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The Interaction of Policy and Enrollment in the Medicaid Buy-In Program, 2005

Final Report

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Henry T. Ireys
Sarah R. Davis
Kristin L. Andrews

Submitted to:

Centers for Medicare and Medicaid Services
OICS/Acquisition and Grants Group
2-21-15 Central Building
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-2292

Project Officer: Steve Hrybyk

Submitted by:

Mathematica Policy Research, Inc.
600 Maryland Ave. S.W., Suite 550
Washington, DC 20024-2512
Telephone: (202) 484-9220
Facsimile: (202) 863-1763

Project Director: Su Liu

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The statements made in this report and the information presented, including material in the appendices, remain the sole responsibility of the authors and should not be interpreted as representing the views of any federal or state agency or administrator.

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EXECUTIVE SUMMARY

The Medicaid Buy-In program was designed to help adults with disabilities to obtain or increase their employment without fear of losing health insurance. Since its inception in 1997, the program has grown considerably. In mid-2005, 32 states were operating a Medicaid Buy-In program, providing health coverage to more than 80,000 workers with disabilities who might not otherwise be eligible for Medicaid. Overall, more than 161,000 individuals participated in state Medicaid Buy-In programs from 1997 to the end of 2005, and, until recently, annual growth rates have been greater than 20 percent. This rate of increase is especially noteworthy compared with overall Medicaid growth rates of 3 to 6 percent between 2003 and 2005[1] and underscores the extent of national support for the program.

Although the first Buy-In program was implemented in 1997, more than half the state programs began in 2001 or later. Consequently, many state programs are still relatively new, and are continuing to evolve in response to implementation challenges and operational experiences. For example, some states recently have altered their eligibility criteria to better focus the program on individuals with disabilities who want and are able to make a sustained commitment to employment.

This report, the latest in a series on participation in the Medicaid Buy-In program, presents a snapshot of the program in 2005 that captures the interplay of policy features, enrollment trends, and participant characteristics that have made the program what it is today. Moving away from the aggregated data used in previous studies, the analysis for this report is based on individual-level data provided by states to CMS through "finder files." MPR linked federal administrative data with state finder files to calculate enrollment figures and trends in 29 state Medicaid programs operating for all of 2005. Analysis of this integrated data set offers unique opportunities for quantitative monitoring of participation in the Medicaid Buy-In program and allows us to show policymakers and program administrators how program features can be altered to shape enrollment trends, better manage program performance, and improve outcomes.

[1] Medicaid Enrollment in 50 States: June 2005 Data Update. Kaiser Family Foundation, December 2006. http://kff.org/medicaid/upload/7606.pdf

Background. The Medicaid Buy-In program, authorized by both the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act), gives states an opportunity to support adults with disabilities who want to work and increase their earnings without losing health care coverage. To obtain health insurance, a typical adult with a disability has to either work enough to be covered by his or her employer (which can be quite difficult depending on the level of the individual's impairments) or work very little (if at all) to be eligible for Medicaid (Friedland and Evans 1996; Sommers 2006/2007). At best, this means not only that employers must offer affordable coverage but also that an individual has to be healthy enough to work consistently. At worst, the requirements create—albeit unintentionally—a disincentive to work altogether: Better to stay unemployed than to lose Medicaid coverage.

The Buy-In program seeks to restore the incentive to work by allowing individuals with disabilities to "buy into" Medicaid by paying premiums or co-payments. To enroll in the program, an individual must be disabled according to Social Security Administration criteria (as adapted for the Medicaid Buy-In program), have earned income, and meet state-established financial requirements.

Program Features. In any given year, states can change the operational features of their Medicaid Buy-In programs to strategically expand or restrict the pool of potential applicants, allow current participants to earn more money, alter the structure of premium payments, or refine grace periods (making it easier or more difficult for participants to stay enrolled if they lose their jobs). Our analysis of policy and procedural changes in state Medicaid Buy-In programs between 2003 and 2005 indicates the following:

- Enrollment rates and participant composition are quite responsive to changes in certain program eligibility criteria, such as income and asset limits, suggesting that administrators have several mechanisms for refining the pool of applicants.

- While only a few states made modest policy changes in 2005, several key issues were capturing administrators' attention, including the implications of tight Medicaid budgets, the challenge of defining "work" operationally, the impact of changes in income and asset eligibility criteria, the influence of other work-incentive programs, and the challenges of establishing cost-effective premium structures.

Enrollment Trends. Analysis of enrollment trends in the Medicaid Buy-In program led to two primary findings. First, the number of states adopting a Buy-In program has increased every year since Massachusetts implemented the first program in 1997. In 2005, however, no state added a program, and Missouri rescinded its program in August of that year. That decision ended a seven-year period of growth in the number of programs nationwide and pushed down national total enrollment considerably. With nearly 18,000 people enrolled in the Missouri Buy-In in June 2005, the total enrollment for all programs went from nearly 80,000 to about 65,000 just three months later. The 29 remaining states, however, saw consistent growth in 2005, with a 21 percent increase in enrollment, following a 24 percent increase in 2004.

Second, the size of the Buy-In program varies widely from state to state—both in absolute numbers of participants and relative to the estimated number of working-age adults with disabilities in the state. This variation stems from differences in the choices states have made in terms of authorizing legislation, program features, and outreach efforts, and in the availability of other federal work incentives.

Participant Characteristics. Our analysis of participant characteristics in 2005 led to the following findings:

- The majority (51 percent) of Buy-In participants were 45 to 64 years old, but the age distribution varied by state depending on which federal law was used to authorize the program. The BBA allows working aged individuals and those age 65 and over to enroll, but the Ticket Act restricts enrollment to working-age adults under 65.

- The most common primary disabling condition of Buy-In participants was mental illness and other mental disorders. About 30 percent of all Buy-In participants had these conditions, and about 12 percent had mental retardation. Slightly less than 10 percent had musculoskeletal disorders, and about 2 percent had sensory disorders.

- During the year prior to Buy-In enrollment, about 70 percent of participants enrolling in the Buy-In in 2005 were Social Security Disability Insurance (SSDI) beneficiaries (including those concurrently enrolled in Supplemental Security Income (SSI)), and about 20 percent were SSI beneficiaries (including those concurrently enrolled in SSDI).

Analyses of data on participants ever enrolled in the Buy-In between 1997 and 2005 indicated that:

- Slightly more than half of all participants (55 percent) became eligible for SSDI more than two years before enrolling in the Buy-In and were therefore Medicare beneficiaries when they enrolled in the program and

- Slightly more than 3 percent of participants were in SSI through the 1619(b) provision in the three months immediately prior to Buy-In enrollment.

It appears that as programs mature, their composition evolves, meaning that the profile of older programs is somewhat different from the profile of newer programs. For example, some states with older programs have adjusted their eligibility requirement to make it slightly more difficult for SSDI recipients to enroll; as a result, a greater proportion of participants are either SSI beneficiaries or individuals with no previous enrollment in either SSI or SSDI.

As states continue to develop their programs, we expect to see additional policy and procedural refinements. Policy changes are likely to be more widespread in 2006 than in 2005 for several reasons: at least five new states initiated a Buy-In program in 2006, many states are still responding to the implications of Medicare Part D for Buy-In enrollment, and states continue to refine their eligibility criteria.

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CHAPTER I

INTRODUCTION

Since the early 1990s, Congress and the President have launched several major initiatives to promote employment of adults with disabilities, including the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) and the New Freedom Initiative authorized in 2001 (U.S. Government Accountability Office 2003). Some of these efforts aim to enhance access to health insurance so that low-income workers with disabilities can increase their earnings without the fear of losing coverage of needed health services. The Medicaid Buy-In program is one of the most important of these efforts, and many policymakers, program administrators, and consumers see this as a promising opportunity to enhance both earnings and access to health care for adults with disabilities who want to participate actively in the nation's work force.

Authorized by the Balanced Budget Act of 1997 (BBA) and the Ticket Act, the Medicaid Buy-In program allows states to expand Medicaid coverage to workers with disabilities whose income and assets would otherwise make them ineligible for Medicaid. To enroll in the program, an individual must have a disability (as defined by the Social Security Administration as adapted for the Medicaid Buy-In program[1]) and income from work, and meet certain financial eligibility requirements established by the states. In most state programs, at least some of the participants "buy into" Medicaid by paying premiums or co-payments that increase as earnings grow.

In mid-2005, 32 states were operating a Medicaid Buy-In program, with a total enrollment of more than 80,000. Overall, more than 161,000 individuals participated in state Medicaid Buy-In programs between their inception and 2005. Sixty-six percent of participants enrolled in the Buy-In program at some point in 2004 (the most recent year for

[1] According to a CMS transmittal letter (Westmoreland 2000), if an applicant to the Medicaid Buy-In program is not an SSI or SSDI recipient, states must do a disability determination to ensure that the individual would meet the definition of disability under the SSI program. The disability test must be identical to the SSI/SSDI disability test except that employment activity, earnings, and substantial gainful activity must not be considered in determining whether the individual meets the definition of disability. For further discussion of the work-related components in the definition of disability used by SSA, see "A Disability System for the 21st Century" (Social Security Advisory Board 2006).

Table I.1. Provisions in Two Federal Laws Establishing the Medicaid Buy-In Program

	Balanced Budget Act (1997)	Ticket to Work Act (1999)
Eligibility groups	Provides for a single Buy-In group	Provides for two groups: - Basic Coverage Group - Medical Improvement Group*
Net family income	Requires states to set upper limit at 250 percent of federal poverty line	No provisions
Monthly countable unearned income	Requires states to set limits to be less than the benefit amount for the SSI program	No provisions
Assets	Requires states to use SSI Resource standards ($2,000 for an individual, $3,000 for a couple)	No provisions
Income disregards	Requires states to apply the same income disregards as the SSI program, and allows states to use additional income disregards	No provisions
Premiums	Does not require states to charge premiums or cost sharing; allows states to require a premium or other cost sharing using sliding scale based on income	Does not require states to charge premiums or cost sharing but if states do so: They may charge 100 percent of the premium to individuals earning more than 250 percent FPL. Individuals earning between 250 and 450 percent FPL must pay less than 7.5 percent of their income in premium. They must charge 100 percent of the premium to individuals with $75,000 or more adjusted gross income.

Source: Social Security Administration. www.ssa.gov; Centers for Medicare and Medicaid Services (CMS), www.cms.hhs.gov

*The Medical Improvement Group covers individuals who lose eligibility under the Basic Coverage Group because they have a medical condition that has improved to the point at which the Social Security Administration (SSA) determines that he or she no longer has a disability. Although six states are authorized to have a Medical Improvement Group, fewer than 25 people were enrolled as of December 2005.

which national earnings data are available) had reported earnings and these individuals earned an average of $7,246 annually. This level of earnings is equivalent to 78 percent of the 2004 federal poverty level and translates into an estimated 28 hours per week if participants earned the 2004 federal minimum wage of $5.15 per hour (Gimm et al. 2007).

The two federal laws authorizing the Medicaid Buy-In program place somewhat different constraints on the design of state programs (Table I.1). Within the broad parameters outlined by these acts, however, states can establish their own earned and unearned income limits, the procedures for verifying participants' income, and the premium amounts (if any) that participants are required to pay. Overall, states have considerable flexibility in designing their Buy-In programs (Jensen et al. 2002).

A. THE BUY-IN PROGRAM'S APPEAL TO POTENTIAL APPLICANTS

One of the greatest strengths of the Medicaid Buy-In program is its potential appeal to working-age adults with disabilities – a group that is quite diverse with regards to disabling conditions, involvement with other work incentive programs, access to health insurance, history of work experience, and personal employment goals. The majority of individuals entering the Buy-In do so for one of two reasons: They want to work more, but fear the loss of current Medicaid coverage if their hours and wages increase; or they need health coverage or extra services their current insurance (most notably Medicare) will not cover. For example:

- About one-fifth of Buy-In participants who enrolled in 2005 were SSI recipients in the prior year. Medicaid covers virtually all SSI beneficiaries automatically, and so their enrollment into the Buy-In allows them to increase earnings beyond what is allowed by the SSI program. For them, the Medicaid Buy-In is not a pathway to new or additional health insurance but rather an opportunity to expand earnings without losing their Medicaid coverage.

- Slightly more than one-half (55 percent) of all participants in the Buy-In program between 1997 and 2005 were Medicare beneficiaries at enrollment because they had been receiving SSDI payments for at least two years. Many of these individuals may have enrolled in the Buy-In program to obtain health services that Medicare does not cover. For this group, the Buy-In program represents an opportunity to use Medicaid as a secondary wraparound health insurance plan. (See chapter IV).

- Other working-age adults who have enrolled in Medicaid Buy-In programs include individuals who have a serious disabling condition but have not been deemed "disabled" under SSA guidelines because they have consistently worked or wanted to work. (In most cases, the ability to work makes it difficult for individuals to meet SSA criteria and therefore to become eligible for either the SSDI or SSI program.) These individuals are likely to be working or looking for work in positions that (1) do not offer health insurance, (2) offer health insurance for which they do not qualify because they have a serious medical

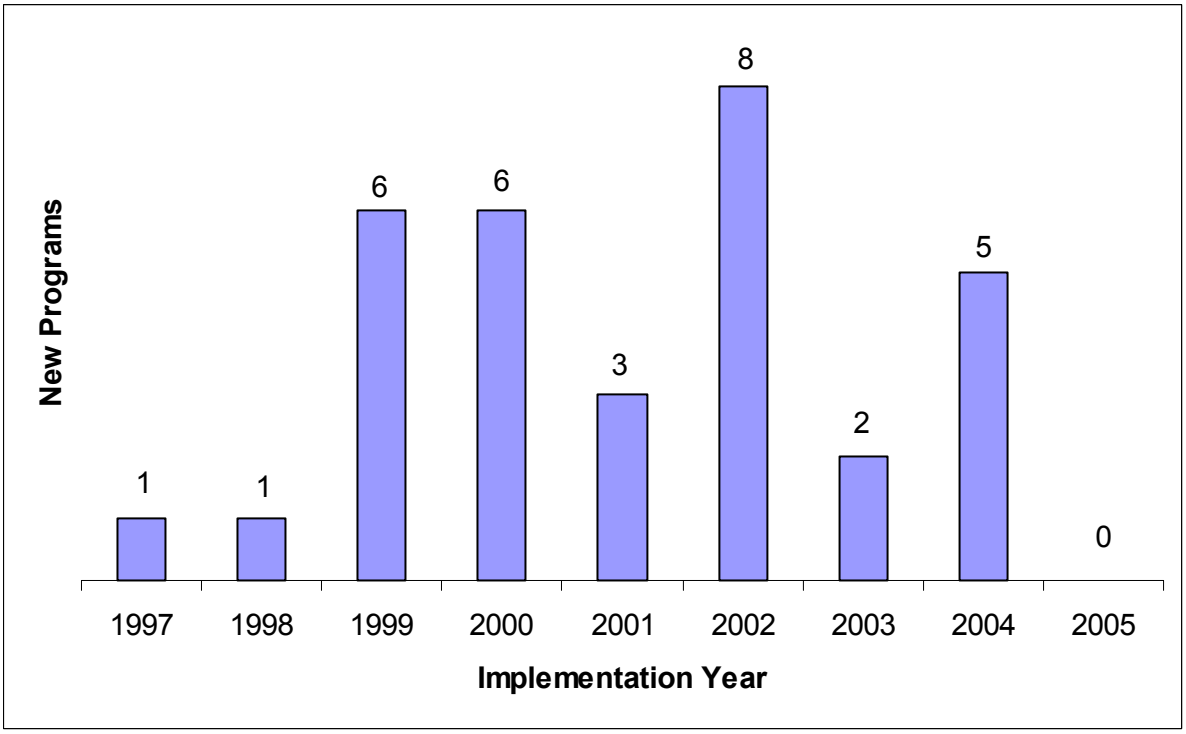
condition or do not work enough hours, or (3) offer health insurance with premiums that are too expensive. For these individuals, the Medicaid Buy-In program offers an opportunity to pursue their personal employment goals while obtaining access to affordable health insurance.

Because states have considerable flexibility in designing the eligibility criteria and operating procedures for their Buy-In programs, they can craft programs to focus on particular subgroups within the overall population of working-age adults with disabilities (Folkemer et al. 2002). For example, if programs set strict limits on participants' unearned income (such as a limit of $600 per month), they can exclude all or most SSDI beneficiaries.

B. GROWTH IN THE NUMBER OF STATES WITH BUY-IN PROGRAMS

The number of state Medicaid Buy-In programs grew consistently between 1997, when the Medicaid Buy-In program was originally established by the BBA, and 2004, when a total of 32 states were operating a Buy-In program. The growth stopped in 2005, when no state initiated a Buy-In program (Figure I.1). Furthermore, one state (Missouri) rescinded its program in August 2005, making the number of participating states 31 by December of 2005.

Figure I.1 Number of New Medicaid Buy-In Programs by Year, 1997-2005



Source: MIG Reporting website; state Medicaid personnel and websites

C. PURPOSE AND OVERVIEW OF REPORT

The Centers for Medicare and Medicaid Services (CMS) provides oversight for the Medicaid Buy-In program and has primary federal responsibility for (1) providing general programmatic guidance, (2) monitoring participation, and (3) developing accurate information for federal and state policymakers. CMS has asked Mathematica Policy Research, Inc. (MPR) to assist it in its monitoring role by developing quantitative measures of participation in the Medicaid Buy-In and using these measures to track policy and enrollment trends.

This report, the latest in a series of annual reports,[2] presents quantitative measures of enrollment and characteristics of participants in the Medicaid Buy-In program. It differs from the previous reports because it uses individual-level data from both state and federal sources to describe enrollment trends and participant characteristics from program inception through the end of 2005. Earlier reports were based on aggregate data that states provided through a standard reporting form.

For this report, states provided CMS with individual-level enrollment data through "finder files." To examine the characteristics of Buy-In participants, MPR linked the finder files data to federal data sources, including information on individuals who received SSA benefits between 1996 and 2005. This data source provides information on Buy-In participants who had been an SSI or SSDI beneficiary between these dates, including data on their ethnic background, primary disabling condition, benefit receipt, earnings, and dates of SSI or SSDI program enrollment. Detailed descriptions of the finder files, data sources, and MPR's linking procedures may be found elsewhere (Liu and Ireys 2006). In addition, MPR collected qualitative data from directors of each state program to identify changes in policies and procedures implemented in 2005.

This report presents quantitative information on participation in 30 state Medicaid Buy-In programs that were operational in 2005.[3] The data used for this report are likely to be quite accurate because (1) each state assembled its files using the same specifications and (2) MPR checked these files for internal consistency and contacted states to resolve any problems.

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[2]Earlier reports, which are available at MPR's website (www.mathematica-mpr.com), include: "Understanding Enrollment and Participant Characteristics of the Medicaid Buy-In Program, 2003-2004" by W. Black and H. Ireys (published in January 2006) and "Explaining Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2002-2003" by J. White and others (published in January 2005).

[3] This report focuses on states that had both a Medicaid Buy-In program and a Medicaid Infrastructure Grant (MIG) for all of 2005 (see Table A.2). Although Arizona and Mississippi had a Buy-In program in 2005, they are not included in the data analysis because they did not have a MIG and were therefore not asked to submit a finder file. Because Missouri rescinded its program in August 2005, we exclude Missouri's data from analyses that examine patterns of enrollment (Chapter III) because we focus on data as of December 2005, after Missouri's program was rescinded. However, we include Missouri's data in analyses of participant characteristics (Chapter IV) because we focus on participants who were ever enrolled in the Buy-In programs.

Chapter II of this report discusses key issues that influence enrollment in Medicaid Buy-In programs and examines how these issues are reflected in policy and procedural changes that states implemented in 2005. Chapter III reviews enrollment trends in the program at both national and state levels and identifies some of the primary factors influencing these trends. Chapter IV presents information on participant characteristics and the final chapter (Chapter V) summarizes major points and identifies issues that are likely to be of concern in the next few years.

Appendix A includes a summary table that presents key administrative features and characteristics of the Buy-In programs in 29 states as of December 2005 and Appendix B contains one-page descriptions of each of these state programs. These descriptions were reviewed and approved by the relevant program directors. Appendices C and D provide detailed back-up tables for Chapters III and IV, respectively.

CHAPTER II

POLICY ISSUES IN MEDICAID BUY-IN PROGRAMS

Medicaid Buy-In programs have several administrative features that policymakers can use to shape program operations and enrollment, including eligibility criteria, premium and cost-sharing structures, and work-related provisions and protections. For example, states can establish an income-eligibility criterion that restricts the potential pool of applicants to individuals with very low earnings. Or they can set up a premium payment structure that subsidizes most participants by requiring payments only when earned income exceeds a relatively high level.

When states initially implement a Medicaid Buy-In program, they establish operational procedures that reflect policy decisions about the program's specific intent and focus. In any given year, only a few states make changes to these procedures. However, changes implemented by any single state may reflect broader policy trends and issues in other states. Furthermore, focused policy changes can accumulate over time and result in significant shifts in policy.

Between 2003 and 2005, states made modest changes in their administrative features and operational procedures (Table II.1). However, these changes reflect several simmering issues that other states are likely to face during the next several years and may lead them to make additional program refinements. These issues include:

- The challenge of tight Medicaid budgets
- The debate regarding a definition of "work"
- Relationships between the Buy-In program and other work incentive efforts
- The impact of altering income and asset eligibility criteria and
- Finding a cost-effective premium structure

In this chapter, we discuss these issues and identify how they are reflected in the policy changes listed in Table II.1.

Table II.1 Policy Changes in State Medicaid Buy-In Programs, 2003 - 2005

State	Description (Effective Date)
Eligibility Criteria	
Vermont	Increased unearned income disregard from $500 of SSDI benefits to all of SSDI and veterans benefits (2005).
	Increased asset limit from $2,000 for an individual and $3,000 for a couple to $5,000 and $6,000, respectively (2005).
North Dakota	Expanded age range from 18–64 to 16–65 (2005).
	Increased asset limit to $13,000, allowing $10,000 to be put toward an individual's Plan for Achieving Self-Support and then combined with the $3,000 Medicaid resource threshold (2005).
Kansas	Added a Medically Improved Group (2005).
South Carolina	Excluded 401(k) balances from countable asset total (2005).
	Removed the $800 minimum earnings requirement from the eligibility criteria (2005).
Pennsylvania	Began allowing presumptive eligibility while individuals are undergoing the disability determination process rather than requiring them to wait until process was completed (2004).
Minnesota	Implemented a $65 disregard on earned income (2004).
Oregon	Implemented a rule that clarified an existing practice that made SSI recipients ineligible for the Buy-In as they are already categorically eligible through other Medicaid that can better serve the population (2005).
	Decreased asset limit from $12,000 to $5,000 (2003).
Missouri	Rescinded Buy-In program (2005).
Premium and Cost-Sharing Structure	
New Hampshire	Instituted flexible premium payment plan (2005).
Vermont	Eliminated premium requirement (2004).
	Increased premiums from $20 to $50 for participants with income between 185 and 225 percent of FPL and from $24 to $60 for participants with income between 225 and 250 percent of FPL (2003).
Utah	Reduced premium to 15 percent of countable income from a range of 30 to 55 percent of countable income (2003).
Minnesota	Instituted minimum monthly premium requirement of $35 (2004).
New Mexico	Increased co-payment amounts from $2-$25 to $5-$30 (2004).

Table II.1 (*continued*)

Work-Related Policies and Protections	
Minnesota	Individuals in day training and habilitation facilities are no longer exempt from the requirement that participants demonstrate payment of income and FICA taxes (2004).
	Amended grace period policy to allow enrollees who lose their job involuntarily or are unemployed due to a medical or disability-related condition to remain in the program for up to four months (2004). Before this change, the grace period did not apply to unemployment due to an involuntary job loss.
New Hampshire	Grace period for enrollees who become unemployed shortened from 12 to 6 months. A second 6 months may be allowed if the individuals can show medical necessity or if they have written documentation of proven job search (2005).
	Buy-In participants must earn at least the federal minimum wage (2005).
	Individuals will not be paid for participation in a program designed to enhance their ability to obtain paid employment (2005).
Vermont	Participants required to demonstrate payment of FICA taxes, Self-Employment Contributions Act tax payments or a written business plan approved and supported by a third party investor or funding source (2005).
Oregon	Increased minimum earning requirement to $920 per quarter (2005).
	Required participants to have earned income of $900 per quarter to be eligible for the Buy-In (2003).

Source: Data provided by state personnel

A. CONTINUED CHALLENGES OF TIGHT MEDICAID BUDGETS

The termination of Missouri's Medicaid Buy-In program, the largest in the country in 2004, was the most notable change in the overall Buy-In program in 2005. With more than 24 percent of the national Buy-In enrollment coming from Missouri alone, the elimination of this program in August 2005 decreased the total national Buy-In enrollment considerably.

Missouri's Buy-In was rescinded in large part because of the governor's effort to reduce Medicaid expenditures in order to curb the state's fiscal crisis. With support of the legislature, the governor eliminated several optional Medicaid eligibility groups, including the Medicaid Assistance for Workers with Disabilities (MAWD) program. The MAWD program was vulnerable because it grew quite quickly, becoming the nation's largest program in the 18 months between its inception in mid-2002 and the end of 2004. However, compared with other states, Missouri's Buy-In program had the lowest percentage of participants with reported earnings: less than 40 percent in 2004 (Liu and Ireys 2006). In 2006, a bill designed to implement a smaller, more focused Buy-In program was introduced early in the legislative session but did not pass.

The experience in Missouri has implications for other states as they try to manage their own Buy-In programs amid significant budget crises. The program's comparatively large enrollment coupled with a low percentage of wage earners cast the Missouri Buy-In program more as a Medicaid expansion than a work incentive program. The fate of the Missouri Buy-In suggests that other Buy-In programs may fare better in legislative reviews if they emphasize their work-incentive features, at least during periods of intense fiscal pressure on Medicaid budgets.

B. DEFINING WORK

The BBA and the Ticket Act both require individuals to be working at the time of application to the Buy-In program, but neither act establishes, or allows states to establish, an eligibility criterion for basic coverage groups based on a minimum number of hours worked or dollars earned in a given period.[1] In a technical assistance document sent to states in 2000 (Westmoreland 2000), CMS notes "a State cannot establish a definition of work or employment for the Basic Coverage Group (or the BBA Group) that sets a minimum standard for number of hours worked during a period of time, or a minimum level of earnings. Any such definition is inherently more restrictive than permitted under the applicable provisions of the Medicaid statute, and as such would be out of compliance with the statute."

Hence, individuals can work a very small number of hours and still be eligible for the basic Medicaid Buy-In program. On the one hand, this policy provides an opportunity for

[1] The Ticket Act explicitly requires individuals in the Medical Improvement Group to work at least 40 hours per month and earn at least minimum wage, but it makes no such provisions for the Basic Coverage Group.

adults with disabilities who have little work experience to enter into employment gradually, and still have access to Medicaid coverage. On the other hand, it can undermine the work incentive feature of the Buy-In program if many participants enroll in the Buy-In with the intention of only working a few hours per month in casual jobs.

