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## Evaluation of the 40 Hours per Month Work Requirement for MassHealth's CommonHealth Working Program

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## Evaluation of the 40 Hours per Month Work Requirement for MassHealth's CommonHealth Working Program

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## Executive Summary

This report responded to a request by the Centers for Medicare and Medicaid Services to evaluate the effectiveness of the 40 hours per month work requirement for eligibility for the Massachusetts Medicaid (MassHealth) “Buy-In” program known as CommonHealth Working (CHW). CommonHealth Working, like other state Buy-In programs, allows workers with disabilities to purchase MassHealth insurance coverage if their income exceeds limits for the standard MassHealth program. CommonHealth Working requires 40 hours of documented work per month (or 240 hours in the past six months) and also has no asset or income limits for eligibility. There are two other CommonHealth “Buy-In” programs: a program (CommonHealth Non-Working) for non-workers with disabilities who meet a “spend down” eligibility criterion and a program for children with disabilities who are under 18 years old.

This evaluation includes: 1) a comparison of CommonHealth Working participant earnings with earnings for participants in Buy-In programs in other states that did and that did not employ similar work requirements; 2) an analysis of the impact of the monthly work requirement on enrollment and case closures in CommonHealth Working; and 3) an analysis of earnings and hours worked and MassHealth expenditures for CommonHealth Working participants. To collect data for this evaluation, the Center for Health Policy and Research (CHPR) research staff compiled and synthesized literature on Medicaid Buy-In programs in other states and performed an analysis of MassHealth administrative data.

## Findings:

- A comparison of CommonHealth Working with other state Buy-In programs showed that the 40 hour work requirement, coupled with having no income or asset limit, served to define a pool of members with higher earnings relative to other states. (For example, Massachusetts ranked third out of 28 states in average earnings among Buy-In participants in 2006; Gimm, Davis, Andrews, Ireys & Liu, 2008). Similar positive outcomes were found in states that used income eligibility minimums that were roughly equivalent to the 40 hour work requirement, despite different regional economic conditions.
- The 40 hour work requirement did not appear to constrain enrollment in CommonHealth Working relative to Buy-In programs in other states. Massachusetts remained among the most populous of the Buy-In programs and Massachusetts ranked 9<sup>th</sup> among 28 states for Buy-In enrollment per 100,000 state residents.
- Analysis of eligibility rules and case closure data indicated that the 40 hour work requirement could have operated to disqualify some people from CommonHealth Working. This would have occurred if individuals were unable to meet the work requirement, they were unable to meet the “spend-down” criterion for CommonHealth Non-Working, and their income and/or assets exceeded limits for the MassHealth standard program.
- Examining the number of hours worked by participants in CommonHealth Working indicated that 40% worked at or near the 40 hour per month mark and up to 79 hours per month. This large proportion suggested that some people may have increased their work hours in order to obtain CommonHealth Working and that, therefore, the work requirement may have succeeded in motivating people to work. Another 21% of CommonHealth Working participants were employed at the full time mark of 160+ hours per month, indicating that the program also provided an opportunity for full time employment and to acquire employer based health insurance. Analysis showed that 9% of participants worked less than 40 hours, and another 30% worked between 80 and 159 hours.
- On average, workers in CommonHealth Working worked 91 hours per month (24 hours per week). The difference between hours worked while enrolled in CommonHealth Working compared to hours worked during periods when individuals were not enrolled in CommonHealth Working was statistically significant.
- Enrollment in CommonHealth Working was associated with lower MassHealth expenditures when compared with enrollment in MassHealth Standard.

In conclusion, the 40 hour work requirement as used in the CommonHealth Working program serves to meet the state's overall mission to provide access to healthcare support to people with disabilities in an effort to assist them in community integration goals inclusive of employment.



## Introduction and Background

The Center for Health Policy and Research (CHPR) conducted an evaluation to address the Special Terms and Conditions for Massachusetts' extension of the MassHealth Section 1115(f) Medicaid Demonstration Waiver, amended on July 1, 2006 (Number: 11-W-00030/1, Title: MassHealth Medicaid Section 1115 Demonstration, Awardee: Massachusetts Executive Office of Health and Human Services, Item number 18), as requested by the Centers for Medicare & Medicaid Services (CMS). The text of the term is copied below:

“The Commonwealth’s evaluation of the MassHealth demonstration shall include a section evaluating the effectiveness of the Safety Net Care Pool and *the 40 hour work requirement for the CommonHealth working adults with disabilities.*”

The employment rate of people with disabilities in the Commonwealth, as well as in the nation, is substantially lower than that of people without disabilities. While it is thought that many people with disabilities can and wish to work, a formidable barrier to their employment is the actual and perceived loss of Medicaid health care benefits if their income rises beyond eligibility levels. Medicaid is especially valuable to people with disabilities as it provides benefits such as personal care assistance and durable medical equipment that are frequently absent from employer-based health plans.

The CommonHealth Program was started in 1988 as a state-funded program to provide health coverage to Massachusetts' uninsured citizens through the state Medicaid program (called MassHealth). The CommonHealth program was designed

to provide healthcare support to people with disabilities in an effort to assist them in community integration goals inclusive of employment. In 1996, the program was folded into the state Medicaid 1115 waiver as a “Buy-In” program to enable people with disabilities to purchase MassHealth coverage through an income-adjusted premium structure if individual or family earnings exceeded the limits for standard MassHealth (133% of the federal poverty level).

CommonHealth includes Buy-In programs for adults who work (CommonHealth Working), adults who do not work (CommonHealth Non-Working), and for children. To be eligible for CommonHealth Working, members have to demonstrate that they are working at least 40 hours a month. To be eligible for CommonHealth Non-Working, members do not need to work, but they must meet a one-time deductible for health-related expenses. None of the CommonHealth programs have income or asset “ceilings” to limit a member’s allowable earnings or assets.

After the start of CommonHealth Working, Buy-In programs became available to state Medicaid programs through two authorizing legislations: the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentive Improvement Act of 1999 (TWIIA). CMS regulations for these programs stipulated that, while a work effort was required (National Consortium of Health Systems Development, 2005) states could not impose minimum work requirements (Black & Ireys, 2006). Hence, with the CommonHealth Working program, Massachusetts was in a unique position to evaluate a Buy-In program’s use of a work requirement and to provide

information to CMS to guide policy regarding work requirements for Buy-In programs.

## **Method**

CMS posed the question of whether the CommonHealth Working 40 hour work requirement was “effective” but did not define how “effectiveness” was to be examined or measured as an outcome. There were a variety of ways that “effectiveness” could have been examined, including whether the work requirement functioned as an incentive that motivated individuals to work more hours than they would have in order to qualify for CommonHealth, whether the work requirement functioned to increase the percentage of people with disabilities who chose to work at all, and whether the work requirement functioned as a barrier to work by discouraging people who did not feel they could meet the requirement. These questions could have been best answered using an experimental design, wherein a sample of people with disabilities were randomly assigned to two groups, in which one employed a 40 hour work requirement and the other did not. However, it would have been nearly impossible to employ such a design.

