jersey	551	Feb. 2001	250% (earned) and 100% (unearned)	\$20,000 individual; \$30,000 couple
Kansas	489	July 2002	300%	\$15,000 couple
Illinois	323	Jan. 2002	200%	\$10,000 individual; \$10,000 couple
Washington	144	Jan. 2002	220%	No limit
Arkansas	65	Feb. 2001	250%	\$4,000 individual; \$6,000 couple ^g
Wyoming	3	July 2002	100%	No limit

Source: State-reported data.

Note: GAO analysis of state-reported data, as of December 2002.

^aStates’ enrollment data represent either the number of participants enrolled on a specific day in December 2002 or the total number who were ever enrolled during that month. Also, some states included individuals who were retroactively enrolled for that month.

¹⁶Indiana set asset requirements for a couple at \$3,000, while Missouri allowed the spouse of a Buy-In participant to retain assets up to \$100,000 and excluded one-half of the participant’s marital assets.

^bIn 2002, the FPL for an individual was \$8,860 annually; for a family of three, the FPL was \$15,020. Not all income is counted in order to calculate “countable” income. Income exclusions include \$20 per month of most income, \$65 per month of wages and one-half of wages over \$65, food stamps, and home energy and housing assistance.

^cNot all assets are counted in order to calculate “countable” assets. Assets excluded are the home a person lives in; a car, depending on its use or value; certain burial spaces and burial funds up to \$1,500; and life insurance with a face value of up to \$1,500.

^dMissouri allowed the spouse of an individual with disabilities to retain assets up to \$100,000 and excluded one-half of the participant’s marital assets.

^eMinnesota originally opted to cover workers with disabilities through the BBA option, implemented in July 1999, and amended its program to follow Ticket to Work Buy-In requirements.

^fConnecticut uses a two-step method that is not based on the FPL to determine income eligibility. First, an applicant’s individual gross income must be \$6,250 a month or less (\$75,000 maximum per year). If the applicant’s income is higher than \$6,250, the state applies a second test whereby the SSI income disregards and impairment-related work expenses are excluded; if an individual’s adjusted income (after applying these exclusions) is less than or equal to \$3,082 per month, the individual is income-eligible for the Medicaid Buy-In.

^gArkansas increases the asset limit by \$200 for each additional family member.

States generally allowed Ticket to Work participants to exclude certain assets from the asset limits. In addition to excluding the value of certain assets that applied to most individuals with disabilities in the Medicaid program when determining eligibility,¹⁷ 10 of the 12 states allowed Buy-In participants to save money in retirement accounts such as Individual Retirement Accounts, Keoghs, and 401(k)s; medical savings accounts; or special accounts that allow individuals to save for expenses such as modifications for job or home and education costs. These accounts are not considered when determining asset limits for participants. Two states—Arkansas and Indiana—set \$10,000 and \$20,000 limits, respectively, on the amount of savings participants can accumulate in these accounts. State officials in a few states said allowing participants to exclude these retirement accounts and other assets helped support states’ goals of affording working individuals with disabilities greater independence and self-sufficiency. For example, under these rules, participants can save to buy cars or homes and can set aside money for retirement.

