Medicaid Expansion for Employed Persons With Disabilities:

Costs and Benefits of the "Ticket to Work" Buy-In

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EXECUTIVE SUMMARY

The federal Ticket to Work and Work Incentives Improvement Act of 1999 (HR 1180) is intended to increase employment opportunities for persons with disabilities, focusing on individuals participating in the two federal income assistance programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). A key provision of the Ticket to Work law gives states the option of expanding Medicaid coverage to employed persons with severe disabilities. The Medicaid expansion, often referred to as a "buy-in," represents a major change in access to health care for persons with severe disabilities by greatly increasing the income and asset thresholds for Medicaid eligibility.

This report, undertaken at legislative request,[1] examines the impacts of implementing the optional Medicaid buy-in provision of the Ticket to Work law.

Key Findings

The potential impacts of the Medicaid expansion program, or Medicaid buy-in, for employed persons with disabilities are examined here. Two key findings are notable:

1. Flexibility in Program Design Enables States to Control Costs and Benefits

- ✓ The Ticket to Work law allows states to establish any income and assets standards, or none at all, to regulate program eligibility. Enrollment and costs will be influenced by how a state designs its program.
- ✓ A similar level of flexibility is allowed regarding the amount and design of program premiums and other fees or cost-sharing amounts.
- ✓ The design of eligibility standards, premiums, and cost-sharing amounts will affect both the number of potentially eligible individuals and the number of individuals with an incentive to participate in the Medicaid buy-in. The program's cost to state government will be directly related to these program design features.

2. Choice of Program Design Affects Enrollment and Incentives: Costs and Benefits of the Medicaid Buy-In Program

To estimate a range of effects in Washington State, two Medicaid buy-in scenarios are examined:

- ✓ **Low State Cost Scenario:** A program with monthly premiums based on income and cost-share amounts similar to the current Medically Needy "spend down" will have enrollment effects of around *883 individuals* by the end of the 2001-03 biennium; of those individuals, *at least 133 will have increased their hours worked* in response to the buy-in. The program will result in a *net General Fund-State increase of about $1 million* in expenditures during the 2001-03 biennium, increasing to *$2.1*

[1] Section 607(8), EHB 2487

million by the 2003-05 biennium. The addition of the cost-share reduces the incentive for some individuals to participate and also reduces General Fund-State expenditures relative to the high state cost scenario.

- ✓ **High State Cost Scenario:** A program with monthly premiums based on income but no cost-share amounts will have an enrollment effect of around *5,864 individuals* by the end of the 2001-03 biennium; of those individuals, *at least 4,750 will have started working or increased their hours worked* in response to the buy-in. The program will result in a *net General Fund-State increase of about $9.6 million* in expenditures during the 2001-03 biennium, increasing to *$18.8 million* by the 2003-05 biennium.

INTRODUCTION

The federal Ticket to Work and Work Incentives Improvement Act of 1999 (HR 1180) represents a major change in access to health care for persons with severe disabilities by greatly increasing the income and asset thresholds for Medicaid eligibility. The Ticket to Work law gives states the option of expanding Medicaid coverage to employed persons with severe disabilities, providing flexibility to establish any income and assets standards, or none at all, to regulate program eligibility. Enrollment and costs will be influenced by how a state designs its program.

States also have flexibility regarding the amount and design of premiums and other fees or cost-sharing amounts program participants will be charged. The design of eligibility standards, premiums, and cost-sharing amounts will affect both the number of potentially eligible individuals and the number of individuals with an incentive to participate in the Medicaid expansion program. The program's cost to state government will be directly related to these program design features.

This report address the following:

- Section I, **Ticket to Work Medicaid Expansion**, describes the Medicaid expansion program (often referred to as the Medicaid buy-in).
- Section II, **Federal Programs for Persons With Disabilities**, explains the current government services provided to persons with disabilities.
- Section III, **Impacts of the Ticket to Work Medicaid Buy-In**, indicates the changes the Medicaid buy-in program would make to these services.
- Section IV, **Considerations and Questions in Structuring the Medicaid Buy-In**, describes key decision points in structuring a buy-in program.
- Section V, **Costs and Benefits Under Two Buy-In Scenarios**, provides impact estimates of two different buy-in scenarios.

I. TICKET TO WORK MEDICAID EXPANSION: HIGHLIGHTS

The Ticket to Work law revises several aspects of the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs as a means of promoting employment for persons with severe disabilities. This report focuses on one specific provision in the law that gives states the option to expand Medicaid coverage to employed persons with severe disabilities. This optional Medicaid expansion is often referred to as the "Medicaid buy-in" program because states may charge premiums to persons receiving Medicaid coverage under the expansion.

Health care and access to health insurance have been cited as critical supports to the employment of persons with severe disabilities. In focus groups conducted in the Seattle area among persons with severe disabilities who have successfully become employed, 64 percent of participants ranked access to health insurance and medical care as a "very important" employment support. Several focus group members referred to concerns about the loss of health care benefits if they become employed or increase their hours of work while enrolled in SSDI or SSI.[2]

Medicaid Buy-In Program Highlights

- States may establish a Medicaid buy-in program for employed persons aged 16 to 64 who meet SSDI/SSI disability standards. States have sole discretion to set income and asset eligibility standards and may choose not to have *any* income or asset standards.

- States have considerable flexibility to establish premiums and cost-sharing fees (co-pays, deductibles, etc.) but are not required to do so.

- The level of services covered is the same as under the Categorically Needy Medicaid program.[3]

- The following persons are eligible for the buy-in:
  - Employed persons remaining on the SSDI caseload;
  - Those who have left the SSDI or SSI programs due to employment but continue to have a severe disability that meets SSDI/SSI standards; and
  - Employed persons who meet the SSDI/SSI disability standards but are not currently enrolled in either program.

[2] See Appendix C for additional details from these focus groups. The focus group findings are a preliminary analysis related to a larger project funded by the U.S. Department of Health and Human Services (DHHS). Until the project is completed, DHHS has requested that the Institute limit distribution of Appendix C. It is anticipated that the final report will be available electronically in early 2001.

[3] The Categorically Needy program provides the widest range of services available through any Medicaid or state-funded medical assistance program.

- States that establish a buy-in program have the option to provide coverage to individuals who participate in the buy-in and later improve medically to a point where they no longer meet SSDI/SSI disability standards but continue to have a “medically determinable severe impairment.”

II. FEDERAL PROGRAMS FOR PERSONS WITH DISABILITIES

Two major federal programs exist to assist individuals with severe disabilities: (1) the Social Security Disability Insurance (SSDI) program for persons who become disabled during their working life, and (2) the Supplemental Security Income (SSI) program for individuals who have had little or no work experience prior to becoming disabled. Persons enrolled in these two programs are most likely to be affected by the Medicaid buy-in.

Cash benefits in both programs are financed with federal funds[4] while health care benefits are paid through the federal Medicare program and the state and federal Medicaid program. From the perspective of an SSDI or SSI recipient, the Medicaid buy-in has the potential to impact both income and medical assistance benefits. From the state's perspective, the buy-in impacts the budget through its effects on the Medicaid program.

Health Care and Employment Provisions

Because the impact of a Medicaid buy-in on SSDI and SSI recipients and on the state is related to the design of these two programs, the current health care and employment provisions are summarized below. In addition, although individuals with severe disabilities who are not currently covered by SSDI or SSI receive few government services, they may be eligible for the Ticket to Work Medicaid buy-in and are thus discussed briefly.

SSDI Beneficiaries

- Health care for SSDI beneficiaries is covered under the federal Medicare program.[5] Health care costs not covered by Medicare (e.g., prescription drugs) may be paid for by the Medicaid Medically Needy program, but only after recipients pay a monthly "spend down" amount equal to the difference between their monthly income and $559.[6]
- Many recipients have health care costs below the spend down amount which they must pay out-of-pocket.
- Recipients who leave SSDI due to employment lose eligibility for Medicaid Medically Needy coverage but continue to be eligible for 39 months of premium-free Medicare coverage, after which they may purchase Medicare.

[4] Most states provide a small cash supplement to SSI recipients. Washington State's supplement, which accounts for about 5 percent of cash benefits paid to SSI recipients, totals approximately $58 million per biennium. Federal funds cover the remaining 95 percent of SSI cash benefits.

[5] SSDI recipients do not receive Medicare coverage during their first 24 months of eligibility. During this period, all health care costs are potentially eligible for Medicaid Medically Needy coverage after spend down has occurred.

[6] The Medicaid Medically Needy spend down amount is calculated by "disregarding" the first $20 in monthly income and then subtracting the SSI monthly cash benefit of $539 from a recipient's remaining income. Therefore, the spend down is equal to monthly income in excess of $559. The spend down is paid by the SSDI beneficiary to a health care provider. The receipt for these expenditures is then used as proof of eligibility for the Medicaid Medically Needy program.

- Earnings below $200 per month (this amount may be increased to $530 next year[7]) do not affect SSDI eligibility; earnings above $200 per month for a nine-month (not necessarily consecutive) "trial work period" lead to loss of SSDI cash benefits if earnings are at least $700 per month at the end of the trial work period. For the following 36 months, cash benefits may be reinstated in any month with earnings below $700.

SSI Beneficiaries

- Health care for SSI beneficiaries is covered by the state and federal Categorically Needy Medicaid program. No out-of-pocket health care costs are incurred by the recipient.
- Earnings between $65 and $1,063 per month result in a loss of 50 cents in SSI cash benefits for each dollar of earnings; earnings between $1,063 and $1,561 per month result in a loss of all SSI cash benefits. Recipients can still maintain their Medicaid eligibility.
- Recipients who earn more than $1,561 per month (approximately 224 percent of the federal poverty level) lose Medicaid eligibility.

Persons With Severe Disabilities Not Currently Enrolled in SSDI or SSI

- There are no government-sponsored health insurance or income assistance programs based on severe, long-term disability status for individuals not enrolled in SSDI or SSI.[8]

[7] The Social Security Administration has issued a proposed rule to increase the minimum monthly earnings that count as part of a "trial work period" from $200 to $530.

[8] Persons with short-term disabilities may qualify for medical benefits and income support through the General Assistance-Unemployable (GA-U) program; GA-U applicants with severe disabilities are generally assisted in applying for SSDI or SSI. Some persons with severe disabilities may be receiving Temporary Assistance for Needy Families (welfare) and related Medicaid coverage based on low income rather than disability status.

III. IMPACTS OF THE TICKET TO WORK MEDICAID BUY-IN

Because of the differences in the mix of services provided to the three groups discussed in the previous section (SSDI, SSI, "not enrolled"), the estimated impact of a Medicaid buy-in program on both individuals and the state Medicaid budget differs for each. The structure of cost-sharing amounts, premiums, and eligibility standards will create different participation incentives for each group. In turn, the decision to participate (or not) in the buy-in will determine the ultimate impact of the program. This section provides an overview of the costs and benefits for individuals in each group as well as for state government.

SSDI Beneficiaries

- For recipients *currently* employed, there is an incentive to enroll in the buy-in program if health care costs not covered by Medicare exceed the buy-in premium plus any cost-share amount.
- For recipients *not currently* employed, there is an incentive to work and enroll in the buy-in program for individuals whose uncovered health care costs are high relative to the buy-in premium and cost-share amounts.
- The main benefits are reduced health care expenses and the ability to increase income through employment while maintaining health care coverage.
- The main costs are premiums and any cost-share amounts.

SSI Beneficiaries

- For *currently* employed recipients who have limited their earnings to the SSI cap of $1,561 per month or less to maintain Medicaid eligibility, the buy-in provides an opportunity to increase earnings while maintaining Medicaid coverage.
- The buy-in program provides no financial incentives for recipients with very low or no earnings.[9]
- The main benefit is the ability to increase income through employment while maintaining health care coverage.
- The main costs are premiums and any cost-share amounts.

Persons With Severe Disabilities Not Enrolled in SSDI or SSI

- The buy-in program provides health care access to employed individuals, especially those without employer-provided health insurance.
- The buy-in also provides an incentive to become employed for non-working individuals without health insurance.

[9] To the extent that a buy-in program minimizes SSI beneficiary concerns that attempting to work could result in loss of health care benefits, the buy-in could increase work efforts among individuals not currently employed. This effect could be reinforced by the Ticket to Work provision stating that employment cannot be used as the basis for initiating a disability review.

- Individuals must undergo disability determination to become eligible for the buy-in program; if this process is viewed as unpleasant or is associated with a "welfare stigma," individuals may be reluctant to apply.
- Lack of current participation in SSDI or SSI may imply that such individuals have access to health care. However, survey evidence suggests that up to 20 percent of severely disabled persons may not be covered by health insurance.[10]
- The main benefit is access to health care.
- The main costs are premiums and any cost-share amounts.