Despite CMS's explicit prohibition against defining employment by setting a minimum number of hours worked or income earned, many states have developed eligibility requirements that aim to exclude individuals who do not have a genuine or sustained commitment to employment. For example, some states use income disregards, where a certain amount of income is defined as not countable; in order for participants to show that they are working, they must show proof of income above the disregarded amount. A few states have set explicit minimum earnings requirements, despite CMS's concern that this policy violates the intent of the federal legislation.

Although many states would like to define work explicitly because they would be able to focus the Buy-In program more deliberately on individuals who want to work above a minimum level, the issue remains unresolved. In 2005, a few states instituted new requirements and procedures as a way of underscoring the importance for participants to have a meaningful commitment to work. For example, Vermont added a requirement that participants must demonstrate payment of FICA taxes and, if applicable, Self-Employment Contributions Act taxes. Other states require Buy-In participants to document their employment status periodically by submitting pay stubs showing that they have reported income to the IRS. As a result, individuals who have only casual jobs, such as babysitting or dog walking, are excluded from these Buy-In programs.

In addition to establishing different approaches to employment verification, states also differ in the extent to which they offer work stoppage protections, otherwise known as "grace periods." About 74 percent of the states with a Buy-In program offer work stoppage protections, ranging from 2 to 24 months. Overall, grace periods help participants to stay enrolled in the Buy-In program if they lose their jobs, have to take a leave of absence because of illness, or are involuntarily laid off. In states without such protections, participants who lose their jobs become ineligible for the Buy-In program—and possibly for Medicaid as well, depending on whether they can qualify for Medicaid through some other eligibility group.

Although grace periods may influence enrollment to a small extent, they are likely to have a greater influence on the percent of participants with earnings. States with long grace periods, for example, may have a greater proportion of participants who have no earned income during the time they are not working but are still enrolled in the Buy-In program.

In 2005, possibly as part of an effort to focus their Buy-In program further on individuals with a strong attachment to the work force, New Hampshire shortened its grace period for participants who lose their jobs from 12 to 6 months. A second 6-month period may be granted, however, if individuals can show medical necessity for an extension or if they have documentation of an employment search. Also, the state now requires individuals to continue working while eligibility for the Buy-In is being determined.

C. Relationships Between the Buy-In program and Other Work Incentive Efforts

States typically have several work-incentive programs for adults with disabilities, and the implementation of a new Buy-In program both affects and is affected by these other initiatives. Two of the most important are the 1619(b) provision and the medically needy program.

Under the 1619 (b) provision of Title XVI of the Social Security Act, SSI recipients can earn up to a designated threshold, based on the cost of healthcare coverage in the state, and still maintain their Medicaid coverage even though they are not receiving SSI cash benefits. In 2005, monthly 1619(b) thresholds ranged from $1,780 to $3,713 in states with Medicaid Buy-In programs.

In general, individuals who are receiving SSI under the 1619(b) provision are likely to be interested in Buy-In programs in states with low 1619(b) thresholds because these individuals can earn more in the Buy-In compared with the 1619(b) program, and still have Medicaid coverage. In states with high 1619(b) thresholds, individuals who are in the 1619(b) program may have little incentive to enroll in the Buy-In program, especially if the Buy-In program itself has strict income eligibility criteria. For these individuals, the SSI 1619(b) provision is a better way to maintain Medicaid because they can earn just as much as they would in the Buy-In program and not be at risk for premium payments.

The 1619(b) provision is important in many states because it provides a natural stepping-stone to participation in the Medicaid Buy-In program for SSI recipients who want to make a serious commitment to employment and grow their earnings over time. In theory, SSI recipients could pursue the following employment trajectory while maintaining Medicaid coverage:

- Basic SSI, where the individual receives standard cash payments from the SSI program and works below SGA ($830 per month in 2005) if at all
- 1619(a), where the individual receives lower cash payments from the SSI program as earnings begin to rise above SGA
- 1619(b), where the individual no longer receives cash payments because earnings have continued to increase; when the earnings threshold is reached, the individual moves off the SSI program
- The Medicaid Buy-In, where the individual at first pays no premium but as earnings continue to rise begins premium payments

Few studies have examined the extent to which SSI recipients enroll in the Medicaid Buy-In program after using the 1619 provisions. In some states, however, workers with disabilities who have low earnings are encouraged specifically to take advantage of the 1619 provisions rather than the Buy-In program, which would have the effect of focusing the Buy-In program on those with more substantial earnings.

A second important program related to the Buy-In is the medically needy or spend down program. Under the provisions of this program, individuals who would have substantial medical expenses if not for enrollment in Medicaid can deduct (or "spend down") these expenses against their earnings. If the resulting amount is below a state-specified threshold, the individual remains eligible for Medicaid. This threshold is often referred to as the "protected income threshold" because it protects a certain amount of income from being counted in determining Medicaid eligibility.

The medically needy program is important for individuals with disabilities who require costly treatments or medications but who nevertheless want to keep working. These individuals can continue to work without fear of losing Medicaid – at least up to the point where earnings do not exceed the designated amount relative to the costs of their medical care. If a state has a low medically needy threshold that protects only a small amount of earnings, the Medicaid Buy-In program offers an attractive means for increasing earned income without losing Medicaid. Participation in the Buy-In also avoids the complicated paperwork involved in spend-down calculations plus potential periods of zero coverage. In contrast, if a state has a generous medically needy program (for example, the threshold is high and therefore protects a substantial amount of earnings), individuals in the medically needy program may have few incentives to enroll in the Buy-In program.

We are not aware of any state Medicaid Buy-In program that altered its eligibility criteria in 2005 to account for the state's medically needy program. However, this issue typically emerges in the early years of a Buy-In program when individuals in the medically needy program assess the relative advantages of the new Buy-In program. If the advantages are substantial, individuals who migrate from the medically needy program can account for a substantial proportion of the early growth of enrollment in a Buy-In program.

D. CHANGES IN INCOME AND ASSET ELIGIBILITY CRITERIA

Buy-In programs vary widely in the earned income limit above which individuals are not eligible for participation.[2] Some programs have relatively low ceilings. For example, in several states, individuals with disabilities who earn more than 200 percent of the FPL ($797.50 per month in 2005 for the contiguous United States) will not be eligible for the Buy-In program. In contrast, Massachusetts has no income ceiling: workers with disabilities can enroll in the state's Buy-In program regardless of their earned income. Generally speaking, setting income limits at high levels or raising existing limits increases the number of potential Buy-In applicants.

Some states also set limits on unearned income, which includes cash payments through the SSDI and SSI programs. Arkansas, for example, has an unearned individual income limit of $579; Maine's unearned income limit is 100 percent of the FPL ($798 in 2005), including spousal income. Michigan's unearned income limit is the same as Maine's except spousal

[2] As mentioned previously, the BBA requires states to set income limits at 250 percent of the federal poverty level (FPL) and assets at $2,000. The Ticket Act does not impose an upper limit.

income is excluded. A few states (such as New Hampshire) adjusted income and asset limits in 2005 to account for increases in the cost of living, but many others did not. Setting limits on unearned income can directly affect the number of SSDI recipients who enroll in a Buy-In program. In December 2004, the average monthly SSDI payment for disabled workers was $894. If a state Buy-In program sets unearned income eligibility limits that are near or below this amount, SSDI beneficiaries are less likely to enroll. In West Virginia's program, for example, an applicant's unearned income had to be equal to or less than $604 in 2005; largely because of this requirement, only 1.5 percent of participants in the state's Buy-In program were SSDI beneficiaries.

In addition, states vary in the amount of assets that they allow individuals to have at the time of application. Some states set a limit of $2,000 on individual assets; other states have no asset limits. Generally, high asset limits mean that a larger pool of workers will be eligible for the Buy-In program, and increases in asset limits could lead over time to somewhat higher enrollment. In 2005, for example, Vermont increased its asset limit from $2,000 for an individual and $3,000 for a couple to $5,000 and $6,000, respectively. This change may contribute eventually to higher enrollment in the state's program, although the effect is likely to be small because, historically, Buy-In applicants do not have substantial assets.

E. SETTING PREMIUM STRUCTURES

Because neither the Ticket Act nor the BBA provides guidelines on premiums or co-payments, states have constructed widely different approaches to the "buy in" feature of their Medicaid Buy-In programs (Table II.2). In some states, virtually all Buy-In participants pay something toward their coverage that other Medicaid beneficiaries do not, either in the form of a flat fee, a premium that varies by income, or higher co-payments for services. In other states, most participants pay no premiums or co-payments because their income is below the state's premium threshold. A few states do not charge premiums or co-payments to any Buy-In participant.

In addition, some states believe that the total dollars collected through premiums are not worth the cost of setting up a collection system. For example, when New Jersey implemented its Buy-In program in 2000, the state decided that it would charge a flat rate for participants; however, New Jersey has never actually collected a premium because the revenue from premiums would not be sufficient to offset the associated administrative costs.

Vermont established a premium structure for the Buy-In program during the program's initial implementation in 2000, increased rates in 2003, and then eliminated the premium requirement altogether in 2004. South Carolina also decided not to charge a premium when it established its program in 1998 because the projected administrative cost was larger than the amount of premiums the state thought it could collect from their participants. In 2005, only New Hampshire reported changing any premium requirement and now allows Buy-In participants the opportunity to pay their premiums over a three- month period based on financial burden and good cause (as determined by the billing or collection agency). This payment plan is only available to enrollees every two years.

Overall, the extent of variation among states with respect to this issue underscores the absence of generally accepted methods for establishing a premium rate structure for Buy-In programs.

Table II.2 Premium Thresholds and Structures in State Medicaid Buy-In Programs, 2005

State	Premium Threshold	Premium Structure (Monthly)
Alaska	100% FPL	A sliding-scale premium as a fixed percentage of income. The maximum premium is 10 percent of net family income.
Arkansas	Not Applicable	No premium required. Co-payments higher than those for regular Medicaid are required when income is above 100% FPL.
California	Net countable income of $1	A sliding-scale premium is based on net countable income. For income from $1 up to 250% FPL, premiums range from $20 to $250 for an individual and $25 to $375 for a couple.
Connecticut	200% FPL	Premiums equal 10% of total income above 200% FPL
Illinois	100% FPL	Premium payment categories are calculated based on the sum of 7.5% of unearned and 2% of earned income.
Indiana	150% FPL	Based on percentage of applicant's and spouse's gross income according to family size.
Iowa	150% FPL	Based on sliding scale premium schedule with 11 premium brackets, from $22 to $355
Kansas	100% FPL	Sixteen premium amounts based on income brackets from $55 to $152 for individual and $74 to $205 for two or more. Cannot exceed 7.5% of income.
Louisiana	150% FPL	$80 for 150%- 200%, $110 for 200%-250% FPL
Maine	150% FPL	$10 premium for 150%-200% FPL, $20 for 200%-250% FPL
Massachusetts	100% FPL	Premiums based on two different sliding scales—one for enrollees with other health coverage, one for enrollees without it. Premiums begin at 100% and increase in increments of $5 to $15 based on 10% increments of FPL.
Michigan	250% FPL	Based on sliding scale ranging from $50 to $920 per month.
Minnesota	All enrollees must pay a minimum premium of $35	Premiums based on a minimum of $35 or a sliding fee scale based on income and household size. The premium gradually increases to 7.5% of income for incomes equal to or above 300% of FPL. Must also pay 0.5 percent of unearned income. No maximum premium amount.
Nebraska	200% FPL	Sliding scale based on income ranging from 2% of income if income is from 200% to 210% of FPL to 10% of income if income is from 240% to 250% of FPL.
Nevada	All enrollees pay at least 5%	Enrollees who earn a monthly net income of $1,595 or less pay 5% of income. Those earning more than $1,595 (up to $1,994) pay 7.5% of income.
	150% FPL	Six brackets from $89 to $239 for individuals.

Table II.2 (*continued*)

State	Premium Threshold	Premium Structure (Monthly)
New Hampshire		Individuals with gross income (spousal included) that exceeds $75,000 are required to pay premiums of 7.5% of the adjusted gross income
New Jersey	150% FPL	Flat rate: $25 individual; $50 couple but is not currently being collected.
New Mexico	Not applicable	No premium required. Co-payments higher than those for regular Medicaid are required at all income levels; clients' responsibility to keep track of co-payments
New York	150% of FPL	3% of net earned income plus 7.5% of net unearned income. Premiums not collected until automated collection and tracking processes are available.
North Dakota	All participants are required to pay a premium	5% of an individual's gross income
Oregon	After 6 months, income in excess of $2,200/month; Unearned income above the SSI level	"Cost share" equal to 100% of unearned income above SSI standard. Premium equal to gross income plus unearned income remaining after "cost share" is paid minus (1) mandatory taxes; (2) approved employment and independence expenses; and (3) 200 percent of FPL, and multiplying the remainder by 2% to 10%.
Pennsylvania	All participants pay a premium	5% of countable income. Premiums of less than $10 are waived.
South Carolina	Not applicable	Premium not required.
Utah	100% FPL	15% of countable income
Vermont	Not Applicable	Premium eliminated in June 2004.
Washington State	$65 earned income and/or $579 unearned income	The lesser of (1) 7.5% total income or (2) a total of the following: 50% unearned income above MNIL plus 5% total unearned income plus 2.5% earned income after deducting $65
West Virginia	All enrollees must pay a minimum premium of $15	Premiums are 3.5% of countable income with a $15 minimum amount. Enrollees must also pay an enrollment fee of $50, which includes the first month's premium.
Wyoming	All enrollees pay a premium	Premiums are 7.5% of earned income and 7.5% of unearned annual income over $600
Wisconsin	150% FPL	Equal to the sum of (1) 3% of an individual's earned income, and (2) 100% of unearned income minus certain needs and expenses and other disregards. If the second calculation is less than $25, this component of the premium is $0.

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CHAPTER III

ENROLLMENT

Analysis of data on enrollment in the Medicaid Buy-In program can provide insights into how well the Buy-In program is attracting new enrollees, reaching its target population, and operating as intended. Examining enrollment data in relation to specific program features (such as income limits) and economic indices (such as statewide unemployment rates) can help to explain why some enrollment trends differ across states. Overall, a better understanding of the factors affecting enrollment can suggest strategies that program administrators can use to better focus the program on those workers with disabilities who are most likely to benefit from participation in the Medicaid Buy-In program.

In this chapter, we address both national and state enrollments in the Medicaid Buy-In program by first describing trends in several quantitative indicators of enrollment, and then by examining data on selected factors affecting these indicators. As noted in Chapter I, our analyses are based on individual-level data for all participants in state Buy-In programs from their inception through December 2005. These data allow us to examine certain enrollment trends (for example, duration of enrollment and number of times participants re-enrolled) with greater precision than was possible in prior years.

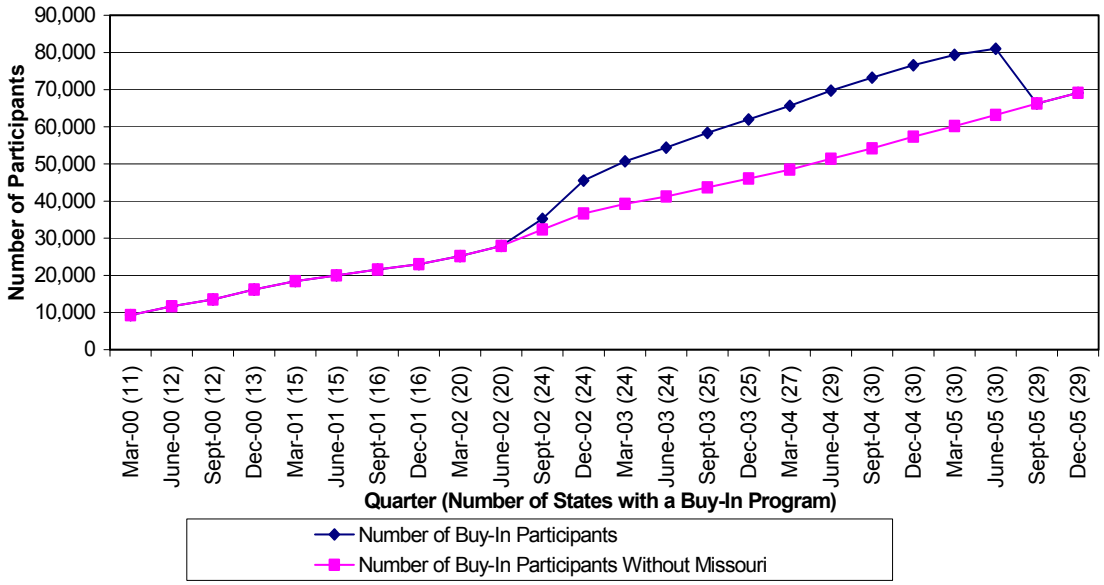
A. NATIONAL BUY-IN ENROLLMENT

As noted in the previous chapter, Missouri rescinded its Buy-In program effective August 2005. Because it had the largest Buy-In enrollment of any state (nearly 18,000 participants in June 2005), its departure made a significant impact on the national Buy-In enrollment. In June 2005, total enrollment in the Medicaid Buy-In program was slightly more than 80,000; three months later, it was about 65,000 (Figure III.1).

However, when considering all other states besides Missouri, quarterly growth in the Medicaid Buy-In program was remarkably consistent from January 2004 to December 2005. Quarterly growth rates ranged from 4.2 to 6.1 percent, with an average increase of about 5 percent. Excluding Missouri, enrollment was 69,092 in December 2005, up from 57,290 one

year earlier; this amounts to an increase of 20.6 percent in 2005 compared with a 24.4 percent increase in 2004 for the same states.[1]

Figure III.1: National Buy-In Enrollment By Quarter, 2000-2005



B. STATE BUY-IN ENROLLMENT

In December 2005, enrollment in 29 state Buy-In programs ranged from 8 participants (Wyoming) to 9,746 participants (Massachusetts), as Table III.1 shows. Although the total number of Buy-In participants is useful for tracking enrollment within each state, it does not account for differences in the number of adults with disabilities who live in each state—a figure that is particularly important when making cross-state comparisons. Therefore, we also examined Buy-In enrollment in relation to the total number of adults with disabilities estimated to live in each state. Using this indicator, enrollment in the Buy-In programs ranged from about 1 person to 457 persons per 10,000 working-age state residents with a disability (Table III.1). We refer to this indicator as a "penetration rate" because it is a rough measure of the extent to which a Buy-In program has reached into a state's population of adults with disabilities.[2] (Appendix Table C.2 shows the percent of working-age adults with a disability, the denominator of the penetration rate, by state.)

[1] With Missouri data included, total enrollment was 76,557 in December 2004 and 69,092 in December 2005, a decrease of 9.8 percent.

[2] In MPR's previous report on Buy-In enrollment (see Black and Ireys 2006), the penetration rate was calculated using a broader population denominator (state residents of working age) rather than working-age state residents with disabilities, which we use in this report. When we compared the two approaches, state rankings changed minimally. We used the disability-specific denominator for this report because it is more

Table III.1: Enrollment In The Medicaid Buy-In Program, By State, 2005

State	Implementation Date	Buy-In Enrollment: December, 2005	Rank[a]	Buy-In Enrollment per 10,000 State Residents with a Disability Age 16 to 64 ("Penetration Rate") December, 2005	Rank[b]
Iowa	March, 2000	9,541	3	457.2	1
Wisconsin	March, 2000	9,718	2	257.7	2
Massachusetts	July, 1997	9,746	1	228.7	3
Minnesota	July, 1999	6,642	4	206.8	4
Connecticut	October, 2000	4,039	7	185.1	5
New Hampshire	February, 2002	1,419	12	148.6	6
Vermont	January, 2000	606	18	114.6	7
Indiana	July, 2002	5,807	5	113.7	8
New Mexico	January, 2001	1,563	11	87.2	9
North Dakota	May, 2004	340	22	83.1	10
Pennsylvania	January, 2002	5,756	6	59.1	11
Maine	August, 1999	716	17	55.1	12
Kansas	July, 2002	1,013	13	51.4	13
New Jersey	February, 2000	1,904	9	38.0	14
Alaska	July, 1999	212	24	36.0	15
New York	July, 2003	4,013	8	29.9	16
Utah	July, 2001	374	21	22.3	17
Oregon	February, 1999	586	19	18.8	18
Louisiana	January, 2004	796	15	18.0	19
Washington	January, 2002	792	16	14.5	20
Illinois	January, 2002	800	14	10.0	21
Nebraska	July, 1999	113	25	9.3	22
West Virginia	May, 2004	216	23	9.1	23
California	April, 2000	1,777	10	7.5	24
Michigan	January, 2004	579	20	6.9	25
Arkansas	February, 2001	112	26	3.6	26
Wyoming	July, 2002	8	29	1.9	27
Nevada	July, 2004	22	28	1.5	28
South Carolina	October, 1998	40	27	1.0	29
Total		69,092		55.9	

Source: Participant-level data submitted by states (April 2006) and data from the 2005 American Community Survey (ACS).

[a]Rank is Buy-in enrollment as of December 2005.
[b]Rank is Buy-in enrollment per 10,000 state residents with a disability age 16 to 64 (the penetration rate) as of December 2005.

(*continued*)
relevant to the Buy-In population. Additional information on the comparison between the two approaches is available from the authors.

In order to calculate penetration rates, we used data from the Census Bureau's 2005 American Community Survey (ACS) on the number of working-age adults with disabilities in each state as the denominator for the penetration rate. Analyses of ACS data are useful because they provide a consistent indicator of the size of the population of working-age adults with disabilities across all states. However, the methods used in the ACS to identify individuals with disabilities are not the same as the methods used by SSA or states to determine disability status.[3] Consequently, not all individuals with disabilities identified in the ACS have disabling conditions that could qualify them for the Medicaid Buy-In program.

In large part, the cross-state variation in penetration rates, illustrated in Table III.1, reflects differences in state Buy-In programs' eligibility criteria and outreach efforts. Because each state focuses on somewhat different groups of individuals, the cross-state variation in penetration rates is expected. For example, some states have crafted their Buy-In program to exclude individuals with substantial unearned income. Other states have launched aggressive campaigns to inform potential participants about the Buy-In program.

C. STATE-LEVEL ENROLLMENT GROWTH

Enrollment in state Medicaid Buy-In programs typically grows quickly in the first year or two after initial implementation, and then slows considerably (Table III.2). For states with at least four years of program data (that is, states that implemented programs before 2003), enrollment growth averaged 67 percent between the first and second years, compared with a 34 percent growth rate between the second and third years, and a 22 percent growth rate between the third and fourth years. In a few states (for example, Massachusetts and Utah), enrollment trends did not follow the typical pattern, possibly reflecting the effects of certain program-related factors, changes in eligibility requirements, or extent of outreach.

As mentioned earlier, the average enrollment growth during 2005 was 20.6 percent across 29 states with a Buy-In program as of December 2005. However, states varied widely with respect to their own growth rates, depending on the year of program implementation. States implementing Buy-In programs from 1997 through 1999 had an average enrollment growth of 10.9 percent in 2005; states implementing programs in 2000 through 2002 had a growth rate of 20.4 percent; and states implementing programs in 2003 or 2004 had an increase of 67.8 percent.

Six of the seven early implementer states (defined as those that implemented a Buy-In before 2000) witnessed a decrease in enrollment at some point after the initial enrollment

[3] The Census Bureau defines disability as a self-reported long-lasting sensory, physical, mental, or emotional condition that can make it difficult for the person to do activities such as walking, climbing stairs, dressing, bathing, remembering, or being able to go outside the home alone or do work at a job or business. For definitions and the specific items related to disability that were used in the American Community Survey, see 2005 Subject Definitions at http://www.census.gov/acs/www/UseData/Def.htm.

Table III.2: Percent Change in Enrollment In Medicaid Buy-In Programs, by State, 1997-2005

Year of Program Implementation	State	Percent Change in Enrollment Over Prior Year: 1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1997	Massachusetts	23	34	35	24	27	3	8	17
1998	South Carolina		128	90	12	-9	-33	2	-26
1999	Alaska[a]			N/A	55	46	18	8	-1
1999	Maine			291	36	8	-16	11	8
1999	Minnesota			77	8	0	4	-4	5
1999	Nebraska			212	3	-4	8	10	-9
1999	Oregon			4,088	52	19	2	-5	0
2000	California				127	32	30	32	50
2000	Connecticut				104	26	19	13	21
2000	Iowa				63	47	26	24	17
2000	New Jersey				5,300	99	62	41	29
2000	Vermont				43	27	12	10	10
2000	Wisconsin				83	124	48	37	24
2001	Arkansas					-44	-15	12	7
2001	New Mexico					63	27	25	20
2001	Utah					17	8	31	20
2002	Illinois					2,909	66	26	15
2002	Indiana						49	16	-13
2002	Kansas						39	25	19
2002	New Hampshire						25	13	-1
2002	Pennsylvania						103	79	82
2002	Washington						66	90	71
2002	Wyoming						33	25	60
2003	New York							185	48
2004	Louisiana								67
2004	Michigan								1,897
2004	Nevada								214
2004	North Dakota								34
2004	West Virginia								167
	Total % Change:	24	166	132	42	59	26	24	21

Source: Participant-level data submitted by states (April 2006)

[a]Alaska implemented a Buy-In program in 1999, but no participants enrolled until 2000.

increase (Table III.2). Between 2002 and 2003, for example, enrollment decreased by 33 percent in South Carolina's program and 16 percent in Maine's. In contrast, few of the 23 state programs implemented in 2000 or later have had enrollment decreases. This pattern may result from the fact that the later-implementing programs have had fewer years of operation in which to experience an enrollment dip or from other factors related to program design. It could also have to do with overall macroeconomic trends, such as employment rates.

Another indicator of enrollment in Medicaid Buy-In programs involves the extent to which participants stay in the program for long periods of time or dis-enroll and then re-enroll frequently. This issue is important because continued enrollment likely reflects a strong attachment to the work force. We examined this issue for an 18-month time period (July 2004 to December 2005) for all states except those that implemented a program in 2003 and 2004. (These were excluded to avoid the effect of rapid enrollment increases typical of new programs.) We examined the retention rate and rate of re-enrollment among those who began an enrollment spell (defined as a continuous period of enrollment) in the Buy-In during this period.

In all states, more than 84 percent of individuals had only one enrollment spell during this 18-month period (Table III.3). This indicates a relatively low rate of re-enrollment overall. However, the states varied widely on participant retention, or the percent who remained continuously enrolled through the end of the 18-month period we examined. In some states (for example, Iowa, New Jersey, and Arkansas), more than 80 percent of individuals stayed enrolled through the end of the 18 month period. In other states (for example, Alaska and Indiana), slightly more than 50 percent stayed enrolled through the end of this period. Several factors may contribute to this variation, including program features and state economic conditions.