This evaluation instead conducted a policy analysis of existing documents as well as analyses of MassHealth administrative data that was available to CHPR. Brief summaries of existing data and reports relevant to this inquiry were compiled and a compendium of these documents and analyses was created by project staff (Ellison & Olin, 2007). Findings were synthesized across these documents and were initially presented to MassHealth executive staff. Summaries of many of the

data sources reviewed are contained in the appendix to this report. Distilling these data led to the development of three research questions listed below. These questions served to guide and organize this analysis of the effectiveness of the work requirement.

*Research Questions:*

- 1) *What can we understand about the functioning of a work requirement in a Buy-In program by comparing the outcomes of the Massachusetts CommonHealth Working Program with other state Buy-In programs?*
- 2) *What is the impact of the 40 hour per month work requirement on CommonHealth Working member coverage and enrollment?*
- 3) *What are the employment outcomes and MassHealth (Medicaid) expenditures for CommonHealth Working members?*

## **Findings**

The analysis and findings for each question are presented below.

### **1) What can we understand about the functioning of a work requirement in a Buy-In program by comparing the outcomes of the Massachusetts CommonHealth Program with other state Buy-In programs?**

Information on the outcomes of Buy-Ins and earnings of members across states was available through the reports of the Mathematica Policy Research Inc. (MPR) (Black & Ireys, 2006; Liu & Ireys, 2006), the contractor to CMS for a national evaluation of the Buy-In programs. Data drawn from these reports were used for comparison with Massachusetts.

Two approaches were taken for the cross state comparison: 1) a comparison of Buy-In outcomes with neighboring states to Massachusetts (MA) that did not have

work requirements; and 2) a comparison of Buy-In outcomes of Massachusetts with other states that had comparable work requirements despite the federal restrictions. Two bordering states to Massachusetts that had no work requirements were selected for comparison: New Hampshire (NH) and Connecticut (CT). Both states had operated Buy-In programs for several years. More importantly, due to their proximity to Massachusetts, both were operating under similar regional economic conditions. Also, both New Hampshire and Connecticut had fairly high income ceilings for their Buy-In programs, which was similar to CommonHealth Working's lack of an income or asset ceiling. In 2005, Connecticut had a yearly income ceiling of \$75,000 and the New Hampshire ceiling was 450% of the federal poverty level.

In addition, three states were identified which despite federal regulations, did impose earning eligibility requirements: Oregon (OR) (\$310/month), South Carolina (SC) (\$810/month) and New Mexico (NM) (\$305/month) (Black & Ireys, 2006). These income requirements were compared to the \$270/month requirement for Massachusetts (calculated at a minimum wage in 2004 of \$6.75 per hour at 40 hours a month).

Table 1 displays 2004 data for Massachusetts and the five other states selected for this comparison. Looking at the New England states, New Hampshire and Connecticut had average monthly earnings for participants in Buy-Ins that were similar (\$720 and \$770 respectively), while the average monthly earnings in Massachusetts were much higher at \$1211. In contrast, the three states profiled in the lower section of the table (OR, NM, SC) imposed income requirements that were

similar to or higher than the equivalent work requirement of Massachusetts. These states had much higher average earnings than New Hampshire and Connecticut, with levels that were similar to the average earnings reported for Massachusetts. All four states with work or earnings requirements (MA, OR, NM, and SC) had higher average earnings when compared to other state Buy-Ins (Black & Ireys, 2006, p.90). The national average for monthly earnings among Buy-In participants with reported earnings (above \$0) in 2004 was \$604 (Liu & Ireys, 2006, p. 36).

**Table 1: Employment Outcomes for Buy-In Programs in Massachusetts and Selected States (2004 data)**

<b>New England states with Buy-Ins</b>	<b>Work or earnings requirement for Buy-In enrollment</b>	<b>Average monthly UI earnings among Buy-In participants with earnings (Black &amp; Ireys, 2006, p.66)</b>	<b>Percent of Buy-In enrollees with earnings above SGA</b>	<b>Top Earners (at least \$16,205 in annual earnings) as a Percent of Total Buy-In Enrollment per state (Gimm, Ireys, &amp; Johnson, 2007)</b>
MA	40 hours (\$270/mo at \$6.75/hour )	\$1,211	47%	23%
CT	Show FICA	\$ 770	22%	8%
NH	Minimum wage, Show FICA	\$ 720	14%	4%
<b>States with Buy-In earnings (or work hours) requirements</b>				
MA	40 hours (\$270/mo at \$6.75 /hour )	\$1,211	47%	23%
OR	\$330/month	\$ 895	24%	11%
NM	\$305/mo	\$1,360	31%	7%
SC	\$810 month	\$1,531	56%	30%

Two other comparisons are displayed in Table 1. MPR data was available for the percent of Buy-In enrollees that had earnings (among those reporting any earnings) above Substantial Gainful Activity set by the SSA, which was \$9,720 in 2004 (Liu & Ireys p. 43). While 47% of CommonHealth Working enrollees had earnings above SGA, in New Hampshire and Connecticut the percent of enrollees with earnings above SGA was much lower (22% and 14% respectively.) In contrast, the states with income requirements had outcomes there were much more similar to those in Massachusetts, even though they were located in other parts of the country. The last column displays MPR data (Gimm, Ireys, & Johnson, 2007) on “Top Earners (at least \$16,205 in annual earnings)”. Again, Massachusetts outcomes were in keeping with those states that had like earnings requirements and these outcomes were consistently higher than the two states profiled that were in the same region as Massachusetts but did not employ work requirements.

These cross-state comparisons demonstrate that states that imposed earnings minimums succeeded in differentiating a Buy-In population that had higher earnings, with a higher proportion of enrollees working above standard gainful activity (SGA) and a higher proportion of enrollees who were top earners.

These data demonstrated that employing a work requirement functioned to define the population that was being served, as “eligibility criteria for the Buy-In program establish parameters for the number and characteristics of enrollees, and states can adjust the criteria to expand or constrain the enrollment levels (Black & Ireys, 2006, p. 17)”. The issue spoke to the intent and design of the Buy-In program

and its justification. Some have argued that permitting very low earners into the program was inconsistent with the program's intent and detrimental to political support of the Buy-Ins (Black & Ireys, 2006). Nationally, Massachusetts was viewed as having succeeded in creating a group of Buy-In members with relatively high incomes by omitting the income or asset limit from its program, thereby removing the "income ceiling", and by establishing a "high bar" of eligibility with the 40 hour work requirement (Gimm, Ireys, & Johnson, 2007, p.3).

## **2) What is the impact of the 40 hour per month work requirement on CommonHealth member coverage and enrollment?**

Another perspective on the effectiveness of the work requirement was gained by asking "what is its impact on enrollment in CommonHealth Working?".

Massachusetts state administrators wanted to know how the work requirement functioned in relation to other MassHealth program eligibility requirements and specifically whether people were being closed out of CommonHealth because of the work requirement. These questions are addressed below.