State Government

- The main benefits for the state are new revenue from the premiums and cost-share amounts and the new tax revenue from individuals who start working or increase their work effort.
- The main costs are the loss of the Medicaid Medically Needy spend down requirement and new health care costs for individuals not previously enrolled in the Medically Needy or Categorically Needy Medicaid programs. SSI recipients add minimally to costs regardless of program design, while costs associated with SSDI recipients are strongly related to the cost-sharing and premium structure chosen by the state. Costs for individuals not enrolled in either program are the hardest to predict due to lack of information about this group.

[10] The Survey of Income and Program Participation analyzed by Stapleton et al. indicates that 18.9 percent of severely disabled persons are uninsured. Similarly, the 1998 Washington State Population Survey suggests that approximately 20 percent of severely disabled persons are uninsured. However, it is not known if the persons indicated in these surveys as severely disabled would meet SSDI/SSI standards. David Stapleton, Gina Livermore, Scott Scrivner, Adam Tucker, and David Wittenberg, *Exploratory Study of Health Care Coverage and Employment of People with Disabilities* (U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, HHS Contract No. 100-93-0012, July 6, 1998).

IV. CONSIDERATIONS AND QUESTIONS IN STRUCTURING THE MEDICAID BUY-IN

States implementing a Medicaid buy-in have considerable latitude in determining eligibility as well as setting premiums and cost-sharing amounts. The design of these features will, in turn, affect buy-in participation and state government costs. This section contains key decision points related to a buy-in program from the perspective of both potential buy-in participants and the state.

Individuals Potentially Eligible for the Buy-In: Participants' Decision Factors

- *Are premiums and cost-share amounts less than the Medicaid Medically Needy spend down or other uncovered health care expenses?* The greater the potential net savings, the more attractive it will be to enroll.
- *Are uncovered health care expenses ongoing or one-time expenses?* Individuals with ongoing health care expenses, such as medication prescribed for a chronic condition, have greater incentives to enroll in the buy-in.
- *Are the savings from buy-in enrollment enough to justify employment effort?* Individuals with severe disabilities face special challenges in finding employment. The smaller the savings associated with the buy-in, the larger the benefits (financial and otherwise) of employment must be for buy-in enrollment to be feasible.

Implementing a Buy-In in Washington State: Decision Factors

- *What are the state's goals for a Medicaid buy-in program?* To encourage employment but reduce state fiscal impacts, premiums and cost-shares could be imposed on unearned income (which includes SSDI cash benefits) but not on earned income. However, if the goal is to maximize the number of individuals who benefit from the buy-in, premiums and cost-share amounts should be set at a minimal level.
- *What, if any, income and asset limits should be used to determine eligibility?* Setting lower eligibility limits will reduce potential costs and can be used to minimize the buy-in participation of those not currently enrolled in SSDI or SSI. However, setting low eligibility limits could also reduce incentives for employment among SSDI and SSI recipients.
- *What, if any, cost-share amounts should be used?* Establishing monthly cost-shares similar in design to the Medicaid Medically Needy spend down formula can minimize program costs but will also minimize program participation. Co-pays or deductibles can be used to reduce unnecessary service utilization but may create new administrative burdens.
- *How much flexibility should the authorizing legislation provide to Washington's Medicaid agency (Medical Assistance Administration of the Department of Social and Health Services)?* Once authorizing legislation is passed,[11] the Medical Assistance Administration submits the design of the buy-in program to the federal

[11] DSHS Medical Assistance Administration views the Medicaid buy-in as a substantive change to the Medicaid program that will require authorizing legislation.

government. Over time, the Medical Assistance Administration can submit program amendments to the federal government to modify eligibility, premiums, or other buy-in provisions. Washington's legislature may wish to place limits on both the initial design of the program and on any subsequent changes for budget and policy reasons.

V. COSTS AND BENEFITS UNDER TWO BUY-IN SCENARIOS

It is clear that decisions on premiums, cost-sharing amounts, and eligibility standards have an important impact on the costs and benefits of a Medicaid buy-in. This section provides estimated impacts under two scenarios:

- **Low State Cost Scenario:** A more restrictive version with both premiums and substantial cost-sharing; and
- **High State Cost Scenario:** A less restrictive version with premiums but no cost-share fees.

For this analysis, results from existing research and relevant data sources have been combined into a simulation model developed by the Institute to estimate the impacts of the two scenarios (see Appendix B for a detailed discussion of methods and data). However, the combination of program changes created by the Ticket to Work legislation and a lack of data in certain key areas creates some uncertainty concerning the costs and benefits of a Medicaid buy-in. Therefore, while the following analysis presents the best available information on buy-in impacts, the results must be considered approximate.

Although this report focuses only on results for these two scenarios, the model can be used to estimate the costs and benefits of other policy scenarios and different underlying assumptions about participant response.

Low State Cost Scenario

- Eligibility is limited to individuals with total income up to 450 percent of the federal poverty level.
- Monthly premiums are equal to 5 percent of all unearned income plus 5 percent of earned income after disregarding the first $65 per month and half the remainder. No premiums are imposed for individuals with total income under 200 percent of the federal poverty level.
- All enrollees must pay a monthly cost-share fee equal to unearned income in excess of the Medicaid Medically Needy standard of $539 per month.
- The net General Fund-State impact is estimated to be $1 million in the 2001-03 biennium (see Exhibit 1 for detailed estimates).
- 186 SSI beneficiaries are expected to participate in the buy-in by the end of the 2001-03 biennium.
- 584 SSDI beneficiaries are expected to participate in the buy-in by the end of the 2001-03 biennium.
- 113 others (non-SSI, non-SSDI) are expected to participate in the buy-in by the end of the 2001-03 biennium.

High State Cost Scenario

- Eligibility is limited to individuals with total income up to 450 percent of the federal poverty level.
- Monthly premiums are equal to 5 percent of all unearned income plus 5 percent of earned income after disregarding the first $65 per month and half the remainder. No premiums are imposed for individuals with total income under 200 percent of the federal poverty level.
- No cost-sharing fees are imposed on enrollees.
- The net General Fund-State impact is estimated to be $9.6 million in the 2001-03 biennium (see Exhibit 2 for detailed estimates).
- 186 SSI beneficiaries are expected to participate in the buy-in by the end of the 2001-03 biennium.
- 5,452 SSDI beneficiaries are expected to participate in the buy-in by the end of the 2001-03 biennium.
- 226 others (non-SSI, non-SSDI) are expected to participate in the buy-in by the end of the 2001-03 biennium.

Exhibit 1

Estimated Costs and Benefits of Low State Cost Scenario:
Cost Share, 5 Percent Premium, January 1, 2002, Implementation

FISCAL YEAR	2002	2003	2004	2005	2006	2007
Totals						
Enrollment	343	883	1,349	1,767	2,248	2,665
Premiums	($129,508)	($387,895)	($727,799)	($1,069,234)	($1,498,237)	($1,908,582)
Cost Share	($171,976)	($379,098)	($552,488)	($624,928)	($699,383)	($771,503)
Change in Spend Down	$236,017	$518,275	$573,212	$630,738	$690,952	$753,958
Medicaid Costs	$825,340	$2,543,617	$4,632,350	$6,341,003	$8,407,631	$10,576,256
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	$602,961	$1,485,050	$2,142,688	$2,085,173	$1,812,646	$1,753,270
Net Medicaid Impact, State	$298,767	$737,030	$1,063,416	$1,034,871	$899,616	$870,148
New General Fund Tax Revenue	$22,237	$113,736	$246,785	$435,589	$684,201	$913,885

NOTE: Line items which represent offsets to Medicaid expenditures (premiums, cost-share amounts) or which represent lower expenditures as a result of the Medicaid buy-in (Medicaid savings) are shown as negative. Line items which represent higher expenditures as a result of the buy-in (change in spend down, Medicaid costs) are shown as positive. Increases in general fund tax revenues are shown as positive.

Exhibit 1, continued

Estimated Costs and Benefits of Low State Cost Scenario: Cost Share, 5 Percent Premium, January 1, 2002, Implementation

Fiscal Year	2002	2003	2004	2005	2006	2007
Individuals Enrolled in or Leaving SSDI						
Historic Exits Due to Employment						
Enrollment	64	195	328	473	633	770
Premiums	($37,847)	($118,607)	($209,449)	($317,517)	($446,899)	($572,812)
Cost Share	($2,366)	($8,571)	($18,004)	($31,689)	($42,043)	($44,271)
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	$160,194	$1,036,162	$1,971,342	$3,195,052	$4,682,322	$6,236,418
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$119,981	$908,984	$1,743,889	$2,845,846	$4,193,380	$5,619,334
Net Medicaid Impact, State	$59,451	$451,129	$865,492	$1,412,393	$2,081,175	$2,788,875
New General Fund Tax Revenue	-	-	-	-	-	-
SSDI Enrollees Employed Prior to Buy-In						
Enrollment	176	389	434	482	532	586
Premiums	($11,376)	($25,769)	($30,275)	($35,386)	($41,177)	($47,728)
Cost Share	($116,456)	($260,392)	($298,365)	($340,131)	($386,019)	($436,388)
Change in Spend Down	$236,017	$518,275	$573,212	$630,738	$690,952	$753,958
Medicaid Costs	$196,099	$439,685	$498,325	$562,035	$631,218	$706,308
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$304,285	$671,798	$742,898	$817,256	$894,974	$976,150
Net Medicaid Impact, State	$150,773	$333,413	$368,700	$405,604	$444,176	$484,463
New General Fund Tax Revenue	-	-	-	-	-	-
SSDI Enrollees Employed in Response to Buy-In						
Enrollment	0	0	0	0	0	0
Premiums	-	-	-	-	-	-
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	-	-	-	-	-	-
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	-	-	-	-		-
Net Medicaid Impact, State	-	-	-	-	-	-
New General Fund Tax Revenue	-	-	-	-	-	-

NOTE: Line items which represent offsets to Medicaid expenditures (premiums, cost-share amounts) or which represent lower expenditures as a result of the Medicaid buy-in (Medicaid savings) are shown as negative. Line items which represent higher expenditures as a result of the buy-in (change in spend down, Medicaid costs) are shown as positive. Increases in general fund tax revenues are shown as positive.

Exhibit 1, continued

Estimated Costs and Benefits of Low State Cost Scenario: Cost Share, 5 Percent Premium, January 1, 2002, Implementation

FISCAL YEAR	2002	2003	2004	2005	2006	2007
Individuals Leaving SSI						
Historic Exits Due to Employment						
Enrollment	19	53	83	118	159	196
Premiums	($23,477)	($67,136)	($110,759)	($165,912)	($234,786)	($304,698)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	$110,765	$319,711	$535,046	$813,199	$1,167,719	$1,537,817
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$87,288	$252,575	$424,287	$647,287	$932,933	$1,233,119
Net Medicaid Impact, State	$43,251	$125,353	$210,574	$321,249	$463,015	$611,997
New General Fund Tax Revenue	-	-	-	-	-	-
Exits Due to Employment in Response to Buy-In						
Enrollment	27	133	274	459	686	870
Premiums	($19,566)	($99,926)	($216,300)	($380,868)	($596,838)	($795,344)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	-	-	-	-	-	-
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	($176,479)	($909,775)	($1,998,886)	($3,573,273)	($5,685,155)	($7,692,202)
Net Medicaid Impact, State	($87,445)	($451,521)	($992,047)	($1,773,415)	($2,821,543)	($3,817,640)
New General Fund Tax Revenue	$22,237	$113,736	$246,785	$435,589	$684,201	$913,885
Persons With Severe Disabilities Not Enrolled in SSDI or SSI						
Enrollment	56	113	230	234	238	243
Premiums	($37,241)	($76,456)	($161,017)	($169,550)	($178,537)	($187,999)
Cost Share	($53,155)	($110,135)	($236,119)	($253,109)	($271,321)	($290,844)
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	$358,282	$748,059	$1,627,637	$1,770,716	$1,926,373	$2,095,712
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$267,886	$561,468	$1,230,501	$1,348,057	$1,476,515	$1,616,870
Net Medicaid Impact, State	$132,737	$278,657	$610,698	$669,041	$732,794	$802,452
New General Fund Tax Revenue	-	-	-	-	-	-

NOTE: Line items which represent offsets to Medicaid expenditures (premiums, cost-share amounts) or which represent lower expenditures as a result of the Medicaid buy-in (Medicaid savings) are shown as negative. Line items which represent higher expenditures as a result of the buy-in (change in spend down, Medicaid costs) are shown as positive. Increases in general fund tax revenues are shown as positive.

