

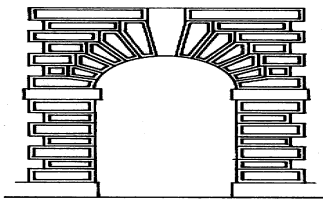
FREEDOM TO WORK 2003

**An Update to the 2000 Medicaid “Buy-In” Program:
A Cost and Feasibility Study**

**Prepared for the Advocacy Center for
Individuals with Disabilities, Inc.**

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EXECUTIVE SUMMARY

Overview:

The Congress passed the Ticket to Work and Work Incentives Act (TWWIIA) 1999 to further expand the incentives available to persons with disabilities who want to work. Fear of losing health care benefits due to earned income is a major area of concern to individuals with disabilities.

In fact, Florida work groups studying this issue in both 2000 and in 2003 found that:

- ✓ There are persons with disabilities who could enter or re-enter the workforce, but who are reluctant to do so for fear of losing their Medicaid health care benefits.
- ✓ Health insurance is a major concern of persons with disabilities.
- ✓ Health insurance is not available to many disabled persons, even if they could afford it.
- ✓ Persons with disabilities have special needs that require extra resources in order to enter or re-enter the workforce.

Clearly, individuals with disability, if they lose their Medicaid due to increases in earnings, enter the ranks of the “uninsured” in Florida, but with added considerations due to their disability. These individuals must be able to maintain health care coverage or they cannot maintain the level of health and physical stability needed to work.

Recognizing these conditions on a national level, the TWWIIA gives states the option to provide Medicaid coverage to persons with disabilities who work by creating two new *optional* Medicaid eligibility groups: the “*Basic Coverage Group*” and the “*Medical Improvement Group*.” States are not, however, required to cover both groups. This study focuses on the Basic Coverage Group.

In 2000 at the request of the legislature, the Florida Agency for Health Care Administration (AHCA) commissioned the Capstone Consulting Group, Inc. to conduct a cost and feasibility study of the Ticket to Work and Work Incentives Act (TWIIA) Medicaid Buy-In option for Florida. This report the: Ticket to Work and Work Incentives Act: The Medicaid Buy-In Program, A Cost and Feasibility Study was completed in December 2000 and is available at the AHCA website.

This initial report reflected the work and recommendations of a Steering Committee comprised of state agency representatives, advocates and legislators. The study findings were based on community forums, a statewide survey of individuals who were identified as potential users of a buy-in type program, and national research.

Work towards the passage legislation that would create a Medicaid Buy-In program in Florida has continued since 2000. A bill has been introduced in each year’s legislative

session. In 2001 a bill did pass and the Department of Children and Families (DCF) developed implementation policy. Due to the events of 9/11 and the resultant economic downturn in the state, the legislation was in effect only one quarter and was repealed effective July 1, 2002. Nineteen individuals were enrolled in this program for one quarter. A decision was made to stop enrollments prior to the official April 1 implementation date due to the uncertainty of future funding for the program.

In light of the need for a Medicaid Buy-In program in Florida a Work Group emerged in 2003 under the leadership of the Florida Advocacy Center for Persons with Disabilities. This work group includes: The Advocacy Center, the Florida Legal Services, the Florida Developmental Disabilities Council, Inc., the National MS Society of North Florida, Florida AIDS Action, and Gulfstream Goodwill.

Because of the rapid development of Buy-In programs in the nation, the work group decided to commission an update to the 2000 study and to review the Florida Buy-In design created by the original Steering Committee. There are now 25 states, many with multi-year experience involved in Medicaid Buy-In programs. In 2000 there were only nine.

The options afforded states under the TWWIA include the ability to eliminate, or set its own income, asset, and resource limits for workers with disabilities that meet the SSA definition of disability.

Recommendations:

With respect to the income and asset eligibility criteria, the committee recommended the following standards:

Income Limits/Income Exclusions:

- **Unearned Income Limit of 88% of the Federal Poverty Level (FPL)**
- **Exclude countable earned income up to 250% net of the federal poverty level (FPL)**

Asset Limits:

- Exclude cash assets in the amount of \$8,000 for a single individual and \$9,000 for a couple.
- Exclude, any retirement account recognized by the Internal Revenue Service.
- Exclude a second vehicle for a couple.

Premiums:

- Participants in the buy-in would be charged a premium once their incomes reached the federal poverty level.

Participation with Employer- Sponsored Health Insurance:

- Medicaid could pay the premiums of an employer-sponsored health plan if it was in the best interest of the state and did not harm the Buy-In participant.

Required Workforce Participation:

- Individuals are required to be employed or engage in preparation for employment.

Protection If Individual Loses Workforce Connection due to Health or Involuntary Separation

- Individual will be allowed to remain in the Buy-In program for up to one-year premium free if they are forced to leave the workforce because of health or involuntary separation.

Costs and Benefits:

The ability to identify the number of persons who may be potentially eligible to participate in the buy-in program is the most difficult, complex, and variable part of this study. However, a figure of 1136 eligible participants is used in the study's projections to account for as many variables as possible.

Regardless of the parameters of eligibility, not everyone eligible to participate in the program will do so.

It is projected that this program will cost the state \$3,462,544. The Federal government will supply the additional \$4,962,162 of resource for full funding of this program. Families USA has identified that every Medicaid dollar spent in Florida generates \$2.82 in business growth, wages, and jobs. Additional wages and taxes generated by the increased earnings of these individuals will also have an economic impact. According to the Able Trust, for every dollar earned by an individual with a disability, \$.23 is generated in income back to the state.

In brief, the Work Group strongly feels that Floridians should be given the freedom to work without fear of risking their health due to lack of health care coverage.

HEALTH CARE ACCESS FOR INDIVIDUALS WITH DISABILITIES WHO WORK: A NATIONAL OVERVIEW

Background:

In 1997 Congress enacted the Balanced Budget Act of 1999 (BBA). This Act was a first step toward providing continuing Medicaid eligibility for workers with disabilities. Section 473 of the act gives states the option of extending Medicaid to persons who would be eligible for SSI except for their earnings.

In 1999 Congress enacted the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). This legislation provided states with new options and flexibility regarding the ability of people with disabilities to join the workforce without fear of losing their Medicare and Medicaid coverage. One of these options permits states to provide coverage under the Medicaid program to individuals with severe disabilities who are working. It also permits the state to eliminate or set more liberal income, asset and resource limits for eligibility purposes.

The major difference between the BBA and TWWIIA for basic coverage is that TWWIIA restricts participation to ages 16 to 64 and BBA has no age restriction. The BBA also restricts earned income to 250% of the federal poverty level however TWWIIA provides states with the option to eliminate or exceed the cap in extending Medicaid coverage to persons with disabilities who are working.

At the time of the 2000 Cost and Feasibility Study, the Capstone Group distributed a state survey of six states who had implemented Buy-In programs. The six states were California, Illinois, Minnesota, Oregon, South Carolina, and Wisconsin. At the time of the 2000 survey, two states had less than six months' experience, one had nine months and two had a year or more. Average length of experience with the program was 9.2 months.

Experience of Implementing States:

In the fall of 2003 at the time of this update, 25 states had some form of Medicaid Buy-In program and some states now had four or more years of experience. Twelve of those states came in under the TWWIIA provision and 13 are the initial BBA states. The southeast states have been the least successful in obtaining funding and legislative authorization for implementing the Buy-In option in their states.

