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

Final Report

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EXECUTIVE SUMMARY

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 (ADA) of 1990 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.

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). It presents descriptive information on participation in state Medicaid Buy-In programs across five topics with important policy implications:

- Enrollment growth

- 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. In addition, 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 in the series (Ireys, White, and Thornton 2003) that 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 and spend-down programs are two important eligibility categories.[1] 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

[1]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 and spend-down programs 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."

eligibility criteria for poverty-level Medicaid coverage relative to other states could cause a disproportionately small number of persons with disabilities to select the Buy-In program, thus potentially 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. 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. In addition, 76 percent of participants 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, 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.[2] 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 "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

[2]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.

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 income threshold above which a premium is required, as set by each state.

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 $886 for Medicaid enrollees with blindness or disabilities overall in 2002 (Holohan and Bruen 2003). Average PMPM Medicaid expenditures for Buy-In participants across states 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. In addition, 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 a grace period tended to have lower average earnings, most likely because it allows 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.

CHAPTER I

INTRODUCTION

A. POLICY CONTEXT

One major barrier to employment for adults with disabilities is the limited availability of affordable private health insurance. The severity and chronicity of pre-existing disabling conditions and high health insurance premiums prevent many individuals with disabilities from obtaining private coverage. In addition, many adults with disabilities require certain costly supports, such as medical devices and personal assistance services, to maintain employment.[1] As a result of these barriers, the unemployment rate among working-age adults with disabilities is quite high and has increased during the last decade (Kaye 2002; Taylor 2001).

The absence of adequate private health insurance for persons with disabilities has caused many of them to rely on Medicaid to provide health benefits. During fiscal year 2002, Medicaid covered 8 million adults with blindness or disability who were under age 65 (Crowley and Elias 2003). Traditional Medicaid benefits are tied to earnings, which means that many people with disabilities fear that increased earnings will cause them to lose Medicaid coverage (Yelowitz 1998). As a result, some individuals with disabilities limit their earnings or do not work at all.

The Medicaid Buy-In program is a state Medicaid option designed to improve incentives for individuals with disabilities to work, or for the employed to increase their earnings by weakening the link between health care and employment (Goodman and Livermore 2004). The Buy-In program makes health care coverage available to eligible workers with disabilities—about 60,000 participants at the end of 2003—and tries to create financial incentives that promote recovery and economic self-sufficiency. Under the Buy-In option, a person typically can earn more money and accumulate more resources than previously allowed under traditional Medicaid and thus maintain important health benefits and employment supports that facilitate higher earnings.

[1]Private coverage may be inadequate for a person's needs because it often does not cover a full array of employment supports (GAO 2003).

The Medicaid Buy-In program is an important component of a broad federal effort, which includes the Americans with Disabilities Act of 1990 (ADA) and, more recently, the President's New Freedom Initiative, to enhance employment opportunities for people with disabilities. The ADA is a landmark piece of legislation that prohibits employers from discriminating against qualified individuals with disabilities in several job practices (Equal Employment Opportunity Commission [EEOC] Web site 2004). The New Freedom Initiative is a federal effort designed "to remove barriers to community living for people with disabilities" (Department of Health and Human Services [DHHS] Web site 2004). Announced in 2001, the New Freedom Initiative is charged with three major goals: (1) promoting full access to community life for people with disabilities through implementation of the Olmstead Supreme Court decision, (2) enhancing employment opportunities for persons with disabilities through implementation of the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act)—one of two federal laws that authorize state Buy-In programs, and (3) creating the New Freedom Commission on Mental Health. (See the DHHS Web site for more detail.) As a group, these federal initiatives established a beachhead to address the disincentives that prevent many individuals with disabilities from seeking and finding employment, and the Buy-In program was intended to make additional inroads in this area.

The federal authorizing legislation of the Buy-In program gives states a high degree of flexibility to customize their Buy-In programs according to their unique needs and objectives. This flexibility, combined with the differences in traditional Medicaid programs among states, means that Buy-In programs vary from state to state.

The Centers for Medicare & Medicaid Services (CMS) are responsible for monitoring the state implementation of the Medicaid Buy-In program, tracking enrollment trends, and examining patterns of participation. These monitoring activities require comprehensive data on several important factors, including:

- The number of individuals entering state Medicaid Buy-In programs
- The number of participants who were Medicaid enrollees prior to enrollment
- Participation in other benefit and health insurance programs
- Participant earnings
- Participants' Medicaid costs
- Participants' premium payments

CMS initiated the study described in this report in order to track: (a) participation in the Medicaid Buy-In program across these dimensions and (b) the relationship between administrative features of public assistance programs and participation in the Buy-In program. Each chapter of this 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. This report builds on and strategically extends the information presented in a previous report (Ireys, White, and Thornton 2003) that was based on data provided by the states for calendar year 2002.

B. OVERVIEW OF THE REPORT

The remainder of this introduction describes the data sources used in this report. In Chapter II, we provide background information about the Medicaid Buy-In program, which includes a discussion of the different means for individuals with disabilities to obtain Medicaid coverage. Chapter III lays out the relationship that exists between key program features and Buy-In participation.

We then address the following questions related to participation in the Buy-In program:

- 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)

Each chapter begins with an overview of the results at the national level and then examines the extent to which variation exists across states. We conclude the report with a summary of the main findings and an overview of the key policy questions related to program monitoring and evaluation.

C. DATA SOURCES AND QUALITY

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. Each of these states has both a Medicaid Buy-In program and a Medicaid Infrastructure Grant (MIG).[2]

[2]CMS funds the MIGs, which provide states with annual grants from $500,000 to $1.5 million to improve the capacity of Medicaid programs to support the competitive employment of individuals with disabilities. Since the MIG money first became available to states in January 2001, 17 states have decided to implement a Buy-In program, joining five MIG states with Buy-In programs that began prior to 2001. States have applied the money to a variety of activities, ranging from policy development to outreach to data improvements. Nine states have implemented a Buy-In program without the benefit of a MIG; data from

1. Data Sources and Methodology

We used four sources of data for this report:

1. Annual state reports on program participation, which provide data on enrollment trends, Medicaid eligibility prior to enrollment in the Buy-In program, Social Security Disability Insurance (SSDI) status at enrollment, health coverage in addition to Medicaid, premium payments, earnings, and Medicaid expenditures,
2. Telephone discussions with Buy-In personnel from 22 states,
3. Quarterly progress reports, which describe administrative features and recent experience of each program, and
4. Existing reports on the Buy-In program, including available studies completed by states.

The 22 states included here are those that submitted an annual state report on program participation in 2003.[3] Of those, 21 also submitted an annual report on participation in 2002.[4] We checked data submitted by states for completeness and any questionable items were referred back to the states for verification or revision. The state reports varied widely as a result of variations in the design and implementation of Buy-In programs in each state.

Most states completed the report based on data from their state Medicaid Management Information System (MMIS) files, state billing and collection records, and unemployment insurance (UI) data systems. Appendix C lists the sources of data that each state used for each item in the annual report and a chart identifying data elements that states were unable to provide.

After states submitted their annual reports, MPR staff contacted Buy-In personnel in each state to discuss its annual report and Buy-In program. The discussions were designed to clarify the reasons behind changes in the state's reports from 2002 to 2003 and, where possible, to identify the reasons behind differences among states. Personnel from each of the 22 states were contacted based on their expertise in two areas: (1) knowledge and understanding of the data collection and data reporting processes in that state and (2) overall familiarity with the Buy-In program's policies and its relationship to Medicaid and other programs in the state targeted to individuals with disabilities.

(*continued*)
these states are not included in this report. Wyoming had both a Buy-In program and a MIG, but had too few participants to be included in our study—only 4 at the end of 2003.

[3]Appendix D contains the raw data that states submitted in their annual reports from 2002 and 2003.

[4]New York did not implement its Buy-In program until 2003 and, thus, did not submit a report on 2002 data.

Prior to contacting state Buy-In personnel, we developed a profile of each state's Buy-In program based on previous reports and studies, state-specific evaluations, and the quarterly reports that each state submits to CMS. Following each discussion, we revised the program descriptions and sent them to each state for review. Appendix A contains a description of each of the 22 state Buy-In programs, all of which have been reviewed by the relevant state personnel.

2. Data Quality

Overall, state annual report data appear to be reliable and their quality improved from 2002 to 2003. More states were able to complete all annual report data elements during the latest round of data collection than during the previous year. During the telephone discussions, staff in several states indicated that data previously reported for 2002 were not accurate. Many of these states submitted revised 2002 data, which are reflected in this report.

At least two factors contributed to the higher quality data reported for 2003. First, each state had one more year to become familiar with and refine their data collection and data reporting processes. The similarity of the data collection methods from 2002 to 2003 facilitated states' efforts to complete their annual reports. Second, some states indicated that they had invested significant resources from their MIG into upgrading their data systems, and, as a result, substantially improved their ability to obtain and report accurate data on Buy-In participation.

Despite these improvements, the reliability of the annual report data still varies somewhat among states, and certain data elements seem to be less reliable than others. For instance, some states had trouble reporting the SSDI status of program participants because this variable is often not included in states' Medicaid Management Information System (MMIS). Under these circumstances, states had to supplement the information using other data systems. One indicator of the problem in reporting SSDI status is a comparison between the percentage of program participants receiving SSDI benefits at enrollment and the percentage of program participants dually eligible for Medicaid and Medicare. After two years of enrollment in the SSDI program, beneficiaries automatically receive Medicare coverage, and, therefore, the percentages of Buy-In participants reported to be in Medicare and reported to be receiving SSDI benefits should be similar. However, for some states, this is not the case for either 2002 or 2003, and 14 states reported a higher percentage of Medicare beneficiaries than SSDI beneficiaries. These states may have problems obtaining accurate information on SSDI.[5]

[5]Among Buy-In participants, the number of SSDI beneficiaries should exceed the number of Medicare beneficiaries by approximately the number of SSDI beneficiaries in the waiting period for Medicare. However, as allowed under the Balanced Budget Act of 1997 but not the Ticket Act, states may allow elderly participants age 65 or older to be enrolled in the Buy-In program. These Medicare beneficiaries may not receive SSDI benefits but do receive retirement benefits. In addition, a Buy-In participant with Medicare coverage who

Another area in which we are aware of shortcomings is earnings data. CMS recommends that states obtain earnings data from state unemployment insurance (UI) systems. UI systems rely on data provided by employers, who are required in all states to report quarterly data on employment and wages to state Employment Security Agencies. Employers that submit these data include private firms, state colleges, universities, hospitals, and state and local governments. According to the Bureau of Labor Statistics (BLS), in 2001, the UI system (including the associated Unemployment Compensation for Federal Employees) covered 99.7 percent of wage and salary civilian employment and about 94.8 percent of the wage and salary component of personal income (BLS 2004). However, coverage for any specific state can be less, depending on the composition of its workforce.

Although the UI system includes data for most working individuals and nearly all individuals who are competitively employed, it excludes several notable groups, thereby affecting the completeness of the earnings data reported here. These excluded groups include self-employed workers, most agricultural workers on small farms, all members of the Armed Forces, elected officials in most states, most employees of railroads, some domestic workers, most student workers at schools, employees of certain small nonprofit organizations, and persons working in sheltered workshops or in vocational rehabilitation programs. States also do not generally have access to data on earnings for workers employed outside of the state. Finally, states do not have access to earnings for individuals who are paid in cash for jobs such as babysitting, participating on consumer advisory panels, and other similar types of activities. Despite these exclusions, the UI system captures most individuals' earnings. Among those Buy-In states that were able to report self-employment earnings in 2003, only 9.5 percent of all Buy-In participants had income from self-employment (see Table D.11).

The UI system is useful for presenting a national picture of total earnings; however, examining state UI data inherently understates *aggregate* earnings for a group, because, for example, some individuals may work out of state. Groups excluded from the UI system appear to cause UI estimates to overstate *average* earnings for the Buy-In population overall because many of those omitted tend to have low earnings from less competitive employment.

The UI system does have some advantages relative to other sources of earnings data. All states can readily access UI data, and the data reports are fairly timely and available on a quarterly basis. The consistency of UI data across states also facilitates state-level comparisons. Comparing earnings data based on other state files is problematic because methodologies to count earnings and exclusions vary from state to state.

(*continued*)
earns above the substantial gainful activity (SGA) level, as defined by the Social Security Administration (SSA) ($800 per month in 2003), may lose SSDI benefits. Therefore, it is possible in some states' Buy-In programs for the number of Medicare beneficiaries to exceed the number of SSDI beneficiaries.

CHAPTER II

BACKGROUND

A. AUTHORIZING LEGISLATION

The Medicaid Buy-In program was established to expand the availability of Medicaid coverage to workers with disabilities and to support their efforts to earn substantial incomes as a pathway toward recovery and economic self-sufficiency. States can add a Buy-In program to their Medicaid program by creating a new eligibility group as authorized under either of two federal laws. The first law, passed as part of the Balanced Budget Act of 1997 (BBA) (P.L. 105-33, 111 Stat. 251), allows states to provide Medicaid coverage to workers with disabilities who cannot qualify for Medicaid because their income or assets are too high. Under the BBA, persons with disabilities are eligible for the Medicaid Buy-In program if they pass a two-step eligibility process. First, individuals must have a net family income less than 250 percent of the federal poverty line, after the appropriate Supplemental Security Income, or SSI, income disregards are applied (GAO 2003).[1] Second, an individual's countable unearned income must be less than the SSI benefit ($552 per month for an individual in 2003) (CMS 1998).

The second law, the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. No. 106-170, 113 Stat.1860, also known as the Ticket Act or the TWWIIA), permits states to establish their own income and resource standards, including the possibility of having no income limits (GAO 2003). The Ticket Act also adds a new eligibility group termed the Medical Improvement Group. Individuals who qualify for the Buy-In program under this eligibility category must have a medical condition that has improved to the point where the Social Security Administration (SSA) determines that he or she is no longer

[1]The BBA requires states to apply SSI income disregards when determining Buy-In eligibility, but states are allowed to institute additional income disregards (e.g., income for home repair) (GAO 2003). States also are allowed to determine how a "family" is defined. For example, some states choose to include spousal income when calculating family net income, and other states do not. In addition, the ability of states to use methodologies other than that used for SSI recipients to determine countable income gives states added flexibility with regard to the income threshold (GAO 2003).

disabled under the SSA definition for disability.[2] Although some states have established the provisions for a Medical Improvement eligibility group, no state had used this category to enroll an individual in the Buy-In program as of the end of 2003.[3]

Eligibility for the Buy-In program is contingent upon earned income from work, but beyond this requirement, neither the BBA nor the Ticket Act establishes a minimum standard for the number of hours to be worked during a period of time or a minimum level of earnings needed to qualify for the Medicaid Buy-In program, and states are not allowed to do so.[4] The Buy-In program in one state (Massachusetts), however, differs from other Buy-In programs in various ways, the most salient of which is its definition of work—Buy-In participants in Massachusetts are required to work at least 40 hours per month. Massachusetts was able to require a minimum work effort because the program was implemented under an 1115 Medicaid demonstration waiver in 1997 and thus was not required to follow the guidelines of either the BBA or the Ticket Act.[5]

As of December 2003, a total of 27 states had a Medicaid Buy-In program. Eight states implemented a Buy-In program by the end of 1999, and that number more than tripled by December 2002, bringing the total number of Buy-In programs to 25. In 2003, two more states (Arizona and New York) initiated Buy-In programs, and four states had done so as of October 2004 (Louisiana, Michigan, North Dakota, and West Virginia) bringing the total number of programs to 31. Two additional states (Nevada and Rhode Island) have enacted Buy-In legislation but had not implemented programs as of October 2004.

As noted in Chapter I, for this report we focus on the 22 states that had both a Medicaid Buy-In program and a MIG in 2003. Table II.1 shows the legislative authority and date of first enrollment for each of these programs. Ten states implemented their Buy-In programs under the authority of the BBA and 12 implemented them under the authority of the Ticket Act. States have designed their Medicaid Buy-In programs in fundamentally different ways, selecting different asset and income standards and different methods for

[2]For more information see http://www.cms.hhs.gov/twwiia/eligible.asp

[3]Connecticut enrolled two individuals in the Medical Improvement Group in 2004. As of December 2003, the following states have Buy-In programs that include Medical Improvement Groups: Arizona, Connecticut, Indiana, Missouri, New York, Pennsylvania, and Washington.

[4]The Ticket Act allows states to define work for individuals in the Medical Improvement Group. States can either adopt the definition of work provided in the legislation (i.e., a minimum of 40 hours per month) or use their own definition.

[5]Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services authority to waive aspects of the federal Medicaid law to permit states to undertake special research and demonstration projects.

Table II.1: Buy-In Program Characteristics, 22 States

State	Federal Authority	Date of 1st Enrollment
Alaska	BBA 1997	July 1999
California	BBA 1997	April 2000
Connecticut	Ticket Act Basic and Medical Improvement	October 2000
Illinois	Ticket Act Basic	February 2002
Indiana	Ticket Act Basic	July 2002
Iowa	BBA 1997	March 2000
Kansas	Ticket Act Basic	July 2002
Maine	BBA 1997	August 1999
Massachusetts	1115 Demonstration Waiver	June 1997
Minnesota	Ticket Act Basic	July 1999
Missouri	Ticket Act Basic	July 2002
Nebraska	BBA 1997	July 1999
New Hampshire	Ticket Act Basic	February 2002
New Jersey	Ticket Act Basic	February 2001
New Mexico	BBA 1997	January 2001
New York	Ticket Act Basic and Medical Improvement	July 2003
Oregon	BBA 1997	February 1999
Pennsylvania	Ticket Act Basic and Medical Improvement	January 2002
Utah	BBA 1997	July 2001
Vermont	BBA 1997	January 2000
Washington	Ticket Act Basic and Medical Improvement	January 2002
Wisconsin	BBA 1997	March 2000

SOURCE: Quarterly reports submitted to CMS.

NOTE: BBA is the Balanced Budget Act of 1997. Ticket Act is the Ticket to Work and Work Incentive Improvement Act. Although Wyoming has had a Medicaid Buy-In program since 2002 and also has a Medicaid Infrastructure Grant, we do not include it in this report because it had only 4 enrollees as of December 2003.

setting Buy-In premiums.[6] Chapter III describes some key dimensions along which state Buy-In programs vary.

B. MEANS OF OBTAINING MEDICAID

In addition to a Medicaid Buy-In program, states offer several means for working persons with disabilities who are living in the community to qualify for Medicaid. These additional means of obtaining Medicaid include (1) SSI benefits;[7] (2) the 1619(b) provision of the Social Security Act, which provides Medicaid coverage to SSI recipients whose income has increased above the cash benefit level for SSI; (3) the medically needy or spend-down program, which provides Medicaid coverage to individuals with high medical expenses relative to their income but whose incomes are too high to qualify them for other means of obtaining Medicaid; and (4) other means of obtaining Medicaid, both mandatory and optional. Table II.2 summarizes some of the various eligibility categories for obtaining Medicaid.

In most states, people who receive cash assistance under the SSI program (including state SSI supplements) automatically qualify for Medicaid benefits. SSI helps individuals with disabilities who have little or no income, few assets, and an insufficient work history to qualify for SSDI by providing cash to meet basic needs for food, clothing, and shelter.[8] Participants who previously received SSI benefits but are now ineligible due to increased earnings, tend to qualify for the Buy-In program because their income or assets exceed the limits set by the SSI program and the 1619(b) provision. Eleven states have selected the 209(b) option that allows states to use more restrictive criteria for disability determination and/or income and asset eligibility than the federal SSI program (GAO 2003).[9]

Under the 1619(b) provision, states are required to provide Medicaid coverage to "qualified severely impaired individuals," defined as workers who remain disabled but whose earnings are insufficient to replace the SSI, Medicaid benefits, and other social services they

[6]See Folkemer et al. (2002) for case studies of selected Buy-In programs. See Jensen et al. (2002) for a discussion of program variations.

[7]When we refer to SSI benefits, we include the 1619(a) provision of the Social Security Act. See Table II.2 for more detail.

[8]It is possible for a person with disabilities to qualify for SSI and SSDI simultaneously if, for example, a person's assets were within the SSI limit and their SSDI benefit was sufficiently low such that (s)he continued to have income below the SSI threshold.

[9]The 11 states that have chosen the 209(b) option are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

Table II.2: Summary of Means of Obtaining Medicaid Eligibility

Category of Coverage	Summary of Eligibility Criteria
Mandatory Coverage	
SSI recipients	In 39 states and the District of Columbia, SSI recipients are automatically eligible for Medicaid.[a]
209(b) category	State establishes a definition of disability and income and asset standards.[b]
SSI "1619(b) provision"	Persons with disabilities who were receiving SSI cash benefits and continue to meet all SSI eligibility requirements, except for excess earnings, and whose income is insufficient to replace SSI, Medicaid benefits, and other social services they would have received in the absence of their earnings.
Spend-down program	"209(b)" states are required to allow persons with disabilities to "spend down" to Medicaid eligibility by deducting incurred medical expenses from income.
Welfare and poverty provisions	Pregnant women and low-income families with children who satisfy state-specific financial eligibility requirements.
Coverage for certain Medicare beneficiaries	States are required to extend limited Medicaid benefits (i.e., paying part or all of a person's cost-sharing obligation to Medicare) to low-income individuals who also qualify for Medicare.[c]
Optional Coverage[d]	
Medicaid Buy-In	Working persons with disabilities with income and asset eligibility criteria set by the state.
Medically needy	Individuals whose income either falls below a state-specified threshold or have sufficient medical expenses that allow them to "spend down" to the state-specific income threshold. Assets also must be within the state-specific limit for the medically needy program.
Poverty-level coverage	Persons with disabilities with income above that required for mandatory coverage but below the federal poverty line.
State supplementary payments recipients	Persons with disabilities receiving state supplementary payments to the federal SSI benefit but not SSI cash benefits.

[a]The 1619(a) provision of the Social Security Act allows SSI recipients to continue receiving cash benefits at a reduced level when their countable income exceeds the substantial gainful activity (SGA) level ($800 in 2003) until earnings are sufficient to completely replace cash benefits. Medicaid eligibility continues until SSI cash benefits cease.

[b]States may set their own Medicaid eligibility criteria and definition of disability for individuals with disabilities as long as these criteria are not more restrictive than those in effect as of January 1, 1972—these states are often called "209(b)" states. The following states included in this study have opted to use 209(b) provisions: Connecticut, Illinois, Indiana, Minnesota, Missouri, and New Hampshire.

[c]States are required to cover these groups with limited benefits but may opt to provide full benefits. These groups include: (1) a Qualified Medicare Beneficiary (QMB), for whom Medicaid will pay all of Medicare Part A and Part B expenses if the individual has income equal to or less than 100 percent of the FPL and assets less than $4,000 ($6,000 for a couple); (2) a Specified Low-Income Beneficiary (SLMB), for whom Medicaid will pay the Medicare Part B premium if the individual has income between 100 and 120 percent of the FPL and assets less than $4,000 ($6,000 for a couple); (3) a Qualifying Individual 1 (QI1), for whom Medicaid will pay the Medicare Part B premium if the individual has income between 120 and 135 percent of the FPL and assets less than $4,000 ($6,000 for a couple); (4) a Qualifying Individual 2 (QI2), for whom Medicaid will pay part of the Medicare Part B premium if the individual has income between 135 and 175 percent of the FPL and assets less than $4,000 ($6,000 for a couple); and (5) a Qualified Disabled and Working Individual (QDWI), for whom Medicaid will cover a portion of the Medicare Part A premium if the individual has income less than 200 percent of the FPL and assets less than $4,000 ($6,000 for a couple) (Schneider et al. 2002).

[d]In addition to the optional groups below, states may choose to provide coverage to low-income individuals with tuberculosis or who are uninsured and have been determined to need treatment for breast or cervical cancer.

would have received in the absence of their earnings (Social Security Administration 2004).[10] Each state has its own 1619(b) income threshold, but someone whose income exceeds this threshold may request that an individual threshold be calculated to take into accounts his or her unique circumstances.

The 1619(b) provision and the Medicaid Buy-In program have similar objectives in that they both promote work by allowing persons with disabilities to maintain health coverage as their earnings increase. In at least two ways, however, Buy-In programs can help states reach their policy goal of promoting employment for adults with disabilities more effectively than the 1619(b) provision. First, the 1619(b) provision does not provide coverage for those who have not received SSI benefits in the past, whereas an individual can be eligible for the Buy-In program regardless of past SSI status. Second, Buy-In programs typically have considerably higher income thresholds (Goodman and Livermore 2004) and asset limits than the 1619(b) provision and therefore are more likely to attract a larger number of workers with disabilities.

However, Medicaid eligibility through the 1619(b) provision would be preferable to the Buy-In program for some individuals. First, Buy-In programs typically charge a premium for Medicaid coverage, but the 1619(b) provision has no cost-sharing requirements. Thus, some individuals may be better off keeping their earnings low enough to qualify for the 1619(b) provision if an anticipated earnings increase would not offset premium payments for the Buy-In program. Second, all states are required to provide Medicaid eligibility through the 1619(b) provision, thus making this means of obtaining Medicaid more portable across states than coverage through Buy-In programs, which are not offered in all states and differ in eligibility criteria from state to state.[11]

Medically needy programs provide a third means of obtaining Medicaid coverage. States have the option to establish medically needy programs that extend Medicaid eligibility to persons with disabilities whose income or assets are too high for them to qualify for the SSI program. Under medically needy programs, medical expenses for persons with disabilities must be deducted from their income to determine eligibility (the so-called "spend-down" process). The person's income (minus incurred medical expenses) and assets must be at or below the medically needy income and asset levels set by the state. State medically needy programs have income and asset levels that usually differ from those used for SSI. Medically needy programs generally provide a disincentive for earnings because all income above the medically needy income limit is subject to the spend-down provisions. Thus, the more a person earns, the more he or she has to spend down to qualify for Medicaid.

[10]For more information about the 1619(b) provision and other SSI work incentives see http://www.ssa.gov/work/ResourcesToolkit/redbook_page.html.

[11]The income threshold for Medicaid eligibility through 1619(b) also differs across states, but state-specific differences among Buy-In programs are more substantial. Chapter III provides a more detailed discussion of the dimensions along which Buy-In programs vary.

In 2003, 36 states including the District of Columbia had medically needy programs that covered individuals with disabilities (CMS 2004). In addition, the 11 states that can use more restrictive rules to determine the eligibility of SSI recipients (the so-called 209(b) states) are required to allow all categorically disabled recipients to spend down their income to Medicaid eligibility levels.[12] In these states, SSI recipients would be ineligible for Medicaid coverage if they do not meet the state's 209(b) definition of disability, if their assets exceed the state's asset requirements, or if their income exceeds the 209(b) income threshold after applying the spend-down provisions.

The medically needy program is an important option for Medicaid eligibility because the income of many beneficiaries with SSDI prevents them from qualifying for SSI benefits or Medicaid coverage. By choosing to provide medically needy coverage, a state makes Medicaid available to persons with disabilities regardless of their income level, assuming that they satisfy the applicable spend-down and asset requirements. For persons with disabilities in a state's medically needy program, the Buy-In program may be a more attractive Medicaid eligibility category because the Buy-In (1) may provide more stable and consistent coverage given that it typically depends on paying a predictable monthly premium rather than having to spend down each month to qualify for Medicaid; (2) lowers out-of-pocket costs for a person if the monthly premium for the Buy-In is lower than the spend-down amount; and (3) allows participants to avoid the onerous process of documenting spend-down expenditures.

Finally, persons with disabilities may qualify for Medicaid through other optional and mandatory eligibility groups. For example, some states opt to provide Medicaid coverage for persons with disabilities who have income at or below the federal poverty line, and some may qualify through the welfare and poverty provisions providing coverage to low-income pregnant women and families.

The advantage that the Medicaid Buy-In program offers over other means for working persons with disabilities to obtain Medicaid eligibility is that it generally allows individuals to (1) have higher earnings, more assets, or both and (2) retain more of their earnings and assets. Overall, the Medicaid Buy-In program was designed to be an attractive option for certain groups of workers with disabilities, including:

- SSDI/Medicare beneficiaries who have to spend down to qualify for Medicaid
- SSDI beneficiaries in the waiting period for Medicare
- SSI beneficiaries who work at a level where their income and resources exceed 1619(b) limits

[12] 209(b) states that choose to have a medically needy program are not required to have a spend-down program.

- Individuals not receiving Medicaid or SSI but who meet the SSA disability definition except that their income or resources exceed designated limits to qualify for those benefits

The various means of obtaining Medicaid coverage can be confusing to individuals with disabilities and state intake workers. At times, there are rather obscure tradeoffs, making it better to qualify through one way than another. For example, persons with disabilities could find themselves having to choose among (1) spending down to become eligible for Medicaid through the medically needy program; (2) keeping earnings below the 1619(b) income threshold to maintain Medicaid eligibility without having to pay a premium; or (3) enrolling in the Buy-In and paying a premium. The tradeoffs can be particularly difficult to understand for persons with disabilities who are working and want to earn more but are hesitant to do so for fear of jeopardizing their health care coverage. Moreover, some states have their own programs providing health coverage (e.g., Pennsylvania's adultBasic program) for which persons with disabilities may qualify, further complicating the decision of which coverage is most appropriate.

CHAPTER III

HOW PROGRAMMATIC FEATURES SHAPE BUY-IN PARTICIPATION

States can exercise considerable control over the characteristics, enrollment patterns, and cost of a Medicaid Buy-In program through the programmatic features that they adopt. States make a series of complex decisions during the design and development of a Buy-In program to tailor the program to their unique environment and to influence the size and composition of program enrollment. These program features do not operate in isolation. Instead, interactions among factors occur in subtle, often complex ways that shape Buy-In participation. It is therefore difficult to ascribe participation patterns to any one factor. 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.

The most important programmatic features that affect Buy-In participation include: (1) income and asset criteria, (2) cost-sharing requirements, (3) work-related policies and protections, and (4) outreach and targeting. One state's program may differ markedly from another's along any or all of these dimensions. While we would like to make hypotheses about the relative importance of these factors on participation, the necessary data to do so are not currently available. In this chapter, we describe these four features and the relationship each of them may have with participation. We then provide detail about these relationships in subsequent chapters based on empirical evidence from the states' annual reports and discussions with Buy-In personnel.

A. INCOME AND ASSET ELIGIBILITY CRITERIA

Eligibility criteria for the Buy-In program help states target certain groups of individuals, and states can tweak these criteria to facilitate or inhibit enrollment of potential Buy-In participants. State Buy-In programs authorized under the BBA limit eligibility to individuals with net family income less than 250 percent of the federal poverty level (FPL), whereas the Ticket Act does not stipulate an income eligibility ceiling. Nevertheless, states authorized under either act have considerable flexibility in determining income and asset eligibility requirements, especially through (1) the treatment of earned and unearned income, (2) selection of an income counting methodology, and (3) the treatment of family income.

One important tool that states have for controlling which groups are eligible for the Buy-In program is the treatment of earned income (i.e., income through work) and unearned

income (i.e., income gained through public assistance programs, such as SSI and SSDI). A Buy-In program with a separate unearned income requirement can restrict the number of new Buy-In participants who are already enrolled in other assistance programs, especially the SSDI program. For example, a state can set a low ceiling on unearned income for the Buy-In program and thereby exclude many SSDI beneficiaries, as well as Temporary Assistance for Needy Families (TANF) recipients and food stamp participants. Six of the 22 states studied in this report have adopted a separate limit for unearned income.[1]

Selection of an income counting methodology is another instrument that states can use to influence the number and characteristics of individuals who are eligible for their Buy-In program.[2] Most states use the SSI counting methodology, which calculates countable income as unearned income minus $20 plus one-half of all earned income above $65. This formula restricts the enrollment of individuals who have high unearned income—primarily SSDI beneficiaries—because it essentially gives unearned income twice the weight of earned income. Four states disregard at least a portion of unearned income from the calculation in order to prevent individuals with high unearned income, namely SSDI beneficiaries, from being excluded from the state's Buy-In program.[3]

States can opt to include or exclude spousal income as countable income. In general, the inclusion of spousal income makes it harder to qualify; however, inclusion of spousal income may help individuals in some states meet an eligibility requirement that program participants have at least some earnings. Fourteen of the 22 states count at least a portion of spousal income as part of the income eligibility test, and 8 states do not.[4]

One of the Buy-In program's most attractive features to persons with disabilities is that it often allows participants to accumulate assets or resources beyond the level allowed under SSI and traditional Medicaid, two programs which, in many states, limit an individual's allowable assets to less than $2,000 plus some exclusions.[5] By increasing the asset limit, the Buy-In program allows a participant to keep more resources without losing Medicaid

[1]These six states are Alaska, Maine, Nebraska, New Jersey, New Mexico, and Vermont.

[2] States that use the SSI counting methodology are required to set a net income limit, that is, a limit on income after SSI deductions have been taken out (letter from Sally Richardson at CMS to state Medicaid directors, March 9, 1998).

[3]California, New Jersey, and Oregon disregard at least a portion of unearned income when determining eligibility. Nebraska disregards unearned income completely for SSDI beneficiaries in a trial work period (see Appendix A for more details).

[4]Massachusetts and Minnesota have no income test, so spousal income is irrelevant. In Minnesota, parental income would be deemed for the eligibility of Buy-In participants who are 16 or 17 years old.

[5]The SSI asset test excludes the recipient's home, car, household goods, burial plots, term life insurance, and income considered part of a Plan for Achieving Self Support (PASS) (Goodman and Livermore 2004).

coverage or without having to reduce assets below a specified limit (usually $2,000 for an individual). States can affect the size of the pool of individuals eligible for the Buy-In program by raising or lowering the asset limit. Several states also permit individuals to accumulate resources in state-sponsored accounts for medical savings, employment, or independence without losing eligibility for the Buy-In program. States vary in the parameters and requirements of these accounts.

B. COST-SHARING STRUCTURE

States vary widely in how they structure cost sharing for Buy-In participants. According to federal legislation, states can charge a fee (i.e., premium, coinsurance, co-payment) to Buy-In participants. Nearly all states have set a premium structure along a sliding scale based on income. Designing a premium structure can be one of the most effective tools for a state to influence enrollment trends. Decisions about who pays a premium, how much each participant pays, and how premiums are graded across different income brackets all shape enrollment patterns. Three features of the premium structure are particularly salient: (1) the income level above which all participants pay a premium, (2) the size of the premium payment, and (3) the treatment of earned and unearned income for premium calculations.

States set an income threshold above which all participants pay a premium. Under a high income threshold, participants usually are less likely to pay a premium than under a lower threshold. Individuals eligible for the Buy-In program in a given state who are ineligible for other means of obtaining Medicaid coverage and have income below the income threshold for premiums should have extra incentive to enroll in the program because they would not have to pay a premium to obtain Medicaid coverage. In a few states, all program participants pay a premium, which may act as a disincentive for people with low income who are otherwise ineligible for Medicaid coverage.

The size of premiums may encourage or discourage individuals to enroll in the Buy-In program. A Buy-In participant with a high premium shoulders a larger financial burden to remain in the program and may be more likely to disenroll. High premiums also increase a state's total revenue from the program. If the budget climate for Medicaid continues to erode, some states may increase Buy-In premiums to boost revenue (and discourage enrollment). Some states are instituting a mandatory one-time entry fee for participants who enroll in the program in lieu of or in addition to a premium payment. These fees may increase revenue generated from the program, especially if the state can avoid the costs of premium collection. Similar to setting rules for income eligibility, a state Buy-In program may implement a separate premium for unearned income (e.g., SSDI benefits) in addition to a premium for earned income, which levies a disproportionately large fee on individuals with unearned income.

C. WORK-RELATED POLICIES AND PROTECTIONS

Many participants in the Buy-In program have not had steady employment during the period immediately prior to enrollment in the Buy-In program because either they feared that increased earnings would cause them to lose cash benefits and health insurance or a

disability prevented them from working. By dissociating Medicaid and disability benefits (i.e., not tying eligibility for Medicaid to cash assistance), the Buy-In program is designed to promote employment. However, some Buy-In participants have trouble maintaining employment because of health issues that arise, the extensive adjustments they may require to maintain employment, or difficulty finding jobs that can accommodate their disability.

To help prevent interruptions in coverage among Buy-In participants, some states offer protections for program participants who either lose a job or cannot work for a period of time due to health problems. The grace period varies by state, both in respect to duration and the criteria for receiving protection. In some states, a participant must be actively seeking employment in order to stay in the program, while other states automatically allow an unemployed participant to remain in the program for a set period of time. A person with disabilities who becomes unable to work would benefit from a grace period if disenrolling from the Buy-In program would result in higher out-of-pocket costs for health coverage if, for example, (1) an individual with high unearned income had to spend down to the medically needy income level; or (2) he or she lost Medicaid coverage and had to purchase health coverage in the private market or do without it altogether. However, it is also possible that being transferred from the Buy-In program to another Medicaid eligibility category (e.g., the medically needy program) could lower out-of-pocket costs.

State Buy-In programs cannot require a minimum number of hours that a person works in order to participate in the Buy-In program. Moreover, states cannot define what constitutes work. These constraints have frustrated program staff in some states who want to limit participation to competitively employed individuals, a policy that they see as consistent with the intent of the federal legislation. Some states have begun to consider policies that ensure program participants work more. For example, Minnesota introduced a policy in 2003 that disregards the first $65 of a participant's monthly earned income.[6] Therefore, if a person does not have monthly earnings above $65, then the person is deemed ineligible for the program. In practice, this policy acts as a work requirement. In another instance, Oregon instituted an "Attachment to the Workforce" policy in May 2003, which specifies that an individual must earn at least $900 per quarter in order to remain eligible for the state's Buy-In program. Oregon personnel view this policy more as an eligibility criterion that promotes workforce participation than a definition of work.

Buy-In programs typically require workers to document their employment status. Some states ask program participants or their employers to submit certain employment verification, such as pay stubs. Other states specify that countable earnings have to be subject to federal income taxes, thereby attempting to make ineligible those individuals solely involved in casual employment.

[6]All Medicaid enrollees in Minnesota are subject to this disregard, which the state terms "Method B" budgeting. Prior to 2003, the state's Buy-In program was exempt from this policy.

Many states offer personal assistance services to Buy-In participants.[7] These supports assist persons with disabilities, in particular those with physical disabilities, to maintain employment in situations where work otherwise would not be possible. Decisions around which services and how many services to cover can have important implications for program enrollment. For example, the Buy-In program in Kansas currently does not cover certain expenses for personal assistance services that might be particularly important to people with physical disabilities. Given that this program characteristic discourages enrollment of some persons with physical disabilities, it is not surprising that most current participants in Kansas' program have other types of disabilities, such as mental illness (Hall and Fox 2003).

D. OUTREACH AND TARGETING

During its implementation phase, state Buy-In programs have the difficult task of targeting and reaching out to eligible persons. Likewise, existing Buy-In programs that hope to attract new individuals are faced with the challenge of determining the most effective methods of outreach. The type and amount of outreach performed by a state's Medicaid office and disability community appears to relate directly to program enrollment. One-third to two-thirds of Buy-In participants first learn about the program from state eligibility workers (Goodman and Livermore 2004). Therefore, an outreach campaign that provides training and education about the Buy-In to eligibility workers should lead to greater awareness of the program and thus increased enrollment.[8] However, budgetary concerns may make states hesitant to conduct extensive outreach activities that could potentially increase enrollment and thus increase program costs.

A state's outreach and targeting has important implications for the composition of the state's Buy-In program. States may vary in their primary target population for the Buy-In program. For example, one state may try to attract SSDI beneficiaries by sending program information to all SSDI beneficiaries, and another state may target individuals without Medicaid coverage by promoting the Buy-In to employees of companies that do not offer employer-based health insurance. The result is that two states may end up with Buy-In populations that have different characteristics and needs.

[7]All states with a MIG are required to offer personal assistance services either through the state Medicaid plan or through a Medicaid waiver.

[8]See Goodman and Livermore (2004) for a discussion of the challenges associated with training eligibility workers and encouraging them to be effective program advocates.

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CHAPTER IV

IS THE BUY-IN PROGRAM GROWING?

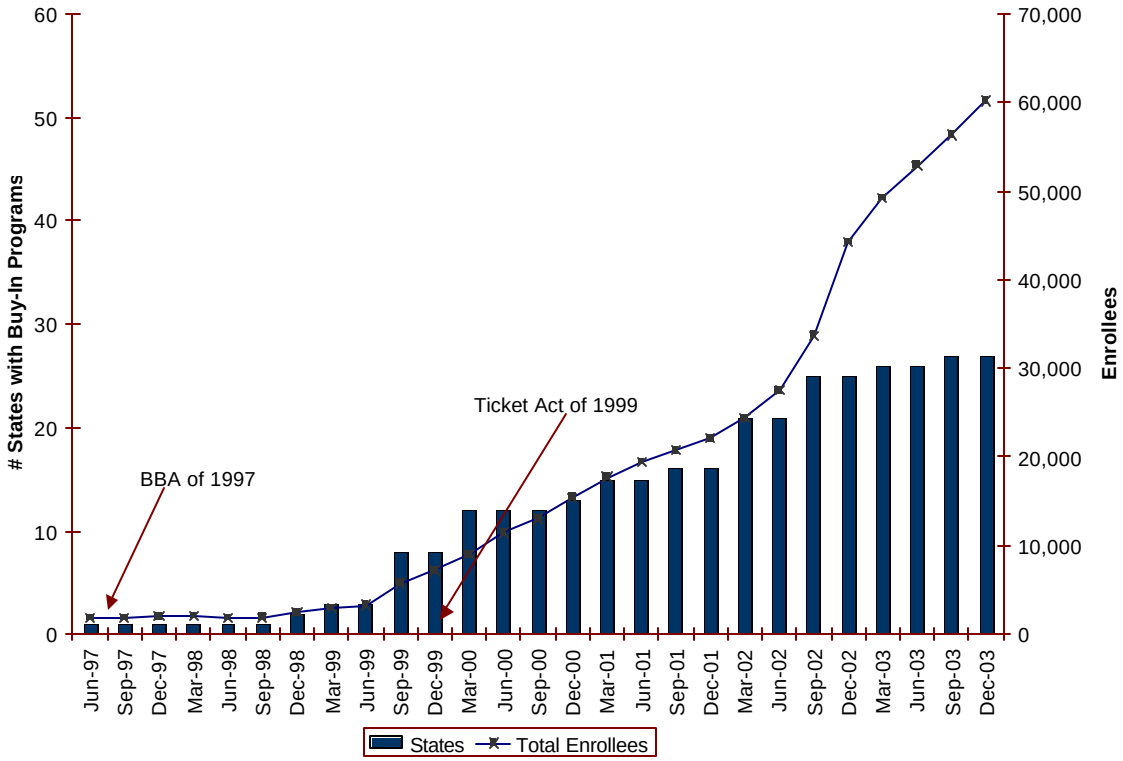
The number of participating states and enrollment levels in state Buy-In programs provide important preliminary indications of the extent to which the program is achieving its goal of supporting the employment of persons with disabilities. Underlying the national trend in Buy-In enrollment are myriad program-related factors that vary by state. This chapter begins by describing enrollment trends in the Buy-In program at the national level and then describes enrollment variation across states.

A. NATIONAL BUY-IN ENROLLMENT

A substantial increase in enrollment at the national level has coincided with the increase in the number of states with Buy-In programs. As noted in Chapter II, state participation in the Buy-In program has risen rapidly since the enactment of the Ticket legislation—8 states had programs in 1999, five years later 31 had programs. National enrollment increased steadily in 2000 and 2001, and the entry of eight states in 2002 and another two in 2003 caused enrollment to nearly triple from about 22,000 participants in December 2001 to approximately 60,000 in December 2003 (Figure IV.1). Over half of this increase can be attributed to three states that implemented new Buy-In programs in 2002—Indiana, Missouri, and Pennsylvania. Missouri alone accounted for over 15,000 participants.

