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RESOURCE PAPER

State Medicaid Options that Support the Employment of Workers with Disabilities

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Executive Summary

This Resource Paper examines the implementation of Medicaid Buy-In programs for workers with disabilities in seven states.¹ The paper discusses the federal authority under which states' Medicaid Buy-In options were implemented, reviews individual states' Buy-In design features, and discusses the relationship between program design and enrollment dynamics during the first two years of program implementation. It also discusses the benefits of the Buy-In option from the vantage point of workers with disabilities. Among the policy questions addressed are:

- Are the barriers to employment experienced by individuals with disabilities amenable to policy interventions alone, and if not, which barriers will require other than a public policy response?
- What evidence is there that Medicaid Buy-In has enabled workers with disabilities to increase their earnings while reducing their fear of loss of health care coverage?
- Has returning to work and/or increasing earnings influenced individuals' sense of self-esteem, work mastery, and work motivation? Are people reporting a higher state of health and well being as they reconnect to the labor market?
- What is the role of individual and societal attitudes in the return-to-work equation? What needs to happen to make employment a real option for people with disabilities?

The data cited in this Resource Paper have been collected during the past four years by the research staff at the Center for Health and Disability Policy at the Oregon Health Policy Institute. They are representative of annual self-administered surveys involving more than 2,500 working age adults with significant disabilities in three states. In addition, the findings from ten focus groups held with workers with disabilities in states across the country² and summaries of two sets of regional meetings held with consumers and state agency personnel involving 27 states³ during 2002 are reported as further evidence of the issues discussed. Finally, we present administrative data collected by the states and reported to the Centers for Medicare and Medicaid Services (CMS) on their Buy-In enrollment experience during CY2001.

Two pieces of federal legislation, the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentive Improvement Act of 1999 (TWWIIA) provide the statutory authority for states to implement a Medicaid Buy-In program for workers with

¹ Connecticut, Iowa, Massachusetts, Minnesota, Oregon, Vermont, and Wisconsin.

² Alaska, New Mexico, Utah, Kansas, Iowa, Vermont, Wisconsin, and Wyoming.

³ Alaska, Connecticut, Delaware, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Dakota, New Mexico, Nevada, Oklahoma, Oregon, Rhode Island, Texas, Utah, Vermont, Washington, Wisconsin, Wyoming.

disabilities by expanding income eligibility limits to 250 percent and 450 percent (or higher) respectively. These authorizing statutes also allow states to waive the eligibility asset limits in existing regulations (\$2,000 for an individual) as well as encourage workers to accrue savings for the future from their earned income. Prior to BBA and TWWIIA, states had the option of establishing a Buy-In program through a Section 1115 waiver; the Commonwealth of Massachusetts was the only state to use this option when in 1997 it implemented the CommonHealth Program.

The overall policy goals of a Medicaid Buy-In option for workers with disabilities are:

- To assure access to a comprehensive health benefit package for individuals with significant disabilities (that is, those meeting the Social Security definition of prolonged or permanent disability) who would otherwise lose or not be eligible for Medicaid by virtue of earned income or accumulated assets.
- To provide appropriate and necessary wrap-around coverage (such as prescription drugs, durable medical equipment, and personal assistance services) for workers with disabilities who are enrolled in Medicare, or who secure employer-based or other private health insurance coverage.
- To promote increased economic security and self-sufficiency among individuals with disabilities who are solely or primarily dependent on disability cash benefits.

Additionally, many states have customized these broad policy goals to reflect particular state policy objectives set forth by legislative and administrative bodies. For example, the legislative intent of implementing a Medicaid Buy-In for workers with disabilities in Iowa was economic development. At the time of its implementation in early 2000, there was a sizeable worker shortage in the state and working age adults with disabilities were identified as an untapped resource in need of development and support.

Early evidence from the states with a Buy-In option is mixed and inconclusive. A review of implementing states' programs suggests that the extent to which a Medicaid Buy-In is embedded in a comprehensive work incentive initiative, the higher the likelihood that the full range of employment supports needed to sustain employment will be available and utilized by Buy-In enrollees. It also has become clear to the early implementer states that enrollee time in the program and the longevity of the program are critical considerations in assessing whether a Buy-In program is meeting its intended policy objectives.

We also have learned that program design features influence who enrolls in a Buy-In, the enrollee's subsequent stability in the program, and related earnings profiles. Federal authorizing legislation provides the states relative flexibility in the design of their Buy-Ins and as a result various program differences can be observed that appear to be influencing enrollment dynamics. These differences include:

- Prior Medicaid generosity including pre-existing eligibility groups, waivers, and optional benefits. Additionally, the availability of state-funded health insurance programs such as pharmacy assistance programs, insurance subsidies for low-income workers, HIV+ insurance supplements, and high-risk pools for individuals with pre-existing medical conditions.
- The ways in which states determine earned and unearned income for eligibility determination purposes, including the methods used for calculating premiums and other cost-sharing obligations.
- The extent to which Buy-In enrollees are permitted to accumulate assets and/or disregard certain savings in the calculation of net assets.
- The extent to which states have attempted to define work for the purposes of Buy-In eligibility.
- Variations in the disability determination process, a requirement of eligibility.
- The availability of benefits counseling that provides accurate and timely information about the impact of work on future disability-related benefits and vocational supports such as assistance in the job search process, getting emotionally and psychologically prepared for employment, and envisioning the possibilities of a career of one's choice.
- The extent to which states have implemented eligibility worker, consumer, and employer outreach and information dissemination campaigns to accompany their Buy-In programs.

In addition to these variations in program design among the states, individual worker characteristics and societal attitudes about disability have been shown to exert a significant influence on who enrolls in a Buy-In and his/her employment success once enrolled. These non-policy factors include:

- The unique challenges to a working life that are associated with different types of disabilities, such as serious and persistent mental illness, and physical and/or cognitive impairments, further complicate program outcomes in the short- and long-term. Work effort, sustainability of employment, and earnings potential can be profoundly affected by the symptoms of chronic illness and the need for assistive technology and reasonable accommodations in the workplace. Each of these factors is more or less of a challenge depending on the nature of the disability and its related functional limitations.
- Societal attitudes about disability have a dampening effect on individuals with disabilities' personal expectations and aspirations about work, their potential to work, and their subsequent successes in the labor market. This was a key message from individuals with disabilities around the country who are trying to maintain a job or return to work. The importance of support from family, friends, employers,

and co-workers in the return-to-work decision and subsequent success on the job cannot be overemphasized as we have learned from a highly diverse group of consumers.

Introduction

Interest in the relationship between the high rates of unemployment among working age individuals with disabilities and access to health insurance coverage has been growing since the early 1990s. An expanding body of evidence suggests that the fear of loss of health insurance coverage among disability beneficiaries is a powerful disincentive to work when more than a token level of earned income can compromise eligibility and health care coverage.