Each state has a different approach to income and asset limits – but all states made some change to the current standards even if it was a small change.

The U.S. General Accounting Office in its 2002 report, *Medicaid and Ticket to Work: State's Early Efforts to Cover Working Individuals with Disabilities*, summarized the states' experience in this way:

“Of the 12 states that had opted to implement Medicaid Buy-In programs under the Ticket to Work authority, all expanded eligibility to include working individuals with higher incomes or more assets than generally allowed under the states’ traditional Medicaid programs. As of December 2002, the 12 states had enrolled over 24,000 working individuals with disabilities. Enrollment ranged from a low of 3 individuals in Wyoming to 8,461 in Missouri. Eleven of the 12 states set Buy-In eligibility limits for income at twice the FPL or higher - \$17,720 per year for an individual in 2002. Additionally, the states’ Buy-In programs generally allowed participants to keep more assets, such as retirement accounts, and medical savings accounts, than allowed in states’ traditional Medicaid programs.”

In addition to increasing income and asset levels, all states took advantage of the statute’s flexibility by requiring participants to buy-in to the program by paying premiums or co-payments. Generally states assessed premiums for individuals with incomes above the FPL and adjusted premiums upward as income increased. Across the 10 states that charged premiums in 2002, the average monthly premiums paid ranged from \$26 in New Hampshire to \$82 in Indiana.

Additionally, the percent of participants who were charged premiums varied significantly across the states, from 12% of participants in Connecticut to all or nearly all participants in Illinois, Pennsylvania, Washington, and Wyoming.

The Medicaid Buy-In Program: Lessons Learned from Nine Early Implementing State by Folkemer, Jensen, Silverstein and Straw, 2002 report on the states that have the most experience, the states that implemented under the Balanced Budget Act. These states include: Alaska, Connecticut, Iowa, Maine, Minnesota, Nebraska, Oregon, Vermont and Wisconsin.

“At the time of the study, approximately 13,000 persons were enrolled in the program in the nine states.”

Major Findings Included:

Eligibility standards and cost-sharing policies show considerable variation across the states and may have a significant impact on program enrollment.

- Most Medicaid Buy-In programs have an upper income limit of 250% of FPL and broadened asset standards, but vary considerably in how they "count" income and assets.
- Limits on unearned income may be an important factor in restraining enrollment in several states.
- Persons with incomes above specified levels must pay premiums. Several states provide enrollment protections for individuals who lose employment while in the Medicaid Buy-In program, but protections are not consistent across the states.

Available Data Are Insufficient To Show Whether The Program Is Meeting Its Objectives:

- Before they began operating their Medicaid Buy-In programs, states developed enrollment and cost projections, often assuming considerable contributions from private insurance and premium payments.
- Preliminary data show actual enrollment exceeding projections in two states, falling short of projections in one state, and matching projections in five states.
- Most Medicaid Buy-In program enrollees are persons who moved from another Medicaid eligibility category to the Medicaid Buy-In program.

Cost Sharing Policies:

In every state, enrollees with incomes exceeding specified levels--ranging between 100 and 200% FPL--are assessed.

<u>Table 3</u>	Cost Sharing Policies: Minimum Income Level and Premium Method			
	Income Level at which Premiums Start	Premium is a <u>Percent of Income</u>	<u>Payment</u> based on <u>Income Brackets</u>	Separate Premiums for <u>Earned</u> and <u>Unearned Income</u>
Alaska	100% FPL net family income	Yes. Varying percent by income with 10% maximum.	No	No
Connecticut	200% FPL net family income	Yes. 10% of family income minus any payments for private health insurance.	No	No
Iowa	150% FPL gross individual income	No	Yes. Eleven brackets with monthly range from \$20 to \$207	No
Maine	150% FPL net family income; no premium if paying Medicare Part B	No	Yes. 150<200% FPL = \$10 monthly. 200<250% FPL = \$20 monthly	No

Minnesota	Gross individual income of 100% FPL for family size (Before 12/01/01, 200% FPL for family size.)	Yes. Scale from 1% to 7.5% of income above 100% FPL. (Before 12/01/01, 10% of income above 200% FPL.)	No	No
Nebraska	200% FPL net family income	No	Yes. Five income bands with premiums from 2% to 10%.	No
Oregon	Two part test: 1. Individual unearned income above SSI level, and 2. Individual's earned income above 200% FPL after work and disability related disregards.	No	No	Yes. All unearned income in excess of SSI income standard. Between 2% and 10% of individual's adjusted earned income and remaining unearned income.
Vermont	185% FPL net family income	No	Yes. 185%-225% FPL= \$10 225%-250% FPL= \$12 (if have private insurance) or \$25 (if no private insurance)	No
Wisconsin	Gross individual income below 150% FPL for enrollee's family size	No	No	Yes. 100% of unearned income minus standard living allowance, work expenses, and medical and remedial expenses. 3% of individual earned income

In addition to this information, the GAO has done a similar review of the early implementing states. (Attachment A)

Two excellent summaries have been developed to survey the varying states' plans, eligibility groups, premium and cost-sharing strategies, etc. The first is the Medicaid Buy-In Reports for Medicaid Infrastructure Grantees: Summary, Reports Submitted June 2002, Compiled by the Oregon Health Institute, and the second is the Figure 6, Medicaid Buy-In Program Comparison Chart, States reporting to CMS, June 2002. (Attachments B and C)

Design Considerations:

The work done by both the GAO and Folkmer et al. caution that each Medicaid Buy-In program must be structured after careful consideration of goals, the existing structure of the State Medicaid Program and the cost considerations.

“In general the higher starting point in terms of income and the tighter restrictions that a state applies to its Medicaid Buy-In program, the lower the enrollment and the smaller the fiscal exposure of the state.”, according to Folkemer et al. It is important to balance the cost considerations with the goal of improving access to health care for individuals with disabilities who want to work.

The creation and structure of a premium is another way to both limit the number of individuals who take advantage of the Buy-In and generate offsetting revenues that will reduce the fiscal impact of the costs of the Buy-In. Premiums are politically attractive and are now used in all of the states that have implemented through the Ticket to Work legislation. As previously discussed premiums structures vary significantly. (Attachments A and B) This is also reflected on the chart shown on page 9.

In developing a premium structure it would appear that ease of administration is one important feature. The development of a premium system does have a cost associated with it and while this may not be a major cost over time, it must be taken into consideration.

The role of the legislature in the development of Medicaid Buy-In programs has also varied. Laws in Iowa and Nebraska created a framework but provided few details. Laws in Alaska, Connecticut, Minnesota, Vermont and Wisconsin included greater detail, including the design of the premium structure, and asset and income standards. In Maine and Oregon, the executive branch through Medicaid State Plan amendments without specific state legislation initiated Medicaid Buy-In programs. Later the legislature provided funding for the new activities.

It is important to realize that these choices exist, determine the best path for the state and to make a separate determination as to how specific the legislation will be and the role that permissive language and intent may play in the final legislation, as opposed to outlining in law the detail of the operational issues like premium design.

The Cornell team that worked with Daniels and Associates to produce, *Final Report for Year 1 of the Medicaid Infrastructure Grant* in the District of Columbia, outlining their proposal for a Medicaid Buy-In for the District, identified guiding principles in their report. They encouraged **simplicity**; easy to use and easy to administer, **fiscal soundness**; **equity**; making sure that participants in like situations will be treated similarly, that if premiums are paid they are comparable to private insurance programs for comparable services, and that premiums reflect the financial situation of the participants and do not serve as a barrier or an unintended deterrent to access of services. They also noted that it is important for the program to be **politically palatable**.