The CommonHealth program showed steady growth in enrollment since its inception 1996, with over 11,000 individuals enrolled in 2007 (Center for Health Policy and Research, 2007). The Massachusetts program remained among the most populous of the Buy-In programs (Liu & Ireys, 2006). Massachusetts also ranked ninth among 28 Buy-In programs in 2004 (Black & Ireys, 2006) for Buy-In enrollment per 100,000 state residents. Hence, the 40 hour work requirement did not appear to restrict program eligibility relative to other states.



Analysis of eligibility requirements showed the circumstances under which people could become enrolled in CommonHealth Working (Massachusetts Medicaid Policy Institute, 2004). As stated, if an individual (ages 18-64) with disabilities had family income too high for MassHealth Standard (133% of Federal Poverty Level), he or she could become eligible for CommonHealth. For CommonHealth Working eligibility, an individual must have worked 40 hours a month (or 240 hours in the past six months) and was required to pay a sliding scale premium. If an individual did not work, he or she could still obtain coverage through CommonHealth Non-Working after meeting a one time deductible for accrued medical expenditures (similar to “medically needy” or “spend down” provisions) and by paying a premium. (Aside from CommonHealth, SSI beneficiaries could continue to have MassHealth coverage despite earnings, according to “1619b” provisions.)

However, there were conditions under which the 40 hour work requirement might have operated to limit enrollment in MassHealth. Individuals with disabilities became ineligible for CommonHealth when they worked less than 40 hours per month and their income or family income were too high for MassHealth Standard but their health care costs did not meet spend down criteria for CommonHealth Non-Working. In the past, individuals who were not eligible for MassHealth could receive some acute healthcare services through the Uncompensated Care Pool. Under the state’s 2006 health reform legislation, which created the Commonwealth Care insurance program, these individuals were required to purchase health insurance.

An analysis of case closures in MassHealth offered further perspective on the effect of the 40 hour work requirement. Data from MassHealth's Medicaid Management Information System (MMIS) was analyzed by CHPR. MMIS data contained fields to display reasons for case closures, and there was a field that indicated whether a case was closed because less than 40 hours per month were worked. Unfortunately, it appeared this field was not used in the MMIS system so these data were unavailable. However, analysis of the MMIS eligibility data in Fiscal Year (FY) '06 showed that there were a total of 12,152 members who had enrolled in CommonHealth Working at some point during that year. Out of these members, 1817 (15%) left MassHealth altogether during FY06; that is, they did not reappear under any other aid category during that year. When CHPR analyzed the reasons listed for why these cases were closed, approximately 30% were listed as "recipient refused to apply for other potential benefits or resources". Another 25% were listed as "failure to complete or return information". "Voluntary withdrawal" was listed for another 14% of the CommonHealth members who left MassHealth in FY '06. The remaining cases were "miscellaneous" and smaller closed categories. It could be assumed that for the 1817 CommonHealth recipients in 2006 who were closed out of all MassHealth categories for that year, some closures were due to working less than 40 hours per month. However, CHPR could not specify the percentage for which this was true. On the other hand among the case closures, 7% had private health insurance and it possible that these individuals discontinued the program due to other adequate coverage.

Further investigation would have determined where and whether additional data on disenrollment due to working less than 40 hours per month was collected. Review of the data would have allowed for an accurate estimate of those members who might have benefited from a more flexible work requirement. It was reasonable to assume that there were people with disabilities in Massachusetts who worked some hours per month, resulting in income or assets that were too high for MassHealth Standard, but who did not or could not work as many as 40 hours per month. A consideration for MassHealth would be to “lower the bar” of the work requirement to less than 40 hours per month. This could potentially expand CommonHealth coverage to a greater population of workers with disabilities.

It is important to consider whether the 40 hour work requirement functions as a barrier to enrollment. As noted, nearly all other states, because they are operating under other federal authorizing legislation for their Buy-In program, can not and do not impose a work requirement. Most states simply require a “work effort” that is made evident through pay stubs, or tax forms; two states accept self report of a work effort (National Consortium of Health Systems Development, 2005). These states “lower the bar” for eligibility in the Buy-In, which encourages enrollment from individuals with disabilities with a modicum of employment. Accordingly, these state Buy-In programs show much weaker earnings outcomes. The issue of whether to impose an hourly or earnings minimum speaks mainly to the purpose and “vision” of the program. Given the low rates of employment found for the very heterogeneous groups of people with disabilities, any work effort may be construed as valuable. If

the purpose of the Buy-In is to remove a barrier to work, namely the loss of Medicaid as incomes rise, then a state might consider much lower thresholds for the Buy-In than the 40 hour Massachusetts work requirement. Certainly, were Massachusetts to have lowered the bar to less than 40 hours it is likely that this would have allowed more people to enroll in CommonHealth Working.

### **3) What are the employment outcomes and MassHealth (Medicaid) expenditures for CommonHealth members?**

This section of the report examined available CommonHealth Working data for earnings of members, number of hours worked, and Medicaid expenditures for these participants.

*Earnings:* Analyses for earnings of Buy-In participants indicated that earnings usually increased after enrollment. For example, a recent MPR report (Liu & Ireys, 2006) analyzed social security earnings files and showed that in Massachusetts, annual earnings among first time Buy-In participants in 2001 or 2002 (including only those with reported earnings) rose from \$10,846 (pre enrollment) to \$12,151 after Buy-In enrollment (p.51). A rise in earnings among Buy-In participants was often found in states irrespective of any work requirement (Liu & Ireys, 2006). For example, in New Hampshire, a rise in earnings was found prior to and immediately following enrollment in the Buy-In, and then earnings tended to level out over the long term. New Hampshire data also suggested that, after fulfilling an initial pent-up demand for the Buy-In, the program attracted new workers with disabilities who had fewer medical conditions and earned more (Clark, Samnaliev, Kumas-Tan, 2006).

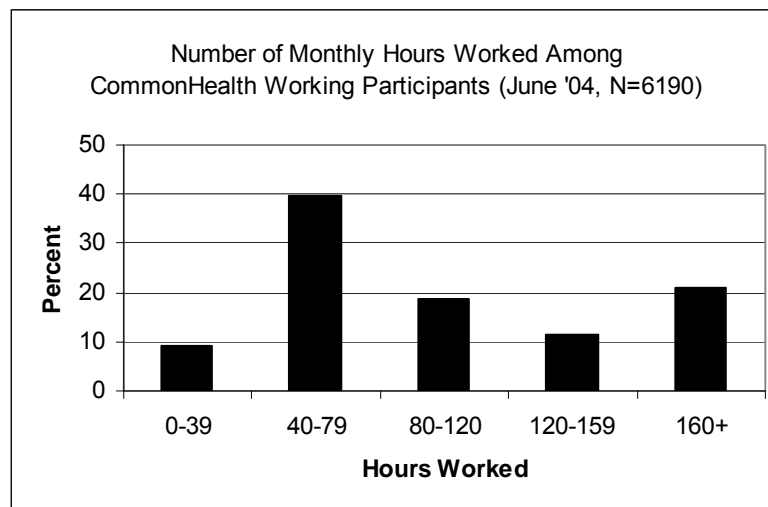
These findings were supported by recent surveys of MassHealth beneficiaries in 2003 and 2005 (Henry et. al., 2003; Henry, 2007). These surveys found that there were working members in both MassHealth Standard and CommonHealth Working. However, CommonHealth Working members tended to have a significantly higher number of hours worked per week, with a greater proportion of members working full time and a greater percentage with earnings over SGA, when compared with workers in MassHealth Standard.

