

November 2006 CMS MIG Conference (Chicago, IL)
Workgroup #4: Enrollment and Cost Estimation

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Session Objectives

- Develop strategies for estimating enrollment in MIG-related programs
 - Identify national and state level data sources for generating estimates
 - Understand how policy changes may influence future enrollment projections
 - Develop an analytical model to define a program's costs and benefits
 - Identify strategies to communicate findings with a policymaking audience
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Workshop Agenda

I. What are States' Enrollment and Cost Estimation Needs?

Buy-In Program Context for Estimating Enrollment or Cost

Virginia recently approved a Buy-In and plans to start enrollment in January 2007.
Montana is working on getting a Buy-In approved by legislature
Alabama is planning the design of a Buy-in and is hoping the legislature will approve it this session.
Utah recently redesigned their premium structure and would like to know the impact on program enrollment
Hawaii is working on a Buy-In proposal and is seeking various cost estimates, drawing from other states
New Mexico must redesign their buy-in, so would like to know the impact on enrollment/ costs from a change in design.

Specific Issues of Interest on Program Enrollment and Cost

- One state noticed that there was a 15% higher cost of Medicaid Buy-In vs. other Medicaid enrollees
- Since data from the States' Medicaid office can be very difficult to obtain (if the MIG is separate from the state Medicaid office), one state wanted to obtain federal data for this purpose- wanted advice on how to obtain this data.
- One state has been having trouble with enrollment/ outreach – they're trying to increase enrollment and change the premium structure to deal with this.
- One state has been asked for cost estimates from the legislature (multiple times)
- One state wanted to do a comparison of costs for the Buy-In population before and after Part D
- One state changed its personal care plan in 2001 and wants to know what the enrollment impact was
- One state has an unearned income cap- originally instituted to protect against an explosion in enrollment but now would like to remove the unearned income cap.

Trying to show that other states have removed their unearned income cap, and the enrollment explosion didn't happen.

Lessons / Recommendations from States

Outreach/ PR campaigns:

- Utah employed an outreach effort that they estimate increased their enrollment by 20% (following the implementation of Part D- outreach occurred in the 2nd quarter of 06.) The state distributed 10,000 brochures on the Buy-In program to eligible workers.
- West Virginia also undertook a PR campaign that greatly increased enrollment.

Encouraging work (earned income):

- Louisiana structured their premiums to reward individuals for earned income vs. unearned income. Their formula for counting income for the premium payment only counts 20% of earned income but a much greater percentage of unearned income.
- West Virginia has a very high limit on earned income (not many are in danger of hitting it)- but does have a modest unearned income limit.

II. Cost and Enrollment Estimation: Methods and Data Sources

A. Identifying your Target Population: Prior Program Participation and the “three Es” (Employment, Eligibility, and Enrollment)

1. Prior Program Participation (SSDI and SSI)

- Of all Buy-In participants nationwide ever enrolled in 2004, the majority of Buy-In participants (71%) come from the SSDI program. Only 25% were not enrolled in either SSDI or SSI before. 3% had participated in both SSDI and SSI before.
- Thus, the former or currently eligible SSDI Population is really the Buy-in program's main target population because they're the most likely to qualify for and take up the program.
- The Buy-in Program may be especially attractive to DI recipients because of the “cash cliff” which puts SSDI recipients at risk of losing their DI benefits if they earn more than SGA (\$860/month for non-blind individuals in 2006) for 12 months or more.

2. Employed / Working Individuals with Disabilities (age 18-64)

To answer this question, several data sources are available.

- SSA dataset- can obtain aggregated data at <http://www.socialsecurity.gov/policy/>. Shows data on number and percent of working SSDI beneficiaries by state. Look for the “Annual Statistical Report on the Social Security Disability Insurance

Program” using the search toolbar. In the table of contents, scroll down the list of charts and tables – “All Disabled Beneficiaries” and “Disabled Workers”

- American Community Survey (ACS) in 2005: Useful as a current snapshot for individuals with disabilities (beyond the SSA definition). Does not breakout by SSDI participation. Can obtain data on number/ percent self-identified as disabled by state (which is different from SSA definition of eligibility). See <http://www.census.gov/acs> and <http://www.disabilitystatistics.org>, which is maintained by Cornell University.

