

# Ticket to Work Program Evaluation Committee



## Report and Recommendations

March 31, 2001



**Ohio Senate**  
Senate Building  
Columbus, Ohio 43215  
614-466-8086  
bharris@mailr.sen.state.oh.us

**Committees:**  
Reference, Chairman  
Education, Vice Chair  
Finance and Financial Institutions  
Economic Development,  
Technology & Aerospace  
Agriculture  
Rules

**Senator Bill M. Harris**  
19th District

March 31, 2001

Controlling Board  
Joint Legislative Ethics Committee  
Ohio School Facilities Commission  
Legislative Committee  
on Education Oversight

The Honorable Richard H. Finan  
President  
Ohio Senate  
State House  
Columbus, OH 43215

The Honorable Larry Householder  
Speaker  
Ohio House of Representatives  
State House  
Columbus, OH 43215

The Honorable Leigh H. Herington  
Senate Minority Leader  
Ohio Senate  
State House  
Columbus, OH 43215

The Honorable Jack Ford  
House Minority Leader  
Ohio House of Representatives  
State House  
Columbus, OH 43215

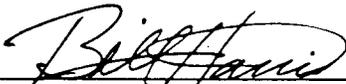
Dear President Finan, Speaker Householder, Senator Herington, and Representative Ford:

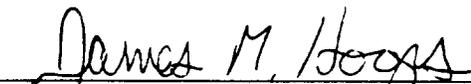
This constitutes the Report and Recommendations of the Ticket to Work Program Evaluation Committee created by Sub. S.B. 346 of the 123rd General Assembly.

The Committee held eleven meetings during the period from February 14, 2001 through March 29, 2001. The Committee received testimony from various departments, organizations, advocates, and consumers. The primary issues examined at these committee meetings were the costs associated with establishing a Medicaid buy-in program for disabled workers, the number of people likely to enroll in such a program, impediments to establishing such a program, and other pertinent issues.

This report includes the Committee's recommendations to the General Assembly and testimony submitted to the Committee during its deliberations.

Sincerely,

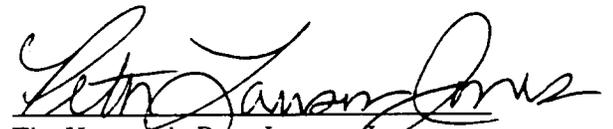
  
The Honorable Bill Harris  
Chairperson

  
The Honorable James M. Hoops



---

The Honorable Eric Fingerhut



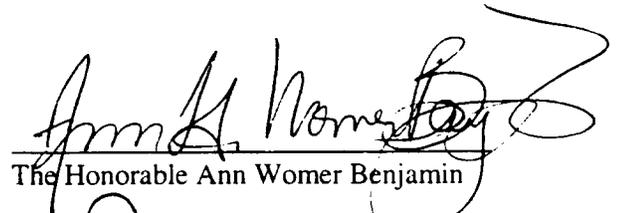
---

The Honorable Peter Lawson Jones



---

The Honorable Robert A. Gardner



---

The Honorable Ann Womer Benjamin



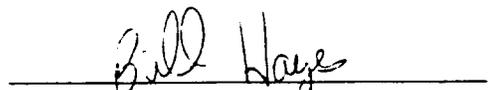
---

William A. Casto II  
Ohio Rehabilitation Services Commission



---

Jeff Davis  
Ohio Department of Mental Retardation and  
Developmental Disabilities



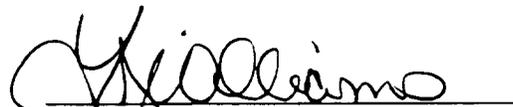
---

Bill Hayes  
Ohio Department of Job and Family Services



---

Mike Hogan  
Ohio Department of Mental Health



---

Tracy Williams  
Office of Budget and Management

# **TICKET TO WORK PROGRAM EVALUATION COMMITTEE**

## **SENATE MEMBERS**

Bill M. Harris, Chairperson

Eric Fingerhut

Robert A. Gardner

## **HOUSE MEMBERS**

James M. Hoops

Peter Lawson Jones

Ann Womer Benjamin

## **EX-OFFICIO MEMBERS**

William A. Casto II	Administrator, Ohio Rehabilitation Services Commission
Jeff Davis	Deputy Director, Ohio Department of Mental Retardation and Developmental Disabilities
Bill Hayes	Assistant Deputy Director, Ohio Health Plans, Ohio Department of Job and Family Services
Mike Hogan	Director, Ohio Department of Mental Health
Tracy J. Williams	Budget Analyst, Office of Budget and Management

# **INTRODUCTION:**

## **THE SIGNIFICANCE OF MEDICAID BUY-IN IMPLEMENTATION**

Work for Ohioans with disabilities...and serious mental illnesses is much more than just a job. Jobs bring dignity, increased opportunities for self-determination. Jobs are people's identity. Jobs are where people meet their friends, and frequently their life partners. And a job is an opportunity to break the cycle of dependence and isolation that so often accompanies a severe mental illness, or any disability. A dozen years ago I was sitting at home, smoking cigarettes, drinking coffee and pacing the floor day after day. A job working evenings as a janitor broke that cycle. I got out of the house. I was able to have some income again. Most important, that job gave me back hope that there was a future. We encourage this committee to recommend that an injection of hope for all people with disabilities can occur if we choose to participate in the Medicaid buy-in option.

*– Doug DeVoe, Executive Director, Ohio Advocates for Mental Health, testimony before the Ticket to Work Program Evaluation Committee on March 8, 2001*

Through the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (Public Law 106-170), the federal government has recognized the need to help people with disabilities join the workforce. Generally, a disabled worker risks losing Medicaid coverage and other forms of assistance if the worker's income exceeds the specified income eligibility level. Since disabled workers may not be able to afford or obtain adequate health care benefits through their employers, the risk of losing Medicaid coverage can create a tremendous disincentive for Medicaid recipients to seek or sustain employment. TWWIIA provides states with the opportunity to extend Medicaid coverage to individuals who are disabled and who, except for income or resources, are eligible for Medicaid. TWWIIA also gives states extensive flexibility in designing Medicaid buy-in programs, allowing each state to establish income limits, asset guidelines, and premiums. Instead of impeding people with disabilities from working, TWWIIA equips states with the tools necessary to encourage and support disabled workers.

Although there are challenges to implementing a state Medicaid buy-in option, the Ticket to Work Program Evaluation Committee values the right of all people, including individuals with disabilities, to make choices, exercise self-determination, live independently, and contribute to society. The fear of losing Medicaid coverage should not impede Ohio's disabled citizens from realizing their life goals, employment opportunities, earning potential, or independence.

It is with these values in mind that the Committee respectfully submits its recommendations.

# **CHAPTER ONE:**

## **CREATION OF THE TICKET TO WORK PROGRAM EVALUATION COMMITTEE**

Under the federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), states may extend Medicaid coverage to employed disabled people whose income would otherwise make them ineligible for coverage.

Section 13 of Sub. S.B. 346 of the 123rd General Assembly created the Ticket to Work Program Evaluation Committee consisting of eleven members:

(1) Three members of the Senate appointed by the President of the Senate, not more than two of whom belong to the same political party as the President;

(2) Three members of the House of Representatives appointed by the Speaker of the House of Representatives, not more than two of whom belong to the same political party as the Speaker;

(3) The Director of Job and Family Services or the Director's designee;

(4) The Administrator of the Rehabilitation Services Commission or the Administrator's designee;

(5) The Director of Mental Retardation and Developmental Disabilities or the Director's designee;

(6) The Director of Mental Health or the Director's designee;

(7) The Director of Budget and Management or the Director's designee.

Sub. S.B. 346 requires the Committee to do the following:

(1) Determine the costs associated with establishing in Ohio the Ticket to Work and Self-Sufficiency Program under the "Ticket to Work and Work Incentives Improvement Act of 1999," 113 Stat. 1860, 42 U.S.C.A. 1320b-19, as well as sources of funds that may be available for the program;

(2) Determine the number of people likely to enroll in such a program;

(3) Determine the barriers and impediments to establishing such a program;

(4) Address any other issues the Committee considers pertinent;

(5) No later than March 31, 2001, submit a report on the matters the Committee is required to consider to the President and Minority Leader of the Senate and the Speaker and Minority Leader of the House of Representatives.

On submission of the report, the Committee ceases to exist.

# **CHAPTER TWO:**

## **RECOMMENDATIONS OF THE TICKET TO WORK PROGRAM EVALUATION COMMITTEE**

### **Background**

Portions of TWWIIA pertain to Medicare and other programs administered by the Social Security Administration that require implementation on the federal level. One component of TWWIIA, and the focus of the Committee's work, is the option afforded states to amend their Medicaid state plans to provide Medicaid coverage for people ages 16 through 64 with disabilities who, except for income, would be eligible for assistance under the Supplemental Security Income (SSI) program. Under TWWIIA, states can establish limits on assets, resources, and income for this new category of individuals that differ from current federal Medicaid limitations. Additionally, states can require people in the new category to "buy-in" to Medicaid by paying premiums for Medicaid coverage, or other cost-sharing charges, on a sliding fee scale based on income.<sup>1</sup>

The Ticket to Work Program Evaluation Committee met eleven times during the period from February 14, 2001 through March 29, 2001 to receive testimony on the subject of establishing a Medicaid buy-in program for working people with disabilities. The Committee received testimony from various departments, organizations, advocates, and consumers. Steven Howe of the University of Cincinnati provided the Committee with a statistical model that was used to estimate the number of Ohioans who would enroll in a Medicaid buy-in program. The Committee considered Mr. Howe's model as it deliberated its recommendations for this report. Mr. Howe testified before the Committee several times, and copies of his testimony can be found in Chapter Four of this report.

### **Recommendations**

The Committee recommends that the General Assembly provide a buy-in to the Medicaid program for certain people with disabilities who are working or who would seek employment if a buy-in program was available. The Committee believes that in order to pursue this course of action, the General Assembly should appropriate sufficient funds to the Department of Job and Family Services (JFS) for fiscal years 2002 and 2003 to allow JFS to begin designing the program and preparing for its implementation. According to representatives of JFS, administrative start-up for the program will cost between \$2.5 million and \$3.0 million. JFS will need to modify Medicaid eligibility systems, contract with a fiscal agent for development and preparation for implementation of monthly premium collection, develop and duplicate brochures and other information materials, and hire five additional

---

<sup>1</sup> For background information on Medicare, the state Medicaid plan, and state options to expand Medicaid coverage under TWWIIA, please refer to Appendix A, Legislative Service Commission research memorandum R-124-0398.

staff to work with contractors and manage project design and implementation. The funds required for program start-up are eligible for a fifty percent federal match.

The Committee recommends that JFS be required to identify and apply for any available grants to help fund administrative start-up costs of the buy-in program.

The Committee recommends that the Medicaid buy-in program be designed with the following eligibility and premium payment parameters:

- Individuals with assets up to \$10,000 be permitted to buy-in to Medicaid (Assets do not include the individual's primary residence, one vehicle, and certain qualified savings accounts such as a medical savings account or retirement savings account.);
- For adults who live alone and adult children who live with their parents, \$20,000 of the person's earned income be disregarded for purposes of determining eligibility (Adult children living with their parents are treated as if they live alone, therefore, parental income would not be considered for purposes of determining eligibility.);
- For an individual living with a spouse, \$20,000 of the individual's earned income be disregarded for purposes of determining eligibility (Total family income, however, would be considered for purposes of determining eligibility.);
- Once all income disregards are taken into account, an individual would be eligible to participate in the buy-in program if family income is less than 250% of the federal poverty level;
- The individual be required to begin paying a premium when the individual's total income (earned and unearned) reaches 150% of the federal poverty level for the family (2001 federal poverty level is \$8,590 for a family of one);
- The individual be required to pay a premium equal to 10% of the difference between the individual's total income and 150% of the federal poverty level for the family.

Given these parameters, Mr. Howe's model estimates that 12,542 individuals can eventually be expected to participate in the Medicaid buy-in program with an annual cost to the state of approximately \$20.4 million. Mr. Howe noted that he does not anticipate this many people enrolling in the program in the first year or two. It may take five to seven years for enrollment to reach the estimated level. Therefore, the estimated annual cost would be less than \$20.4 million in years prior to meeting full enrollment.

The Committee believes that in designing the Medicaid buy-in program, JFS should be required to convene an advisory group to gather input from interested parties and advocacy groups on certain aspects of the program's implementation.

The Committee recommends that JFS be given a minimum of 18 months for design and preparation for implementation and that JFS be required to implement the Medicaid buy-in program not later than July 1, 2003. The Committee also recommends that, as the

implementation date approaches, the General Assembly appropriate, to JFS for fiscal years 2004 and 2005, the funds necessary to provide Medicaid services under the buy-in program.

The Committee acknowledges an issue raised by JFS regarding the recommended eligibility parameters for assets. Since Medicaid eligibility is "categorical," a person is eligible if the person meets the eligibility criteria for a specific category. When a person no longer meets the eligibility criteria for a particular category, the person may meet the eligibility criteria for a different category. If Ohio implements a Medicaid buy-in program with higher asset limits and different disregards than those already established for the Aged, Blind, and Disabled (ABD), a person who is no longer eligible under the new buy-in category will be subject to the much more restrictive asset limits of ABD Medicaid.<sup>2</sup> However, at this time, the Committee recommends that the General Assembly move forward with the Medicaid buy-in program as outlined above and, at a later date, consider expanding or changing the eligibility for the buy-in program to address the concerns raised by JFS.

---

<sup>2</sup> A person may become ineligible under the buy-in program if the person turn 65 years of age or becomes too ill to continue working.

# **CHAPTER THREE:**

## **POSITION STATEMENTS OF EX-OFFICIO COMMITTEE MEMBERS**

The following pages consist of position statements prepared by ex-officio Committee members at the request of Chairperson Harris discussing their recommendations to the Committee.



30 East Broad Street · Columbus, Ohio 43266-0423  
[www.state.oh.us/odjfs](http://www.state.oh.us/odjfs)

March 16, 2001

Senator Bill M. Harris  
Senate Building  
Columbus, Ohio 43215

Dear ~~Senator Harris:~~ *Bill*

This letter is in response to your request for the Department's recommendations regarding the Joint Ticket to Work Committee evaluating Medicaid buy-in provisions under the Balanced Budget Act of 1997 and The Ticket to Work and Work Incentives Improvement Act of 1999. The Medicaid buy-in options now available to states make tremendous policy sense. They allow states to develop programs that better meet their needs, and help ensure that people with disabilities who want to work can go to work by removing the barrier of loss of health coverage through Medicaid. The Administration has included this policy option within its Ohio Access report and planning process.

The Study Committee asked whether a Medicaid buy-in could be restricted to only those individuals currently eligible for Medicaid in hopes that this could limit the cost and exposure to the State. The ODJFS has followed up with the Health Care Financing Administration (HCFA) on this question. HCFA confirmed our initial response, that a program could not be limited to current Medicaid eligibles, and anyone meeting the asset and income limits would have access to the coverage.

At this point in time, Ohio is facing its most difficult budget in nearly a decade. In particular the Medicaid budget is extremely tight, and as you are aware, the Medicaid buy-in program is not the only increase or expansion that has been suggested for inclusion in an annual budget which is already in excess of 7 billion dollars. Even a conservative program would cause some increase in expenses in Medicaid's 525 line, and a small program would still require all the administrative work to implement and operate it.

The Department's recommendation is that this program should be recognized as a good policy option for the state, but one which is not fiscally feasible within ODJFS's proposed budget. If the Study Committee and General Assembly want to make a commitment to such a program in this budget cycle, ODJFS would require new monies to its SFY 02/03 budget to fund both the medical and administrative costs, including staffing and systems redesign. In addition, it would take upwards of 18 months for ODJFS to design and implement such a program, should money be found to move forward, with ODJFS needing the administrative dollars up front.

Please keep in mind that Ohio would implement a Medicaid Buy-in through a state plan amendment, making it an entitlement to anyone who meets the program eligibility criteria. The income, asset, and premium level choices will greatly affect the number of people who choose this option and, therefore, the cost of this coverage opportunity. ODJFS's preference would be to keep these criteria simple to understand and implement, such as avoiding the use of numerous disregards to either income or assets.

Your committee has also had discussion regarding an Infrastructure Grant being offered by the Health Care Financing Administration. This grant opportunity allows states to apply for funds to develop the infrastructure for a Medicaid buy-in program, but focuses heavily on personal care benefit issues. To qualify for funding through this grant, states must demonstrate that they offer personal care assistance services sufficient to support competitive employment. States that apply and do not meet the personal care requirements could be placed in a reserved status. This status means that the state will not get any grant funds until it increases the availability to personal care assistance services. Ohio currently offers personal care services only as a benefit through waivers programs. Ohio has not made a commitment to increase this benefit. Therefore, the Department believes if Ohio applied we would be given "reserved" status, and would get no grant funds.

Before Ohio could make any commitment related to personal care, we need to know more about the cost and benefit of doing so. We submitted a letter of intent to HCFA stating that we would be interested in applying for the grant if it could be used to study the issue of personal care in Ohio, such as cost and cost effectiveness, without Ohio first having to make a commitment to specific changes. If HCFA responds favorably, that such an application would be considered viable, then we will move forward with the application.

I appreciate your leadership on this Study Committee. It is an unfortunate reality that the State's budget constraints and conflicting priorities make this a difficult choice at this time. However, the study committee has been a good opportunity for raising awareness and understanding of the option. As ODJFS and its sister agencies move forward with Ohio Access, and further develop the vision and plan for improving services in Ohio for people with disabilities, the Medicaid buy-in option will be part of the conversation.

Lastly, I would like to mention that the Department is encouraged by the National Governors Association's drive for Medicaid reform that would increase the flexibility of the Medicaid program, allowing states, among other things, the ability to modify benefit design for targeted populations. If this flexibility is realized, the State would have increased ability to develop cost effective programs meeting the needs of Ohioans.

Sincerely,

A handwritten signature in black ink, appearing to read "Jo Ann Davidson", written over a large, stylized loop that extends downwards from the signature.

Jo Ann Davidson  
Director



March 16, 2001

Memorandum To: The Honorable Senator Bill Harris

From: Thomas W. Johnson, Director  
Office of Budget & Management 

Subject: Joint Ticket to Work Study Committee Report

The Ticket to Work and Work Incentives Improvement Act of 1999 enables states to provide a number of employment incentives for persons with disabilities. Under your leadership, the Joint Ticket to Work Committee is examining the possibility of extending Medicaid benefits to Ohioans with disabilities who choose to enter or re-enter the workforce. A Ticket to Work initiative would benefit those Ohioans with disabilities who want to work, but are unable to do so because they would lose their health care benefits through Medicaid if their income increased.

I offer several observations for your consideration as you complete the Committee's report:

- 1) While Ohio's fiscal condition remains stable, the state faces a difficult budget environment characterized by lower than projected revenues in the current fiscal year, a slowing economy, increasing Medicaid costs, and school funding issues raised by the Ohio Supreme Court. As a member of the Senate Finance Committee, I know that you are aware that resources for expansion are limited in the FY 2002-2003 budget in light of these conditions.
- 2) The Ohio Access report, recently submitted to Governor Taft, contains a recommendation to explore options such as Ticket to Work which create opportunities for people with disabilities to work while still receiving health care coverage. This course of action would encourage self-sufficiency, as well as personal and family responsibility.
- 3) There are many unknown factors which could affect the penetration rate, and therefore the cost, of a Ticket to Work initiative. These factors include, but are not limited to, the income threshold established for eligibility, the amount charged for a monthly premium, and the asset threshold established for program participants. Assumptions regarding the number of individuals who would participate who are currently unknown to Ohio's Medicaid program are critical, as well. A significant amount of analysis will be necessary in order to develop a viable program model.
- 4) Any type of Medicaid expansion requires the Department of Job and Family Services to assume additional administrative responsibility. Depending on the size and scope of the Ticket to Work initiative, additional resources for staff and/or administrative overhead may be necessary in order to develop and manage the program.

In light of the observations detailed above, it seems a Ticket to Work Initiative, if recommended, should be limited to a pilot project during the FY 2002-2003 biennium. Although it would require additional appropriation not currently included in the ODJFS budget, a pilot project would be much easier to manage from a budget perspective because the number of participants and/or amount of total expenditures could be limited. If additional resources can not be identified by the General Assembly for a pilot project, the initiative should be examined for the FY 2004-2005 biennium.

I believe that a Ticket to Work initiative would be a positive step forward for Ohio in light of the recent Ohio Access findings, and I would be happy to offer assistance in any fiscal analysis that would be necessary as the state continues to explore possibilities in this area.

c: Joint Ticket to Work Committee Members



# Ohio Department of Mental Health

---

30 East Broad Street  
Columbus, Ohio 43266-0414

Phone: (614) 466-2596  
TDD: (614) 752-9696  
Fax: (614) 752-9453

March 19, 2001

**TO: Senator Bill Harris, Chair**  
**Ticket to Work Program Evaluation Committee**

**FR: Michael F. Hogan, Ph.D.**  
**Director**

**RE: Ticket to Work recommendations**

Per your request, attached is a copy of the Ohio Department of Mental Health's recommendations for the Ticket to Work Program Evaluation Committee. I hope this is helpful.

Please call me at 466-2337 if you have any questions.

MFH:ja

Attachment

Ohio Department of Mental Health  
Recommendations for Implementation of Medicaid Buy-In

Submitted by ODMH Director Michael F. Hogan, Ph.D.  
To the Ticket to Work Program Evaluation Committee

March 19, 2001

Introduction and Recommendation

People recovering from mental illness represent the largest disability category in Ohio of persons receiving SSI/SSDI benefits. Therefore, they have much interest in the discussions and final recommendations of the Ticket to Work Program Evaluation Committee. **The Ohio Department of Mental Health believes that developing a Medicaid Buy-In plan for Ohio is the single most powerful thing that can be done to break the cycle of dependency for people struggling with a mental illness.**

Seventy percent of people with a severe and persistent mental illness report that they want to work -- but only ten percent actually work. For most people with SSI, the income level at which they lose Medicaid under current incentives is not sufficient to afford treatment and medication for a severe mental illness. The current system is a Catch-22 that encourages dependency -- stay poor and under-employed and keep your health benefits through Medicaid, or work and lose your health coverage.

**For these reasons, ODMH recommends that Ohio design and implement a Medicaid Buy-In option authorized by federal Ticket to Work legislation.** This recommendation is in line with the report of the Commission on Mental Health Services, which recently completed a 13-month review of the public mental health system. The Commission's report, which includes recommendations for a strategic plan to improve mental health services to Ohioans, strongly supports the implementation of Medicaid Buy-In options.

Cost Issues

Implementation of Buy-In options will clearly support recovery and reduce dependency for people with disabilities. What is not as clear is the cost of implementing the Buy-In options. We salute the hard work of Chairman Harris and the members of the Ticket to Work Program Evaluation Committee to study the cost impact of this program. The information provided to the Committee thus far has been extremely valuable, and we look forward to the final report.

We wish to comment on several issues related to the potential cost impact of the program. Most of the discussion to date has focussed on costs to the Medicaid program broadly. However, the largest group of Ohioans with disabilities is people with a mental illness-related impairment. A large portion of the costs of care for these individuals is not through the mainstream Medicaid program, but through the public mental health system, **including the Community Mental Health Medicaid program administered by ODMH under agreement with ODJFS.** Therefore, the fiscal impact of implementing Medicaid Buy-In would be shared by the publicly funded mental health system.

Considering the impact of a Buy-In program on mental health costs is crucial since mental health is experiencing significant financial stress from a combination of flat or reduced state and local revenue, increased demand for services and increased Medicaid match demands.

We have analyzed the cost impact to the best of our ability and foresee a positive, not negative impact on the mental health system of implementing a Buy-In program. One might think that adjustments to current eligibility rules would cause additional financial stress to the mental health system. We strongly believe this is erroneous. First, a significant majority of SSDI or SSI recipients or prospective applicants who have a severe mental disorder are already served in the mental health system. Many of these persons are also Medicaid eligible, and only a very small number now even attempt to work for fear of loss of benefits. If implementation of the Ticket to Work provisions, including Medicaid Buy-In, encourages a portion of such persons to work, there would be a positive fiscal impact on the mental health system. Medicaid eligibility for such persons would continue, which would represent **no change** in terms of system financing; and administrative costs would be **reduced** because the burdensome activities associated with assisting clients in meeting spend down requirements would no longer be necessary.

Additionally, we wish to provide information that might assist in assessing cost impact more broadly. There are currently in Ohio approximately 115,000 persons ages 18 through 64 who receive SSDI and/or SSI benefits because they have a mental illness. Of this total number, approximately 65,000 persons receive SSDI benefits and approximately 63,000 persons receive SSI benefits. Approximately 13,000 persons receive both SSDI and SSI benefits because their income from SSDI falls below the SSI benefit standard.

Of the total 115,000 persons receiving SSDI and or SSI because of mental illness, approximately 60,000 are served in the publicly funded mental health system. Of that total approximately 55,000 persons have been made eligible for Medicaid and thus already receive Medicaid mental health services through the ODMH community mental health Medicaid program. Approximately 15,000 of those must "spend down" a portion of their monthly income in order to become eligible.

While this quantifies the universe of Ohioans with mental illness who are enrolled in SSI/SSDI, it does not define the number of persons who would enroll in a Medicaid Buy-In program. We believe that the analysis that Professor Steven R. Howe presented to the Committee on March 14, is a credible methodology. It provides a reasonable estimate of the numbers of people across all disability groups that might make use of Medicaid Buy-In. He also accurately points out that "advocates and legislators...have three powerful levers" that can limit the program's financial impact upon the State -- the earned income disregard, income and asset limits, and premiums.

Our experience leads to the conclusion that there will not be a massive influx of persons with mental illness who would immediately enroll in a Medicaid Buy-In program. At the same time, we believe that larger numbers of individuals may enroll and return to work

over the long term (e.g. 8-10 years). ODMH has had considerable experience implementing the only Social Security Administration demonstration grant nationally to focus on improving employment by providing work incentive counseling to mentally ill persons. Mental health consumers have been very cautious about putting their Medicaid coverage at risk, as Medicaid provides access to services and medications that they know are crucial to avoiding the terror of psychosis or depression. When existing work incentives are explained and offered, many resist enrolling in these programs because people they know have attempted to work and lost their benefits.

This destructive cycle occurs because of personal and institutional inability to successfully deal with the complexity of benefits and work incentives (e.g. due to high case manager caseloads and staff turnover). Even though the four sites funded by the demonstration grant are attempting to ameliorate these problems, progress is slow. Therefore, we conclude that consumer hesitation due to bad experiences within the current system will take some time to disappear. We believe that after the buy-in has been established successfully for some years, changing the culture of “realistic depression,” enrollment levels among people recovering from serious mental illness will increase more than Professor Howe projects. But it is not possible to assess these “out year” possibilities with great clarity.

Based on the available evidence, Professor Howe defines previous employment as a strong predictor of those SSI/SSDI beneficiaries most likely to enroll. This is a credible approach that is consistent with the research literature. Because mental illness usually strikes at the age when people are entering the workforce, a successful work history rarely ensues. Additionally, neither the vocational rehabilitation system nor the mental health system is effectively assisting these individuals to enter employment.

Elimination of the Rehabilitation Services Commission Pathways program because of limits in federal vocational rehabilitation matching funds will further limit job opportunities for people recovering from mental illness in the next few years. Budget erosion in mental health will similarly limit ability to implement employment-oriented services. Therefore, we do not foresee a sizeable increase in rehabilitation support, despite our desire to do this.

A third consideration will limit the rapid influx into a Buy-In program of persons of all disability groups who are not current SSI/SSDI beneficiaries. Medicaid Buy-In is targeted to those persons who already have established disability status and want to work. Among people with a mental illness, Ohio has worked hard for many years to establish SSI/SSDI eligibility. As a result of these efforts, Ohio ranks third among all states in the proportion of persons within the state who are determined disabled due to mental illness. Therefore, if Medicaid Buy-In is adopted in Ohio, there likely will be fewer additional people entering the disability rolls as a result of mental illness than in other states.

We believe, as with welfare reform, the positive impact of employment and productivity should not be ignored in considering the fiscal impact of the program. Encouraging people with disabilities to find and maintain employment will also have a positive impact

on Ohio's tax base. In a 1995 study, the California Department of Rehabilitation demonstrated that on average, for every mental health consumer who became employed, \$239 was paid each month in federal, state, local and sales taxes. Additionally, an average of \$200 per month was saved in public assistance and SSI payments, and an average of \$187 per month was saved in public mental health services costs. While Ohio's experience will of course differ from California's experience five years ago, the fiscal impact of a Medicaid Buy-In will most likely include benefits as well as costs.

### Conclusion

ODMH would again like to thank Chairman Harris and the members of the Committee for their hard work on this important issue. We realize that the ultimate decision about implementing Medicaid Buy-In will require additional study and deliberation by the General Assembly and the Taft Administration to identify and prioritize scarce resources. It is our hope that the Committee's report will provide a strong basis for that discussion. We argue that prioritizing resources in favor of increased personal responsibility and productivity is perhaps an even more important consideration than expansion of services that provide for the mere movement from institution to community, without an element of real community participation.



*State of Ohio*  
**Rehabilitation Services Commission**

---

400 E. Campus View Blvd., Columbus, OH 43235-4604  
(800) 282-4536; (614) 438-1210

March 20, 2001

The Honorable Bill Harris  
19<sup>th</sup> Senate District  
Senate Office Building  
Columbus, OH 43215-4276

Dear Senator Harris:

The State of Ohio has a great opportunity, through implementation of a Medicaid buy-in program, to increase the number of people with disabilities who will join the workforce at a time when more workers are needed to fill jobs. Individuals with disabilities often fear taking this step towards independence due to the potential loss of health insurance coverage.

The Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999 give states the option of allowing working individuals with disabilities to "buy into" Medicaid to provide continued health insurance coverage necessary to keep them on the job. The enabling federal legislation provides states with great flexibility in designing such a program.

Creation of a Medicaid buy-in supports the vision and mission of the Ohio Department of MR/DD (ODMR/DD), the Ohio Rehabilitation Services Commission (ORSC), and the Ohio Department of Job and Family Services (ODJFS). Notably, the 2001 *Ohio Access for People With Disabilities* report to Governor Taft recommends that the state explore options, especially Medicaid buy-in, that create opportunities for persons with disabilities to work while still receiving health care coverage.

Access to health insurance, in particular Medicaid, is governed by rules about financial eligibility. Unfortunately, these rules often force a person with a disability to choose between work and health insurance, between doing something useful that helps raise his or her standard of living and having essential day-to-day and frequently life-sustaining medical coverage. To be effective, a buy-in program should enable work while maintaining Medicaid coverage. It should be affordable to the individual participant. It should minimize administrative and program costs to the state as much as possible without also resulting in minimal participation. We would like to take this opportunity to recommend several design elements to be considered in an initial implementation strategy for the State of Ohio. The important thing to be remembered at this stage, is to start somewhere, with modifications as needed, to get this important program off the ground.

## Recommendations for the Committee's Report

### Model

During the Ticket to Work Study Committee's hearings, researcher Steve Howe has been presenting results of a model projecting participation and cost of a Medicaid buy-in program in Ohio. He is able to adjust variables within the model to reflect different criteria, such as income eligibility, asset limits, and premium calculation. As a starting point, we recommend continuing to use Mr. Howe's model as the base from which various eligibility criteria can be modified to increase or decrease projected participation and cost as desired.

Income eligibility in Mr. Howe's model seems reasonable since it addresses concerns about excessive family income and at the same time not penalizing the individual with some family income. Income eligibility is calculated by 1) disregarding the individual's earned income, 2) counting the individual's unearned income, e.g. SSDI, in family income, and 3) comparing family income (earned and unearned) to 250% of the Federal Poverty Level (FPL) for household size. If family income is below 250% FPL, the individual is eligible. If family income is above 250% FPL, the individual is not. Given the State's current fiscal situation, an option that would reduce participation and cost would be to also count the individual's earned income at some level.

Premium calculation in Mr. Howe's model also seems reasonable. If the individual's total earned and unearned income is greater than 150% FPL for the household size, the amount of income above that 150% FPL is multiplied by 7.5%. The resulting figure is the individual's premium to "buy into" Medicaid. This particular feature would be more attractive to persons on Social Security Disability Insurance (SSDI), and less attractive to persons on Supplemental Security Income (SSI).

We recommend that any amount paid by an individual toward premiums for employer/private insurance should be deducted from the individual's premium obligation to participate in the Medicaid buy-in. By encouraging people to purchase private health insurance, many of their health care costs will be covered before the first dollar of Medicaid is obligated. This will result in significant cost savings to the Medicaid program, which will assist in offsetting the added administrative burden incurred by the collection of premiums.

Asset limits is an important criterion for determining eligibility. If it is made too strict, as it currently is with regular Medicaid, it does not allow the individual to truly become self-sufficient and rise out of poverty. There are three possible directions to go with asset limits:

- 1) set specific and low limits, and allow the individual to have special savings and other accounts, e.g.

Asset limits at \$1500 per individual and \$2,250 for couples using current Medicaid standards for establishing countable assets (i.e., a car, personal affects such as clothes and household items, a home)

Disregards to include assets held in approved accounts determined by the State to enhance independence and/or increase employment opportunities, e.g.

- ✓ Home ownership account
- ✓ Transportation account
- ✓ Assistive technology accounts
- ✓ Retirement accounts
- ✓ Medical savings accounts

2) set a higher amount, e.g. \$5,000 or \$10,000, and give the individual choice in managing his or her money to purchase needed equipment, housing, etc. To facilitate movement back onto regular Medicaid, if the person becomes unable to work, the individual would be allowed a period of time, e.g. six months, to use the funds in his or her accounts. This may be more affordable and less maintenance-intensive than option 1) above, depending on the costs of overseeing and administering special savings accounts.

3) set the asset limits somewhere between those in options 1) and 2), and provide more limited disregard accounts than in option 1).

Other recommendations

- Administrative costs for ODJFS must be included in the cost of any Medicaid buy-in program.
- A legislative work incentives committee will be established to review the results of implementing the program 24 months after enactment, members to include current Study committee membership and participants of the Medicaid Buy-in program.
- ODJFS should be encouraged to apply for available funds through HCFA and if necessary seek waivers of current regulations to allow Ohio to access these funds. ODJFS should be encouraged also to apply for other sources of available funds such as the Robert Wood Johnson Foundation planning and demonstration grants.

In closing, we feel this program will be of great benefit to individuals with disabilities. Further, many of these individuals will take on more personal responsibility and become tax payers rather than tax users. This will lead to greater independence and inclusion as a citizen in the state of Ohio.

Sincerely,



William A. Casto, II  
Interim Administrator



March 20, 2001

Ohio Ticket to Work Study Committee  
Senator Bill Harris, Chairman  
Ohio Senate  
Statehouse  
Columbus, Ohio 43215-4276

Dear Senator Harris and Members of the Committee:

I very much appreciate the opportunity to provide comments and recommendations to the committee on the value and structure of a "Medicaid Buy-In" program. I applaud the efforts of the committee and its chairman to thoughtfully address this issue and recognize the significance of its product to the disability community.

The federal legislation creating the Ticket to Work and Work Incentives Improvement Act of 1999 has given states a powerful tool in dealing with the staggering rates of unemployment for persons with disabilities. In discussions over costs and possible implementation of a Medicaid Buy-In component, we must realize that the need for health insurance and other Medicaid benefits is but one of several acknowledged barriers to employment. Lack of available, affordable transportation, personal assistance services, housing, assistive technology and employer bias are all very real impediments to those individuals with disabilities who seek meaningful employment.

As the committee finalizes its recommendations, I believe a real opportunity exists for Ohio's general assembly to acknowledge through this report, in concert with individuals with disabilities, advocates and state agencies, the value and importance of individual independence and choice. This means that state policy in Ohio should be designed and implemented to encourage and empower individuals with disabilities to live as independently as possible, to become taxpaying citizens, and to have and make choices about work opportunities that are important to them.

With the above overall goals in mind, the following are thoughts concerning the possible components of a Medicaid Buy-in model or program design.