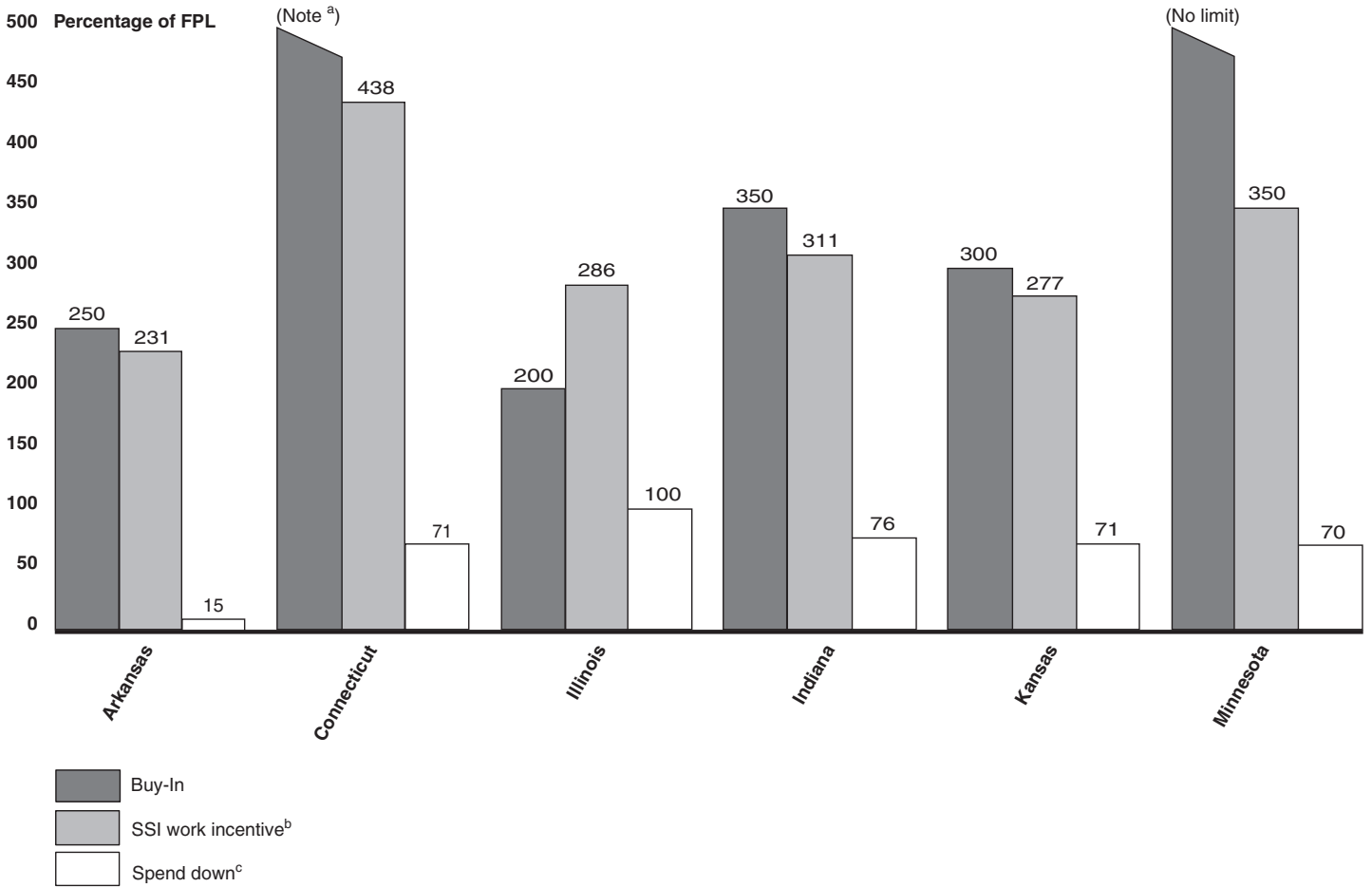
¹⁷For example, a home, personal property, one vehicle under certain conditions, a burial space, and life insurance valued at up to \$1,500 are disregarded for individuals applying for Medicaid.