*Hours worked:* CHPR was also able to conduct an analysis of the hours worked by participants in CommonHealth working during FY '04,'05, and '06. A computation was made of monthly hours worked by CommonHealth Working participants, as reported in the MassHealth eligibility data set (MA 21). Data were collected during members' eligibility application, and for yearly renewals or other self-reported changes in work status. Analysis showed that over these three years, the average number of hours per month reported worked was 91 or about 24 hours per week (calculated for 16,853 individuals enrolled in CommonHealth Working at any point and for any duration from FY '03 through FY '06). There was a statistically significant difference between the number of hours worked while enrolled in CommonHealth Working compared to average hours worked for periods when not enrolled ( $p < 0.001$ ). In contrast, the average number of hours worked per month was 12 for CommonHealth Non-Working and 13 for MassHealth Standard in the same period. Using a one month snapshot of data for 6,190 CommonHealth

Working participants in June '04, about 91% worked more than the 40 hour minimum threshold.

Further analysis of the distribution of the number of hours worked by members can be used to shed light on the functioning of the 40 hour work requirement. Evidence that a larger proportion of people clustered around working 40 hours could indicate that people were increasing their hours worked in order to pass this threshold and become eligible for CommonHealth Working. To determine whether this type of cluster occurred, a one-month snapshot of data was examined. Figure 1 shows data for 6,190 CommonHealth Working members in June 2004, with “number of hours worked” reported in 40-hour increments.

**Figure 1: Number of Monthly Hours Worked Among CommonHealth Working Participants (June 2004)**



As shown in the figure, only 9% of the individuals worked less than 40 hours per month (individuals with no reported earnings were counted as working zero hours). The largest proportion of participants (39.8) worked 40 – 79 hours. The next

largest proportion of participants (20.9) worked more than 160 hours per month, indicating full time work. These findings suggest two interpretations. First, the clustering in the 40-79 hour interval suggests that individuals are motivated to work the 40 hour minimum in order to qualify for CommonHealth Working. Second, the large proportion at the full time mark (160+ hours per month) suggests that CommonHealth Working also provides an opportunity for people with disabilities to be employed full time. Full time work also affords opportunities to obtain employer-based health insurance. For example, an analysis of a cohort of 1431 individuals who were enrolled in MassHealth for 12 months and then enrolled in CommonHealth Working for 12 months, showed a statistically significant rise in the proportion of individuals having private health insurance from pre (9.06%) to post enrollment (10.96%).

*Medicaid Expenditures.* CommonHealth Working enrollees tended to have lower per member per month (PMPM) expenditures than MassHealth Standard enrollees. An analysis by CHPR (Hashemi, Hooven, Zhang, & Himmelstein, 2004) of MassHealth expenditures for individuals who were enrolled continuously in CommonHealth Working for one year and had moved to this program after one year of continuous enrollment in MassHealth Standard, found that PMPM costs were reduced from \$794 to \$595 post CommonHealth Working enrollment. There were also changes in the constellation of services used (decreased mental health residential costs and increased personal care attendant costs). There was also an

increase in third party insurance among CommonHealth Working members, including Medicare and commercial health insurance.

While the factors that caused an individual to move from MassHealth to CommonHealth are not completely understood, it is clear that CommonHealth Working participation was associated with reduced costs to MassHealth. Therefore, in Massachusetts, the 40 hour work requirement functioned within a program that is associated with lower Medicaid expenditures. While the impact of taking away the requirement and thereby altering the population eligible CommonHealth Working is unknown, one can surmise that people will enroll who are unable to work the 40 hours and may have greater health care utilization and costs to MassHealth.

## **Conclusions**

The CommonHealth Working program, with no income or asset limit and with a minimum monthly work requirement, is a successful design for fulfilling the broader goal of the Medicaid Buy-In programs, which is to promote employment opportunities for people with disabilities by eliminating the potential loss of Medicaid as a barrier to employment (Liu & Ireys, 2006). The CommonHealth Working program, as presently configured with the 40 hour work per month requirement, enjoys national distinction as having enrollment with higher than average earnings and other better employment outcomes. Moreover, enrollment in Commonwealth Working is associated with lower Medicaid expenditures and increased use of third party insurance.



It is difficult to know whether the work requirement “incentivized” work or merely permitted those who were able to work an opportunity to do so without penalty, i.e. loss of health insurance. However, the findings for hours worked did supply some evidence that individuals worked at least 40 hours in order to get or keep their CommonHealth Working insurance.

If Massachusetts were to lower the bar of entry for CommonHealth Working by allowing fewer work hours per month, more individuals may be “incentivized” to work more. However, the addition of more workers who work fewer hours would likely lead to a decrease in average earnings for CommonHealth Working enrollees. In addition to considering changes to the monthly work requirement, MassHealth could consider adopting an earnings requirement that would replace the hours worked requirement. This option would allow for the CommonHealth Working program to be more consistent with other state Buy-In programs. Finally, MassHealth could consider using the available data field for “case closure due to not working 40 hours” in order to better assess the impact of the 40 hour per month work requirement on enrollment.

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## **Appendix:** Report Summaries from the *Evaluation of the MassHealth CommonHealth Work Requirement Compendium*

- I. Pathways to Public Health Insurance Coverage for Massachusetts Residents
- II. Understanding MassHealth Members with Disabilities
- III. Participation in the Medicaid Buy-In Program: A Statistical Profile from Integrated Data
- IV. Characteristics of Disabled Individuals who Move from a Standard Medicaid Program to a Medicaid Buy-In Option
- V. Analysis of MassHealth Employment and Disability Survey (MHEDS) I and II Data
- VI. Who are the Top Earners in the Medicaid Buy-In Program?
- VII. How Much are Medicaid Buy-In Participants Earning?
- VIII. Evaluation of the Medicaid for Employed Adults with Disabilities (MEAD) Program: 2002 – 2005 (New Hampshire)
- IX. Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2003-2004

## I. Pathways to Public Health Insurance Coverage for Massachusetts Residents<sup>1</sup>

Project Team: Strother, Tutty, Masters, Seifert, Turnbull, Himmelstein  
Massachusetts Medicaid Policy Institute

Center for Health Policy and Research (CHPR), UMass Medical School, 2004

**Introduction:** Most non-elderly individuals, in Massachusetts and the rest of the country, secure health insurance through their employers. Massachusetts also offers relatively broad opportunities to secure coverage through public-sector programs or assistance in paying for employer-sponsored health insurance. By providing this information, the hope is to increase knowledge of public health insurance programs in the Commonwealth, illustrate the eligibility pathways into these insurance programs, and identify gaps in the current system that lead to uninsured residents.

