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Explaining Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2002-2003

Executive Summary

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EXECUTIVE SUMMARY[1]

OVERVIEW

Persons with disabilities who wish to enter or remain in the labor force face multiple challenges, including those originating from the nature of their disabilities, the limited availability of employer-based and individual private health coverage, and the risk that higher earnings could cause them to lose public assistance they might receive. As a result, the unemployment rate among people with disabilities has been high and has increased (Kaye 2002; Taylor 2001).

The Medicaid Buy-In program was enacted to encourage work by reducing work disincentives. Specifically, it allows people with disabilities to earn more and still be eligible to obtain Medicaid coverage. Participants "buy in" to the program by paying a premium or co-payment and receive full Medicaid benefits in return. The Buy-In program is one major component of a broad federal and state effort to support the employment of people with disabilities that includes the Americans with Disabilities Act of 1990 (ADA) and the President's New Freedom Initiative.

State Buy-In programs are authorized under two separate acts, the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act). Both give states a high degree of flexibility to customize their Buy-In programs according to the state's unique needs and objectives. This flexibility, combined with the state-specific variation in traditional Medicaid programs, means that Buy-In programs vary greatly from state to state. To date, 31 states have implemented Medicaid Buy-In programs, whose total enrollment was approximately 60,000 participants at the end of 2003.

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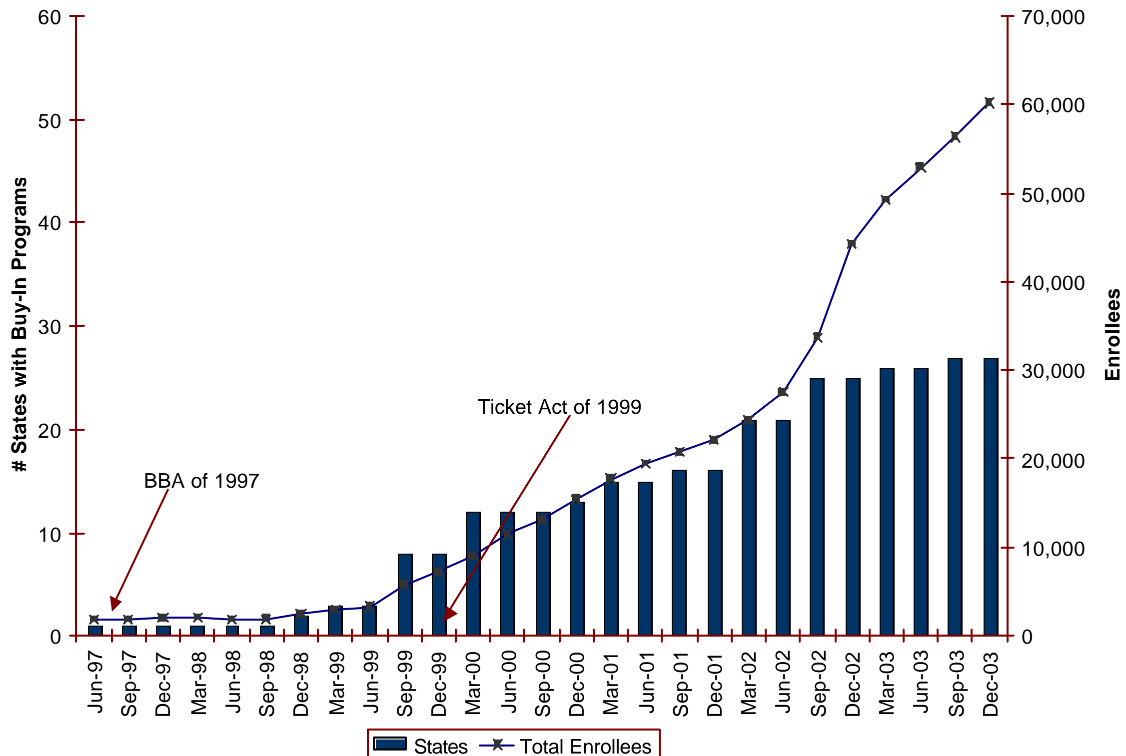
[1]This executive summary is distilled from the full report, "Explaining Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2002-2003." The full report is available online at www.mathematica-mpr.com/publications/redirect_pubsdb.asp?strSite=pdfs/explainfull.pdf.

