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Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



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

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Office of the Assistant Secretary for Planning and Evaluation

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EXECUTIVE SUMMARY

Purpose of Report

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

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

Other Reports Prepared by Project

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

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

Overall Purposes of the Study

The overall project had several purposes.

- To examine and describe the early implementation experiences of nine states that opted for the Medicaid Buy-In program for working disabled persons.
- To use the descriptive information to inform and provide technical assistance to various state-level stakeholders about the lessons that can be learned from these states.
- To inform federal policy makers so that they can better understand the experiences of states implementing Medicaid Buy-In programs.

Major Findings

1. **Preliminary Considerations by States in Designing Medicaid Buy-In Programs and Related Work Incentive Initiatives**
 - **Framing the issue.** Stakeholders are finding more interest in adopting Medicaid Buy-In programs when they characterize their efforts as part of an "employment initiative" (rather than as a health reform initiative) that includes, but is not limited to, the enactment of a Medicaid Buy-In program.
 - **Devising a comprehensive, person-centered initiative.** In order to address the multiplicity of barriers to work facing persons with significant disabilities, states are adopting comprehensive, person-centered approaches. The health care component of a comprehensive initiative may include a Medicaid Buy-In program, but it may also include changes to the regular Medicaid program, changes to the state SSI supplementation program, and/or changes to the manner in which the Medicaid and state SSI supplementation programs are administered. In addition to a health care component, other components of a comprehensive initiative may include, benefits counseling, enhanced vocational rehabilitation services, seeking authority from SSA to continue the connection to cash assistance as earnings increase (i.e., changing the rules governing eligibility for SSDI cash benefits to provide for gradual rather than precipitous loss of SSDI cash payments (demonstration authority required from SSA), housing and transportation components, and involvement by employers).
 - **Understanding the "starting point" of state Medicaid Buy-In programs.** The design and implementation of the Medicaid Buy-In program cannot be viewed in isolation; rather, it must be viewed in the context of a state's overall Medicaid program and other state-specific initiatives (e.g., state SSI supplementation program). It is critical to understand a state's "starting

point" (i.e., the Medicaid standards and state SSI supplementation program standards prior to the enactment of the Medicaid Buy-In program). For example, the higher the percentage of SSDI recipients who are already eligible for Medicaid (and Section 1619 work incentives) in a state, the smaller the fiscal impact of the Medicaid Buy-In program on the state.

Similarly, assessing the relative success of a Medicaid Buy-In program must be viewed in the context of the state's starting point. A person who becomes eligible to buy into Medicaid under a state's Medicaid Buy-In program in State A may already have been eligible for Medicaid in State B under its regular Medicaid program. In other words, a state's large enrollment in its Medicaid Buy-In program may be the result of its extensive outreach campaign and the progressive policies governing the Medicaid Buy-In program (e.g., using minimal premiums and no unearned income limits). On the other hand, the large enrollment in the Medicaid Buy-In program may be because the state's regular Medicaid program is very restrictive (e.g., no medically needy program or the medically needy protected income level is less than the federal SSI benefit standard).

- **Understanding the value and limitations of relying on the experiences of other states.** There is a wealth of knowledge that can be gleaned from reviewing the experiences of other states that have implemented Medicaid Buy-In programs. It is critical, however, to understand whether other states are comparable in terms of such considerations as: the existing regular Medicaid eligibility categories; the existence of and policies governing the state SSI supplementation program; the design of the Medicaid Buy-In program (including the fiscal assumptions, policy objectives, policy tradeoffs, eligibility categories and cost-sharing); and the administration of the Medicaid program and its state SSI supplementation program.
- **Understanding the impact of federal policies on state options.** In designing Medicaid Buy-In programs, state policy makers and other stakeholders need to recognize that significant numbers of persons participating in Medicaid Buy-In programs are increasing their disposable income but are unwilling to earn more than \$780 per month (Substantial Gainful Activity, or SGA) because of the "cash cliff" under the SSDI program (a person who earns more than SGA for more than 12 months will lose eligibility for SSDI). In states collecting earnings data, only 14 percent of enrollees in Medicaid Buy-In programs had earnings over SGA.

2. Designing Medicaid Buy-In Programs

- **Focus of the program.** The focus of the Medicaid Buy-In program depends on the relative emphasis placed on enabling disabled persons with substantial employment and earnings to buy into Medicaid and/or enabling disabled persons who have modest employment and earnings to increase

their disposable income. The focus of a Medicaid Buy-In program can have a significant effect on how many people are enrolled in the program. The greater the relative focus on disabled persons with modest employment and earnings, the greater the potential enrollment and fiscal exposure of the state.

- **Policy objectives.** Policy objectives may include increasing the percentage of Medicaid Buy-In participants who have earnings from employment and/or increased disposable income; increasing the percentage of enrollees that have some of their health care needs paid for by private insurance; and/or increasing the percentage of persons who have reduced dependency or are no longer dependent on cash benefits or health care entitlement services.
- **Using eligibility criteria to affect enrollment and fiscal exposure.** In order to control costs, the state may limit eligibility into the Medicaid Buy-In program through various means including by using unearned income eligibility limits or indirectly, through unearned income limits by requiring minimal earnings levels. The higher the earnings level eligibility requirement and the lower the unearned income limit for eligibility, the lower the participation rate in the Medicaid Buy-In program and the lower the costs of the program to the state.
- **Using premiums and premium levels to affect enrollment and fiscal exposure.** The state may restrict access to the Medicaid Buy-In program by prescribing the circumstances under which an individual is required to pay a premium and the size of the premium (including, for example, applying a different premium against unearned income (SSDI benefits) than against earned income). The higher the premium amount based on level of unearned income, the lower the participation rate and the lower the net cost to the program per participant. A high premium on unearned income has the effect of limiting the program to individuals with higher earnings.

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

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

- **Regular Medicaid program.** States may use various Medicaid eligibility categories (such as the federal poverty level option or the medically needy option) to increase the number of disabled workers who qualify for regular Medicaid.
4. **Redesigning the Methods of Administration for the Medicaid and State SSI Supplementation Programs to Improve Access to Work Incentives**
- **In general.** The state has the discretion to adopt methods for administering the state SSI supplementation program and the Medicaid program that facilitate access to and use of work incentives designed to increase the level of economic self-sufficiency of persons with significant disabilities.
 - **Underutilization of Section 1619.** The work incentives made available under Section 1619 continue to be underutilized resulting in persons with disabilities not earning commensurate with their abilities and/or not benefiting from health-related services and supports to which they are entitled. Underutilization and access to Section 1619 work incentives is particularly a problem in those 17 states that do not provide automatic eligibility for Medicaid for SSI recipients.
 - **Automatic Medicaid eligibility for federal SSI recipients.** A state may permit a federal SSI recipient to be automatically eligible for Medicaid.
 - **Single application for SSI and Medicaid.** A state may permit a federal SSI recipient to make a single application for SSI and Medicaid. A single application will most likely result in more Medicaid eligible individuals who actually use the benefits made available under the Medicaid program.
 - **State SSI supplementation program rules relating to eligibility for Medicaid.** A state has the authority to make persons not eligible for federal SSI but who are eligible for the state SSI supplementation program entitled to protections offered to federal SSI beneficiaries, including the right to maintain eligibility for Medicaid even when they are no longer eligible for cash assistance under the state SSI supplementation program.

I. PURPOSE AND OVERVIEW

As we begin the new millennium, individuals with significant disabilities have greater opportunities for employment than ever before in the history of our Nation. These opportunities are aided by advancements in public understanding of disability and innovations in assistive technology, medical treatment, and rehabilitation. These opportunities also are aided by important public policy initiatives such as the work incentive provisions in Section 1619 of the Social Security Act, the Medicaid Buy-In option in Section 4733 of the Balanced Budget Act of 1997, the Ticket to Work and Work Incentives Improvement Act (TWWIIA), the Workforce Investment Act, the Individuals with Disabilities Education Act, the Rehabilitation Act, and the Americans with Disabilities Act.

In addition, coverage under Medicaid in many states of personal assistance services, prescription drugs, durable medical equipment, as well as basic health care remove many of the barriers between significant disability and work. This coverage includes powerful and proven tools facilitating the ability of individuals with significant disabilities to obtain and retain employment.

Despite such historic opportunities and the desire of millions of disability recipients to work and support themselves, few of the more than 8.4 million Americans with significant disabilities who receive cash assistance under the Social Security Disability Insurance (SSDI) program or the Supplemental Security Income (SSI) program return to work. In fact, according to the General Accounting Office less than one-half of 1 percent of SSDI and SSI recipients leave the disability rolls and return to work.

The reality facing many persons with significant disabilities is that too often they are unable to obtain health insurance in the private sector that provides coverage of the services and supports that enable them to live independently and enter, remain in, or rejoin the workforce. Thus, there is a need to supplement private insurance or rely on Medicaid for necessary services and supports.

For individuals with disabilities currently receiving health care under Medicaid, the fear of losing their health care and related services is one of the greatest barriers keeping such individuals from maximizing their employment, earnings potential, and independence. For many individual SSDI and SSI recipients, the risk of losing Medicare and Medicaid coverage that is linked to their cash benefits is a risk that is an equal or greater work disincentive than the loss of cash benefits associated with working.

In addition to the fear of losing health care coverage, SSDI and SSI recipients and other individuals with significant disabilities cite as barriers to employment the cumulative effect of the following: financial disincentives to work and earn income, lack of adequate employment training and placement services, continuing discrimination, complexity of existing work incentives, and the lack of benefits counseling providing accurate and easy-to-understand information about their options.

Individuals also cite the lack of a comprehensive integrated system of short and long-term services and supports that address the individual's overall needs, including education, training, health care, housing, food, and transportation. The design of a comprehensive, person-centered system requires breaking down policy "silos" and designing a system that recognizes the interplay between cash assistance programs (such as SSI and SSDI), health entitlement programs (particularly Medicaid), and other programs.

Eliminating barriers to health care and other needed services and supports and creating financial incentives to work can greatly improve the short and long-term financial independence and financial well-being of current SSI and SSDI recipients. So concluded Congress when it included a Medicaid Buy-In option in Section 4733 of the Balanced Budget Act of 1997 and when it enacted TWWIIA. By authorizing states to offer Medicaid Buy-In programs, these landmark pieces of legislation opened a window of opportunity for states to develop comprehensive work incentive initiatives that encourage people with disabilities to work or increase their level of work, thereby reducing or eliminating their dependency on cash assistance programs.

To date, 19 states¹ have implemented Medicaid Buy-In programs for working persons with disabilities; several additional states have enacted legislation aimed at creating such programs;² and one state (Massachusetts) created a similar program under Section 1115 Demonstration Project authority under the Social Security Act. A number of additional states are exploring the possibility of implementing Medicaid Buy-In programs.

As a general proposition, states do not make major changes to entitlement programs like Medicaid without the existence of accurate, relevant, comprehensive, easy-to-understand information. State policy makers demand such information before they will support new policy initiatives. They need answers and information regarding such issues as:

- Who needs the services and supports?
- How many people are likely to "sign-up?"
- How much will it cost?
- What options are available for designing a program that provides necessary services and still limits the state's fiscal exposure?

¹ Alaska, Arkansas, California, Connecticut, Iowa, Maine, Mississippi, Minnesota, Nebraska, New Hampshire, New Jersey, New Mexico, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, and Wisconsin.

² States enacting legislation include Arizona, Colorado, Illinois, Indiana, Kansas, Missouri, Oklahoma, New York, Texas, and West Virginia

The best source of information is often the experience of other states. Policy makers do not like to reinvent the wheel; they want to know what has worked, what has not worked, and why. The experience of nine of the states that are among the first to develop and implement a Medicaid Buy-In program and related employment initiatives can provide an invaluable source of insight to other states considering the development and implementation of such initiatives (early implementer states).³

The purpose of this paper⁴ is to provide policy frameworks to assist stakeholders⁵ design and implement Medicaid Buy-In programs and related work incentive initiatives to enhance the level of economic self-sufficiency of persons with significant disabilities. Of particular focus of the paper are the design decisions affecting enrollment, costs, and a state's fiscal exposure. The policy frameworks describe the interrelationship between federal and state cash assistance programs (particularly SSI, SSDI, and state SSI supplementation programs) and health entitlements (particularly the Medicaid program). The policy frameworks are derived from the experiences of the nine early implementation states.

The paper includes six major sections. The first section is the introduction.

The second section describes the preliminary considerations used by states considering the enactment of a Medicaid Buy-In program and related work incentive initiatives. The framework describes why it is important to critically assess and understand: how to frame the policy issue, the scope of the employment initiatives, the appropriate policy context of the initiatives in the state, the value and the limitations of learning from the experience of other states, and federal policy constraints on state options.

The third section describes the broad discretion currently available to states under Medicaid, including options available to states to establish eligibility criteria for adults with disabilities under the Medicaid program, state options to establish a state SSI supplementation program, and state options available to administer the Medicaid and state SSI supplementation programs. The descriptions provide a basis and starting point for understanding the range of policy options available to states to increase the level of economic self-sufficiency enjoyed by persons with significant disabilities, including, but not limited to, the establishment of a Medicaid Buy-In program.

³ The states include: Alaska, Connecticut, Iowa, Maine, Minnesota, Nebraska, Oregon, Vermont, and Wisconsin. These nine states were included in the nine state Case Studies described in footnote 4.

⁴ In addition to this policy paper, the authors prepared two reports. The first report includes in-depth case studies of the nine early implementer states entitled, *Medicaid Buy-In Programs: Case Studies of Early Implementer States*. The second report, *The Medicaid Buy-In Program: Lessons Learned from "Early Implementer" States*, compares the nine states included in the Case Study across the primary topic areas and themes addressed in the Case Studies.

⁵ The stakeholders include Medicaid directors, state policy makers, the disability community, service providers, and employers. The intended audience of this paper also includes federal policy makers who need to understand the key issues states encounter in their efforts to enhance employment opportunities for persons with significant disabilities.