Buy-In Programs May Offer Greatest Benefit to DI Participants

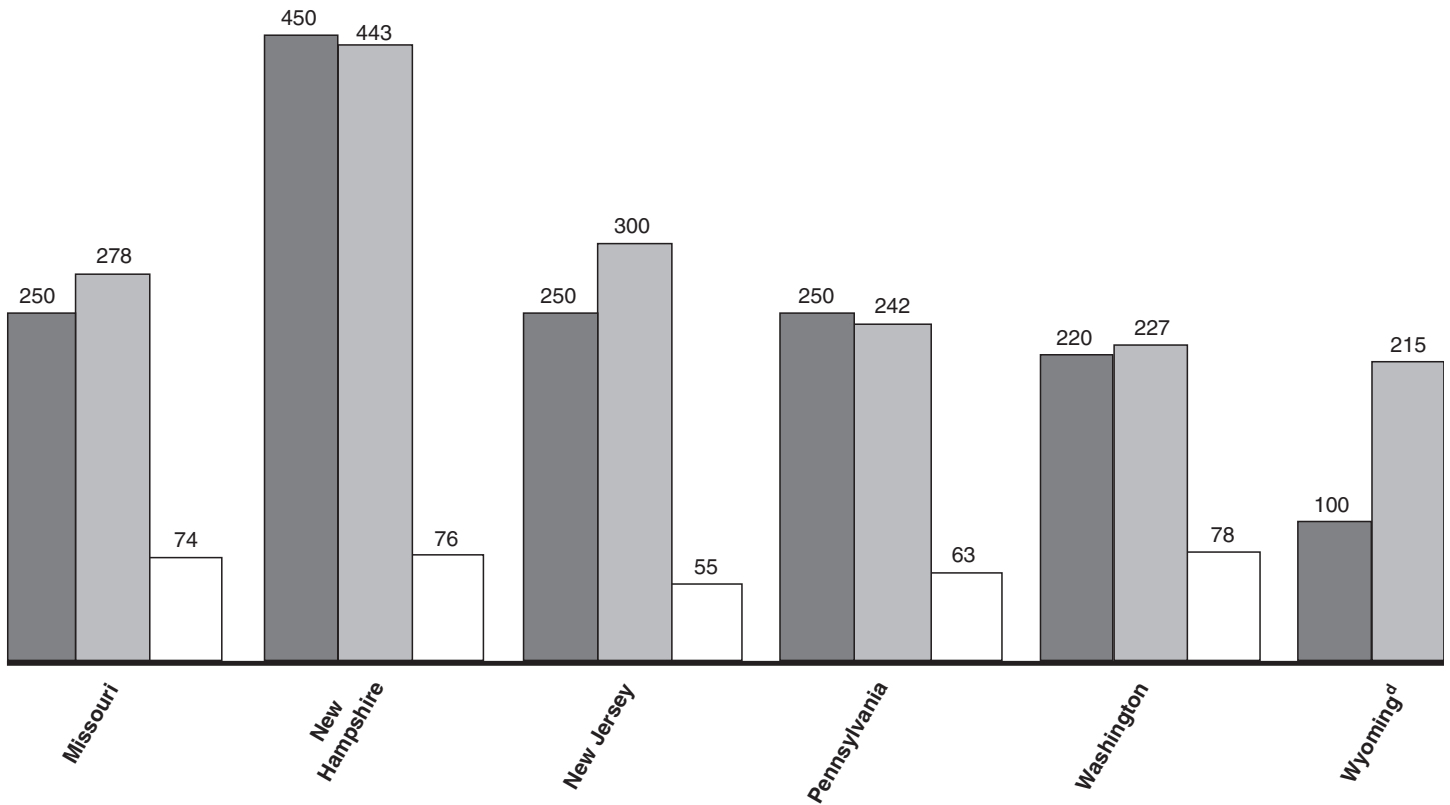
In most of the 12 states, the Buy-In programs were especially beneficial for DI-eligible individuals who, in contrast to most SSI individuals, were not always eligible for Medicaid coverage. Prior to the Ticket to Work legislation, DI individuals in 11 of the 12 states could qualify for Medicaid by spending down their incomes to specified levels (Wyoming did not offer a spend-down option).¹⁸ In these 11 states, the spend-down income eligibility levels ranged from 15 percent to 100 percent of the FPL. Under the new Buy-In programs, the income eligibility levels significantly exceeded those established under the spend-down categories (see fig. 2), thus allowing individuals to qualify for the Medicaid Buy-In directly—rather than spending down their incomes to qualify for Medicaid coverage. For example, an individual receiving DI in Arkansas could obtain Medicaid coverage through the Buy-In program with an income up to 250 percent of the FPL; prior to the Buy-In, the individual would have had to incur medical expenses that reduced his or her income to approximately 15 percent of the FPL in order to qualify for the spend-down category of Medicaid. This allows an individual with disabilities in Arkansas to maintain an income of up to \$22,150 per year under the Buy-In, whereas that person would have had to spend down to an income of \$1,300 a year to qualify for Medicaid.

¹⁸States may offer spend-down coverage through an optional medically needy eligibility category. However, 209(b) states that do not offer a medically needy eligibility category must allow individuals who are aged, blind, or disabled (including SSI and DI individuals) to spend down their incomes, using their incurred medical expenses, to meet the 209(b) category income eligibility requirements.

Figure 2: Twelve States' Medicaid Buy-In, SSI Work Incentive, and Spend-Down Income Eligibility Levels, as a Percentage of the FPL



Source: State-reported data, SSA data on SSI work incentive, and Kaiser Family Foundation data on spend down.



Note: GAO analysis of states', SSA's, and the Kaiser Family Foundation's data, as of December 2002.

^aConnecticut uses a two-step method that is not based on the FPL to determine Medicaid Buy-In income eligibility. First, an applicant's individual gross income must be \$6,250 a month or less (\$75,000 maximum per year). If the applicant's income is higher than \$6,250, the state applies a second test whereby SSI income disregards and impairment-related work expenses are excluded; if an individual's adjusted income (after applying these exclusions) is less than or equal to \$3,082 per month, the individual is income-eligible for the Medicaid Buy-In.

^bSSI's work incentive program, known as Section 1619(b), 42 U.S.C. 1382h(b), provides for continued Medicaid eligibility for individuals whose incomes are too high to qualify for an SSI cash payment but are not high enough to offset the loss of Medicaid or publicly funded attendant care.

^cSpend-down refers to two approaches to Medicaid eligibility. First, most states offer spend-down coverage through their medically needy category of eligibility, where individuals deduct incurred medical expenses from their income to spend down into Medicaid coverage. Second, 209(b) states that use their 1972 state assistance eligibility rules in determining Medicaid eligibility for individuals with disabilities must allow individuals who are aged, blind, or disabled (including SSI and DI individuals) to spend down their incomes by incurred medical expenses, regardless of whether they offer a medically needy eligibility category in Medicaid. Of the six 209(b) states with Ticket to Work Medicaid Buy-In programs, two states—Indiana and Missouri—do not offer medically needy coverage, but these states must allow individuals with disabilities to spend down into Medicaid.