Grace periods also appear to play a role in enrollment duration. One would expect that, on average, participants in states with a grace period would tend to be enrolled for more months than participants in states without one. Analyses generally support this hypothesis: Average enrollment duration was 22.5 months in states with grace periods of at least four months, compared with an average enrollment duration of 19.3 months in states with no grace periods (results not shown)

D. EXAMPLES OF FACTORS AFFECTING ENROLLMENT

Many factors interact to influence enrollment trends in a Medicaid Buy-In program, including the program's administrative parameters, income thresholds for related public programs (for example, the SSI or medically needy programs), and the larger economic environment. To illustrate key relationships, we examine two of the many variables that shape enrollment in the Buy-In program: (1) a program's income and asset limits and (2)

Table III.3: Participant Retention And Re-Enrollment, By State, July 2004- December 2005

Implementation Year	State	Number Enrolling in the Buy-In Between July 2004 and December 2005[a]	Percent with Only One Enrollment Spell	Number with Only One Enrollment Spell	Of Those with Only One Enrollment Spell, Percent who Remained Continuously Enrolled from July 2004- December 2005
1997	Massachusetts	6,081	97.8	5,947	71.6
1998	South Carolina	22	100.0	22	68.2
1999	Alaska	205	95.6	196	52.0
1999	Maine	606	95.7	580	54.8
1999	Minnesota	2,078	95.1	1,976	76.0
1999	Nebraska	96	96.9	93	59.1
1999	Oregon	277	99.3	275	78.2
2000	California	1,421	98.7	1,402	78.9
2000	Connecticut	1,986	90.9	1,805	80.7
2000	Iowa	4,162	97.3	4,050	84.6
2000	New Jersey	1,041	99.1	1,032	88.1
2000	Vermont	398	93.2	371	55.3
2000	Wisconsin	5,091	94.4	4,806	81.3
2001	Arkansas	21	100.0	21	95.2
2001	New Mexico	1,396	97.6	1,362	75.7
2001	Utah	553	84.6	468	32.9
2002	Illinois	538	98.0	527	73.8
2002	Indiana	4,399	92.1	4,051	52.7
2002	Kansas	541	97.4	527	81.2
2002	New Hampshire	1,032	93.9	969	56.0
2002	Pennsylvania	4,817	97.1	4,678	83.4
2002	Washington	651	97.8	637	83.7
2002	Wyoming	8	100.0	8	75.0
	Total:	37,420	95.7	35,803	74.3

Source: Participant-level data submitted by states (April 2006)

[a]Includes all Buy-In participants who began a spell of Buy-In enrollment at some time between July 1, 2004 and December 31, 2005, including those who may have been enrolled in the Buy-In previously under a separate spell of enrollment.

selected economic factors in the state. Information on the effect of other potentially important factors can be found elsewhere (Black and Ireys 2006, Jensen et. al 2002).[4]

1. Income and Asset Criteria

Numerous factors influence enrollment in a Buy-In program and some of them, such as eligibility criteria, can be used by administrators to manage program access. In particular, three eligibility criteria have the most direct effect on enrollment levels:

- Earned income
- Unearned income and
- Assets

To assess the effects of these program features on enrollment, we constructed an index of restrictiveness to distinguish programs that are minimally restrictive from those that are maximally restrictive. States were scored based on their restrictiveness in each of the three categories and a total score, ranging from 0 to 12, was calculated as illustrated in Table III.4.

Table III.4: Index of Eligibility Restrictiveness

Threshold	Category	Score
Earned Income	No Limit	0
	450% to 800% FPL	1
	300% to 350% FPL	2
	250% FPL	3
	220% to 225% FPL	4
	200% FPL	5
Asset Limit	No Limit	0
	$20,000 to $25,000	1
	$12,000 to $15,000	2
	$8,000 to $10,000	3
	$4,000 to $5,000	4
	$2,000	5
Separate Unearned Income Limit	No	0
	Yes	3
Total Score		0 to 12

[4]Examining the effect of some factors is problematic either because states vary considerably in how they structure certain components of their programs or because the effect is so small that it is difficult to measure. For example, one would assume that states with higher premiums would be less attractive to potential applicants than states with lower premiums, all other things being equal. However, states vary so widely in relation to premium structures (see Table II.2) that comparisons are not practical. In theory, the stringency of income verification procedures also could influence enrollment if some individuals elected not to enroll because they would have to document their earnings frequently. The effect of this, however, is likely to be small and difficult to measure accurately.

We then examined the index of restrictiveness in relation to penetration rates (Table III.5). For example, Massachusetts has no limit on participants' earned income, unearned income, or assets, giving it a score of 0 (meaning minimally restrictive). Wyoming has fairly stringent limits on these three criteria, giving it a score of 12 (meaning highly restrictive). As expected, Massachusetts' penetration rate of 229 persons per 10,000 adults with disabilities is higher than Wyoming's rate of 2 persons (Table III.5). While the association between penetration rates and the index of eligibility restrictiveness is not perfect (Vermont, for example, has fairly restrictive criteria but a relatively high penetration rate), it demonstrates that program administrators have several mechanisms through which they can directly influence Buy-In enrollment.[5]

2. State Economic Factors

In addition to the income and asset criteria noted above, several other factors external to the Medicaid Buy-In program can affect Buy-In enrollment. These features include (1) the employment environment for individuals with disabilities, as indicated by the state percent of SSI recipients who worked in 2005;[6] and (2) the general work environment, as indicated by the state unemployment rate in 2005. A state's employment environment for individuals with disabilities, including level of employment support and employer attitudes toward hiring individuals with disabilities, theoretically influences the ability and desire of individuals with disabilities to work. A state's unemployment rate gauges the availability of work for all residents, including those with disabilities. We examined these two external indicators in relation to state penetration rates.

In general, states with high penetration rates had higher rates of SSI recipients who were employed in 2005 (Table III.6). For example, Iowa had a penetration rate that was the highest among the states we examined and also had the largest percentage of SSI recipients who worked. California had a low penetration rate compared with other Buy-In states and had a low percentage of SSI recipients who worked. In the eight states with the highest penetration rates, an average of 9.9 percent of SSI recipients worked in 2005. In the seven states with the lowest penetration rates, an average of 5.5 percent of SSI recipients worked in 2005.

States with high penetration rates also tended to have low unemployment rates. In the eight states with the highest penetration rates, the unemployment rate in 2005 was 4.7 percent on average. In the seven states with the lowest penetration rates, the unemployment rate in 2005 was 5.1 percent on average.

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[5] For readers interested in the relevant correlation coefficient, we found the correlation between penetration rate and eligibility restrictiveness to be -0.48.

[6] Rather than using percent of SSDI recipients who work as the indicator here, we used percent of SSI recipients who work because this percentage will be fairly exogenous to the effect of the Buy-In program. Many SSDI recipients who work also will be enrolled in the Buy-In, thereby diminishing its value as an independent indicator of employment.

Table III.5: Buy- In Features Affecting Enrollment: Income And Asset Limits

State	Implementation Date	Buy-In Enrollment per 10,000 State Residents with a Disability Age 16 to 64		Buy-in Income and Asset Limits:			Index of Eligibility Restrictiveness
		December, 2005	Rank	Earned Income Threshold (Percent of FPL)	Individual Asset Limit	Unearned Income Limit	
Iowa	March, 2000	457.2	1	250[a]	12,000[c]	No	5
Wisconsin	March, 2000	257.7	2	250[a]	15,000[c]	No	5
Massachusetts	July, 1997	228.7	3	No Limit	No Limit	No	0
Minnesota	July, 1999	206.8	4	No Limit	20,000	No	1
Connecticut	October, 2000	185.1	5	783[f]	10,000	No	4
New Hampshire	February, 2002	148.6	6	450	22,694[dh]	No	2
Vermont	January, 2000	114.6	7	250[a]	5,000[ch]	Yes	10
Indiana	July, 2002	113.7	8	350	2,000	No	7
			Average				**4.6**
New Mexico	January, 2001	87.2	9	250[ag]	10,000	Yes	9
Pennsylvania	January, 2002	59.1	10	250[af]	10,000[c]	No	6
Maine	August, 1999	55.1	11	250 [af]	8,000[c]	Yes	4
Kansas	July, 2002	51.4	12	300[af]	15,000[c]	No	4
New Jersey	February, 2000	38.0	13	250[a]	20,000	Yes	7
Alaska	July, 1999	36.0	14	250[a]	2,000[c]	Yes	11
Utah	July, 2001	22.3	15	250[af]	15,000[c]	No	5
Oregon	February, 1999	18.8	16	250[g]	5,000	No	7
			Average				**6.6**
Washington	January, 2002	14.5	17	220 [af]	No Limit	No	4
Illinois	January, 2002	10.0	18	200[af]	10,000[c]	No	8
Nebraska	July, 1999	9.3	19	250[ag]	4,000[c]	Yes	10
California	April, 2000	7.5	20	250 [af]	2,000	Yes	11
Arkansas	February, 2001	3.6	21	250[a f]	4,000	Yes	4
Wyoming	July, 2002	1.9	22	225[ai]	2,000[c]	Yes	12
South Carolina	October, 1998	1.0	23	250[af]	2,000	Yes	11
			Average				**8.6**
Median:		55.1		250	10,000	No	5

Table III.5 (*continued*)

[a]Includes spousal income
[b]Includes spousal income
[c]Includes spousal assets
[d]For a married couple, NH's asset limit is $34,041
[e]West Virginia has an additional $5,000 liquid asset exclusion
[f]Includes earned plus unearned income, after disregards and exclusions
[g]Nebraska has a two-part income test- (1) The sum of the spouse's earned income and all unearned income must be less than SSI standard; (2) Countable income up to 250% FPL.
[h]Disregards assets accumulated since enrollment
[i]Wyoming's income and asset limit is 300% of the SSI income standard, approximately 225% of the federal poverty level, for both income and assets combined.
[j]Vermont has a two-part income test: (1) Family net income less than medically needy protected income level after disregarding earnings, SSDI benefits, and veteran's benefits (2) Family net income less than 250% FPL.

Sources: Participant-level data submitted by states (April 2006) and the Ticket to Work Medicaid Infrastructure Grant Reporting website (http://www.dehpg.net/TicketToWork/Finder.aspx)

Note: Only states implementing Buy-In programs in 2002 and earlier are included in this table. This allows for more equal comparison on enrollment-related indicators because states that have recently implemented a program are still in the stage of rapid enrollment growth, which can hide or distort the effect of other indicators

Table III.6: Contextual Features Affecting Buy-In Enrollment: Percent of SSI Beneficiaries Employed And State Unemployment Rates In 2005

State	Buy-In Enrollment per 10,000 State Residents Age 16 to 64 with a Disability: As of December, 2005	Rank	Contextual Features (Percent): SSI Recipients Who were Employed in 2005	2005 State Unemployment Rate
Iowa	457.2	1	16.2	4.6
Wisconsin	257.7	2	11.8	4.7
Massachusetts	228.7	3	7.3	4.8
Minnesota	206.8	4	15.3	4.0
Connecticut	185.1	5	8.2	4.9
New Hampshire	148.6	6	9.8	3.6
Vermont	114.6	7	9.3	3.5
Indiana	113.7	8	6.1	5.4
		Average	**9.9**	**4.7**
New Mexico	87.2	9	4.9	4.4
Pennsylvania	59.1	10	5.3	5.0
Maine	55.1	11	7.2	4.8
Kansas	51.4	12	11.1	5.1
New Jersey	38.0	13	6.4	4.4
Alaska	36.0	14	6.6	6.8
Utah	22.3	15	10.8	4.3
Oregon	18.8	16	7.6	6.1
		Average	**6.3**	**4.9**
Washington	14.5	17	5.9	5.5
Illinois	10.0	18	5.9	5.7
Nebraska	9.3	19	14.6	3.8
California	7.5	20	5.2	5.4
Arkansas	3.6	21	4.5	4.9
Wyoming	1.9	22	15.0	3.6
South Carolina	1.0	23	5.2	6.8
		Average	**5.5**	**5.5**
Average	67.9		6.6	5.1

Sources: Participant-level data submitted by states (April 2006); SSI Disabled Recipients Who Work, 2005 (released May 2006). Available at: http://www.ssa.gov/policy/data_sub109.html#sub122; Local Area Unemployment Statistics. Bureau of Labor Statistics. Available at: http://data.bls.gov/PDQ/outside.jsp?survey=la

Note: Only states implementing Buy-In programs in 2002 and earlier are included in this table. This allows for more equal comparison on enrollment-related indicators because states that have recently implemented a program are still in the stage of rapid enrollment growth, which can hide or distort the effect of other indicators.

Although neither the percent of SSI workers nor the state unemployment rate is perfectly associated with penetration rates, the relationship is strong enough to show that enrollment in state Buy-In programs is affected by broad economic factors, in addition to specific program features discussed previously.[7]

E. SUMMARY AND IMPLICATIONS

Many factors influence states' Medicaid Buy-In enrollment levels. The analyses presented in this chapter demonstrate that some program factors, such as income and asset criteria, have direct and substantial effects on enrollment, most likely by altering the number of those eligible to enroll. Other program factors have somewhat weaker or more indirect effects on enrollment. Our analyses show, for example, that in states with grace periods, participants tend to have somewhat longer periods of enrollment compared with participants in states without grace periods.

Several other program-related features are likely to shape enrollment in the Medicaid Buy-In program but are difficult to quantify reliably. For example, some states have engaged in more outreach efforts to inform potential participants about the Medicaid Buy-In program than other states. These efforts may substantially increase applications for the Buy-In program, which in turn could lead to increased enrollment. To date, however, this issue has not been examined systematically, in part because it is difficult to quantify outreach efforts.

As previous reports noted (Black and Ireys, 2006), the availability and income thresholds of programs that provide alternative pathways to Medicaid coverage (such as the SSI 1619 provisions and the medically needy program) can influence enrollment in the Buy-In program by shaping its relative attractiveness to potential Buy-In applicants. The Buy-In program will offer a greater benefit to the extent that these other programs are either unavailable or have low thresholds on allowable income, relative to the limits set for the Buy-In itself. Similarly, the availability and generosity of state SSI supplementation also may influence the attractiveness of Buy-In enrollment among SSI recipients; potential participants in states with generous state supplementation may have to earn more to make it worth their while to give up their SSI cash benefits than potential participants in states with low or no state supplementation.

Finally, employer attitudes toward hiring individuals with disabilities, which vary by state and region, may have substantial influence on the ability of potential Buy-In participants to find and keep competitive work. Research studies have just begun to examine employer attitudes, and results of these studies may have important implications for outreach and marketing efforts related to the Buy-In program.

[7] For readers interested in the relevant correlation coefficient, we found the correlation between penetration rate and percent of SSI recipients who work to be 0.49, and the correlation between penetration rate and state unemployment rate in 2005 to be –0.27.

In sum, our analyses in this chapter suggest three important conclusions:

1. Federal and state Medicaid administrators and policymakers can use several administrative mechanisms to shape Buy-In enrollment. Altering income and asset criteria probably have the most direct effects on enrollment, but grace periods, income verification procedures, and the extent of outreach efforts may also impact enrollment.

2. Broad economic factors, such as employer attitudes and unemployment rates can affect enrollment in the Medicaid Buy-In program.

3. The factors affecting the *number* of participants enrolling a Buy-In program can also shape the *characteristics* of these participants. In turn, the composition of the group of participants in a state's Buy-In program determines that program's overall profile on measures of earnings and medical expenditures. A program, for example, that attracts younger workers with disabilities could have a different profile compared with a program that primarily attracts their older counterparts. We will examine these issues more closely in the next chapter.

CHAPTER IV

PARTICIPANT CHARACTERISTICS

In addition to understanding enrollment trends in the Medicaid Buy-In program, policymakers and program administrators usually want to know who is participating and whether the mix of participants is consistent with program goals. In this chapter, we address these questions by providing information on characteristics of Medicaid Buy-In participants. Specifically, this chapter examines participants in state Buy-In programs in terms of their:

- Demographic characteristics
- Primary disabling condition and
- Prior and current participation in other public programs including
  - SSDI
  - SSI (including the 1619(b) provision) and
  - Medicare

By examining these participant characteristics, policymakers and program administrators can begin to assess whether current policies and outreach efforts are effective in reaching the various groups of adults with disabilities for whom the Medicaid Buy-In program was designed.

To conduct the analyses presented in this chapter, we used data from the following two sources:

- State-submitted finder files, which provide data on the age, gender, and ethnicity (white or non-white) of all Buy-In participants ever enrolled from program inception through 2005[1] and

[1] We included data from Missouri in these analyses because the program was not rescinded until August 2005.

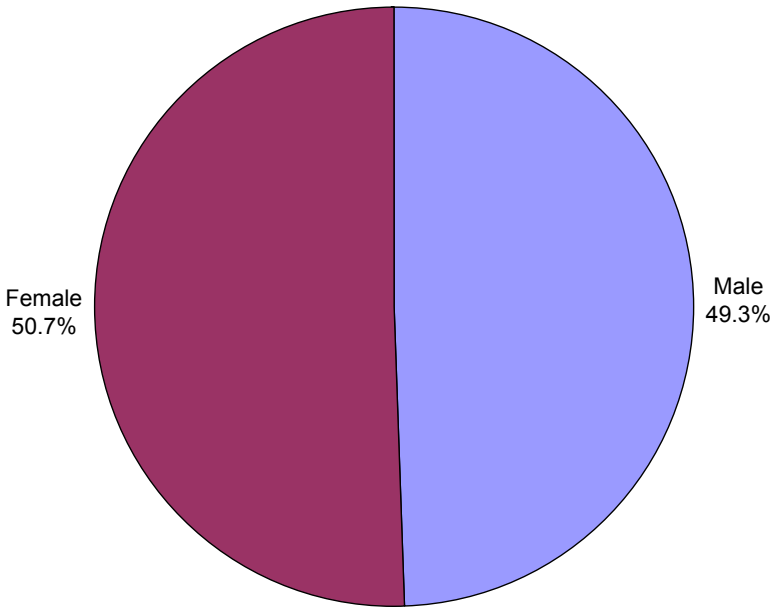
- The Ticket Research File (TRF), which provides data on ethnicity, primary disabling condition, and receipt of SSI, SSDI, or Medicare for individuals who received SSI or SSDI benefits between 1996 and 2005 and were between the ages of 18 and 64 when receiving these benefits.

About 84 percent of Buy-In participants received SSDI and/or SSI benefits at some point between 1996 and 2005. Therefore, TRF data are not available for the remaining 16 percent who were not SSI or SSDI recipients during this period, or were not between the ages of 18 and 64 when receiving the benefits. States vary widely on the percent of Medicaid Buy-In participants who are not in the TRF data. West Virginia has the highest proportion of participants who are not in the TRF data (87.1 percent), while Kansas has the lowest (1 percent).

A. DEMOGRAPHIC CHARACTERISTICS

Roughly equal numbers of men and women have enrolled in the Medicaid Buy-In program (Figure IV.1). California has the highest percent of male enrollees (56.4 percent), while West Virginia has the lowest (31.8 percent). (Appendix Tables D.1 and D.2 provide demographic information on Buy-In participants in each state.)

Figure IV.1: Gender of Individuals Ever Enrolled in the Medicaid Buy-In Program, 1997-2005

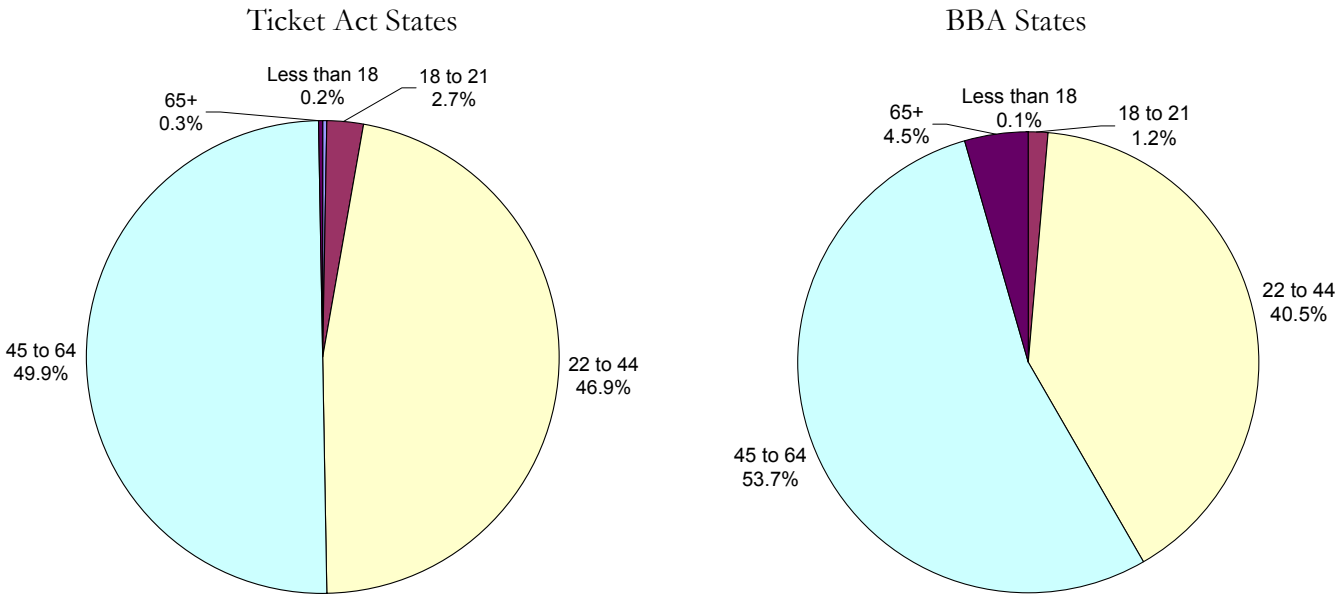


Sources: Finder files submitted by states (April 2006) and the Ticket Research File (TRF).

Nationally, the majority (50.7 percent) of Buy-In participants are in the 45-to-64 age group, but the age distribution is somewhat different for states with programs authorized under the BBA, compared with programs authorized under the Ticket Act (Figure IV.2)

because the BBA allows individuals age 65 and over to enroll, while the Ticket Act restricts enrollment to working-age adults under 65.

Figure IV.2: Age of Individuals Ever Enrolled in the Medicaid Buy-In Program, 1997- 2005



Sources: Finder files submitted by states (April 2006) and the Ticket Research File (TRF)

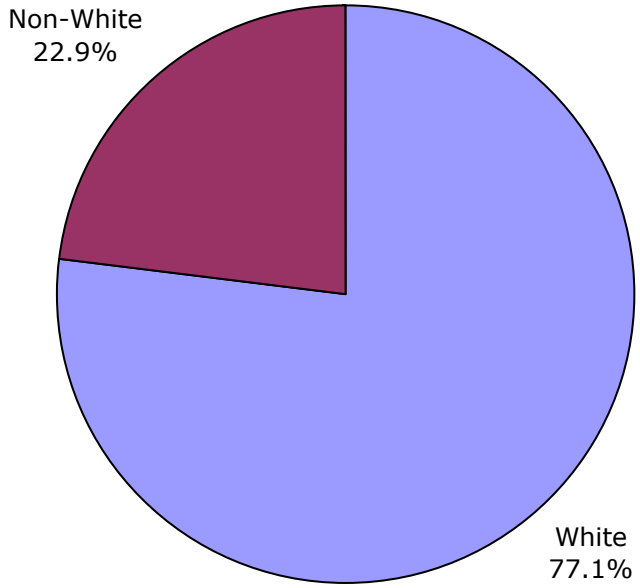
Note: States authorized by the Ticket Act (as of 2005) include: Arkansas, Connecticut, Illinois, Indiana, Kansas, Louisiana, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New York, North Dakota, Pennsylvania, Washington, West Virginia, and Wyoming. States authorized by BBA (as of 2005) include: Alaska, California, Iowa, Maine, Minnesota, Nebraska, New Mexico, Oregon, South Carolina, Utah, Vermont, and Wisconsin. Massachusetts was authorized under an 1115 Demonstration waiver, but is included in the Ticket Act chart.

At the state level, Nevada had the highest percentage of participants aged 22 to 44 (63.0 percent) and under the age of 22 (7.4 percent). Missouri had the highest percentage of enrollees aged 45 to 64 (64 percent); Alaska, a BBA state, had the highest percentage of participants over the age of 64 (10.3 percent).

The majority of all ever-enrolled Buy-In participants (77.1 percent) are white, according to the state-submitted finder file data (Figure IV.3). We also analyzed specific ethnicity according to the TRF data. (As mentioned previously, these data do not include Buy-In participants who were not SSI or SSDI recipients between 1996 and 2005 or who were not between the ages of 18 and 64 when receiving these benefits.) Analysis of TRF data shows that 71.4 percent of all Buy-In participants are recorded as white (Figure IV.4). Additionally, 6.4 percent of all Buy-In participants are recorded as African American, and 2.4 percent are recorded as having Hispanic or Latino origins. An additional 0.6 percent of all Buy-In participants are recorded as Asian or Pacific Islander, and 0.5 percent are recorded as American Indian or Alaskan Native. An additional 2 percent of all participants did not have

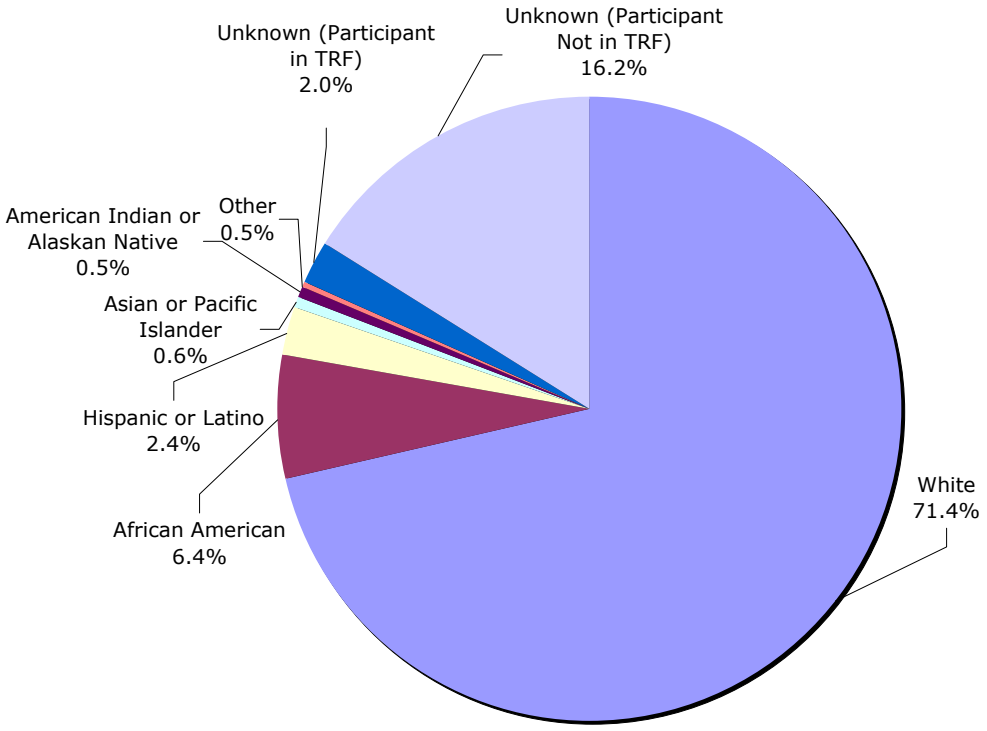
an ethnicity indicated in the TRF data, and 16.2 percent were not in the TRF data. At the state level, analysis of both the TRF and the state-submitted finder file data show that North Dakota has the highest percentage of participants who are white (90.0 percent in the TRF data and 97.8 percent in the finder file data). Conversely, New Mexico has the highest percentage of non-white participants, at 55.8 percent (based on the finder file data), as well as the highest percentage of participants with Hispanic or Latino origins.