The fourth section describes a policy framework for designing Medicaid Buy-In programs. The framework includes an analysis of the major deliberations relating to the design of the program, including decisions relating to the purposes of the program, the focus of the program, and policy tradeoffs (such as decisions affecting enrollment, costs, and fiscal exposure).

The fifth section describes a policy framework for redesigning existing Medicaid and state SSI supplementation programs to enhance the economic self-sufficiency of persons with significant disabilities. The framework includes an analysis of possible modifications to the state SSI supplementation program to increase access to current SSI/Medicaid work incentives under Section 1619 and modifications to non-SSI-related Medicaid eligibility programs to increase access to Medicaid work incentives.

The sixth section includes a policy framework for modifying the administration of Medicaid eligibility and the administration of state SSI supplementation programs to increase access to work incentives.

The final section restates the purpose of the paper and summarizes the major policy considerations identified in the paper.

II. PRELIMINARY CONSIDERATIONS BY STATE

In light of the enactment of TWWIIA, many states are exploring the possibility of adopting Medicaid Buy-In programs to increase the economic self-sufficiency of persons with significant disabilities, particularly SSI and SSDI recipients. The purpose of this section is to describe the preliminary considerations a state should analyze before deciding whether to adopt a Medicaid Buy-In program and/or related work incentive initiatives. This section highlights the following policy considerations:

- How should the policy issue be framed?
- What should be the scope of the policy initiatives?
- What is the policy context within the state?
- What is the value and limitations of learning from the experiences of other states?
- What constraints are placed on state options by federal policies?

A. Framing the Issue

The enactment of Section 4733 of the Balanced Budget Act of 1997 and TWWIIA authorized states to enact Medicaid Buy-In programs for workers with disabilities. These federal laws did much more however, they opened a policy window of opportunity for state policy makers to increase awareness and refocus attention on the critical policy issue of how to improve the quality of life for persons with significant disabilities by enhancing their level of economic self-sufficiency and, at the same time, reducing or eliminating their dependency on federal and state cash assistance programs.

In other words, the policy consideration guiding the actions of state policy makers is **not** simply whether to adopt a Medicaid Buy-In program; the policy consideration is what fiscally- responsible employment initiatives (additions or modifications to existing state policies), including, but not limited to, the enactment of a Medicaid Buy-In program, will enhance the level of economic self-sufficiency of persons with significant disabilities and at the same time reduce or eliminate dependency on federal and state cash assistance and health care programs.

The framing of the issue in this manner is important for three reasons. First, it is important to describe the initiative as an employment initiative. The goal of an employment initiative is to increase the productivity of state residents (thereby enhancing the economic/fiscal status of the state). Modifications to health care policies

(Medicaid) are appropriately viewed as means to enhance the state's and individual's economic status; not simply as a means to enhance access to health care.

Second, it is important to recognize that the design and implementation of a Medicaid Buy-In program is one possible strategy for enhancing economic self-sufficiency for persons with significant disabilities; however, there may be other health-related strategies that may result in comparable or greater outcomes for persons with significant disabilities in a state (e.g., modifications to existing Medicaid eligibility categories and policy, modifications to the existing state SSI supplementation program, and improvements relating to the administration of SSI and Medicaid work incentives).

Finally, it is important that any policy initiative recognize the diversity of the population of persons with significant disabilities to be served. The overall policy objective is to enhance the level of economic self-sufficiency of persons with significant disabilities (e.g., increase the percentage of program participants who have earnings from employment). For some individuals this may mean no dependency on federal or state cash assistance programs (elimination of dependency). For others, however, it may mean a reduction (rather than an elimination) of dependency on cash assistance and health care programs.

B. Determining the Scope of the Employment Initiative -- Devising a Comprehensive, Person-Centered Initiative

In order to address the multiplicity of barriers to employment faced by persons with significant disabilities, many states are adopting comprehensive person-centered employment initiatives. These initiatives are "comprehensive" in the sense that they include the following components:

- A health care component (e.g., protections against loss of Medicaid when an individual works);
- Benefits counseling;
- Enhanced vocational rehabilitation;
- Protections for program participants, including requests for demonstration authority from the Social Security Administration (SSA) for SSDI recipients assessing the efficacy of gradual rather than precipitous loss of cash assistance;
- Assistance in securing and retaining transportation, housing and food assistance;
- Employer involvement;
- Meaningful collaboration and coordination; and
- Program evaluation.

These initiatives are "person-centered" in the sense that they are responsive to the individualized goals and aspirations of each person with a severe disability and empower these individuals with information to make informed choices related to work.

C. Understanding the Baseline of State Programs and Fiscal Constraints

The design of a Medicaid Buy-In program cannot be viewed in isolation; rather, the key components of a Medicaid Buy-In program must be viewed in the context of a state's overall Medicaid program and other state-specific initiatives (such as state SSI supplementation). In other words, policy deliberations require knowledge of the state's baseline in order to measure the impact of any change. Every state starts from a different baseline (e.g., regular Medicaid eligibility rules, state SSI supplementation program).

Thus, the purpose, function, size and need for a Medicaid Buy-In program will vary depending on the components of the regular Medicaid program, the state SSI supplementation program, and the state's policies and procedures governing the administration of its Medicaid and state SSI supplementation programs.

In addition, the design of the Medicaid Buy-In program must be viewed in the context of the current fiscal constraints facing the state and the relative priority that state policy makers place on employment initiatives for persons with disabilities. Some states are willing to earmark significant additional funds to the implementation of the Medicaid Buy-In program whereas in other states the Medicaid Buy-In program must be budget neutral. Several states are now reporting actual data and experience, which can be compared with fiscal and budget estimates.

D. Understanding the Value and the Limitations of Relying on the Experiences of Other States

There is a wealth of knowledge that can be gleaned from reviewing the experiences of those states that have already enacted and have experience implementing Medicaid Buy-In programs and related employment initiatives. The experience of these states provides invaluable guidance for states considering the enactment of Medicaid Buy-In programs and related employment initiatives.

It is critical, however, that the state seeking guidance understand how its circumstances correspond to those of the states from which it is seeking guidance in such areas as: the existing regular Medicaid eligibility categories and rules and the state's SSI supplementation program; the design of the Medicaid Buy-In program, including fiscal assumptions, policy objectives, policy tradeoffs, eligibility categories and cost-sharing; and the administration of the Medicaid program and the state SSI supplementation program to improve access to work incentives. Before a state seeks guidance from other states' experiences in constructing its employment initiative, it is necessary for the state to understand the "starting points" of its and the other state's regular Medicaid program.

E. Understanding the Impact of Federal Policies on State Policy Options

In the early to mid 1990's, a number of states were contemplating the feasibility of designing comprehensive strategies to integrate health and income assistance reforms into a single work incentive research and demonstration project. The goal of these reforms was to eliminate work disincentives (i.e., to "make work pay"). The expectation was that states would be granted demonstration authority to devise Medicaid Buy-In programs for SSI and SSDI recipients so they would not lose health care when they increased their earnings. The expectation was also that states would be granted demonstration authority to test the efficacy of replacing the SSDI "cash cliff" with gradual rather than a precipitous loss of SSDI cash payments as earnings increased. Under current SSDI law, SSDI recipients are subject to a "cash cliff" (i.e., precipitous rather than gradual loss of cash assistance when they earn more than the Substantial Gainful Activity (SGA) level).

When TWWIIA was signed into law, many of these states pursued Medicaid Buy-In programs authorized by the legislation. In addition, several states, recognizing that many SSDI recipients might choose not to earn more than SGA (and thereby risk losing their eligibility for SSDI), sought demonstration authority from SSA to test the effect of eliminating the "cash cliff." As of the date this policy paper was completed, these requests have not been granted.

Thus, state policy makers and other stakeholders must recognize that significant numbers of persons participating in Medicaid Buy-In programs may be unwilling to earn more than SGA because of the cash cliff under the federal SSDI program. Based on data available from the states in the Case Study, there were approximately 13,230 enrollees in Medicaid Buy-In programs. Of those 12,106 Medicaid Buy-In enrollees in the five states with earnings information available, only approximately 14 percent (1,692) had earnings in the month reported that exceeded the SGA test for disability under the SSDI program.

Table 1 shows earnings of persons who are enrolled in state Medicaid Buy-In programs in the states of Connecticut, Iowa, Minnesota, Wisconsin and Oregon. Earnings data was available only from these five states of the nine states in the Case Study.

Table 2 shows earnings data for these five states, using two benchmarks: (1) SGA earnings test for 2001 (\$740) and (2) earnings over \$1,000.⁶

In sum, the SSDI "cash cliff" appears to be playing a major role in the decisions made by Medicaid Buy-In program participants as they decide on their level of work

⁶ The \$1,000 benchmark is simply included as another measure of work effort.

effort. Therefore, states are faced with devising Medicaid Buy-In programs within the constraints of federal SSDI law.

TABLE 1. Earned Income of Medicaid Buy-In Enrollees							
State: Total Enrollees & Earnings by Date of Data	Under \$200	\$200- 399	\$400- \$599	\$600- \$799	\$800- \$999	\$1,000 & More	
Connecticut Enrollees 1,600 - 10/1/01 Earnings Data 10/01	18.6%	19.5%	27.7%	17.5%	5.3%	12%	
Minnesota Enrollees 6,200 - 7/1/01 Earnings Data 7/01	35%	22.4%	21%	11.8%	3.5%	6.3%	
	Under \$250		\$251- \$500	\$501- \$750	\$751- \$1000	Over \$1000	
Wisconsin Enrollees 1,590 - 7/1/01 Earnings Data 7/01	26%		26.6%	22%	4.4%	4.9%	
Iowa Enrollees 2,105 - 4/1/01 Earnings Data 8/00	57%		24%	14%	3%	2%	
	Under \$200	\$200- \$399	\$400- \$599	\$600- \$699	\$700- \$899	\$900- \$1199	\$1200 & More
Oregon Enrollees 511 - 9/30/01 Earnings Data 3/01	9.4%	16.6%	13.7%	6.9%	11.9%	9.7%	31.8%

TABLE 2. Earnings of Medicaid Buy-In Enrollees: Over SGA and Over \$1,000					
State	Total Medicaid Buy-In Enrollees	Approximate Number with Earnings Over SGA	Approximate Percent with Earnings Over SGA	Approximate Number with Earnings Over \$1000	Approximate Percent with Earnings Over \$1000
Connecticut Enrollees 1,600 - 10/1/01 Actual Earnings Data 10/01	1,600	332	21%	193	12%
Minnesota Enrollees 6,200 - 7/1/01 Actual Earnings Data 7/01	6,200	827	13%	608	10%
Wisconsin Enrollees 1,590 - 7/1/01 Earnings Data 7/01	1,590	150	10%	75	5%
Iowa Enrollees 2,105 - 4/1/01 Earnings Data Estimated Based on Data 8/00	2,105	123	6%	35	2%
Oregon Enrollees 511 - 9/30/01 Earnings Data Estimated Based on Earnings Data 3/01	511	260	51%	195	38%
SUBTOTAL	12,106	1,692	14%	1,108	9%
Enrollees in States without Earnings					
Alaska 5/01	99				
Maine 12/01	633				
Nebraska 4/01	112				
Vermont 7/01	280				
SUBTOTAL	1,124				
TOTAL	13,230				

III. UNDERSTANDING ELIGIBILITY AND ADMINISTRATIVE POLICY OPTIONS FOR MEDICAID AND STATE SSI SUPPLEMENTATION PROGRAMS

State policy makers enjoy broad discretion under federal law to establish eligibility criteria for adults with disabilities under the Medicaid program (including the Medicaid Buy-In program) and to establish a state supplement to the federal SSI program (state SSI supplementation programs). For SSI or SSDI recipients, a state's Medicaid eligibility criteria and its decision regarding the establishment of a state SSI supplementation program can facilitate or impede decisions by SSI or SSDI recipients whether to work or increase their work effort.

State policy makers also enjoy broad discretion in selecting the methods used for administering the Medicaid eligibility criteria and a state SSI supplementation program ("methods of administration"). The decisions regarding the administration of the Medicaid program (i.e., the ease or difficulty in accessing or remaining eligible for Medicaid) may affect whether an adult with a disability works or increases his or her work effort.

This section describes state options for establishing eligibility criteria for adults with disabilities under the regular Medicaid program, the Medicaid Buy-In program, and state SSI supplementation programs. This section also describes state options for establishing "methods of administration" under the Medicaid and state SSI supplementation programs.

This section is included because it is critical for stakeholders to understand that the design of a Medicaid Buy-In program cannot be viewed in isolation; rather, the key components of a Medicaid Buy-In program must be viewed in the context of a state's overall Medicaid program and other state-specific initiatives (such as the state SSI supplementation program). In other words, policy deliberations require knowledge of the state's baseline in order to measure the impact of any change. Every state starts from a different baseline (e.g., regular Medicaid eligibility rules, state SSI supplementation program). The state must identify the highest level of income standard for Medicaid eligibility and the work incentives, or lack thereof, for each of the following programs:

- Medicaid eligibility based on SSI-combined federal benefit and state SSI supplement (if any);
- Medicaid eligibility based on poverty level or standard of need income standard; and
- Medicaid eligibility based on the medically needy option.

A. The Starting Point -- State Options for Establishing Eligibility for Adults with Disabilities Under the Medicaid Program

The choices available to a state in determining the amount of income an individual can have to get into and remain eligible for the Medicaid program are based on the following considerations:

- Does the state use SSI criteria for determining Medicaid eligibility for SSI recipients?
- Does the state use its own criteria for determining Medicaid eligibility for SSI recipients?
- Does the state supplement the federal SSI benefit standard to increase the SSI standard in the state and thus the SSI-related Medicaid eligibility standard?
- Does the state provide Medicaid eligibility based on non-SSI income eligibility standards?
- Does the state provide Medicaid eligibility through a "medically needy" program that enables adults with disabilities to "spend down" to a state-specified income level?
- Does the state provide Medicaid eligibility for a limited number of persons under waivers?