**Constituent Services**

1810 Sullivant Avenue, Columbus, Ohio 43223-1239 • Phone: (614) 466-6896 • Fax: (614) 752-5302 • TDD: (614) 752-4688

Web Site: <http://odmrdd.state.oh.us>

The State of Ohio is an Equal Opportunity Employer and Provider of Services

- There may be an advantage to identifying specific asset disregards designed to enhance independence and increase employment opportunities. Such disregards could include accounts for home ownership, transportation, medical savings, assistive technology and retirement.
- Ensure that unearned income such as SSDI, VA, and PERS under a certain monthly amount does not automatically exclude individuals from the program.
- Consider the manner in which Medicaid currently deals with family income. In determining eligibility for individuals over 18 years of age who live with parents, the parents income is not counted. In the MRDD system, many adult individuals still live with family not out of choice but out of necessity because of the lack of available residential options.
- Consider the policy constraints on self sufficiency outlined in the Governor's Ohio Access report, pages 75 and 76 (attached)
- Establish criteria for determining effectiveness of Medicaid Buy-in initiative.
- Maintain some sort of legislative oversight or review of the Medicaid Buy-in initiative. One possibility is to require committee review at a certain point after initial enactment.

I would like to thank all members of the committee for their efforts and their interest. We would be willing to offer any assistance you would like to further develop concepts and language as this effort continues. Feel free to contact me at 466-0129 or Jeff Davis at 644-6300.

Sincerely,



Kenneth W. Ritchey, Director

c: Mark Gerhardstein, Assistant Director  
Jeff Davis, Deputy Director, Constituent Services  
Nancy McAvoy, Deputy Director, Community Services

- Work more closely with Ohio's jobs programs for persons leaving welfare. Also, the state agencies should work more closely with the Rehabilitation Services Commission and its initiatives.

Examine alternatives to the traditional provision of long term care. In addition to increasing its workforce development efforts, the state must create strategies to examine innovative responses to the direct care workforce shortage. These initiatives may be aligned with the principles detailed in President Bush's New Freedom Initiative, which he proposed to Congress on February 1, 2001.

- Examine "scope of practice" issues, including delegated nursing and responsible alternatives to delegated nursing.
- Explore the use of available technology which can allow individuals to stay home and decrease the need for human help to reduce reliance on an overburdened labor force. Increase utilization of existing technological advances, including the expanded use of telemedicine.
- Explore the increased use of independent service providers. The use of independent workers by consumers gives them more control and allows for greater self-determination.

**E. Overcome policy constraints on self-sufficiency and personal and family responsibility.**

A consistent theme throughout the public process that surrounds the development of the Ohio Access report, was that there are currently far too many policy barriers that inhibit persons with disabilities from achieving self-sufficiency. To the extent that such barriers exist, the state has an important role in developing mechanisms to remove those barriers.

Also, while the state plays an important role in financing and organizing long-term care services, the fact remains that the vast majority of long-term care, services, and supports is provided informally by relatives, neighbors, and friends. Thus, the state also has an important role in supporting this informal network. While none of the listed recommendations below guarantee that the existing barriers to self-sufficiency and personal responsibility will be removed, each of the recommendations should be evaluated.

- Provide better information and assistance for consumers and their caregivers. Recognizing that people access services and information in many different ways, the agencies recommend movement toward the concept of "no wrong door" where Ohioans are given consistent, accurate, and timely information regardless of how they choose to enter the system. In the short term, mechanisms toward this approach include Ohio Helps and the Long-Term Care Consumer Guide – both Internet-based approaches – and the statewide toll free number that will be implemented this winter by Ohio Department of Aging.

## **Recommendations**

---

- Explore options that create opportunities for people with disabilities to work while still receiving health care coverage, especially the federally created "ticket to work" initiative.
- Explore the potential of the expanded opportunities states have been offered under Section 1902r of the Social Security Act that could remove barriers that exist in Medicaid eligibility requirements.
- Examine successful programs, such as the LEAP program in Cleveland that trains persons with disabilities to become care workers themselves.
- Develop a public policy by which those with resources may contribute some portion toward funding needed community services without jeopardizing their eligibility for those services. This overcomes Medicaid's "all or nothing" approach, whereby either 1) the individual is economically eligible for the program and receives an extensive entitlement to a wider array of services than is available under any private insurance plan, or 2) the individual qualifies for no benefits at all.
- Encourage Ohioans to plan for their future needs for long-term care, services, and supports. Few Ohioans consider that they may need such supports in the future and even fewer consider the purchase of long-term care insurance. In part, this is because these policies, like Medicaid itself, emphasize institutional placement over community placement. However, newer policies may provide consumers with more choices and controls while still preserving private resources and assets. The state can play an important role as new insurance products develop as well as an important role in ensuring that the insurance products offered in Ohio are of high quality. The Department of Aging currently offers a free, in-home assessment to any Ohioan concerned with the future need for long-term care and services to encourage Ohioans to plan in advance of the actual need for services.

## **Conclusion**

The Ohio Access report is a blueprint for Ohio's future. In order to achieve the new vision for elders and persons with disabilities, the state must work with consumers and their families, local funding partners, and providers to overcome the barriers and constraints identified in this report. The implementation of the strategies outlined in Section VIII will require the commitment of all of these stakeholder groups, as well as the realignment of limited resources to purposefully and efficiently match capacity to demand.

The agencies recognize that the new vision cannot be achieved quickly. Ohio's current system of long-term care and services has evolved over many years and the issues highlighted in this report will not be resolved in the near term. However, Ohio Access marks a beginning, not an end point, and with the concerted efforts of all affected Ohioans, a vision based on self-determination and person-centered planning will be realized for our futures.

# **CHAPTER FOUR:**

## **MEDICAID BUY-IN STATISTICAL MODELS**

Steven R. Howe of the University of Cincinnati was retained by the Ohio Developmental Disabilities Council to develop a statistical model that could be used to estimate the number of Ohioans who would enroll in a Medicaid buy-in program. The following pages consist of Dr. Howe's written testimony presented to the Committee that provides the details of his statistical model.

2  
3 **Estimating the Number of Ohioans Who**  
4 **Would Enroll in a Medicaid Buy-In Program**

5  
6 Steven R. Howe  
7 University of Cincinnati  
8 March 14, 2001  
9

10  
11 **Background**  
12

13 The federal Balanced Budget Act of 1997 allowed states to expand their Medicaid  
14 programs to cover persons with disabilities who are working. The Ticket to Work and  
15 Work Incentives Improvement Act of 1999 (TWWIIA) allowed states to be even more  
16 flexible in creating such programs. Beginning in 2002, simply being employed will no  
17 longer be a disqualification for the continuation of Social Security Disability Insurance  
18 (SSDI) benefits or Supplemental Security Income (SSI) benefits. While being gainfully  
19 employed will continue to be a disqualification for a person making an initial application  
20 for SSDI or SSI, states may declare an employed person to be eligible for Medicaid under  
21 a new buy-in program if the person meets all of the other standards for disability that are  
22 part of the SSDI/SSI determination process.  
23

24 I was retained by the Ohio Developmental Disabilities Council to develop a statistical  
25 model that could be used to estimate the number of Ohioans who would enroll in a  
26 Medicaid buy-in program. The goal in developing a statistical model is to permit the  
27 study of various policy options. For example, without a model someone might argue that  
28 since Ohio has about two and a half times as many residents aged 18-65 as Minnesota,  
29 then Ohio should have about two and a half times as many people participating in a buy-  
30 in program. There are numerous problems with such an approach: (1) Minnesota might  
31 have different income and asset limitation guidelines, (2) Minnesota might be more or  
32 less successful than Ohio in encouraging persons with disabilities to work, and (3)  
33 Minnesota's program may have a different set of policies for the payment of premiums.  
34 Ironically, under the initial set of assumptions I used, my model does produce an estimate  
35 for Ohio that is very nearly equal to two and a half times the projection of eventual  
36 enrollment developed by Minnesota. However, I will argue toward the end of my  
37 testimony that Minnesota's projections for its program are too low.  
38

39 **Data Sources**  
40

41 The model was developed using three years of data for Ohio from the Current Population  
42 Survey (CPS), conducted by the U.S. Bureau of the Census and the Bureau of Labor  
43 Statistics. Data from the Annual Demographic Files for March 1998 to 2000 were  
44 analyzed. These files contained records for a total of 795 Ohioans ages 18-65 with work  
45 disabilities, which I judged to be sufficient for the purpose of developing the model.  
46 Thus, each person in the combined file for all three years represents an average of about

47 840 people. This number is their "weight," which I mention manipulating in some of the  
48 following material.

49

50 I also ran my model, again using CPS data, for Minnesota and Wisconsin.

51

52 I supplemented my analyses of CPS data with a variety of data available from the US  
53 Bureau of the Census and the Social Security Administration (SSA).

54

55

## 55 Results

56

### 57 The Population of Persons with Severe Work Disabilities

58

59 Table 1 shows that there are 442,534 Ohioans ages 18-65 with a severe work disability.  
60 In developing Table 1, the first step was to make a minor adjustment in the weights  
61 assigned in the CPS to match Census Bureau estimates for the July 1998 population of  
62 Ohioans between the ages of 18 and 65 (6,887,990). I then determined that 9.7% of the  
63 persons in that age group in the CPS reported that they had a work disability (668,480).  
64 (Ohio has nearly exactly the same proportion of persons with work disabilities as the  
65 country as a whole.) For the purpose of my work, a person was defined as having a work  
66 disability if he or she reported: (1) a health problem that limits or prevents work; (2) a  
67 disability as the main reason for not working the previous year; (3) a retirement due to  
68 health reasons; (4) not currently working or looking for work because of a disability; or  
69 (5) working part-time because of a disability.

70

71 The second step was to reduce the population of 668,480 persons with any kind of work  
72 disability to only those persons with severe work disabilities. Nationally, 66.2% of  
73 persons with a work disability report a severe work disability, and in the absence of a  
74 better state-specific estimate, I assumed that the same percentage of Ohioans with a work  
75 disability could be characterized as having a severe one. The actual adjustment involved  
76 the following considerations.

77

- 78 • I first assumed that anyone who is already receiving Social Security Disability  
79 Income (SSDI) or Supplemental Security Income (SSI) would meet the standard  
80 for having a severe disability. Incidentally, the CPS data agreed reasonably  
81 closely to reports from the Social Security Administration on the number of  
82 people getting either SSDI or SSI or both, although I did go ahead and make a  
83 slight adjustment to the CPS results so that the number of SSDI and SSI  
84 recipients matched SSA published reports exactly.
- 85
- 86 • After assuming that all 305,285 persons on SSDI/SSI would qualify as having a  
87 severe disability, I then had to decide whom among the remaining 363,195  
88 people would qualify as having one. I did this by changing the weights for  
89 individuals in the sample so that they would represent a smaller number of people  
90 in the population. But because one of the striking differences between people  
91 with severe versus other work disabilities is that persons with severe work

- 92 disabilities are much less likely to be employed, I took account of a person's  
93 current employment status in making these adjustments.  
94
- 95 • Based on national results, it is known that only 8.3% of persons with a severe  
96 work disability are employed at any point in time. However, based on SSI  
97 program data, it is also known that there is considerable variation among states in  
98 the proportion of people with severe work disabilities who work. Nationally, only  
99 6.6% of SSI recipients work but in Ohio 8.1% do.
  - 100
  - 101 • Therefore, in estimating how many persons with severe disabilities in Ohio work,  
102 I inflated the national rate (8.3%) by a factor of 1.23 (8.1%/6.6%), to arrive at my  
103 estimate that 10.2% of the Ohio population of persons with severe work  
104 disabilities is currently employed. Knowing that I needed to have 45,128 working  
105 persons in my reduced count, I adjusted the weights of persons not currently on  
106 SSDI/SSI according to whether or not they were employed.

107  
108 In reviewing Table 1, it is important to note that there is a difference between a person  
109 currently working and a person having recent evidence of work. For reasons just  
110 explained, 10.2% of the people in Table 1 (45,128) can be expected to be working at any  
111 point in time, but a far greater number (126,253, or 28.5%) will show evidence of recent  
112 work. In order for a person to be designated as having shown evidence of recent work,  
113 they had to satisfy one of the following conditions: (1) currently employed, (2) employed  
114 at any point in preceding calendar year, (3) being currently unemployed but looking for  
115 work, or (4) report a desire to work. Or, to make the point more relevant to the prediction  
116 problem, presumably people who have shown any kind of recent evidence or interest in  
117 work will be more likely to take advantage of a new buy-in program than people who  
118 have neither worked, nor looked for work, nor indicated a desire to work for the previous  
119 15 months.

120  
121 Note also that of the people in Table 1, 183,507 (41.5%) already receive Medicaid.  
122

### 123 **Persons Meeting Income and Asset Standards**

124  
125 Table 2 is just like Table 1 except that it is restricted to persons meeting the income and  
126 asset limitations inherent in a set of program guidelines that I was asked to model. Under  
127 those assumptions:

- 128
- 129 • Persons with disabilities would be eligible for an expanded Medicaid program  
130 only if their family income was less than or equal to 250% of the Federal Poverty  
131 Level. However, to encourage work, any earned income of a person with a  
132 disability would be entirely disregarded in determining whether the family income  
133 criterion was met.
- 134
- 135 • Persons with severe work disabilities would also have to meet stringent  
136 limitations on their assets. Specifically, individuals would be restricted to assets  
137 of \$1,500 for a single person or \$2,250 for a couple. However, several important

138 asset classes would be disregarded, including: the value of the home used as a  
139 primary residence, the value of an automobile, the value of qualified retirement  
140 accounts, and the value of medical spending accounts. As a result, it is estimated,  
141 based on Census Bureau data on household asset ownership, that as many as 90%  
142 of families in the lowest 20% of the population income distribution meet this asset  
143 requirement, as would 75% of those in the next 20% of the income distribution.  
144

145 As a result of applying these two restrictions, the number of Ohioans 18-65 with a severe  
146 work disability who would potentially qualify under the proposed program drops from  
147 442,534 (Table 1) to 294,872 (Table 2).  
148

#### 149 **Persons Who Might Work**

150  
151 Table 3 contains estimates of the number and percentage of persons from Table 2 who  
152 might be expected to work if various work incentives are implemented in Ohio, including  
153 the buy-in program. The expected employment rates vary from cell to cell but were  
154 always determined as follows. First I assumed that new policies would increase the rate  
155 of current employment by 33% among people with any history of recent work. These  
156 adjustments were applied separately to each cell according to SSDI/SSI status and  
157 Medicaid status. Second, I assumed that the employment rate for people with no work  
158 history would be 7.5% of people in a corresponding income/insurance cell who did have  
159 a history of recent work. Overall, 8.3% of the people shown in Table 2 are currently  
160 working, and I project that number to increase to 13.6%. Later, when I present the results  
161 of running my model for other states, I will address the question of why employment  
162 rates do not change more dramatically.  
163

#### 164 **Take-Up Rates**

165  
166 Table 4 shows the number and percentage of people from Table 3 who would be  
167 expected to participate in the new program. Assigning an expected enrollment probability  
168 to different types of people involved the following considerations:  
169

- 170 • If someone currently receives Medicaid and has no spend-down, there would be  
171 few incentives to enroll in the new program. However, persons in this situation  
172 might eventually have earnings that outpace their eligibility under Section 1619a  
173 or Section 1619b and so a zero take-up rate would have been inappropriate.  
174 Instead it was set at 10%.  
175
- 176 • In contrast, for someone who does now receive Medicaid but has a spend-down,  
177 there would be a strong incentive to enroll in the new program. It was assumed  
178 that 100% of persons with spend-down would enroll, thus depriving the state of  
179 that revenue.  
180
- 181 • For people with no Medicaid and no other form of health insurance, a substantial  
182 take-up rate of 60% was projected; however, this rate was reduced modestly for  
183 persons with a small premium and was reduced all the way down to 25% for

184 persons with a premium in excess of 4% of total family income, based on research  
185 from the Urban Institute on the effects of premiums on enrollment in health  
186 programs.

187

- 188 • For people with no Medicaid and some other form of health insurance (most  
189 typically Medicare), fairly low enrollment rates were assumed (20%) even  
190 without a premium payment, and these rates were further reduced as premiums  
191 increased.

192

193 It is, therefore, projected that a total of 13,468 people might eventually enroll in this  
194 program, of which 4,091 are current Medicaid beneficiaries. The overall enrollment rate  
195 turned out to be 33.6% of all persons in Table 3.

196

197 Three important caveats must be mentioned:

198

- 199 • Under no circumstances do I anticipate this many people enrolling in the program  
200 in the first year or two of its existence. Initial take-up rate will be a function of  
201 publicity, outreach activities, and the speed with which administrative systems  
202 can be implemented.

203

- 204 • Remember that a take-up rate of only 10% is assumed for people who are  
205 currently receiving Medicaid, and that is to recognize the possibility that if such  
206 persons begin to work, they might eventually have earnings sufficient to move  
207 them out of Section 1619a or 1619b eligibility. If, in designing its administrative  
208 systems, the Ohio Department of Jobs and Family Services (ODJFS) designates  
209 people with a disability who are working as being covered under this program  
210 even though they are eligible under 1619a or 1619b then my projected  
211 enrollments will be too low. However, such additional enrollees would be  
212 associated with no net increase in state spending.

213

- 214 • Long term – and by that I mean five to ten years out – systems for employment  
215 support for persons with disabilities in Ohio might improve to the extent that the  
216 employment rate for this population might increase. That would tend to increase  
217 enrollment in the program.

218

## 219 **Costs**

220

221 There are four elements to the projected cost of a buy-in program for persons with  
222 disabilities:

223

- 224 • Benefit costs
- 225
- 226 • Loss of spend-down
- 227
- 228 • Collection of premiums

229

230 • Administrative costs

231

232 Taking the last item first, I am not qualified to project the administrative costs for  
233 ODJFS, so I will merely note that these costs will include: (1) an increased number of  
234 disability determinations, (2) the costs associated with premium collection, and (3) the  
235 basic administrative overhead associated with running any Medicaid program, a huge  
236 category that covers information systems, department administration, preparation of  
237 materials for public education, and so on. It is worth noting that I was asked to study a set  
238 of program options that do not include cost-sharing (other than premiums) for fear that  
239 the administrative costs of such an option would outweigh collections.

240

241 As shown in Table 5, I project that the state will lose \$6.6 million in spend-downs (an  
242 average of about \$260 per person per month for people who have a spend-down).

243

244 I also project that the state will gain \$4.3 million in premiums collected.

245

246 In preparing my benefit cost, I was advised by ODJFS that it would be reasonable to  
247 assume that the monthly cost of providing Medicaid to a person 18-65 years old with a  
248 disability who was living in the community is \$437/month in 2001. Note, however, that a  
249 large proportion of the people in Table 5 have Medicare or some other form of health  
250 insurance. For many of these people, Medicaid would be a wrap-around program, and  
251 therefore less expensive. However, it is unknown whether these proportions are  
252 substantially different from the population of persons now receiving Medicaid. If not,  
253 then the blended rate of \$437/month is accurate.

254

255 Total benefit costs of the fully subscribed buy-in program are therefore projected to be  
256 equal to:

257

258 Monthly premiums (\$437) for persons not now on Medicaid (9,377) x 12

259

260 + loss of spend-down – the collected premiums = \$51,534,715.

261

262 The state share of the monthly premiums is 41.9%, which makes the state's cost of the  
263 program, once it is fully subscribed, \$23,013,519.

264

## 265 **Comparisons to Other States**

266

267 States have wide latitude in how to structure and administer Medicaid buy-in programs.  
268 To date, ten states have implemented programs and others have programs under  
269 development. Most of these state programs have been in operation for about 12 months  
270 and in several of the states the programs seem to have little public visibility. I would,  
271 therefore, be reluctant to draw too many conclusions from their experiences to date. In  
272 contrast, Minnesota and Wisconsin have widely publicized programs and their programs  
273 have been in operation for at least a year.

274

275 In both Wisconsin and Minnesota considerably more SSI recipients work (14.4% and  
276 16.7% respectively) than is the case in Ohio. What determines the proportion of a state's  
277 residents who have severe disabilities who are able to work? My view is that a myriad of  
278 factors are responsible, including, to name just a few, state investment in workforce  
279 development, the quality of the health care and social services systems, and the relative  
280 size of different sectors of the state's economy (e.g., agriculture, information  
281 technology). Thus, states such as Wisconsin and Minnesota start off with much higher  
282 rates of persons with disabilities working and that they will continue to have higher rates.  
283 In other words, I am assuming that the effects of a Medicaid buy-in program within a  
284 state will be proportional to its current employment rate for persons with disabilities, and  
285 I reject the idea that simply because Ohio implements such a program we will experience  
286 increases in employment so dramatic that our employment rates will soar to the top of  
287 national rankings

288  
289 I ran my model for Wisconsin and Minnesota, making suitable adjustments for state  
290 income, asset and premium policies. The results are shown in Table 6. Note that my  
291 projections are conservative with respect to the proportion of enrollees who are presently  
292 Medicaid recipients. However, neither the Wisconsin nor the Minnesota program has  
293 been in operation very long. Presumably people with no Medicaid experience will take  
294 longer to begin participating in the program.

295  
296 It is important to note that the projections produced by the state of Wisconsin were  
297 carried out under a more conservative set of income and premium assumptions than were  
298 used in the enabling legislation, so my guess that Wisconsin's own estimate was for 4,000  
299 participants is just that, a guess. Officially, Wisconsin projected 2,146 enrollees, but that  
300 was under the assumption that no earned income would be disregarded and the all  
301 program enrollees would be charged a one-time fee to enroll.

302  
303  
304

### Conclusions

305 With the exception of California, whose buy-in program is new and poorly publicized,  
306 and not surprisingly poorly subscribed, Ohio would be the most populous state with a  
307 Medicaid buy-in program for persons with severe disabilities. In considering how to limit  
308 its financial exposure, advocates and legislators should bear in mind that there are three  
309 powerful levers that can be used to affect eligibility and take-up rates:

310

311 • The earned income disregard

312

313 • Income and asset limits

314

315 • Premiums

316

317 I will be happy to run my model under any proposed combination of guidelines in  
318 helping to identify the characteristics of a buy-in program that the state can afford.

Table 1: Persons by Disability Income by Medicaid Status by Work Status

Universe: Ohioans Ages 18 - 65 with a Severe Disability

Persons Who Receive SSDI or SSI Income	Evidence of Work	No Evidence of Work	Total
Receives Medicaid	27,310	126,966	154,276
Does Not Receive Medicaid	25,155	125,853	151,009
Total	52,465	252,819	305,285

Persons Who Do Not Receive SSDI or SSI Income	Evidence of Work	No Evidence of Work	Total
Receives Medicaid	14,380	14,851	29,231
Does Not Receive Medicaid	59,408	48,610	108,018
Total	73,787	63,462	137,249

All Persons	Evidence of Work	No Evidence of Work	Total
Receives Medicaid	41,690	141,817	183,507
Does Not Receive Medicaid	84,563	174,464	259,026
Total	126,253	316,281	442,534

Table 2: Persons by Disability Income by Medicaid Status by Work Status

Universe: Ohioans Ages 18 - 65 with a Severe Disability and with Adjusted Family Income at or below 250% of Federal Poverty Level and with Non-Exempt Assets Less than \$1,500 (Person) or \$2,250 (Couple)

Persons Who Receive SSDI or SSI Income	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives SSDI/SSI	25,077	109,332	134,409
Does Not Receive SSDI/SSI	12,154	69,291	81,444
Total	37,231	178,622	215,853

Persons Who Do Not Receive SSDI or SSI Income	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives SSDI/SSI	14,380	13,311	27,690
Does Not Receive SSDI/SSI	28,854	22,474	51,328
Total	43,233	35,785	79,019

All Persons	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives SSDI/SSI	39,457	122,642	162,099
Does Not Receive SSDI/SSI	41,008	91,765	132,773
Total	80,465	214,408	294,872

Table 3: Number and Percentage of Persons Projected to Hold Jobs Under New Policy by Disability Income by Medicaid Status by Work Status (Assumes No Barriers to Enrollment)

Universe: Ohioans Ages 18 - 65 with a Severe Disability and with Qualifying Incomes and Assets

Persons Who Receive SSDI or SSI Income	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives Medicaid	9,956 39.7%	3,280 3.0%	13,235 9.8%
Does Not Receive Medicaid	7,430 61.1%	3,177 4.5%	10,607 13.0%
Total	17,386 46.7%	6,457 3.6%	23,843 11.0%

Persons Who Do Not Receive SSDI or SSI Income	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives Medicaid	1,647 11.5%	115 0.9%	1,762 6.4%
Does Not Receive Medicaid	13,721 47.6%	802 3.6%	14,522 28.3%
Total	15,368 35.5%	917 2.6%	16,285 20.6%

All Persons	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives Medicaid	11,603 29.4%	3,395 2.8%	14,998 9.3%
Does Not Receive Medicaid	21,151 51.6%	3,979 4.3%	25,130 18.9%
Total	32,754 40.7%	7,374 3.4%	40,128 13.6%

Table 4: Projected Enrollment

Universe: Ohioans Ages 18 - 65 with a Severe Disability and with Qualifying Incomes and Assets and with a Job

Persons Who Receive SSDI or SSI Income	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives Medicaid	2,745 27.6%	1,132 34.5%	3,878 29.3%
Does Not Receive Medicaid	2,435 32.8%	1,009 32.4%	3,443 32.5%
Total	5,180 29.8%	2,141 33.2%	7,321 30.7%

Persons Who Do Not Receive SSDI or SSI Income	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives Medicaid	185 11.2%	28 24.3%	213 12.1%
Does Not Receive Medicaid	5,537 40.4%	397 49.5%	5,934 40.9%
Total	5,721 37.2%	426 46.5%	6,147 37.7%

All Persons	Evidence of Work		Total
	Evidence of Work	No Evidence of Work	
Receives Medicaid	2,930 25.3%	1,161 34.2%	4,091 27.3%
Does Not Receive Medicaid	7,971 37.7%	1,406 35.3%	9,377 37.3%
Total	10,901 33.3%	2,567 34.8%	13,468 33.6%

Table 5: Projected Program Costs

	Current Medicaid Recipient			Total
	No Spend Down	Spend Down	Not on Medicaid	
No Health Insurance or Medicaid Only	1,612	94	5,108	6,814
Medicare	195	1,710	1,715	3,620
Any Other Health Insurance	183	296	2,554	3,033
<b>Total</b>	<b>1,990</b>	<b>2,101</b>	<b>9,377</b>	<b>13,468</b>
Amount of Spend Down Lost	\$6,651,167			
Amount of Premiums Collected	\$4,290,929			
Total Benefit Cost of Program	\$51,534,715			
State Share of Benefit Cost of Program	\$23,013,519			

Table 6: Comparisons to Other States

	Ohio	Minnesota	Wisconsin
Population Ages 18-65	6,887,990	2,880,251	3,182,224
SSI Employment rate	8.1%	16.7%	14.0%
Income Limitation	250% of FPL, disregarding all earned income by the person disabled	None	250% of FPL disregarding 50% of all earned income in the family
Asset Limitation (all three states have similar exclusions)	Approx. \$2,000	Approx. \$15,000	Approx. \$18,000
Persons with Severe Disabilities	442,534	147,007	193,422
Current Employment Rate for Persons with Severe Disabilities	10.3%	21.3%	18.4%
Persons who Meet Income and Asset Requirements	294,872	125,982	164,963
Projected Population Who Might Work	40,128	35,312	41,291
Projected Enrollment (Present Methodology)	13,468	12,308	14,427
Projected % on Medicaid	60%	53%	40%
Actual Enrollment		4,000	900
Actual % on Medicaid		70%	60%
Enrollment Projected Using that State's Methodology		5,347	4,000 (?)
Enrollment began		July 1999	March 2000

## Testimony for the Ticket to Work Study Committee

### **The Effects of the Earned Income Disregard, Asset Level and Premium Structure on the Number of Ohioans Who Would Enroll in a Medicaid Buy-In Program**

Steven R. Howe  
University of Cincinnati  
March 15, 2001

#### **Model Correction**

In further exploring the model that I presented yesterday in my testimony, I discovered one group of people for whom I applied a take-up rate incorrectly. In correcting that mistake, my projected enrollment in the program was reduced. I took that opportunity to implement the following minor modifications to my model that I decided would be appropriate after talking with staff members from the Ohio Department of Jobs and Family Services:

- Take-up rates for persons with health insurance, but without Medicaid, were increased from 20% to 25%.
- Take-up rates for persons without health insurance were increased from 60% to 70%.
- The effect of premiums on persons without any form of health insurance was decreased since persons with disabilities might feel more compelled to buy insurance regardless of cost than persons without disabilities.

The net effect of all of these relatively minor changes was to change my projected enrollment in Table 4 from 13, 468 persons to 12,730 persons. Tables 1, 2 and 3 are unaffected.

#### **Adult Children Living with Parents**

In response to Senator Fingerhut's point about adult children, I determined that roughly 45% of individuals projected to enroll in a Medicaid buy-in program live alone, and that roughly 14% are adult children living with their parents. (The remaining people live with partners or children.) I say "roughly" because I investigated this finding with respect to 36 different combinations of policy options, and the results never varied by more than a few percentage points under any set of options.

I was not able to modify my model to handle family income for these families in a fashion that would have kept the financial resources of the adult child separated from the resources of his or her parents. However, I do not disagree that doing so would be a way

to avoid penalizing parents who care for their adult children and I could examine such as policy in the future, when I have the time to make the necessary changes in my model.

### **Enrollment As Affected by Policy Options**

In preparation for the meeting today, I ran my model under 36 different sets of policy options represented by all possible combinations of the following parameters:

- Premiums either begin with the first dollar of income (0% FPL) or with the first dollar of income above 150% of the Federal poverty level (150% FPL).
- Premiums are 2.5%, 5.0% or 7.5% of the dollar amount defined above.
- Assets are limited to \$2,000 or \$20,000 after exclusion of home, care, retirement accounts and medical saving accounts.
- 0%, 50% or 100% of the earned income of a person with a disability is disregarded.

The results are shown in the attached supplemental table. The box that is highlighted in the table corresponds to the policy options inherent in the results I presented yesterday.

Supplemental Table: Effects of Varying Earned Income Disregard, Asset Level and Premium Structure on Enrollment Rates for a Medicaid Buy-In Program in the State of Ohio

Asset Limit of \$2,000						Asset Limit of \$20,000					
Premium Begins	Premium Amount	Earned Income Disregard	Enrollment	State Cost (Millions)	% With a Premium	Premium Begins	Premium Amount	Earned Income Disregard	Enrollment	State Cost (Millions)	% With a Premium
0% FPL	2.5%	100%	11,172	\$19.3	100	0% FPL	2.5%	100%	13,260	\$22.7	100
		50%	9,107	\$15.9	100			50%	10,526	\$18.5	100
		0%	6,811	\$12.6	100			0%	7,767	\$14.4	100
	5.0%	100%	9,257	\$11.9	100		5.0%	100%	10,931	\$13.8	100
		50%	7,455	\$10.9	100			50%	8,604	\$12.5	100
		0%	5,511	\$9.1	100			0%	6,283	\$10.4	100
	7.5%	100%	8,799	\$12.9	100		7.5%	100%	10,329	\$8.0	100
		50%	7,045	\$8.0	100			50%	8,110	\$9.2	100
		0%	5,198	\$7.4	100			0%	5,917	\$8.4	100
150% FPL	2.5%	100%	13,143	\$26.0	43	150% FPL	2.5%	100%	15,583	\$30.7	44
		50%	10,955	\$21.7	32			50%	12,644	\$25.2	33
		0%	8,362	\$17.1	23			0%	9,520	\$19.6	24
	5.0%	100%	12,730	\$22.9	41		5.0%	100%	15,032	\$27.8	42
		50%	10,704	\$20.4	31			50%	12,339	\$23.8	32
		0%	8,267	\$16.7	22			0%	9,406	\$19.2	23
	7.5%	100%	12,313	\$20.4	29		7.5%	100%	14,498	\$24.0	40
		50%	10,460	\$19.4	29			50%	12,040	\$22.6	30
		0%	8,174	\$16.4	21			0%	9,294	\$18.8	22

Testimony for the Ticket to Work Study Committee

**The Effects of the Earned Income Disregard, Asset Level and  
Premium Structure on the Number of Ohioans Who  
Would Enroll in a Medicaid Buy-In Program**

Steven R. Howe  
University of Cincinnati  
March 21, 2001

**Model Enhancements**

I have made a number of enhancements to the model, most merely for the sake of improving computational efficiency. However, in improving the program code related to spend down computations I was able to substantially lower expected loss of spend down, although it is still very likely over-estimated.

As an example of the relatively minor impact of all of the changes, last week I testified that if 100% of earned income were to be disregarded, if assets were limited to \$2,000, if premiums began at 150% of Federal Poverty Level, and if premiums were 5% of the excess above 150% FPL, then projected enrollment in the program would be 12,730. Under identical circumstances, the new model projects enrollment to be 12,662.

A complete list of model specifications is included in the appendix to this testimony.

**Modeling Enrollment**

The attached tables show enrollment under a variety of policy options laid out in the appendix.

Not included in my packet of materials today are the additional 9 pages of tabular results under the assumption that earned income for people working now would increase by 25% after the implementation of a buy-in program. Those enrollment figures never differed from the ones shown by more than a few hundred people.