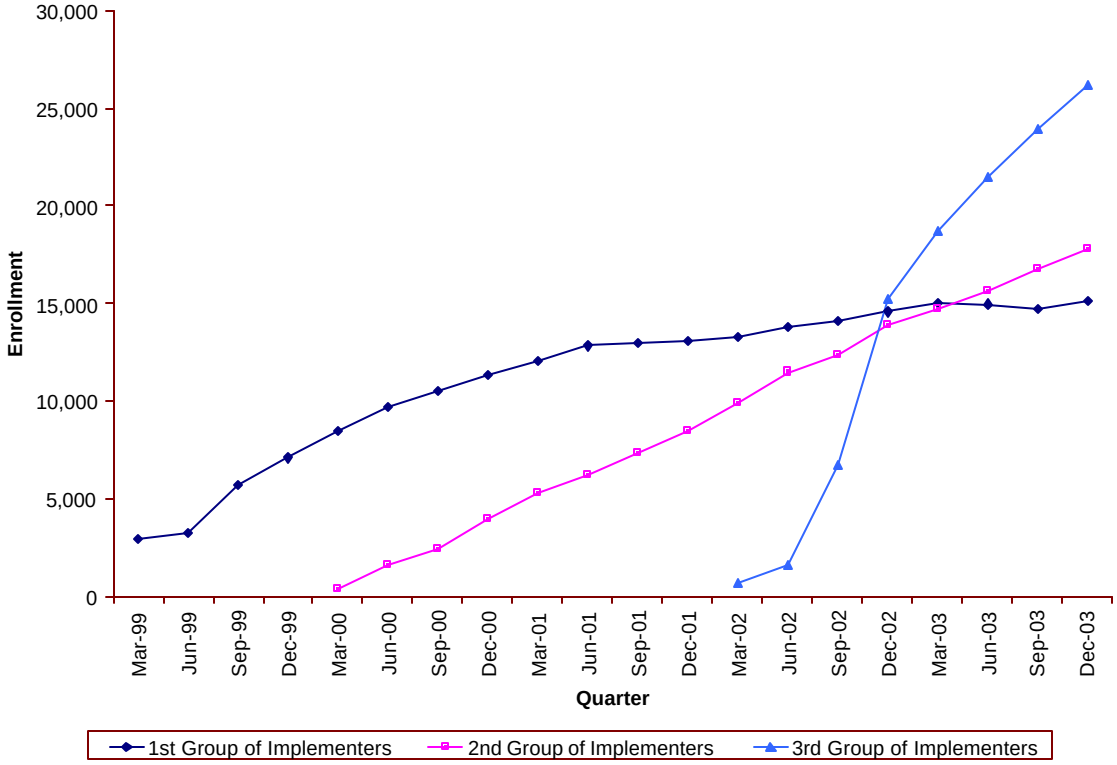
To illustrate the extent to which the recent increase in Buy-In enrollment is attributable to new versus more established Buy-In programs, we divided the 22 programs into three groups of roughly equal size based on their date of implementation (Figure IV.2). The first group of implementers includes Buy-In programs that began before January 2000; the second group includes programs implemented in 2000 or 2001; and the third group includes programs implemented after 2001. Figure IV.2 demonstrates that the most recently implemented Buy-In programs (i.e., the third group of implementers) had total enrollment of over 25,000 within two years of program implementation and accounted for the vast majority of the increase in national Buy-In enrollment. As noted above, the enrollment growth for the third group of implementers was concentrated in a small number of states—Indiana, Missouri, and Pennsylvania.

Figure IV.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 (Table D.4)

Figure IV.2: Total Number Enrolled in the Medicaid Buy-In Program, by Implementation Group and by Quarter, 1999-2003, 22 States



SOURCE: State quarterly progress reports (Table D.4).

NOTE: First group of implementers (implemented before January 2000): Alaska, Maine, Massachusetts, Minnesota, Nebraska, and Oregon.

Second group of implementers (implemented in 2000 or 2001): California, Connecticut, Iowa, New Jersey, New Mexico, Utah, Vermont, and Wisconsin.

Third group of implementers (implemented after December 2001): Illinois, Indiana, Kansas, Missouri, New Hampshire, New York, Pennsylvania, and Washington.

Enrollment among the second group of implementers since December 2001 has grown steadily while enrollment in the more established programs (i.e., the first group of implementers) grew more slowly during this time. Enrollment among the second group of implementers increased from about 8,500 in December 2001 to approximately 17,800 in December 2003. As with the third group, enrollment growth in the second group was concentrated in a small number of states—Iowa and Wisconsin, which constituted 69 percent of the total enrollment growth of the second group of implementers during this time period.

As shown in Figure IV.3, the states with the highest rate of enrollment growth between 2002 to 2003 tend to have been implemented after December 2001 (i.e., the third group of implementers defined above), and the states with the slowest growth tend to be implemented before January 2000 (i.e., the first group of implementers defined above). Of the eight states whose enrollment grew by more than a third between the end of 2002 and the end of 2003, six were in the third group of implementers. All five states that experienced the lowest rate of growth were in the first group of implementers. The trends described above suggest that more established Buy-In programs tend to grow more slowly than younger programs. However, a number of programmatic and contextual factors also may influence the enrollment growth of a state's Buy-In program.

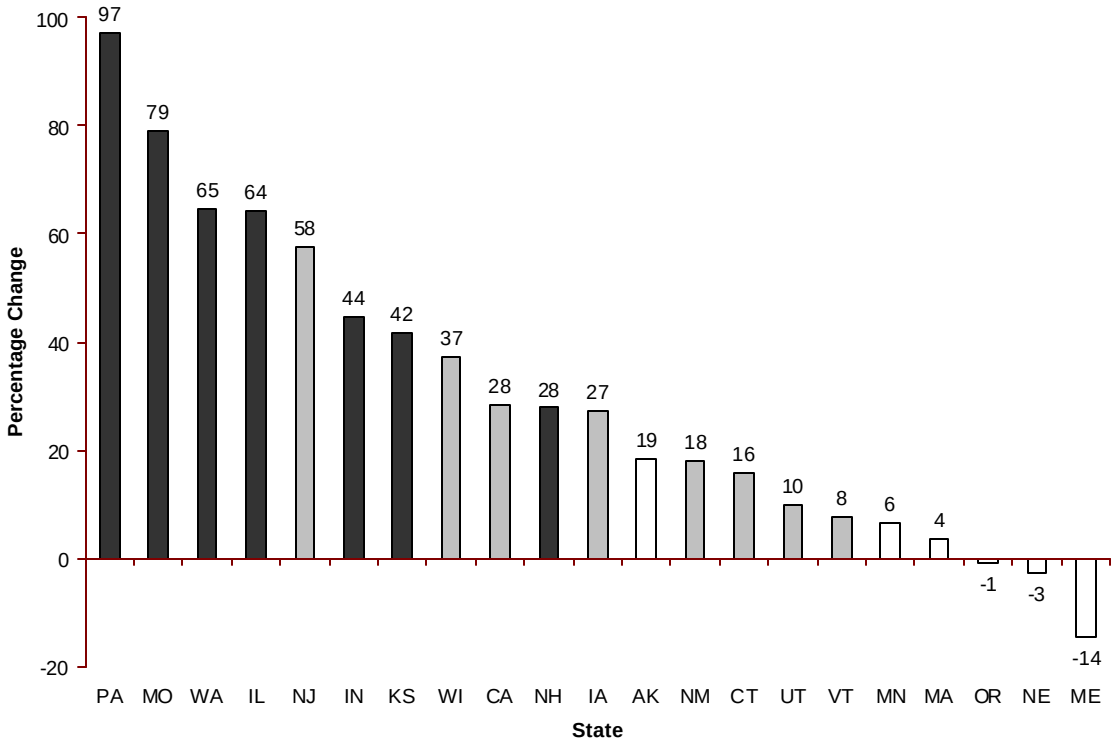
B. STATE-LEVEL BUY-IN ENROLLMENT

In December 2003, enrollment in state programs ranged from 111 individuals in Nebraska to 15,155 individuals in Missouri (Table IV.1). To account for differences in the size of each state, we also present Buy-In enrollment per 100,000 state residents age 18 to 64 (hereafter, enrollment per 100,000) in Table IV.1.[1] One might expect a program's duration to be related to its enrollment per 100,000, but the evidence in Table IV.1 does not support this finding. Some states that implemented programs early on (i.e., Alaska, Oregon, and Nebraska) have fewer than 50 participants per 100,000 residents; others that implemented programs more recently (i.e., Missouri, New Hampshire, and Indiana) have more than 130 participants per 100,000 residents.

As discussed below, several other factors, in addition to program duration, influence enrollment levels. These factors include operational features (such as income and asset limits), the presence of other public assistance programs, and the extent of outreach efforts.

[1]We also calculated Buy-In enrollment as a proportion of a state's population eligible for the program. Using this approach, we found that state rankings were similar to those shown in Table IV.1. Table D.5 in Appendix D contains these results as well as information on our methodology.

Figure IV.3: Percent Change in Buy-In Enrollment Between December 2002 and December 2003, 21 States



□ First Group of Implementers
▒ Second Group of Implementers
■ Third Group of Implementers

SOURCE: State data submitted to CMS in quarterly progress reports (Table D.4)

NOTE: State personnel in Maine noted that problems with their eligibility system may have resulted in inaccurate enrollment numbers.

Table IV.1: Buy-In Enrollment in December 2003 per 100,000 State Residents Age 18 to 64

State	Implementation Group[a]	Total Number Enrolled	Enrollment per 100,000 State Residents Age 18-64
Missouri[b]	3	15,155	428
Iowa	2	6,231	343
Minnesota	1	6,487	203
Massachusetts	1	7,213	176
Wisconsin	2	5,269	154
New Hampshire	3	1,237	150
Indiana[b]	3	5,186	135
Connecticut[b]	2	2,908	134
Vermont[b]	2	455	113
New Mexico[b]	2	943	82
Maine[b]	1	576	69
Alaska[b]	1	192	46
Kansas	3	672	40
Pennsylvania[b]	3	2,466	32
Oregon[c]	1	585	26
New Jersey	2	951	18
Utah[b]	2	198	14
Nebraska[b]	1	111	10
Illinois[b]	3	531	7
Washington	3	237	6
New York[b]	3	702	6
California[b]	2	859	4

SOURCE: State data submitted to CMS in quarterly progress reports (Table D.4), US Census Bureau (2005).

NOTE: Buy-In enrollment per 100,000 state residents age 18 to 64 is calculated based on US Census Bureau estimates for July 2003. State personnel in Maine noted that problems with their eligibility system may have resulted in inaccurate enrollment numbers.

[a] States in the first group of implementers began their program before January 2000, states in the second group of implementers began their program in 2000 or 2001, and states in the third group of implementers began their program after December 2001.

[b] Buy-In program has an asset limit of $10,000 or less.

[c] Prior to July 2003, Oregon's asset limit was $12,000 (not including spousal resources). Beginning July 2003, the asset limit was $5,000 (not including spousal resources).

1. Program Features

Two of the most important features that influence program enrollment are the income and asset levels that states establish to help determine an applicant's eligibility. Lower income and asset thresholds appear to contribute to lower enrollment. For example, four of the five states with the lowest enrollment per 100,000 (i.e., 10 per 100,000 residents or less) have asset limits of $10,000 or below (Table IV.1). Furthermore, two of these four states (Illinois and New York) with both low enrollment per 100,000 and asset limits of $10,000 or below take spousal assets into account, which effectively lowers the asset limit for these states further.[2] In contrast, of the five states with the highest enrollment per 100,000 (i.e., more than 150 per 100,000 residents), only one (Missouri) has an asset limit of $10,000 or below and none take spousal assets into account.[3] The other four states have asset limits of at least $12,000.

In addition, the three states with the highest income eligibility criteria (Connecticut, Massachusetts, and Minnesota) have more than 130 participants per 100,000 residents (Table IV.1).[4] Furthermore, a change in how states treat earned income may cause a corresponding change in enrollment. As noted in Chapter III, Oregon is one of three states (Minnesota and New Mexico are the others) that have instituted what are, in effect, minimum earned income requirements for participants. Oregon's establishment of this requirement in May 2003 may have contributed to its decrease in enrollment from 739 in March 2003 to 585 the following December, although other factors may have contributed as well (see Appendix A for more detail).

The presence of an unearned income limit restricts the pool of persons with disabilities who are eligible for the Buy-In program, and one would expect the presence of an unearned income limit to constrain enrollment.[5] Although the information in Table IV.1 does not provide evidence of a relationship between an unearned income limit and enrollment per

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[2]The other states that include spousal assets in their asset limit are Indiana, Kansas, Pennsylvania, and Utah. Oregon began including spousal assets in July 2003. See Table A.1 of Appendix A for additional state-level information about asset limits.

[3]As we describe later in this chapter, other factors may have bolstered Missouri's enrollment level, despite its having the lowest asset limit—$1,000 for an individual—among the 22 states in this report. In addition, Washington has relatively low enrollment (6 participants per 100,000 residents) despite the absence of an asset limit. These outliers highlight the fact that enrollment patterns result from the subtle and often complex interactions among multiple factors.

[4]Massachusetts and Minnesota do not limit earned income at all, and Connecticut has a gross individual income limit of $75,000 per year. None of these three states limit unearned income.

[5]The following six states limit unearned income when determining eligibility for the Buy-In program: Alaska, Maine, Nebraska, New Jersey, New Mexico, and Vermont.

100,000, personnel from some states suggested that such an association may exist. State officials in Maine commented that the state instituted an unearned income limit for its Buy-In program as a mechanism to limit enrollment, given that it was unable to set a minimum work requirement.[6] Similarly, state officials in Iowa and Missouri suggested that the absence of an unearned income requirement may have contributed to high Buy-In enrollment per 100,000.

Another program feature that may affect enrollment is the presence of a grace period. Participants' movement into and out of state Buy-In programs, also known as "churning," may be related to the presence or absence of a grace period, which provides temporary protection from the loss of Buy-In coverage. Theoretically, a grace period may limit re-enrollment by enabling participants to remain enrolled if they lose their job or cannot work due to an illness. Although we did not find compelling evidence of a relationship between grace periods and re-enrollment in the annual report data, personnel from some states with a grace period indicated that it may have limited re-enrollment in their state's program.[7] State staff also cited participants' delinquency in paying premiums as another major contributor to participants cycling on and off of the Buy-In program. An additional program feature—states' cost sharing structure—may also be associated with enrollment trends, and Chapter VII addresses this issue.

2. Program Context

The Buy-In program is a single, albeit important, component in what is usually a complex mosaic of programs to provide health coverage and other assistance to persons with disabilities. As a result, the larger context of medical assistance programs in each state has important implications for the number and type of persons with disabilities who enroll in the Buy-In program.

A high income threshold in other Medicaid eligibility categories (e.g., medically needy or categorical Medicaid eligibility) could constrain Buy-In enrollment because a narrower band of income levels qualify for coverage through the Buy-In program. For example, California's Buy-In enrollment per 100,000 is the lowest among the 22 states in this report (Table IV.1). State officials in California noted that one reason for its low enrollment per 100,000 is the state's high income thresholds for other Medicaid categories. For example, Medicaid covers adults with disabilities in California who have income below 133 percent of the FPL, which is higher than most other states with a Buy-In program.[8] In addition, two states—Missouri

[6]Buy-In participants in Maine are required to have monthly unearned income less than or equal to 100 percent of the FPL plus $75 ($823 per month in 2003).

[7]See Appendix D, Table D.3 for state-level information on re-enrollment among new Buy-In participants.

[8]Of the 22 states analyzed in this report, California is one of only 4 (Alaska, Maine, and Massachusetts are the others) that provide Medicaid, either categorically or through the medically needy group, to persons with disabilities above 100 percent of the FPL.

and Iowa—with the highest enrollment per 100,000 have restrictive Medicaid eligibility criteria relative to other states. Neither state (1) offers an alternative to the medically needy or spend down programs for persons with disabilities who have not been on SSI in the past or (2) extends Medicaid eligibility to SSI recipients with higher incomes through a state supplement to the federal SSI benefit.[9] However, the data do not indicate a strong association between enrollment per 100,000 and eligibility thresholds for other means of obtaining Medicaid eligibility, which underscores the fact that there are multiple factors that ultimately determine Buy-In enrollment per 100,000.

In some states with high enrollment per 100,000, large numbers of enrollees transferred into the Buy-In from other Medicaid eligibility groups such as the poverty-level or medically needy/spend down categories.[10] For instance, three states with relatively high enrollment per 100,000—Missouri, Minnesota, and Indiana—have large numbers of Buy-In participants who perform work in day training and habilitation facilities (sometimes called "sheltered workshops") and who transferred into the Buy-In program from traditional Medicaid. Financial factors also may have affected the transfer of persons with disabilities into Minnesota's Buy-In program from other Medicaid eligibility categories. The Buy-In premium was typically much less than the spend-down amount in Minnesota, which made spend-down enrollees eager to transfer into the Buy-In program.

Separation between the Buy-In program and the Medicaid administrative infrastructure may limit enrollment in some states. In Illinois, which has 7 participants per 100,000, the Buy-In program is separate from the traditional Medicaid program. Persons with disabilities undergo a separate application process in a separate location, which does not allow for a direct or automatic transfer into the Buy-In program. Potential enrollees must be aware of the Buy-In program and independently initiate the application, a process that may create some barriers to enrollment. Buy-In officials in Illinois noted that the separation between the Buy-In and Medicaid programs resulted directly from the disability community's desire to promote the image of the Buy-In as a work incentive program. Washington's Buy-In program, which has 6 participants per 100,000, is similar to the Illinois program. Applicants in Illinois are required to apply for the program at a single, centralized location rather than at any Medicaid office, which also may contribute to its lower than expected enrollment.

3. Outreach

As noted in Chapter III, each state's level of outreach may contribute to both the Buy-In program's enrollment level and growth rate. For example, in Missouri, which has the highest Buy-In program enrollment per 100,000, state officials noted that vigorous outreach efforts by advocate groups contributed greatly to the initial growth of the program. In this

[9]See Table A.1 in Appendix A for more information about eligibility criteria for the Buy-In program and other Medicaid eligibility categories.

[10]Chapter V provides more detail about the experience of Buy-In participants in Medicaid prior to Buy-In enrollment.

state, because of a delay in the appropriation of funds for the Buy-In program, about 1½ years lapsed between the time the Buy-In legislation was written and when the program was implemented. State officials commented that this delay gave advocates ample time to "beat the bushes," spreading the word about the program and encouraging individuals in the medically needy program to enroll in the Buy-In program. State officials in Minnesota also commented that its rapid initial enrollment growth was closely related to (1) the high level of outreach done by advocacy groups and the disability community as a whole; and (2) their county eligibility workers whose thorough knowledge of the Buy-In program made them effective at transferring persons with disabilities into the Buy-In program.

There also were states in which limited outreach may have constrained enrollment. In California, for example, state officials noted that getting the word out about new programs has been difficult given the size of the state and the range of health coverage possibilities available to persons with disabilities. They noted that outreach has thus far been limited, but they plan to step up their outreach activities to enlarge the program.

C. OTHER MEASURES OF BUY-IN ENROLLMENT

Examining the enrollment of a state's Buy-In program at the end of a given year, as we do in this chapter, is one measure of Buy-In enrollment. In subsequent sections of this report, we use two other measures of enrollment: the number of individuals who enrolled for the first time in a given year, and the number of individuals who were enrolled for the entire fourth quarter of a given year. The first of these two groups allows us to describe characteristics of new Buy-In participants. The second allows us to analyze characteristics of participants who were enrolled for at least three months. For comparison, Table IV.2 includes the size of these two samples in calendar year 2003 and compares them to the enrollment count as of the end of 2003.

Table IV.2: Number of Participants Enrolled in Medicaid Buy-In Programs in 22 States, Calendar Year 2003

State	First-Time Participants	Fourth-Quarter Participants	End-of-Year Enrollment
Alaska	129	179	192
California	471	807	859
Connecticut	1,285	2,505	2,908
Illinois	381	446	531
Indiana	3,702	5,006	5,186
Iowa	2,238	6,169	6,231
Kansas	355	621	672
Maine	435	733	576
Massachusetts	3,349	6,253	7,213
Minnesota	1,862	6,178	6,487
Missouri	8,781	13,678	15,155
Nebraska	44	102	111
New Hampshire	510	1,110	1,237
New Jersey	543	892	951
New Mexico	731	890	943
New York	672	617	702
Oregon	338	565	585
Pennsylvania	1,815	2,196	2,466
Utah	229	118	198
Vermont	265	385	455
Washington	122	208	237
Wisconsin	2,759	5,165	5,269
Total	31,016	54,823	59,164

SOURCE: State Annual Buy-In Reports for 2003 and state quarterly progress reports (Tables D.2 and D.4).

NOTE: First-time participants are individuals who enrolled in the Buy-In program for the first time in calendar year 2003. Fourth-quarter participants are individuals who were enrolled in the Buy-In program for the entire fourth quarter of the calendar year 2003. End-of-Year Enrollment provides a count of those participants who were enrolled in the Buy-In program as of December 31, 2003. Discussions with state personnel in Maine suggested potential inaccuracies with its data on enrollment as of the end of calendar year 2003.

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CHAPTER V

WHO PARTICIPATES IN THE BUY-IN PROGRAM?

Examining the other work incentive programs and health insurance options in which adults with disabilities are enrolled prior to their enrollment in the Buy-In program can shed light on whether the Buy-In program is attracting the individuals for whom it was designed. For example, a state Buy-In program that enrolls only SSDI beneficiaries serves a somewhat different purpose from one that enrolls only SSI recipients.

Participation in the Buy-In program involves complex interactions across a series of publicly funded health insurance and benefit programs, the most important of which are Medicaid, Medicare, SSI, and SSDI. This chapter describes the experience of Buy-In participants in these public assistance programs—and in private health insurance coverage—prior to and concurrent with their participation in the Buy-In program.

A. PRIOR ENROLLMENT IN MEDICAID

The Buy-In option is one of many ways to qualify for Medicaid coverage. As described in Chapter II of this report, individuals with disabilities may be eligible to receive Medicaid benefits under several eligibility categories, one of which is the Buy-In program. This section describes the national trend of Medicaid coverage prior to enrollment in the Buy-In program, then discusses the state variation in this trend, and finally describes the Medicaid eligibility groups for which individuals qualify prior to enrolling in the Buy-In program.

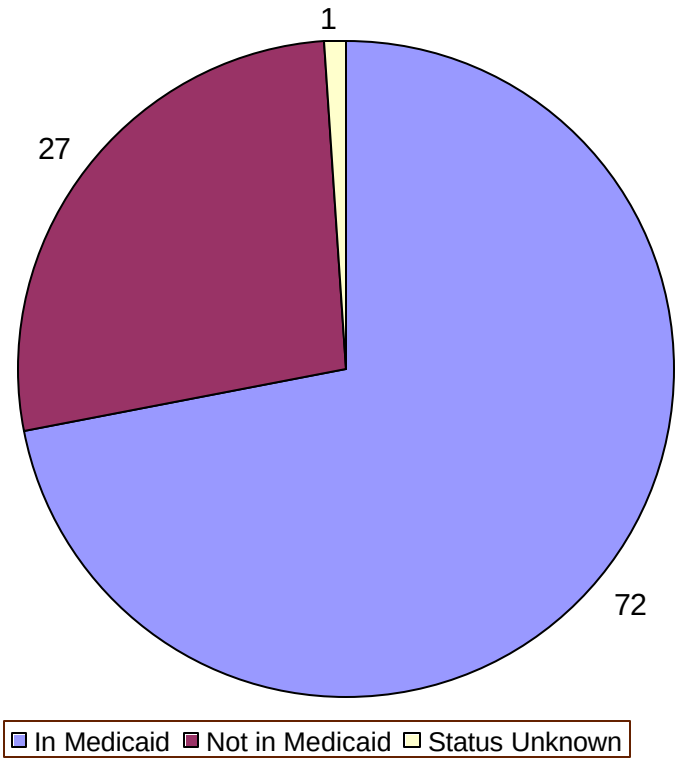
1. National Trends

A large majority of participants who were new to the Buy-In program in calendar year 2003 had previously been enrolled in Medicaid: 73 percent (see Figure V.1).[1] This proportion is nearly the same as the proportion seen in 2002 when close to the 74 percent had been enrolled in Medicaid prior to enrolling in the Buy-In program. The Buy-In

[1]Prior eligibility is defined as being enrolled in Medicaid for at least 30 consecutive days in the 12 months immediately prior to the date they became enrolled in the Buy-In program.

program, therefore, appears to attract primarily people with disabilities who already had experience with the Medicaid program and extends Medicaid coverage to a small proportion of individuals who were outside the Medicaid system.

Figure V.1: Medicaid Eligibility Status for New Participants Prior to Enrollment in the Medicaid Buy-In Program, 19 States, Calendar Year 2003



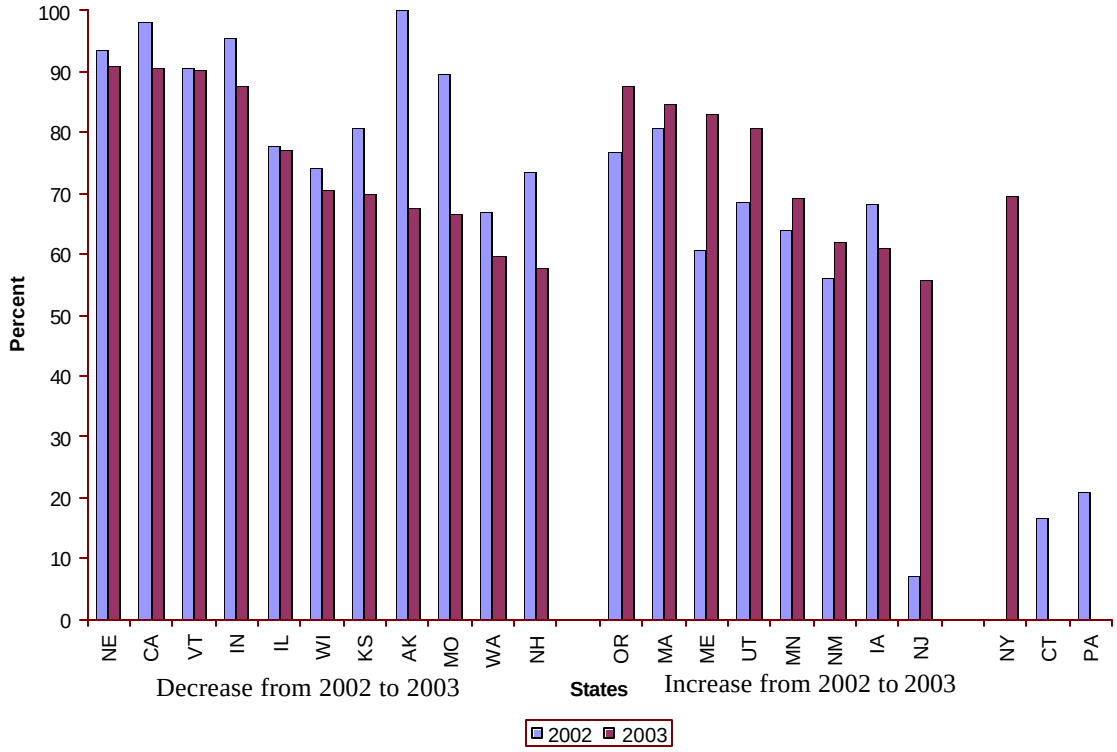
SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.6).

NOTE: The above data refer to individuals who enrolled in the Buy-In program for the first time in 2003. Connecticut and Pennsylvania did not submit data for 2003. New York was excluded because its program was not implemented until July 2003.

2. State-Level Trends in Medicaid Status

In 2003, the proportion of individuals entering Buy-In programs who had prior Medicaid coverage varies considerably across states from a low of 56 percent in New Jersey to a high of 91 percent in Nebraska (Figure V.2). States can make a number of policy decisions that have implications for which groups of individuals will be attracted to the Buy-In program, including the level of outreach to potential enrollees, programmatic changes in other Medicaid eligibility categories, and the presence of state-funded insurance programs.

Figure V.2: Percent of New Participants in Medicaid Prior to Enrollment in the Buy-In Program, 22 States, Calendar Years 2002-2003



SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.6).

NOTE: The above data refer to individuals who enrolled in the Buy-In program for the first time in a given year. New Jersey may have experienced a large change because its enrollment of new Buy-In participants increased substantially from 30 in 2002 to 302 in 2003. New York did not report data for 2002 because its Buy-In program was not implemented until July 2003. Connecticut and Pennsylvania did not submit data for 2003. Those states that had a decrease in the percentage of Medicaid participants from 2002 to 2003 are displayed on the left in descending order based on the 2003 percentage, and those states that had an increase are displayed on the right in descending order based on the 2003 percentage.

The vigor of a state's outreach initiatives may affect the number of Medicaid beneficiaries that enroll in the Buy-In program. Buy-In personnel in California noted that the state's outreach efforts through 2003 were limited to individuals who were already Medicaid beneficiaries because of the state's size and the breadth of other programs competing for attention and resources. As a result, only a small number of individuals without recent Medicaid experience learned about the Buy-In program and decided to enroll—10 percent in 2003 and 2 percent in 2002.

Changes to a state's Medicaid program that make its eligibility criteria more restrictive may also attract participants previously enrolled in Medicaid to the Buy-In program. Prior to October 2002, Missouri paid all of the medical bills for individuals in the state's spend-down program.[2] In October 2002, Missouri stopped this practice at CMS' request. In response to this policy change, many individuals in the spend-down program who could not afford to pay their spend-down amount decided to move into the state's Buy-In program. The influx of participants into Missouri's Buy-In program that ensued during late 2002 and early 2003 translated into a high percentage of new participants with prior Medicaid experience (90 percent in 2002 and 67 percent in 2003). A similar effect occurred in Oregon when it eliminated its medically needy program in February 2003. As a result, many enrollees in Oregon's medically needy program transferred to the Buy-In program, which drove up the percentage of new participants with prior Medicaid eligibility from 77 to 88 percent.

The existence of state-funded insurance programs for individuals with disabilities may lower the percentage of individuals who had previous Medicaid experience. For example, only 21 percent of new participants in Pennsylvania had prior Medicaid coverage in 2002.[3] New enrollees in Pennsylvania may have been enrolled previously in adultBasic, a state-funded program that provides health insurance to low-income adults, although the extent to which participants moved from adultBasic to the Buy-In program is unknown.

Several states including Alaska, California, and Connecticut, indicated that the quality of their data on prior Medicaid enrollment may be questionable. Staff from Alaska believed that the data from 2003 are more accurate than the previous year's. Staff from California attributed the large distributional change of its participants' prior Medicaid status to a change in its Medicaid Management Information System (MMIS) coding and believed that the data for 2003 are more reliable than the data for 2002. In Connecticut, eligibility data often are overwritten during period updates, making it difficult to obtain the Medicaid status at enrollment. For this reason, the state did not submit data for 2003 and questioned the validity of the 2002 data.

3. Importance of Medicaid Eligibility Groups

As discussed in Chapter II, Buy-In participants with prior Medicaid enrollment qualified for Medicaid through a number of different options. Table V.1 shows the distribution of participants' prior Medicaid eligibility across the most prevalent traditional Medicaid eligibility groups: cash assistance (SSI, a state supplement, or the 1619(a) provision), the medically needy group (including the spend-down group for 209(b) states), the poverty-level group, and all other Medicaid eligibility groups (including the 1619(b) provision).

[2]Missouri does not have a medically needy program; however, as a 209(b) state, Missouri must allow individuals with disabilities to spend down into Medicaid eligibility.

[3]Pennsylvania was unable to access data on prior Medicaid enrollment for 2003.

Table V.1: Percent of New Participants In Medicaid Eligibility Groups Prior to Enrollment in the Medicaid Buy-In Program, by State, Calendar Years 2002 - 2003

State	Total Participants with Medicaid Eligibility Prior to Buy-In Enrollment		Percent of Participants with Medicaid Prior to Enrollment							
			Cash Assistance		Medically Needy		Poverty-Level		Other	
	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	131	87	90	97	0	0	1	0	9	3
California	395	426	4	6	13	48	14	25	69	21
Connecticut	257	0	0	N/R	0	N/R	97	N/R	3	N/R
Illinois	328	294	1	0	89	66	10	34	0	0
Indiana [a]	3,596	3,248	0	1	0	0	100[a]	99[a]	0	0
Iowa	1,539	1,369	28	31	28	27	28	26	16	16
Kansas	416	248	5	21	51	46	0	20	43	14
Maine	274	361	28	26	1	1	46	60	25	14
Massachusetts	3,054	2,832	1	1	0	0	29	32	70	67
Minnesota	1,094	1,287	17	19	38	33	4	14	41	34
Missouri	7,278	5,862	4	14	81	55	8	5	8	25
Nebraska	44	40	18	28	9	3	73	70	0	0
New Hampshire	797	295	32	54	63	40	4	6	1	0
New Jersey [b]	30	302	73	22	0	0	0	52	27	26
New Mexico	354	454	76	92	0	0	9	5	15	4
New York	0	468	N/A	4	N/A	91	N/A	0	N/A	5
Oregon	223	296	1	1	27	42	11	22	61	35
Pennsylvania	307	0	11	N/R	65	N/R	19	N/R	4	N/R
Utah	182	185	11	4	35	89	45	7	10	1
Vermont	270	239	9	10	61	63	1	0	29	27
Washington	95	73	9	14	67	42	9	12	14	32
Wisconsin	2,023	1,946	24	20	30	27	8	8	37	45
Total	22,687	20,312	10	14	39	30	28	29	22	27

SOURCE: State Annual Buy-In Reports for 2002 and 2003.

NOTE: These data refer to those individuals who enrolled in the Buy-In program for the first time in a given year. Column headings correspond to the Medicaid Assistance Status (MAS) categories as described in the Medicaid Statistical Information System (MSIS). See Appendix E for definitions for these Medicaid eligibility groups.

[a] Indiana could not differentiate between individuals in its poverty-level group and individuals in its spend-down program. State staff said that 42 percent of all enrollees (new participants and established participants) were previously enrolled in their Medicaid spend-down group prior to enrolling in the Buy-In program.

[b] New Jersey experienced a large shift in the distribution across eligibility groups, which may be the result of a large increase in the number of new participants from 2002 to 2003.

N/A = not applicable
N/R = not reported

States include in the cash assistance group those individuals enrolled in the Buy-In program for the entire fourth quarter of a given year who either had been receiving SSI cash benefits prior to enrollment, including state supplementary payments, or had been eligible under Section 1931 of the Social Security Act.[4] A former SSI recipient who transfers from traditional Medicaid to the Buy-In program should do so because the person's income or assets increase above SSI limits and above the limits set for the 1619(a) and 1619(b) provisions.

Table V.1 shows that in 16 states less than one-third of new Buy-In participants in 2003 received cash assistance immediately prior to enrollment in the Buy-In program and, in 8 states, 10 percent or less received cash assistance.[5] These findings suggest that a minority of Buy-In participants are former SSI recipients.

In contrast to the pattern prevailing in most states, 97 percent of Buy-In participants in Alaska and 92 percent in New Mexico were former recipients of cash assistance. Alaska does not have a medically needy group, and the state has a high threshold for its poverty-level program that offers categorical Medicaid eligibility to all individuals with disabilities with a monthly income below $1,025, which is $91 above 100 percent of the FPL for Alaska.[6] Officials from Alaska believe that because many individuals are covered under traditional Medicaid categories, the residual pool of potential participants may be more likely to enter the Buy-In program from the cash assistance category. In New Mexico, the program provides Medicaid coverage to SSDI beneficiaries in the waiting period for Medicare, most of whom formerly received SSI benefits.[7]

Individuals who qualify for Medicaid under the medically needy or spend-down groups deduct medical expenses from their income until net income is below a threshold set by the state. To qualify, individuals typically have high medical expenses, although some may qualify because their income is below the threshold for the medically needy program but above the threshold used by other traditional Medicaid categories. In 2003, the medically needy or spend-down categories were the most common categories of Medicaid coverage prior to enrollment in the Buy-In program in nine states. These groups accounted for more than a third of new enrollees in 11 states.

In some states, such as Utah, the Buy-In program has substituted for the spend-down program as a way to obtain Medicaid coverage. At least two factors led 89 percent of new

[4]Section 1931 is related to eligibility based on state Aid to Family and Dependent Children (AFDC) eligibility standards in effect on July 16, 1996. Very few enrollees from this eligibility group appear to enroll in the Buy-In program.

[5]Connecticut and Pennsylvania did not submit data on prior Medicaid status for 2003.

[6]Federal poverty guidelines for Alaska are higher than those for the 48 contiguous states

[7]In addition, New Mexico does not have a poverty-level pathway or a medically needy pathway to Medicaid coverage for individuals with disabilities.

participants in Utah who had prior Medicaid eligibility to transition from the medically needy group to the Buy-In program in 2003. First, Utah reduced the monthly premiums for the Buy-In program from 20 percent of countable income to 15 percent. Second, according to Utah personnel, state intake workers may automatically transfer an individual enrolled in Medicaid through the medically needy group into the Buy-In program if the person becomes eligible for the Buy-In program. A Utah official said that some participants may not even realize that they are enrolled in the Buy-In program.

States can extend categorical Medicaid eligibility to all individuals who have income less than 100 percent of the poverty level ($748 per month in 2003) and assets less than state-specified resource limits. Nine of the 22 states with Buy-In programs have adopted this poverty-level group, including the three states that have a majority of new participants who were formerly in the poverty-level group: Maine (60 percent), Nebraska (70 percent), and New Jersey (52 percent).[8] This category also includes individuals whose Medicare expenses are fully or partly paid by Medicaid (i.e., Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualifying Individuals (QIs), and Qualified Disabled and Working Individuals (QDWIs)).[9] Based on data from states that lack the poverty-level option, these dual eligible groups make up a relatively small percentage of this category—0 percent in New York and Vermont and 5 percent or less in Missouri and New Mexico.

Other mandatory and optional ways to qualify for Medicaid coverage also exist, including 1115 demonstration waivers, the 1619(b) work incentives provision, disabled adult children (DAC) with no SSI, and widows and widowers with disabilities who do not have SSI.[10] Massachusetts is the only state to have a majority of its participants transition to the Buy-In program from an 1115 demonstration waiver program. MassHealth, the Medicaid program in Massachusetts, is authorized under the 1115 waiver and covers all individuals with disabilities regardless of income and assets. Two-thirds of the state's new participants in 2003 entered the Buy-In program through this waiver program.

The 1619 provisions are particularly important feature of Medicaid programs, because they accomplish similar objectives to the Buy-In program in that they provide a work incentive for persons with disabilities by partially unlinking employment and earnings from

[8]The states that provide categorical Medicaid eligibility for individuals with disabilities below a specified income are California, Illinois, Maine, Massachusetts, Minnesota, Nebraska, New Jersey, Pennsylvania, and Utah.

[9]See Chapter II for more detail.

[10]A child with disabilities who receives a dependent's or survivor's benefit form Social Security, if single, may continue benefits even into his or her adult years. If a disabled adult child (DAC) loses SSI eligibility due to increased income and is at least 18 years old, the individual is entitled to keep Medicaid coverage. Elderly, disabled widows and widowers who do not qualify for SSI are eligible to receive full Medicaid benefits if they would meet the SSI standard but for an increase in SSDI benefits.

Medicaid coverage. A participant who transfers from a 1619 program to the Buy-In program usually does so because of increased income or assets. Judging from the low percentage of individuals entering the Buy-In program through the "other" means of obtaining Medicaid coverage—in only four states is this percentage greater than a third—the 1619(b) provision is being used in most states by only a small percentage of the Buy-In population.

B. PARTICIPATION IN OTHER BENEFIT AND HEALTH INSURANCE PROGRAMS

State-reported data show that most individuals who enroll in the Buy-In program receive disability benefits and have other types of health insurance coverage in addition to Medicaid coverage. This section examines the frequency with which Buy-In participants—on the national and state levels—are enrolled in the SSDI program and have other types of health insurance coverage in addition to Medicaid.

1. National Trends

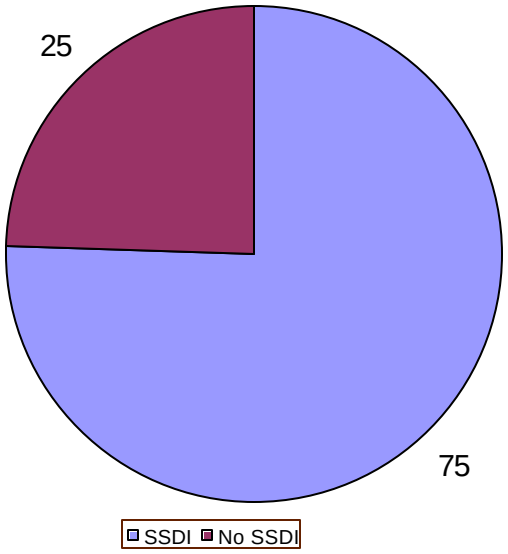
As shown in Figure V.3, three-quarters of participants who enrolled in the Buy-In program for the first time in 2003 were receiving SSDI benefits at the time of their enrollment.[11] Personnel from several states reported that SSDI beneficiaries are the primary target population of their Buy-In program, given that, in most states, SSDI beneficiaries have already met the Medicaid (and SSI) definition of disability and have some previous work experience (at least enough to qualify for SSDI benefits).[12] In addition, SSDI beneficiaries often have no easy access to Medicaid coverage, unlike SSI recipients who may be categorically eligible for Medicaid or eligible through the 1619 provisions. Individuals who were not on SSDI and have never received SSI assistance would need to go through an extensive eligibility determination process, including a disability determination, in order to qualify for the Buy-In program. Medically needy enrollees often face the same obstacle to obtaining Medicaid coverage.

SSDI beneficiaries are automatically eligible to receive Medicare coverage after a 24-month waiting period. In light of the large percentage of Buy-In participants who were receiving SSDI payments prior to enrollment in the Buy-In program, one would expect the

[11]This percentage applies only to those Buy-In participants whose SSDI status could be determined. See Table D.5 in Appendix D for a more complete look at SSDI participation. In 2002, 73 percent of Buy-In participants were receiving SSDI benefits at enrollment.

[12]209(b) states may use a more restrictive definition of disability than that used by the SSI and SSDI programs, which means that a small group of individuals receiving SSI and/or SSDI benefits may not be considered as having a disability based on the Medicaid program's definition in the 209(b) states that exercise this option.