Exhibit 2

Estimated Costs and Benefits of High State Cost Scenario: No Cost Share, 5 Percent Premium, January 1, 2002, Implementation

FISCAL YEAR	2002	2003	2004	2005	2006	2007
Totals						
Enrollment	2,418	5,864	7,699	8,859	9,655	10,365
Premiums	($325,462)	($859,061)	($1,304,643)	($1,744,544)	($2,261,954)	($2,739,617)
Cost Share	-	-	-	-	-	-
Change in Spend Down	$867,243	$2,064,239	$2,625,492	$2,979,620	$3,192,251	$3,417,626
Medicaid Costs	$5,190,390	$13,324,702	$18,353,764	$21,909,964	$25,112,263	$28,053,660
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	$5,575,259	$13,720,032	$17,892,027	$19,952,635	$20,954,243	$21,834,811
Net Medicaid Impact, State	$2,762,541	$6,800,656	$8,868,136	$9,888,862	$10,384,791	$10,820,538
New General Fund Tax Revenue	$425,196	$1,121,037	$1,624,724	$2,054,384	$2,452,826	$2,846,208

NOTE: Line items which represent offsets to Medicaid expenditures (premiums, cost-share amounts) or which represent lower expenditures as a result of the Medicaid buy-in (Medicaid savings) are shown as negative. Line items which represent higher expenditures as a result of the buy-in (change in spend down, Medicaid costs) are shown as positive. Increases in general fund tax revenues are shown as positive.

Exhibit 2, continued

Estimated Costs and Benefits of High State Cost Scenario: No Cost Share, 5 Percent Premium, January 1, 2002, Implementation

Fiscal Year	2002	2003	2004	2005	2006	2007
Individuals Enrolled in or Leaving SSDI						
Historic Exits Due to Employment						
Enrollment	68	207	346	498	633	770
Premiums	($40,213)	($125,584)	($221,085)	($334,229)	($446,899)	($572,812)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	$170,206	$964,688	$1,617,621	$2,325,272	$2,954,657	$3,598,092
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$129,994	$839,104	$1,396,536	$1,991,043	$2,507,759	$3,025,280
Net Medicaid Impact, State	$64,412	$416,447	$693,101	$988,155	$1,244,601	$1,501,446
New General Fund Tax Revenue	-	-	-	-	-	-
SSDI Enrollees Employed Prior to Buy-In						
Enrollment	287	629	698	771	849	931
Premiums	($23,247)	($52,347)	($61,186)	($71,199)	($81,508)	($91,954)
Cost Share	-	-	-	-	-	-
Change in Spend Down	$255,686	$558,142	$614,156	$672,787	$734,137	$798,309
Medicaid Costs	$342,477	$944,819	$1,087,351	$1,246,544	$1,424,282	$1,602,926
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$574,916	$1,450,614	$1,640,321	$1,848,133	$2,076,911	$2,309,280
Net Medicaid Impact, State	$284,871	$719,940	$814,091	$917,228	$1,030,771	$1,146,096
New General Fund Tax Revenue	-	-	-	-	-	-
SSDI Enrollees Employed in Response to Buy-In						
Enrollment	1,905	4,617	6,010	6,719	6,971	7,233
Premiums	($144,476)	($361,155)	($494,042)	($580,398)	($634,118)	($692,810)
Cost Share	-	-	-	-	-	-
Change in Spend Down	$611,557	$1,506,097	$2,011,337	$2,306,833	$2,458,115	$2,619,317
Medicaid Costs	$3,850,378	$9,599,366	$13,079,200	$15,311,553	$16,676,046	$18,171,257
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$4,317,459	$10,744,308	$14,596,495	$17,037,988	$18,500,043	$20,097,764
Net Medicaid Impact, State	$2,139,301	$5,323,805	$7,232,563	$8,442,323	$9,166,771	$9,958,442
New General Fund Tax Revenue	$402,960	$1,007,301	$1,377,938	$1,618,795	$1,768,625	$1,932,323

NOTE: Line items which represent offsets to Medicaid expenditures (premiums, cost-share amounts) or which represent lower expenditures as a result of the Medicaid buy-in (Medicaid savings) are shown as negative. Line items which represent higher expenditures as a result of the buy-in (change in spend down, Medicaid costs) are shown as positive. Increases in general fund tax revenues are shown as positive.

Exhibit 2, continued

Estimated Costs and Benefits of High State Cost Scenario: No Cost Share, 5 Percent Premium, January 1, 2002, Implementation

Fiscal Year	2002	2003	2004	2005	2006	2007
Individuals Leaving SSI						
Historic Exits Due to Employment						
Enrollment	19	53	83	118	159	196
Premiums	($23,477)	($67,136)	($110,759)	($165,912)	($234,786)	($304,698)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	$110,765	$319,711	$535,046	$813,199	$1,167,719	$1,537,817
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$87,288	$252,575	$424,287	$647,287	$932,933	$1,233,119
Net Medicaid Impact, State	$43,251	$125,353	$210,574	$321,249	$463,015	$611,997
New General Fund Tax Revenue	-	-	-	-	-	-
Exits Due to Employment in Response to Buy-In						
Enrollment	27	133	274	459	686	870
Premiums	($19,566)	($99,926)	($216,300)	($380,868)	($596,838)	($795,344)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	-	-	-	-	-	-
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	($176,479)	($909,775)	($1,998,886)	($3,573,273)	($5,685,155)	($7,692,202)
Net Medicaid Impact, State	($87,445)	($451,521)	($992,047)	($1,773,415)	($2,821,543)	($3,817,640)
New General Fund Tax Revenue	$22,237	$113,736	$246,785	$435,589	$684,201	$913,885
Persons With Severe Disabilities Not Enrolled in SSDI or SSI						
Enrollment	112	226	288	293	358	364
Premiums	($74,482)	($152,912)	($201,271)	($211,938)	($267,805)	($281,999)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	$716,564	$1,496,119	$2,034,546	$2,213,395	$2,889,559	$3,143,569
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$642,082	$1,343,207	$1,833,275	$2,001,457	$2,621,754	$2,861,570
Net Medicaid Impact, State	$318,152	$666,633	$909,855	$993,323	$1,301,176	$1,420,197
New General Fund Tax Revenue	-	-	-	-	-	-

NOTE: Line items which represent offsets to Medicaid expenditures (premiums, cost-share amounts) or which represent lower expenditures as a result of the Medicaid buy-in (Medicaid savings) are shown as negative. Line items which represent higher expenditures as a result of the buy-in (change in spend down, Medicaid costs) are shown as positive. Increases in general fund tax revenues are shown as positive.

As Exhibits 1 and 2 show, the design of the buy-in program is directly related to number of participants (both in total and the number who are newly employed) and the increase in Medicaid expenditures. In general, greater financial participation on the part of enrollees will be associated with lower program enrollment, smaller increases in employment, and lower Medicaid costs. Alternatively, lower fees, cost-shares and premiums will be associated with higher program enrollment, larger increases in employment, and higher Medicaid costs.

In addition to the costs and benefits associated with providing Medicaid coverage to buy-in participants, there are costs associated with the actual operation of the buy-in program. A federal infrastructure grant will cover some of these costs; state and federal governments fund the remainder equally. Operating costs are displayed in Exhibit 3.

Exhibit 3
Operating Costs of the Medicaid Buy-In Program

FISCAL YEAR	2002	2003	2004	2005	2006	2007
FTE	3.5	3.5	3.5	3.5	3.5	3.5
SALARIES	$137,000	$137,000	$137,000	$137,000	$137,000	$137,000
BENEFITS	$36,000	$36,000	$36,000	$36,000	$36,000	$36,000
GOODS AND SERVICES	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
LEASES	$17,000	$17,000	$17,000	$17,000	$17,000	$17,000
EQUIPMENT	$40,200	$8,000	$8,000	$8,000	$8,000	$8,000
TRAVEL	$6,000	$6,000	$6,000	$6,000	$6,000	$6,000
INFORMATION SERVICES	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000
PREMIUM SYSTEM	$150,000	-	-	-	-	-
MONITORING AND REPORTING	$134,000	-	-	-	-	-
TOTAL, ALL FUNDS	$543,200	$227,000	$227,000	$227,000	$227,000	$227,000
TOTAL, STATE FUNDS	$86,100	$93,750	$113,500	$113,500	$113,500	$113,500

Source: DSHS Medical Assistance Administration

Note: Expenses associated with the premium collection system and the monitoring and reporting system are fully funded through a federal infrastructure grant associated with the Medicaid buy-in. This grant also funds one program manager FTE for fiscal year 2002 and one half-time program manager FTE for fiscal year 2003.

It is important to note that the cost and benefit estimates rely, in part, on inferences and assumptions that cannot be tested without a buy-in program. One way to assess the risk associated with these estimates is to perform sensitivity analyses where costs and benefits are re-estimated after changing a key assumption. Exhibits 4, 5, and 6 provide the change in estimates associated with altering several important assumptions.

Sensitivity Analysis of Medicaid Buy-In Estimates

SSI Exits Due to Employment in Response to Buy-In. The Medicaid savings associated with this group of individuals are related to the receipt of employer-provided health insurance—anyone who loses his or her Categorically Needy Medicaid coverage due to employment and chooses *not* to enroll in the buy-in represents a reduction in Medicaid costs. The estimates in Exhibits 1 and 2 assume that 40 percent of this group will choose not to enroll in the buy-in. Exhibit 4 provides a high-cost estimate based on 20 percent of this group not enrolling in the buy-in and a low-cost estimate assuming 60 percent choose not to enroll in the buy-in.

Exhibit 4
SSI Exits in Response to Buy-In

BIENNIUM	2001-03			2003-05		
	BASE COST ESTIMATE	HIGH COST ESTIMATE	LOW COST ESTIMATE	BASE COST ESTIMATE	HIGH COST ESTIMATE	LOW COST ESTIMATE
LOW STATE COST SCENARIO						
ENROLLMENT	883	927	838	1,767	1,920	1,614
NET MEDICAID COST, STATE FUNDS	$1 million	$1.3 million	$0.8 million	$2.1 million	$3.2 million	$1 million
HIGH STATE COST SCENARIO						
ENROLLMENT	5,864	5,908	5,820	8,859	9,012	8,705
NET MEDICAID COST, STATE FUNDS	$9.6 million	$9.8 million	$9.4 million	$18.8 million	$19.9 million	$17.7 million

SSDI Enrollees Employed in Response to Buy-In. This group consists of individuals who are expected to start working in response to the buy-in program. It is assumed that these individuals would have sufficient incentive to participate in the buy-in only under the high state cost scenario. The enrollment and costs associated with this group are based in large part on the experience of the Minnesota buy-in program which has a design similar to the high state cost scenario.

After 12 months of operation, it is estimated that 6.4 percent of Minnesota SSDI recipients were enrolled in its buy-in program, with the enrollment continuing to grow by over 5 percent per month. However, the Minnesota program has only been in operation since July 1999; most other state buy-in programs have been in effect for an even shorter period. Whether the Minnesota experience is representative of what will occur in other states is uncertain. Exhibit 5 provides a high-cost estimate assuming that 7.4 percent of SSDI recipients will be enrolled in the buy-in after 12 months and a low-cost estimate assuming that 5.4 percent of SSDI recipients will be enrolled in the buy-in after 12 months.

Exhibit 5
SSDI Enrollees Employed in Response to Buy-In

BIENNIUM	2001-03			2003-05		
	BASE COST ESTIMATE	HIGH COST ESTIMATE	LOW COST ESTIMATE	BASE COST ESTIMATE	HIGH COST ESTIMATE	LOW COST ESTIMATE
LOW STATE COST SCENARIO						
ENROLLMENT	883	NA	NA	1,767	NA	NA
NET MEDICAID COST, STATE FUNDS	$1 million	NA	NA	$2.1 million	NA	NA
HIGH STATE COST SCENARIO						
ENROLLMENT	5,864	6,663	5,065	8,859	10,021	7,696
NET MEDICAID COST, STATE FUNDS	$9.6 million	$10.9 million	$8.3 million	$18.8 million	$21.5 million	$16.1 million

Persons With Severe Disabilities Not Enrolled in SSDI or SSI. The estimates in Exhibits 1 and 2 are based on the assumption that only 1 percent of these individuals will initially enroll in the buy-in, increasing to 3 percent by fiscal year 2007. The low participation rate for this group is based on the experience of state buy-in programs to date. Most enrollees in these programs have had recent Medicaid coverage, which is not consistent with participation by individuals who are not recent SSDI or SSI beneficiaries. In addition, the "welfare stigma" associated with applying for Medicaid may deter buy-in enrollment by this group. Exhibit 6 provides a high-cost estimate increasing participation of this group from an initial 2 percent to 6 percent by 2007 and a low-cost estimate assuming no participation at all.