**Methods and Population:** This publication highlights these coverage options and the health care resources available to the uninsured, underinsured, elderly, and residents with disabilities of Massachusetts. For this summary we examined the pathway to coverage for people who are ‘considered disabled by SSA or State Criteria’ To qualify for MassHealth Standard or CommonHealth, an individual with a disability must be “permanently and totally disabled” as the term is defined by one of three programs: the federal Social Security Administration, the Disability Evaluation Service for MassHealth; or the Massachusetts Commission for the Blind (certification of legal blindness).

**Summary of Findings:** Flow Chart (4) Considered Disabled by SSA or State Criteria: If a person is eligible for SSI they receive MassHealth Standard coverage. The specific population we looked at are not eligible for SSI, over the age of 19, are ‘citizen or qualified’, do not work 40 hours or more a month, has a family income above 133% of FPL. This population may be eligible for the MassHealth CommonHealth Non-Working program if they can meet a one-time deductible, “non-working individuals with disabilities under age 65 whose household income is greater than 133% FPL must pay a one-time only deductible to qualify for the CommonHealth program”.

### Discussion Points:

- People who are ineligible for MassHealth Standard due to income, who do not work at least 40 hours per month and can not make the one-time deductible required for CommonHealth Non-Working, have the option of using ‘Free Care’ through the Uncompensated Care Pool (UCP) if they have income between 200% - 400% of FPL, or they may be eligible for Medical Hardship Assistance to those who qualify if > 400% FPL.
- The above implies that there are a pool of people (of indeterminate number) who “fall through the cracks” of CommonHealth coverage because of the 40 hour work requirement. A lowering of the work requirement bar will permit more people to receive CommonHealth coverage.
- The option of use of the free care pool by CommonHealth ineligible is subject to change in relationship to health care reform and universal coverage.

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<sup>1</sup> Summary prepared by Leslie Olin, CHPR, 2007.

## II. Understanding MassHealth Members with Disabilities<sup>1</sup>

Massachusetts Medicaid Policy Institute in collaboration with  
Center for Health Policy and Research (CHPR), UMass Medical School and  
Boston University School of Public Health, Health and Disability Working Group, June 2004

**Introduction:** Non-elderly people with disabilities comprise one-fifth of MassHealth enrollment and an even greater portion of the expenditures, yet their circumstances and the role of Medicaid in financing essential services for them are not well understood. This report seeks to promote understanding and support informed policy decisions about this group.

**Methods and Population:** This report focuses members under age 65 who are eligible for MassHealth on the basis of disability. Data and information were gathered from several sources including MassHealth claims and eligibility files, U.S. Census Bureau 2000.

**Summary of Findings:** The average annual per member spending for MH members with disabilities was \$9,768 for age 0-64 members with disabilities. For SSI Disabled the average was \$9612, for Medicaid Disabled \$10212, and for CommonHealth Members \$9336. Since most members with disabilities are older adults (41-64) they account for nearly two-thirds of total costs. The majority of spending is for Prescription Drugs and Community Supports, 29% Drugs and 22% Community Supports. Community Supports (PCA, Home Health, Day Treatment) account for almost one quarter of total spending, they also represent the most significant portion of expenditures across all of the disabled categories. PMPM spending for SSI Disabled was \$801, for CommonHealth \$778 and for Medicaid Disabled \$851. The pattern of spending varies significantly for those who have other insurance coverage than for those who do not. MH spending is lower for members who have other insurance; however these members rely on MH to provide wrap around coverage for essential services (medication and PCA services). MH spending PMPM is higher for those without other insurance at \$879 pmpm, MH pays \$734 for those with other coverage, a difference of \$145 pmpm.

### Discussion Points:

Continue to support and encourage participation in the community and workplace.

- MH adults members with disabilities have the potential to return to work, find independence and self-sufficiency.
- Help manage program spending and invest in enrollees so they have a greater chance of returning to work or staying employed despite their disability.
- MBI programs are designed to increase independence and employment for people with disabilities – address barriers health care barriers faced by these members.
- There are strong incentives for this population to retain MH CH coverage, cost of private health insurance is high, and certain necessary services (PCA, DME) may not be covered outside of MH.
- MH CH coverage provides benefits that make work possible for some (pharmaceuticals for those with psychiatric and cognitive disabilities or PCA services for those with physical disabilities).
- MH CH members who work contribute to the cost of their health care through premiums and also pay taxes.

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<sup>1</sup> Summary prepared by Leslie Olin, CHPR, 2007.

### III. Participation in the Medicaid Buy-In Program: A Statistical Profile from Integrated Data<sup>1</sup>

May 2006 Mathematica Policy Research, Inc., Washington, DC.

**Introduction:** The ‘Participation in the Medicaid Buy-In Program: A Statistical Profile from Integrated Data’ (Liu & Ireys, 2006) is the first MPR report using the new longitudinal, person-level data to support the analysis of the Medicaid Buy-In (MBI) programs.

**Methods and Population:** This longitudinal database was used to examine MBI program participation over time; longitudinal patterns of earnings and medical expenditures, CMS policy changes on program costs and enrollment, participant characteristics, program performance and earnings, issues and trends. This summary describes the Massachusetts Medicaid Buy-In program (MassHealth CommonHealth) outcomes for enrollment and member characteristics, earnings profile, medical expenditures profile, and Buy-In summary profile.

**Summary of Findings:** State specific highlights include earliest MBI program implemented (7/1997), the second highest average annual earnings in 2003 – 2004 at \$13,000 out of 27 states; ranked fourth in earnings above substantial gainful activity (SGA) at \$810 out of 27 states; ranked fifth in average annual earnings in 2003 & 2004 for first time enrollees in 2004 out of 27 states; had the fourth largest difference in average annual earnings of pre and post enrollment out of 23 states; and lastly, ranked third with 47% of members having higher post enrollment earnings compared with pre-enrollment earnings of first time members in 2001 or 2002.

#### Discussion Points:

- MA has higher Buy-In participant earnings due to the lack of income or asset limits (only state with no asset limits)
- Most other state MBI programs do not have a minimum work requirement for Buy-In enrollment
- States can adjust eligibility criteria and work related policies to expand or restrain enrollment levels. The BBA legislation limits the net family income to <250% FPL, whereas the Ticket Act has no income eligibility ceiling but provides flexibility to determine income/asset levels.
  - State Examples of eligibility criteria changes:
    - North Dakota expanded age range from 18 – 64 to 16 – 64
    - South Carolina has excluded 401k balances from countable asset total and requires that participants must have earned income of at least \$810 (2004) per month to enroll and remain in the program.
    - New Mexico and Oregon requires earned income of \$900 per quarter to be eligible for their Buy-In.
  - State Examples of Work Related Policies and protections:
    - New Hampshire added requirement for applicants to continue working while eligibility is being determined. Participants must earn at least the federal minimum working wage. The grace period for enrollees who become unemployed shortened from 12 to 6 months.
    - Vermont requires proof of employment in several ways: payment of FICA taxes, Self-Employment Contributions Act (SECA) payments, or a written business plan approved and supported by a third-party investor or funding source.

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<sup>1</sup> Summary prepared by Leslie Olin, CHPR, 2007.