Inflation Factor of 1.0

Disregard 100% of Person's Earnings

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600
\$2,000	2.50%	0% FPL	11,102	\$4,808,134	\$5,455,951	\$17,438,528	\$24,184,694
		50% FPL	12,421	\$4,808,134	\$4,349,664	\$21,066,182	\$28,752,811
		100% FPL	12,880	\$4,808,134	\$3,374,991	\$22,942,654	\$30,965,652
		150% FPL	13,074	\$4,808,134	\$2,617,364	\$24,086,912	\$32,254,122
		200% FPL	13,254	\$4,808,134	\$2,068,946	\$25,010,988	\$33,318,318
		250% FPL	13,312	\$4,808,134	\$1,628,543	\$25,576,206	\$33,930,092
	5.00%	0% FPL	9,188	\$4,808,134	\$9,059,936	\$10,053,826	\$15,389,792
		50% FPL	11,199	\$4,808,134	\$7,432,229	\$15,494,247	\$22,252,348
		100% FPL	12,144	\$4,808,134	\$5,940,203	\$18,852,541	\$26,306,756
		150% FPL	12,662	\$4,808,134	\$4,781,204	\$21,082,071	\$28,935,591
		200% FPL	12,944	\$4,808,134	\$3,760,353	\$22,674,807	\$30,741,638
		250% FPL	13,137	\$4,808,134	\$3,068,700	\$23,769,367	\$31,986,481
	7.50%	0% FPL	8,710	\$4,808,134	\$12,948,436	\$5,220,629	\$10,179,091
		50% FPL	10,513	\$4,808,134	\$10,177,666	\$11,392,280	\$17,630,922
		100% FPL	11,634	\$4,808,134	\$8,130,566	\$15,616,401	\$22,674,797
		150% FPL	12,246	\$4,808,134	\$6,496,164	\$18,500,379	\$26,030,610
		200% FPL	12,696	\$4,808,134	\$5,222,943	\$20,697,895	\$28,572,886
		250% FPL	12,930	\$4,808,134	\$4,242,088	\$22,159,379	\$30,213,644
\$10,000	2.50%	0% FPL	12,564	\$4,808,134	\$6,343,835	\$19,771,798	\$27,719,447
		50% FPL	14,027	\$4,808,134	\$5,083,518	\$23,869,964	\$32,876,124
		100% FPL	14,543	\$4,808,134	\$3,953,513	\$26,026,705	\$35,415,835
		150% FPL	14,774	\$4,808,134	\$3,064,119	\$27,383,773	\$36,947,344
		200% FPL	14,979	\$4,808,134	\$2,424,653	\$28,455,251	\$38,179,962
		250% FPL	15,052	\$4,808,134	\$1,923,638	\$29,113,402	\$38,896,724
	5.00%	0% FPL	10,361	\$4,808,134	\$10,375,141	\$11,321,683	\$17,621,126
		50% FPL	12,581	\$4,808,134	\$8,526,960	\$17,443,036	\$25,336,362
		100% FPL	13,658	\$4,808,134	\$6,860,215	\$21,268,564	\$29,967,111
		150% FPL	14,260	\$4,808,134	\$5,506,295	\$23,876,366	\$33,042,609
		200% FPL	14,593	\$4,808,134	\$4,337,297	\$25,727,939	\$35,148,781
		250% FPL	14,826	\$4,808,134	\$3,582,677	\$26,977,309	\$36,582,691
	7.50%	0% FPL	9,795	\$4,808,134	\$14,740,015	\$5,818,972	\$11,632,061
		50% FPL	11,779	\$4,808,134	\$11,599,533	\$12,760,215	\$20,016,149
		100% FPL	13,045	\$4,808,134	\$9,286,644	\$17,566,598	\$25,772,688
		150% FPL	13,760	\$4,808,134	\$7,402,253	\$20,929,652	\$29,703,965
		200% FPL	14,281	\$4,808,134	\$5,938,592	\$23,473,349	\$32,650,513
		250% FPL	14,557	\$4,808,134	\$4,850,968	\$25,133,670	\$34,524,448
\$20,000	2.50%	0% FPL	13,351	\$4,808,134	\$6,757,353	\$21,091,469	\$29,685,593
		50% FPL	14,904	\$4,808,134	\$5,416,330	\$25,468,282	\$35,194,749
		100% FPL	15,453	\$4,808,134	\$4,208,798	\$27,776,327	\$37,913,282
		150% FPL	15,703	\$4,808,134	\$3,256,450	\$29,237,882	\$39,564,771
		200% FPL	15,923	\$4,808,134	\$2,574,475	\$30,384,497	\$40,884,695
		250% FPL	16,003	\$4,808,134	\$2,044,109	\$31,086,966	\$41,651,358
	5.00%	0% FPL	10,989	\$4,808,134	\$10,991,942	\$12,089,395	\$18,905,258
		50% FPL	13,343	\$4,808,134	\$9,030,889	\$18,617,325	\$27,136,623
		100% FPL	14,495	\$4,808,134	\$7,268,217	\$22,703,903	\$32,090,012
		150% FPL	15,143	\$4,808,134	\$5,823,341	\$25,502,919	\$35,394,120
		200% FPL	15,501	\$4,808,134	\$4,581,752	\$27,483,716	\$37,650,639
		250% FPL	15,755	\$4,808,134	\$3,793,628	\$28,811,515	\$39,179,736
	7.50%	0% FPL	10,378	\$4,808,134	\$15,585,244	\$6,259,021	\$12,540,686
		50% FPL	12,480	\$4,808,134	\$12,250,661	\$13,652,818	\$21,477,798
		100% FPL	13,830	\$4,808,134	\$9,800,970	\$18,782,302	\$27,630,535
		150% FPL	14,601	\$4,808,134	\$7,796,367	\$22,386,885	\$31,851,747
		200% FPL	15,160	\$4,808,134	\$6,244,385	\$25,104,050	\$35,003,522
		250% FPL	15,458	\$4,808,134	\$5,105,070	\$26,864,623	\$36,995,823

Inflation Factor of 1.0

Disregard 50% of the Person's Earnings

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600
\$2,000	2.50%	0% FPL	9,013	\$1,796,869	\$3,082,619	\$14,141,675	\$19,896,069
		50% FPL	10,234	\$1,796,869	\$2,128,914	\$17,377,307	\$23,982,855
		100% FPL	10,676	\$1,796,869	\$1,386,528	\$18,977,677	\$25,903,251
		150% FPL	10,862	\$1,796,869	\$873,877	\$19,856,312	\$26,918,396
		200% FPL	10,988	\$1,796,869	\$527,904	\$20,461,091	\$27,619,710
		250% FPL	11,032	\$1,796,869	\$305,730	\$20,776,886	\$27,970,425
	5.00%	0% FPL	7,360	\$1,796,869	\$4,925,524	\$9,110,289	\$13,675,388
		50% FPL	9,271	\$1,796,869	\$3,586,017	\$14,001,265	\$19,891,053
		100% FPL	10,168	\$1,796,869	\$2,414,707	\$16,921,764	\$23,463,995
		150% FPL	10,611	\$1,796,869	\$1,588,905	\$18,649,837	\$25,528,613
		200% FPL	10,871	\$1,796,869	\$978,625	\$19,784,461	\$26,858,816
		250% FPL	10,967	\$1,796,869	\$579,137	\$20,375,256	\$27,520,969
	7.50%	0% FPL	6,950	\$1,796,869	\$6,946,221	\$6,298,932	\$10,569,115
		50% FPL	8,696	\$1,796,869	\$4,729,546	\$11,753,875	\$17,231,925
		100% FPL	9,786	\$1,796,869	\$3,209,828	\$15,358,600	\$21,614,353
		150% FPL	10,368	\$1,796,869	\$2,136,893	\$17,611,608	\$24,307,526
		200% FPL	10,753	\$1,796,869	\$1,344,634	\$19,185,748	\$26,173,305
		250% FPL	10,903	\$1,796,869	\$818,661	\$20,008,237	\$27,106,393
\$10,000	2.50%	0% FPL	9,961	\$1,796,869	\$3,474,796	\$15,838,149	\$22,371,605
		50% FPL	11,281	\$1,796,869	\$2,406,010	\$19,407,606	\$26,873,807
		100% FPL	11,768	\$1,796,869	\$1,566,895	\$21,202,728	\$29,025,516
		150% FPL	11,985	\$1,796,869	\$979,763	\$22,223,403	\$30,207,903
		200% FPL	12,129	\$1,796,869	\$586,431	\$22,917,024	\$31,013,531
		250% FPL	12,179	\$1,796,869	\$339,889	\$23,270,815	\$31,407,326
	5.00%	0% FPL	8,131	\$1,796,869	\$5,519,656	\$10,212,526	\$15,410,366
		50% FPL	10,199	\$1,796,869	\$4,035,266	\$15,597,091	\$22,249,686
		100% FPL	11,189	\$1,796,869	\$2,718,651	\$18,866,614	\$26,247,640
		150% FPL	11,697	\$1,796,869	\$1,775,040	\$20,855,849	\$28,626,891
		200% FPL	11,994	\$1,796,869	\$1,081,463	\$22,154,134	\$30,150,730
		250% FPL	12,103	\$1,796,869	\$640,725	\$22,816,617	\$30,895,923
	7.50%	0% FPL	7,663	\$1,796,869	\$7,758,574	\$7,056,004	\$11,911,580
		50% FPL	9,543	\$1,796,869	\$5,286,920	\$13,060,975	\$19,234,470
		100% FPL	10,748	\$1,796,869	\$3,597,233	\$17,089,367	\$24,135,193
		150% FPL	11,416	\$1,796,869	\$2,375,601	\$19,680,754	\$27,237,496
		200% FPL	11,857	\$1,796,869	\$1,476,377	\$21,484,479	\$29,378,597
		250% FPL	12,029	\$1,796,869	\$901,387	\$22,405,346	\$30,428,476
\$20,000	2.50%	0% FPL	10,540	\$1,796,869	\$3,691,622	\$16,896,009	\$23,904,920
		50% FPL	11,932	\$1,796,869	\$2,556,710	\$20,689,882	\$28,690,580
		100% FPL	12,448	\$1,796,869	\$1,663,922	\$22,602,205	\$30,983,187
		150% FPL	12,681	\$1,796,869	\$1,037,381	\$23,698,470	\$32,254,657
		200% FPL	12,836	\$1,796,869	\$618,833	\$24,440,375	\$33,117,175
		250% FPL	12,890	\$1,796,869	\$358,499	\$24,816,102	\$33,535,943
	5.00%	0% FPL	8,596	\$1,796,869	\$5,847,849	\$10,908,963	\$16,488,988
		50% FPL	10,778	\$1,796,869	\$4,278,523	\$16,628,043	\$23,755,916
		100% FPL	11,828	\$1,796,869	\$2,881,542	\$20,110,406	\$28,016,121
		150% FPL	12,372	\$1,796,869	\$1,876,437	\$22,241,690	\$30,567,469
		200% FPL	12,690	\$1,796,869	\$1,138,637	\$23,629,430	\$32,197,635
		250% FPL	12,807	\$1,796,869	\$674,444	\$24,333,032	\$32,990,535
	7.50%	0% FPL	8,095	\$1,796,869	\$8,208,955	\$7,558,286	\$12,769,203
		50% FPL	10,075	\$1,796,869	\$5,590,495	\$13,930,026	\$20,540,907
		100% FPL	11,354	\$1,796,869	\$3,804,414	\$18,217,126	\$25,760,882
		150% FPL	12,070	\$1,796,869	\$2,505,172	\$20,991,703	\$29,085,755
		200% FPL	12,542	\$1,796,869	\$1,550,163	\$22,919,764	\$31,376,762
		250% FPL	12,727	\$1,796,869	\$946,860	\$23,897,027	\$32,493,512

Inflation Factor of 1.0

Disregard Up to \$10,000 of the Person's Earnings

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600	
\$2,000	2.50%	0% FPL	8,122	\$1,402,528	\$2,355,428	\$13,639,174	\$19,081,985	
		50% FPL	9,290	\$1,402,528	\$1,483,299	\$16,704,667	\$22,965,596	
		100% FPL	9,719	\$1,402,528	\$839,222	\$18,181,905	\$24,753,603	
		150% FPL	9,890	\$1,402,528	\$425,754	\$18,938,977	\$25,638,838	
		200% FPL	9,990	\$1,402,528	\$175,037	\$19,396,698	\$26,173,771	
		250% FPL	10,019	\$1,402,528	\$61,674	\$19,570,427	\$26,370,015	
		5.00%	0% FPL	6,598	\$1,402,528	\$3,700,711	\$9,347,430	\$13,691,217
	50% FPL	8,428	\$1,402,528	\$2,466,206	\$13,992,653	\$19,608,630		
	100% FPL	9,316	\$1,402,528	\$1,467,889	\$16,730,634	\$22,995,502		
	150% FPL	9,708	\$1,402,528	\$770,186	\$18,233,026	\$24,798,040		
	200% FPL	9,933	\$1,402,528	\$327,446	\$19,135,036	\$25,871,357		
	250% FPL	10,003	\$1,402,528	\$118,899	\$19,489,428	\$26,280,149		
	7.50%	0% FPL	6,201	\$1,402,528	\$5,151,323	\$7,129,091	\$11,186,517	
	50% FPL	7,915	\$1,402,528	\$3,197,146	\$12,275,965	\$17,524,260		
	100% FPL	8,990	\$1,402,528	\$1,903,834	\$15,634,705	\$21,653,399		
	150% FPL	9,546	\$1,402,528	\$1,043,993	\$17,632,386	\$24,075,493		
	200% FPL	9,884	\$1,402,528	\$456,301	\$18,912,478	\$25,613,848		
	250% FPL	9,980	\$1,402,528	\$167,769	\$19,389,391	\$26,161,027		
	\$10,000	2.50%	0% FPL	9,006	\$1,402,528	\$2,677,822	\$15,265,690	\$21,435,439
			50% FPL	10,270	\$1,402,528	\$1,695,945	\$18,649,068	\$25,714,572
			100% FPL	10,744	\$1,402,528	\$964,067	\$20,314,347	\$27,728,007
150% FPL			10,941	\$1,402,528	\$483,661	\$21,197,367	\$28,761,201	
200% FPL			11,057	\$1,402,528	\$193,585	\$21,728,087	\$29,381,680	
250% FPL			11,091	\$1,402,528	\$66,673	\$21,925,570	\$29,605,486	
5.00%			0% FPL	7,325	\$1,402,528	\$4,199,221	\$10,449,982	\$15,390,962
50% FPL		9,302	\$1,402,528	\$2,816,614	\$15,568,600	\$21,903,102		
100% FPL		10,286	\$1,402,528	\$1,687,471	\$18,648,560	\$25,710,713		
150% FPL		10,736	\$1,402,528	\$876,345	\$20,391,674	\$27,801,456		
200% FPL		10,994	\$1,402,528	\$362,371	\$21,436,082	\$29,043,715		
250% FPL		11,073	\$1,402,528	\$128,567	\$21,836,085	\$29,505,711		
7.50%		0% FPL	6,870	\$1,402,528	\$5,824,715	\$7,930,472	\$12,537,986	
50% FPL		8,718	\$1,402,528	\$3,632,835	\$13,607,479	\$19,514,937		
100% FPL		9,910	\$1,402,528	\$2,185,410	\$17,379,921	\$24,154,605		
150% FPL		10,550	\$1,402,528	\$1,187,933	\$19,700,118	\$26,968,173		
200% FPL		10,939	\$1,402,528	\$505,210	\$21,187,368	\$28,755,511		
250% FPL		11,047	\$1,402,528	\$181,419	\$21,727,338	\$29,376,114		
\$20,000		2.50%	0% FPL	9,547	\$1,402,528	\$2,856,634	\$16,277,326	\$22,891,109
			50% FPL	10,879	\$1,402,528	\$1,811,587	\$19,874,365	\$27,440,036
			100% FPL	11,382	\$1,402,528	\$1,030,903	\$21,651,638	\$29,589,034
	150% FPL		11,593	\$1,402,528	\$515,680	\$22,601,824	\$30,701,460	
	200% FPL		11,718	\$1,402,528	\$204,845	\$23,171,253	\$31,367,344	
	250% FPL		11,754	\$1,402,528	\$70,130	\$23,382,261	\$31,606,809	
	5.00%		0% FPL	7,764	\$1,402,528	\$4,474,651	\$11,140,627	\$16,441,950
	50% FPL	9,848	\$1,402,528	\$3,006,247	\$16,580,330	\$23,362,939		
	100% FPL	10,893	\$1,402,528	\$1,804,424	\$19,867,186	\$27,427,507		
	150% FPL	11,375	\$1,402,528	\$934,593	\$21,739,828	\$29,674,195		
	200% FPL	11,651	\$1,402,528	\$383,487	\$22,860,841	\$31,007,783		
	250% FPL	11,735	\$1,402,528	\$135,289	\$23,287,373	\$31,500,832		
	7.50%	0% FPL	7,277	\$1,402,528	\$6,199,066	\$8,451,460	\$13,392,932	
	50% FPL	9,223	\$1,402,528	\$3,870,392	\$14,482,124	\$20,804,431		
	100% FPL	10,489	\$1,402,528	\$2,334,897	\$18,505,692	\$25,756,044		
	150% FPL	11,176	\$1,402,528	\$1,266,564	\$20,998,831	\$28,780,632		
	200% FPL	11,592	\$1,402,528	\$534,604	\$22,596,266	\$30,700,888		
	250% FPL	11,708	\$1,402,528	\$190,826	\$23,172,390	\$31,363,676		

Disregard Up to \$10,000 of the Person's Earnings and Up to \$10,000 of Anyone Else's Earnings

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600
\$2,000	2.50%	0% FPL	8,791	\$1,402,528	\$2,614,369	\$14,838,476	\$20,825,207
		50% FPL	9,986	\$1,402,528	\$1,651,334	\$18,050,125	\$24,875,584
		100% FPL	10,452	\$1,402,528	\$925,782	\$19,691,833	\$26,859,016
		150% FPL	10,638	\$1,402,528	\$459,062	\$20,535,287	\$27,842,992
		200% FPL	10,745	\$1,402,528	\$183,554	\$21,031,869	\$28,422,034
		250% FPL	10,774	\$1,402,528	\$62,925	\$21,213,382	\$28,626,256
	5.00%	0% FPL	7,180	\$1,402,528	\$4,138,607	\$10,176,661	\$14,993,083
		50% FPL	9,076	\$1,402,528	\$2,769,930	\$15,100,221	\$21,242,607
		100% FPL	10,030	\$1,402,528	\$1,630,602	\$18,123,689	\$24,968,855
		150% FPL	10,442	\$1,402,528	\$832,177	\$19,769,290	\$26,930,450
		200% FPL	10,685	\$1,402,528	\$343,610	\$20,757,002	\$28,104,342
		250% FPL	10,758	\$1,402,528	\$121,383	\$21,131,049	\$28,535,017
	7.50%	0% FPL	6,721	\$1,402,528	\$5,723,933	\$7,688,587	\$12,168,286
		50% FPL	8,511	\$1,402,528	\$3,601,051	\$13,167,475	\$18,898,957
		100% FPL	9,659	\$1,402,528	\$2,123,573	\$16,871,489	\$23,433,463
		150% FPL	10,272	\$1,402,528	\$1,131,797	\$19,124,210	\$26,156,514
		200% FPL	10,633	\$1,402,528	\$479,165	\$20,520,919	\$27,830,762
		250% FPL	10,734	\$1,402,528	\$171,215	\$21,028,856	\$28,413,294
\$10,000	2.50%	0% FPL	9,928	\$1,402,528	\$3,034,135	\$16,921,439	\$23,841,683
		50% FPL	11,228	\$1,402,528	\$1,925,392	\$20,512,499	\$28,358,641
		100% FPL	11,752	\$1,402,528	\$1,083,080	\$22,398,099	\$30,633,385
		150% FPL	11,970	\$1,402,528	\$529,192	\$23,400,108	\$31,802,542
		200% FPL	12,095	\$1,402,528	\$205,042	\$23,983,503	\$32,482,635
		250% FPL	12,129	\$1,402,528	\$68,302	\$24,191,728	\$32,717,523
	5.00%	0% FPL	8,126	\$1,402,528	\$4,801,842	\$11,595,516	\$17,188,553
		50% FPL	10,197	\$1,402,528	\$3,230,656	\$17,108,170	\$24,171,366
		100% FPL	11,269	\$1,402,528	\$1,911,077	\$20,571,139	\$28,433,814
		150% FPL	11,746	\$1,402,528	\$961,136	\$22,513,071	\$30,745,756
		200% FPL	12,028	\$1,402,528	\$384,169	\$23,673,955	\$32,124,440
		250% FPL	12,111	\$1,402,528	\$131,791	\$24,100,396	\$32,615,806
	7.50%	0% FPL	7,588	\$1,402,528	\$6,612,671	\$8,708,345	\$13,899,909
		50% FPL	9,542	\$1,402,528	\$4,183,081	\$14,855,795	\$21,434,112
		100% FPL	10,833	\$1,402,528	\$2,487,911	\$19,093,092	\$26,619,617
		150% FPL	11,549	\$1,402,528	\$1,308,058	\$21,760,609	\$29,842,029
		200% FPL	11,970	\$1,402,528	\$536,079	\$23,407,129	\$31,814,751
		250% FPL	12,084	\$1,402,528	\$185,903	\$23,988,842	\$32,482,826
\$20,000	2.50%	0% FPL	10,584	\$1,402,528	\$3,257,453	\$18,142,573	\$25,601,594
		50% FPL	11,957	\$1,402,528	\$2,069,449	\$21,975,060	\$30,420,467
		100% FPL	12,517	\$1,402,528	\$1,164,776	\$23,999,357	\$32,862,382
		150% FPL	12,752	\$1,402,528	\$566,838	\$25,083,330	\$34,127,644
		200% FPL	12,885	\$1,402,528	\$217,725	\$25,711,867	\$34,860,406
		250% FPL	12,922	\$1,402,528	\$71,956	\$25,935,024	\$35,112,429
	5.00%	0% FPL	8,665	\$1,402,528	\$5,152,479	\$12,431,605	\$18,467,288
		50% FPL	10,856	\$1,402,528	\$3,471,383	\$18,317,107	\$25,921,025
		100% FPL	11,998	\$1,402,528	\$2,055,881	\$22,033,400	\$30,495,507
		150% FPL	12,512	\$1,402,528	\$1,029,876	\$24,130,205	\$32,991,717
		200% FPL	12,814	\$1,402,528	\$408,002	\$25,381,770	\$34,478,156
		250% FPL	12,903	\$1,402,528	\$138,902	\$25,838,032	\$35,004,230
	7.50%	0% FPL	8,084	\$1,402,528	\$7,085,352	\$9,329,395	\$14,928,918
		50% FPL	10,151	\$1,402,528	\$4,488,404	\$15,892,250	\$22,971,047
		100% FPL	11,529	\$1,402,528	\$2,675,137	\$20,437,382	\$28,535,159
		150% FPL	12,299	\$1,402,528	\$1,401,524	\$23,320,683	\$32,018,870
		200% FPL	12,752	\$1,402,528	\$569,328	\$25,096,852	\$34,147,139
		250% FPL	12,875	\$1,402,528	\$195,853	\$25,719,903	\$34,863,281

Inflation Factor of 1.0

Disregard Up to \$20,000 of the Person's Earnings and Up to \$20,000 of Anyone Else's Earnings

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600
\$2,000	2.50%	0% FPL	10,897	\$1,952,178	\$4,075,675	\$17,329,055	\$24,584,812
		50% FPL	12,234	\$1,952,178	\$2,923,693	\$21,014,939	\$29,215,836
		100% FPL	12,735	\$1,952,178	\$1,966,132	\$22,955,800	\$31,523,466
		150% FPL	12,948	\$1,952,178	\$1,290,564	\$24,055,143	\$32,780,876
		200% FPL	13,138	\$1,952,178	\$852,691	\$24,892,410	\$33,767,115
		250% FPL	13,191	\$1,952,178	\$541,449	\$25,317,614	\$34,234,827
	5.00%	0% FPL	8,964	\$1,952,178	\$6,531,431	\$11,079,192	\$16,919,756
		50% FPL	11,065	\$1,952,178	\$4,912,142	\$16,659,325	\$23,977,276
		100% FPL	12,069	\$1,952,178	\$3,378,196	\$20,173,647	\$28,230,273
		150% FPL	12,608	\$1,952,178	\$2,335,379	\$22,326,443	\$30,797,088
		200% FPL	12,912	\$1,952,178	\$1,515,362	\$23,764,170	\$32,465,219
		250% FPL	13,068	\$1,952,178	\$1,004,131	\$24,599,407	\$33,421,310
	7.50%	0% FPL	8,422	\$1,952,178	\$9,138,819	\$7,395,040	\$12,833,974
		50% FPL	10,336	\$1,952,178	\$6,447,846	\$13,685,496	\$20,467,029
		100% FPL	11,564	\$1,952,178	\$4,473,592	\$18,042,909	\$25,713,354
		150% FPL	12,239	\$1,952,178	\$3,033,438	\$20,862,935	\$29,048,069
		200% FPL	12,724	\$1,952,178	\$2,051,626	\$22,842,938	\$31,400,395
		250% FPL	12,949	\$1,952,178	\$1,386,295	\$23,970,135	\$32,699,868
\$10,000	2.50%	0% FPL	12,791	\$1,952,178	\$4,890,874	\$20,686,083	\$29,498,072
		50% FPL	14,287	\$1,952,178	\$3,500,675	\$24,960,021	\$34,847,638
		100% FPL	14,868	\$1,952,178	\$2,337,252	\$27,283,632	\$37,603,996
		150% FPL	15,129	\$1,952,178	\$1,513,139	\$28,637,905	\$39,156,018
		200% FPL	15,355	\$1,952,178	\$982,444	\$29,647,095	\$40,343,686
		250% FPL	15,419	\$1,952,178	\$617,616	\$30,149,260	\$40,897,076
	5.00%	0% FPL	10,554	\$1,952,178	\$7,834,528	\$13,277,588	\$20,424,202
		50% FPL	12,914	\$1,952,178	\$5,881,700	\$19,762,110	\$28,599,034
		100% FPL	14,078	\$1,952,178	\$4,015,837	\$23,960,577	\$33,667,558
		150% FPL	14,724	\$1,952,178	\$2,733,951	\$26,587,855	\$36,796,664
		200% FPL	15,090	\$1,952,178	\$1,742,719	\$28,332,842	\$38,822,800
		250% FPL	15,274	\$1,952,178	\$1,142,494	\$29,320,228	\$39,954,595
	7.50%	0% FPL	9,881	\$1,952,178	\$10,895,742	\$8,852,550	\$15,490,460
		50% FPL	12,035	\$1,952,178	\$7,688,390	\$16,187,953	\$24,365,616
		100% FPL	13,469	\$1,952,178	\$5,309,854	\$21,402,915	\$30,638,558
		150% FPL	14,286	\$1,952,178	\$3,548,793	\$24,857,184	\$34,724,391
		200% FPL	14,866	\$1,952,178	\$2,351,375	\$27,261,176	\$37,578,433
		250% FPL	15,136	\$1,952,178	\$1,574,132	\$28,598,816	\$39,125,099
\$20,000	2.50%	0% FPL	13,737	\$1,952,178	\$5,278,305	\$22,382,901	\$31,972,309
		50% FPL	15,327	\$1,952,178	\$3,776,083	\$26,975,069	\$37,717,021
		100% FPL	15,951	\$1,952,178	\$2,516,617	\$29,487,926	\$40,697,389
		150% FPL	16,235	\$1,952,178	\$1,623,332	\$30,962,071	\$42,388,194
		200% FPL	16,479	\$1,952,178	\$1,049,592	\$32,054,513	\$43,674,111
		250% FPL	16,548	\$1,952,178	\$658,408	\$32,595,103	\$44,270,429
	5.00%	0% FPL	11,337	\$1,952,178	\$8,445,944	\$14,390,678	\$22,180,528
		50% FPL	13,848	\$1,952,178	\$6,339,183	\$21,360,988	\$30,964,931
		100% FPL	15,097	\$1,952,178	\$4,320,765	\$25,899,407	\$36,443,304
		150% FPL	15,796	\$1,952,178	\$2,930,430	\$28,752,343	\$39,841,787
		200% FPL	16,192	\$1,952,178	\$1,859,354	\$30,643,674	\$42,039,071
		250% FPL	16,391	\$1,952,178	\$1,216,453	\$31,706,655	\$43,258,741
	7.50%	0% FPL	10,603	\$1,952,178	\$11,724,896	\$9,613,998	\$16,845,198
		50% FPL	12,895	\$1,952,178	\$8,271,912	\$17,499,112	\$26,383,488
		100% FPL	14,436	\$1,952,178	\$5,706,549	\$23,136,261	\$33,166,405
		150% FPL	15,323	\$1,952,178	\$3,799,165	\$26,889,710	\$37,608,432
		200% FPL	15,950	\$1,952,178	\$2,504,539	\$29,494,628	\$40,702,086
		250% FPL	16,242	\$1,952,178	\$1,674,074	\$30,935,434	\$42,370,547

Inflation Factor of 1.0

Disregard Up to \$30,000 of the Person's Earnings and Up to \$30,000 of Anyone Else's Earnings

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600
\$2,000	2.50%	0% FPL	11.855	\$3,120,497	\$5,182,856	\$18,025,086	\$25,517,657
		50% FPL	13,181	\$3,120,497	\$3,924,636	\$21,810,722	\$30,246,013
		100% FPL	13,694	\$3,120,497	\$2,861,171	\$23,886,895	\$32,699,924
		150% FPL	13,906	\$3,120,497	\$2,062,841	\$25,107,952	\$34,078,658
		200% FPL	14,105	\$3,120,497	\$1,512,625	\$26,075,846	\$35,202,344
		250% FPL	14,163	\$3,120,497	\$1,087,364	\$26,624,502	\$35,797,026
	5.00%	0% FPL	9,879	\$3,120,497	\$8,612,042	\$10,702,649	\$16,743,046
		50% FPL	11,975	\$3,120,497	\$6,822,375	\$16,462,135	\$23,983,266
		100% FPL	12,972	\$3,120,497	\$5,068,784	\$20,189,682	\$28,447,094
		150% FPL	13,535	\$3,120,497	\$3,832,112	\$22,587,353	\$31,277,815
		200% FPL	13,840	\$3,120,497	\$2,788,624	\$24,251,508	\$33,173,476
		250% FPL	14,024	\$3,120,497	\$2,078,053	\$25,347,172	\$34,412,779
	7.50%	0% FPL	9,306	\$3,120,497	\$12,171,509	\$5,998,852	\$11,612,416
		50% FPL	11,198	\$3,120,497	\$9,172,713	\$12,573,325	\$19,520,609
		100% FPL	12,435	\$3,120,497	\$6,928,030	\$17,225,342	\$25,070,556
		150% FPL	13,127	\$3,120,497	\$5,191,539	\$20,380,836	\$28,755,334
		200% FPL	13,621	\$3,120,497	\$3,904,607	\$22,684,814	\$31,438,669
		250% FPL	13,876	\$3,120,497	\$2,956,467	\$24,158,666	\$33,108,611
\$10,000	2.50%	0% FPL	14,139	\$3,120,497	\$6,268,232	\$21,971,352	\$31,340,714
		50% FPL	15,647	\$3,120,497	\$4,722,976	\$26,444,743	\$36,906,293
		100% FPL	16,253	\$3,120,497	\$3,404,088	\$28,979,574	\$39,894,668
		150% FPL	16,516	\$3,120,497	\$2,408,062	\$30,511,814	\$41,626,914
		200% FPL	16,761	\$3,120,497	\$1,732,392	\$31,706,015	\$43,014,525
		250% FPL	16,834	\$3,120,497	\$1,224,974	\$32,371,780	\$43,739,354
	5.00%	0% FPL	11,806	\$3,120,497	\$10,360,226	\$13,197,441	\$20,820,459
		50% FPL	14,195	\$3,120,497	\$8,171,264	\$20,002,529	\$29,347,351
		100% FPL	15,371	\$3,120,497	\$5,999,616	\$24,542,938	\$34,771,303
		150% FPL	16,061	\$3,120,497	\$4,452,643	\$27,530,644	\$38,296,399
		200% FPL	16,435	\$3,120,497	\$3,174,385	\$29,582,562	\$40,636,891
		250% FPL	16,663	\$3,120,497	\$2,329,576	\$30,907,810	\$42,141,340
	7.50%	0% FPL	11,069	\$3,120,497	\$14,519,531	\$7,532,239	\$14,593,560
		50% FPL	13,233	\$3,120,497	\$10,893,702	\$15,332,583	\$23,950,989
		100% FPL	14,701	\$3,120,497	\$8,151,185	\$20,994,214	\$30,701,443
		150% FPL	15,559	\$3,120,497	\$5,990,631	\$24,938,511	\$35,311,071
		200% FPL	16,166	\$3,120,497	\$4,416,973	\$27,778,849	\$38,623,879
		250% FPL	16,484	\$3,120,497	\$3,298,957	\$29,561,024	\$40,653,783
\$20,000	2.50%	0% FPL	15,199	\$3,120,497	\$6,740,851	\$23,832,206	\$34,071,948
		50% FPL	16,805	\$3,120,497	\$5,069,655	\$28,648,935	\$40,061,953
		100% FPL	17,457	\$3,120,497	\$3,640,514	\$31,394,529	\$43,298,582
		150% FPL	17,744	\$3,120,497	\$2,560,356	\$33,063,191	\$45,186,754
		200% FPL	18,009	\$3,120,497	\$1,831,436	\$34,357,472	\$46,691,913
		250% FPL	18,090	\$3,120,497	\$1,288,172	\$35,074,582	\$47,473,868
	5.00%	0% FPL	12,687	\$3,120,497	\$11,111,207	\$14,386,979	\$22,733,806
		50% FPL	15,235	\$3,120,497	\$8,750,249	\$21,713,097	\$31,911,917
		100% FPL	16,500	\$3,120,497	\$6,400,698	\$26,627,976	\$37,783,657
		150% FPL	17,249	\$3,120,497	\$4,724,868	\$29,875,146	\$41,616,934
		200% FPL	17,655	\$3,120,497	\$3,346,682	\$32,097,531	\$44,154,203
		250% FPL	17,903	\$3,120,497	\$2,444,847	\$33,524,256	\$45,776,711
	7.50%	0% FPL	11,879	\$3,120,497	\$15,534,204	\$8,301,734	\$16,028,546
		50% FPL	14,188	\$3,120,497	\$11,629,951	\$16,699,369	\$26,102,203
		100% FPL	15,770	\$3,120,497	\$8,674,390	\$22,823,812	\$33,408,631
		150% FPL	16,703	\$3,120,497	\$6,337,263	\$27,111,681	\$38,424,122
		200% FPL	17,362	\$3,120,497	\$4,644,299	\$30,186,324	\$42,014,128
		250% FPL	17,709	\$3,120,497	\$3,454,856	\$32,103,406	\$44,202,618

Inflation Factor of 1.0

Disregard Up to \$10,000 of the Person's Earnings and Up to \$10,000 of Anyone Else's Earnings if Parent in Home

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600	
\$2,000	2.50%	0% FPL	8,119	\$1,402,528	\$2,358,445	\$13,612,895	\$19,047,029	
		50% FPL	9,283	\$1,402,528	\$1,484,097	\$16,671,277	\$22,920,050	
		100% FPL	9,711	\$1,402,528	\$836,680	\$18,149,121	\$24,707,641	
		150% FPL	9,881	\$1,402,528	\$423,987	\$18,903,544	\$25,589,529	
		200% FPL	9,981	\$1,402,528	\$174,342	\$19,359,685	\$26,122,693	
		250% FPL	10,010	\$1,402,528	\$61,437	\$19,532,409	\$26,317,728	
	5.00%	0% FPL	6,603	\$1,402,528	\$3,710,915	\$9,332,062	\$13,673,922	
		50% FPL	8,421	\$1,402,528	\$2,469,329	\$13,957,191	\$19,561,105	
		100% FPL	9,309	\$1,402,528	\$1,463,628	\$16,702,872	\$22,955,795	
		150% FPL	9,700	\$1,402,528	\$766,997	\$18,200,752	\$24,752,539	
		200% FPL	9,925	\$1,402,528	\$326,131	\$19,099,112	\$25,821,543	
		250% FPL	9,994	\$1,402,528	\$118,445	\$19,451,872	\$26,228,416	
	7.50%	0% FPL	6,203	\$1,402,528	\$5,164,261	\$7,106,547	\$11,160,390	
		50% FPL	7,910	\$1,402,528	\$3,203,389	\$12,241,536	\$17,479,318	
		100% FPL	8,984	\$1,402,528	\$1,898,641	\$15,609,676	\$21,617,098	
		150% FPL	9,539	\$1,402,528	\$1,039,752	\$17,602,580	\$24,032,987	
		200% FPL	9,876	\$1,402,528	\$454,477	\$18,877,555	\$25,565,218	
		250% FPL	9,970	\$1,402,528	\$167,125	\$19,352,266	\$26,109,815	
	\$10,000	2.50%	0% FPL	9,003	\$1,402,528	\$2,681,547	\$15,237,968	\$21,398,767
			50% FPL	10,262	\$1,402,528	\$1,696,955	\$18,613,747	\$25,666,453
			100% FPL	10,735	\$1,402,528	\$960,807	\$20,280,294	\$27,680,036
150% FPL			10,931	\$1,402,528	\$481,309	\$21,159,904	\$28,708,887	
200% FPL			11,047	\$1,402,528	\$192,691	\$21,688,524	\$29,327,027	
250% FPL			11,080	\$1,402,528	\$66,372	\$21,884,703	\$29,549,265	
5.00%		0% FPL	7,331	\$1,402,528	\$4,211,957	\$10,434,825	\$15,374,901	
		50% FPL	9,295	\$1,402,528	\$2,820,708	\$15,530,628	\$21,852,494	
		100% FPL	10,279	\$1,402,528	\$1,682,048	\$18,620,937	\$25,670,764	
		150% FPL	10,727	\$1,402,528	\$872,099	\$20,358,391	\$27,754,175	
		200% FPL	10,984	\$1,402,528	\$360,679	\$21,397,909	\$28,990,673	
		250% FPL	11,063	\$1,402,528	\$127,991	\$21,795,805	\$29,450,191	
7.50%		0% FPL	6,873	\$1,402,528	\$5,840,842	\$7,906,268	\$12,510,768	
		50% FPL	8,712	\$1,402,528	\$3,640,993	\$13,570,498	\$19,467,204	
		100% FPL	9,904	\$1,402,528	\$2,178,809	\$17,355,551	\$24,118,682	
		150% FPL	10,542	\$1,402,528	\$1,182,266	\$19,670,103	\$26,924,848	
		200% FPL	10,930	\$1,402,528	\$502,864	\$21,150,493	\$28,704,006	
		250% FPL	11,037	\$1,402,528	\$180,601	\$21,687,598	\$29,321,246	
\$20,000		2.50%	0% FPL	9,543	\$1,402,528	\$2,860,523	\$16,247,958	\$22,852,238
			50% FPL	10,870	\$1,402,528	\$1,812,604	\$19,836,814	\$27,388,857
			100% FPL	11,372	\$1,402,528	\$1,027,240	\$21,615,527	\$29,538,087
	150% FPL		11,582	\$1,402,528	\$513,038	\$22,561,881	\$30,645,633	
	200% FPL		11,706	\$1,402,528	\$203,847	\$23,128,954	\$31,308,896	
	250% FPL		11,742	\$1,402,528	\$69,795	\$23,338,506	\$31,546,609	
	5.00%	0% FPL	7,770	\$1,402,528	\$4,488,343	\$11,125,094	\$16,425,731	
		50% FPL	9,839	\$1,402,528	\$3,010,626	\$16,539,929	\$23,309,101	
		100% FPL	10,885	\$1,402,528	\$1,798,331	\$19,838,260	\$27,385,519	
		150% FPL	11,365	\$1,402,528	\$929,822	\$21,704,571	\$29,624,008	
		200% FPL	11,639	\$1,402,528	\$381,598	\$22,820,090	\$30,951,127	
		250% FPL	11,724	\$1,402,528	\$134,649	\$23,244,269	\$31,441,411	
	7.50%	0% FPL	7,280	\$1,402,528	\$6,216,367	\$8,426,056	\$13,364,507	
		50% FPL	9,216	\$1,402,528	\$3,879,239	\$14,442,844	\$20,753,800	
		100% FPL	10,482	\$1,402,528	\$2,327,473	\$18,480,373	\$25,718,513	
		150% FPL	11,167	\$1,402,528	\$1,260,191	\$20,967,240	\$28,734,881	
		200% FPL	11,582	\$1,402,528	\$531,986	\$22,556,965	\$30,645,952	
		250% FPL	11,696	\$1,402,528	\$189,915	\$23,129,886	\$31,304,978	

