

**Analysis of Medical
Expenditures and Service Use
of Medicaid Buy-In
Participants, 2002 - 2005**

Executive Summary

October 29, 2009

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EXECUTIVE SUMMARY

Congress established the Medicaid Buy-In program when it passed the Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act (Ticket Act) of 1999. Under the program, so named because participants “buy into” Medicaid by paying monthly premiums or co-payments, states can offer Medicaid coverage to workers with disabilities whose income and assets would otherwise make them ineligible for Medicaid. To enroll in the program, individuals must have a disability as defined by the Social Security Administration (SSA) and meet certain work and financial eligibility requirements.

Since its inception, the Medicaid Buy-In program has offered state policymakers an important option for providing health care coverage to working adults with disabilities. More than 200,000 people have enrolled in the program at some point between 1997 and 2007, and as a result, have access to health services covered by their state Medicaid plans. Most Buy-In participants are also covered by Medicare because they receive Social Security Disability Insurance (SSDI) payments. Analyzing the Medicaid and Medicare expenditures of Buy-In participants offers useful information to policymakers and program administrators who are interested in monitoring spending trends for future budget and outreach planning. It can also foster a better understanding of how service needs vary among Buy-In participants. This information can help states to ensure their Buy-In programs will continue to meet the on-going needs of workers with disabilities.

In this report, we specifically examine the following questions:

- What were the annual and per member, per month (PMPM) expenditures of Buy-In participants enrolled between 2002 and 2005?
- How did expenditures and service use in 2005 vary by type of service and by participant characteristic—nationwide and by state?

- Among those first-time Buy-In participants who had prior Medicaid and/or Medicare coverage, how did their expenditures change around the time of Buy-In enrollment?

A. Summary of Key Findings

1. Expenditures of Buy-In Participants

Combined Medicaid and Medicare inflation-adjusted expenditures¹ for Buy-In participants nationwide increased from \$887 million to \$1.9 billion between 2002 and 2005, with nearly three quarters of services paid for by Medicaid. This growth in total expenditures reflects increasing Medicaid Buy-In program enrollment, which more than doubled over this same period—rising from 51,152 to 107,687 individuals.

Although total Medicaid expenditures rose as enrollment increased, Medicaid PMPM costs were relatively stable, varying between \$1,287 and \$1,161 depending on the year. Medicare PMPM costs reflect a somewhat different pattern. For dual Buy-In participants, their Medicare PMPM costs rose from \$493 in 2002 to \$608 in 2004, before falling back to \$597 in 2005.²

Dual Buy-In participants nationwide had higher PMPM Medicaid expenditures than non-duals in each year between 2002 and 2005. Duals represent 75 percent of Buy-In participants nationwide, and are more prevalent than in the broader population (41 percent) of all disabled Medicaid enrollees. This finding suggests that dual participants may have more severe conditions or different service needs than non-duals. However, in three-fourths of Buy-In states, Medicaid PMPM expenditures were lower among duals than non-duals. Duals can have lower Medicaid

¹ All expenditures were adjusted to 2005 dollars using the Consumer Price Index (CPI) for all goods and services.

² These trends could, in part, be a reflection of changes occurring among overall Medicare and Medicaid populations during the same time period.

expenditures than non-duals because Medicare is the first payer for many services, such as inpatient hospital care.

We also compared Buy-In participants with other working-age disabled Medicaid enrollees and found that Buy-In participants in 2005 incurred lower annual Medicaid expenditures per enrollee than other adult disabled Medicaid enrollees. This difference was observed nationwide and in most states with a Buy-In program, and suggests that Buy-In participants who are working may require fewer services or a less expensive mix of services than other disabled Medicaid enrollees.

States varied considerably in their 2005 Medicaid PMPM expenditures from slightly more than \$600 to more than \$3,600 in 2005 (the national average was \$1,224). The three states with the highest PMPM expenditures were Wyoming (\$3,623), Indiana (\$2,163), and Minnesota (\$2,104). State differences in PMPM Medicaid expenditures may be due to variation in program eligibility criteria, participant mix of characteristics, and scope of covered services across states.

2. Variation in Expenditures by Type of Service and Participant Characteristic

Prescription drugs accounted for the largest share of total Medicaid spending (36 percent or \$436 in PMPM expenditures) and were used by more participants than any other service (91 percent). This finding is based on 2005 data, one year before Medicare Part D was implemented. Community long-term care (LTC) services, which include personal assistance services (PAS), represented the second largest share of total Medicaid spending (22 percent or \$270 PMPM Medicaid expenditures).

Inpatient hospital expenditures accounted for the largest share of Medicare spending (44 percent or \$264 PMPM expenditures) among dual Buy-In participants in 2005. The second largest category of Medicare spending was Part B carrier services, which include physician visits and lab tests (25 percent or \$151 PMPM expenditures).