Figure IV.3: Ethnicity Of Individuals Ever Enrolled in the Medicaid Buy-In Program, State-Submitted Finder File Data, 1997- 2005



Source: Finder files submitted by states (April 2006).

Figure IV.4: Ethnicity of Individuals Ever Enrolled in the Medicaid Buy-In Program, TRF Data, 1997- 2005



Sources: Finder files submitted by states (April 2006) and the Ticket Research File (TRF)

B. PRIMARY DISABLING CONDITIONS

The most common primary disabling condition of Buy-In participants is mental illness and other mental disorders (Figure IV.5). Nearly 30 percent of all Buy-In participants had these conditions listed as their primary disabling condition in the TRF data.[2]

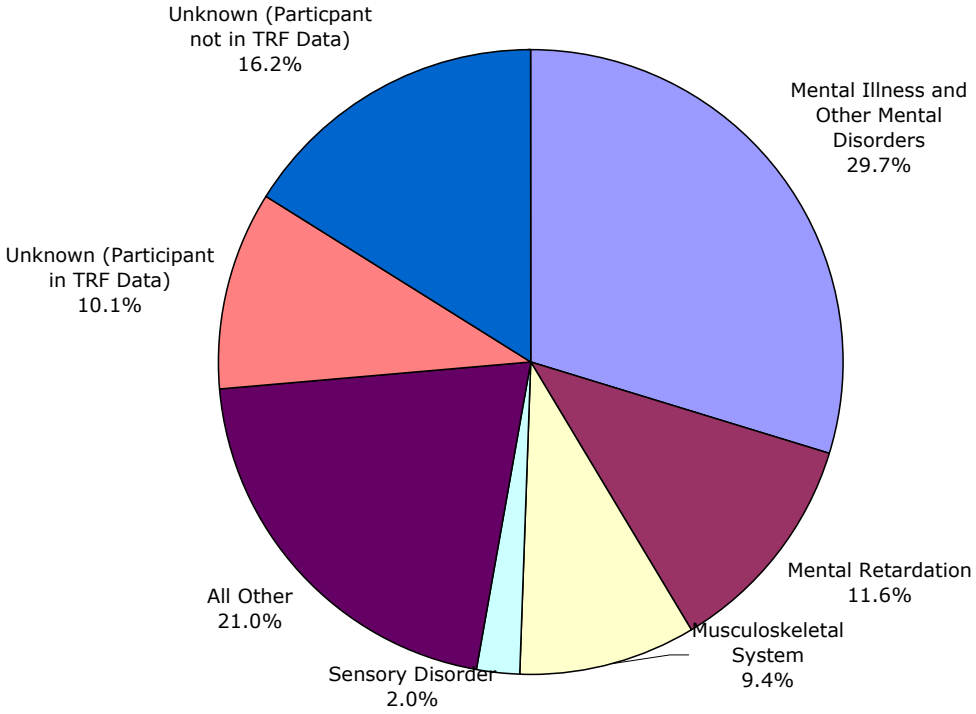
About 12 percent of all Buy-In participants had mental retardation as their primary disabling condition, slightly less than 10 percent had musculoskeletal disorders, and about 2 percent had sensory disorders. Twenty-one percent of participants had various other primary disabling conditions.[3] Additionally, 10.1 percent of all participants were found in the TRF, but information on their primary disabling conditions was not available. Overall,

[2] Primary disabling condition identifies the primary impairment code used in the medical determination of an individual's eligibility for disability benefits. Buy-In participants are grouped based on their primary disabling condition at the first month of Buy-In enrollment.

[3] Other primary disabling conditions include the following: infectious and parasitic diseases, HIV/AIDS, neoplasm, endocrine or nutritional, blood or blood-forming, nervous system, circulatory system, respiratory system, digestive system, genitourinary system, skin or subcutaneous tissue, congenital anomalies, injuries, and other conditions.

16.2 percent of participants were not in the TRF. Appendix Table D.3 includes state data on primary disabling conditions.

Figure IV.5: Primary Disabling Condition of Individuals Ever Enrolled in the Medicaid Buy-In Program, 1997 - 2005



Sources: Finder files submitted by states (April 2006) and the Ticket Research File (TRF)

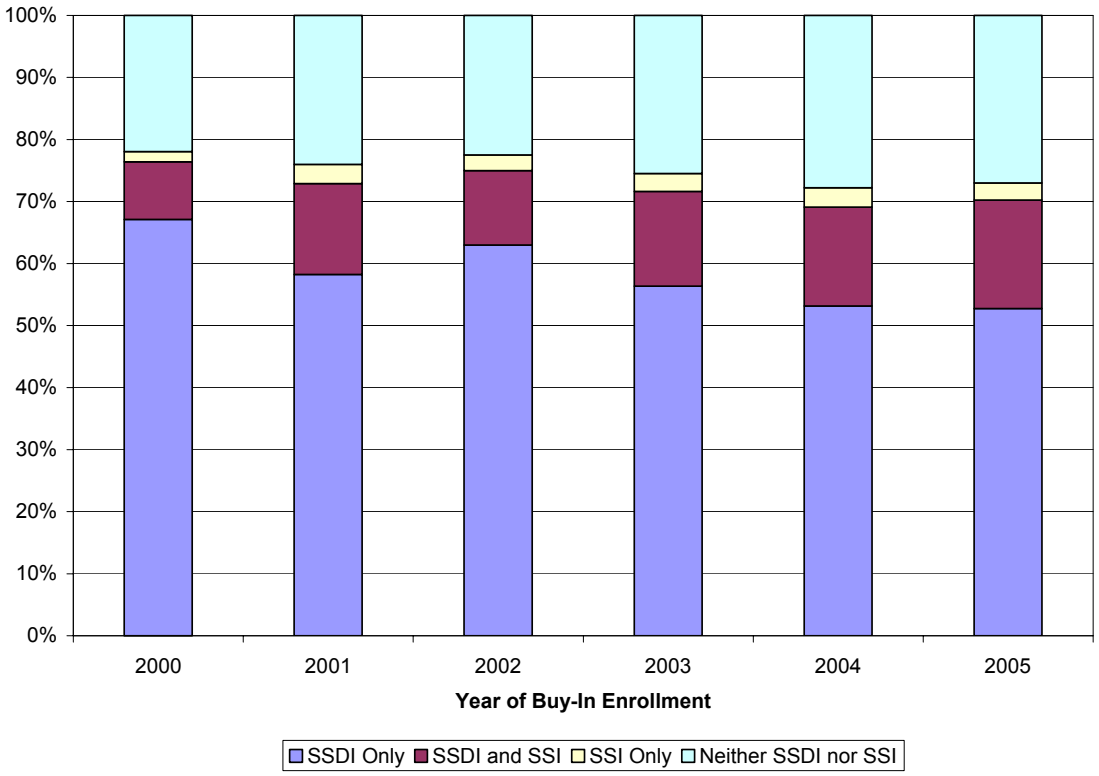
C. PUBLIC PROGRAM PARTICIPATION

Given that the Medicaid Buy-In program is one of many federal initiatives designed to assist working-age adults with disabilities, it is not surprising that many Buy-In participants have had experience with other disability-related public programs. For example, as Figure IV.6 shows, during the year prior to their Buy-In enrollment, about 70 percent of participants who enrolled in the Buy-In in 2005 were SSDI beneficiaries (including those concurrently enrolled in SSI), and about 20 percent were SSI beneficiaries (including those concurrently enrolled in SSDI).

The percent of new Buy-In participants receiving SSI or SSDI benefits during the year prior to Buy-In enrollment changed over time between 2000 and 2005 (Figure IV.6). Over this period, an increasing percentage of new Buy-In enrollees did not receive either of these benefits during the year prior to Buy-In enrollment (27 percent among 2005 enrollees, up from 22 percent among 2000 enrollees (Figure IV.6)). Over this same period, an increasing percentage of new Buy-In participants received SSI benefits during the year prior to enrollment (about 20 percent of the 2005 enrollees compared with about 11 percent of 2000

enrollees). Finally, a decreasing percentage of participants had received only SSDI in the year prior to enrollment (that is, they were not dually enrolled in SSDI and SSI): Among 2005 enrollees, about 53 percent received only SSDI benefits during the year prior to Buy-In enrollment, compared with about 67 percent among the 2000 enrollees.[4] (See Appendix Tables D.4 and D.5 for prior program participation by state.)

Figure IV.6: Percent Of Participants Receiving SSDI and SSI Benefits for at Least One Month During the Year Prior to Buy-In Enrollment, 2000-2005



Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF).

Note: Each year represents only those participants who enrolled in the Buy-In for the first time during that year.

1. Medicare Eligibility Among SSDI Recipients

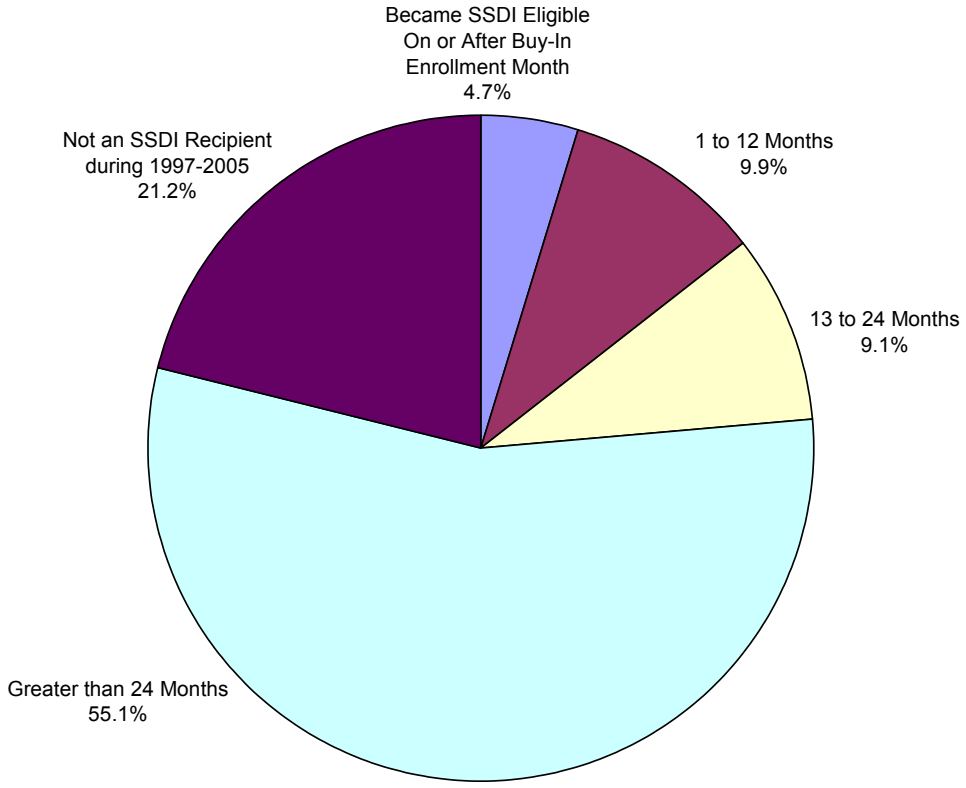
Many policymakers are interested in knowing whether individuals who are SSDI beneficiaries have Medicare coverage when they enroll in the Medicaid Buy-In program because this information indicates whether the Buy-In is providing primary or secondary

[4] We did not include Missouri participants in the 2005 figure because all were disenrolled as of August of 2005 when the Missouri Buy-In ended.

health insurance to these participants. We examined Medicare eligibility among the 79 percent of Buy-In enrollees who were ever recipients of SSDI between 1997 and 2005.[5]

As a first step, we examined the percent of Buy-In participants who became SSDI recipients more than two years before enrolling in the Buy-In since in theory these individuals would have reached the end of the waiting period for Medicare coverage. As Figure IV.7 shows, 55.1 percent of all Buy-In participants were in this group as of December 2005, meaning that they enrolled in the Buy-In already having Medicare coverage. In addition, 19.0 percent became SSDI recipients within the two-year period before Buy-In enrollment. About 5 percent became SSDI recipients after enrolling in the Buy-In.

Figure IV.7: Number of Months that Participants Received SSDI Benefits Prior to First Buy-In Enrollment



Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF) Data

Additional analyses (Appendix Table D.6) confirm that nearly all of those who gained SSDI benefits more than two years before enrolling in the Buy-In (that is, 55 percent of all

[5]See Appendix Table D.6. This analysis only includes those becoming eligible for Medicare in conjunction with SSDI. A small percentage of additional Buy-In participants (including the 1.5 percent of participants age 65 and above) will also be Medicare eligible on the basis of age or other reasons.

Buy-In participants) were Medicare beneficiaries at Buy-In enrollment. An additional 8.1 percent of all Buy-In participants became Medicare eligible within the first year following Buy-In enrollment, and another 5.9 percent became Medicare eligible between one and two years after enrolling in the Buy-In. These individuals represent the group of Buy-In participants who became SSDI recipients within the two-year period preceding Buy-In enrollment; that is, their waiting period ended at some point after enrolling in the Buy-In, at which point they became Medicare eligible.

States vary widely in the percentage of Buy-In enrollees who become Medicare eligible, in part because of the wide variation in percent that are SSDI recipients (Appendix Table D.5). For example, West Virginia had the lowest percentage of SSDI participants (5.7 percent), and consequently had the lowest percent of participants who were Medicare beneficiaries at Buy-In enrollment (2.3 percent). Conversely, Nebraska had the highest percent of participants who were Medicare eligible at enrollment into the Buy-In program (92.2 percent).

2. Transitioning from SSI and SSI 1619(b) to the Buy-In

Analyzing the participation and timing of receipt of SSI and SSI 1619(b) benefits in relation to Buy-In enrollment gives useful insight into what percentage of Buy-In participants are transitioning from SSI to the Buy-In, and the extent to which these individuals are using the 1619(b) provision. As noted in Chapter II, the 1619(b) provision allows individuals who have started earning enough income so they no longer qualify for SSI cash payments to retain their Medicaid coverage, but only up to a certain level of earned income. It is reasonable to assume that individuals transitioning from SSI cash payments to work would first utilize the 1619(b) provision to retain their Medicaid benefits, before transitioning to the Buy-In. Overall, we found that 3.3 percent of all participants used the 1619(b) provision during the 3 months prior to enrolling in the Buy-In (Table IV.1). As expected, states varied with respect to this percentage, from a high of 18.5 percent in New Jersey to less than one percent in Illinois, Minnesota, and Wyoming.

About 40 percent (39.4 percent) of participants who were ever-enrolled in the Buy-In program have received SSI benefits at some point between 1996 and 2005 (Table IV.1). This percentage is about twice as high as the percent of participants (20 percent) who enrolled in the Buy-In program in 2005 and had SSI during the year prior to Buy-In enrollment.

In theory, most participants in the Buy-In program who have experience with the SSI program will have enrolled in the SSI program before they enroll in the Buy-In. However, some Buy-In participants could exit the Buy-In program and then enroll in SSI. We

Table IV.1: Receipt Of SSI and Use of the 1619(B) Provision Among Buy-In Participants, 1997-2005

State	Number Ever-Enrolled in the Buy-In through December 2005	Percent of Buy-In Participants Who Between 1997 and 2005: Ever Received SSI Benefits	Ever Used the SSI 1619(b) Provision	Used the 1619(b) Provision during the Quarter Prior to Buy-In Enrollment
New Mexico	3,757	76.8	7.7	3.0
Wyoming	18	72.2	11.1	0.0
Nevada	27	66.7	33.3	18.5
Nebraska	412	61.4	20.9	7.0
Michigan	677	57.3	27.2	6.6
South Carolina	185	55.7	27.6	13.5
Kansas	1,571	52.6	17.1	2.4
Connecticut	7,825	50.6	25.9	12.8
Alaska	727	49.9	14.2	6.2
Louisiana	992	47.9	18.4	3.1
North Dakota	417	47.7	23.3	3.8
Vermont	1,753	47.5	20.1	8.8
Iowa	14,311	47.5	9.8	2.4
Oregon	1,707	46.0	21.0	5.7
Washington	1,083	45.6	18.9	3.0
Maine	2,936	45.3	20.0	9.7
New York	4,821	45.0	20.7	1.8
Arkansas	280	45.0	13.9	2.9
Wisconsin	14,337	43.3	12.0	2.7
New Jersey	2,682	43.1	14.0	3.8
Utah	1,844	42.4	15.4	5.6
Illinois	1,475	41.9	20.4	8.2
New Hampshire	2,924	39.6	16.5	5.6
Missouri	27,013	39.1	6.7	2.3
Indiana	14,423	34.5	13.5	4.6
California	3,337	33.3	12.3	0.8
Minnesota	15,479	31.8	11.7	3.0
Pennsylvania	7,829	31.5	8.0	2.0
Massachusetts	26,324	29.0	8.7	0.8
West Virginia	264	7.6	1.5	0.4
Total:[a]	161,123	39.4	12.0	3.3

Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF) Data.

[a]Some individuals were enrolled in more than one state over the course of their Buy-in participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.

investigated this issue and found that 3.7 percent of all Buy-In participants first became SSI-eligible during or following Buy-In enrollment.[6]

D. SUMMARY AND IMPLICATIONS

Analyzing characteristics of Buy-In participants at both the national and state levels can help policymakers and researchers know whether program goals are being met, and whether outreach efforts or eligibility features should be adjusted to achieve a different participant mix than what is currently enrolled. Key findings from our analyses in this chapter lead to the following important conclusions:

- From a national perspective, during the period between 1997 and 2005:
  - About half of Buy-In participants were adults in their later work years (age 45-64).
  - About 30 percent of Buy-In participants had mental illness or other mental disorders and about 12 percent had mental retardation as their primary disabling condition.
  - About 72 percent of participants were SSDI beneficiaries during the year prior to enrolling in the Buy-In.
- States vary widely in the percentage of participants with particular characteristics. Several factors may contribute to this variation, including:
  - The federal legislative authority through which the program was implemented,
  - The program's specific administrative features and outreach efforts, and
  - The larger programmatic and economic environment of the state.

As Buy-In programs mature, the participant mix may change over time. Some states, for example, appear to be making changes that may increase the proportion of participants who have previously received SSI or who have never been SSI or SSDI beneficiaries. Future changes in the percent of participants who move from 1619(b) to the Buy-In are likely to be of interest to policymakers because this index is an important measure of increased independence from public support.

[6] Technically, it should not be possible for an individual to be an SSI recipient and a Buy-In participant at the same time. However, the TRF and state-submitted finder files show that a few individuals have a small overlap between SSI eligibility and Buy-In eligibility. In most cases, this probably results when participants in the Buy-In gain eligibility for SSI, presumably because they are unable to continue working, and some time elapses before the individual is administratively switched into the new eligibility group.

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CHAPTER V

SUMMARY AND IMPLICATIONS

A. POLICY OVERVIEW

Since the first state adopted a Medicaid Buy-In program a decade ago, it has become a popular option. Between 1997 and 2005, 32 states implemented a Buy-In program, or 64 percent of all states.[1] With the exception of Missouri, these programs remain operational, and enrollment in most of them has consistently increased.

The program appeals to a wide range of adults with disabilities who are interested in working or working more, because it offers a way to (1) keep or obtain health insurance coverage not otherwise available and (2) become or remain independent of federal income-support programs. Depending on the particular backgrounds and work experiences of adults with disabilities, the Medicaid Buy-In program provides different opportunities:

- To SSDI beneficiaries who want to return to work, the program represents an opportunity to gain access to needed health services that are not available either because they have no insurance or because the insurance they have (such as Medicare) does not cover certain services.

- To SSI beneficiaries, the program provides an opportunity to increase earnings without losing the Medicaid coverage that they already have.

- To working-age adults with disabilities who are not SSDI or SSI beneficiaries and who can not find adequate and affordable health insurance in the private sector, the Medicaid Buy-In program offers an opportunity to obtain such coverage while pursuing personal employment goals.

Because the authorizing federal statutes give states considerable flexibility in designing their Buy-In programs, the states have crafted programs with different administrative features that affect the particular mix of individuals enrolling in the program. For example,

[1] These states include 62 percent of the U.S. population.

some programs have set strict limits on participants' unearned income, thereby excluding some or most SSDI beneficiaries.

Information gathered for this and previous reports suggests that after initial program implementation, administrators in most states make only modest changes in the program's operational features in any single year. And when changes are made, such as altering eligibility parameters or income verification procedures, they typically reflect strategic efforts to better focus the program on individuals who intend to pursue competitive employment.

For example, to avoid enrolling individuals who are unable to maintain a consistent link to the workforce or who work primarily in casual jobs, Medicaid Buy-In programs in some states have reduced grace periods or strengthened requirements for documenting participants' earnings. Other changes have involved relatively modest alterations in income or asset criteria to make the program more attractive to particular groups of working-age adults. Missouri's rescission of its program appears to be an atypical example of a major policy change in this area.

B. SUMMARY OF FINDINGS

1. Enrollment

Overall, more than 161,000 individuals participated in state Medicaid Buy-In programs between their inceptions and the end of 2005. As of December 31, 2005, enrollment ranged from 8 to 9,746 individuals across 29 state Medicaid Buy-In programs. Because the total number of Buy-In participants does not account for differences in states' populations, we also examined Buy-In enrollment in relation to the total number of working-age adults with disabilities estimated to live in each state. Using this indicator, which we refer to as the penetration rate, enrollment in the Buy-In programs ranged from about 1 person to 457 persons per 10,000 state residents with a disability aged 16 to 64 years.

Most states that implement Medicaid Buy-In programs typically witness rapid growth in program enrollment over the first few years. For states with at least four years of program data, we found that enrollment growth averaged 67 percent between the programs' first and second years, compared with a 34 percent growth rate between the second and third years, and a 22 percent growth rate between the third and fourth years. We also found that in six of the seven early implementer states (defined as those that implemented a Buy-In before 2000), enrollment leveled off after the initial period of rapid growth.

Overall, annual rates of enrollment growth in the Medicaid Buy-In program (excluding Missouri) exceeded 20 percent each year between 2000 and 2005. As one would expect, growth rates vary by state depending on the year of implementation. States implementing Medicaid Buy-In programs from 1997 through 1999 saw an average enrollment growth of 10.9 percent in 2005; states implementing programs in 2000 through 2002 saw a growth rate of 20.4 percent; and states implementing programs in 2003 or 2004 saw an increase of 67.8 percent.

In contrast, annual growth rates in the Medicaid program overall were lower and more variable between 2000 and 2005. From 2000 to 2002, total Medicaid enrollment accelerated from a 3.1 percent growth rate in 2000, to a 7.9 percent increase in 2001, and a 9.5 percent rise in 2002. After 2002, in response to an economic downturn, enrollment growth began to slow, decreasing to a 5.6 percent growth rate in 2003 and 4.1 percent in 2004. The annual growth rate of Medicaid programs across all states continued to fall in 2005, with only 3.2 percent increase in enrollment.[2]

2. Factors Affecting Enrollment

Although many factors affect enrollment in a state's Medicaid Buy-In program, three financial eligibility criteria are particularly critical: earned income, unearned income, and assets. To assess the effects of these program features on enrollment, we constructed an index of restrictiveness based on these three program features and examined states' restrictiveness scores in relation to penetration rates (defined as the number of participants enrolled in the Buy-In program relative to a state's estimated population of working-age adults with disabilities). As expected, we found that states with more restrictive criteria tended to have lower penetration rates, underscoring the fact that program administrators can use these eligibility criteria to influence levels of Buy-In enrollment.

Other factors external to a state's Medicaid Buy-In program also can affect enrollment levels. These factors include, for example, the general level of employment support for individuals with disabilities in a particular state and the state's overall economic environment. Our analyses show that states with high penetration rates tend to have higher rates of SSI recipients who were employed in 2005 coupled with low unemployment rates. Although neither the percentage of SSI workers nor the state unemployment rate is perfectly correlated with penetration rate, the relationship appears strong enough to show that enrollment in state Buy-In programs is affected by broad economic factors.

3. Participant Characteristics

Nationally, enrollment in the Buy-In is evenly divided by gender and about 50 percent of participants are in the 45 to 64 age group. States enacting Buy-In programs under the Ticket Act have a slightly younger age profile, compared with states enacting a program under the BBA, largely because the Ticket Act prevents states from enrolling workers over age 65. Although information about ethnicity is not available for all participants, it appears that more than 70 percent of Buy-In participants ever enrolled through 2005 were white, fewer than 10 percent were African American, and fewer than 5 percent were Hispanic or Latino. These percentages vary widely by state, as one would expect.

The primary disabling condition is not known for all Medicaid Buy-In participants, but the available data show that about 30 percent of participants ever enrolled in the program

[2] Medicaid Enrollment in 50 States: June 2005 Data Update. Kaiser Family Foundation, December 2006. http://kff.org/medicaid/upload/7606.pdf

through 2005 had mental illnesses or other mental disorders as their primary disabling condition. About 12 percent of participants had mental retardation as the primary disabling condition, slightly less than 10 percent had musculoskeletal disorders, and about 2 percent had sensory disorders.

Given that the Buy-In is one of many federal programs designed to assist working-age adults with disabilities, it is not surprising that many Buy-In participants have had experience with these other programs. Of all those enrolling in the Buy-In for the first time in 2005, about 70 percent of participants were SSDI beneficiaries (including those enrolled also in SSI) during the year prior to Buy-In enrollment, and about 20 percent were SSI beneficiaries (including those enrolled also in SSDI). Between 2000 and 2005, an increasing percentage of new Buy-In enrollees had participated in neither SSI nor SSDI in the year prior to Buy-In enrollment: 27 percent had not done so in 2005, up from 22 percent in 2000.

Almost 80 percent of Buy-In participants had been SSDI beneficiaries for at least a month at some point between 1997 and 2005, and 70 percent of these (that is, about 55 percent of all Buy-In participants) had been beneficiaries for more than two years before enrolling in the Buy-In. Because SSDI recipients are automatically eligible for Medicare after two years of receiving SSDI benefits, the majority of SSDI recipients who enroll in the Buy-In already have Medicare at the time of their enrollment.

About 20 percent of participants who enrolled in the Buy-In in 2005 had SSI at some point during the year before their Buy-In enrollment, and nearly 40 percent of all participants ever enrolled in the Buy-In had been in the SSI program at some point between 1997 and 2005. Overall, 12 percent of all participants ever enrolled in a Buy-In program received Medicaid through the 1619(b) provision at some point between 1997 and 2005, or about 30 percent of all participants who ever received SSI.