Figure 1: Number of States Implementing Medicaid Buy-In Programs and Total Enrollment, 1997-2003, 27 States



SOURCE: State data submitted to CMS in quarterly progress reports

TWENTY-TWO STATES REPORTED ON BUY-IN PARTICIPATION

This report profiles Buy-In participation in calendar years 2002 and 2003 for 22 states with a Medicaid Buy-In program and a Medicaid Infrastructure Grant (MIG).[2] It presents descriptive information on participation in state Medicaid Buy-In programs across five topics with important policy implications:

- Enrollment growth

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[2] The analyses in this report are based on data and information collected from 22 states: Alaska, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Utah, Vermont, Washington, and Wisconsin.

- Types of people who enter a Buy-In program
- Participants' earnings
- Participants' premiums
- Participants' Medicaid expenditures

Our work draws primarily from two sources of data: (1) annual reports on program participation, submitted by states and derived from their various databases, and (2) telephone discussions with Buy-In personnel from the 22 states. The discussions were designed to clarify the reasons behind changes in the reported data from 2002 to 2003 and, where possible, to identify the reasons behind differences among states. This report is the second in a series of reports on Buy-In participation and builds heavily on the information presented in the first report (Ireys, White, and Thornton 2003), which was based on data provided by the states for calendar year 2002.

BUY-IN PROGRAM FEATURES AND CONTEXT

A state can exercise considerable influence over the size, participant characteristics, and cost of a Medicaid Buy-In program through the programmatic features that the state adopts. However, these features do not operate in isolation. Interactions among the features occur in subtle, often complex ways that shape Buy-In participation. To develop a complete picture of the driving forces behind participation, especially in light of large cross-state variation, an observer has to be mindful of these interactions. Among the most important programmatic features that affect Buy-In participation are: income and asset eligibility criteria, cost-sharing requirements, work-related policies and protections, and outreach activities.

In addition, design features of states' underlying Medicaid programs affect participation in Buy-In programs. States offer several means for working adults with disabilities to obtain Medicaid eligibility. In particular, the SSI program, including the 1619 provisions, and the medically needy program are two important eligibility categories.[3] Also, some states offer categorical ("poverty-level") Medicaid coverage to persons with disabilities who have income above that required for mandatory coverage but below the federal poverty line. The eligibility criteria for these other means of obtaining Medicaid eligibility affect the number of individuals who are eligible for the Buy-In program. For instance, generous eligibility criteria for poverty-level Medicaid coverage relative to other states could cause a disproportionately

[3]The 1619 provisions extend Medicaid eligibility to workers with disabilities who had previously received SSI benefits but whose current earnings make them ineligible for full cash benefits. The medically needy program provide Medicaid coverage to persons with disabilities whose income, after medical expenses are deducted, falls below the medically needy income limit set by the state. This is the so-called "spend-down process."

small number of persons with disabilities to select the Buy-In program, thus resulting in relatively low Buy-In enrollment.

FINDINGS

We studied enrollment trends and patterns of participation across Buy-In programs to answer five policy questions, and our main findings are below. Common to all results is the considerable amount of state variation.

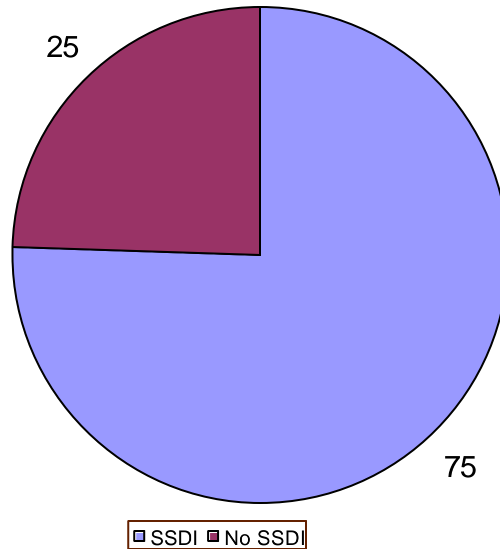
1. ***Enrollment in state Buy-In programs grew dramatically during 2002 and 2003***, nearly tripling from 22,000 in December 2001 to about 60,000 in December 2003 (see Figure 1). The rapid growth was due in large part to three states (Indiana, Missouri, and Pennsylvania) that implemented Buy-In programs in 2002. Enrollment at the end of 2003 varied among states from approximately 100 in Nebraska to over 15,000 in Missouri.

2. ***The majority of new Buy-In participants were already connected to public health insurance and disability-related programs when they enrolled.*** Nationally, 73 percent of new 2003 Buy-In participants were previous Medicaid enrollees, and 75 percent were Social Security Disability Insurance (SSDI) beneficiaries (see Figure 2). In addition, 76 percent of participants who were enrolled during the entire fourth quarter of 2003 were dually enrolled in Medicaid and Medicare in 2003. Each of these proportions varied markedly among states. In addition, new participants who were previously enrolled in Medicaid qualified for Medicaid through a variety of eligibility categories, though the medically needy program was most common in 9 of 21 states. In 2003, 27 percent of new participants did not have Medicaid coverage prior to enrolling in the Buy-In program.