Individuals with a significant level of impairment expected to last for longer than 12 months, and for whom a work history exists, qualify for Social Security Disability Insurance (SSDI) benefits based on qualifying quarters of FICA [Federal Insurance Contributions Act, this is the payroll deduction of 12.4% taken from all workers paychecks as their contribution to the federal retirement, Medicare and disability insurance system under the Social Security Act] tax contributions. In the alternative, individuals with a similar level of impairment but insufficient work history and limited assets qualify for Supplemental Security Income (SSI). In the case of SSDI, the program is funded through the Social Security Trust Fund, whereas the SSI program is funded through the federal budget with states having the option of supplementing the federal cash payment with state general funds.

A long-standing policy conundrum for both disability benefit programs is that national population statistics reveal extremely low rates of employment once an individual qualifies for disability cash benefits. Since the definition of disability for Social Security purposes is predicated on the inability to work at a gainful activity level (\$780/month in 2002), individuals who apply for disability benefits are resigning themselves to a life without meaningful work, regardless of their continued potential as a worker or their desire to maintain a substantive connection to the labor market.

Data generated from a growing number of focus groups and surveys conducted since 1993 with Social Security beneficiaries have found a high level of fear related to loss of health care benefits as a major barrier to return-to-work efforts.⁴ Yet, despite these fears, a large

⁴ See Bartfeld J. and Hanes P. *Dane County Employment Barriers Survey for Persons with Physical Disabilities*. Employment Resources, Inc. 1993.; Hanes P. and Associates. *Alaska Employment Barriers Survey*. Submitted to Alaska Governor's Council on Disability and Education, 1997.; Hanes P., Edlund T, and Maher A. *3-State Work Incentive Initiative: Oregon, Vermont, and Wisconsin, Implementation Evaluation Report*, Center for Health and Disability Policy, Oregon Health Policy Institute, May 2001.; Hanes P. et al. *Final Evaluation Report of the Dane County Employment Initiative*. 1998; Hanes P., Boone J. and Goldsmith K. *Measurement Capacity Development Project Focus Group Summary*. Submitted to the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2002.; Johnson-LaMarche H. *The Barriers to Employment Faced by Persons with Disabilities*. Prepared for the 1997 Vermont General Assembly, Vermont Department of Aging and Disabilities, 1997; Harris Survey, 1997.

percentage of beneficiaries express a desire to work.⁵ Economic studies⁶ also confirm that this link between disability cash payment programs and health care coverage is a significant disincentive to employment as disability benefit programs and the health insurance to which they are linked (Medicare and Medicaid), are dependent on proving the inability to work at “gainful” levels.

In 1998, The Robert Wood Johnson Foundation (RWJF) supported the development of comprehensive work incentive demonstration initiatives in three states – Oregon, Vermont, and Wisconsin – for a three-year period through 2001. The grants were coordinated by the Center for Health Care Strategies under the Building Health Systems for People with Chronic Illnesses Program. In each state, a Medicaid Buy-In option for workers with disabilities was included in the intervention with wrap-around services that included benefits analysis and counseling and a range of vocational supports. Vermont and Wisconsin included a plan to expand existing Social Security work incentives through waivers that would allow SSI and SSDI beneficiaries to retain a portion of their cash benefits as they return to work and increase their earnings. This comprehensive approach taken in Vermont and Wisconsin recognized that the Buy-In was a necessary but not sufficient tool to assist people with disabilities in their return-to-work efforts.

A second work incentive initiative, the State Partnership Initiative, funded through a partnership between the Social Security Administration and the Rehabilitation Services Administration, was made available to 16 states in 1998. All three RWJF-funded states also received funding under SPI for a five-year period (1998-2003). As a result of this dual funding in Oregon, Vermont, and Wisconsin, an extension to the RWJF grants was provided to synchronize the reporting of net program outcomes in late 2003.

Shortly after the start-up of the three states’ work incentive initiatives, Congress passed the Ticket to Work and Work Incentives Improvement Act of 1999, thus providing another source of funding to the states to promote policy change. TWWIIA provides federal authority for many of the demonstration components included in the three states’ initiatives and expands the work incentives available to Social Security beneficiaries, particularly related to Medicare eligibility through an “easy return” provision for individuals who enter the world of work and then must return to beneficiary status.

Needless to say, from an evaluation perspective, the significant changes taking place in the policy environment at both the state and federal levels during the past four years

⁵ Taylor H. *Many People with Disabilities Feel Isolated, Left Out of Their Communities and Would Like to Participate More*. Harris Poll #34, July 2000.; Taylor H. *Conflicting Trends in Employment of People with Disabilities*. Harris Poll #59, October 2000.

⁶ O'Day B. “Policy Barriers for People with Disabilities Who Want to Work.” *American Rehabilitation*, Winter 1999.; O'Day B. and Berkowitz M. “Disability Benefit Programs: Can We Improve The Return-to-Work Record?” *Handbook of Disability Studies*, 2001.; National Academy of Social Insurance. *Balancing Security and Opportunity: The Challenge of Disability Income Policy. Summary & Overview Report of the Disability Policy Panel*. 1996.; Stapleton D., Livermore G., Scrivner S., Tucker A., and Wittenburg D. *Exploratory Study of Health Care Coverage and Employment of People with Disabilities: Final Report*. The Lewin Group, 1998.; Stapleton D. and Tucker A. *Will Expanding Health Care Coverage for People with Disabilities Increase Their Employment and Earnings? Evidence from an Analysis of the SSI Work Incentive Program*. The Lewin Group, 1999.

have made attempts to infer causality from any one of the states' original interventions quite problematic, yet the lessons we are learning from these ambitious demonstration projects have been significant and powerful as they spread across the country.

This Resource Paper reports on data collected in Oregon, Vermont, and Wisconsin during the first three years of program implementation and supplements these data with state Medicaid Buy-In data collected by all seven states under the terms of their Medicaid Infrastructure Grant (MIG). The MIG Program was authorized by TWWIIA and is administered by the Centers for Medicare and Medicaid Services. It provides states an annual grant of \$500,000 for health systems development for up to 11 years (2000–2013).⁷

Medicaid Buy-In Programs

States' Design and Implementation Strategies

States have a range of options for the design of their Medicaid Buy-In programs. These choices allow states to tailor the Buy-In to fit into their existing Medicaid program in terms of scope of coverage and eligibility groups. Additionally, this flexibility in program design allows states to target a specific population group thereby linking broader work incentive policy objectives to the Buy-In Program.

Although not specified in federal statute, most states have targeted their Buy-In programs to the SSDI population, as it remains the most vulnerable in terms of access to comprehensive health care coverage. SSDI beneficiaries become eligible for Medicare coverage once an initial 24-month waiting period has been met, but often during this time they go without coverage, are underinsured, or qualify for SSI cash assistance and Medicaid if their SSDI cash benefit is sufficiently low. Once on Medicare, beneficiaries generally find the benefit inadequate to meet their health maintenance needs, particularly the lack of coverage for prescription drugs and certain durable medical equipment.

Conversely, the SSI Program links directly to Medicaid and has a range of work incentive options built into the program that predate the Balanced Budget Act and TWWIIA. The most significant among these is the 1619b program that allows recipients to work off cash benefits and maintain their eligibility for Medicaid while increasing earnings. In most states, the 1619b threshold exceeds \$20,000/year. Although the earnings of most states' SSI-related Buy-In enrollees are well within this income limit, the added benefit of the Buy-In to SSI recipients is that it allows them to accrue assets they would otherwise be unable to save under the rules that govern Medicaid eligibility.