*Participation in the Medicaid Buy-In Program: A Statistical Profile (continued)*

**I. Profile of Buy-In Enrollment & Participant Characteristics: Massachusetts Only**

- a. Number of MA Buy-In Participants Ever Enrolled By Year: Sorted by Implementation Date 7/1997

Year	2000-2004	2000	2001	2002	2003	2004
Enrollment	19,361	6,453	7,657	9,765	10,949	10,858

*Data Source: Medicaid Buy-In (MBI) finder files - 27 states*

- b. Year-To-Year Change in the Number of MA Participants Ever Enrolled in the Buy-In by Year

Year	<b>2000 - 2001</b>	<b>2001 - 2002</b>	<b>2002 - 2003</b>	<b>2003 - 2004</b>
% Change	19%	28%	12%	-1%

*Data Source: MBI finder files from 24 states*

- c. Prior Medicare Eligibility Among Those Ever Enrolled in the MA Buy-In: 2000 – 2003

- 11,052 Participants
  - 65% of Participants with Medicare Eligibility
  - 15% of Participants with SSDI but NO Medicare

*Source: MBI finder files from 23 states*

**II. Profile of Earnings: Massachusetts Only**

- a. Percentage of Buy-In participants with reported earnings: 2003 – 2004

- 85% reported earnings in 2003 (Average % of participants with earnings was 67%)
- 81% reported earnings in 2004 (Average % of participants with earnings was 69%)

*Source: MBI finder files from 27 states and Master Earnings File (MEF) from SSA*

- b. Average annual earnings among Buy-In participants with reported earnings: 2003 - 2004  
**Massachusetts had the second highest average annual earnings** among participants with reported earnings in 2003-2004 of \$13,000.

*Source: MBI finder files from 27 states and MEF*

- c. Percentage reporting earnings above SGA, and above 200% of FPL: 2004

**MA ranked 4<sup>th</sup>** out of 27 states by **% with earnings above than SGA.**

- About 43% earned above SGA (\$9,720 per year)
- About 23% earned above 200% of FPL (\$18,620 per year)

*Source: MBI finder files from 27 states and MEF*

- d. Average annual earnings in 2003 and 2004 of first-time Buy-In enrollees in 2004 found in MEF

→ **MA ranked 5<sup>th</sup>** out of 27 states

<u>Average Annual Earnings</u>	<u>Year</u>
\$7,397	2003
\$8,955	2004
121%	2004 (as a Percentage of 2003 Earnings)

*Source: MBI finder files from 27 states and the MEF, sorted by average annual earnings*

- e. Annual earnings before and after enrollment among first time Buy-In members in 2001 or 2002 found in MEF by state.



*Participation in the Medicaid Buy-In Program: A Statistical Profile (continued)*

MA had the **4<sup>th</sup> largest difference in average annual earning from pre-enrollment** and post- enrollment out of 23 states.

- Number of participants 6,600
- Average annual earnings pre-enrollment \$10,846
- Average annual earnings post-enrollment \$12,151
- Difference \$1,305**

*Source: MBI finder files from 23 states and MEF.*

*Figures are based on average annual earnings for three years before the year of enrollment.*

- f. Percentage of first-time Buy-In members in 2001 or 2002 found in MEF with higher post-enrollment earnings compared with pre-enrollment earnings.

**MA ranked 3<sup>rd</sup> with members having higher earnings after enrollment**

- Massachusetts had 6,600 participants enrolled, **47%** had higher earnings after enrollment.
- The average increase in earnings after enrollment was \$7,414.

*Source: MBI finder files from 23 states and MEF*

- g. Number and % of Participants Ever Enrolled in MBI Program, 2004  
Number of Participants 10,858 19% had No Reported Earnings

\$1-2,400	\$2,401-4,800	\$4,801 – 7,200	\$7,201– 9,310*	\$9,311 – 9,720~	\$9,721 – 12,000	\$12,001– 14,400	\$14,401– 6,800	\$16,801– 18,620	\$18,621+^
10%	13%	15%	13%	2%	8%	6%	6%	4%	23%

\* 100FPL

~ SGA

^ Above 200% FPL

*Source: MBI finder files from 27 States & MEF*

**III. Profile of Medical Expenditures: Massachusetts Only**

- a. Per member per month (PMPM) Medicaid expenditures among selected participants ever enrolled in the Buy-In 2002.

- Number participants 5,984
- **PMPM combined expenditures \$1,161**
- PMPM expenditures paid by Medicaid \$796 69%
- PMPM expenditures paid by Medicare \$366 31%

*Source: Finder files from 22 states, Medicaid Statistical Information Systems (MSIS) from CMS, Medicare Enrollment Data Base (EDB) (Ever enrolled Buy-In participants in 2002), matched with Medicaid claims data and Medicare EDB.*

**IV. MA Buy-In Profile Summary Massachusetts Only**

- a. 2001 & 2002 Enrollment: **6,691 enrolled for 15 months on average**, with 30% enrolled for at least 24 months.
- b. 2000 – 2004 Summary: 19,361 Enrolled
  - Churning
    - o 78% had a single enrollment spell and 18% had two enrollment spells. The maximum number of spells was 7. (*Source: MBI Finder Files from 27 states*)

*Participation in the Medicaid Buy-In Program: A Statistical Profile (continued)*

- Demographics
  - o Average age was 43
  - o 51% were between the ages of 21 – 44
  - o 49% were male
  - o 43% were white

(may include missing data supplied in finder file).

*Source: MBI Finder Files from 27 states*

- Impairment
  - o 27% had mental illness or other mental disorder;
  - o 6% had mental retardation,
  - o 6% had musculoskeletal system impairment,
  - o 2% sensory,
  - o 15% Other
  - o 44% Unknown (missing).

*Source: MBI Finder Files from 27 states and Ticket Research File (TRF)*

- Prior SSI & SSDI
  - o 50% with SSDI only, 1% with SSI only, <0.5% with SSI/SSDI,
  - o 49% with no SSI or SSDI

*Source: MBI Finder Files from 27 states and TRF*

- Prior Work Incentive Participation
  - o 0.1% with 1619a
  - o 1.2% with 1619b

*Source: MBI Finder Files from 27 states and TRF*

**Data Sources**

MBI-In finder files – Includes SSN, DOB, gender, race, enrollment start and end dates, Medicaid Identification number, State abbrev. (27 states: AL, AK, CA, CT, IL, IN, IO, KS, LA, ME, MA, MI, MN, MS, NB, NH, NJ, N M, NY, OR, PA, SC, UT, VT, WA, WV and WI)

Ticket Research File (TRF) from SSA – Longitudinal data (1/94 -12/04), one-time data on individuals 18 – 64 who participated in SSI or SSDI at any time from 1/96 – 9/04. Include identifiers, disabling conditions, program participation status, benefit payments. Does not include MBI participants.

Master Earnings File (MEF) from SSA – Earnings data from (W2 reports). Includes identifying information, summary and detailed annual earnings data.

Medicaid Statistical Information Systems (MSIS) from CMS – Provided to CMS by states, includes quarterly eligibility and claims data. Consists of demographic and monthly enrollment data. Claims files include encounter data: service type, provider, dates, costs, capitation payments.