Exhibit 6
Persons With Severe Disabilities Not Enrolled in SSDI or SSI

BIENNIUM	2001-03			2003-05		
	BASE COST ESTIMATE	HIGH COST ESTIMATE	LOW COST ESTIMATE	BASE COST ESTIMATE	HIGH COST ESTIMATE	LOW COST ESTIMATE
LOW STATE COST SCENARIO						
ENROLLMENT	883	996	770	1,767	2,001	1,532
NET MEDICAID COST, STATE FUNDS	$1 million	$1.4 million	$0.6 million	$2.1 million	$3.4 million	$0.8 million
HIGH STATE COST SCENARIO						
ENROLLMENT	5,864	6,090	5,638	8,859	9,151	8,566
NET MEDICAID COST, STATE FUNDS	$9.6 million	$10.6 million	$8.6 million	$18.8 million	$20.7 million	$16.9 million

APPENDIX A: BACKGROUND ON SSDI, SSI, TICKET TO WORK LEGISLATION, AND OTHER STATE BUY-IN EXPERIENCES

Description of State and Federal Programs for Persons With Disabilities: Social Security Disability Insurance, Supplemental Security Income, and Health Care Coverage

The Social Security Administration manages two large federal programs that pay monthly cash benefits to qualified individuals with severe disabilities: the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. SSDI was created in 1956 as a social insurance program parallel in purpose and structure to the Social Security retirement (Old-Age and Survivors Insurance) program that pays monthly benefits to retirees and survivors.[12] SSI, on the other hand, is a social assistance program enacted in 1972 that pays monthly cash benefits to persons who are blind or disabled and who have limited income and resources.[13] Medical or mental health conditions meeting the definition of "severe disability" are the same for both programs.

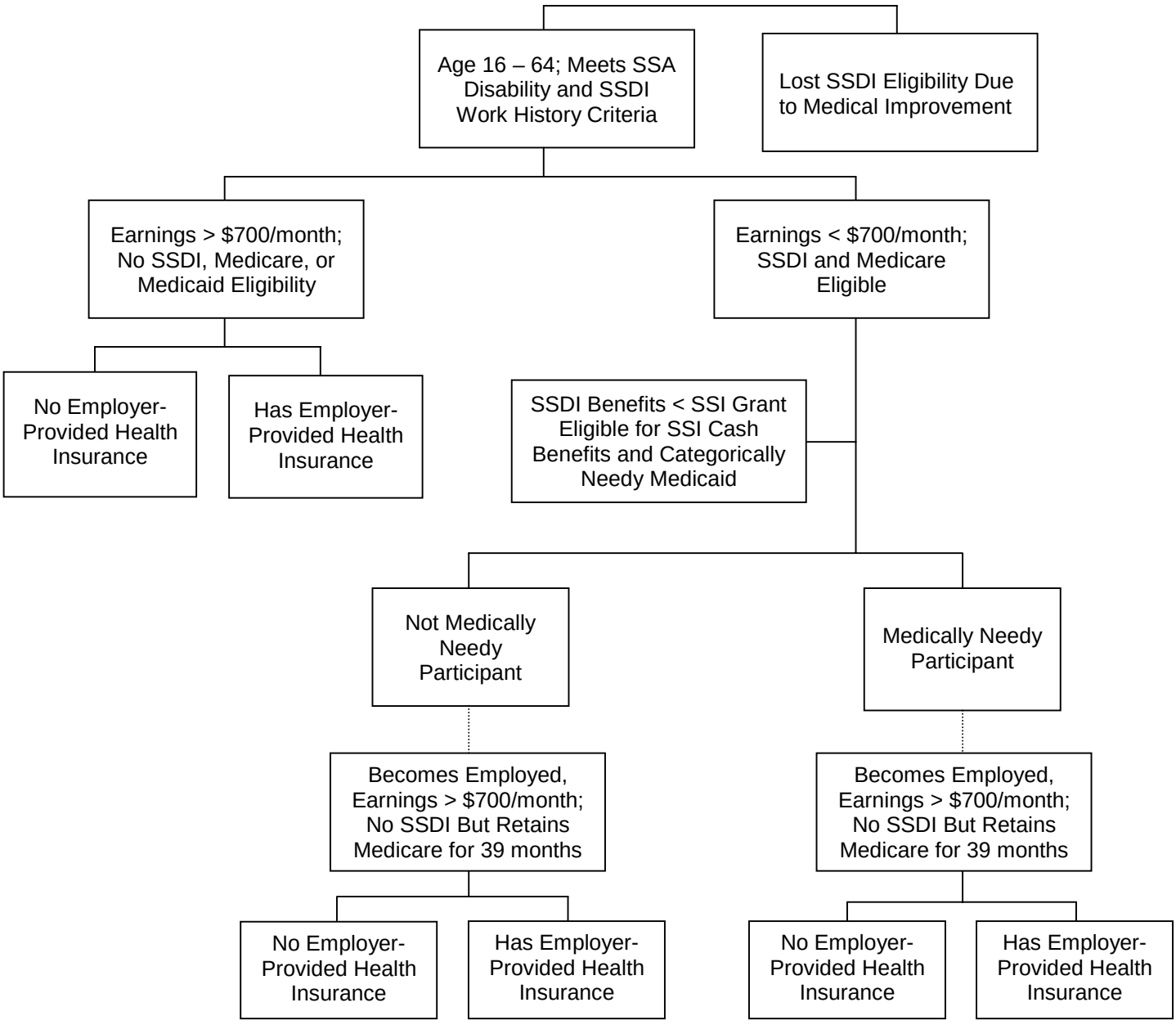
In addition to cash benefits, SSDI and SSI recipients are also entitled to federal or federal and state health care assistance. Exhibits A-1 and A-2 display cash and medical programs for eligible persons with disabilities.

[12] The program descriptions in this section borrow heavily from "Social Security and Supplemental Security Income Disability Programs: Managing for Today, Planning for Tomorrow," Social Security Administration, March 11, 1999.

[13] SSI also provides cash benefits to persons aged 65 and over, regardless of disability status, who have limited income and resources. Because the Ticket to Work legislation only addresses individuals aged 16 to 64 who have a disability, the SSI aged population will be ignored for purposes of this report.

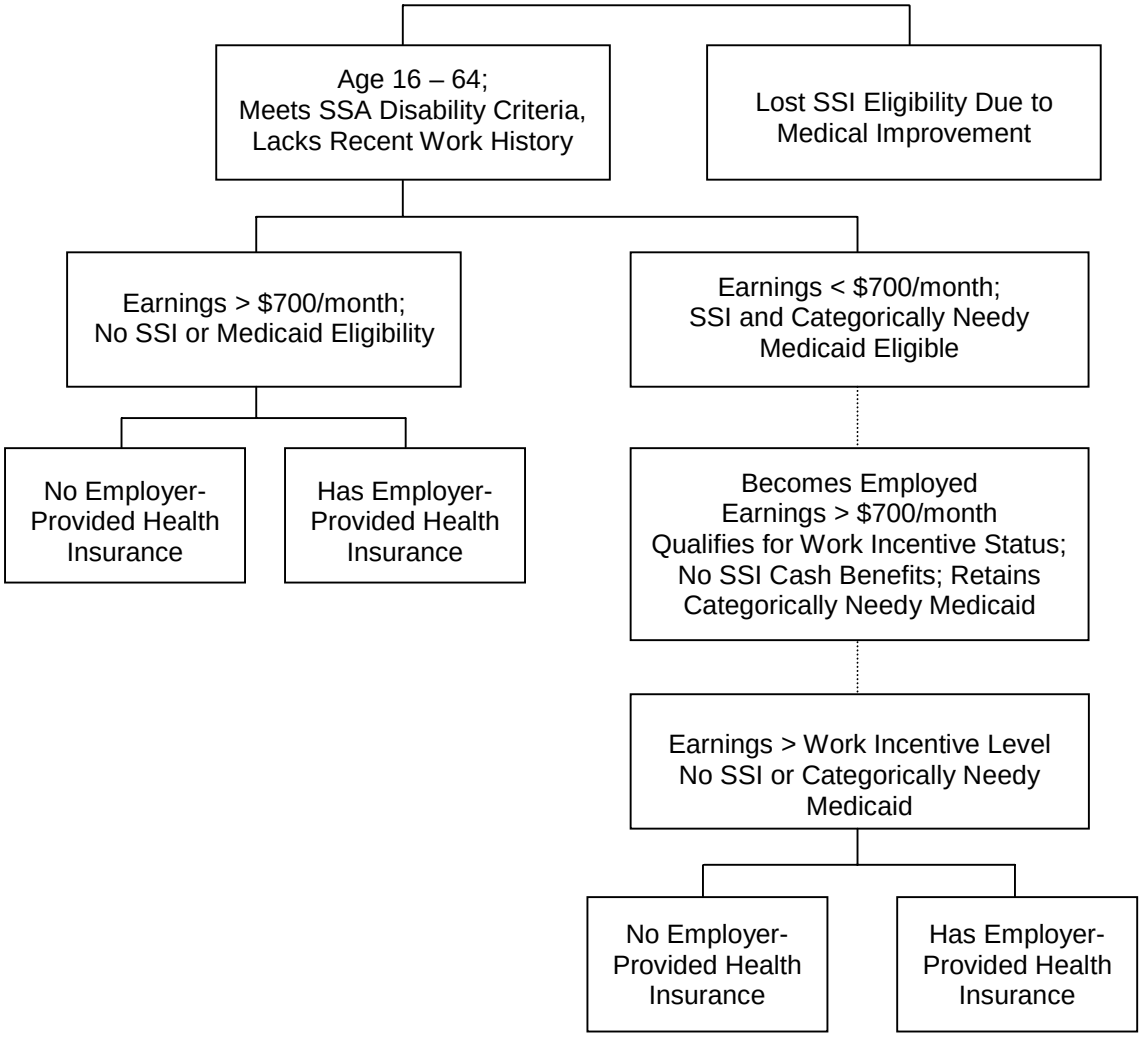
Exhibit A-1

Social Security Disability Insurance Program Flowchart:
Current Law Without Medicaid Buy-In



WSIPP 2000

Exhibit A-2
Supplemental Security Income Program Flowchart:
Current Law Without Medicaid Buy-In



Social Security Disability Insurance. Individuals who work in covered employment and pay Social Security payroll taxes are eligible for SSDI. Workers with at least 20 calendar quarters of Social Security-covered employment in the previous eight years qualify for SSDI, although the work history requirement varies with an individual's age. Workers aged 31 and under must have Social Security-covered employment in at least half the quarters since reaching age 21, with a minimum of six quarters of covered employment.[14]

If a worker's earnings stop or become greatly reduced (earnings must be below $700 per month at the time of application for SSDI) due to a severe physical or mental impairment and he or she has met the requirement for covered employment, the worker and his or her dependents or survivors are eligible to receive benefits to replace a portion of lost wages. These benefits are paid from the Social Security trust fund and are financed by workers' payroll taxes. SSDI benefits are based on previous earnings and are not means-tested—as long as earned income is below $700 per month, other sources of income do not affect the amount of SSDI benefits. In 1999, the average SSDI recipient in Washington State received $757.70 per month in benefits.[15]

Supplemental Security Income. Eligibility for SSI requires that individuals meet the same disability standards as under the SSDI program. SSI eligibility, like SSDI, also requires that individuals have monthly earned income below $700 at the time of application.

Unlike SSDI, eligibility for SSI does not require a work history, and the monthly cash benefits are means-tested. In Washington State, the maximum SSI grant is $539 per month, although this amount is reduced if recipients have other sources of earned or unearned income. SSI benefits are paid from federal general revenues with a small state-funded supplement.

SSDI and SSI Dual Eligibility. Individuals who qualify for SSDI but have monthly benefits below the SSI grant amount are eligible for both SSDI and SSI cash benefits. Assuming that SSDI benefits are an individual's only source of income, SSI benefits will equal the difference between the maximum SSI grant of $539 and the SSDI benefit amount after "disregarding" the first $20 of SSDI benefits. In other words, an individual with a $300 monthly SSDI benefit would be considered to have $280 in income for SSI benefit calculation purposes after disregarding the first $20 of SSDI benefits, leaving the individual eligible for $259 per month in SSI benefits ($539 - $280).

Health Care Coverage for SSDI and SSI Recipients. In addition to cash benefits, SSDI recipients qualify for federal Medicare health care coverage after a 24-month waiting period. At that time, they automatically receive coverage for hospital services and are eligible for coverage of physician services by paying a monthly premium of $45.[16] Medicare requires cost-sharing for some services; it does not cover prescription drugs, vision aids, or personal care services.

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[14] Committee on Ways and Means, U.S. House of Representatives, *1998 Green Book* (WMCP: U.S. Government Printing Office, May 1998), 105-107.
[15] Table 5.J8, Annual Statistical Supplement 2000, *Social Security Bulletin*. http://www.ssa.gov/statistics/Supplement/2000/. This amount is for December 1999.
[16] This is the premium for 2000.