Disregard Up to \$20,000 of the Person's Earnings and Up to \$20,000 of Anyone Else's Earnings if Parent in Home

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600
\$2,000	2.50%	0% FPL	9,711	\$1,952.178	\$3,566,329	\$15,242,451	\$21,529,925
		50% FPL	10,987	\$1,952.178	\$2,566,391	\$18,640,084	\$25,821,893
		100% FPL	11,434	\$1,952.178	\$1,740,222	\$20,331,733	\$27,836,364
		150% FPL	11,629	\$1,952.178	\$1,155,207	\$21,303,042	\$28,951,760
		200% FPL	11,803	\$1,952.178	\$772,597	\$22,050,457	\$29,835,246
		250% FPL	11,848	\$1,952.178	\$495,826	\$22,420,567	\$30,240,171
	5.00%	0% FPL	7,932	\$1,952.178	\$5,669,148	\$9,679,481	\$14,676,327
		50% FPL	9,906	\$1,952.178	\$4,281,186	\$14,751,866	\$21,122,993
		100% FPL	10,826	\$1,952.178	\$2,976,576	\$17,850,993	\$24,891,470
		150% FPL	11,323	\$1,952.178	\$2,088,129	\$19,758,531	\$27,179,127
		200% FPL	11,596	\$1,952.178	\$1,368,659	\$21,028,763	\$28,654,792
		250% FPL	11,737	\$1,952.178	\$919,184	\$21,768,863	\$29,503,295
	7.50%	0% FPL	7,487	\$1,952.178	\$8,006,374	\$6,479,098	\$11,153,987
		50% FPL	9,270	\$1,952.178	\$5,626,945	\$12,169,829	\$18,079,828
		100% FPL	10,385	\$1,952.178	\$3,934,342	\$15,998,204	\$22,704,840
		150% FPL	10,985	\$1,952.178	\$2,702,806	\$18,445,959	\$25,606,242
		200% FPL	11,426	\$1,952.178	\$1,851,590	\$20,200,219	\$27,697,335
		250% FPL	11,626	\$1,952.178	\$1,266,675	\$21,191,350	\$28,839,984
\$10,000	2.50%	0% FPL	10,843	\$1,952.178	\$4,048,748	\$17,253,047	\$24,470,410
		50% FPL	12,229	\$1,952.178	\$2,914,344	\$21,026,638	\$29,228,411
		100% FPL	12,726	\$1,952.178	\$1,971,206	\$22,945,191	\$31,510,792
		150% FPL	12,956	\$1,952.178	\$1,294,891	\$24,085,815	\$32,824,603
		200% FPL	13,155	\$1,952.178	\$854,874	\$24,943,917	\$33,838,650
		250% FPL	13,205	\$1,952.178	\$546,166	\$25,359,873	\$34,294,608
	5.00%	0% FPL	8,858	\$1,952.178	\$6,405,961	\$10,981,558	\$16,738,904
		50% FPL	11,007	\$1,952.178	\$4,847,817	\$16,608,849	\$23,883,978
		100% FPL	12,032	\$1,952.178	\$3,365,992	\$20,117,764	\$28,148,994
		150% FPL	12,605	\$1,952.178	\$2,334,517	\$22,334,503	\$30,807,833
		200% FPL	12,920	\$1,952.178	\$1,510,185	\$23,802,583	\$32,516,029
		250% FPL	13,079	\$1,952.178	\$1,009,676	\$24,634,055	\$33,470,950
	7.50%	0% FPL	8,342	\$1,952.178	\$9,012,208	\$7,356,395	\$12,733,689
		50% FPL	10,276	\$1,952.178	\$6,338,157	\$13,674,186	\$20,410,587
		100% FPL	11,521	\$1,952.178	\$4,434,323	\$18,000,582	\$25,640,593
		150% FPL	12,218	\$1,952.178	\$3,014,900	\$20,850,018	\$29,023,420
		200% FPL	12,724	\$1,952.178	\$2,033,922	\$22,877,932	\$31,441,838
		250% FPL	12,953	\$1,952.178	\$1,387,362	\$23,993,834	\$32,732,804
\$20,000	2.50%	0% FPL	11,513	\$1,952.178	\$4,314,441	\$18,461,208	\$26,228,316
		50% FPL	12,976	\$1,952.178	\$3,105,456	\$22,480,719	\$31,296,146
		100% FPL	13,504	\$1,952.178	\$2,098,517	\$24,531,275	\$33,735,969
		150% FPL	13,753	\$1,952.178	\$1,374,361	\$25,760,337	\$35,153,359
		200% FPL	13,965	\$1,952.178	\$904,359	\$26,679,675	\$36,240,299
		250% FPL	14,019	\$1,952.178	\$577,254	\$27,122,288	\$36,725,996
	5.00%	0% FPL	9,399	\$1,952.178	\$6,810,231	\$11,768,622	\$17,970,334
		50% FPL	11,669	\$1,952.178	\$5,156,591	\$17,759,440	\$25,578,909
		100% FPL	12,760	\$1,952.178	\$3,578,448	\$21,509,403	\$30,138,956
		150% FPL	13,375	\$1,952.178	\$2,474,666	\$23,891,645	\$32,998,061
		200% FPL	13,713	\$1,952.178	\$1,594,718	\$25,466,045	\$34,831,490
		250% FPL	13,884	\$1,952.178	\$1,065,637	\$26,350,959	\$35,849,128
	7.50%	0% FPL	8,845	\$1,952.178	\$9,567,564	\$7,907,483	\$13,697,478
		50% FPL	10,885	\$1,952.178	\$6,726,799	\$14,628,570	\$21,865,916
		100% FPL	12,211	\$1,952.178	\$4,705,942	\$19,248,315	\$27,455,040
		150% FPL	12,960	\$1,952.178	\$3,189,804	\$22,310,109	\$31,093,361
		200% FPL	13,503	\$1,952.178	\$2,143,215	\$24,484,311	\$33,688,160
		250% FPL	13,749	\$1,952.178	\$1,461,997	\$25,671,928	\$35,064,662

Disregard Up to \$30,000 of the Person's Earnings and Up to \$30,000 of Anyone Else's Earnings if Parent in Home

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	State Cost @ \$600
\$2,000	2.50%	0% FPL	10,420	\$2,948,475	\$4,516,022	\$15,732,228	\$22,185,005
		50% FPL	11,684	\$2,948,475	\$3,442,733	\$19,214,857	\$26,566,312
		100% FPL	12,141	\$2,948,475	\$2,537,429	\$21,013,715	\$28,698,464
		150% FPL	12,335	\$2,948,475	\$1,850,969	\$22,086,197	\$29,914,932
		200% FPL	12,514	\$2,948,475	\$1,371,911	\$22,940,213	\$30,908,805
		250% FPL	12,563	\$2,948,475	\$997,637	\$23,419,627	\$31,427,436
	5.00%	0% FPL	8,610	\$2,948,475	\$7,456,895	\$9,234,661	\$14,360,798
		50% FPL	10,575	\$2,948,475	\$5,952,504	\$14,457,023	\$20,969,956
		100% FPL	11,483	\$2,948,475	\$4,481,940	\$17,717,138	\$24,897,569
		150% FPL	11,999	\$2,948,475	\$3,436,167	\$19,823,497	\$27,399,525
		200% FPL	12,275	\$2,948,475	\$2,526,734	\$21,291,937	\$29,076,472
		250% FPL	12,438	\$2,948,475	\$1,906,708	\$22,251,498	\$30,162,679
	7.50%	0% FPL	8,142	\$2,948,475	\$10,610,805	\$5,163,007	\$9,946,829
		50% FPL	9,901	\$2,948,475	\$8,015,679	\$11,068,460	\$17,087,026
		100% FPL	11,017	\$2,948,475	\$6,121,427	\$15,123,864	\$21,948,535
		150% FPL	11,629	\$2,948,475	\$4,649,200	\$17,843,217	\$25,133,063
		200% FPL	12,074	\$2,948,475	\$3,535,264	\$19,872,563	\$27,503,854
		250% FPL	12,300	\$2,948,475	\$2,710,613	\$21,160,568	\$28,964,690
\$10,000	2.50%	0% FPL	11,641	\$2,948,475	\$5,075,674	\$17,862,351	\$25,318,408
		50% FPL	13,022	\$2,948,475	\$3,858,877	\$21,744,927	\$30,195,313
		100% FPL	13,532	\$2,948,475	\$2,826,489	\$23,788,185	\$32,615,624
		150% FPL	13,762	\$2,948,475	\$2,036,805	\$25,042,806	\$34,043,665
		200% FPL	13,967	\$2,948,475	\$1,492,786	\$26,019,401	\$35,181,609
		250% FPL	14,024	\$2,948,475	\$1,077,859	\$26,557,130	\$35,765,143
	5.00%	0% FPL	9,609	\$2,948,475	\$8,313,497	\$10,578,289	\$16,525,107
		50% FPL	11,761	\$2,948,475	\$6,630,121	\$16,390,629	\$23,877,542
		100% FPL	12,776	\$2,948,475	\$4,963,435	\$20,082,717	\$28,325,101
		150% FPL	13,372	\$2,948,475	\$3,763,291	\$22,521,070	\$31,225,302
		200% FPL	13,691	\$2,948,475	\$2,733,438	\$24,205,177	\$33,153,444
		250% FPL	13,878	\$2,948,475	\$2,052,018	\$25,279,348	\$34,374,111
	7.50%	0% FPL	9,062	\$2,948,475	\$11,775,535	\$6,024,620	\$11,564,263
		50% FPL	10,981	\$2,948,475	\$8,862,216	\$12,600,248	\$19,505,924
		100% FPL	12,232	\$2,948,475	\$6,739,187	\$17,181,837	\$25,004,551
		150% FPL	12,945	\$2,948,475	\$5,059,522	\$20,331,145	\$28,702,032
		200% FPL	13,458	\$2,948,475	\$3,801,452	\$22,654,204	\$31,422,329
		250% FPL	13,720	\$2,948,475	\$2,903,792	\$24,093,628	\$33,063,829
\$20,000	2.50%	0% FPL	12,346	\$2,948,475	\$5,374,984	\$19,115,315	\$27,150,366
		50% FPL	13,807	\$2,948,475	\$4,080,163	\$23,252,232	\$32,347,379
		100% FPL	14,349	\$2,948,475	\$2,980,004	\$25,434,683	\$34,933,522
		150% FPL	14,598	\$2,948,475	\$2,137,352	\$26,783,170	\$36,470,685
		200% FPL	14,818	\$2,948,475	\$1,559,853	\$27,826,329	\$37,687,533
		250% FPL	14,880	\$2,948,475	\$1,122,583	\$28,396,338	\$38,307,054
	5.00%	0% FPL	10,179	\$2,948,475	\$8,769,731	\$11,377,198	\$17,792,182
		50% FPL	12,456	\$2,948,475	\$6,987,936	\$17,564,959	\$25,623,359
		100% FPL	13,538	\$2,948,475	\$5,217,318	\$21,506,526	\$30,374,685
		150% FPL	14,179	\$2,948,475	\$3,940,266	\$24,120,142	\$33,486,836
		200% FPL	14,521	\$2,948,475	\$2,847,788	\$25,918,657	\$35,548,701
		250% FPL	14,722	\$2,948,475	\$2,133,058	\$27,056,953	\$36,844,986
	7.50%	0% FPL	9,590	\$2,948,475	\$12,399,476	\$6,563,109	\$12,536,336
		50% FPL	11,619	\$2,948,475	\$9,310,235	\$13,556,918	\$20,986,540
		100% FPL	12,951	\$2,948,475	\$7,063,807	\$18,442,405	\$26,856,389
		150% FPL	13,719	\$2,948,475	\$5,279,538	\$21,815,761	\$30,822,472
		200% FPL	14,270	\$2,948,475	\$3,949,069	\$24,294,305	\$33,729,245
		250% FPL	14,551	\$2,948,475	\$3,011,570	\$25,817,633	\$35,471,085

## Summary of Model Assumptions and Parameters

**Table 1**

Ages of eligible persons	18 to 65
Number of persons 18 - 65	6,887,990
Criteria for identifying a person as having a work disability (persons aged 62 or older who identify themselves as retired are excluded)	
Reports a health problem which prevents or limits work	
Reports retiring or leaving a job for health reasons	
Reports disability/illness main reason for not working previous year	
Reports being not in the labor force because of a disability	
Reports health/medical reasons for working part-time	
Number of recipients of federal disability income (assumes nobody under the age of 18 or above the age of 65 is on SSDI. Also assumes nobody under the age of 65 receives SS Retirement).	
Social Security Disability Income (SSDI) recipients	188,806
Supplemental Security Income recipients	163,039
Criteria for identifying a person as having a recent work history	
Reports working anytime during previous year	
Reports being employed or unemployed (i.e., in labor force)	
Reports wanting a regular job, either full-time or part-time	
Reports having spent any time looking for work previous year	
Number of persons in Ohio with work disabilities, as defined above	668,480
Proportion of persons with work disabilities who have severe disabilities (national data applied to Ohio)	0.662
Employment rate for persons on SSI	
Ohio	8.1
National	6.5
National employment rate for persons with severe disabilities	8.3
Ohio employment rate for persons with severe disabilities [ $10.3 = 8.3 * (8.1/6.5)$ ]	10.3
Number of persons in Ohio with severe work disabilities ( $442,534 = 668,480 * .662$ )	442,534
All persons receiving SSDI or SSI are presumed to be severely disabled	
Persons with work disability but not on SSDI/SSI are weighted according to their current employment status in reducing the population to 442,534	
Weight multiplier for persons currently employed	0.151052
Weight multiplier for persons currently unemployed	0.552002

**Table 2**

Persons who have recent work experience and had earned income in the previous year have their personal incomes inflated by the amount shown to the right. All of the increase is assigned to earnings. Their unearned income is kept constant. **Varies**  
1.00  
1.25

Persons without recent work experience, or without earned income in the previous year, are allocated an amount of earned income equal to that of the first person previous to them in the data file who had earned income the previous year. These allocations are made prior to the earnings inflation (described above). People who get earned income allocated are presumed to have constant unearned income.

All income adjustments are made prior to determining income eligibility.

Income eligibility is satisfied when adjusted family income is less than or equal to 250% of the Federal Poverty Level for the family as a whole. For Ohio, adjusted family income was calculated in each of the following ways: **Varies**  
Methods  
1 - 9

1. Disregard 100% of the person's earnings
2. Disregard 50% of the person's earnings
3. Disregard up to \$10,000 of the person's earnings
4. Disregard up to \$10,000 of the person's earnings and up to \$10,000 in earnings by anyone else in the household.
5. Disregard up to \$20,000 of the person's earnings and up to \$20,000 in earnings by anyone else in the household.
6. Disregard up to \$30,000 of the person's earnings and up to \$30,000 in earnings by anyone else in the household.
7. Disregard up to \$10,000 of the person's earnings and, if the person lives with parents, up to \$10,000 of other earnings.
8. Disregard up to \$20,000 of the person's earnings and, if the person lives with parents, up to \$20,000 of other earnings.
9. Disregard up to \$30,000 of the person's earnings and, if the person lives with parents, up to \$30,000 of other earnings.

Maximum amount of assets allowed, after excluding home, car, retirement savings and medical savings accounts. **Varies**  
\$2,000  
\$10,000  
\$20,000

It was assumed that everybody currently on Medicaid would meet the asset limitation criteria because they meet more stringent criteria now and in acquiring new assets would be able to stay beneath the limit.

For people not on Medicaid currently, assets were determined based on current, not inflated, family income because it was assumed that a family would meet the criteria at the time of joining the program and then manage their assets so as to stay under the limit.

Following are the percentages of people who were assumed eligible with the asset limitation criterion set at \$2,000/family, by income:

Under \$14,500	90%
\$14,500 to \$26,572	75%
\$26,573 to \$40,541	66%
\$40,542 to \$62,741	50%
\$62,742 or more	25%

Following are the percentages of people who were assumed eligible with the asset limitation criterion set at \$10,000/family, by income:

Under \$14,500	95%
\$14,500 to \$26,572	89%
\$26,573 to \$40,541	83%
\$40,542 to \$62,741	77%
\$62,742 or more	71%

Following are the percentages of people who were assumed eligible with the asset limitation criterion set at \$20,000/family, by income:

Under \$14,500	100%
\$14,500 to \$26,572	96%
\$26,573 to \$40,541	92%
\$40,542 to \$62,741	88%
\$62,742 or more	84%

**Table 3**

The following steps were taken to estimate employment rates.

1. Within each of the four groups of people with a recent work history defined by Medicaid status and disability income status, compute the proportion who are currently employed.
2. Multiply that rate by 1.33. (do not let it exceed 0.9).
3. For each of the four corresponding groups of people with no recent

**Table 4**

People who already receive Medicaid are examined to see if they have a spend down.

All spend down calculations are based on a current Medicaid recipient's current income, not projected income under the buy-in program.

To calculate the spend down, first determine if the person has one.

1. Subtract \$20 from all monthly unearned income for the person except SSI payments.
2. Subtract \$65 from all monthly earned income for the person and divide by 2 (or subtract \$85 if person has no unearned income).
3. Add together the remaining earned and unearned income and
4. Any amount in excess of zero means the person has a spend down.

One problem with this methodology is that the person may not have medical bills in excess of their spend down in a given month, and so the model probably overstates the spend down revenue that would be lost to the state under a buy-in program.

Persons eligible for Section 1619a or 1619b are presumed to be taking advantage of it, and so any calculated spend down for them is set to 0.

Premiums are calculated based on a defined percentage of the person's total income (not the family's income) in excess of a set percentage of the FPL for the family.

% of FPL at which premiums begin	<b>Varies</b> 0 to 250 by 50
----------------------------------	------------------------------------

% of income above cutoff due as a premium	<b>Varies</b> 2.5, 5.0,
---	----------------------------

Take up rates are calculated as follows:

For persons with no health insurance (except perhaps Medicaid), no spend down and no premium:

With Medicaid	0.10
Without Medicaid	0.70

For persons with some other health insurance (and perhaps also Medicaid), no spend down and no premium:

With Medicaid	0.05
Without Medicaid	0.25

Persons with a spend down (which means they are already on Medicaid).	1.00
---	------

For persons with a premium, the above takeup rates are adjusted

1%	0.9
2%	0.8
3%	0.7
4%	0.6
5%	0.5

**Table 5**

Loss of spend down is over-stated because it assumes every recipient has at least a certain minimum in medical bills every month.

Premiums assume perfect collection efficiency.

No administrative costs are assumed.

Monthly costs of benefits per recipient	<b>Varies</b> \$434 \$600
---	---------------------------------

Testimony for the Ticket to Work Study Committee

**Additional Information on The Impact of Policy Options**

Steven R. Howe  
University of Cincinnati  
March 22, 2001

The first of the three attached tables (page 2) is exactly like "Tables Page 8" I presented in my testimony yesterday with the following changes:

- Premiums are assumed not to begin until at least 150% of the Federal Poverty Level.
- A fourth premium amount has been included (10% of the difference between the person's total income and the starting point (e.g., 150% FPL).
- Only one state monthly cost is shown (\$437/month) in order to keep the table as simple as possible.

In 2001, the Federal Poverty Level for one person is \$8,590. The following illustrates a person's monthly premiums assuming that they have an income of either \$15,000 or \$25,000, assuming that they live alone, and assuming that premiums begin with the first dollar after 150% of FPL.

Premium Amount	Annual Income	
	\$15,000	\$25,000
2.5%	\$4.41	\$25.24
5.0%	\$8.81	\$50.48
7.5%	\$13.22	\$75.72
10.0%	\$17.63	\$100.96

The second and third of the attached tables are just like the first except:

- Only the person with a disability has any income disregarded.
- Adult children living with their parents are treated as one-person households for the purpose of income and asset eligibility.

The first of the two tables shows the effect of disregarding \$10,000 of income for determining eligibility and the second shows the effect of disregarding \$20,000.

Inflation Factor 1.0

Disregard Up to \$20,000 of the Person's Earnings and Up to \$20,000 of Anyone Else's Earnings if Parent in Home

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437
\$2,000	2.50%	150% FPL	11,629	\$1,952,178	\$1,155,207	\$21,303,042
		200% FPL	11,803	\$1,952,178	\$772,597	\$22,050,457
		250% FPL	11,848	\$1,952,178	\$495,826	\$22,420,567
	5.00%	150% FPL	11,323	\$1,952,178	\$2,088,129	\$19,758,531
		200% FPL	11,596	\$1,952,178	\$1,368,659	\$21,028,763
		250% FPL	11,737	\$1,952,178	\$919,184	\$21,768,863
	7.50%	150% FPL	10,985	\$1,952,178	\$2,702,806	\$18,445,959
		200% FPL	11,426	\$1,952,178	\$1,851,590	\$20,200,219
		250% FPL	11,626	\$1,952,178	\$1,266,675	\$21,191,350
	10.00%	150% FPL	10,779	\$1,952,178	\$3,394,844	\$17,348,442
		200% FPL	11,222	\$1,952,178	\$2,219,605	\$19,418,769
		250% FPL	11,500	\$1,952,178	\$1,495,442	\$20,709,182
\$10,000	2.50%	150% FPL	12,956	\$1,952,178	\$1,294,891	\$24,085,815
		200% FPL	13,155	\$1,952,178	\$854,874	\$24,943,917
		250% FPL	13,205	\$1,952,178	\$546,166	\$25,359,873
	5.00%	150% FPL	12,605	\$1,952,178	\$2,334,517	\$22,334,503
		200% FPL	12,920	\$1,952,178	\$1,510,185	\$23,802,583
		250% FPL	13,079	\$1,952,178	\$1,009,676	\$24,634,055
	7.50%	150% FPL	12,218	\$1,952,178	\$3,014,900	\$20,850,018
		200% FPL	12,724	\$1,952,178	\$2,033,922	\$22,877,932
		250% FPL	12,953	\$1,952,178	\$1,387,362	\$23,993,834
	10.00%	150% FPL	11,982	\$1,952,178	\$3,778,273	\$19,616,352
		200% FPL	12,493	\$1,952,178	\$2,429,802	\$22,007,901
		250% FPL	12,815	\$1,952,178	\$1,637,648	\$23,462,962
\$20,000	2.50%	150% FPL	13,753	\$1,952,178	\$1,374,361	\$25,760,337
		200% FPL	13,965	\$1,952,178	\$904,359	\$26,679,675
		250% FPL	14,019	\$1,952,178	\$577,254	\$27,122,288
	5.00%	150% FPL	13,375	\$1,952,178	\$2,474,666	\$23,891,645
		200% FPL	13,713	\$1,952,178	\$1,594,718	\$25,466,045
		250% FPL	13,884	\$1,952,178	\$1,065,637	\$26,350,959
	7.50%	150% FPL	12,960	\$1,952,178	\$3,189,804	\$22,310,109
		200% FPL	13,503	\$1,952,178	\$2,143,215	\$24,484,311
		250% FPL	13,749	\$1,952,178	\$1,461,997	\$25,671,928
	10.00%	150% FPL	12,708	\$1,952,178	\$3,993,919	\$20,999,575
		200% FPL	13,256	\$1,952,178	\$2,555,297	\$23,561,962
		250% FPL	13,602	\$1,952,178	\$1,723,684	\$25,110,419

Inflation Factor 1.0

Disregard Up to \$10,000 of the Person's Earnings (Treat Adult Children as If They Lived Alone)

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437	
\$2,000	2.50%	150% FPL	9,636	\$1,476,402	\$444,654	\$18,317,677	
		200% FPL	9,740	\$1,476,402	\$188,976	\$18,784,663	
		250% FPL	9,775	\$1,476,402	\$65,752	\$18,981,880	
	5.00%	150% FPL	9,453	\$1,476,402	\$805,058	\$17,595,862	
		200% FPL	9,678	\$1,476,402	\$354,189	\$18,502,282	
		250% FPL	9,758	\$1,476,402	\$126,868	\$18,896,133	
	7.50%	150% FPL	9,283	\$1,476,402	\$1,089,360	\$16,968,672	
		200% FPL	9,623	\$1,476,402	\$493,262	\$18,257,548	
		250% FPL	9,734	\$1,476,402	\$179,582	\$18,791,418	
	10.00%	150% FPL	9,087	\$1,476,402	\$1,299,255	\$16,364,830	
		200% FPL	9,522	\$1,476,402	\$602,644	\$17,948,607	
		250% FPL	9,714	\$1,476,402	\$229,475	\$18,709,124	
\$10,000	2.50%	150% FPL	10,591	\$1,476,402	\$505,322	\$20,362,276	
		200% FPL	10,711	\$1,476,402	\$209,158	\$20,903,606	
		250% FPL	10,752	\$1,476,402	\$71,333	\$21,127,451	
	5.00%	150% FPL	10,385	\$1,476,402	\$916,021	\$19,536,120	
		200% FPL	10,643	\$1,476,402	\$392,204	\$20,588,216	
		250% FPL	10,733	\$1,476,402	\$137,663	\$21,032,207	
	7.50%	150% FPL	10,189	\$1,476,402	\$1,239,535	\$18,814,301	
		200% FPL	10,581	\$1,476,402	\$546,386	\$20,314,738	
		250% FPL	10,706	\$1,476,402	\$194,856	\$20,917,852	
	10.00%	150% FPL	9,969	\$1,476,402	\$1,480,411	\$18,126,896	
		200% FPL	10,468	\$1,476,402	\$667,907	\$19,966,016	
		250% FPL	10,685	\$1,476,402	\$249,325	\$20,828,313	
	\$20,000	2.50%	150% FPL	11,199	\$1,476,402	\$538,789	\$21,666,821
			200% FPL	11,327	\$1,476,402	\$221,367	\$22,247,539
			250% FPL	11,370	\$1,476,402	\$75,103	\$22,486,642
5.00%		150% FPL	10,978	\$1,476,402	\$976,836	\$20,782,372	
		200% FPL	11,254	\$1,476,402	\$415,127	\$21,912,199	
		250% FPL	11,351	\$1,476,402	\$144,997	\$22,385,515	
7.50%		150% FPL	10,769	\$1,476,402	\$1,321,488	\$20,009,043	
		200% FPL	11,189	\$1,476,402	\$578,248	\$21,621,269	
		250% FPL	11,323	\$1,476,402	\$205,155	\$22,264,473	
10.00%		150% FPL	10,535	\$1,476,402	\$1,578,505	\$19,274,271	
		200% FPL	11,068	\$1,476,402	\$706,833	\$21,249,466	
		250% FPL	11,300	\$1,476,402	\$262,696	\$22,169,791	

Inflation Factor 1.0

Disregard Up to \$20,000 of the Person's Earnings (Treat Adult Children as If They Lived Alone)

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437
\$2,000	2.50%	150% FPL	11,425	\$2,046,792	\$1,193,706	\$20,794,735
		200% FPL	11,605	\$2,046,792	\$801,996	\$21,560,290
		250% FPL	11,657	\$2,046,792	\$512,169	\$21,961,969
	5.00%	150% FPL	11,113	\$2,046,792	\$2,159,295	\$19,208,510
		200% FPL	11,390	\$2,046,792	\$1,423,691	\$20,498,975
		250% FPL	11,543	\$2,046,792	\$950,172	\$21,288,114
	7.50%	150% FPL	10,761	\$2,046,792	\$2,795,137	\$17,847,832
		200% FPL	11,211	\$2,046,792	\$1,926,777	\$19,632,429
		250% FPL	11,429	\$2,046,792	\$1,311,198	\$20,691,142
	10.00%	150% FPL	10,532	\$2,046,792	\$3,506,920	\$16,682,351
		200% FPL	11,003	\$2,046,792	\$2,314,711	\$18,825,647
		250% FPL	11,296	\$2,046,792	\$1,550,711	\$20,183,413
\$10,000	2.50%	150% FPL	12,659	\$2,046,792	\$1,340,225	\$23,365,764
		200% FPL	12,864	\$2,046,792	\$889,330	\$24,246,276
		250% FPL	12,924	\$2,046,792	\$566,306	\$24,698,461
	5.00%	150% FPL	12,299	\$2,046,792	\$2,417,528	\$21,561,386
		200% FPL	12,619	\$2,046,792	\$1,573,762	\$23,057,001
		250% FPL	12,793	\$2,046,792	\$1,047,503	\$23,944,076
	7.50%	150% FPL	11,895	\$2,046,792	\$3,120,432	\$20,019,512
		200% FPL	12,414	\$2,046,792	\$2,120,003	\$22,088,674
		250% FPL	12,663	\$2,046,792	\$1,441,236	\$23,279,228
	10.00%	150% FPL	11,634	\$2,046,792	\$3,906,788	\$18,710,109
		200% FPL	12,177	\$2,046,792	\$2,537,039	\$21,188,469
		250% FPL	12,516	\$2,046,792	\$1,703,940	\$22,718,304
\$20,000	2.50%	150% FPL	13,413	\$2,046,792	\$1,422,937	\$24,943,451
		200% FPL	13,633	\$2,046,792	\$941,253	\$25,887,160
		250% FPL	13,697	\$2,046,792	\$599,083	\$26,368,553
	5.00%	150% FPL	13,026	\$2,046,792	\$2,563,346	\$23,016,727
		200% FPL	13,370	\$2,046,792	\$1,662,485	\$24,621,600
		250% FPL	13,556	\$2,046,792	\$1,106,517	\$25,565,856
	7.50%	150% FPL	12,592	\$2,046,792	\$3,301,773	\$21,373,311
		200% FPL	13,149	\$2,046,792	\$2,234,675	\$23,593,209
		250% FPL	13,416	\$2,046,792	\$1,520,067	\$24,859,908
	10.00%	150% FPL	12,314	\$2,046,792	\$4,130,267	\$19,982,314
		200% FPL	12,895	\$2,046,792	\$2,668,709	\$22,638,477
		250% FPL	13,260	\$2,046,792	\$1,794,917	\$24,266,052

Testimony for the Ticket to Work Study Committee

**Additional Information on The Impact of Policy Options**

Steven R. Howe  
University of Cincinnati  
March 22, 2001

**Revised March 23, 2001**

The first of the three attached tables (page 2) is exactly like "Tables Page 8" I presented in my testimony yesterday with the following changes:

- Premiums are assumed not to begin until at least 150% of the Federal Poverty Level.
- A fourth premium amount has been included (10% of the difference between the person's total income and the starting point (e.g., 150% FPL).
- Only one state monthly cost is shown (\$437/month) in order to keep the table as simple as possible.

In 2001, the Federal Poverty Level for one person is \$8,590. The following illustrates a person's monthly premiums assuming that they have an income of either \$15,000 or \$25,000, assuming that they live alone, and assuming that premiums begin with the first dollar after 150% of FPL.

Premium Amount	Annual Income	
	\$15,000	\$25,000
2.5%	\$4.41	\$25.24
5.0%	\$8.81	\$50.48
7.5%	\$13.22	\$75.72
10.0%	\$17.63	\$100.96

The second and third of the attached tables are just like the first except:

- Only the person with a disability has any income disregarded.
- Adult children living with their parents are treated as one-person households for the purpose of income and asset eligibility.

The first of the two tables shows the effect of disregarding \$10,000 of income for determining eligibility and the second shows the effect of disregarding \$20,000.

