

## Medicaid Buy-in Options: Helping the Severely Disabled and Chronically Ill Keep Health Coverage and Employment

Working-age adults with severe disabilities and chronic conditions have historically been discouraged from seeking employment for fear of losing health care benefits under Medicaid. Even earning a modest income can disqualify such individuals from receiving crucial Medicaid benefits. Legislation in recent years, however, allows states to give severely disabled persons an opportunity to earn more and keep Medicaid coverage at little or no cost.

### Easing Work Restrictions for Medicaid-Dependent Individuals with Disabilities

The Balanced Budget Act of 1997 and the Ticket to Work and Work Incentive Improvement Act of 1999 gave states the option of allowing individuals with severe disabilities to earn more money while retaining Medicaid or Medicare benefits. Without that option, some disabled persons on Medicaid who could work didn't consider employment opportunities for fear of losing health care and other benefits that enable them to live in the community.

Eligibility for Medicaid and Medicare for persons with disabilities has long been linked to receipt of one of two forms of Social Security cash benefits. Qualifying for either Social Security Disability Income (SSDI) or Supplemental Security Income (SSI) is heavily dependent on showing that program applicants cannot work. SSI provides a minimum income to people with severe disabilities with very low incomes, while SSDI provides somewhat higher cash benefits to workers who become disabled. After a two-year waiting period, individuals on SSDI become eligible for Medicare. Those on SSI are generally eligible for Medicaid.

More than 3.8 million working-age disabled adults receive SSI, while nearly 5 million receive benefits through SSDI. Few individuals among these populations work.

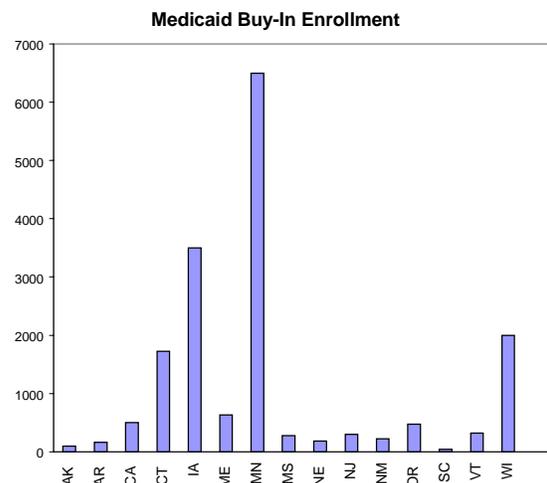
But the number of those now seeking work is beginning to change, albeit slowly, thanks to recent legislation. States now have flexibility to break the link between

Medicaid and cash benefits by extending Medicaid coverage to working disabled beneficiaries whose income would have prevented them from qualifying for the program. States can increase Medicaid income and resource limits for these individuals, and have the option to offer Medicaid to disabled workers whose medical conditions improve to the point where they no longer qualify for Supplemental Security Income.

### Limited Response by States

As of the beginning of 2002, only 15 states had implemented a Medicaid buy-in option.<sup>1</sup> Of those states, four had the lion's share of enrollment. Connecticut, Iowa, Minnesota and Wisconsin enrolled 85 percent of the 17,000 individuals enrolled in state Medicaid buy-in options (see Figure 1). Massachusetts implemented a similar program in 1988 that counts another 5,700 enrollees.

**Figure 1**



Social Security and other income can be too high for many persons on SSDI to receive Medicaid and its valuable prescription drug and personal assistance

benefits, although they receive basic health benefits from Medicare after a two year waiting period. Some states have designed their buy-in programs to limit or exclude enrollment of SSDI beneficiaries. Nevertheless, the principal source of national enrollment in Medicaid buy-in programs has been SSDI, although it was expected by many to be SSI/Medicaid beneficiaries.

### **Costs, Beneficiary Fears Stunt Buy-in Program Growth**

Fear of unpredictable or spiraling costs is the most common reason why more states haven't participated in the buy-in program. Cost-related concerns are paramount for states now confronting budgetary crises.

Enrollment has also been light in most states with buy-in programs. The number of persons who can meet the strict definition of disability and still be able to find or perform work without additional assistance may be limited. Another plausible reason for low enrollment may be that individuals who have gone through the lengthy ordeal of qualifying for Social Security income support and related health coverage --much of which is based on inability to work--fear those benefits could be jeopardized if they enroll in a buy-in program and begin working.

### **Options to Increase State and Beneficiary Participation**

Evidence from states with higher enrollment levels in their buy-in programs suggests that such programs can be important for promoting employment, particularly among those with previous work experience. Incremental steps to increase the program's impact include:

- Launching a federal information campaign to assure beneficiaries that important benefits will not be lost if they participate in the program.
- Permitting states to conduct limited demonstrations to gain experience and cost information before full implementation, and providing technical assistance to states to help them design effective programs.
- Increasing the regular federal funding rate to state Medicaid buy-in programs.
- Expanding the program to provide health insurance to persons with disabilities and chronic conditions still in the labor force who can't get private insurance.

### **Conclusion**

The Medicaid buy-in options were created to give people with chronic conditions and disabilities the ability to return to work, without losing essential health care coverage and supportive services they depend on through Medicaid. Although the results of the Medicaid buy-in effort to date are less than expected, the program is still an important step forward in health care and disability policy. We should consider building on this initial step so the program's full potential can be realized.

### **About Partnership for Solutions**

The Partnership for Solutions, led by Johns Hopkins University and The Robert Wood Johnson Foundation, is an initiative to improve the care and quality of life for the more than 125 million Americans with chronic health conditions. The Partnership is engaged in three major activities: conducting original research and identifying existing research that clarifies the nature of the problem; communicating research findings to policymakers, business leaders, health professionals, advocates and others; and working to identify promising solutions to the problems faced by people with chronic health conditions. Organizations involved in the Partnership include: Alzheimer's Association, American Academy of Pediatrics, American Diabetes Association, American Geriatrics Society, Family Voices, National Alliance for the Mentally Ill, and National Chronic Care Consortium.

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<sup>i</sup> Thus far in 2002, an additional six states have brought Medicaid Buy-In plans into operation. Florida also implemented a program that has, at least temporarily, been eliminated during 2002.