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Estimating the Cost and Utilization of Wraparound Coverage for Employed People with Disabilities

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The Affordable Care Act (ACA) expanded health insurance to many working-age adults with disabilities, but the new coverage and existing insurance options are unlikely to fully meet the employment-related health care needs of this population. A policy or program that provides services or financial support to "wrap around" the new ACA coverage or other private and public coverage may be a viable option for meeting the health care needs of these adults and for supporting their employment (Perriello 2015). This brief presents information that can support policy discussions about wraparound programs by quantifying the costs and use of care for employed people with disabilities who have access to wraparound coverage through the Massachusetts Medicaid Buy-In program as a supplement for their primary insurance.

Introduction

The U.S. system of health insurance has important limitations for workers with disabilities. Health insurance available through private providers and Medicare generally places limits on covered services and does not cover some disability-related services that support independent living and employment. Medicaid programs generally do not have these limitations, but participation is restricted to those with low income and assets. As a result, some people with

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disabilities must choose between gainful employment and access to comprehensive health insurance that covers disability-related services.

There is no reason to expect that the new health insurance coverage provided under the Affordable Care Act (ACA) will alter the relationship between access to disability-related services and income. Although the ACA is expected to expand access to private health insurance for an estimated 2 million people with disabilities (Gettens et al. 2011), the standards for the ACA marketplace-based coverage are comparable to those offered by private insurance before the ACA (Corlette et al. 2013). This level of coverage may not meet all the health care needs of people with disabilities who want to stay employed and need extra support to do so (Hyde and Livermore 2014).

By implementing a Medicaid Buy-In (MBI) program, however, states have been able to weaken or break the link between low income and coverage for disability-related services. MBI programs allow workers with disabilities whose income would make them ineligible for traditional Medicaid to purchase Medicaid insurance. Although MBI programs operate in most states, few states have income limits as high as those in the Massachusetts program, CommonHealth Working (CHW). Most MBI programs limit income to around 250 percent of the federal poverty level (FPL) or lower, including one state's program that has an income limit below 100 percent FPL (National Council on Disability 2015). Massachusetts, Minnesota, and Connecticut are noteworthy exceptions.

Wraparound coverage similar to that provided through MBI programs could provide disability-related services that are not otherwise covered by primary insurance plans; this coverage could also protect policy holders with disabilities from incurring excessive out-of-pocket costs. Information on the cost and utilization of the wraparound services that would be covered is needed to advance the policy debate related to wraparound insurance for people with disabilities. One focus group study (Gettens and Henry 2014) identified the needs among employed and potentially employed people with disabilities that could be addressed through wraparound coverage, including long-term community support services, units of services beyond limits imposed by primary insurance plans, and cost protections. This brief presents findings from a quantitative analysis to build on the qualitative evidence from Gettens and Henry.

Massachusetts as a Case Study

We analyzed the wraparound costs and utilization of CHW enrollees who used the program to supplement their primary insurance (Medicare or private insurance) in 2012. Because Massachusetts implemented health care reform in 2006 that is similar to the ACA, and because the state has an MBI program with high income limits, it is well suited to serve as a case study on the wraparound services used by insured workers with disabilities.

CHW enrollees must have medically determinable conditions that would meet the Social Security Administration's medical-eligibility criteria were they not actually engaged in substantial employment: they must work at least 40 hours per month and have household income at or above 133 percent FPL. There are no upper limits on income or assets. Qualifying individuals pay a monthly premium based on income.

CHW supplements Medicare and private insurance in two ways: it is a second payer for services covered by the primary plan and a primary payer for services not covered by the primary plan. Specifically, CHW may pay balances, including deductibles or co-payments, on services covered by primary insurance, such as medically necessary inpatient and outpatient services. CHW also covers services not typically covered by primary insurance, such as community-based services that support independent living. Examples include personal assistant services (PAS), community-based mental health services, and home health services. CHW also covers services that may be limited by Medicare and private plans. Examples include behavioral health care, durable medical equipment, and medications.

Characteristics of Workers Who Use CHW as Wraparound Insurance

Of the 20,007 workers enrolled in CHW in 2012, 15,338, or 77 percent, were 21 to 64 years old and had primary coverage through Medicare or private insurance, thus meeting the inclusion criteria for our study. During one or more months in 2012, CHW provided secondary coverage to Medicare for 84 percent of CHW enrollees in the study population, to private insurance for 9 percent of the study population, and to both Medicare and private insurance for 8 percent of the study population. On average, CHW served as wraparound insurance for 8.5 months of the year.

