SUBJECT: Establishing a Medicaid buy-in program for people with disabilities

COMMITTEE: Public Health — committee substitute recommended

VOTE: 8 ayes — Gray, Coleman, Capelo, Delisi, Longoria, Maxey, Uresti, Wohlgemuth

0 nays

1 absent — Glaze

WITNESSES: For — Diana Kern, Amy Mizcles, NAMI Texas; Dennis Borel, Coalition for Texans with Disabilities; Kim McPherson, The Mental Health Association in Texas; *Registered but did not testify:* Anne Dunkelberg, Center for Public Policy Priorities; Linda Rushing, Texas Conference of Catholic Health Facilities; Susan Jones, Texas Hospital Association; Susan Marshall, The ARC of Texas; Lisa McGiffert, Consumers Union; Leslie Hernandez, National Association of Social Workers, Texas; Christine Fisher, Leigh Redmond, Texas Mental Health Consumers; Carolyn Parker, Texas AIDS Network; John Umphress, Texas Association of Public and Nonprofit Hospitals; Angela Shannon; Helen Kent Davis, Texas Medical Association; Hannah Riddering, Texas National Association for Women; Thanh Trinh

Against — None

On — Suzanne Elrod, Texas Center for Disability Studies, UT-Austin; Jonas Schwartz, Advocacy, Inc.; *Registered but did not testify:* Lori Roberts, Sharon Cohen, Texas Department of Health, Children with Special Health Care Needs Division

BACKGROUND: Under federal law, individuals who are disabled and receive Supplemental Security Insurance (SSI) benefits also are eligible for Medicaid, the state-federal health-care program for low-income people. To be eligible for SSI, individuals must be disabled and earn below a certain income level. Under Texas law, Medicaid is funded through the Department of Health (TDH) and administered by the Department of Human Services (DHS).

As individuals with disabilities enter the workforce, their income can rise to levels that disqualify them for SSI, which then causes them to lose Medicaid benefits. This often is cited as one reason why, while the desire to work may be high, the employment rate for people with disabilities remains low.

To address this barrier to employment for people with disabilities, the federal Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) made it possible for states to provide a Medicaid buy-in program for disabled people who would like to work and still retain their Medicaid benefits. It also directed the U.S. Department of Health and Human Services to establish a grant program to fund states' efforts to change their Medicaid regulations to meet the needs of people with disabilities who want to work.

Funding for these changes is administered through the Medicaid Infrastructure Grant program. Established in 1999, $250 million in federal funding to support demonstration projects was authorized for six years.

Only two states, Rhode Island and Mississippi, took advantage of the first round of infrastructure grants. Grants to these two states will total $29.5 million over six years, leaving about 88 percent of the available grant funds for a second round of grants, which will begin in 2002. To participate in the second round, states must submit their grant applications by May 21, 2001.

Eligibility for infrastructure grant funding is tied to a state's level of personal assistance services. HCFA provides a "reserved" level of grant funding for states that do not provide a certain level of personal assistance services but does not release funds until the state achieves the desired service level. States that provide some personal assistance services can be eligible for the "transitional" grant, which is a $500,000 minimum grant for one year. To obtain amounts above the minimum, a state must have individuals enrolled in a Medicaid buy-in program. Any additional funding counts as a portion of the states' contribution to the Medicaid premium for these individuals.

Under 42 U.S.C. §1396d (v) (1), a person with a "medically-improved disability" is defined as a person between the ages of 16 and 64 who is employed at least 40 hours per week at least at minimum wage, and who ceases to be eligible for medical assistance because of medical improvement but continues to have a severe medically-determinable impairment. The work

requirement also can be met by effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the state and approved by federal authorities.

DIGEST:

CSHB 1087 would add sec. 32.053 to the Human Resources Code, which would direct DHS to create a demonstration project for a Medicaid buy-in program at three different sites in accordance with the federal Ticket to Work and Work Incentives Improvement Act of 1999.

The eligible population would include people who are between the ages of 16 and 64, have an income above the SSI limit and are employed with a "medically-improved disability." DHS also could establish income, assets, and resource limitations for eligibility and require participants to pay premiums or other cost-sharing payments.

This bill would direct DHS to evaluate the efficacy of the demonstration project by December 1, 2002. If the program was effective, DHS would be directed to incorporate this program into the agency's budget request for fiscal 2004-05. Authorization for the demonstration program would expire September 1, 2003.

CSHB 1087 also would direct the Health and Human Services Commission (HHSC) to pursue the Ticket to Work grant to support the infrastructure of the demonstration project. It also would direct DHS to pursue any waivers or other authorization from HCFA that it would need to implement the demonstration project by September 1, 2002. The agency could delay implementing the demonstration project until all federal waivers or authorizations were granted.

