

# Securing the Social Contract: Reforming Social Security Disability



National Council on Disability  
January 29, 2015

National Council on Disability  
1331 F Street, NW, Suite 850  
Washington, DC 20004

***Securing the Social Contract: Reforming Social Security Disability***

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January 29, 2015

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## National Council on Disability

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An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

### Letter of Transmittal

January 29, 2015

President Barack Obama  
The White House  
1600 Pennsylvania Avenue, NW  
Washington, DC 20500

Dear Mr. President:

The National Council on Disability (NCD) is pleased to submit the enclosed report, *“Securing the Social Contract: Reforming Social Security Disability”* for your consideration and review. The 2011 prediction of the Social Security Trustees’ Report that the trust fund payouts will exceed revenue still stands. The longstanding challenges facing recipients of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) regarding work disincentives along with the increasing numbers of claims linked to the nation’s slowly recovering economy have been highlighted by policymakers repeatedly as needing reform.

This NCD report analyzes various proposals for SSI and SSDI reform, including the examination of Medicaid policy on the ability of people with disabilities to work. It also identifies measures that could (a) move people currently utilizing SSI/DI into the workforce; (b) decrease a likelihood of using such benefits for sole income; and (c) serve as financing options to extend the life of both programs.

Among its specific and critical research questions, NCD’s report asks:

1. What would a fundamental restructuring of the SSI and SSDI system require to align it with the goals of the Americans with Disabilities Act (ADA), which celebrates its 25<sup>th</sup> anniversary this year? In essence, how would an effective reform proposal:
  - a. Eliminate the current requirement by the Social Security Administration that an SSDI applicant declare him/herself unable to work in order to be eligible for benefits;
  - b. Provide job retention supports to working people with disabilities who are at risk of job loss as a result of their disability; and
  - c. Assist people with disabilities who are at risk of job loss because they are not receiving reasonable accommodations?

2. Given the extremely diverse populations served by the SSI and SSDI programs, how might different reform strategies disproportionately impact—(positively or negatively)—particular segments of the population within the disability community?

Based on findings pertaining to these and related questions, NCD is carrying out its role as an independent advisor on disability matters to you, Mr. President, Congress, and other federal agencies. This NCD report proposes a number of policy recommendations to reform Social Security, such as decoupling health care benefit and cash benefit eligibility; providing wraparound health benefits; improving the examination, planning, and gradual phase-in of a revised disability definition for benefit eligibility; early intervention; and implementing evidence-based practices that target youth and people with mental health needs among vulnerable groups.

As always, NCD looks forward to working with the Administration and Congress to advance thoughtful and beneficial reforms to critical programs like SSI/DI so that Americans with disabilities in need of income support are assisted but without sacrificing the goals of the ADA—equality of opportunity, full participation, independent living, and economic self-sufficiency.

Sincerely,

/s/

Jeff Rosen  
Chairperson

(The same letter of transmittal was sent to the President Pro Tempore of the U.S. Senate and the Speaker of the House of Representatives.)

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## **Acknowledgments**

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## **Dedication**

This report honors the memory of Allen C. Jensen. He possessed a rare perspective on the historical evolution of disability policy from a time before the “disability rights movement” was referred to by that name. In 1975, Jensen moved from a position with the National Governors Association to the U.S. House of Representatives Committee on Ways and Means, where he served as Supplemental Security Insurance (SSI) specialist until 1989. He held numerous positions as a policy consultant and researcher, and wrote papers on Medicaid, SSI, Social Security Disability Insurance (SSDI), aging, mental health, and employment programs. Jensen passed away in April 2013 while working on this project. At the time of his death, he was affiliated with the Center for Health Policy Research at George Washington University, Washington, DC.

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## Preface

In 1998, the National Council on Disability (NCD) partnered with the Social Security Administration (SSA) to conduct a national policy review of barriers to successful education and employment outcomes. The report, published in 2000, was motivated by the fact that “thousands of young people under the age of 30 come into the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs and the majority of them never leave.”<sup>1</sup> For at least the past decade, both SSA and its advisory board have raised concerns, and the agency has taken actions to address the need for SSI and SSDI improvements with regard to disability determination, program data gathering, and related processes, including work incentives and supports.<sup>2</sup> Despite those efforts, only a limited change in the number of people going on and staying on the benefit rolls has been documented during the period from that NCD and SSA joint review to a related NCD report in 2005<sup>3</sup> and the publication of this report. The report recommendations reflect NCD’s role as an independent federal agency charged with advising the President, Congress, and federal agencies on policies, programs, practices, and procedures that affect people with disabilities.

The report has eight chapters. Each chapter addresses a key question or questions and is organized into subsections: topic and goal, outline of issues, results of a research review, and recommendations. Chapter 1 addresses factors that could encourage people with disabilities to continue their work efforts and either delay applying or not apply for benefits. Chapter 2 examines actions employers can take to retain people in the workforce, thus forestalling the need for workers with disabilities to apply for SSI or SSDI benefits. Chapter 3 examines the current status of the Medicaid Buy-In—the state-optional program that allows working people with disabilities to access health care and provides important long-term supports and services to sustain working. In Chapter 4, we summarize evidence that the current Social Security definition of disability strongly discourages beneficiaries from working, and we propose an

alternative definition that does not equate disability with a complete inability to work. Chapter 5 discusses the implications of the proposed definition of disability for those who are currently eligible for SSI and SSDI benefits. Chapter 6 looks at the Ticket to Work program's intended objectives and at suggestions for reinvigorating the program. Chapter 7 reviews three examples of effective strategies for change given certain supports for people with disabilities: youth in transition from high school, people with psychiatric disabilities, and programs under the Medicaid Infrastructure Grants. Finally, Chapter 8 reviews the status of states' supplemental payments to the SSI program and discusses whether policy action is needed.

## Executive Summary

“Living independently and with dignity means [having the] opportunity to participate fully in every activity of daily life. The ADA offers such opportunity to [people] with disabilities.” *Cong. Rec.* No.136, S9695 (July 13, 1990).

This statement from the historical debates on the Americans with Disabilities Act (ADA) captures U.S. Senator Robert Dole’s vision of a full, inclusive future for people with disabilities. By enacting the ADA, Congress recognized the need to change the accepted idea that people with a variety of disabilities should be relegated to a position outside society’s economic and social mainstream.

The 2001 amicus brief of the National Council on Disability (NCD) in support of the respondent (*Toyota v. Williams*) shows that Congress was particularly concerned about high unemployment faced by people with disabilities. Title I of the ADA was adopted as a tool to encourage workplace participation, which is a critical element of full community integration. Yet, nearly 30 years after ADA enactment, attitudes, access, and accommodations remain barriers to inclusive living and earning.

This NCD report examines complex policy in two benefit programs linked to key aspects of the ADA: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). The report covers the definition of disability, related research findings, employment incentives in lieu of long-term social benefits as sole income, and recommendations for action by specific entities. The findings call attention to policies and practices that involve comprehensive and affordable health care, workplace supports and services, Medicaid Buy-In programs, tax reform, temporary private disability insurance funding of supports (e.g., accommodations, rehabilitation, employer training opportunities), technical support for problem solving, and safeguards for people under a revised disability definition.

Among the recommendations to the Administration, federal agencies, and Congress, NCD proposes actions to improve equal workplace access and accommodations for people with disabilities. The recommendations focus primarily on decoupling health care benefit and cash benefit eligibility; providing wraparound health benefits; improving the examination, planning, and gradual phase-in of a revised disability definition for benefit eligibility; ensuring management proficiency, early intervention, and improved federal collaboration efforts; identifying ways to boost work incentives; implementing evidence-based practices that address youth and people with mental health needs among vulnerable groups; and reviewing state supplemental systems.

# CHAPTER 1. Individual Workplace Supports

## Goal of Chapter

Effective interventions prior to application for Social Security disability programs are necessary to reduce the number of disability applications. The question addressed by this chapter is, “What supports are needed to prevent or forestall the progression of people with disabilities or disabling conditions toward applying for SSI and SSDI benefits?” The chapter focuses on supports that can be targeted toward people with potentially disabling conditions to enable them to handle impediments that may jeopardize their ability to work. The goal of the chapter is to describe government policies and private sector initiatives that can be applied to reduce the number of people applying for disability benefits as their long-term sole income source.