Medicare Enrollment Data Base (EDB) and Claims Files from CMS – Used to establish entitlement for Medicare beneficiaries. Contains information on types, dates, costs of services used.

## IV. Characteristics of Disabled Individuals Who Move from a Standard Medicaid Program to a Medicaid Buy-In Option<sup>1</sup>

By Hashemi, L., Hooven, FH., Zhang, J., Himmelstein, J.

Presented at American Public Health Association, Washington, DC, November , 2004

**Introduction:** The prospect of losing publicly funded health insurance is a significant barrier to employment for people with disabilities. Work incentives and Medicaid “Buy-In” programs were designed to remove this barrier and promote employment for people with disabilities by providing continued health coverage.

**Methods and Population:** This summary document describes individuals who left the MassHealth Standard (MHS) program and returned to work. We hoped to learn from administrative data how the costs of care changed for those who moved, and what the demographics, healthcare use, and disability characteristics were for those who transitioned from the MHS program to CommonHealth (CH). The study population included MassHealth members with disabilities that moved from the MHS program to the CHWorking program during fiscal years 2000 through 2002, which were enrolled in the MHS program for at least one year and transitioned into and remained in the CH program for at least one additional year following the move.

**Summary of Findings:** The results showed that 5,104 individuals were enrolled in the CH program on 6/30/01, 31% (N=1,564) had been enrolled in MHS prior to their enrollment in CH. 25% (N=397) of those members now in CH had been enrolled in MHS for at least one year prior to transitioning in to the CH program, and then remained enrolled in CH for at least one year post move. Summary of findings indicate that “movers” differ significantly from those who do not move. There were more males (56%), and they were significantly younger (average age 41). Among “movers” almost one-third (29%) had a psychiatric disorder as compared to only 21% in the CH, and 38% in the MHS only program. After the move to CH the per-member per-month (PMPM) cost was reduced from \$794 to \$595. The Department of Mental Health residential setting decreased significantly from 35% to 10% of costs. Personal Care Attendant (PCA) use increased significantly from 8% to 29% of costs. PMPM for members who picked up TPL after their move was significantly lower (\$778 vs. \$459).

### Discussion Points

- The Buy-In program may reduce state costs for members who move from MassHealth Standard to CommonHealth.
- Payments appear to be reduced through acquisition of other insurance. More information is needed about changes in overall healthcare use.
- The association between Buy-In program enrollment and reduced residential care for people with mental illness should be explored further.
- Other sources of data should be used to understand differences between those that return to work or increase income, and those who do not.

**Study Limitations:** Data obtained was from an administrative database created for eligibility and claims processing and not for research. Using claims-based diagnosis may undercount certain disabling conditions, and overestimate others.

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<sup>1</sup> Summary by Leslie Olin, CHPR, 2007.

## V. Analysis of MassHealth Employment and Disability Survey (MHEDS) I and II data

By Alexis Henry, 2007

Center for Health Policy and Research (CHPR), UMass Medical School

**Introduction:** Survey data is available on workers and non-workers in the MassHealth programs conducted by Alexis Henry at CHPR. A preliminary analysis was made for this evaluation of the work requirement and more detailed analyses can be conducted in the future.

**Methods and Population:** This survey was conducted by CHPR in 2003 and 2005 to a random sample of participants in Medicaid Standard, CommonHealth Working and Non –Working programs. Phone and mail methods were used with self-report, Spanish language survey and phone translation was available. This analysis was conducted for 940 CommonHealth participants who reported to be working at the time of the survey and for 148 MassHealth Standard beneficiaries who also reported to be working, spread across the two survey time points.

**Summary of Findings:** Findings for MHEDs I (2003) show statistically significant differences in the job characteristics of workers in CommonHealth vs. those in MassHealth Standard. On average, CommonHealth workers worked far more per week (26 hours vs. 20 hours); a larger proportion worked fulltime, earned over SGA and worked for more than one year. A greater proportion has employer based health insurance although the proportion was still small in either case. These findings were largely the same in MHEDs II (2005) however the proportional difference between workers in Standard vs. CommonHealth were closer and were non-significant for number of hours worked and proportion working full time.

### Discussion points

- This is another piece of evidence that CommonHealth participants earn more, work more hours and have better job tenure than do working beneficiaries of MassHealth Standard. The smaller difference between MHEDs I and II samples in full time status and hours worked per week is attributed to a sample in II that although randomly selected, turned out to have poorer health status than in MHEDS I.
- Although a causal inference cannot be made, and the program's work requirement does by design cull out individuals who are capable or motivated to work at least 40 hours per month, we can say with confidence that the program succeeds in identifying and serving a population among people with disabilities who would not have been able to work as much without losing their Medicaid were it not for CommonHealth the program.
- Although the CommonHealth program is designed only to accept workers who work at least 40 hours per month, this does not necessarily entail full time employment or greater job tenure, however these positive associations with CommonHealth status were found.

## VI. Who are the Top Earners in the Medicaid Buy-In Program?<sup>1</sup>

*Working with Disability*, 3, March 2007

Gimm, Ireys, and Johnson

Mathematica Policy Research Inc., Washington, DC

**Introduction:** This is one of a series of policy briefs that MPR prepares for CMS on the Buy-In programs nationally. This brief describes the characteristics of the top 10 percent of all earners in Medicaid Buy-In (MBI) programs in 2004.

**Methods and Population:** The data are taken from state Buy-In enrollment records and linked with SSA Master Earnings file which contains information reported to the IRS on W- forms, 2004. Analysis was made of the top 10% of earners across 27 states.

**Summary of Findings:** The top 10 percent of all earners in the Buy-In nationally earned on average \$25,231 (271% of 2004 FPL). Average yearly earnings for the remaining 90% were \$5,248. Top earners were more likely to be: non-white and to have not received SSI or SSDI in the previous year. South Carolina and Massachusetts had the greatest share of Buy-In participants who were top earners (e.g., at least 16,205 in annual earnings).

### Discussion points

- Policymakers would like to see the Buy-In as a springboard to employment.
- SSI beneficiaries who want to work are less likely to use the Buy-In compared to those on SSDI because SSI recipients are eligible for continued Medicaid up to state 1619b levels.
- MA has created a pool of participants with a relatively high income by omitting an income and an asset limit from its program thereby removing an “income ceiling”.
- Like SC, MA has done this also by creating a high bar for entry into the Buy-In, for 40 hour work requirement equivalent to the SC earning requirement of \$810 per month.
- Top earners in states must be considered in light of the state programs: “including the combined influence of income limits, asset restrictions and spousal income considerations.”
- “the program’s broader goals to promote employment opportunities for adults with disabilities who want to enter or increase their involvement in the workforce, working for even a limited number of hours can be a major step toward independence and can bring non-financial benefits.”

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<sup>1</sup> Summary prepared by Marsha Ellison, CHPR, 2007.

## VII. How much are Medicaid Buy-In Participants Earning?<sup>1</sup>

*Working with Disability, 1, May 2006*

Black, Liu, & Ireys

Mathematica Policy Research Inc., Washington, DC.

