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Health & Disability Advocates

Any Health Care Reform Must Allow Continuation of Robust Medicaid Buy-In Programs for Working People with Disabilities

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National health care reform must meet the unique health care needs of people with disabilities, from children to older adults, together with the needs of all people in the United States. More than 54 million – approximately 18 percent – of Americans currently experience a disability and it is estimated that 30 percent of Americans entering the workforce will become disabled before they retire. People with disabilities comprise one of the largest minority groups in the US and it is a contingent that is growing larger every day due to the aging of the population.

Obtaining health coverage for a person with disabilities can be challenging in an employer-based health insurance environment as people with disabilities are more likely to be unemployed or underemployed than people without disabilities. The inability to obtain adequate, affordable health care coverage often causes individuals with disabilities to fall into deeper levels of poverty, forego necessary treatment, or declare bankruptcy because of medical costs.

- People with disabilities have high health care needs, yet are disproportionately underinsured as compared to people without disabilities.
- As a group, people with disabilities have lower income than persons without disabilities and, therefore, are less able to afford private health insurance.
- People with disabilities experience significant cost barriers in obtaining private health insurance policies because of underwriting practices that increase premiums based on health status.
- People with disabilities have more difficulty accessing comprehensive private insurance due to pre-existing health conditions, limitations or caps on benefits including those for treatment of mental illness, and the lack of important long-term care services such as personal attendant care for activities of daily living in the home and on the job.

To date, Medicaid is the only option for coverage that meets the needs of many working people with disabilities in the home and workplace. Forty-two states[1] have created "Medicaid Buy-in"

[1] AK, AR, AZ, CA, CT, GA, IA, ID, IL, IN, KS, KY, LA, MA (1115 waiver), MD, ME, MN, MO, MS, MI, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OR, PA, RI, SC, SD, TX, UT, VA, VT, WA, WI, WV, and WY; MT has passed legislation authorizing a Medicaid Buy-in but has not yet implemented the program.

programs under the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999. The Medicaid Buy-in programs allow individuals to work and earn higher levels of income while still maintaining or obtaining Medicaid eligibility by "buying in" (paying premiums or other cost-sharing) to the Medicaid insurance system. Roughly 100,000 working people with disabilities are accessing health care through the Medicaid Buy-in programs in 2009. These programs allow continued access to necessary health care services, including services that are not normally covered by private insurance but are necessary for these individuals to maintain employment. Medicaid Buy-In Programs are seen as a key linchpin for all of the public policy efforts to bring more and more people with disabilities into the workforce. Without these programs, with or without healthcare reform, many individuals with disabilities who could and would otherwise work will not be able to do so. Premium payments, cost-sharing requirements, and eligibility criteria vary by state. For more information about individual state programs go to Medicaid Buy-In Program Summaries 2008 (http://www.nchsd.org/library/file.asp?id=300731).

Any healthcare reform must assure that Medicaid Buy-In Programs remain available for the 100,000 currently enrolled in the Programs and any working individuals with disabilities who need to access Medicaid in the future. Over the past decades, Congress has made substantial and important changes and improvements to the Social Security Programs, the Department of Labor One-Stop System, Vocational Rehabilitation, Medicaid and Medicare, as well as employment discrimination prohibitions under the Americans with Disabilities Act. The purpose of each of these important steps forward is to assure that more and more individuals with disabilities are able to join or return to the workforce at increasing levels of self-sufficiency. Pulling back on any of these important reforms, especially access to healthcare through Medicaid, and that important purpose is significantly undermined. For example, increased funding for state Vocational Rehabilitation agencies under the recent stimulus package won't be nearly as impactful if those it was meant to assist cannot take jobs for fear of losing access to necessary healthcare services provided only by Medicaid.

In the **America's Healthy Future Act of 2009**, Section 1602 Income Eligibility for Nonelderly Determined Using Modified Gross Income, without further clarification, could dramatically and negatively impact the Medicaid Buy-in programs across the country. This provision would require states to use the "modified gross income"—created to determine an individual's premium credit assistance amount—to also determine the individual's eligibility for Medicaid, as well as their premium and cost-sharing obligations. States would no longer be able to use any income disregards, which are now used to make certain populations with earned and unearned income above 133 percent of the federal poverty level eligible for services.