**Medicaid Buy-In
Design Considerations Checklist**

Who Needs the Services?

What Services are they Currently Receiving?

What is the Cost of Serving these Individuals?

Is the Cost Different than the Average Cost of Serving a Traditional Medicaid Recipient?

What Design Options Do We Want to Consider?

Eligibility

Income

Resources

Other Options

Requiring Labor Force Participation

Requiring Participation in Costs

Premium

Other Cost-Sharing

Cobra-type Protection Related to Illness or Involuntary Separation

Facilitation of the Purchase of Employer-Sponsored Health Insurance

The AHCA Medicaid Buy-In Task Force in 2000 clearly identified recommendations on increases to Income and Resources limits that were both an improvement for individuals with disabilities and politically palatable. We will discuss these further in the Florida Experience section.

The Task Force did not however consider or make recommendations on the option identified in the Considerations Chart above as “other options”. These have emerged from the experience of other states. They deserve consideration and discussion.

Issue: Requiring Labor Force Participation:

This design feature is used in some states as a cost-limiting feature. It would appear consistent with the intent of the Buy-In to require labor force participation but addition of this feature might have some administrative costs associated with the tracking of this information.

The chart below outlines the Work-Related Policies and Protections from the early implementing states. The summary reflects the wide variety of approaches.

<u>Table 4</u>			
Work-Related Policies and Protections			
	Work Requirements	Protections for Temporary Loss of Employment	Protections When Returning to Other Eligibility Categories
Alaska	Must have earned income.	None	None
Connecticut	Must make FICA contributions.	Can continue Buy-In for one year after losing employment.	Assets in retirement, Medical Savings Accounts, and approved accounts not counted during the individual's lifetime.
Iowa	Must have earned income.	Yes. May remain eligible for six months after work stoppage.	None
Maine	Must have earned income.	None	None
Minnesota	Some income from work every 30 days.	Previously, up to 2 months of medical leave and allowances for switching jobs. After 12/1/01, up to 4 months of leave.	As of 12/1/01, up to \$20,000 in assets protected for one year.
Nebraska	Must have earned income.	None	None
Oregon	Must have taxable income.	None	None
Vermont	Must have earned income.	None	None
Wisconsin	Must be working or enrolled in an employment counseling program. Can remain in employment counseling for up to one year.	Can enroll in health and employment counseling (time limited and restricted to twice in 5yr period). Can waive work requirement for six months due to a health setback.	None

The District of Columbia did require work force participation in their report, but used a broad definition. They defined workforce participation as:

Employment is defined as:

- a. Individual receives income from wages.
- b. Individual receives income from self-employment.

Preparation for employment is defined as being engaged in activities in preparation for employment including but not limited to: enrollment in a vocational rehabilitation program; enrollment or registration with the department of workforce development; participation in a transition from school to work program, participation with an approved provider of employment services.

In any definition of labor force participation it is important to review the intended and unintended consequences of the definition chosen. It is important to remember for instance that not all income comes from wages upon which F.I.C.A. is paid – this would exclude self-employed individuals. Under current CMS policy states may not require a certain number of hours participants must work. This is an on-going discussion between states and CMS.

Premiums and Cost Sharing Strategies:

Table 3 on page 9 identifies the approaches that the early implementing states took on the issues of charging a premium and cost sharing. As previously mentioned all of the states that have implemented under the TWWIA have included a premium. Additional information is available in the charts in Attachments A and B.

Overall, three approaches can be taken:

- The language of the Buy-In legislation can be permissive. The language would allow the department to charge a premium or develop cost-sharing programs as appropriate.
- The language of the Buy-In legislation can identify that premiums and cost-sharing policies will be adopted and remain silent on the administrative details.
- The language of the Buy-In legislation can explicitly detail the structure of the premium system and the cost-sharing requirements.

As shown on Table 3 – choices in the area of premiums and cost sharing include:

- Identifying an income level at which premiums are required.

- Identifying whether the premium will be a percent of income.
- Decision on the use of income brackets.
- Decision on how earned and unearned income will be treated.

Cobra-Type Protection Related To Illness or Involuntary Separation:

A number of states that have Buy-In programs who require labor force participation allow for a period of time – up to two years in the case of Michigan, one of the newest Buy-In states coming on line in 2003. Connecticut does one year, when an individual can continue to participate in the Medicaid Buy-In even if the individual has lost their attachment to the workforce, if the separation is due to health or involuntary job loss.

Since Buy-In income and asset limits are different from the mainstream program, this gives the individual a period of transition if they never return to the workforce, and a period of support if the separation is indeed temporary.

Facilitation of the Purchase of Employer-Sponsored Health Insurance:

Some states have sought to facilitate the purchase of employer-sponsored health insurance. Connecticut is one state that does this. Connecticut requires a premium but allows individuals to deduct the cost of the premiums of an employer-related health plan. Wisconsin also requires a premium but allows for Medicaid to pay for insurance coverage for any individual eligible for Medicaid through his (or his spouse's) employer's health plan, if doing so would cost less than Medicaid.

Cost Estimates and Cost Modeling Efforts:

“In trying to determine the cost and feasibility of a Medicaid Buy-In program states relied primarily on existing Medicaid data, especially eligibility and claims data for current and former Medicaid clients, and Social Security Administration data on SSI and SSDI recipients. Some states used surveys and studies from state vocational rehabilitation, state mental health or developmental disabilities agencies” according to Folkemer et al.

Many states identified early implementing states that had similar demographics and Medicaid program structures and used their experiences. Some states could realize benefits from shifting state costs to the federal cost sharing design of Medicaid and were able to project cost neutral estimates or in some states, costs that were advantageous to the state because of cost-shifting.

Cost Considerations Included:

- Projected number of enrollees.
- Projected number moving from one Medicaid program to another.
- Identification of individuals moving from state-funded programs and an estimate of the dollars saved.
- Projected premium revenue.
- Projected number of individuals who would qualify for private insurance.
- Estimated length of time an individual would remain on the program.

In general, Folkemer et al found that “premium payments and private insurance offsets have been lower than expected, due in part to lower than expected levels of earned income and insufficient work hours to qualify for private insurance coverage.” Data available from Connecticut and Minnesota who do make provisions for transition to private health insurance reported that only 12% of individuals left the rolls for this reason.

Both GAO and the Folkemer et al reports showed that there is not always a direct correlation between the cost estimating projections and the actual experience of the states. Out of seven states reviewed by Folkemer et al, 2 states exceeded enrollment projections, 1 state fell short, and five states matched their projects.

States made projections in many areas with mixed results:

Previous Enrollment in Medicaid – Consistent with projections

Private Health Insurance – only 12% in the two states reported, lower than projected

Premium Payments – Lower than expected revenue generator. Looking at seven states, this was the experience:

% Projected/State

- 58% Alaska
- 40% Oregon
- 30% Iowa
- 17% Minnesota
- 16% Wisconsin
- 15% Connecticut
- 11% Maine

Summary of the National Experience:

It is hard to identify a definitive pattern either in policy, practice, or outcomes. Each state has crafted programs, policies and practices that meet their individual needs based on factors unique to their state's population and the State specific Medicaid program design.