Table 1 displays the Medicaid options and state-funded programs available to working-age individuals with disabilities in the seven states prior to the implementation of their

⁷ Oregon, Vermont, and Wisconsin each received a Medicaid Infrastructure Grant for a four-year period beginning in FY2000.

Medicaid Buy-In program, while Table 2 details the Buy-In design features among the seven states and includes CY2001 enrollment/enrollee characteristics.

The comprehensiveness of a state's health care coverage for working age adults with disabilities is not measured simply by the number of eligibility groups or programs available, but also by the standard of need at which eligibility has been set (percentage of the federal poverty level (FPL)) and the scope of benefits available to the group. For example, Oregon had a Medically Needy option that allows individuals with disabilities to "spend down" into Medicaid eligibility as a result of medical expenses, but the benefit package covers only pharmacy and rehabilitation mental health services.⁸ Alternatively, the Medically Needy option in the other six states includes the full range of benefits available to other categorical eligibility groups.

Table 1
State Eligibility Groups Available for Working Age Adults with Disabilities

Eligibility Group	CT	IA	MA	MN	OR	VT	WI
SSI Disabled (categorical eligibility)	58/80% ⁹ FPL	74% FPL ¹⁰	74% FPL	67% FPL	74% FPL	74% FPL	74% FPL
State Supplement to SSI cash payment ¹¹	Maximum SSI/SSP payment \$747/mo	N/A	Maximum SSI/SSP payment \$681/mo	Maximum SSI/SSP payment \$592/mo	Maximum SSI/SSP payment \$532/mo	Maximum SSI/SSP payment \$571/mo	Maximum SSP ¹² payment \$615/mo
Medically Needy (protected income level) ¹³	\$476/ \$575 ¹⁴	\$483	No income limit	\$482	\$413	\$791/ \$733	\$592
Poverty level Medicaid Option	N/A	N/A	Yes 100% FPL	Yes 100% FPL	N/A	N/A	N/A
1115 MA Expansion Waiver	Pharmacy 300% FPL	N/A	HIV+ 200% FPL MassHealth 150% FPL	MinnesotaCare 175% FPL ¹⁵	OHP 100% FPL	VHAP 175% FPL	N/A
Buy-In for Workers with Disabilities	450% FPL	250% FPL	No income limit	No income limit	250% FPL	250% FPL	250% FPL
State Spending per capita all ages (1999) ¹⁶	\$1202	\$719	\$1455	\$808	\$774	\$839	\$767

⁸ Oregon's Medically Needy Program was eliminated by the Legislature in February 2003 in response to the state's fiscal crisis.

⁹ In Connecticut, the need standard is regional, based on factors related to local economic conditions.

¹⁰ 100% of FPL in 2001 was \$716/mo. In 1634 states where eligibility for Medicaid is automatic once eligible for SSI, Medicaid eligibility is set at the SSI payment level (\$530/mo in 2001) or 74% of FPL.

¹¹ National Association of State Medicaid Directors Survey, 2001.

¹² Wisconsin covers SSP-only recipients who were eligible prior to 1995. The supplement is being phased out.

¹³ National Association of State Medicaid Directors Survey, 2001.

¹⁴ Regionally adjusted.

¹⁵ MinnesotaCare is a state-funded Medicaid expansion program.

Table 2 - Medicaid Buy-In Design Features in 7 States

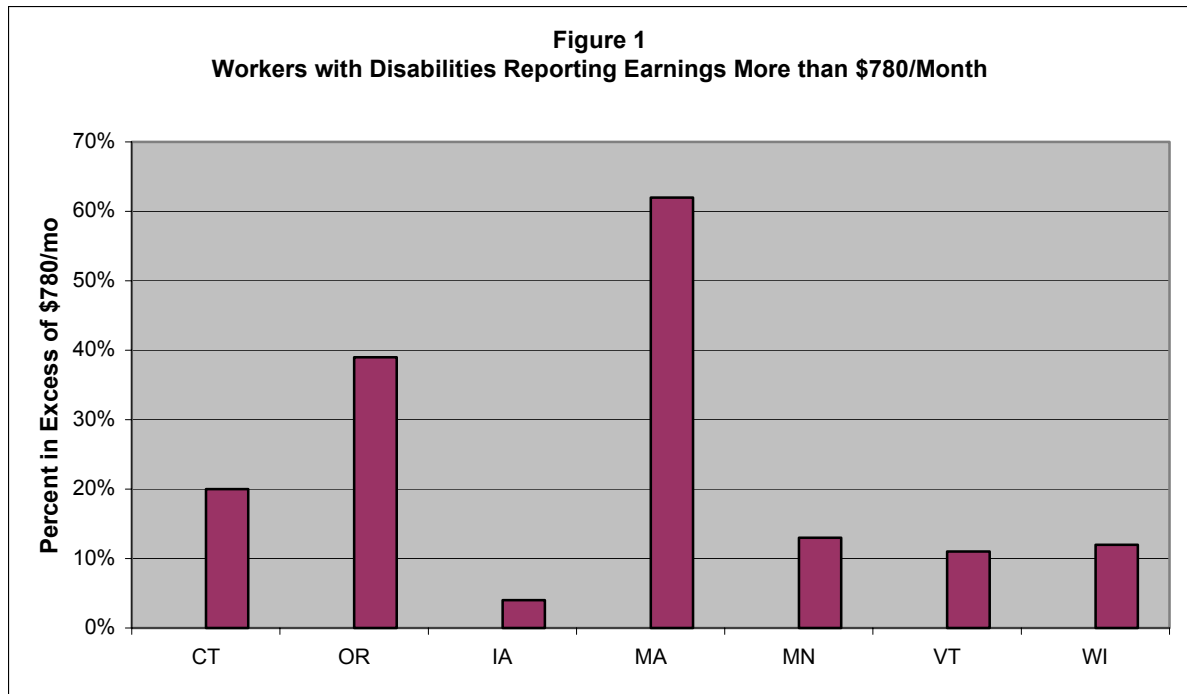
Program Features	CT	IA	MA	MN	OR	VT	WI
Date Implemented	10/1/00	3/1/00	7/1/97	7/1/99	2/1/99	1/1/00	4/1/00
Authorizing Legislation	TWWIIA Basic	BBA	1115 Waiver	TWWIIA Basic	BBA	BBA	BBA
Income and Asset Eligibility Thresholds	Income up to \$75,000.	Net individual income below 250% of FPL.	No upper income limit.	No income limit.	Net individual income below 250% of FPL.	Net family income below 250% of FPL.	Net family income below 250% of FPL.
	Individual asset limit is \$10,000.	Individual asset limit is \$12,000.	No asset limit.	Individual asset limit is \$20,000.	Individual asset limit is \$12,000.	Individual asset limit is \$2,000.	Individual asset limit is \$15,000.
Asset Accumulation Features	Retirement and medical savings accounts are excluded; provision for an approved Independence Account.	Retirement and medical savings accounts are excluded; provision for an approved Independence Account.	N/A	Retirement and medical savings accounts are excluded.	Retirement and medical savings accounts are excluded; provision for an approved Independence Account.	Savings up to 100% of earnings once enrolled.	Retirement accounts excluded from assets; provision for an approved Independence Account.
Premium Structure and Other Cost-Sharing Features	No premium under 200% of FPL; over 200%, 10% of excess income adjusted for family size; not to exceed 7.5% of net family income.	No premium below 150% of FPL; sliding fee schedule based on 11 income brackets.	No premiums below 200% of FPL; full coverage premium ranges from 0-15% of gross family income.	No premiums below 100% of FPL. At 100%, sliding fee scale from 1% - 7.5% of family income.	There is a cost-share if unearned income exceeds the Supplemental Income standard; if adjusted income exceeds 200% of FPL there is also a premium.	No premium if income is less than 185% of FPL; \$20 if between 185-225% of FPL; \$50 if between 225-250% of FPL.	No premium if income less than 150% of FPL; 3% of income if greater than 150% of FPL.
% Enrollees paying a premium	13%	29%	70%	32%	1% pay premium; 33% pay cost-share	4%	15%
Enrollment as of 12/31/01	2,036	3,376	5,156	6,310	348	313	1,698
% Previously enrolled in Medicaid in prior 12 mo.	53%	23%	31%	61%	69%	88%	63%
% Moving from MN Group to Buy-In	N/A	50%	N/A	51%	37%	32%	40%
% Buy-In enrollees receiving SSDI benefits	86%	93%	40%	93%	82%	N/A	46%
% Buy-In enrollees also eligible for Medicare	84%	84%	51%	89%	74%	91%	79%
% Buy-In enrollees with other third party coverage	16%	5%	16%	13%	14%	41%	10%