1. Medicaid Eligibility Policy Options for Federal SSI Recipients

State policy makers essentially have two policy options related to Medicaid eligibility for federal SSI recipients. Under Option 1, a state may provide Medicaid eligibility for all persons determined eligible for SSI (i.e., SSI recipients are categorically eligible for Medicaid).⁷ In order to be eligible for the SSI program, an individual must meet certain criteria related to his or her disability as well as criteria related to his or her income level. Under Option 2, a state may decide not to use the SSI criteria for eligibility for Medicaid and instead develop its own income, resources and disability criteria so long as the criteria are not more restrictive than the state's approved Medicaid plan in January 1972 -- the year the SSI law was enacted. These states are commonly referred to as "Section 209(b) states." This provision is also codified in Section 1902(f) of the Medicaid law.⁸

⁷ The state Medicaid agency can provide automatic Medicaid eligibility for all persons eligible for SSI or the state can require a separate application.

⁸ A Section 209(b) state is required to provide continued Medicaid for SSI recipients whose earnings make them ineligible for SSI cash benefits. Continued Medicaid must be provided if the SSI recipient had been eligible in the previous month for Medicaid under the state's Medicaid plan.

2. Extending Medicaid Eligibility to SSI Recipients Through the State SSI Supplementation Program

As explained above under Option 1, a state may provide categorical Medicaid eligibility for federal SSI recipients. In addition, federal Medicaid law permits a state to extend Medicaid eligibility to individuals who are eligible for SSI on the basis of a state SSI supplementation program.⁹ Therefore, when a state decides to establish a state SSI supplementation program, it may also be making a decision affecting the income eligibility standard for Medicaid. One effect of this decision is to increase the percentage of SSDI recipients in the state who are "SSI recipients" and thus eligible for Medicaid.

In order to understand the relationship between state SSI supplementation programs and Medicaid eligibility, the following aspects of the issue must be understood:

- What is meant by the term "SSI recipient."
- How and from whom an individual receives SSI payments.
- The impact on Medicaid eligibility of a decision by the state to administer its own state SSI supplementation program.
- The impact of a decision by the state administering its own state SSI supplementation program to extend Medicaid eligibility under Section 1619(b) to persons initially eligible for the state SSI supplementation program but who are no longer receiving cash benefits.

A person is considered an "SSI recipient" if he or she is entitled to:

1. Federal SSI payment based on the federal SSI benefit standard;
2. State SSI supplementation payment based on the state SSI supplementation benefit standard; or
3. An SSI payment based on an SSI benefit standard which is the federal SSI benefit standard plus the amount of the state SSI supplement.

There are four scenarios describing how and from whom an individual receives SSI cash payments in a state with a state SSI supplementation program. A state that provides for a state SSI supplement of the federal SSI standard can choose to enter into an agreement with SSA to administer the state SSI supplementation program. If the state enters into such an agreement, it must use the same income disregards and asset criteria as the federal SSI program. A state may also choose to administer its own state SSI supplementation program and provide categorical Medicaid eligibility for those individuals eligible for the state supplement. This includes individuals who are only

⁹ Forty-three states provide some state SSI supplement. In 23 states, however, the state SSI supplement is only for individuals in group living arrangements (not for those living independently).

eligible for the state SSI supplement but have too much unearned income to be eligible for federal SSI benefits. If the state administers its state SSI supplementation program, it can use its own income disregards and asset criteria.

Understanding these scenarios is important because although the SSI program is viewed primarily as a federal program, state decisions regarding the nature and administration of a state SSI supplementation program have a significant impact on eligibility for and accessibility to a state's Medicaid program.

First, in a state in which SSA administers the state SSI supplementation program, an SSI recipient can receive a single check from SSA that includes both the federal SSI payment and the state SSI supplementation payment.¹⁰

Second, in a state in which SSA administers the state SSI supplementation program, an SSI recipient can receive a single check from SSA that includes only the state SSI supplementation payment. Under this scenario, the individual does not receive federal SSI funds because the individual has too much income to be eligible for the federal SSI benefit.

Third, in a state in which the state administers its state SSI supplementation program, an SSI recipient can receive two checks (a check for the federal SSI payment and a check from the state for the SSI supplementation payment).

Fourth, in a state in which the state administers its state SSI supplementation program and the individual is not eligible for a federal SSI payment (because the individual has too much income to be eligible for the federal SSI benefit), an SSI recipient can receive a single check from the state (rather than from SSA).

Using the examples of state SSI supplementation programs in Vermont and Maine, the following illustrates the impact of different state SSI supplementation amounts and disregards on Medicaid eligibility. Before presenting these examples, however, it is important to review federal policies regarding an individual's eligibility for a federal SSI payment in a state with no state SSI supplementation program. Under existing federal policy, an individual is eligible for SSI if his or her unearned income (e.g., SSDI) is less than the federal SSI benefit standard (\$531 per month in 2001) plus \$20 (the initial federal SSI income disregard). In sum, \$551 in 2001 is the "unearned income limit" for eligibility for federal SSI in a state with no state SSI supplementation program. It can be said that the federal SSI unearned income limit also creates an unearned income limit for the Medicaid program in those states that use SSI criteria for Medicaid eligibility.¹¹

¹⁰ Under federal SSI regulations, SSA will administer up to six "categories" of state SSI supplementation benefit standards. States with multiple categories of state SSI supplementation have created categories based primarily on special living arrangements needs related to individuals with disabilities.

¹¹ The combined federal/state benefit standard (i.e., combination of federal SSI benefit standard and the state SSI supplement) in 2001 in the nine Case Study states varied from \$893 in Alaska to \$533 in Oregon. (See **Table 4**).

As explained above, it is important to understand that under federal SSI regulations (not SSI law) when SSA administers the state SSI supplementation program, the income disregards used in the state SSI supplementation program must be identical to federal income disregards. In contrast, when the state administers its own state SSI supplementation program, it has the option to adopt the federal income disregards or it may adopt its own income disregards. It is also important to understand that under existing federal Medicaid policy, a state can use SSI-related Medicaid eligibility standards based on the amount of state SSI supplementation and state-developed income disregards.

The contrasting state SSI supplementation programs in the states of Vermont and Maine will now be used to demonstrate the impact of state policies on Medicaid eligibility. As explained above, an individual with unearned income of more than \$551 (the federal SSI unearned income limit) is not eligible to SSI and therefore is not eligible for Medicaid. In a state with a state SSI supplementation program, the unearned income limit is increased by the amount of the state SSI supplement. For example, in Vermont, individuals living independently with an unearned income of as much as \$611 in 2001 (\$531 (the federal SSI benefit standard) plus \$20 (the initial federal SSI income disregard) plus \$60 (which is the state SSI supplementation amount)) are still eligible for SSI and therefore are still eligible for Medicaid.

In a state with a state-administered state SSI supplementation program in which the individual has too much income to be eligible for federal SSI but is eligible for a state SSI supplementation check, the individual can be made eligible for Medicaid based on the receipt of the state SSI supplementation check. In this scenario, for purposes of the state SSI supplementation program, the state can use the federal income disregard (\$20) or have an additional income disregard. For example, in Maine there is an income disregard of \$75 (\$20 (federal income disregard) plus an additional state income disregard of \$55) for eligibility for the state SSI supplementation program. In the State of Maine, the state SSI supplementation amount is \$10 per month. Thus, because of the state SSI supplementation and the additional state unearned income disregard, an individual is eligible for Medicaid with a higher unearned income than would be possible under federal SSI benefit standard and income disregards.

In addition to determining whether to extend Medicaid eligibility to persons using state-specific SSI benefit standards and income disregards, the state may determine whether it wants to extend Medicaid eligibility to persons whose earnings were initially low enough to qualify for state SSI supplementation but who, because of increased earnings are no longer eligible for cash payments. The authority to extend eligibility in this situation is parallel to the work incentives for those who receive federal SSI payments.

The federal SSI program provides for a gradual reduction in SSI benefits to a recipient as the individual's earnings increase. During this period, the individual remains

eligible for Medicaid.¹² Even after the federal SSI recipient's earnings make the individual no longer eligible for SSI cash payments, the individual still remains eligible for Medicaid as if he or she was receiving cash payments (Section 1619(b) and 1905(q) of the Social Security Act). This period of eligibility continues until the individual reaches an earnings level referred to as the "Section 1619(b) threshold."¹³

As shown in **Table 3**, among the nine states included in the Case Study, the Section 1619(b) threshold ranges from \$20,767 to \$35,598.¹⁴ Also **Table 3** shows the unearned income limit for the SSI program (including state SSI supplementation) and eligibility for Medicaid under Section 1619(b) and 1905(q) provisions. The states of Connecticut and Wisconsin (with state-administered state SSI supplementation) provide that persons receiving state-administered state SSI supplementation (without any federal SSI payments) continue to be eligible for Medicaid if they are no longer eligible for state SSI supplementation because of earnings. In other words, as shown in **Table 3**, in Connecticut and Wisconsin, an individual who has unearned income less than the combined federal SSI unearned income limit (\$551 in 2001) plus the state SSI supplement is eligible for Medicaid under Section 1619.

State	State's Unearned Income Limit for Section 1619(b)	Annual Section 1619(b) Threshold	Monthly: Section 1619(b)
Connecticut	\$747	\$36,598	\$3,050
Alaska*	\$552	\$35,209	\$2,934
Minnesota*	\$552	\$30,444	\$2,537
Oregon	\$554	\$24,277	\$2,023
Vermont	\$590	\$23,818	\$1,985
Maine*	\$552	\$23,379	\$1,948
Nebraska*	\$552	\$22,796	\$1,900
Wisconsin	\$613	\$22,249	\$1,854
Iowa	\$552	\$20,767	\$1,731

* States with state-administered state SSI supplementation and state does not provide continued Medicaid if individual loses state supplementation because of earnings.

¹² A working disabled individual with no unearned income in a state without state SSI supplementation will continue to receive a declining amount of SSI benefits as his or her earned income rises until the individual reaches the "break-even" point, which in 2001 was \$1,147 per month.

¹³ The threshold amount is based on the average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual's state of residence plus the earned income break-even point of individuals living alone. If the individual's earnings exceed the threshold, an individualized threshold can be calculated that considers the person's actual Medicaid use, work expenses, and publicly funded personal assistant services.

¹⁴ In determining the Section 1619(b) threshold for these states, SSA calculates the SSI earned income break-even point to include the state-administered SSI supplementation. SSA determines the threshold levels for a state using the following formula: twice the state SSI supplementation rate times 12 (if any) plus twice the federal SSI benefit standard plus \$85 times 12 plus the average per capita Medicaid expenses for a non-institutionalized SSI recipient for a year. The threshold amount for Alaska is increased by \$8,688 because of the \$362 a month state-administered state SSI supplementation program.

In contrast, in the other states in the Case Study with state-administered state SSI supplementation programs (Alaska, Maine, Minnesota, and Nebraska), the state SSI supplementation is not used to increase the unearned income limit for the Section 1619 work incentive program. Therefore, in these states, when an individual loses state SSI supplementation because of earnings he or she is not provided continued Medicaid under Section 1619(b).

3. Medicaid Eligibility Based on Poverty Level and Standard of Need Options

States have the option to provide Medicaid coverage to persons with disabilities under the "poverty level option." States also can use what is called the "standard of need" option to provide Medicaid coverage, which essentially has the same impact as the poverty level option. Under these options, state can use "income disregards" in determining the income to be counted toward the poverty level or standard of needs. For example, the State of Maine provides for a \$75 income disregard in determining countable income and therefore eligibility under the poverty level option. The poverty level or standard of need Medicaid eligibility option results in an income eligibility "cliff" above which a person is not eligible for Medicaid. As will be discussed later, some states use the Medicaid Buy-In program to remove that "cliff."

Four states among the nine Case Study states (Alaska, Maine, Minnesota and Nebraska) use the poverty level or standard of need income eligibility standard option.

4. Medicaid Eligibility Based on Medically Needy and Spend Down Options

States have the option to provide Medicaid eligibility for individuals with significant disabilities who have income too high to be eligible for SSI but low enough, after paying some of their health care bills, to meet an income standard under the state's medically needy category of eligibility for Medicaid. To be eligible under the state's "medically needy" program, the individual must be determined to have a severe disability (medical impairments and not working or have limited earnings). The income standard is generally called the "protected income level" (PIL). Among the nine Case Study states, the PIL under the medically needy program ranges from \$413 to \$733.¹⁵

In states that have chosen the Section 209(b) option and do not have a medically needy program, the state must allow an individual to "spend down" to the federal SSI standard and become eligible for Medicaid.

Some states, including Wisconsin and Iowa of the nine Case Study states, have provided some work incentives under their medically needy program by allowing for earned income disregards in determining whether a person with a disability has spent down to the state's PIL.

¹⁵ It should be recognized that there are federal Medicaid law restraints on the level at which a state can set their medically needy "protected income level" under the medically needy program. That is, it cannot be higher than 133 percent of the income standard for the TANF program for low-income families with children in the state.

5. State Option to Establish Eligibility for Medicaid Under Waiver Programs

In addition to establishing eligibility for Medicaid under the Medicaid State Plan, states have the authority to establish eligibility for a limited number of persons with disabilities (who are not otherwise eligible for Medicaid) under the Home and Community-Based Services (HCBS) or the Section 1115 waiver authorities.

B. Comparison of States by Highest Medicaid Eligibility Criteria or “Starting Point” for Medicaid Eligibility (Examples from States)

This subsection includes a comparison of states by highest Medicaid eligibility criteria or "starting point" for Medicaid eligibility. This comparison provides a framework for understanding eligibility for and administration of Medicaid and state SSI supplementation programs. The key point made in this subsection is that a state cannot look separately at income standards established under the SSI and Medicaid programs in determining the starting point for making improvements in the options available to individuals with significant disabilities interested in increasing their level of economic self-sufficiency. Instead, the state must identify the highest level of income standard and the work incentives or lack thereof in each of the following programs:

- SSI benefit standard (including the state SSI supplement);
- Poverty level or standard of need income standard; and
- PIL standard under the medically needy program.

Set out below are descriptions of actual options (eligibility and methods of administration) selected by the nine states included in the Case Study in narrative and table form.