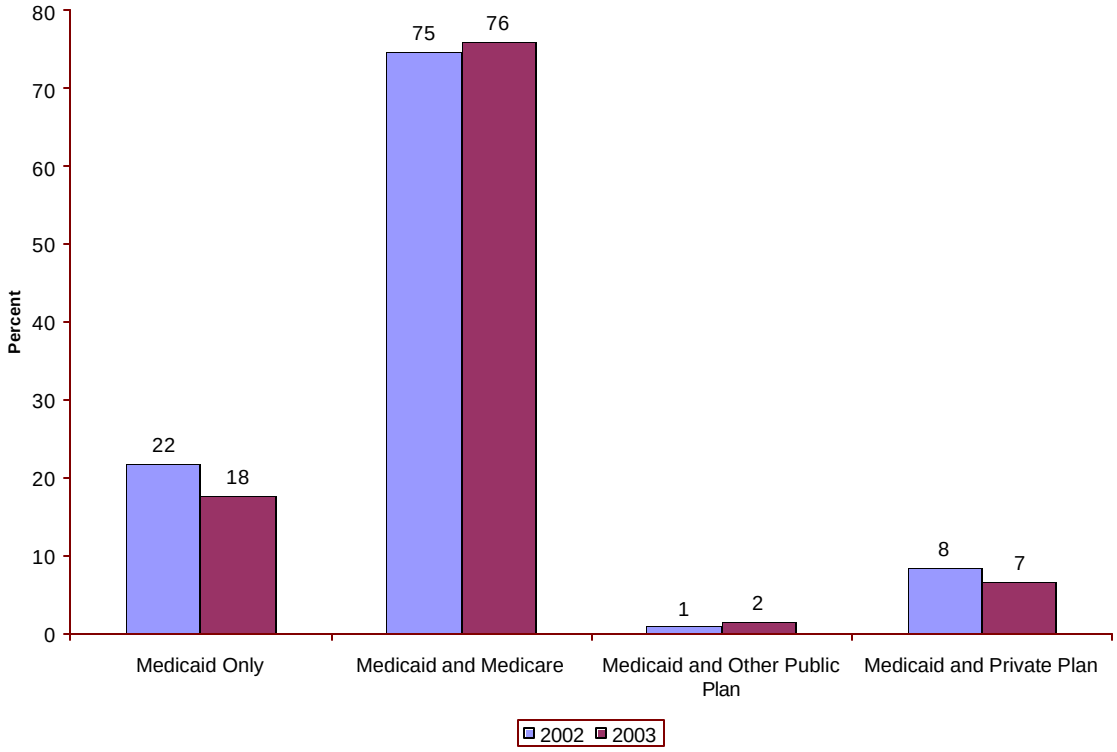
Figure V.3: SSDI Status of New Participants at the Time of Enrollment in the Medicaid Buy-In Program, 21 States, Calendar Year 2003



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 V.4: Type of Health Insurance in Addition to Medicaid for Buy-In Participants, 21 States, Calendar Years 2002- 2003



SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.9).

NOTE: The above data refer to individuals who were enrolled in the Buy-In program for the entire fourth quarter of a given calendar year. Missouri did not report these data for 2002. New York is excluded because its Buy-In Program was not implemented until July 2003.

percentage of Buy-In participants enrolled in Medicare to be of a similar magnitude. Of participants enrolled in the Buy-In program for the entire fourth quarter of 2003, 76 percent were also dually enrolled in Medicare (Figure V.4). In 2002, the figure was 75 percent.

Most Buy-In participants have Medicare, private health insurance, another source of public coverage, or some combination thereof. In fact, less than one out of five Buy-In participants (18 percent) relied solely on Medicaid coverage for health insurance in 2003, down from 22 percent in 2002 (see Figure V.4). Of participants who were enrolled in the Buy-In program for the entire fourth quarter of 2003, 7 percent had private health care coverage in 2003.[13] These data are consistent with GAO findings that most Buy-In participants do not have jobs that offer affordable employer-based health insurance (GAO 2003).

2. State-Level Trends

The proportion of Buy-In participants with experience in other public assistance programs, either prior to or while enrolled in the Buy-In program, varies widely across states. This section examines the variation and discusses some possible underlying causes.

a. SSDI Status

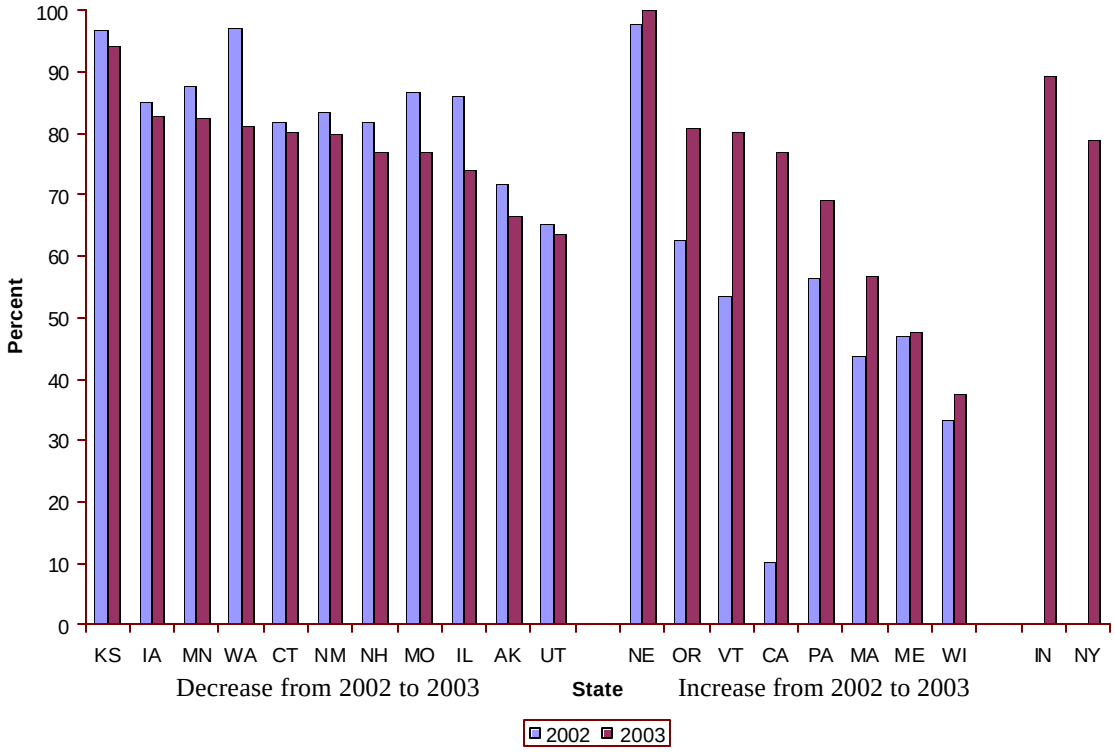
In all but two states, a majority of new Buy-In participants in 2003 were SSDI beneficiaries at the time of their enrollment in the Buy-In program, and, in 14 states, SSDI beneficiaries made up at least three-fourths of new Buy-In participants (see Figure V.5). At least two programmatic factors are indicative of SSDI participation among Buy-In enrollees: (1) the separate treatment of unearned income and (2) the proportion of participants who transfer into the Buy-In from a spend-down or medically needy eligibility category.

A state Buy-In program can discourage the enrollment of SSDI beneficiaries through the differential treatment of earned and unearned income in its eligibility criteria or cost sharing requirements. Maine reported that 48 percent of its Buy-In participants received SSDI benefits in 2003, compared to the national average of 75 percent, most likely because Buy-In participants in Maine are required to have countable unearned income equal to or less than 100 percent of the FPL plus $75. Many SSDI beneficiaries who receive a large SSDI payment would not be eligible for the Buy-In program,[14] and, thus, the overall proportion of SSDI beneficiaries in Maine's Buy-In program is lower than most other states. Wisconsin is similar in that SSDI beneficiaries comprised only 59 percent of its Buy-In

[13]The percentage includes people with private Medigap policies, dental insurance, and coverage through a spouse.

[14]The national average SSDI benefit for disabled workers was $862 per month in 2003, or 108 percent of the FPL (SSA 2004).

Figure V.5: Percent of Buy-In Participants Receiving SSDI Benefits at Enrollment, by State, Calendar Years 2002- 2003



SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.7).

NOTE: This figure includes only those individuals whose status could be determined (97 percent of all new participants in 2003 and 96 percent in 2002). New Jersey was excluded because it could not determine the SSDI status of its participants for 2002. Indiana could not determine SSDI participation for 2002. Buy-In personnel in California noted that the state's SSDI data were incorrect for 2002. Wisconsin could not determine the SSDI status for 36 percent of its new participants in 2002 and 37 percent in 2003. Indiana could not report SSDI status in 2002. New York's Buy-In program was not implemented until July 2003. Those states that had a decrease in the percentage of SSDI beneficiaries from 2002 to 2003 are displayed on the left in descending order based on the 2003 percentage, and those states that had an increase are displayed on the right in descending order based on the 2003 percentage.

population for whom SSDI status could be determined in 2003 (37 percent of all participants)—partly because the premium charged by the program is equal to 100 percent of all unearned income minus certain needs ($655 per month in 2003) and expenses.[15] Wisconsin's Buy-In participants also pay a premium equal to 3 percent of the individual's earned income.

Conversely, a Buy-In program's policies can encourage enrollment of SSDI beneficiaries; for example, all of Nebraska's Buy-In participants in 2003 were SSDI beneficiaries. The state's program has an unearned income limit but disregards all unearned income for SSDI beneficiaries in a trial work period. The lack of an unearned income limit allows all SSDI beneficiaries in the trial work period, including those receiving large SSDI benefits, to be eligible for the Buy-In program. According to staff from Nebraska, most individuals covered by its Buy-In program participate in the SSDI trial work period, which may last for up to 48 months.[16]

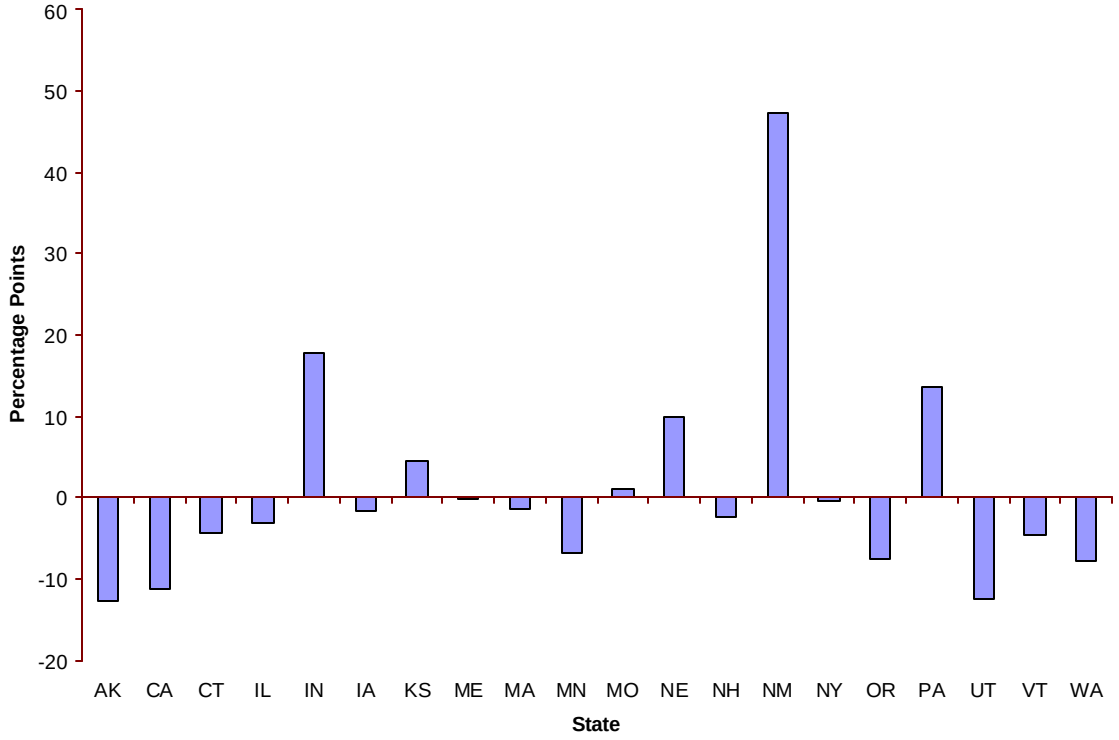
A state Buy-In program that draws heavily on participants from a medically needy or spend-down category often attracts a large number of SSDI beneficiaries. The medically needy category is an important Medicaid eligibility category, because the income of many SSDI beneficiaries does not meet the income requirements of the SSI program or the state's various other Medicaid categories for individuals with disabilities, such as a poverty-level option. Personnel in Kansas' Buy-In program believe that the large percentage of new Buy-In participants who are SSDI beneficiaries—94 percent in 2003—is at least partly related to the high percentage of enrollees that were previously enrolled in Medicaid under the medically needy group prior to the initiation of the state's Buy-In program. Oregon is another example of the relationship between SSDI and the medically needy group. The percentage of SSDI beneficiaries among new Buy-In participants increased from 63 percent in 2002 to 81 percent in 2003. State officials attributed this change to the state's discontinuation of its medically needy option in February 2003, causing many SSDI beneficiaries enrolled in the medically needy group to move into the Buy-In program.

States have generally had difficulties identifying the number of new Buy-In participants receiving SSDI benefits. Figure V.6 graphs the difference between the percentages of new

[15]The state could not determine the SSDI status of 37 percent of its participants. At most, the proportion could be 74 percent (37+37=74).

[16]The trial work period (TWP) consists of (1) nine months of the SSDI TWP; (2) the SSDI cessation month (month 10 following the beginning of the TWP); (3) the SSDI grace months (months 11 and 12 following the beginning of the TWP); and (4) the 36-month extended period of SSDI eligibility.

Figure V.6: Difference Between the Percent of New Buy-In Participants Receiving SSDI Benefits at Enrollment and the Percent of Buy-In Participants Receiving Medicare Benefits in the Fourth Quarter, by State, Calendar Year 2003



SOURCE: State Annual Buy-In Report for 2003 (Tables D.7 and D.10)

NOTE: The data that describe the SSDI status of participants refer to those individuals who enrolled in the Buy-In program for the first time in 2003. This figure includes only those individuals whose SSDI status could be determined. New Jersey was excluded because it could not determine the SSDI status of its participants for 2002 and 2003. Wisconsin is not included because it could not determine the SSDI status of some of its participants. The data that describe the Medicare status of participants refer to those individuals who were enrolled in the Buy-In program for the entire fourth quarter of 2003.

Buy-In participants receiving SSDI benefits at enrollment and Buy-In participants receiving Medicare benefits in the fourth quarter of 2003.[17] As previously stated, we would expect these percentages to be similar because SSDI beneficiaries are automatically eligible to receive Medicare coverage after a 24-month waiting period, although the percentage of SSDI beneficiaries should be higher than the percentage of Medicare beneficiaries because at least some SSDI beneficiaries are in the 24-month waiting period for Medicare. However, in 14 states, the percentage of Medicare beneficiaries exceeds the percentage of SSDI beneficiaries (as illustrated by the negative numbers in Figure V.6), indicating that data quality may be a concern in those states. Based on interviews with state personnel, it is not clear why this occurred, although in a few state Buy-In programs authorized under the authority of the BBA, elderly Buy-In participants age 65 or older may be enrolled in Medicare but not receive SSDI benefits.[18] In addition, a Buy-In participant with Medicare coverage who earns above SGA level, as defined by SSA ($800 in 2003), may lose SSDI benefits. Therefore, it is possible in some states' Buy-In programs for the number of Medicare beneficiaries to exceed the number of SSDI beneficiaries.

b. Medicare Status

In 18 of 22 states, over 70 percent of the participants who were enrolled in the Medicaid Buy-In program for the entire fourth quarter of 2003 were dually enrolled in both Medicaid and Medicare (Figure V.7). States with higher than average proportions of dual enrollment tend to have higher proportions of SSDI participants, which is not surprising. Persons with disabilities on Medicare may wish to join the Buy-In program because it offers the full Medicaid benefit package in a given state and typically covers several services that help them maintain employment, most notably pharmaceuticals,[19,20] and states may choose to provide additional employment supports, including personal assistance services.[21] Many Medicare

[17]The number of individuals receiving SSDI benefits at enrollment and the number of individuals receiving both Medicaid and Medicare coverage are based on different samples. The proportion of Buy-In participants receiving SSDI at enrollment is based on the sample of new program participants, and the proportion with both Medicaid and Medicare coverage is calculated among Buy-In participants enrolled for the entire fourth quarter of a given year. The difference in sample composition may account for a portion of the discrepancy, but it is unlikely to account for all of it, especially in states where the difference is large.

[18]The Ticket Act requires that Buy-In programs be limited to working people ages 16-64 with disabilities.

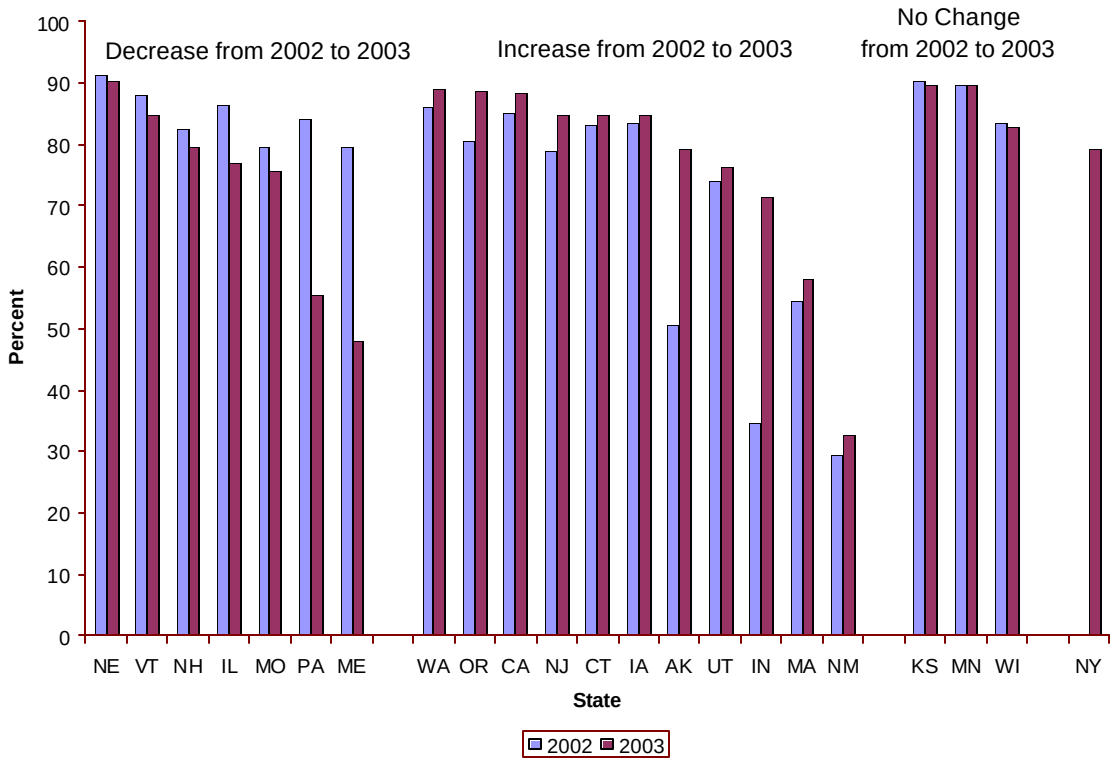
[19]According to Liu et al. (2004), prescription drugs composed the largest share of Medicaid expenditures for Buy-In participants in 2001.

[20]The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 extended limited pharmaceutical coverage to Medicare beneficiaries starting in 2006.

[21]See Goodman and Livermore (2004) for a full list of mandatory and voluntary Medicaid services covered by Medicaid but not Medicare.

beneficiaries who are not enrolled in a Buy-In program choose to spend down their income and assets to obtain Medicaid services, because pharmaceuticals, personal assistance services, and other services not covered by Medicare are of such high value to participants.

Figure V.7: Percent of Buy-In Participants Receiving both Medicaid and Medicare Benefit During the Fourth Quarter, by State, Calendar Years 2002-2003



SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.10)

NOTE: The above data refer to individuals who were enrolled in the Buy-In program for the entire fourth quarter of a given year. In the past, Pennsylvania has had difficulty reporting Medicare status in its MSIS files (Anomaly notes for the Medicaid Analytical eXtract (MAX) files FY 1999). Maine introduced a new prescription drug program under an 1115 demonstration waiver in fiscal year 2002, which may have thrown off its dual flags (Anomaly notes for the FY 2002-03). State personnel in Alaska stated that they had difficulties reporting data on Buy-In participants with Medicare coverage. Medicaid officials in Indiana were not sure why the percentage of dual enrollees in Medicare and Medicaid changed so dramatically in their state between 2002 and 2003. Those states that had a decrease in the percentage of Medicare beneficiaries are displayed on the left in descending order based on the 2003 percentage, those states that had an increase are displayed in the middle, and those states that had no change are displayed on the right.

In two of the four states in which less than 70 percent of the participants are enrolled in both Medicaid and Medicare—New Mexico and Massachusetts—the low percentage appears to be the result of the design of the Buy-In program or the Medicaid program. New Mexico had the lowest percentage of dually enrolled participants out of the 22 states (33 percent), because the state's Buy-In program provides Medicaid coverage primarily to SSDI beneficiaries who are not yet eligible to receive Medicare coverage. In Massachusetts, state personnel said that most SSDI beneficiaries enroll in the state's Medicaid program under a separate non-working benefit plan for people with disabilities. Thus, the percentage of Buy-In participants receiving Medicare coverage is low.

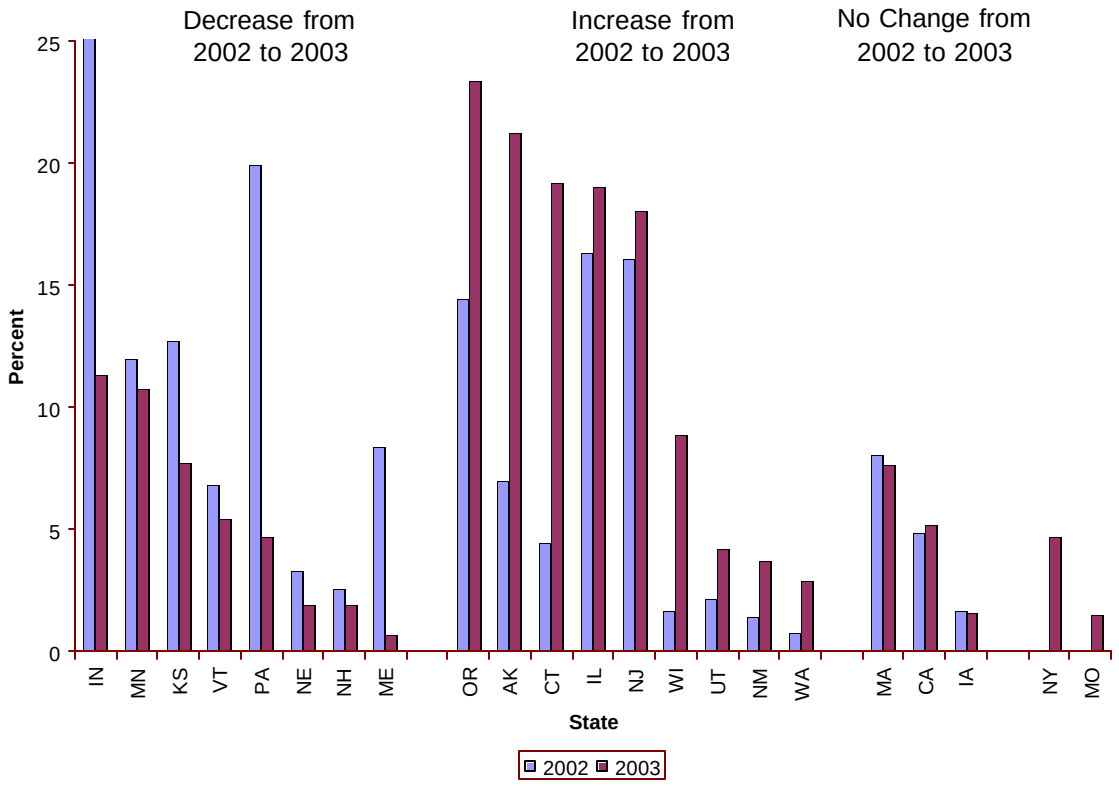
c. Private Health Insurance Coverage

In most states, private health insurance was not common among Buy-In participants. In 2003, only five states (Alaska, Connecticut, Illinois, New Jersey, and Oregon) reported private insurance coverage for more than 15 percent of program participants; only two states (Alaska and Oregon) reported more than 20 percent of Buy-In participants were enrolled in a private plan (Figure V.8). These figures include individuals with coverage through a spouse, private Medigap policies, and dental insurance. The overwhelming majority of Buy-In participants rely on publicly funded health coverage, namely Medicaid and Medicare.

Despite the low percentage of Buy-In participants with private coverage, some states have implemented policies designed to increase the prevalence of private coverage among Buy-In participants. Most states with a Buy-In program pay premiums for cost-effective private health insurance coverage for Buy-In participants. Illinois promotes the Buy-In program as a plan to supplement private coverage, which may explain why the state has a relatively high proportion (19 percent) of participants with Medicaid and private coverage. Minnesota and Massachusetts have no income eligibility limit for the Buy-In program, which may attract workers with higher earnings who are more likely to have private coverage. The percentage of Buy-In participants with private health insurance in both states—11 percent in Minnesota and 8 percent in Massachusetts—was higher than most other states with a Buy-In program.

Of the 22 states described in this report, Oregon has the highest percentage of participants with private insurance (23 percent). This state requires Buy-in participants to seek third party coverage as a condition of eligibility, according to state staff, and the program's cost-sharing requirements are more likely to attract individuals with higher earnings and with a job that offers employer-sponsored coverage, partly because the individual needs more income to pay these large cost-sharing obligations.

Figure V.8: Percent of Buy-In Participants Covered by Medicaid and Private Coverage During Fourth Quarter, by State, Calendar Years 2002-2003



SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.9)

NOTE: The above data refer to individuals who were enrolled in the Buy-In program for the entire fourth quarter of a given year. New York's Buy-In program was not implemented until July 2003. Missouri did not report these data for 2002. Several states had data quality concerns with the completeness and accuracy of their counts of Buy-In participants with private health insurance, including: Alaska and Connecticut in 2002, and Indiana, Maine, and Wisconsin in 2002 and 2003. Those states that had a decrease in the percentage of individuals with private coverage are displayed on the left in descending order based on the 2003 percentage, those states that had an increase are displayed in the middle, and those states that had no change are displayed on the right.

CHAPTER VI

HOW MUCH ARE BUY-IN PARTICIPANTS EARNING?

Policies that link Medicaid coverage to the receipt of cash assistance benefits often establish disincentives for individuals with disabilities to work. Earnings from employment may jeopardize an individual's cash benefits *and* health coverage, creating a powerful incentive to keep earnings low.

The Buy-In legislation aims to de-link cash assistance and Medicaid for individuals with disabilities, allowing them to increase their earnings without the fear of losing health coverage (GAO 2003, Goodman and Livermore 2004). Nevertheless, some Buy-In participants may lose SSDI cash assistance benefits if their earnings increase above the Social Security Administration's definition of substantial gainful activity (SGA), which was $800 per month in 2003.[1,2] As noted in Chapter V, three-fourths of new Buy-In participants receive SSDI cash assistance, so the need to keep their SSDI payments may be a strong disincentive for these participants to earn more than the SGA level. Furthermore, an increase in earnings could also affect the eligibility of persons with disabilities for other means-tested programs (e.g., food stamps, housing subsidies), rendering the tradeoffs associated with higher earnings even more complex. For this report, we did not have access to the data needed to determine the total economic impact of employment on a Buy-In participant.

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[1]SSDI beneficiaries whose earnings in a given month exceeded $590 in 2003 were considered to be in a "trial work period" (TWP). A person with disabilities may remain in a TWP for up to nine (not necessarily consecutive) months during a given 60-month period. Once a person's nine-month TWP has expired, he or she begins a three-year extended period of eligibility (EPE) during which SSDI cash benefits are received only when earnings are below the SGA level. After the EPE has lapsed, SSDI benefits cease when earnings rise above SGA. See http://www.ssa.gov/work/ResourcesToolkit/redbook_page.html for more detail.

[2]In this chapter, we assume that earnings above $800 per month constitute earnings above the SGA level, which is correct for 2003 and an approximation for 2002 when the SGA level was $780 per month.

A central question for policymakers concerning the Buy-In program is its effectiveness at promoting employment and increased earnings. The extent to which this occurs depends on the complex interaction between an individual's circumstances and a Buy-In program's unique features.[3] Two studies have found evidence of higher average earnings among Buy-In participants relative to before they enrolled in the program (Clark et al. 2004, Porter 2004). Pre-enrollment earnings data were not available for the analysis presented in this chapter, but we examine earnings for a cohort of Buy-In participants to address the question of how their earnings change over the course of Buy-In enrollment.

This chapter reports earnings information for participants in 19 Buy-In programs. Each of these states reported earnings data from its unemployment insurance (UI) system, the characteristics of which were described in Chapter II. We begin below with a brief discussion of earnings at the national level and move to a discussion of how average earnings vary across states and potential factors contributing to this variation. We then discuss how earnings change over time for two different samples of Buy-In participants.

A. NATIONAL EARNINGS

About 4 in 10 (39 percent) Buy-In participants reported earnings from the UI system in 2003 (Figure VI.1), which is lower than in 2002 when about half (47 percent) reported earnings. In Section C.1 below, we provide more detail about the particular states that were the primary sources of this decrease.

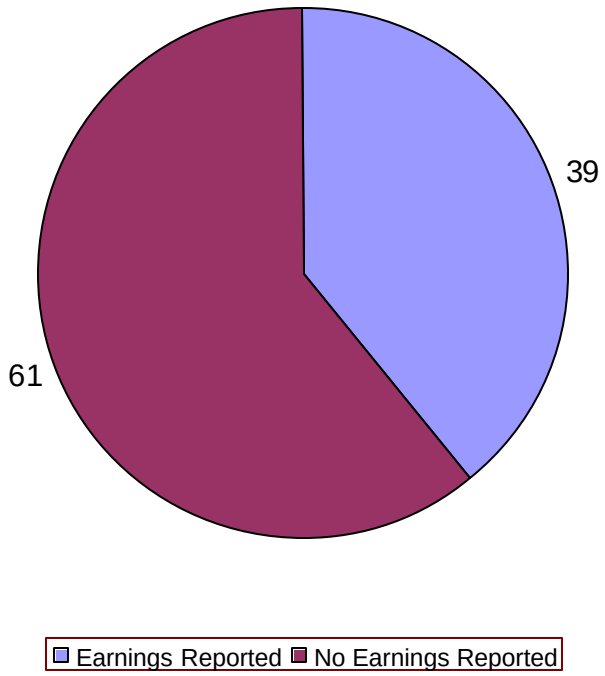
Among those individuals who reported earnings, average monthly earnings in 2003 were $739, which was nearly 8 percent below the 2003 SGA level of $800. This represents a growth in average monthly reported earnings of approximately 3 percent from 2002, when they were $716.

Figure VI.2 illustrates the distribution of monthly earnings and how the distribution changed between 2002 and 2003. In 2003, 72 percent of Buy-In participants with UI earnings had monthly earnings below the SGA level, which is slightly less than the 75 percent of Buy-In participants who had monthly earnings below the SGA level in 2002. In both years, about one-fifth of participants with reported earnings earned no more than $200 per month.

The proportion of individuals with monthly earnings at or above the SGA level drops markedly as earnings exceed the SGA level: The proportion of individuals with earnings in the $801-$1,000 range (8 percent in 2003) is 10 percentage points lower than the proportion of individuals in the $601-$800 range (18 percent in 2003) (Figure VI.2). In both 2002 and 2003, about 10 percent of Buy-In participants earned over $1,600 per month. We do not have information about the characteristics of people in a given earnings category, but further data collection may provide insights into how individual characteristics differ across earnings categories.

[3]Goodman and Livermore (2004) provide a review of studies analyzing how Buy-In participants' earnings change over time.

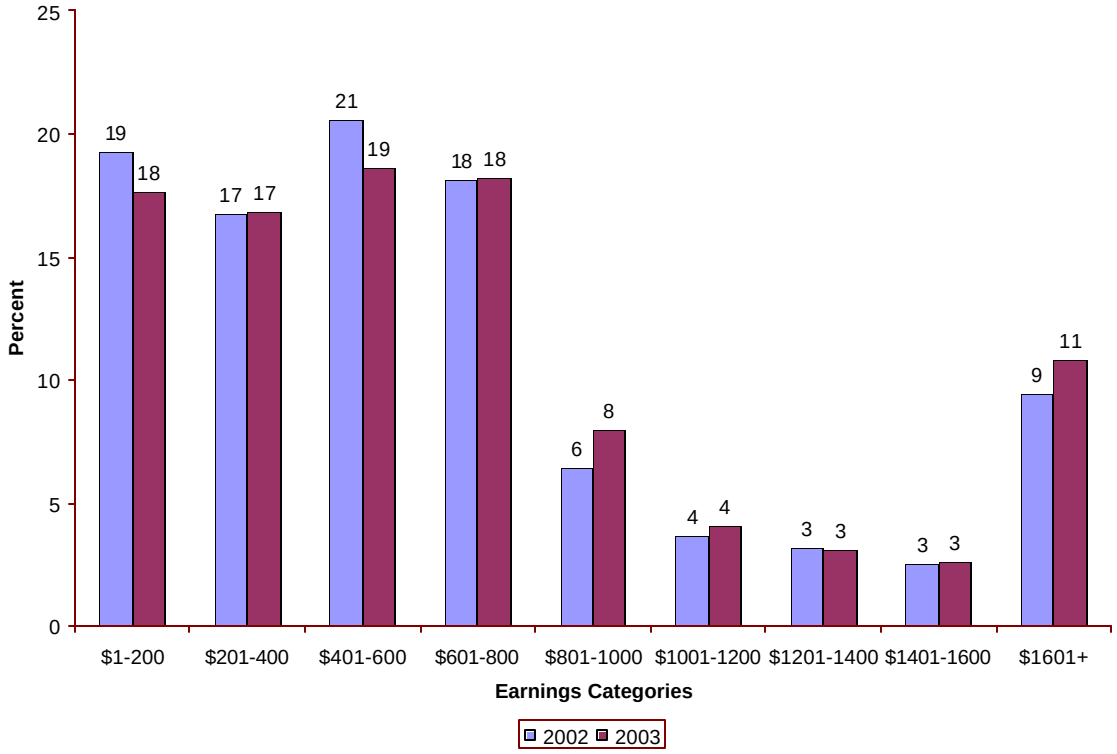
Figure VI.1: Percent of Buy-In Participants with UI Earnings Reported in the Fourth Quarter of 2003, 19 States



SOURCE: State Annual Buy-In Reports for calendar year 2003 (Table D.11).

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 non-comparable with other states.

Figure VI.2: Percent of Buy-In Participants with Reported Monthly Earnings Across Selected Monthly Earnings Categories, 2002 (16 States) and 2003 (19 States)



SOURCE: State Annual Buy-In Reports for calendar years 2002 and 2003 (Tables D.11 and D.12).

NOTE: Reported UI earnings are for Buy-In participants enrolled during the entire fourth quarter of either 2002 or 2003. Percentage distribution for a given year may not sum to 100 due to rounding. New Jersey did not submit earnings data for 2002, and New York's Buy-In program did not begin until 2003. Data for three states are not included because they either did not use the UI system (Indiana and Pennsylvania in both years) or used a data source in addition to the UI system (California in 2002 and Nebraska in both years), thus rendering their data non-comparable with other states.

B. STATE EARNINGS

Figure VI.3 illustrates the state variability in the average monthly earnings of Buy-In participants and how earnings changed between 2002 and 2003.[4] State variability in average monthly earnings results from several factors including: program design features, the prevalence of self-employment among Buy-In participants, and the proportion with UI earnings.

1. Program Design Features

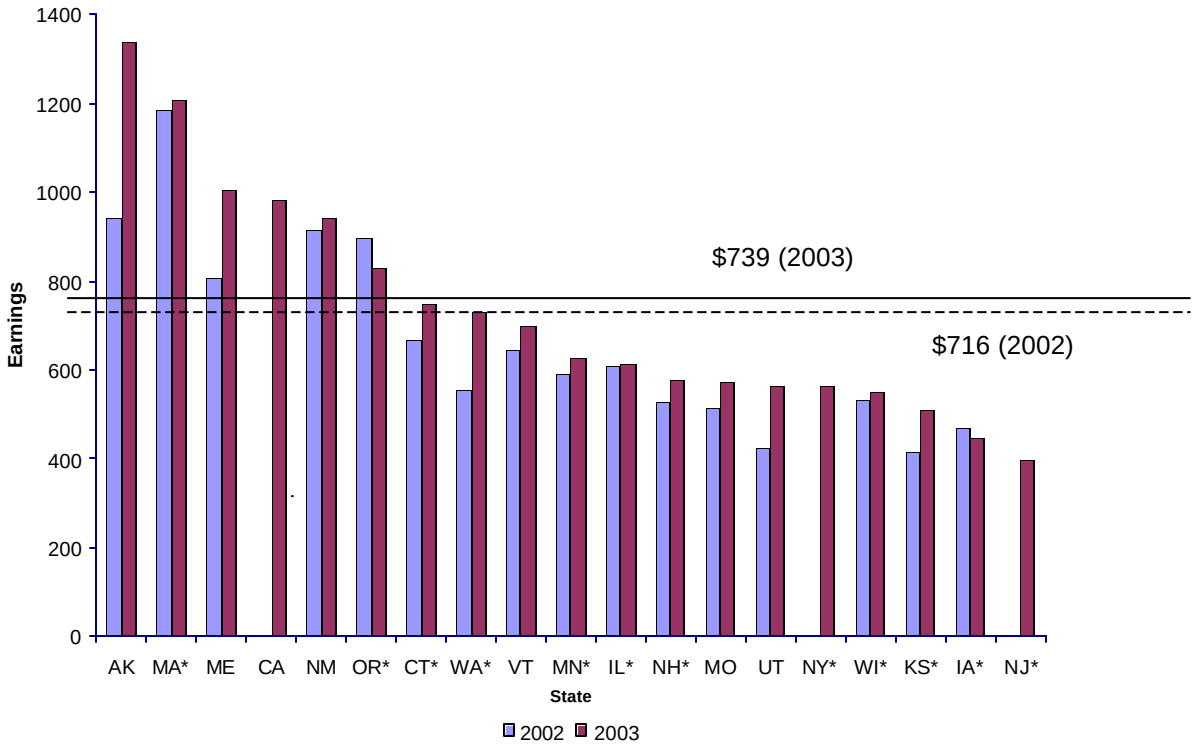
The four states with the highest average monthly earnings in 2003 (Alaska, Massachusetts, Maine, and California) have relatively high income thresholds for traditional Medicaid eligibility for persons with disabilities, thus potentially increasing income levels for Buy-In participants relative to other states. In Alaska, an individual with earnings up to $1,025 per month would be eligible for the state SSI supplement and Medicaid coverage. The eligibility threshold for Medicaid coverage in Massachusetts is also high relative to other states with Buy-In programs (133 percent of the FPL). This was the case in California and Maine as well, where persons with disabilities who had monthly incomes above the federal poverty line were potentially eligible for traditional Medicaid. In California, the Medicaid income threshold was $978 in 2003 (i.e., the federal poverty level of $748 plus a $230 disregard) and the threshold was $803 in Maine (i.e., $748 plus a $55 disregard). High average wages for Buy-In participants also may reflect a higher wage level in the state as a whole—the average annual wage for the overall population in Alaska, California, and Massachusetts is above the median wage level for the overall population among the 22 states addressed in this report (BLS 2004a).

At least two programs that have participants with above average earnings—Massachusetts and New Mexico—have program features that may promote the enrollment of persons with disabilities who have relatively high earnings. Massachusetts' Buy-In program, for example, requires that persons with disabilities work at least 40 hours per month, which limits enrollment of individuals with earnings below $200.[5] In addition, the absence of an income and asset limit for Massachusetts' Buy-In program encourages individuals with high earnings to enroll. To enroll in New Mexico's program, an individual must have a recent attachment to

[4]The percentage was calculated among participants with reported earnings in state UI systems. Discussions with state officials suggest potential inaccuracies with the following data points: Alaska (2002), Connecticut (2003), and Maine (2003).

[5]Forty hours of work per month at the federal minimum wage of $5.15 would yield a gross monthly income of $206. Massachusetts, because it authorized its Buy-In program through a Medicaid 1115 waiver, is the only state that is allowed to set a minimum work requirement.

Figure VI.3: Average Monthly Earnings for Buy-In Participants with Reported Earnings in 2002 (16 States) and 2003 (19 States)



SOURCE: State Annual Buy-In Reports for calendar years 2002 and 2003 (Tables D.11 and D.12).

NOTE: Solid line represents mean earnings across 19 states in 2003. Dotted line represents mean earnings across 16 states in 2002. Means for each year are weighted based on the enrollment of each state's Buy-In program. New Jersey did not submit earnings data for 2002, and New York's Buy-In program did not begin until 2003. The mean in 2003 was $737 for the states that provided data in 2002 (i.e., all states above except for California, New Jersey, and New York). Data from three states are not included because they either did not use the UI system (Indiana and Pennsylvania in both years) or used a data source in addition to the UI system (California in 2002 and Nebraska in both years), thus rendering their data non-comparable with other states. Discussions with state officials suggest potential inaccuracies with the following data points: Alaska (2002), Connecticut (2003), and Maine (2003).

*State has a grace period that allows a Buy-In participant without earnings (e.g., due to involuntary job loss or health problems) to remain enrolled for a period of time. See Table A.1 of Appendix A for more detail.

the workforce, defined as having or expecting to have gross earnings above $890 per month in the current calendar quarter.[6]

Grace periods allow Buy-In participants to remain enrolled in the Buy-In program during periods of unemployment that arise due to health problems or a job loss. Theoretically, grace periods should be associated with lower average earnings because individuals who are working will have gaps in their earnings that would lower overall averages. The data appear consistent with this prediction: in Figure VI.3, 12 of the 19 states offer a grace period. All five states with the lowest average earnings have a grace period, while four of the five states with the highest average earnings do not.[7]

This finding may result from at least two interrelated factors. First, states may vary in the percent of participants who actually use the grace period.[8] Second, the measurement period may have an effect. For this analysis, we analyzed earnings for a three-month period (the fourth quarter of a given year) and found that states without a grace period tend to have higher earnings. If a participant had earnings in the first month of a quarter but then became unable to work, he or she would be included in the calculation of average earnings for states with a grace period but would not be included for states without a grace period (because the person would be disenrolled from the program). Analyzing average monthly (rather than quarterly) earnings for states with and without a grace period, however, may yield different results. In any case, future studies should examine in more depth the relationship between grace periods and average earnings for Buy-In participants.

2. Self-Employment

The UI system omits income from sources such as self-employment and employment across state lines.[9] Ten states reported data on self-employment earnings for their Buy-In participants in 2003.[10] Among these states, the percent of Buy-In participants with self-

[6]Buy-In participants in New Mexico also may be SSDI beneficiaries in the two-year waiting period for Medicare, and the program does not impose a work requirement on these individuals. However, because calculations of the average monthly earnings of Buy-In participants does not include individuals who do not work, which implies that they do not have reported earnings in the UI system, the presence of these individuals in the Buy-In program would have little effect on our calculation of average earnings.

[7] We did not find a relationship between the length of the grace period and earnings.

[8]The percent of participants who use grace periods is not included in the states' annual report to CMS and was not collected during interviews with state personnel.

[9]Chapter I provides more detail about the characteristics of the UI system.