3. ***Earnings were generally low among Buy-In participants.*** Of the 39 percent of Buy-In participants nationally who had reported earnings in state unemployment insurance (UI) systems (see Figure 3), about 7 in 10 had earnings below the Social Security Administration's (SSA's) substantial gainful activity (SGA) level (i.e., $800 per month in 2003). Broadly speaking, the data indicate that Buy-In participants have employment that allows them to maintain their eligibility for SSDI benefits.[4] The proportion of participants with monthly earnings just above the SGA level was much lower than the number of participants with earnings just below the SGA level, suggesting that the SSDI

[4]Earnings above the SGA level for extended periods of time will eliminate SSDI cash benefits and could jeopardize assistance from other means-tested public programs, such as food stamps and housing subsidies.

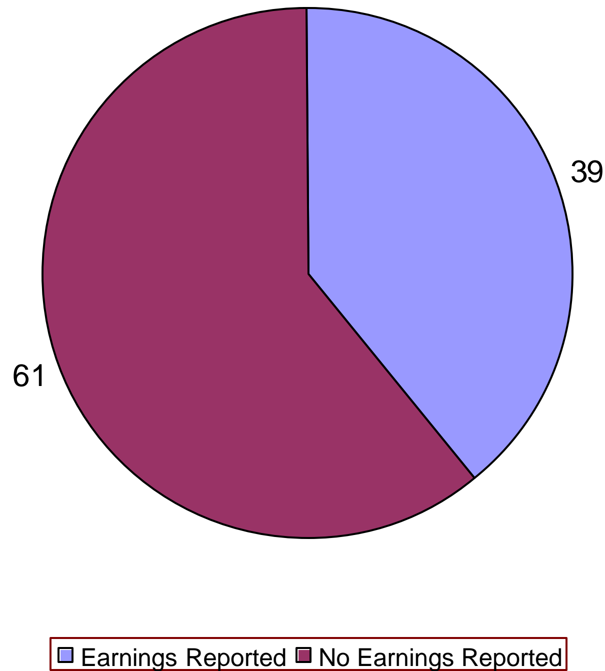
Figure 2: SSDI Status of New Participants at the Time of Enrollment in the Medicaid Buy-In Program, 21 States, Calendar Year 2003



SOURCE: State Annual Buy-In Report for 2003 (Table D.7).

NOTE: This figure includes only those individuals whose SSDI status could be determined (97 percent of all new Buy-In participants). New Jersey could not determine the SSDI status of its participants. Wisconsin could not determine the SSDI status of some of its participants; this figure includes the participants whose SSDI status could be determined.

Figure 3: Percent of Buy-In Participants with UI Earnings Reported in the Fourth Quarter of 2003, 19 States



SOURCE: State Annual Buy-In Reports for calendar year 2003.

NOTE: Reported UI earnings are for Buy-In participants enrolled during the entire fourth quarter of calendar year 2003. Data for three states are not included because they either did not use the UI system (Indiana and Pennsylvania) or used a data source in addition to the UI system (Nebraska), thus rendering their data incomparable with other states.

"cash cliff" may inhibit some Buy-In participants who are SSDI beneficiaries from increasing their earnings above the SGA level. Average monthly earnings among those participants who had reported earnings varied in 2003 from $397 in New Jersey to $1,337 in Alaska.

4. ***Average monthly premiums for Buy-In participants ranged from $13 in Alaska to $145 in Utah.*** All but two states charged premiums to Buy-In participants. In 2003, 38 percent of Buy-In participants paid premiums. The percentage of participants who paid a premium varied greatly by state and appeared to relate inversely to the state-defined income threshold above which a premium is required.

5. ***Medicaid expenditures of Buy-In participants tended to be substantially higher than the average Medicaid enrollee with blindness or a disability.*** Per member per month (PMPM) Medicaid costs were $1,016 for Buy-In participants in 2002 compared to an estimated $886 for Medicaid enrollees with blindness or disabilities overall in 2002 (Holohan and Bruen 2003). Average PMPM Medicaid expenditures for Buy-In participants increased by 16 percent from $1,016 in 2002 to $1,176 in 2003. Across states, average monthly PMPM expenditures in 2003 ranged from $367 in Maine to $2,813 in Indiana.