1. Comparison of Case Study States Highest Medicaid Eligibility Standards

Table 4 shows for each state:

- The SSI benefit standard (which impacts Medicaid income eligibility);
- The use of the poverty level or standard of need option to create a Medicaid eligibility standard (where used);
- The PIL for the medically needy program.

As shown in **Table 4**, the highest Medicaid eligibility criteria is created by:

- The state SSI supplementation programs in five states;
- The poverty level or standard of need option in four states; and
- The medically needy PIL in one state.

As shown in **Table 4**, the highest Medicaid eligibility standard among the nine Case Study states is \$984 under the Alaska standard of need option. The lowest is

\$531 in Iowa, which is based on the federal SSI standard. (Iowa does not have a state SSI supplementation program, does not use the poverty level option, and the PIL is less than the federal SSI standard). The second highest Medicaid eligibility standard (\$791) is Maine where the state uses the Medicaid poverty level option with an income disregard of \$75 in determining countable income. The third highest Medicaid standard (\$748) among the nine Case Study states is established in the State of Connecticut under its state SSI supplementation program. The fourth highest Medicaid eligibility standard (\$733) is Vermont with a PIL under its medically needy program. The highest Medicaid eligibility standard in two of the remaining four states is derived from the state SSI supplementation program (Wisconsin-\$615, Oregon-\$533). In the final two remaining states (Minnesota-\$716 and Nebraska-\$716), the highest Medicaid eligibility standard is derived from the state's use of the poverty level option.

The variations among the Case Study states (regarding the level and basis of their highest Medicaid eligibility standard) illustrates the critical point made earlier in the paper that before a state seeks guidance from other states in constructing its employment initiative, it is necessary for the state to understand the "starting points" of its and other state's regular Medicaid program and state SSI supplementation program.

TABLE 4. State SSI and Medicaid Income Standards Highest Level in State			
State (By Level of State SSI Supplement)	SSI Combined Federal & State Supplement	Medicaid Other Categorical Income Standard	Medically Needy Protected Income Level
Alaska	\$893*	\$984 (Standard of Need)	
Connecticut	\$748**		\$477
Wisconsin***	\$615*		\$592
Minnesota Pre 7/1/01	\$612**		\$482
Minnesota Effective 7/1/01	\$612**	\$716 (Poverty Level Option) Effective 7/1/01	70% poverty - \$501 Effective 7/1/01 80% poverty Effective 7/1/02
Vermont	\$590		\$733
Maine****	\$541*	\$791 (Poverty Level Option)	\$315
Nebraska	\$539*	\$716 (Poverty Level Option)	\$392
Oregon	\$533*		\$413
Iowa	\$531		\$483
* States with state-administered SSI supplementation program			
** States with state-administered SSI supplementation and using Section 209(b) Medicaid eligibility option			
*** Wisconsin state SSI supplement is only available to those receiving federal SSI payments.			
**** Maine provides for a \$55 unearned income disregard in addition to the \$20 federal income disregard in determining eligibility for the \$10 state SSI supplement.			

2. Comparing the Impact of Case Study States Using Highest Medicaid Eligibility Standards

A primary impetus for developing a Medicaid Buy-In program and related state work incentive initiatives was to reduce work disincentives for SSDI recipients. Many SSDI recipients are not able to utilize the Sections 1619 work incentives because their

SSDI benefits exceed the unearned income limits for SSI in the state. In addition, some SSDI recipients in the Case Study states were ineligible for Medicaid because their SSDI exceeded the total income limits under the state Medicaid poverty level or standard of need eligibility criteria.

Based on the highest Medicaid income eligibility standard in the state, there is wide variations among the Case Study states as to the percentages of SSDI recipients who were ineligible for Medicaid prior to the state implementing a Medicaid Buy-In program. **Table 5** is one means of illustrating the variations among the states. Data from the SSA provides the information on the benefits levels (by \$100 brackets) of the SSDI disabled workers in each state. **Table 5** compares the approximate percentage of SSDI disabled workers who were financially ineligible for Medicaid prior to the state implementing a Medicaid Buy-In program. As shown in the table, the percentage ranges from 24 percent in Alaska to 69 percent in Iowa among the nine Case Study states.¹⁶

TABLE 5. State Medicaid Standards Prior to the Medicaid Buy-In Percent of SSDI Disabled Workers Above Non-Medicaid Buy-In Highest Medicaid Income Limit in State		
	State's Non-Medicaid Buy-In Highest Medicaid Income Limit*	Approximate Percent of SSDI Disabled Workers Above Highest Income Limit**
Alaska	\$984	24%
Maine	\$791	32%
Connecticut	\$748	48%
Vermont	\$733	42%
Nebraska	\$716	43%
Wisconsin	\$635	47%
Minnesota	\$632	57%
Minnesota After 7/1/01	\$716	45%
Oregon	\$553	68%
Iowa	\$551	69%
* Income disregard applied to highest standard where applicable		
** Based on data from December 1999 SSDI disabled workers benefit levels		

3. Comparison Among Case Study States of "Methods of Administration"

Table 6 illustrates the choices made by the nine states included in the Case Study regarding the administration of SSI-related Medicaid eligibility and of state SSI supplementation programs. As can be seen from a review of the table, four of the states have automatic Medicaid for federal SSI recipients, three states use federal SSI criteria but require a separate application to the state for Medicaid, and two states have their own Medicaid eligibility criteria and therefore require a separate application for Medicaid.

With respect to the administration of the state SSI supplementation programs, only one of the eight states that provide for state SSI supplementation use federal

¹⁶ Data on the benefit levels for SSDI disabled workers in the states can be found in the Annual Statistical Supplement published by SSA. The information is available on the SSA web site at <http://www.ssa.gov/statistics/Supplement/2000/supp2000.pdf>.

administration. The other seven states with SSI state supplementation programs require SSI recipients to make a separate application for the state supplement. In these seven states, the individuals eligible only for the state supplement must also make a separate application for Medicaid. Only Connecticut and Wisconsin continue Medicaid for state supplement-only recipients (no federal SSI) that lost their state SSI supplement because of earnings.

TABLE 6. Administration of Medicaid Eligibility Criteria and State SSI Supplementation					
State	Automatic Medicaid for Federal SSI Recipient (No separate application to state Medicaid)	Use of Federal SSI Criteria (Separate application to state for Medicaid required)	State Criteria for Medicaid Eligibility 209(b) Option (Separate application to state for Medicaid required)	Federally Administered State SSI Supplement	State-Administered State SSI Supplement
Alaska		X			X
Connecticut			X		X
Wisconsin	X				X
Minnesota			X		X
Vermont	X			X	
Maine	X				X
Nebraska		X			X
Oregon		X			X
Iowa	X				

IV. A POLICY FRAMEWORK FOR DESIGNING A MEDICAID BUY-IN PROGRAM

The enactment of TWWIIA has focused special attention on the question whether a state should enact a Medicaid Buy-In program to increase the level of economic self-sufficiency of persons with significant disabilities, particularly SSI and SSDI recipients.

Section II described the preliminary considerations a state should analyze prior to deciding whether to adopt a Medicaid Buy-In program and/or related work incentive initiatives. Section III described the Medicaid eligibility policies for adults with disabilities. Section III also explained that there are considerable variations among the states in the “starting points” of their Medicaid program for adults with disabilities.

The purpose of this section is to present a policy framework for designing a Medicaid Buy-In program based on the experience of the nine early implementation states included in the Case Study. The policy framework has two major components. The first component describes the possible focus and policy objectives of the Medicaid Buy-In program. The second component describes means of implementing the policy objectives as well as controlling the fiscal exposure of the state through the selection of various program design elements (eligibility and premiums) and other variables.

More specifically, in designing a Medicaid Buy-In program, state policy makers must address the following policy considerations:

- What should be the focus and policy objectives of the program?
- What policy tradeoffs should the state make in its effort to balance policy objectives and concerns with controlling costs and fiscal exposure?
- How does the state limit eligibility? Does the state limit eligibility for the program by establishing "earnings" level requirements for eligibility or participation or "unearned" income eligibility limits for participation in the program comparable to the limits used in the SSI-related Medicaid eligibility standards?
- How and to what extent does the state use premiums and other cost-sharing policies to reduce the net cost of the program?
- Does the state establish eligibility and premium policies related to special circumstances such as resources and spousal income?

A. Determining the Focus and Policy Objectives of the Medicaid Buy-In Program

In order to ensure that work incentives (under the SSI and Medicaid programs) are responsive to and useable by persons with disabilities, it is essential that the state determine the focus and policy objectives of the program. The initial step in determining the focus of the program is for the state to take into account the characteristics of persons with significant disabilities as they attempt to work. Characteristics of persons with disabilities and the changes related to employment and related needs include a recognition that: their ability to work and the level at which they work may vary over time, their level of earnings may affect the basis of their eligibility for Medicaid, and the basis of their eligibility for income assistance may change over time as their living arrangements and family situation changes.

It is also important for states to take into consideration the needs of persons with disabilities for simplicity and convenience in administering its programs. States must recognize that the need for health and income support services and types of services may change over time, the need for a smooth transition from one category of Medicaid eligibility to another as an individual's level of earnings changes, and the need to minimize the obligation to reapply for Medicaid under a new category when the basis for their eligibility changes. In addition, it is important for a state to recognize that persons with disabilities should be enabled to make informed choices and have minimal uncertainty related to the impact of their decision to work on continued eligibility for income assistance and health services and supports.

In deciding the relative emphasis or focus of a state's Medicaid Buy-In program, the state can overtly decide to create a Medicaid Buy-In program that (1) limits or targets the Medicaid Buy-In program to only those with substantial work effort, (2) rewards increased but modest work effort by persons with significant disabilities, or (3) includes dual purposes (i.e., provides work incentives for those with substantial earnings and provides Medicaid to low-income individuals without requiring "spend downs" to incomes less than the federal SSI standard).

Choosing the relative emphasis or focus of the program will involve setting priorities and deciding how to serve a population with different kinds of disabilities and with a range of capabilities of working or increasing their work effort. If a state chooses to restrict the Medicaid Buy-In program enrollment to persons with substantial employment and earnings, there are a number of means to accomplish that priority even though federal law does not specifically provide that a state can establish a minimum work or earnings requirement in a Medicaid Buy-In program. It needs to be recognized that if a state creates a program that only serves those with relatively high and stable earnings, then those who can only increase their disposable income by more modest increases in their earnings may not be given access to benefits from a Medicaid Buy-In program.

A state can focus on enabling persons with modest employment and earnings to be eligible for a state's Medicaid Buy-In program, thereby increasing their disposable income. However, public support may lessen for a program sold and labeled or defined as a work incentive for persons to lessen their dependency on public benefits if a state creates a Medicaid Buy-In program that enables persons in the state's medically needy program to avoid a "spend down" and thus increase their disposable income without an appreciable increase in their work effort.

Under current federal SSDI policy, unless a state builds in explicit restraints limiting the program to persons with substantial earnings, the primary effect of the Medicaid Buy-In program is likely to be to increase the disposable income of SSDI recipients -- not reduce the SSDI payments. In other words, SSDI-only recipients will be able to increase their earnings to nearer the SGA level and obtain Medicaid without a "spend down." Thus, for individuals with a combination of increased earnings and reduced health care expenditures (because of no longer having to use SSDI income for health care) it appears that a significant number of individuals in states with low PIL under their medically needy program could nearly double their disposable income without exceeding the SGA level.

A focus on increasing the disposable income of significant number of persons with disability should not be minimized. With a significant numbers of states with PIL under the medically needy program less than or near the federal SSI standard, increasing their disposable income to near the Federal Poverty Level (FPL) can, for some, provide more independent living arrangement opportunities -- a goal basically unattainable if disposable income is less than \$500. For example, an individual with \$700 of SSDI in a state with a PIL of \$500, when combined with earnings of \$700, would have disposable income of \$1,400 compared to \$500 under the medically needy program.

Consistent with the focus of the program agreed to by the state policy makers, the following are possible policy objectives for a Medicaid Buy-In program:

- Increase the percentage of program participants who have earnings from employment.
- Increase the level of disposable income because of earnings by participants.
- Increase the percentage of a state's employment initiative participants who have some of their health care needs and related services covered with employer-based benefit programs.
- Increase the number of SSDI and SSI recipients who have reduced dependency or are not longer dependent on cash benefits or health care entitlement services.

B. Policy Tradeoffs -- Program Design Elements Affecting Enrollment and a State's Fiscal Exposure (Eligibility Criteria, Premiums, Resources)

When a state adopts a Medicaid Buy-In program as part of its Medicaid state plan, it creates an entitlement for health care services and supports for a defined population (i.e., who is and is not eligible for Medicaid). The term "entitlement" means that a state must provide a specified level of health care services and supports, regardless of cost. The choices to be made by a state in developing a Medicaid Buy-In program involve tradeoffs between the goal of creating incentives for and rewarding work effort and the need to control or restrict the enrollment to fit within the financial resources available in the state. Thus, whenever a state considers making changes to its Medicaid program (including the establishment of a Medicaid Buy-In program), a critical consideration is the potential fiscal exposure of the state.

In determining a state's potential fiscal exposure, two related factors must be considered - - the state's starting point (i.e., Medicaid eligibility criteria in effect prior to the enactment of the Medicaid Buy-In program) and the restrictions governing the Medicaid Buy-In program (i.e., eligibility criteria, premiums and premium levels, and resources policies). This subsection restates the importance of understanding a state's starting point (see Section II and Section III) and then describes the range of restrictions a state may place on its Medicaid Buy-In program. The subsection concludes with a summary describing the policy tradeoffs. The major points made in this subsection are as follows. The primary variables affecting the relative enrollment and cost of a Medicaid Buy-In program are a state's starting point related to its Medicaid eligibility criteria and the restrictions that a state applies to its Medicaid Buy-In program. As will be demonstrated from examples of the nine Case Study states, the restrictions within the new entitlement category of a new Medicaid Buy-In can take a variety of forms depending on the priorities of the state, the focus of the Medicaid Buy-In, and the amount of additional resources available in the state. The higher the starting point and the tighter the restrictions that a state applies to its Medicaid Buy-In program, the lower the enrollment and the smaller the fiscal exposure of the state. The higher the percentage of SSDI recipients eligible for SSI, Medicaid and Section 1619(b) work incentives (because of state SSI supplementation), the more modest the fiscal impact on the state.