[10]Unless noted otherwise, the following states reported self-employment earnings information in both 2002 and 2003: California, Connecticut, Indiana (2003 only), Kansas, Minnesota, New Hampshire, New Mexico, Utah, Vermont, and Washington (2003 only).

employment earnings in 2003 ranged from 1 percent in Connecticut and Washington to 25 percent in Utah.[11]

Monthly self-employment earnings among participants who reported them averaged $145 in 2003, ranging from $188 in Minnesota to $588 in Vermont. In states that submitted data on self-employment earnings, average self-employment earnings were lower than average UI earnings. Average UI earnings among the states that submitted self-employment earnings data were $662 in 2003 and nearly six times larger than average self-employment earnings of $114 for the same year.[12] Lower self-employment earnings relative to UI earnings could be due in part to the possibility that UI earnings are more likely than self-employment earnings to originate from competitive employment. Personnel in California, Minnesota, and Wisconsin noted that some of what they classified as self-employment income comes from participants performing miscellaneous chores for friends or neighbors for low levels of compensation.

3. Proportion with UI Earnings

To better understand the extent to which Buy-In participants' had earnings that were not reported in the UI system, we examined the proportion of Buy-In participants with UI earnings in each state (Table VI.1). This proportion varies substantially across states and ranges from a low of 3 percent in New Jersey to a high of 78 percent in Washington and Kansas. State personnel provided some insight into the factors that might be driving this variation. In Missouri, Iowa, and Wisconsin, which have the second (Missouri—19 percent), third (Iowa—25 percent) and fourth (Wisconsin—37 percent) lowest proportions of participants with UI earnings, state staff noted that their low rates of UI earnings may be due in part to large numbers of participants who receive earnings for "minimal work" and from sources that may be less likely to report earnings to the UI system.[13]

Employment verification requirements also may contribute to a state's proportion of Buy-In participants with UI earnings. Six out of the nine states with the highest proportion of Buy-In participants with UI earnings require verification that income and/or FICA taxes are being paid. However, none of the seven states with the lowest proportion of Buy-In participants with UI earnings require participants to document that they are paying income and/or FICA taxes. These simplified verification requirements may contribute to the low proportion of

[11]See Tables D.13 and D.14 for more detailed information on self-employment earnings. Wisconsin and Nebraska were unable to provide data on average self-employment earnings in 2003, but they did provide the proportion of participants with such earnings.

[12]Indiana was excluded when these means were calculated because it did not use the UI system to report earnings data, which causes its data to be non-comparable with other states.

[13]Staff in Wisconsin also noted that the relatively low proportion of participants with UI earnings could also be due in part to difficulties matching Buy-In participants with the UI data.

Table VI.1: Percent of Buy-In Participants with Earnings and with Earnings Above the SGA Level in Fourth Quarter of 2002 and 2003, by State

	Number of Fourth-Quarter Participants		Percent with UI Earnings			Percent Earning Above SGA[a]		
State	2002	2003	2002	2003	Change	2002	2003	Change
Washington[b]	136	208	80	78	-2	14	22	8
Kansas[b]	384	621	73	78	5	5	12	7
Maine	617	733	58	76	17	22	36	15
New York[b]	N/A	617	N/A	73	N/A	N/A	18	N/A
Vermont	336	385	73	72	-1	15	19	4
Oregon	531	565	72	72	0	24	22	-2
Illinois[b]	177	446	72	69	-2	11	14	3
New Hampshire[b]	880	1,110	71	66	-6	12	14	2
Connecticut[b]	2,075	2,505	74	61	-14	16	16	0
California	N/R	807	N/R	58	N/A	N/R	23	N/A
Minnesota	5,932	6,178	54	55	1	9	10	1
Massachusetts[b]	5,918	6,253	54	53	-1	27	27	0
Utah	138	118	46	52	6	4	5	1
Alaska	186	179	36	41	5	17	27	10
New Mexico	712	890	25	39	14	11	34	23
Wisconsin	3,339	5,165	44	37	-7	7	6	0
Iowa	4,811	6,169	33	25	-8	4	3	-1
Missouri	4,736	13,678	26	19	-7	4	5	0
New Jersey	N/R	892	N/R	3	N/A	N/R	0	N/A
Total	30,908	47,519	47	39	-8	12	11	-1
Correlation with change in percent with UI earnings								0.78

SOURCE: State Annual Buy-In Report Form for 2003. See Tables D.11 and D.12 for state-level data on UI earnings.

NOTE: Data are for participants enrolled for the entire fourth quarter of a given calendar year. States are presented in descending order of their percent with UI earnings in 2003. Data for three states are not included because they either did not use the UI system (Indiana and Pennsylvania in both years) or used a data source in addition to the UI system (California in 2002 and Nebraska in both years), thus rendering their data non-comparable with other states. Discussions with state officials suggest potential inaccuracies with earnings data for the following states and years: Alaska (2002), Connecticut (2003), and Maine (2003). New York's program did not exist in 2002 and New Jersey did not submit earnings data for 2002. Appendix E provides a detailed discussion of the robustness of the correlation between the percent of participants with UI earnings and the percent with earnings above $800 per month.

[a] The proportion of fourth quarter participants with earnings above the SGA level for a given year was calculated as the number of fourth quarter participants with UI earnings above $800 per month divided by the total number of fourth quarter participants. Therefore, participants without reported UI earnings were assumed to have earnings below $800 per month. The SGA level was $800 per month in 2003 and $780 per month in 2002. The percentages in these columns therefore represent an accurate indication of the proportion of Buy-In participants enrolled for the entire fourth quarter of a given year who earned above SGA in 2003, and an approximation of the percent who earned above SGA in 2002.

[b] State requires Buy-In participants to verify that income and/or FICA taxes are being withheld from their income.

participants with UI earnings. In New Mexico, Buy-In participants who are SSDI beneficiaries and in the 24-month waiting period for Medicare comprise about half of the state's Buy-In population and are not required to demonstrate that they have earnings. In fact, New Mexico state staff noted that only about 4 in 10 participants in New Mexico's program were working at the end of 2002. These factors may contribute to its low ranking (15th out of 19 states) for the proportion of participants with UI earnings.

C. CHANGES IN EARNINGS OVER TIME

To gain insight into how earnings for Buy-In programs change over time, we analyze two different samples of Buy-In participants. In Section C.1 below, we compare earnings for Buy-In participants enrolled for the entire fourth quarter of 2002 (i.e., the fourth quarter group of 2002) to earnings for the fourth quarter group of 2003. We also examine how the percentage of the fourth-quarter group with UI earnings changes from one year to the next. In Section C.2, we analyze earnings for a cohort of Buy-In participants.

1. Changes in State Earnings and Percent with Earnings Between 2002 and 2003

Average UI earnings increased in 14 of the 16 states with two years of data (Figure VI.3). Of the 14 states that experienced an increase in earnings, 8 states saw the proportion of fourth-quarter group members with reported earnings decline (Table VI.1). State personnel were generally unclear as to why earnings among Buy-In participants in their program changed over time. However, our analysis below of earnings for a cohort of Buy-In participants examines in more detail how earnings change over time.

Overall, the proportion of Buy-In participants with reported earnings decreased by 8 percentage points from 47 percent in 2002 to 39 percent in 2003 (Table VI.1). This drop resulted primarily from decreases in four states between 2002 and 2003: (1) Connecticut (decreased from 74 percent in 2002 to 61 percent in 2003); (2) Iowa (decreased from 33 percent in 2002 to 25 percent in 2003); (3) Missouri (decreased from 26 percent in 2002 to 19 percent in 2003 and accounted for one-fourth of enrollment in 2003); and (4) Wisconsin (decreased from 44 percent in 2002 to 37 percent in 2003). Despite discussing these changes with state personnel, we could not determine whether the source of the overall decrease was due to a lower likelihood of having UI earnings among (1) new participants, (2) ongoing participants, or (3) both. Results below in Section C.2 suggest that this decrease was due, at least it part, to a decline in the proportion of ongoing participants with UI earnings.

The information presented in Section B.3 above suggests that the proportion of Buy-In participants with UI earnings is associated with the program's income verification requirements. One might expect that, if a given Buy-In program's participants are more (less) likely to have earnings, then these participants might also be more (less) likely to earn above the SGA level. Furthermore, if this association is causal, then a change in verification requirements could potentially induce a change in the proportion with earnings above the SGA level. We do not have sufficient data to determine whether, for example, an increase in the stringency of verification requirements causes the proportion of participants earning above the SGA level to increase as well. However, we can determine whether a positive

correlation exists between changes in the percent of participants with UI earnings and changes in the percent with earnings above the SGA level.

To investigate this relationship, we calculated the proportion of *all* Buy-In participants in the fourth quarter group who earned above the SGA level. This calculation assumes that participants without UI earnings have earned income below the SGA level. We then estimated the correlation between the change in this proportion between 2002 and 2003 and the change in the percent of participants with UI earnings for the same time period. We found a positive correlation of 0.78 between changes in the proportion of a state's Buy-In population with UI earnings and changes in the proportion earning above SGA (Table VI.1).[14]

Below, in Section C.2, we analyze a cohort of individuals who were enrolled in the Buy-In program in the fourth quarter of both 2002 *and* 2003 (i.e., the longitudinal group). When we calculated the correlation between changes in the percent of participants with UI earnings and the percent with earnings above SGA for this group, we found a weaker correlation of 0.31 (Table IV.2). The weaker correlation for the longitudinal group suggests that the correlation of 0.78 noted above for the fourth-quarter group is driven primarily by new (rather than ongoing) participants.

Why do we see a positive correlation between changes in the percent of Buy-In participants with UI earnings and changes in the percent of participants earning above the SGA level? If one assumes that participants without UI earnings earn less than $800 per month, then an influx of new Buy-In participants without UI earnings would decrease both the overall proportion of participants with UI earnings and the proportion earning above the SGA level. Most states were unclear as to what factors were driving changes in the proportion of their Buy-In participants with UI earnings. However, staff in New Mexico noted that the increase in the percent of participants with UI earnings from 25 percent in 2002 to 39 percent in 2003 may have been in response to the state's additional efforts to encourage its participants to increase their work effort. Therefore, it is not surprising that the

[14]We tested the validity of the assumption that participants without UI earnings have earned income below SGA and found a similar positive correlation between changes in the percent with UI earnings and changes in the percent earning above SGA when self-employment data were included for the seven states that provided self-employment earnings data in both years. The similarity of the results is consistent with the assertion that this assumption is valid. In addition, we also found a positive correlation between changes in the percent with UI earnings and changes in (1) average UI earnings, which assumes that participants not in the UI system have zero earnings; and (2) average earnings when self-employment data were included for the seven states that provided self-employment earnings data in both years. Appendix E provides a detailed discussion of how we investigated the robustness of the positive correlation between changes in the percent of participants with UI earnings and changes in the percent of the Buy-In population earning above the SGA level.

larger proportion of participants with earnings in this state was accompanied by a larger proportion that earned above the SGA level.

2. Changes in Earnings for a Cohort of Buy-In Participants

The cohort of Buy-In participants we analyze in this section consists of individuals who were enrolled for the entire fourth quarter of two consecutive years—2002 *and* 2003 (i.e., the longitudinal group). Because these individuals were enrolled in both periods, it is smaller than the fourth-quarter group (i.e., participants enrolled for the entire fourth quarter of a given year) analyzed above. In 2002, 74 percent of participants in the fourth quarter group were also in the longitudinal group, and 48 percent of longitudinal group participants in 2003 were also in the fourth quarter group.

The longitudinal group is a smaller proportion (48 percent) of the fourth-quarter group in 2003 primarily because the former does not include (1) new Buy-In enrollees who entered the program during the first three quarters of 2003; and (2) participants who disenrolled from the Buy-In program during the first three quarters of 2003. As a result, the longitudinal group may not be representative of the population of Buy-In participants and is likely more indicative of the behavior of participants who have been in the program for an extended period of time.

Average monthly earnings of longitudinal group members with UI earnings increased in 15 of the 18 states that provided these data (Table VI.2), which is consistent with the results presented above in Figure VI.3 showing that average earnings increased in 14 of 16 states. However, the proportion of the longitudinal group with UI earnings decreased between 2002 and 2003 in all but one state. These results suggest that the substantial decrease in the percent of fourth-quarter participants with UI earnings described in Section A was due at least in part to *ongoing* (as opposed to new) Buy-In participants. However, as noted above in Section C.1, it appears to be the earnings of *new* Buy-In participants that are driving the positive correlation between changes in the percent of participants with earnings and changes in the percent with earnings above SGA.[15]

Results in Table VI.2 demonstrate that average monthly earnings (among participants with reported earnings) for the longitudinal group increased by 4 percent between 2002 and 2003. However, it is unclear whether the increase in earnings among longitudinal group participants with earnings was due to higher earned income among participants with UI earnings or a decrease in the proportion of participants with earnings. The percent of the longitudinal group with UI earnings decreased from 47 to 43 percent between 2002 and 2003, so it is possible that longitudinal group members who dropped off the UI system

[15] Given the available data, we were unable to verify this finding by examining the change in earnings of new program participants.

Table VI.2: Average Monthly Earnings for the Longitudinal Group of Buy-In Participants, 2002-2003, by State

State	Total Longitudinal Group Participants	Average Monthly Earnings (Among participants with UI earnings)			Percent with UI Earnings			Percent Earning above SGA[a] (Among all longitudinal group participants)		
		2002	2003	% Change	2002	2003	Change	2002	2003	Change
Alaska	66	$1,233	$1,452	18	30	29	-2	17	18	2
California	453	$847	$943	11	60	56	-4	18	21	-4
Connecticut	1,450	$716	$757	6	73	61	-11	15	15	0
Illinois	114	$582	$535	-8	74	66	-8	9	7	-2
Iowa	4,057	$464	$440	-5	32	26	-6	4	3	-1
Kansas	305	$419	$471	12	82	76	-6	5	10	5
Maine	449	$991	$1,098	11	77	73	-4	36	37	1
Massachusetts	3,316	$1,222	$1,274	4	64	55	-8	31	27	-3
Minnesota	4,503	$591	$630	6	55	53	-3	9	9	0
Missouri	3,925	$469	$480	2	22	21	-2	3	4	1
New Hampshire	654	$516	$532	3	74	66	-8	11	11	1
New Jersey	377	$418	$593	42	1	1	0	0	0	0
New Mexico	322	$986	$1,024	4	15	14	-1	6	12	6
Oregon	320	$1,103	$1,110	1	72	72	-1	31	30	-1
Utah	55	$453	$444	-2	55	49	-5	5	4	-2
Vermont	197	$591	$632	7	74	74	-1	12	18	6
Washington	99	$599	$699	17	83	76	-7	15	20	5
Wisconsin	2,751	$526	$545	4	44	42	-3	6	7	1
Total	23,413	$716	$746	4	47	43	-5	11	11	0
Correlation with change in % with UI Earnings										0.31

SOURCE: State Annual Buy-In Report Form for 2003. (Tables D.15 and D.17)

NOTE: Data above are for participants enrolled for the entire fourth quarter of 2002 *and* 2003. States are ranked by their percent with UI earnings. Data for three states are not included because they either did not use the UI system (Indiana and Pennsylvania in both years) or used a data source in addition to the UI system (Nebraska), thus rendering their data non-comparable with other states. Discussions with state officials in Connecticut and Maine suggest potential inaccuracies with its earnings data. New York was unable to submit these data because its Buy-In program did not begin until 2003.

[a]The SGA level was $800 per month in 2003 and $780 per month in 2002. The percentages in these columns therefore represent an accurate indication of the proportion of Buy-In participants enrolled for the entire fourth quarter of a given year who earned above SGA in 2003, and an approximation of the percent who earned above SGA in 2002.

between 2002 and 2003 may have had relatively low UI earnings in 2002, which could cause average earnings in 2003 to be higher relative to the prior year even if earnings among participants with UI earnings in both years remained constant.

To gain insight into how earnings for the population of longitudinal group participants changed between 2002 and 2003, we calculated the proportion of the *all* longitudinal group participants (as opposed to longitudinal participants with earnings) earning above SGA. To do this, we assumed that longitudinal group participants without UI earnings had earned income of less than $800 per month. As noted above, the increase in earnings between 2002 and 2003 among longitudinal participants with UI earnings occurred concurrently with a decline in the proportion of participants with earnings. As a result, Table IV.2 indicates that there was no change between 2002 and 2003 in the percent of longitudinal group participants with earnings above SGA. Analysis of a cohort of individuals who are both enrolled in the Buy-In program *and* who have UI earnings in the fourth quarter of two consecutive years would provide a better measure of how earnings for a cohort of Buy-In participants changed from one year to the next. However, a more thorough understanding of the differences between Buy-In participants with and without UI earnings would then be necessary to understand the extent to which this and other analyses based on UI earnings may be generalized to the overall Buy-In population.

Although average earnings increased among longitudinal group members with UI earnings, the decrease in the proportion of longitudinal group participants with reported earnings suggests that earnings among some Buy-In participants (i.e., participants who had UI earnings in 2002 and did not have UI earnings in 2003) may have fallen.[16] Other studies (Clark et al. 2004, Porter 2004, and Tremblay and Porter 2004) have found that average earnings among new enrollees decrease following enrollment, which would be consistent (assuming the assumption above holds) with the lower proportion of longitudinal group participants in 2003 (versus 2002) with UI earnings but not consistent with the potential earnings growth among participants with earnings. A longitudinal analysis at the individual-level that includes information on a person's earnings prior to and during Buy-In enrollment could provide additional insight into this issue.

Factors independent of the Buy-In program such as a state's economic conditions could also influence the wages and types of jobs available to Buy-In participants. For example, the unemployment rate for the civilian non-institutionalized population increased between 2002 and 2003 for 15 of the 17 states, which may have put downward pressure on earnings for participants in these states' programs (BLS 2004b). Additional analysis at the individual-level with a comparison group to take into account the environment in which the Buy-In program

[16]This assumes that earnings for participants with earnings in the UI system are higher, on average, than other participants. Self-employment earnings data presented above for some states suggest that average self-employment earnings are lower than average UI earnings, which is consistent with this assumption.

is operating would be necessary to determine the independent effect of the Buy-In program on the employment and earnings of Buy-In participants.

D. POLICY IMPLICATIONS

The positive correlation between changes in the percent of Buy-In participants with UI earnings and changes in the percent with earnings above the SGA level suggests that policies that may influence the proportion of Buy-In participants with UI earnings (e.g., income verification requirements) may also influence the proportion of the Buy-In population that is earning above the SGA level. However, such a relationship is based on the limited available evidence and is insufficient to conclude that there is an independent causal relationship between the stringency of employment verification requirements and the prevalence of Buy-In participants with earnings above the SGA level in a given Buy-In program. Additional analysis of individual-level earnings data could provide insight into how the employment patterns of Buy-In participants, both new and ongoing, change over time.

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CHAPTER VII

HOW MUCH ARE PARTICIPANTS' PREMIUMS?

The designers of the Medicaid Buy-In program wanted it to resemble a traditional health insurance plan for which consumers share the costs of coverage by paying premiums, but the specific procedures for establishing premiums or other cost-sharing methods were left to the states. As a result, cost-sharing requirements vary widely among the states, influencing both the number of participants who pay premiums as well as the amount paid.

These requirements have important implications for enrollment patterns because potential participants weigh out-of-pocket costs incurred under a Buy-In program against costs of other available options, such as the amount they must spend down to be eligible for the state's medically needy program or the amount they must pay for a private health plan. For example, in a state where an individual's spend-down requirements for the medically needy program are less than the Buy-In premium, individuals have more of a financial incentive to enroll in Medicaid through the medically needy eligibility category than through the Buy-In program.

Premium design also directly affects the cost of the program to a state. States can adjust the premium structure in order to increase or decrease the overall cost of the program. If the budget climate continues to worsen for states, Medicaid programs may seek to recoup losses by increasing premiums charged to Buy-In participants.

During the design of a cost-sharing structure, states make a number of key decisions along a range of programmatic dimensions, the most important of which are (1) the income threshold above which premium payments begin, (2) the size of premium payments, and (3) the use of unearned income as a basis for determining premium payments.

A. INCOME THRESHOLD FOR PREMIUMS

Most state Buy-In programs that adopt a premium structure set an income threshold above which all Buy-In participants are required to pay a premium. As shown in Table VII.1, those states in which a large proportion of participants pay a premium tend to have a low

Table VII.1: Relationship Between the Percent of Participants Required to Pay Premiums and the Income Threshold for Premiums, by State, 2003

State	Total Number of Participants	Percent Required to Pay Premiums	Income Threshold Above Which Premium Is Required (% of FPL)[d]
California	807	100	0
Pennsylvania	2,196	70	0
Washington	208	100	1
Alaska	179	63	100
Illinois [a]	446	100	100
Kansas	621	69	100
Minnesota	6,178	97	100
Utah	118	87	100
Indiana	5,006	11	150
Iowa	6,169	26	150
Maine	733	12	150
Massachusetts	6,253	91	150
Missouri	13,678	14	150
New Hampshire	1,110	29	150
New Jersey [b]	892	0	150
New York	617	0	150
Wisconsin	5,165	11	150
Vermont	385	8	185
Connecticut	2,505	13	200
Nebraska	102	1	200
Oregon [c]	565	2	200
New Mexico [a]	890	N/A	N/A
Total	54,823	38	

SOURCE: State Annual Buy-In Reports for 2003 and state-submitted data (Table D.19).

NOTE: The data above are for individuals who were enrolled for the entire fourth quarter of the given year. New York's Buy-In Program was implemented in July 2003. States may use different methodologies to count income. For instance, some use net income; some use gross income. Some include spousal income; some do not.

[a]Illinois and New Mexico requires participants to pay a co-payment for selected Medicaid services. Illinois charges its participants co-payments and premiums. New Mexico only uses co-payments.
[b] New Jersey did not require participants to pay a premium because the amount to be collected was too small to justify administrative costs.
[c] Oregon reported that 299 participants paid an average "cost-share" of $122 in 2003, which is actually a premium based on unearned income. The cost-share is not reflected in this table.

N/A = not applicable

income threshold at which participants begin paying premiums, and vice versa. Overall, the percentage of participants required to pay a premium varied across states in 2003 from 0 to 100 percent.

Two states, California and Pennsylvania, require that all participants pay a premium.[1,2] Other states—including Illinois, Minnesota, and Utah—functionally charge each participant a premium. These three states set the income thresholds for premiums at 100 percent of the FPL, but all individuals who have incomes below the federal poverty level enroll in the states' poverty-level category for Medicaid eligibility or in the states' special Medicaid waiver programs, but they do not enroll in the Buy-In program. Thus, nearly all Buy-In participants from these three states paid a premium in 2003.[3]

States setting high income thresholds for premiums typically have a much smaller proportion of participants paying premiums. For example, Nebraska's Buy-In program set its income threshold for premiums at 200 percent of the FPL. Only one participant (or 1 percent) had family income between 200 and 250 percent of the FPL in 2003 and, therefore, was required to pay a premium. Connecticut's Buy-In program set its income threshold for premiums at 200 percent of the FPL for family income, and only 13 percent of the state's Buy-In participants paid a premium in 2003.

States determine how to count income for determining premium payments. Different income methodologies mean that, for instance, some states count family income while others count only individual income.

B. PREMIUM AMOUNT

As shown in Table VII.2, average monthly premium payments among premium-paying Buy-In participants in 2003 ranged from a low of $13 in Alaska and Maine to a high of $145 in Utah.[4] To help alleviate pressures on the Medicaid budget, a few states have redesigned their Buy-In premium structures—or considered doing so—in order to contain program costs through either a corresponding drop in enrollment, increased revenue, or both. For

[1]All participants in Washington State also paid a premium in 2003. Premium payments begin when a participant's monthly earnings exceeds a nominal amount of $66.

[2]Buy-In staff in Pennsylvania suspect that data quality issues caused the state to report less than 100 percent of its participants to have paid a premium in 2003.

[3]Some participants who have incomes less than 100 percent of the FPL may not pay a premium because they are unemployed and receiving temporary job-loss protection under the Buy-In program.

[4]Buy-In personnel in Alaska noted that the large change in the average monthly premium from 2002 to 2003 might be a result of data inaccuracies.

Table VII.2: Average Monthly Premium Amounts of those Buy-In Participants Required to Pay, by State, 2002-2003

	Total Participants		Average Monthly Premium ($)	
State	2002	2003	2002	2003
Alaska [a]	186	179	43	13
California	651	807	35	30
Connecticut	2,075	2,505	40	49
Illinois [a]	177	446	48	48
Indiana	2,344	5,006	64	82
Iowa	4,811	6,169	35	36
Kansas	384	621	67	62
Maine	617	733	12	13
Massachusetts	5,918	6,253	44	50
Minnesota	5,932	6,178	40	44
Missouri	4,736	13,678	65	66
Nebraska	91	102	72	111
New Hampshire	880	1,110	34	34
New Jersey [b]	516	892	0	0
New Mexico [a]	712	890	N/A	N/A
New York [c]	N/A	617	N/A	0
Oregon [d]	531	565	30	45
Pennsylvania	888	2,196	43	40
Utah	138	118	321	145
Vermont	336	385	18	27
Washington	136	208	81	82
Wisconsin	3,339	5,165	131	139
Total	35,398	54,823	48	51

SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.19)

NOTE: The data above are for individuals who were enrolled for the entire fourth quarter of the given year. New York's Buy-In Program was implemented in July 2003.

[a] Alaska, Illinois, and New Mexico required participants to pay a co-payment for selected Medicaid services. Alaska only charged a co-payment in 2002. Illinois charged its participants co-payments and premiums. New Mexico only used co-payments.
[b] New Jersey did not require participants to pay a premium because the amount to be collected was too small to justify the administrative costs.
[c] New York did not collect premiums in 2003 because its billing and collections system was not operational.
[d] Oregon reported that 299 participants paid an average "cost-share" of $122 in 2003, which is actually a premium based on unearned income.

N/A = not applicable

example, Utah increased Buy-In premiums from 25 percent to 35 percent of a person's income in July 2002, resulting in average monthly premiums of $321 in 2002, which was almost three times greater then the next highest state (Wisconsin). In some cases, this change caused payments to quadruple (Julnes et al. 2003), which predictably coincided with a sharp decrease in enrollment (see Chapter III). In July 2003, however, Utah revised the premium structure again, and the average monthly premium dropped to $145. By the end of the year, enrollment rates started to increase.

Another method that a Buy-In program can use to contain costs is a mandatory one-time entree fee for participants who enroll in the program, in lieu of, or in addition to, a premium payment. For example, West Virginia, which implemented its Buy-In program on May 1, 2004, charges all participants a $50 enrollment fee that includes the first month's premium.

C. PREMIUMS BASED ON UNEARNED INCOME

States may implement an additional premium based on unearned income, such as SSDI benefits. A premium based on unearned income may discourage some with low earnings from enrolling if this premium represents a significant portion of income. Wisconsin implemented a premium based primarily on total unearned income (costs for certain needs and services are disregarded). Oregon charges a premium—which the state refers to as a "cost share"—equal to all unearned income above the SSI monthly benefit amount ($554 per month in 2003), excluding any special needs. New York charges a premium equal to 7.5 percent of unearned income, although the state has placed a moratorium on premiums until its collection system is operational. Illinois, Minnesota, and Washington also have separate premiums for unearned income.

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CHAPTER VIII

WHAT ARE BUY-IN PARTICIPANTS' MEDICAID EXPENDITURES?

The cost of providing Medicaid coverage is a crucial issue for state policymakers trying to limit the growth in overall Medicaid expenditures, and there are at least three key questions that they need to answer to determine the costs associated with the Buy-In program. First, policymakers must estimate enrollment levels and the extent to which the program will attract new people to enroll in Medicaid. As discussed in Chapter IV, a program's enrollment level results from complex interactions among a program's structural (e.g., income threshold and cost-sharing requirements) and contextual features (e.g., eligibility criteria for other Medicaid coverage groups).

A second key question for state policymakers involves determining expenditure levels of program participants. More specifically, will a Buy-In program tend to attract people with Medicaid expenditures that are higher than the average Medicaid enrollee with disabilities or will the opposite be true? Some Buy-In programs, for example, may attract disproportionate numbers of adults with severe functional impairments who may have higher-than-average Medicaid costs. Other programs, however, may attract persons with disabilities who require less medical care to function in the workplace and thus have lower Medicaid expenditures. In addition, three recent studies of Buy-In participants have found that Buy-In participants with Medicaid coverage prior to Buy-In enrollment have higher Medicaid expenditures than those who do not (Clark et al. 2003, Liu et al. 2004, Tremblay and Porter 2004). We explore these relationships in more depth below.

Finally, a third question of interest to state policymakers is whether per member per month (PMPM) Medicaid expenditures for a person with disabilities changes over the course of participation in the Buy-In program. Underlying this question is the issue of how employment *affects* Medicaid expenditures—a topic that has received little research attention. Theoretically, employment might cause Medicaid expenditures for a person with disabilities to: (1) increase, because employment might cause a person with disabilities to be exposed to a higher likelihood of injury or disease; (2) decrease, due to the beneficial psychological effects that employment might have; or (3) have no measurable effects.

This chapter describes PMPM Medicaid expenditures for the total cost (state and federal dollars) of all Medicaid services paid by the state, including waiver services (e.g.,

home and community based services) and monthly capitation payments for individuals enrolled in managed care programs, but excluding administrative costs and premiums paid by Medicaid for third-party insurance or Medicare. The chapter begins with a brief overview of average PMPM Medicaid expenditures across all Buy-In programs. We then analyze state-level data on expenditures and discuss some of the potential sources of the observed variation across states. To conclude, we provide an illustrative example of how these state-level data might be used to determine how expenditures change over time, and whether this change results from increases in enrollment or PMPM expenditures.

A. NATIONAL MEDICAID EXPENDITURES

Per member per month (PMPM) Medicaid expenditures for Buy-In participants are higher than those for the average Medicaid enrollee with blindness or a disability—$1,016 PMPM for Buy-In participants versus $886 PMPM for Medicaid enrollees with blindness or a disability overall in 2002 (Holohan and Bruen 2003). Furthermore, Buy-In participants' PMPM Medicaid expenditures increased to $1,176 in 2003, a 16 percent increase from the year before. This change is somewhat higher than the 10 percent growth in overall Medicaid expenditures between 2002 and 2003 (NASBO 2003). Figure VIII.1 illustrates how Buy-In participants are distributed across expenditure categories and how this distribution changed between 2002 and 2003.[1]

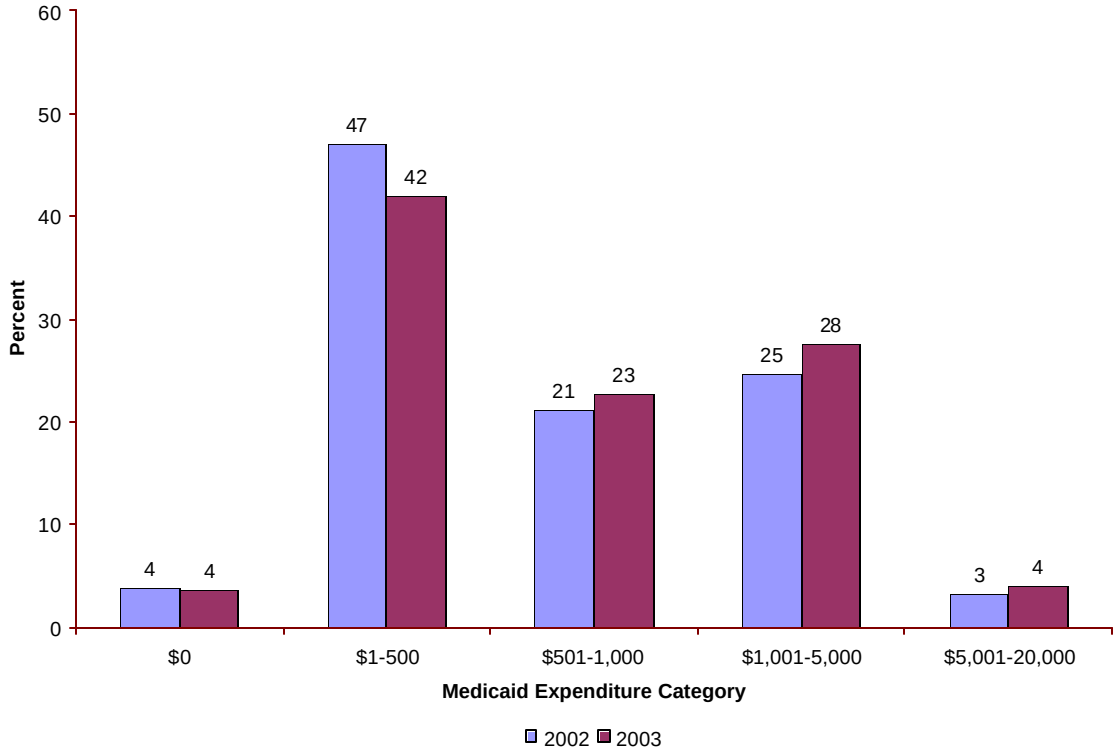
B. STATE MEDICAID EXPENDITURES

PMPM Medicaid expenditures for Buy-In participants vary substantially across states and over time (Figure VIII.2), from less than $500 in Maine to over $1,500 in Indiana, Minnesota, New Hampshire, and New York in 2003. Expenditures increased from 2002 to 2003 in 16 of the 21 states that reported data for both years and dropped in only 5 states (Connecticut, Maine, New Jersey, Utah, and Washington).

Expenditures in a given Buy-In program could be higher relative to other programs if it enrolls a disproportionate number of people with functional impairments that are more severe than the average person with disabilities. State personnel in both Indiana and Minnesota noted that they enrolled large numbers of individuals in their Buy-In programs with severe functional impairments who work in day training and habilitation facilities (sometimes called "sheltered workshops"). These individuals, according to state staff, have high Medicaid expenditures compared to the average person with disabilities and may have been a contributing factor to the high Medicaid expenditures relative to other Buy-In programs—2003 Medicaid expenditures for Buy-In participants in Indiana and Minnesota rank first and fourth, respectively, among the 22 Buy-In programs in this report.

[1] The addition of New York in 2003 had a negligible effect on the overall distribution of monthly Medicaid expenditures presented in Figure VIII.1 because the state accounts for only 1 percent of the overall Buy-In population.

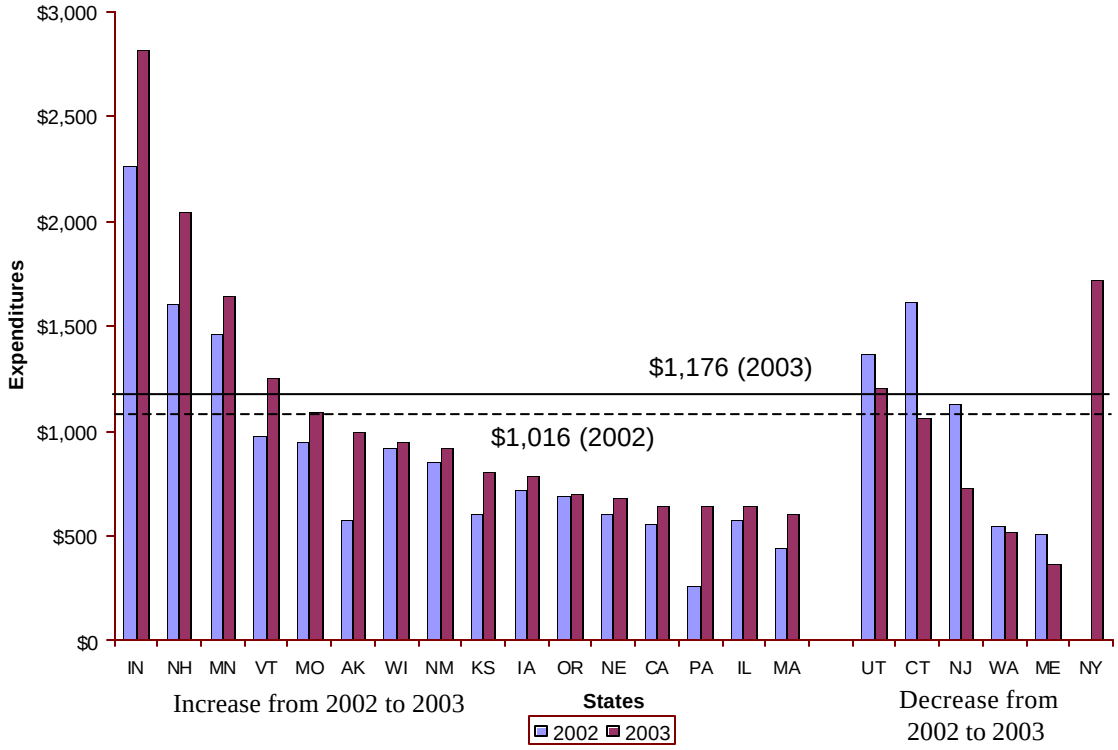
Figure VIII.1: Percent of Buy-In Participants by Category of Monthly Medicaid Expenditures, 2002 (21 States) and 2003 (22 States)



SOURCE: State Annual Buy-In Report Form for 2002 and 2003 (Table D.20).

NOTE: The data above are for individuals enrolled for the entire fourth quarter of either 2002 or 2003. New York's Buy-In program did not begin until 2003. Less than one-half of one percent had monthly expenditures over $20,000. Percentages may not sum to 100 for a given year due to rounding and the omission of the $20,000+ category.

Figure VIII.2 Average Monthly Medicaid Expenditures for Buy-In Participants in the Fourth Quarter of 2002 and 2003



SOURCE: State Annual Buy-In Reports for 2002 and 2003 (Table D.20).

NOTES: Medicaid expenditures are measured in terms of PMPM. The solid line represents the mean across the 22 states in 2003. The dotted line represents the mean across the 21 states in 2002. Means for each year are weighted based on the enrollment of each state's Buy-In program. The data above are for individuals enrolled for the entire fourth quarter of either 2002 or 2003. States in which PMPM Medicaid expenditures increased from 2002 to 2003 are on the left, and those states that had a decrease are on the right. New York's Buy-In program did not begin until 2003. State officials in Alaska suggested that the 2002 PMPM expenditure data may be incorrect.

Another factor that may be related to variation in Medicaid expenditures across states is the extent to which a program's enrollees had Medicaid coverage prior to Buy-In enrollment. As noted above, evidence from other studies suggests that Buy-In participants enrolled in Medicaid prior to Buy-In enrollment have higher expenditures than participants who were not. However, the aggregate data for this report do not allow us to calculate PMPM Medicaid expenditures separately for participants with and without prior experience in the Medicaid program prior to Buy-In enrollment.[2]

Data on a Buy-In program's Medicaid expenditures may also reflect the underlying cost of providing Medicaid coverage to persons with disabilities in a given state. Our results are consistent with Liu et al. (2004), which found that states with relatively high PMPM expenditures for the Medicaid program as a whole also tended to have high PMPM Medicaid expenditures for Buy-In participants. Table VIII.1 presents data on overall PMPM Medicaid expenditures in 2000 for the blind and for persons with disabilities and provides an indication of how states vary in the underlying cost of providing Medicaid services. Two states—California and Washington, rank low (i.e., 18th and 21st, respectively) in their average Medicaid costs for this population, which is consistent with the results in Figure VIII.2 where these states also had low Medicaid expenditures (i.e., they ranked 17th and 21st in 2003, respectively) for their Buy-In participants. Conversely, state personnel in New Hampshire and New York, where Medicaid expenditures rank second and third, respectively, noted that this pattern could result in part from high overall Medicaid expenditures in their states, which is also consistent with the information in Table VIII.1, where Medicaid expenditures in New Hampshire and New York for 2000 rank third and second, respectively.[3]

Although the aggregate data analyzed above suggest some sources of variation in Medicaid expenditures, individual-level data on Medicaid expenditures are required to conduct a more comprehensive analysis. Furthermore, additional data are required to analyze how Medicaid costs change once a person enrolls in the Buy-In program. For these types of analyses, individual-level longitudinal data on Medicaid expenditures need to be linked to earnings.

[2] We did not find a relationship between the proportion of new Buy-In participants with prior Medicaid coverage and Medicaid expenditures for participants enrolled in the fourth quarter of a given year using the annual report data. The lack of a relationship could be because these two measures are calculated for different samples.

[3] Personnel from New Hampshire note that Buy-In participants who *were not* enrolled in Medicaid prior to Buy-In enrollment had PMPM expenditures in calendar year 2003 that were less than half those of participants who *were* enrolled in Medicaid prior to Buy-In enrollment (see also Clark, Swain, and Peacock 2003, Chart 2).

Table VIII.1: Medicaid Expenditures for the Blind and Disabled Population in 2000

	Medicaid Expenditures for the Blind and Disabled
Connecticut	$1,612
New York	1,596
New Hampshire	1,519
Minnesota	1,396
Alaska	1,320
Maine	1,220
New Jersey	1,129
Utah	1,058
Kansas	1,021
Illinois	989
Massachusetts	989
Iowa	987
Nebraska	947
Indiana	943
Wisconsin	940
Vermont	879
New Mexico	842
Missouri	777
California	720
Oregon	708
Washington	536
Pennsylvania	525
Total[a]	979

SOURCE: Kaiser Family Foundation. "State Health Facts Online." Available at http://statehealthfacts.kff.org.

NOTE: Medicaid expenditures are in terms of per member per month (PMPM).

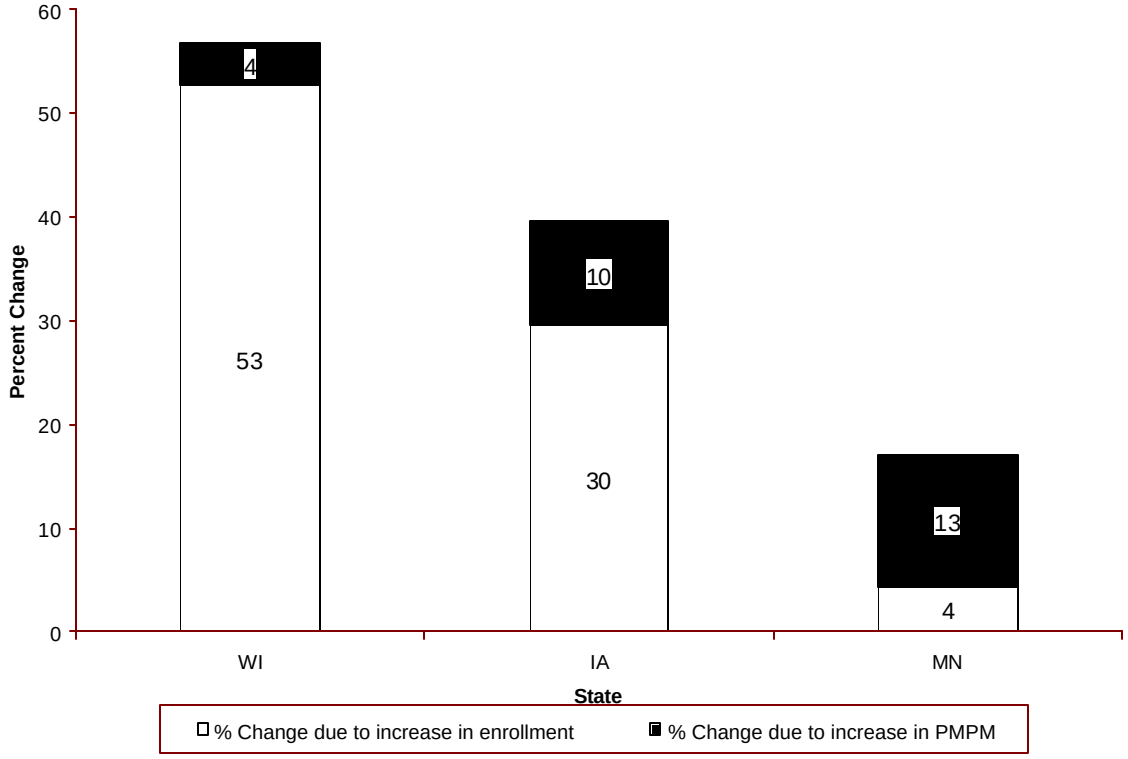
[a]This is the average PMPM Medicaid expenditures for the blind and disabled for the 22 states in the table.