## Outline of Issue

The most effective return-to-work interventions minimize or eliminate the amount of time a formerly employed person is out of the workforce. Because the frequency of exit from long-term public disability programs is low, both in the United States and in comparable nations,<sup>4</sup> an effective policy approach is to incentivize continued attachment to the workforce and provide workplace supports to prevent the need for people to ever go on public long-term disability benefits in the first place.

Return-to-work approaches can be distinguished on multiple dimensions. Approaches can vary on a continuum from being completely voluntary to being completely compulsory. They may be implemented through the public sector, the private sector, or both. Eligibility standards and processes can vary in rigor or be used to determine access to one program or multiple programs. Interventions can be provided before application to a Social Security disability program, concurrent with the application process, or after claimants have gained eligibility.<sup>5</sup> It is important that the beneficiary

receive some level of useful and personalized services and supports, as well as access to health care.

## **Research Review Findings**

A review of specific proposals for return-to-work interventions put forth in the past two decades reveals some combination of early intervention before application to SSDI or SSI and changes to income support and health care program rules under which beneficiaries can test their ability to work. Wittenburg and Loprest (2004)<sup>6</sup> provide an excellent conceptual overview of the field. Proposals with particular relevance for the reform of the Social Security disability programs include Berkowitz (1996), McDonald and O'Neil (2006), Autor and Duggan (2010), Mann and Stapleton (2011), Burkhauser and Daly (2011), and Liebman and Smalligan (2013).<sup>7</sup> In most cases, the authors are cautious about rapid and full implementation of their proposals, especially those that substantively change some aspect of the Social Security disability programs. They often suggest demonstration projects as a first step, both to assess the effectiveness and cost of rule changes and service approaches and to obtain the experience needed to facilitate ramping up these changes to a national scale.

There have been a few demonstrations of interventions that might help a person with a disability or a potentially disabling condition continue working. These interventions provide varying levels of useful and personalized services and supports, as well as access to health care. Two recent federal demonstration programs illustrate what these supports might be and how they might be provided.

### ***Demonstrations to Maintain Independence and Employment***

The Demonstrations to Maintain Independence and Employment (DMIE) program has provided useful answers to the question of whether providing medical assistance and other supports will forestall or prevent the loss of employment and independence owing to a potentially disabling condition.<sup>8</sup> The DMIE program was authorized under



section 204 of the Ticket to Work and Work Incentive Improvement Act (TW-WIIA) legislation and administered through the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Funding for this initiative ended in September 2009. According to the original program announcement, “This demonstration grant provides an opportunity to investigate the question: can a program of medical assistance and other supports forestall or prevent the loss of employment and independence due to a potentially disabling and medically determinable physical or mental impairment?”<sup>9</sup> To answer this question, states were to provide “Medicaid-like” benefits and employment supports to people with potentially disabling conditions and monitor their employment and health outcomes in comparison with those of a control group that did not receive benefits and supports. For the purposes of the funding, employment at baseline for potential study participants was defined as working at least 40 hours per month and earning at least federal minimum wage; states could not impose an earnings ceiling. The demonstrations were required to use an experimental design, with random assignment of participants to intervention and control groups.

Four states implemented DMIE projects: Hawaii, Kansas, Minnesota, and Texas. Across the four states, a total of 4,054 people participated in the projects; the maximum length of time that at least some participants received study benefits ranged from 42 months in Kansas to just 18 months in Hawaii. Each state’s DMIE targeted different populations and provided different medical and support services, with the exception that all states provided some form of personal case management or coaching to intervention group members. Nevertheless, some general findings can be drawn from the states’ experiences.

First, targeting the correct point for intervention on the trajectory to full disability for a person with a potentially disabling condition is challenging. If the intervention is offered too soon, it is not perceived as needed. Conversely, if it is offered too late, it may not be sufficient to prevent the progression of the condition to full disability. Miller (2005) found that the trajectory from onset of illness to application for Social Security benefits averages seven years for men and eight years for women.<sup>10</sup> If a person has no

involvement with state or federal insurance or work support systems before reaching the tail end of that trajectory, it becomes virtually impossible to stop the trend. Each of the four DMIE programs sought to target interventions at the correct point.

Confirming previous research,<sup>11</sup> the people in the DMIE programs who were most likely to be diverted from applying for disability benefits were those with lower incomes. In the Texas and Minnesota DMIE programs targeting low-income people, SSA administrative records showed that applications for disability benefits were slightly but significantly lower among intervention group members than control group members (4.8% and 6.9%, respectively).<sup>12</sup> Similarly, in Kansas, when only study participants working fewer than 90 hours per month at baseline were considered, the DMIE intervention led to a significantly lower number of disability applications among intervention group members.<sup>13</sup> Because the SSA administrative data has a significant time lag, the Minnesota DMIE evaluators also collected self-reported information from participants regarding their applications for federal disability benefits; significantly more control group members (14%) than intervention group members (7%) reported applying for benefits.<sup>14</sup>

In addition to these quantitative results, state evaluators reported important findings based on qualitative data. For example, all states used some type of personal contact as part of their intervention, such as case management, program navigation, or coaching. Across all states, participants reported that these personal services were especially important in helping them manage their often complex mental and physical health conditions, navigate the health care system, and work toward personal and employment goals.<sup>15</sup> In Minnesota, participants who were particularly engaged with these personal supports had significantly better outcomes with regard to disability applications.<sup>16</sup>

In Kansas, where participants were predominantly middle income, focus group meetings with intervention and control group members revealed that access to adequate health care is a much larger driver than cash assistance in the decision to apply for disability benefits.<sup>17</sup> However, simply having health insurance is not sufficient to delay disability applications. Coverage as usual through the high-risk pool in Kansas was associated with extremely high premiums, deductibles, and out-of-pocket requirements for

enrollees; this resulted in many people forgoing care despite being insured.<sup>18</sup> Thus, an important finding as health reform is implemented is that, for people with high-cost chronic conditions, insurance must be comprehensive and affordable enough that services are used when needed to prevent the progression to disability; in other words, coverage with high deductibles and out-of-pocket spending requirements may not serve this population well nor prevent their decline to disability.

Finally, a takeaway message from the DMIE and other federal demonstrations, such as the Accelerated Benefits demonstration discussed below, is that a study period of three years or less is likely not sufficient to document longer-term trends in health and employment. The progression to disability typically occurs over a period of seven to eight years;<sup>19</sup> demonstrations should be designed to run at least that long, if possible.

### ***Accelerated Benefits Demonstration***

The Accelerated Benefits (AB) demonstration, administered by the Social Security Administration, was designed to test whether early access to health care coverage and related services would improve health and employment outcomes for new SSDI beneficiaries. In particular, the demonstration targeted beneficiaries in their 24-month waiting period for Medicare coverage who did not have any health insurance, a situation encountered by more than one in five new beneficiaries.<sup>20</sup> A total of 2,005 people were recruited; 8 were determined to be ineligible for SSDI, so 1,997 participants were assigned randomly to one of three groups between October 2007 and January 2009, and were followed for 15 to 28 months.<sup>21</sup> Eligibility criteria included being between the ages of 18 and 54 with reasonable expectation of returning to work; at least 18 months until Medicare eligibility to receive AB services soon after the onset of disability; and residing in one of 53 selected metropolitan areas with large numbers of SSDI beneficiaries. The participants were assigned to three groups: (1) control (no health insurance and no support services); (2) AB health benefits (health insurance covering up to \$100,000 in services, with low copayments); and (3) AB Plus (AB health benefits plus medical case management, a goal attainment program, and employment and benefits counseling).

Overall, the people assigned to the AB and AB Plus groups used more health care and reported less unmet medical need than the control group members. They also spent less out of pocket on health care and self-reported improved health.<sup>22</sup> Those in the AB Plus group were more likely to seek employment. Over the life of the study, the AB and AB Plus groups did not have significantly higher employment rates than the control group.<sup>23</sup> However, two years after the study ended, continued monitoring of outcomes by the Social Security Administration<sup>24</sup> indicated that AB Plus group members had a 5.3 percentage point (almost 50%) increase in employment and an \$831 increase in annual earnings. These findings are promising and again illustrate the fact that changes in the disability trajectory and employment outcomes must be monitored over a longer period than that historically funded by federal demonstration projects.