¹⁶ Includes state-funded health care expenditures for Medicaid, the State Children's Health Insurance Program, state employees' health benefits, insurance and access expansion, public health-related expenditures, state facility-based services, and community-based services. Sources of state expenditures include general funds, other state funds, and federal funds.

As can be observed in Table 1, Massachusetts and Minnesota stand out in terms of health care coverage (excluding the Buy-In option) for low-income individuals with disabilities. This coverage includes regular Medicaid, Section 1115 waiver expansions, and state-funded health insurance programs. From the information available, one could conclude that the more generous a state's overall health care spending, the more likely it is the state's Buy-In program will cast a wide eligibility net as confirmed in Table 2. An alternative scenario that has been posited is that in a more inclusive state, the Buy-In program is more circumscribed in its design, thus serving as a "niche" program intended to fill a relatively narrow eligibility gap, as could be argued of Vermont's program when viewed relative to its 1115 waiver, the Vermont Health Access Plan.

To illustrate the earlier point, the Buy-In programs in Massachusetts and Minnesota have no income eligibility limits and generous asset tests resulting in a broadly inclusive eligibility net. Whether a consequence of program design or not, both states have experienced robust enrollments since program inception relative to other states. Alternatively, Vermont also is a state with a generous array of health care coverage options for low-income individuals, but it chose to keep its Buy-In circumscribed by maintaining the restrictive Medicaid asset test (\$2,000 for an individual) for eligibility. Although Vermont allows individuals to save up to 100 percent of their earned income after enrollment, this restrictive eligibility test at application may be screening out SSDI beneficiaries with greater earning potential who would benefit from the program but for their assets.

One test of this theory is to look at the earnings levels of enrollees across the seven states. In CY2001, Vermont was second only to Iowa in the low earning levels of its Buy-In enrollees – 40 percent of Vermont's enrollees had reported earnings of less than \$200/month and 89 percent had reported earnings less than \$780/month (see Figure 1). A significant proportion of Vermont's enrollees had zero earnings reported (29 percent), a figure that is obviously dragging the earned income average down, but it raises policy questions about the eligibility determination process used to enroll individuals in the Buy-In program.



Alternatively, Connecticut, which has a moderately inclusive Medicaid program (it is a 209b state, which means that it can set a lower income test for Medicaid eligibility than other states), has a higher income eligibility limit (450 percent of FPL) and a generous asset limit for its Buy-In option relative to most states. Again, this combination appears to have influenced Connecticut's enrollment uptake.

A common characteristic of the four states with more inclusive coverage of people with disabilities is that their total per capita state spending on health care is well above the national average, leaving the reader to ponder the influence of political culture and community values on how states approach the health care access issue. Although not the subject of this Resource Paper, it is illuminating to note the aggressiveness with which these states pursued getting to 100 percent access beginning in the early 1990s and through 2000 when their economies were strong.

A policy question of interest to all the states with a Medicaid Buy-In, as well as those interested in implementing one, relates to how wide the eligibility door can be opened at the front end and still achieve the policy goals of a work incentive program downstream.

It is quite possible that a major distinguishing characteristic of individuals who opt into a state's Buy-In, particularly in those states with more inclusive eligibility criteria, is the desire and decision to earn income. Consider two like individuals, one enrolled in welfare-related Medicaid and the other in the Buy-In option. They could have identical demographic profiles, including gross income, yet one has earnings and the other not. Among the former, policymakers should take comfort in the fact that the Buy-In option has provided the opportunity and support needed for adults with disabilities to re-enter

the world of work, at whatever level of effort and earnings possible, recognizing the limitations related to their disabilities. An open door policy will most likely promote the Buy-In policy goal of promoting greater economic security and self-sufficiency through return-to-work decisions made by formerly disenfranchised workers.

Design Impacts: The Early Implementer States

Oregon was the first state in the country to implement a Medicaid Buy-In program using the 1997 Balanced Budget Act in February of 1999 followed five months later by Minnesota. As noted in Table 2, despite initially using the same legislative authority, the enrollment experience of these two states has differed dramatically. Minnesota experienced a constant upward growth trend in enrollment while Oregon's enrollment remained consistent, flat, and stable over time. After a year of program experience, Minnesota made modifications to its Buy-In option, including eliminating the upper income limit for program eligibility by using the liberal income eligibility option in TWWIIA and adjusting the premium structure.

In addition to different income eligibility thresholds, the individual asset limit in Minnesota is significantly higher, thus providing the opportunity for individuals with disabilities who have accumulated a modest level of assets to be eligible for the Buy-In without the need to liquidate or spend down assets. With the exception of Massachusetts, where there is no asset limit, Minnesota has the most generous asset limit among the seven states.

A final difference in program design worth noting between the two states is that of cost-sharing obligations. Minnesota has a simple premium structure that exempts individuals with incomes below 100 percent of the federal poverty level from paying a premium and then, based on a sliding fee schedule, assesses a premium based on income in excess of 100 percent of FPL. The sliding fee begins at one percent of gross income in excess of 100 percent of FPL with the maximum being 7.5 percent of adjusted income in excess of 300 percent of FPL. Alternatively in Oregon, a monthly cost-share is imposed on all unearned income over the state's Supplemental Income Program standard (\$514/month). This feature particularly affects SSDI beneficiaries who were higher wage earners when in the active labor market, and thus have higher monthly cash benefits. The net effect of Oregon's co-insurance has been that the average monthly cost-share in 2001 for those required to pay was \$91, versus an average monthly premium in Minnesota of \$36 for those enrollees with a premium obligation.