C. TOTAL STATE MEDICAID EXPENDITURES

The prominence of Medicaid expenditures in a state's budget causes policymakers to closely monitor expenditure changes from year to year. The two primary determinants of total Medicaid expenditures for Buy-In participants are the number of participants and average monthly Medicaid expenditures. Ideally, we would use individual-level data on Medicaid expenditures to determine the extent to which total Medicaid expenditures for Buy-In participants grew between 2002 and 2003. Although individual-level data were not available for this analysis, we can provide a reasonable approximation for how total Medicaid expenditures for Buy-In participants increased between 2002 and 2003 by using data on PMPM Medicaid expenditures and enrollment to calculate total expenditures. Figure VIII.3 provides an illustrative example of how total Medicaid expenditures for Buy-In participants in three states—Wisconsin, Iowa, and Minnesota—changed between 2002 and 2003 and the extent to which the change was attributable to either changes in the number of total participants or average expenditures. In Wisconsin, for example, total Medicaid expenditures for Buy-In participants increased by 57 percent, of which the vast majority (53 percentage points of the total 57 percent increase) was due to an increase in enrollment. In Minnesota, however, a much smaller portion of the increase in total expenditures was due to higher enrollment—total expenditures increased by 17 percent between 2002 and 2003, of which about a third (4 percentage points of the total 17 percent increase) was due to higher enrollment. In Minnesota, the majority of the increase in overall expenditures resulted from a rise in PMPM costs.

Analysis of individual-level Medicaid data would allow us to examine total Medicaid expenditures for Buy-In participants more rigorously by disaggregating the expenditure growth into enrollment and PMPM costs for various subgroups (e.g., disability type) and analyzing how health service use of Buy-In participants changes over time.

Figure VIII.3: Percent Change in Total Medicaid Expenditures for Buy-In Participants Between the Fourth Quarter of 2002 and 2003



SOURCE: State Annual Buy-In Reports for 2002 and 2003.

NOTE: Figures are based on data for Medicaid Buy-In participants enrolled for the entire fourth quarter of 2002 or 2003. The results above are approximations of the extent to which the increase in Medicaid expenditures were attributable to either increases in enrollment or PMPM expenditures and were calculated as follows: Let $P_{(X)}$=PMPM Medicaid expenditures for Buy-In participants in the fourth quarter of year X, $N_{(X)}$=Buy-In enrollment for the fourth quarter of year X, and $EXP_{(X)}=P_{(X)}*N_{(X)}$=total Medicaid expenditures for the Buy-In program in the fourth quarter year X. The percentage change in total expenditures is therefore $\{[EXP_{(2003)}/EXP_{(2002)}]-1\}$. The percentage change in total Medicaid expenditures for Buy-In participants due to an increase in PMPM expenditures is approximated by the following equation: $[\ln(P_{(2003)}/P_{(2002)})/\ln(EXP_{(2003)}/EXP_{(2002)})]*\{[EXP_{(2003)}/EXP_{(2002)}]-1\}$. The percentage change in total Medicaid expenditures for Buy-In participants due to an increase in enrollment is approximated by $[\ln(N_{(2003)}/N_{(2002)})/\ln(EXP_{(2003)}/EXP_{(2002)})]*\{[EXP_{(2003)}/EXP_{(2002)}]-1\}$. This method provides more accurate estimates in cases where the percentage change in total expenditures was small.

CHAPTER IX

SUMMARY AND NEXT STEPS

Federal legislation establishes broad parameters for the Medicaid Buy-In program and gives states substantial flexibility in implementing almost all program components. As a result, state Medicaid Buy-In programs vary widely and represent different operational approaches to assisting adults with disabilities to increase earnings and still maintain health insurance coverage.

This study has provided an important opportunity to analyze the Buy-In program at the national level and to observe the extent to which quantitative measures of enrollment and participant characteristics vary across states. Furthermore, the availability of data for both 2002 and 2003 provides information on changes in state Buy-In programs over a two-year time period. To supplement these data, we held discussions with personnel in each state to obtain their views concerning the factors, both programmatic and contextual, that may underlie state differences. Combined, these two sources of data yielded important insights into the relationship between program structure, enrollment patterns, and participation trends.

A. SUMMARY OF FINDINGS

We addressed the following five general questions using aggregate data from 22 Buy-In programs. Our assessment provides a profile of the program at the national level and describes the extent of variation across states.

1. ***Is the Buy-In program growing?*** Enrollment in Buy-In programs grew dramatically in the 2002 and 2003 period. The addition of new states with Buy-In programs caused enrollment to nearly triple from approximately 22,000 in December 2001 to about 60,000 in December 2003. This rapid growth was due in large part to three states (Indiana, Missouri, and Pennsylvania) that implemented Buy-In programs in 2002.

2. ***Who participates in the Buy-In program?*** Buy-In programs are attracting individuals who were previous Medicaid enrollees, SSDI beneficiaries, and dually eligible for Medicaid and Medicare. Nationally in 2003, about three-fourths of

Buy-In participants were in Medicaid at some point during the year prior to enrolling in the Buy-In program. A similar proportion was receiving SSDI cash benefits at enrollment. Among those enrolled during the fourth quarter of 2003, 76 percent were dually enrolled in Medicaid and Medicare. Each of these proportions varied markedly across states: the percentage of new Buy-In participants in Medicaid prior to enrollment ranged from 56 percent in New Jersey to 91 percent in Nebraska; the percentage with SSDI benefits at enrollment varied from 47 percent in Maine to 100 percent in Nebraska; and the percentage enrolled in both Medicaid and Medicare during the fourth quarter of 2003 ranged from 33 percent in New Mexico to 90 percent in Nebraska, Kansas, and Maine.

3. ***How much are Buy-In participants earning?*** The data suggest that, nationally, the majority of Buy-In participants are SSDI beneficiaries and these participants seek employment that allows them to maintain their eligibility for SSDI cash benefits. Earnings above the substantial gainful activity (SGA) level ($800 per month in 2003) for extended periods of time will eliminate SSDI cash benefits. Of the 39 percent of Buy-In participants who had earnings in state UI systems in 2003, about 7 in 10 had earnings below the SGA level (i.e., $800 per month in 2003) established by the SSI and SSDI programs. The proportion of individuals with monthly earnings drops markedly when earnings reach the SGA level: 18 percent had monthly earnings between $601 and $800 in 2003 whereas only 8 percent had earnings in the $801 to $1,000 range.

4. ***How much are Buy-In participants' premiums?*** In 2003, 38 percent of Buy-In participants paid premiums. Average monthly premiums among Buy-In participants who paid them ranged from $13 in Alaska to $145 in Utah. All but two states charged premiums to Buy-In participants, and in three states all participants paid premiums.

5. ***What are Buy-In participants' Medicaid expenditures?*** Buy-In participants' Medicaid expenditures per member per month (PMPM) are higher ($1,016 PMPM in 2002) than the average Medicaid enrollee with blindness or a disability ($886 PMPM in 2002, according to Holohan and Bruen 2003). Average PMPM Medicaid expenditures for participants enrolled in the Buy-In program for the entire fourth quarter of 2003 increased by 16 percent across states from $1,016 in 2002 to $1,176 in 2003. Across states, average monthly expenditures ranged from $367 in Maine to $2,813 in Indiana in 2003.

B. RELATIONSHIP BETWEEN PROGRAM DESIGN AND OUTCOMES

Buy-In outcomes, such as enrollment and participants' earnings and expenditures, are the product of complex interactions among myriad factors.[1] Information in the previous

[1]Jensen et al. (2002) provides a comprehensive discussion of the tradeoffs states face when designing their Buy-In program.

chapters provides some insight into the relationship between states' program design choices and the outcomes of their Buy-In program. This section contains a summary of the associations between program design and outcomes, but 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. Consequently, our findings cannot provide states with a definitive recipe for achieving particular outcomes. For example, using a low asset limit for Buy-In eligibility may be effective in constraining program enrollment in most circumstances, but the actual effect of this policy choice will be determined by its interaction with other important factors (e.g., extent of outreach or eligibility criteria for other Medicaid eligibility categories).

1. Enrollment

- ***Income and asset eligibility criteria.*** How states define the income and asset eligibility criteria for their Buy-In program affects the size of the eligible population and, consequently, enrollment patterns. We found that states with low enrollment per 100,000 residents age 18 to 64 (hereafter, enrollment per 100,000) were more likely to have low asset limits, and that the reverse was also true. In addition, the three states with the highest income limits also had high enrollment per 100,000. States that wish to limit or expand enrollment may want to consider revising their income and asset eligibility criteria.

  A limit on a Buy-In participant's unearned income is another mechanism available to states that may constrain Buy-In enrollment by limiting the number of new participants who are already enrolled in other cash assistance programs, especially SSDI beneficiaries who comprise approximately 75 percent of the Buy-In population.

- ***Cost-sharing structure***. States may use the premium structure to alter the cost to enrollees of participating in the program. By doing so, they also change the incentive for participants to enroll or remain enrolled and may therefore affect enrollment patterns. For example, state personnel in Utah indicated that an increase in the Buy-In program's premium, implemented in response to state budget shortfalls, led to a subsequent decrease in Buy-In enrollment. 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.

- ***Grace period***. States wishing to minimize interruptions in Medicaid coverage due to participants' health problems or loss of employment have instituted a grace period during which an individual can remain enrolled in the Buy-In program despite a lack of earnings. Although we did not find conclusive evidence of a relationship between the presence of a grace period and participants' cycling on and off of the Buy-In program (i.e., "churning"), our

discussions with state personnel suggest that having a grace period may limit churning.

- ***Program context.*** The size of the population eligible for the Buy-In program is determined in part by the income and asset thresholds for other means of obtaining Medicaid coverage in a state (e.g., traditional Medicaid, the medically needy program, SSI, and the 1619 provisions). Although evidence of this theoretical relationship was limited in the data, we did find that some states with high (low) enrollment per 100,000 also had eligibility criteria for traditional Medicaid and the medically needy program that were more (less) restrictive than other states.

  The theoretical relationship between program context and enrollment also implies that changes in, for example, the income threshold for traditional Medicaid or the medically needy program could impact Buy-In enrollment. In Missouri, for instance, state personnel noted that one reason for its Buy-In program's rapid increase in enrollment was a substantial increase in out-of-pocket costs for enrollees in its spend down program.

- ***Outreach.*** The level of outreach conducted by the state or advocacy groups to educate persons with disabilities and eligibility workers about the Buy-In program appears to contribute to Buy-In enrollment levels. States with existing programs hoping to increase Buy-In enrollment may wish to invest in a higher level of outreach.

2. 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 and a lower proportion earning above the SGA level. We also found that the proportion of Buy-In participants with UI earnings was related to the proportion earning above the SGA level. Therefore, policies (e.g., imposing more stringent verification requirements) that could potentially increase the proportion of participants with earnings also may increase the proportion with earnings above the SGA level.

- ***Grace period.*** Theoretically, the presence of a grace period should lower the average earnings of participants in a Buy-In program because it allows participants to remain in the program during spells of unemployment, but there was no conclusive evidence of this relationship. We did find limited evidence that states without a grace period tended to have higher average earnings.

- ***Program context.*** In addition to potentially influencing enrollment patterns across states, the eligibility criteria for other means of obtaining Medicaid eligibility also may indirectly affect the earnings of Buy-In participants. For example, we found limited evidence that states with relatively high income

thresholds for traditional Medicaid tended to have high average earnings among Buy-In participants compared to other states.

3. Medicaid Expenditures

We documented extensive cross-state variation in average monthly Medicaid expenditures, but the extent to which program features were associated with this variation was unclear. Personnel from some states noted that their high average expenditures may be driven by the enrollment of large numbers of participants with severe functional impairments. Evidence from previous studies suggests that individuals who were in Medicaid prior to enrolling in the Buy-In program have higher average expenditures than those who do not (Clark et al. 2003, Liu et al. 2004, Tremblay and Porter 2004). This observation suggests that personnel estimating future Medicaid expenditures will want to consider the number of individuals whom the state expects to enter the Buy-In program from other Medicaid eligibility categories and their health and functional status.

As existing Buy-In programs mature and new programs are implemented, states will increasingly have the opportunity to reevaluate their policy choices. The changes that ensue from a Buy-In program's decision to modify its policies 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.

C. NEXT STEPS

Our findings underscore the variability across states in terms of the size of the Medicaid Buy-In program, participation trends, and most program features. Although the data do not allow direct measurement of the relationship between the each state's program design and program outcomes, our findings show that the choices that states make when establishing their programs have implications for enrollment patterns and program effects. To further understand these implications, several important policy questions should be addressed, such as:

- ***What is the relationship between the characteristics and context of state Buy-In programs and Buy-In enrollment?*** As noted above, we found that the programmatic and contextual features of a state's Buy-In program are associated with enrollment patterns. Further examination of this issue using individual-level data could reveal the extent of this association as well as the relative importance of other key factors (e.g., a person's earnings and medical expenditures) that affect individuals' decisions to enroll or remain in the program.

- ***To what extent does the Buy-In program affect participants' earnings and work patterns?*** Perhaps the most important question related to the success of the Buy-In program, this question follows directly from one of the Buy-In

program's primary goals—reducing the work disincentive created by the linkages among earnings, cash assistance, and Medicaid coverage. Based on our analysis of UI earnings for a cohort of Buy-In participants, we could not determine how earnings change for the cohort over time because of changes in the proportion of the cohort with UI earnings from one year to the next. Obtaining data on a cohort of Buy-In participants with UI earnings in the fourth quarter of two consecutive years could provide greater insight into how earnings change over the course of Buy-In enrollment. In addition, aggregate data alone do not allow us to determine whether the program affects earnings or whether program characteristics attract individuals with either high or low earnings. Longitudinal data at the individual level and a comparison group are needed to observe how an individual's earnings and employment patterns are influenced by enrollment in the Buy-In program.

- ***To what extent does the work disincentive caused by the SSDI "cash cliff" discourage Buy-In participants from working more?*** Results based on data from each state's UI data system demonstrated that only about one-fourth of Buy-In participants who reported UI earnings earn above the SGA level, suggesting that the SSDI "cash cliff" inhibits some Buy-In participants from increasing their earnings above the SGA level. The three-fourths of participants who are receiving SSDI benefits at Buy-In enrollment may be especially sensitive to this disincentive. However, it is unclear how the earnings of SSDI beneficiaries change after joining the Buy-In program. Again, individual-level data on earnings both prior to and during Buy-In enrollment, for participants with and without SSDI, would be required to examine this issue in more depth.

- ***How are participants' Medicaid expenditures related to program characteristics?*** Individual-level Medicaid claims data for Buy-In participants would enable a more comprehensive examination of how and why average monthly Medicaid expenditures vary across states. These additional data would allow for the construction of measures such as the type of disability, the prevalence of individuals with multiple disabilities, and the distribution of Medicaid expenditures across service types (e.g., inpatient, personal assistance services). These data would also permit us to examine how Medicaid expenditures change for individuals over the course of Buy-In enrollment. Finally, taking into account cross-state variation in coverage and reimbursement rates for states' Medicaid programs could provide additional insight into sources of variation in Medicaid expenditures for Buy-In participants.

- ***What implications does the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 have on Buy-In programs and their participants?*** The implementation of the Medicare prescription drug benefit in 2006 means that Buy-In participants who are Medicare beneficiaries will receive their prescription drug coverage through Medicare beginning in 2006 rather than Medicaid, as is currently the case. Questions of whether coverage through Medicare will be adequate and the extent to which cost

sharing will change under the new law concern beneficiaries, policymakers, and advocates. Furthermore, the extent to which state Medicaid expenditures will change as a result of the MMA's shifting responsibility for the financing of prescription drugs from states to the federal government is unknown.[2] SSDI beneficiaries' continued participation in the Medicaid Buy-In program after 2006 may depend partly on the extent to which these individuals value Medicaid coverage either because it covers services that Medicare does not or because it helps them finance their Medicare premiums and cost sharing.

Overall, as noted above, the use of individual-level data would allow for the consideration of many of these policy questions. Possible data sources include eligibility and claims files from the Medicaid Statistical Information System (MSIS) and from Medicare standard analytical files, as well as data from the Social Security Administration (SSA) databases. Common identifiers in these data 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 SSDI. At least one previous study of Buy-In participation in five states has demonstrated the feasibility of developing and analyzing individual-level data (Liu et al. 2004).

In addition to enabling researchers to address more of the questions posed above, a person-level database of longitudinal records would benefit states. First, states that are considering implementing a new Buy-In program or altering an existing one would benefit from such detailed information when making policy decisions. Second, the availability of individual-level data from eligibility and claims files could potentially replace some of the data required by the annual report on Buy-In participation and thus decrease the states' reporting burden. Finally, using a single data source for all states would improve data quality and facilitate cross-state comparisons.

[2]The "phased-down State contribution" component of the MMA legislation (otherwise known as the "clawback") requires states to finance up to 90 percent of the cost of providing Medicare drug coverage to individuals enrolled in both Medicaid and Medicare (Schneider 2004). States also may experience higher administrative costs and greater enrollment of dual eligibles because of the very low beneficiary cost sharing for dual eligibles in Part D and the additional publicity generated as part of MMA implementation.

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APPENDIX A

CHARACTERISTICS OF STATE BUY-IN AND MEDICAID PROGRAMS, 2003

This appendix provides a summary of state Buy-In programs in two forms. First, we provide a table containing each state's Buy-In program characteristics. This table contains information on (1) the medically needy income limit; (2) the income standard for categorical Medicaid coverage (e.g., the poverty-level option); and (3) the combined federal SSI benefit and state supplement, all of which are important for understanding the context of public assistance programs in which the Buy-In program operates. Below is an explanation of the categories used in Table A.1 and a short description of the relevance of each program characteristic.[1]

Following the table are one- to two-page descriptions of each of the 22 Buy-In programs addressed in this report. We presented information for each state's program in the following categories: (1) overview; (2) eligibility criteria and program context; (3) premium structure; (4) other policies; and (5) program experience. We combined categories in some states where we thought it was appropriate and where we were missing needed information.

Implementation date	This indicates when the program began and is important because a program's enrollment tends to grow at a slower rate as it matures.
Federal authority	BBA = Balanced Budget Act of 1997 Ticket Act = Ticket to Work and Work Incentives Improvement Act of 1999 The federal authority denotes the set of regulations to which the state's Buy-In program must adhere. The BBA and the Ticket Act have somewhat different requirements. For instance, the BBA sets the income eligibility threshold at 250 percent of the FPL, and the Ticket Act allows states to establish their own income standards.

[1]The information in Table A.1 was taken from Jensen (2004) and discussions with state Buy-In personnel.

Income eligibility	This information describes how much income a program participant is allowed to have in each state. These criteria may influence Buy-In enrollment. Income eligibility is presented as a percentage of the federal poverty line (FPL). The table also indicates whether the state counts spousal income when determining Medicaid Buy-In eligibility.[2]
Resource limit	This is the maximum level of assets that a participant can accumulate and remain eligible for the Buy-In program. Similar to income eligibility, the resource limit may influence Buy-In enrollment.
Medically needy income limit	This is the maximum amount of income a person may have to be eligible for the medically needy program; one means for persons with disabilities to obtain Medicaid coverage. If a person's income is above this limit, he or she must spend down until his or her income is below it to become eligible for Medicaid through the medically needy program. A low medically needy income limit implies that it is more difficult for an individual to spend down and qualify for Medicaid, which may make the Buy-In program a relatively more attractive option. We present the monthly limit in 2003 for an unmarried person with disabilities
Income standard for other categorical Medicaid	This is the income threshold below which an individual with disabilities is categorically eligible for Medicaid. States that provide categorical coverage up to a high level may have a smaller pool of individuals who are eligible for the Buy-In program. We present the monthly income threshold in 2003 for an unmarried person with disabilities to qualify for categorical Medicaid eligibility (e.g., the poverty-level option).

[2]In states that use SSI methodology, countable income is unearned income minus $20 plus one-half of all earned income above $65. Therefore, countable income can be less than half of an individual's earned income.

SSI benefit	SSI benefit (combined state and federal) is the total amount of cash benefits that an SSI recipient receives from the federal and state governments. The benefit level can have a major impact on Medicaid eligibility levels in states. A high benefit level expands mandatory Medicaid coverage to a larger number of individuals and, thus, makes the Buy-In program an option to a smaller number of workers with disabilities. Monthly combined federal and state SSI benefit in 2003 for an unmarried person with disabilities
1619(b) income threshold	This is the ceiling for former SSI recipients to receive mandatory Medicaid coverage. Therefore, a high 1619(b) threshold provides Medicaid coverage to a larger number of people and should reduce the pool of Buy-In eligibles. Monthly income threshold for an unmarried person with disabilities in 2003
Premium threshold	This is the income level above which Buy-In participants are required to pay a premium, and it is related to the number of people who pay a premium, which, in turn, relates to how costly the Buy-In program is for participants.
Cost-sharing policy	This determines who pays a premium, how much each participant pays, and how premiums are graded across different income brackets, all of which shape enrollment patterns.
Income verification requirements	This describes the procedures for verifying participants' income. Because states cannot define work or require participants to work a minimum number of hours, income verification requirements are one way to influence the employment practices of its Buy-In enrollees.
Work stoppage protection	These provisions allow a person with disabilities to remain enrolled in the Buy-In program without earnings The presence of a grace period may minimize the cycling of participants on and off of the program and also may influence the earning patterns of program participants.

TABLE A.1

CHARACTERISTICS OF STATE BUY-IN AND MEDICAID PROGRAMS, 2003

	Alaska	California	Connecticut	Illinois
Implementation date	July 1999	April 2000	October 2000	January 2002
Federal authority	BBA	BBA	Ticket Act Basic and Medical Improvement	Ticket Act Basic
Income eligibility	Earned income: Up to 250% FPL for Alaska[a] (includes spousal income) Unearned income must be at or below $1,025 per month	Up to 250% FPL (include spousal income)	Up to $75,000 per year (excludes spousal income)	Up to 200% FPL (includes spousal income)
Resource limit	$2,000 individual $3,000 couple	$2,000 individual $3,000 couple	$10,000 individual $15,000 couple	$10,000 (includes spousal resources)
Medically needy income limit	N/A	$600	$477	$283[b]
Income standard for other categorical Medicaid	$1,025	$748 + $230 disregard = $978	N/A	$748
SSI benefit (combined federal and state)	$914	$757 from January through May, $778 from June through December	$747	Individually budgeted
1619(b) income threshold, 2003	$3,026	$2,236	$3,311	$2,117
Premium threshold	100% FPL	Net countable income of $1	200% FPL	100% FPL
Cost-sharing policy	A sliding-scale premium as a fixed percentage of income. The maximum premium is 10 percent of net family income.	A sliding-scale premium is based on net countable income. For income from $1 up to 250% FPL, premiums range from $20 to $250 for an individual and $25 to $375 for a couple.	Premiums equal 10% of total income above 200% FPL	Premium payment categories are calculated based on the sum of 7.5% of unearned and 2% of earned income.
Income verification requirements	Eligibility is based entirely upon receipt of earned income, which includes spousal income. Not required to demonstrate that income and FICA taxes are being paid.	Proof of employment (e.g., pay stubs or written verification from the employer). Self-employed or contractor provide records (e.g., W-2 forms, 1099 IRS form). Not required to demonstrate that income and FICA taxes are being paid.	Must have payroll taxes, including FICA, taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records.	Employment must be verified by pay stubs and employer documents that income is subject to income taxes and FICA.
Work stoppage protection	None	None	Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay the monthly premium based on remaining income.	Up to 90 days if premiums are paid and a letter from a physician is submitted stating that the enrollee is unable to work due to health problems.

[a]Federal poverty guidelines for Alaska are higher than those for the 48 contiguous states

[b]Although Illinois had a medically needy income level of $283 in 2003, the disregard of income between $283 and the federal poverty level ($748 in 2003) gives the state, in effects, a medically needy income level of $748.

	Indiana	Iowa	Kansas	Maine
Implementation date	July 2002	March 2000	July 2002	August 1999
Federal authority	Ticket Act Basic	BBA	Ticket Act Basic	BBA
Income eligibility	Up to 350% FPL (excludes spousal income)	Up to 250% FPL (includes spousal income)	Up to 300% FPL (includes spousal income)	Up to 250% FPL on total income, up to 100% FPL on unearned income (includes spousal income)
Resource limit	$2,000 (includes spousal resources)	$12,000 individual $13,000 couple	$15,000 (includes spousal resources)	$8,000 individual $12,000 couple
Medically needy income limit	$552	$483	$475	$315
Income standard for other categorical Medicaid	N/A	N/A	N/A	Federal Poverty Level option is $803 (includes $55 income disregard)
SSI Benefit (combined federal and state)	$552	$552	$552	$562 plus $55 income disregard for state SSI supp.
1619(b) income threshold, 2003	$2,362	$1,762	$2,129	$1,871
Premium threshold	150% FPL	150% FPL	100% FPL	150% FPL
Cost-sharing policy	Based on percentage of applicant and spouse's gross income according to family size.	Based on sliding scale premium schedule with 11 premium brackets, ranging from $20 to $201[a]	Sixteen premium amounts based on income brackets from $55 to $152 for individual and $74 to $205 for two or more. Cannot exceed 7.5% of income.	$10 premium for 150%-200% FPL, $20 for 200%-250% FPL
Income verification requirements	Must have pay stubs and documentation that enrollee is paying income and FICA taxes.	Must have earned income verifiable by pay stubs, completed tax forms, or a signed statement from a person's place of work. Not required to demonstrate that income and FICA taxes are being paid.	Employment must be verifiable by pay stubs and employer documents that income is subject to FICA taxes.	Must have earned income. Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	Enrollment can continue for up to 1 year after losing employment.	6 months	6 months	None

[a]In 2003, Iowa started to link the premium amount to state employees' health insurance and reviewed annually. Effective January 1, 2004, the number of premium brackets increased to 16, and the premium ranged from $22 to $355.

	Massachusetts	Minnesota	Missouri	Nebraska
Implementation date	July 1997	July 1999	July 2002	7/1/1999
Federal authority	1115 Demonstration Waiver	BBA (prior to Oct 2000), Ticket Ac Basic (as of Oct 2000)	Ticket Act Basic	BBA
Income eligibility	No limit	No upper income limit. Must have monthly wages or self-employment earnings of more than $65. (excludes spousal income)	Up to 250% FPL (excludes spousal income unless spouse's income is over $100,000)	Two-part income test: (1) Countable income must be less than SSI standard ($552 in 2003)[b]; (2) up to 250% FPL (includes spousal income)
Resource limit	No limit	$20,000 individual (excludes spousal resources)	$999.99 individual (excludes spousal resources)	$4,000 individual $6,000 couple
Medically needy income limit	N/A[a]	$561 (75% of FPL)	209(b) state with required spend-down program - $552	$392
Income standard for other categorical Medicaid	$995	$748 (100% of FPL)	N/A	$748
SSI Benefit (combined federal and state)	$681	$633	$552	$560
1619(b) income threshold	$2,397	$2,616	$2,130	$2,109
Premium threshold	150% FPL (prior to March 2003); A minimum $12 (as of March 2003).	All enrollees must pay a minimum premium of $35.	150% FPL	200% FPL
Cost-sharing policy	Premiums based on two different sliding scales—one for enrollees with other health coverage, one for enrollees without it. As of Mar 2003, all enrollees pay a premium based on a sliding income scale with a $12 minimum amount.	Premiums based on a minimum of $35 or a sliding fee scale based on income and household size. The premium gradually increases to 7.5% of income for incomes equal to or above 300% of FPL. No maximum premium amount.	Four premium brackets: 151% to 175% FPL; 176% to 200% FPL; 201% to 225% FPL; and 226% to 250% FPL. Premiums are a percentage of income ranging from 4% for the lowest bracket to 7% for the highest bracket.	Sliding scale based on income ranging from 2% of income if income is from 200% to 210% of FPL to 10% of income if income is from 240% to 250% of FPL.
Income verification requirements	Demonstrate at least 40 hours of work per month and that income taxes are being paid.	Earned monthly income above $65. Not required to demonstrate that income and FICA taxes are being paid.	Must be employed. Not required to demonstrate that income and FICA taxes are being paid.	Must have earned income based on pay stubs, employer forms, or tax returns. Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	Up to 3 months if the participant maintains the premium payments.	Up to 4 months if no earned income due to medical condition or involuntary job loss.	None	None

[a] Massachusetts is unique in that, rather than have a medically needy or spend down program as many other states do, all persons with disabilities who are not eligible for the working benefit plan of CommonHealth (i.e., the state's Buy-In program) are eligible for the non-working benefit plan, which requires that participants meet a one-time deductible to receive coverage. See the summary below for additional information.

[b] In Nebraska, countable income includes earned income from spouse and unearned income from applicant unless the applicant is in an SSDI trial work period, in which case the applicant's unearned income is disregarded

	New Hampshire	New Jersey	New Mexico	New York
Implementation date	February, 2002	February, 2000	January, 2001	7/1/2003
Federal authority	Ticket Act Basic	Ticket Act Basic	BBA	Ticket Act Basic and Medical Improvement
Income eligibility	Up to 450% FPL on earned income (includes spousal income)	Up to 250% FPL on earned income; up to 100% FPL on unearned income disregarding SSDI or SSI benefit (includes spousal income)	Up to 250% FPL on earned income, and up to $1,090/month on unearned income (include spousal income)	Up to 250% FPL (includes spousal income)
Resource limit	$20,889 individual [b] $31,334 couple	$20,000 individual $30,000 couple	$10,000 individual $15,000 couple	$10,000 (includes spousal resources)
Medically needy income limit	$566	$367	N/A	$642
Income standard for other categorical Medicaid	N/A	$748	N/A	N/A
SSI Benefit (combined federal and state)	$579	$583	$552	$639
1619(b) income threshold	$3,460	$2,262	$1,899	$2,845
Premium threshold	150% FPL	150% FPL	Not applicable	150% of FPL
Cost-sharing policy	Six brackets from $80 to $220 for individuals; individuals with gross income (spousal included) that exceeds $75,000 are required to pay premiums of 7.5% of the adjusted gross income	Flat rate $25 individual $50 couple	Co-payments required at all income levels, no co-pays for Native Americans; clients responsibility to keep track of co-payments	3% of net earned income plus 7.5% of net unearned income. Premiums not collected until automated premium collection and tracking processes are available.
Income verification requirements	Must be employed (proven with a pay stub or 1099 estimated tax statement if the individual is self-employed). Must also demonstrate that appropriate FICA contributions are being made.	Be employed full or part time. Not required to demonstrate that income and FICA taxes are being paid.	Proof that the applicant earned or expects to earn sufficient wages in calendar quarter to count toward Social Security coverage ($890 in a quarter in 2003).[a] Not required to demonstrate that income and FICA taxes are being paid.	Must have earned income and. demonstrate that income and FICA taxes are being paid.
Work stoppage protection	12 months	Up to 26 weeks if the person has worker's compensation or Temporary Disability Insurance and intends to return to work	None	Up to 6 months in a 12-month period for medical reasons and involuntary job loss with intent of returning to work

[a]New Mexico waives its work requirement for Buy-In participants in the two-year waiting period for Medicare.

[b]Participants in New Hampshire who disenroll from the Buy-In program but remain enrolled in Medicaid have "asset continuity," allowing them to keep the assets acquired during Buy-In enrollment in a separate bank account that is excluded from Medicaid eligibility requirements.

	Oregon	Pennsylvania	Utah	Vermont
Implementation date	February, 1999	1/1/2002	June 1, 2001	January 1, 2000
Federal authority	BBA	Ticket Act Basic and Medical Improvement	BBA	BBA
Income eligibility	Up to 250% FPL on adjusted earned income (excludes spousal income) As of May 2003, participants must have minimum earnings of $900 per quarter.	Up to 250% FPL (includes spousal income)	Up to 250% FPL (includes spousal income).	Two-part test for family income: 1) Income less than 250% FPL, 2) Income less earnings plus $500 of DI at or below MNIL or SSI standard
Resource limit	$12,000 for individuals before July 2003; since July 2003, $5000 for new or re-certified individual	$10,000 (includes spousal resources)	$15,000 (includes spousal resources)	$2,000 individual $3,000 couples Disregards assets accumulated since enrollment
Medically needy income limit	$413[a]	$425	$748[b]	$733
Income standard for other categorical Medicaid	N/A	$748	$748	N/A
SSI Benefit (combined federal and state)	$554	$579	$552	$607
1619(b) income threshold	$2,126	$1,816	$1,634.33	$1,980
Premium threshold	After 6 months, income in excess of $2,200/month; Unearned income above the SSI level	All participants pay a premium	100% FPL	185% FPL
Cost-sharing policy	"Cost share" for unearned income above SSI standard; premium for income above 200% FPL (add remaining unearned income after cost-share is paid, minus certain taxes and expenses). Premium adjusted to 2-10% of income	5% of countable income. Premiums of less than $10 are waived.	In July 2002, the premium increased from 20% of countable income to a range from 30% to 55% of countable income. In July 2003, the premium was reduced to 15% of countable income	Two premium brackets: From 185-225% FPL, $20; from 225-250% FPL, $24. In July 2003, the amount rose to $50 and $60, respectively.
Income verification requirements	Must have at least $900 per quarter. Not required to demonstrate that income and FICA taxes are being paid.	Must provide verification of earned income. Not required to demonstrate that income and FICA taxes are being paid.	Pay stubs or business plan. Not required to demonstrate that income and FICA taxes are being paid.	Must have earned income. Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	Eligibility for persons retaining an employment relationship with employer and for persons otherwise eligible for Medicaid	May remain in program and have premium waived for up to 2 months if unable to work due to job loss or health problems.	None.	None

[a]Oregon eliminated its medically needy program on February 1, 2003.
[b]In July 2003, Utah increased the medically needy income threshold from $386 per month to $748 per month.

	Washington State	Wisconsin
Implementation date	January 2002	March 2000
Federal authority	Ticket Act Basic and Medical Improvement	BBA
Income eligibility	220% FPL (includes spousal income)[a]	Up to 250% FPL (includes spousal income)
Resource limit	No resources test	$15,000 individual (excludes spousal resources)
Medically needy income limit	$571	$592
Income standard for other categorical Medicaid	N/A	N/A
SSI Benefit (combined federal and state)	$570.90 (state-administered supplementation program)	$636
1619(b) income threshold	$1,695	$1,929
Premium threshold	$66 earned income	150% FPL
Cost-sharing policy	The lesser of (1) 7.5% total income or (2) a total of the following: 50% unearned income above MNIL plus 5% total unearned income plus 2.5% earned income after deducting $65	Equal to the sum of (1) 3% of an individual's earned income, and (2) 100% of unearned income minus certain needs and expenses and other disregards. If the second calculation is less than $25, the person pays $0.
Income verification requirements	Must have payroll taxes taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records	Required to either work or participate in an employment counseling program, which one can do for up to a year. Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay the monthly premium based on remaining income.	Work requirement may be waived for up to 6 months for health problems. May also enroll in employment counseling.[b]

[a]Only the participant's income is counted if spousal income is less than half of the SSI standard.
[b]Wisconsin limits the duration and frequency (twice in a five-year period) of enrollment in employment counseling.

ALASKA

Overview. The Working Disabled Medicaid Buy-In program was implemented in July 1999 under the authority of the BBA. Enrollment has increased steadily since the program's inception, reaching 192 enrollees as of December 2003. Although enrollment in the Working Disabled Medicaid Buy-In program is low relative to other states, it is substantially higher than the Alaska Department of Health and Human Services originally predicted.

Alaska's Buy-In program is one component of a broader initiative called Alaska Works that is designed to "address the major barriers keeping people with disabilities who receive public support from working" (Folkemer et al. 2002, Health and Social Services, State of Alaska 2004).

Eligibility Criteria and Program Context. To be eligible for Alaska's Buy-In program, disabled adults must (1) be ineligible for Alaska's state SSI supplement (Adult Public Assistance or APA), which is accompanied by Medicaid coverage; and (2) pass both a net family income test and an unearned income test. The family income test requires that the net countable income of each family member be below 250 percent of the FPL for Alaska.[3] The unearned income test requires that the individual's unearned income be at or below the income standard for the Adult Public Assistance program ($1,025 in 2003). In addition, an individual may accumulate up to $2,000 in resources.

Alaska's combined federal and state SSI supplement of $914 is by far the largest among states with Buy-In programs. Alaska's 1619(b) income threshold—the amount of earned income that SSI recipients are allowed to have and still maintain Medicaid eligibility—is also higher than most states with Buy-In programs. Alaska elected the standard of need option that provides Medicaid coverage for all individuals with income at or below $1,025 ($91 above 100 percent of the FPL for Alaska). Alaska does not require that the Buy-In participant actually work, only that earned income from the participant or spouse has rendered the recipient ineligible for SSI or Adult Public Assistance. If a Buy-In participant and his/her spouse do not have earnings because the participant is unable to work due to factors such as health problems or involuntary loss of employment, the state will re-evaluate that participant's eligibility for Adult Public Assistance and Medicaid.

Premium Structure. Most Buy-In participants—63 percent of those enrolled in the fourth quarter of 2003—paid premiums that averaged $13. Premiums are required for enrollees with incomes above 100 percent FPL and are calculated along a sliding fee scale as a fixed percentage of the participant's income. The maximum premium amount is 10 percent of net family income.

[3]Federal poverty line guidelines for Alaska are higher than those for the 48 contiguous states.

CALIFORNIA

Overview. The Medi-Cal Working Disabled Program (WD) was launched in April 2000 under the authority of the Balanced Budget Act of 1997. Enrollment in WD (669 individuals as of December 31, 2002) has fallen far short of the state's original prediction of between 6,835 to 13,811 enrollees by the end of the second year (Jee and Menges 2003). The stalled development of WD may be the result of at least two factors: (1) unintended enrollment disincentives inherent in the state's other public assistance programs and (2) WD design and implementation features, including a limited outreach effort.

Eligibility Criteria and Program Context. Compared with other states, California has a high combined federal and state SSI supplemental benefit ($757 per month from January through May 2003 and $778 per month from June through December 2003). It also has a high income threshold ($600 for an individual) for the medically needy program, which means that individuals in this program can have higher earnings (after medical bills are taken into account) than in other states and still have access to Medicaid. The presence of other pathways to Medicaid may, in effect, be competing with for enrollment with WD and thus limit its size.

The WD asset limit of $2,000 for an individual ($3,000 for couples) is lower than for many other states' Buy-In programs. WD has a typical income eligibility limit of 250% of FPL, but it is one of only a few programs that exempts disability income (i.e., SSDI benefits) from its counting methodology, which should allow individuals receiving large SSDI benefits to enroll. However, those who receive SSDI, which is a program without an asset limit, may be unable to enroll in WD if they exceed the asset limit.

Premium Structure. WD charges premiums ranging from $20 to $250 per month for an individual and $30 to $375 per month for couples. Although the premium is determined by a sliding scale based on income, all enrollees who have any income at all must pay a premium. This premium structure may act as an enrollment disincentive, because (1) for participants with incomes close to 250 percent of the FPL, the premiums may appear to be unaffordable, and (2) the medically needy program offers an attractive alternative pathway to Medicaid for those who have fewer health care needs.[4]

Other Policies. Another factor that may discourage eligible individuals from enrolling in WD is the link between coverage and work. Individuals are required to provide proof of employment to enroll in the program and to remain eligible. Individuals who lose a job—even as a result of "good cause," such as hospitalization—can retain their WD coverage only for two months. This short grace period could discourage enrollment or cause involuntary disenrollment.

[4]With medically needy program, they only share cost in months when they have received a service, instead of paying a monthly premium.

Program Experience. Limited outreach and dissemination efforts may be additional impediments to program growth. According to surveys of enrollees and interviews with county eligibility workers, there is a lack of awareness about the program among potential participants and intake workers who staff Medicaid and other benefit program offices (Jee and Menges 2003).

CONNECTICUT

Overview. Connecticut's Medicaid for the Employed Disabled program, enacted in October 2000 under the authority of the Ticket Act of 1999, was designed as a work incentive program to allow disabled individuals to retain Medicaid coverage as their earnings from work increased. This state was the first to establish a Buy-In program offering both the Basic Insurance Group and the Medical Improvement Group; the first two participants enrolled in the latter in 2004. Enrollment in the Medicaid for the Employed Disabled program grew quickly early on, reaching 1,600 enrollees after its first year. Participation in the program has since increased to 2,908 as of December 2003, making it the seventh largest Buy-In program.

Eligibility Criteria and Program Context. The Medicaid for the Employed Disabled program has a relatively high income eligibility threshold of $75,000, and its resource (asset) limit of $10,000 is equal to median among Buy-In programs. Connecticut is one of the only states to vary its state SSI supplement amount based on an individual's financial resources; the maximum combined federal and state SSI income benefit was $747 per month in 2003, the second highest among all states with Buy-In programs (Jensen 2004). Connecticut is among those states that have chosen to use eligibility criteria that are different from SSI [that is, the 209(b) option], which enabled Connecticut's Buy-In program to have a lower asset limit than SSI sets for Medicaid eligibility—$1,600 for individuals and $2,400 for couples compared to the SSI limits of $2,000 and $3,000 respectively.

Connecticut also has a high 1619(b) income threshold ($3,311 per month) among states with Buy-In programs (Wiener 2003). However, compared to other Buy-In states with Medically Needy programs, Connecticut has a low Medically Needy protected income level ($477), which might make its Buy-In program more attractive as a pathway to Medicaid than spending down below $477 (Jensen 2004).

Premium Structure. Buy-In participants in Connecticut are required to pay premiums equal to 10 percent of their income in excess of 200 percent of the FPL. Program participants with income less than 200 percent of the FPL, or 87 percent of participants in 2002, pay no premium at all (Ireys, White, and Thornton 2003). An individual's premium is reduced by the amount paid out-of-pocket for medical insurance premium payments. The individual's net premium obligation may not exceed 7.5 percent of net countable income.

Other Policies. Participants in the Medicaid for the Employed Disabled are required to work for pay and to make appropriate FICA contributions, either through payroll

deductions or as self-employed individuals. Buy-In enrollment can continue for one year after the loss of employment due to a health crisis or involuntary dismissal if the person either plans to return to employment when the health crisis ends or is seeking new employment.

ILLINOIS

Overview. Illinois implemented its Health Benefits for Workers with Disabilities (HBWD) program in January 2002 under the authority of the Ticket Act of 1999. According to HBWD personnel, the program was designed primarily as a work incentive for individuals with disabilities because the disability community insisted that participants needed "real" work experience in order to promote higher earnings. Enrollment in the HBWD program has increased modestly since its inception, reaching 531 at the end of 2003. This level of enrollment was significantly lower than the 3,200 participants that were projected to enroll by the end of 2002. Potential reasons behind this shortfall may include a low income threshold for the Buy-In program, a separate Buy-In application process from general Medicaid, and the HBWD premium requirement (see below for more detail).

Eligibility Criteria and Program Context. The HBWD program is available to persons with disabilities with incomes less than 200 percent of the FPL and resources less than $10,000. The HBWD income threshold, which is low relative to other Buy-In states, may constrain enrollment in the HBWD program because the allowable income spans a narrow range—from 100 percent to 200 percent of the FPL. Other potential reasons for lower enrollment than the state originally expected include the following:

- The HBWD program requires applicants to verify that they are paying the applicable income and FICA taxes on all earned income (including self-employment income), which is stricter than in some other Buy-In states.