^dWyoming does not provide a spend-down option.

Buy-In programs afforded DI beneficiaries more immediate—and sometimes expanded—Medicaid coverage. In addition to relieving individuals of the requirement to spend down their income to qualify for Medicaid, DI individuals, who are not entitled to receive Medicare coverage until they have been receiving DI cash benefits for 24 months, also received more immediate health insurance coverage through the Medicaid Buy-In. Buy-In participants may also have access to a more expanded benefit package than individuals who receive Medicaid through a state’s medically needy program.¹⁹

However, when considering participation in the Buy-In program, DI beneficiaries must weigh the benefits of the higher earnings allowed under the program against the possible loss of DI cash benefits and Medicare coverage if their earnings increase beyond a certain threshold. Specifically, after a 9-month trial work period and a 36-month extended period of eligibility, if a DI beneficiary’s earnings increase over the SGA limit in any month, the individual loses DI eligibility entirely. Additionally, DI beneficiaries who earn more than the SGA level after the initial 9-month trial period could lose Medicare coverage after 8-1/2 years. The loss of entitlement for Medicare may be of concern for those individuals with disabilities who would not reach age 65 by the end of the 8-1/2-year time

¹⁹States may offer different sets of benefits depending on whether an individual’s eligibility for Medicaid is considered mandatory or optional by federal statute; optional benefits may vary by state. Most adults with disabilities who receive SSI payments have mandatory coverage under Medicaid, while individuals who are medically needy (and spend down to receive Medicaid benefits) are considered to be in the optional category. Thus, adults with disabilities who move from medically needy coverage to the Medicaid Buy-In may receive additional benefits, depending on states’ coverage policies.

period.²⁰ To the extent that a state reduced its Medicaid Buy-In eligibility level, or discontinued its Buy-In program, these former DI-eligible Buy-In participants could potentially be without health care coverage until they reached age 65.

In contrast, SSI beneficiaries have different considerations than those weighed by DI beneficiaries in deciding whether to enroll in the Medicaid Buy-In program. Most SSI beneficiaries were assured eligibility for Medicaid and thus did not need the Buy-In program or to spend down their incomes in order to qualify for Medicaid. SSI beneficiaries in Medicaid would receive the same benefit package as those in a Buy-In program. Even SSI beneficiaries who worked could remain eligible for Medicaid as participants in a work incentive program, which allowed individuals to increase their incomes while maintaining their Medicaid coverage. In 5 of the 12 states, Buy-In income eligibility levels were lower than the Medicaid eligibility levels for individuals in the SSI work incentive program, and Buy-In eligibility levels only slightly exceeded those for the SSI work incentive beneficiaries in another 5 states. Additionally, beneficiaries in SSI's work incentive program are not subject to premium payments in Medicaid, while Buy-In programs generally have imposed premium requirements for participants.

All States' Buy-In Programs Required Cost Sharing

States may require Buy-In participants to share in the cost of their health care coverage. All 12 states adopted cost-sharing mechanisms, primarily premiums or copayments, for Buy-In participants. States calculated premiums for Buy-In participants using various methods. For example, Pennsylvania and Washington set premiums as a percentage of allowable income, while Indiana and Kansas established varying premium levels for different incomes. (See table 4.) Generally, states assessed premiums when income was at 100 percent of the FPL or higher. Among states that charged premiums in 2002, the percentage of participants whose incomes were high enough to be charged premiums varied significantly across the

²⁰Under section 1818A of the Social Security Act, a disabled individual who has lost entitlement to premium-free Medicare part A solely because of SGA may be able to enroll in part A as long as the disability continues. The individual is responsible for paying the premiums. Furthermore, an individual who has lost his or her benefits under DI due to earning more than SGA and who then fails to earn at least SGA due to being disabled, could be eligible for reinstatement of his or her DI benefits and Medicare coverage. Section 112 of the Ticket to Work legislation allows certain previously entitled individuals to request expedited reinstatement of disability benefits under title II and title XVI when their disabling impairment no longer permits them to perform SGA.

states, from 12 percent of participants in Connecticut to all or nearly all participants in Illinois, Pennsylvania, Washington, and Wyoming. Average monthly premiums ranged from \$26 to \$82, with nearly half of the states setting premiums from \$40 to \$60. Two states—Arkansas and New Jersey—did not charge premiums as of December 2002. Stating that premiums were difficult to administer and collect, Arkansas chose not to impose a premium requirement. New Jersey has a premium requirement for participants with incomes greater than 150 percent of FPL; however, the state did not assess premiums because only about 5 percent of beneficiaries owed a payment.