Assuming both states identified SSDI beneficiaries as the target population for their Buy-In programs – 93 percent of Buy-In enrollees in Minnesota and 82 percent in Oregon are SSDI beneficiaries – Oregon's cost share may be serving as a deterrent to enrollment for those with higher SSDI cash benefits but for whom the cost share is prohibitive. For example, a SSDI beneficiary with a \$1,200/month cash benefit would have a \$686/month Buy-In co-insurance payment on top of her/his Medicare Part A co-insurance obligation and Part B monthly premium. In this circumstance, an individual with an obvious work history continues to be trapped by the work disincentives inherent

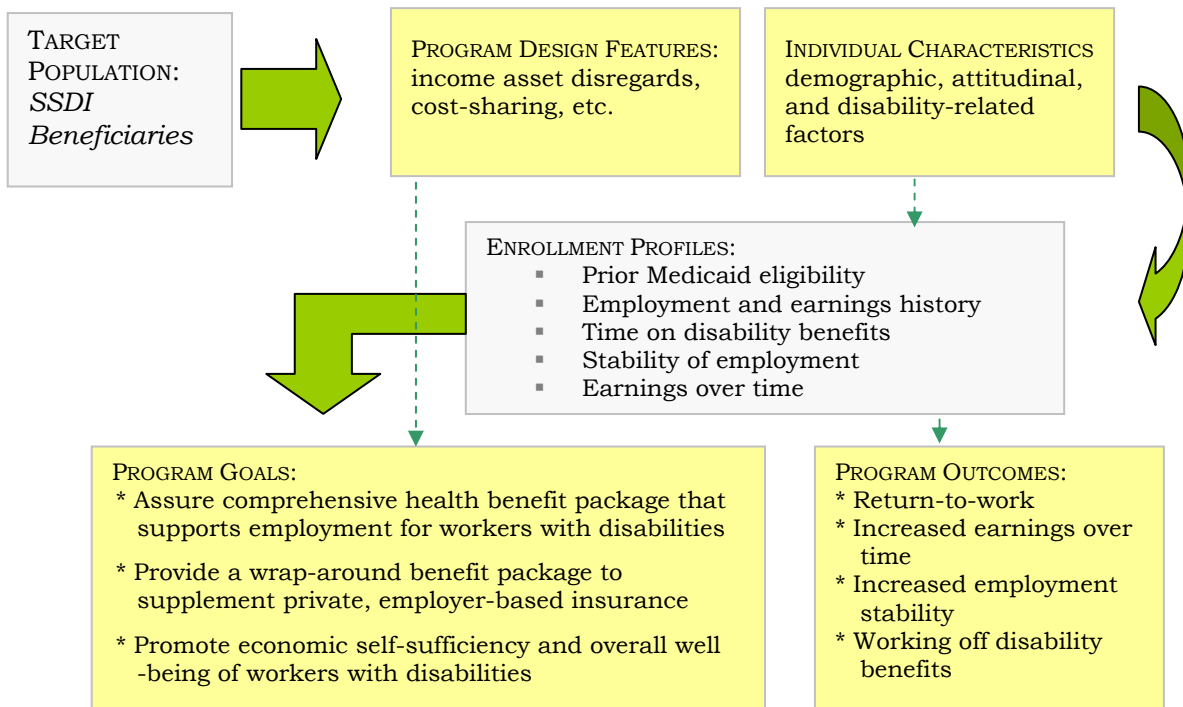
in the SSDI program in spite of her/his potential to work towards economic self-sufficiency.

Many have argued that the Oregon Buy-In Program is the truest example of a work incentive program with the goal of moving beneficiaries off benefits and into the competitive labor market. This observation is based, in part, on the higher than average earnings reported for Oregon Buy-In enrollees relative to other states. But recent data from CMS reports reveals higher rates of gainful work activity among Buy-In enrollees in Massachusetts and Alaska, two states with very different programs from each other and from Oregon. Massachusetts' working CommonHealth members have a significantly larger group of enrollees with incomes in excess of \$780/month than Oregon (see Figure 1), second only to Alaska which has a very circumscribed eligibility threshold and only 119 enrollees since it was implemented in 1999. As a result of these mixed findings, we are left with little definitive evidence that any particular design feature can predict the earnings achieved by program participants. It is also worth noting that states' economic conditions and unemployment rates will undoubtedly influence the earnings experience of Buy-In enrollees as well.

There are many examples of differences among the states that appear to be influencing who is enrolling in the Buy-In programs; but there are no definitive trends or consistent interpretations to explain how these design features have resulted in one program functioning as "true" work incentives relative to the others. We suggest that this is because of the complex web of factors external and internal to the target population, including the powerful influence of individual characteristics such as work motivation, sense of skills mastery, and the support individuals get or do not get from family, friends, employers, and co-workers that appear to be influencing program outcomes.

What we have yet to learn is what factors influence the decision to work in one individual and not the other. Figure 2 provides a graphic representation of the interrelationship between program design and individual characteristics. Wrapping around these factors are broader system level barriers that, through their design, have isolated people with disabilities from the world of work. Included among these are the disability cash benefit system and the health and mental health care delivery systems that seek to protect "patients" as opposed to encourage individual autonomy and self-sufficiency among working age adults regardless of their functional limitations.

Figure 2
The Alchemy of Buy-In Program Design, Enrollment, and Outcomes



We have observed over the past three years, as more states implement a Buy-In program, that if it is not part of a larger social contract between people with disabilities and the communities in which they live, the policy goals of the program will likely not be realized. Included in this social contract is a commitment to consumer, employer, and community outreach, and education that leads to informed decision-making about both the benefits and consequences of work and the impact of informed choice on the full integration of people with disabilities into the life of their communities.

In the alternative, the Buy-In program risks becoming just another eligibility group to which an automated eligibility system assigns individuals with a certain profile who apply for Medicaid benefits. We have learned from surveys with newly enrolled Buy-In enrollees in several states that they are unaware that they enrolled in a work incentive program. This finding has obvious implications for the ability of these programs to reach their intended policy goals, most especially that of promoting economic gain and the overall well-being of individuals enrolled in the program.

Non-Program Factors Influencing Buy-In Enrollment

Because the factors that contribute to high unemployment rates are multi-faceted and therefore complex, it is most probable they will not be remedied by policy interventions alone. Self-reports from participants in the Three-State Work Incentive Initiative and

findings from focus group meetings concur on several important points. Preeminent among these is that societal attitudes, including those of employers and co-workers, are critical to the success that workers with disabilities will achieve as they re-enter the labor market. Low expectations from families, friends, and professional counselors contribute significantly to the decision not to return to work. Many highly trained professionals with disabilities have described being directed by vocational counselors onto the lowest rung of the service industry ladder when they seek out vocational counseling to venture back into the labor market. Oftentimes these societal attitudes result in a personal sense of being devalued as a worker to the point that work does not seem like a viable option, or equally discouraging, that menial work without a career expectation or gainful wages is all that is possible. Comments from the focus groups included:

"I feel my job market is very limited because of my health problem. I feel employers are being advised by insurance carriers not to hire people with health problems. I feel I have to accept substandard pay to ensure employment."