Data and Methods

This issue brief is based on an analysis of Medicaid eligibility data from Massachusetts and CHW claims data. The former include information on demographics, income, and CHW eligibility. We used CHW claims data to generate cost and utilization statistics for workers who used CHW as wraparound coverage in 2012. We classified claims into the following service categories: community-based services (non-mental health); behavioral health; inpatient and outpatient; professional services (non-institutional, non-mental health services provided by physicians and other medical professionals); pharmacy; and other non-institutional, non-mental health services. For more details, refer to Gettens et al. (2016).

CHW enrollees in the study population were predominately older adults with a relatively low income. Nearly two-thirds were between ages 50 to 64. Among all enrollees in the study population for whom records were available, earnings were relatively low. Indeed, 83 percent of the study population who received Medicare earned less than $1,000 per month, likely reflect the fact that those enrolled in Medicare were presumably current or recent Social Security Disability Insurance (DI) beneficiaries. In contrast, only 31 percent of the study population with private insurance had earnings below $1,000 per month, and 47 percent earned more than $2,000 per month. Few (31 percent) with private insurance received DI benefits. Consistent with the earnings pattern, 78 percent of the study population who had primary insurance through Medicare had an income below 250 percent FPL relative to 42 percent of those with private insurance.

Wraparound Expenditures and Utilization

Expenditures for all CHW enrollees in the study population totaled $55 million in 2012, or $427 per member per month (PMPM), as shown in Table 1. Ninety percent of the study popultaion had a claim during 2012. Accordingly, per *user* per month costs for those with CHW claims were only slightly higher than per member per month costs: $448.

Table 1. Expenditures and utilization by service categories for CHW participants in 2012

Service Category	Total Expenditures (Million $)	Per Member Per Month Expenditures ($)	Per User Per Month Expenditures ($)	Unduplicated Users (%)
Community-Based Services (Non-mental Health)	30.0	231	1,957	10.7
Behavioral Health	10.0	77	170	41.3
Community-Based Mental Health	5.0	38	444	7.8
Psychiatric Treatment	4.2	33	78	37.7
Substance Abuse Services	0.8	6	256	2.2
Inpatient and Outpatient Services	4.9	38	58	58.4
Professional Services[a]	2.7	21	27	69.6
Pharmacy	1.9	15	22	61.7
Other	5.9	45	67	59.1
Total	55.4	427	448	90.1

[a]Professional services include non-institutional, non-mental health services provided by physicians and other medical professionals.

Expenditures were highest in two service categories: community-based services and supports (non-mental health) and behavioral health services (which encompass both mental health and substance abuse services). The former accounted for over $30 million in expenditures, driven by $20.8 million spent on PAS. Few in the study population (11 percent) used these community-based services and supports, but for those who did, the average cost was high. For example, only 6 percent used PAS, but their average expenditures totaled $2,260 per user per month. Conversely, over 40 percent used a behavioral health service, but their average expenditures were more moderate—$170 per user per month. Spending on behavioral health totaled $10 million; half was for community-based mental health services.

The majority of CHW enrollees in the study population used professional services (70 percent), pharmacy (62 percent), and inpatient and outpatient services (58 percent), accounting for $2.7 million, $1.9 million, and $4.9 million of total annual expenditures, respectively. Professional services and pharmacy services were both relatively low in cost (less than $27 per user per month), whereas inpatient and outpatient services cost more ($58 per user per month).

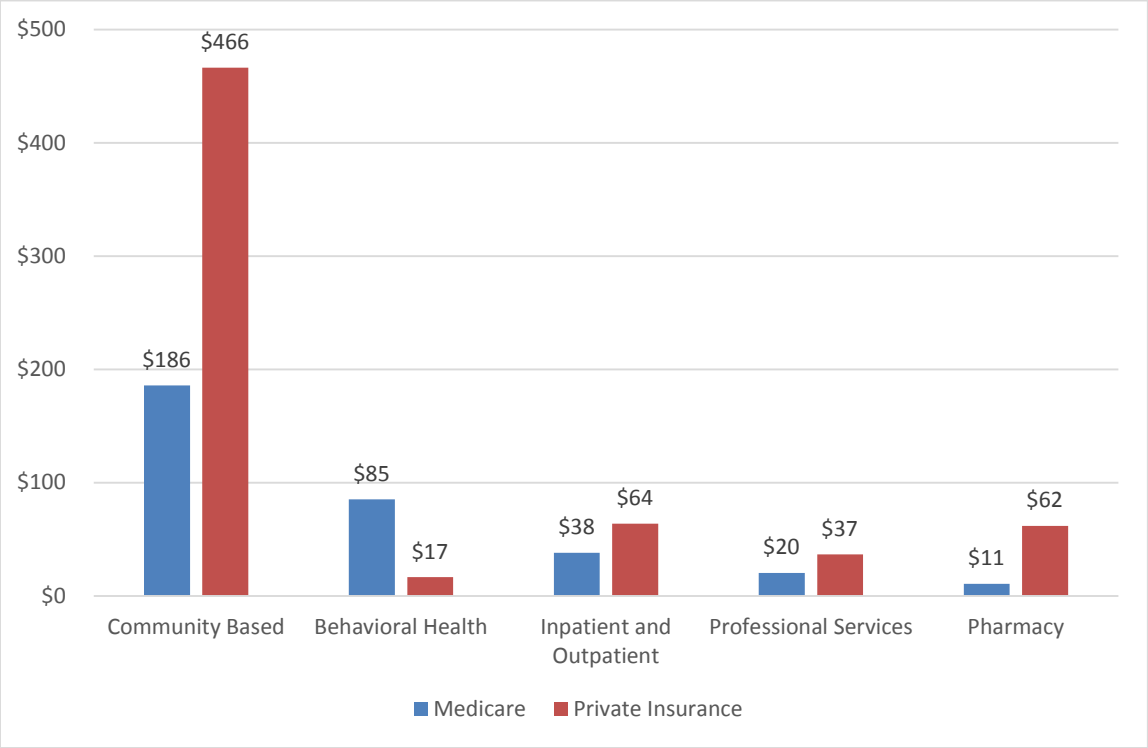
Variation in Wraparound Expenditures by Primary Insurance Provider