It does appear that individuals in the existing programs are not experiencing increases in the amount of earned income that is being reported. This may be due to disincentives within the Social Security benefits system, including the SSDI: "cash cliff", the severity of the individual disabilities and the general economic environment.

It is also noted in the literature reviewed that the Medicaid Buy-In is only one piece of an effective state initiative to help individuals with disabilities work. Other factors include the responsiveness of the workforce development system and vocational rehabilitation agency within the state and the impact of Social Security Administration initiatives in the area of Ticket to Work and Work Incentives.

Two other trends are emerging. One, the last thirteen states that have implemented a Buy-In program have included premiums in the design. Two, states are not being inundated with individuals flocking to the Buy-In program from outside the Medicaid system. Most states have reported consistently that a high percentage of individuals coming to the Buy-In program have been enrolled in a Medicaid program immediately prior to enrolling in the Buy-In program.

THE FLORIDA EXPERIENCE

The Florida Experience, 2000-2003:

In 2000 at the request of the legislature, the Florida Agency for Health Care Administration (AHCA) commissioned the Capstone Consulting Group, Inc. to conduct a cost and feasibility study of the Ticket to Work and Work Incentives Act (TWIIA) Medicaid Buy-In option for states. This report the: Ticket to Work and Work Incentives Act: The Medicaid Buy-In Program, A Cost and Feasibility Study was completed in December 2000 and is available at the AHCA website.

This initial report reflected the work and recommendations of a Steering Committee comprised of state agency representatives, advocates and legislators. The study findings were based on community forums, a statewide survey of individuals who were identified as potential users of a buy-in type program, and national research.

Work towards the passage legislation that would create a Medicaid Buy-In program in Florida has continued since 2000. A bill has been introduced in each year's legislative session. In 2001 a bill did pass and the Department of Children and Families (DCF) developed implementation policy. Due to the events of 9/11 and the resultant economic downturn in the state, the legislation was repealed prior to the schedule July 1, 2002 implementation after only a quarter of operation. Knowing the uncertainty of the program, the Department of Children and Families halted implementation in early April 2002.

In light of the need for a Medicaid Buy-In program in Florida a Work Group emerged in 2003 under the leadership of the Florida Advocacy Center for Persons with Disabilities. This work group includes: The Advocacy Center, the Florida Legal Services, the Florida Developmental Disabilities Council, Inc., the National MS Society of North Florida, Florida AIDS Action, and Gulfstream Goodwill.

A full review of the legislative history of work towards obtaining passage of a Medicaid Buy-In program in Florida is included in this report. (Attachment D)

An Overview of Florida's Medicaid Program:

Florida currently provides Medicaid coverage for persons with a disability. The major groups for which coverage is provided include those persons receiving Social Security Disability Insurance benefits, Supplemental Security Income, Medicaid for the Aged and Disabled (MEDS-AD), and Medically Needy and individuals who meet the Social Security Administration's definition of disability and except for income would be eligible for SSI. Full Medicaid coverage is provided to these groups with the exception of the Medically Needy group. Coverage for that group is limited to non-institutional care and also requires a spend-down. The spend-down will be discussed later in the report.

Description of Current Coverage for Persons with Disabilities:

SSI:

Individuals who receive Supplemental Security Income (SSI) cash benefits administered by the Social Security Administration (SSA) are automatically eligible for Medicaid in Florida.

Assets and Income Standards: Currently, to be eligible for SSI, an individual must be aged (65 or older), blind, or disabled, and have countable resources that total no more than \$2,000, and have a countable income of less than \$552 a month. To be determined disabled, the individual must be unable to engage in any substantial gainful activity (SGA) because of a medically determined physical or mental impairment that has lasted, or can be expected to last for a continuous period of not less than 12 months, or result in death.

Any work activity is evaluated on the basis of earnings in order to determine whether the work activity is SGA. If the impairment is other than blindness, earnings averaging over \$800 a month generally demonstrate SGA. If blind, earnings over \$1330 a month generally demonstrate SGA.

The following types of assets and income are considered when determining financial eligibility.

Types of assets that are counted:

- Real property, other than homestead;
- Bank accounts, including CDs, money market certificates;
- Stocks, bonds;
- Trusts; and
- Life insurance cash value if the face value of the policies totals more than \$1500 for SSI recipients.

Types of assets that are excluded:

- Homestead, if an individual or a dependent lives there, or if the individual is absent but intends to return;
- Vehicle (one is excluded);
- Burial funds up to \$1500 for SSI recipients;
- Life insurance if the face value does not exceed \$1500 for SSI recipients; and
- Restricted burial funds.

Income from the following sources is counted:

Unearned Income: Unearned income is any cash benefit that is received by the individual that is not payment for work. The following are examples of unearned income:

- Social Security Benefits;
- Veterans Administration Benefits;
- Pensions;
- Interest Income;
- Income from mortgages; and
- Contributions.

Earned Income: Earned income is income that is received as payment for work.

The chart on the following page outlines the current asset and income limits for Medicaid for Aged and Disabled Programs. (The Medicaid program applies more liberal methodologies than SSI in counting income and assets.)

Medically Needy Program:

Florida also has a Medically Needy Program for persons with high medical bills but whose income is too high to qualify for traditional Medicaid programs. These individuals would otherwise qualify for existing programs were it not for income and assets exceeding limits. Medically Needy enrollees must meet a monthly share of cost to receive Medicaid coverage.

To be eligible a disabled individual must meet the technical requirements regarding disability; have resources that total no more than \$5,000 for an individual or \$6,000 for a couple; and meet the monthly share of cost determined from monthly income.

The share of cost is the difference between the payment standard and the individual's countable income. The payment standard is currently set at \$180 for an individual and \$241 for a couple. The share of cost is treated as the amount that offsets an individual's income to the payment standard. When medical bills exceed the share of cost, the person becomes eligible for Medicaid for the remainder of that month only.

For example, for a disabled individual that has a countable income of \$1,000 per month, he/she must incur \$820 (\$1,000 minus \$180) in medical expenses in a given month after which they are eligible for Medicaid coverage for the remainder of that month.

Summary of Services Available Under Current Medicaid Program:

The Florida Medicaid program covers the following services for adults, within certain limitations and exceptions.

- Inpatient hospital
- Outpatient hospital
- Physician and physician assistant
- Transplant services
- Laboratory and X-ray
- Skilled and intermediate care nursing facilities
- State mental health hospital
- Non-hospital related mental health and substance abuse services
- Home health care
- Rural health clinic
- County health department clinic services
- Dialysis center services
- Transportation
- Ambulatory surgical centers
- Podiatry
- Dental
- Visual services
- Hearing services
- Prescribed drugs
- Durable medical equipment and medical supplies
- Advanced Registered Nurse Practitioner
- Registered Nurse First Assistants
- Chiropractic services
- Augmentative and communication systems
- Medicare premiums; deductible; and coinsurance (In certain situations.). This coverage is referred to as the state “Buy-In”.

Although persons with disabilities and their advocates have long expressed the need for “Personal Attendant Services”, they are not included in the above list of services covered by Medicaid. These services are available only to Home and Community Based Services (HCBS) participants. The need for such services was once again highlighted during the two public forums held in conjunction with the 2000 study. There are many persons with disabilities who are employable, if they had someone to assist them with their personal needs in preparation for getting to work and while on the job. Assistance with personal hygiene needs, grooming, dressing, etc. is critical for their employability.