1. Fiscal Exposure, the Income Eligibility Gap and the "Starting Point"

As explained in Section II and Section III, the fiscal exposure of a state is related to the size of the "gap" between the income eligibility standard at the "starting point" for Medicaid in a state prior to the creation of a Medicaid Buy-In program and the major elements of the Medicaid Buy-In program's eligibility limits and premium structure. A state's "starting point" is the baseline (i.e., the highest Medicaid state plan financial eligibility standard in place prior to the establishment of its Medicaid Buy-In program).

As a means of illustrating the range of "starting points" in the nine Case Study states, **Table 7** shows the highest Medicaid eligibility standard in place and the source of the standard.

TABLE 7. Medicaid "Starting Points"		
Year 2001		
State	Starting Point	Source
Alaska	\$984	Standard of need
Maine	\$791	Poverty level with disregards
Connecticut	\$748	State SSI supplementation
Vermont	\$733	Medically needy protected income level
Nebraska	\$716	Poverty level
Minnesota	\$716	Poverty level
Wisconsin	\$615	State SSI supplementation
Oregon	\$533	State SSI supplementation
Iowa	\$531	Federal SSI standard

2. Using Eligibility Criteria to Affect Enrollment and Fiscal Exposure

The state may limit eligibility into the Medicaid Buy-In program through various means, including by using unearned income eligibility limits or indirectly, through unearned income limits, by requiring minimal earnings levels.

a. Using minimal earnings levels

A state can limit the Medicaid Buy-In program to those with substantial earnings by using an unearned income limit. A state can require a minimal level of earnings in its Medicaid Buy-In program as a means for an individual to be exempt from a low unearned income limit. This is the case in Nebraska's Medicaid Buy-In program. The state has crafted an unearned income limit equal to the federal SSI standard plus the \$8 state SSI supplement (\$540) but then exempts persons from the limit if they have earnings in a month that is sufficient to be considered a Trial Work Period month (\$530 in 2001).

b. Using unearned income eligibility limits

States may also limit the potential number of SSDI recipients and others with unearned income by establishing an upper limit on the amount of unearned income for eligibility. Unearned income limits are currently used in Medicaid to limit participation in the following ways:

- The SSI program has an unearned income limit through the disregard of only \$20 of unearned income in determining eligibility.
- The ability to participate in the SSI/Medicaid Section 1619 and Section 1905(q) work incentives program is limited in the same way as participation in SSI is limited (i.e., by the requirement that the individual must be otherwise eligible for SSI except for earnings).

- If a state has a poverty level-based Medicaid program for individuals with disabilities and the aged such a program has a "total income" limit that can also have the effect of being an unearned income eligibility limit.
- A state's Medicaid HCBS waiver programs can have unearned income limits that by federal law cannot exceed 300 percent of the federal SSI benefit standard.

A state can minimize its fiscal exposure under the Medicaid Buy-In program by using an unearned income eligibility limit that is the same or a modest increase above the Medicaid "starting point." The means available to a state for establishing such a limit may vary from state to state. The means used by three of the states in the Case Study include the following:

- Alaska -- An individual's unearned income must be less than the Alaska state SSI supplement standard (called APA standard of need in Alaska), which is \$951 in 2001.
- Maine -- An individual's unearned income must be less than the income eligibility standard used by Maine in determining eligibility under its Medicaid poverty level program that is 100 percent of poverty plus a \$75 disregard for a total of \$791 in 2001.
- Vermont -- The state uses its medically needy program's PIL of \$733 and then applies a \$500 unearned income disregard in determining an unearned income limit for their Medicaid Buy-In program.

For example, in the State of Maine approximately 30 percent of those receiving SSDI as disabled workers have SSDI benefits higher than the unearned income limit (\$791) in the state's Medicaid Buy-In program.

3. Using Premiums and Premium Levels to Affect Enrollment and Fiscal Exposure

The state may restrict access to the Medicaid Buy-In program by requiring an individual to pay a premium and prescribe the size of the premium. A state's Medicaid Buy-In program's premium structure can restrict entry into the program or reduce its net cost.

- a. *Applying a different premium against unearned income (SSDI benefits) than against earned income*

A major variable affecting the enrollment and cost of a state's Medicaid Buy-In program is the total amount of money an individual must spend to enroll in the Medicaid

Buy-In program in comparison to the amount the individual is required to spend to enroll in other categories of Medicaid.

Some states have restricted the potential population that will use the Medicaid Buy-In program and thus reduce the fiscal exposure of the state by imposing high premiums or cost-sharing by enrollees -- making it not financially worthwhile to enroll if an individual has a low level of earnings.

As discussed earlier, prior to enactment of the Medicaid Buy-In program, enrollment in Medicaid for those not eligible because of SSI eligibility could be required to "spend down" to qualify for coverage under the medically needy option. Alternatively, a state can provide categorical Medicaid for those not eligible as an SSI recipient by allowing those with income less than some percent of the FPL to be eligible for Medicaid without a spend down to a PIL. This creates a total income limit (unearned plus earned income) on eligibility for Medicaid.

Under the Medicaid Buy-In program, states have additional options for cost-sharing, including premiums and fees, and broad discretion in determining the income levels that trigger fees. The decision to treat earned and unearned income differently has a direct impact on the categories of persons who enroll in the Medicaid Buy-In program. Because the Medicaid Buy-In program is designed for working individuals, some states have separated the two types of income -- earned and unearned. Those states that separate the two types of income give more favorable treatment to earned income either by "counting" the dollars from the two sources differently when assessing eligibility or "counting" them differently when determining cost-sharing obligations. In other words, a dollar earned is less likely to be a "disqualifying" dollar than one that is unearned and is likely to be subject to a lower amount of cost-sharing.

The means that have been used by states in establishing different premiums on unearned compared to earned income include the following:

- In Oregon, a Medicaid Buy-In program participant must pay as a premium the amount of unearned income that is in excess of the SSI standard in the state. In contrast, the percent of earned income to be paid as a premium after deductions for work-related expenses is only 1 percent and increases up to a maximum of 10 percent.
- In Wisconsin, the state has a separate premium on unearned income that is above the SSI standard in the state but the premium is not required until the individual's total income is over 150 percent of the poverty level.

In contrast, if a state creates a Medicaid Buy-In eligibility category without an unearned income limit, but instead relies primarily on total income-based premiums as a "limit" on eligibility, then the state is using premiums as an offset to the cost of the Medicaid Buy-In program. A major variable for these states is the size of the "income eligibility gap" between the highest Medicaid income eligibility criteria under the regular

Medicaid categories based on SSI and poverty level-based income standards or medically needy PILs compared to the income level at which the Medicaid Buy-In program enrollees starts to pay a premium.

b. Using minimal premiums and no unearned income limits

As was discussed earlier, unless a state builds in explicit restraints that limit the program to persons with substantial earnings, a primary role of the Medicaid Buy-In program will be to increase the disposable income of SSDI recipients. In other words, SSDI-only recipients will be able to increase their earnings to nearer the SGA level and obtain Medicaid without a spend down. If there is a substantial gap between a state's cost-sharing policies under the Medicaid Buy-In program and those under regular Medicaid categories, more people are likely to participate in the Medicaid Buy-In program. In other words, a Medicaid Buy-In program offering individuals the opportunity to convert from a hefty spend down to a small monthly premium by enrollment is likely to be very attractive.

The states of Iowa, Minnesota and Connecticut do not use premiums based on unearned income as a means to restrict enrollment in the Medicaid Buy-In program and do not use separate unearned income eligibility limits. The result is that these states have the highest enrollment in the Medicaid Buy-In program. In response to the large enrollment in Minnesota's Medicaid Buy-In program, state policy makers modified the premium structures. Premiums must now be paid at 100 percent of poverty instead of beginning at 200 percent of poverty.

c. Setting income level for start of premium and amount of premium

In designing a Medicaid Buy-In program, state policy makers must weigh the amount of subsidy or assistance that they are willing to provide to a disabled worker with earnings against the amount that they will require the individual to pay as a premium (as an offset to the cost of providing health services under Medicaid). A basic concept of most states' Medicaid Buy-In programs is that when an individual has substantial earnings, the individual should pay a premium in a somewhat similar manner as if he/she were part of a private insurance program. However, Medicaid is more than an alternative to private health insurance to low-income individuals. Medicaid provides health care services that are not provided under most private health insurance programs or under Medicare (e.g., personal assistance, pharmacy benefits and other ongoing rehabilitation support services).

A Medicaid Buy-In program also is a means to provide some measure of equalization or parity for persons with significant disabilities who have high disability-related work expenses -- which can be partially offset with Medicaid-funded services -- compared to those without such significant disabilities. It should also be noted that under the Section 1619(b) program, with threshold amounts for continued Medicaid in most states over \$20,000 of earnings, a premium is not paid. Therefore, there is the

issue of equity between those who have continued Medicaid under Section 1619(b) and continued Medicaid under a Medicaid Buy-In program.

Medicaid Buy-In program premiums based on the total income of the individual varies by the income level base at which premiums start to be paid and the amount of the premiums. In some states, the premiums are a percent of total income above some percent of poverty. In other states, the premium is based on income brackets stated as a percent of poverty with the same premium amount within an income bracket.

Among the Case Study states that do not have a separate premium based on unearned income, the income level base varies between 100 percent and 200 percent of poverty plus impairment-related expenses. For example, in Minnesota individuals with gross income equal to or greater than 100 percent of the FPL pay a sliding-scale premium. The scale begins at 1 percent of income for those with income at 100 percent of the FPL and gradually increases to 7.5 percent of income for income equal to or greater than 300 percent of the FPL.

As discussed in Section II, a relatively small percent of the Medicaid Buy-In participants are paying a premium based on total income because of the small percent who have earnings over SGA or \$1,000. Therefore, the experience to date indicates that Medicaid Buy-In premiums do not constitute a significant financial offset to the cost of the Medicaid services provided (see **Table 2**). However, the premium policies established by the state is important in ensuring a positive perception of the Medicaid Buy-In program. In other words, there should be an appropriate balance between the need to provide access to subsidized health care services under Medicaid to compensate for extra expenses related the disability and the responsibility of an individual to pay a premium based on his or her income.

d. Using the waiver cost-share structure as a premium

In some states the policies established by the state related to a premium to be paid by a Medicaid Buy-In enrollee from unearned income (e.g., SSDI) closely resembled the “cost-sharing” required of participants in the state’s Medicaid HCBS waiver program. In some states, Wisconsin for example, the maintenance allowance for the HCBS waiver program provided that a portion of the earned income was disregarded so that there were incentives to have some earnings -- compared to every dollar of earnings being paid back to the state as a “costshare.”

4. Determining Resource Policies and Other Variables Affecting Enrollment and Costs

The Medicaid Buy-In programs include a number of SSI-related Medicaid eligibility criteria in an effort to be more responsive to the needs of non-elderly individuals with disabilities who are able to work in spite of their disability. For example, most states have established eligibility policies for their Medicaid Buy-In programs that are different than the SSI policies on resources limits and how the income and resources of the

spouse of an individual should be considered. Data is not yet available which can provide for an analysis of the impact of these policies.

a. Resource limits

The SSI eligibility criteria allow for countable resources to not exceed \$2,000 and at the same time disregard the entire value of the SSI recipient's residence. This provision was intended to be responsive to the circumstances of the elderly at age 65 who have a home they have acquired over a lifetime before retirement. However, the acquisition of a home as a residence for a young disabled individual is not possible, for example, in the case of a working disabled individual whose disability began in their twenties and are not able to save more than \$2000 -- an insufficient amount to move toward eventual purchase of a modest home.

Therefore, states Medicaid Buy-In resources eligibility limits for the non-elderly persons with disabilities are more reflective of the needs and goals of younger persons with disabilities who want to use some of their earnings for saving toward the eventual acquisition of a home, a car or to use for education. The provision in SSI law that provides for disregards of income and resources under pre-approved Plans for Achieving Self Supports (PASS plans) served as a partial model for some of the specific resources disregards included in state Medicaid Buy-In programs. However, some states went beyond the allowable temporary resources disregards in PASS plans to also allow for disregarding retirement accounts and medical savings accounts to enable working persons with disabilities to use earnings to build toward greater independence and security. Some states have also chosen to simply increase the countable resources limit instead of detailing resources that are excluded as a means to not only give more discretion to the individual but also to simplify administration.¹⁷

b. Reducing marriage penalties

SSI law and much of related Medicaid eligibility policies consider the income and resources of the spouse of a person with a disability in determining eligibility for SSI and Medicaid. Private insurance coverage may be available to a working person with disabilities through their spouse's employer-based health insurance plan. However, a primary goal of many policy makers devising state Medicaid Buy-In programs was to create a health care entitlement program for working persons with disabilities that would provide access to services under the Medicaid Buy-In program that are not available under private insurance plans. Therefore, a number of states have developed

¹⁷ From the Connecticut Medicaid Manual:

- a. "The asset limit is \$10,000.00 for an individual and \$15,000.00 for a married couple living together.
- b. In addition to the assets excluded under the Medicaid program, the following assets are also excluded: (1) Retirement and medical savings accounts established pursuant to 26 USC 220 and held by either the individual or his/her spouse; and (2) accounts held by the individual or spouse and designated by such person as being held for the purpose of buying goods or services that will increase the employability of the individual. Such accounts are subject to the approval of the Department.
- c. The assets excluded in paragraph b. above retain their excluded status for the life of the individual, even if he or she loses eligibility under this coverage group."

alternatives to the SSI-related policies and have either totally disregarded the income and resources of the spouse or provided that the income of the spouse is not counted in determining eligibility for the Medicaid Buy-In program but is counted in determining the amount of the premiums to be paid.¹⁸

C. Interaction Between Medicaid “Starting Point” and Medicaid Buy-In Restrictions

As was stated earlier, the primary variables affecting the relative enrollment and the cost of a Medicaid Buy-In program is a state's "starting point" and its restrictions in the Medicaid Buy-In program. In general, the higher the starting point and the tighter the limitations that a state applies to the Medicaid Buy-In program, the lower the enrollment and the smaller the fiscal exposure of the state.