Table 4: Twelve States' Premium Requirements for Ticket to Work Medicaid Buy-In Programs

State	Percentage of FPL at which state assesses premiums	Monthly premium	Participant's average monthly premium	Percentage of participants charged premiums
Arkansas ^a	N/A	N/A	N/A	N/A
Connecticut	200%	10% of family's income that exceeds 200% of the FPL for the appropriate family size; not to exceed 7.5% of net family income for families with incomes less than 450% of the FPL. Family includes the participant and his or her spouse. ^b	\$50 ^c	12%
Illinois	100%	24 premium levels based on the participant's earned and unearned income, ranging from \$6 to \$100. Premiums increase as income increases.	\$48	99.7%
Indiana	150%	Six premium levels based on the participant's income, ranging from \$48 to \$187, and six premium levels based on participant's and spouse's income, ranging from \$65 to \$254. Premiums increase as income increases.	\$82 ^c	22%
Kansas	100%	Eight premium, levels based on the participant's income, ranging from \$55 to \$152, and eight premium levels, based on participant's and spouse's income, ranging from \$74 to \$205. Premiums increase as income increases.	\$68	57%
Minnesota	100%	Premium begins at 1% of income and the percentage of the premium increases as income increases, up to a premium of 7.5% of participant's income.	\$57	77%
Missouri	150%	Four premium levels, ranging from approximately \$48 to \$123. Premiums increase as income increases.	^d	16%
New Hampshire	150%	Six premium levels, ranging from \$80 to \$220. Premiums increase as income increases.	\$26 ^e	15%
New Jersey	^f	^f	^f	^f
Pennsylvania	N/A	5% of countable income (premiums under \$10 are not collected).	\$43	95%
Washington	N/A	The lesser of 50% of unearned income above \$571, plus 5% of total unearned income, plus 2.5% of earned income minus \$65, or (2) 7.5% of total income.	\$70	100%
Wyoming	N/A	7.5% of earned income plus 7.5% of unearned income over \$600 per year.	\$44	100%

Source: State-reported data.

Legend: N/A = not applicable

Note: GAO analysis of state data, as of December 2002.

^aArkansas' Medicaid Buy-In program did not impose premiums.

^bThe FPL calculation is dependent upon family size. For example, 100 percent of the FPL for an individual in 2002 was \$8,860 annually, while 100 percent of the FPL for a family of three was \$15,020.

^cState reduces a participant's premium liability by any amount the participant pays for employer-sponsored coverage.

^dMissouri does not collect data on average monthly premiums.

^eAlthough premiums in New Hampshire begin at \$80 per month, nearly half of the participants have premiums reduced because the state allows deductions for the costs of premiums that participants pay for Medicare and employee-sponsored health insurance for family members.

^fNew Jersey has a premium requirement for participants with incomes greater than 150 percent of FPL; however, as of December 31, 2002, the state was not assessing premiums because only about 5 percent of beneficiaries owed a payment.

Three states—Connecticut, Indiana, and New Hampshire—reported discounting the Buy-In premium if participants also paid premiums for Medicare part B, for employer-sponsored insurance coverage, or for individual insurance coverage. For example, New Hampshire deducted the Medicare part B premium from a participant's total Buy-In premium. If a Buy-In participant were paying a Medicare part B premium of \$54 a month, his or her Medicaid Buy-In premium would be discounted by that amount. Thus, if a participant's Buy-In premium were \$80 a month, the monthly premium for the Buy-In program would be discounted to \$26 a month. In Connecticut, any amount that participants pay for Medicare part B premiums, employer-sponsored coverage, or other out-of-pocket medical insurance is deducted from their premium liability. For example, if a participant owes a Buy-In premium of \$100 a month and also is paying an employer \$80 a month for private coverage, the individual's Buy-In premium liability would be reduced to \$20.

Participants in 8 of the 12 states also were required to pay copayments for health care services, such as \$0.50 to \$3 for an office visit or prescription drugs. Copayments for inpatient hospital care generally varied from \$3 per day in Illinois to \$48 per hospital stay in Kansas. In 7 of these states, copayments were the standard cost-sharing requirements for Medicaid. The remaining state—Arkansas—imposed a two-level copayment system for participants. Arkansas Buy-In participants with incomes below 100 percent of the FPL had the same copayment requirements and were charged the same amounts for pharmacy and inpatient hospital services as usually prescribed under the state's Medicaid program. Participants with incomes of 100 percent of the FPL or greater were charged additional copayments for services and equipment such as physician services (\$10 per visit), outpatient mental and behavioral health services (\$10 per visit), and prosthetic devices (10 percent of the maximum Medicaid payment).