- The HBWD program has a separate application process for eligibility determination from the process used for traditional Medicaid. In fact, the HBWD office is located in a different building from the rest of Medicaid in order to keep the programs totally distinct. Many other states allow individuals to complete Buy-In applications at local Medicaid offices, and some have provided Buy-In intake as part of an automatic enrollment process. The Illinois Buy-In, however, is identified primarily as a work incentive program, not as an extension of, or alternative to, regular Medicaid.

- Some potential HBWD enrollees may find it financially advantageous to remain in the spend-down program rather than enroll in HBWD for two reasons. First, individuals may not have to pay for all medical costs incurred while meeting the spend-down limit, which is also the case in many other states with medically needy programs. As a result, out-of-pocket expenses for individuals in the

medically needy program may be less than the premium for some individuals in the HBWD program. Second, an HBWD participant is required to pay a premium each month, whereas a person eligible for Medicaid under the spend-down option only needs to meet the spend-down criteria when the person wants Medicaid to cover medical costs for a particular month.

Illinois has a low medically needy income threshold ($283) relative to other states, but state officials noted that the medically needy income threshold is essentially equal to 100 percent of the FPL because income between $283 and 100 percent of the FPL is disregarded. In addition, the state has a 1619(b) threshold of $2,167, which is close to the median among states with a Buy-In program. Illinois provides a supplement to the federal SSI benefit, and it is one of two states with a Buy-In program that varies its state SSI supplement amount based on an individual's financial resources (Connecticut is the other).

Premium Structure. Monthly premium payments ranged from $6 to $100 in 2003, according to state officials. Premium categories are calculated based on a premium grid that includes earned and unearned income parameters. Generally premiums are based on about 2 percent of earned and 7.5 percent of unearned income. More than 99 percent of HBWD participants were required to pay premiums in 2003.

Other Policies. If an HBWD participant is unable to work due to medical reasons, (s)he may remain in the program for up to 90 days before being disenrolled, provided premiums are paid. However, if a participant stops working due to a non-medical reason and is not employed within 30 days, then the individual's enrollment is discontinued.

Program Experience. HBWD personnel believe that the program has made strong outreach efforts. Early on, staff mailed out 4,000 brochures to potential applicants, but they indicated that the outcome of this effort was disappointing. HBWD staff have worked with mental health centers, county and private hospitals, the Department of Human Services, Vocational Rehabilitation counselors, eligibility counselors, local Medicaid offices to spread information about the program.

INDIANA

Overview. Indiana implemented its Medicaid for Employees with Disabilities (M.E.D. Works) program in July of 2003 under the the Ticket Act of 1999. Enrollment in the program got off to a quick start, reaching 1,553 enrollees within three months of the program's inception and 5,186 participants by December of 2003.

Program enrollment has been substantially higher than originally expected, primarily because of the high enrollment of developmentally disabled individuals, many of whom perform minimal work in sheltered workshops. After showing positive earnings, these individuals are typically transferred into the M.E.D. Works program. State officials noted

that changes to the program are being considered to require a more substantial work effort to remain enrolled.

Eligibility Criteria and Program Context. Disabled individuals in Indiana who are employed and have countable incomes below 350 percent of the FPL are eligible for the M.E.D. Works program. This income limit is high relative to other state Buy-In programs. Although the resource limit of $2,000 is low among Buy-In programs, the state does exclude up to $20,000 of resources in an Independence and Self-Sufficiency Account—these funds are designed to improve employability and independence. The use of such an account has to be approved by the program, and very few participants (i.e. fewer than 15, according to state officials) have one. The maximum allowable income level for Indiana's Spend-Down program is identical to the federal SSI benefit of $552. Indiana's 1619(b) income threshold $2,362 per month is high relative to other states with Buy-In programs. SSI recipients in Indiana are not automatically eligible for Medicaid, because the state chose Medicaid eligibility criteria that are more restrictive than those for SSI eligibility through the 209(b) option: the Buy-In program's resources limit is $1,500 for an individual versus the $2,000 SSI limit. The income eligibility threshold for both the SSI and Medicaid programs in 2003 was $552.

Premium Structure. The premium amount M.E.D. Works participants pay is based on their income bracket. Individuals with income below 150% of FPL do not pay premiums. The premium ranges from $48 for those participants with incomes from 150-175 percent of the FPL to $161 for those with incomes from 300-350 percent of the FPL. Eleven percent of M.E.D. Works participants who were enrolled for the entire fourth quarter of 2003 paid premiums, which averaged $82.

Other Policies. A Buy-In enrollee is able to remain in the program for up to 12 months after losing employment for involuntary reasons if (1) (s)he requests in writing that Buy-In coverage continue; (2) (s)he continues to meet the eligibility requirements described above; and (3) (s)he maintains a connection to the workforce (e.g. workforce development). The amount an individual pays for private health coverage is deducted from their premium amount. Eleven percent of M.E.D. Works participants enrolled in the fourth quarter of 2003 were also enrolled in private health coverage.

Program Experience. Nearly 9 in 10 (88%) of Buy-In participants who enrolled for the first time in 2003 were in Medicaid for at least 1 month during the year prior to enrollment. The fact that most enrollees are transferring from one Medicaid eligibility category to another suggests that the M.E.D. Works program is functioning primarily as a work incentive for current Medicaid beneficiaries rather than providing Medicaid coverage among disabled individuals without Medicaid coverage. However, as noted above, state officials would like to alter program policies to promote a more substantial work effort.

The Family and Social Services Administration, which administers Indiana's M.E.D. Works program, is conducting activities to disseminate information about the program. These activities include developing materials such as fliers, brochures, and fact sheets containing program information, and developing and conducting training sessions.

IOWA

Overview. Iowa's Buy-In program, Medicaid for Employed People with Disabilities (MEPD), was launched in March 2000 under the authority of the Balanced Budget Act of 1997. The Iowa business community led efforts to pass the state's legislation, which was framed and marketed as a work incentive rather than a health insurance expansion (Folkemer et al. 2002). The state estimated that 700 individuals would enroll in the program by June 2002 (Folkemer et al. 2002), whereas actual enrollment reached 4,092 by that date (Ireys, White, Thornton 2003). The broader environment of employment supports for persons with disabilities, as well as several design and implementation features of the Buy-In program, may have contributed to the steady enrollment growth.

Eligibility Criteria and Program Context. Participants in the MEPD program must be under the age of 65, meet the SSI definition of disability, and have earned income from employment or self-employment, verified through pay stubs, tax forms, or signed statement from a person's employer.

A high rate of employment among SSI beneficiaries may indicate an overall environment in Iowa that supports employment of individuals with disabilities (Social Security Administration 2002). Thus, people with disabilities in Iowa may be more likely to obtain and keep a job, and find the MEPD program useful for maintaining appropriate health insurance coverage.

The state's spend-down level for the medically needy program is low compared to other states, making it more difficult for individuals to qualify for basic Medicaid, and hence more likely to enroll in the MEPD program (Crowley 2003). In fact, half of all new participants to MEPD moved from the medically needy program in 2001 (Hanes and Folkman 2003).

Premium Structure. Individuals must pay a monthly premium based on gross income according to a sliding scale premium schedule with 11 premium brackets ranging from $0 to $201.[5] If an individual's gross income (including spousal income) is below 150 percent FPL, then no premium must be paid. Only 29 percent of participants were required to pay a premium in 2002, and the average monthly premium of those who paid a premium was $35 (Ireys, White, and Thornton 2003).

Other Policies. A program participant who loses a job can remain in the program for up to six months if the participant shows the intention to return to work. Personal assistance services are only available to program participants if they qualify for waiver services.

[5]In 2003, the premium amount was linked to state employees' health insurance and reviewed annually. Effective January 1, 2004, the premium structure had 16 brackets, and the premium ranged from $22 to $355.

Program Experience. Iowa has not performed specific outreach activities targeted to the Buy-In program since 2001, although the state has hosted a national conference on partnering with industry to employ people with disabilities. According to Iowa MEPD staff, information about the program has spread primarily through word of mouth.

Data from 2001 indicate that nearly 40 percent of program participants worked 10 hours or less, and 57 percent of participants have monthly earnings less than $250 (Iowa DHS Web site). The program provided work incentives to nearly 5,000 participants by the end of 2003, though participants' earnings and hours worked tend to be modest. Data from the Unemployment Insurance system for 2002 indicate that monthly earnings among MEPD participants averaged $471, which was lower than the average of $736 across 21 Buy-In states.

KANSAS

Overview. Working Healthy, the Kansas Medicaid Buy-In program, was implemented in July 2002 to encourage persons with disabilities to seek work and earn more without endangering their health insurance coverage (Hall and Fox 2002). Enrollment in the program has continued to grow since inception and has exceeded initial projections.

Eligibility Criteria and Program Context. To qualify for Working Healthy, a person must (1) have a disability determined by Social Security, (2) be at least 16 years of age but no older than 64, (3) have total household income less than 300 percent of the FPL, (4) not be receiving Home and Community Based Services (HCBS) or living in a nursing facility, and (5) have resources that are less than $15,000.

Many programmatic features of the Working Healthy program should make it attractive to eligible persons and facilitate higher enrollment. First, most new program participants (51 percent) previously had Medicaid coverage under the medically needy option. The medically needy income limit is relatively low ($475 per month), which makes it harder for participants to spend down to the necessary level and makes the Buy-In program look more desirable by comparison. Second, Kansas has no state supplementation to its SSI cash benefit. The low SSI benefit may encourage individuals to seek work under the Buy-In program in order to increase income. Third, the resource limit of $15,000 is relatively generous compared to other Buy-In states among which the median resource limit is $10,000. Fourth, the state has been active in reaching out to potential and current participants and other stakeholders. These factors signify that enrollment in the program should continue to increase over time. Offsetting these features, however, is the lack of availability of personal assistance services for Buy-In enrollees. Kansas is applying for an 1115 waiver to provide these services in the future.

Premium Structure. Participants are charged a monthly premium if adjusted net income is over 100 percent of the FPL. The program has a sliding fee scale based on income. There are eight premium levels for single participants that range from $55 to $152

and eight premium levels for two people or more that range from $74 to $205. The premium cannot exceed 7.5 percent of the participant's income. The percentage of premium payers has increased since inception, from 59 percent in 2002 to 69 percent in December 2003; however, the average premium fell slightly from $67 in 2002 to $62 in 2003 (Mathematica 2004).

Other Policies. Currently, Working Healthy does not have personal care services available to program participants, although the state is working to secure an Independence Plus waiver to offer these services to program participants. Work requirements in the state are fairly stringent. Employment must be verifiable by pay stubs and employer documents that prove income is subject to an income test and FICA deductions. A person who loses a job may remain in the program for up to six months.

Program Experience. According to a study by Kansas University, the majority of Working Healthy participants (52 percent) in November 2002 had a mental illness (Hall and Fox 2003). The program currently does not cover expenses for personal assistance services, which might make the program more attractive for other types of persons with disabilities, such as those with physical disabilities. A survey conducted by the same group in June 2003 indicated that, for participants for whom information about job types was known, two-thirds held jobs within the service or maintenance sector, and more than half worked 19 hours per week or less (Hall 2003). The most common reason cited by disenrollees for leaving the program was the loss of a job, and consequently being deemed ineligible for the program (Hall 2003).

Working Healthy is administered through the Kansas Department of Social and Rehabilitation Services. The program office has sponsored a number of outreach activities, including orientations for providers and benefit specialists and conferences targeted to various stakeholders. An advisory council meets on a quarterly basis to provide knowledge and expertise to program staff.

MAINE

Overview. The MaineCare Workers with Disabilities (WWD) Option started in 1999 to allow persons with disabilities work more without fear of losing their Medicaid benefits. From implementation of the program in August 1999 to September 2002, program enrollment rose steadily to a high of 775 participants. By June 2003, enrollment had dropped by nearly a third, probably due to the state's dependence on a manual eligibility re-determination conducted by the state while their eligibility system was malfunctioning.[6]

[6]According to state officials, the manual eligibility re-determination system caused a reduction in enrollment because caseworkers found that some WWD enrollees were ineligible for the program.

Since then, however, program enrollment has rebounded and risen at a slow rate. Low enrollment in the WWD program (576 individuals in December 2003) may be a result of many contributing factors, including a separate income limit for unearned income, a high income limit for the Poverty Level option to Medicaid, a limited pool of medically needy enrollees to draw from, and no work protections in case of job loss.

Eligibility Criteria and Program Context. To be eligible for the WWD program, participants must have earned income and meet a two-step income test. First, countable unearned income must be equal to or less than 100 percent of the FPL plus $75. Second, total countable earned and unearned income must be less than 250 percent of the FPL. According to a WWD official, the unearned income limit was established in lieu of a work requirement as a mechanism to control program growth by limiting enrollment to SSDI beneficiaries with low unearned income. In 2003, only 48 percent of new program participants received SSDI benefits, which is considerably lower than the 73 percent across the 22 Buy-In states in this report. The asset limit for program participants (which excludes certain items, such as home, car, and some savings) is $8,000 for an individual and $12,000 for a couple.

Unlike many other states with a Buy-In program, new WWD enrollees with experience in other Medicaid components during the year prior to enrollment were most likely to have been in the state's Medicaid poverty level option. The income threshold for the poverty level option is high: $803 including disregards. Individuals who are eligible for Medicaid through this pathway would automatically receive full Medicaid benefits without paying a premium. Thus, for many individuals, the poverty level option is more advantageous than the Buy-In program.

Two elements of the context of WWD in Maine should promote enrollment—relative to other states, Maine has a low medically needy income level ($315 per month) and a low combined federal and state SSI payment ($562 plus a $55 income disregard). However, these factors appear to have done little to attract large numbers of individuals to the program. In fact, less than five people with Medicaid coverage prior to enrollment in the Buy-In program had been eligible for Medicaid under the medically needy option. The spend-down limit in Maine may be so low as to discourage eligible individuals from seeking enrollment in Medicaid via that pathway. Thus, the program is attracting few individuals who have been previously eligible for Medicaid via the spend-down option.

Premium Structure. The premium amount is based on countable monthly income projected for a six-month eligibility period. Individuals with monthly countable income under 150 percent or those individuals paying a Medicare Part B premium pay no premium for the Buy-In program. If monthly countable income is between 150 percent and 200 percent of the FPL, the monthly premium is $10. Individuals with income over 200 percent of the FPL have a $20 premium. Only 12 percent of program participants were required to pay a premium in 2003, and the average premium for these individuals was $13 per month in 2003, a relatively modest sum compared to other states (Mathematica 2004).

Other Policies. Participants who suffer a job loss receive no protection under the current system; loss of earned income causes a participant to be disenrolled from the

program. Individuals with a drop in income that is expected to last more than one month may be transferred to a Medicaid eligibility group without a premium (Folkemer et al. 2002).

Program Experience. The WWD program has an advisory group—represented by state and federal government officials, consumer and advocacy groups, and service providers—that meets on a quarterly basis. The program established the Continuing Health Options and Incentives via Coordinated Employment Supports, or CHOICES, sponsored by the Muskie School of Public Service at the University of Southern Maine, to better inform the program through surveys and other research.

The state's major outreach effort related the program in 2003 centered around the production and distribution of brochures with information on the program. Also, the state held three conferences targeting persons with disabilities and providers.

MASSACHUSETTS

Overview. CommonHealth, a benefit plan within Massachusetts' Medicaid program (MassHealth) for individuals with disabilities, was originally established as a state-funded plan to provide medical assistance to the working disabled and was integrated into an 1115 waiver on July 1, 1997. Massachusetts' Buy-In program is the oldest in the nation. Observers of the Buy-In program in Massachusetts have commented on the surprising growth in the number of participants given the alternative Medicaid coverage options offered by the state to working individuals with disabilities—as of December 2003, the CommonHealth program had 7,213 enrollees, making it the second largest Buy-In program in the nation.[7]

Eligibility Criteria and Program Context. The program has no income or asset limits, but participants must work 40 hours per month to obtain and maintain Buy-In eligibility.[8] The context of Massachusetts' Buy-In program is characterized by generous eligibility criteria relative to other states with Buy-In programs. Massachusetts provides Medicaid coverage to disabled individuals with incomes below 133 percent of the FPL. The standard combined federal and state SSI benefit of $681 is higher than most other Buy-In states, suggesting that relative to their counterparts in other states, workers with disabilities in Massachusetts could have relatively high SSI benefits and still maintain the basic Medicaid

[7]Fishman and Cooper (2002), for example, write "Notably, Medicaid buy-in enrollment has grown strongly even with attractive alternative eligibility pathways to Medicaid and buy-in requirements that together strictly limit the buy-in to the work incentives population."

[8]Enrollees may also be eligible by working an average of 40 hours per month over 6 months. The BBA and Ticket Act forbid setting limits on hours worked, but Massachusetts was able to do so under the 1115 waiver.

coverage (Jensen et al. 2003). Only five other states with Buy-In programs exceed Massachusetts' 1619(b) threshold of $2,397 (Weiner 2003), suggesting that Massachusetts' workers with disabilities who have relatively high incomes could maintain eligibility for Medicaid through the SSI program. Furthermore, all disabled individuals who work less than 40 hours per month are eligible for the non-working benefit plan of CommonHealth. The non-working benefit plan of CommonHealth is different from a traditional medically needy or spend-down program because participants only need to meet a one-time deductible rather than continue to meet the monthly spend-down requirement (Fishman and Cooper 2002). Therefore, workers with disabilities who do not qualify for SSI can potentially obtain Medicaid coverage regardless of their income and/or asset levels.

Premium Structure. Premiums are established based on one of two sliding scales—one scale for those with other health insurance, and one for those without it. Prior to March 2003, premiums were required for enrollees with incomes above 150 percent of the FPL. Beginning in March 2003, all CommonHealth participants pay a premium along a sliding scale based on income. Participants pay a minimum premium of $12 per month. Approximately 9 in 10 Buy-In enrollees in Massachusetts paid an average monthly premium of $50 in 2004.

Program Experience. Overall, the presence of other pathways to Medicaid for the disabled in Massachusetts, along with the Buy-In program's explicit criterion for steady work, would suggest that the eligible population in this state would be limited. However, Massachusetts has been aggressive in its outreach to address the concern among adults with disabilities that beginning or returning to work inevitably means losing publicly funded health insurance. One of the major milestones reported by the state is its development and distribution of new marketing materials that spread the word that individuals can work and keep their Medicaid coverage. In addition, the absence of asset and income limits in the Buy-In program means that workers with disabling conditions who have large assets or high incomes are still eligible.

MINNESOTA

Overview. Minnesota's Medicaid Buy-In program, Medical Assistance for Employed Persons with Disabilities (MA-EPD), was implemented in July 1999 under the authority of the Balanced Budget Act of 1997 and, in October 2000, was converted to the Ticket to Work and Work Incentives Improvement Act of 1999. Building on work they had done educating the disabled community about work incentives in the early 1990's, the Minnesota Consortium for Citizens with Disabilities provided the main impetus behind enactment of the MA-EPD program.

The program grew quickly, with approximately 5,000 enrollees within a year of the program's inception and approximately 6,500 as of December 2003, making it one of the largest Buy-In programs. The rapid enrollment and growth of the program was a direct result of extensive outreach done by the disability community and advocacy groups. State

officials also noted that the transfer of individuals from other Medicaid programs into the Buy-In was an important factor fueling the rapid growth early in the program and remains a factor—69 percent of new Buy-In participants in 2003 were in Medicaid for at least one month during the year prior to enrollment. State officials also noted that enrollment grew early on because Medicaid served a large number of individuals in day training and habilitation facilities who subsequently transferred into MA-EPD.

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

Eligibility Criteria and Program Context. MA-EPD extended Medicaid coverage to employed Minnesotans age 16 to 65 with disabilities. Minnesota is unique in that its MA-EPD program has no upper limit for income eligibility and has an individual asset limit of $20,000, which is high relative to other Buy-In programs. Minnesota elected the Medicaid poverty level option for disabled individuals, providing these individuals with Medicaid eligibility if their monthly countable income is below the federal poverty line (that is, $748 in 2003). Both the medically needy protected income level in Minnesota ($561 in 2003, or 75 percent of the FPL) and state SSI benefit ($633 in 2003) are higher than in most other Buy-In states.

Premium Structure. All MA-EPD participants must pay a monthly premium that is the greater of a sliding fee scale or a minimum of $35.[9] There is no maximum income limit or maximum premium amount. Buy-In participants who have incomes at or above 300 percent of the FPL are charged 7.5 percent of their gross income. Participants who have unearned income also pay an additional premium equal to 0.5 percent of their gross unearned income.

Other Policies. Effective July 2004, the first $65 of earned income is disregarded when determining eligibility for the program, which implies that a participant needs monthly earnings of greater than $65 to be eligible for the program.[10] In addition, Buy-In participants

[9]Prior to January 2004, MA-EPD participants with incomes over 100 percent of the FPL paid a premium based on a sliding fee scale (i.e., the minimum premium of $35 was not required).

[10]All Medicaid enrollees in Minnesota are subject to this disregard, which the state terms "Method B" budgeting. Prior to 2003, the state's Buy-In program was exempt from this policy.

need to have Medicare and Social Security taxes withheld from wages or paid from self-employment earnings in order to provide proof of employment. MA-EPD participants may remain enrolled for up to four months without earnings if they become unable to work due to either medical reasons that are verified by a physician or an involuntary job loss. Buy-In participants can be reimbursed for private health insurance premiums if doing so is cost-effective for the state.

MISSOURI

Overview. Missouri established the Medical Assistance for Workers with Disabilities (MAWD) program under the authority of the Ticket Act in July 2002. Since implementation, enrollment has increased rapidly. At the end of 2003, the number of participants enrolled in MAWD (15,155) was more than double any other state program, despite the program being one of the more recent implementers (July 2002). The high enrollment may be driven partly by an influx of individuals from the state's spend-down program, as well as active outreach from the state's disability community.

Eligibility Criteria and Program Context. To be eligible for MAWD, a person with disabilities must have earnings from employment or self-employment and gross income less than 250 percent of FPL. The person also must have resources less than $1,000—the most restrictive assets test of any Buy-In program in the nation. The low resource requirement likely shrinks the pool of individuals who are eligible for the program.

Missouri is a 209(b) state, a designation that allows the state to use more restrictive eligibility criteria than are used by SSI. The 209(b) states do not have a medically needy pathway to Medicaid, per se, but they must offer a spend-down option for eligible individuals. Prior to October 2002, the state's Medicaid program paid all medical bills, including the spend-down amount, for persons with disabilities in the state's spend-down program. As of October 2002, the state stopped paying the spend-down amount, and this caused the out-of-pocket costs for individuals in the spend-down program to increase substantially. Consequently, many individuals in the Medicaid spend-down program moved to the Buy-In program because the Buy-In premium was often less burdensome than the spend-down amount. In 2003, about 55 percent of program participants were in the spend-down category in the year prior to enrolling in MAWD.

Missouri does not use the SSI methodology to determine income eligibility for the Buy-In program; instead, the determination is based strictly on a gross income test. For some participants, especially those with low unearned income, this income counting methodology can be twice as restrictive as the SSI methodology (see Exhibit III.5 from Goodman and

Livermore 2004).[11] The state's relatively high 1619(b) income threshold was higher than the MAWD income threshold for an individual with no unearned income (Goodman and Livermore 2004), which should draw more people into the 1619(b) work incentive option rather than the Buy-In program.

Premium Structure. Participants with gross income less than 150 percent FPL pay no premium. The remaining participants fall into one of four premium categories ranging from four percent for the category with the lowest income level to seven percent for the highest income bracket. Less than 15 percent of program participants paid a premium in 2003, and the average monthly premium of those who were required to pay was $66.

Other Policies. The program offers no protection in the event of a job loss; unemployed individuals are disenrolled but may be moved to another Medicaid eligibility category. Missouri's MAWD program contains several income and asset exclusions for participants, including: (1) retirement accounts that are funded by earnings accrued while participating in MAWD; (2) medical expense accounts set up through the participant's employer; (3) family development accounts that have a religious or charitable community-based organization serving as the administrator; and (4) independent living development accounts that provide savings for several services (e.g., housing, personal assistance services). These exclusions are maintained until the participant reaches age 65 if the person is transferred to another Medicaid category.

Program Experience. Personnel in Missouri noted that the state's disability community is very well-informed, which may have contributed to growth in the program. Prior to implementation, the disability community heavily marketed the MAWD program. State officials noted that, when the spend-down rules changed, outreach by the disability community resulted in increased awareness of MAWD as an alternative to Medicaid eligibility and thus led many to transfer from the spend-down program to MAWD.

NEBRASKA

Overview. Nebraska enacted its Medicaid Insurance for Workers with Disabilities program in July 1999 under the BBA 1997 legislation and had 111 enrollees as of end of 2003. Enrollment has been lower than expected, and this is likely due to the program's eligibility criteria described below.

[11]The SSI methodology counts one-half of all earned income above $65, whereas Missouri is based on a strict gross income test. Therefore, the earnings limit for MAWD participants is significantly less than for participants in states that use the SSI counting methodology. For MAWD participants with low unearned income, this decrease in annual earnings potential is particularly striking and may be up to two times lower than other states.

Eligibility Criteria and Program Context. Eligibility for the Buy-In program in Nebraska involves passing a two-step income test:

- First, the sum of the spouse's earned income and the applicant's unearned income must be below the federal benefit rate (i.e., $552 in 2003). The applicant's unearned income is disregarded if (s)he is an SSDI beneficiary in a trial work period (TWP) as defined by Nebraska's Buy-In program.[12] The TWP, as defined by Nebraska's Buy-In program, involved earning at least $570 per month (2003) in a given month.

- Once the first part of the income test has been passed, the applicant is eligible if countable family income, including unearned income, is below 250 percent of the FPL. Applicants can have up to $4,000 in assets ($6,000 for couples).

The disregard of all unearned income for SSDI recipients in a TWP has the effect of targeting individuals who are both on SSDI and participating in competitive employment. Given these requirements, it is not surprising that all first-time enrollees in Nebraska's Buy-In in 2003 were SSDI beneficiaries at enrollment. Being in a TWP as defined by Nebraska's Buy-In program, and thus having earnings above $570 (in 2003), greatly increases the likelihood of being eligible for the program, because all unearned income is disregarded. This is likely to be the reason for which average earnings among Buy-In participants who reported them were higher in Nebraska than in most other Buy-In states.

Another contributing factor to relatively high earnings among Buy-In enrollees in Nebraska may be that the state has chosen to cover disabled individuals with income below 100 percent of the FPL. This provides regular Medicaid to some disabled individuals with low income. Other important contextual factors in Nebraska include (1) a 1619(b) threshold of $2,109 per month; (2) a state supplement to the federal SSI benefit of $8 for a combined federal and state SSI benefit of $560 in 2003; and (3) a low medically needy income limit ($392) relative to other Buy-In states with medically needy programs.

Premium Structure. Buy-In enrollees with countable family income between 200 and 250 percent of the FPL are required to pay a premium ranging from 2 percent of countable family income for enrollees from 200 and 209 percent of the FPL to 10 percent for enrollees from 240 to 249 percent of the FPL. The vast majority of Buy-In enrollees in Nebraska do not pay a premium—only one person enrolled in the fourth quarter of 2003 did so.

[12] For purposes of determining Buy-In eligibility, Nebraska considers the following as part of the trial work period (TWP): (1) the SSDI TWP (9 months); (2) the SSDI cessation month (month 10 following the beginning of the TWP); (3) the SSDI grace months (months 11 and 12 following the beginning of the TWP); and (4) the 36-month extended period of SSDI eligibility.

NEW HAMPSHIRE

Overview. New Hampshire established the Medicaid for Employed Adults with Disabilities (MEAD) program on February 2002 under the authority of the Ticket Act. A total of 985 people enrolled in MEAD during its first year of operation, more than early estimates of 500 enrollees (Clark et al. 2003). MEAD participants also experienced substantially higher post-enrollment earnings, but did not significantly increase the costs to the state Medicaid program (Clark et al. 2003). Generous eligibility requirements and a major outreach effort are among the main factors that may contribute to growth of MEAD.

Eligibility Criteria and Program Context. New Hampshire is a 209(b) state and deviates from SSI methodology in determining Medicaid eligilibility: an individual must have a medical impairment that has persisted or is expected to persist for a minimum of 48 months. New Hampshire's medically needy protected income level ($566) and combined federal and state SSI benefit ($579) are typical among all states with Buy-In programs. Its 1619(b) earnings threshold is the highest in the country, which allows Medicaid recipients to earn more before losing coverage and suggests that the large number of individuals that are eligible for Medicaid under 1619(b) would limit the eligible population for the Buy-In program.

New Hampshire has particularly generous Buy-In eligibility criteria. The MEAD program allows participants to have net family income up to 450 percent of the FPL and assets below $20,889 ($31,334 for a couple). The lenient income and asset test should attract many disabled workers to enroll in the Buy-In program.

Premium Structure. MEAD charges no monthly premium if an enrollee's net income is below 150 percent of the FPL. Six bands of premiums are charged for enrollees with net income between 150 percent and 450 percent of the FPL, ranging from $80 to $210 per month. Employer-sponsored insurance premiums and Medicare premiums both are deducted from the Buy-In premiums. Only 29 percent of participants paid any premium in 2003, and the average monthly premium was $34.

Other Policies. Like many other states, MEAD requires proof of employment at enrollment. If a program participant loses a job but intends to return to work, MEAD provides up to a one-year grace period for an individual (Wiener 2003). This period of protection for job loss is longer than many states, and is another feature that may facilitate enrollment.

Program Experience. New Hampshire has made a major effort not only to promote the MEAD program, but also to help the state's disabled population seek and maintain employment. For example, grants were given to independent living centers to provide outreach for MEAD (Wiener 2003); MEAD benefits specialists, located at One-Stop centers, were mobilized to provide benefits evaluation and education; and the state helped to sponsor

a yearly conference focusing on disabilities, diversity, and employment, including a job fair in conjunction with an exhibition on assistive technology for people with disabilities.

NEW JERSEY

Overview. New Jersey's Buy-In program, NJ Workability, was implemented in February 2000 under the authority of the Ticket Act of 1999. Enrollment in the program reached 951 by the end of 2003.

Eligibility Criteria and Program Context. New Jersey provides categorical Medicaid eligibility for persons with disabilities whose incomes are less than 100 percent of the FPL ($748 per month). Hence, although the medically needy protected income threshold is relatively low in New Jersey ($367 per month), many disabled persons with higher incomes still can qualify for Medicaid eligibility. First-time enrollees in NJ Workability were less likely than enrollees in other Buy-In programs to have been in Medicaid during the year prior to Buy-In enrollment—56 percent of first-time enrollees in NJ Workability had been, compared to 73 percent across the 22 Buy-In programs analyzed in this report.

NJ Workability's average income eligibility limit (250 percent of the FPL) and relatively high asset limit ($20,000 for individual) may promote enrollment. However, the program also has a separate unearned income limit. As a result, persons with disabilities who have unearned income (e.g., pensions, interest, private disability or retirement benefits) above 100 percent of the FPL after disregarding the SSDI/SSI benefits would not be eligible to enroll in the program, which may restrict Buy-In enrollment. Therefore, it is unclear whether the net effect of these policies promotes or restricts enrollment.

Premium Structure and Other Policies. New Jersey has a flat-rate premium requirement ($25 per month for an individual and $50 for couples) for participants with incomes greater than 150 percent of FPL. However, as of December 31, 2002, the state was not assessing premiums because only about five percent of beneficiaries owed a payment (GAO 2003). In the event of a temporary job loss, a person with disabilities may stay on NJ Workability if (s)he has worker's compensation or Temporary Disability Insurance (TDI) and is still employable (i.e., the worker intends to return to work). The protection period can be as long as 26 weeks for people with TDI.

Program Experience. There were extensive outreach activities in New Jersey during 2003. According to program staff, over 300 training sessions were given to non-profit organizations, front-line caseworkers, and other state agencies, such as the Social Security office, Vocational Rehabilitation services, etc. Information also was disseminated through brochures and booklets, directly targeting individuals with disabilities.

NEW MEXICO

Overview. The Working Disabled Individuals (WDI) program, New Mexico's Buy-In program, was launched on January 2001 under the authority of the Balanced Budget Act (BBA) of 1997. Enrollment in WDI was 943 as of December 2003. The program functions primarily as "Medigap" coverage for individuals in the 24-month waiting period for Medicare.

Eligibility Criteria and Program Context. Eligibility for the WDI program requires that persons with disabilities be age 18 and over and pass both an earned and an unearned income test. First, applicants must have countable income at or below 250 percent of the FPL, and have resources of at most $10,000 ($15,000 for couples). Second, WDI requires that participants have less than $1090 per month (in 2003) of unearned income.

Qualifying for WDI also requires that a person with disabilities have a recent attachment to the workforce, defined as having gross earnings in a quarter sufficient to meet SSA's definition of a "qualifying quarter" (i.e., $890 in 2003). Given that this requirement is waived for SSDI beneficiaries during their 24-month waiting period for Medicare, it is not surprising that SSDI beneficiaries comprise a majority of first-time enrollees—80 percent of first-time enrollees in New Mexico were SSDI beneficiaries compared to 73 percent across the 22 states analyzed in this report. According to a state official, Medi-gap participants are not required to work in order to maintain eligibility for the Buy-In program.

Health coverage options for persons with disabilities in New Mexico, other than WDI, are limited. New Mexico does not have a medically needy program or provide categorical Medicaid eligibility to persons who have a low income. In addition, the state does not provide a state supplement to the federal SSI benefit, and its 1619(b) income threshold ($1,899 per month) is lower than many Buy-In states.

Premium Structure. Instead of collecting monthly premiums, WDI requires participants at all income levels (except for Native Americans) to pay copayments for certain services and items at the time of service. The co-payments range from $5 per outpatient visit to $25 per inpatient hospital admission.

Other Policies. Although New Mexico does not directly provide protections for temporary loss of employment, participants can still maintain their eligibility for the whole quarter, as long as they show proof of employment at the beginning of the quarter. Therefore, the WDI program, in effect, has a grace period of up to three months during which participants could remain enrolled after having lost their job. Participants in the 24-month waiting period for Medicare do not need to maintain employment in order to remain eligible for the WDI program.

The state has made strong efforts to disseminate information on WDI through focus groups and one-stop career centers and improve processing of applications by field

caseworkers (MIG quarterly report 2003). WDI also has benefited from other employment support programs for disabled individuals in the state; as a result, the percent of working individuals in WDI reached 40 percent at the end of 2003 (MIG quarterly report 2003).

NEW YORK

Overview. New York implemented its Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program in July 2003 under the authority of the the Ticket Act of 1999. New York is one of the few states that chose to have a Medical Improvement Group, which allows a disabled individual to remain enrolled in MBI-WPD after their disability improves if they continue to retain a severe medical impairment, work at least 40 hours per month and earn at least the federal minimum wage. No one has yet enrolled under the Medical Improvement Group. As of the end of 2003, six months after implementation, 702 individuals were enrolled in the MBI-WPD program.

Eligibility Criteria and Program Context. The MBI-WPD program provides Medicaid coverage for disabled individuals age 16 to 64 with countableincome at or below 250 percent of the FPL and assets at or below $10,000. The combined federal SSI benefit and state supplement in New York for 2003 ($639) is higher than most other Buy-In states, as are the income thresholds for 1619(b) ($2,845) and its Medically Needy program ($642).

Premium Structure. MBI-WPD policy requires enrollees with countable income above 150 percent of the FPL to pay a premium equal to the sum of 3 percent of net earned income and 7.5 percent of net unearned income. However, the state currently is not collecting premiums while it implements an automated premium payment collection and tracking system, which is expected to be functioning in 2005.

Other Policies. MBI-WPD participants can maintain their enrollment for up to 6 months in a 12-month period if they are unable to work due to (1) health reasons; or (2) involuntary loss of employment, assuming they intend to return to work.

Program Experience. State personnel anticipate continued enrollment growth, potentially reaching as many as 20,000 enrollees within five years of the program's implementation, as outreach activities and awareness of the program continue. Outreach activities for MBI-WPD have thus far involved using the Medicaid Infrastructure Grant to fund outreach and education contractors that are providing information and education to specific target populations. In addition, state personnel have put together printed materials to disseminate program-related information—for example, they have produced a color brochure and a "toolkit" to help community advocates effectively spread the word about the program.

OREGON

Overview. Oregon was the first state in the country to implement a Medicaid Buy-In program under the authority of the BBA (February 1999). As part of a comprehensive work incentives initiative, Oregon's Employed Persons with Disabilities (EPD) program targeted those who are most ready to work but might not due to a fear of losing health care coverage. Some observers have argued that it is the truest example of a work incentives program because of the program's cost-sharing structure and work requirement. Unlike other states with long program histories (for example, Minnesota), Oregon's Buy-In enrollment has been stable over time (Hanes and Folkman 2003).

Eligibility Criteria and Program Context. To be eligible for the EPD program, a person with disabilities must have taxable income, earn income less than 250 percent of the FPL (unearned income is disregarded), and have assets less than $12,000. Oregon has a relatively low income eligibility threshold for its SSI state supplement, 1619(b) program, and now-discontinued medically needy program, all of which should contribute to a reservoir of disabled individuals who may be eligible for EPD.

Oregon implemented three major changes to its Medicaid program in 2003 that may have affected Buy-In enrollment. First, Oregon's Department of Human Services eliminated its medically needy program on February 1, 2003 as part of a statewide deficit-reduction plan. Given the similarities between the populations in the medically needy and EPD programs, many individuals previously enrolled in the medically needy program transitioned to the EPD program. This shift increased the percentage of new EPD participants who were eligible for Medicaid prior to their enrollment in EPD (from 77 percent in 2002 to 88 percent in 2003), and especially increased the percentage of these individuals who were previously enrolled in Medicaid through the medically needy program (from 27 percent in 2002 to 42 percent in 2003).

Second, the state instituted an "Attachment to the Workforce" policy in May 2003, which requires that participants earn at least $900 per quarter to enter or remain in the program. Low-income EPD participants would have been deemed ineligible for the program and thus program enrollment could have dampened as a result of this policy.

Third, the asset limit for an individual was lowered from $12,000 to $5,000 as of July 1, 2003.[13] Participants were given a one-year grace period and were permitted to move assets into an approved account (if eligible). EPD staff have closely monitored the effects of the asset limit reduction and have not seen any direct evidence that this policy has adversely affected enrollment. Furthermore, a consumer focus group conducted by the Oregon Health Policy Institute did not identify any client concerns with this policy change.

[13]In Oregon, retirement accounts, medical savings accounts, and approved accounts for employment or independence are all excluded from countable assets.

Overall, EPD enrollment dropped from 739 in March 2003 to 585 the following December, which may have been in response to the new earnings requirement, the drop in the asset limit, or both of these policies.

Premium Structure. One deterrent to enrollment in EPD may be its cost-sharing design (Fishman and Cooper 2002, Hanes et al. 2002, Hanes and Folkman 2003). Participants in EPD pay a monthly premium on earned income and a "cost share" based on unearned income.[14] The "cost-share" is equal to all unearned income above the SSI monthly benefit standard ($552 per month in 2003). The premium on earned income is equal to gross income plus any unearned income remaining after the cost share is paid minus (1) mandatory taxes; (2) approved employment and independence expenses; and (3) 200 percent of the federal poverty level, and multiplying the remainder by 2 to 10 percent. About 33 percent of EPD enrollees paid a cost share, and only 1 percent of enrollees paid a premium on earned income (Hanes and Folkman 2003). The cost share likely serves as an obstacle to enrollment for individuals with high unearned income, particularly those with large SSDI benefits. Only those individuals most confident in their ability to maintain overall income given the premium requirements would likely enroll in EPD. The premium and cost share requirements, together with a strict employment requirement at enrollment, reflect EPD's original intent as a work incentive initiative and contribute to both the steady enrollment and higher levels of post-enrollment employment and earnings in Oregon (Hanes and Folkman 2003).

Program Experience. The overall economic climate in Oregon during the last year also may significantly affect many of the program's outcomes. Poor economic conditions resulted in a state budget shortfall, which required a reevaluation of the programs offered by Oregon's Department of Human Services. In addition, Oregon had the highest average unemployment rate in the United States in 2003, which made it difficult for any Oregonians – including those with disabilities—to gain or maintain employment during this time.

PENNSYLVANIA

Overview. The Medical Assistance for Workers with Disabilities (MAWD) program began in January 2002 under the authority of the Ticket Act. Pennsylvania is one of the few states that included both the basic and medically improved group.[15] Although enrollment in

[14]The "cost share" is essentially a premium on unearned income.

[15]To be eligible for the Basic Insurance Group, one must be certified as disabled based on the SSI/SSDI criteria (with the exception of the requirement that (s)he be unable to work) and be employed and receiving compensation. Eligibility for the medically improved group involves (1) having a medically improved disability; (2) having previously been a worker with a disability who participated in medical assistance; and (3) employed at least 40

the program is lower than originally projected, it has grown consistently since program implementation and reached nearly 2,500 enrollees by December 2003.

Eligibility Criteria and Program Context. Persons with disabilities age 16 to 65 are eligible for MAWD in Pennsylvania if they are employed and receive compensation, have countable income below 250 percent of the FPL, and have countable resources at or below $10,000.[16] The state has a 1619(b) income threshold of $1,816 per month and has a combined federal and state SSI benefit of $579.40.

Pennsylvania has elected the poverty-level option for its Medicaid program; persons with disabilities who have incomes below 100% of the FPL are eligible. Pennsylvania also has a medically needy program with an income threshold of $425 per month, but state officials noted that some individuals may choose not to apply, because the program does not cover prescription drugs. Therefore, medical assistance provided through Medicaid's poverty-level option or MAWD, both of which cover prescription drugs, is preferable for persons with disabilities who have those options. Prescription drug coverage is a particularly salient issue for MAWD enrollees, because about 50 percent of program participants have mental health problems, for which the need for prescription drug coverage is more acute than many other disabling conditions.

Premium Structure. MAWD participants are required to pay a premium equal to 5 percent of their countable income. County workers have been given an increasing amount of flexibility to keep participants in the program if they are unable to pay their premium. Early on, many of these participants would have disenrolled. Data from 2003 indicate that approximately 70 percent of MAWD enrollees paid a premium that averaged $40 per month.

Other Policies. Pennsylvania's MAWD program has a number of other policies that are worthy of note:

- If an enrollee is unable to work due to health problems or job loss (referred to as "good cause"), they can remain on the program with their premium waived for up to two months. In an effort to minimize program churning, the state has broadened the definition of "good cause."

- Pennsylvania has a number of Medicaid waivers designed to assist individuals with disabilities and the elderly by providing services designed to promote independence and prevent institutionalization. State officials noted that they are working to inform persons with disabilities that they should apply for these programs.

(*continued*)
hours per month for at least minimum wage. State officials noted that no one has yet enrolled under the medically improved group.

[16]Asset (resource) limits include the assets (resources) of the applicant's spouse.

- To prevent a potential enrollee from going without health coverage during the disability determination process, the state has begun providing coverage under MAWD while this process is underway.

- Early in the program, there was confusion as to what constituted self-employment because verification requirements were not consistent across state agencies. Since then, however, the state has developed a self-employment verification form that has substantially reduced confusion in this area.

Program Experience. State officials noted that MAWD has caused a fundamental shift in the approach among some staff in County Assistance Offices (CAO) to the eligibility determination process. Now, rather than go strictly "by the book" when conducting an eligibility determination, intake workers make an extra effort to get their clients into the appropriate program.