One means of illustrating the impact of these variables is to show the number of Medicaid Buy-In enrollees in a state as a percentage of the total number of SSDI disabled workers in the state. Among the nine Case Study states, the percentage ranged from 9.6 percent in Minnesota (with the largest percentage enrollment of 6,200 out of 64,370 SSDI disabled workers) to 3.1 percent in Connecticut (with moderate percentage enrollment of 1,600 out of 51,370 SSDI disabled workers) to 0.5 percent in Nebraska (with the smallest percentage enrollment of 112 out of 24,590 SSDI disabled workers). Minnesota is a state with a relatively low starting point and minimal restrictions in their Medicaid Buy-In program. Connecticut is a state with a high starting point and few restrictions. In contrast, Nebraska, has a relatively high starting point and significant restrictions in the Medicaid Buy-In program.

Table 8 shows the impact of these variables for all nine states included in the Case Study.

¹⁸ Minnesota -- Spouses income is not considered in determining eligibility or amount of premium.
Connecticut -- Does not count spouses income at eligibility but does count it when determining premium to be paid.

TABLE 8. Relative Use of Medicaid Buy-In Program			
State	SSDI Disabled Workers*	Medicaid Buy-In Enrollees**	Percent Medicaid Buy-In Enrollees of Number of SSDI Disabled Workers
Minnesota <i>Low starting point Few restrictions</i>	64,370	6,200	9.6%
Iowa <i>Low starting point Few restrictions</i>	46,020	2,105	4.6%
Connecticut <i>High starting point Few restrictions</i>	51,370	1,600	3.1%
Vermont <i>High starting point Medium restrictions</i>	12,560	280	2.2%
Wisconsin <i>Low starting point Medium restrictions</i>	79,480	1,590	2.0%
Maine <i>High starting point High restrictions</i>	33,210	633	1.9%
Alaska <i>High starting point High restrictions</i>	6,830	99	1.4%
Oregon <i>High starting point High restrictions</i>	54,950	511	0.9%
Nebraska <i>High starting point High restrictions</i>	24,590	112	0.5%
* State data from December 1999			
** Data on enrollment is the most recent from state. See Table 2 for the date.			

D. Summary

1. A State's Medicaid Buy-In Program Design Options

As discussed earlier, a state has several options in choosing the relative focus of the Medicaid Buy-In program. The following is a summary of the primary tools a state can use to establish the relative focus of its program.

Focus on enabling persons with substantial employment and earnings to buy into Medicaid.

- Maximize the use of a portion of unearned income as part of the Medicaid Buy-In premium to ensure that only those with significant employment and earnings will find it advantageous to move to the Medicaid Buy-In program.

- Maximize the use of unearned income limits that only disregard unearned income if there is a significant earnings and work effort.

Focus on enabling significant numbers of disabled persons who have modest employment and earnings to increase their disposable income and buy into Medicaid.

- Minimize the use of unearned income eligibility limits.
- Minimize the use of a separate portion of the Medicaid Buy-In premium based on unearned income.
- Provide Medicaid Buy-In as an explicit option for persons currently only eligible for Medicaid under the state's medically needy program.

2. Variables Impacting Participation In and Net Cost of a Medicaid Buy-In Program

In general, the higher the "starting point" and the tighter the restrictions that a state applies to its Medicaid Buy-In program, the lower the enrollment and the smaller the fiscal exposure of the state.

Set out below is a summary of specific variables impacting participation in and the net cost of a Medicaid Buy-In program:

- The lower the unearned income limit for eligibility, the lower the participation rate.
- The higher the "earnings level" requirement for eligibility, the lower the participation rate.
- The higher the premium amount based on level of unearned income, the lower the participation rate and the lower the net cost per participant.
- The higher the premium based on total income, the lower the net cost of the program.
- The lower the total income level at which premiums must be paid, the lower the net cost of the program.
- The higher the percent of spouse's income is counted in determining premiums, the lower the net cost of the program.
- The fewer the deductions for disability-related expenses in determining countable income for premiums, the lower the net cost of the program.

V. A POLICY FRAMEWORK FOR REDESIGNING STATE SSI SUPPLEMENTATION AND MEDICAID PROGRAMS TO INCREASE ACCESS TO WORK INCENTIVES

There are three complementary approaches discussed in this paper for achieving the overall policy objective of increasing the economic self-sufficiency of persons with significant disabilities through changes in health and related policies. The first approach is to add a Medicaid Buy-In program (Section IV). The purpose of this section is to describe the second approach -- a policy framework for redesigning state SSI supplementation programs and modifying existing Medicaid eligibility criteria to increase access to work incentives.

A. Redesigning the State's SSI Supplementation Program to Increase Access to Work Incentives

State decisions regarding the design of state SSI supplementation programs can have a major impact on Medicaid eligibility levels in states and access to the work incentives under the Section 1619 provisions in current SSI law and Section 1905(q) of Medicaid law.¹⁹ Under Sections 1619 and 1905(q), SSI recipients can:

- Increase their disposable income with substantial earnings,
- Continue Medicaid when they have such earnings, and
- Enjoy income security under the SSI program by being able to return to cash payment status from Medicaid-only status if their ability to work ceases or is significantly reduced.

The advantage of the Section 1619 program is that an individual whose earnings exceed the SGA earnings level can continue to receive SSI cash benefits and Medicaid under the provisions of Section 1619(a) of the Social Security Act as long as the individual meets the SSI income and resources tests. In other words, there is not the "cash cliff" as found in the SSDI program.

¹⁹ The federal SSI program provides for a gradual reduction in SSI benefits to a recipient as the individual's earnings increase. During this period, the individual remains eligible for Medicaid. Even after the federal SSI recipient's earnings make the individual no longer eligible for SSI cash payments, the individual still remains eligible for Medicaid as if he or she was receiving cash payments (Section 1619(b) and 1905(q) of the Social Security Act). This period of eligibility continues until the individual reaches an earnings level referred to as the "Section 1619(b) threshold." The threshold amount is based on the average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual state of residence plus the earned income break-even point of individuals living alone. If the individual's earnings exceed the threshold, an individualized threshold can be calculated that considers the person's actual Medicaid use, work expenses, and publicly funded personal assistant services.

Further, under SSI law (Section 1619(b) of the Social Security Act) and Medicaid law (Section 1905(q) of the Social Security Act) an individual remains eligible for Medicaid for as long as needed (under specified circumstances) even though the individual's countable earned income exceeds the SSI benefit standard (including state supplementation) and the individual no longer receives SSI cash benefits.

Another advantage of the Section 1619 work incentives provisions is that persons under the SSI program may move back and forth between SSI cash payment with Medicaid (SSI payment status under Section 1611 and 1619(a) of the Social Security Act) and non-cash payment status with Medicaid (SSI status under Section 1619(b) of the Social Security Act) without a time limit. Therefore the program is designed to recognize that, for many persons with significant disabilities, their ability to work varies over time.

In addition, SSI recipients who become ineligible for SSI cash benefits or SSI status under Section 1619(b) because of excess income or resources go into a suspension status for up to 12 months. They can be reinstated to SSI payment status or SSI status under Section 1619(b) without a new application if their income and resources are reduced to a level that they once again meet the SSI criteria if they are within 12 months of their loss of SSI payment status or SSI status under Section 1619(b).

To enable more persons with significant disabilities to take advantage of this policy, the state can:

- Increase the income standard for the state SSI supplement, thereby increasing the number of SSDI recipients who can qualify for SSI and the Section 1619 work incentives because their SSDI benefit amount is less than the combined federal and state SSI standard.
- Increase the earned or unearned income disregards under a state-administered state SSI supplement program, thereby increasing the number of SSDI recipients who can qualify for SSI and the Section 1619 work incentives because their "countable income" is less than the SSI standard.
- Provide state SSI supplement to those in all living arrangements and not limit the supplement to those in group living arrangements.

States control the scope and breadth of the Section 1619 and 1905(q) options by their decisions on whether and by how much to supplement the federal SSI benefits. Because SSDI beneficiaries who receive state SSI supplementation become eligible for Section 1619 work incentives, a state's decisions about SSI supplementation directly affect how many persons on SSDI have access to SSI-related work incentives.

Some states may inadvertently be limiting access to SSI work incentives by tying state SSI supplement payments to a particular residential setting. In some states with

state SSI supplements for group living arrangements, SSA administers part of the state SSI supplementation program and the state administers the portion related to group living (e.g., adult foster homes or domiciliary care). In other states the only state SSI supplementation is for group living arrangements.

When an SSDI beneficiary qualifies for SSI solely due to group living-based state SSI supplementation, the SSDI beneficiary faces the loss of categorical Medicaid if he or she moves from the group setting to a more independent living arrangement. For such individuals, the loss of Medicaid also means loss of access to the Section 1619 SSI and Medicaid work incentives. States could provide additional work incentives under the state SSI supplementation program for those disabled persons who can work and are able to move out of a group home and live independently in the community (through use of additional disregards of unearned income).

Table 3 in Section III shows the Section 1619(b) threshold for each of the nine Case Study states. States have devised a variety of combinations of state-administered state SSI supplementation and a mix of federal and state responsibilities for Medicaid eligibility determinations. For example, Maine uses its own income disregards for the state-administered state SSI supplementation program. The use of its own income disregards is allowable because SSA does not administer the state SSI supplement.²⁰ Maine does not apply the provisions of Section 1619(b) to persons only eligible for state SSI supplements (i.e., persons who do not receive a federal SSI check in addition to their state supplement check). If such a person loses eligibility for the state SSI supplement because countable earnings raise his/her income over the state SSI supplement threshold, Maine does not provide the individual with Medicaid coverage available through Section 1619(b) work incentives.

B. Redesigning the Non-SSI-Related Medicaid Eligibility Criteria to Increase Access to Work Incentives

When a state is deciding how to achieve the policy objective of increasing the level of economic self-sufficiency of persons with significant disabilities, it can look at the non-SSI-related Medicaid income eligibility options used by a state. While none of these options were originally designed to support work, each of them can be crafted to provide preferential access to Medicaid for disabled persons entering the workforce. Under each of the options, there are variations on the ability of SSDI beneficiaries (and former beneficiaries) to retain Medicaid after they go to work.

²⁰ Maine provides for a \$55 income disregard in addition to the federal \$20 unearned income disregard in determining eligibility for the state SSI supplement. The state SSI supplement is \$10 in all cases. However, that payment makes them eligible for SSI and Medicaid without a spend down.

1. Options for Work Incentives Under Federal Poverty Level or Standard of Need Option for Categorical Medicaid Eligibility

States have the option to provide Medicaid coverage to persons with disabilities whose countable income does not exceed 100 percent of the FPL and whose resources do not exceed the SSI standard. Two of the Case Study states, Maine and Nebraska, chose this option prior to implementing their Medicaid Buy-In program. Alaska uses the “standard of need” Medicaid option to provide categorical Medicaid for persons with disabilities. Under this option, a state sets an income eligibility standard below which an individual is eligible for categorical Medicaid. However, the FPL Medicaid eligibility option results in an income eligibility “cliff” above which a person is not eligible for Medicaid. A state with a poverty level-based Medicaid eligibility program can provide for earned income disregards in determining eligibility and thus create a limited work incentive.

2. Options to Create Work Incentives Under the Medically Needy Option or Spend Down

States have the option to provide Medicaid eligibility for individuals with significant disabilities who have income too high to be eligible for SSI but low enough, after paying some of their health care bills, to meet an income standard under the state’s medically needy category of eligibility for Medicaid. To be eligible under the state’s “medically needy” program the individual must be determined to have a severe disability (medical impairments and not working or has limited earnings). The income standard is generally the PIL.

In states that have chosen the Section 209(b) option and do not have a medically needy program, the state must allow an individual to spend down to the federal SSI standard and become eligible for Medicaid. Some states, including Wisconsin and Iowa of the nine Case Study states, provide work incentives under their medically needy program by allowing for earned income disregards in determining whether a person with a disability has spent down to the state’s PIL.

The Medicaid medically needy program has the advantage of not having an income eligibility “cliff.” Instead this option provides the flexibility for an individual with SSDI income just above the PIL to “spend down” a small amount to receive a significant value of health services under Medicaid. On the other hand, if the individual’s SSDI income is significantly above the state’s PIL there is a significant financial barrier to access to Medicaid.²¹

²¹ It is important to note that both the poverty level option and the medically needy option for persons with disabilities carry with them an attachment to disability criteria for the SSDI program. In other words, to remain eligible for Medicaid under the medically needy program or the poverty level option, an individual must continue to be eligible on the basis of disability -- that is, limit their work effort.

VI. A POLICY FRAMEWORK FOR REDESIGNING THE ADMINISTRATION OF THE MEDICAID AND STATE SSI SUPPLEMENTATION PROGRAMS RELATED TO ACCESS TO WORK INCENTIVES

There are three complementary approaches discussed in this paper for achieving the overall policy objective of increasing the level of economic self-sufficiency of persons with significant disabilities through changes in health and related policies. The first approach is to add a Medicaid Buy-In program (Section IV). The second approach is to redesign state SSI supplementation programs and modify existing Medicaid eligibility criteria (Section V). The purpose of this section is to describe the third approach -- to present a policy framework for modifying the methods used for administering the regular Medicaid program, the Medicaid Buy- In program, and the state SSI supplementation program.

Specifically, this section:

- Frames the policy issue to be considered.
- Reviews the characteristics and needs of persons with disabilities who work.
- Reviews the joint federal and state government administrative responsibilities for continued benefits and services for working persons with disabilities.
- Describes administrative options for enhancing the use of work incentives by integrating the administration of federal and state SSI Supplementation and Medicaid programs.
- Describes administrative options for emphasizing individualized determinations of need and provision of necessary benefits, services, and supports.
- Analyzes the policy options and tradeoffs a state makes to implement work incentives.