SSDI recipients with health care expenses not covered by Medicare are, in some cases, eligible to "spend down" part of their income to qualify for the Medicaid Medically Needy program. To be eligible for the Medicaid Medically Needy program, an individual must have a monthly income of $559 or less (the SSI grant amount plus the $20 income disregard) or have out-of-pocket medical expenses which, when subtracted from income, would have the effect of reducing their income to $559. This process is referred to as "spend down"; the Medicaid Medically Needy program then covers any medical expenses beyond the amount necessary to spend down to $559 in monthly income. Unlike the federally funded Medicare program, the Medicaid Medically Needy program is funded roughly 50 percent by the federal government and 50 percent by state general fund revenue.

SSI recipients (including persons with SSDI and SSI dual eligibility) qualify for Categorically Needy Medicaid coverage at the time they become eligible for SSI. The Categorically Needy Medicaid program covers a wide scope of health care services and requires no cost-sharing or spend down. The Categorically Needy Medicaid program is funded roughly 50 percent by the federal government and 50 percent by state general fund revenue.

Work Incentives. Individuals with disabilities face additional challenges in seeking and obtaining employment. To encourage SSDI and SSI recipients to participate in the labor market, both programs have established provisions to enable recipients to work while maintaining eligibility for cash and health care benefits. The work incentive provisions for each program are detailed in Exhibit A-3.

Exhibit A-3
Highlights of SSDI and SSI Work Incentive Provisions[17]

Program	Provision
Income Safeguards	
SSDI	Trial work period: Allows beneficiaries to work for 9 months (not necessarily consecutively) within a 60-month rolling period during which they may earn any amount without affecting benefits. After the trial work period, cash benefits continue for 3 months, then stop if countable earnings are greater than the "substantial gainful activity" (SGA) amount of $700 a month.
	Extended period of eligibility: Allows for a consecutive 36-month period after the trial work period in which cash benefits are reinstated for any month countable earnings are $700 or less. This period begins the month following the end of the trial work period.
SSI	Earned income exclusion: Allows recipients to exclude more than half of earned income when determining the SSI payment amount.
	Section 1619 (a): Allows recipients to continue to receive SSI cash payments even when earnings exceed $700 a month. However, as earnings increase the payment decreases.
	Plan for Achieving Self-Support (PASS): Allows recipients to exclude from their SSI eligibility and benefit calculation any income or resources used to achieve a work goal.
SSDI and SSI	Impairment-related work expenses: Allows the costs of certain impairment-related items and services needed to work to be deducted from gross earnings in figuring SGA and cash payment amount. For example, attendant care services received in the work setting are deductible while nonwork-related attendant care services performed at home are not.
	Subsidies: Allows the value of the support a person receives on the job to be deducted from earnings to determine SGA. An example of such support is the value of supervision provided to a worker with a disability that is in addition to that provided to other workers receiving the same pay.
Medical Coverage Safeguards	
SSDI	Continued Medicare coverage: Allows for continued Medicare coverage for at least 39 months following a trial work period as long as one continues to be medically disabled.
	Medicare buy-in: Allows beneficiaries to purchase Medicare coverage after the 39-month premium-free coverage ends. Beneficiaries pay the same monthly cost as uninsured retired beneficiaries pay.
SSI	Section 1619 (b): Allows recipients to continue receiving Medicaid coverage when earnings become too high to allow a cash benefit. Coverage continues until earnings reach a threshold amount, which varies in every state. The current annual threshold amount in Washington is $18,729.

[17] Adopted from Table 3.2, U.S. General Accounting Office, "SSA Disability: Program Redesign Necessary to Encourage Return to Work," HEHS-96-62, April 1996.

Eligibility Safeguards

SSDI

Reentitlement to cash benefits and Medicare: After a period of disability ends, allows beneficiaries who become disabled again within 5 years (7 years for widow(ers) and disabled adult children) to be reentitled to cash and medical benefits without another 5-month waiting period.

SSI

Property essential to self-support: Allows recipients to exclude from consideration in determining SSI eligibility the value of property that is used in a trade or business or for work. Examples include the value of tools or equipment.

SSDI and SSI

Continued benefit while in an approved vocational rehabilitation program: Allows a person actively participating in a vocational rehabilitation program to remain eligible for cash and medical benefits even if he or she medically improves and is no longer considered disabled by SSA.

There are a number of differences in work incentive provisions between SSDI and SSI. For example, the SSI program allows working recipients to receive cash benefits which are gradually reduced as earnings increase, while the SSDI program allows recipients to receive earnings over $700 per month for up to nine months with no loss of cash benefits; after nine months, cash payments stop completely.

However, General Accounting Office[18] and Social Security Administration researchers[19] have raised questions concerning the effectiveness of these work incentive provisions. Knowledge or understanding of the provisions does not appear to be widespread; SSDI and SSI recipients fear that work may lead to loss of health care benefits, and some provisions appear to reduce the incentive to earn beyond a certain level.

The Ticket to Work and Work Incentives Improvement Act

Medical and technological advances, combined with the passage of the federal Americans with Disabilities Act in 1990, have helped improve opportunities for persons with disabilities to become employed. However, individuals with disabilities continue to face challenges in the workplace, and the number of individuals with disabilities receiving cash and medical assistance from the SSDI and SSI programs has grown by over 55 percent since 1990.[20] As noted above, the existing work incentives in the SSDI and SSI programs do not appear to be effective. This combination of factors led, in part, to passage of the federal Ticket to Work and Work Incentives Improvement Act of 1999.

The Ticket to Work legislation includes changes to health care coverage, vocational rehabilitation and employment service provision, and program operation intended to increase the incentives to work for persons with disabilities receiving SSDI or SSI benefits. The following is a brief review of the major incentive provisions and their potential impact, focusing particularly on how they may interact with a Medicaid buy-in program.

- Effective October 2000, states have the option of expanding Medicaid eligibility to employed persons whose disabilities meet SSDI/SSI standards. States have flexibility in setting income and asset limits for eligibility as well as in establishing sliding-scale premiums and other cost-sharing measures.

- Effective October 2000, premium-free Medicare Part A (hospital insurance) coverage is extended for an additional 4½ years for SSDI recipients who lose SSDI cash benefits due to employment.

[18] U.S. General Accounting Office, "SSA Disability: Program Redesign Necessary to Encourage Return to Work," HEHS-96-62, April 1996.
[19] John C. Hennessey and L. Scott Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work," *Social Security Bulletin* 58, no. 1 (1995); and John C. Hennessey, "Factors Affecting the Work Efforts of Disabled-Worker Beneficiaries," *Social Security Bulletin* 60, no. 3 (1997).
[20] Nationally, the SSI caseload for persons who are blind or have a disability has grown by 55 percent between 1990 and 1999 while the SSDI caseload has grown by 62 percent between 1990 and 1999.

- Effective January 2001, a medical review cannot be initiated for individuals making use of the expanded vocational rehabilitation and employment services ("tickets") provided under the bill.

- Effective January 2001, expedited reinstatement of benefits is required for individuals whose cash benefits have ended because of earnings but who are unable to continue working due to disability at any time within the following 60 months.

- Effective January 2002, a medical review cannot be initiated because of work activity for individuals receiving SSDI benefits.

- Ticket to Work legislation creates a system of employment networks to expand the availability of vocational rehabilitation and employment services to SSDI and SSI recipients. Participating SSDI and SSI beneficiaries will be given "tickets" entitling them to vocational and employment services that any employment network will accept. Participation in the ticket program is voluntary, and the program will be phased in over a three-year period starting in January 2001.

This report focuses on the expected impacts of the first provision listed above, the optional Medicaid expansion for employed persons with severe disabilities, often referred to as the Medicaid buy-in. Participating in the buy-in provides enrollees with a very broad scope of health care coverage under the Categorically Needy Medicaid program, for which they may have to pay a monthly premium, some type of cost-sharing amount (for example, $5 for a doctor visit), or both. As noted in the body of the report, three groups are potential buy-in participants: (1) current SSDI recipients, (2) current SSI recipients, and (3) persons who qualify for either SSDI or SSI based on the severity of their disabilities but are not currently enrolled in either program.

Medicaid Buy-In Programs: Experience in Other States

The Medicaid buy-in program authorized by the Ticket to Work legislation became effective in October 2000, so it is not yet possible to use other states' experiences to estimate the costs and benefits of a buy-in program in Washington. However, the federal Balanced Budget Act of 1997, which authorized a Medicaid buy-in program for persons with disabilities, is similar to the Ticket to Work buy-in program. Several states have implemented this earlier buy-in program, and it is useful to look at their experiences. Exhibit A-4 indicates the cost-sharing and premium provisions for most states with a buy-in program implemented under the Balanced Budget Act of 1997.

Exhibit A-4

State Medicaid Programs for the Working Disabled: Cost-Sharing Requirements

State and Program Authority	Initial Cost-Sharing	Premium Level	Premium Type	Point-of-Service Level	Copayments
Alaska **BBA'97**	None	100% FPL,* adjusted for family size.	Graduated premium not to exceed 10% of net earned income. Net earned income is gross income minus half of earned income, and minus impairment-related work expenses.	None	None
Arkansas **BBA'97**	None	None	Unknown	100% FPL	• Physician visit: $10. • Brand name drugs: $15. • Generic drugs: $10. • Inpatient hospital: 25% of the first day's Medicaid rate.
California **BBA'97 plus 1902(r)(2)**	None	All beneficiaries must pay a monthly premium.	Based on countable income, ranging from $20 to $250 for an individual to $30 to $375 for a couple.	None	None
Connecticut **Section 201(a)(1) of P.L. 106-170**	None	200% FPL, adjusted for family size.	10% of countable income above 200% FPL minus any premiums paid for health insurance by any family member.	None	None
Iowa **BBA'97 plus 1902(r)(2)**	None	150% FPL	Graduated premium not to exceed amount charged for state private rate group health insurance.	None	None
Maine **BBA'97**	None	Premium assessed when countable income exceeds $1,044 per month for a single person.	Premium is $10 to $20 per month depending upon income level.	None	None
Massachusetts **1115(b) Waiver**	None	Gross earned and unearned income above 200% FPL, adjusted for family size.	Graduated up to 15% at 800% FPL.	None	None

**FPL: Federal Poverty Level*

Exhibit A-4, continued

State Medicaid Programs for the Working Disabled: Cost-Sharing Requirements

State and Program Authority	Initial Cost-Sharing	Premium Level	Premium Type	Point-of-Service Level	Copayments
Minnesota **BBA'97 plus 1902(r)(2)**	None	Gross earned and unearned above 200% FPL,* adjusted for family size. If married, spouse's income not counted.	10% of gross earned and unearned income that exceeds 200% of FPL.	None	None
Nebraska **BBA'97**	None	200% FPL	Graduated up to maximum of 10% of income above 200% FPL.	None	None
Oregon **BBA'97 plus 1902(r)(2)**	Unearned income in excess of state's SSI standard ($501.70). (NOTE: Cost-sharing is applied on an ongoing monthly basis.)	Countable income above 200% FPL, adjusted for family size. Countable income defined as gross earned income minus income taxes, impairment-related work expenses, and employment and independence expenses.	Graduated from 2.5% to 10%. Not imposed until second 6 months.	None	None
South Carolina **BBA'97**	Unknown	Unknown	Unknown	Unknown	Unknown
Vermont **BBA'97 plus 1902(r)(2)**	None	Gross earned and unearned income above 185% FPL.	Graduated fee: • No fee for income under 185% FPL. • $12 per month for 185% to 225% FPL. • $25 per month for 225% to 250% FPL.	None	None
Wisconsin **BBA'97 plus 1902(r)(2)**	Unearned income in excess of the sum of: (1) SSI income standard in state ($597 in CY 1999), and (2) individual's medical and remedial expenses and impairment-related work expenses. (NOTE: Cost-sharing is applied on an ongoing monthly basis.)	150% FPL, adjusted for family size.	3.5% of gross earned income.	None	None

**FPL: Federal Poverty Level*
Source: Department of Social and Health Services, Medical Assistance Administration

Oregon.[21] The Oregon buy-in program was implemented in February 1999 and, as of May 2000, had 350 enrollees. Individuals are eligible for the buy-in if they meet SSDI/SSI disability standards, are employed, are aged 18 to 64, and have net earned income below 250 percent of the federal poverty level. Oregon defines net earned income as one-half of monthly earnings above $65.

Enrollees are required to pay a monthly cost-sharing fee equal to their unearned income in excess of the SSI grant amount. In addition, enrollees with net earned income above 200 percent of the federal poverty level pay a monthly premium ranging from 2.5 to 10 percent of net earned income.

The fiscal impacts of the buy-in are estimated[22] to be small for two reasons. First, approximately 90 percent of enrollees were previously covered under Oregon's Medicaid Medically Needy program; thus, most enrollees were already receiving state-funded health care services prior to the buy-in. Second, for individuals who were covered under the Medicaid Medically Needy program, the monthly cost-sharing fee is almost as large as their previous Medicaid Medically Needy spend down amount. This means that any additional health care expenses incurred by the buy-in program for former Medicaid Medically Needy recipients are almost completely offset by the monthly cost-sharing fee.