Both the DMIE and Accelerated Benefits programs illustrate the importance of access to comprehensive and affordable health care in encouraging employment. For example, some participants cited the addition of wraparound health services plus employment supports through the DMIE as influencing their decisions to avoid applying for benefits and continue working.<sup>25</sup> Such findings about health coverage attitudes emphasize the importance of federal policy changes that decouple eligibility for public health insurance from eligibility for cash assistance.

## **Recommendation**

### ***Recommendation 1:***

Congress should decouple eligibility for health care benefits from eligibility for cash benefits. Comprehensive and affordable health insurance alone is sufficient to support employment efforts for many people with disabilities or potentially disabling conditions. However, this decoupling should be in one direction only: If the person needs and qualifies for cash assistance, he or she should also qualify for and receive health care benefits.

## CHAPTER 2. **Employer Incentive Mechanisms to Reduce SSDI Entry**

### **Topic and Goal of Chapter**

Some people have argued that the most efficient way to forestall applications to Social Security disability programs is to enhance employers' efforts to maintain workers with disabilities in the workforce through various strategies.<sup>26</sup> This chapter responds to the following questions posed by NCD: "What incentive mechanisms could be used to encourage employers to increase efforts to provide workplace accommodations for employees with disabilities and to encourage more employers to offer private disability insurance, thereby avoiding the routine of employees with disabilities going onto SSDI rolls? What is revealed from specific evaluation of the potential for using an experience rating system whereby employers whose employees have a lower rate of SSDI retirements pay lower SSDI payroll taxes?" The goal of this chapter is to review effective practices in private disability insurance, payroll tax reform, disability management, and employer technical assistance that offer promise for policy recommendations.

### **Outline of Issue**

The longer a person is absent from the labor force, the more difficult it is to get a job.<sup>27</sup> Strategies to enhance workforce attachment include private disability insurance that provides for temporary wage replacement and incentives for employers to invest in rehabilitation or accommodations. We evaluate a specific proposal for payroll tax reform that applies an "experience rating" to incentivize retention of workers with disabilities, and we review other employer strategies, including so-called "disability management" approaches that enable employees to continue in some productive capacity. Other enhancements that encourage retention include various forms of technical assistance to

help employers address the sometimes complex challenges of accommodating disability in their workplaces.

## **Research Review Findings**

### ***Private Disability Insurance***

Workers who experience chronic illness or disability not caused by the work environment typically progress through various levels or types of support.<sup>28</sup> The sequence often begins with paid time off in the form of sick leave and then, if available, employer-sponsored short-term (or temporary) disability insurance, followed by employer-sponsored long-term disability insurance, and finally application for publicly funded Social Security Disability Insurance (SSDI). This progression is usually only available for full-time workers who receive employer benefits, and only if the employer provides these benefits.

Workers' compensation insurance, designed specifically to address job-related illnesses and injuries, is mandated by legislatures in every state. Workers' compensation benefits cover approximately 90 percent of workers in the civilian labor force, compared with only about 38 percent of U.S. workers covered by private disability insurance that applies when the illness or injury is not job-related.<sup>29</sup>

Short-term disability<sup>30</sup> insurance begins when sick leave runs out. This is a discretionary employment benefit; although common, it is not universally offered by employers.<sup>31</sup> Considered a wage replacement, these benefits are usually paid as a percentage of wages or as a flat dollar amount, typically for a 6- to 12-month period.<sup>32</sup> Long-term disability insurance provides payments to workers who are unable to work for an extended period, usually as a percentage of the person's previous earnings. Long-term disability benefits usually begin after short-term disability runs out or after an identified waiting period. These benefits generally continue until retirement or a specified age.<sup>33</sup> Almost all private long-term disability insurance is coordinated with SSDI benefits. This

means that private long-term disability benefits are reduced dollar for dollar by the amount of SSA benefits.<sup>34</sup> If it appears that a worker will be unlikely to return to work because of the disability, the insurance company very often will encourage the worker to apply for SSDI benefits so that the long-term benefits can be reduced or discontinued.

McMahon and colleagues (2000) describe the “progression of disability benefits” phenomenon as “predictable and progressive movement through a system of economic disability benefits resulting in their ultimate placement into the Social Security disability system.”<sup>35</sup> The migration of disability claims follows a typical pattern: Within a three-year time frame, approximately one in nine (11.5%) employees who receive short-term disability benefits progress to long-term disability benefits; from this group, approximately one in three (33.9%) progress to SSDI benefits. Systematic movement through the progression of disability benefits is clearly related to employee age—workers over the age of 45 progress from short-term to long-term disability and SSDI faster and at considerably higher rates than younger workers.<sup>36</sup>

Stay-at-work and return-to-work are preferred options in private long-term disability and workers’ compensation programs, and they provide a framework for structuring health promotion and vocational rehabilitation interventions. When an employee is deemed “disabled” from his or her own occupation or previous position with an employer, he or she may file a claim for long-term disability benefits. The definition of disability in private insurance is based on a contractual definition that is not necessarily the same as the Social Security Administration’s (SSA’s) definition.

In examining the breakdown of private disability benefits by occupation, the data shows that a much larger percentage of covered workers are managerial and professional (51% for short-term, 57% for long-term) than middle-income workers in sales and support positions (36% for short-term, 31% for long-term). The lowest wage workers in service occupations are much less likely to have short-term disability benefits (19%) and very few have long-term disability benefits (9%). Compared with people who do not have disabilities, people with disabilities are less likely to have managerial and professional jobs and more likely to have service or production jobs.<sup>37</sup> Thus, people with

disabilities are much less likely than people without disabilities to be covered by disability insurance.

### ***Mandated Disability Benefits***

Five states require all employers to provide short-term disability benefits: California, Hawaii, New Jersey, New York, and Rhode Island.<sup>38</sup> Analyses of these states' experiences illustrate that employers derive a benefit from state-mandated disability insurance.<sup>39</sup> Under both workers' compensation and disability insurance systems, many employers have discovered inherent incentives in helping the employee return to work quickly. The employee has specific knowledge of the job and work environment that can make return-to-work quicker and more effective. The training and experience of that employee is an investment, and a return to work will preserve that human capital. Also, by retaining the worker, the employer limits the possibility of paying permanent disability benefits to him or her.<sup>40</sup> Wage replacement reduces the stress that is often associated with a disability. Less stress speeds up recovery time, which reduces absenteeism and benefits the employer's bottom line. The employer receives some reciprocal benefits associated with the employee's ability to maintain some level of consumption while avoiding bankruptcy. And society benefits when employees, provided with wage replacement through disability insurance, retain their ability to buy essential goods and continue to consume.<sup>41</sup>

Mandated insurance regulations level the playing field, because all employers incur the same basic costs for employees.<sup>42</sup> Otherwise, employers who generously provide disability benefits without a mandate are at a competitive disadvantage compared with companies that do not provide them. Insurance rates for group disability insurance would be much less costly than individual policies if all workers were covered. In addition, there are broader societal benefits to a public policy of compulsory disability insurance. The five states that require short-term disability insurance are, as a group, below the national average for per capita bankruptcy filings compared with states that do not have compulsory short-term disability insurance.<sup>43</sup>



Workers who are at risk or employed in hazardous industries are more likely to participate in voluntary disability insurance, thus raising the cost for all who are in the insurance pool. This is known as the “adverse selection problem.” Requiring all employers to offer such coverage—as is currently the case with unemployment insurance and workers’ compensation insurance—would eliminate the adverse selection problem.<sup>44</sup>

### ***Experience Rating***

As mentioned above, many employers encourage their employees who are receiving long-term disability to apply for SSDI to reduce the employers’ long-term disability costs.<sup>45</sup> Burkhauser and Daly (2012) have suggested that this incentive could be reversed with an “experience rating system” whereby employers’ Social Security contribution would depend on the percentage of their employees who end up on SSDI.<sup>46</sup> The proposed system is intended to provide incentives for enhancing work retention practices and increasing investment in accommodations to help employees stay connected to the labor force.

The rationale is that if the payroll tax were changed from a flat percentage of wages to a rate based on the occurrence of disability in that industry or company, employers would have more “skin in the game.” By investing in actions that reduce or delay disability onset and help their employees continue working, employers would avoid having to pay greater costs for the workers who end up on SSDI.<sup>47</sup> Employers would be less likely to shift the cost to taxpayers, because they would have more incentive to use return-to-work services and provide accommodations to maintain the workers’ employment. A recent study of employers who provided accommodations in workers’ compensation situations found evidence that employers are more likely to invest in return-to-work services and maintain the worker in some type of job if the premiums are experience-rated.<sup>48</sup> However there is no empirical evidence to suggest what level of payroll tax differential would be an optimal motivator.