A. Framing the Issue

Existing SSI and Medicaid law includes numerous work incentives that are designed to achieve the overall policy objective of enhancing the level of economic self-sufficiency of individuals with significant disabilities by providing continued eligibility to health care. Examples of work incentives include:

- Earned income disregards so there is no sudden loss of SSI or Medicaid;

- Continued eligibility for SSI and Medicaid if earnings exceed the SGA test;
- Continued Medicaid when an individual is no longer eligible for SSI cash benefits; and
- The ability to return to cash benefits and continue Medicaid if the ability to work is reduced.

These work incentives are intended to allow individuals to remain eligible for Medicaid and attached to the SSI income assistance program even though the basis for their eligibility may change over time. Existing Medicaid and SSI law provides significant flexibility to states in determining how to administer these programs.

The policy issue facing states is whether the methods chosen for administering the state SSI supplementation and the Medicaid programs facilitate or impede access to and use of work incentives designed to increase the level of economic self-sufficiency of persons with significant disabilities.

B. Understanding the Characteristics and Needs of Persons with Disabilities Who Work

In order to ensure that work incentives under the SSI and Medicaid programs are responsive to and usable by persons with disabilities, it is essential that the methods of administration used by a state take into account the characteristics of persons with significant disabilities as they attempt to work. Characteristics of persons with disabilities and the changes related to employment and related needs include:

- Their ability to work and the level at which they work may vary over time.
- Their level of earnings may affect the basis of their eligibility for Medicaid.
- The basis of their eligibility for income assistance may change over time as their living arrangements and family situation changes.

It is also important for states to take into consideration the needs of persons with disabilities for simplicity and convenience in adopting methods for administering its programs. States must recognize that:

- The need for health and income support services and types of services may change over time.
- The need for a smooth transition from one category of Medicaid eligibility to another as an individual's level of earnings changes.
- The need to minimize the obligation to reapply for Medicaid under a new category when the basis for their eligibility changes.

- Persons with disabilities should be enabled to make informed choices and have minimal uncertainty related to the impact of their decision to work on continued eligibility for income assistance and health services and supports.

C. Federal and State Government Administrative Responsibilities for Continued Benefits and Services for Working Persons with Disabilities

The work incentives summarized above are intended to provide an integrated and seamless package of ongoing income and health services and supports for an individual who attempts to work in spite of a significant disability. Specifically, the work incentive provisions in Section 1619 of SSI law and Section 1905(q) of Medicaid law are intended to reduce the uncertainty and risks felt by persons with disabilities by enabling such individuals to maintain a connection to both the SSI income assistance program and the Medicaid program when they work or increase their level of earnings.

SSA administers the federal SSI program; whereas the Medicaid program is administered by the state. Most states have adopted a state SSI supplement to the federal SSI program, which in some states is administered by SSA and in other states by the state. In some states, SSI recipients are automatically eligible for Medicaid. In other states, a separate application for Medicaid is required. Also, state and local jurisdictions and private, non-profit providers administer most rehabilitation and social services programs intended to encourage, prepare and provide employment support services for persons with disabilities to work. A high level of communication and cooperation among those who administer these programs at the federal, state and local level is required to ensure that the persons with significant disabilities are provided integrated and ongoing benefits and supports.

D. Options for Integrating Federal and State SSI Supplementation and Medicaid Programs

Set out below are the options available to states for administering federal and state SSI supplementation and Medicaid programs and the impact these options can have on the usability, access and effectiveness of current work incentives.

1. Full Integration

The SSI program was originally designed as a means to ensure a national minimum level of income assistance for persons with disabilities and the elderly. SSA administers the national SSI program. In addition, in order to integrate income assistance and Medicaid programs, Congress enabled states to provide “automatic” eligibility for Medicaid for those receiving an SSI payment from SSA. Through an electronic transfer of information from SSA to the state Medicaid agency, an individual

can be made eligible for Medicaid without making a separate application to the state or local agency that administers Medicaid.

SSI recipients may retain their eligibility for Medicaid even when they no longer receive any federal SSI cash benefits. Under the provisions of Section 1619(b) of the SSI law, the basis for the individual's eligibility for Medicaid changes from their status of actually receiving SSI payments to being “considered to be SSI recipients for purposes of Medicaid.” The information conveyed by SSA uses a different code. Nonetheless, for purposes of the state Medicaid eligibility, there is a seamless continuation of Medicaid eligibility for the individual without a new application for Medicaid required. Thus, “automatic” eligibility for Medicaid also can work for “SSI recipients” who are no longer receiving any federal SSI cash benefits.

Similarly, a state that provides for a state SSI supplement of the federal SSI benefit can choose to enter into an agreement with SSA to administer the state SSI supplementation program and provide automatic eligibility for individuals not eligible for cash benefits under the federal SSI program but that receive cash benefits under the state SSI supplementation program. If the state enters into such an agreement, it must use the same income disregards and asset criteria for its state SSI supplement as the federal SSI program. With federal administration of the state SSI supplement, an individual with earnings continues to receive a declining amount of SSI payment as his or her earnings increase. Because of the state SSI supplement, the individual with earnings will continue to receive some SSI up to a higher earnings level than if the SSI benefit standard in the state was the federal standard.

Among the nine Case Study states, only Vermont has fully integrated its federal SSI, state SSI supplementation and Medicaid eligibility determination. The State of Iowa does not have a state SSI supplementation program for the general SSI population but provides for automatic Medicaid eligibility for federal SSI recipients.

2. *Partial Integration*

A state can provide “automatic” eligibility for Medicaid for those who receive federal SSI benefits but also have a state-administered state SSI supplementation program. In those cases where the individual receives some federal SSI payments there is Medicaid eligibility without a separate application to the state or local agency. However, for those individuals who are only eligible for state-administered state SSI

supplements, they must make an application for the state SSI payment and also make a separate application for Medicaid as a recipient of state SSI supplementary payments.²²

Wisconsin and Maine provide a single application for those receiving federal SSI and Medicaid. For those only receiving state SSI supplementation, the states require the submission of a separate application for the state supplement and another application for Medicaid.

Maine uses its own income disregards for the state-administered state SSI supplementation program. The use of its own income disregards is allowable because SSA does not administer the state SSI supplementation program.²³ Maine does not apply the provisions of Section 1619(b) to persons only eligible for state SSI supplements (i.e., persons who do not receive a federal SSI check in addition to their state SSI supplement check). If such a person loses eligibility for the state SSI supplement because countable earnings raise his/her income over the state SSI supplement threshold, Maine does not provide the individual with Medicaid coverage available through Section 1619(b) work incentives.

3. No Integration

Another combination is found in states that utilize the SSI criteria for determining Medicaid eligibility but the individual must make a separate application to the Medicaid agency to be determined eligible. These states also have state-administered state SSI supplementation program. The continuation of Medicaid eligibility under Section 1619(b) (when an SSI recipient's earnings makes them no longer eligible for SSI cash payment) will require a state to have a means in place to ensure that individuals who lose their federal SSI payment status (because of earnings) are continued on Medicaid as if they were still receiving SSI cash payments and informed that they remain eligible for Medicaid under Section 1619(b). In other words, the state must utilize SSA data to track the SSI status of such individuals and ensure continued Medicaid eligibility.

²² The authority for a state to provide Medicaid for persons who are only eligible for state-administered state SSI supplementation is in Section 1902(a)(10)(A)(ii)(XI) of the Social Security Act and reads as follows:

“(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1616 or 1634;”

The reference to sections 1616 is to agreements for federal administration of state SSI supplements. The reference to Section 1634 is to the provision for automatic eligibility for Medicaid for SSI recipients.

²³ Maine provides for a \$55 income disregard in addition to the federal \$20 unearned income disregard in determining eligibility for the state SSI supplement. The state SSI supplement is \$10 in all cases. However, that payment makes them eligible for SSI and Medicaid without a spend down.

The other combination is found in the Section 209(b) states that have their own criteria for Medicaid eligibility and who administer their own state SSI supplementation programs. The same set of administrative issues arises as described above.

Data from the states provides evidence that this lack of integration of SSI and Medicaid eligibility has a significant impact on the actual enrollment in Section 1619(b) Medicaid work incentives. For example, in the State of Virginia, of the approximately 1,692 persons who were identified by SSA as being in a Section 1619(b) status in September 2001, only 322 or 19 percent were actually receiving Medicaid under the Virginia state Medicaid program on the basis of Section 1619(b). Virginia's experience indicates that there are serious problems related to the administration of the program for ensuring that those who lost their SSI cash payment status because of earnings actually remained eligible for Medicaid under the provisions of Section 1619(b).

E. Tradeoffs Related to the Methods Selected for Administering the State SSI Supplementation and Medicaid Programs

From a state's perspective, there is a desire to have maximum flexibility in the design and implementation of its state initiatives. At the same time, the state is concerned with costs and burdens its places on itself related to the administration of its programs.

An individual with a disability wants the state to administer its programs consistent with two policy goals. First, the individual wants the program to be comprehensive and person- centered (i.e., address the multiplicity of barriers faced by individuals with disabilities that want to work, be responsive to individual needs, and provide for informed choice). At the same time, the individual wants the programs to provide maximum ease of access to work incentives, including the smooth transition from one category of eligibility to another as his or her level of earnings changes. In other words, from the perspective of the disabled individual, a goal is to minimize the need to reapply for Medicaid under a new category when the basis for their eligibility changes. The phrase "ease of access" includes minimizing uncertainty regarding continued eligibility for various cash assistance, services and supports when beginning to work or when earnings fluctuate; ease of getting to and applying for benefits and services (including the number of different applications for eligibility or change in eligibility status that a state must process).

Achieving these goals (which may not always be totally compatible) often requires that the state, as part of their methods of administration, provide benefits counseling or other strategies to enable individuals to make informed choices related to work.

1. Minimize the Administrative Burden Placed on the State

Administrative burden placed on a state can be minimized by, among other things, reducing the number of persons who are making application to the state and reducing the need for re-determining eligibility based on changes in earnings.

In order to minimize administrative burden, the state may:

- Contract with SSA to administer the state SSI supplementation program;
- Contract with SSA to provide automatic Medicaid for SSI recipients (including those eligible on the basis of state SSI supplementation).

2. Enhance State Flexibility in the Design of its Program

A state also desires maximum discretion with respect to the comprehensiveness of its initiatives (i.e., the ability to address the multiplicity of barriers faced by individuals and to integrate income assistance and Medicaid with other benefit program applications) and the targeting of benefits and services to meet individualized needs (person-centered).

In order to maximize state flexibility, the state may want to administer its own state SSI supplementation program (rather than contracting with SSA) in order to:

- Ensure Medicaid services and income supports targeted to meet individual needs related to work and independent living; and
- Establish resource tests, income tests, and income disregards different from the SSI program.

However, a state still can enjoy some degree of flexibility and respond to individual needs if it chooses to contract with SSA to administer most of its state SSI supplementation program categories; but the state also retains responsibility for administering certain categories of state SSI supplementation based on individualized determination of need.

Set out below in chart form is a summary of the policy options related to the administration of Medicaid eligibility for SSI recipients as described above.

STATE OPTION	IMPACT ON ACCESS TO WORK INCENTIVES
<p>Section 1634 Option -- A state enters into an agreement with SSA under which SSA determines eligibility for Medicaid</p>	<ul style="list-style-type: none"> • SSI recipients do not have to make a separate application for Medicaid. • Automatic continuation of Medicaid under Section 1619(b) when earnings take them out of SSI cash payment status. • Persons who are only eligible for SSI because of the state SSI supplement, and SSA administers supplement, are provided the protections under Section 1619 for continued SSI and Medicaid if their earnings take them over the SGA earnings test level or income means test level.
<p>State Uses SSI criteria for eligibility for Medicaid for SSI recipients but separate application for Medicaid required by SSI recipient</p>	<ul style="list-style-type: none"> • State must ensure that individuals who lose their SSI payment status because of earnings are informed that they remain eligible for Medicaid under Section 1619(b). • State must utilize SSA data to track status of individual and ensure continued Medicaid eligibility. • If state administers state SSI supplement, including those without federal SSI benefits, individual should remain eligible for Medicaid under Section 1619(b) if earnings takes them above state SSI supplement standard.
<p>State 209(b) Option -- State uses Medicaid eligibility criteria that are different than the SSI standards but not more restrictive than the state's approved Medicaid state plan in January 1972 -- the year the SSI law was enacted</p>	<ul style="list-style-type: none"> • SSI recipients are required to make a separate application to the state for Medicaid to become eligible. • Section 209(b) states must provide continued Medicaid eligibility under Section 1619(b) when an SSI recipient loses SSI benefit payment status because their earnings takes them above the SSI benefit standard if in the previous month they were eligible for Medicaid under the state's Medicaid program. • State must ensure that individuals who lose their SSI payment status because of earnings are informed that they remain eligible for Medicaid under Section 1619(b). • State must utilize SSA data to track status of individual and ensure continued Medicaid eligibility.

VII. SUMMARY OF MAJOR POLICY CONSIDERATIONS

This final section of this paper restates the purposes of the paper and then summarizes the major policy considerations identified in the paper.

A. Purpose and Overview

The purpose of this paper is to provide policy frameworks to assist stakeholders design and implement Medicaid Buy-In programs and related work incentive initiatives to enhance the level of economic self-sufficiency of persons with significant disabilities. Of particular focus of the paper are the design decisions affecting enrollment, costs, and a state's fiscal exposure. The policy frameworks describe the interrelationship between federal and state cash assistance programs (particularly SSI, SSDI, and state SSI supplementation programs) and health entitlements (particularly the Medicaid program). The policy frameworks are derived from the experiences of the nine early implementation states included in the Case Study.

B. Preliminary Considerations

1. *Framing the Issue*

The enactment of Section 4733 of the Balanced Budget Act of 1997 and TWWIIA authorized states to enact Medicaid Buy-In programs for workers with disabilities. But, these federal laws did much more -- they opened a policy window of opportunity for state policy makers to refocus attention on the critical policy issue of how to improve the quality of life for persons with significant disabilities by enhancing their level of economic self-sufficiency (making "work pay") and, at the same time, reducing or eliminating their dependency on federal and state cash assistance programs.