Older Buy-In participants who were dual had higher Medicare service use rates and incurred higher Medicare PMPM expenditures than younger participants (\$785 for those 65 years or older; \$731 for those 51-64 years, \$512 for those 31-50 years, and \$378 for those 30 years or younger). However, adults between 31 and 50 years of age had the highest level of Medicaid PMPM expenditures (\$1,304) in 2005. Participants who were at least 65 years of age had the lowest PMPM Medicaid expenditures and service use rate. This is expected because after turning 65, they became eligible for Medicare, which is the primary payer for inpatient and physician services.

SSDI only beneficiaries were the most likely to use any Medicaid (97 percent) or Medicare service (91 percent), suggesting that SSDI beneficiaries may have greater need for services than other groups of Buy-In participants. Among dual participants who are eligible for both Medicaid and Medicare services, SSDI-only beneficiaries had the second-highest level of PMPM Medicare expenditures (\$629) after persons with no prior history of receiving SSA benefits (\$691), who are mostly 65 years or older.

Individuals with mental retardation or developmental disabilities had the highest Medicaid PMPM expenditures (\$2,124) and service use rate (97 percent), but among duals, incurred the lowest Medicare PMPM expenditures (\$242) in 2005. This finding suggests that differences in the scope of covered services may affect expenditures by type of disabling condition. For example, intermediate care facilities for persons with mental retardation or developmental disabilities are included in Medicaid long-term care services but are not covered by Medicare.

3. Change in Expenditures of First-Time Participants

About one-third of first-time Buy-In participants in 2004 did not have Medicaid coverage in the year prior to enrollment. Average monthly Medicaid expenditures in 2005 for this group of participants were 30 percent lower than for participants with prior Medicaid coverage. This

suggests that when states consider expanding Buy-In coverage to those who have not previously been covered by Medicaid, these new enrollees—though representing a new burden on state Medicaid budgets—would not be as costly as persons who migrate from another Medicaid eligibility category in the short term.

Among the remaining first-time participants who had Medicaid coverage in the year prior to Buy-In enrollment, average monthly Medicaid expenditures were 12 percent higher in the year after Buy-In enrollment than in the year before. Among first-time participants who were dually enrolled in the year before and after Buy-In enrollment, average monthly Medicare expenditures increased by 39 percent as well. These findings may reflect typical increases in expenditures as people age or expenditure differences associated with Buy-In enrollment and will require further investigation. Also, although expenditures were higher for these individuals overall, about forty percent of each group had lower Medicaid and Medicare expenditures in 2005 than in 2003, respectively.

Among first-time Buy-In participants who became newly dual in the year during or after Buy-In enrollment, average monthly Medicaid expenditures fell by more than 12 percent. We also found preliminary evidence that some shifting of expenditures from Medicaid to Medicare is occurring for new dual participants. This pattern of shifting expenditures is likely to have increased after 2006, when Medicare began covering prescription drugs under Part D.

B. Implications

Analyzing the Medicaid and Medicare expenditures of Buy-In participants offers a useful snapshot of trends that can help policymakers and program administrators plan future budgets, assess program performance, and improve access to Medicaid services so workers with disabilities can become or remain employed. Our findings have three key implications:

- Total Medicaid and Medicare expenditures will rise as enrollment in the Buy-In program continues to grow. Most of the increase can be attributed to growing enrollment of new participants; a portion of this increase may result from increased Medicaid expenditures for some participants as they age or change the type of services they need. Only a minority of Buy-In participants is new to Medicaid; these new enrollees would require additional budget funding.
- Buy-In participants are less expensive than other adult disabled Medicaid enrollees. Therefore, states without a Buy-In program should consider starting a new one. Also, state policymakers have considerable flexibility in designing or refining Medicaid Buy-In programs. Given the findings in this report, they may wish to consider focusing their programs and outreach toward younger workers with disabilities.
- For dual Buy-In participants, Medicaid PMPM expenditures have remained stable over time, but Medicare costs have steadily increased. Though this trend may not be unique to the Buy-In population, it is particularly consequential because the majority of Buy-In participants are SSDI beneficiaries. This pattern of increasing Medicare expenditures is likely to have continued after Part D was implemented in 2006.

This study is based on information integrated from multiple state and federal data sources including Buy-In participant files provided by the states, Medicaid eligibility and claims files, Medicare claims records, and administrative data from the Social Security Administration (SSA). We reviewed the completeness of all data and communicated with the states to resolve problems in the state finder files when possible. As a result, this study provides the most comprehensive information to date on patterns of Medicaid and Medicare spending among Buy-In participants.

This study also has built a foundation for examining other questions related to Buy-In participant health care use and expenditures. These questions include, for example: To what extent does the increase in Medicaid and Medicare expenditures over time reflect a worsening of health status that is unrelated to employment? What are the characteristics and employment outcomes of Buy-In participants who experience a decrease in expenditures? Answers to these questions may help to further our understanding of how Buy-In participants use the Buy-In program to maintain or increase earnings.

The Centers for Medicare & Medicaid Services (CMS) will continue to monitor participation in the Medicaid Buy-In program. The use of quantitative methods for tracking the medical expenditures, enrollment, and earnings of Buy-In participants and the capacity to integrate information from state and federal administrative data sources will provide CMS and other policymakers with valuable information to help shape programs that improve the employment and health outcomes of workers with disabilities.

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