"Before working I was on SSDI, SSI, and food stamps. When I went to work I immediately lost \$185 of SSI and food stamps. I was taking home \$134 every two weeks in 1997. Financially I did not come ahead by working. It does not always pay to go to work. Vocational rehab doesn't train us for anything but minimum wage jobs. I have been going to college part time on my own through financial aid."

"I get \$703/month disability, I get Medicaid after a spend down of \$432/quarter, my medications cost \$300-\$400/month, housing expenses are about \$390/month; because I live with my daughter (she's 23) I'm not eligible for food stamps. Because of financial difficulties at times, I have to go without medical care which makes my diseases harder to control, which lowers school attendance, which leads to failure and no job. Even with a job, if I don't have proper medical care, no medical care equals no job equals no future. I may as well be dead."

The Oregon Health Policy Institute has been tracking the beliefs, attitudes, and behavioral intentions of work incentive participants and a non-participant cohort in Oregon, Vermont, and Wisconsin over a three-year period with annual self-administered surveys. Using four separate scales (Self-esteem, Barriers to Work, Work Motivation, and Mastery),¹⁷ we have monitored attitudinal changes among program participants over their time in the program. Within these groups of program participants we have documented significant reductions in self-reported work motivation and self-esteem among Oregon participants; significant reductions in work motivation and mastery in Vermont; and significant reductions in self-esteem in Wisconsin among program participants in the period between enrollment and their first year anniversary in the program. It should be noted that the large majority of these participants were working.¹⁸

These preliminary data from the Three-State Work Incentive Initiative provide a rather disturbing picture of individual consumers' reported self-esteem, confidence, and sense of mastery as they attempt to re-enter the labor market. This is despite the best attempts of the states to moderate the policy environment. The elimination of certain policy barriers such as loss of health insurance coverage, protection of unearned income, and promotion of savings and asset accumulation to date have not been successful at bolstering

¹⁷ Hanes P., Edlund T., and Maher A. *A Three-State Work Incentive Initiative: Oregon, Vermont, and Wisconsin, Implementation Evaluation Report*. Center for Health and Disability Policy, Oregon Health Policy Institute, May 2002. www.nchsd.org

¹⁸ These changes were statistically significant, with a p value of .05 using a paired samples t-test.

individuals' self-esteem and work mastery, two very necessary ingredients to work success in all workers, with or without disabilities. Clearly the provision of benefits counseling and vocational supports has resulted in a larger group of individuals making informed choices about the impact of returning to work on their benefits, but the expectations of work and the hopes associated with returning to work are often unrealized as consumers have told us about being met by a hostile or unaccommodating work environment.

We further probed these attitude changes by looking at the group of individuals within the full participant group in each state that had at some point in time enrolled in the Medicaid Buy-In. One of the more interesting findings about the Medicaid Buy-In groups in Vermont and Wisconsin is that they are significantly different from the larger group of work incentive participants on a number of socio-demographic characteristics. For the first time we have been able to identify a profile of individuals who make the choice to enroll in the Medicaid Buy-In within the context of a broader range of work incentive services that include benefits counseling and other vocational supports.

In both Vermont and Wisconsin, the work incentive participants enrolled in the Buy-In are significantly older; more likely to be an SSDI-only beneficiary than other work incentive participants; and by definition, significantly more likely to have a work history prior to the onset of cash benefits. In Wisconsin, the differences between the two groups were even more notable in terms of racial differences (more likely to be white), education (more likely to have greater than a high school education), and primary disability (more likely to have a mental disability and to have a lower score on the mental health status screen).¹⁹

Other interesting findings include the significantly higher level of fear of loss of economic standing (i.e., not able to earn enough to make up lost benefits) reported at baseline among those Vermont program participants that at some time enrolled in the Buy-In and how this fear had significantly decreased by the first year follow-up survey, suggesting that benefits counseling has had a positive influence on the decision to risk working. A similar finding of reduced fear also was observed in Wisconsin, but not at a level of statistical significance. Although among this same group, Vermont work incentive participants in the Buy-In program also reported significantly *more fear* about losing their health care coverage once they return to work, in spite of the fact that they had returned to work as evidenced by having been enrolled in the Buy-In option. Again, this same observation can be noted in the Wisconsin Buy-In group, but not at a level of statistical significance as in Vermont. What is noteworthy in both of these examples is that all these consumers have been exposed to benefits counseling, and yet it appears that this counseling has not fully dispelled their fears of losing needed benefits.

There are hopeful examples that with continued experience in the labor market, a health care assurance, and easy transition back on benefits when work is not possible, these fears will dissipate over time. This is precisely the reason that time in program and experience in the labor market are critical components needed to appropriately measure

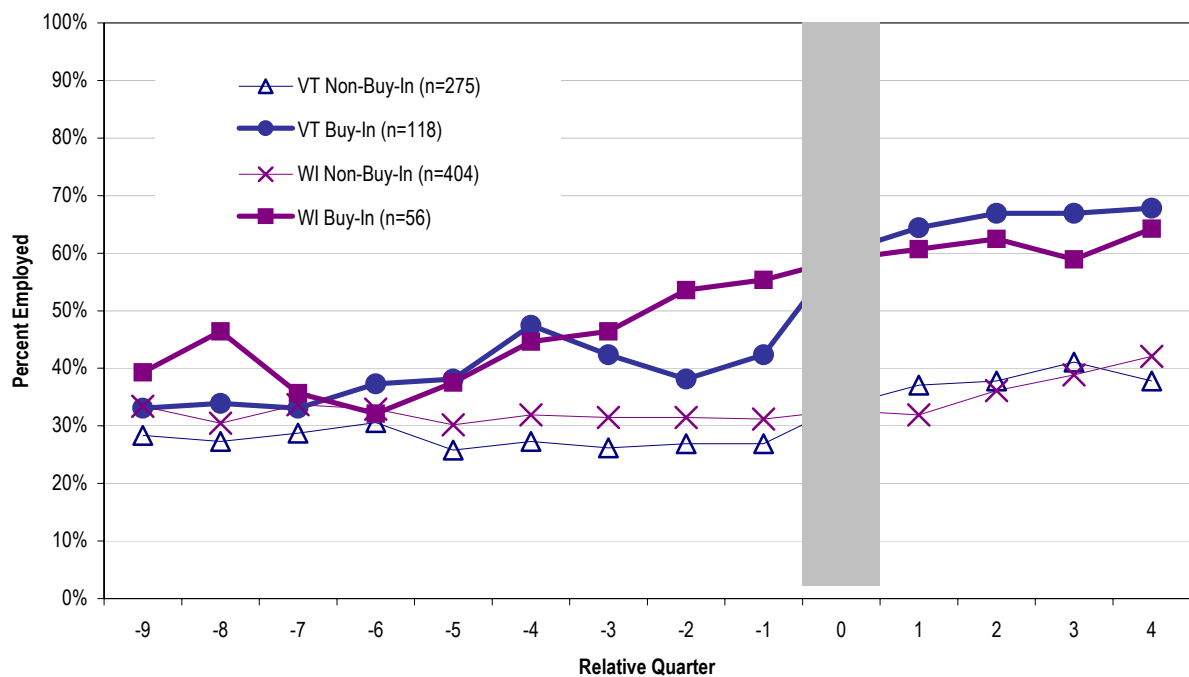
¹⁹ See Table 6 in the Appendix.

program outcomes. To prematurely judge program impact a year or two post start-up is to disregard the growing evidence that returning to work is a very complex process for people living with a disability.