In other words, the policy consideration guiding the actions of state policy makers is not simply whether to adopt a Medicaid Buy-In program. The policy consideration is what fiscally- responsible employment initiatives (additions or modifications to existing state policy), including, but not limited to, the enactment of a Medicaid Buy-In program, will enhance the level of economic self-sufficiency of persons with significant disabilities.

2. *Devising Comprehensive, Person-Centered Initiatives*

In order to address the multiplicity of barriers to employment faced by persons with significant disabilities, many states are adopting comprehensive person-centered employment initiatives. These initiatives are "comprehensive" in the sense that they include the following components: a health care component (e.g, protections against

loss of Medicaid when an individual works, benefits counseling, enhanced vocational rehabilitation, protections for program participants (including requests for demonstration authority from SSA for SSDI recipients assessing the efficacy of gradual rather than precipitous loss of cash assistance), assistance in securing and retaining transportation, housing and food assistance, employer involvement, meaningful collaboration and coordination, and program evaluation). These initiatives are "person-centered" in the sense that they are responsive to the individualized goals and aspirations of each person with a severe disability and empower these individuals with information to make informed choices related to work.

3. Understanding the Baseline of State Programs and Fiscal Constraints

The design of a Medicaid Buy-In program cannot be viewed in isolation; rather, the key components of a Medicaid Buy-In program must be viewed in the context of a state's overall Medicaid program and other state-specific initiatives (such as state SSI supplementation). In other words, policy deliberations require knowledge of the state's baseline in order to measure the impact of any change. Every state starts from a different baseline (e.g., regular Medicaid eligibility rules, state SSI supplementation program).

The key point is that a state cannot look separately at income standards established under the SSI and Medicaid programs in determining the starting point for making improvements in the options available to individuals with significant disabilities interested in increasing their level of economic self-sufficiency. Instead, the state must identify the highest level of income standard and the work incentives or lack thereof for each of the following programs: SSI-combined federal benefit and state supplement, poverty level or standard of need income standard, and medically needy program -- PIL.

In addition, the design of the Medicaid Buy-In program must be viewed in the context of the current fiscal constraints facing the state and the relative priority that state policy makers place on employment initiatives for persons with disabilities. Some states are willing to earmark significant additional funds to the implementation of the Medicaid Buy-In program, whereas in other states the Medicaid Buy-In program must be budget neutral.

4. Relying on the Experience of Other States

There is a wealth of knowledge that can be gleaned from reviewing the experiences of those states that have already enacted and have experience implementing Medicaid Buy-In programs and related employment initiatives. The experience of these states provides invaluable guidance for states considering the enactment of Medicaid Buy-In programs and related employment initiatives. It is critical, however, that the state seeking guidance understand how its circumstances correspond to those of the states from which it is seeking guidance in such areas as: the existing regular Medicaid eligibility categories and rules and the state's SSI supplementation program; the design of the Medicaid Buy-In program, including fiscal assumptions,

policy objectives, policy tradeoffs, eligibility categories and cost-sharing; and the administration of the Medicaid program and the state SSI supplementation program to improve access to work incentives.

5. *Taking Into Account the Impact of Federal Policies on State Policy Options*

State policy makers and other stakeholders must recognize that significant numbers of persons participating in Medicaid Buy-In programs may be unwilling to earn more than SGA level because of the "cash cliff" under the federal SSDI program. (In general, an SSDI recipient loses eligibility when he/she earns more than SGA. The SSDI "cash cliff" appears to be playing a major role in the decisions made by Medicaid Buy-In program participants regarding their level of work effort. Therefore, states are faced with devising Medicaid Buy-In programs within the constraints of federal SSDI law.

C. Designing a Medicaid Buy-In Program

1. *Focus and Policy Objectives of the Program*

In order to ensure that work incentives (under the SSI and Medicaid programs) are responsive to and useable by persons with disabilities, it is essential that the state determine the focus and policy objectives of the program. In deciding the relative emphasis or focus of a state's Medicaid Buy-In program, the state can overtly decide to create a Medicaid Buy-In program that (1) limits or targets the Medicaid Buy-In program to only those with substantial work effort, (2) rewards increased but modest work effort by persons with significant disabilities, or (3) includes dual purposes (i.e., provides work incentives for those with substantial earnings and provides Medicaid to low-income individuals without requiring "spend downs" to incomes less than the federal SSI standard).

Policy objectives may include increasing the percentage of Medicaid Buy-In participants who have earnings from employment or increased disposable income; increasing the percentage of enrollees who have some of their health care needs covered by employer-based benefit programs; increasing the number of SSI and SSDI recipients who have reduced dependency or are no longer dependent on cash benefits or health care entitlement services.

2. *Fiscal Exposure in General -- The Income Eligibility Gap and Starting Point*

When a state adopts a Medicaid Buy-In program as part of its Medicaid state plan, it creates a new entitlement for health services for a defined population. Before adopting any change to an entitlement program, a state is likely to consider the fiscal exposure resulting from the change. The fiscal exposure of the state is directly related to the size of the "gap" between the income eligibility standard at the "starting point" for Medicaid in a state prior to the creation of a Medicaid Buy-In program and the Medicaid Buy-In

program's unearned income limit or the income point at which a Medicaid Buy-In premium is first paid or some combination of the two. For example, the higher the percentage of SSDI recipients in the state who are already potentially eligible for SSI, Medicaid, and Section 1619 work incentives, the more modest the fiscal impact on the state.

The primary variables affecting the relative enrollment and cost of the various states' Medicaid Buy-In programs are the states' "starting points" related to their Medicaid eligibility criteria and the "restrictions" that states apply to their Medicaid Buy-In programs. In general, the higher the starting point and the tighter the limitations that a state applies to its Medicaid Buy-In program, the lower the enrollment and the smaller the fiscal exposure of the state.

3. Using Eligibility Criteria to Affect Enrollment and Fiscal Exposure

The state may limit eligibility into the Medicaid Buy-In program through various means, including unearned income eligibility limits. Also, a state can require a minimal level of earnings as a means for an individual to be exempt from a low unearned income limit. The lower the unearned income limit for eligibility, the lower the participation rate. The higher the earnings level requirement for eligibility, the lower the participation rate.

4. Using Premiums and Premium Levels to Affect Enrollment and Fiscal Exposure

The state may restrict access to the Medicaid Buy-In program by prescribing the circumstances under which an individual is required to pay a premium and the size of the premium. A state may restrict access to the Medicaid Buy-In program and limit the program to those with substantial earnings by applying a different premium against unearned income (SSDI benefits) than against earned income. In addition, a state may encourage earnings at all levels and increase the disposable income of working disabled persons with minimal premiums and no unearned income limits. Further, the state may make their Medicaid Buy-In program's premium structure similar to the Medicaid waiver program by similarly applying the "cost-sharing" provisions in the state's HCBS waiver program as an "unearned income premium" in their Medicaid Buy-In program.

The higher the premium amount based on level of unearned income, the lower the participation rate and the lower the net cost per participant. The higher the premium based on total income, the lower the net cost of the program. The lower the total income level at which premiums must be paid, the lower the net cost of the program. The higher the percent of spouse's income is counted in determining premiums, the lower the net cost of the program. The fewer the deductions for disability-related expenses in determining countable income for premiums, the lower the net cost of the program.

D. Redesigning the State SSI Supplementation Program and the Medicaid Program to Increase Access to Work Incentives

1. Redesigning the State's SSI Supplementation Program to Increase Access to Work Incentives

State decisions regarding the design of state SSI supplementation programs can have a major impact on Medicaid eligibility levels in states and access to the work incentives under the Section 1619 provisions in current SSI law and Section 1905(q) of Medicaid law. Under Section 1619 and 1905(q), SSI recipients can: increase their disposable income with significant earnings; continue Medicaid when they have such earnings; and enjoy income security under the SSI program by being able to return to cash payment status from Medicaid-only status if their ability to work ceases or is significantly reduced. To enable more persons with significant disabilities to take advantage of this policy, the state can: increase the income standard for the state SSI supplement, thereby increasing the number of SSDI recipients who can qualify for SSI and the Section 1619 work incentives because their SSDI benefit amount is less than the combined federal and state SSI standard; increase the earned or unearned income disregards under a state- administered state SSI supplement program, thereby increasing the number of SSDI recipients who can qualify for SSI and the Section 1619 work incentives because their "countable income" is less than the SSI standard; or provide state SSI supplement to those in all living arrangements and not limit the supplement to those in group living arrangements.

2. Redesigning the Non-SSI-Related Medicaid Eligibility Criteria to Increase Access to Work Incentives

When a state is deciding how to achieve the policy objective of increasing the level of economic self-sufficiency of persons with significant disabilities, it can look at the non-SSI- related Medicaid income eligibility options used by a state. While none of these options were originally designed to support work, each of them can be crafted to provide preferential access to Medicaid for persons entering the workforce. Under each of the options, there are variations on the ability of SSDI beneficiaries (and former beneficiaries) to retain Medicaid after they go to work.

States have the option to provide Medicaid coverage to persons with disabilities whose countable income does not exceed 100 percent of the FPL and whose resources do not exceed the SSI standard (i.e., the option for work incentives under FPL or standard of need option). However, the FPL Medicaid eligibility option results in an income eligibility "cliff" above which a person is not eligible for Medicaid. A state with a poverty level-based Medicaid eligibility program can provide for earned income disregards in determining eligibility and thus create a limited work incentive.

State may also use the option to create work incentives under the medically needy option or spend down. States have the option to provide Medicaid eligibility for individuals with significant disabilities who have income too high to be eligible for SSI

but low enough, after paying some of their health care bills, to meet an income standard under the state's medically needy category of eligibility for Medicaid. To be eligible under the state's "medically needy" program the individual must be determined to have a severe disability (medical impairments and not working or has limited earnings). The income standard is generally the PIL.

In states that have chosen the Section 209(b) option and do not have a medically needy program, the state must allow an individual to spend down to the federal SSI standard and become eligible for Medicaid.

The Medicaid medically needy program has the advantage of not having an income eligibility "cliff." Instead this option provides the flexibility for an individual with SSDI income just above the PIL to "spend down" a small amount to receive a significant value of health services under Medicaid. On the other hand, if the individual's SSDI income is significantly above the state's PIL there is a significant financial barrier to access to Medicaid. Some states have applied an earned income disregard in determining the amount of the spend down.

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

Existing SSI and Medicaid law includes numerous work incentives that are designed to achieve the overall policy objective of enhancing the level of economic self-sufficiency of individuals with significant disabilities by providing continued eligibility to health care. These work incentives are intended to allow individuals to remain eligible for Medicaid and attached to the SSI income assistance program even though the basis for their eligibility may change over time. Existing Medicaid and SSI law provides significant flexibility to states in determining how to administer these programs.

The work incentives are intended to provide an integrated and seamless package of ongoing income and health services and supports for an individual who attempts to work in spite of a significant disability. Specifically, the work incentive provisions in Section 1619 of SSI law and Section 1905(q) of Medicaid law are intended to reduce the uncertainty and risks felt by persons with disabilities by enabling such individuals to maintain a connection to both the SSI income assistance program and the Medicaid program when they work or increase their level of earnings.

SSA administers the federal SSI program; whereas the Medicaid program is administered by the state. Most states have adopted a state SSI supplement to the federal SSI program, which in some states is administered by SSA and in other states by the state. In states without automatic Medicaid eligibility for SSI recipients, the individual must make a separate application to the Medicaid agency to be determined eligible. A high level of communication and cooperation among those who administer these programs at the federal, state and local level is required to ensure that the

persons with significant disabilities are provided integrated and ongoing benefits and supports.

The policy issue facing states is whether the methods chosen for administering the state SSI supplementation and the Medicaid programs facilitate or impede access to and use of work incentives designed to increase the level of economic self-sufficiency of persons with significant disabilities.

Set out below is a summary of the policy options related to the administration of Medicaid eligibility for SSI recipients.

Section 1634 Option -- A State enters into an agreement with the SSA under which SSA determines eligibility for Medicaid.

- SSI recipients do not have to make a separate application for Medicaid.
- Automatic continuation of Medicaid under Section 1619(b) when earnings take them out of SSI cash payment status.
- Persons who are only eligible for SSI because of the state SSI supplement, and SSA administers supplement, are provided the protections under Section 1619 for continued SSI and Medicaid if their earnings take them over the SGA earnings test level or income means test level.

States uses SSI criteria for eligibility for Medicaid for SSI recipients but separate application for Medicaid required by SSI recipient.

- State must ensure that individuals who lose their SSI payment status because of earnings are informed that they remain eligible for Medicaid under Section 1619(b).
- State must utilize SSA data to track status of individual and ensure continued Medicaid eligibility.
- If state administers state SSI supplement, including those without federal SSI benefits, individual should remain eligible for Medicaid under Section 1619(b) if earnings takes them above state SSI supplement standard.

State Option: "209(b) Option -- State uses Medicaid eligibility criteria that are different than the SSI standards but not more restrictive than the state's approved Medicaid state plan in January 1972 -- the year the SSI law was enacted.

- SSI recipients are required to make a separate application to the state for Medicaid to become eligible.

- Section 209(b) states must provide continued Medicaid eligibility under Section 1619(b) when an SSI recipient loses SSI benefit payment status because their earnings takes them above the SSI benefit standard if in the previous month they were eligible for Medicaid under the state's Medicaid program.
- State must ensure that individuals who lose their SSI payment status because of earnings are informed that they remain eligible for Medicaid under Section 1619(b).
- State must utilize SSA data to track status of individual and ensure continued Medicaid eligibility.

CASE STUDIES AND TECHNICAL ASSISTANCE FOR MEDICAID BUY-INS FOR PEOPLE WITH DISABILITIES

Reports Available

Medicaid Buy-In Programs: Case Studies of Early Implementer
States

HTML <http://aspe.hhs.gov/daltcp/reports/Elcasest.htm>
PDF <http://aspe.hhs.gov/daltcp/reports/Elcasest.pdf>

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