D. LIMITATIONS OF THE STUDY

The data used for this study are drawn from several different administrative files. As noted in Chapter 1, states provided us with finder files that included data on all participants in their Medicaid Buy-In programs between program inception and the end of 2005. We checked these data files for accuracy and completeness, and resolved any issues directly with the states. In a few instances, states re-sent us new finder files. We used the finder files to locate individuals in the TRF file and then abstracted the relevant data.

Because we verified information in the state data files to the extent possible, our findings on enrollment are likely to be as accurate as possible. Any inaccuracies or other limitations in our enrollment analyses would result from problems in a state's capacity to identify Buy-In participants and the dates of their participation. For example, states may have not included all participants in their files or have reported start- or end-dates inaccurately. Reporting problems may be especially likely for participants who enrolled in the Buy-In program in November or December of 2005; these individuals may not have been entered into state administrative files for several months after enrollment and therefore may not have been included in the finder files that were sent to us in early 2006.

To assess this issue further, we examined concordance in the overlapping years between finder files submitted by states in 2005 (for all participants between inception and the end of 2004) with the finder files received in 2006 (for all participants between inception and the end of 2005). In most states, discrepancies were minor, suggesting that the states' finder files contained accurate information. In a few states, we found sufficient discrepancies to warrant further conversations with these states to ensure that the 2005 finder files were accurate.

One of the major limitations of the study involves the absence of data on ethnic background and disabling condition for the 16 percent of participants who were not SSI or SSDI beneficiaries at any time between 1996 and 2005. Because these individuals were not in the TRF, this information was not available. We hope to use other sources of information (such as data from the Medicaid Statistical Information System, or MSIS) to address these data gaps in future studies.

This study was not designed to examine employment and earnings of Buy-In participants. Because of its critical importance to policymakers and program administrators, this topic has been the subject of two issue briefs (see Black and Ireys 2005 and Gimm et al. 2006) and will be the primary focus of a subsequent report.

E. IMPLICATIONS AND NEXT STEPS

Employment represents something very different for young men and women than it does for older adults, regardless of whether they have a disability or not. In the early years of adulthood, work can be an important part of a person's social and professional identity because it provides a way to meet people, generate assets, and establish a sense of self. For younger adults with a disability, some of whom may be receiving SSI benefits, the problems of finding a job that also offers health insurance coverage can be difficult. Because it provides Medicaid coverage while allowing participants to enter or stay in the developmentally important world of work, the Buy-In program can be a critical stepping-stone toward future independence for these young men and women.

Older adults typically have some history of work experience, and employment itself may be less a pathway toward a future identity than a necessity for supporting a particular lifestyle. For older adults with disabilities -- especially those receiving SSDI payments -- access to health care and predictable benefit payments may be far more important than the social and psychological benefits of a job. SSDI beneficiaries may view employment as a means of increasing their incomes, but they also will assess the value of this opportunity relative to the risks of decreased benefit payments. For many older adults who are SSDI beneficiaries and want to work, the Buy-In offers additional health insurance coverage (beyond the Medicare coverage that most already have at entry to the Buy-In program) as well as the chance to work.[3]

[3] For more information on work incentive programs and health coverage, see Davis and Ireys (2006).

Although policy changes in 2005 were few and narrow in intent, they indicate continued interest among policymakers and program administrators to focus Buy-In programs on groups of adults with disabilities who want to establish or maintain a substantive work commitment. This direction implies that, as the program continues to mature, more Buy-In participants are likely to be in the younger age groups and fewer are likely to be SSDI beneficiaries. In turn, changes in the mix of Buy-In participants will alter other indicators of Buy-In performance, such as the percentage of participants who have reported earnings and average earnings.

The first Buy-In program was implemented a decade ago, but most state programs are still relatively young. As a result, most states are still responding to the challenges of initial implementation and are just beginning to understand what steps they can take to modify their program to strengthen its impact. As states continue to implement their programs, we expect to see further refinements in policies and procedures and anticipate that policy changes in the Buy-In program will be more widespread in 2006 than in 2005 for several reasons: at least five new states initiated a Buy-In program in 2006, many states were responding to the implementation of Medicare Part D for Buy-In enrollment, and several states continued to refine program enrollment by altering eligibility criteria.

The use of quantitative methods for tracking Buy-In participation and the capacity to link information from multiple data files will continue to provide CMS and the larger community of policymakers, program administrators, and advocates with the information they need to monitor the impact of policy changes and enrollment trends on the outcomes of participation in the Medicaid Buy-In program. In our next report (scheduled for release later this year), we expect to assess as fully as possible the extent to which the Buy-In program is accomplishing its goal of enhancing employment and earnings of adults with disabilities. This will include examining factors that may influence the amount and growth of a participant's earnings in the years after enrollment in the Buy-In program compared with the years before enrollment, the relationship between administrative features of Buy-In programs and participant earnings, the way in which employment is affected by duration and continuity of program enrollment, and differences in earnings among subgroups of Buy-In participants.

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APPENDIX

OVERVIEW OF APPENDICES

The following appendices contain summaries and tables that help illustrate individual state program features, enrollment data, and participant characteristics. The information in the table in Appendix A and the material incorporated into the one-page descriptions of state Medicaid Buy-In programs in Appendix B were gathered from state personnel through electronic questionnaires sent out in July 2006 and, when appropriate, follow up telephone interviews. Based on this information, we drafted the descriptions of the state programs, sent them to state program directors for review, and revised the descriptions as needed. Although each description has been reviewed by the program director, the responsibility for the accuracy of these descriptions remains with the authors.

Appendix C contains a supplemental table showing Buy-In enrollment by state and year. The participant-level data for this table were collected through state submitted finder files. The Tables in Appendix D present selected Buy-In participant characteristics and reflect analyses based on merging the state submitted finder files with Ticket Research File (TRF) data.

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APPENDIX A

CHARACTERISTICS OF STATE BUY-IN AND MEDICAID PROGRAM, 2005

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Table A.1. Characteristics of State Buy-In and Medicaid Programs, 2005

	Alaska	Arkansas	California	Connecticut
Implementation date	July 1999	February 2001	April 2000	October 2000
Federal authority	BBA	Ticket Act Basic	BBA	Ticket Act Basic and Medical Improvement
Income eligibility	Earned income: Up to 250% FPL for Alaska[a] (includes spousal income) Unearned income must be at or below $1,047 per month	Up to 250% FPL net personal income (earned plus unearned, after disregards); unearned income must be less than SSI standard plus $20. Spousal income not counted.	Up to 250% FPL (includes spousal income, excludes SSDI benefits)	Up to $75,000 per year (excludes spousal income)
Individual asset limit	$2,000 (includes spousal resources)	$4000 individual,	$2,000 (excludes spousal resources)	$10,000 (excludes spousal resources)
Medically needy income limit (monthly)	N/A	$108	$600	$477
Income standard for poverty-level Medicaid (monthly)	$1,075	N/A	$1,028 (includes a $230 disregard)	N/A
SSI Benefit (combined federal and state) (monthly)	$941[b]	$579	$812	$747
1619(b) income threshold (monthly)	$3,422	$1,923	$2,562	$3,757
Premium threshold	100% FPL	N/A	Net countable income of $1	200% FPL
Premium structure	A sliding-scale premium as a fixed percentage of income. The maximum premium is 10 percent of net family income.	No premium required. Co-payments higher than those for regular Medicaid are required when income is above 100% FPL.	A sliding-scale premium is based on net countable income. For income from $1 up to 250% FPL, premiums range from $20 to $250 for an individual and $25 to $375 for a couple.	Premiums equal 10% of total income above 200% FPL
Income verification requirements	Eligibility is based entirely upon receipt of earned income, which includes spousal income. Not required to demonstrate that income and FICA taxes are being paid.	Required to demonstrate that earned income is reported to the IRS (see statement at comment DHS5)	Proof of employment (e.g., pay stubs or written verification from the employer). Self-employed or contractor provide records (e.g., W-2 forms, 1099 IRS form). Not required to demonstrate that income and FICA taxes are being paid.	Must have payroll taxes, including FICA, taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records.
Work stoppage protection	None	Up to six months given that participant states his/her intention to return to work	If an enrollee is out of work "for good cause" – such as being laid-off, a worksite closure, health problems due to one's disability, or a loss of current transportation with no other means of transportation – a 2 month grace period is granted	Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay the monthly premium based on remaining income.

[a]Federal poverty guidelines for Alaska are higher than those for the 48 contiguous states
[b]Alaska provides Medicaid coverage to people with disabilities receiving only the SSI supplement who have countable income up to $1,075 per month.

	Illinois	Indiana	Iowa	Kansas
Implementation date	January 2002	July 2002	March 2000	July 2002
Federal authority	Ticket Act Basic	Ticket Act Basic	BBA	Ticket Act Basic and Medical Improvement
Income eligibility	Up to 200% FPL (includes spousal income)	Up to 350% FPL (excludes spousal income)	Up to 250% FPL (includes spousal income)	Up to 300% FPL (includes spousal income)
Individual asset limit	$10,000 (includes spousal resources)	$2,000 (excludes spousal resources)	$12,000 (includes spousal resources)	$15,000 (includes spousal resources)
Medically needy income limit (monthly)	$283	$564	$483	$475
Income standard for poverty-level Medicaid (monthly)	$816	N/A	N/A	N/A
SSI Benefit (combined federal and state) (monthly)	Individually budgeted	$579	$579	$579
1619(b) income threshold (monthly)	$2,390	$2,433	$1,891	$2,400
Premium threshold	100% FPL	150% FPL	150% FPL	100% FPL
Premium structure	Premium payment categories are calculated based on the sum of 7.5% of unearned and 2% of earned income.	Based on percentage of applicant and spouse's gross income according to family size.	Based on sliding scale premium schedule with 11 premium brackets, ranging from $27 to $422	Sixteen premium amounts based on income brackets from $55 to $152 for individual and $74 to $205 for two or more. Cannot exceed 7.5% of income.
Income verification requirements	Employment must be verified by pay stubs and employer documents that income is subject to income taxes and FICA.	Must have pay stubs and documentation that enrollee is paying income and FICA taxes.	Must have earned income verifiable by pay stubs, completed tax forms, or a signed statement from a person's place of work. Not required to demonstrate that income and FICA taxes are being paid.	Employment must be verifiable by pay stubs and employer documents that income is subject to FICA taxes.
Work stoppage protection	Up to 90 days if premiums are paid and a letter from a physician is submitted stating that the enrollee is unable to work due to health problems.	Enrollment can continue for up to 1 year after losing employment.	6 months	6 months

	Louisiana	Maine	Massachusetts	Michigan
Implementation date	January 2004	August 1999	July 1997	January 2004
Federal authority	Ticket Act Basic	BBA	1115 Demonstration Waiver	Ticket Act Basic
Income eligibility	Up to 250% FPL (excludes spousal income)	Up to 250% FPL on total income, up to 100% FPL on unearned income (includes spousal income)	No limit	No earned income limit. Unearned income limit is 100% FPL (excludes spousal income)
Individual asset limit	$25,000 (excludes spousal resources)	$8,000 (includes spousal resources)	No limit	$75,000 (excludes spousal resources)
Medically needy income limit (monthly)	$100	$315	N/A[a]	$350
Income standard for poverty-level Medicaid (monthly)	N/A	$853	The income standards are variable depending on the population, ranging from 100% - 200% FPL ($797 - $1595 for a family of 1)	$776
SSI Benefit (combined federal and state) (monthly)	$579	$579 + $55 income disregard for state SSI supplement and $10 state supplemental check	$693	$593 (Includes $579 federal and $14 state supplement)
1619(b) income threshold (monthly)	$1,965	$2,864	$2,649	$1,780
Premium threshold	150% FPL	150% FPL	100% FPL	250% FPL
Premium structure	$80 for 150%- 200%, $110 for 200%-250% FPL	$10 premium for 150%-200% FPL, $20 for 200%-250% FPL	Premiums based on two different sliding scales—one for enrollees with other health coverage, one for enrollees without it. Premiums begin at 100% and increase in increments of $5 to $16 based on 10% increments of the FPL.	Based on sliding scale ranging from $50 to $920 per month.
Income verification requirements	Required to demonstrate that income and FICA taxes are being paid	Must have earned income. Not required to demonstrate that income and FICA taxes are being paid.	Demonstrate at least 40 hours of work per month.	Must be employed on a regular and continuing basis. Not required to demonstrate the income or FICA taxes are being paid.
Work stoppage protection	Individuals in the Buy-In who lose their jobs can retain their MPP eligibility for up to 6 months provided they intend to return to the workforce.	None	Up to 3 months if the participant maintains premium payments. Eligibility is re-determined as soon as the participant reports loss of employment.	Up to 24 months if the result of an involuntary layoff or determined to be medically necessary

[a] Massachusetts is unique in that, rather than have a medically needy or spend down program as many other states do, all persons with disabilities who are not eligible for the working benefit plan of CommonHealth (i.e., the state's Buy-In program) are eligible for the non-working benefit plan, which requires that participants meet a one-time deductible to receive coverage.
[b]Massachusetts covers nonworking people with disabilities with incomes at or below 133 percent of the FPL through its Section 1115 demonstration waiver.

	Minnesota	Nebraska	Nevada
Implementation date	July 1999	July 1999	July 2004
Federal authority	BBA (prior to Oct 2000), Ticket Act Basic (as of Oct 2000)	BBA	Ticket Act Basic
Income eligibility	No upper income limit. Must have monthly wages or self-employment earnings of more than $65. (excludes spousal income)	Two-part income test: (1) sum of spouse's earned income and applicant's unearned income must be less than SSI standard ($564 in 2004)[a]; (2) countable income up to 250% FPL (includes spousal income)	Up to 250% FPL on earned income and $699 unearned income
Individual asset limit	$20,000 (excludes spousal resources)	$4,000 (includes spousal resources)	$15,000 (excludes spousal resources)
Medically needy income limit (monthly)	$798	$392	N/A
Income standard for poverty-level Medicaid (monthly)	$798	$776	$1060
SSI Benefit (combined federal and state) (monthly)	$645	$687	$579
1619(b) income threshold (monthly)	$3,294	$2,567	$2,228
Premium threshold	All enrollees must pay a minimum premium of $35.	200% FPL	All enrollees pay at least 5%
Premium structure	Premiums based on a minimum of $35 or a sliding fee scale based on income and household size. The premium gradually increases to 7.5% of income for incomes equal to or above 300% of FPL. Must also pay 0.5 percent of unearned income. No maximum premium amount.	Sliding scale based on income ranging from 2% of income if income is from 200% to 210% of FPL to 10% of income if income is from 240% to 250% of FPL.	Enrollees who earn a monthly net income $1,595 or less pay 5% of income. Those earning more than $1,595 (up to $1,994) pay 7.5% of income.
Income verification requirements	Earned monthly income above $65. Required to demonstrate that FICA taxes are being paid.	Must have earned income based on pay stubs, employer forms, or tax returns. Not required to demonstrate that income and FICA taxes are being paid.	Must provide proof of employment (pay stub) or self-employment (tax return).
Work stoppage protection	Up to 4 months if no earned income due to medical condition or involuntary job loss.	None	Three months, as long as premiums continue to be paid.

[a]In Nebraska, the applicant's unearned income is disregarded if he or she is in an SSDI trial work period.

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

	New Hampshire	New Jersey	New Mexico	New York
Implementation date	February 2002	February 2000	January 2001	July 2003
Federal authority	Ticket Act Basic	Ticket Act Basic	BBA	Ticket Act Basic and Medical Improvement
Income eligibility	Up to 450% FPL on earned income (includes spousal income)	Up to 250% FPL on earned income; up to 100% FPL on unearned income disregarding SSDI benefits (includes spousal income)	Up to 250% FPL on earned income, and up to $1,148/month on unearned income (includes spousal income). Must earn at least $900 per quarter.	Up to 250% FPL (includes spousal income)
Individual asset limit	$22,694 for an individual; $32,921 for a married couple	$20,000 (excludes spousal resources)	$10,000 (excludes spousal resources)	$10,000 (includes spousal resources)
Medically needy income limit (monthly)	$591	$367	N/A	$667
Income standard for poverty-level Medicaid (monthly)	N/A	$776	N/A	N/A
SSI Benefit (combined federal and state) (monthly)	$606	$595.25	$579	$666
1619(b) income threshold (monthly)	$3,274	$2,337	$2,278	$3,131
Premium threshold	150% FPL	150% FPL	Not applicable	150% of FPL
Premium structure	Six brackets from $89 to $239 for individuals. Individuals with gross income (spousal included) that exceeds $75,000 are required to pay premiums of 7.5% of the adjusted gross income	Flat rate[a] $25 individual $50 couple	No premium required. Co-payments higher than those for regular Medicaid are required at all income levels; clients' responsibility to keep track of co-payments	3% of net earned income plus 7.5% of net unearned income. Premiums not collected until automated premium collection and tracking processes are available.
Income verification requirements	Must be employed (proven with a pay stub or 1099 estimated tax statement if the individual is self-employed). Must demonstrate that appropriate FICA contributions are being made. Must not be earning less than the hourly federal minimum wage and not be paid as a participant in a program designed to enhance an individual's ability to obtain paid employment.	Be employed full or part time. Not required to demonstrate that income and FICA taxes are being paid.	Proof that the applicant earned or expects to earn sufficient wages in calendar quarter to count toward Social Security coverage ($900 in a quarter in 2005).b Not required to demonstrate that income and FICA taxes are being paid.	Must have earned income and demonstrate that income and FICA taxes are being paid.
Work stoppage protection	Six months. An enrollee can obtain a subsequent 6-month grace period if the individual demonstrates medical necessity or has documentation of a proven job search to employers.	Up to 26 weeks if the person has worker's compensation or Temporary Disability Insurance and intends to return to work	None	Up to 6 months in a 12-month period for medical reasons and involuntary job loss with intent of returning to work

[a]New Jersey does not collect premiums because the revenue would be insufficient to offset the administrative costs.
[b]New Mexico waives its work requirement for SSDI recipients in the two-year waiting period for Medicare.

	North Dakota	Oregon	Pennsylvania	South Carolina
Implementation date	May 2004	February 1999	January 2002	October 1998
Federal authority	Ticket Act Basic	BBA	Ticket Act Basic and Medical Improvement	BBA
Income eligibility	Up to 225% FPL (excludes spousal income)	Up to 250% FPL on adjusted earned income (excludes spousal income) Participants must have minimum earnings of $900 per quarter.	Up to 250% FPL (includes spousal income)	Up to 250% FPL (includes spousal income), unearned income must be below SSI standard ($579)
Individual asset limit	$13,000 (includes spousal resources)	$5000 (excludes spousal resources)	$10,000 (includes spousal resources)	$2,000 (excludes spousal resources)
Medically needy income limit (monthly)	$500	N/A	$425	N/A
Income standard for poverty-level Medicaid (monthly)	N/A	$585.70	$776	$817
SSI Benefit (combined federal and state) (monthly)	$579	$580.70 (includes a $1.70 state supplement)[a]	$606.40	$603
1619(b) income threshold (monthly)	$2,613	$2054	$2,066	$2,049
Premium threshold	All participants are required to pay a premium	After 6 months, income in excess of $2,200/month; Unearned income above the SSI level	All participants pay a premium	N/A
Premium structure	5% of an individual's gross income	"Cost share" equal to 100% of unearned income above SSI standard. Premium equal to gross income plus unearned income remaining after "cost share" is paid minus (1) mandatory taxes; (2) approved employment and independence expenses; and (3) 200 percent of FPL, and multiplying the remainder by 2% to 10%.	5% of countable income. Premiums of less than $10 are waived.	Premium not required.
Income verification requirements	May verify earned income with a letter from an employer or a pay stub. Not required to demonstrate that income or FICA taxes are being paid.	Must have at least $920 per quarter. Not required to demonstrate that income and FICA taxes are being paid.	Must provide verification of earned income. Not required to demonstrate that income and FICA taxes are being paid.	Income verification required, FICA and income tax payment is not.
Work stoppage protection	Enrollees may continue enrollment if they experience a job loss due to health problems. (If they are likely to return to work and/or if over 3 months, must have a physician's statement.	Eligibility for persons retaining an employment relationship with employer and for persons otherwise eligible for Medicaid	May remain in program and have premium waived for up to 2 months if unable to work due to job loss or health problems.	None

[a]Oregon provides Medicaid coverage to individuals not receiving SSI but who have countable income below $580.70.

	Utah	Vermont	Washington State
Implementation date	June 2001	January 2000	January 2002
Federal authority	BBA	BBA	Ticket Act Basic and Medical Improvement
Income eligibility	Up to 250% FPL (includes spousal income).	Two-part test for family income: 1) Income less than 250% FPL, 2) Income does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings, SSDI benefits, and any veteran's disability benefits of the individual working with disabilities.	220% FPL (includes spousal income)[a]
Individual asset limit	$15,000 (includes spousal resources)	$5,000 (individual) $6,000 (couple) Disregards assets accumulated from earnings since enrollment	No limit
Medically needy income limit (monthly)	$776	$841	$579
Income standard for poverty-level Medicaid (monthly)	$776	N/A	N/A
SSI Benefit (combined federal and state) (monthly)	$579	$655	$579
1619(b) income threshold (monthly)	$2,193	$2,638	$1,886
Premium threshold	100% FPL	N/A	$65 earned income and/or $579 unearned income
Premium structure	15% of countable income	Premium eliminated in June 2004.	The lesser of (1) 7.5% total income or (2) a total of the following: 50% unearned income above MNIL plus 5% total unearned income plus 2.5% earned income after deducting $65
Income verification requirements	For wage employment, worker must demonstrate that FICA taxes are being paid. For self employment, worker must have a tax return or business plan. Not required to demonstrate that income and FICA taxes are being paid.	Earnings of the working individual with disabilities shall be documented by evidence of FICA tax payments, Self-employment Contributions Act tax payments, or a written business plan approved and supported by a third-party investor or funding source.	Must have payroll taxes taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records
Work stoppage protection	None.	None	Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay the monthly premium based on remaining income.

[a]Only the participant's income is counted if spousal income is less than half of the SSI standard.

	West Virginia	Wisconsin	Wyoming
Implementation date	May 2004	March 2000	July 2002
Federal authority	Ticket Act Basic and Medical Improvement	BBA	Ticket Act Basic
Income eligibility	Up to 250% FPL, unearned income must be equal to or less than SSI benefit ($584 in 2005) plus $20 (excludes spousal income)	Up to 250% FPL (includes spousal income)	$1,737
Individual asset limit	$2000 ($5000 liquid asset exclusion)	$15,000 (excludes spousal resources)	$2000
Medically needy income limit (monthly)	$200	$592	N/A
Income standard for poverty-level Medicaid (monthly)	N/A	N/A	300% of SSI payment level
SSI Benefit (combined federal and state) (monthly)	$579	$683	$589.44
1619(b) income threshold (monthly)	$2,029	$2,,493	$1915.67
Premium threshold	All enrollees must pay a minimum premium of $15	150% FPL	All participants pay a premium
Premium structure	Premiums are 3.5% of countable income with a $15 minimum amount. Enrollees must also pay an enrollment fee of $50, which includes the first month's premium.	Equal to the sum of (1) 3% of an individual's earned income, and (2) 100% of unearned income minus certain needs and expenses and other disregards. If the second calculation is less than $25, this component of the premium is $0.	7.5% earned income and 7.5% of unearned annual income over $600
Income verification requirements	Must be employed and earning at least the minimum wage. Not required to demonstrate that income or FICA taxes are being paid.	Required to either work or participate in an employment counseling program, which one can do for up to a year. Not required to demonstrate that income and FICA taxes are being paid.	No.
Work stoppage protection	Coverage can continues for up to 6 months after an involuntary loss of employment if participant continues to pay premiums and show proof of job search efforts	Work requirement may be waived for up to one year after initial enrollment provided an employment plan is approved by the Medicaid Agency.[a]	No.

[a]Wisconsin limits the duration and frequency (twice in a five-year period) of enrollment in employment counseling.

APPENDIX B

STATE SUMMARIES

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ALASKA

Overview. The Working Disabled Medicaid Buy-In program was implemented in July 1999 under the authority of the Balanced Budget Act of 1997. Enrollment increased from 75 in December 2000 to 212 five years later-- substantially higher than the Alaska Department of Health and Human Services originally predicted. As of December 2005, Alaska's enrollment represented 36 persons per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. To be eligible for Alaska's Buy-In program, disabled adults must (1) be ineligible for Alaska's state SSI supplement (Adult Public Assistance or APA), which is accompanied by Medicaid coverage; and (2) pass both a net family income test and an unearned income test. The family income test requires that the net countable income of the entire household be below 250 percent of the FPL for Alaska, which was $2,490 for 2005 for a household size of one. The unearned income test requires that the individual's unearned income be at or below the income standard for the Adult Public Assistance program ($1,075 in 2005). In addition, an individual may accumulate up to $2,000 in assets.

Alaska's combined federal and state SSI supplement of $941 (in 2005) is by far the largest among states with Buy-In programs. Alaska elected the standard of need option that provides Medicaid coverage for all individuals with income at or below $1,075 (in 2005) ($798 above 100 percent of the FPL for Alaska 2005). If a Buy-In participant and his or her spouse do not have earnings because the participant is unable to work due to factors such as health problems or involuntary loss of employment, the state will re-evaluate that participant's eligibility for Adult Public Assistance and Medicaid.

Premium Structure. Most Buy-In participants—65 percent of those enrolled in the fourth quarter of 2004—paid premiums that averaged $35. Premiums are required for enrollees with incomes above 100 percent FPL and are calculated along a sliding fee scale as a fixed percentage of the participant's income. The maximum premium amount is 10 percent of net family income.

Other Policies. Alaska does not require that the Buy-In participant actually work, only that earned income from the participant or their spouse has rendered the recipient ineligible for SSI or Adult Public Assistance.

Outreach and Other Efforts. The staff of the Alaska Comprehensive Medicaid Infrastructure Grant regularly provides training and information about the program to individuals with disabilities, state agency staff, service providers and advocacy groups.

ARKANSAS

Medicaid for the Working Disabled (WD) was implemented under the Ticket Act of 1999 on February 1, 2001. According to state personnel, the program intended to target two groups of individuals: (1) SSI beneficiaries who wanted to work but were afraid of losing their benefits and (2) employed workers with disabilities who were uninsured or lacked adequate health coverage. As enrollment outpaced the state's projections, two eligibility criteria were added in September 2001: an unearned income limit and an IRS documentation requirement. As a result, many people were terminated from the program during the annual re-certification process. As of December 2005, the program had 112 enrollees, down from a high of 198 in December 2001, or about 4 persons per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. Arkansas has a net personal income threshold of 250 percent FPL and an unearned income limit of SSI level, or $579. The net income limit increases according to family size. The asset limit in Arkansas, $4,000 for an individual and $6000 for a couple, increases by increments of $200 with each additional child living in the home. Countable assets do not include any type of retirement account. Arkansas also has "approved accounts," which can be set up by participants to divert funds for the purpose of enhancing independence and increasing employment opportunities. These accounts have a $10,000 sheltered limit; excess monies count toward the buy-in asset threshold. In addition, all participants must report income to the IRS and provide verification. Arkansas does not have a categorical Medicaid option, and their medically needy coverage requires single people to spend down to $108.