Experience rating might be promising when the goal is to reduce SSDI entry among employees with a connection to a particular employer. However, a large disadvantage would accrue to workers with disabilities who move between jobs and employers. Workers today are fairly mobile, and many do not have a strong connection to a single employer. These workers would find it much harder to obtain employment if their “disability” was associated with a higher cost to their employer, so experience rating would have a detrimental effect on the hiring of people with disabilities. It is important that a reform policy not create a further disadvantage for a vulnerable group. Employers would be reluctant to hire people with disabilities if there was potential that their payroll taxes would increase. Thus, the huge potential for a negative impact on overall employment opportunities for people with disabilities makes experience rating an impractical and self-defeating solution to the problem of unemployment.

### ***Disability Management Strategies***

Employers need specific strategies and incentives to retain workers with disabilities and prevent or delay early exit from the workforce and progression to the public benefit system. Disability management models hold promise as successful options for employers, employees, and the government. The process is generally voluntary for the employee and, in recent years, a model of partial disability similar to the workers’ compensation system has evolved. The partial disability model allows for some cash and medical benefits when the person is able to return to work in a part-time or reduced capacity. This approach allows the person to remain attached to the workforce longer, maintain earnings by combining wages and partial disability benefits, and delay application for Social Security benefits.

Disability management can be described in general terms as “a proactive, employer-based approach developed to (a) prevent the occurrence of accidents and disability, (b) provide early intervention services for health and disability risk factors, and (c) foster coordinated administrative and rehabilitative strategies to promote cost-effective restoration and return to work.”<sup>49</sup> The primary goals of disability management are

improving workforce health and productivity, reducing costs associated with medical care and disability benefits, reducing absences and workplace disruption caused by the onset of disability among employees, reducing the personal cost of disability for employees, and complying with the Americans with Disabilities Act (ADA) and other pertinent legislation. Disability management is intended to coordinate disability services and programs; however, lack of an integrated approach can lead to employers and insurers shifting long-term disability expenses to public benefit programs, specifically SSDI.

## **Health Promotion**

One of the key components of disability management is health promotion. Perhaps the most straightforward way to reduce SSDI entry is to prevent long-term illness or injury. Businesses have successfully adopted health promotion strategies that help prevent disability and reduce the overall costs of the health insurance plan they provide to their employees. Unfortunately, only about 7 percent of employers use health promotion program components recommended for successful workplace health promotion.<sup>50</sup> For this reason, federal initiatives need to invest in programs that promote healthy environments in a cost-effective way. Such programs are grounded in behavior change theory and are individualized for those with high health risks.<sup>51</sup>

Because employee retention and prevention of unnecessary early exit from the workforce are key features of disability management, the goals are to improve health, manage health conditions, resolve disability issues, and bring employees back to work.<sup>52</sup> To better understand the effectiveness of disability management strategies, it is critical to incorporate the demand-side (employer) perspective.

## **Retention Strategies**

The Society for Human Resource Management (SHRM), in collaboration with Cornell University, conducted a survey of its members regarding organizational practices and policies related to retention and advancement of people with disabilities.<sup>53</sup> The survey found that about 81 percent have return-to-work or disability management programs for

employees who are ill or injured or become disabled, and more than half reported flexible work arrangements for all employees. Less than half (42%) of the employers invite employees to confidentially disclose their disability via staff surveys. The policies and procedures the businesses considered most effective were a disability-focused employee network related to retention and advancement of employees with disabilities (54%), return-to-work or disability management programs (49%), and flexible work schedules (47 percent).

Recently the Office of Disability Employment Policy (ODEP) of the U.S. Department of Labor summarized promising and emerging practices for the retention of people with disabilities identified in federal agency plans submitted under Executive Order 13548.<sup>54</sup> This Executive Order aims to add 100,000 people with disabilities to the federal government workforce over the next five years. Among the promising practices are policies that promote workplace flexibility; support for the use of telework, flex-place, and flextime options; review of proposed terminations to ensure that disability accommodations are considered; adoption of disability management and prevention programs (return-to-work programs); and establishment of a mechanism such as a centralized accommodation fund or centralized expertise.

The ODEP summary results were similar to those of an employer survey conducted in Wisconsin as part of the Medicaid Infrastructure Grant (MIG).<sup>55</sup> In this survey, employers reported practicing flexibility and providing basic accommodations, but they said they needed assistance in finding appropriate workplace accommodation resources to help them match accommodations to employee needs, especially when the needs are complex. WorkSource Wisconsin was created as a demand-side organization, designed by employers for employers; however, small employers are more likely than larger employers to use WorkSource Wisconsin as a resource.

### **Technical Assistance in Disability Management**

Effective disability management can be very complex and daunting, especially for employers that lack robust human resource assets. Habeck and colleagues (2010)

found that employers with at least 1,000 employees are substantially more likely than those with 100 or fewer employees to report using disability management strategies (84% to 5%).<sup>56</sup> This large discrepancy may be due to the costs of implementing disability management or to a lack of awareness by smaller employers that these options are available. The cost-benefit of disability management is much more likely to be realized by larger employers.

The Disability Management Employer Coalition (DMEC) offers private technical assistance resources for small to mid-sized employers. DMEC is a nonprofit employer organization with more than 3,500 members; it focuses on integrated disability management.<sup>57</sup> Research conducted by DMEC among its employer members provides compelling evidence to support the promotion and expansion of disability management strategies.<sup>58</sup> Employers cited the following as the most important factors in retention effectiveness: (a) providing development opportunities for employees at all levels; (b) seeking the ideas and involvement of employees; and (c) ensuring that employees know how their work and performance support the company's mission. This is consistent with previous demand-side research indicating that employers and employees have a similar need to understand that accommodations and return-to-work services should take place over time and are not limited to one-time interventions.<sup>59</sup>

Businesses also can network through the United States Business Leadership Network® (USBLN). This network helps businesses increase disability inclusion in the workplace, supply chain, and marketplace. With strong connections to the U.S. Chamber of Commerce and governors' and mayors' committees on disability, the USBLN provides national recognition for businesses that include people with disabilities in their workforce.<sup>60</sup>

A potential solution to ensure cost-effective disability management services for both small and large employers is to engage the State Vocational Rehabilitation Agency (SVRA) as a partner in this effort at the federal and state levels. SVRAs typically provide services to people with disabilities who are attempting to enter or reenter the workforce. In recent years there has been a growing recognition among state vocational rehabilitation (VR) programs of the need to focus more on the employer perspective.

The National Employment Team (NET), supported by the Council of State Administrators of Vocational Rehabilitation, is a national initiative to help SVRAs refocus their resources toward employers as customers. Using a “dual customer approach,” the NET office provides leadership and technical assistance to SVRAs in developing strategies and sharing best practices for the placement and retention of employees with disabilities.<sup>61</sup>

The dual customer approach is a role expansion for a public agency that has traditionally operated from a human services model of assisting people with disabilities. By law, VR services must be provided to an eligible person with a disability; thus eligibility determination must precede provision of significant services to an employer. This process may create barriers to the timely provision of consultation services to an employer. For information about how certain states are applying the dual customer approach, see the websites listed in the endnotes for Vermont,<sup>62</sup> Oklahoma,<sup>63</sup> and Wisconsin.<sup>64</sup>

### ***Other Resources for Employers***

State Vocational Rehabilitation Agencies are in a position to facilitate solutions to employers’ human resource problems, not only through SVRA staff expertise but also through partnerships with a sophisticated network of technical and legal services and resources. Many employers are not aware of the specialized assistance available from the Job Accommodation Network, ADA centers, state assistive technology centers, and University Centers of Excellence in Developmental Disabilities.

The Job Accommodation Network (JAN) has shown that the benefits employers receive from making accommodations far outweigh the costs, which are low. JAN is a free online network that includes a searchable accommodations database, publications and resources, an American Disabilities Act library, news, training, and online or phone consultation. Surveys of employers who use JAN have reported benefits such as retaining valuable employees, improving productivity and morale, reducing workers’ compensation and training costs, and improving company diversity.<sup>65</sup>

The ADA National Network is another useful resource for businesses.<sup>66</sup> The network is composed of 10 ADA centers around the country that provide training and technical assistance on the ADA and its implementation. Employers who call a toll-free number will be connected to the center in their region. They will receive individualized assistance tailored to meet their particular needs and can also take advantage of the many free or low-cost training opportunities offered by the ADA centers, such as webinars and state and regional conferences.