Inflation Factor 1.0

Disregard Up to \$20,000 of the Person's Earnings and Up to \$20,000 of Anyone Else's Earnings if Parent in Home

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437
\$2,000	2.50%	150% FPL	11,629	\$1,952,178	\$1,155,207	\$21,303,042
		200% FPL	11,803	\$1,952,178	\$772,597	\$22,050,457
		250% FPL	11,848	\$1,952,178	\$495,826	\$22,420,567
	5.00%	150% FPL	11,323	\$1,952,178	\$2,088,129	\$19,758,531
		200% FPL	11,596	\$1,952,178	\$1,368,659	\$21,028,763
		250% FPL	11,737	\$1,952,178	\$919,184	\$21,768,863
	7.50%	150% FPL	10,985	\$1,952,178	\$2,702,806	\$18,445,959
		200% FPL	11,426	\$1,952,178	\$1,851,590	\$20,200,219
		250% FPL	11,626	\$1,952,178	\$1,266,675	\$21,191,350
	10.00%	150% FPL	10,779	\$1,952,178	\$3,394,844	\$17,348,442
		200% FPL	11,222	\$1,952,178	\$2,219,605	\$19,418,769
		250% FPL	11,500	\$1,952,178	\$1,495,442	\$20,709,182
\$10,000	2.50%	150% FPL	12,956	\$1,952,178	\$1,294,891	\$24,085,815
		200% FPL	13,155	\$1,952,178	\$854,874	\$24,943,917
		250% FPL	13,205	\$1,952,178	\$546,166	\$25,359,873
	5.00%	150% FPL	12,605	\$1,952,178	\$2,334,517	\$22,334,503
		200% FPL	12,920	\$1,952,178	\$1,510,185	\$23,802,583
		250% FPL	13,079	\$1,952,178	\$1,009,676	\$24,634,055
	7.50%	150% FPL	12,218	\$1,952,178	\$3,014,900	\$20,850,018
		200% FPL	12,724	\$1,952,178	\$2,033,922	\$22,877,932
		250% FPL	12,953	\$1,952,178	\$1,387,362	\$23,993,834
	10.00%	150% FPL	11,982	\$1,952,178	\$3,778,273	\$19,616,352
		200% FPL	12,493	\$1,952,178	\$2,429,802	\$22,007,901
		250% FPL	12,815	\$1,952,178	\$1,637,648	\$23,462,962
\$20,000	2.50%	150% FPL	13,753	\$1,952,178	\$1,374,361	\$25,760,337
		200% FPL	13,965	\$1,952,178	\$904,359	\$26,679,675
		250% FPL	14,019	\$1,952,178	\$577,254	\$27,122,288
	5.00%	150% FPL	13,375	\$1,952,178	\$2,474,666	\$23,891,645
		200% FPL	13,713	\$1,952,178	\$1,594,718	\$25,466,045
		250% FPL	13,884	\$1,952,178	\$1,065,637	\$26,350,959
	7.50%	150% FPL	12,960	\$1,952,178	\$3,189,804	\$22,310,109
		200% FPL	13,503	\$1,952,178	\$2,143,215	\$24,484,311
		250% FPL	13,749	\$1,952,178	\$1,461,997	\$25,671,928
	10.00%	150% FPL	12,708	\$1,952,178	\$3,993,919	\$20,999,575
		200% FPL	13,256	\$1,952,178	\$2,555,297	\$23,561,962
		250% FPL	13,602	\$1,952,178	\$1,723,684	\$25,110,419

Inflation Factor 1.0

Disregard Up to \$10,000 of the Person's Earnings (Treat Adult Children as If They Lived Alone)

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437
\$2,000	2.50%	150% FPL	10,549	\$1,360,050	\$464,721	\$20,313,546
		200% FPL	10,660	\$1,360,050	\$200,344	\$20,804,223
		250% FPL	10,695	\$1,360,050	\$70,892	\$21,006,992
	5.00%	150% FPL	10,362	\$1,360,050	\$842,622	\$19,564,243
		200% FPL	10,595	\$1,360,050	\$375,294	\$20,505,123
		250% FPL	10,679	\$1,360,050	\$137,208	\$20,917,896
	7.50%	150% FPL	10,185	\$1,360,050	\$1,143,871	\$18,906,411
		200% FPL	10,537	\$1,360,050	\$523,791	\$20,245,966
		250% FPL	10,651	\$1,360,050	\$193,533	\$20,804,617
	10.00%	150% FPL	9,978	\$1,360,050	\$1,363,257	\$18,270,050
		200% FPL	10,431	\$1,360,050	\$642,086	\$19,917,202
		250% FPL	10,630	\$1,360,050	\$248,277	\$20,715,698
\$10,000	2.50%	150% FPL	11,584	\$1,360,050	\$526,617	\$22,531,723
		200% FPL	11,711	\$1,360,050	\$221,583	\$23,098,849
		250% FPL	11,752	\$1,360,050	\$76,952	\$23,328,623
	5.00%	150% FPL	11,372	\$1,360,050	\$955,982	\$21,676,911
		200% FPL	11,639	\$1,360,050	\$415,256	\$22,764,919
		250% FPL	11,734	\$1,360,050	\$148,977	\$23,229,732
	7.50%	150% FPL	11,170	\$1,360,050	\$1,297,782	\$20,922,467
		200% FPL	11,575	\$1,360,050	\$579,868	\$22,475,813
		250% FPL	11,704	\$1,360,050	\$210,101	\$23,105,601
	10.00%	150% FPL	10,938	\$1,360,050	\$1,548,632	\$20,199,816
		200% FPL	11,456	\$1,360,050	\$711,231	\$22,105,284
		250% FPL	11,681	\$1,360,050	\$269,867	\$23,009,039
\$20,000	2.50%	150% FPL	12,254	\$1,360,050	\$561,242	\$23,973,419
		200% FPL	12,390	\$1,360,050	\$234,540	\$24,581,497
		250% FPL	12,434	\$1,360,050	\$81,042	\$24,826,877
	5.00%	150% FPL	12,028	\$1,360,050	\$1,018,979	\$23,058,806
		200% FPL	12,313	\$1,360,050	\$439,559	\$24,226,378
		250% FPL	12,415	\$1,360,050	\$156,959	\$24,721,898
	7.50%	150% FPL	11,812	\$1,360,050	\$1,382,985	\$22,251,056
		200% FPL	12,245	\$1,360,050	\$613,772	\$23,918,903
		250% FPL	12,383	\$1,360,050	\$221,267	\$24,590,348
	10.00%	150% FPL	11,565	\$1,360,050	\$1,650,477	\$21,478,880
		200% FPL	12,119	\$1,360,050	\$752,811	\$23,523,939
		250% FPL	12,360	\$1,360,050	\$284,391	\$24,488,298

Inflation Factor 1.0

Disregard Up to \$20,000 of the Person's Earnings (Treat Adult Children as If They Lived Alone)

Asset Limit	Premium Amount	Premium Begins	Projected Enrollment	Spend Down Lost	Premiums Paid	State Cost @ \$437
\$2,000	2.50%	150% FPL	12,358	\$1,824,796	\$1,351,234	\$22,786,167
		200% FPL	12,547	\$1,824,796	\$938,114	\$23,589,328
		250% FPL	12,598	\$1,824,796	\$623,787	\$24,011,071
	5.00%	150% FPL	12,021	\$1,824,796	\$2,438,952	\$21,020,637
		200% FPL	12,302	\$1,824,796	\$1,663,888	\$22,362,781
		250% FPL	12,463	\$1,824,796	\$1,152,433	\$23,205,023
	7.50%	150% FPL	11,617	\$1,824,796	\$3,115,255	\$19,507,171
		200% FPL	12,099	\$1,824,796	\$2,245,020	\$21,364,424
		250% FPL	12,338	\$1,824,796	\$1,601,887	\$22,498,430
10.00%	150% FPL	11,360	\$1,824,796	\$3,870,770	\$18,235,453	
	200% FPL	11,862	\$1,824,796	\$2,676,655	\$20,450,860	
	250% FPL	12,181	\$1,824,796	\$1,893,743	\$21,884,053	
\$10,000	2.50%	150% FPL	13,679	\$1,824,796	\$1,509,339	\$25,536,876
		200% FPL	13,893	\$1,824,796	\$1,035,934	\$26,457,158
		250% FPL	13,952	\$1,824,796	\$686,287	\$26,930,892
	5.00%	150% FPL	13,292	\$1,824,796	\$2,717,752	\$23,541,375
		200% FPL	13,617	\$1,824,796	\$1,832,997	\$25,090,047
		250% FPL	13,798	\$1,824,796	\$1,265,014	\$26,034,222
	7.50%	150% FPL	12,833	\$1,824,796	\$3,464,971	\$21,835,817
		200% FPL	13,385	\$1,824,796	\$2,463,518	\$23,979,619
		250% FPL	13,657	\$1,824,796	\$1,754,166	\$25,251,364
	10.00%	150% FPL	12,542	\$1,824,796	\$4,297,676	\$20,412,295
		200% FPL	13,117	\$1,824,796	\$2,928,476	\$22,963,941
		250% FPL	13,485	\$1,824,796	\$2,074,163	\$24,576,183
\$20,000	2.50%	150% FPL	14,502	\$1,824,796	\$1,602,375	\$27,257,506
		200% FPL	14,732	\$1,824,796	\$1,096,765	\$28,243,301
		250% FPL	14,795	\$1,824,796	\$726,190	\$28,747,659
	5.00%	150% FPL	14,088	\$1,824,796	\$2,881,979	\$25,128,390
		200% FPL	14,436	\$1,824,796	\$1,937,759	\$26,789,122
		250% FPL	14,630	\$1,824,796	\$1,337,053	\$27,794,167
	7.50%	150% FPL	13,595	\$1,824,796	\$3,668,186	\$23,311,322
		200% FPL	14,187	\$1,824,796	\$2,599,571	\$25,609,947
		250% FPL	14,479	\$1,824,796	\$1,851,864	\$26,963,081
	10.00%	150% FPL	13,284	\$1,824,796	\$4,546,129	\$21,798,981
		200% FPL	13,900	\$1,824,796	\$3,085,041	\$24,532,439
		250% FPL	14,296	\$1,824,796	\$2,187,776	\$26,248,277

# **CHAPTER FIVE:**

## **COMMITTEE MEETING MINUTES AND TESTIMONY**

The following pages consist of the Committee's minutes and written testimony submitted by witnesses before the Committee.

**OHIO SENATE  
TICKET TO WORK COMMITTEE**

**Minutes of  
February 14, 2001  
Committee Meeting**

**The organizational meeting of the Ticket to Work committee was called to order by Senator Harris in Senate Meeting Room 45, at approximately 2:30 p.m. Due to the number in attendance the meeting was moved to the Senate Finance Hearing Room.**

**Senators Harris, Gardner and Fingerhut were present along with representatives of the Ohio Department of Job and Family Services, the Ohio Rehabilitation Services Commission, the Ohio Department of Mental Health, the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Department of Budget and Management and the Ohio Legislative Service Commission. Also represented were the Ohio Association of Rehab Facilities and the Governors' Council on People with Disabilities.**

**The objective of this study committee is to determine (1) the cost associated with establishing the program under the federal act, (2) sources of funds that may be available for such a program, (3) the number of people likely to enroll in, and (4) the barriers and impediments to establishing, an Ohio ticket to work program for people with disabilities. On March 31, 2001 the Committee must complete its work and submit its report to the President and Minority Leader of the Senate and the Speaker and Minority Leader of the House of Representatives, and upon submitting the report the Committee will cease to exist.**

**Senator Harris discussed the testimony of the next meeting and his expectations for the Committee Report. Those members not in attendance were Representative Ann Womer-Benjamin, Representative Jim Hoops and Representative Peter Lawson Jones.**

**There being no further business relative to organizational issues the committee adjourned. The first committee meeting will be held Wednesday, February 21, 2001 at 2:30 p.m. in the Senate Majority Caucus Room.**

**OHIO SENATE  
TICKET TO WORK COMMITTEE**

**Minutes of  
February 21, 2001  
Committee Meeting**

**The first meeting of the Ticket to Work committee was called to order by Chairman Harris at approximately 2:30 p.m. in the Senate Finance Hearing Room.**

**Senators Harris, Gardner and Fingerhut, and Representatives Womer-Benjamin, Jones, and Hoops were present along with Bill Hayes of the Ohio Department of Job and Family Services, Bill Casto of the Ohio Rehabilitation Services Commission, Roy Pierson of the Ohio Department of Mental Health, Joe Swinehart of the Ohio Department of Budget and Management constituting a quorum. The Legislative Service Commission, the Ohio Statewide Independent Living Council, the Ohio Association of Rehab Facilities, the Federation for Community Planning, the Cerebral Palsy Association of Ohio, the Ohio Advocates for Mental Health, the Family Service Council of Ohio and the Governors' Council on People with Disabilities were also represented.**

**The first order of Business was proponent testimony of the Ohio Department of Job and Family Services, by Sukey Barnum. Ms. Barnum's written testimony is attached.**

**The Chair then called upon Kim D. Linkinhoker from the Ohio Rehabilitation Services Commission regarding the Medicaid Buy-In process and Medicaid Infrastructure Grants. Written testimony is attached.**

**The Chair stated the next order of business was proponent testimony from Denise Weisenborn, State Commissioner for the Ohio Rehabilitation Services Commission. Written testimony is attached.**

**Senator Harris discussed the testimony of the next meeting and the need to expand the meetings starting next week to include Thursday meetings at 2:30 p.m. in the Senate Finance Hearing Room.**

**Those members not in attendance were Jeff Davis, Ohio Department of MR/DD.**

**There being no further business the committee adjourned at approximately 4:30 p.m. The next committee meeting will be held Wednesday, February 28, 2001 at 2:30 p.m. in the Senate Finance Hearing Room.**

**Testimony on Medicaid Eligibility for People with Disabilities**  
**For Ticket to Work Study Committee Meeting, 2/21/01**  
*Provided by Sukey Barnum, Ohio Department of Job and Family Services*

Thank you Chairperson Harris and members of the Ticket to Work Study Committee. I am pleased to attend today's meeting and provide information helpful to understanding and assessing Medicaid options available to the State through the Ticket to Work and Work Incentives Improvement Act of 1999.

In order to understand the impact of implementation of Ticket to Work, or other options for increasing access to health coverage for people with disabilities who want to work, it is important to understand the current eligibility standards for Medicaid for people with disabilities. So, today, I would like to briefly outline what those standards are. I will also take a few moments to provide information on options for changing those standards. There is some flexibility that the committee may want to consider as part of the continuum of options. And lastly, I will outline the options available to create a Medicaid buy-in program under authority of the Balanced Budget Act of 1997, and the Ticket to Work and Work Incentives Improvement Act of 1999.

Any of you who have experience with Medicaid eligibility know that it is quite complex and frustrating. For the purpose of this testimony, I am providing a very general overview that includes the fundamental components and standards. I will also be focusing on financial eligibility, and not addressing other criteria. The information I am sharing is not for people with an institutional level of care who access care through a nursing facility or waiver. The eligibility information I am presenting is for people living in the community receiving a regular Medicaid card covering Medicaid State Plan Services.

Because Medicaid is a means tested program, there are financial eligibility criteria. There are two components of that financial eligibility: Income and Assets. I'll begin by addressing the asset restrictions.

### **Asset Limits**

An asset limit is an established financial threshold for the value of an individual's or couple's assets. If countable assets are over the limit, then there is no eligibility for Medicaid. If countable assets are under the limit, there may be eligibility depending on whether other criteria are met.

When counting assets for the purpose of determining Medicaid eligibility, only some of the assets are considered. It is only those assets that are used in determining Medicaid eligibility. In general, assets that are NOT countable include: a home, as long as it is being used by the applicant/consumer, or his spouse or other legal dependent; a car, or a portion of the value of a car; and personal affects such as clothes and household items. In general, assets that are countable include: savings, stocks, bonds, and non-homestead properties (meaning real property that is not one's home). The premise has been that a person should be able to retain the home they are living in, and have transportation to work and medical appointments, but that a person is responsible for supporting their own health care with their own resources if they have them.

The asset limit for an individual is \$1,500, and the asset limit for a couple is \$2,250.

### **Income Limits**

The income limit for eligibility is an established threshold for the amount of an individual's income. If countable monthly income is at or below the threshold, there may be eligibility, dependent on whether other criteria are met.

If a person's countable monthly income is above the threshold, but he meets all other eligibility criteria, there may still be eligibility. A person can spend down to the threshold by incurring medical costs. A person is informed of the difference between his countable monthly income and the threshold. This is the person's "spenddown" amount. Once a person has incurred medical costs up to the spenddown amount, he can gain eligibility for the remainder of the month.

Only certain income is counted when determining eligibility. Some types of income are not counted, such as SSI. Once all the countable types of income have been totaled, that sum is run through a formula to arrive at countable income before it is compared with the threshold.

The threshold for income eligibility is \$ 460 a month for an individual, and \$ 796 for a couple. By reversing the formula that arrives at countable income, actual income upper limit for an individual is \$1,005, and for a couple is \$1,677, plus any of the income that was not counted for the purpose of eligibility, such as SSI.

The reason we are here today is to explore options for removing barriers to work. A major concern people have expressed is that they cannot accept jobs, or sometimes raises, for fear of losing health coverage. There are some protections in place today.

When an eligible individual has an income increase allowing her to earn more than the threshold limit, her Medicaid can be protected under Supplemental Security Income Work Incentive provisions, 1619(a) and (b). 1619 protection exists today and is different than the buy-in options under the Ticket to Work Act.

An SSI and Medicaid recipient enters 1619 when his earnings go over the threshold. Not only does the person retain SSI and Medicaid, but he is not subject to the spenddown provisions, and therefore does not have to incur medical expenses monthly in order to access Medicaid.

Protection under 1619 continues until one of two things happens: 1) an individual's assets exceed the asset limit, or 2) when income exceeds the upper limit for 1619. In 2000, the upper limit was \$21,809, or about 260% of the federal poverty level.

### **Options for expanding access to health coverage**

Ohio has a range of options for increasing access to health coverage for people with disabilities. To the extent that these options expand financial eligibility for people with disabilities, they also incentivize employment by removing concerns that increased income or assets will cause a loss

of Medicaid coverage. I would like to describe the range of Ohio's options by briefly explaining some flexibility that exists within our current eligibility programs, and then explain the opportunity presented by provisions in the Balanced Budget Act of 1997, and the Ticket to Work and Work Incentives Improvement Act of 1999.

I will begin by explaining potential modifications to current eligibility programs. These potential modifications make up what might be considered the modest end of the spectrum, creating limited increase in access but moving in the right direction.

With approval from HCFA, the Administration, the Ohio General Assembly, and with sufficient additional funding, the ODJFS could, within limits, modify policies on how we treat and count income and assets. One set of options is to increase the limits on income and asset thresholds. The other set of options would be to exclude certain types of income, expenses, or assets from consideration when determining countable income or assets.

An example of increasing the threshold would be to increase the asset limit from \$1,500 to \$2,000. An example of excluding certain types of expenses would be to exclude from consideration some or all of the cost of food or housing.

If the committee or General Assembly determines that pursuing a Medicaid buy-in program is too costly, these modifications to treatment of income and assets could be used as a less ambitious approach to barrier removal for people with disabilities who want to work. It is important to note that these modifications would impact a broader population than the Medicaid buy-in options because changes would impact eligibility not just for people with disabilities who want to and are able to work, but also the aged (65 and older) and people with disabilities who cannot work. For example, if the asset limit were increased, the new limit would be used in determining eligibility for all people applying for coverage, both those who work, and those who do not.

I will now outline the opportunities that states have for creating Medicaid buy-in programs

targeted to people who work. Two recent federal legislative initiatives have expanded states' abilities to incentivize work by allowing people to buy-in to Medicaid: the Balanced Budget Act of 1997 (BBA), and the Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA).

Section 4733 of BBA allows states to create a Medicaid buy-in program for working people with income at or below 250% of the federal poverty level. Eligible individuals must meet the Social Security Definition of disability; and be eligible for SSI if it were not for earned income. Under BBA the state has some flexibility on treatment of income and assets. States implementing this coverage must offer the full Medicaid benefit package to eligible. States implementing this coverage may, but do not have to, impose cost sharing. Cost sharing can be in the form of premiums and/or co-payments, but must be on a sliding scale such that cost sharing never exceeds 7.5% of a person's annual income.

Section 201 of TWWIIA further expand states' options for implementing a Medicaid buy-in program. Again, the target population is people with disabilities who work. TWWIIA allows states to implement a Medicaid buy-in for people age 16 through 64 who would be eligible for SSI if it were not for earned income, meaning that to be eligible a person must meet Social Security's definition of disability. Under TWWIIA, there is no upper poverty limit for implementing the buy-in, but people with income above 450% of FPL must pay the entire premium, while people under 450% of FPL can only be subject to cost sharing if it is on a sliding scale and does not exceed 7.5% of a person's annual income.

TWWIIA also contains authority to implement coverage for a group of people called "The Medical Improvement Group". This group would include people who once met the Social Security definition of disability, but no longer do because of a medical improvement. This coverage can only be offered if a state has also offered coverage to the basic coverage group described first.

To summarize the opportunities presented by BBA and TWWIIA, I would like to leave the

Committee with what I believe is a good working summary of the stakes in the ground, and where the state has policy discretion.

### Stakes in the Ground

- Eligibility and coverage must be statewide;
- The full Medicaid benefit package must be provided;
- Eligibles must meet the Social Security Definition of disability;
- Cost sharing cannot exceed 7.5% of a person's income.

### State latitude

- Set income limits within a range;
- Determine how to treat certain types of income;
- Set asset limits;
- Determine how to treat different types of assets;
- Set premium and sliding scale for cost sharing within limits.

To be clear, implementing programs under BBA or TWWIA is different than modifying current eligibility standards. Implementing under BBA and/or TWWIA is creating a new category of eligibility targeted at a specific population of people with disabilities who work.

Thank you for the opportunity to appear before this study committee and share information about Medicaid eligibility for people with disabilities, and certain options for expanding access.

## **Medicaid Buy-In States Status**

### **■ State Plans Approved by Health Care Financing Agency (HCFA)**

- I Alaska**
- I California**
- I Maine**
- I Minnestota**
- I Nebraska**
- I Oregon**
- I S. Carolina**
- I Wisconsin**

### **■ State Plans at HCFA pending approval**

- I Arkansas**
- I Connecticut**
- I Iowa**
- I Mississippi**
- I New Jersey**
- I Vermont**



**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**Health Care Financing Administration**

---

Center for Medicaid and State Operations  
7500 Security Boulevard  
Baltimore, MD 21244-1

**TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT OF 1999**  
**MEDICAID INFRASTRUCTURE GRANTS**

**To Support the Competitive Employment of People with Disabilities**

**Sponsored By:**

**The Health Care Financing Administration**  
**CFDA No. 93.779**

**January 11, 2001**

# **Executive Summary**

## **Ticket to Work and Work Incentives Improvement Act of 1999 Medicaid Infrastructure Grants**

The Health Care Financing Administration (HCFA) is soliciting proposals from States to develop infrastructures to support the competitive employment of people with disabilities by facilitating targeted improvements to States' Medicaid programs. Section 203 of the Ticket to Work and Work Incentives Improvement Act of 1999 directed the Secretary of the Department of Health and Human Services (DHHS) to establish a grant program to support State efforts to enhance employment options for people with disabilities. HCFA is the designated DHHS agency with administrative responsibility for this grant program.

The grant program was authorized for 11 years beginning in FY 2001, and \$150 million in funding was appropriated for the first five years of the program. The minimum grant award to an eligible State is \$500,000 per fiscal year. There is a tiered eligibility structure for this grant program and States are eligible to request funding in consecutive grant years. All States are eligible to apply for funding, and funds will be allocated to any State which successfully competes for the program.

While HCFA anticipates that the proposals that are submitted by the States will vary, there is the expectation that States participating in this grant program use the funds to remove the barriers to employment of persons with disabilities by creating health systems change through the Medicaid program. Included in this concept is the development of certain core Medicaid components in each State that enable people with disabilities not only to work, but to sustain their health coverage if they find they need to relocate to another State for employment purposes. Continuity of health coverage is an important principle which Congress has emphasized in other legislation as well, such as the Health Insurance Portability and Accountability Act. An adequate Medicaid personal assistance services (PAS) program and a Medicaid buy-in for employed people with disabilities are, therefore, significant components of the Ticket to Work and Work Incentives Improvement Act. This grant program provides money to the States to develop these core elements.

Recognizing that the best source of assistance in developing State policy is other States, the Medicaid Infrastructure Grant Program also provides funding for States with experience in removing barriers to employment for people with disabilities who wish to share their experience by participating in a State-to-State Medicaid Infrastructure Partnership.

Either of the following may apply: (a) the Single State Medicaid Agency; or (b) any other agency or instrumentality of a State (as determined under State law) in partnership, agreement and active participation with the single State Medicaid Agency, the State Legislature, or the Office of the

Governor. For purposes of this grant program, "State" is defined as each of the 50 states, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

The grant period will run 12 months from January 1, 2002 through December 31, 2002, with subsequent annual continuation requests possible for States that qualify for multi-year funding. The minimum grant award will be \$500,000 per year. No State or local matching funds are required.

# TIMETABLE

MILESTONE	DATE
Notice of Intent to Apply Due	March 15, 2001
Applicants Conference	Spring 2001
Application Due Date	May 21, 2001

<b>Grant Period</b>	<b>January 1, 2002 – December 31, 2002</b>
<b>Grant Periods Thereafter</b>	<b>Calendar Years</b>

FEBRUARY 20, 2001

MY NAME IS DENISE WEISENBORN. I WANT TO THANK YOU FOR THE OPPORTUNITY TO PRESENT ANOTHER PERSPECTIVE ON THE NEED FOR A MEDICAID BUY-IN IN OHIO.

IN THE NEXT FEW WEEKS, YOU WILL BE RECEIVING A LARGE AMOUNT OF STATISTICAL INFORMATION ON MEDICAID. I AM HERE TODAY TO TALK TO YOU ABOUT REAL PEOPLE, REAL CONSUMERS, THEIR SITUATIONS AND HOW THEY WOULD BENEFIT FROM A MEDICAID BUY-IN.

LET ME TELL YOU FIRST ABOUT CINDY. CINDY WAS BORN WITH WHAT IS COMMONLY REFERRED TO AS "BRITTLE BONE DISEASE." SHE IS 28 YEARS OLD

AND HOLDS A BACHELOR'S DEGREE IN RADIO AND TV BROADCASTING. CINDY RELIES ON A CUSTOM-MADE ELECTRIC WHEELCHAIR TO GET AROUND, AS WELL AS SEVERAL OTHER TYPES OF ADAPTIVE EQUIPMENT. CINDY HAS ALL THE CREDENTIALS, AS WELL AS THE TIME AND ENERGY, TO WORK AS A FILM EDITOR OR ASSISTANT PRODUCER. EVERYTIME SHE INTERVIEWS FOR A POSITION, THE JOB REQUIRES FULL-TIME EMPLOYMENT. SHE CANNOT PURSUE THESE POSITIONS BECAUSE SHE WOULD LOSE HER MEDICAID AND, THEREFORE, WOULD NOT BE ABLE TO AFFORD THE REPAIR/REPLACEMENT OF HER ASSISTIVE DEVICES. PRESENTLY, SHE IS TAKING PIZZA DELIVERY ORDERS. EVEN HERE SHE HAD TO TURN DOWN ADDITIONAL WORK HOURS ONLY BECAUSE IT WOULD HAVE PUT HER OVER THE MEDICAID CAP.

CAROL IS ANOTHER CONSUMER WHO LIVES INDEPENDENTLY. SHE HAS A FORM OF MUSCULAR DYSTROPHY, IS 39 YEARS OLD AND HAD A BACHELOR'S DEGREE IN ART. CAROL DEPENDS COMPLETELY ON HER HOME HEALTH AIDES TO GET OUT OF BED IN THE MORNING, TO COOK HER MEALS, TO GIVE HER A SHOWER, AND TO DO OTHER DAILY ACTIVITIES. SHE RECEIVES ALL OF THIS ASSISTANCE THROUGH MEDICAID. CAROL CANNOT SELL/EXHIBIT HER BEAUTIFUL DRAWINGS BECAUSE SHE KNOWS THE INCOME WOULD CAUSE HER TO LOSE HER MEDICAID WAIVER BENEFITS. SHE WOULD THEN BE FORCED TO RETURN TO LIVE WITH HER PARENTS

WHO ARE ELDERLY AND CAN NO LONGER ADQUATELY CARE FOR HER.

FINALLY, I BELIEVE THAT MY OWN LIFE SERVES AS A GOOD EXAMPLE OF THE REASONS FOR IMPLEMENTING A MEDICIAD BUY-IN. I AM A STATE COMMISSIONER AND I HAVE BEEN A LICENSED ATTORNEY FOR THE PAST 20 YEARS. AT THE SAME TIME, I ALSO HAVE A PROGRESSIVE NEURO-MUSCULAR DISEASE AND REQUIRE 24-HOUR CARE. PRESENTLY, MEDICAID PROVIDES THE AMOUNT OF CARE THAT I NEED AS WELL AS THE OXYGEN EQUIPMENT RENTAL WHICH IS APPROXIMATELY \$400 PER MONTH. DUE TO MY EDUCATION AND EXPERIENCE, I HAVE THE OPPORTUNITY TO REACH MY POTENTIAL IN LIFE. INSTEAD, I AM FORCED TO DECLINE WELL PAYING LEGAL POSITIONS/CASES AND MUST VOLUNTEER MANY HOURS OF WORK TIME IN ORDER TO PROTECT MY MEDICAID BENEFITS. FOR WITHOUT THESE BENEFITS MY ONLY ALTERNATIVE WOULD BE TO LIVE IN A NURSING HOME.

SO I ASK THAT WHEN YOU STUDY THE INFORMATION YOU WILL BE RECEIVING, WHICH WILL UNDOUBTELY INCLUDE A COST-VS-BENEFIT ANALYSIS, PLEASE KEEP IN MIND THE SAMPLE OF CONSUMERS I HAVE PORTRAYED TO YOU TODAY. THANK YOU!

OHIO SENATE  
TICKET TO WORK COMMITTEE

Minutes of  
February 28, 2001  
Committee Meeting

The Ticket to Work committee was called to order by Chairman Harris at approximately 2:30 p.m. in the Senate Finance Hearing Room.

Senators Harris, and Representatives Womer-Benjamin and Jones were present along with Bill Hayes of the Ohio Department of Job and Family Services, Bill Casto of the Ohio Rehabilitation Services Commission, Mike Hogan of the Ohio Department of Mental Health, Tracy Williams of the Ohio Department of Budget and Management. **Senator Harris declared the committee a sub-committee due to the lack of a quorum.** The Legislative Service Commission, the Ohio Association of Rehab Facilities, the Federation for Community Planning, the Cerebral Palsy Association of Ohio, and the Governors' Council on People with Disabilities were also represented.

The first order of Business was proponent testimony of the Ohio Department of Job and Family Services, by Sukey Barnum. Ms. Barnum's written testimony is attached.

The Chair stated the next order of business was proponent testimony from Kim D. Linkinhoker of the Ohio Rehabilitation Services Commission regarding the Medicaid Buy-In policies in other states on income, resources and premiums. Written testimony is attached.

Those members not in attendance were Jeff Davis, Ohio Department of MR/DD, Senator Fingerhut, Senator Gardner and Representative Hoops.

There being no further business the committee adjourned at approximately 4:00 p.m. The next committee meeting will be held Thursday, March 1, 2001 at 2:30 p.m. in the Senate Finance Hearing Room.



30 East Broad Street • Columbus, Ohio 43266-0423  
[www.state.oh.us/odjfs](http://www.state.oh.us/odjfs)

## Memorandum February 16, 2001

To: Senator William Harris  
From: Sukey Barnum, Chief, Bureau of Consumer and Program Support  
Subject: Materials for February 21 Ticket to Work Study Committee Meeting

Thank you for the opportunity to testify at the February 21, 2001 meeting of the Ticket to Work Study Committee. I hope that the information on Medicaid eligibility, and state options for increasing access to health care for people with disabilities was helpful to the committee in setting the stage for the remainder of the committee's work.

This memo is to confirm my attendance at the February 28, 2001 Study Committee Meeting to provide testimony on certain financing issues. I will also take this opportunity to follow up on last Wednesday's meeting.

During the question and answer portion of my testimony, I promised to follow up with the committee on a point, and I also noted several questions that were raised throughout the meeting. I am providing confirmation of my answer to the committee, and addressing several of the other questions that came up. I hope this information can be shared with the entire committee.

Senator Fingerhut asked for clarification about on whom the State may impose cost sharing, and on whom the State must impose cost sharing. The State may impose cost sharing on individuals with income under \$75,000 annually. If the State chose to implement a program allowing people with income higher than \$75,000 to buy-in to Medicaid, then the State would have to require full payment of the premium. If the State chose to implement cost sharing, for individuals under 450% (\$37,575 for an individual) of the FPL, cost sharing cannot exceed 7.5% of the individual's income.

The Committee questioned whether an employer could pay the premium for a consumer. Yes, an employer could pay the premium for a consumer. A related question was whether the State could require an employer to pay the premium. Additional conversation would be required with the Health Care Financing Administration, as well as within the state about such a policy. On the face of it, the policy would create equity issues between self employed individuals, individuals whose employers do not offer health coverage at all, and individuals whose employers do offer health coverage. Such a policy may also violate federal Medicaid provisions of comparability and statewideness because of those equity issues.

The Committee asked whether Medicaid could act as a "wraparound" for someone's private insurance. Medicaid is the payer of last resort when a consumer has third party insurance. If Ohio implemented a Medicaid buy-in program, this would continue to be true. A person with private insurance could choose to buy-in to Medicaid and her private coverage would pay first. Medicaid would pay for Medicaid covered services not paid by the private insurance. Because we would have to offer the full Medicaid benefit package, the premium would be set assuming access to that set of benefits.

Lastly, the Committee discussed whether a Medicaid buy-in had to be implemented in a state for that state to be included in the larger Ticket to Work Program. The actual "Ticket to Work" program is a federal program that will ultimately be rolled out to all states. The Medicaid buy-in is an option for states. Ohio will be included in the Ticket to Work Program whether or not we implement a Medicaid buy-in program.

**Testimony on Medicaid and Finance Issues For Medicaid Buy-In Programs  
For Ticket to Work Study Committee Meeting, 2/28/01**

*Provided by Sukey Barnum, Ohio Department of Job and Family Services*

Good afternoon Chairperson Harris and members of the Ticket to Work Study Committee. I am here today to provide some preliminary information on finance issues related to state implementation of a Medicaid buy-in program for people with disabilities who work. I am not here today to provide budget estimates, but rather to set the stage for considerations of the committee with regard to financing such a program.

I would like to begin by revisiting my previous testimony which laid out the stakes in the ground and the policy options available to the state. The stakes included: eligibility and coverage must be statewide; the full Medicaid benefit package must be provided; eligibles must meet the Social Security definition of disability; and cost sharing (at least for those under 450% of the federal poverty level) cannot exceed 7.5% of the individual's annual income. Where the state has policy discretion is: to set income limits and determine how to treat different types of income; to set asset limits and determine how to treat different types of assets; and to set the premium and sliding scale for cost sharing within limits.

In my previous testimony I did not address, but believe it is important for the committee to know as a stake in the ground, that states do not have the authority to define "work" for the purpose of determining who is eligible under a buy-in. While the program concept is to encourage employment and increased earnings, states cannot define work. This means that Ohio could not establish either a minimum amount of earned income, or hours of paid employment that an individual would have to engage in to be eligible under a buy-in program. This does leave Medicaid buy-in programs open to some level of misuse where individuals misrepresent employment in order to gain eligibility under the buy-in rather than pay a spenddown.

An example of this type of scenario in Minnesota was a women who stated her employment was fixing meals for her live-in boyfriend. Technically, if he paid her any amount of money, and she

in fact cooked his meals, this would be work. The State's recourse is to set criteria for verifying employment and income through collection of income stubs, and the like. There are some kinds of employment that do not require reporting to Medicare or Social Security, and in those instances, such documentation would not be available. Policies would be needed to determine how to handle such circumstances.

The choices a state makes about any of the above elements has a financial impact on the program and cost to the state. The more liberal the income and asset policies are, more people will be eligible, and the financial impact to the state greater. Conversely, the more conservative the income and asset policies are, fewer people will be eligible, and the financial impact to the state less. Another example is the use of cost sharing. If a state elects to impose no or low cost sharing, more people will choose to take advantage of the program. If a state elects to set higher cost sharing requirements, then fewer people will choose to take advantage of the program. Each choice plays into the number of people potentially eligible, the number of people who would actually take advantage, and subsequently the cost to the state.

As Ohio considers the options, several financial issues need to be in the forefront including: how to think about revenue from any cost sharing; implementation and operational costs; service costs; and number of people potentially eligible and likely to take advantage. I will briefly address each of these issues.

### **Premium Considerations**

One of the new elements presented by Medicaid buy-in is how to think about any revenue from cost sharing and how that plays into the financing of the program. The amount of revenue will depend on how many people are eligible and what premium levels are set. The state may want to be cautious in assuming that revenue generated by cost sharing will significantly offset the cost of implementing and operating the program. The revenue generated by collecting premiums is not available for use as state match. Whatever we collect, the federal government gets its share back. Any revenue collected reduces our federal reimbursement by the federal share

(approximately 60%) of the amount of revenue.

To be simplistic about it, if Ohio's total quarterly expenditures for this population were 1 million dollars, we would normally claim federal reimbursement of approximately \$600,000 for that quarter. If in that quarter we collected \$60,000 in premiums, we would have to determine the federal portion of that amount, basically 60% of that \$60,000, and offset our reimbursement request by that amount. 60% of \$60,000 is \$36,000. So instead of claiming \$600,000 in reimbursement from the federal government, we would be claiming \$564,000.

The impact of consumer cost sharing on the financing of a Medicaid buy-in program depends on many things. Given that revenue generated cannot be used as state match, only a portion of that revenue will offset state costs. Early feedback from Minnesota is that they originally assumed some cost offset from premium collection, but have not collected sufficient revenue to impact program cost to the state. Of the 4,683 people eligible for their buy-in program in May of 2000, only 453 were paying premiums at an average of \$36 a month. For the same month, Minnesota experienced service costs for the population totaling over 3.7 million dollars, an average per person monthly expenditure of over \$800. This information is specific to Minnesota and their model, so is not necessarily indicative of what Ohio's experience would be, but is useful to illustrate some considerations in determining cost sharing policies, and cost impact to the state.

### **Implementation and Operational Considerations**

I would next like to address implementation and operational costs of implementing a buy-in program. I will not dwell on these, but want to at least say out loud the types of administrative costs and investments that would need to be included in funding a Medicaid buy-in program:

- Information systems modifications;
- Eligibility determinations;
- Premium collection and tracking mechanisms;
- Fiscal reporting changes and account structure modifications;
- Communications;

- Program evaluation;
- Program management.

Through a combination of increased staffing and contracts, each of these items would need to be addressed, in addition to the policy and rule work that the department would need to engage in to develop rules, and gain approval from the Health Care Financing Administration.

### **Service Costs**

ODJFS has data on how much it costs on average to provide coverage to individuals in different eligibility categories and different settings. In estimating service costs for this potential new group of eligibles, there is no direct experience and different assumptions will lead to different cost estimates. Assumptions that may be in a costing model include: which and how many services will consumers use; and to what extent will consumers have third party coverage.

The answer to which and how many services will consumers use is difficult to answer. Consumers will minimally have access to the full Medicaid State Plan benefit package. The State also has an option to modify its Home and Community Based Waivers to allow consumers in those waivers to be eligible for Medicaid buy-in.

Fundamentally though, health care to support employment may differ considerably from currently available health care. The state may well see consumers in this targeted population use the benefit package available in a much different way than current eligibles. Consumers may, for example, take increased advantage of the Core and Core Plus home care services available through the State Plan Benefit Package, or the home care waiver services available through certain home and community based services waivers should the state choose to make that an option. It is conceivable that individuals in nursing facilities or intermediate care facilities for the mentally retarded will take advantage of the buy-in option.

Below is a chart that shows average annual costs for different Medicaid eligibles in the Aged, Blind, Disabled category.

<b>ABD Service Type</b>	<b>Annual Cost</b>
Community	\$2,300
Nursing Facility	\$39,600
ICF/MR	\$81,600- \$91,600
ABD Total	\$12,000

A couple of comments about these numbers:

1. These are reporting numbers, not budget estimate numbers, so given health care inflation, these will be higher in the future.
2. These numbers do not separately break out the annual cost of people on home and community based waivers, although their experience is reflected in the ABD total. The annual cost of a waiver consumer spans a range, but is higher than the community ABD, and generally lower than the nursing facility ABD.