Expenditures were highest for CHW enrollees in our study population with private insurance (and no Medicare): $692 PMPM; the program spent substantially less on those with Medicare (and no private insurance): $386 PMPM.[1] Expenditures within service categories also varied across primary insurance types (Figure 1). For both types of primary insurance, the highest total expenditures were for non-mental health community-based services and supports, but PMPM expenditures for these services and supports were substantially higher for those with private insurance than for those with Medicare ($466 relative to $186). This pattern is driven partly by use: 10 percent of Medicare participants in our study population used non-mental health

[1] For simplicity, we do not present results for the 955 individuals with both Medicare and private insurance. Refer to Gettens et al. (2015) for results that include those with both Medicare and private insurance.

community-based services and supports, compared with 14 percent of those with private insurance.

Figure 1. Per member per month Medicaid expenditures by service and primary insurance type



Note: Services categorized as "other" were omitted.

Behavioral health services account for the second highest expenditures for CHW enrollees with Medicare ($85 PMPM), but expenditures in this service category were only one-fifth of that amount for CHW enrollees with private insurance ($14 PMPM). However, expenditures for pharmacy as well as inpatient and outpatient services were relatively high for those with private insurance—$62 and $64 PMPM, respectively. Costs for services in the other categories were relatively low regardless of primary insurance type.

Discussion

Many working people with disabilities in Massachusetts use CHW as wraparound coverage to access services that are not covered by their primary insurance and to pay the balance on services partly covered by private insurance or Medicare. Specifically, CHW wraparound expenditures totaled $55 million in 2012, or $427 per member per month. This underscores the fact that private insurance and Medicare do not fully meet the needs of all workers with disabilities.

A substantial portion of total expenditures for CHW enrollees who use the program for wraparound coverage went to community-based services and supports—services that are

generally covered by Medicaid but not by private insurance or Medicare. For example, insurance coverage for PAS, the service category that represents the highest CHW expenditures, is limited. Medicare provides some unskilled personal care, but this is generally offered only for a limited time after a hospitalization. Overall, the use of high-cost community-based services among the study population was relatively low. Nonetheless, these services may have been vital to maintaining employment among the workers with disabilities who used them (Dowler 2011).

Substantial CHW expenditures went to services at least partly covered by private insurance and Medicare, including psychiatric treatment, pharmacy, professional services, and inpatient and outpatient services. The expenditures included cost-sharing or more comprehensive coverage than what is available through Medicare or private insurance, such as drugs in the Medicaid formulary that are not in Medicare or private insurance formularies.

Across all service categories, expenditures varied by primary insurance type. It is likely that this finding reflects differences in both the relative generosity of Medicare and private insurance, and in the characteristics of their enrollees.

Implications for Wraparound Insurance

The research findings reported here demonstrate that insured workers with disabilities have health-related needs that are not met by Medicare or private insurance. The total CHW expenditures for wraparound services suggest that two main factors drive the need for these services: (1) primary insurance limits or does not cover community-based services and supports, and (2) some workers have high out-of-pocket costs for services that primary insurance does cover. Addressing both factors through wraparound insurance would help to meet the health-related needs of many working people with disabilities, and it would potentially support employment. More research is needed to determine the extent to which access to wraparound services affects employment and participation in income maintenance programs such as DI, as well as the cost-effectiveness of providing wraparound insurance.

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