Buy-In Participants in Four States Generally Had Prior Medicaid Coverage and Worked in Low-Wage Jobs

In the four states in which we conducted more detailed work—Connecticut, Illinois, Minnesota, and New Jersey—Buy-In programs enrolled many individuals who previously were enrolled in Medicaid, often in eligibility categories with more restrictive income limits, such as the medically needy category. Buy-In participants in the four states generally also had Medicare coverage. Across the four states, few Buy-In participants had coverage from private insurance at the time of their enrollment in the Medicaid Buy-In programs. Based on the limited participation in private insurance, officials in several states did not believe that “crowd-out”—the substitution of newly available public coverage for private health insurance—was a concern for the Medicaid Buy-In programs. The limited employment information available for participants from two of the four states—Connecticut and Minnesota—showed that Buy-In participants generally were employed in low-wage jobs—many making less than the SGA threshold, which at the time was \$780 per month. These four states, however, had little information regarding the extent to which the Buy-In programs fostered employment among individuals with disabilities.

Buy-In Participants Often Had Previous Coverage under Medicaid and Medicare

Across these four states, the share of Buy-In participants with previous Medicaid coverage was 53 percent in Connecticut, 81 percent in Illinois, 61 percent in Minnesota, and 58 percent in New Jersey. Whereas previous Medicaid coverage was largely due to eligibility through spend-down provisions, Buy-In participation allowed them to retain more of their income or assets and still qualify for Medicaid. Of those who switched from existing Medicaid coverage to the Buy-In program, Illinois and Minnesota estimated that 79 percent and 51 percent of participants, respectively, were beneficiaries who originally had spent down their income to qualify for Medicaid. While not offering a specific estimate, a New Jersey official indicated that most of the Buy-In participants who were enrolled in Medicaid before switching to the Buy-In category also had spent down their income to qualify for Medicaid. Buy-In eligibility was particularly beneficial for individuals in New Jersey because the state’s Medicaid coverage for medically needy beneficiaries did not include prescription drugs or community-based long-term care services, both of which were covered under the Buy-In.

In three of the four states—Connecticut, Minnesota, and New Jersey—more than 80 percent of Buy-In participants also received health care coverage through Medicare.²¹ (See table 5.) State officials reported that those with Medicare relied on the Medicaid Buy-In for purposes of obtaining outpatient prescription drug coverage since Medicare generally does not cover this benefit. Few participants—less than 10 percent of participants in any of the four states—reported having employer-sponsored coverage at the time of their enrollment into the Medicaid Buy-In programs. For example, Connecticut, which requires Buy-In applicants who have access to employer-sponsored insurance coverage to apply for this coverage, found that less than 6 percent of Buy-In applicants had health care coverage through their workplace. For Buy-In participants with private health insurance coverage, which often has more limited benefits than those covered by Medicaid, the Buy-In can serve as a “wrap around” to private coverage by providing such services as home health and personal care, and items such as durable medical equipment.²²

²¹Illinois was unable to identify Buy-In participants who had Medicare.

²²Medicaid-eligible individuals enrolled in employer-sponsored health plans are entitled to receive full Medicaid benefits. The health plans become the primary payers for the services they cover. States must provide coverage for those Medicaid services not included in the employer plans.

Table 5: Number of Buy-In Participants Reporting Other Sources of Health Care Coverage in Four States

State	Participants with other sources of coverage ^a (percentage of total enrollment)		
	Medicare	Employer-sponsored coverage	Other ^b
Connecticut	1,870 (82%)	128 (5.6%)	34 (1.5%)
Illinois	^c	4 (1.6%)	3 (1.2%)
Minnesota	5,394 (90%) ^d	459 (7%) ^e	367 (6%) ^e
New Jersey	408 (82%)	38 (7.3%)	8 (1.5%)

Source: State-reported data.

Note: GAO analysis of state data, as of December 2002.

^aThese categories are not mutually exclusive, as individuals may have more than one source of coverage.

^b“Other” may include coverage held through a spouse or other family member, or Medicare supplemental coverage. Most Medicare beneficiaries purchase Medicare supplemental coverage (known as Medigap) to protect themselves against large out-of-pocket costs and help fill Medicare’s coverage gaps.

^cIllinois was unable to identify Buy-In participants who had Medicare.

^dMinnesota’s Medicare data are as of September 2002.

^eMinnesota’s employer-sponsored and other coverage data are as of December 2001.

According to officials in several states, crowd-out was not a concern for Buy-In programs because most participants did not report having private health insurance coverage at the time of their enrollment into the Medicaid Buy-In programs. For example, Minnesota and New Jersey state officials said they did not view crowd-out as a significant issue for this population because many of the participants worked part-time and were rarely offered private insurance coverage. Additionally, both Minnesota and Connecticut required individuals to either enroll or remain enrolled in employer-sponsored coverage if it was offered. As of December 2002, these states had not formally analyzed whether Buy-In participants withdrew from private health insurance coverage prior to obtaining Medicaid coverage. New Jersey officials plan to monitor whether employees are deciding to or are being urged to pursue the Buy-In program rather than their employer-sponsored coverage.