3. *Eligibility*

- Existing Medicaid eligibility standards in most states are tied to income limits such as SGA, or a % of the federal poverty level (FPL).
- Medicaid enrollment statistics may be found at the state-level from the agency that handles Medicaid data. Alternatively, state-level data may be accessed at the Kaiser Foundation’s state health facts website, which is user-friendly (not only for state-level Medicaid enrollment, but also Medicaid expenditures, state demographics, etc.) See <http://www.statehealthfacts.org>
- Estimating the number eligible for the Buy-In program will depend on state-specific program features (income limits and asset limits). Higher income limits will raise the number of eligibles; lower limits reduce the number of eligibles.
- Therefore, the Buy-In’s target population is whatever percent is above the existing Medicaid eligibility standard (for states whose Medicaid is not tied to SGA, target population is those who are above the Medicaid income threshold.)

4. *Enrollment*

- Predicting what percent of your target population will enroll is the most difficult step in program enrollment estimation.
- What are the alternative options of individuals with disabilities? If you are dual-eligible, does it make sense to opt for the Buy-In program? Enrollment or yield may also depend on the design of cost-sharing features (premiums, co-payments).
- Data from cross-state comparisons can be helpful. Look to other states with similar program design features in order to get a sense for the % range of individuals with disabilities eligible for the Buy-In program that enroll. But this is a very rough guess, and should not be relied upon as a “hard estimate”.
- Actual enrollment figures by state may be found in MPR’s Statistical Profile Report, which is updated annually. See <http://www.mathematica-mpr.com> and search for “Statistical Profile” using the search toolbar.

5. *Cost Estimation*

- Utilization of Buy-In enrollees is the key factor for estimating cost. Difficult to predict because it depends on how Buy-In enrollees are using the program (e.g. wrap-around coverage, prescriptions only?), which will vary from state to state.
- Medicaid Expenditures PMPM (per-member, per month) is used to determine cost estimates. May be found in MPR's Statistical Profile, which is updated annually. See <http://www.mathematica-mpr.com> and search for "Statistical Profile".
- Time period and references matter. For enrollment and cost, be sure to specify the time definition you are using. (e.g., quarterly enrollment?, annual enrollment?, current enrollment at a point in time (may exclude people who were on Buy-In for a short time) versus "ever enrolled" in a year.)

B. Program Features: Impact on Enrollment and Cost

1. Income/ Earnings limits
 - increases in limits should lead to increased enrollment and cost
 - obtaining data on earnings of potential enrollees: target population survey can be helpful, but sometimes quality of responses is poor
 - wide variation across states – many states use 250% FPL
 - based on the experience of other states, changing the income/earnings limit has the greatest influence on the number of potential enrollees
2. Asset Limits
 - increases should lead to increased enrollment and cost
 - different limits for individuals vs. couples/families
 - not all states have asset limits
3. Cost-sharing requirements (premiums, deductibles, co-payments)
 - increases should lead to decreased enrollment and cost
 - cost-sharing features vary widely from state to state, in many states, monthly premiums begin to take effect starting at 100% FPL and up
 - some states use a sliding scale, others have multiple tiers or cliffs, and one state has an enrollment fee in addition to monthly premiums

C. Communicating Findings

1. Who is your target audience?
 - For most states it was the state legislature or other stakeholders.
2. What are the expectations of your audience?
 - Depending on the goals of the state's legislature, the best strategy is usually to market the buy-in as a work incentive program (due to states' budget pressures) rather than as a Medicaid expansion.

- One state mentioned that it's smart to avoid promising that a certain number will increase work due to the Buy-In, because legislatures have a way of coming back later with those numbers, and at the outset these numbers are difficult to estimate.

3. How are the findings going to be used?

- Several states currently without a Buy-In are using the findings to develop proposals for Buy-In programs or to get their Buy-In proposal approved.
- States with an existing Buy-In are using the findings to predict the cost or enrollment implications of various policy changes or determine what policy changes should be made to reach a certain enrollment goal or cost criteria.