Minnesota.[23] The Minnesota buy-in program became effective in July 1999, and, as of April 2000, had 4,172 enrollees. Individuals are eligible for the buy-in if they meet SSDI and SSI disability standards, are employed, and are aged 18 to 64. There are no eligibility restrictions related to either earned or unearned income. The Minnesota program has no cost-sharing requirements but does impose a 10 percent premium on all income, earned or unearned, above 200 percent of the federal poverty level.

A February 2000 forecast update estimated the state's share of the program's cost at $9.3 million in FY 2001, $11.1 million in FY 2002, and $13.2 million in FY 2003. Actual costs incurred by the program will not be available until mid-2001. The greater fiscal impact of the Minnesota program compared with Oregon's is largely due to the difference in cost-sharing.

In Oregon, cost-sharing is set to recoup most of the Medicaid Medically Needy spend down amount which was lost as individuals shifted from the Medically Needy program to the buy-in. Cost-sharing also serves as an enrollment disincentive to SSDI recipients with uncovered medical expenses below the cost-sharing amount.

Without a similar cost-sharing feature in Minnesota, any SSDI recipient enrolled in the Medicaid Medically Needy program who either is or can become employed at any level will find it advantageous to switch to the buy-in program. In so doing, the SSDI recipient will receive Medicaid coverage for services that the Medically Needy program covered and for

[21] Information on the Oregon program is from telephone conversations with Doug Stone, Oregon Department of Human Services, Division of Senior and Disabled Services, and Tina Edlund, Oregon Health Sciences University, May 2000.

[22] Until additional tracking capabilities and computer support are added, Oregon is unable to specifically keep track of buy-in expenses.

[23] Information on the Minnesota program is from Karen Gibson, Minnesota Department of Human Services, Division of Medical Assistance, July 2000.

the spend down services for which they were paying out-of-pocket, but with no required spend down or other cost-sharing payment. The loss of spend down payments from former Medicaid Medically Needy participants is estimated to cost the state $3.1 million by FY 2003.

The lack of a cost-sharing charge similar to Oregon's also means that SSDI recipients with out-of-pocket medical expenses too low to qualify for the Medicaid Medically Needy program are able to enroll in the buy-in and have these expenses covered, assuming they either are employed or are able to become employed. Approximately 25 percent of Minnesota's buy-in enrollees did not previously participate in the Medicaid program, although it is unclear how many are SSDI recipients who were unable to qualify for the Medically Needy program. Buy-in participants not previously enrolled in any Medicaid program are estimated to cost the state $10.2 million by FY 2003.

Vermont.[24] Vermont's buy-in program is similar in structure to Minnesota's, although the eligibility requirement for income is more restrictive. Implemented in January 2000, the program had 160 enrollees by May 2000. Individuals are eligible for the buy-in if they meet SSDI and SSI disability standards, are employed, are aged 18 to 64, and have total income below 250 percent of the federal poverty level.

Vermont has no cost-sharing fee. Enrollees pay a monthly premium of $12 if their income is between 185 and 225 percent of the federal poverty level and $25 if their income is between 226 and 250 percent of the federal poverty level.

To help in estimating the costs of the buy-in, a sample of 500 Vermont SSDI recipients receiving vocational rehabilitation services were analyzed. Because vocational rehabilitation is voluntary, participation indicates an interest in employment in the near future. Therefore, these individuals are considered to be likely buy-in participants.

Approximately 90 percent of the SSDI recipients receiving vocational rehabilitation services were found to be receiving Medicaid Medically Needy benefits, with average Medicaid-covered expenses of $4,200 per year. This implies that buy-in participants will be primarily individuals currently receiving assistance from the Medically Needy program and therefore do not represent new costs to the state. This information, combined with the requirement for a monthly cost-share essentially equal to the Medically Needy spend down amount, has led to the expectation that buy-in costs will be relatively small.

[24] See Peter Baird and Mary Alice Mowry, "Vermont Work Incentive Initiative," MS Powerpoint presentation available at http://www.uiowa.edu/~lhpdc/work/States/Vt/Vermont.html.

APPENDIX B: COST AND BENEFIT ESTIMATES

Section III identifies the costs and benefits of a Medicaid buy-in program for individuals in each of the three potentially eligible groups as well as for the state. This appendix provides detailed information on how that general information on costs and benefits was combined with data from a variety of sources to estimate buy-in participation, premium and cost-share payments, and changes in state health care expenditures.

The basic approach taken in estimating impacts of the Medicaid buy-in relies on two techniques.[25] The first is making use of aggregated data sources to define a probability distribution for a particular type of information. For example, the Social Security Administration publishes annual information that groups SSDI recipients in Washington State by ranges of SSDI benefits (e.g., less than $300 per month, $300 to 399 per month, etc.).[26] From this information, it is possible to "fit," or estimate, a probability distribution to the data. In turn, this probability distribution provides a way to estimate the fraction of SSDI recipients who have benefits higher (or lower) than a particular value. Probability distributions were also defined in this way for earnings of SSI beneficiaries, earnings and unearned income of individuals not enrolled in the SSI or SSDI programs, receipt of employer-provided health insurance, and medical expenses.

Secondly, once probability distributions are defined, it is possible to estimate key aspects of the buy-in through a simulation approach. A simulation provides the answer to a "what if" scenario by drawing on the probability distributions associated with the relevant pieces of information. In some cases, estimates from existing research or historic data series are incorporated into simulations. For example, the U.S. Department of Health and Human Services commissioned research that estimated the impact on earnings of increasing the SSI 1619(b) threshold by $1,000.[27] These impacts are combined with an estimated distribution of earnings for working SSI recipients to simulate the impact of the Medicaid buy-in on employed SSI recipients.

In some instances, it is also necessary to make reasonable assumptions in areas for which no data are available. For example, the fraction of persons who are expected to participate in the buy-in, given the scenario, is generally assumed to start at something less than 100 percent of those eligible and slowly phase up to or near 100 percent. This type of assumption is based on the expected need for outreach efforts to make potential Medicaid buy-in participants aware of the program. It also reflects concerns that SSDI and SSI recipients are likely to have about the permanence of the buy-in program. To the extent that potential participants believe the buy-in is a temporary program, they will have

[25] Impact estimates relied heavily on the @RISK software package, version 4.0, by Palisade. This software has capabilities to fit probability distributions to data as well as to perform simulations.
[26] See Table 5.J, Annual Statistical Supplement 2000, *Social Security Bulletin*, http://www.ssa.gov/statistics/Supplement/2000/
[27] David Stapleton, Gina Livermore, Scott Scrivner, Adam Tucker, and David Wittenberg, *Exploratory Study of Health Care Coverage and Employment of People with Disabilities* (U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, HHS Contract No. 100-93-0012, July 6, 1998).

concerns that becoming employed could lead to a loss of disability-based benefits in the future.

DSHS's Medical Assistance Administration, the agency that would be responsible for a Medicaid buy-in program, has estimated that six months would be necessary to set up the administrative apparatus before anyone could be enrolled. Therefore, all estimates in this report assume a program effective date of July 1, 2001, but program enrollment would not start until January 1, 2002.

Social Security Disability Insurance (SSDI)

The following is a brief discussion of the methods and data sources used to estimate Medicaid buy-in impacts on three groups of individuals recently or currently receiving SSDI benefits.

Historic Exits Due to Employment: These are SSDI recipients who would have left SSDI due to employment, even in the absence of a Medicaid buy-in program. Therefore, any Medicaid expenses associated with a buy-in for these individuals represent new Medicaid costs. Because these individuals would have become employed without a buy-in, there are no new general fund taxes, as the increased income for this group is not attributable to the buy-in.

Enrollment: Approximately 9 percent of SSDI recipients leave the program each year; of those, 11 percent leave due to either medical improvement or employment.[28] This implies that 1 percent of recipients leave SSDI each year due to either medical improvement or employment. We assumed that half, or 0.5 percent of the SSDI caseload, left due to employment.

Research by Social Security Administration staff[29] indicates that about 30 percent of individuals who leave SSDI due to employment or medical improvement return to the program somewhere between one month and ten years after exiting. Because this is not sufficiently specific for cost estimation purposes, we assumed that half of those returning to SSDI do so within one year while the remainder return over the course of the following ten years.

Individuals with dual SSDI and SSI eligibility are covered under the Categorically Needy Medicaid program and face different incentives than SSDI recipients. Therefore, the above figures on SSDI exit and return rates were applied to the SSDI caseload after

[28] See *http://www.ssa.gov/OACT/STATS/dibStat.html*; 9.1 percent is the average termination rate from 1993 to 1999 excluding 1997 because changes in eligibility for persons with drug or alcohol dependence temporarily inflated the termination rate that year. Kalman Rupp and Charles G. Scott, "Trends in the Characteristics of DI and SSI Disability Awardees and Duration of Program Participation," *Social Security Bulletin* 59, no. 1, 1996. Exit rates for employment and for medical improvement do not appear to be reported separately in Social Security Administration sources.

[29] L. Scott Muller, "Disability Beneficiaries Who Work and Their Experience Under Program Work Incentives," *Social Security Bulletin* 55, no. 2, 1992; Janice Dykacz, "Return of Disabled-Worker Beneficiaries to the DI Program: Some Insights from the New Beneficiary Follow-up," *Social Security Bulletin* 61, no. 2, 1998.

being reduced by the number of individuals eligible for both SSDI and SSI. Using this "net" approach and the above information implies that about 330 individuals left the SSDI program due to employment during calendar year 2002. Approximately 50 of those individuals will return to SSDI during calendar year 2003, with another 50 returning over the course of the subsequent nine years.

Premiums and Cost Share Amounts: Premiums and cost shares are estimated assuming that the income distribution for this group (earned and unearned) is the same as for persons in the 1998 Washington State Population Survey (SPS)[30] who reported that they had a severe disability, had earnings, and did not report coverage under Medicaid or Medicare (i.e., SSDI "historic exiters" are assumed to have the same income distribution as working persons with a severe disability who are not enrolled in SSDI or SSI).

Medicaid Costs: Costs for this group are based on the current Categorically Needy Medicaid/Medicare dual eligible per capita rate (including mental health, personal care services, and Part B Medicare premium payments) that was calculated by DSHS's Medical Assistance Administration. Based on the 1998 SPS data on persons with severe disabilities who are employed, it is assumed that 81 percent of this group receives employer-provided health insurance, and 19 percent do not. All of the uninsured and half of the insured are assumed to participate in the buy-in; the per capita amount is reduced by 50 percent for insured persons who participate in the buy-in.

Participation/Phase-in: About 80 percent of this group is assumed to participate in the buy-in in FY 2002, increasing to 100 percent participation in FY 2005 under the scenario with a cost share (low state cost scenario); participation is assumed to start at 85 percent under the no cost share scenario (high state cost scenario).

Employed Prior to Buy-In: This group contains two subgroups. The first subgroup (employed/MN) consists of individuals who, prior to the Medicaid buy-in, were employed, participating in the Medicaid Medically Needy program in one or more months during the year, and had a spend down. This subgroup has an incentive to participate in the buy-in in either the cost share or no cost share scenario. New Medicaid costs equal expenses not covered by Medicare but below the spend down amount in those months when individuals are not eligible for the Medically Needy program plus Medicare Part B premiums of $45.50 per month. The second subgroup (employed/no-MN) consists of individuals who were employed prior to the buy-in but did not participate in the Medically Needy program. These persons will only participate in the buy-in if there is no (or a small) cost share, since their uncovered health care expenses are below the spend down level. Since they were not in the Medically Needy program prior to the buy-in, all their Medicaid expenses are new costs.

Enrollment: Data on persons in the employed/MN subgroup come from monthly ACES/eligibility data provided by the DSHS Forecasting Office. Between November 1998 and October 1999, an average of 299 individuals who were employed participated

[30] The Washington State Population Survey collects data from a representative sample of state residents on topics such as employment, work experience, income, health, health insurance, and a variety of other areas. The survey was designed by the Office of Financial Management and administered by the Washington State University Social and Economic Sciences Research Center.

in the Medically Needy disabled program and had a spend down. However, many Medicaid Medically Needy participants do not participate in the program for 12 months per year. In calendar year 1999, the average monthly Medically Needy caseload[31] for persons with a spend down was 4,774. However, a total of 8,441 individuals with a spend down had one or more months of coverage during 1999. Using this information, the monthly average of 299 employed/MN participants with a spend down was estimated to represent 529 persons with an average of seven months of Medically Needy usage.

Based on Social Security Administration data on the number of working SSDI recipients in Washington[32] and the Medically Needy data, an estimated 265 employed SSDI recipients exist who are not participating in the Medicaid Medically Needy program. These individuals are assumed to have uncovered health care costs which are below the spend down amount.