Premium Structure. Although Arkansas does not charge a premium, it does require a co-payment for some WD Medicaid recipients. Individuals with countable income below 100 percent FPL are subject to the usual state Medicaid coinsurance amount, which equals 10 percent of the first day of a Medicaid-covered hospital stay and co-payments of $0.50 to $3 for every prescription. Recipients earning more than 100 percent FPL are assessed higher co-payments. Arkansas reported an average co-payment of $22 for participants in the fourth quarter of calendar year 2004.

Other Policies. Arkansas has a six-month grace period to protect enrollees in the event of an involuntary, temporary job loss.

Outreach and Other Efforts. In 2005, the state launched a statewide outreach campaign funded by their Medicaid Infrastructure Grant.

CALIFORNIA

Overview. The Medi-Cal Working Disabled Program (WD) was launched in April 2000 under the authority of the Balanced Budget Act of 1997. Enrollment in WD (1,777 individuals as of December 2005) represents about 8 enrollees per 10,000 state residents age 16-64 with a disability. At least two factors contribute to California's relatively low enrollment: (1) high income thresholds in other Medicaid eligibility categories and (2) a low asset limit.

Eligibility Criteria and Program Context. WD has an income eligibility limit of 250 percent of FPL, but it is one of the few programs that exempt SSDI benefits when calculating countable income. The WD asset limit of $2,000 for an individual ($3,000 for couples) is lower than many other states' Buy-In programs.

Compared with other states, California has a high combined federal and state SSI supplemental benefit ($812 per month in 2005). It also has a high income threshold ($600 for an individual) for the Medically Needy program, which means that individuals in this program can have higher earnings (after medical bills are taken into account) than in other states and still have access to Medicaid.

Premium Structure. WD charges premiums ranging from $20 to $250 per month for an individual and $25 to $375 per month for couples. Individuals who do not pay their premium can remain on the program for up to two months before being disenrolled. The premium is determined by a sliding scale based on income, and all enrollees must pay a premium. This premium structure may act as an enrollment disincentive because (1) for participants with incomes close to 250 percent of the FPL, the premiums may appear to be unaffordable and (2) the medically needy program offers an attractive alternative pathway to Medicaid for those who have fewer health care needs. Participants in the medically needy program share cost only in months when they have received a service, and do not have to pay a monthly premium.

Other Policies. California grants 2-month grace periods to individuals who have lost their job because of a lay off, worksite closure, disability-related health problems, or loss of transportation.

Outreach and Other Efforts. The state strengthened its outreach efforts in 2004 by creating and distributing brochures about the WD program and employment and support services available to persons with disabilities. In addition, local planning committees sponsored training sessions regarding various work incentives, including WD. State personnel noted that these outreach efforts contributed to higher enrollment growth, particularly in areas where outreach has been more intensive.

CONNECTICUT

Overview. Connecticut's Medicaid for the Employed Disabled program, enacted in October 2000 under the authority of the Ticket Act of 1999, was designed as a work incentive program to allow individuals with a disability to retain Medicaid coverage as their earnings from work increased. This state was the first to establish a Buy-In program offering both the Basic Insurance Group and the Medical Improvement Group; the first two participants enrolled in the latter in 2004. As of December 2005, enrollment in the Medicaid for the Employed Disabled program reached 4,039, representing about 185 individuals per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. The Medicaid for the Employed Disabled program has a relatively high-income eligibility threshold of $75,000, and an asset limit of $10,000. Connecticut is one of two states to vary its state SSI supplement amount based on an individual's financial resources; the maximum combined federal and state SSI income benefit was $747 per month in 2005. Connecticut also has a high 1619(b) income threshold ($3,757 per month) among states with Buy-In programs. However, compared to other Buy-In states with medically needy programs, Connecticut has a low Medically Needy protected income level ($477 per month in 2005), which might make its Buy-In program more attractive as a pathway to Medicaid than spending down below this level.

Premium Structure. Buy-In participants in Connecticut are required to pay premiums equal to 10 percent of their income in excess of 200 percent of the FPL. Program participants with income less than 200 percent of the FPL or 92 percent of participants in 2005, paid no premium at all. An individual's premium is reduced by the amount paid out-of-pocket for medical insurance premium payments. For individuals with net family income between 250% and 450% of the federal poverty level, the individual's net premium obligation may not exceed 7.5 percent of net countable income.

Other Policies. Participants in the Medicaid for the Employed Disabled are required to work for pay and to make appropriate FICA contributions, either through payroll deductions or as self-employed individuals. Buy-In enrollment can continue for one year after the loss of employment due to health problems or involuntary dismissal if the person either plans to return to employment when the health problems end or is seeking new employment.

Outreach and Other Efforts. In 2005, Connecticut began outreach efforts to explain how the advent of Medicare Part D coverage would impact prescription drug coverage under Medicaid for Medicaid Buy-in participants. They also did mailings to MBI participants in the Job Loss Extension category offering vocational services in order to facilitate participants' return to work.

ILLINOIS

Overview. Illinois implemented its Health Benefits for Workers with Disabilities (HBWD) program in January 2002 under the authority of the Ticket Act of 1999. According to HBWD personnel, the program was designed primarily as a work incentive for individuals with disabilities because the disability community insisted that participants needed "real" work experience in order to promote higher earnings. Enrollment in the HBWD program has increased modestly since its inception, reaching 800 in December 2005, representing about 10 individuals per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. The HBWD program is available to persons with disabilities with incomes less than 200 percent of the FPL and assets less than $10,000. The HBWD income threshold is low relative to other Buy-In states. Illinois has a low medically needy threshold, ($283) but exempts income up to 100% of the federal poverty level threshold for people with disabilities and the aged and blind population

Premium Structure. Premium categories are calculated based on a premium grid that includes earned and unearned income parameters. Generally premiums are based on about 2 percent of earned and 7.5 percent of unearned income. Ninety-nine percent of HBWD participants were required to pay monthly premiums in 2004, which averaged $51. Those who earn less than 100 percent FPL do not pay a premium.

Other Policies. If an HBWD participant is unable to work due to medical reasons, he or she may remain in the program for up to 90 days before being disenrolled, provided premiums are paid. However, if a participant stops working due to a non-medical reason and is not employed within 30 days, the individual's enrollment is discontinued. The HBWD program requires applicants to verify that they are paying the applicable income and FICA taxes on all earned income (including self-employment income).

Outreach and Other Efforts. HBWD personnel believe that the program has made strong outreach efforts. Early on, staff mailed out 5,000 brochures to potential applicants, but they indicated that the outcome of this effort was disappointing. HBWD staff has worked with mental health centers, county and private hospitals, the Department of Human Services, Vocational Rehabilitation counselors, eligibility counselors, and local Medicaid offices to spread information about the program. The program has distributed over 30,000 applications and brochures and conducted in-service training for over 200 state and federal agencies and disability organizations. HBWD works closely with SSA offices and Work Incentive Planning & Assistance (WIPA) to identify eligible individuals. Through the Medicaid Infrastructure Grant (MIG), HBWD was able to produce and purchase radio commercials about the program. HBWD's website (www.hbwdillinois.com) generates a large number of inquiries and applications since it is linked to by all appropriate Illinois state websites.

INDIANA

Overview. Indiana implemented its Medicaid for Employees with Disabilities (M.E.D. Works) program in July 2002 under the Ticket Act of 1999. Enrollment in the program reached 1,553 enrollees within three months of the program's inception and 5,807 participants by December of 2005, about 114 persons per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. Disabled individuals in Indiana who are employed and have countable incomes below 350 percent of the FPL are eligible for the M.E.D. Works program. Although the asset limit of $2,000 is low among Buy-In programs, the state does exclude up to $20,000 of assets in an Independence and Self-Sufficiency Account. The use of such an account has to be approved by the program, and very few participants (i.e. fewer than 15, according to state officials) have one. The maximum allowable income level for Indiana's Spend-Down program is identical to the federal SSI benefit of $579. SSI recipients are not automatically eligible for Medicaid, because the state chose Medicaid eligibility criteria that are more restrictive than those for SSI eligibility through the 209(b) option.

Premium Structure. Premium amounts are based on income. Those who earn less than 150 percent of FPL do not pay a premium. Individuals who earn 150-175 percent of FPL pay $48, and 300-350 percent of the FPL pay $161. Twenty-eight percent of participants enrolled for the entire fourth quarter of 2004 paid premiums, which averaged $74. The amount an individual pays for private health coverage is deducted from their premium amount.

Other Policies Buy-In enrollees are able to remain in the program for up to 12 months after losing employment for involuntary reasons if he or she (1) requests in writing that Buy-In coverage continue; (2) maintains program eligibility; and (3) sustains a connection to the workforce (for example, workforce development). Participants must also document that they are paying income and FICA taxes.

Outreach and Other Efforts. The Family and Social Services Administration, which administers Indiana's M.E.D. Works program, is conducting activities to disseminate information about the program. In 2005, Indiana developed and rolled launched a website called Hoosiers Ready to Work containing comprehensive information about the MED Works program and other federal work incentives. This website was well received. In the future, Indiana hopes to continue updating the site with additional information. In 2006, the state will hold a forum to educate people around Employment Networks and the new Ticket To Work regulations due out in the summer of 2006.

IOWA

Overview. Iowa's Buy-In program, Medicaid for Employed People with Disabilities (MEPD), was launched in March 2000 under the authority of the Balanced Budget Act (BBA) of 1997. The state estimated that 700 individuals would enroll in the program by June 2002, whereas actual enrollment reached 4,092 by that date. As of December 31, 2005, there were 9,541 enrollees, or about 457 individuals per 10,000 working aged state residents with a disability.

Eligibility Criteria and Program Context. Participants in the MEPD program may have income up to 250 percent of FPL and assets of up to $12,000 for a single person and $13,000 for a couple; both of these limits include family contributions. Additionally, individuals must be under the age of 65, meet the SSI definition of disability, and have earned income from employment or self-employment, verified through pay stubs, tax forms, or signed statement from a person's employer. The state's spend-down level for the medically needy program of $483 is low compared to other states.

Premium Structure. Individuals must pay a monthly premium based on gross income according to a sliding scale premium schedule with 16 premium brackets ranging from $27to $ 422. If an individual's gross income (including spousal income) is below 150 percent of the FPL, then no premium is required. Records show that 25 percent of participants were required to pay a premium in 2005, and the average monthly premium of those who paid a premium was $41.

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

Outreach and Other Efforts. Iowa has not performed specific outreach activities targeted to the Buy-In program since 2001, although the state has hosted a national conference on partnering with industry to employ people with disabilities. The Income Maintenance staff in the local Department of Human Services offices advises individuals when this Medicaid coverage group is available to them.

KANSAS

Overview. Working Healthy, the Kansas Medicaid Buy-In program, was implemented in July 2002 under the Ticket Act of 1999. As of December 2005, Kansas had 1,013 enrollees in the Working Healthy program --about 51 persons per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. To qualify for Working Healthy, a person must have total household income less than 300 percent of the FPL and have assets that are less than $15,000. Kansas added a Medically Improved Group in February 2005, which will allow individuals to remain on the program if (1) their disability improves to the point where it is no longer considered a disability and (2) they work at least 40 hours per month while earning at least the federal minimum wage. The Working Healthy program has a low medically needy income limit of $475 per month. SSI recipients in Kansas can receive a maximum of $579 because the state does not supplement SSI cash benefit.

Premium Structure. Participants are charged a monthly premium if adjusted net income is over 100 percent of the FPL. The program has a sliding fee scale based on income. There are sixteen premium levels for single participants that range from $55 to $152 and from $74 to $205 for two or more people. The premium cannot exceed 7.5 percent of the participant's income.

Other Policies. Work requirements in the state are fairly stringent. Employment must be verifiable by pay stubs and employer documents that prove income is subject to an income test and FICA contributions. The Working Healthy program also has a six-month grace period.

Outreach and Other Efforts. Working Healthy is administered through the newly created Kansas Health Policy Authority. The program office has sponsored a number of outreach activities, including orientations for providers and benefit specialists and conferences targeted to various stakeholders. An advisory council meets on a quarterly basis to provide knowledge and expertise to program staff. Kansas withdrew the 1115 Independence Plus application and instead submitted a State Plan amendment under the Deficit Reduction Act of 2005 – Flexibility in Benefits provisions.

LOUISIANA

Lousiana implemented the Medicaid Purchase Plan for Workers with Disabilities (MPP) in January 2004 under the Ticket Act of 1999. Viewed by the state as a work support program, the MPP targets any person with a disability who works. As of December 2005, enrollment was 796—18 individuals per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. Based on individual earnings, Louisiana has a countable income threshold of 250 percent of the FPL. There is no separate unearned income limit. The asset limit is $25,000, exclusive of retirement accounts, life insurance polices, medical savings accounts, and spousal property. The eligibility criteria for other pathways to Medicaid are restrictive relative to other states. Louisiana provides only limited categorical Medicaid eligibility to SSI/former SSI recipients and individuals in nursing facilities or waiver programs. The state's medically needy income threshold is also low relative to other states ($100 per month).

Premium Structure. Any enrollee with countable income over 150 percent FPL must pay a premium. The structure in Louisiana has two-tiers: 150-200 percent FPL and 200-250 percent FPL, requiring a monthly payment of $80 and $110 respectively. As of December 2005, 8.8 percent of MPP enrollees paid a premium. Louisiana reports that the reason it chose 150 percent FPL as the threshold, which is higher than the 1619(b) threshold, was to give individuals in the 1619(a) and 1619(b) categories an incentive to enroll in the Buy-In program.

Other Policies. Individuals in the Buy-In program who lose their jobs remain eligible for the MPP for up to 6 months provided that they intend to return to the workforce. Louisiana also reimburses a number of individuals with group health insurance for the cost of this coverage. In addition, Louisiana requires individuals to pay all applicable income and FICA taxes on their reported earnings regardless of whether they are ultimately below the taxable level.

Outreach and Other Efforts. Louisiana's outreach activities include job fairs for people with disabilities. In the aftermath of Hurricanes Katrina and Rita, the state held eight of the nine job fairs scheduled for 2005 and connected about 1,000 job seekers with 192 businesses. Job fairs were planned again for 2006.

MAINE

Overview. Authorized under the Balanced Budget Act of 1997, the MaineCare Workers with Disabilities (WWD) Option started in August 1999 to allow persons with disabilities to work more without losing their Medicaid benefits. Enrollment stood at 716 as of December 2005 -- representing about 55 enrollees per 10,000 adults with a disability living the state.

Eligibility Criteria and Program Context. To be eligible for the WWD option, participants must have earned income and meet a two-step income test: countable unearned income must be equal to or less than 100 percent of the FPL and total countable earned and unearned income must be less than 250 percent of the FPL. According to a WWD official, the unearned income limit was established in part due to concern about the absence of a work requirement, and that SSDI beneficiaries with high-unearned income who enrolled with little incentive to work might drive up program costs. The asset limit for program participants (which excludes certain items, such as home, car, and some savings) is $8,000 for an individual. Compared with other states, Maine has a low medically needy income level ($315 per month) and a low combined federal and state SSI payment ($579 plus a $55 income disregard and $10 state supplemental check). However it has a categorical Medicaid eligibility based on poverty with a high-income threshold ($853 per month) relative to other states.

Premium Structure. The premium amount is based on countable monthly income projected for a six-month eligibility period. Individuals with monthly countable income under 150 percent of the FPL or those individuals paying a Medicare Part B premium pay no premium for the Buy-In program. If monthly countable income is between 150 percent and 200 percent of the FPL, the monthly premium is $10. Individuals with income over 200 percent of the FPL have a $20 premium. Only 6 percent of program participants were required to pay a premium in 2004, and the average premium for these individuals was $13 per month, a relatively modest sum compared with other states.

Other Policies. Participants who suffer a job loss may be disenrolled from the program and possibly transferred to a Medicaid eligibility group without a premium.

Outreach and Other Efforts. The program partners with the Continuing Health Options and Incentives via Coordinated Employment Supports, or CHOICES, a Medicaid Infrastructure Grant (MIG) operated out of the Muskie School of Public Service at the University of Southern Maine. The state's primary outreach activities in 2004 involved updating brochures and maintaining a web site with program information. The state's outreach activities in 2005 were included in a broader system assessment and strategic planning effort under the MIG Comprehensive Employment Opportunity (CEO) grant, and included focus groups, surveys and other engagement with various stakeholders. In 2005, the grant began some targeted outreach and education to dual eligibles with disabilities related to the new Medicare Part D program.

MASSACHUSETTS

Overview. CommonHealth, a benefit plan within Massachusetts' Medicaid program (MassHealth) for individuals with disabilities, was originally established as a state-funded plan to provide medical assistance to the working disabled and was integrated into an 1115 waiver on July 1, 1997. Massachusetts' Buy-In program is the oldest in the nation and as of December 2005, with 9,746 enrollees, the largest. This enrollment represents about 229 individuals per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. CommonHealth has no income or asset limits, but participants must work 40 hours per month to obtain and maintain Buy-In eligibility. Enrollees may also be eligible by working an average of 40 hours per month over 6 months. The standard combined federal and state SSI benefit of $693 in 2005 is higher than most other Buy-In states. Similarly, Massachusetts' 1619(b) threshold of $2,649 is very high compared with others states, suggesting that workers with disabilities in this state who have higher incomes than most other Buy-In states can still maintain eligibility for Medicaid through the SSI program. CommonHealth also has a non-working benefit plan for individual with disabilities who work less than 40 hours per month; this plan is different from a traditional medically needy or spend-down program because participants only need to meet a one-time deductible rather than continue to meet the monthly spend-down requirement. In addition, Massachusetts also provides categorical Medicaid coverage to persons with disabilities with incomes below 200 percent of the FPL.

Premium Structure. Premiums are established based on one of two sliding scales—one scale for those with other health insurance, and one for those without it. Premiums begin at 100 percent FPL and increase in $5 to $15 allotments based on 10 percent increments of FPL. Approximately 9 in 10 Buy-In enrollees in Massachusetts paid a monthly, with a premium average of $47 in 2004.

Other Policies. CommonHealth allows for a 3-month grace period in the case of job loss if the participant continues to pay their monthly premium. Eligibility is re-determined as soon as the participant reports loss of employment.

Outreach and Other Efforts. Massachusetts has implemented a variety of strategies to inform people about the Buy-In and to address the concern among adults with disabilities that beginning or returning to work inevitably means losing publicly funded health insurance. In 2005, Massachusetts launched a new set of outreach activities, which integrate information about CommonHealth, other work incentive programs, and employment services using peer education and other strategies with consumers and direct service providers.

MICHIGAN

Michigan's Freedom to Work program was implemented on January 1, 2004, under the Ticket Act of 1999. There were 579 individuals enrolled in the program as of December 20005, representing about 7 Buy-In enrollees per 10,000 working aged state residents with a disability.

Eligibility Criteria and Program Context. The continued eligibility criteria for an enrolled Freedom to Work participant are generous compared with most states, including an unlimited earned income level and an asset limit of $75,000 and unlimited retirement account balances. However, two other criteria are more restrictive relative to other states: an unearned income limit of 100 percent FPL, and a requirement that an individual must be eligible for Medicaid, excluding the spend-down program, in the month prior to Buy-In enrollment. Michigan is working with its Medical Services Administration to coordinate policy between Freedom to Work/Medicaid Buy-in State Plan Amendment and the language in the Freedom to Work legislation. Michigan has both a poverty level Medicaid category and a Medicaid spend-down program in which the range of protected income is $350 to $408.

Premium Structure. Freedom to Work has a four-tiered premium structure based on an earnings range defined by the FPL. Individuals with monthly net countable income less than 250 percent of the FPL are not required to pay a premium; participants with monthly net countable income from 250 to 350 percent of the FPL pay a $50 monthly premium; those with monthly net countable income from 350 to 500 percent of the FPL pay a $190 monthly premium; those with net countable income from 500 percent to net countable earnings of $75,000 pay $460 monthly; and those earning $75,000 or more per year pay $920 per month. Failure to pay in a timely manner will result in a "lock-out" or ineligibility for the program. In 2004, none of the 125 first-time enrollees were required to pay a premium.

Other Policies. Buy-In participants are allowed a grace period of up to 24 months if the temporary breaks are the result of an involuntary layoff or are determined to be medically necessary. According to the state, a number of individuals with private insurance are reimbursed for the cost of this coverage, which may explain the comparatively high rate of enrollees (12 percent) who have both Medicaid and private insurance.

Outreach and Other Efforts. More than 50 outreach presentations were conducted in 2005 reaching over 2,000 individuals, advocacy organizations, and agencies. A core group of advocates, Medicaid Infrastructure Grant staff, and State agency staff began to determine how to best address challenges in the Freedom to Work/Medicaid Buy-in program. Medicare Part D outreach provided "Train the Trainers" sessions as well as further overviews of Freedom to Work.

Michigan also commissioned an evaluation of the program's effectiveness, which was initially delayed due to initial low enrollee participation in its Buy-in, but was recently completed and will be available for distribution following State administrative review.

MINNESOTA

Overview. Minnesota's Medicaid Buy-In program, Medical Assistance for Employed Persons with Disabilities (MA-EPD), was implemented in July 1999 under the authority of the Balanced Budget Act of 1997 and, in October 2000, was converted to the Ticket to Work and Work Incentives Improvement Act of 1999. The program grew quickly, with approximately 5,000 enrollees within a year of the program's inception and 6,642 as of December 2005, representing about 207 individuals per 10,000 adult state residents with a disability.

Eligibility Criteria and Program Context. The MA-EPD program has no upper limit for income eligibility and has an individual asset limit of $20,000, which is high relative to other Buy-In programs. The first $65 of earned income is disregarded when determining eligibility for the program, which implies that a participant needs monthly earnings of greater than $65 to be eligible for the program. In addition, Buy-In participants need to have Medicare and Social Security taxes withheld from wages or paid from self-employment earnings in order to provide proof of employment. Minnesota elected the Medicaid poverty level option for disabled individuals, providing these individuals with Medicaid eligibility if their monthly countable income is below the federal poverty line ($798 in 2005). Both the medically needy protected income level in Minnesota ($798 in 2005) and state SSI benefit ($645 in 2005) are higher than in most other Buy-In states.

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

Other Policies. Beginning in January 2004, MA-EPD participants may remain enrolled for up to four months without earnings if they become unable to work due to either medical reasons that are verified by a physician or an involuntary job loss. Prior to this change, the program allowed participants to remain on the program if they were unemployed due to a verifiable medical condition.

Outreach and Other Efforts. The rapid enrollment and growth of the program early on was a direct result of extensive outreach done by the disability community and advocacy groups. Currently, outreach is primarily done through counties that administer the MA-EPD program. Information and training is also offered through the Minnesota Work Incentives Connection (Minnesota's Work Incentive Planning and Assistance organization), the Disability Linkage Line and professional conferences and training activities coordinated through the Medicaid Infrastructure grant staff. In 2007, Minnesota will be focusing on outreach to businesses, and youth in transition.

NEBRASKA

Overview. Nebraska enacted its Medicaid Insurance for Workers with Disabilities (MIWD) program in July 1999 under the BBA 1997 legislation and had 113 enrollees as of end of 2005, representing about 9 Buy-In enrollees per 10,000 state residents age 16-64 with a disability. Enrollment has been lower than expected, probably because of restrictive eligibility criteria.

Eligibility Criteria and Program Context. Eligibility for the Buy-In program in Nebraska involves passing a two-step income test. First, the sum of the spouse's earned income and the applicant's unearned income must be below the federal benefit rate (i.e., $576 in 2005). The applicant's unearned income is disregarded if he or she is an SSDI beneficiary in a trial work period (TWP). Second, after passing the first part of the income test, the applicant must have countable family income, including unearned income, below 250 percent of the FPL. Applicants can have up to $4,000 in assets ($6,000 for couples). The disregard of all unearned income for SSDI recipients in a TWP has the effect of targeting individuals who are on SSDI and participating in competitive employment.

An important component of the context of MIWD is the fact that the state has chosen to provide Medicaid coverage to disabled individuals with income below 100 percent of the FPL (i.e., $797 in 2004). Other important contextual factors in Nebraska include (1) a 1619(b) threshold of $2,567 per month; (2) a combined federal and state SSI benefit of $576 in 2005; and (3) a low medically needy income limit ($392 per month) relative to other Buy-In states with medically needy programs.

Premium Structure. Buy-In enrollees with countable family income between 200 and 250 percent of the FPL are required to pay a premium ranging from 2 percent of countable family income for enrollees from 200 and 209 percent of the FPL to 10 percent for enrollees from 240 to 249 percent of the FPL. The vast majority of Buy-In enrollees in Nebraska do not pay a premium—only two percent of participants enrolled for the entire fourth quarter of 2004 did so.

Other Policies. Enrollees must provide proof of earned income through pay stubs, employer forms, and tax returns; they are not required to demonstrate that income and FICA taxes are being paid. Nebraska does not have a grace period in cases of enrollee job loss.

Outreach and Other Efforts. Nebraska is currently conducting awareness Training to Medicaid Eligibility Staff statewide. They have completed 6 of 9 trainings to date with the final training scheduled for March 2007. In 2006, they will start promoting MIWD through monthly trainings with federal, state & local systems representatives as well as students with disabilities on college campuses statewide.

NEW HAMPSHIRE

Overview. New Hampshire established the Medicaid for Employed Adults with Disabilities (MEAD) program on February 2002 under the authority of the Ticket Act. As of December 2005, there were 1,419 people in the MEAD program, about 148 individuals per 10,000 adults with a disability living in the state.

Eligibility Criteria and Program Context. MEAD began with particularly generous eligibility criteria: family income up to 450 percent of the FPL and assets below $21,947 for an individual and $32,921 for a married couple. However, in February 2005, the state made the following changes: (1) Buy-In participants must earn at least the federal minimum wage; (2) applicants must continue working while eligibility is being determined; and (3) assets that Buy-In participants acquire while on the program are no longer disregarded when they transfer to regular Medicaid. New Hampshire's medically needy protected income level ($591) and combined federal and state SSI benefit ($606) are typical among all states with Buy-In programs. Its 1619(b) earnings threshold is among the highest compared with other states with Buy-In programs.

Premium Structure. MEAD does not charge a monthly premium to enrollees with countable income below 150 percent of the FPL. There are six premium categories for enrollees with countable income, ranging from $89 to $239 per month. Individuals with gross income (spousal included) exceeding $75,000 are required to pay premiums of 7.5% of their adjusted gross income. Employer-sponsored insurance premiums and Medicare premiums both are deducted from the Buy-In premiums. Thirty-two percent of participants paid a premium in 2004, and the average monthly premium was $37. The state instituted a time-limited payment plan in February 2005 allowing individuals to pay it the premium over a three-month period or to be exempt from payment if they can prove good cause.