A separate but important consideration is that people may demand or desire a set of services not covered by Medicaid. This gets at the distinction between health care to support employment and currently available health coverage. Ohio does not have personal assistance as a part of the State Plan benefit package. Personal assistance is a service that many people have advocated for at state and federal levels and through proposed legislation. The decision for Ohio regarding personal care is a separate decision from the Medicaid buy-in discussion because it is a different financial and programmatic commitment. Putting personal care on Ohio's Medicaid State Plan would make it available to all Medicaid consumers, and at considerable cost to the State.

#### **Number of People Potentially Eligible**

Lastly, and most obviously, the number of people potentially eligible and the number who take advantage of a Medicaid buy-in option would have a fundamental financial impact. As I previously stated, the income and asset limits set will drive the number of people potentially eligible. The amount of cost sharing will drive the number of people who take advantage.

Through census and survey information, there is relatively reliable data on demographics related to income. However, there is not such demographic data available about people's assets. There is also not a definitive answer to how many potentially eligible people will take advantage of a buy-in program. There are other state experiences to look at, but none will replicate Ohio's population, nor will it likely be identical to an Ohio model. So in making estimates, there are some unknown factors.

There are three groups likely to come forward to take advantage of such a program:

1. Current Medicaid consumers who take advantage of the opportunity to get a job, or increase earnings;
2. Low income people with disabilities who may periodically gain eligibility through spenddown provisions;
3. And people who have never accessed the Medicaid system but find that they can benefit from a buy-in program to access health coverage.

Costs will be driven to some extent also by the numbers of people in each group that come to the door. Minnesota expected that 80% of their buy-in eligibles would come from Medicaid, including anyone who had any months of Medicaid in the last year. Their experience to this point has been closer to 70%, which means a higher number of people are new to the system.

I believe testimony on March 8, 2001 will further address sizing the population, and estimating the number of people who would be expected to access such a program.

I hope this information is helpful as the committee hears additional testimony and considers the financial side of implementing a Medicaid buy-in program. Thank you for the opportunity to testify. I would be happy to answer any questions of the committee.

Ticket to Work and Work Incentives Improvement Act of 1999  
Medicaid Infrastructure Grants

Sponsored by: The Health Care Financing Administration

I. Purpose

To develop infrastructures to support the competitive employment of people with disabilities by improving Medicaid programs.

II. Who May Apply

Either of the following may apply:

- The Single State Medicaid Agency ( in OHIO it would be ODJFS)
- Any other agency or instrumentality of a State in partnership, agreement and active participation with the Single State Medicaid Agency
- State Legislature
- Office of the Governor

III. Amounts and Timelines for Funding

The grant period for this award will run 12 months from January 1, 2002, through December 31, 2002. The minimum grant award will be \$500,000 per year.

IV. Uses of Grant Funds

Funds may be used for infrastructure, that is, to establish or improve the capability to provide or manage necessary health care services or support for competitive employment of people with disabilities who may be Medicaid eligible.

Funds may be used for four purposes:

- *Medicaid Buy-in*: Planning, design, implementation and/or effective management of any of the Medicaid buy-in options under BBA or Ticket to Work
- *Medicaid Services*: Planning, design, or initial management and/or evaluation of improvements to make the Medicaid State Plan or Medicaid waivers provide more effective support to workers with disabilities
- *Demonstration to Maintain Independence and Employment*: Planning, design, and initial implementation of demonstrations that offer Medicaid coverage for people who do not meet the SSI disability test but have a potentially severe physical or mental impairment
- *State to State Medicaid Infrastructure Partnerships*: These states must provide technical assistance to other states and share implementation strategies with other states.

V. Due Date

Applications are due on May 21, 2001

Medicaid Buy-in  
Policies in Other States on Income, Resources and Premiums

	<i>Income Disregards and Policies</i>	<i>Resource Disregards and Policies</i>	<i>Premiums and Other Cost Sharing Charges</i>
Alaska	<ul style="list-style-type: none"> <li>-Payments received from the Alaska Longevity Bonus Program are disregarded to the extent the payment does not cause total gross income to exceed 300 percent of the SSI FBR.</li> <li>-All earned income of a spouse or other family member of the disabled individual is excluded.</li> </ul>	<ul style="list-style-type: none"> <li>-Up to \$2,000 per individual per year in distributions from Alaska Native Claims Settlement Act corporations is excluded.</li> <li>-Dividends and benefit payments from the Alaska Permanent Fund Dividend Program are excluded.</li> </ul>	<ul style="list-style-type: none"> <li>-Premiums are based on net family income.</li> <li>-No premiums are charged if income is below 100 percent of the poverty level; maximum premium is 10 percent of net family income.</li> </ul>
California	<ul style="list-style-type: none"> <li>-When determining the 250% of federal poverty amount, all disability income is excluded.</li> </ul>	<ul style="list-style-type: none"> <li>-Resources are limited to \$2,000 for a single person and \$3,000 for a couple.</li> <li>-Resources in retirement accounts are disregarded.</li> </ul>	<ul style="list-style-type: none"> <li>-No co-pays.</li> <li>-Premiums run from \$20 to \$250/month for an individual and \$30 to \$375/month for a couple, based on net countable income.</li> </ul>
Connecticut (proposed)	<ul style="list-style-type: none"> <li>-All countable income up to 200% of the federal poverty level. Countable income does not include impairment-related work expenses.</li> <li>-Spousal income is disregarded.</li> <li>-Gross income must be less than \$75,000.</li> </ul>	<ul style="list-style-type: none"> <li>-Up to \$10,000 in assets for single person (\$15,000 for married couple).</li> <li>-Disregard retirement and medical savings accounts of person with disability and his or her spouse, and any money in approved accounts that is intended to be used to increase employability.</li> </ul>	<ul style="list-style-type: none"> <li>-For persons with incomes above 200% of federal poverty level, the contribution is 10% of the amount in excess of the 200% figure less any premiums paid for health insurance coverage for any family member.</li> </ul>
Iowa	<ul style="list-style-type: none"> <li>-Standard BBA definition</li> </ul>	<ul style="list-style-type: none"> <li>-Up to \$10,000 in "available assets."</li> <li>-Any resources held in retirement accounts, medical savings accounts, or assistive technology accounts.</li> </ul>	<ul style="list-style-type: none"> <li>-For persons with gross incomes (counting all earned and unearned income) above 150% of the federal poverty level, there is a monthly premium ranging from \$20 to \$201</li> </ul>
Maine	<ul style="list-style-type: none"> <li>-Countable unearned income (non-work income such as Social Security or other pensions) must be equal to or under \$696/month for one person, or \$938 for a couple.</li> <li>-Countable unearned and earned income together must be under \$1,740/month for one person, or \$2,344 for a couple.</li> <li>-Note: the above numbers refer to "countable income." Some deductions from gross income are used to determine "countable income." Also, the numbers given are based on the Federal Poverty Level (FPL) for the year 2000, and which is adjusted in the spring of each year.</li> </ul>	<ul style="list-style-type: none"> <li>-Have assets under \$8,000 for an individual, or \$12,000 for a couple. Exemptions include at least a primary residence, and an automobile (if required for transportation to work or to medical services). Other asset exemptions might also apply.</li> </ul>	<ul style="list-style-type: none"> <li>-Coverage is free until countable income exceeds \$1,044 per month for a single individual, then costs \$10-\$20 per month depending upon income level.</li> <li>-No premium is due if someone is already paying for their Medicare Part B premium (\$45.50/month).</li> </ul>
Minnesota	<ul style="list-style-type: none"> <li>-In determining whether the 250 percent of poverty family income test is met, all earned and unearned income of the applicant and family members is disregarded.</li> <li>-In determining eligibility for the applicant all unearned income of the applicant, and all earned and unearned income of an ineligible spouse, is disregarded.</li> </ul>	<ul style="list-style-type: none"> <li>-Resources of an ineligible spouse are excluded.</li> <li>-The following resources of the applicant are excluded: Retirement accounts including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, pension plans, and medical expense accounts through the employer.</li> <li>-\$18,000 in resources in addition to those excluded above is excluded.</li> </ul>	<ul style="list-style-type: none"> <li>-Premiums are 10 percent of individual's gross income, starting at 200 percent of the poverty level based on family size.</li> <li>-No cost-sharing charges apply</li> </ul>

Medicaid Buy-in  
Policies in Other States on Income, Resources and Premiums

	<i>Income Disregards and Policies</i>	<i>Resource Disregards and Policies</i>	<i>Premiums and Other Cost Sharing Charges</i>
Mississippi	<ul style="list-style-type: none"> <li>-An individual must have earned income less than \$1,740 and unearned income less than \$990.</li> <li>-A couple must have earned income less than \$2,344 and unearned income less than \$1,316.</li> </ul>	<ul style="list-style-type: none"> <li>-\$4,000 for an individual.</li> <li>-\$6,000 for a couple.</li> </ul>	?
Nebraska	<ul style="list-style-type: none"> <li>-In determining eligibility under the individual income test, disregard all earnings, plus unearned income contingent upon a trial work period (such as a Social Security Trial Work Period).</li> </ul>	<ul style="list-style-type: none"> <li>-Disregard an additional \$2,000 in resources for an individual and an additional \$3,000 in resources for a couple.</li> </ul>	<ul style="list-style-type: none"> <li>-The amount of the individual's cost share is based on a progressive rate dependent on adjusted income (unearned income plus earned income, minus any allowable disregards) in excess of 200 percent of the Federal poverty level. The minimum rate is 2 percent and the maximum rate is 10 percent.</li> </ul>
Oregon	<ul style="list-style-type: none"> <li>-An amount of unearned income equal to the Oregon Supplemental Income program standard is disregarded.</li> <li>-The total amount of any special needs allowances (as defined under Oregon Administrative Rules) is disregarded.</li> </ul>	<ul style="list-style-type: none"> <li>-\$10,000 in resources is excluded.</li> <li>-Any funds held in Approved Accounts are excluded.</li> <li>-Approved Accounts must be separate from non-exempt resources.</li> <li>-Approved Accounts must be used to save for expenses determined by the State to enhance independence and or increase employment opportunities. Approved Accounts may include accounts commonly used for future retirement and or medical needs, such as IRAs and medical savings accounts.</li> <li>-Accounts must be approved by the State before the exclusion can be applied.</li> </ul>	<ul style="list-style-type: none"> <li>-If unearned income in excess of the Oregon Supplemental Income Program standard goes to the State as cost-sharing.</li> <li>-In addition to the above, individuals are required to pay cost-sharing charges if unearned income remaining after the above charge, combined with earned income after allowable disregards, exceeds 200 percent of the poverty level. Cost-sharing charges under this formula range from a minimum of 2 percent to a maximum of 10 percent of income.</li> </ul>
South Carolina	<ul style="list-style-type: none"> <li>-Income identified as inkind support and maintenance is disregarded.</li> </ul>	<ul style="list-style-type: none"> <li>The following disregards apply:</li> <li>-the value of one automobile</li> <li>-the value of life estate interest in real property</li> <li>-the value of household goods and personal effects</li> <li>-the value of undivided interest in heirs' property</li> <li>-the cash value of life insurance if the combined face value is \$5,000 or less</li> <li>-the individual is resource-eligible for a month if his resources meet the resource standard at any time during the month</li> </ul>	<ul style="list-style-type: none"> <li>-No payment of premiums or other cost-sharing charges is required.</li> </ul>

Medicaid Buy-in  
Policies in Other States on Income, Resources and Premiums

	<i><b>Income Disregards and Policies</b></i>	<i><b>Resource Disregards and Policies</b></i>	<i><b>Premiums and Other Cost Sharing Charges</b></i>
Wisconsin	-All of the applicant's unearned income, and any unearned income deemed available from an ineligible spouse, is disregarded in determining the applicant's eligibility. This disregard does not apply when determining whether the 250 percent of poverty family income test is met.	<ul style="list-style-type: none"> <li>- \$13,000 in resources is excluded.</li> <li>- Resources of an ineligible spouse are excluded.</li> <li>- Funds held in an Independence Account are excluded.</li> <li>- Only deposits made after the individual is eligible for Medicaid under the BBA group are excluded.</li> <li>- Deposits cannot exceed 50 percent of earned income in any calendar year.</li> <li>- Accounts must be separate from non-exempt resources and are subject to prior approval by the State.</li> <li>- Amounts deposited and all gains, dividends and interest earned in an employer's retirement fund and an individual's IRA account after becoming eligible for Medicaid qualify as part of an Independence Account if properly registered with the State.</li> </ul>	<ul style="list-style-type: none"> <li>- Total monthly premium is based on the sum of premiums on earned and unearned income as described below.</li> <li>- Premium for earned income - 3.0 - 3.5 percent of earned income.</li> <li>- No premium based on earned income will be assessed for individuals whose total gross income (earned and unearned) is less than 150 percent of the poverty level.</li> <li>- Premium for unearned income - 100 percent of total unearned income remaining after the following deductions:</li> <li>- A maintenance allowance not less than the sum of \$20, plus the SSI Federal Benefit Rate, plus the State supplemental payment rate.</li> <li>- Medical and remedial expenses.</li> <li>- Impairment-related work expenses.</li> <li>- Deductions in excess of the individual's total unearned income are subtracted from gross monthly earned income before calculating the earned income premium.</li> <li>- Payment of all or part of premium charges can be waived based on a finding of undue hardship</li> </ul>
Vermont	-Standard BBA definition (?)	?	Persons with incomes between 185% and 250% of poverty will be charged a fee of \$10 to \$25/month.

	Name and Contact Information	Contact Information	Website for Medicaid Buy-in States
Alaska	Millie Ryan Millie_Ryan@health.state.ak.us (907) 269-8992  Kevin Henderson kevin_henderson@health.state.ak.us (907) 465-5821		<a href="http://www.hss.state.ak.us/dma/table.htm">http://www.hss.state.ak.us/dma/table.htm</a>  This site does not appear to have information
California	Vickie Partington Medi-Cal Eligibility Branch (916) 654-5909 Vpartington@dhs.ca.go		<a href="http://www.dhs.ca.gov/org_indx.htm">http://www.dhs.ca.gov/org_indx.htm</a>  This site does not appear to have information
Connecticut (proposed)	Larry Carlson		<a href="http://www.state.ct.us/opapd/legislative_update_copy(1).htm#WORK%20INCENTIVES">http://www.state.ct.us/opapd/legislative_update_copy(1).htm#WORK%20INCENTIVES</a>
Iowa	John Hale jdhale@dodgenet.com  Jim Overland Iowa Department of Human Services (515) 281-8908		<a href="http://www.dhs.state.ia.us">http://www.dhs.state.ia.us</a>  This site does not appear to have information
Maine	Larry Glantz  glantz@usm.maine.edu		<a href="http://www.state.me.us/dhs/beas/buyin/welcome.htm">http://www.state.me.us/dhs/beas/buyin/welcome.htm</a>
Minnesota	Karen Gibson (651) 296-1281 karen.gibson@state.mn.us		<a href="http://www.dhs.state.mn.us">http://www.dhs.state.mn.us</a>
Mississippi	Betty Williams ELBRW.LAKELAND.DOM@medicaid.state.ms.us  Rose Compere exrec@medicaid.state.ms.us		This site does not appear to have information <a href="http://www.dom.state.ms.us/Bene/P6.pdf">http://www.dom.state.ms.us/Bene/P6.pdf</a>
Nebraska	George Kahlandt (402) 471-9267 George.Kahlandt@hhss.state.ne.us		<a href="http://www.hhs.state.ne.us/med/medindex.htm">http://www.hhs.state.ne.us/med/medindex.htm</a>
Oregon	Doug Stone (503) 945-5836 douglas.e.stone@state.or.us		This site does not appear to have any information <a href="http://www.sdsd.hr.state.or.us/programs/epd.htm">http://www.sdsd.hr.state.or.us/programs/epd.htm</a>
South Carolina	Sally Brown (803) 898-2627 brownsa@dhhs.state.sc.us		<a href="http://www.state.sc.us/dhhs/Medicaid_info/medicaidindex.htm">http://www.state.sc.us/dhhs/Medicaid_info/medicaidindex.htm</a>
Wisconsin	Karen Tritz Center for Delivery Systems Development tritzkl@dhfs.state.wi.us 608-266-2361		This site does not appear to have any information.
Vermont	Peter Baird peterb@dad.state.vt.us		

### Enrollment and Costs for Medicaid Buy-in

Ohio Developmental Disabilities Council  
Steve Howe

	<i>Estimated 1998 State Population *</i>	<i>Estimated Number 18-64</i>	<i>Estimated Number 18-64 with Severe Disabilities **</i>	<i>Date Program Took Effect</i>	<i>Enrollment (as of 3/2000)</i>	<i>% Already on Medicaid</i>	<i>Cost</i>	<i>Notes</i>
Alaska	615,205	388,162	21,402	07/01/98	47	80	?	
California	32,682,794	20,154,829	1,111,259	04/01/00	2 (33 as of now)	?	Not yet known	
Connecticut (proposed)	3,272,563	1,995,839	110,043	?	?		?	
Iowa	2,861,025	1,707,790	94,161	03/01/00	606	?	?	
Maine	1,247,554	780,161	43,015	08/01/99	210 (400 as of now)	90	?	
Minnesota	4,726,411	2,880,251	158,806	07/01/99	4,000 Projected to increase to 5,347	70	\$11 million projected to increase to \$27 million	Enrollment was twice what was expected
Mississippi	2,751,335	1,659,061	91,474	07/01/1999 (rules liberalized 7/1/2000)	12 first year 47 now		Services to 25 people for \$48,000	Funded with \$1 million in tobacco funds
Nebraska	1,660,772	987,573	54,451	06/01/90	50 (88 as of now)	95	?	Trial work requirement thought to help keep numbers down
Oregon	3,282,055	2,025,958	111,703	02/01/99	280 (450 as of now)	90		
South Carolina	3,839,578	2,416,012	133,209	10/01/98	50 (75 as of now)	> 50		
Vermont	590,579	376,803	20,775	01/01/00	160	92	?	?
Wisconsin	5,222,124	3,182,224	175,455	03/15/00	53	60		25 - 30% have private insurance

**\*Estimated population counts are from the Census Bureau**

**\*\*The estimated number with severe disabilities is based on...**

OHIO SENATE  
TICKET TO WORK COMMITTEE

Minutes of  
March 1, 2001  
Committee Meeting

The meeting of the Ticket to Work committee was called to order by Chairman Harris at approximately 2:30 p.m. in the Senate Finance Hearing Room.

Senators Harris, Gardner and Representative Jones were present along with Bill Hayes of the Ohio Department of Job and Family Services, Bill Casto of the Ohio Rehabilitation Services Commission, Jeff Davis of MR/DD and Tracy Williams of the Ohio Department of Budget and Management. **Senator Harris declared the committee a sub-committee due to the lack of a quorum.** The Legislative Service Commission, the Ohio Association of Rehab Facilities, the Federation for Community Planning, the Cerebral Palsy Association of Ohio, OSU Rehab Services, COVA Job Place, OCPC/Goodwill Services, Ohio Advocate for Mental Health, and the Governors' Council on People with Disabilities were also represented.

The first order of Business was interested party testimony provided by Bruce Growick, Ph.D, of Ohio State University. Dr. Growick's written testimony is attached.

The Chair recognized Mark Seifarth from the Ohio Rehabilitation Services Commission with proponent testimony. Mr. Seifarth's written testimony is attached.

The Chair initiated a round of discussion between Dr. Growick, Mr. Seifarth, Kim D. Linkinhoker of the Ohio Rehabilitation Services Commission and John Connelly of the Ohio Rehabilitation Services Commission.

Those members not in attendance were Senator Fingerhut, Representative Womer-Benjamin, Representative Hoops, and Mike Hogan of the Department of Mental Health.

There being no further business the committee adjourned at approximately 4:05 p.m. The next committee meeting will be held Wednesday, March 7, 2001, at 2:30 p.m. in the Senate Finance Hearing Room.

**Testimony on the Purpose of the new Federal Law  
entitled Ticket-to-Work, Work Incentives Improvement  
Act (PL 106-170)**

Provided by Bruce Growick, Ohio State University, 3/1/01

Thank you Chairperson Harris and members of the Ticket to Work Study Committee for inviting me to present to you today on the overall intent and purpose of the new federal legislation entitled Ticket-to-Work, Work Incentives Improvement (TTW-WIIA) Act of 1999.

I have been involved in the development of this law for the last six years, representing the International Association of Rehabilitation Professionals (IARP). IARP is a 3200 member association representing rehabilitation professionals who work mostly in the insurance industry by helping individuals with disabilities in workers' compensation, long and short-term disability, and even personal injury become employed. During the last six years I have attended meetings in Wash., D.C., presented at the Social Security Subcommittee of the U.S. House Ways & Means, and published a number of articles on the reason for and the development of TTW-WIIA. I have also helped one of our local social service agencies here in Central Ohio, the Center on Vocational Alternatives, obtain a five year,

1.2 million dollar federal grant from SSA to assist beneficiaries in understanding and accessing this new law.

At present, we are at the implementation stage of TTW-WIIA in that the federal Social Security Administration is promulgating the rules and regulation governing the implementation of the ticket portion of TTW-WIIA, while many States, like Ohio, are examining the advantages of extending healthcare to Medicaid recipients who become employed. I think it is indeed important that Ohio provide a Medicaid extension for those beneficiaries who want and can return to work. It is in Ohio's best interest to do so.

But, just as important, the members of this committee need to understand that there are two parts to this law: incentives to beneficiaries to obtain employment, such as extended healthcare, and vouchers for improved access to VR services. The extension of healthcare, either Medicaid or Medicare to individuals with disabilities who work, is predicated on the expectation that SSA Beneficiaries will be able to receive vocational rehabilitation (ie, return-to-work) services. In fact, the initial impetus for the development of TTW-WIIA as legislation was based on the GAO conducted research indicating that the availability of VR services from the public sector alone was not enough to help beneficiaries return to work. The GAO

reviewed and recommended the provision of rehabilitation services in the private sector to SSA beneficiaries. The GAO also confirmed the fact, through a national survey, that most beneficiaries of SSA would indeed try to obtain employment if they could assure themselves of continued healthcare, and were not penalized for doing so.

So interestingly, the Ticket portion of TTW-WIIA actually preceded the introduction of healthcare incentives related to beneficiaries obtaining work. Both parts of the bill certainly complement each other in helping to address the much needed access and use of vocational rehabilitation by persons who want to become employed. The eventual expectation is that TTW-WIIA will save the SSA disability trust fund from bankruptcy, and at the same time provide much needed access to VR services by those individuals who can benefit from it.

However, to accomplish this outcome, it is paramount that the States do two things: extend healthcare to beneficiaries when they return to work, **AND** develop ways in which the private-sector will be able to complement the public-sector in the delivery of rehabilitation services. I know it is the immediate purview of this committee to investigate the fiscal propriety of extending healthcare to medicaid recipients who return to work. We need to do that. But, I think it is equally important to encourage collaboration

between the public and private sectors of rehabilitation. The field of vocational rehabilitation has undergone some tremendous changes in the last few years that have produced the need for this collaboration.

Most dramatically, in 1996 according to the GAO only 1 in 500, or less than 1/2 of 1% of the beneficiaries who were referred to the State-Federal system of VR, were returned to work. The goals/objectives and some of the procedural elements of the State-Federal system of VR have not always been conducive to the efficient and effective delivery of services to SSA beneficiaries. For example, the Rehabilitation Services Commission in Ohio operates under an "order of selection" rule in that the most severely disabled are served first. Only recently have SSA Beneficiaries met this criterion, and therefore have not always been served promptly. Also, the State-Federal system does not have a preferred hierarchy of providing services where clients are expected to return to their same work field with a reasonable accomodation.

The collaboration between the private and public sectors of VR services has been most evident right here in our own state in the area of workers' compensation. The Ohio Bureau of Workers' Compensation, of which I am also a past Director under the Celeste Administration, has transferred the responsibility of the delivery of rehabilitation services from

the public to the private-sector. It has closed its operation of two Rehabilitation Centers, the Camera Center in Columbus and the Walker Center in Cleveland, and has restructured the responsibilities of their case managers. Instead of providing services directly, the rehabilitation counselors at the Ohio BWC now oversee services provided by the private-sector.

Both the cost savings, and the improvement of services have been significant at the Ohio BWC . So much so, the Ohio BWC has issued rebates to its premium holders without sacrificing the quality and quantity of rehabilitation services to its claimants. The Ohio Rehabilitation Services, through the TTW-WIIA legislation, has the same opportunity to collaborate with the private-sector so that consumers have **real choice** in the delivery of services.

**I urge you as legislators and guardians of the tax fund to encourage the Ohio Rehabilitation Services to embrace TTW-WIIA not only for the extension of healthcare coverage to medicaid recipients who can work, but also for the opportunity to deregulate itself through the ticket portion of the law. In this way, more beneficiaries who want to avail themselves of services can, and the disability trust fund of the SSA will remain solvent.**

For your further edification as part of my testimony, I have submitted for your perusal a copy of the slides I use in presenting an overview of PL 106-170, a copy of an article which summarizes the law, and a copy of a commentary I wrote stressing the overall political implications of TTW-WIIA. I hope this information is helpful to you in your deliberations, and I am happy to answer now or later any questions you might have. Thank you for this opportunity to share with you my viewpoint on the implementation of TTW-WIIA in Ohio. I appreciate it.

Testimony before  
Joint Ticket to Work Program Evaluation Committee  
By Ohio Rehabilitation Services Commission  
March 1, 2001

The Ticket to Work portion of the Ticket to Work and Work Incentives Improvement Act is intended to give persons with disabilities receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) a greater choice of approved providers of rehabilitation services to help them become employed. Persons receiving SSDI/SSI have a disability severe enough so they have not been able to work for at least the previous 12 consecutive months.

- Under Ticket to work, SSDI/SSI recipients selected by the Social Security Administration (SSA) would be given a ticket, not a voucher, that allows them to receive services from an SSA approved employment network of their choice. Then, the employment network receiving the ticket may bill SSA directly under one of two structures. It is a ticket to get in the door with an approved employment network not a limited, cashable voucher.

The ticket provides choice. However, it is possible an employment network, which could be one vendor or multiple vendors, may elect to provide all the services under a ticket itself. This may in fact give the consumer many fewer choices than exist in the public Vocational Rehabilitation (VR) system. ORSC purchases from over 170 private for-profit and not-for-profit rehabilitation facilities throughout Ohio.

- Studies and quotations from the 1980's and 1990's that cite a very low percentage of people receiving SSDI/SSI being returned to work by VR misrepresent the actual success because they include all SSDI/SSI recipients, many of whom are not eligible or interested in returning to work – e.g. children with disabilities and persons well beyond retirement age.
- One of the major reasons that recipients of SSDI/SSI often do not access or complete VR services, which are voluntary, is because of their concern over the potential loss of medical benefits due to increased earning from a job – a major focus of this Evaluation Committee.

- Ohio is NUMBER ONE in the entire United States in putting people to work from SSDI /SSI rolls. In fiscal year 2000, 3451 persons receiving SSDI /SSI were rehabilitated into a job by the Ohio Rehabilitation Services Commission. That constitutes 47% of the total rehabilitations, 7,339 that ORSC achieved in fiscal year 2000.
- The Ohio Rehabilitation Services Commission is under a federally mandated order of selection to serve persons with severe disabilities first. Since SSDI/SSI recipients have not worked for at least an entire year, the vast majority *are* persons with severe disabilities and have been eligible for VR services. Order of selection actually increases the opportunity for VR services to be provided to these recipients. Their eligibility was further reinforced by the 1998 amendments to the federal Rehabilitation Act, which created a presumptive eligibility for recipients of SSDI/SSI to receive VR Services.
- Ohio employs masters' degree level counselors to work with consumers with disabilities in developing a plan for employment. ORSC, like the Bureau of Workers Compensation (BWC) and VR agencies in other states, purchases the needed employment and training services from private for-profit and not-for-profit local rehabilitation facilities throughout the state.

Additionally BWC and RSC continue a cash transfer agreement in which RSC provides VR services leading to jobs to BWC's recipients with the most severe injuries and disabilities.

- Consumers of VR Services from ORSC are provided with information to help them make informed choices in the selection of services, in their local communities, of private sector rehabilitation facilities and providers, that will lead to employment.
- In expectation of implementation, from the federal level, of the "ticket" portion of the Ticket to Work in Ohio, ORSC has convened a study group of private for-profit and not-for-profit rehabilitation facilities and consumers with disabilities. This group is examining the development of employment networks that will afford the greatest array of services and choices for ticket consumers.

Mark Seifarth, Legislative Liaison,  
Ohio Rehabilitation Services Commission

OHIO SENATE  
TICKET TO WORK COMMITTEE

Minutes of  
March 8, 2001  
Committee Meeting

The meeting of the Ticket to Work committee was called to order by Chairman Harris at approximately 2:30 p.m. in the Senate Finance Hearing Room.

Senators Harris, Fingerhut and Representative Jones were present along with Bill Hayes of the Ohio Department of Job and Family Services, Bill Casto, Administrator, the Ohio Rehabilitation Services Commission, Jeff Davis of MR/DD Judy Wortham, Deputy Director, Ohio Department of Mental Health, and Tracy Williams of the Ohio Department of Budget and Management. **Senator Harris declared the committee a sub-committee due to the lack of a quorum.** The Legislative Service Commission, the Ohio Association of Rehab Facilities, the Cerebral Palsy Association of Ohio, OSU Rehab Services, Ohio Advocate for Mental Health, League of Women Voters, and the Governors' Council on People with Disabilities were also represented.

The first order of Business was proponent testimony continued from last meeting provided by John Connelly of the Ohio Rehabilitation Services Commission. Mr. Connelly's written testimony is attached.

The Chair then recognized Judy Wortham, Deputy Director, Ohio Department of Mental Health with proponent testimony. Deputy Director Wortham's written testimony is attached.

Joan Lawrence, Director, Ohio Department of Aging, provided proponent testimony regarding Ohio Access. Ohio Access Final Report is attached.

The Chair recognized Sukey Barnum, Ohio Department of Job and Family Services with proponent testimony. Ms. Barnum's written testimony is attached.

The Chair called Kitty Burgett, Self and Faces of Stark County, who furnished proponent testimony regarding her daughter. Ms. Burgett's written testimony is attached.

Final testimony was given by Doug DeVoe, Ohio Advocates for Mental Health. Mr. DeVoe's written proponent testimony is attached.

Those members not in attendance were Senator Gardner, Representative Womer-Benjamin, and Representative Hoops.

The Chair then gave a brief review of the task set forth for this study committee and a basic review of what we have accomplished, stating the direction of future meetings.

There being no further business the committee adjourned at approximately 4:10 p.m. The next committee meeting will be held Wednesday, March 14, 2001, at 2:30 p.m. in the Senate Finance Hearing Room.

**TESTIMONY BEFORE THE TICKET TO WORK STUDY COMMITTEE  
ON  
FEDERAL TICKET-TO-WORK AND WORK INCENTIVES  
IMPROVEMENT ACT**

**By: John Connelly of the Rehabilitation Services Commission**

-In the words of a famous Civil War Admiral, which is somewhat comparable to a Marine General, David Farragut said as he led his ships into Mobile Bay, "Damn the torpedoes and full speed ahead." The Social Security Administration (SSA) seems to have adopted this attitude in the implementation of the Ticket to Work portion of the Work Incentives Improvement Act.

-SSA intends to implement the Ticket to Work Program in all states by January 2004. Unlike the Medicaid portion of the bill where states have a major role in implementation, the Ticket to Work Program is completely under SSA's discretion.

-SSA has identified thirteen states as being in the first implementation wave. Ohio is not among them and is not expected to be brought on line until the end of the implementation.

-SSA has selected Maximus to be the national program manager of the Ticket to Work Program. The primary responsibilities of Maximus will be to recruit and monitor employment networks (ENs) and insure that there are sufficient ENs available in each state.

-The actual service delivery to the ticket holder is done by an EN. An EN is any public or private entity willing to provide employment and VR services to a ticket holder. An EN may be a single entity or a consortium of entities.

-The ticket holder may select the EN they wish to be served by. However, an EN, except for public VR agencies such as RSC, may reject the ticket if it so chooses. The EN must offer the ticket holder informed choice in the selection of a job goal and services but not in the selection of the service provider.

-If the ticket holder is dissatisfied with the EN's services; he/she can take their ticket to another EN.

-ENs may get paid by SSA in one of two ways. The two payment methodologies are Outcome Payment or Outcome-Milestone Payment. Under either of these methods the ticket holder must work at certain levels of pay and periods of time before the EN can receive payment. There is a risk that an EN could spend money on services and not get paid. This may influence which tickets ENs choose to accept.

-A public VR agency, such as RSC, must enroll to be an EN. Unlike other ENs, RSC must accept all ticket holders who come to its door. In addition to having choice as to the job and services, the consumer also has a choice of the provider who will deliver the services. They may choose from an array of over 170 accredited private for profit or non-profit vendors as well as local public vendors.

-Given the law and the proposed Regulations, RSC has formed a study group that includes consumer and vendor representation to determine how RSC and the vendors can form an effective EN based on the law and the regulations that SSA is in the process of adopting.

-There are still many unknowns about the implementation of the legislation in regard to the Ticket to Work Program. This is not true of the Medicaid portion of the legislation. Hopefully, much can be learned from the pilot ticket states. A major concern is how SSA may issue the Tickets.

-The implementation of the Ticket to Work Program is completely under the purview of SSA. States may comment on the proposed Regulations, which are now out for comment. Where states do have the latitude under this law is in the Medicaid Buy In portion of the Act.

Ohio Department of Mental Health  
Testimony for the Joint Committee on  
Ticket to Work and Medicaid Buy-In (March 8, 2001)

Senator Harris, distinguished members of the panel. I am Judy Wortham, Deputy Director of the Ohio Department of Mental Health for Program and Policy Development. I would like to thank you for the opportunity to speak to you today.

You have had previous speakers who have done a fine job of outlining the technical and state level financial aspects of the Medicaid Buy-In authorized by the federal Ticket to Work legislation. I would like to take this opportunity to briefly discuss the human impact of this reform legislation, especially for persons recovering from serious mental illness. We believe that Ohio's approach to this opportunity should consider the financial benefits to people and the economy, as well as the impact on government.

The Department's perspective is shaped by our experiences with a five-year Social Security Administration demonstration grant to improve the employment rate of SSI/SSDI beneficiaries by providing work incentive counseling. Of the 18 demonstration grants nationally, ODMH is the only grantee focusing in on people with a serious mental illness.

This group of people represents the largest disability category in Ohio of persons receiving SSI/SSDI benefits<sup>1</sup>. People recovering from mental illness therefore have more

---

<sup>1</sup>Annual Statistical Supplement, 2000. Table 5.J12.—Number of disabled workers, by diagnostic group. December 1999. SSA; web access at, [www.ssa.gov/statistics/Supplement200](http://www.ssa.gov/statistics/Supplement200)

to gain or lose from action on this issue than any other group. Roughly 64,000 Ohioans with serious and persistent mental illness are served in our system and receive SSI/SSDI benefits<sup>2</sup>. Seventy percent of persons with severe and persistent mental illness report they want to work but only 10% actually work. Our current system, like the old welfare system, encourages dependency. For these persons, Medicaid Buy-In, as defined by either the Balanced Budget Act of 1997 or the Ticket to Work Act of 1999, represents a real opportunity to get off the benefits rolls, out of extreme poverty, and on to the tax rolls.

You may hear that current benefits provide various programs to facilitate employment while keeping Medicaid eligibility. What we have learned through our special Social Security funded Demonstration Project is that these programs are so complex that they are used by very few individuals—especially those with disabilities. For those recovering mentally ill individuals who do work, current programs as a practical matter limit most to dead-end, high stress, part time jobs that are not a way out of poverty and “disability dependence.”

The reasons for this are straightforward.

First, for persons who have SSI, the point at which a person loses Medicaid under current incentives is not sufficient for most persons to live and afford their psychiatric medication. The new psychiatric medications are effective but they are also costly.

---

<sup>2</sup> Information from ODMH MHIS Data

Many consumers face costs of \$10,000/year for medicines. Without the medication, the person loses their ability to maintain stability, and loses their ability to work. It is a Catch-22. Stay poor and under-employed and keep your benefits, or work and lose your health coverage. We note that for the vast majority of eligible individuals, state and local governments are already paying the costs of their Medicaid coverage.