It should also be noted the scope of services provided under Medicaid in some cases provide important services that are not always available in employer-sponsored or private health plans, even in those cases where this insurance is available. Prescription drug coverage, particularly for individuals with certain disabilities is essential. Individual with mental illness and individuals who had organ transplants are two such groups

SSI-Related Programs -- Financial Eligibility Standards: July 2003

Program	INCOME		ASSETS		Personal / Maintenance Need Standard		Diversion
	Individual	Couple	Individual	Couple	Individual	Couple	
*Supplemental Security Income (SSI)	\$ 552	\$ 829	\$2000	\$3000			Child Allocation \$277
*MEDS-AD	\$ 659	\$ 889	\$5000	\$6000			
*QMB 100% of FPL	\$ 749	\$ 1,010	\$5000	\$6000			
*SLMB	\$ 898	\$1,212	\$5000	\$6000			
*QI1 (PBMO) (Limited Funding)	\$ 1,011	\$1,364	\$5000	\$6000			
Silver Saver	<u>659.01</u> to \$898.00	\$889.01 to \$1,212.00	N/A	N/A			
*Working Disabled	\$1,497	\$2020	\$5000	\$6000			
Medically Needy	\$ 180	\$ 241	\$5000	\$6000			
Institutional Care (ICP)	\$1,656	\$ 3,312	\$2000	\$3000	\$35	\$70	
Hospice	\$1,656	\$ 3,312	\$2000	\$3000	FPL-\$749 (ICP PNA \$35)	FPL-\$1010 (ICP PNA \$70)	For community Hospice spouse Spouse only: use FBR . with dependents (or dep. only): use CNS
HCBS	\$1,656	\$ 3,312	\$2000	\$3000	ALW only PNA= \$630.40		
OSS (OSS income limit varies by type of facility)	\$630.40 or \$737.00	\$1,260.80 or \$1,474.00	\$2000	\$3000	\$54	\$108	Medicare Premiums: \$58.70
HCDA	\$1,656	\$3,312	\$2000	\$3000			

*A \$20 general exclusion applies in these programs. Individuals can have up to \$20 more in unearned income and pass the income test.

Social Security Work Incentive Programs:

Current SSA Work Incentives

Disabled persons receiving SSI can continue to receive their SSI cash benefits under Section 1619(a) of the Social Security Act when their income is at the level of Substantial Gainful Activity (SGA) if they:

- Have been eligible for an SSI payment for at least one month before beginning to work at the SGA level;
- Continue to be disabled; and
- Meet all other eligibility rules, including the income and resource tests.

Therefore, in states like Florida where people on SSI are automatically eligible for Medicaid, they will continue to be eligible for Medicaid, if they meet the income and asset test for SSI.

For those disabled persons who are able to work at a level such that their earnings along with other income becomes too high for an SSI cash payment, Section 1619(b) provides that they can continue to qualify for Medicaid coverage if they:

- Have been eligible for an SSI cash payment for at least one month;
- Continue to be disabled;
- Still meet all other eligibility rules, including the resources test;
- Need Medicaid in order to work; and
- Have gross earned income that is insufficient to replace SSI, Medicaid, and any publicly funded attendant care.

Data provided by the Social Security Administration indicates that in March 2003, there were 653 individuals in Florida, earning an average of \$1002 per month, who were participating in Section 1619 (a) incentives. Another 3283 individuals, earning an average of \$1021 per month were participating in Section 1619 (b) incentives. In all, only 3936 disabled recipients in Florida, aged 18-64, were participating in section 1619 incentives in March 2003.

THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT OF 1999 (TWWIIA): THE STATE OPTION FOR EXPANDING MEDICAID COVERAGE FOR INDIVIDUALS WITH DISABILITIES THAT WANT TO WORK

Under the TWWIIA, states are given the option to provide Medicaid coverage to persons with disabilities who work by creating two new *optional* Medicaid eligibility groups.

The first group is called the “Basic Coverage Group”. Under this group, states can choose to cover individuals at least age 16, but less than 65 years of age who, except for earned income, would be eligible to receive SSI benefits regardless of whether they had ever received SSI cash benefits. Moreover, the state establishes the income and asset limits that may be more liberal than SSI, but not more restrictive.

The second new eligibility group is called the “Medical Improvement Group.” Under this group, states can choose to cover employed individuals with a medically improved disability who lose Medicaid eligibility under the Basic Coverage Group described above because *their medical conditions have improved to the point where they are no longer disabled under the SSI definition of disability*. It is extremely difficult for these individuals to obtain health care insurance on the open market – even when their disabling condition has improved to the point they may become employed.

States are not required to cover both groups. However, if a state elects to provide coverage for the Medical Improvement Group, it must also cover the Basic Coverage Group. States may also impose premiums or other cost-sharing charges on a sliding scale based on income for individuals eligible for either of the new eligibility groups.

It is also important to note that as an entitlement program, changes made in the Medicaid State Plan must apply to all individuals who are eligible for Medicaid services. You cannot, therefore, limit eligibility to only existing Medicaid recipients.

A PROGRAM DESIGN FOR FLORIDA

The TWWIA offers states flexibility for a Medicaid “Buy-In”.

In developing the 2000 recommended “Buy-In” program design for Florida’s Medicaid program, five major sources of information were identified

- Two public forums (Orlando and Miami);
- A survey of selected states with “Buy-In” programs;
- A survey of randomly selected individuals from two groups currently known to the Medicaid program (Medicaid Disabled, and Medically Needy);
- Selected data from the Florida Medicaid program; and
- Advocacy representation on the Steering Committee.

In developing this 2003 update the following approach was taken:

- Extensive review of the 25 states that now have some form of Medicaid Buy-In was done as discussed in the National Experience Section of this report.
- All numbers from the 2000 study were reviewed and updated as necessary. This included eligibility information, Social Security Substantial Gainful Activity levels, demographics and cost information.
- Based on national experience a design considerations checklist was developed.
- A Work Group has been established to review the material and make recommendations on the design considerations.

PROGRAM DESIGN ELEMENTS

As in the 2000 study, the 2003 Work Group felt that there were certain basic conditions that predicated the need for a change to the current Medicaid system for individuals with disabilities that want to work and the state adoption of a Medicaid Buy-In option.

These are:

- ✓ There are persons with disabilities who could enter or re-enter the workforce, but who are reluctant to do so for fear of losing their health care benefits.
- ✓ Health insurance is a major concern of persons with disabilities.
- ✓ Health insurance is not available to many disabled persons, even if they could afford it.
- ✓ Persons with disabilities have special needs that require extra resources in order to enter or re-enter the workforce.

The Work Group recommendations are:

Name of the Florida Medicaid Buy-In Program:

Recommendation:

Freedom to Work

Rationale

Freedom to Work without fear of risking health or the stability of their disabling condition for every Floridian with a disability is the goal of this legislation.

Income Limit/Income Exclusions:

Recommendation:

Income set at 88% of the FPL

Exclude countable earned income up to 250% net of the federal poverty level (FPL).

Rationale

The income exclusion for the current Medicaid Aged and Disabled (MEDS) program is 88% of FPL, or \$659 for an individual or \$888 for a couple, less a \$20 disregard.

The purpose of the Buy-In program is to afford Medicaid coverage to persons with disabilities who work. By not applying disregards to unearned income, expansion of coverage extends only to those who are employed. While the state is permitted to exclude all earned income, a threshold of 250% was selected by five of the six states surveyed. At that level, an individual could have a net earned income of up to \$1,871 per month and be eligible for the Buy-In program.