UTAH

Overview. The Medicaid Work Incentive Program (MWI), Utah's Buy-In program, was enacted on July 1, 2001 under the authority of the Balanced Budget Act of 1997. It was implemented as part of the Utah Work Incentive Initiative (UWIN), a broader initiative coordinated across several state agencies to better inform and support people with disabilities in their employment. In addition to the Medicaid Buy-In program, UWIN includes resources such as: the Utah Benefits Planning Assistance and Outreach (UBPAO) to educate SSDI beneficiaries on the effect of employment on benefits eligibility; personal assistance services available under the Medicaid state plan, available Ticket to Work supports; and information resources available for employers seeking to hire qualified individuals with disabilities. Utah had 198 enrollees as of December 2003, which is lower than the median enrollment (672) during that month among the 27 states with a Buy-In program. Enrollment dipped sharply from 230 in June 2002 to 170 the following September, due to a large premium increase that occurred in July 2002. Since September 2002, quarterly enrollment has fluctuated between 165 and 198 participants.

Eligibility Criteria and Program Context. A Utah resident with disabilities is eligible to enroll in the MWI program if (1) family income is at or below 250 percent of the FPL and (2) family resources less than $15,000.[17] The individual also must be working. Perhaps most notable about the context in which the MWI program operates is that beginning in July 2003, the medically needy protected income level increased from $386 to $748, making it higher than any other state with a Buy-In program. In addition, Utah has elected to have a

[17]Both the income eligibility threshold and the resource limit include spousal income/resources.

poverty level option for its Medicaid program, thus establishing the income threshold for Medicaid eligibility at $748 per month. Utah does not provide a supplement to the federal SSI benefit, and Utah's 1619(b) threshold of $1634 per month is low relative to other Buy-In states.

Premium Structure. Buy-in participants with income levels of at least 100 percent of the FPL are required to pay premiums equal to 15 percent of a participant's countable income. The vast majority of participants enrolled in the fourth quarter of 2003 (87%) paid premiums averaging $145 per month, which is high compared to other Buy-In states. As noted above, Utah increased its MWI premium in July 2002 from 20 percent of countable income to a range from 30 to 55 percent of countable income. In some cases, this change "caused premiums to quadruple," and this was followed by sharp decrease in enrollment as noted above (Julnes et al. 2003). In July 2003, however, the premium structure was revised a second time and remains 15 percent of countable income.

Other Policies. Utah initially had a policy whereby MWI enrollees who lost their job involuntarily could remain in the program for up to 12 months, but this policy was eliminated as of July 2002.

Program Experience. Focus group results presented in Julnes et al. (2003) suggest that the MWI program has received positive reviews from participants. In addition, data from a telephone survey illustrate how the MWI program has helped enrollees. Nearly half (46%) of MWI participants who had been continuously enrolled in the program from its inception through August 2002 noted that the program had helped them "go to work," and 12 percent noted that enrollment allowed them to "take on more responsibilities" (Julnes et al. 2003). However, this study found that the premium increase that occurred in July 2002 had a substantial impact on program participants. Thirteen of the sixteen (81%) MWI participants interviewed who had disenrolled and returned to the program at least twice noted that they cycled on and off of the program because the premium was unaffordable (Julnes et al. 2003).

VERMONT

Overview. Medicaid for Employed People with Disabilities (MEPD), Vermont's Medicaid Buy-In program, was implemented in January 1, 2000 under the authority of the Balanced Budget Act (BBA) of 1997. MEPD was implemented as part of the Vermont Work Incentives Initiative (VWII), a broader initiative seeking to implement and advocate system-wide reforms to support people with disabilities in employment. The VWII, in addition to implementing a Medicaid Buy-In program, provides benefit counseling for individuals with disabilities.

As of December 2003, Vermont had 455 enrollees in the MEPD program. This enrollment may be limited by a number of factors (described below), including the separate

unearned income limit inherent in a BBA Buy-In, no protection for work stoppage, and the competing availability of an array of other state-offered options for health care coverage.

Eligibility Criteria and Program Context. MEPD has a two-step income test: 1) employed persons with disabilities must have a family net income less than 250 percent of FPL, and 2) income does not exceed either the Medicaid protected income level or the SSI payment level, whichever is higher, after disregarding the earnings and up to $500 of SSDI benefits of the individual. The program's resource limit is set at $2,000 per individual and $3,000 per couple at enrollment. After enrollment, there is no limit on the amount of assets that may be accumulated from the earnings of the person with disabilities, provided liquid assets from such earnings are kept in a separate bank account. The separate unearned income eligibility may prevent many SSDI beneficiaries from meeting income eligibility criteria.[18] This, combined with the low asset limit of $1,000 at enrollment, may contribute to the program's low enrollment. In addition, the MEPD program may be intended to fill a narrow eligibility gap, as Vermont residents with low incomes already have access to a wide array of health care coverage options, most notably the Vermont Health Access Plan (VHAP), a Section 1115 waiver.

Vermont has a high medically needy protected income level of $733 per month (second only to Utah's limit of $748), which makes it easier for eligible persons to meet the spend-down amount and lessens the relative advantage of enrolling in the Buy-In to avoid a large spend-down. Nevertheless, the majority of MEPD participants were eligible for Medicaid through the medically needy pathway prior to enrollment in the MEPD program.

Premium Structure. Buy-In participants with income levels below 185% of the FPL are not required to pay premiums. The MEPD program has two income brackets that require a premium: before July 2003, those earning between 185-225 percent of FPL paid $20, and those earning between 225-250 percent of FPL paid $24 per month. Starting in July 2003, the monthly premium rose to $50 and $60, respectively. Only 8 percent of Buy-In participants paid a premium in the fourth quarter of 2003, and the average monthly premium for these participants for that quarter was $27 (Ireys, White, and Thornton 2003).

Other Policies. Participants are required to have earned income, and the state offers no work stoppage protection for a program participant that loses a job.

Program Experience. Vermont eligibility staff and benefit counselors are trained specifically on the MEPD program. The state also has disseminated pamphlets and other educational materials about the program. While the state covers personal assistance services (PAS), only a small handful of program participants receive these services, possibly because the approval process is extensive and lengthy, and possibly because the majority of consumers who would meet the activities-of-daily-living or institutional-level-of-care

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

eligibility criteria for PAS have already acquired health coverage under an alternative program and are not currently seeking the earnings protection of the Buy-In.

WASHINGTON

Overview. Washington adopted its Buy-In program, Healthcare for Workers with Disabilities (HWD), in January 2002 under the authority of the Ticket Act. It is one of a few states that elected to cover both the Basic Coverage Group and the Medical Improvement Group. As of December 2003, the cumulative enrollment in HWD reached 277. Although this number almost doubled after the program's first year of implementation, enrollment remained relatively low compared to most other Buy-In programs. An economic downturn, the short program history, and some program features (highlighted below) may have contributed to the slow growth of HWD.

Program Context and Eligibility Criteria. Washington's general Medicaid eligibility is typical among states with a Buy-In program – its combined federal and state SSI benefit ($570.90) and medically needy protected income level ($571) are relatively generous compared to many other states with Buy-In programs. However, Washington's 1619(b) earning threshold ($1,695 in 2003) is among the lowest in the country, which should expand the number of individuals ineligible for Medicaid through the 1619(b) option but eligible for HWD.

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

Premium Structure. All HWD participants enrolled during the entire fourth quarter of 2002 and 2003 paid a premium based on both unearned and earned income. The premium level is the lesser of 7.5 percent of total income or the sum of the following: 50 percent unearned income above the Medically Needy Income Level (MNIL) ($571 in 2003), plus 5 percent of total unearned income, plus 2.5 percent earned income after a $65 deduction. Premiums among Buy-In participants averaged $82 per month in 2003. This amount is higher than most states with Buy-In programs, and may act as a disincentive for some eligible individuals to enroll in the Buy-In program.

Other Policies. Washington has a clearly defined work requirement for HWD participants. Participants in the Basic Coverage Group must have earnings subject to federal income taxes, and self-employed participants must provide tax forms or business license/records. Participants in the Medical Improvement Group must work at least 40 hours per month and earn at least minimum wage. If HWD participants lose their job, they can choose to continue enrollment through the end of their current 12-month certification period, as long as (1) the job loss is due to a health crisis or involuntary dismissal; (2) they

intend to return to work; and (3) they continue to pay monthly premiums based on their remaining income.

Program Experience. Because of state budgetary pressures, rescinding the HWD program was proposed in 2003. The program survived, partly due to strong support for it among the disability community, but outreach activities were temporarily scaled down, which may slow the dissemination of information to eligible individuals.

So far, enrollment of HWD applicants has been completed at one centralized state office. In the near future, enrollment will begin to occur at regional offices, which may initially impair centralized customer service, but ultimately should increase awareness of and participation in the program

WISCONSIN

Overview. Wisconsin established its Medicaid Purchase Plan (MAPP) in March 2000 under the authority of the Balanced Budget Act as a program designed to increase work incentives for persons with disabilities. Enrollment was "modest" during the program's first year of implementation (Innovative Resource Group 2002). Since then, however, enrollment has grown more quickly, and the MAPP has become the fifth largest Buy-In program in the nation with 5,269 participants as of December 2003.

Eligibility Criteria and Program Context. Wisconsin's MAPP program is available to persons with disabilities age 18 and over with net countable income up to 250 percent of the FPL and resources up to $15,000. In addition, MAPP participants are allowed, once enrolled, to accumulate assets above the resource limit (APS Healthcare 2003).[19] MAPP has an above-average combined federal and state SSI supplement ($636) and an above-average protected income level for its medically needy program ($592), compared to other states with Buy-In programs (Jensen 2003). These factors, in conjunction with a relatively high 1619(b) threshold of $1,929 (Wiener 2003), suggest that a large proportion of individuals with disabilities in Wisconsin may already be eligible for Medicaid through other pathways.

Premium Structure. MAPP participants with countable income from 150 to 250 percent of the FPL pay a premium equal to the sum of (1) 3 percent of an individual's earned income, and (2) 100 percent of unearned income less certain needs and expenses. The vast majority of MAPP participants (89 percent) enrolled in the fourth quarter of 2003 did not pay a premium, suggesting that the countable income among these individuals was less than 150 percent of the FPL. Premiums among the 11 percent of participants who paid a premium ranged from $25 to $875 in June 2003 (APS Healthcare 2003).

[19]Only one percent of MAPP participants in June 2003 had pursued this option.

Other Policies. MAPP participants either have earnings from work or participate in health and employment counseling (HEC) for up to a year, after which earnings from employment are required. Based on the most recent evaluation report, few MAPP participants take advantage of the option to participate in HEC—68 individuals were actively doing so in July 2002 (APS Healthcare 2003). For MAPP participants with health problems that prevent them from working, Wisconsin waives the work requirement for up to 6 months. However, information from a focus group suggests that this work protection feature may be less attractive in practice than initially expected because (1) it requires participants to have been enrolled in the Buy-In program for at least six months, and (2) it only can be used twice every three years (Innovative Resource Group 2001).

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

- Enrollment was initially cumbersome because MAPP county workers conducted the eligibility determination process manually until fall 2001, when this process was automated (APS Healthcare 2003)

- Training of county economic support (ES) workers did not begin until after MAPP was implemented, and a survey of ES workers found that only one in four workers felt that their MAPP training was sufficient (Innovative Resource Group 2002).

- Comments from program participants suggest that information about the program could be disseminated more effectively (APS Healthcare 2003).

One outreach activity currently being developed is called Club MAPP, which is designed to inform MAPP participants about available work incentives by mailing information directly to participants.

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APPENDIX B

INSTRUCTION GUIDE FOR COMPLETING THE ANNUAL BUY-IN REPORT ON PROGRAM PARTICIPATION

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The Medicaid Buy-In Program:

Completing the Annual Report on Program Participation in Calendar Year 2003

Instruction Guide

Prepared by Mathematica Policy Research, Inc.
for the Centers for Medicare & Medicaid Services

Data Element 1: Enrollment Totals

A. Wording

1(a) How many individuals enrolled for the first time in the Medicaid Buy-In during calendar year 2003? (The "first-time" group)

1(b) How many individuals re-enrolled in the Medicaid Buy-In during calendar year 2003? (The "re-enrolled" group)

1(c) Of the individuals in 1(b), how many times did these individuals re-enroll in 2003?

1) 1
2) 2
3) 3
4) 4-6
5) 7 or more

6) Number of people with re-enrollments - sum of 1) thru 5)

7) If there is a difference between 1(b) and 1(c)6), please explain:

1(d) How many individuals were enrolled in the Buy-In program for the entire 12 months of 2003? (The "continuously enrolled" group)

1(e) How many individuals were enrolled in the Buy-In program for the entire fourth quarter of 2003? (The "fourth-quarter" group)

1(f) How many individuals were enrolled in the Buy-In for the entire fourth quarter of 2003 and for the entire fourth quarter in 2002? (The "longitudinal" group)

1(g) How many individuals have been enrolled in the Buy-In program since its inception? (The "cumulatively enrolled" group)

Recommended data source for Element 1: MMIS eligibility file

B. Instructions

A person is considered "enrolled" if that person is included in the Buy-In program at any time in calendar year 2003 as indicated in the state eligibility files.

Item 1(a) is presumed to be an unduplicated count of individuals enrolled for the first time. These include individuals who have either never participated in the Buy-In program or have not participated since January 2000. States are not expected to search their enrollment records for dates prior to January 2000.

Item 1(b) defines the *re-enrolled group*. This group reflects the "churning" or turnover rate for this program. "Re-enrolled" individuals are defined as those who had (a) a previous enrollment in the Buy-In program at any time since the inception of the program or since January 2000, whichever is later, (b) became disenrolled, and then (c) enrolled again in the Buy-In program in 2003. (States are not expected to search their enrollment records for dates prior to January 2000.) This includes individuals who first enrolled in 2003. An individual should not be considered "re-enrolled" unless there is an actual gap in Medicaid Buy-In coverage. For example, an individual may be disenrolled but is then re-enrolled retroactive to when they were disenrolled (thus making his or her enrollment continuous). For the purposes of this item, this individual would not be considered re-enrolled. We recognize that the length of the gap may vary across states.

Item 1(c) asks for the number of re-enrollments that each individual in the *re-enrolled group* amassed during 2003.

Item 1(d) refers to the *continuously enrolled group* and reflects those individuals who remain on the Buy-In for the entire year.

Item 1(e) refers to the *fourth-quarter group*. This group provides a standard count of participants who have been enrolled for a discrete period of time.

Item 1(f) refers to the *longitudinal group*. This group provides a standard approach for tracking how earnings change for participants who have been in the program for at least two quarters in two consecutive years. To be included in this group, individuals do not have to be continuously enrolled between the two quarters.

Item 1(g) refers to the *cumulatively enrolled group*. We recognize that reporting this information will be more difficult for some states than others depending on the program start date. For states whose programs started in 2003, the number in the cumulatively enrolled group will equal the number in the *first-time group*. Going forward, the cumulatively enrolled can be calculated by adding the counts of first-time enrolled in each year. For programs that started prior to 2003, we are asking states to determine an unduplicated cumulative count as accurately as possible using available data going back to the program's inception or January 2000, whichever is later.

Data Element 2: Medicaid Eligibility Status

A. Wording

2. How many individuals in the first-time group were enrolled in Medicaid for at least 30 consecutive days in the 12 months immediately prior to the date they became enrolled in the Buy-In program and in what eligibility category were they enrolled?

(a) Number enrolled in Medicaid for at least 30 days in prior year - sum of 1) thru 6) below:

1) Receiving Cash or Eligible under Section 1931 (SSI):
2) Medically needy:
3) Poverty-related:
4) Other:
5) 1115 Demonstration:
6) Medicaid status unknown:

(b) Number not enrolled in Medicaid for at least 30 days in prior year:

(c) Number for whom Medicaid status is undetermined:

(d) Number of first-time enrollees - sum of boxes (a), (b), and (c):

(e) Number from Data Element 1(a):

(f) If there is a difference between lines (d) and (e), please explain:

Recommended data source for Element 2: MMIS eligibility file

B. Instructions

Categories 1) thru 5) under 2(a) correspond to the Medicaid Assistance Status (MAS) categories as described in the Medicaid Statistical Information System (MSIS). See Appendix A for a definition of the groups in 2(a)1) through 2(a)5).

In determining if an individual is "eligible for Medicaid for at least 30 consecutive days," account for the following:

- If an individual has been in more than one eligibility group in the designated period, select and record the most recent eligibility group.

- Include those individuals who are eligible to receive services, but they do not need to have received services.

- Include individuals who may have been enrolled in an 1115 waiver or any HIFA Waiver.

- Do not include any individuals who did not meet their spend-down and therefore never become eligible for Medicaid.

- Do not include any State-only funded programs in this group.

Individuals with any variation of SSI payments, including 1619(a) or state Supplementation, will be counted in line 2(a)1).

For Section 209(b) states with no Medically Needy option (e.g., Missouri and Indiana), the mandatory spend-down group should be included under line 2(a)2), the Medically Needy category.

The "Poverty Related" group includes persons who are eligible as a QMBs, SLMBs, and QDWIs (see Appendix).[1]

The "Other" group includes individuals in 1619(b), DAC with no SSI, and Disabled Widows and Widowers with no SSI.

Item 2(a)6), Medicaid status unknown, and item 2(c), Medicaid status undetermined, are mutually exclusive. The former indicates that an individual is enrolled in Medicaid but the category is unknown, while the latter indicates that the state could not determine if the individual is enrolled in Medicaid.

[1] Information on QMBs, SLMBs, and QDWIs can be found at: http://www.cms.gov/glossary/ and http://www.cms.hhs.gov/dualeligibles/ftshhmpg.asp

Data Element 3: SSDI Status

A. Wording

3. How many individuals in the first-time group were receiving SSDI benefits at the time of their enrollment?

(a) Number receiving SSDI benefits:

(b) Number not receiving SSDI benefits:

(c) SSDI status undetermined:

(d) Number of first-time enrollees - sum of boxes (a), (b), and (c):

(e) Number from Data Element 1(a):

(f) If there is a difference between lines (d) and (e), please explain:

Recommended data source for Element 3: MMIS eligibility file

B. Instructions

This count only includes individuals receiving SSDI benefits at the time of enrollment.

When considering an individual's eligibility to receive SSDI benefits:

- Do not include spouses' SSDI or other Title II benefits.
- Do not include individuals who have not yet been determined eligible to receive SSDI.

If some or all of the SSDI records for your state has been over-written since individuals' time of enrollment, include the new SSDI status and note this occurrence in item 3(f).

Data Element 4: Other Health Coverage

A. Wording

4. How many individuals in the 2003 fourth-quarter group also had other health care coverage through public or private third-party insurance at any point during the fourth quarter of 2003? In what type of plans were these individuals enrolled? For how many of these individuals did the state pay premiums?

(a) Number with health care coverage in addition to Medicaid:

1) Medicare:

Number of these individuals (in line 1) for whom the state paid the premiums at any time in the fourth quarter:

2) Other public plan:
3) Private plan:
4) Other:

Number of these individuals (total of lines 2-4) for whom the state paid premiums at any time in the fourth quarter:

(b) Number with only Medicaid:

(c) Number in the fourth-quarter group - sum of boxes (a) and (b):

(d) Number from Data Element 1(e):

(e) If there is a difference between lines (c) and (d), please explain:

Recommended data source for Element 4: MMIS eligibility file

B. Instructions

This count only reflects coverage that enrollees had during the fourth quarter of 2003.

A public plan is any other government-operated health insurance plan. Examples of entries in item 4(a)2) are CHAMPUS, VA, or other military health insurance plans. An example of 4(a)3) is employer-based insurance, including Blue Cross/Blue Shield plans.

The category of "Other" in line 4(a)4) includes individuals with any other health insurance coverage even if this other insurance coverage is not specified or known.

If individuals have multiple coverages, include them in all appropriate lines.

Data Element 5: Premiums and Cost-sharing

A. Wording

5. Of those individuals in the 2003 fourth-quarter group, how many were required to pay premiums, cost-shares, or co-payments during this time, and what was the average amount?

(a) Number of participants required to pay premiums:

(b) Average monthly premium due for fourth quarter of 2003 for those in 5(a):

(c) Number of participants required to cost-share:

(d) Average monthly cost share due for fourth quarter of 2003 for those in 5(c):

(e) Number of participants required to co-pay:

(f) Average monthly co-pay due for fourth quarter of 2003 for those in 5(e):

Recommended data source for Element 5: Billing and Collection System

B. Instructions

Items (a), (c), and (e) are not mutually exclusive.

Count individuals who would be required to cost-share or co-pay for services if they would have used services, even though they actually may not have used services during this period.

This item asks for how much was owed, not how much was actually collected. When calculating this dollar amount, please use the following guidelines:

- Subtract any refunds due back to individuals because of disenrollment or any other reason.
- Do not count premiums past due during, but not for, the fourth quarter.

For the purposes of this form, cost-share is defined as paying a specific percentage of costs for a service, visit, or episode of treatment. Co-payment is defined as paying a specific dollar amount per service, visit, or episode of treatment.

5(b), 5(d) and 5(f) should be calculated as follows: take the total amount of premiums (or cost-shares or copays, as appropriate) for the fourth quarter, divide by the number of participants in 5(a) (or 5(c) or 5(e)) then divide the result by 3. For example, an individual who had a three-month premium history of $15, $0, and $10 would have an average monthly premium of $8.33, not $12.50.

We only want cost-sharing payment information (premiums, co-pays, other cost-shares) specific to the Medicaid Buy-In, not of the state's Medicaid program in general. If the state requires all Medicaid eligibles to pay a pharmacy co-pay, do not include it here. If the pharmacy co-pay is only applicable to the Buy-In, do include those individuals and the amount.

Data Element 6: Reported Fourth-Quarter UI Earnings

A. Wording

6. What were the monthly reported UI earnings for individuals in the 2003 fourth-quarter group during the fourth quarter of 2003?

(a) Total reported UI earnings for the entire 2003 fourth-quarter group for the fourth quarter of 2003:

(b) Number of individuals with 2003 monthly reported UI earnings during the fourth quarter in the following categories:

1) No earnings reported (or $0)
2) $1 – 200
3) $201 – 400
4) $401 – 600
5) $601-800
6) $801-1,000
7) $1,001-1,200
8) $1,201-1,400
9) $1,401-1,600
10) $1,601+

(c) Number with 2003 monthly reported UI earnings during the fourth quarter - sum of 2) thru 10):

(d) Number of people in the fourth-quarter group (from Data Element 1(e)):

(e) Does the difference between lines (c) and (d) equal the number of individuals in line 6(b)1)? Please mark an "X" in the corresponding box to the right

(f) If the answer to line (e) is no, please explain below:

Recommended data source for Element 6: Unemployment Insurance System

B. Instructions

States should use the Unemployment Insurance system to identify quarterly earnings.

For item 6(a), sum the total fourth quarter earnings across all individuals in the group.

For item 6(b), calculate total earnings for each individual by identifying the individual's earnings for the quarter and dividing by three.

Self-employment earnings will not be included (see Data Element 6A).

Please note that item 6(b)1) should include individuals with missing records and individuals for whom $0 were reported.

Data Element 6A: Self-Employment Earnings

A. Wording

OPTIONAL - For those states that can report self-employment data, please answer the following question:

6A. How much did the fourth-quarter group earn through self-employment?

(a) Total self-employment earnings for the fourth quarter of 2003:

(b) Number with 2003 self-employment earnings during the fourth quarter in the following categories:

1) $0
2) $1 – 200
3) $201 – 400
4) $401 – 600
5) $601-800
6) $801-1,000
7) $1,001-1,200
8) $1,201-1,400
9) $1,401-1,600
10) $1,601+

(c) Number with 2003 self-employment monthly earnings during the fourth quarter - sum of 2) thru 10):

(d) Number of people in the fourth-quarter group (from Data Element 1(e)):

(e) Does the difference between lines (c) and (d) equal the number of individuals in line 6A(b)1)? Please mark an "X" in the corresponding box to the right

(f) If the answer to line (e) is no, please explain below:

Recommended data source for Element 6A: MMIS eligibility file

B. Instructions

States should use the Eligibility system to determine self-employment earnings. Use gross earnings before taxes.

For item 6A(a), sum the total fourth quarter earnings across all individuals in the group.

For item 6A(b), calculate total earnings for each individual by identifying the individual's earnings for the quarter and dividing by three.

Data Element 7: Change in Reported UI Earnings Over Time

A. Wording

7. For individuals in the longitudinal group, what were mean monthly reported UI earnings in the fourth quarter of 2003 as compared with their mean monthly reported UI earnings in the fourth quarter of 2002?

(a) Total reported UI earnings for fourth quarter of….

(b) Percent change from 2002 to 2003:

(c) Number with mean monthly reported UI earnings in the fourth quarter of 2002 and 2003:

1) No earnings reported (or $0)
2) $1 – 200
3) $201 – 400
4) $401 – 600
5) $601-800
6) $801-1,000
7) $1,001-1,200
8) $1,201-1,400
9) $1,401-1,600
10) $1,601+

(d) Number with monthly reported UI earnings during the fourth quarters of 2002 and 2003 - sum of 1) thru 10):

(e) Number in the longitudinal group (from Data Element 1(f)):

(f) If there is a difference between lines (d) and (e), please explain:

Recommended data source for Element 7: Unemployment Insurance System

B. Instructions

This data element should only be completed by states that had Buy-In programs that were operational prior to October 1, 2002.

States should use the Unemployment Insurance system to collect quarterly earnings and divide the earnings by 3 before entering the figure into the data chart.

We recognize that the UI system does not capture self-employment. We also recognize that participants in the longitudinal group may have reported earnings in one year but not the other. These individuals should still be included in the counts. In the year in which the individual has no reported earnings, he should be counted in line 7(c)1).

Data Element 8: Medicaid Expenditures

A. Wording

8. For individuals in the 2003 fourth-quarter group, what was the average per member per month Medicaid expenditure for the time spent in the Buy-In during 2003?

(a) Average per member per month expenditure in 2003:

(b) Number of individuals with average monthly expenditures in the following ranges:

1) $0
2) $1 – 500
3) $501 – 1,000
4) $1,001 - 5,000
5) $5,001 - 20,000
6) $20,001 and above

(c) Number of individuals with expenditures - sum of 1) thru 6):

(d) Number of individuals in the 2003 fourth-quarter group (from Data Element 1(e)):

(e) If there is a difference between lines (c) and (d), please explain:

Recommended data source for Element 8: MMIS claims files

Note that 8(a) and 8(b) use different methods to calculate average expenditures (see instructions).

B. Instructions

Item 8(a) should be calculated by:

(1) Summing payments on all claims for all individuals across the selected months (i.e., the months in 2003 during which the individuals were enrolled in the Buy-In program),

(2) Adding the total number of enrollment months (i.e., the number of months during which individuals were enrolled in the Buy-In program),

(3) Dividing the sum of all payments by the sum of total number of enrollment months.

Item 8(b), the average monthly expenditure, is calculated by:

(1) Summing payments on all claims for each individual across the selected months (i.e. the months in 2003 during which the individual was enrolled in the Buy-In program),

(2) Dividing by the number of months to obtain a monthly average for each individual, and

(3) Calculating the frequency of individual monthly averages in the given ranges.

When calculating this element, please use the following guidelines:

- Include the total Medicaid costs (State and Federal dollars) for all Medicaid services, including waiver services.
- Include the monthly capitation payment for individuals enrolled in managed care programs (if applicable).
- Include those individuals in the average that had no services.
- Include the amount paid, not the amount billed.
- Do not include administrative costs.
- Do not include premiums paid for third-party insurance or Medicare.

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APPENDIX C

STATE SOURCES OF DATA FOR COMPLETING THE ANNUAL BUY-IN REPORT

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TABLE C.1

SOURCES OF DATA USED TO COMPLETE STATE ANNUAL REPORT FORM, 2003

State Recommended Source	Data Element 1 MMIS eligibility file	Data Element 2 MMIS eligibility file	Data Element 3 MMIS eligibility file	Data Element 4 MMIS eligibility file	Data Element 5 Billing and Collection System	Data Element 6 Unemployment Insurance System	Data Element 6A MMIS eligibility file	Data Element 7 Unemployment Insurance System	Data Element 8 MSIS claims files
Alaska	MMIS eligibility file	MMIS eligibility file	EIS eligibility file	MMIS eligibility file	Billing and Collection	Unemployment Insurance System		Unemployment Insurance System	MMIS claims files
California	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file and HIPP file	MMIS eligibility file	Unemployment Insurance System	Individual Medi-Cal recipient's case files	Unemployment Insurance System	MMIS claims file
Connecticut	MMIS eligibility file		MMIS eligibility file	MMIS eligibility file	Billing and Collection	Unemployment Insurance System	MMIS eligibility files	Unemployment Insurance System	MMIS claims files
Illinois	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	Billing and Collection	Unemployment Insurance System		Unemployment Insurance System	MMIS claims files
Indiana	ICES eligibility file	AIM claims payment system	ICES eligibility file	ICES eligibility file	Billing and Collection	ICES eligibility system	ICES eligibility system	ICES eligibility system	AIM claims payment system
Iowa	MMIS eligibility file	MMIS eligibility file	BENDEX	MMIS eligibility file	Billing and collection system	Unemployment Insurance System		Unemployment Insurance System	MMIS claims files
Kansas	MMIS eligibility file	MMIS eligibility file	KS Automated Eligibility Child Support Enforcement System (KAECSES)	MMIS eligibility file	Billing & Collections System	Unemployment Insurance System	MMIS eligibility file & KAECSES	Unemployment Insurance System	MMIS claims files
Maine	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file; TPL data	MMIS claims file; premium data file	Unemployment Insurance System		Unemployment Insurance System	MMIS claims files
Massachusetts	MMIS eligibility file	MMIS eligibility data	SVES	eligibility, premium	premium	DOR		DOR	Traps claims data
Minnesota	MMIS Eligibility File	MMIS Eligibility File	PA Eligibility File	MMIS Eligibility File	Billing and Collection System	Unemployment Insurance System	PA Eligibility File	Unemployment Insurance System	MMIS Claims Files
Missouri	Income Maintenance Eligibility File	Income Maintenance Eligibility File and SDX (SSI) File	Income Maintenance Eligibility File	MMIS eligibility file	Income Maintenance Eligibility File	Employment Security File		Employment Security File n/a	Medicaid Paid Claims File

TABLE C.1 (*continued*)

State Recommended Source	Data Element 1 MMIS eligibility file	Data Element 2 MMIS eligibility file	Data Element 3 MMIS eligibility file	Data Element 4 MMIS eligibility file	Data Element 5 Billing and Collection System	Data Element 6 Unemployment Insurance System	Data Element 6A MMIS eligibility file	Data Element 7 Unemployment Insurance System	Data Element 8 MSIS claims files
Nebraska	NFOCUS eligibility system	DataScan eligibility file	NFOCUS income tables	TPL subsystem	program staff	SEW file interface in NFOCUS		SEW file interface in NFOCUS	DataScan
New Hampshire	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	Billing and Collection	Unemployment Insurance System	MMIS eligibility files	Unemployment Insurance System	MSIS claims files
New Jersey	Recipient History Master file	Recipient History Master file		TPL data		Unemployment Insurance System		Unemployment Insurance System	Claims history
New Mexico	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file		Unemployment Insurance System	MMIS eligibility file	Unemployment Insurance System	MMIS Claims Files
New York	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file		Unemployment Insurance System	MMIS eligibility file		MMIS Claims Files
Oregon	MMIS Eligibility file	MMIS Eligibility, SSA SDX	SSA BENDEX	MMIS Eligibility file	Payment System	Unemployment Insurance System		Unemployment Insurance System	MMIS Claims Files
Pennsylvania	Client Information System(CIS)		CIS	CIS	Premium billing system	CIS, Income Eligibility Verification System (IEVS)		CIS/IEVS	Office of Medical Assistance Programs-Data Warehouse
Utah	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	Unemployment Insurance System	MMIS eligibility files	Unemployment Insurance System	MMIS claims files
Vermont	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	MMIS eligibility file	Billing and Collection	Unemployment Insurance System	MMIS eligibility files	Unemployment Insurance System	MMIS claims files
Washington	Automated Client Eligibility System (ACES)	ACES/Monthly SDX/503 LEADS	ACES Unearned Income	TPL Medicare; MMIS	Office of Financial Recovery	Unemployment Insurance System		Unemployment Insurance System	MMIS (ticket to Work File)
Wisconsin	MMIS eligibility file	CARES (Client Assistance for Re-employment and Economic Support System	CARES (Client Assistance for Re-employment and Economic Support System	MMIS and Health Insurance Purchase Plan (HIPP)	MMIS eligibility file	Unemployment Insurance System and MMIS eligibility file		Unemployment Insurance System and MMIS	MMIS

[a]This is the name for the unemployment insurance system in Nebraska. State personnel indicated that they used information from sources in addition to their UI system to collect earnings data.

TABLE C.2

DATA SUBMITTED FOR 2003 ANNUAL BUY-IN REPORTS

State	Report Submitted	Basic Info	Data Element 1	Data Element 2	Data Element 3	Data Element 4	Data Element 5	Data Element 6	Data Element 6A (Optional)	Data Element 7	Data Element 8
Alaska									N/S		
California											
Connecticut				✓							
Illinois									N/S		
Indiana											
Iowa									N/S		
Kansas											
Maine									N/S		
Massachusetts									N/S		
Minnesota											
Missouri									N/S		
Nebraska									N/S		
New Hampshire											
New Jersey					✓				N/S		
New Mexico											
New York									N/S	N/A	
Oregon									N/S		
Pennsylvania				✓					N/S		
Utah											
Vermont											
Washington											
Wisconsin											

Note: Blank cells indicate that item was completed. ✓ indicated incomplete items.

N/S = not submitted
N/A = not applicable

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APPENDIX D

SUPPORTING TABLES

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TABLE D.1

SUMMARY OF BUY-IN ENROLLMENT AND PARTICIPANT CHARACTERISTICS, BY STATE, 2003

	Enrollment as of December 2003	% in Medicaid prior to Buy-In Enrollment[a]	% with SSDI at Buy-In Enrollment[b]	% Dually Enrolled in Medicare	Average Monthly Earnings[c] ($)	Average Monthly Premium[d] ($)	Average PMPM Medicaid Expenditures ($)
Alaska	192	67	67	79	1,337	13	994
California	859	90	77	88	984	30	647
Connecticut	2,908	N/R	80	85	749	49	1,058
Illinois	531	77	74	77	612	48	641
Indiana	5,186	88	89	72	N/R	82	2,813
Iowa	6,231	61	83	85	446	36	786
Kansas	672	70	94	90	509	62	802
Maine	576	83	48	48	1,003	13	367
Massachusetts	7,213	85	57	58	1,209	50	605
Minnesota	6,487	69	83	90	628	44	1,648
Missouri	15,155	67	77	76	573	66	1,088
Nebraska	111	91	100	90	N/R	111	679
New Hampshire	1,237	58	77	80	579	34	2,046
New Jersey	951	56	N/R	85	397	0	731
New Mexico	943	62	80	33	943	0	918
New York	702	70	79	79	563	0	1,723
Oregon	585	88	81	89	829	45[e]	698
Pennsylvania	2,466	N/R	69	56	N/R	40	646
Utah	198	81	64	76	564	145	1,202
Vermont	455	90	80	85	698	27	1,256
Washington	237	60	81	89	729	82	516
Wisconsin	5,269	71	37	83	552	139	948
Total	59,164	73	73	76	739	51	1,176

SOURCE: State Annual Buy-In Reports for 2003.

NOTE: Data for enrollment in Medicaid and SSDI are for individuals who enrolled in the Buy-In program for the first time in 2003. Data for enrollment in Medicare, earnings, premiums, and Medicaid expenditures are for individuals enrolled for the entire fourth quarter of 2003.

[a]Connecticut and Pennsylvania did not submit data on Medicaid enrollment for 2003.
[b]New Jersey was unable to determine SSDI status for its Buy-In participants.
[c]Data for three states are not included because they eitehr 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.
[d]New Jersey did not require participants to pay a premium because the amount to be collected was too small to justify the administrative costs. New York did not collect premiums because their automated premium collection system was not yet operational.
[e]Oregon also charges participants a premium, or a "cost share," equal to all unearned income above the SSI monthly benefit amount, excluding any special needs.

N/R = not reported.

TABLE D.2

NUMBER OF PARTICIPANTS IN THE MEDICAID BUY-IN PROGRAM IN SELECTED ENROLLMENT GROUPS, BY STATE, 2002-2003

State	First-time Group		Re-enrolled Group		Continuously Enrolled Group		Fourth-quarter Group		Longitudinal Group		Cumulative Group	
	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	131	129	6	39	65	83	186	179	79	66	338	540
California	403	471	66	56	384	492	651	807	310	453	1,205	1,680
Connecticut	1,534	1,285	342	754	1,245	1,536	2,075	2,505	905	1,450	3,829	5,114
Illinois	421	381	10	47	5	173	177	446	N/A[c]	114	421	803
Indiana	4,297	3,702	30	4,297	N/A[b]	2,534	2,344	5,006	N/A[c]	1,803	4,297	7,999
Iowa	2,253	2,238	303	382	3,067	4,438	4,811	6,169	2,729	4,057	6,625	8,864
Kansas	516	355	4	19	N/A[b]	400	384	621	N/A[c]	305	516	880
Maine	451	435	76	363	379	472	617	733	320	449	1,696	2,128
Massachusetts	3,777	3,349	466	909	3,588	4,127	5,918	6,253	3,237	3,316	12,554	16,599
Minnesota	1,706	1,862	799	798	4,447	4,718	5,932	6,178	4,389	4,503	10,948	11,712
Missouri	8,122	8,781	11	195	N/A[b]	8,080	4,736	13,678	N/A[c]	3,925	8,122	16,903
Nebraska	47	44	10	9	59	77	91	102	51	60	257	303
New Hampshire	1,084	510	43	96	N/A[b]	778	880	1,110	N/A[c]	654	1,084	1,644
New Jersey	419	543	9	27	251	508	516	892	169	377	723	1,561
New Mexico	630	731	23	49	301	410	712	890	217	322	1,195	2,194
New York	N/A[a]	672	N/A[a]	0	N/A[a]	N/A[a]	N/A[a]	617	N/A[a]	N/A[a]	N/A[a]	672
Oregon	291	338	47	74	326	346	531	565	299	320	993	1,331
Pennsylvania	1,476	1,815	72	353	7	997	888	2,196	N/A[c]	776	1,476	3,291
Utah	265	229	89	136	51	45	138	118	31	55	463	694
Vermont	298	265	127	145	153	223	336	385	141	197	942	1,204
Washington	142	122	15	6	5	123	136	208	N/A[c]	99	142	277
Wisconsin	2,722	2,759	250	412	1,424	3,201	3,339	5,165	1,194	2,751	4,847	7,616
Total	30,985	31,016	2,798	9,166	15,757	33,761	35,398	54,823	14,071	26,052	62,673	94,009

SOURCE: 2002 and 2003 State Annual Buy-In Report Form.

NOTE: The **First-time Group** is an unduplicated count of individuals enrolled for the first time in the Medicaid Buy-In Program in a given year (i.e., either 2002 or 2003). The **Re-enrolled Group** are those individuals who had a previous enrollment in the Buy-In program at any time since the inception of the program, became disenrolled, and then enrolled again in the Buy-In program in a given year. The

TABLE D.2 (*continued*)

Continuously Enrolled Group reflects those individuals who remained on the Buy-In for the entire calendar year. The **Fourth-quarter Group** provides a standard count of participants who have been enrolled for the entire fourth quarter of the given year. The **Longitudinal Group** for 2002 (2003) provides a count of individuals enrolled in the Buy-In program for the entire fourth quarter of 2002 (2003) and for the entire fourth quarter of 2001 (2002). The **Cumulative Group** contains an unduplicated count of individuals enrolled in the Buy-In Program from its inception to the end of the given calendar year.

N/A = not applicable.

[a] New York's Buy-In program was not implemented until July 2003.
[b] Buy-In programs were not implemented until after calendar year 2002 began.
[c] Buy-In programs did not exist in 2001.

TABLE D.3

NUMBER OF REENROLLMENTS FOR BUY-IN PARTICIPANTS, BY STATE, 2002-2003

State	Total Participants who Reenrolled		Number of Re-enrollments							
			1		2		3		4 to 6	
	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	6	39	6	21	0	18	0	0	0	0
California	66	56	59	56	7	0	0	0	0	0
Connecticut	342	754	144	395	189	322	9	31	0	6
Illinois	10	47	10	43	0	4	0	0	0	0
Indiana	30	4,297	29	4,088	1	200	0	9	0	0
Iowa	303	382	296	372	7	10	0	0	0	0
Kansas	4	19	4	19	0	0	0	0	0	0
Maine	76	363	76	333	0	30	0	0	0	0
Massachusetts	466	909	456	885	9	24	1	0	0	0
Minnesota	799	798	781	776	18	22	0	0	0	0
Missouri	11	195	11	192	0	3	0	0	0	0
Nebraska	10	9	10	8	0	1	0	0	0	0
New Hampshire	43	96	43	94	0	2	0	0	0	0
New Jersey	9	27	9	27	0	0	0	0	0	0
New Mexico	23	49	0	39	22	10	1	0	0	0
New York	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
Oregon	47	74	46	67	1	6	0	1	0	0
Pennsylvania	72	353	58	265	10	67	3	20	1	1
Utah	89	136	68	89	13	25	3	10	5	12
Vermont	127	145	118	129	7	15	2	1	0	0
Washington	15	6	15	6	0	0	0	0	0	0
Wisconsin	250	412	246	410	4	2	0	0	0	0
Total	2,798	9,166	2,485	8,314	288	761	19	72	6	19

SOURCE: State Annual Buy-In Report Forms for 2002 and 2003.

NOTE: These enrollments refer to individuals who had a previous enrollment in the Buy-In at any point since its inception, became disenrolled, and then enrolled again in the given year.

N/A = not applicable because Buy-In program did not exist in 2002

TABLE D.4

TOTAL QUARTERLY ENROLLMENT IN THE MEDICAID BUY-IN, 1999-2003, BY STATE

State	Jun-99	Sep-99	Dec-99	Mar-00	Jun-00	Sep-00	Dec-00	Mar-01	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03	Sep-03	Dec-03
Alaska		16	27	38	56	67	77	90	108	113	118	128	143	155	162	164	179	185	192
Arizona																145	236	321	395
Arkansas								170	183	188	186	97	70	64	65	58	49	38	35
California				0	53	72	217	275	377	457	502	569	574	633	669	707	746	803	859
Connecticut							651	1,028	1,274	1,600	1,985	2,204	2,306	2,267	2,514	2,519	2,663	2,772	2,908
Illinois												16	82	167	323	403	454	481	531
Indiana														1,553	3589	4024	4,560	4,882	5,186
Iowa				274	1,131	1,550	1,957	2,338	2,630	2,937	3,338	3,637	4,092	4,436	4,890	5,121	5,496	5,869	6,231
Kansas														297	474	537	563	606	672
Maine		82	168	253	335	443	524	561	607	638	690	710	744	775	673	644	521	566	576
Massachusetts	3,199	3,379	3,448	3,731	4,039	4,241	4,464	4,778	5,112	5,227	5,391	5,781	6,227	6,515	6,957	6,928	6,968	6,760	7,213
Minnesota*		2,148	3,294	4,237	5,001	5,429	5,837	6,166	6,495	6,444	6,314	6,098	6,101	6,072	6,092	6,483	6,510	6,463	6,487
Mississippi		3	6	10	22	37	64	85	130	169	234	275	315	356	372	405	431	459	481
Missouri														2,402	8,461	10954	12,954	13,946	15,155
Nebraska		9	22	30	55	88	90	96	92	95	88	87	87	90	114	114	114	111	111
New Hampshire												353	677	841	968	1,050	1,122	1,199	1,237
New Jersey								N/R	N/R	N/R	N/R	55	405	473	603	665	665	840	951
New Mexico								167	287	399	497	587	675	671	799	786	811	842	943
New York																		500	702
Oregon	84	125	166	209	252	263	335	396	434	444	464	502	521	546	591	739	690	624	585
Pennsylvania												299	869	1,356	1,250	1,599	1,599	2,120	2,466
South Carolina	22	27	37	43	53	56	68	83	84	88	84	82	67	69	77	70	46	53	53
Utah										96	161	183	230	170	180	190	190	165	198
Vermont				84	174	197	226	260	266	288	328	344	365	384	423	443	456	461	455
Washington												20	58	106	144	170	195	207	237
Wisconsin				80	284	605	942	1,234	1,386	1,568	1,714	2,310	2,869	3,313	3,837	4,282	4,655	5,047	5,269
Wyoming														1	1	1	1	6	4
Total	3,305	5,789	7,168	8,989	11,455	13,048	15,452	17,727	19,465	20,751	22,094	24,337	27,477	33,712	44,228	49,201	52,874	56,326	60,132

SOURCE: State data submitted to CMS in quarterly progress reports.