This is of great concern because roughly 90 percent of states with Medicaid Buy-in programs currently use the SSI income disregards[2] to determine a person's countable income for

[2] Using SSI methodology means disregarding $65 plus 1/2 of earned income, as well as applying other SSI exclusions and disregards. These include a $20 general income disregard, spousal and parent deeming rules, an exclusion of income put in a Plan for Achieving Self Support (PASS), a disregard for Impairment Related Work Expenses (IRWEs, pronounced "er-wees"), and so on. Once the SSI

calculating income eligibility. Prohibiting states from using these standard income disregards in the Medicaid Buy-in programs could lower the income eligibility limits to less than half of the current amounts, forcing a proportion of Medicaid Buy-in enrollees off the program. The result would be either the loss of their health care insurance (because they were no longer eligible for Medicaid) or the loss of their job (because they would have to quit to maintain their Medicaid health coverage).

Certain groups are exempted from the prohibition on income disregards. However, these exemptions do not include key participants in the Medicaid Buy-In Programs. Under the current bill released on October 19, 2009, individuals eligible for SSI, those receiving an SSDI check, the medically needy and those participating in Medicaid waivers will still be allowed the income disregards. However, these categories do not cover all of those eligible for the Medicaid Buy-In Programs. In particular, the current bill fails to exempt the following key groups from the income disregard prohibition:

1) Working people with disabilities who meet or equal the Social Security definition of disability but cannot or do not want to receive cash disability benefits, and never have;

2) people who used to receive a cash disability benefit but no longer do so because they are working and earning too much money to qualify; and

3) individuals who have disabling conditions that have improved to the point they no longer meet the Social Security definition of disability, yet they require Medicaid services (such as prescription drugs) to maintain their ability to work.[3]

Ironically, these are also the individuals most likely to work at higher levels of income and use the Medicaid Buy-In Programs to reach higher levels of self-sufficiency and integration into the community. And, access to Medicaid is vitally important for these groups of individuals, even if they are no longer receiving cash disability benefits, because their ability to continue working so often depends on services and supports only Medicaid provides. As explained above, the private health insurance exchange MAY NOT BE A FEASIBLE OPTION for these individuals, given their unique health care needs. Instead, people with disabilities would be forced to leave their jobs or cut their hours to obtain appropriate health care, thereby undoing 25 years of work incentive policy advances in this country. The list of exceptions in subsection (D) should include individuals who are eligibility for Medicaid through a Medicaid Buy-in program. This would provide states the continued flexibility to implement income disregards to allow a working person with a disability to access these important programs.

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methodology is applied, the enrollee's net family income is compared to 250% FPL, or whatever other income threshold a state has set.

[3] Group 2 includes Social Security Disability Insurance beneficiaries who have worked themselves off a cash benefit, such as those in an "Extended Period of Eligibility." Group 3 are individuals who are eligible for a Medicaid Buy-in program's "medical improvement" category, offered by 11 states – AZ, CT, IN, KS, MO, NC, NY, OH, PA, WA and WV.

Next Steps

The final healthcare reform act must ensure that working people with disabilities retain the options they currently have to participate in the work force and maintain adequate and affordable health care. Any legislation should embed Medicaid Buy-in coverage or its equivalent among the options available to individuals with disabilities, and provide states the flexibility they need to support individuals with disabilities in employment.

The issue outlined in this policy brief is the most challenging issues facing working people with disabilities. Since 2000, the federal government has funded more than 42 states with Medicaid Infrastructure Grants through the Ticket to Work and Work Incentives Improvement Act of 1999 to build comprehensive infrastructure with the ultimate goal of "bridging" Medicaid and Medicare to private insurance. A collaborative of states is working together under a state to state resource center, the National Consortium for Health Systems Development (NCHSD). For more information about the Medicaid Infrastructure Grants please go to www.nchsd.org.

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