A second disincentive relates to persons who have SSDI. Their Medicare coverage does not pay for prescription drugs, nor does it cover all the costs of doctors. And Medicare discriminates in its coverage against mental health care, requiring a 50% co-pay for therapy. With Medicaid Buy-In, if a person with SSDI pays a premium, they can have Medicaid coverage as a “wrap-around” to their Medicare coverage. Medicaid would pay for prescription drugs and any other costs that Medicare will not cover, and the person would continue to be eligible for Buy-In until gross earnings are about \$42,000/year. Again, this would be a “foot-up” for a person to achieve independence.

Another key aspect of this reform is that it would allow our consumers to receive Medicaid covered services without being subject to current “spend down” provisions. We recognize that the intent of the spend down is probably to make more people eligible for coverage by including the costs of care as an offset to income. As a practical matter, the way this works for people with mental illness is to create an additional hassle every month about their coverage status. We appreciate the great cooperation and assistance from ODJFS in helping us find ways to help consumers with the current spend down provision. However, the provision itself is an impediment to productivity.

The unemployment and underemployment of people recovering from mental illness is a tragedy. Many of these individuals would benefit from the late Governor Jim Rhodes' famous statement to the effect that "many ills are cured by a job." Because of this, an independent Mental Health Commission that was appointed by ODMH Director Hogan to review the public mental health system and make recommendations about a new strategic plan for mental health in Ohio, has recently recommended that Ohio should adopt the Medicaid Buy-In options that are available to us. I am pleased to present the Committee with a copy of the Commission's final report. These issues are addressed on pg. 21-22.

I would also note that the Taft Administration has been studying the various long-term care systems and agencies under the Governor's Ohio Access initiative. The Final Report of this study looks at long-term care services, particularly for the elderly, and people with mental retardation and mental illness. Ohio Department of Aging Director Joan Lawrence will be testifying today about the link between the Ohio Access initiative and Ticket to Work and the Medicaid Buy-in.

I would also like you to know that persons who have lived through the experiences I talk about are going to give testimony today. I would like to express my appreciation of their efforts and courage to provide their own stories.

Thank you for this opportunity for me to give testimony today.

**Joan W. Lawrence, Director, Ohio Department of Aging, submitted as written testimony on 03/08/01 the complete "Ohio Access for People with Disabilities" report. This is an excerpt of that report.**

## **Ohio Access for People with Disabilities**



**Final Report to Governor Taft**

**February 28, 2001**

**Table of Contents**

I. Executive Summary.....1

II. Overview of Community-Based Long Term Care Services in Ohio.....5

III. Services Offered for Specific Populations.....9

Department of Job and Family Services 9

Department of Mental Health 15

Department of Mental Retardation & Developmental Disabilities 22

Department of Aging 26

Department of Health 31

Department of Alcohol & Drug Addiction Services 34

IV. Public Involvement in the Ohio Access Process .....37

V. Federal Constraints.....45

VI. Challenges to State Disability Policy.....51

VII. FY 2002-2003 Executive Budget.....61

VIII. Recommendations.....69

IX. Appendices.....77

Appendix I: Web Sites Containing Related Information 77

Appendix II: Figures Contained in the Ohio Access Report 79

Appendix III: Acronyms Contained in the Ohio Access Report 81

**Respectfully Submitted**

Thomas W. Johnson, Director, Office of Budget and Management (Chair)

Jacqueline Romer-Sensky, Director, Department of Job and Family Services

Michael F. Hogan, Ph. D., Director, Department of Mental Health

Kenneth W. Ritchey, Director, Department of Mental Retardation and Developmental Disabilities

Joan W. Lawrence, Director, Department of Aging

J. Nick Baird, M.D., Director, Department of Health

Luceille Fleming, Director, Department of Alcohol and Drug Addiction Services

---

## Executive Summary

In June 2000, Governor Taft announced his continuing commitment to provide community-based alternatives for elders and persons with disabilities. In so doing, he outlined Ohio Access and its three guiding principles:

- 1) Increase Community Capacity. Publicly financed delivery systems should be responsive to consumer demand for choice of services and supports and the need to develop additional capacity in community based services. Current delivery systems must be improved to assist families, communities, and state and local governments in meeting their responsibilities.
- 2) Prioritize Resources. Reform/expansion of any delivery system must be accomplished by balancing competing priorities within the limited resources of families, community based organizations, and state and local governments. Government agencies need to develop a process to determine where reform is most needed and can be achieved. Part of this is seeking cost efficiencies and appropriateness of care, especially in institutional settings, thereby making more dollars available to support community-based care.
- 3) Assure Quality and Accountability. All publicly financed delivery systems must assure clinical, programmatic, and fiscal accountability and compliance at federal, state, local, and provider levels. Responsibility must be clearly defined at each level to ensure significant aspects of program design, including quality assurance, consumer health and safety, and sufficient and appropriate match.

Governor Taft instructed members of his cabinet to conduct a broad review of the state's existing system of services for persons with disabilities, obtain feedback from the public, and make recommendations for improving these services over the next six years, consistent with the three guiding principles. The Office of Budget and Management coordinated this initiative with the participation of the Departments of Job and Family Services, Mental Health, Mental Retardation and Developmental Disabilities (MR/DD), Health, Aging, and Alcohol and Drug Addiction Services.

The review of the system as it exists today, coupled with feedback from consumers and their advocates, lead the agencies involved in Ohio Access to call for a **new vision** of a service delivery system for persons with disabilities. Ohio Access honors the commitment of families who provide care and supports them in their efforts. Eighty percent of all long term care is provided by an informal network of care including family, friends, and neighbors. Government programs should respect and integrate with the family's historic and primary role in care giving. This vision emphasizes consumer choice, control, and autonomy. The cornerstone of the vision is consumer self determination and a person centered planning approach with assistance from family, friends and caregivers. Consumers will be given more **control** over the funds available for their care and be integrally involved in the **choice** of services and caregivers comprising their individual service plan. A holistic approach to person centered planning and care will ensure consideration of each consumer's physical, mental, emotional and spiritual needs.

## Executive Summary

---

Supported employment services programs will be further developed and more widely available and barriers to employment will be removed for consumers able to enhance their financial self-sufficiency.

Expected outcomes of this new vision include enhanced consumer: 1) independence, 2) personal dignity and responsibility, 3) access to community services and decreased reliance on institutional care settings, 4) quality of life, 5) health and safety, as well as 6) the most efficient use of limited funds. This approach will drive the development of home and community based care choices in support of health, wellness and prevention of unnecessary, premature institutionalization. The future array of service alternatives will ensure options, including quality institutional care where it is clinically appropriate and cost-efficient, consistent with each consumer's need and desire. Home and community-based options should be the norm rather than the exception.

To achieve this new vision, it is recommended that Ohio adopt the following goals:

- Elders and persons with disabilities live with dignity in settings they prefer.
- Elders and persons with disabilities receive safe, high-quality long-term care, services, and supports wherever they live.
- Relatives, neighbors, and friends who care for and support elders and persons with disabilities receive the information and services they need to plan for their future and support their caregiver role.

The report begins with an overview of state supported community-based long-term care services in Ohio. Section III describes the currently offered community services for persons with disabilities and is organized by agency. Section IV summarizes several different public processes that were used to gain consumer feedback on Ohio's system and the call by consumers for a new vision in how Ohio provides services to persons with disabilities. More specific recommendations are available through each agency's website. Section V addresses federal constraints that have contributed to the current institutional bias present in publicly funded programs. Section VI discusses specific challenges to state policy that exist and must be addressed for the vision articulated in this report to become reality. Section VII discusses short-term priorities that are contained in the FY 2002-2003 budget recently submitted by Governor Taft to the Ohio General Assembly. These recommendations, in a period of constrained growth and in light of present budget realities, serve as markers toward the new vision detailed in the final section of the report. Specific recommendations in Section VIII include:

**A. Match capacity with demand.** Put simply, expenditures for publicly funded care in Ohio are misaligned with the expectations and desires of Ohio's consumers. This misalignment has been created by federal and state reliance on institutional services over many years, including statutory reimbursement methodologies for institutional services, and the absence in most systems of a comprehensive state policy (such as Ohio Access) in favor of community-based services. The Governor's budget is an important first step in that it proposes adjustments to the current reimbursement system for institutional care that will slow the growth

in the cost of these services, while at the same time investing an additional \$145 million dollars in the expansion of home and community-based services for persons with disabilities. The state must work with existing private institutions and institutional providers to examine ways to transition to new models of community-based care and in diversifying their businesses.

**B. Generate and sustain the necessary resources to expand community services.**

A review of successful system realignment efforts here in Ohio, as exemplified by the Mental Health Act of 1988, and in other states makes evident how essential comprehensive structural reform is in achieving a balanced and sustainable delivery system. Isolated program initiatives alone will not be effective. Financing, statutes, regulations, local infrastructure, and the support of affiliated public agencies must be strategically aligned to achieve the intended results. A sustained reduction of institutional capacity and funding will not occur without a comprehensive, strategic focus. Without a shift of some funding to community settings, alternative community services will not grow and be sustained.

**C. Overcome federal policy constraints.** With a new administration on the federal level comes a new opportunity for Ohio to realign its public support for services for elders and persons with disabilities. Ohio must work with the National Governors' Association and other national groups to lobby for more flexible regulations. At the same time, state policy makers must continue to be responsive to the Health Care Financing Administration and the federal Office of Civil Rights to assure Ohio's compliance with the mandates of the Americans with Disabilities Act (ADA), allowing consumers to choose the most integrated settings for services.

**D. Address the health care workforce shortage.** Ohio must encourage public and private efforts to reengineer the direct care workforce and improve efficiency. Good management techniques and the adoption of best practices can create a work environment in which people are treated fairly and professionally. Job satisfaction is more than just wages and benefits. More emphasis should be placed on training and supporting supervisors who make the transition from direct care. The state should encourage the creation of demonstration projects to increase workforce efficiency.

In addition to increasing its workforce development efforts, the state must create strategies to examine innovative responses to the direct care workforce shortage. These initiatives may be aligned with the principles detailed in President Bush's New Freedom Initiative, which he proposed to Congress on February 1, 2001.

**E. Overcome policy constraints on self-sufficiency and personal responsibility.** A consistent theme throughout the public process that surrounds the development of the Ohio Access report, was that there are currently far too many policy barriers that inhibit persons with disabilities from achieving self-sufficiency. To the extent that such barriers exist, the state has an important role in developing mechanisms to remove those barriers.

Also, while the state plays an important role in financing and organizing long-term care services, the fact remains that the vast majority of long-term care, services, and supports is provided informally by relatives, neighbors, and friends. The state has an important role in supporting, not replacing, this informal network.

## **Executive Summary**

---

The recommendations are intentionally general in nature and must be further developed and refined with consumer, family, provider, and community input over the next six years.

The Ohio Access report is a blueprint for Ohio's future. In order to achieve the new vision for elders and persons with disabilities, the state must work with consumers and their families, local funding partners, and providers to overcome the barriers and constraints identified in this report. The implementation of the strategies outlined in Section VIII will require the commitment of all of these stakeholder groups, as well as the realignment of limited resources to purposefully and efficiently match capacity to demand.

The agencies recognize that the new vision cannot be achieved quickly. Ohio's current system of long-term care and services has evolved over many years and the issues highlighted in this report will not be resolved in the near term. However, Ohio Access marks a beginning, not an end point, and with the concerted efforts of all affected Ohioans, a vision based on self-determination and person-centered planning will be realized for our futures.

---

## Recommendations

The analysis of current state supported programs, the examination of both historic and future trends, and the voices of literally thousands of consumers and their advocates lead Ohio to a new vision for the delivery of long-term care, services and supports. Thousands of Ohioans are faced with the challenges of advanced age or living with disabilities. Eighty percent of all long term care is provided by an informal network of care including family, friends, and neighbors. The value of services provided by the informal care giving network in Ohio has been estimated to be \$8 billion per year, which is more than the amount Ohio spends annually for all Medicaid services.

Continuing to live independently and avoiding institutional placement is of primary concern to elders and people with disabilities – and a diminished prospect without appropriate home and community-based care. Through public forums, elders, people with disabilities, and their family and friends who support them have overwhelmingly expressed a desire for independence and home and community care choices. Many of these individuals have family members who want them to remain at home if at all possible. These individuals want more control over their own care and decision making in order to prevent institutional placement to maximize the effectiveness of services.

The Medicaid program, which funds most of Ohio's long term care, has a strong institutional bias due to current federal requirements and historic state financing and program design. These constraints significantly limit coverage and the provision of services consumers desire and demand. In addition, the cost of institutional care is growing at an unsustainable rate and there is strong evidence supporting the cost effectiveness of home and community-based care. At the same time, institutional care is an important component of a complete array of services that must be available to consumers. Ohio Access does not substitute one needed service for another. It is driven by the need for Ohio to provide a full array of cost-effective choices for consumers.

### **The New Vision:**

Ohio Access honors the commitment of families who provide care and supports them in their efforts. It is based on the premise that government programs should respect and integrate with the family's historic and primary role in care giving. Ohio Access supports this role by: 1) changing the way consumers are involved in their long-term care plan decision making and service delivery, and 2) shifting the focus of resource allocation to home and community based care aligned with consumer desire and demand.

The **cornerstone** of the Ohio Access vision is consumer self determination and a person centered planning approach with assistance from family, friends and caregivers. Consumers will be given more **control** over the funds available for their care and be integrally involved in the **choice** of services and caregivers comprising their individual service plan. A holistic approach to person centered planning and care will ensure consideration of each consumer's physical, mental, emotional and spiritual needs. Supported employment services programs will be

## **Recommendations**

---

further developed and more widely available, and barriers to employment will be removed for consumers able to enhance their financial self-sufficiency.

Expected outcomes of this new vision include enhanced consumer: 1) independence, 2) personal dignity and responsibility, 3) access to community services and decreased reliance on institutional care settings, 4) quality of life, 5) health and safety, as well as 6) the most efficient use of limited funds. This approach will drive the development of home and community based care choices in support of health, wellness, and prevention of unnecessary, premature institutionalization. The future array of service alternatives will ensure options, including quality institutional care where it is clinically appropriate and cost-efficient, consistent with each consumer's need and desire. Community alternatives should be the norm rather than the exception.

**Ohio's Goals for Elders and Persons with Disabilities.** To achieve this new vision, it is recommended that Ohio adopt the following goals:

- Elders and persons with disabilities live with dignity in settings they prefer.
- Elders and persons with disabilities receive safe, high-quality long-term care, services, and supports wherever they live.
- Relatives, neighbors, and friends who care for and support elders and persons with disabilities receive the information and services they need to plan for the future and support their caregiver role.

**Barriers to achieving a new vision for Ohio.** In acting on these commitments and achieving the new vision where community services are the norm and institutional placement the exception, Ohio faces significant barriers:

- A need to realign Ohio's spending on institutional care to match capacity with consumer demand;
- Limited resources to expand and sustain community services;
- Federal policy constraints;
- A shortage of a trained workforce to support persons with disabilities; and
- Constraints on self-sufficiency and personal responsibility.

**Recommended Strategies for Overcoming Barriers to Achieving the Vision.** The state agencies responsible for the provision of long-term care, services and supports recognize that the recommendations for overcoming the identified barriers are not achievable in the short-term. Budget constraints consistent with a slowing economy and the urgency of the need to address school funding coupled with the fact that these barriers have developed and existed for

many years and in some cases are beyond the state's control, necessitate a longer term strategy to be implemented over a six year period.

### **A. Match capacity with demand.**

This report has highlighted the fact that there is an historic imbalance in public spending for institutional services in Medicaid and certain long-term care systems. This is certainly a byproduct of a system where institutional care was the norm and not the exception. While Ohio has dramatically increased its spending on community services for persons with disabilities over the last decade, the funding imbalance has been so great that 75% of the funding for Medicaid long-term care, services, and supports is still used for institutional care.

Put simply, expenditures for publicly funded care in Ohio are misaligned with the expectations and desires of Ohio's consumers. The statewide vacancy rate in nursing facilities is approximately 13% at a time when a significant waiting list exists for Ohio's home and community-based waiver for persons with physical disabilities. This misalignment has been created by federal and state reliance on institutional services over many years, including statutory reimbursement methodologies for institutional services, and the absence in most systems of a comprehensive state policy (such as Ohio Access) in favor of community-based services. Therefore, in most systems, it is not possible to correctly align public resources with consumer expectations in the short term. Yet, consumer expectations for community care can not feasibly be met without reduced institutional utilization and the closure and consolidation of institutions that are not needed and/or are too expensive. The recommendations below should be regarded as a start at addressing the imbalance rather than a total solution.

The budget is a zero-sum game because all state agencies are competing for the same pool of limited resources. It is important to note that in the MH system, where legal and financial responsibility for institutional and community resources have been consolidated in a fixed point of local responsibility, expenditures for institutional services have been reduced by almost two-thirds from 1991 levels. During this period community services have expanded significantly and overall growth (i.e., community and institutional services combined) is less than 50%. The success of the Department of Mental Health suggests that further investments for community-based services in other delivery systems should be made, at least in part, by a reduction in institutional spending.

The Governor's budget is an important first step in that it proposes adjustments to the current reimbursement system for institutional care that will slow the growth in the cost of these services, while at the same time investing an additional \$145 million dollars in the expansion of home and community-based services for persons with disabilities. Increased spending on home and community-based services will allow state agencies to serve an additional 5,000 consumers during the next biennium. Beyond the proposed budget, other complementary recommendations include:

- Ohio must realign its public resources in response to consumer demand.
- The state must work with existing private institutions and institutional providers to examine new ways to transition to new models of community-based care and in diversifying their businesses.

## **Recommendations**

---

- Implement a small transition pilot program that allows those living in nursing homes to successfully transition to community living if they desire.
- Implement self-determination strategies in the twelve developmental centers operated by ODMRDD to allow individuals who choose to leave the centers to have the needed funding for community services. As individuals choose to leave, the capacity of the developmental center will be reduced.

### **B. Generate and sustain the necessary resources to expand community services.**

Beyond recommendations that realign institutional spending, over time the state must generate and sustain the necessary resources to support consumer desires to live in community settings whenever possible.

A review of successful system realignment efforts here in Ohio, as exemplified by the Mental Health Act of 1988, and in other states makes evident how essential comprehensive structural reform is in achieving a balanced and sustainable delivery system. Isolated program initiatives alone will not be effective. Financing, statutes, regulations, local infrastructure, and the support of affiliated public agencies must be strategically aligned to achieve the intended results. A sustained reduction of institutional capacity and funding will not occur without a comprehensive, strategic focus. Without a shift of some funding to community settings, alternative community services will not grow and be sustained.

It is also important to underscore strategies to sustain community-based delivery systems as we match capacity with demand. The budget challenges which exist in Ohio's community mental health system, for example, presents the very real possibility of a destabilized community system resulting in an increased demand for institutional capacity that no longer exists.

- Consistent with the Governor's proposed budget, redesign the current home and community-based waiver programs operated by ODMR/DD and ODJFS, consistent with the principles of consumer choice and control and high quality.
- To help sustain community-based delivery systems, obtain a waiver of Medicaid requirements in order to establish a range of cost and quality controls which will permit the state systems to manage a program of Medicaid funded services within available resources that maximizes the effectiveness of state and local resources.
- Successful transition to a community-based system requires that the state explore consumer demand for alternatives such as assisted living.
- Study ways to better link all programs that provide community services to persons with disabilities to end the fragmentation that currently exists. Better linkages are needed at the federal, state, and local level.
- Take steps to promote the efficiency of provider agency operations. Necessary actions include increased automation and standardization as required by the Health

Insurance Portability and Accountability Act (HIPAA), providing regulatory relief from unnecessary paperwork requirements (while maintaining the focus on accountability) and a better focus on program outcomes that benefit consumers.

- Clarify the role, responsibilities, and strengthen accountability for local and regional entities responsible for assisting consumers and their families in accessing and coordinating services.
- Increase the participation of consumers and family members in assessing the quality and effectiveness of services.

### **C. Overcome federal policy constraints.**

Section V of this report highlights the significant federal constraints faced by Ohio in achieving a new vision where consumer choice controls the setting in which services are received. With a new administration on the federal level comes a new opportunity for Ohio to realign its public support for services for elders and persons with disabilities. The following recommendations are offered by the state agencies responsible for the provision of publicly funded long-term care, supports, and services:

- Working with the National Governors Association, advocate for additional flexibility in the provision of long-term care, services and supports with the Health Care Financing Administration leadership, including the ability for Ohio to provide targeted, affordable home and community-based services without a federal Medicaid waiver to eliminate bureaucracy and time delays in program implementation.
- Continue to be responsive to the Health Care Financing Administration and the federal Office of Civil Rights to assure Ohio's compliance with the mandates of the Americans with Disabilities Act (ADA), allowing consumers to choose the most integrated settings for services.
- Seek federal approval for additional state flexibility in adopting market-based and value purchasing-driven strategies for working with service providers, such as competitive rate-setting processes and selective contracting with providers of services.
- Seek additional federal flexibility in the type of community services and work with the new federal administration to better address the housing needs of low-income persons with disabilities, including those wishing to relocate from institutions.

### **D. Address the health care workforce shortage.**

The labor shortage of health care and related community services workers in Ohio and throughout the United States has persisted for a number of years. According to forecasts, this is expected to not only continue but worsen – despite the evident slowing of the economy. There are a number of reasons for the shortage. Census projections indicated that fewer people will enter the labor market. This demographic reality means that health care and community services providers will be competing with other employers for a limited group of workers. There is a public perception that these positions are poorly compensated, considering the difficulty of the work and the responsibility and reliability required. Lack of worker

## **Recommendations**

---

recognition and satisfaction contributes to low worker retention. Specific barriers exist in the areas of worker transportation and training. Ohio must develop and test new strategies that enable health care and related professions to compete with other expanding job opportunities for a limited number of workers.

In November, a consortium of public and private agencies under the leadership of Ohio Department of Aging hosted a Governor's summit dealing with the critical issue of the need for workers to provide health care and related community services and supports in both community and institutional settings. In the longer term, the administration should build on the impetus provided by the summit to develop innovative ways to deal with worker shortages. Of special interest is that many of the recommendations below contribute not only to alleviating the worker shortage, but at the same time are responsive to the desire of consumers for greater control over service provision. The agencies propose the following recommendations:

Enhance workforce development initiatives. Ohio must encourage public and private efforts to reengineer the direct care workforce and improve efficiency. Good management techniques and the adoption of best practices can create a work environment in which people are treated fairly and professionally. Job satisfaction is more than just wages and benefits. More emphasis should be placed on training and supporting supervisors who make the transition from direct care.

The state should encourage the creation of demonstration projects to increase workforce efficiency. These include centralized recruitment and retention programs such as the program operated by the Council on Aging of Southwestern Ohio, creation of "career ladders" within the profession, provision of additional scholarship opportunities, and sponsorship of recognition events. Examine the use of payments to family members and other informal caregivers on a controlled basis for some services. Ohio should also study the use of worker owned cooperatives that offer higher wages and more benefits, such as the Paraprofessional Healthcare Institute.

- Build on the success of the Governor's Summit on the Health Care Worker Shortage by exploring the creation of a public-private work group under the auspice of the Governor to link workforce development activities with strategies to address the particular shortage of health care workers.
- Conduct a labor market analysis for each group of health care professional and each type of setting. Non-medical providers, such as those who provide homemaker services should also be included in this analysis.
- Study wage and rate issues to improve consistency across state-funded programs.
- Better align the need for health care and community services workers with Ohio's technical and vocational preparation programs, slated for expansion in the Governor's budget.
- Work with Ohio's nursing programs to increase student enrollment and retention.

- Work more closely with Ohio's jobs programs for persons leaving welfare. Also, the state agencies should work more closely with the Rehabilitation Services Commission and its initiatives.

Examine alternatives to the traditional provision of long term care. In addition to increasing its workforce development efforts, the state must create strategies to examine innovative responses to the direct care workforce shortage. These initiatives may be aligned with the principles detailed in President Bush's New Freedom Initiative, which he proposed to Congress on February 1, 2001.

- Examine "scope of practice" issues, including delegated nursing and responsible alternatives to delegated nursing.
- Explore the use of available technology which can allow individuals to stay home and decrease the need for human help to reduce reliance on an overburdened labor force. Increase utilization of existing technological advances, including the expanded use of telemedicine.
- Explore the increased use of independent service providers. The use of independent workers by consumers gives them more control and allows for greater self-determination.

### **E. Overcome policy constraints on self-sufficiency and personal and family responsibility.**

A consistent theme throughout the public process that surrounds the development of the Ohio Access report, was that there are currently far too many policy barriers that inhibit persons with disabilities from achieving self-sufficiency. To the extent that such barriers exist, the state has an important role in developing mechanisms to remove those barriers.

Also, while the state plays an important role in financing and organizing long-term care services, the fact remains that the vast majority of long-term care, services, and supports is provided informally by relatives, neighbors, and friends. Thus, the state also has an important role in supporting this informal network. While none of the listed recommendations below guarantee that the existing barriers to self-sufficiency and personal responsibility will be removed, each of the recommendations should be evaluated.

- Provide better information and assistance for consumers and their caregivers. Recognizing that people access services and information in many different ways, the agencies recommend movement toward the concept of "no wrong door" where Ohioans are given consistent, accurate, and timely information regardless of how they choose to enter the system. In the short term, mechanisms toward this approach include Ohio Helps and the Long-Term Care Consumer Guide – both Internet-based approaches – and the statewide toll free number that will be implemented this winter by Ohio Department of Aging.

## **Recommendations**

---

- Explore options that create opportunities for people with disabilities to work while still receiving health care coverage, especially the federally created “ticket to work” initiative.
- Explore the potential of the expanded opportunities states have been offered under Section 1902r of the Social Security Act that could remove barriers that exist in Medicaid eligibility requirements.
- Examine successful programs, such as the LEAP program in Cleveland that trains persons with disabilities to become care workers themselves.
- Develop a public policy by which those with resources may contribute some portion toward funding needed community services without jeopardizing their eligibility for those services. This overcomes Medicaid’s “all or nothing” approach, whereby either 1) the individual is economically eligible for the program and receives an extensive entitlement to a wider array of services than is available under any private insurance plan, or 2) the individual qualifies for no benefits at all.
- Encourage Ohioans to plan for their future needs for long-term care, services, and supports. Few Ohioans consider that they may need such supports in the future and even fewer consider the purchase of long-term care insurance. In part, this is because these policies, like Medicaid itself, emphasize institutional placement over community placement. However, newer policies may provide consumers with more choices and controls while still preserving private resources and assets. The state can play an important role as new insurance products develop as well as an important role in ensuring that the insurance products offered in Ohio are of high quality. The Department of Aging currently offers a free, in-home assessment to any Ohioan concerned with the future need for long-term care and services to encourage Ohioans to plan in advance of the actual need for services.

## **Conclusion**

The Ohio Access report is a blueprint for Ohio’s future. In order to achieve the new vision for elders and persons with disabilities, the state must work with consumers and their families, local funding partners, and providers to overcome the barriers and constraints identified in this report. The implementation of the strategies outlined in Section VIII will require the commitment of all of these stakeholder groups, as well as the realignment of limited resources to purposefully and efficiently match capacity to demand.

The agencies recognize that the new vision cannot be achieved quickly. Ohio's current system of long-term care and services has evolved over many years and the issues highlighted in this report will not be resolved in the near term. However, Ohio Access marks a beginning, not an end point, and with the concerted efforts of all affected Ohioans, a vision based on self-determination and person-centered planning will be realized for our futures.

**Testimony on Medicaid Buy-in**  
**For Ticket to Work Study Committee Meeting, 3/8/01**  
*Provided by Sukey Barnum, Ohio Department of Job and Family Services*

Good afternoon Chairperson Harris and members of the Ticket to Work Study Committee. In previous testimony I have explained current Medicaid eligibility standards, the Medicaid buy-in options provided to the State in federal law, and financing issues. To better enable the committee to discuss the pros and cons of different models, today I will lay out a possible model and walk through what that would mean in terms of a person's income, assets, and cost sharing responsibilities under the model.

The model I am laying out is not a proposed model. It is one of many options that the state has. The purpose of my testimony is to give the committee a better sense of what the program could look like, and some information that may be helpful when developing recommendations about actual income and assets limits, as well as premium amounts.

For the purposes of conversation, let us assume that Ohio chose a model for a Medicaid buy-in with the following criteria:

- upper income threshold at 250% of the federal poverty level, gross income;
- asset threshold at \$5,000 using same methodology as under current Medicaid;
- Monthly premiums on a sliding scale, assuming 7.5% of income for specified intervals.

**250% of the Federal Poverty Level**

To give a better idea of what income levels people would be making in actual dollars, I am providing a chart that lays out the poverty level for reference, and 250% of the federal poverty level for family units of 1,2, & 3. Also for reference, I am including not only annual, but also monthly and hourly. The monthly figure assumes consistent employment and earnings over the course of a year. The hourly figure assumes full time employment.

## 2001 Federal Poverty Level and 250% of the Federal Poverty Level

Family Unit	100% FPL Annual	100% FPL Monthly	100% FPL Hourly	250%FPL Annual	250% FPL Monthly	250% FPL Hourly
1	\$8,590	\$716	\$4	\$21,475	\$1,789	\$10.33
2	\$11,610	\$968	\$5.58	\$29,025	\$2,418	\$13.96
3	\$14,630	\$1,219	\$7.03	\$36,575	\$3,047	\$17.59

### Asset Threshold

If Ohio set an asset threshold at \$5,000 using current counting methodology, in addition to non-counted assets (home, all or part of a car, and personal affects), a person would be able to maintain up to \$5,000 in other assets (savings, other property, etc...).

### Monthly Premiums

If Ohio set monthly premiums on a sliding scale, assuming 7.5% of annual income for intervals of 100-125% of FPL, 125-150%, 150-175%, 175-200%, 200-225%, and 225-250%, the premium schedule would look as follows:

Income Range	Premium Based On	Calculation	Monthly Premium
100-125% FPL	7.5% of 100% FPL	$(.075 \times 8,590)/12$	\$53
125-150% FPL	7.5% of 125% FPL	$(.075 \times 10,737)/12$	\$67
150-175% FPL	7.5% of 150% FPL	$(.075 \times 12,885)/12$	\$80
175-200% FPL	7.5% of 175% FPL	$(.075 \times 15,032)/12$	\$94
200-225% FPL	7.5% of 200% FPL	$(.075 \times 17,180)/12$	\$107
225-250% FPL	7.5% of 225% FPL	$(.075 \times 19,327)/12$	\$120

This methodology establishes income ranges and then applies the allowed percentage of cost sharing to the lower end of the range. To look at other cost sharing levels, the 7.5% can be downward adjusted in the calculation, or other models can be developed.

Poverty level and premium figures can be used as a baseline for committee conversation about what a viable buy-in model would look like. I would be happy to respond to any questions.

## ***ELIZABETH'S TICKET TO THE FUTURE***

As the parent of a sixteen year old daughter, I am of course, concerned about her growing up, obtaining a good education, and becoming a productive member of society. However, whether all this happens will depend largely on whether she is able to obtain quality psychiatric care on an ongoing basis – for the rest of her life. You see, Elizabeth, my bright, talented teenage daughter was diagnosed a year ago with schizo-affective disorder. It began with severe depression. Later she began to experience hallucinations. Finally, voices in her head were urging her to harm herself and others. I missed two weeks of work while she was on a suicide watch. Her condition is presently well controlled with medication and by excellent psychiatric and psychological care. However, the only reason such quality care is available to her, is because our family income qualifies my children for Healthy Start Medicaid. I have been forced to decline additional work hours and turn down raises on my job in order to maintain their eligibility. Without Medicaid, Elizabeth's care and medication would be totally out of our financial reach.

However, Elizabeth will soon be legally an adult, and on her 19<sup>th</sup> birthday, her Healthy Start eligibility will end. If she cannot afford to continue her medication, she will not be able to function, let alone hold a job. College will be out of the question. Elizabeth has tremendous potential. She went through the Canton City Schools High Ability Program and was near the top of her class until the depression hit. She has inherited her late father's extraordinary musical talent and is accomplished on the oboe. She would like to study psychology and pursue the field of music therapy. She had even considered attending Lutheran Seminary after college.

“Ticket To Work” would literally be Elizabeth’s ticket to her future. If she cannot afford her mental health care, she will not be able to support herself and will become just another example of untapped, unrealized potential, living in a world of her own. If, on the other hand, she is able to buy into Medicaid on a sliding scale determined by her income, she will make the world she lives in, our world, a better place.

Kitty Burgett  
1237 Oxford Ave. NW  
Canton, Ohio 44703  
(330) 453-8859

*oamh*



(800) 429-8885  
(614) 267-4829  
Fax (614) 267-4550

Disability Policy Coalition  
4550 Indianola Ave. • Columbus OH 43214-2246  
*Advocating for community inclusion*

## Ohio Advocates for Mental Health

*WE CARE Network, Inc.*

5022 Sinclair Road

Columbus, OH 43229-5431

**(800) 589-2603** (in Ohio)

**(800) 860-0118** (nationwide)

(614) 888-8912 (in Columbus)

(614) 88809478 FAX

Testimony to the  
Ticket to Work and  
Work Incentives Improvement Committee  
created under the authority of Senate Bill 346

Senator Bill Harris, Chair

E-mail: [oamh@ohioadvocates.org](mailto:oamh@ohioadvocates.org)

[www.ohioadvocates.org](http://www.ohioadvocates.org)

Chairman Harris and members of the Senate Bill 346 Work Incentives Committee. Thank you for the opportunity to testify before the committee this afternoon.

My name is Doug DeVoe. I'm executive director of Ohio Advocates for Mental Health – a position I've held for nearly 11 years. OAMH is a statewide advocacy organization of and for people who have been diagnosed with a mental illness. We've been advocating for independence and recovery for people labeled as mentally ill since 1984. I'm also representing Disability Policy Coalition and the 20 disability advocacy organizations that belong to that coalition.

The Ticket to Work and Work Incentives Improvement Act has two distinct, but largely unrelated, parts. The Ticket to Work portion relates primarily to where and how one gets vocational rehabilitation services. And although there are times that people call my office very frustrated with vocational rehabilitation services --- and it might be nice to have an alternative program to which I could refer people --- that is far less important to us than the Medicaid Buy-in portion. And until I see a number of providers willing to take the risks inherent in becoming a provider network I'll reserve judgment on the viability.

Medicaid Buy-in relates specifically to the elimination of a significant disincentive for people with disabilities in going to work --- loss of healthcare benefits.

We are at an interesting point in Ohio's history. Unemployment has been at all-time low levels. Employers are complaining that they can't get or keep good employees. Ohio is competing in a global market place to keep and attract businesses to keep our economy growing. Yet, fully two-thirds of Ohioans with disabilities aren't employed. And when asked about the greatest impediment to returning to work, the answer is frequently the fear of losing their Medicaid health insurance.

Now, we recognize the Medicaid is currently experiencing some significant problems, and that Senate Bill 346 that created this committee was passed to bail out a \$750 million shortfall for Medicaid just this year.

However, for a moment, let's assume that a Joe Smith is receiving Supplemental Security Benefits from Social Security, and Medicaid coverage from the Ohio Department of Job and Family Services. He probably also is receiving a HUD housing supplement, as well as food stamps. If Joe goes to work at a decent job, he get his own apartment of his choosing and in the neighborhood he chooses. Someday he may buy his own home. He'll give up the SSI benefits, and drop food stamp coverage. Joe will begin paying city, state and federal income taxes, as well as paying more sales tax as his earnings increase. If we continue to provide health insurance coverage until he can get a private insurer it seems to me that the federal government wins, Ohio wins, Joe's community wins and Joe wins.

Now let's assume that Susie is working, but has a fairly significant disability and on-going medical costs. She works for a small company of less than ten employees. Susie's employers insurance company tells her employer that the rates for his employee coverage will increase significantly if they cover Susie. And they won't cover Susie at all for some pre-existing conditions. So the employer offers health insurance to everyone up to a dollar cost level, with the employee picking up the difference. Susie doesn't make enough to pay that cost, so she goes without insurance. When her illness progresses until she can't work, she quits or is fired and goes back on disability benefits and Medicaid. If the employer were able to provide coverage through Medicaid for Susie and keep a good employee, again the employer wins, the country wins, the community wins and Susie wins.