To summarize the differences observed between work incentive participants who have chosen to enroll in the Buy-In option at some point in their program tenure relative to those who have not, the data suggest that as a group they are considerably more likely to be employed over the whole period of earnings observed (see Figure 3). We still have much to learn about the differences in these two groups, including how this learning should inform policy in terms of targeting those beneficiaries most likely to return to work. Early evidence suggests that work history and educational attainment may be two likely candidates for predicting future work effort after the onset of disability and disability-related benefits.

Figure 3

Employment by Relative Quarter Vermont and Wisconsin Work Incentive Participants by Buy-In Status



The Buy-In Option: Changing Rhetoric, Changing Policy Goals

When the “early innovator” states of Oregon, Minnesota, Vermont, and Wisconsin first began work incentive discussions with the Social Security Administration in the mid-1990s, the dialogue was about testing new and innovative strategies to promote work

among SSA beneficiaries with the goal of successfully transitioning them off of cash benefits and into competitive employment at a living wage.

One of the earlier lessons learned through the RWJF-funded work incentive feasibility study in Wisconsin (1996-98) was that policy barriers explain a large part of why workers with disabilities remain outside the competitive labor market, but they do not account for all the barriers these workers encountered. Further research has shown that the barriers to employment experienced by working age adults with disabilities include a broad range of structural, attitudinal, and highly personal factors related to work history, education and training, and impairment-related challenges that are often unique to the individual and his/her type of disability.

We have learned from consumers that the availability of benefits and vocational counseling are critical supports for achieving sustained employment over time. Also, we have learned that the complexities of the disability determination process and the conflicting messages about work and its consequences for benefits and health care coverage historically have served as powerful disincentives to working. The critical role benefits specialists have played in providing accurate and timely information appears to be a necessary component of a successful return-to-work experience. Vocational supports such as assistance in the job search process, getting emotionally and psychologically prepared for employment, and imagining the possibilities of a career of one's choice, are among the vocational services consumers report as essential first steps in returning to work.

In those states with well-developed disability advocacy networks, early enrollment in the Buy-In has been more vigorous than in states where the option was implemented with little publicity or outreach. Outreach is a double-edged implement for most states, particularly as the economy has soured and Medicaid program expansions are not seen as viable. Arguments about longer-term budget neutrality that results from cost offsets achieved when people are working, paying taxes, and feeling healthier, are difficult to make when immediate competing funding priorities have reached a critical threshold.

Disability policy and the disability service system, including cash benefits and health care coverage, have been designed to discourage work by building dependency and disempowerment into the system. It will be difficult for workers with disabilities to achieve maximum economic security and maintain their access to the health and income safety net until the safety net is securely in place at all points on the employment path that these workers traverse.

A more recent challenge faced by federal and state policymakers has been reorienting their thinking about the policy goals that are achievable through the Buy-In and other work incentive strategies that are currently being tested around the country. This reorientation involves an acknowledgement that total economic self-sufficiency may not be a realistic goal for most people who live with a severe and debilitating disability and/or chronic illness, but rather that employment ought to be viewed as a form of social

exchange in which most adults, when given the choice, will choose to participate. This choice needs to be supported and reinforced by public and private policies that promote work at any level possible without the threat of loss of health care coverage and an income support safety net. However minimal that safety net may be, it should be strong and secure.

It will be some time before the philosophy and force of law embodied in the Americans with Disabilities Act have diffused throughout society's institutions such that disability is truly viewed as a natural and predictable event in the course of human experience. Until society embraces this fact, people living with disabilities who desire to participate in the labor market will be faced with formidable barriers that will be difficult to overcome with policy interventions alone.

APPENDICES

Table 3
Attitudes, Beliefs, and Work Readiness Attributes at Baseline
Vermont and Wisconsin Work Incentive Participants by Buy-In Status

	Vermont		Wisconsin	
	Non-Buy-In (n=396)	Buy-In (n=145)	Non-Buy-In (n=487)	Buy-In (n=69)
Attitudes ^(a)				
Self Esteem	3.76 (296)	3.97 (112)	4.19 (444)	3.92 (65)
Barriers to Work	2.70 (292)	2.63 (107)	2.75 (434)	2.72 (66)
Work Motivation	3.62 (293)	3.65 (112)	3.83 (429)	3.75 (67)
Mastery	3.31 (290)	3.43 (111)	3.63 (438)	3.53 (67)
Barriers to Work (subset of scale items) ^(b)				
Working for pay will affect my ability to keep my SS cash benefits	4.02 (303)	3.98 (113)	4.04 (452)	4.12 (66)
If I work for pay, it will be hard to earn enough money to make up for lost SS benefits	3.72 (299)	4.14 (113)	3.67 (454)	3.76 (68)
I will not be/I worry that I will not be eligible for Medicare or Medicaid if I return to work	3.03 (304)	3.14 (113)	3.15 (450)	3.24 (68)
It will be difficult to re-qualify for SS disability benefits in the future if I work	3.38 (302)	3.30 (112)	3.35 (452)	3.38 (68)
Health Status				
Physical Health ^(c)	40.82 (267)	40.36 (104)	39.85 (420)	40.03 (63)
Mental Health ^(d)	40.69 (267)	40.08 (104)	47.00 (420)	43.38 (63)

Notes: Shaded cells indicate a significant difference between Buy-In enrollees and non-enrollees among all work incentive participants within the state per independent samples t-test ($p < 0.05$).

(a) Scale values range from 1-5. Higher scores indicate more positive attitudes.

(b) Rank values range from 1-5. Higher scores indicate higher perceived barriers. These are a subset of items contained in the Barriers to Work Scale.