Available Employment Information Shows Participants Worked in Low-Wage Jobs and Experienced Minimal Increases in Earnings

In the three states with data available, working individuals with disabilities who qualified for the Medicaid Buy-In program generally worked in low-wage jobs. (See table 6.) While one purpose of the Ticket to Work legislation was to enable individuals with disabilities to reduce their dependency on federal cash benefit programs through earnings from work, available data from Connecticut, Illinois, Minnesota showed that few participants earned more than the SGA limit, which was \$780 in December 2002. Sixty-four percent of participants in Connecticut, 61 percent of participants in Illinois, and 77 percent of participants in Minnesota had earned income well below the SGA limit. None of these states had asked participants to identify their occupation or the industry in which they were employed on their Medicaid Buy-In applications; however, some states may conduct broader analyses of participants' employment as part of required evaluations under a related Ticket to Work grant program.²³

²³Section 203 of the Ticket to Work and Work Incentives Improvement Act of 1999 authorized the Medicaid Infrastructure Grant Program, which is an 11-year grant program beginning in fiscal year 2001 (\$150 million for the first 5 years) that allows states to design, establish, and operate state "infrastructures" to facilitate the competitive employment of individuals with disabilities. Grant activities include (1) implementing Medicaid Buy-In programs, (2) developing demonstration programs that offer the ability to purchase Medicaid coverage for people with a severe impairment who do not yet meet the SSI disability test, (3) making significant improvements to Medicaid services that support people with disabilities in their competitive employment efforts, and (4) creating regional technical assistance centers for health care improvements supporting employment—known as State-to-State Medicaid Infrastructure Partnerships. As of December 2002, thirty-eight states received Infrastructure Grants, including 10 of the 12 states with Medicaid Buy-In programs (all except Arkansas and Indiana). Indiana was awarded an Infrastructure Grant in 2003.

Table 6: Average Monthly Income for Ticket to Work Buy-In Participants in Four States

State	State-reported categories of average monthly income from earnings	Percentage of participants ^a
Connecticut ^b	\$200 or less	23
	\$201-\$600	41
	\$601-\$800	17
	\$801 and greater	19
Illinois	\$200 or less	12
	\$201-\$599	49
	\$600-\$799	23
	\$800 and greater	17
Minnesota	Less than \$200	36
	\$200-\$599	41
	\$600-\$799	12
	\$800 and greater	10
New Jersey	^c	^c

Source: State-reported data.

Note: GAO analysis of state data, as of December 2002.

^aPercentages may not add to 100 due to rounding.

^bConnecticut's data on earned income are from 2001.

^cState did not provide these data.

Two of the four states we reviewed could identify whether participants had increased their earnings once enrolled in the Buy-In. Forty percent of Minnesota participants and 28 percent of Connecticut participants increased their earnings between the time of initial enrollment and December 2001, the most recent date for which these data were available.²⁴ Average monthly increases over previous earnings were \$306 in Minnesota and \$332 in Connecticut. New Jersey and Illinois were not able to provide this information. Minnesota found that 64 percent of those in the state's Buy-In program as of December 2001 earned wages for at least one 3-month period in the 2-year period prior to enrollment.²⁵ Minnesota officials

²⁴Connecticut officials said that as a part of their state's Infrastructure Grant, their primary research question will be to determine whether the Medicaid Buy-In, along with other factors such as participation in vocational rehabilitation and a new benefits counseling program, leads to increases in earnings among participants.

²⁵Minnesota officials used data collected by the state's Department of Economic Security from employers who report information on employees who pay federal taxes.

cautioned that the analysis was limited by the lack of detail in the state database; for example, they did not know whether participants were disabled during this entire period, or whether individuals were consistently employed.

Agency and State Comments

We provided a draft of this report for comment to CMS and the 12 states in our sample. In its comments, CMS said that, in addition to the states with existing BBA and Ticket to Work Buy-In programs, at least three more states are planning to implement a Medicaid Buy-In program within the coming year, which would result in over half of the states offering health insurance to workers with disabilities. CMS noted that the expansion of Medicaid coverage to these individuals is encouraging particularly because states are experiencing fiscal budget constraints. CMS also said that it is collecting information on Medicaid Buy-In participants' earnings and Medicaid costs for the first 2 years of operation. In addition, CMS expects to complete an extensive study of states' experiences for 2001 and 2002 with the Buy-In programs authorized under both the BBA and the Ticket to Work and Work Incentives Improvement Act of 1999 in the fall of 2003 and to report its findings in 2004.

CMS also suggested that, in view of general concerns over racial disparities and access to care in rural areas, it might be helpful for us to comment on these demographic factors as part of our findings. We did not include these factors in our scope of work, even for the four states where we did more detailed work, and therefore cannot comment on them. CMS provided technical comments, which we have incorporated as appropriate. The full text of CMS's written comments appears in appendix II.