In Ohio we serve nearly 300,000 people in the public mental health system. Two-thirds of those people are not working. Of the 50,000 adults labeled, as severely mentally disabled 90 percent are unemployed. People with mental illnesses are already discriminated against in health insurance coverage with artificial annual and lifetime caps – a problem we don't appear to have the political will to correct in Ohio.

In December I had the opportunity to travel to Long Beach, CA, to visit The Village Project. This project was funded a dozen years ago to serve people in Los Angeles County who were the highest cost clients in the public mental health system. For a decade they have seen dramatically reduced costs for hospitalization and treatment, while 60 percent of their clients are either working or in training or education programs to go to work. They see work as a first priority. Interestingly, in their experience they have used a variety of tests and evaluation tools to evaluate "readiness" for work. All of those techniques were ineffective in predicting work success except for one factor --- **the desire of the person to work.**

What I'm proposing today is that a graduated implementation of Medicaid Buy-in be considered where:

1. People currently not working who are on Medicaid may keep their Medicaid coverage until they reach 250 percent of poverty level or are able to get private insurance. Implement this as step 1 July 1, 2001.
2. For people currently working we could offer an opportunity for the employer, the employee or some combination to pay premiums to get Medicaid coverage. I propose including this voluntary group in Medicaid Buy-in by July 1, 2002.
3. Complete Medicaid Buy-in costing and analysis, program participation criteria and budgeting to include all disabled Ohioans by July 1, 2003.

In closing let's be clear about one thing. Work for Ohioans with disabilities, and for us Ohioans with serious mental illnesses, is much more than just a job. Jobs bring dignity, increased

opportunities for self-determination. Jobs are people's identity. Jobs are where people meet their friends, and frequently their life partners.

And a job is an opportunity to break the cycle of dependence and isolation that so often accompanies a severe mental illness, or any disability. A dozen years ago I was sitting home, smoking cigarettes, drinking coffee and pacing the floor day after day. A job working evenings as a janitor broke that cycle. I got out of the house. I was able to have some income again. Most important, that job gave me back hope that there was a future. We encourage this committee to recommend that an injection of hope for all people with disabilities can occur if we choose to participate in the Medicaid Buy-in option.

Thank you for the opportunity to testify before this committee today.

OHIO SENATE  
TICKET TO WORK COMMITTEE

Minutes of  
March 14, 2001  
Committee Meeting

The meeting of the Ticket to Work committee was called to order by Chairman Harris at approximately 2:30 p.m. in the Senate Finance Hearing Room.

Senators Harris, Fingerhut, and Gardner, Representative Womer-Benjamin and Jones were present along with Bill Hayes of the Ohio Department of Job and Family Services; Bill Casto, Administrator, the Ohio Rehabilitation Services Commission; Jeff Davis of MR/DD; Mike Hogan, Director, Ohio Department of Mental Health; and Tracy Williams of the Ohio Department of Budget and Management constituting a quorum. The minutes from the February 28, March 1, and March 8 meeting were presented. Senator Gardner moved they be accepted and Representative Womer-Benjamin seconded the motion, there being no additions or corrections the minutes were approved as read. The Legislative Service Commission, the Ohio Association of Rehab Facilities, the Ohio Developmental Disabilities Council, the University of Cincinnati and the Governors' Council on People with Disabilities were also represented.

The first order of Business was proponent testimony given by Karla Lortz, the Governors' Council on People with Disabilities. Ms. Lortz's written testimony is attached.

The Chair then recognized Steven Howe of the University of Cincinnati. Professor Howe's written testimony is attached.

Those members not in attendance were Representative Hoops.

The Chair then gave a brief review of the task set forth for this study committee and a basic review of what we have accomplished, stating the direction of future meetings. He also invited Professor Howe back tomorrow for a Committee discussion relative to his testimony.

There being no further business the committee adjourned at approximately 4:05 p.m. The next committee meeting will be held Thursday, March 15, 2001, at 2:30 p.m. in the Senate Finance Hearing Room.



*Wayne P. Cocchi, Chair  
Karla M. Lortz, Executive Secretary*

*400 E. Campus View Blvd., Columbus, Ohio 43235-4604 614-438-1391 Voice/TTI  
Toll-free in Ohio 1-800-282-4536 Ext. 139  
FAX (614) 438-127  
Email [rsc\\_kml@rscnet.a1.state.oh.us](mailto:rsc_kml@rscnet.a1.state.oh.us)  
[www.state.oh.us/gcp](http://www.state.oh.us/gcp)*

**TESTIMONY  
March 8, 2001**

Senator Harris and members of the committee. Thank you for this opportunity to provide testimony on this very important issue. By way of introduction, my name is Karla Lortz, and I am the Executive Secretary for the Governor's Council on People with Disabilities. While you have more information about me than you ever wanted to know, I would like to just take a moment to personalize my remarks.

I have been employed in some aspect of disability work for nearly 40 years – first in a private, nonprofit organization and then in state government. One of the reasons I have been able to succeed and maintain that employment is because I have been very fortunate to have good health care benefits. Other people with disabilities are not so lucky.

The Governor's Council on People with Disabilities is a 21 member bipartisan, advisory body appointed by the governor for 3 year terms. The majority of the members must be people with disabilities. It is an advisory body to the governor & to the legislature on issues that effect Ohioans with disabilities. In addition, it is the state liaison to the U.S. Dept. of Labor's Office of Disability Employment Policy and to the National Organization on Disability. It was established in 1948 in response to the employment and other needs of returning WW II veterans with disabilities. While it has been reorganized several times, the most recent revision of its mission statement in October, 2000 clearly states the importance of employment in the lives of people with disabilities.

Due to the volume of information you have seen and heard, I would like to refocus attention on the issue that the Council considers most important – Medicaid Buy-In.

Scott Lay, Oregon State Human Resources Dept., has said, “If you are unemployed & not disabled, on the side of the road with a sign saying “will work for food” you will be seen as lazy. If you are disabled & not working, then you are meeting societies low expectations and probably pitied.”

Advocates, consumers and others have and continue to assist people with disabilities to overcome the disincentives and become active participants in the workforce. The one constant disincentive is obtaining adequate health care coverage, including personal assistance services. The risk of losing Medicare or Medicaid coverage is a far greater disincentive than the potential loss of income supports.

Federal legislation enacted in 1997 as well as the Ticket to Work and Work Incentives Improvement Act of 1999 provides states with the option of extending Medicaid coverage to working people with disabilities whose incomes would otherwise disqualify them from the program.

Currently, 16 states have either implemented buy-in programs for working people with disabilities or have enacted legislation to create such programs. Information about all of them can be found in the National Conference of State Legislatures publication [Ticket to Work: Medicaid Buy-In Options for Working People with Disabilities](#). It is also available on the Web.

While one size certainly does not fit all, I urge this committee to look at these other programs for ideas and recommendations to get Ohio moving down the road to

Medicaid Buy-In. Keep in mind that all of the programs are relatively new and, with the exception of Minnesota, relatively small. Most enrollees previously received Medicaid. All states impose a fee or premium on participants whose incomes are above a certain level.

States all seem to view their buy-in programs as “works in progress” and expect to make policy changes to encourage simplicity, equity and consistency in their programs & to ensure that costs are maintained a reasonable levels.

Other state legislatures have enacted the following types of legislation to further the development of Medicaid Buy-In:

- Requiring a study of work incentives
- Authorizing a work incentives demonstration project
- Providing authority to the executive branch of government to develop a Medicaid buy-in program
- Specifying details of a state Medicaid buy-in work incentives program
- Establishing various components of a comprehensive state work incentives initiative

In addition to these possibilities, HCFA has monies available for infrastructure grants to assist states in Medicaid buy-in development. I certainly hope that this committee will urge ODJFS to apply for this money.

It is virtually impossible to expect Ticket to Work and the Workforce Incentives Improvement Act to have any impact on the employment of people with disabilities without Medicaid Buy-In. It is time for Ohio to move forward in improving the

opportunities and eliminating the disincentives to employment for people with disabilities.

It is my hope that through the testimony and documentation that the committee will be able to develop some concrete recommendations that will truly project Ohio to the forefront in these efforts.

## *MISSION STATEMENT*

The Governor's Council on People with Disabilities exists to:

- Advise the Governor and General Assembly on statewide disability issues
- Educate and advocate for:
  - Partnerships at the local, state and national level
  - Promotion of equality, access and independence
  - Development of employment opportunities
- Promote the value of diversity, dignity and the quality of life for people with disabilities
- Be a catalyst to create systematic change to promote awareness of disability-related issues that will ultimately benefit all citizens of Ohio

# VITA

Karla M. Lortz  
31 Stonebrook Drive  
Delaware, Ohio 43015  
(614) 369-5730 (home)  
(614) 438-1393 (work)

## EDUCATION

Otterbein College 1960-1964 - B.A. Degree in Speech, English, Education  
Kent State University 1966-1967 - M.Ed. in Rehabilitation Counseling

## WORK EXPERIENCE

*Rehabilitation Services Commission  
Ohio Governor's Council on People with Disabilities  
400 East Campus View Blvd.  
Columbus, Ohio 43235-4604  
January 17, 1978 - present*

Since 1989, I have been the Executive Secretary for the Governor's Council on People with Disabilities. In this capacity, I have administrative responsibility for the twenty-one member Council, write and publish materials on a variety of disability-related issues, and provide technical assistance to employers and the general public on disability issues. Prior to my appointment as Executive Secretary, I worked for the Council as a Program Specialist on a variety of activities related to employment and building accessibility.

*Ohio Bureau of Employment Services  
145 South Front Street  
Columbus, Ohio 43215  
November 29, 1976 - January 15, 1978*

Project Coordinator for Project Employ. This program was conceived, designed and written by my husband and me. Utilizing C.E.T.A. Title III funds, the program hired handicapped persons to counsel and place other handicapped persons in competitive employment.

*Rehabilitation Service Commission  
4656 Heaton Road  
Columbus, Ohio 43229  
November 12, 1972 - November 26, 1976*

Counselor Manager for the Bureau of Services for the Visually Impaired. Later I was promoted to Vocational Supervisor and then to Rehabilitation Supervisor. In all positions, I was providing or assisting others to provide vocational rehabilitation and job placement for visually impaired persons.

In August, 1975, I was promoted to Program Specialist for the Governor's Council on Disabilities Persons. I was responsible for the Student Awards and the Recognition Programs, published a monthly newsletter, and prepared a questionnaire which laid the groundwork for the Ohio Whitehouse Conference on Handicapped Individuals.

*Goodwill Industries of Ohio  
1331 Edgehill Road  
Columbus, Ohio 43212  
January 6, 1970 - November 8, 1972*

As a Work Adjustment Counselor, I assisted handicapped persons with their adjustment to the world of work. I also developed, wrote, and implemented programs for professional staff, line supervisory personnel, and students from Ohio State University.

*Goodwill Industries of Southeastern Ohio  
108 Main Street  
Zanesville, Ohio  
November 6, 1967 - December 31, 1969*

As Director of Personnel and Rehabilitation, I organized a work evaluation and work adjustment program for persons with disabilities referred by various community agencies as well as supervised six staff persons and made numerous community contacts.

*Goodwill Industries of Central Ohio  
1331 Edgehill Road  
Columbus, Ohio 43212  
June 1, 1964 - August 26, 1966*

Positions held during this period included Costume Shop Manager, Intake Interviewer, and Personnel Supervisor.

### HONORS AND AWARDS

High School Salutatorian (1960), first place winner Cox Debate Tournament (1962), first place winner Weinland Writing and Spelling Contest (1963), National Goodwill Worker of the Year (1965), National Registry for Prominent Americans and International Notables (1970-1971 editions), Outstanding Service Citation by the Neighborhood Youth Corps (1970), Citation for Meritorious Service from the President's Committee on Employment of the Handicapped (1973), Outstanding Young Woman in America (1977 edition), Columbus Pilot Club Handicapped Professional Woman of the Year, 1978, Outstanding Achievement Award from the Ohio School Psychologists Association (1992).

### ORGANIZATIONS AND ACTIVITIES

Phi Kappa Delta Forensic Honorary, Phi Sigma Epsilon Sorority, National Rehabilitation Association, Central Ohio Rehabilitation Association (Secretary 1971, 1972), Cosponsor of Swinger (a group of teenagers with physical disabilities, 1972, 1973), promoted passage of Senate Bill 162 (Human Rights for the Handicapped, 1975), Columbus Wheelchair Awareness Committee (publicity chairperson, 1976), Governor's Planning Committee for the Ohio Whitehouse Conference on Handicapped Individuals (issues committee, 1976), Ohio Coalition of Citizens with Disabilities (treasurer, 1976, board member 1977, president 1978-1981, Ohio Whitehouse Conference on Libraries and Special Concerns (delegate and nominal group leader, 1978), National White House Conference on Libraries Delegate, 1979, State Superintendents Advisory Council on Special Education, 1979-1980, State Coordinator for a Section 504 Workshop for 50 persons with disabilities, 1979, OSU Disability Services Advisory Committee, 1980-1982, Mid Ohio Board for an Independent Living Environment (chair, 1984), Ohio Council of Churches Disabilities Task Force, Alpha Industries Board 1982-1984, Columbus Legal Aid Board, 1982-1984, Delaware Business and Professional Women, Ohio Easter Seals Board, JTPA State Jobs Training Coordinating Council.

### PUBLICATIONS

"HISTORY OF REHABILITATION" OHIO ALMANAC 1980

"AN INCLUSIVE COMMUNITY: DREAM OR REALITY" OHIO CHRISTIAN NEWS - OCTOBER 1981

OHIO SENATE  
TICKET TO WORK COMMITTEE

Minutes of  
March 15, 2001  
Committee Meeting

The meeting of the Ticket to Work committee was called to order by Chairman Harris at approximately 2:30 p.m. in the Senate Finance Hearing Room.

Senators Harris and Fingerhut, Representative Womer-Benjamin and Hoops were present along with Bill Hayes of the Ohio Department of Job and Family Services; Bill Casto, Administrator, the Ohio Rehabilitation Services Commission; Jeff Davis of MR/DD; and Tracy Williams of the Ohio Department of Budget and Management. **The committee was declared a sub-committee due to the lack of a quorum.** The Legislative Service Commission, the Ohio Rehab Services Commission, the Ohio Developmental Disabilities Council, the University of Cincinnati and the Governors' Council on People with Disabilities and Assistive Technology of Ohio were also represented.

The first order of Business was continued proponent testimony given by Steven Howe of the University of Cincinnati. Professor Howe's written testimony is attached.

Those members not in attendance were Senator Gardner, Representative Jones, and Mike Hogan, Ohio Department of Mental Health.

The Chair then gave a brief review of the task set forth for this study committee and a basic review of what we have accomplished, stating the direction of future meetings

There being no further business the committee adjourned at approximately 4:10 p.m. The next committee meeting will be held Wednesday, March 21, 2001, at 2:30 p.m. in the Senate Finance Hearing Room.

OHIO SENATE  
TICKET TO WORK COMMITTEE

Minutes of  
March 22, 2001  
Committee Meeting

The meeting of the Ticket to Work committee was called to order by Chairman Harris at approximately 2:35 p.m. in the Senate Finance Hearing Room.

Senators Harris and Fingerhut, Representative Womer-Benjamin and Jones were present along with Bill Hayes of the Ohio Department of Job and Family Services; sitting in for Bill Casto, Administrator, the Ohio Rehabilitation Services Commission was Mark Seifarth and Jeff Davis of MR/DD. **Due to the lack of a quorum Senator Harris declared the committee would continue as a sub-committee.** The Legislative Service Commission, the Ohio Rehab Services Commission, the Cerebral Palsy Association, the University of Cincinnati and the Governors' Council on People with Disabilities and the Ohio Association of Rehab Facilities were also represented.

The first order of business was proponent testimony given by Karla M. Lortz of the Disability Policy Coalition. Ms. Lortz's written testimony is attached.

The second person to give testimony was Steven Howe of the University of Cincinnati providing additional information on the Impact of Policy. Dr. Howe's written testimony is attached.

Sukey Barnum of the Ohio Department of Job and Family Services provided interested party testimony. Ms. Barnum's written testimony is attached.

Those members not in attendance were Senator Gardner and Representative Hoops, Tracy Williams, Ohio Department of Budget and Management.

The Chair then gave a brief comment regarding the draft of the final report which will be reviewed at the Wednesday meeting, looking to the voting and signing of the final report on Thursday.

There being no further business the committee adjourned at approximately 4:10 p.m. The next committee meeting will be held Wednesday, March 28, 2001, at 2:30 p.m. in the Senate Finance Hearing Room.



**Testimony for the Ticket to Work Study Committee  
Presented by Karla Lortz  
On behalf of the Disability Policy Coalition  
3/22/01**

Senator Harris, members of the committee, I appreciate the opportunity to make additional comments regarding the outcome of this committee's efforts to provide the opportunity for people with disabilities who want to work to maintain vital health care coverage as they make the move from dependence on public income supports to becoming wage earners and tax payers.

People with disabilities are very aware of the competing financial priorities, which this General Assembly faces. We applaud efforts to strengthen the educational system and enhancements to community supports currently being recommended. All of these efforts will lead to greater opportunities for people with disabilities to contribute to the wellbeing and support not only of themselves, but for their families and communities.

The issue facing this committee is how large a program and how fast to implement. Getting started is the key. Designing a program that remains within budgetary limits yet accomplishes the goal of decreasing barriers to work will be most effectively accomplished with the active participation of people most directly impacted. This participation should include direct input at the study and design phase, through implementation and monitoring of the program to determine effectiveness.

To get started, we recommend:

1. The Department of Jobs and Family Services actively pursue all federal dollars or private funds, such as through the Robert Wood Johnson Foundation, to support the analysis and infrastructure design. Support for the policy analysis could also be obtained through cooperative agreements with other state agencies involved in providing services to people.
2. Create a steering committee comprised primarily of people with disabilities, their families and advocates to assist in the design and implementation of the Medicaid Buy-In program.
3. Extend the charge of this Ticket to Work Study committee to include oversight for the analysis, design, implementation and monitoring of the program.

## **Disability Policy Coalition**

4550 Indianola Ave. • Columbus OH 43214-2246 • (800) 429-8885 • (614) 267-4829 • (614) 267-4550 fax

**Testimony on the Purpose of the new Federal Law entitled Ticket-to-Work, Work Incentives Improvement Act (PL016-170)**

Provided by Ron Swain, Benefits Consultant for COVA (Center of Vocational Alternatives) 03/07/01

Thank you for the opportunity to share my views on the TTWWIA. I am employed as a Benefit Consultant for COVA, a non-profit agency serving people with disabilities. In 1999, I helped obtain passage of this legislation by actively lobbying Congress. I have met with Congressman Ted Strickland and the staff of Congressman Dave Hobson and Senators Dewine and Voinovich regarding this legislation. In addition, I am the Director of the Benefits Planning, Assistance and Outreach Social Security grant for central and southeastern Ohio.

My comments will be limited to the Medicaid Buy-in provision of this legislation. In the past seven years COVA has provided benefits consultation to over 1700 disability benefit recipients throughout Ohio. We have witnessed first hand the disincentives of Ohio's current Medicaid rules.

There are significant numbers of Social Security Disability Insurance (SSDI) Title II beneficiaries who do not return to work due to Ohio's Medicaid eligibility structure. Any of these individuals who receive more than \$550 in a monthly SSDI check are faced with a major barrier. That barrier is an increase in Medicaid spenddown of one dollar for every two dollars earned (\$1 increase/\$2 earned) after a \$65 exclusion. Spenddown means an out-of-pocket medical expense for the individual.

A Supplemental Security Income (SSI) recipient can receive the Federal Benefit Rate of \$530 monthly without spenddown. An SSDI beneficiary receiving the same amount (\$530) must "spend down" all but \$20 to the state's Medicaid spenddown threshold of \$460 in countable income. This means there is a \$50 spenddown for the person who has worked and paid into the Social Security system. This penalizes those who have worked. They are further penalized when they return to work and must maintain Medicaid due to the severity of their impairments.

An SSI recipient can earn up to \$1817 monthly or \$21,804 annually without spenddown under a special provision called 1619(b). More SSI recipients are transitioning off SSI but maintaining Medicaid than ever before. They often start off working part-time and gradually work up to full-time. Some are even able to fully transition off all benefits once they begin full-time work. When they transition off Medicaid they save both state and federal dollars.

SSDI beneficiaries are those who have worked and who are more likely to work again, perhaps working at a level to ultimately transition off benefits. Ohio's current Medicaid rules often prevent this. When factoring in taxes, SSDI beneficiaries who are meeting their increased Medicaid spenddown while working are working for less than half price.

The people who have contributed to our economy through past work efforts are the ones being penalized by current Medicaid rules. They are doubly penalized by 1) having a spenddown and being forced to live on less, and 2) having an increase in that spenddown while working.

Medicaid for SSDI beneficiaries is, in effect, a 50% tax on those individuals with disabilities who choose to work. These individuals have contributed in the past, but are prevented by our Medicaid system from contributing to Ohio's economy now.

Unfortunately, Ohio has one of the most restrictive Medicaid policies in the United States. For individuals with disabilities, this is the major barrier to employment. Structuring a Medicaid Buy-in (via the TTWWIIA) would allow Ohio citizens with disabilities who want to work to do so.

## **Testimony of Denise Weisenborn, Ohio Rehabilitation Services Commission**

**03/22/01**

I'm not speaking to you today as a Commissioner, but rather as a consumer. For the past several weeks you have received excellent input from various agencies, outside experts, and interested parties. Because you are about to make decisions which will have a direct impact on the lives of thousands of consumers, I am coming before you today to present what I believe to be the consumer's perspective on a model for Medicaid buy-in.

Starting with the income threshold, any model must be at least 250% of poverty level (earned and unearned income) in order for there to be an incentive to the consumer. However, once that level is reached a consumer would be more willing and capable of paying 7.5% premiums for Medicaid.

Also in determining income, consumers would want a 100% of the spouse's income to be disregarded as well as 50% of the parents' income if the individual was still living with the parents.

As far as assets, the present \$1500 could remain the same with the idea of a \$10,000 separate account to be used as needed by the consumer. This could be categorized as any expenditure not covered by Medicaid. I think this idea is important to include because quality of life issues go hand-in-hand with a person working in the community.

Finally, I want to thank this Committee for its diligence and support of a topic that is as important as any other for this state, and I encourage you to work with your colleagues to find the necessary funds to start the implementation of the Medicaid buy-in in this coming biennium.

**Testimony on Medicaid Buy-in- Administrative Costs  
For Ticket to Work Study Committee Meeting, 3/22/01**  
*Provided by Sukey Barnum, Ohio Department of Job and Family Services*

Good afternoon Chairperson Harris and members of the Ticket to Work Study Committee. Today, I will be laying out some estimates for administrative costs of implementing and operating a Medicaid buy-in program. These estimates are based on conversations with Minnesota and Wisconsin. I rely more heavily on Wisconsin's experience since Wisconsin has a similar eligibility system to Ohio, and has a county administered, state supervised Medicaid program. Ohio's administrative costs will vary from these two states based on different infrastructure in place. And Ohio's costs may vary depending on different decisions about methods of implementation and administration.

There will be two types of administrative cost related to any Medicaid buy-in program. The first are start up costs including, but not limited to: program design and development; systems modifications; procurement of a fiscal agent for premium collection; materials development, reproduction, and distribution; training; and outreach. The second are operating costs including but not limited to: program management; eligibility determinations; disability determinations; payment of the fiscal agent; evaluation and reporting; and a variety of other costs based on increased use of existing infrastructure and requirements (i.e. auditing, claims processing, SUR).

I do not have an actual bottom line administrative cost for Wisconsin, but I do have some estimates for discrete implementation elements:

- 1.2 million dollars for modifications to the eligibility systems
- \$600,000 for fiscal agent to develop and prepare for implementation of monthly premium collection
- \$50,000 for development and duplication of brochures and other informational materials
- Five staff to work with contractors, and manage project design and implementation- ~ \$600,000

These elements add up to over 2.4 million dollars. Adding other costs for training, outreach, postage, travel, and others, administrative costs could exceed 2.5 million dollars. Ohio should expect to have slightly higher costs for start up of a buy-in program. ODJFS systems modification costs may be more than Wisconsin, possibly in the range of 1.5 to 2 million depending on the business rules. Ohio should assume somewhere between 2.5 and 3 million dollars.

Operating costs may vary depending on choices about how the program is administered. Minnesota has centralized eligibility determination for its Medicaid buy-in program. This has pros and cons. Statewide training and maintenance of a program to ensure understanding and appropriate administration of eligibility determinations at a county level may not be efficient given the expected number of participants. However, there is not currently a centralized eligibility determination function in Ohio, and developing one would take additional resources not captured in the above estimate for start up costs.

Because no take up rates have been assumed, and no administrative model has been confirmed, it is not possible to precisely assess operating costs. Operating costs include eligibility determination, disability determination, premium establishment and collection, card issuance, claims processing, program monitoring and evaluation, contract management, and all the other administrative functions performed by ODJFS in operating the Medicaid program. Some of these costs would be entirely new costs (staff or functions) and some would be increases costs already incurred. A preliminary estimate of staffing would be \$500,000 for staff and contracts to manage and administer the program and fiscal agent contract; conduct evaluation; and handle increased disability determinations. Cost estimates for eligibility determinations, and payment of the fiscal agent would be to some extent based on take up of the eligible population, and of those, how many would be subject to premium payment (assuming there would be no premium payment until 150% of federal poverty level). Eligibility determination costs are also driven by the frequency of redetermination. To give a ballpark, assuming the combined cost of eligibility determination and premium collection over the course of a year is \$250 per eligible, and

assuming in the first year, approximately one third of your assumed ultimate take-up come into the program, or about 4,500, then the annual cost for eligibility and premium collection for the program would be somewhere around 1.13 million. This kind of calculation does not account for the fact that not all 4,500 will be on all year, but all the eligibility determinations would be in the year, plan however many months of premium collection.

I hope to get additional information from Wisconsin about how their fiscal agent contract is paid, meaning is it a per member per month kind of payment or other. As soon as I have this information, I will forward it to Chairman Harris and the Legislative Services Commission.

To summarize, preliminary estimates for start up cost is upwards of 2.5 to 3 million dollars. Annual operating costs of could equal 1.63 million dollars. These estimates are not all encompassing and do not consider other all operating costs of the department and Office of Ohio Health Plans. Additionally, costs will vary depending on different decisions made about the model to be implemented, and the method of administration.

# APPENDIX A:

## MEDICARE AND MEDICAID COVERAGE OF PERSONS WITH DISABILITIES UNDER THE FEDERAL TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT OF 1999

### SUMMARY

Medicare is a federal health insurance program for eligible persons who are age 65 or older or disabled. Ohio's Medicaid program coverage includes people who are aged, blind, or disabled and meet certain criteria. The federal Ticket to Work and Work Incentives Improvement Act of 1999 extends the length of Medicare coverage for eligible disabled persons who return to work and provides states the opportunity to expand Medicaid coverage for the working disabled and to receive federal grants to help extend other state services.

### **Background on Medicaid and Medicare**

Medicare is a federal health insurance program for eligible persons who are age 65 or older or disabled. Medicare has two components: Part A and Part B. Part A covers hospital services. Part B covers physician, lab, x-ray, and other services. Medicare beneficiaries are subject to various cost-sharing expenses, including premiums, deductibles, and co-insurance. Generally, to be eligible for Medicare a disabled person must be a recipient of Social Security Disability Insurance benefits, which requires that the person has been employed in a position covered by Social Security prior to becoming disabled.

Medicaid is a joint state-federal health plan that provides health care coverage to families, children, aged, and disabled persons who meet criteria established by the Social Security Act, federal regulations, the Ohio Revised Code, and state rules. Medicaid covers many services, including hospital, physician, prescription, and long-term care services. In Ohio, The Office of Ohio Health Plans in the Ohio Department of Job and Family Services is responsible for the oversight and administration of the Medicaid State Plan. The Health Care Financing Administration of the U.S. Department of Health and Human Services oversees state operations of Medicaid programs.

Because Medicaid is a program for low-income persons, an applicant's income may not exceed income limits established by state rules. Not all income available to an applicant is counted in determining whether the applicant's income exceeds the income limit. Income not counted is considered an "exemption" or "disregard."

Only income remaining after all exemptions and disregards are applied is considered countable income and used in eligibility determination.

The federal poverty level (FPL) is a set of income guidelines established annually by the federal government and released by the U.S. Department of Health and Human Services. Public assistance programs like Medicaid generally define income standards in relation to FPL. In 2001, a family of three in Ohio was at the poverty level if the family members' combined annual income did not exceed \$14,630.<sup>3</sup>

Just as there is an income limit for Medicaid, there is also a resource limit. A resource is money or property a person owns, has the right, authority, or power to convert to cash, and is not legally restricted from using for his or her support and maintenance. Certain resources may be excluded from consideration in determining whether an applicant's resources exceed the resource limit. Only those resources not excluded are considered countable resources and used in the eligibility determination process.

### **Aged, Blind, or Disabled**

One of the categories of people eligible for Medicaid benefits are those who are aged, blind, or disabled (ABD). According to the 1998 *Ohio Medicaid Report* produced by the former Ohio Department of Human Services, financially qualifying Ohioans who are age 65 or older, blind, or have disabilities make up approximately 28% of Ohio's Medicaid recipients. At the same time, this population accounts for well over half of Medicaid spending in Ohio.

The ABD population covered under the state Medicaid plan consists of people, including children, with disabling conditions such as blindness, mental retardation, mental illness, and certain physical disabilities. Some people with disabilities who are not substantially impaired by their conditions and thus are not eligible for Medicaid through the ABD category may qualify because of limited income through the Ohio Works First (OWF)<sup>4</sup> or Healthy Start<sup>5</sup> programs.

---

<sup>3</sup> The 2001 Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia are \$8,590 for a family of one, adding \$3,020 for each additional person.

<sup>4</sup> The Personal Responsibility Act of 1996 changed entitlement to cash benefits for Aid to Families with Dependent Children (ADC) to a new program called Temporary Assistance for Needy Families (TANF). Ohio's TANF program is called Ohio Works First (OWF). OWF is established under Chapter 5107. of the Revised Code.

<sup>5</sup> Healthy Start is a Medicaid program established under § 5111.013 of the Revised Code that provides medical assistance to qualifying pregnant women and young children.

## **Social Security Disability Insurance and Supplemental Security Income**

The U.S. Social Security Administration awards disability benefits under two separate programs: social security disability insurance (SSDI) and supplemental security income (SSI). SSDI is an income assistance program supervised by the Social Security Administration that allows people who have worked a specified amount of time to receive income when they become disabled. SSDI is not based on financial need. Rather, individuals who are blind or disabled who have prior work history under Social Security are eligible to receive SSDI benefits.

SSI is a federal program administered by the Social Security Administration that provides cash assistance to people 65 or older or people (including children) who are blind or disabled. Unlike the SSDI program, a person need not have a work history, but must have a low income and few resources, to be eligible for SSI.

"Disability," under Social Security law, means that a person has a physical or mental problem that prevents that person from maintaining substantial gainful activity. "Substantial gainful activity" is employment that produces an income greater than an amount specified by federal regulations. As of July 1, 1999, substantial gainful activity is fixed at earnings greater than \$700 per month. The Social Security Administration must also determine that the person's medical condition is such that the person would be unable to adjust to other work. The medical condition responsible for the disability must be expected to last at least one year or to result in death.

## **Ticket to Work and Work Incentives Improvement Act of 1999**

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) was signed on December 17, 1999.

### **Medicare**

SSDI beneficiaries are currently given a grace period of nine months in which they may return to work without risking their disability or Medicare benefits. When a beneficiary achieves a monthly income at or above the substantial gainful activity level (\$700) after the nine-month period, disability payments cease. If the beneficiary maintains employment while the disabling condition persists, the beneficiary can receive Medicare coverage for an additional 39 months, or 48 months total. TWWIIA extends this Medicare coverage for working SSDI beneficiaries to eight and one half years.

The Social Security Administration is required to perform continuing disability reviews to ascertain whether an individual receiving SSDI benefits remains disabled

and consequently eligible to sustain benefits. Currently, any indication of recovery from disability, including return to work, can provoke a continuing disability review. TWWIIA provides that, as of January 1, 2002, a return to work will not by itself initiate a continuing disability review for SSDI beneficiaries who have received benefits for at least 24 months. The Social Security Administration is also prohibited from holding a continuing disability review while a beneficiary is receiving services as a result of redeeming a ticket under the new Ticket to Work Program (see **Vocational Rehabilitation**, below).

Presently, SSDI beneficiaries whose benefits are terminated due to work activity may have their benefits reinstated at any time during a 36-month period of prolonged eligibility without having to submit a new application for disability determination. TWWIIA allows SSDI and SSI beneficiaries whose benefits cease due to work activity to have their benefits restored without submitting a new application for disability determination. This provision stipulates that the person's cessation of employment must be due to his or her health and a request for reinstatement of benefits must be submitted within 60 months subsequent to the month employment was terminated. The beneficiary would also be able to obtain interim cash and Medicare or Medicaid benefits for up to six months pending the decision related to reinstatement of benefits. If it is determined that benefits are not to be reinstated, temporary benefits would end but temporary benefits previously awarded would not be regarded as overpayment.

### **Medicaid**

TWWIIA allows states to establish one or both of two new Medicaid eligibility categories. States may establish a category covering people between the ages of 16 and 64 with disabilities who, except for income, would be eligible for SSI. For this new category of beneficiaries, states are permitted to establish limits on assets, resources and income that differ from current federal limitations. States that choose to offer Medicaid coverage to people in this category may also provide coverage to a second eligibility category--employed people with disabilities whose medical conditions have improved to the point where they are no longer eligible for SSI or SSDI, but who continue to have potentially severe disabilities. States can require people in the new categories to pay premiums for Medicaid coverage, or other cost-sharing charges, set on a sliding fee scale based on income. People with incomes above 250% percent of the FPL may be required to pay the full premium cost, but premiums may not exceed 7.5% of income for people with incomes between 250% and 450% of the FPL. People with annual earnings above \$75,000 per year are required to pay all of the premium costs. States have the option of subsidizing premium costs for people in this category, but federal matching funds cannot be used for this purpose.

### **Vocational rehabilitation**

In addition to the changes to Medicare and Medicaid, TWWIIA establishes the Ticket to Work program. Under this program, SSDI and SSI disability beneficiaries are each to be issued a ticket or voucher that they may present to any participating vocational rehabilitation agency to obtain various services designed to facilitate entry into the workforce. Participation in the Ticket to Work program is voluntary for vocational rehabilitation agencies, SSDI, and SSI disability beneficiaries. The Commissioner of Social Security is to select certain sites to begin implementation of this program beginning January 1, 2001. The Ticket to Work program is to be fully operational in the entire country by January 1, 2004.

### **Federal assistance**

In order to provide states with support, TWWIIA authorizes the U.S. Secretary of Health and Human Services to do both of the following:

- Award grants to qualifying states to devise and implement institutions that provide support services to working people with disabilities, and to operate outreach campaigns to educate them about these new benefits;
- Initiate state demonstration programs that would grant medical assistance comparable to Medicaid for working persons age 16-64 who have potentially severe disabilities.

## **Bibliography**

Christian, Stephen M. and Martha P. King. *Medicaid Survival Kit*. National Conference of State Legislatures, 1999

Ohio Department of Human Services. *Ohio Medicaid Report*, December 1998

*Social Security Benefit Programs for the Aged or Disabled*, Neighborhood Legal Services, Inc., 1997, available in <<http://www.nls.org/benefits/ssdssi.htm>>

U.S. Social Security Administration, *Fact Sheet: Ticket to Work and Work Incentives Improvement Act of 1999* (last modified Dec. 1999)  
<<http://www.socialsecurity.gov/work/factsheet.htm>>

U.S. Social Security Administration, *Questions and Answers* (visited Jan. 6, 2000)  
<<http://www.socialsecurity.gov/work/Q&A.htm>>.

U.S. Social Security Administration, *Social Security Legislative Bulletin, 106-15: President Clinton Signs The Ticket To Work And Work Incentives Improvement Act Of 1999* (last modified Dec. 17, 1999)  
<[http://www.ssa.gov/legislation/legis\\_bulletin\\_121799.html](http://www.ssa.gov/legislation/legis_bulletin_121799.html)>

Wilson, Joy Johnson, *The Ticket to Work and Work Incentives Improvement Act of 1999* (visited Jan. 2, 2000) <<http://www.ncsl.org/statefed/health/ticktowrk.htm>>

r0398.124/bc

R:124.ticketreport/mlp