Other Policies. MEAD requires participants to prove employment status through pay stubs or 1099 estimated tax statement for self-employed individuals; proof that FICA taxes are being paid is also required. New Hampshire also has a six-month grace period. An enrollee can obtain a six-month extension if documentation on his or her medical condition or employment search is provided.

Outreach and Other Efforts. New Hampshire has made a major effort to promote the MEAD program and help the state's disabled population seek and maintain employment. The MEAD program as awarded several grants to provide outreach, benefits evaluation and education, sponsor an annual conference focusing on disability, diversity and employment, disseminate information on the new Medicare Part D benefit. Grant recipients have included independent living and One-Stop centers, the state Minority Health Office, and statewide ServiceLink organizations. In addition to grant recipients, three universities have been involved in various initiatives to build capacity for supported employment, conduct a survey for better employment outcomes and provide a report on participants' employment earnings, health care utilization, and state expenditures.

NEW JERSEY

Overview. New Jersey's Buy-In program, NJ Workability, was implemented in February 2000 under the authority of the Ticket Act of 1999. Enrollment in the program reached 1,904 as of December 31, 2005. This represents about 38 persons per 10,000 adults with a disability in the state.

Eligibility Criteria and Program Context. NJ Workability's has a typical income eligibility limit (250 percent of the FPL) but a relatively high asset limit ($20,000 for individual). The program also has a separate unearned income limit, although SSDI benefits are not counted. As a result, persons with disabilities who have unearned income (for example, from pensions, interest, or retirement accounts) above 100 percent of the FPL—after disregarding SSDI benefits—would not be eligible. New Jersey provides categorical Medicaid eligibility for persons with disabilities whose incomes are less than 100 percent of the FPL ($776 per month in 2005). Hence, persons with disabilities who have incomes below this amount can qualify for Medicaid eligibility. Compared with other states, the medically needy protected income threshold is relatively low in New Jersey ($367 per month).

Premium Structure. As a matter of policy, New Jersey has a flat-rate premium requirement ($25 per month for an individual and $50 for couples) for participants with incomes greater than 150 percent of FPL, but does not collect premiums because the revenue from doing so would not offset administrative costs.

Other Policies. In the event of a temporary job loss, a person with disabilities may stay on NJ Workability if he or she has worker's compensation or Temporary Disability Insurance (TDI) and is still employable (that is, the worker intends to return to work). The protection period can be as long as 26 weeks for people with TDI.

Outreach and Other Efforts. New Jersey continued outreach activities in 2005 by conducting, for example, presentations about the program and distributing informational materials. In 2005, many training sessions were given to non-profit organizations, front-line caseworkers, and other state agencies, such as the Social Security office, Vocational Rehabilitation services, etc.

NEW MEXICO

Overview. The Working Disabled Individuals (WDI) program, New Mexico's Buy-In program, was launched on January 2001 under the authority of the Balanced Budget Act (BBA) of 1997. Enrollment in WDI was 1,563 as of December 31, 2005—about 87 persons per 10,000 adults with a disability. The program offers health coverage for many non-working individuals in the 24-month waiting period for Medicare in addition to workers with disabilities.

Eligibility Criteria and Program Context. Eligibility for the WDI program requires that persons with disabilities 1) be at least age 18, 2) have countable earned income at or below 250 percent of the FPL, 3) have assets of less than $10,000 ($15,000 for couples), and 4) have less than $1,178 per month (in 2005) of unearned income. Qualifying for WDI also requires that a person with disabilities have a recent attachment to the workforce, defined as having gross earnings in a quarter sufficient to meet SSA's definition of a "qualifying quarter" (that is, $900 in 2005). However, SSDI recipients who are in the two-year waiting period for Medicare are not required to work in order to maintain eligibility until the waiting period ends.

Health coverage options for workers with disabilities in New Mexico, other than WDI, are limited. New Mexico does not have a medically needy program or provide categorical Medicaid eligibility to individuals with extremely low incomes. In addition, the state does not provide a state supplement to the federal SSI benefit, and its 1619(b) monthly income threshold ($2,278 in 2005) is lower than many Buy-In states.

Premium Structure. Instead of collecting monthly premiums, WDI requires participants at all income levels (except for Native Americans) to pay copayments for certain services and items at the time of service. Co-payments range from $5 to $30.

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

Outreach and Other Efforts. WDI's outreach efforts have focused on peer associates who do presentations and distribute brochures about the program. Information about WDI was also given out at various health and job fairs.

NEW YORK

Overview. New York implemented its Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program in July 2003 under the authority of the Ticket Act of 1999. New York is one of the few states that chose to have a Medical Improvement Group, which allows individuals with disabilities to remain enrolled in MBI-WPD after their disability improves if they continue to have a severe medical impairment, work at least 40 hours per month, and earn at least the federal minimum wage. As of December 2005, no one has enrolled under the Medical Improvement Group. Enrollment in the MBI-WPD program was 4,013 as of December 31, 2005—about 30 persons per 10,000 adults with disability.

Eligibility Criteria and Program Context. The MBI-WPD program provides Medicaid coverage for disabled individuals age 16 to 64 with countable income at or below 250 percent of the FPL and assets at or below $10,000. The combined federal SSI benefit and state supplement in New York for 2005 ($666) is higher than most other Buy-In states, as are the income thresholds for 1619(b) ($3,131) and its medically needy program ($667).

Premium Structure. MBI-WPD policy requires enrollees with countable income at or above 150 percent of the FPL to pay a premium equal to the sum of 3 percent of net earned income and 7.5 percent of net unearned income. However, the state currently is not collecting premiums because it is implementing an automated premium payment collection and tracking system, which is expected to be functioning in 2007.

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

Outreach and Other Efforts. State personnel anticipate continued enrollment growth, potentially reaching as many as 20,000 enrollees within five years of the program's implementation, as outreach activities and awareness of the program continue. Outreach activities for MBI-WPD have thus far involved using the Medicaid Infrastructure Grant monies to fund outreach and education contractors, who are providing information and education to specific target populations. In addition, state personnel have developed printed materials (e.g., a color brochure and a "toolkit") to help community advocates effectively spread the word about the program.

NORTH DAKOTA

Overview. North Dakota's Workers with Disabilities (WWD) Coverage program was passed on May 3, 2004, under the Ticket Act of 1999 and went into effect on June 1, 2004. Two committees took the lead in shaping and implementing the legislation: the implementation committee, which included mostly consumers, providers, and advocates; and the steering committee, which included legislators, the state Medicaid director, and several other state agency directors. The program was designed to target the SSDI population, those in the medically needy program, and other working adults with disabilities. By the end of 2004, 254 people had enrolled in the program, roughly 10 percent more than the 225 initially projected. As of December 31, 2005, 340 individuals were enrolled – about 83 persons per 10,000 adults with disabilities in the state.

Eligibility Criteria and Program Context. North Dakota's low countable net income threshold (225 percent FPL) is among the most restrictive relative to other states. However, the absence of an unearned income limit and a moderately generous asset limit ($13,000 plus burial accounts) make the overall criteria less restrictive than many other programs. North Dakota does not have categorical Medicaid eligibility for individuals with very low income. Its medically needy program has a monthly income threshold of $500, which is in the middle range for the Buy-In states.

Premium Structure. All enrollees must pay a premium equal to five percent of his or her income. The average premium paid in 2004 was $58. In addition, each person must pay a one-time enrollment fee of $100. If premiums remain outstanding for three months, individuals are removed from the program.

Other Policies. North Dakota does not have a formal grace period as a matter of written policy. However, the state allows an individual to quit one job and take another even if the new position does not begin in the next calendar month. In addition, if an individual falls ill for an extended period and is planning and able to return to work, he or she will not lose benefits. The original legislation had a sunset review clause that required the program to be reauthorized by June 30, 2005. As a result of that review, the age range was expanded from 18-64 to 16-65 and additional assets were allowed; more importantly, the program is now in state statute without further sunsetting provisions.

Outreach and Other Efforts. North Dakota has done a significant amount of outreach, including a campaign that involved a 30-second television spot that aired for five months as well as an international award-winning promotional video. Information packets also were sent to county Social Security offices, disability advocates, and individuals on the implementation committee. In total, North Dakota estimates that it has distributed 700 to 800 packets.

OREGON

Overview. Oregon was the first state in the country to implement a Medicaid Buy-In program under the authority of the BBA, in February 1999. As part of a comprehensive work incentives initiative, Oregon's Employed Persons with Disabilities (EPD) program offers an opportunity to engage in competitive employment without losing health care coverage. As of December 31, 2005, 586 individuals were enrolled in the program – about 19 per 10,000 adults with disabilities.

Eligibility Criteria and Program Context. To be eligible for the EPD program in 2005 a person with disabilities had to have taxable income, earnings less than 250 percent of the FPL, and assets less than $5,000 (retirement accounts, medical savings accounts, and approved accounts for employment or independence are excluded from countable assets). Unearned income was disregarded for eligibility purposes, but was factored into a cost share calculation. Additionally, in 2005 participants had to earn at least $920 per quarter to enter or remain in the program.

Oregon has a relatively low monthly income threshold for 1619(b) ($2,054 in 2005) and a low SSI state supplement ($1.70). Its medically needy program was eliminated in February 2003 as part of a statewide deficit-reduction plan; this prompted some individuals previously enrolled in the medically needy program to transition into the EPD program.

Premium Structure. In 2005 participants in EPD paid a monthly premium on earned income and a "cost share" based on unearned income. The "cost-share" was equal to all unearned income minus the maintenance standard (SSI amount plus the state supplement). The premium on earned income was equal to gross income plus any unearned income remaining after the cost share was paid minus (1) mandatory taxes; (2) approved employment and independence expenses; and (3) 200 percent of the federal poverty level, and multiplying the remainder by 2 to 10 percent. The cost share likely served as a deterrent to enrollment for individuals with high-unearned income, particularly those with large SSDI benefits.

Other Policies. As of October 2005, participants who had to stop working for health or other reasons, but who retained an employment relationship with their employer and those otherwise eligible for Medicaid were allowed to remain in the program for a 12 month period.

Outreach and Other Efforts. In 2005, EPD began a pilot project in collaboration with the Medicaid Infrastructure Grant that assists participants in making timely cost share and premium payments. EPD staff did both general and targeted training and information sharing sessions throughout the year for participants, interested stakeholders, and agency staff.

PENNSYLVANIA

Overview. The Medical Assistance for Workers with Disabilities (MAWD) program began in January 2002 under the authority of the Ticket Act. Pennsylvania includes both the basic and medically improved group in the program; with 14 individuals enrolled in the latter as of November 30, 2005. Enrollment has grown consistently, reaching 5,756 participants as of December 31, 2005, representing about 59 individuals per 10,000 adults with disabilities in the state.

Eligibility Criteria and Program Context. Persons with disabilities ages 16 to 64 are eligible for MAWD if they are employed and receive compensation, have countable income below 250 percent of the FPL, and have countable assets at or below $10,000. Pennsylvania has elected the poverty-level option for its Medicaid program; persons with disabilities who have incomes below 100 percent of the FPL are eligible. The state has a 1619(b) monthly income threshold of $2,066 (toward the lower end of the range) and a combined federal and state SSI benefit of $606.40 (in the middle range). The state's medically needy program has an income threshold of $425 per month (lower than most states), but does not cover prescription drugs.

Premium Structure. MAWD participants are required to pay a premium equal to 5 percent of their countable income after deductions. Data from 2005 indicate that approximately 93 percent of MAWD enrollees paid a premium, averaging $42 per month.

Other Policies. The County Assistance Offices (CAOs) have been given an increasing amount of flexibility to keep participants in MAWD that are unable to pay their premium. Determined on a case-by-case basis, an enrollee who is unable to work due to health problems or job loss can remain in the program with their premium waived for up to two months. To prevent a potential enrollee from going without health coverage, the state provides coverage under MAWD during the disability determination process. Because verification requirements for self-employment were not consistent across state agencies, the state developed a standard self-employment verification form.

Outreach and Other Efforts. Many state and county level agencies have helped with MAWD outreach efforts. An on-going effort called "Children in Transition" informs caregivers and youth about benefits available to them, including MAWD, after graduation from High School. The Offices of Mental Retardation and Mental Health do outreach tailored to their consumers. Specialized outreach efforts for the Office of Vocational Rehabilitation and Social Security Administration offices include the distribution of educational kits, brochures and videos to a wide variety of individuals, organizations and businesses and are available in Spanish and English. Mini-grants, capped at $7,500 per organization, have been awarded to recipients such as centers for independent living, Benefits Counseling Programs, schools, social service and advocacy agencies. Many CAOs have a specialized staff person who provides outreach for the MAWD, performs initial eligibility determinations and continues work with individuals after they are deemed eligible.

SOUTH CAROLINA

Overview. The Medicaid for the Working Disabled program was implemented under the Balanced Budget Act of 1997 (BBA) on October 1, 1998. As of December 31, 2005, 40 individuals were enrolled (representing 1 individual per 10,000 adults with a disability in the state), down from 54 a year earlier and from a high of 87 at the end of 2001.

Eligibility Criteria and Program Context. Medicaid Buy-In applicants must meet two income tests. In the first test, monthly family income, after certain deductions, must be below 250 percent of the FPL. In the second test, only the individual's unearned monthly income is counted and must be less than the SSI limit of $603 in 2005. The asset limit is $2,000 for an individual, excluding spousal resources and 401(k) accounts. Overall, South Carolina's eligibility criteria are fairly stringent compared with most other states.

South Carolina offers a categorical Medicaid option for people with disabilities who earn less than 100 percent FPL and have less than $4,000 in assets (a higher limit than required under the Buy-In program). There is no medically needy program in South Carolina.

Premium Structure. Standard Medicaid co-payments are required of Buy-In enrollees, but there are no additional premiums or cost-shares. According to state officials, administrative costs associated with collecting and otherwise managing premiums payments would likely outweigh premium collections.

Other Policies. South Carolina requires income verification during the annual re-certification in the form of a pay stub or employer letter. The program does not have a grace period in case of job loss.

Outreach and Other Efforts. In 2005, South Carolina worked with 18 disability organizations to disseminate information about the Medicaid for the Working Disabled program. Information was disseminated through newsletters, special mailings, support group meetings, resource fairs, and conference sessions. Additionally, six disability organizations held two intensive consumer/family trainings with 25 participants each regarding employment and work incentives for people with disabilities. The Medicaid Division of Training also will begin providing sensitivity training for eligibility staff so that they may better support people with disabilities.

UTAH

Overview. Utah's Medicaid Work Incentive (MWI) program was enacted on July 1, 2001 under the authority of the Balanced Budget Act of 1997. It was implemented as part of the Utah Work Incentive Initiative (UWIN), a broader initiative coordinated across several state agencies to better inform and support people with disabilities in their employment. The MWI program had 374 enrollees as of December 31, 2005 – about 22 persons per 10,000 adults with disabilities in the state.

Eligibility Criteria and Program Context. A Utah resident with disabilities is eligible to enroll in the MWI program if (1) he or she is working, (2) family income is at or below 250 percent of the FPL, and (3) countable family assets are less than $15,000. The medically needy protected income level is $776, higher than any other state with a Buy-In program. In addition, Utah has a poverty level option, so individuals with disabilities who have monthly income less than 100 percent of the FPL may be eligible for Medicaid. Utah does not provide a supplement to the federal SSI benefit, which was $579 in 2005, and Utah's 1619(b) monthly income threshold of $2,193 is lower than most other Buy-In states.

Premium Structure. Buy-in participants with income levels of at least 100 percent of the FPL are required to pay premiums equal to 15 percent of a participant's countable income. About 90 percent of participants enrolled in the fourth quarter of 2004 paid premiums, which averaged $162 per month (high compared to other Buy-In states).

Other Policies. Utah initially had a policy whereby MWI enrollees who lost their job involuntarily could remain in the program for up to 12 months, but this policy was eliminated as of July 2002. Wage earner enrolled in the MWI must show proof of FICA tax payment.

Outreach and Other Efforts. Outreach has conducted through consumer job fairs, agency information fairs, disability-related conferences, and employment specialists' trainings. Findings from focus groups in 2002 suggest positive effects of the MWI program. Based on data from a telephone survey, 46 percent of MWI participants continuously enrolled in the program from its inception through August 2002 noted that the program had helped them "go to work," and 12 percent noted that enrollment allowed them to "take on more responsibilities."

Medicaid policy staff provides quarterly training to all eligibility workers. Further training of agency staff such as Vocational Rehabilitation counselors, employment specialists, and support coordinators occurs regularly.

VERMONT

Overview. Medicaid for Working People with Disabilities (WPWD), Vermont's Medicaid Buy-In program, was implemented in January 1, 2000 under the authority of the Balanced Budget Act (BBA) of 1997. WPWD was implemented as part of the Vermont Work Incentives Initiative (VWII), a broader effort to implement system-wide reforms to support people with disabilities in finding and keeping employment. As of December 31, 2005, WPWD had 606 enrollees – about 115 persons per 10,000 adults with disabilities in the state.

Eligibility Criteria and Program Context. WPWD has a two-step income test: 1) employed persons with disabilities must have a family net income less than 250 percent of FPL and 2) income can not exceed either the Medicaid protected income level or the SSI payment level, whichever is higher, after disregarding earnings and SSDI benefits. The asset limit at enrollment is $5,000 per individual and $6,000 per couple. After enrollment, there is no limit on the amount of assets that a participant may accumulate from earnings. The program has an unearned income eligibility limit of $500, which prevents many SSDI beneficiaries from meeting eligibility criteria. Compared with other states, Vermont has a high medically needy threshold of $800 per month.

Premium Structure. WPWD participants are required to pay the co-payments and coinsurance that is required of all Medicaid beneficiaries.

Other Policies. Vermont does not have a grace period. In an effort to more clearly define the types of income that considered valid for eligibility determination purposes, the state requires that participants demonstrate that their earnings were subject to Federal Insurance Contributions Act (FICA) taxes. Self-employed individuals are required to show evidence of Self-employment Contributions Act (SECA) taxes or a business plan supported by a third-party investor or funding source.

Outreach and Other Efforts. Vermont eligibility staff and benefit counselors are trained specifically on the WPWD program. The state also has disseminated pamphlets and other educational materials about the program. While the state covers personal assistance services (PAS), only a small handful of program participants receive these services, possibly because the approval process is extensive and lengthy, and possibly because the majority of consumers who would meet the activities-of-daily-living or institutional-level-of-care eligibility criteria for PAS have already acquired health coverage under an alternative program and are not currently seeking the earnings protection of the Buy-In.

WASHINGTON

Overview. Washington adopted its Buy-In program, Healthcare for Workers with Disabilities (HWD), in January 2002 under the authority of the Ticket Act. The state elected to cover both the Basic Coverage Group and the Medical Improvement Group, although no one has yet enrolled in the Medical Improvement Group. As of December 31, 2005, 792 individuals were enrolled in HWD—about 15 persons per 10,000 adults with disabilities in the state.

Program Context and Eligibility Criteria. Applicants to HWD do not have to meet any asset test, but must have net income less than 220 percent of the FPL. Washington does not have a poverty level option; therefore individuals with disabilities who have monthly income less than 100 percent of the FPL are not eligible for Medicaid. The state's 1619(b) earning threshold ($1,886 in 2005) is low relative to other Buy-In states but it's protected income level of $579 for the medically needy program is higher than most other Buy-In states. The combined federal and state SSI benefit of $579 is similar to many other states.

Premium Structure. The premium amount is the lesser of 7.5 percent of total income or the sum of the following: 50 percent unearned income above the medically needy income level, plus 5 percent of total unearned income, plus 2.5 percent earned income after a $65 deduction. All HWD participants enrolled during the entire fourth quarter of 2004 paid a premium; overall, monthly premiums averaged $86 in 2004.

Other Policies. If HWD participants lose their job, they can choose to continue enrollment through the end of their current 12-month certification period, as long as (1) the job loss is due to a health crisis or involuntary dismissal; (2) they intend to return to work; and (3) they continue to pay monthly premiums based on their remaining income. Participants in the basic coverage group must have earnings subject to federal income taxes, and self-employed participants must provide tax forms or business records. Participants in the medical improvement group must work at least 40 hours per month and earn at least minimum wage.

Outreach and Other Efforts. The state continues to fund and facilitate community activities that support and strengthen the awareness and use of SSA and Medicaid work incentives, including its HWD program. One of the primary goals of the state's Medicaid Infrastructure Grant program is to increase the number of individuals with disabilities who make an informed choice to work in an environment that empowers them with opportunities for career advancement and asset development.

WEST VIRGINIA

In April 2003, West Virginia established the Medicaid Work Incentive (M-WIN) under the Ticket Act of 1999, covering both the basic and the medically improved groups. The program began enrolling participants on May 1, 2004 and included 216 individuals as of December 31, 2005—about 9 persons per 10,000 adults with disabilities in the state. The only entrance to the program is through enrollment in the basic coverage group; thus far, only one individual has moved from the basic to the medically improved group.

Eligibility Criteria and Program Context. The program's countable income limit, based on individual earnings, is 250 percent FPL, and the unearned income limit is $584. The program has a $2,000 asset limit, but an individual may exclude $5,000 in liquid assets. (A couple may have $10,000 in liquid asset exclusions, with a $3,000 asset limit.) Retirement accounts are excluded from countable assets, as are independence accounts. Basic group enrollees must be engaged in competitive work in an integrated setting earning at least minimum wage. Those who move into the medically improved group are subject to the same eligibility criteria as the basic group except that they must earn a monthly wage equivalent to working 40 hours per month at minimum wage. West Virginia does not offer a categorical Medicaid option for individuals with very low incomes. The state has a low medically needy protected income level ($200 per month) compared with other states, and a combined state and federal SSI benefit ($579) that is similar to most other states. The 1619(b) monthly income threshold is $2,029, which is low relative to other states.

Premium Structure. The M-WIN premium is based on a sliding scale according to the average monthly gross income, established every 6 months. The premium amount ranges from a minimum of $15 to no more than 3.5 percent of an individual's gross annual income. Each individual also must pay a $50 enrollment fee, which includes the first month's premium. Medicaid coverage begins on the first day of the month following payment of the enrollment fee.

Other Policies. M-WIN has a grace period under which enrollees who have lost their jobs will not lose their Medicaid benefits for six months as long as they submit a written request within 30 days of job termination to continue their coverage. In addition, they must continue to pay monthly premiums and maintain a connection to the workforce by enrolling in a vocational rehabilitation program, registering with the Office of Work Force Development, participating in a transitional school-to-work program, or providing documentation from their employer stating that they are on temporary involuntary leave. All enrollees are required to verify income through a pay stub, self-employment records, or an employer letter, but they do not have to document payment of FICA or income taxes.

Outreach and Other Efforts. The state made substantial outreach and dissemination efforts in 2005 that contributed to a 167 percent increase in enrollment during the year.

WISCONSIN

Overview. Wisconsin established its Medicaid Purchase Plan (MAPP) in March 2000 under the authority of the Balanced Budget Act as a program designed to increase work incentives for persons with disabilities. MAPP has become the second largest Buy-In program in the nation with 9,718 participants as of December 31, 2005—about 258 persons per 10,000 adults with disabilities in the state.

Eligibility Criteria and Program Context. Wisconsin's MAPP program is available to persons with disabilities age 18 and over with net countable income up to 250 percent of the FPL and assets up to $15,000. In addition, MAPP participants are allowed, once enrolled, to accumulate assets above the resource limit. Compared to other states with Buy-In programs, MAPP has an above average combined federal and state SSI supplement ($683) and protected income level for its medically needy program ($592). The state also has a relatively high monthly 1619(b) threshold of $2,304.

Premium Structure. MAPP participants with countable income from 150 to 250 percent of the FPL pay a premium equal to the sum of 1) three percent of an individual's earned income and 2) 100 percent of unearned income less the standard living allowance and exclusions. About 90 percent of MAPP participants enrolled in the fourth quarter of 2004 did not pay a premium, suggesting that the countable income among these individuals was below 150 percent of the FPL. Premiums among the 10 percent of participants who paid a premium averaged $143 in 2004.

Other Policies. If MAPP participants do not have earnings from work, they may participate in health and employment counseling (HEC) for up to a year, after which earnings from employment are required. However, less than five percent of MAPP participants take advantage of this option. For MAPP participants with health problems that prevent them from working, Wisconsin waives the work requirement for up to 6 months. To be eligible for this work protection feature, participants must be enrolled in the Buy-In program for at least six months and it only can be used twice every three years.

Outreach and Other Efforts. Local Collaborations is an outreach initiative designed to inform MAPP participants about available work incentives by convening groups of MAPP participants and area employment professionals to discuss employment and benefit concerns on an ongoing basis.

WYOMING

Overview. Wyoming's Medicaid Buy-In Program, Employed Individuals with Disabilities (EID), was authorized under the Ticket Act and implemented in July 2002; however, eligibility criteria established in the original version of the legislation was too restrictive. CMS gave Wyoming conditional status in 2003 and 2004 to work through eligibility requirements with the state Legislature. Many key legislators and state administrators did not fully understand the Buy-In program were reluctant to expand public benefits in Wyoming. Through extensive discussions during individual and committee meetings state Medicaid officials and MIG staff members were finally successful in convincing four key bipartisan legislators to support legislation expanding benefits under Wyoming's EID Program, which made the program compliant with CMS rules in 2005. As of December 2005, 8 individuals were enrolled in EID, or about 2 people per 10,000 working aged state residents with a disability.

Program Context and Eligibility Criteria. EID had an income limit of $1,737 and an asset limit of $2000 in 2005. Wyoming has a poverty level Medicaid option for individuals who earn up to 300 percent of SSI, or $1,737 per month. Because this limit is the same as the income limit for the Buy-In program, relatively few low-income workers have joined the Buy-In to obtain Medicaid. The Buy-In program, however, does allow individuals to keep somewhat more assets than the poverty-level option. The state's 1619(b) income threshold of $1915.67 is higher than the income limit for the Buy-In program. State respondents note that low enrollment in Wyoming is likely linked to a lack of knowledge about the program and not program context or eligibility criteria as the program was not advertised (due to state Medicaid rules that prohibits marketing) nor were field workers trained or written policy manuals written about EID.

Premium Structure. All EID participants are required to pay a premium of 7.5 percent of earned income and 7.5 percent of unearned income over $600. Individuals who are unable to pay premiums lose Medicaid coverage.

Other Policies. Participants in the EID are required to submit pay stubs for income verification, as are enrollees in traditional Medicaid. Wyoming does not have a grace period. Individuals who are no longer working lose Medicaid coverage the month after a ten-day notice is provided.

Outreach and Other Efforts. Wyoming MIG staff has reached out to state and local business council staff and Chamber of Commerce officials to help them recognize people with disabilities as an overlooked employment force. Also, in and before 2005, MIG staff worked with Business Leadership Network (BLN) representatives to promote people with disabilities as important, viable and effective human resources to their members. In addition to these industry-focused efforts, Wyoming is currently working to create a brochure about the Medicaid Buy-In to increase awareness of the program as well as preparing to host town hall meetings and presentations in ten to twelve communities, focusing on providers and potential participants.