CSHB 1087 would take effect September 1, 2001.

SUPPORTERS SAY:

CSHB 1087 would remove a significant barrier to work for people with disabilities. The way that SSI eligibility is determined provides a disincentive to work. People with disabilities who can work often cannot afford the medical costs associated with a disability or the full range of services that Medicaid covers. A person with a disability may be capable of earning enough money to give up the SSI cash benefit, but not enough to replace the Medicaid benefit. This disincentive makes people with

disabilities dependent on cash assistance and discourages them from pursuing the therapeutic benefits of work.

A Medicaid buy-in program would promote independence for people with disabilities. Like CHIP for families with children, the buy-in aspect of this demonstration program would encourage graduated self-sufficiency and remove the stigma of "welfare" associated with Medicaid.

This project would not cost the state any general revenue funds. The fiscal note for this bill projects a net positive gain of approximately $250,000 in fiscal 2002-03. It assumes that 30 of the 300 participants would be new to the Medicaid program and that the participants' premiums for the program would be sufficient to cover the premiums for the people new to Medicaid. The infrastructure costs associated with this demonstration program would be paid through federal infrastructure grants, so no additional burden would be placed on the agencies that administer Medicaid.

CSHB 1087 would not create a perpetual program. Because this is a demonstration project with a specific expiration date and an evaluation check point, the state could try a buy-in program. If the program had adverse unintended consequences, then it could be allowed to expire. If it works as intended, then the Legislature could choose to continue it.

OPPONENTS SAY:

CSHB 1087 would encourage people with disabilities to remain dependent on the state. SSI has specific income limits because if a person can earn above those levels, that person should not be receiving public assistance either in cash or benefits. Health insurance is expensive for many people, but the state should encourage people with disabilities to make the necessary adjustments to their budget and pay for it rather than continuing to receive public assistance.

A Medicaid buy-in program would promote a false sense of independence for people with disabilities. If these individuals need the richer benefits package provided by Medicaid over the private insurance they could obtain on the free market, time in this program is unlikely to change those needs. Unlike CHIP, where there is a reasonable expectation that families will move through the levels of graduated self-sufficiency to full independence,

individuals who buy into Medicaid are unlikely to ever graduate from the program.

CSHB 1087 would rely on federal funds that the state may not be eligible to receive. The bill's fiscal note assumes that costs associated with implementing and evaluating the program would be paid by federal infrastructure grants. To obtain those funds, the agency would need to submit an application in the next 32 days to meet the deadline of May 21, 2001.

Even if the agency submitted the application on time, considerable doubt exists about Texas' eligibility for these grants, as the funds are tied to states' level of personal assistance services. Because of the current level of personal assistance services in Texas, it is most likely that Texas only would be eligible either for the "reserved" or "transitional" level of grants. Therefore, the highest amount of funding that Texas could receive in infrastructure grants in fiscal 2002 is $500,000. This is less than the $715,000 that the fiscal note assumes Texas would need to spend to develop the infrastructure for the demonstration program.

CSHB 1087 could commit Texas to funding additional Medicaid waiver slots. This bill would direct HHSC to comply with any prerequisite imposed under federal law prior to receiving an infrastructure grant. Because personal assistance services are funded as a part of Medicaid-waiver programs, the adequacy of the state's personal assistance services would be based on the adequacy of the state's waiver programs. If HCFA determined that the state's current funding level for Medicaid waiver slots did not provide sufficient personal assistance services, then HHSC would be required to meet this prerequisite by adding waiver slots. While the Article 11 "wish list" in CSSB 1 includes $416 million for Medicaid waiver slots, compliance with HCFA's standards for personal assistance services to obtain an infrastructure grant could involve expanding the number of waiver slots even more.

CSHB 1087 would exacerbate the state's Medicaid case load problems. The House already has passed an emergency appropriations bill (HB 1333 by Junell), in part, to cover a shortfall of $600 million in Medicaid. The state should not expand Medicaid eligibility in an environment of rising case loads and costs.

NOTES:

The companion bill, SB 831 by Moncrief, passed the Senate by 30-0 on March 22 and was reported favorably, without amendment, by the House Public Health Committee on April 11, making it eligible to be considered in lieu of HB 1087.

The committee substitute for HB 1087 stipulates the number of sites for the demonstration project and adds direction to HHSC to pursue the Ticket to Work infrastructure grants and to DHS to pursue any necessary federal waivers or authorizations for the demonstration project.

The fiscal note for CSHB 1087 estimates a net positive impact of $248,638 to general revenue in fiscal 2003-04. It assumes that 300 individuals would participate in the program and that the program would provide 12 months of coverage in 2003. Of those 300 participants, 270 would be existing Medicaid recipients, 30 would be new to the program. Half of the participants would pay $68 per month in premiums and the other half would pay $136.