Multiple federal agencies fund programs that provide technical assistance to employers on hiring and supporting people with disabilities; however, there is little or no coordination of these resources across agencies, and the potential for overlap and gaps is great.

### ***Public Information Campaigns Focused on Employers***

Surveys of employers have found a generally favorable view of hiring and accommodating people with disabilities; however, barriers still exist to hiring and retaining these employees.<sup>67</sup> These barriers include cost, ignorance, and fear of legal liability. Solutions include more awareness of disability and expertise in accommodations.

Current public information campaigns that focus on hiring people with disabilities target both employers and potential employees. For individuals, the focus is typically on job readiness, interview tips, job fairs, and how to be available to employers. For employers, the focus is on the benefits of hiring people with disabilities. Examples of these campaigns include “What Can You Do?” (<http://www.whatcanyoudocampaign.org>) and “Think Beyond the Label” (<http://www.thinkbeyondthelabel.com>). These campaigns rarely focus on retaining employees who have a disability. Existing public information campaigns could expand by explaining how retaining good workers, even those who get sick or injured, makes good business sense. They could also include more information on accommodations and on collaborating with accommodation experts—such as ADA centers or the Job Accommodation Network—to encourage employers to hire people with disabilities and to retain current employees who develop a disability.

## **Recommendations (*numbering continues from previous chapter*)**

### ***Recommendation 2:***

State legislatures should enact mandatory disability insurance for all workers similar to requirements for workers' compensation insurance.

### ***Recommendation 3:***

The U.S. Department of Labor (DOL) should identify and disseminate evidence-based practices in disability management to employers. Priority should be given to small employers that do not have specialized human resource staff. The DOL could award grants to build capacity among employers to share disability management expertise using the Disability Management Employer Coalition as a model.

### ***Recommendation 4:***

The U.S. Department of Education, Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration should promote the dual customer approach in the Vocational Rehabilitation program by issuing clarifying guidance to State Vocational Rehabilitation Agencies so that regulations do not pose barriers to serving employed eligible people with disabilities. The goal should be to facilitate employee retention.

### ***Recommendation 5:***

The Administration should assign a federal interagency work group to prepare an analysis of potential overlap and gaps in technical assistance to employers on accommodating disability in the workplace. Examples of federal programs include the Job Accommodation Network, the ADA National Network, Assistive Technology Centers, University Centers for Excellence in Disability Research, and Protection and Advocacy agencies. The purpose of such an analysis would be to better match resources with employer needs, thus increasing job retention of employees with disabilities.



## CHAPTER 3. **Health Care Access for Working People with Disabilities: Medicaid Buy-In**

### **Goal of Chapter**

Medicaid Buy-In (MBI) programs are optional Medicaid eligibility groups that allow people with disabilities to begin or increase employment while maintaining their eligibility for Medicaid; they often pay a prorated premium for coverage when earnings exceed a certain threshold. These programs are intended to act as a work incentive by ensuring continued access to Medicaid coverage even when earnings exceed typical eligibility limits. Chapter 3 answers these questions: “Based on the most current evidence-based research, does the MBI opportunity affect work activity; if so, how? How should the buy-in be modified to promote work opportunities for people with disabilities?” The goal of Chapter 3 is to identify policy options that would continue existing programs and expand health care services that people with disabilities need in order to work.

### **Outline of Issue**

MBI programs began operating as early as 1997 and currently operate in 45 states under one of three federal authorities: the Balanced Budget Act of 1997 (BBA), the Ticket to Work and Work Incentives Improvement Act of 1999 (TW-WIIA), or section 1115 Demonstration Waivers. Each of these federal statutes provides broad rules under which the programs must operate while also giving states some flexibility in their rules for eligibility, resource and asset limits and exclusions, cost-sharing policies, and work-related requirements and protections.

Generally, programs run under the TW-WIIA authority have more freedom with regard to income and asset rules, with the exception that TW-WIIA limits participation to people ages 16–64, while BBA imposes no age restrictions. Notably, however, both laws

prevent states from establishing a minimum number of hours worked or amount earned in a given period for basic program eligibility. (Eligibility for the medically improved group under TW-WIIA is statutorily defined as working at least 40 hours per month and earning at least minimum wage). Variability from state to state in key program design features has a large influence on overall enrollment rates, which people enroll, employment experiences and earnings of enrollees. For example, enrollees in states with income floors and stringent work verification policies tend to have higher rates of employment and earnings.<sup>68</sup>

In 2010, MBI programs nationally had more than 175,000 enrollees.<sup>69</sup> In general, MBI enrollees tend to work part time and earn less than substantial gainful activity<sup>70</sup> (SGA) level. In this sense, MBIs have not typically served as programs through which people with disabilities quickly and completely leave the federal disability rolls. Nevertheless, MBIs provide many important benefits to enrollees and to the states that operate them. Enrollees can earn more income and accumulate greater assets while maintaining essential health care coverage than would be possible under traditional Medicaid. Thus they have opportunity to gradually stabilize their health and economic status and leave the rolls when and if their disability and situation allow. Recent research has shown that having adequate health insurance makes people with potentially disabling conditions less likely to apply for Social Security benefits.<sup>71</sup>

States, too, realize benefits in operating MBIs by collecting premiums, sales/use tax revenue, and income taxes from enrollees who otherwise might not contribute directly to the state's economy. Early evidence also suggests that employment—even part-time employment—is associated with better health outcomes for participants, potentially reducing state and federal health care expenditures for them.<sup>72</sup>

## Research Review Findings

### *State-by-State Comparison of MBI Policies*

Most of the national-level data available on MBI programs comes from data compiled by Mathematica Policy Research (MPR). States with Medicaid Infrastructure Grant (MIG) funding were required to share data about their enrollees during their funded periods with MPR, which lasted through 2011. See Appendix A, Table A-1, for information on states operating MBI programs at the writing of this NCD report. Questions answered through the MBI programs in Appendix A, Table A-1 include these: “Whose income is counted? What is the countable income eligibility limit? What ‘disregards’ apply in determining countable income and whether there is a separate unearned income limit?” Appendix A, Table A-2, lists policy parameters operating in each state with a MIG program. Questions in Table A-2 address resource limits, whether retirement accounts are excluded from countable assets, whether medical savings accounts are excluded from countable assets, and whether approved accounts for employment or independence are excluded. Appendix A, Table A-3, outlines state cost-sharing policies such as minimum income level and premium calculation method, as well as the income level at which premiums or cost shares start, the premium as a percentage of income, payment based on income brackets, and separate premiums or cost sharing for earned and unearned income.

Earnings among MBI enrollees have been relatively low, with an average annual income nationally of \$8,677 in 2009.<sup>73</sup> Substantial variability from state to state can be attributed to program design features and local labor markets. Because Medicaid rules prohibit states from defining “employment,” enrollees include people with very low incomes. Many states have work stoppage protections for the MBIs, which provide a grace period during which an enrollee who becomes unemployed remains eligible for a given number of months (see Appendix A, Table A-4 for work requirements and work stoppage protections). States offer grace periods ranging from two months to two years, with most allowing six months. This feature is critical to provide ongoing access to health coverage during an exacerbation of a health condition, a disability, or a

temporary lapse in employment, but it must be balanced against the role of MBIs as a work program.

Across states, certain subgroups tend to have higher earnings. For example, people in the medically improved group achieved mean earnings of \$16,458 in 2009, 40 percent above the Social Security Administration's SGA limit for that year and 52 percent above the federal poverty level for an individual.<sup>74</sup> Similar to the overall MBI population, people with psychiatric disabilities are the single largest group of people with disabilities represented in the medically improved population.<sup>75</sup> An analysis found that MBI participants with psychiatric disabilities were younger than other participants and more likely to be employed and to increase their earnings over time.<sup>76</sup> Finally, MBI participants with psychiatric disabilities were most likely to enter a trial work period or extended period of eligibility.<sup>77</sup>

Another review of MBI programs<sup>78</sup> showed that younger enrollees who are nonwhite and who have not been attached previously to SSI/Medicaid earn more than other enrollees. Among the top 10 percent of earners nationally, 60 percent were in the 21–44 age range, though that group represented only 45 percent of total enrollees. In contrast with nondisabled workers, an inverse relationship between age and earnings exists for MBI enrollees, with a drop of \$91 in earnings for each one-year increase in age.