(c) Possible range: 9.94-70.13; US general population mean=50.12

(d) Possible range: 5.89-72.28; US general population mean=50.04

Table 4
Paired Differences in Attitudes Between Baseline and First Year Follow-Up Survey
Vermont and Wisconsin Work Incentive Participants by Buy-In Status

	Vermont		Wisconsin	
	Non-Buy-In (n=396)	Buy-In (n=145)	Non-Buy-In (n=487)	Buy-In (n=69)
Self Esteem (n)	(175)	(77)	(263)	(41)
Baseline (mean)	3.69	4.06	4.17	3.88
First Year Follow-Up (Mean)	3.66	3.83	4.14	3.77
Paired Difference (Mean)	-0.03	-0.23	-0.03	-0.11
Barriers to Work	(171)	(69)	(259)	(43)
Baseline (mean)	2.69	2.64	2.74	2.66
First Year Follow-Up (Mean)	2.47	2.56	2.81	2.65
Paired Difference (Mean)	-0.22	-0.08	0.07	-0.01
Work Motivation	(173)	(74)	(253)	(46)
Baseline (mean)	3.62	3.66	3.82	3.75
First Year Follow-Up (Mean)	3.49	3.49	3.80	3.56
Paired Difference (Mean)	-0.12	-0.17	-0.02	-0.19
Mastery	(175)	(74)	(259)	(44)
Baseline (mean)	3.32	3.39	3.62	3.46
First Year Follow-Up (Mean)	3.21	3.31	3.57	3.30
Paired Difference (Mean)	-0.11	-0.08	-0.05	-0.15

Source: Baseline and First Year Follow-Up Surveys, RWJF Three-State Work Incentive Initiative

Notes: OHPI is still collecting First Year Follow-Up Surveys. Therefore, sample sizes are smaller in analyses involving follow-up data. Follow-up data are current as of March 2003. Shaded cells indicate a significant difference between baseline and follow-up (paired difference) per paired samples t-test ($p < 0.05$). Scale values range from 1-5. Higher scores indicate more positive attitudes.

Table 5
Paired Differences in Perceived Barriers: Baseline and First Year Follow-Up Surveys
Vermont and Wisconsin Work Incentive Participants by Buy-In Status

	Vermont		Wisconsin	
	Non-Buy-In (n=396)	Buy-In (n=145)	Non-Buy-In (n=487)	Buy-In (n=69)
Working for pay will affect my ability to keep my SS cash benefits	(185)	(81)	(272)	(45)
Baseline (mean)	4.04	4.11	4.08	4.07
First Year Follow-Up (Mean)	3.83	3.88	3.88	3.80
Paired Difference (Mean)	-0.22	-0.23	-0.19	-0.27
If I work for pay, it will be hard to earn enough money to make up for lost SS benefits	(184)	(82)	(276)	(45)
Baseline (mean)	3.80	4.12	3.77	3.84
First Year Follow-Up (Mean)	3.83	3.65	3.51	3.67
Paired Difference (Mean)	0.03	-0.48	-0.26	-0.18
I will not be/I worry that I will not be eligible for Medicare or Medicaid if I return to work	(187)	(80)	(275)	(47)
Baseline (mean)	3.07	3.25	3.19	3.28
First Year Follow-Up (Mean)	3.73	3.75	3.40	3.53
Paired Difference (Mean)	0.66	0.50	0.21	0.26
It will be difficult to re-qualify for SS disability benefits in the future if I work	(185)	(79)	(273)	(47)
Baseline (mean)	3.34	3.38	3.42	3.34
First Year Follow-Up (Mean)	3.56	3.78	3.18	3.60
Paired Difference (Mean)	0.22	0.41	-0.24	0.26

Source: Baseline and First Year Follow-Up Surveys: RWJF Three-State Work Incentive Initiative

Notes: OHPI is still collecting First year follow-up surveys; therefore sample sizes are smaller in analyses involving follow-up data. Follow-up data are current as of March 2003. Shaded cells indicate a significant difference between baseline and follow-up (paired difference) per paired samples t-test ($p < 0.05$). Rank values range from 1-5. Higher scores indicate higher perceived barriers. These items are a subset of those contained in the Barriers to Work Scale.

Table 6
Paired Differences in Health Status: Baseline and First Year Follow-Up Survey
Vermont and Wisconsin Work Incentive Participants by Buy-In Status

	Vermont		Wisconsin	
	Non-Buy-In (n=396)	Buy-In (n=145)	Non-Buy-In (n=487)	Buy-In (n=69)
Physical Health	(159)	(65)	(242)	(41)
Baseline (mean)	39.82	40.55	40.31	38.51
First Year Follow-Up (Mean)	40.33	39.93	39.47	41.77
Paired Difference (Mean)	0.52	-0.62	-0.84	3.26
Mental Health	(159)	(65)	(242)	(41)
Baseline (mean)	40.73	39.81	46.89	42.80
First Year Follow-Up (Mean)	39.40	39.87	46.33	41.04
Paired Difference (Mean)	-1.33	0.06	-0.55	-1.76

Source: Baseline and First Year Follow-Up Surveys: RWJF Three-State Work Incentive Initiative

Notes: OHPI is still collecting First year follow-up surveys; therefore sample sizes are smaller in analyses involving follow-up data. Follow-up data are current as of March 2003. Shaded cells indicate a significant difference between baseline and follow-up (paired difference) per paired samples t-test ($p < 0.05$).

(a) Possible range: 9.94-70.13; US general population mean=50.12

(b) Possible range: 5.89-72.28; US general population mean=50.04

Table 7
Self-Reported Program Satisfaction among Work Incentive Initiative Participants at
Baseline and First Year Follow-Up

	Oregon					Vermont					Wisconsin				
	Yr 1	Yr 2	Mean Diff.	p	n	Yr 1	Yr 2	Mean Diff.	p	n	Yr 1	Yr 2	Mean Diff.	p	n
Overall, my monthly premium for the Medicaid program seems like a fair amount to pay*	3.69	3.67	-0.02	0.9339	52										
Overall, my cost share for the Medicaid program seems like a fair amount to pay*	3.67	3.52	-0.15	0.4833	46										
Overall, I am satisfied with the program	3.93	3.87	-0.06	0.6182	83										
In general, the caseworker/benefits counselor/contact person took/takes the time to answer all my questions and concerns	4.30	4.20	-0.10	0.483	81	4.33	4.09	-0.24	0.018	118	4.52	4.48	-0.04	0.579	145
In general, the caseworker/benefits counselor helped/helps me make informed choices about my Medicaid/Medicare benefit options	4.11	3.88	-0.23	0.113	81	3.85	3.70	-0.16	0.192	109	4.20	4.30	0.09	0.400	132
In general, my benefits counselor/contact person explains things to me in a way I can understand						4.12	3.98	-0.13	0.260	119	4.46	4.41	-0.05	0.523	146
In general, the information I receive from my benefits counselor/contact person helps me make informed choices about my employment options						4.01	3.79	-0.21	0.069	117	4.34	4.18	-0.15	0.107	146
In general, the information I receive from my benefits counselor/contact person helps me make informed choices about my Social Security cash benefits						4.10	3.84	-0.26	0.035	112	4.37	4.33	-0.04	0.680	133
Overall, the benefits counseling provided fits my needs						3.92	3.61	-0.32	0.007	114	4.18	4.15	-0.03	0.702	147
In general, I am in charge of planning my employment goals											4.25	4.31	0.06	0.437	147
In general, the information I receive from the contact person I work with most helps me make informed choices about my career goals											4.11	3.97	-0.14	0.0794	142
Overall, the employment planning services provided fit my needs											3.94	3.99	0.05	0.6046	144

Differences in bold are significant at the p=0.10 level

For all items, 1=Strongly Disagree, 5=Strongly Agree - so negative differences are a NEGATIVE finding

*Does not apply "responses" were excluded from analysis