N/R = not reported. The program was operational but its enrollment data were not reported.

TABLE D.5

BUY-IN ENROLLMENT IN DECEMBER 2003 AS A PERCENTAGE OF SSDI BENEFICIARIES NOT ELIGIBLE FOR MEDICAID WITHOUT A SPEND DOWN

State	Buy-In Enrollment, 2003 (A)	SSDI Beneficiaries, 2003 (B)	Highest monthly income level to receive other Medicaid (C)	Percent of SSDI Beneficiaries with SSDI Benefits Over Highest Medicaid Level (D)	SSDI Beneficiaries Not Eligible for Medicaid Without Spending Down (E)	Buy-In Enrollment as a Percentage of Eligible SSDI Beneficiaries (F)
Massachusetts	7,213	138,588	$995	30%	41,576	17.3%
Iowa	6,231	53,793	$552	70%	37,601	16.6%
Missouri	15,155	143,681	$552	72%	103,881	14.6%
Minnesota	6,487	80,252	$748	73%	58,183	11.1%
Connecticut	2,908	60,506	$747	54%	32,492	8.9%
Wisconsin	5,269	98,234	$636	73%	71,220	7.4%
Vermont	455	14,246	$733	46%	6,496	7.0%
Alaska	192	8,719	$1,025	32%	2,764	6.9%
New Hampshire	1,237	28,510	$566	77%	21,981	5.6%
Indiana	5,186	127,447	$552	74%	93,928	5.5%
New Mexico	943	38,332	$552	72%	27,522	3.4%
Maine[a]	576	41,733	$803	43%	17,737	3.2%
Kansas	672	47,741	$552	72%	34,135	2.0%
Pennsylvania	2,466	259,516	$748	52%	134,170	1.8%
Utah	198	25,583	$748	48%	12,178	1.6%
New Jersey	951	140,617	$748	57%	80,011	1.2%
Oregon	585	67,580	$554	73%	49,333	1.2%
Nebraska	111	29,638	$748	45%	13,426	0.8%
Illinois	531	202,250	$748	53%	106,788	0.5%
California	859	500,805	$978	35%	175,282	0.5%
Washington	237	108,082	$571	73%	79,224	0.3%
New York	702	371,648	$642	76%	282,452	0.2%

Source: Concept and format borrowed from Goodman and Livermore (2004). (A) State data submitted to CMS in quarterly progress reports; (B) SSA August 2004, Table 9; (C) Based on information provided by state Buy-In personnel; (D) Computed based on SSDI benefit levels, SSA August 2004, Table 16; (E, F) Computed.

Note: The size of the population eligible for the Buy-In program is affected by a state's eligibility criteria for Medicaid, and to take this into account, we adopted the strategy above, used by Goodman and Livermore (2004), to estimate Buy-In enrollment as a proportion of the population of persons with disabilities who are eligible for the Buy-In program. This strategy involves using the number of SSDI beneficiaries in a given state who would be ineligible for Medicaid without spending down as a proxy for the number of people eligible for the Buy-In program. SSDI beneficiaries comprise approximately 75 percent of new Buy-In enrollees (Figure V.3), suggesting that this may be a reasonable proxy. These rankings are similar to a simple per capita measurement based on a state's population age 18 to 64 (see Table IV.1).

[a]State personnel in Maine noted that problems with their eligibility system may have resulted in inaccurate enrollment numbers.

TABLE D.6

MEDICAID STATUS OF BUY-IN PARTICIPANTS PRIOR TO ENROLLMENT, BY STATE, 2002-2003

State	Total Participants (Number)		Medicaid Status					
			Enrolled in Medicaid (Percent)		Not Enrolled in Medicaid (Percent)		Medicaid Status Undetermined (Percent)	
	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	131	129	100	67	0	33	0	0
California	403	471	98	90	2	10	0	0
Connecticut	1,534	1,285	17	N/R	43	N/R	40	N/R
Illinois	421	381	78	77	22	23	0	0
Indiana	4,297	3,702	95	88	5	12	0	0
Iowa	2,253	2,238	68	61	32	39	0	0
Kansas	516	355	81	70	19	30	0	0
Maine	451	435	61	83	39	17	0	0
Massachusetts	3,777	3,349	81	85	19	15	0	0
Minnesota	1,706	1,862	64	69	36	31	0	0
Missouri	8,122	8,781	90	67	10	33	0	0
Nebraska	47	44	94	91	6	9	0	0
New Hampshire	1,084	510	74	58	26	42	0	0
New Jersey	419	543	7	56	93	44	0	0
New Mexico	630	731	56	62	44	38	0	0
New York	N/A	672	N/A	70	N/A	30	N/A	0
Oregon	291	338	77	88	23	12	0	0
Pennsylvania	1,476	1,815	21	N/R	79	N/R	0	N/R
Utah	265	229	69	81	31	19	0	0
Vermont	298	265	91	90	9	10	0	0
Washington	142	122	67	60	33	40	0	0
Wisconsin	2,722	2,759	74	71	26	29	0	0
Total	30,985	31,016	74	73	23	27	2	0

SOURCE: 2002 and 2003 State Annual Buy-In Report Form.

NOTE: The above enrollment data refers to individuals who enrolled in the Buy-In for the first time in a given year. Connecticut and Pennsylvania did not submit data on Medicaid enrollment for 2003.

N/A = not applicable
N/R = not reported

TABLE D.7

SSDI STATUS AT BUY-IN ENROLLMENT FOR PARTICIPANTS, BY STATE, 2002-2003

State	Total Participants		SSDI Status					
			Percent with SSDI Benefits		Percent with No SSDI Benefits		Percent with Status Undetermined	
	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	131	129	72	67	28	33	0	0
California	403	471	10	77	90	23	0	0
Connecticut	1,534	1,285	82	80	18	20	0	0
Illinois	421	381	86	74	14	26	0	0
Indiana	N/R	3,702	N/R	89	N/R	11	N/R	0
Iowa	2,253	2,238	85	83	15	17	0	0
Kansas	516	355	97	94	3	6	0	0
Maine	451	435	47	48	53	52	0	0
Massachusetts	3,777	3,349	44	57	56	43	0	0
Minnesota	1,706	1,862	88	83	12	17	0	0
Missouri	8,122	8,781	87	77	13	23	0	0
Nebraska	47	44	98	100	2	0	0	0
New Hampshire	1,084	510	82	77	18	23	0	0
New Mexico	630	731	84	80	16	20	0	0
New York	N/A	672	N/A	79	N/A	21	N/A	0
Oregon	291	338	63	81	37	19	0	0
Pennsylvania	1,476	1,815	57	69	43	31	0	0
Utah	265	229	65	64	35	36	0	0
Vermont	298	265	54	80	46	20	0	0
Washington	142	122	97	81	3	19	0	0
Wisconsin	2,722	2,759	33	37	31	26	36	37
Total	26,269	30,473	70	73	26	24	4	3

SOURCE: State Annual Buy-In Report Form for 2002 and 2003.

NOTE: The data refer to individuals enrolled in the Buy-In program for the first time in the given year. Both Indiana and New Jersey were unable to determine SSDI status for their programs in 2002 and New Jersey was unable to do so in 2003 as well.

N/A = not applicable
N/R = not reported

TABLE D.8

HEALTH INSURANCE STATUS FOR BUY-IN PARTICIPANTS DURING
THE FOURTH QUARTER OF 2002 AND 2003, BY STATE

State	Total Participants		Percent with Medicaid Only	
	2002	2003	2002	2003
Alaska	186	179	42	12
California	651	807	15	11
Connecticut	2,075	2,505	12	2
Illinois	177	446	11	19
Indiana	2,344	5,006	54	17
Iowa	4,811	6,169	15	14
Kansas	384	621	8	9
Maine	617	733	18	52
Massachusetts	5,918	6,253	37	34
Minnesota	5,932	6,178	7	8
Missouri	4,736	13,678	N/R	19
Nebraska	91	102	9	10
New Hampshire	880	1,110	16	18
New Jersey	516	892	17	13
New Mexico	712	890	68	65
New York	N/A	617	N/A	16
Oregon	531	565	12	5
Pennsylvania	888	2,196	14	11
Utah	138	118	22	22
Vermont	336	385	11	14
Washington	136	208	13	10
Wisconsin	3,339	5,165	16	15
Total	35,398	54,823	22	18

SOURCE: State Annual Buy-In Report Form for 2002 and 2003

NOTE: The data above are for individuals enrolled for the entire fourth quarter of a given year

N/A = not applicable
N/R = not reported

TABLE D.9

PARTICIPANTS WITH OTHER HEALTH INSURANCE IN ADDITION TO MEDICAID
DURING THE FOURTH QUARTER OF 2002 AND 2003, BY STATE

State	Total Participants		Health Insurance Status									
			Total with Coverage in Addition to Medicaid		Percent with Coverage in Addition to Medicaid							
					Medicare		Other Public Plan		Private Plan		Other	
	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	186	179	58	88	51	79	17	17	7	21	0	0
California	651	807	85	89	85	88	6	1	5	5	0	0
Connecticut	2,075	2,505	88	98	83	85	0	0	4	19	0	0
Illinois	177	446	89	81	86	77	0	0	16	19	0	0
Indiana	2,344	5,006	46	83	35	72	0	0	25	11	0	0
Iowa	4,811	6,169	85	86	83	85	0	0	2	2	0	0
Kansas	384	621	92	91	90	90	0	1	13	8	0	0
Maine	617	733	82	48	80	48	0	0	8	1	0	0
Massachusetts	5,918	6,253	63	66	55	58	0	0	8	8	0	0
Minnesota	5,932	6,178	93	93	90	90	1	1	12	11	0	0
Missouri	4,736	13,678	N/R	81	80	76	N/R	4	N/R	2	N/R	0
Nebraska	91	102	91	90	91	90	0	0	3	2	4	2
New Hampshire	880	1,110	84	82	82	80	3	3	3	2	0	0
New Jersey	516	892	83	87	79	85	0	0	16	18	0	0
New Mexico	712	890	32	35	29	33	0	0	1	4	4	0
New York	N/A	617	N/A	84	N/A	79	N/A	0	N/A	5	N/A	0
Oregon	531	565	88	95	80	89	23	40	15	23	0	0
Pennsylvania	888	2,196	86	89	84	56	0	0	20	5	42	28
Utah	138	118	78	78	74	76	4	0	2	4	0	0
Vermont	336	385	89	86	88	85	0	0	7	5	0	0
Washington	136	208	88	92	86	89	0	0	1	3	1	0
Wisconsin	3,339	5,165	84	85	83	83	0	0	2	9	0	0
Total	35,398	54,823	78	82	75	76	1	2	8	7	1	1

SOURCE: State Annual Buy-In Report Form for 2002 and 2003.

NOTE: The data above represent individuals enrolled for the entire fourth quarter of the given year. Missouri did not submit 2002 data on participants with coverage in addition to Medicaid and Medicare. New York's Buy-In program did not begin until 2003

N/A = not applicable
N/R = not reported

TABLE D.10

PERCENT OF PARTICIPANTS WITH MEDICAID AND MEDICARE
DURING THE FOURTH QUARTER OF 2002 AND 2003, BY STATE

State	Total Participants		Percent with Medicaid and Medicare		Percent with both Medicaid and Medicare for Whom State Paid Medicare Premium	
	2002	2003	2002	2003	2002	2003
Alaska	186	179	51	79	100	100
California	651	807	85	88	100	99
Connecticut	2,075	2,505	83	85	22	74
Illinois	177	446	86	77	22	28
Indiana	2,344	5,006	35	72	100	100
Iowa	4,811	6,169	83	85	80	84
Kansas	384	621	90	90	N/R	100
Maine	617	733	80	48	N/R	93
Massachusetts	5,918	6,253	55	58	40	46
Minnesota	5,932	6,178	90	90	83	79
Missouri	4,736	13,678	80	76	48	44
Nebraska	91	102	91	90	100	99
New Hampshire	880	1,110	82	80	27	23
New Jersey	516	892	79	85	N/R	62
New Mexico	712	890	29	33	60	80
New York	N/A	617	N/A	79	N/A	N/R
Oregon	531	565	80	89	91	44
Pennsylvania	888	2,196	84	56	59	43
Utah	138	118	74	76	100	100
Vermont	336	385	88	85	2	2
Washington	136	208	86	89	92	96
Wisconsin	3,339	5,165	83	83	6	5
Total	35,398	54,823	75	76	54	58

SOURCE: State Annual Buy-In Report Form for 2002 and 2003

NOTE: The data above are for individuals enrolled for the entire fourth quarter of a given year

N/A = not applicable
N/R = not reported

TABLE D.11

NUMBER AND PERCENT OF PARTICIPANTS WITH REPORTED UI EARNINGS IN THE FOURTH QUARTER OF 2003, BY STATE

	Number of Fourth-Quarter Participants	Participants with Earnings		Average Monthly Earnings ($)	Total Quarterly Earnings ($)	Percent of Individuals with Monthly Earnings in Selected Categories								
		Number	Percent			$1-200	$201-400	$401-600	$601-800	$801-1000	$1001-1200	$1201-1400	$1401-1600	$1601+
Alaska	179	73	41	1,337	292,848	5	8	10	11	10	7	5	7	37
California	807	470	58	984	1,387,762	10	11	20	20	10	5	4	4	15
Connecticut	2,505	1,516	61	749	3,408,351	10	20	22	22	11	5	3	0	8
Illinois	446	309	69	612	567,594	13	18	25	24	9	3	2	2	4
Iowa	6,169	1,524	25	446	2,039,156	32	22	19	15	5	2	1	1	2
Kansas	621	484	78	509	739,097	19	26	24	15	7	3	1	1	3
Maine	733	554	76	1,003	1,667,181	5	10	14	22	15	6	5	5	18
Massachusetts	6,253	3,310	53	1,209	12,008,827	6	9	16	18	8	5	6	5	27
Minnesota	6,178	3,377	55	628	6,363,031	22	19	19	21	7	3	2	2	5
Missouri	13,678	2,626	19	573	4,513,091	26	17	18	14	8	5	4	3	4
New Hampshire	1,110	731	66	579	1,269,351	20	22	19	18	9	3	2	2	4
New Jersey	892	26	3	397	30,983	27	23	38	0	8	0	4	0	0
New Mexico	890	345	39	943	976,069	4	4	3	3	4	4	4	8	67
New York	617	453	73	563	765,136	16	18	22	20	7	5	3	2	8
Oregon	565	406	72	829	1,010,291	9	17	22	21	8	4	3	3	12
Utah	118	61	52	564	103,176	11	20	26	33	7	0	0	0	3
Vermont	385	279	72	698	584,447	10	16	24	23	9	5	4	1	7
Washington	208	163	78	729	356,270	15	15	18	25	9	5	3	2	9
Wisconsin	5,165	1,904	37	552	3,152,647	26	20	19	17	7	3	2	2	5
Total	47,519	18,611	39	739	41,235,308	18	17	19	18	8	4	3	3	11

SOURCE: State Annual Buy-In Report Form for 2002 and 2003

NOTE: The data above are for individuals enrolled for the entire fourth quarter of a given year. Percentages for a given state may not sum to 100 due to rounding. 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.

TABLE D.12

NUMBER AND PERCENT OF PARTICIPANTS WITH REPORTED UI EARNINGS
IN THE FOURTH QUARTER OF 2002, BY STATE

	Number of Fourth-Quarter Participants	Participants with Earnings		Average Monthly Earnings ($)	Total Quarterly Earnings ($)	Percent of Individuals with Monthly Earnings in Selected Categories								
		Number	Percent			$1-200	$201-400	$401-600	$601-800	$801-1000	$1001-1200	$1201-1400	$1401-1600	$1601 +
Alaska	186	67	36	942	189,343	12	10	13	16	13	9	7	1	16
Connecticut	2,075	1,542	74	665	3,077,796	19	17	23	20	6	4	3	1	7
Illinois	177	127	72	607	231,138	12	13	33	26	5	2	2	6	2
Iowa	4,811	1,570	33	471	2,217,844	28	21	20	18	5	2	2	1	2
Kansas	384	282	73	415	350,797	23	31	24	15	4	1	0	0	1
Maine	617	359	58	806	868,056	13	16	18	16	7	9	7	4	11
Massachusetts	5,918	3,201	54	1,188	11,404,125	6	9	17	17	7	5	6	6	25
Minnesota	5,932	3,196	54	590	5,661,454	24	18	22	19	6	2	2	1	5
Missouri	4,736	1,229	26	513	1,891,268	26	20	22	15	6	4	2	2	3
New Hampshire	880	628	71	530	998,677	24	21	22	16	5	3	3	1	4
New Mexico	712	178	25	917	489,652	10	10	15	20	16	7	5	4	13
Oregon	531	381	72	895	1,022,879	14	15	19	18	7	6	2	3	16
Utah	138	63	46	422	79,783	32	21	30	8	3	0	0	3	3
Vermont	336	246	73	645	476,027	14	20	20	26	6	4	2	3	6
Washington	136	109	80	554	181,084	19	21	17	26	10	2	3	0	3
Wisconsin	3,339	1,480	44	532	2,364,062	26	19	22	18	6	2	2	1	4
Total	30,908	14,658	47	716	31,503,985	19	17	21	18	6	4	3	3	9

SOURCE: State Annual Buy-In Report Forms for 2002.

NOTE: The data above are shown for those participants who were enrolled for the entire fourth quarter of 2002. New Jersey did not submit earnings data, and New York's program did not begin until 2003. Percentages for a given state may not sum to 100 due to rounding. Data for four 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 (California and Nebraska), thus rendering their data incomparable with other states.

TABLE D.13

PARTICIPANTS WITH SELF-EMPLOYMENT EARNINGS IN THE FOURTH QUARTER OF 2003 AND AMOUNT OF EARNINGS, BY STATE

	Average Monthly Earnings ($)	Total Quarterly Earnings ($)	Total Fourth-Quarter Participants	Total with Self-Employment Earnings	Percent with Self-Employment Earnings	Number of Participants with Monthly Self-Employment Earnings in Selected Categories								
						$1-200	$201-400	$401-600	$601-800	$801-1000	$1001-1200	$1201-1400	$1401-1600	$1601+
California	400	87,640	807	73	9	37	16	4	2	7	1	2	0	4
Connecticut	370	37,765	2,505	34	1	16	9	6	0	2	0	0	0	1
Indiana	413	287,614	5,006	232	5	109	46	24	7	18	13	2	5	8
Kansas	430	25,770	621	20	3	6	6	3	3	1	0	0	0	1
Minnesota	188	343,466	6,178	610	10	458	80	38	11	6	4	1	1	11
Nebraska	N/R	N/R	102	5	5	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
New Hampshire	258	40,300	1,110	52	5	25	13	9	3	2	0	0	0	0
New Mexico	434	35,139	890	27	3	0	7	6	0	2	3	0	0	9
Utah	230	20,704	118	30	25	13	4	2	3	4	0	0	0	4
Vermont	588	79,321	385	45	12	14	12	5	3	4	2	1	0	4
Washington	193	1,157	208	2	1	2	0	0	0	0	0	0	0	0
Wisconsin	N/R	N/R	5,165	1,072	21	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R

SOURCE: State Annual Buy-In Report Form for 2002 and 2003.

NOTE: The data above represent individuals enrolled for the entire fourth quarter of 2003. The following states did not submit self-employment earnings data: Alaska, Illinois, Iowa, Maine, Massachusetts, Missouri, New Jersey, Oregon, and Pennsylvania.

N/A = not applicable
N/R = not reported

TABLE D.14

PARTICIPANTS WITH SELF-EMPLOYMENT EARNINGS IN THE FOURTH QUARTER OF 2002 AND AMOUNT OF EARNINGS, BY STATE

	Average Monthly Earnings ($)	Total Quarterly Earnings ($)	Total Fourth-Quarter Participants	Total with Self-Employment Earnings	Percent with Self-Employment Earnings	Number of Participants with Monthly Self-Employment Earnings in Selected Categories								
						$1-200	$201-400	$401-600	$601-800	$801-1000	$1001-1200	$1201-1400	$1401-1600	$1601+
California	131	32,682	651	83	13	45	12	7	5	5	1	3	1	4
Connecticut	770	62,400	2,075	27	1	5	7	4	4	1	1	0	1	4
Kansas	409	17,166	384	14	4	1	0	2	1	1	3	1	1	4
Minnesota	166	272,684	5,932	549	9	430	67	21	15	8	1	0	2	5
New Hampshire	361	28,150	880	26	3	11	4	5	4	0	1	1	0	0
New Mexico	426	20,438	712	16	2	1	3	3	1	0	0	0	2	6
Utah	265	23,073	138	29	21	12	7	1	0	4	0	0	1	4
Vermont	799	91,111	336	38	11	12	3	9	5	3	1	1	1	3

SOURCE: State Annual Buy-In Report Forms for 2002.

NOTE: The data above represent individuals enrolled for the entire fourth quarter of 2002. The following states did not submit self-employment earnings data: Alaska, Illinois, Indiana, Iowa, Maine, Massachusetts, Missouri, Nebraska, New Jersey, Oregon, Pennsylvania, Washington, and Wisconsin. New York did not have a Buy-In program in 2002.

TABLE D.15

CHANGE IN TOTAL QUARTERLY UI EARNINGS, AVERAGE MONTHLY EARNINGS, AND PERCENT WITH UI EARNINGS FROM 2002 TO 2003, BY STATE

State	Total Participants	Total Quarterly Earnings		Average Monthly Earnings[a]		Percent with Earnings	
		2002	2003	2002	2003	2002	2003
Alaska	66	$73,984	$82,782	$1,233	$1,452	30	29
California	453	$691,235	$718,357	$847	$943	60	56
Connecticut	1,450	$2,267,176	$2,023,209	$716	$757	73	61
Illinois	114	$146,704	$120,299	$582	$535	74	66
Iowa	4,057	$1,831,924	$1,405,822	$464	$440	32	26
Kansas	305	$315,293	$329,057	$419	$471	82	76
Maine	449	$1,025,815	$1,073,757	$991	$1,098	77	73
Massachusetts	3,316	$7,725,635	$7,018,564	$1,222	$1,274	64	55
Minnesota	4,503	$4,419,876	$4,492,021	$591	$630	55	53
Missouri	3,925	$1,235,843	$1,174,120	$469	$480	22	21
New Hampshire	654	$750,349	$688,869	$516	$532	74	66
New Jersey	377	$3,761	$5,339	$418	$593	1	1
New Mexico	322	$141,954	$138,301	$986	$1,024	15	14
Oregon	320	$764,148	$762,586	$1,103	$1,110	72	72
Utah	55	$40,755	$35,979	$453	$444	55	49
Vermont	197	$258,858	$274,901	$591	$632	74	74
Washington	99	$147,332	$157,280	$599	$699	83	76
Wisconsin	2,751	$1,921,631	$1,873,779	$526	$545	44	42
Total	23,413	$23,762,273	$22,375,022	$716	$746	47	43

SOURCE: State Annual Buy-In Report Forms for 2002 and 2003.

NOTE: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2003 and for the entire fourth quarter of 2002. New York was unable to provide these data for the 2003 Annual Report because it did not implement its Buy-In program until 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 non-comparable with other states.

[a]Calculated among participants with UI earnings.

N/A = not applicable
N/R = not reported

TABLE D.16

CHANGE IN TOTAL QUARTERLY UI EARNINGS, AVERAGE MONTHLY EARNINGS, AND PERCENT WITH UI EARNINGS FROM 2001 TO 2002, BY STATE

State	Total Participants	Total Quarterly Earnings		Average Monthly Earnings[a]		Percent with Earnings	
		2001	2002	2001	2002	2001	2002
Alaska	79	$87,966	$74,228	$977	$884	38	35
Connecticut	905	1,427,457	1,297,720	615	647	86	74
Iowa	2,729	1,469,660	1,438,213	453	473	40	37
Maine	320	472,313	441,632	772	796	64	58
Massachusetts	3,237	8,189, 967	7,094,788	1,295	1,259	65	58
Minnesota	4,389	4,236,221	4,197,400	579	600	56	53
New Mexico	217	120,970	141,954	840	986	22	22
Oregon	299	747,970	693,448	1,160	1,085	72	71
Utah	31	20,334	21,791	295	346	74	68
Vermont	141	176,392	178,756	582	567	72	74
Wisconsin	1,194	1,135,705	1,065,541	549	558	58	53
Total	13,541	$18,084,955	$16,645,471	$782	$778	57	53

SOURCE: State Annual Buy-In Report Forms for 2002 and 2003.

NOTE: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2002 and for the entire fourth quarter of 2001. The following states were unable to provide these data for the 2002 Annual Report because they did not have Buy-In programs for the entire 2001 calendar year: Illinois, Indiana, Kansas, Missouri, New Hampshire, New York, and Pennsylvania. Data for California and Nebraska were excluded because these states used sources in addition to the UI system to provide these data.

[a]Calculated among participants with UI earnings.

N/A = not applicable
N/R = not reported

TABLE D.17

MEAN MONTHLY UI EARNINGS IN 2002 AND 2003, BY STATE

State	Total Participants with Earnings		Percent of Participants with Monthly Earnings in Selected Categories [a]																	
			$1-200		$201-400		$401-600		$601-800		$801-1000		$1001-1200		$1201-1400		$1400-1600		$1601+	
	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	20	19	5	5	0	0	10	5	30	26	5	5	10	11	15	5	0	0	25	42
California	272	254	14	13	10	11	25	20	21	19	9	13	6	6	3	4	1	3	11	12
Connecticut	1,056	891	7	9	20	19	29	22	24	25	6	11	4	3	3	2	1	2	7	9
Illinois	84	75	11	15	13	19	32	29	32	27	6	5	0	1	1	1	5	1	0	1
Iowa	1,315	1,066	27	32	22	22	21	19	18	15	5	5	2	2	1	1	1	1	2	2
Kansas	251	233	22	17	31	31	26	24	16	15	4	8	2	3	0	1	0	0	0	2
Maine	345	326	4	5	10	10	19	12	20	22	11	15	7	4	7	4	5	6	17	22
Massachusetts	2,107	1,837	4	5	9	9	19	16	19	20	6	7	5	4	5	4	6	5	27	29
Minnesota	2,491	2,378	23	22	18	19	23	20	21	22	6	7	2	2	2	2	1	1	4	5
Missouri	878	815	28	31	21	19	23	20	15	13	5	6	4	4	2	3	1	1	2	2
New Hampshire	485	432	21	22	23	26	25	18	16	17	5	9	3	2	3	2	1	2	3	3
New Jersey	3	3	33	0	0	33	33	33	0	0	33	33	0	0	0	0	0	0	0	0
New Mexico	48	45	13	4	2	7	21	0	23	0	15	0	6	2	2	4	2	9	17	73
Oregon	231	229	10	7	12	14	18	19	18	18	6	10	7	4	3	4	5	3	22	20
Utah	30	27	23	19	13	26	40	19	13	30	7	7	0	0	0	0	3	0	0	0
Vermont	146	145	14	13	21	19	23	23	27	21	5	12	4	3	1	3	2	2	3	5
Washington	82	75	16	16	22	15	15	19	29	24	10	11	2	4	2	3	0	0	4	9
Wisconsin	1,218	1,146	26	27	19	19	23	19	18	19	5	7	2	2	2	2	1	1	4	4
Total	11,062	9,996	17	18	17	17	23	19	19	20	6	8	3	3	3	2	2	2	9	10

SOURCE: State Annual Buy-In Report Forms for 2002 and 2003.

NOTE: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2003 and for the entire fourth quarter of 2002. New York was unable to provide these data because it did not implement its Buy-In program until 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 non-comparable with other states.

[a]Percentages calculated among participants with UI earnings.

TABLE D.18

MEAN MONTHLY UI EARNINGS IN 2001 AND 2002, BY STATE

State	Total Participants with Earnings		Percent of Participants with Monthly Earnings in Selected Categories [a]																	
			$1-200		$201-400		$401-600		$601-800		$801-1000		$1001-1200		$1201-1400		$1400-1600		$1601+	
	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
Alaska	30	28	7	4	10	7	20	25	17	18	7	18	13	14	7	4	3	0	17	11
Connecticut	774	669	16	20	19	16	26	25	21	21	7	7	2	3	2	2	2	1	5	6
Iowa	1,081	1,014	25	27	22	22	25	21	17	19	5	4	2	2	1	1	1	1	1	2
Maine	204	185	12	12	16	16	23	21	15	15	9	6	9	6	4	8	5	4	7	11
Massachusetts	2,108	1,879	5	5	9	9	17	19	17	18	6	7	5	5	6	5	6	6	29	27
Minnesota	2,440	2,330	22	24	21	18	24	22	19	19	5	6	2	2	2	2	1	1	4	5
New Mexico	48	48	13	13	13	2	19	21	23	23	10	15	8	6	2	2	0	2	13	17
Oregon	215	213	8	12	17	15	15	16	15	16	7	7	7	5	5	4	5	5	22	20
Utah	23	21	48	43	13	14	30	29	9	10	0	0	0	0	0	0	0	5	0	0
Vermont	101	105	14	15	16	21	27	18	25	31	11	8	3	2	1	0	1	3	3	2
Wisconsin	689	636	18	21	23	19	25	25	23	21	5	6	2	1	1	1	1	1	4	4
Total	7,713	7,128	16	18	17	16	22	21	18	19	6	6	3	3	3	3	3	3	11	11

SOURCE: State Annual Buy-In Report Forms for 2002.

NOTE: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2002 and for the entire fourth quarter of 2001. New Jersey did not submit earnings data in 2002. The following states were unable to provide these data for the 2002 Annual Report because they did not have Buy-In programs for the entire 2001 calendar year: Illinois, Indiana, Kansas, Missouri, New Hampshire, New York, and Pennsylvania. Data for California and Nebraska were excluded because these states used sources in addition to the UI system to provide these data.

[a]Percentages calculated among participants with UI earnings.

TABLE D.19

NUMBER OF PARTICIPANTS REQUIRED TO PAY PREMIUMS AND CO-PAYMENTS
AND AVERAGE MONTHLY AMOUNTS, BY STATE, 2002-2003

State	Total Participants		Premiums				Co-Payments			
			Percent Required to Pay		Average Monthly Premium ($)		Percent Required to Pay		Average Monthly Co-Payment ($)	
	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	186	179	49	63	43	13	100	N/R	20	N/R
California	651	807	100	100	35	30	0	0	0	0
Connecticut	2,075	2,505	17	13	40	49	0	0	0	0
Illinois	177	446	99	100	48	48	100	100	N/R	N/R
Indiana[a]	2,344	5,006	44	11	64	82	0	0	0	0
Iowa	4,811	6,169	29	26	35	36	0	0	0	0
Kansas	384	621	59	69	67	62	0	0	0	0
Maine	617	733	16	12	12	13	0	0	0	0
Massachusetts	5,918	6,253	74	91	44	50	0	0	0	0
Minnesota	5,932	6,178	83	97	40	44	0	0	0	0
Missouri	4,736	13,678	11	14	65	66	0	0	0	0
Nebraska	91	102	3	1	72	111	0	0	0	0
New Hampshire	880	1,110	11	29	34	34	0	0	0	0
New Jersey	516	892	0	0	0	0	0	0	0	0
New Mexico	712	890	0	0	0	0	100	100	N/R	N/R
New York	N/A	617	N/A	0	0	0	0	0	0	0
Oregon[b]	531	565	2	2	30	45	0	0	0	0
Pennsylvania	888	2,196	93	70	43	40	0	0	0	0
Utah	138	118	82	87	321	145	0	0	0	0
Vermont	336	385	12	8	18	27	0	0	0	0
Washington	136	208	100	100	81	82	0	0	0	0
Wisconsin	3,339	5,165	13	11	131	139	0	0	0	0
Total	35,398	54,823	44	38	48	51				

SOURCE: State Annual Buy-In Report Form for 2002 and 2003.

NOTE: The data above are for individuals who were enrolled for the entire fourth quarter of the given year. New Jersey did not require participants to pay a premium because the amount to be collected was too small to justify administrative costs. New York did not collect premiums because their automated premium collection system was not yet operational.

[a]The change in the percentage of Indiana's participants who paid a premium from 44 percent in 2002 to 11 percent in 2003 may be linked to the inadvertent inclusion of Medicare premiums in the 2002 data.

[b]Oregon also charges participants a premium, or a "cost share," equal to all unearned income above the SSI monthly benefit amount, excluding any special needs.

N/A = not applicable

N/R = not reported

TABLE D.20

AVERAGE PER MEMBER PER MONTH (PMPM) MEDICAID EXPENDITURES DURING THE FOURTH QUARTER, BY STATE, 2002-2003

	Average PMPM ($)		Total Participants		Percent of Participants in Expenditure Categories											
					$0		$1-500		$501-1,000		$1,001-5,000		$5,001-20,000		$20,001+	
State	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002	2003
Alaska	572	994	186	179	10	6	87	42	3	25	0	27	0	1	0	0
California	559	647	651	807	1	5	70	55	17	20	11	20	1	0	0	0
Connecticut	1,616	1,058	2,075	2,505	2	13	32	40	21	18	39	25	6	4	0	0
Illinois	575	641	177	446	7	3	50	42	27	22	16	29	1	2	0	1
Indiana	2,260	2,813	2,344	5,006	8	7	33	28	13	14	26	29	17	21	4	1
Iowa	722	786	4,811	6,169	0	0	50	49	28	27	21	23	0	1	0	0
Kansas	609	802	384	621	4	2	57	48	20	24	19	26	0	1	0	0
Maine	505	367	617	733	6	27	74	56	7	7	10	8	2	3	0	0
Massachusetts	441	605	5,918	6,253	8	6	67	61	15	17	10	15	0	0	0	0
Minnesota	1,467	1,648	5,932	6,178	2	1	37	31	20	21	36	40	6	7	0	0
Missouri	950	1,088	4,736	13,678	6	2	44	40	22	24	26	31	1	2	0	0
Nebraska	605	679	91	102	1	2	58	61	22	23	19	13	0	2	0	0
New Hampshire	1,602	2,046	880	1,110	2	2	28	22	22	22	42	46	6	8	0	0
New Jersey	1,128	731	516	892	4	5	37	52	21	21	35	21	3	1	0	0
New Mexico	854	918	712	890	3	3	33	26	47	50	16	20	1	1	0	0
New York	N/A	1,723	N/A	617	N/A	12	N/A	34	N/A	17	N/A	30	N/A	7	N/A	0
Oregon	690	698	531	565	0	0	45	44	39	39	15	16	0	0	0	0
Pennsylvania	260	646	888	2,196	0	0	28	29	38	38	33	33	0	0	0	0
Utah	1,372	1,202	138	118	1	0	25	13	38	36	32	48	4	3	0	0
Vermont	980	1,256	336	385	1	2	46	37	15	17	36	42	1	2	0	0
Washington	551	516	136	208	1	2	65	56	20	31	14	10	0	0	0	0
Wisconsin	919	948	3,339	5,165	2	2	51	50	21	22	23	24	2	2	0	0
Total	1,016	1,176	35,398	54,823	4	4	47	42	21	23	25	28	3	4	0	0

SOURCE: State Annual Buy-In Report Form for 2002 and 2003

NOTE: The data above are for individuals enrolled during the entire fourth quarter of the given year.

N/A = not applicable

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APPENDIX E

SUPPLEMENTAL METHODOLOGICAL INFORMATION FOR CHAPTER VI

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This appendix provides supporting detail on the methodology used in Chapter VI to determine the extent to which changes in the proportion of Buy-In participants with UI earnings are positively correlated with changes in the proportion of participants who have earnings above the SGA level.[1] Below, we present evidence that the positive correlation between these measures is robust and not materially influenced by the incorporation of self-employment income. In addition, we show that changes in the percent of participants with UI earnings are also correlated with the percent change in average earnings for the overall Buy-In population. However, we believe that estimates of the percent of participants earning above the SGA level (i.e., Specifications (A) and (B) below) are based on more realistic assumptions than estimates of average earnings among the overall Buy-In population (i.e., Specifications (C) and (D) below), and this is why we presented results for Specification (A) in Chapter VI. When referring to a correlation for a given specification below, we always refer to the correlation between changes in the percent with UI earnings between 2002 and 2003 and changes in the value of a given specification between 2002 and 2003. Table E.1 presents the results from this sensitivity analysis and provides detail on each specification.

Results for Specification (A) in Table E.1 are those presented in Chapter VI and show a positive correlation of 0.78 between the changes in the percent of participants with UI earnings and the percent with earnings above the SGA level. Specification (A) assumes that individuals without UI earnings earn below $800 per month.

We investigate the validity of this assumption by incorporating self-employment earnings data into Specification (B).[2] In Specification (B), which produces a positive correlation of 0.73, we incorporate the self-employment earnings data that some states submitted, and we restricted the analysis to those seven states reporting both self-employment and UI earnings data. The presence of strong positive correlations between changes in the percent of participants with earnings above the SGA level and the percent of participants with UI earnings for both Specifications (A) and (B) suggests that the use of UI earnings alone in Specification (A) does not affect the general results.

Given that we found a positive correlation between changes in the percent of participants with UI earnings and changes in one measure of earnings—in this case, changes in the percent of participants who earn above the SGA level—we might also expect to find a positive correlation between changes in the percent of participants with UI earnings and the changes in average earnings. For Specification (C), we calculate average earnings for all states by assuming that participants without UI earnings have zero earnings. In Specification (D),

[1]As in Chapter VI, we assume that earnings above $800 per month constitute earnings above the SGA level, which is correct for 2003 and an approximation for 2002 when the SGA level was $780 per month.

[2]See notes to Table E.1 for assumptions made for these and other specifications.

we incorporate self-employment income to calculate average earnings for the seven states that submitted self-employment earnings data for both 2002 and 2003. For Specification (D), we assume that participants have zero earnings if they do not have earnings in the UI system or from self-employment. We find strong positive correlations between changes in Specifications (C) and (D) and changes in the percent of participants with UI earnings.

TABLE E.1

CORRELATION BETWEEN THE PERCENT OF BUY-IN PARTICIPANTS WITH EARNINGS AND DIFFERENT EARNINGS MEASURES, 2002-2003, BY STATE

	Number of Fourth-Quarter Participants		Percent with UI Earnings			Percent Earning Above SGA[a]						Average Earnings ($)					
						UI Earnings Only (A)			UI + Self-Employment Earnings (B)			UI Earnings Only (C)			UI + Self-Employment Earnings (D)		
State	2002	2003	2002	2003	Change	2002	2003	Change	2002	2003	Change	2002	2003	% Change	2002	2003	% Change
Alaska	186	179	36	41	5	17	27	10				339	545	61			
California	N/R	807	N/R	58	N/A	N/R	23	N/A				N/R	573	N/A			
Connecticut	2,075	2,505	74	61	-14	16	16	0	16	16	0	494	454	-8	504	459	-9
Illinois	177	446	72	69	-2	11	14	3				435	424	-3			
Iowa	4,811	6,169	33	25	-8	4	3	-1				154	110	-28			
Kansas	384	621	73	78	5	5	12	7	7	12	5	305	397	30	319	411	29
Maine	617	733	58	76	17	22	36	15				469	758	62			
Massachusetts	5,918	6,253	54	53	-1	27	27	0				642	640	0			
Minnesota	5,932	6,178	54	55	1	9	10	1	9	11	1	318	343	8	333	362	9
Missouri	4,736	13,678	26	19	-7	4	5	0				133	110	-17			
New Hampshire	880	1,110	71	66	-6	12	14	2	12	14	2	378	381	1	389	393	1
New Jersey	N/R	892	N/R	3	N/A	N/R	0	N/A				N/R	12	N/A			
New Mexico	712	890	25	39	14	11	34	23	12	35	23	229	366	59	239	379	59
New York	N/A	617	N/A	73	N/A	N/A	18	N/A				N/A	413	N/A			
Oregon	531	565	72	72	0	24	22	-2				642	596	-7			
Utah	138	118	46	52	6	4	5	1	11	12	1	193	291	51	248	350	41
Vermont	336	385	73	72	-1	15	19	4	18	22	5	472	506	7	563	575	2
Washington	136	208	80	78	-2	14	22	8				444	571	29			
Wisconsin	3,339	5,165	44	37	-7	7	6	0				236	203	-14			
Total[a]	30,908	47,519	47	39	-8	12	11	-1	12	11	-1	340	289	-15	377	412	9
Correlation with change in % with UI earnings								0.78[b]			0.73			0.86			0.93

SOURCE: State Annual Buy-In Report Form for 2003. See Tables D.11 and D.12 for state-level data on UI earnings and Tables D.13 and D.14 for state-level self-employment earnings data.

NOTE: Data are for participants enrolled for the entire fourth quarter of a given calendar year. Data for four states are not included because they either did not use the UI system (Indiana and Pennsylvania in both years) or used a data source in addition to the UI system (California in 2002, Nebraska in both years), thus rendering their data non-comparable with other states. Discussions with state officials in Connecticut and Maine suggest potential inaccuracies with its earnings data.

[a]The SGA level was $800 per month in 2003 and $780 per month in 2002. Therefore, the percent of participants with earnings above $800 per month is equal to the percent above SGA in 2003 but only an approximation of the percent with earnings above SGA in 2002.

TABLE E.1 (*continued*)

[b]This correlation is 0.73 for the seven states with self-employment earnings data.

N/A = not applicable
N/R = not reported

Specification A: The proportion of fourth quarter participants with earnings above SGA for a given year was calculated as the number of fourth quarter participants with UI earnings above $800 per month divided by the total number of fourth quarter participants. Therefore, participants without reported UI earnings were assumed to have earnings below $800 per month.

Specification B: The proportion of fourth quarter participants with earnings above SGA was calculated as the sum of (1) the number of fourth quarter participants with UI earnings above $800 per month; and (2) the number of fourth quarter participants with self-employment earnings above $800 per month. This sum was divided by the total number of fourth quarter participants. Participants without either UI or self-employment earnings were assumed to earn less than $800 per month and those with reported earnings were assumed to have earnings from only one source (i.e., either UI or self-employment, but not both).

Specification C: Average earnings among all fourth quarter participants was calculated as (total UI earnings)/(total number of fourth quarter participants). This calculation assumes that participants without UI earnings had earnings of zero.

Specification D: Average earnings among all fourth quarter participants was calculated as (total UI earnings + total self-employment earnings)/(total number of fourth quarter participants). This calculation assumes that all participants without self-employment or UI earnings had earnings of zero.