By working at whatever level they are able, MBI enrollees risk proving that they are “not disabled.” Should they become unable to maintain employment in the future, their participation in the MBI could be used as evidence that they are not qualified for SSDI. It is crucial that SSDI remain a viable safety net for people with disabilities who make the effort to work; thus, any refinement of the disability definition or determination process must include provisions that allow access to benefits even after prolonged periods of work activity. The disability definition in Chapter 4 includes this provision. Otherwise, people might not take the risk of employment.

The MBI experience strongly suggests a need to completely delink eligibility for public insurance coverage from eligibility for income support, basing eligibility for insurance on

medical need alone.<sup>79</sup> As explained above, having access to adequate insurance often allows people with potentially disabling conditions to forgo applying for disability benefits as a route to needed health care. Indeed, researchers have documented a phenomenon they call “health insurance motivated disability enrollment” (HIMDE), wherein people with disabilities and high medical costs apply for federal financial disability programs primarily, or even exclusively, to obtain health coverage.<sup>80</sup> Delinking insurance eligibility from eligibility for cash assistance would not only relieve many of the current unsustainable financial strains on the SSDI program, it would also remove barriers to increased earnings such as the SSDI cash cliff and the 1619(b) earnings threshold.

The cash cliff is a major barrier to increased earnings for MBI participants. Nationally, the enrollee majority is for SSDI beneficiaries (71 percent in 2006).<sup>81</sup> A study among MBI enrollees in Kansas, more than 90 percent of whom receive SSDI benefits, indicated that one-fourth would definitely work more if SSDI had a gradual benefit offset and an additional one fourth might work more if extra job supports were available, such as flexible hours, better health care, transportation, and job training. Those who said they would work more in such a scenario were statistically more likely to have reported turning down a raise or increase in hours in the past to avoid losing benefits, so they had concrete experience with the issue.<sup>82</sup>

### ***Identification of Promising and Best Practices***

Promising and best practices for MBIs must be considered in the context of the goals of the program for both states and individuals.<sup>83</sup> These goals might be as simple as increased income or access to Medicaid for participants or as broad as creating a path off of cash benefits. The buy-in programs also must be considered in the context of the state’s larger Medicaid program. For example, in states with low protected income levels for medically needy individuals, the MBI plays a very important role in providing consistent access to Medicaid coverage for people with higher SSDI benefits or

earnings from employment. This consistent access to Medicaid, in turn, can help to stabilize health and empower enrollees to increase their work efforts.<sup>84</sup>

Regardless of other individual and state goals, policy measures that support increased earnings for MBI participants are likely to be beneficial for all stakeholders. And despite broad variation in starting points for MBIs from state to state, several program features are consistently associated with higher earnings. First, asset limits should be as high as possible in the state environment. Currently, 22 states allow assets of \$10,000–\$15,000 for an individual or couple; 4 states do not have a ceiling.<sup>85</sup> Having cash assets allows for greater financial stability and the ability to deal with emergencies that might otherwise result in unemployment; for example, vehicle repairs. Besides cash assets, some states allow participants to accumulate funds in retirement accounts, medical savings accounts, and individual development accounts (see Appendix A, Table A-2).<sup>86</sup> Allowing these additional modes of savings provides extra incentives for participants to earn more and plan for the possibility of leaving federal cash assistance programs.

States that have stricter requirements with regard to income verification tend to have higher earners. Although federal statutes prohibit states from defining employment, they can develop policies for how individuals verify their employment status (see Appendix A, Table A-4). For example, the Iowa MBI requires only that an employer provide a signed statement. In Kansas, participants must show proof of having paid FICA or SECA (self-employment) taxes. Perhaps not surprisingly, only 43 percent of Iowa enrollees had earnings at a level reported to the IRS, whereas 93 percent of Kansas enrollees did. Similarly, in 2005, 60 percent of Iowa enrollees worked 10 hours or less per week, compared with 25 percent in Kansas. This report does not recommend an earnings floor, but NCD endorses policies that require verification of earned income for MBI enrollees.

Another MBI design issue related to earnings is whether spousal earnings are considered in determining program eligibility. Arguably, if MBIs are designed to allow a person to earn more and potentially separate from federal cash assistance, only that person's earnings should be considered. Nevertheless, 18 states consider family

income, which disqualifies many people from participating. See Appendix A, Table A-1 for a state-by-state comparison of MBI income eligibility criteria in October 2012.

Finally, MBI participants have consistently cited loss of federal and state supports as a result of increased income as a reason for limiting their work activity. In particular, they report having lost their eligibility for the following programs: Supplemental Nutrition Assistance Program (SNAP)/food stamps, Section 8 housing, State Children's Health Insurance Program (SCHIP) coverage for their children, the Low Income Energy Assistance Program (LIEAP), and state childcare subsidies.<sup>87</sup> It is a testament to the success of the buy-in that people are earning enough to lose eligibility for these programs, but it is also problematic when \$10 in additional earnings results in \$100 in lost benefits. Better coordination of the Medicaid Buy-In program with other state and federal programs is essential to continued increase in work activity.

### ***Role of MBI as a Means to Avoid the Need for SSI/SSDI***

As noted above, the large majority of MBI enrollees nationally are SSDI beneficiaries who had some attachment to SSA cash benefits before the Medicaid Buy-In. The proportion of SSDI beneficiaries and those with previous Medicaid eligibility on MBI programs varies from state to state. One state that bucks the national trend is Indiana, where fully 35 percent of MBI program enrollees have never received SSI or SSDI cash benefits.<sup>88</sup> In the Indiana program, enrollees who do not receive cash benefits have higher earnings and lower medical costs than other enrollees.<sup>89</sup> Clearly, these people do not encounter the SSDI cash cliff as a barrier to increased earnings. The main issue to be resolved is whether their working with a disability will in any way endanger their eligibility for cash benefits later, should they need them.

In Indiana (as in all 11 of the 209(b) states), a person must submit separate applications for Medicaid and for SSI benefits.<sup>90</sup> This process might have the effect of steering people with disabilities away from cash benefits if Medicaid is available separately. In this situation, vocational rehabilitation (VR) counselors, Medicaid case workers, and

other disability service providers can potentially be very important in informing applicants of their options. In non-209(b) states with MBI programs, a special disability determination process is available for people who are already working. However, states report difficulty operating a process that simultaneously disregards work activity above SGA while considering functional capacity to engage in work.<sup>91</sup> The revised definition of disability later in Chapter 4 proposes a resolution to this policy dilemma. On the other hand, MBIs also provide a vital source of health insurance coverage for new SSDI beneficiaries in their 24-month waiting period for Medicare coverage.<sup>92</sup> Indeed, the New Mexico MBI extends automatic eligibility to these people.

### ***Possible Effects of the Affordable Care Act (ACA)***

Effective September 23, 2010, the ACA mandated that group and individual policies include coverage for dependent adult children up to age 26. This provision potentially allows young adults with disabilities to enter the workforce part time or with an employer that does not provide health insurance, and still access health insurance through a parent. (However, the ACA does not require employers to provide health insurance for part-time employees.) If the parent's insurance is adequate to meet the adult child's needs, it essentially provides the opportunity for a private "trial work period" for the young adult that does not necessitate any attachment to the Social Security disability system.

In addition to the ACA's provision for coverage of young adult dependents, both the Medicaid expansion and the health insurance marketplaces have the potential to greatly expand access to insurance coverage for people with disabilities. A recent simulation study<sup>93</sup> suggested that at least 2 million people with disabilities would gain new coverage through ACA programs. As these authors pointed out, the incredible irony in the current U.S. health care system is that a person with a disability is more likely to be *uninsured* if he or she is working, a fact that could change under health reform. Of particular importance is the fact that private insurers will no longer be able to deny coverage on the basis of a preexisting condition.