Examples:

The following examples illustrate how the income limit would be applied to determine eligibility under the current Medicaid income limits and the increased income limits recommended for the Medicaid Buy-In program.

Example 1

Anna receives \$650 each month in Social Security Disability (SSDI) benefits and has an opportunity to work and earn \$700 each month in earned income.

Without a Medicaid Buy-In, eligibility for Medicaid is calculated based upon the current limit of 88% of the FPL \$659 per month (unearned income plus earned income). Anna is eligible for Medicaid based upon her disability benefits but will no longer be eligible should she choose to work. **Anna is forced to choose between Medicaid eligibility and work.**

Unearned Income	Earned Income
\$650 (SSDI)	\$700 (gross monthly wages)
- \$ 20 (general income disregard)	- \$65 (earned income disregard)
\$630 total unearned income	\$635
	÷ 2 (1/2 remaining earnings)
	\$317.50 total earned income

The countable unearned income of \$630 is below 88% of the federal poverty level (\$659). Therefore, the individual would be eligible to participate in the Medicaid program – Meds AD.	The countable earned income of \$317.50 when added to the unearned income of \$560 is well above 88% of the federal poverty level (\$659). Therefore, the individual would not be eligible to participate in the Medicaid program – Meds AD.
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Medicaid Eligibility
\$630 Unearned Income
+\$317.50 Earned Income
\$947.50 Total Income
Income over Medicaid (Meds-AD) limit.

With a Medicaid Buy-In, eligibility for Medicaid is calculated based upon an unearned income limit of 88% of the FPL (\$659 per month). Earned income limit of 250% of the FPL (\$1871) is excluded. Anna is eligible for Medicaid based upon her disability benefits. Should Anna choose to work, she will still be eligible for Medicaid. **Anna can work AND maintain Medicaid eligibility.**

Unearned Income \$650 (SSDI) - \$ 20 (general income disregard)	Earned Income \$700 (gross monthly wages) - \$65 (earned income disregard)
\$630 total unearned income	\$635 ÷ 2 (1/2 remaining earnings)
The countable unearned income of \$630 is below 88% of the federal poverty level (\$659). Therefore, the individual would be eligible to participate in the Medicaid “Buy-In” program.	\$317.50 total earned income The countable earned income of \$317.50 is below 250% of the federal poverty level (\$1,871). Therefore, the individual would be eligible to participate in the Medicaid “Buy-In” program.

Medicaid Eligibility
\$630 Unearned Income
+\$ -0- \$317.50 Earned Income excluded as it is below 250%FPL)
\$630. Total Countable Income
Income under Medicaid Buy-In limits.

Example 2

Henry receives \$580 in Social Security Disability Insurance (SSDI) and has an opportunity to work and earn \$1770 in earned income.

Without a Medicaid Buy-In, eligibility for Medicaid is calculated based upon the current limit of 88% of the FPL \$659 per month (unearned income plus earned income). Henry is eligible for Medicaid based upon his disability benefits but will no longer be eligible should he choose to work. **Henry is forced to choose between Medicaid eligibility and work.**

Unearned Income \$580 (SSDI) - \$ 20 (general income disregard) \$560 total unearned income	Earned Income \$1770 (gross monthly wages) - \$65 (earned income disregard) \$1705 ÷ 2 (1/2 remaining earnings) \$852.50 total earned income
The countable unearned income of \$560 is below 88% of the federal poverty level (\$659). Therefore, the individual would be eligible to participate in the Medicaid program – Meds AD.	The countable earned income of \$852.50 when added to the unearned income of \$560 is well above 88% of the federal poverty level (\$659). Therefore, the individual would not be eligible to participate in the Medicaid program – Meds AD.

Medicaid Eligibility \$580.00 Unearned Income +\$852.50 Earned Income \$1432.50 Total Income Income over Medicaid (Meds-AD) limits.

With a Medicaid Buy-In, eligibility for Medicaid is calculated based upon an unearned income limit of 88% of the FPL (\$659 per month). Earned income up to 250% of the FPL (\$1871) is excluded under the Buy-In program. Henry is eligible for Medicaid based upon his disability benefits. Should Henry choose to work, he will still be eligible for Medicaid. **Henry can work AND maintain Medicaid eligibility.** It is important to note that earnings at this level will cause Henry to lose his SSDI cash benefits that will decrease his dependency on Federal Social Security benefits.

Unearned Income \$580 (SSDI) - \$ 20 (general income disregard)	Earned Income \$1770 (gross monthly wages) - \$65 (earned income disregard)
\$560 total unearned income	\$1705 ÷ 2 (1/2 remaining earnings)
	\$852.50 total earned income -0- income counts because of the exclusion of earned income up to 250%FPL.
The countable unearned income of \$560 is below 88% of the federal poverty level (\$659). Therefore, the individual would be eligible to participate in the Medicaid "Buy-In" program.	The countable earned income of \$852.50 is below 250% of the federal poverty level (\$1,871). Therefore, the individual would be eligible to participate in the Medicaid "Buy-In" program.

Medicaid Eligibility \$580.00 Unearned Income \$-0- \$852.50 Earned Income is excluded up to 250% of FPL
\$1432.50 Total Income \$ 580.00 Countable Income
Income under Medicaid Buy-In limits.

Although it is unlikely that many persons with disabilities would be able to reach such an income level, those with countable earned income of up to \$1871 per month would be eligible to participate in the Medicaid Buy-In program under the proposed countable earned income limit of 250% of the FPL.

Asset Limits/Asset Exclusions:

Under TWWIA, states can set a limit at any point and can exclude additional assets.

Recommendation:

Asset Limit: Cash assets in the amount of \$8,000 for a single individual and \$9,000 for a couple.

Exclusions: Any retirement account recognized by the Internal Revenue Service.

Rationale:

Persons with disabilities have many expenses associated with employment not generally faced by non-disabled workers. For example, a modified vehicle may be required for transportation to and from work. Or some individuals may require adaptive equipment, a communication augmentation device, work site modification, or other forms of assistive technology. It is also important for a person with a disability to have an emergency fund available to meet unexpected expenses such a loss of a hearing aid, repair and maintenance of a modified vehicle, etc.

The work group reviewed asset limits established by other states and selected those recommended above.

Recommendation:

Exclude a second vehicle for a couple.

Rationale:

Transportation is a major barrier to persons with disabilities. That barrier becomes even more critical for a couple. For example, one spouse may require a modified vehicle for transportation to work and the other spouse may make weekly visits to the doctor or therapist. The spouse may also be employed and must provide his/her own transportation (Note: Many persons with disabilities live in areas without public transportation or easily accessed transportation for the disadvantaged.)

Premiums:

Recommendation:

Participants in the Buy-In program would be charged a premium.

Rationale:

The law provides that a state may require payment of 100% of the premium for individuals with incomes over 250% but below 450% of

the federal poverty level, EXCEPT that the premium may not exceed 7.5% of the individual's income.

The Work Group believes this is an important cost-limiting factor. Individuals will be required to share in the cost of their medical insurance once their earned income reaches the FPL. The cost will be on a sliding scale from 2% to 7.5% for individuals with income up to 250% of the FPL.

The cost-limiting factor will be two fold. One, some individuals will choose not to participate because of the premium. Two, revenue will be contributed by participants in the plan to offset some of the additional costs to the state.

It should be noted that all of the states that have passed Medicaid Buy-In programs under the TWWIA have included some form of premium or other cost sharing element. This is a departure from the experience of the original BBA states.