Premiums and Cost Share Amounts: For the employed/MN subgroup, premiums, cost shares, and foregone spend down are all based on the data provided by the DSHS Forecasting Office. For the employed/no-MN subgroup, no income data are available. Therefore, the distribution of earned and unearned income is assumed to be the same as for the employed/MN with spend down group.

Medicaid Costs: New Medicaid costs for the employed/MN subgroup are equal to Medicare Part B premiums plus uncovered health care expenses for the average of five months in each year in which these individuals are not participating in the Medicaid Medically Needy program. No data are available on health care expenditures for this group during those five months; they are assumed to equal 25 percent of the average spend down amount. For the employed/no-MN subgroup, no health care expenditure information is available. Therefore, this group is assumed to have health care costs equal to 50 percent of the employed/MN with spend down group spend down amount of $203 per month. New Medicaid costs equal that amount plus Medicare Part B premiums and an adjustment for personal care services.

Participation/Phase-in: In the scenario with a cost share, 60 percent of this combined group is assumed to participate in the buy-in in FY 2002 phasing up to 85 percent by FY 2007. In the no cost share scenario, participation is assumed to start at 65 percent and increase to 90 percent by FY 2007.

Employed in Response to Buy-In: Under the scenario with a cost share, it is assumed that only those SSDI recipients who are employed and have a Medically Needy spend down have an incentive to participate in the buy-in. States with cost shares set at an amount

[31] All references to the Medicaid Medically Needy program in this report are to individuals who qualify based on a disability or blindness. Data on individuals over age 64 who qualify for the Medically Needy program are excluded.

[32] An extract of the Master Beneficiary Record created by B.J. Olson at the Social Security Administration indicates that an average of 950 SSDI recipients in Washington started a Trial Work Period in 1995, 1996, and 1997. Reducing this number by the 529 employed persons with Medically Needy coverage and a spend down and the estimated 156 employed persons with Medically Needy coverage and no spend down leaves 265 employed SSDI recipients not participating in the Medically Needy program prior to any Medicaid buy-in.

similar to the Medically Needy spend down (e.g., Oregon) have experienced fairly small participation in their buy-in programs. However, once the cost-share is eliminated, anyone with uncovered health care costs who is able to work does have an incentive to get a part-time job and enroll in the buy-in.

Enrollment: The size and participation of this group is difficult to estimate as there are no data sources to indicate how many SSDI recipients might be willing and able to work nor are there any indications of how many of these individuals would be able to find employment. Therefore, the best source of information is the Minnesota buy-in program, which does not impose a cost share. The Minnesota program currently has about 6.4 percent of its SSDI caseload enrolled after 12 months. Applying this percentage to the Washington SSDI caseload, then subtracting the employed SSDI group, provides the basis for the estimates in Exhibit 2.

The Minnesota program has experienced very rapid enrollment growth. Although enrollment is slowing, Minnesota has experienced monthly enrollment increases equivalent to annual growth rates of 40 to 80 percent between April and July 2000. Such growth is clearly not sustainable, given the number of SSDI recipients who are unable to work or for whom the costs of working will far exceed any benefits from a Medicaid buy-in. Therefore, the initial number of newly employed SSDI recipients who enroll in the buy-in is assumed to grow at 40 percent in the second full year of the buy-in, declining to 22 percent growth in the third full year, and then to the recent overall SSDI caseload growth of 3.8 percent for the fourth full year and into the future.

This group is made up of individuals who are either (a) not employed, participating in the Medicaid Medically Needy program, and have a spend down, or (b) not employed and not a Medically Needy participant.[33] The number of individuals from each group is assumed to be proportional to the size of each group.

Premiums and Cost Share Amounts: In each case, earnings are assumed to be 50 percent of the earned income of the employed/MN with spend down group. For individuals participating in the Medically Needy program, unearned income data has been made available by DSHS's Forecasting Office. For individuals not participating in the Medically Needy program, their unearned income is assumed to be SSDI benefits only; those benefits are assumed to be distributed in the same manner as the Washington State SSDI caseload as a whole. Premiums are calculated from simulations performed on the above information. There are no cost share estimates for this group, as they are assumed to participate in the buy-in only under the "no cost share" scenario.

Spend Down: The change in the spend down is zero for persons not participating in the Medically Needy program. For Medically Needy participants, spend down is assumed to average $133 per month based on data provided by DSHS's Forecasting Office.

Medicaid Costs: Medicaid costs for persons not participating in the Medically Needy program are assumed to equal 50 percent of spend down for the employed/MN with

[33] Anyone participating in the Medicaid Medically Needy program who is not employed and does not have a spend down has no financial incentive to participate in the buy-in.

spend down group plus the Medicare Part B premium and an adjustment for personal care services. For Medically Needy participants, new Medicaid costs are limited to the Medicare Part B premium and an adjustment for personal care services.

New General Fund Tax Revenue: The individuals in this group are assumed to become employed in response to the Medicaid buy-in program. Therefore, the earned income received by these individuals is an increase in state personal income over the level that would have occurred without a buy-in. The increase in general fund tax revenue is assumed to be equal to 7 percent of this new revenue, based on information from the Department of Revenue on the share of income subject to Washington State taxes.

Participation/Phase-in: Based on Minnesota's enrollment experience in the first year of their buy-in program, participation in the 2001-03 biennium is assumed to average 65 percent of the individuals ultimately expected to enroll in the buy-in. This participation rate phases up to 100 percent by FY 2005.

Supplemental Security Income (SSI)

Historic Exits Due to Employment: These are individuals who would have left the SSI caseload due to employment in the absence of a Medicaid buy-in. Therefore, any Medicaid expenses associated with a buy-in represent new Medicaid costs. Because these individuals would have become employed without a buy-in, there are no new general fund taxes, as the increased income for this group is not attributable to the buy-in.

Enrollment: From Social Security Administration data,[34] it is possible to estimate an annual exit rate due to employment equal to 0.1 percent of the national SSI caseload; it is assumed that this rate is also a reasonable estimate of Washington State exits due to employment. About 47 percent of individuals who leave SSI due to employment return to the caseload within one year;[35] the number of returners were subtracted from exits to obtain a net annual number of exits due to employment.

Premiums and Cost Shares: Premiums were calculated through simulation, assuming the same distribution of earned income as for employed persons with severe disabilities from the 1998 SPS data. Unearned income in this population is very low (by definition, the major source of unearned income, SSI cash benefits, is zero) so there is no cost share.

Medicaid Costs: Medicaid costs are based on the Categorically Needy per capita rate including mental health services. The percentage of individuals receiving employer-provided health insurance is assumed to be the same as for employed persons with severe disabilities from the 1998 SPS data (81 percent). All uninsured individuals and half those insured are assumed to participate in the buy-in; individuals with insurance are assumed to have a Medicaid cost equal to 50 percent of the Categorically Needy per capita rate.

[34] See Table 8, "SSI Disabled Recipients Who Work," Social Security Administration, March 2000, http://www.ssa.gov/statistics/ssi_qtrly/index.html.
[35] Satya Kochhar and Charles Scott, "SSI Case Closures," *Social Security Bulletin* 61, no. 1, 1998.

Participation/Phase-in: In FY 2002, 80 percent of eligible exiters are assumed to participate in the buy-in, increasing to 100 percent by FY 2006.

Exits Due to Employment in Response to Buy-In: These are individuals who have constrained their earnings to stay below the 1619(b) threshold for fear of losing Medicaid coverage. Because the buy-in enables them to purchase Medicaid and earn more than the 1619(b) limit, they increase their earnings, lose their 1619(b) status, and enroll in the buy-in.

Enrollment: The number of 1619(b) recipients in Washington, the percentage of the SSI caseload with 1619(b) status, and earned and unearned income for 1619(b) participants are available from Social Security Administration publications.[36] An analysis of persons using 1619(b) status demonstrates that monthly averages understate the total number of SSI recipients using 1619(b) over the course of the year.[37] Based on this information, we estimate the number of Washington SSI recipients in 1619(b) status one or more months over the year. This provides the basis for estimating the number of individuals who will potentially be induced to leave SSI as a result of the buy-in. As with the historic exiters, it is assumed that 47 percent of these "induced" exiters will return to the SSI program within one year.

The analysis of 1619(b) recipients referenced above found that a $1,000 change in the 1619(b) threshold resulted in increased earnings ranging from $2,500 to $10,000 per year for the average 1619(b) participant. Using the midpoint of this impact and combining it with the change in the threshold for Medicaid eligibility (which is equal to the buy-in eligibility limit of 450 percent of the federal poverty level minus the current 1619(b) threshold), it is possible to estimate the additional income which results from the impact of the buy-in. When this impact is combined with income data for 1619(b) participants prior to the buy-in, it is possible to estimate the number of people who exit SSI due to employment as a result of the buy-in.

Premiums and Cost Shares: Premiums are calculated from the estimates of earned and unearned income produced as part of the analysis to identify individuals who would leave SSI. Earned and unearned income prior to the buy-in is based on Social Security Administration data.[38] Unearned income is not high enough in this group to create any cost share liability.

Medicaid Costs: Medicaid costs are zero, as this group has Categorically Needy coverage in the absence of a buy-in and would presumably retain it if they were not induced to leave SSI due to the buy-in.

Medicaid Savings: To the extent that individuals in this group receive employer-provided health insurance as they increase their work effort, they will either choose not to enroll in the buy-in or will enroll, but some Medicaid costs will be offset by employer-provided health insurance. Medicaid savings are based on the assumption that a combination of these two effects will reduce Medicaid costs for this group by 40 percent based on the Categorically Needy per capita rate including mental health. This group is

[36] "SSI Disabled Recipients Who Work," Social Security Administration, March 2000.
[37] Stapleton et al.
[38] "SSI Disabled Recipients Who Work," Social Security Administration, March 2000.

assumed to be less likely to have a job with employer-provided health insurance than the "historic exiters" group, which is comprised of individuals who would have left the SSI caseload even in the absence of the buy-in program.

New General Fund Tax Revenue: New general fund tax revenues are estimated to be 7 percent of the increase in earnings associated with the buy-in.

Participation/Phase-in: The participation rate for this group is assumed to start at a fairly low rate (10 percent in FY 2002) due to SSI recipient concerns about permanency of changes associated with the buy-in, need for outreach, adjustments in work schedules, etc. The participation rate is assumed to increase to 60 percent of potential enrollees by FY 2007.

Persons With Severe Disabilities Not Enrolled in SSDI or SSI

Persons Employed Prior to the Buy-In: According to various household surveys, a substantial number of individuals who are not enrolled in the SSDI or SSI programs indicate that they have a severe disability. By some estimates, up to one-third of these individuals are employed.[39] Eligibility for the Medicaid buy-in program requires that individuals be employed and have a severe disability as defined by the SSDI and SSI programs. However, there is no requirement of current or past participation in SSDI or SSI. Therefore, individuals in this group are eligible to participate in the buy-in.

Enrollment: Estimates of the number of employed persons with severe disabilities in Washington, as well as their earned and unearned income, are from the 1998 SPS data. Disability status is self reported and the SPS sample is quite small, so it is possible that not all of these individuals would meet SSDI and SSI disability standards.

Approximately 43 percent of individuals who apply for SSDI or SSI and receive a disability determination from DSHS's Medical Assistance Administration are judged to have a severe disability.[40] Therefore, only 43 percent of the employed persons with severe disabilities in the SPS data are assumed to be potentially eligible for the Medicaid buy-in. After adjusting for the number of individuals who would be ineligible for the buy-in because their income exceeds the eligibility threshold of 450 percent of the federal poverty level, nearly 17,000 persons remain. This number is further reduced to 10,800 by assuming that all uninsured workers and half the insured workers would be the maximum number interested in the buy-in.

Premiums and Cost Shares: Premiums and cost shares are estimated based on the income data from the 1998 SPS data.

[39] John M. McNeil, "Employment, Earnings, and Disability," July 3, 2000, http://www.census.gov/hhes/www/disability.html

[40] E-mail from Don Larsen, Division of Disability Determination Services, Department of Social and Health Services, June 16, 2000.

Medicaid Costs: Medicaid costs are based on the Categorically Needy per capita rate, including mental health costs. Insured individuals are assumed to incur Medicaid costs equal to 50 percent of the per capita rate.

Participation/Phase-in: Because this group is employed and is not enrolled in SSDI or SSI, it seems reasonable to assume that few will be willing to put themselves through the disability determination that would be necessary to enroll in the buy-in. This is especially likely when many (81 percent based on the SPS data) have employer-provided health insurance. In addition, most states with a buy-in program have found a fairly low fraction (10 percent is common) of participants who had no Medicaid eligibility prior to enrolling in the buy-in.