Regulations for coverage under the Medicaid expansion are still being developed, and final parameters will have a large effect on whether the coverage is sufficient to meet the needs of people with disabilities, especially those who need attendant services. A study of the Kansas MBI found that when attendant services were not covered, people with physical disabilities were less likely to enroll.<sup>94</sup> On the other hand, eligibility for the Medicaid expansion under the ACA's modified adjusted gross income (MAGI) option for people with incomes up to 138 percent of the federal poverty level (FPL) does not consider assets.<sup>95</sup> Thus, many people who may not have qualified for Medicaid Buy-Ins because of their or their spouses' assets could potentially obtain Medicaid coverage in 2014. Federal regulations stipulate that people with disabilities will have the option of enrolling in a state MBI program with higher income eligibility levels if the program would better serve their needs compared with the income eligibility limits under the MAGI limits. Currently, 38 state MBI programs have individual or family countable income limits above the MAGI option of 138 percent FPL. However, states may also choose not to continue Medicaid Buy-In programs, which are optional, after the implementation of ACA programs. Finally, it should be noted that some states are considering discontinuing or radically weakening their existing MBI programs once the Medicaid maintenance-of-effort requirements are lifted in the ACA. There is some evidence that this is already occurring in Kentucky and Louisiana.<sup>96</sup>

Similarly, some people with incomes above 100 percent FPL who are currently participating in MBIs might be able to obtain marketplace coverage with premiums that are cheaper (because they are subsidized for incomes up to 400 percent FPL) than the premiums they pay for MBI coverage. Again, the comprehensiveness of the coverage available in the marketplaces will play a major role in whether people with disabilities who need attendant services choose to enroll. As Henry, Long-Bellil, Zhang, and Himmelstein (2011) documented, attendant services are especially important in supporting work efforts for many people with disabilities.<sup>97</sup> Indeed, lack of coverage for attendant services in either expanded Medicaid or insurance through the exchanges may prove to be the single largest barrier to obtaining employment for many people with disabilities. The Community Living Assistance Services and Supports (CLASS) Act

portion of the ACA, which would have helped pay for these services separately from health insurance, has been completely abandoned owing to costs.<sup>98</sup>

A final consideration related to the ACA and MBIs is the possibility of creating a national Medicaid Buy-In program as a means of providing wraparound coverage for people with disabilities who are able to obtain coverage through the Medicaid expansion or the marketplaces. To the extent that such a national program could provide long-term services and supports not available through expanded Medicaid or the marketplace, it could play a key role in supporting employment for people with disabilities. Moreover, the MBI could be specifically designed to be available separately from disability-related cash benefit programs. A national Medicaid Buy-In program would also address the current problem of extreme variation in MBI rules and policies among states by creating a uniform eligibility standard. Existing state-to-state variation in rules and policies has the potential to result in job lock for people with disabilities who want to improve their employment. For example, a person who lives in a state with generous income and asset limits might be unable or unwilling to accept a higher paying job in a state in which the MBI has lower income and asset limits.

## **Recommendations (*numbering continues from previous chapter*)**

### ***Recommendation 6:***

State legislatures should preserve Medical Buy-In programs that are crucial for supporting people with disabilities in working. A state-by-state advocacy effort should be launched to preserve and strengthen MBI programs. Efforts should be undertaken to incorporate MBI enrollment in state marketplace programs established through the Affordable Care Act.

### ***Recommendation 7:***

In order to facilitate access to the Medicaid Buy-In program for people who are not currently on SSI or SSDI, states should use an independent contractor or

other disability determination evaluation process outside the Social Security Administration for applicants.

***Recommendation 8:***

Concurrent with efforts to preserve Medical Buy-In on the state level, Congress should authorize funding and structure of a national MBI program. The program should be structured in such a way that it can be used as wraparound coverage for people with disabilities who obtain coverage through the Medicaid expansion or the marketplaces. The MBI should be specifically designed to be available separately from disability-related cash benefit programs.

***Recommendation 9:***

Congress should amend the Affordable Care Act so that people with disabilities can be eligible for MBI wraparound coverage in addition to subsidies for ACA marketplace coverage.

***Recommendation 10:***

The Administration should identify and authorize collaboration by the federal agencies in forming an interagency work group to propose rule changes in federal benefit programs and reduce work disincentives linked to federal program conflicts. This effort should begin with SSA, CMS, and Department of Labor programs.

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## CHAPTER 4. **Redefining Disability for SSDI and SSI, Medicaid and Medicare**

### **Goal of Chapter**

Chapter 4 briefly summarizes evidence that the current Social Security definition of disability strongly discourages beneficiaries from working and proposes an alternative definition that does not equate disability with a complete inability to work. This chapter responds to the following NCD question: “What would a fundamental restructuring of the SSI and SSDI system require to align it with the goals of the Americans with Disabilities Act; that is, to eliminate the requirement that SSDI applicants declare themselves unable to work in order to be eligible for benefits?” The goal of Chapter 4 is to propose an alternative disability definition and determination process—applicable to Social Security, Medicare, and Medicaid—that is consistent with the Americans with Disabilities Act (which encourages optimal work effort) and that will result in enhanced productivity and employment by people with disabilities.

### **Outline of Issue**

The basic definition of disability in the ADA is “with respect to an individual, ... a physical or mental impairment that substantially limits one or more major life activities of such individual.”<sup>99</sup>

This definition incorporates an understanding that has been accepted in virtually all conceptual frameworks about disability since Saad Nagi’s development of the Disablement Model in the mid-1960s.<sup>100</sup> This understanding is that disability is not strictly an attribute of individuals but occurs as an interaction between individuals and their physical and social environments. This notion has been echoed by Silverstein in his New Disability Paradigm.<sup>101</sup> Moreover, the prevailing trend has been to give

increased standing to the importance of environmental factors. Thus, there has been increased emphasis on function as a basis of assessing disability, including assessment not only of individuals' levels of functional capacity in relevant environments but of how environmental features limit functional capacity to perform or participate.<sup>102</sup>

The statutory definition of disability contained in the Social Security Act has remained essentially unchanged since 1967:

The inability to do any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.<sup>103</sup>

Additionally, the definition specifies that impairments must be—

Of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.<sup>104</sup>

All initial adult claims for Social Security disability benefits follow a 5-step “sequential evaluation process” that is intended to answer the following questions:

- **Step 1:** Is the individual engaging in substantial gainful activity (SGA)?
- **Step 2:** Does the individual have a medically determinable severe impairment?
- **Step 3:** Does the individual have an impairment(s) that meets or equals a Listed Impairment?
- **Step 4:** Can the individual perform any past relevant work? “Past relevant work” is defined as work done at the SGA level, generally within the 15-year period

prior to adjudication of the claim and long enough for the applicant to have acquired any skills necessary to do the job.

- **Step 5:** Can the individual perform other work in the regional or national economy?

### ***How the Current Definition Discourages Work***

The very wording of the disability definition has strong negative effects on the employment-related activities and outcomes of both claimants and those who become beneficiaries.<sup>105</sup> Four features of the SSA definition discourage work effort: (1) disability is understood solely as inability to work; (2) inability to perform work must be shown to result from one or more impairments directly arising from a medical condition; (3) disability under this definition is an all-or-nothing condition, with no partial determination allowable; and (4) actual or potential monthly earnings at the SGA level, regardless of the severity of the medical condition, threaten eligibility for disability benefits. Thus, work that produces or has potential for producing SGA earnings puts access to income support, health care, and other in-kind benefits at risk. In the case of health care and long-term support services, it is likely that earnings or other income sources are insufficient to meet those service needs. These four features, particularly through their interactions, work against even modestly successful employment outcomes.

## **Research Review Findings**

### ***Negative Effects of the Definition on Employment Outcomes***

There is much evidence to support the claim that the current Social Security disability definition has powerful negative effects on employment efforts and outcomes for both claimants and beneficiaries beyond people's physical or mental limitations or work environments. This definition of disability, along with the rules and procedures used to conduct disability assessments, plants the seeds of failure for future return-to-work efforts. The current process requires that people repeatedly deny that they have the

basic abilities to work. Although the definition does allow for work below the level of SGA, most applicants and beneficiaries do not make the nuanced distinction between SGA-level work and no work whatsoever.

Some studies describe ways in which the disability definition and adjudication process influence the behavior of claimants and beneficiaries. Some observers focus on the rational decision-making processes of claimants and beneficiaries, even if they use incomplete or erroneous information. Other observers emphasize the socialization process that forms an individual's identity as a person who is incapable of working. This socialization can generate fear, feelings of dependency, and a sense of powerlessness that drive individual behavior. Some literature indicates that many people with disabilities choose which identity to portray and to what extent, depending on the situation and their goals.<sup>106</sup> Even beneficiaries who assert that it is possible to work at very high levels acknowledge that it is not easy to do so and, in most cases, requires access to health care and long-term support.<sup>107</sup> Yet these are the program benefits most at risk under the current disability definition.