The current Medicaid state plan has this provision.

Facilitation of the Purchase of Employer-Sponsored Health Insurance:

Recommendation:

Medicaid Buy-In program premiums may be used to pay the premium for employer-sponsored health insurance, if this is advantageous to the state and does no harm to the Buy-In participant in terms of reduction or elimination of essential services to maintain health and ability to work.

Rationale:

It makes good business sense to utilize private health insurance when it is beneficial to the state and does no harm to the participant.

The private insurance plan could be the prime insurer and as in the Medicare program, Medicaid would be the payer of last resort.

Workforce Participation Requirement:

Recommendation:

Individuals participating in the Buy-In Program must be either employed or preparing for employment.

Employment is defined as:

Individual is receiving income from wages;

Individual is receiving income from self-employment.

Preparation for Employment is defined as:

Being engaged in activities in preparation for employment including, but not limited to: Enrollment in a vocational rehabilitation program; enrollment or registration with the department of workforce development; participation in a transition from school to work program, participation with an approved provider of employment services.

Rationale:

Workforce participation is the sole purpose of the Medicaid Buy-In. This position is also a cost-limiting factor and insures the state that the original intent is being met.

Cobra-Type Protection for Individuals Who Lose Employment Due to Health or Involuntary Separation from Employment or Employment Preparation:

Recommendation:

If a participant in the Buy-In program loses their attachment to the workforce for reasons of health or involuntary separation from employment or employment preparation activities, the individual may remain in the Buy-In program for a period of up to one year.

No premium participation would be required during this period.

Rationale:

Because the Buy-In program has income and asset limits that are higher than the traditional Medicaid program, this protection is essential and will serve to protect the individual's progress towards independence if he or she must leave the workforce due to health or involuntary separation.

POTENTIALLY ELIGIBLE POPULATION

Clearly, the ability to identify the number of persons who may be potentially eligible to participate in the buy-in program is the most difficult, complex, and variable part of this study. A thorough review of the experience of the 25 states surveyed did not result in a formula for successfully predicting participation.

Regardless of the parameters of eligibility, not everyone eligible to participate in the program will do so. In fact, only one half of one percent of the individuals receiving SSDI or SSI leave the benefit rolls because they become employed. Some of the reasons for non-participation are:

- The criteria used to determine an individual eligible for *SSI disability* benefits is extremely stringent and many are simply too disabled to work – even though they would like to do so. In fact, the consumer survey showed that less than 7.5% of those surveyed are working – and then only part-time.
- Many of those eligible will not be able to find employment commensurate with their disabling condition, education, and prior work history.
- Many of the “working disabled” are already working at their maximum in terms of health related constraints. Over 50 percent of the group who responded to the consumer survey in 2000 reported working less than 21 hours a week.

In trying to project the number of individuals who may become eligible for a Medicaid “Buy-In” program using the above income and asset criteria, the following data was considered:

- 653 individuals in Florida, earning an average of \$1002 per month, were participating in Section 1619(a) incentives during March 2003.
- 3283 individuals, earning an average of \$1021 per month, were participating in Section 1619(b) incentives during December 2002.
- As of October 3, 2003, the Department of Children and Families (DCF) reported 44,746 disabled individuals between the ages of 16 and 64 in Florida’s SSI-related Medically Needy program, the program for which individuals must meet a share of cost, or spend-down amount (see pages 24). Of those only 3,351 had unearned income below 88% of the FPL. The average unearned income was \$566.58. Of the 3351, only 1059 had earnings budgeted:

319 between \$1.00 and \$500.00

687 between \$500.00 and \$1800.00
41 greater than \$1800.00

Of the 1059 with earnings and who unearned income under 88% of the FPL, 185 were meeting their share of cost and consequently Medicaid Eligible.

- As of October 3, 2003, DCF reported 40,384 disabled individuals between the ages of 16 and 64 with cases, open and enrolled, in Florida's Medicaid Aged and Disabled (MEDS) program, the program for which an individual's income cannot exceed \$659 (see chart on page 24).
- In FY 02-03, 287 individuals lost their coverage specifically because of initial or increased earnings (specific closure codes in the FLORIDA system). In FY01, the number was 156 and in FY 02 the number was 248.
- Of the 40,384 MEDS disabled individuals, 2044 had earned income. Of those 2044:
 - 1593 had income greater than \$1 and less than \$500;
 - 270 had income greater than \$500 and less than \$1,800;
 - 0 had income greater than \$1,800.

Scenarios and Data Considerations:

It is known that nationally only one half of one percent (.05%) of Social Security Beneficiaries ever leave the benefit rolls. The new work incentives created by the TWWIIA have not significantly affected this experience.

Individuals in the Florida Buy-In Program as outlined in this study would be required to be at least 16, but less than 65 years of age, who are disabled as SSI defines the term. They would also be required to have unearned incomes of less than 88% of the FPL upon entering the program.

As mentioned previously, approximately 3936 individuals continue to receive Medicaid benefits under Section 1619(b) of the Social Security Act. These individuals already exceed the usual income standard for SSI participation.

The DCF data indicated a total of approximately 3103 individuals in either MEDS AD or Medically Needy had earned income in 02/03 greater than \$1. We do know that

approximately 287 individuals lost their MEDS program coverage in FY02-03 each year for initial and increased earnings. The 2000 survey results also showed that only a small percent of those working believed they could expand their hours due to multiple disabling conditions.

There is a degree of uncertainty as to the numbers of the current disabled population already covered in a Medicaid program that might be able to avail themselves of the opportunity provided under the Buy-In program. The national experience covers a range from 23.3% in Iowa to 96.3% in Nebraska. (Attachment B)

We believe that the number for estimating purposes should be the 1059 individuals on Medically Needy with unearned income less than 88% of the FPL and with earnings. From this group 185 have met their share of cost and are already receiving Medicaid services. This would leave a group of 874 individuals who would be projected to be a new cost to Medicaid. In addition to the 874 individuals we know from national experience that others, including individuals outside of Medicaid, may also participate and based on CMS reports from June, 2002 we have projected this number to be 30%. This represents the average of thirteen states that reported that 67% of the individuals on their state's Buy-In program had been eligible for Medicaid for at least 30 consecutive days in the 12 months immediately prior to the date they became eligible for the Buy-In.

To reiterate statements made by other states regarding enrollment projections, there is not sufficient data to accurately forecast projections for these new buy-in programs with certainty. This scenario also applies to forecasting enrollment in Florida's Freedom to Work program, but this projection does reflect the experience of the states that most Buy-In participants come directly from a Medicaid program and that there is no large group of individuals who are going to come onto Medicaid rolls due to this expansion of service parameters.