RELATIONSHIP BETWEEN PROGRAM DESIGN AND PARTICIPATION

The nature of the aggregate data available for our analyses makes it impossible to isolate the impact of a particular policy on Buy-In participation, because the actual effect of a policy is the product of complex interactions among myriad factors. However, we were able to find several associations between program design and Buy-In enrollment and participants' earnings.

Enrollment

Like many choices regarding health insurance, an individual's decision to enroll in the Buy-In program tends to follow basic economic patterns. That is, more people will decide to enroll in the Buy-In program if: the price is low; Buy-In eligibility criteria (i.e., asset and income criteria and a grace period) are lenient; fewer alternative coverage options exist; and outreach (i.e., marketing) is active.

- ***Income and Asset Eligibility Criteria.*** States with low enrollment per 100,000 residents age 18 to 64 tend to set low asset limits. Conversely, the three states with the highest income limits had high levels of enrollment per 100,000. A separate limit on a participant's unearned income may constrain Buy-In enrollment by limiting the number of participants who are receiving cash assistance from other programs, such as SSDI.

- ***Cost-sharing Structure.*** Buy-In enrollment patterns are likely to be affected by policies that influence the number of participants who pay premiums (e.g.,

the income threshold above which a person must pay a premium), the premium amounts, and the gradation of premiums across income brackets.

- ***Program Context.*** Some states with high Buy-In enrollment per 100,000 residents tend to have more restrictive eligibility criteria for traditional Medicaid and the medically needy program than other states.

- ***Outreach.*** The intensity of outreach conducted by the state or advocacy groups to educate persons with disabilities and eligibility workers about the Buy-In program appears to relate directly to Buy-In enrollment levels.

- ***Grace Period.*** The presence of a grace period, which allows an individual to remain enrolled in the Buy-In program despite a lack of earnings, may limit participants' cycling on and off of the Buy-In program.

Earnings

- ***Employment Verification.*** States with more lenient income verification requirements tended to have a lower proportion of their Buy-In population with reported earnings in the UI system. In addition, the proportion of Buy-In participants with UI earnings was related to the proportion earning above the SGA level. Imposing more stringent verification requirements could potentially increase the proportion of participants with competitive earnings.

- ***Program Context.*** States with relatively high income thresholds for traditional Medicaid tended to have high average earnings among Buy-In participants compared to other states.

- ***Grace Period.*** States with grace periods tended to have lower average earnings, most likely because they allowed participants to remain in the program during spells of unemployment.

The changes that ensue as maturing Buy-In programs re-evaluate their policy choices will provide valuable information about the relationship between program design features and outcomes. Therefore, continuing to monitor each state's program will provide critical feedback about the program's evolution and important insights into the relationship between policies and participation.

NEXT STEPS

To further understand the implications of our findings, several important policy questions should be addressed, such as:

- To what extent does the Buy-In program affect participants' earnings and work patterns?

- To what extent does the work disincentive caused by the SSDI "cash cliff" discourage Buy-In participants from working more?

- How are participants' Medicaid expenditures related to program characteristics?

- What implications does the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) have on Buy-In programs and their participants?

To properly address these and other policy questions, researchers need access to individual-level national data and a feasible comparison group. Three possible data sources include the Medicaid Statistical Information System (MSIS), the Medicare standard analytical files, and data from SSA. Common identifiers in these sources permit the linkage of detailed longitudinal information on both Medicaid and Medicare health care expenditures, earnings, and demographic information for the three-fourths of Buy-In participants enrolled in the SSDI program. Analysis of longitudinal, person-level data could be valuable to states that are planning to implement a new Buy-In program or modify an existing one and could potentially reduce states' reporting burden.

OVERVIEW OF FULL REPORT

The Centers for Medicare & Medicaid Services (CMS) initiated the study described in this report in order to track: (a) participation in the Medicaid Buy-In program across several dimensions and (b) the relationship between administrative features of public assistance programs and participation in the Buy-In program. Each chapter of the full report addresses a key policy question about the characteristics of Buy-In participants and describes important ways that program structure may affect enrollment and participant characteristics. These questions include:

- Is the Buy-In program growing? (Chapter IV)

- Who participates in the Buy-In program? (Chapter V)

- How much are Buy-In participants earning? (Chapter VI)

- How much are participants' premiums? (Chapter VII)

- What are Buy-In participants' Medicaid expenditures? (Chapter VIII)

Chapter IX provides a summary of the main findings and an overview of the key policy questions related to program monitoring and evaluation. Appendix A contains a brief description of the Buy-In programs in each of the 22 states.

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