This is consistent with the assumption that few persons not recently enrolled in SSDI or SSI will participate in a buy-in. Even in Minnesota, which has the lowest participant cost of any buy-in program, about 70 percent of participants had recent Medicaid coverage prior to buy-in participation, and 90 percent had current SSDI cash benefits. Therefore, the participation rate for this group is assumed to be 1 percent in FY 2002, increasing to 2 percent under the cost share scenario; for the no cost share scenario, participation starts at 2 percent and increases to 3 percent.

Potential Sources of Error in Cost and Benefit Estimates

The estimates in this report make use of established techniques and past research where possible. However, as noted above, some portions of the estimation process required that reasonable, but untestable, assumptions be made. For example, the effect of the specific combination of employment incentives created by the Ticket to Work legislation is unknown—these changes to the SSDI and SSI programs have never been made before, so no data exist to indicate how individuals will react. The stronger the reaction to these incentives, the greater will be the participation in the buy-in.

Moreover, many of the new incentives are not effective until 2001 or later. This means that, depending upon outreach efforts and individual beliefs concerning the permanency of these changes, the reaction to these new incentives will occur over time rather than all at once.

Exhibit B-1 lists potential sources of error in the program cost estimates and indicates the direction of that error. It is worth noting that many of the sources of error have the potential to either increase or decrease General Fund-State expenditures. Therefore, while the estimates are reasonable and reflect a substantial amount of analysis and discussion, they must be viewed as approximate.

Exhibit B-1
Potential Sources of Error in Cost Estimates

SOURCE	ISSUE	POTENTIAL IMPACT
Response to Incentives	Combined employment impact of Ticket to Work changes unknown; little available research	+ or –
Employer Insurance Coverage	Higher/lower rate of employer coverage will increase/decrease Medicaid costs; available data may not reflect experience of persons eligible for buy-in	+ or –
Income of Buy-In Enrollees	Premium payments may be under- or over-stated if income is under- or over-estimated; available data may not reflect experience of persons eligible for buy-in	+ or –
Enrollment of Non-SSI/Non-SSDI	Size of this group is uncertain; other states' experiences suggest small impact from this group	+ or –
Timing of Buy-In Enrollment	Outreach, concerns about permanence of buy-in, etc., will affect the timing, size of buy-in enrollment	+ or –
SSDI Enrollment	Enrollment of SSDI recipients with health costs below Medically Needy spend down is uncertain; estimated health care costs may be too high/low	+ or –
Impact on TANF Caseload	Individuals with severe disabilities may be on TANF and choose to enroll in buy-in	–
Impact on BHP Enrollment	Individuals with severe disabilities may be enrolled in the Basic Health Plan and choose to switch to buy-in	–
Impact on Special Programs	Programs that assist SSDI recipients with kidney disease, HIV-AIDS, and other diseases may experience some savings	–
Impact on Other Subsidies	Increased earnings will reduce food stamps, HUD housing subsidies; this may offset some employment incentives of Ticket to Work provisions	–
Employment & Health Care Costs	Potential that employment reduces health care costs; more research needed to verify	–
"Unintended" Outreach	Buy-in outreach efforts may identify individuals eligible for other state-sponsored medical assistance	+
Administrative Simplicity	Simplicity of buy-in premiums over Medically Needy program rules may increase enrollment	+

Note: **+** indicates potential to increase costs to state; **–** indicates potential to decrease costs to state.

Baseline Costs for a Medicaid Buy-In Program

To monitor the actual costs of a Medicaid buy-in program over time, it is helpful to know the costs the Medicaid program would have incurred in the absence of a buy-in. Using expected per capita costs for the Medicaid Medically Needy and Categorically Needy programs and identifying buy-in participants who would have continued to receive Medicaid coverage without a buy-in, it is possible to calculate such baseline estimates. Exhibit B-2 contains baseline costs estimates for the low state cost and high state cost scenarios.

Several groups of potential buy-in enrollees (SSDI and SSI "historic exiters," SSDI recipients not participating in the Medically Needy program, persons with severe disabilities not enrolled in SSDI or SSI) are excluded from baseline costs. This is because individuals in these groups would not have qualified for Medicaid in the absence of a buy-in program. It is also important to realize that the baseline estimates make use of the same behavioral assumptions used to estimate the costs and benefits of the buy-in. Careful analysis of the buy-in program over time will be required to identify actual enrollee behavior and may necessitate modifications to the baseline cost estimates.

Exhibit B-2
Baseline Cost Estimates

FISCAL YEAR	2002	2003	2004	2005	2006	2007
LOW STATE COST SCENARIO						
MEDICAID COSTS, ALL FUNDS	$1,353,613	$3,866,642	$5,854,515	$8,590,519	$12,159,947	$15,686,622
MEDICAID COSTS, STATE FUNDS	$670,715	$1,919,015	$2,905,596	$4,263,474	$6,034,982	$7,785,270
HIGH STATE COST SCENARIO						
MEDICAID COSTS, ALL FUNDS	$3,701,694	$9,923,732	$14,161,261	$18,433,095	$23,010,214	$27,647,731
MEDICAID COSTS, STATE FUNDS	$1,834,189	$4,925,148	$7,028,234	$9,148,345	$11,419,969	$13,721,569

Cost and Benefit Estimates Arranged by Medicaid Eligibility Group

To assist in potential budget development activities, the cost and benefit estimates in Exhibits 1 and 2 have been rearranged to reflect the Medicaid eligibility of buy-in participants prior to the buy-in. Exhibit B-3 displays the costs and benefits for the low state cost scenario grouped by new Medicaid enrollees (i.e., individuals not enrolled in any Medicaid program prior to the buy-in), individuals transferring from the Medicaid Medically Needy program to the buy-in, and individuals transferring from the Categorically Needy Medicaid program to the buy-in. Exhibit B-4 reflects the same rearrangement of cost and benefit estimates for the high state cost scenario.

Exhibit B-3

Estimated Costs and Benefits of Low State Cost Scenario: Cost Share, 5 Percent Premium, January 1, 2002, Implementation

FISCAL YEAR	2002	2003	2004	2005	2006	2007
New Medicaid Enrollees: Would Not Be a Medicaid Enrollee Without Buy-In						
Enrollment	140	361	641	825	1,030	1,209
Premiums	($98,565)	($262,199)	($481,224)	($652,980)	($860,221)	($1,065,510)
Cost Share	($55,521)	($118,706)	($254,123)	($284,798)	($313,364)	($335,115)
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	$629,241	$2,103,932	$4,134,024	$5,778,967	$7,776,413	$9,869,947
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$475,155	$1,723,027	$3,398,677	$4,841,190	$6,602,828	$8,469,323
Net Medicaid Impact, State	$235,439	$855,139	$1,686,763	$2,402,682	$3,276,984	$4,203,325
New General Fund Tax Revenue	-	-	-	-	-	-
Individuals Transferring From Medically Needy Program						
Enrollment	176	389	434	482	532	586
Premiums	($11,376)	($25,769)	($30,275)	($35,386)	($41,177)	($47,728)
Cost Share	($116,456)	($260,392)	($298,365)	($340,131)	($386,019)	($436,388)
Change in Spend Down	$236,017	$518,275	$573,212	$630,738	$690,952	$753,958
Medicaid Costs	$196,099	$439,685	$498,325	$562,035	$631,218	$706,308
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$304,285	$671,798	$742,898	$817,256	$894,974	$976,150
Net Medicaid Impact, State	$150,773	$333,413	$368,700	$405,604	$444,176	$484,463
New General Fund Tax Revenue	-	-	-	-	-	-
Individuals Transferring From Categorically Needy Program						
Enrollment	27	133	274	459	686	870
Premiums	($19,566)	($99,926)	($216,300)	($380,868)	($596,838)	($795,344)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	-	-	-	-	-	-
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	($176,479)	($909,775)	($1,998,886)	($3,573,273)	($5,685,155)	($7,692,202)
Net Medicaid Impact, State	($87,445)	($451,521)	($992,047)	($1,773,415)	($2,821,543)	($3,817,640)
New General Fund Tax Revenue	$22,237	$113,736	$246,785	$435,589	$684,201	$913,885
Totals						
Enrollment	343	883	1,349	1,767	2,248	2,665
Premiums	($129,508)	($387,895)	($727,799)	($1,069,234)	($1,498,237)	($1,908,582)
Cost Share	($171,976)	($379,098)	($552,488)	($624,928)	($699,383)	($771,503)
Change in Spend Down	$236,017	$518,275	$573,212	$630,738	$690,952	$753,958
Medicaid Costs	$825,340	$2,543,617	$4,632,350	$6,341,003	$8,407,631	$10,576,256
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	$602,961	$1,485,050	$2,142,688	$2,085,173	$1,812,646	$1,753,270
Net Medicaid Impact, State	$298,767	$737,030	$1,063,416	$1,034,871	$899,616	$870,148
New General Fund Tax Revenue	$22,237	$113,736	$246,785	$435,589	$684,201	$913,885

Exhibit B-4

Estimated Costs and Benefits of High State Cost Scenario: No Cost Share, 5 Percent Premium, January 1, 2002, Implementation

FISCAL YEAR	2002	2003	2004	2005	2006	2007
New Medicaid Enrollees: Would Not Be a Medicaid Enrollee Without Buy-In						
Enrollment	1,859	4,480	5,869	6,663	7,136	7,558
Premiums	($267,542)	($665,928)	($965,817)	($1,219,914)	($1,505,532)	($1,767,179)
Cost Share	$116,456	$260,392	$298,365	$340,131	$386,019	$436,388
Change in Spend Down	$517,032	$1,264,737	$1,676,711	$1,918,136	$2,042,305	$2,174,573
Medicaid Costs	$4,275,325	$11,092,565	$15,413,210	$18,488,861	$21,367,192	$23,954,304
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$4,641,271	$11,951,766	$16,422,469	$19,527,214	$22,289,984	$24,798,086
Net Medicaid Impact, State	$2,299,750	$5,924,671	$8,140,975	$9,680,271	$11,050,483	$12,294,214
New General Fund Tax Revenue	$327,717	$819,212	$1,120,641	$1,316,524	$1,438,377	$1,571,508
Individuals Transferring From Medically Needy Program						
Enrollment	532	1,251	1,556	1,736	1,834	1,937
Premiums	($38,354)	($93,206)	($122,525)	($143,762)	($159,584)	($177,094)
Cost Share	($116,456)	($260,392)	($298,365)	($340,131)	($386,019)	($436,388)
Change in Spend Down	$350,211	$799,502	$948,781	$1,061,484	$1,149,946	$1,243,053
Medicaid Costs	$915,065	$2,232,137	$2,940,554	$3,421,102	$3,745,071	$4,099,356
Medicaid Savings	-	-	-	-	-	-
Net Medicaid Impact, All Funds	$1,110,467	$2,678,041	$3,468,444	$3,998,694	$4,349,415	$4,728,927
Net Medicaid Impact, State	$550,236	$1,327,507	$1,719,209	$1,982,006	$2,155,851	$2,343,964
New General Fund Tax Revenue	$75,243	$188,089	$257,297	$302,271	$ 330,248	$360,815
Individuals Transferring From Categorically Needy Program						
Enrollment	27	133	274	459	686	870
Premiums	($19,566)	($99,926)	($216,300)	($380,868)	($596,838)	($795,344)
Cost Share	-	-	-	-	-	-
Change in Spend Down	-	-	-	-	-	-
Medicaid Costs	-	-	-	-	-	-
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	($176,479)	($909,775)	($1,998,886)	($3,573,273)	($5,685,155)	($7,692,202)
Net Medicaid Impact, State	($87,445)	($451,521)	($992,047)	($1,773,415)	($2,821,543)	($3,817,640)
New General Fund Tax Revenue	22,237	113,736	246,785	435,589	684,201	913,885
Totals						
Enrollment	2,418	5,864	7,699	8,859	9,655	10,365
Premiums	($325,462)	($859,061)	($1,304,643)	($1,744,544)	($2,261,954)	($2,739,617)
Cost Share	-	-	-	-	-	-
Change in Spend Down	$867,243	$2,064,239	$2,625,492	$2,979,620	$3,192,251	$3,417,626
Medicaid Costs	$5,190,390	$13,324,702	$18,353,764	$21,909,964	$25,112,263	$28,053,660
Medicaid Savings	($156,912)	($809,849)	($1,782,586)	($3,192,404)	($5,088,317)	($6,896,858)
Net Medicaid Impact, All Funds	$5,575,259	$13,720,032	$17,892,027	$19,952,635	$20,954,243	$21,834,811
Net Medicaid Impact, State	$2,762,541	$6,800,656	$8,868,136	$9,888,862	$10,384,791	$10,820,538
New General Fund Tax Revenue	$425,196	$1,121,037	$1,624,724	$2,054,384	$2,452,826	$2,846,208