APPENDIX C

BACK-UP TABLES FOR CHAPTER III

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TABLE C.1

YEARLY BUY-IN ENROLLMENT: 1997-2005

Year of Program Implementation	State	Buy-In Enrollment as of December 31 of the Year: 1997	1998	1999	2000	2001	2002	2003	2004	2005
1997	Massachusetts	2114	2604	3488	4726	5842	7441	7678	8327	9746
1998	South Carolina	0	18	41	78	87	79	53	54	40
1999	Alaska[a]	0	0	0	75	116	169	199	214	212
1999	Maine	0	0	124	485	661	717	600	666	716
1999	Minnesota	0	0	3288	5825	6298	6302	6549	6311	6642
1999	Nebraska	0	0	34	106	109	105	113	124	113
1999	Oregon	0	0	8	335	510	606	617	588	586
2000	California	0	0	0	230	522	688	893	1183	1777
2000	Connecticut	0	0	0	966	1975	2489	2966	3343	4039
2000	Iowa	0	0	0	2193	3576	5244	6589	8144	9541
2000	New Jersey	0	0	0	6	324	646	1048	1481	1904
2000	Vermont	0	0	0	247	354	449	502	550	606
2000	Wisconsin	0	0	0	941	1720	3852	5712	7848	9718
2001	Arkansas	0	0	0	0	198	111	94	105	112
2001	New Mexico	0	0	0	0	498	814	1036	1299	1563
2001	Utah	0	0	0	0	189	221	239	312	374
2002	Illinois	0	0	0	0	11	331	549	693	800
2002	Indiana	0	0	0	0	0	3869	5769	6695	5807
2002	Kansas	0	0	0	0	0	489	681	849	1013
2002	New Hampshire	0	0	0	0	0	1015	1270	1432	1419
2002	Pennsylvania	0	0	0	0	0	871	1769	3162	5756
2002	Washington	0	0	0	0	0	147	244	463	792
2002	Wyoming	0	0	0	0	0	3	4	5	8
2003	New York	0	0	0	0	0	0	948	2706	4013
2004	Louisiana	0	0	0	0	0	0	0	478	796
2004	Michigan	0	0	0	0	0	0	0	29	579
2004	Nevada	0	0	0	0	0	0	0	7	22
2004	North Dakota	0	0	0	0	0	0	0	254	340
2004	West Virginia	0	0	0	0	0	0	0	81	216
	Total Enrollment[b]	2,114	2,622	6,983	16,205	22,978	36,617	46,047	57,290	69,092

Source: Participant-level data submitted by states (April 2006)

[a]Even though Alaska implemented a Buy-In program in 1999, no participants were enrolled until 2000.
[b]Some individuals were enrolled in more than one state over the course of their Buy-In participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.

TABLE C.2

PERCENT OF RESIDENTS AGE 16 to 64 WITH A DISABILITY, BY STATE

State	Number	Percent
Alaska	58,911	13.8
Arkansas	314,050	18.1
California	2,357,073	10.3
Connecticut	218,162	9.8
Illinois	797,221	9.8
Indiana	510,616	12.9
Iowa	208,682	11.2
Kansas	197,149	11.4
Louisiana	443,364	15.5
Maine	129,945	15.1
Massachusetts	426,204	10.4
Michigan	835,017	12.9
Minnesota	321,129	9.6
Missouri	535,867	14.5
Nebraska	121,053	11.0
Nevada	147,732	9.5
New Hampshire	95,475	11.2
New Jersey	501,133	9.1
New Mexico	179,241	14.6
New York	1,343,101	10.9
North Dakota	40,907	10.2
Oregon	311,930	13.2
Pennsylvania	973,492	12.5
South Carolina	401,805	14.9
Utah	167,777	10.8
Vermont	52,875	12.9
Washington	544,482	13.2
West Virginia	236,443	20.2
Wisconsin	377,053	10.6
Wyoming	42,657	12.7

Source: 2005 American Community Survey, US Census Bureau. Available at: http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2005_EST_G00_&_lang=en&_ts=175093627438

APPENDIX D

BACK-UP TABLES FOR CHAPTER IV

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TABLE D.1

DEMOGRAPHIC CHARACTERISTICS OF MEDICAID BUY-IN PARTICIPANTS

State	Number Ever Enrolled in the Buy-In through December 2005	Gender (Percent)		Age (Percent)[a]					Legislative Authority (BBA or Ticket Act Basic)
		Male	Female	Under 18	18-21	22 to 44	45 to 64	65+	
Alaska	727	53.9	46.1	0.3	1.0	40.4	48.0	10.3	BBA
Arkansas	280	47.9	52.1	0.7	3.6	41.1	54.6	0.0	Ticket Act Basic
California	3,337	56.4	43.6	0.1	0.4	32.2	59.1	8.2	BBA
Connecticut	7,825	50.5	49.5	0.0	2.9	58.3	38.4	0.3	Ticket Act Basic[c]
Illinois	1,475	49.0	51.0	0.1	1.9	52.5	45.5	0.0	Ticket Act Basic
Indiana	14,423	50.5	49.5	0.1	4.2	51.4	44.2	0.1	Ticket Act Basic
Iowa	14,311	49.6	50.4	0.0	1.0	40.1	58.4	0.4	BBA
Kansas	1,571	47.6	52.4	0.0	1.5	51.6	46.9	0.1	Ticket Act Basic[c]
Louisiana	992	44.5	55.5	0.1	2.2	44.4	53.3	0.0	Ticket Act Basic
Maine	2,936	49.8	50.2	0.1	1.8	49.6	41.0	7.5	BBA
Massachusetts	26,324	49.2	50.8	0.6	3.7	48.0	46.4	1.2	1115 Waiver
Michigan	677	46.5	53.5	0.0	0.4	49.5	49.9	0.1	Ticket Act Basic
Minnesota	15,479	50.4	49.6	0.1	1.7	52.1	46.0	0.1	BBA[b]
Missouri	27,013	47.1	52.9	0.0	1.6	34.4	64.0	0.0	Ticket Act Basic
Nebraska	412	49.8	50.2	0.0	0.7	58.5	40.5	0.2	BBA
Nevada	27	37.0	63.0	0.0	7.4	63.0	29.6	0.0	Ticket Act Basic
New Hampshire	2,924	50.0	50.0	0.0	4.4	55.0	40.6	0.0	Ticket Act Basic
New Jersey	2,682	48.4	51.6	0.0	2.5	55.1	42.3	0.1	Ticket Act Basic
New Mexico	3,757	51.8	48.2	0.0	1.5	38.9	56.5	3.1	BBA
New York	4,821	54.0	46.0	0.0	1.4	52.5	46.0	0.1	Ticket Act Basic[c]
North Dakota	417	54.2	45.8	0.0	1.0	51.1	48.0	0.0	Ticket Act Basic
Oregon	1,707	48.2	51.8	0.0	1.0	50.6	45.9	2.5	BBA
Pennsylvania	7,829	44.2	55.8	0.3	3.2	45.2	51.3	0.1	Ticket Act Basic[c]
South Carolina	185	45.9	54.1	0.0	4.9	59.5	35.7	0.0	BBA
Utah	1,844	50.2	49.8	0.4	1.4	48.6	46.3	3.3	BBA
Vermont	1,753	50.7	49.3	0.0	1.0	48.4	44.4	6.1	BBA
Washington	1,083	49.8	50.2	0.0	1.3	46.5	52.2	0.0	Ticket Act Basic[c]
West Virginia	264	31.8	68.2	0.0	5.3	48.9	45.5	0.4	Ticket Act Basic[c]
Wisconsin	14,337	50.0	50.0	0.0	1.4	37.4	53.7	7.5	BBA
Wyoming	18	44.4	55.6	0.0	0.0	55.6	44.4	0.0	Ticket Act Basic
Total:[d]	161,123	49.3	50.7	0.2	2.3	45.1	51.0	1.5	N/A

TABLE D.1 (*continued*)

Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF).

[a]Age is measured at participant's first Buy-In enrollment date.
[b]Minnesota's Buy-In was originally authorized via the BBA through October 2000, and subsequently via Ticket Act Basic as of November 2000.
[c]These states also have a medical improvement group.
[d]Some individuals were enrolled in more than one state over the course of their Buy-In participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.

TABLE D.2

DEMOGRAPHIC CHARACTERISTICS OF MEDICAID BUY-IN PARTICIPANTS

State	Number Ever Enrolled in the Buy-In through December 2005	Ethnicity: Percent[a]								Ethnicity: Percent[d]	
		White	African American	Hispanic or Latino	Asian or Pacific Islander	American Indian or Alaskan Native	Other	Unknown, Unknown, Participant in TRF[b]	Participant not in TRF[c]	White	Non-White
Alaska	727	58.2	5.0	2.6	4.4	10.9	6.5	2.1	10.5	61.3	38.7
Arkansas	280	77.1	8.6	1.4	0.0	0.0	0.0	0.7	12.1	87.5	12.5
California	3,337	66.0	7.8	8.6	2.3	0.6	1.4	1.9	11.4	72.8	27.2
Connecticut	7,825	66.5	15.0	7.0	1.1	0.2	0.6	2.7	6.7	73.8	26.2
Illinois	1,475	74.2	11.8	2.1	0.9	0.3	0.2	1.2	9.4	83.5	16.5
Indiana	14,423	60.8	7.9	0.6	0.2	0.1	0.2	1.9	28.3	87.4	12.6
Iowa	14,311	89.2	3.9	0.9	0.5	0.3	0.3	1.8	3.1	70.7	29.3
Kansas	1,571	85.1	8.5	2.2	0.6	0.8	0.3	1.5	1.0	89.0	11.0
Louisiana	992	40.3	30.3	1.0	0.4	0.3	0.1	1.5	26.0	53.5	46.5
Maine	2,936	77.1	0.5	0.4	0.6	0.4	0.1	1.6	19.1	94.4	5.6
Massachusetts	26,324	57.8	5.3	2.8	0.7	0.1	0.6	2.1	30.5	45.0	55.0
Michigan	677	71.6	19.6	2.1	0.6	0.4	0.4	1.2	4.0	74.9	25.1
Minnesota	15,479	85.1	4.4	0.9	0.7	0.6	0.4	2.7	5.1	91.3	8.7
Missouri	27,013	75.9	6.0	0.4	0.3	0.3	0.1	1.5	15.4	89.2	10.8
Nebraska	412	85.2	8.5	1.5	0.5	1.9	0.5	1.5	0.5	87.1	12.9
Nevada	27	81.5	11.1	0.0	0.0	0.0	3.7	0.0	3.7	85.2	14.8
New Hampshire	2,924	79.1	0.9	0.4	0.5	0.4	0.2	1.4	17.1	97.1	2.9
New Jersey	2,682	62.5	16.1	3.8	1.5	0.1	0.8	1.9	13.4	73.0	27.0
New Mexico	3,757	48.0	2.5	28.8	0.4	4.2	3.0	1.3	11.9	44.2	55.8
New York	4,821	74.8	9.6	2.0	0.7	0.3	0.7	3.3	8.6	80.3	19.7
North Dakota	417	90.9	0.5	0.2	0.7	1.0	1.0	2.6	3.1	97.8	2.2
Oregon	1,707	82.2	3.4	2.3	1.1	0.9	0.3	2.3	7.4	91.9	8.1
Pennsylvania	7,829	54.5	6.6	0.9	0.4	0.2	0.1	1.1	36.2	87.8	12.2
South Carolina	185	40.5	39.5	1.1	0.0	0.0	0.0	0.0	18.9	51.9	48.1
Utah	1,844	73.9	1.1	4.4	1.3	1.1	0.9	1.4	15.9	95.6	4.4
Vermont	1,753	88.4	0.7	0.3	0.5	0.7	0.2	2.6	6.6	78.4	21.6
Washington	1,083	79.0	3.7	1.8	2.8	0.7	1.3	2.3	8.3	83.6	16.4
West Virginia	264	12.1	0.8	0.0	0.0	0.0	0.0	0.0	87.1	95.8	4.2
Wisconsin	14,337	80.6	6.3	1.1	0.5	0.5	0.3	2.7	8.0	85.7	14.3
Wyoming	18	83.3	0.0	5.6	0.0	0.0	0.0	0.0	11.1	94.4	5.6

State	Number Ever Enrolled in the Buy-In through December 2005	Ethnicity: Percent[a]								Ethnicity: Percent[d]	
		White	African American	Hispanic or Latino	Asian or Pacific Islander	American Indian or Alaskan Native	Other	Unknown, Participant t in TRF[b]	Unknown, Participant not in TRF[c]	White	Non-White
Total[e]	161,123	71.4	6.4	2.4	0.6	0.5	0.5	2.0	16.2	77.0	23.0

Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF).

[a] Ethnicity according to the Ticket Research File (TRF).
[b]"In TRF" indicates that the individual was found in the Ticket Research File, meaning that he or she received SSDI and/or SSI benefits at some point between January 1996 and December 2005 and was between 18 and 64 years of age when receiving these benefits.
[c]"Not in TRF" indicates that the individual was not found in the Ticket Research File, meaning that he or she did not receive SSDI or SSI benefits at any point between January 1996 and December 2005, or was not between the ages of 18 and 64 during that period.
[d]Ethnicity according to state-submitted finder file data
[e]Some individuals were enrolled in more than one state over the course of their Buy-In participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.

TABLE D.3

DISABILITY-RELATED CHARACTERISTICS OF MEDICAID BUY-IN PARTICIPANTS

State	Number Ever Enrolled in the Buy-In through December 2005	Primary Disabling Condition of Buy-In Participants: Mental Illness and Other Mental Disorders	Mental Retardation	Musculo-skeletal Disorder	Sensory Disorder	All Other	Unknown, Participant in TRF [a]	Unknown, Participant Not in TRF [b]
Alaska	727	25.7	5.9	14.6	3.6	29.7	10.0	10.5
Arkansas	280	23.9	7.5	12.5	2.5	29.3	12.1	12.1
California	3,337	33.7	7.0	9.7	2.6	28.3	7.3	11.4
Connecticut	7,825	41.6	19.0	4.4	3.1	17.0	8.1	6.7
Illinois	1,475	44.5	16.0	4.6	3.1	16.3	6.2	9.4
Indiana	14,423	16.5	23.1	2.4	0.9	10.6	18.1	28.3
Iowa	14,311	34.4	10.9	14.5	2.4	28.2	6.7	3.1
Kansas	1,571	46.3	15.7	8.3	3.2	21.2	4.3	1.0
Louisiana	992	15.3	7.3	9.2	4.1	26.8	11.3	26.0
Maine	2,936	33.4	8.7	8.6	2.7	16.8	10.7	19.1
Massachusetts	26,324	26.2	6.0	6.5	1.8	15.3	13.7	30.5
Michigan	677	43.9	12.4	9.9	3.5	21.4	4.9	4.0
Minnesota	15,479	41.5	17.4	5.5	2.4	19.3	8.8	5.1
Missouri	27,013	19.6	8.0	17.4	1.0	28.8	9.8	15.4
Nebraska	412	37.4	11.2	11.7	4.9	31.3	3.2	0.5
Nevada	27	40.7	7.4	7.4	0.0	37.0	3.7	3.7
New Hampshire	2,924	49.3	11.3	4.3	1.4	10.0	6.7	17.1
New Jersey	2,682	42.0	10.7	4.8	3.8	18.8	6.6	13.4
New Mexico	3,757	25.5	2.6	15.7	2.5	34.2	7.7	11.9
New York	4,821	36.9	22.1	4.9	3.2	15.5	8.9	8.6
North Dakota	417	26.6	37.4	5.5	1.9	17.5	7.9	3.1
Oregon	1,707	33.0	13.4	8.7	3.7	26.1	7.9	7.4
Pennsylvania	7,829	22.9	4.9	8.5	1.5	19.0	6.9	36.2
South Carolina	185	14.1	12.4	2.2	5.4	20.5	26.5	18.9
Utah	1,844	33.5	7.5	7.6	2.7	23.2	9.6	15.9
Vermont	1,753	43.6	8.0	11.3	3.4	21.2	6.0	6.6
Washington	1,083	51.0	11.8	5.2	2.0	16.5	5.2	8.3
West Virginia	264	2.3	0.0	0.8	0.4	2.3	7.2	87.1
Wisconsin	14,337	32.5	11.7	11.6	2.1	24.6	9.5	8.0
Wyoming	18	5.6	0.0	5.6	0.0	61.1	16.7	11.1
Total [c]	161,123	29.6	11.6	9.4	2.0	21.0	10.1	16.2

Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF).

[a] "In TRF" indicates that the individual was found in the Ticket Research File, meaning that he or she received SSDI and/or SSI benefits at some point between January 1996 and December 2005 and was between 18 and 64 years of age when receiving these benefits.

[b] "Not in TRF" indicates that the individual was not found in the Ticket Research File, meaning that he or she did not receive SSDI or SSI benefits at any point between January 1996 and December 2005, or was not between the ages of 18 and 64 during that period.

[c] Some individuals were enrolled in more than one state over the course of their Buy-In participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.

TABLE D.4

RECEIPT OF SSI AND SSDI BENEFITS DURING THE YEAR PRIOR TO BUY-IN ENROLLMENT

State	Number Ever Enrolled in the Buy-In through December 2005[a]	During Year Prior to Buy-In Enrollment, Percent who Received: SSDI Only	SSI Only	Both SSI and SSDI	Neither SSI nor SSDI
Alaska	727	56.7	8.0	12.7	22.7
Arkansas	280	56.4	2.1	16.4	25.0
California	3,337	71.7	1.3	7.3	19.7
Connecticut	7,825	56.5	9.9	20.4	13.2
Illinois	1,475	69.1	3.3	10.8	16.8
Indiana	14,423	41.7	4.0	11.4	42.9
Iowa	14,311	65.7	2.3	23.4	8.7
Kansas	1,571	77.7	1.1	14.9	6.2
Louisiana	992	44.1	3.7	13.5	38.7
Maine	2,936	54.1	2.4	13.6	29.9
Massachusetts	24,037	45.5	1.0	5.5	47.9
Michigan	677	79.0	2.2	10.0	8.7
Minnesota	15,479	74.7	1.4	11.8	12.2
Missouri	27,013	60.0	3.2	13.6	23.2
Nebraska	412	72.8	2.4	19.2	5.6
Nevada	27	48.1	11.1	18.5	22.2
New Hampshire	2,924	56.8	3.9	15.9	23.5
New Jersey	2,682	64.2	1.2	13.8	20.8
New Mexico	3,757	16.7	7.1	58.3	17.9
New York	4,821	74.7	0.8	8.0	16.5
North Dakota	417	77.2	0.5	15.6	6.7
Oregon	1,707	67.7	2.6	12.5	17.3
Pennsylvania	7,829	43.6	1.5	11.0	43.9
South Carolina	185	33.0	5.4	10.3	51.4
Utah	1,844	55.3	2.1	16.0	26.6
Vermont	1,753	67.8	2.2	18.0	12.0
Washington	1,083	74.3	1.0	9.3	15.3
West Virginia	264	1.5	1.1	1.5	95.8
Wisconsin	14,337	65.7	2.0	17.7	14.6
Wyoming	18	38.9	5.6	33.3	22.2
Total[b]	158,836	57.5	2.7	14.3	25.5

Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF).

[a]This analysis is restricted to participants enrolling in the Buy-In after January 1998 so that there would be more than one year of data prior to Buy-In enrollment for all participants included in the analysis.
[b]Some individuals were enrolled in more than one state over the course of their Buy-In participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.

TABLE D.5

RECEIPT OF SSDI BENEFITS AMONG BUY-IN PARTICIPANTS

State	Number Ever Enrolled in the Buy-In through December 2005[a]	Percent Who Ever Received SSDI Benefits (1997-2005)	Among Buy-In Participants, When Were SSDI Benefits First Received? Greater than Two Years Prior to Buy-In Enrollment	Between One and Two Years Prior to Buy-In Enrollment	During the Year Prior to Buy-In Enrollment	During the Year Following Buy-In Enrollment	Greater than One Year Following Buy-In Enrollment	No Receipt of SSDI Benefits (1997 - 2005)
Alaska	727	77.3	54.7	9.8	9.2	2.3	1.2	22.7
Arkansas	280	81.4	56.1	10.4	8.6	3.9	2.5	18.6
California	3,337	85.2	68.2	8.8	6.4	0.8	0.9	14.8
Connecticut	7,825	83.5	63.5	8.5	7.5	1.6	2.5	16.5
Illinois	1,475	84.9	69.2	8.3	5.2	1.0	1.3	15.1
Indiana	14,423	63.6	46.6	4.2	4.5	5.0	3.2	36.4
Iowa	14,311	93.3	61.2	12.5	16.7	1.7	1.1	6.7
Kansas	1,571	96.8	76.4	10.0	8.6	1.1	0.7	3.2
Louisiana	992	66.1	44.4	7.8	10.1	3.9	0.0	33.9
Maine	2,936	76.4	56.9	7.3	5.6	3.7	3.0	23.6
Massachusetts	22,410	62.2	41.1	7.9	6.6	2.7	3.9	37.8
Michigan	677	93.2	83.3	5.0	4.7	0.1	0.0	6.8
Minnesota	15,479	92.3	68.3	9.9	10.1	1.8	2.2	7.7
Missouri	27,013	79.1	53.6	10.2	11.1	2.6	1.5	20.9
Nebraska	412	96.8	70.4	12.6	11.9	0.5	1.5	3.2
Nevada	27	81.5	63.0	11.1	3.7	3.7	0.0	18.5
New Hampshire	2,924	78.3	60.9	7.4	6.4	2.1	1.4	21.7
New Jersey	2,682	83.3	61.4	10.1	9.4	1.5	0.9	16.7
New Mexico	3,757	80.8	14.9	18.8	43.5	2.5	1.2	19.2
New York	4,821	87.9	76.6	5.9	3.8	1.3	0.3	12.1
North Dakota	417	95.9	80.3	6.5	7.4	1.7	0.0	4.1
Oregon	1,707	88.1	73.0	5.8	5.3	1.5	2.5	11.9
Pennsylvania	7,829	58.5	36.9	8.3	10.9	1.4	1.1	41.5
South Carolina	162	69.1	45.1	1.9	3.1	10.5	8.6	30.9
Utah	1,844	79.2	56.1	8.5	8.4	5.1	1.1	20.8
Vermont	1,753	89.8	69.5	9.9	8.6	1.0	0.8	10.2
Washington	1,083	88.6	73.5	8.8	4.9	0.6	0.7	11.4
West Virginia	264	5.7	2.7	0.0	1.5	1.1	0.4	94.3
Wisconsin	14,337	88.0	60.9	10.3	14.0	1.8	1.1	12.0
Wyoming	18	77.8	27.8	11.1	33.3	5.6	0.0	22.2

State	Number Ever Enrolled in the Buy-In through December 2005[a]	Percent Who Ever Received SSDI Benefits (1997-2005)	Among Buy-In Participants, When Were SSDI Benefits First Received? Greater than Two Years Prior to Buy-In Enrollment	Between One and Two Years Prior to Buy-In Enrollment	During the Year Prior to Buy-In Enrollment	During the Year Following Buy-In Enrollment	Greater than One Year Following Buy-In Enrollment	No Receipt of SSDI Benefits (1997 - 2005)
Total[b]	157,186	78.7	55.0	9.1	10.3	2.4	2.0	21.3

Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF).

[a]This analysis is restricted to participants enrolling in the Buy-In after January 1999, so that there would be more than two years of data prior to Buy-In enrollment for all participants included in the analysis.

[b]Some individuals were enrolled in more than one state over the course of their Buy-In participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.

TABLE D.6

MEDICARE ELIGIBILITY AMONG BUY-IN PARTICIPANTS RECEIVING SSDI

State	Number Ever Enrolled in the Buy-In through December 2005	Percent of Buy-In Participants Who Ever Received Medicare (1997 – 2005):[a]	Percent of Buy-In Participants Who First Received Medicare:			Percent of Buy-In Participants With SSDI Benefits and No Medicare Eligibility (1997-2005)	Percent of Buy-In Participants Who Did Not Receive SSDI Benefits (1997-2005)
			Prior to Buy-In Enrollment	Within One Year following Buy-In Enrollment	Greater than One Year Following Buy-In Enrollment		
Alaska	727	71.1	55.0	8.8	7.3	6.2	22.7
Arkansas	280	76.1	54.3	10.4	11.5	5.4	18.6
California	3,337	79.9	68.0	7.1	4.7	5.3	14.8
Connecticut	7,825	78.8	63.3	7.7	7.8	4.7	16.5
Illinois	1,475	79.7	70.0	6.0	3.6	5.2	15.1
Indiana	14,423	57.0	46.4	4.4	6.3	6.6	36.4
Iowa	14,311	84.1	61.8	11.5	10.8	9.2	6.7
Kansas	1,571	91.5	77.8	8.8	4.9	5.3	3.2
Louisiana	992	53.6	44.6	7.4	1.7	12.5	33.9
Maine	2,936	71.4	56.5	6.1	8.8	5.0	23.6
Massachusetts	26,324	55.9	40.5	6.1	9.4	6.7	37.4
Michigan	677	86.1	84.9	1.2	0.0	7.1	6.8
Minnesota	15,479	88.3	68.6	8.8	10.9	4.0	7.7
Missouri	27,013	72.8	53.8	9.9	9.1	6.2	20.9
Nebraska	412	92.2	71.6	10.9	9.7	4.6	3.2
Nevada	27	66.7	59.3	7.4	0.0	14.8	18.5
New Hampshire	2,924	73.0	61.1	7.2	4.7	5.3	21.7
New Jersey	2,682	75.8	62.3	8.5	5.0	7.5	16.7
New Mexico	3,757	55.3	15.3	16.9	23.2	25.5	19.2
New York	4,821	84.1	78.1	4.9	1.0	3.8	12.1
North Dakota	417	89.7	82.5	6.2	1.0	6.2	4.1
Oregon	1,707	85.7	72.8	5.3	7.6	2.4	11.9
Pennsylvania	7,829	49.4	37.6	6.7	5.0	9.1	41.5
South Carolina	185	61.6	41.1	2.7	17.9	5.9	32.4
Utah	1,844	71.8	56.9	8.2	6.7	7.4	20.8
Vermont	1,753	85.2	69.3	8.6	7.4	4.6	10.2
Washington	1,083	82.5	74.6	5.7	2.2	6.0	11.4
West Virginia	264	2.3	2.3	0.0	0.0	3.4	94.3
Wisconsin	14,337	79.5	61.9	9.2	8.6	8.5	12.0
Wyoming	18	38.9	27.8	5.6	5.6	38.9	22.2
Total[b]	161,123	71.4	54.9	8.1	8.5	7.0	21.6

TABLE D.6 (*continued*)

Sources: Participant-level data submitted by states (April 2006) and the Ticket Research File (TRF).

[a]This analysis only includes those becoming eligible for Medicare in conjunction with SSDI. A small percentage of additional Buy-In participants (including the 1.5 percent of participants age 65 and above) will also be Medicare eligible.
[c]Some individuals were enrolled in more than one state over the course of their Buy-In participation, but the national total does not double-count these individuals. Thus, the national total will be less than the sum of the state totals.