**Introduction:** This is one of a series of policy briefs that MPR prepares for CMS on the Buy-In programs nationally. This brief describes the proportion of Buy-In participants working and how much they earn.

**Methods and Population:** The data are taken from 27 state Buy-In enrollment records and linked with SSA Master Earnings file which contains information reported to the IRS on W- forms. 2004.

### Summary of Findings:

Majority (average of 66%) reported earnings, MA had above average report of working (82%) though less than the median (more states had higher proportions of working Buy-In members. U.S. average earnings were \$7, 246 (78% FPL) which is comparable at 28 hours per week worked based on minimum wage (\$5.15 per hour in 2004). {The MA 40 hour work requirement per month at minimum wage yields income of \$206, \$2472 yearly}. While these wages suggest poverty level income for most participants, individuals probably have other sources of income (e.g., SSDI). Three broad factors are responsible for state-to-state variation in average earnings of participants: 1) Program context i.e., the local economy can influence wages and number and type of available jobs, the criteria for other public programs for working adults with disabilities; 2) program features e.g., income ceilings, asset limits; 3) participant characteristics.

SC= 14,200; MA \$12,400; NH \$5,900; CT \$7,300; OR \$8,200, NM \$8,100.

### Discussion points

- MA has created a pool of participants with a relatively high income by omitting an income and an asset limit from its program thereby removing an “income ceiling”.
- SC and MA are the two states with the highest average annual earnings, explained in part by the SC earning requirement of \$810 per month and by the high work requirement (40 hours) of MA.
- OR and NM also compare favorably to other states ranking above average in earnings, and in the upper half of states. These two states also have higher income floors for MBI participation that are comparable to MA. CT and NH (other New England states) have much lower average earnings. (CT has a high income ceiling but a moderate asset limit; NH has a high family income and asset ceiling and both similar to MA have a high 1619b threshold, NH requires minimum wage earnings).

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<sup>1</sup> Summary by Marsha Ellison, CHPR, 2007.

## VIII. Evaluation of the Medicaid for Employed Adults with Disabilities (MEAD) Program: 2002 – 2005 (New Hampshire)<sup>1</sup>

By Clark, Samnaliev, and Kumas –Tan, 2006  
Center for Health Policy and Research (CHPR), UMass Medical School

**Introduction:** This report describes the New Hampshire Medicaid Buy-In program for enrollment, participant earnings, health care provider payments, costs to the state, and other health insurance. NH requires participants to earn at least minimum wage and document payroll tax payments to maintain eligibility. MEAD asset ceilings are \$21,197. NH has a stricter standard for disability impairment (four years). Single person's income could not exceed 450% of the federal poverty level. Monthly spend-down requirements for the Medically Needy Medicaid participants are not required when enrolled under MEAD.

**Methods and Population:** This report analyzed Buy-In membership file data and Medicaid claims data for MEAD participants in FY05 including re-enrollees, drop-outs and a comparison group of other Medicaid recipients. Earned and unearned income data were available.

### Summary of Findings:

Income. 2,236 people participated in MEAD during FY05. Earnings averaged \$482 per month. Average monthly earnings for MEAD participants were 10 times greater than those of a similar group of Medicaid workers who did not enroll in MEAD. Overall there was a significant increase in earnings for MEAD participants post enrollment. Earnings increased more among low earners than among high earners.

Payments. MEAD participants have lower health care costs than a comparison groups of other Medicaid beneficiaries with disabilities (controlling for differences in baseline by the CDPS - PMPM \$1237 for MEAD and \$1949 for other Medicaid beneficiaries).

Once enrolled, average Medicaid payments for MEAD increase at a rate less than or equal to that for other beneficiaries. MEAD enrollment lowers state costs for people already enrolled in Medicaid "making it financially feasible to offer enrollment to working Medicaid beneficiaries".

Enrollees with no prior Medicaid. In FY 05 more than 300 people with disabilities received Medicaid coverage for the first time through MEAD. Overall MEAD participants with no prior Medicaid coverage paid more in premiums, and they had higher average earnings (\$738)/mo) with lower unearned income and fewer medical conditions.

Third party health insurance. 86% of MEAD participants had additional health insurance.

### Discussion points

- Although authors cannot make a causal claim to the impact of MEAD enrollment and its availability to people with disabilities, nonetheless there is a significant increase found in earnings for participants post enrollment.
- Buy-In participants earn more than a comparable group of Medicaid participant workers not in the Buy-In. It is reasonable to assume that a Buy-In program does provide an incentive for higher income even without an SGA income floor or hours worked requirement.
- Over time MEAD began to draw in a new group of people with disabilities who were not prior Medicaid beneficiaries, who were healthier and earned more money, and did so at a fairly low cost to the state.
- The authors conclude the MEAD is relatively inexpensive and has benefited people with disabilities by removing an important barrier to work.

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<sup>1</sup> Summary prepared by Marsha Ellison, CHPR, 2007.

## IX. Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2003 – 2004<sup>1</sup>

Black & Ireys, Mathematica Policy Research Inc., Washington, DC., 2006

**Introduction:** This is one of a series of policy reports that MPR prepares for CMS on the Buy-In programs nationally.

**Methods and Population:** The data are taken from 27 state Buy-In enrollment records and state Unemployment Insurance records.

**Summary of Findings:** Program penetration (Buy-In enrollment per 100,000 working age residents) was greater in states with high income eligibility criteria than in states with other Medicaid pathways. Penetration is also related to premium structure, grace period, the relative availability of other ways to obtain Medicaid coverage for workers with disabilities. States requiring participants to maintain a minimum earnings level to enroll or remain in the Buy-In tended to have average earnings higher than most other states.

There has been concern by states that coverage through the Buy-In for very low earners is detrimental to political support for the program and is inconsistent with the program’s intent. States have instituted changes in earnings requirements and income verification techniques to address this. There is no rigorous evidence of the Buy-Ins’ effect on worker’s effort and whether their earnings are greater than they would have been absent the program. Analyses support findings that individuals in better health have higher earnings. States with higher average earnings tended to report lower PMPM expenditures.

### Massachusetts findings and other states in 2004

State	Work /income requirement for Buy-In (App A)	Ave. monthly UI earnings among Buy-In with earnings (Table D.1)	% of Buy-In Enrollment with earnings above SGA among those with UI earnings	Ave. PMPM Medicaid expenditures (Table D.1)
<b>MA</b>	40 hours (\$206/mo at \$5.15/hour )	1,211	51	\$582
<b>CT</b>	fica	770	31	\$1178
<b>NH</b>	Minimum wage, fica	720	29	\$1382
States with income requirements				
<b>OR</b>	\$330/month	895	35	\$697
<b>SC</b>	\$810 month	1531	71	\$1077
<b>NM</b>	(\$305/mo)	1360	56	\$892

### Discussion points

- Earnings reported in states with high earnings requirement and MA have higher than average earnings than in other states with no such requirements
- Income criteria are associated with program enrollment
- A state that has a wide range of Medicaid options for working people with disabilities should have a lower Buy-In enrollment, some evidence was found for this

<sup>1</sup> Summary by Marsha Ellison, CHPR, 2007.