Eleven of the 12 states responded with technical comments, which we incorporated where appropriate.

We will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services and other interested parties. We also will make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or members of your staffs have any questions regarding this report, please contact me on (202) 512-7118 or Carolyn Yocom at (202) 512-4931. Other major contributors to this report were Catina Bradley, Karen Doran, Kevin Milne, and Elizabeth T. Morrison.

Kathryn G. Allen

Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Methodology for Developing Estimates and Characteristics of Working-Age Individuals with Disabilities

To develop a national estimate and compare the characteristics of working-age individuals with disabilities with those for working-age individuals in the rest of the population, we analyzed data available from the Medical Expenditure Panel Survey (MEPS) household component, which provides data on individuals' demographics, employment, health characteristics, and medical spending.

MEPS, conducted by the Agency for Healthcare Research and Quality (AHRQ), consists of four surveys and is designed to provide nationally representative data on health care use and expenditures for U.S. civilian noninstitutionalized individuals. For our analysis, we used one of the four surveys—the Household Component. The Household Component is a survey of individuals regarding their demographic characteristics, health insurance coverage, and health care use and expenditures. The 1997 and 1998 versions of the MEPS Household Component were the most recently available at the time of our analysis that had both (1) a pooled estimation file published by AHRQ that allows pooling 2 or 3 years of data, and (2) complete demographic, health insurance, and health care expenditure data. We pooled data from 1997 and 1998 in order to increase our sample sizes for individuals with disabilities. Using the Medical Care Consumer Price Index from the Bureau of Labor Statistics, we inflated 1997 medical care expenditures to 1998 values.

Our estimate of working-age individuals with disabilities includes individuals aged 16 to 64 with one or both of these conditions: (1) needing help or supervision in performing activities of daily living (ADL) or instrumental activities of daily living (IADL) because of an impairment or a physical or mental health problem¹ or (2) being completely unable to work at a job, do housework, or go to school.

Our analyses of working-age individuals with disabilities are based on a sample size of 1,680, representing a population of 6.68 million individuals with disabilities. Table 7 shows the unweighted and weighted sample sizes on which our analyses are based.

¹MEPS identifies ADLs as basic physical activities such as bathing, dressing, or getting around the house and identifies IADLs as cognitive or social functions such as using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping. MEPS offers a relatively expansive definition of disability in that it does not distinguish the number of ADLs or IADLs with which an individual may require assistance.

**Appendix I: Methodology for Developing
Estimates and Characteristics of Working-Age
Individuals with Disabilities**

Table 7: MEPS Sample and Estimated Population Sizes, 1997 and 1998

	Individuals with disabilities aged 16-64	Rest of the general population aged 16-64
Sample size (unweighted)	1,680	32,068
Estimated population size (weighted)	6,682,106	166,509,028

Source: Agency for Healthcare Research and Quality.

Note: GAO's analysis of AHRQ's MEPS household component, 1997 and 1998.

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 10 2003

TO: Kathryn G. Allen
Director, Health Care—Medicaid
General Accounting Office

FROM: Thomas A. Scully *Tom Scully*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, *MEDICAID AND TICKET TO WORK: States' Early Efforts to Cover Working Individuals with Disabilities*, (GAO-03-587)

Thank you for the opportunity to review and comment on the above-referenced draft report. The GAO draft report is very clear and provides useful information on the characteristics of individuals with disabilities, including their health care costs and health insurance coverage, as well as conveying states' progress in designing and implementing the Medicaid Buy-In program. We believe that the GAO report provides the most comprehensive treatment to date on this complex subject.

Prior to the passage of the Ticket to Work legislation, a total of eight states offered Medicaid coverage to disabled workers under the Balanced Budget Act (BBA) of 1997. This enabled disabled workers to retain their health insurance while still maintaining employment. Since the passage of the Ticket to Work legislation in 1999, four more states have implemented a Medicaid Buy-In under the BBA and a total of 12 states have implemented a Medicaid Buy-In under the this legislation. We note that at least three more states are planning to implement a Medicaid Buy-In, and we expect that over half the states nationally will offer health insurance to disabled workers within the coming year. The expansion of health coverage to disabled workers is encouraging particularly in view of the tight fiscal budgets that states are currently experiencing.

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We believe it is important to include the fact that CMS is also collecting information on Medicaid Buy-In participants' earnings and costs. By fall of 2003, we expect to complete an extensive study of the experience of the Buy-In programs authorized by both the BBA and the Ticket to Work and Work Incentives Improvements Act of 1999. Information on the years 2001 and 2002 will be available in early 2004.

It may also be helpful for GAO to comment on any of its findings relative to two demographic factors that were not included in the report—race and urban/rural differences. Given concerns that exist over racial disparities and rural residents' access to health care services, this information may help to inform future Congressional discussions.

We look forward to working with GAO on this and other issues.

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