FISCAL IMPACT AND BENEFITS

Costs: (Based upon an estimated 1136 enrollees)

Agency for Health Care Administration

Medical Services

	Per Person	Total
Estimated Medical Costs Per Person Per Year	\$7,454.04	\$8,467,789.40
Estimated Drug Rebates Per Person Per Year	<u>(\$720.00)</u>	<u>(\$817,920.00)</u>
Total Medical Services Cost	\$6,734.04	\$7,649,869.40
<i>State Cost @ 41.10% (10/1/03)</i>	\$2,767.69	\$3,144,096.30
<i>Federal Match @ 58.90%(10/1/03)</i>	\$3,966.35	\$4,505,773.10

Administration

Changes to Florida Medicaid Management Information System (FMMIS)		\$ 100,000
Estimated Additional Claims Processing Costs for FMMIS		
New and Retained Eligibles	1136	
Average Number of Claims per Eligible per Year	120	
Estimated Total Additional Claims	136,320	
Cost per Claim	\$0.207	
Total Additional Claims Processing Costs		\$ 28,218.24
<i>General Revenue @ 25%</i>		\$ 32,054.56
<i>Administrative Trust Fund @ 75%</i>		\$ 96,163.68
 Total Cost for Agency for Health Care Administration		 \$7,778,087.60

Department of Children and Families

Florida System (programming & testing)		\$ 611,325*
Florida System (CPU time)		\$ 200,000
Staffing (Public Assistance Specialists – 2 F.T.E.)		<u>\$ 65,360</u>
 Total Cost for Department of Children and Families		 \$ 876,685
 Total Projected Cost for Implementation		 \$8,654,773
 Projected Potential for Premium Income		 \$230,067
 Total Cost after Premiums Income Develops		 \$8424706
 <i>Total Cost to State (41.10%)</i>		 <i>\$3,462544</i>

*Initial discussions with DCF indicate that current projects are coming in at less than this amount but no projection could be provided at this time.

Notes on the Cost Projections

These cost projections were updated in October 2003, with data collected from AHCA and DCF. The design and format of the information is consistent with the 2000 report. National experience shows that 80% of individuals who are participating in the Buy-In are also receiving Medicare and need Medicaid primarily for prescription drugs not covered currently by Medicare or available from any other source. The cost per person for this “wrap-around” coverage concurrent with Medicare is less than the full cost of an individual served by Medicaid alone.

It is important to note that as of Oct. 2003, the match split between the state and CMS changes. Currently CMS will pay 58.9% If the total costs of this expansion of Medicaid services.

It is also known that revenue will be generated by the premium portion of this design. The amount and timing of the revenue is uncertain as it is dependent on levels of participation and the ability of participants to increase their earnings above the FPL.

It is known that all TWWIIA states are now collecting a premium. It is also known that an average of 35% of Buy-In participants pay premiums. It is also known that across the twelve states reporting in this study to CMS, the average premium paid was \$48.22. (Oregon Institute, CMS Report Summary 2002)

If every participant paid a premium, the total generated would be 657,335 (48.22X1136x12). Given the experience of other states we using the 35% figure and are estimating that \$230,067 will be generated at a minimum annually by the premium. We believe this number to be conservative and believe that the percentage may range from 35-50%. At 50%, \$328,667 would be collected. Once again, enrollment levels and earnings will be the variables in this equation.

There are two other factors to consider in relation to the premium contribution to this design. One, the initial year, or perhaps two may not generate this level of cost-sharing revenue due to the likelihood that enrollments will increase over time and the program will not have a full complement on day one. Also, individuals must obtain employment and have earnings rise to above 100% of the FPL before they are required to pay a premium.

The other issue is that the cost of the collection of premiums and the details of this cost are not available to us at this time since the cost would be inherent in how the collection system was designed and implemented.

It should be noted that the premium structure in Florida is structured to include more individuals in the cost-sharing, at earlier levels and at a greater percentage in general than the other four states.

Benefits/Savings:

The most tangible benefit to the state would be from the increased state and federal taxes paid by those employed. A December 1999 study commissioned by the Able Trust reported that 23 percent of a disabled individual's earned income would be returned to the state and federal governments in taxes. It is also known that each dollar generated in a community has an economic impact.

Families USA, in the 2003 report, *Medicaid: Good Medicine for State Economies* identified that in 2003 each dollar spent on Medicaid will generate \$2.82 in the economy. The growth was tracked in the categories of business growth, wages and jobs

Some of the Buy-In states are beginning to review the impact of work on health and health care costs. Initial information regarding this work promises documentation of improved health and overall reduction in health care costs for individuals with disabilities that work. The State of Massachusetts has studied this issue under their Medicaid Infrastructure Grant and is readying a report on their findings.

The Able Trust study further concluded that there are other intangible or non-monetary outcomes that can be seen as benefits. In addition to employment, those benefits can include:

- Increased educational attainment;
- Access to equipment or resources needed for independence;
- Improved self-image and greater self-esteem;
- Improved communication and interpersonal skills;
- Improved job-related skills;
- Improved self-sufficiency and decreased dependency upon other forms of support; and
- Overall increased quality of life.

Literature Reviewed:

The Medicaid "Buy-In" Program: A Cost and Feasibility Study, AHCA, The Capstone Group, December 1, 2000

Medicaid and Ticket to Work, States' Early Efforts to Cover Working Individuals with Disabilities. United States General Accounting Office: Report to Congressional Committees, June 2003

"Summary of Governor's FY 2002-2003 Budget Recommendation", Agency for Health Care Administration, 2002

District of Columbia Medicaid Infrastructure Grant, Year 1 Final Report, Cornell Center for Policy Research and its subcontractor Susan Daniels, March 31, 2003

Medicaid Buy-In Programs for Workers with Disabilities, National Conference of State Legislatures' LegisBrief, Volume 10, Number 46, November/December 2002

Medicaid Buy-In Programs: Case Studies of Early Implementer States, U.S. Department of Health and Human Services, Donna Folkemer, Allen Jensen, Robert Silverstein, Tara Straw, May 2002

Policy Frameworks for Designing Medicaid Buy-In Programs and Related State Work Incentive Initiatives, U.S. Department of Health and Human Services, Donna Folkemer, Allen Jensen, Robert Silverstein, Tara Straw,

The Medicaid Buy-In Program: Lessons Learned from Nine Early Implementing States, U.S. Department of Health and Human Services, Donna Folkemer, Allen Jensen, Robert Silverstein, Tara Straw

Medicaid Buy-In Reports for Medicaid Infrastructure Grantees, Summary, Reports Submitted June 2002, compiled by the Oregon Health Policy Institute

Medicaid Purchase Plan Evaluation, Annual Report, Center for Delivery Systems Development Financing, Department of Health and Family Services, Innovative Resource Group, LLC, Madison, Wisconsin, November 2002

Medicaid Buy-In Eligibility Groups, Center for Medicare and Medicaid Services, <http://cms.gov/twwiia/elgible.asp>

SSI Annual Statistical Report, 2002 – Recipients that Work, Social Security Administration, 2002

SSI Annual Statistical Report, 2000 – Recipients that Work, Social Security Administration, 2000

A Blueprint for Self-Determination in Florida, Tom Nerney, Florida Disabilities Council, Inc, 2003

Ohio Medicaid Buy-In Campaign: Advocacy Planning Guide, Ohio Developmental Disabilities Council, 2003

SSI Related Programs Fact Sheet January 2003,
http://www5.myflorida.com/cf_web/myflorida2/healthhuman/ess/ssifactsheet.pdf

Basic Medicaid Caseload, Historical and Forecasted: Average Month Caseload by Fiscal Year, FY 1994-95 to 2003-04, Social Services Estimating Conference, February 14, 2003.

Medicaid Information Package, Legislative Affairs Office, State of Michigan, Department of Community Health

Medicaid: Good Medicine for State Economies, FamiliesUSA 2003

Relevant Websites:

National Center for Medicaid and Medicare Services
www.cms.gov

Social Security Administration
www.ssa.gov

Florida Agency for Health Care Administration
Myflorida.com

Florida Department of Children and Families
Myflorida.com