Multiple surveys of adults who report living with serious disabilities have shown that approximately 80 percent indicate a desire to work.<sup>108</sup> A far smaller proportion actually works. In the 2008 American Community Survey (ACS), just before the onset of the Great Recession, 39.5 percent of working-age people with disabilities reported being employed.<sup>109</sup> Among these, 25.4 percent reported full-time/full-year employment. Another 8.7 percent, who were not currently employed, reported looking for work. Thus, approximately 48 percent of these ACS respondents could be viewed as being attached to the labor force.<sup>110</sup> These numbers represent a broader population than adult SSDI and SSI beneficiaries and one that is generally believed, on average, to have less-severe impairments and to face less-severe external barriers to working.

As the ACS does not provide information specifically about Social Security disability program participants, other sources must be used to get relevant information. Gina Livermore's work identifying "work-oriented" beneficiaries is among the most valuable.<sup>111</sup> Livermore differentiates respondents on the 2004 National Beneficiary



Survey (NBS) into two groups on the basis of their answers about employment expectations. Approximately 40 percent of respondents met her criteria for classification as work-oriented. Examining respondent reports about their work, job training, and jobseeking activities, Livermore found that 52 percent of work-oriented beneficiaries reported performing at least one of these activities either currently or recently. In contrast, among the respondents she classified as not work-oriented, only 6 percent reported performing at least one of these activities. The combined rate across beneficiaries was 24 percent.<sup>112</sup> Using matched administrative data about employment outcomes for 2004 through 2007, Livermore determined that

“as expected, work-oriented beneficiaries were significantly more likely than other beneficiaries to have earnings. Nearly half (45 percent) of all work-oriented beneficiaries had earnings in at least 1 of the 4 years, compared with only 15 percent of non-work-oriented beneficiaries. Among those with earnings, work-oriented beneficiaries had higher average earnings than non-work-oriented beneficiaries (\$7,091 versus \$5,121), were significantly more likely to have worked above the annualized SGA level in at least 1 year (28 percent versus 19 percent), and were more likely to have earnings in multiple years (80 percent versus 66 percent).”

The combined percentage of those beneficiaries with documented employment over the four-year period was 27 percent.<sup>113</sup>

These studies confirm not only that a sizable number of beneficiaries profess an interest in working but that they have taken significant steps to translate that interest into action, albeit not in ways that suggest a strong likelihood of achieving economic independence or of leaving benefit status for any protracted period. The studies suggest that the two-fifths of beneficiaries who appear to be work-oriented and about a quarter of all beneficiaries who had documented employment over the four year period may constitute a minimum number of beneficiaries who might seriously attempt work under a definition that does not discourage work.

Multiple studies report that people with disabilities who are beneficiaries or claimants fear the loss of eligibility for Social Security disability benefits, whether the cash benefit

itself or access to health care. We found no studies that indicated that these concerns were nonexistent or minimal. Respondents report concerns about the consequences of work activity during initial applications; after award, especially in anticipation of future continuing disability reviews (CDRs); and in any reinstatement proceedings.<sup>114</sup> SSDI beneficiaries who were still in the two-year waiting period before Medicare entitlement expressed strong concerns about endangering their eligibility through work activity.<sup>115</sup> In one study, respondents clearly indicated that even if work activity did not negatively affect their income support and health care benefits, they worried that it might affect their eligibility or the cost of other services they received or might seek.<sup>116</sup>

Amid the generalized fear about the consequences of work, beneficiaries who attempted working were especially concerned about making sure they limited their hours and earnings. Some people feared that work activity in itself might negatively affect their continued attachment to a disability program and many were concerned about keeping earnings below some critical level, even if they were not specifically aware of the SGA level.<sup>117</sup> Multiple articles suggested that respondents had engaged in “parking” (intentionally earning income below the SGA level) to keep earnings under SGA or what they perceive or fear to be the “danger level.”<sup>118</sup> Studies that have attempted to assess the relative strength of various barriers to work have found that the perceived effect of the disabling condition is viewed as by far the strongest single barrier.<sup>119</sup> Concern about losing benefits ranked second or was clustered in a group of other frequently cited barriers. Finally, several studies noted that many respondents either held misconceptions about some aspect of Social Security policies and procedures or recognized serious limitations in their understanding.<sup>120</sup>

### ***Problems with the Current Determination Process***

The psychological experience of the disability determination process reduces the likelihood that a person will return to work if he or she is awarded benefits. It is a complex and lengthy process that can last from several months to several years. Claimants are required to produce comprehensive evidence to support their attestation

of disability under the SSA standard. This attestation is reiterated frequently, sometimes under oath. It is very clear to the claimant that disability and capacity to perform work competitively are mutually exclusive concepts.

By design, individual characteristics of age, educational attainment, and the history and nature of past work favor certain applicants over others. Thus, two people with the same medical condition can receive opposite determinations of eligibility on the basis of SSA's expectations about each claimant's ability to make a vocational adjustment to any work that exists in the local, regional, or national economy.<sup>121</sup> This set of intentional, built-in biases makes it more likely that older, less-educated claimants will receive benefits, especially if their past work involved greater physical or mental capacities and few, if any, special skills.

### ***How the Disability Definition Is Operationalized***

Initial eligibility is assessed through a 5-step sequential evaluation process.<sup>122</sup>

- **Step 1:** Is the individual engaging in substantial gainful activity?

This step is based on the logical assumption that earning at SGA is prima facie evidence that one is not disabled.

- **Step 2:** Does the individual have a medically determinable severe impairment?

At this step, a person must meet a two-part standard. First, he or she must have an impairment (or combination of impairments) documented by signs, symptoms, and laboratory findings. Second, these impairments must be "severe."

- **Step 3:** Does the individual have an impairment(s) that meets or equals a Listed Impairment?

The Listing of Impairments (aka "the Listings") is a collection of more than 100 medical conditions.<sup>123</sup> Each listing is composed of medical signs, symptoms,

and laboratory findings. Documentation that these elements, or their equivalent, are present assumes that SGA-level work is not possible and generally ends with the award of disability benefits. If these elements are not found, the process proceeds to Step 4. It should be noted that the Listings, while written with employment as their context, are not primarily employment-centric. Rather, the limitations of functioning they describe imply significant limitations of functioning in every setting generally applicable to adults. This is an important concept that will be discussed more fully later in this chapter.

- **Step 4:** Can the individual perform any past relevant work?

This step first establishes the claimant's residual physical and mental functional capacity (RFC) for work, then compares that to the demands of past work. The RFC determination evaluates the person's ability to meet the demands of work, including physical demands (e.g., lifting, climbing, handling, or fingering); visual demands; communicative demands (hearing and speaking); environmental demands, (e.g., heat, cold, dust, hazardous machinery); and mental demands (e.g., understanding, remembering, applying instructions, interacting with others, acting appropriately). Given its complexity and subjective elements, this step results in a high degree of decisional variance, which is problematic for SSA, Congress, and, most important, the people who go through the process.

- **Step 5:** Can the individual perform other work in the national economy?

In this final step, the decision maker compares the applicant's RFC with the physical and mental demands of jobs other than those he or she has held—jobs that exist in “substantial” numbers either locally or nationally. “Local” is defined as the entire state of residence and sometimes nearby states as well.

The fifth step follows a set of vocational guidelines that take into account the person's RFC, age, and education, and the presence or absence of skills developed during the performance of any past relevant work that might be useful in performing other jobs.<sup>124</sup>

These rules are contained in tables (vocational grids) that dictate a certain decision if all the factors are present and no others come into play. Specifically, the grid prescribes that a person is not disabled if he or she retains the capacity to perform other work that exists in “significant” quantity somewhere or that the person is disabled if no such jobs exist or their incidence is “less than significant” anywhere. The guides do not consider such factors as whether there are any openings for these jobs or whether the claimant would be hired.

The rules consider several factors to be adverse for a vocational adjustment to other work; for example, age 50 and above; less than 12th grade education; or lack of substantial work in the relevant 15-year period since the onset of a disability. Local economic conditions can also play a role, as people with work limitations may be let go from their jobs more quickly than unimpaired workers in a poor economy.<sup>125</sup> However, NCD was informed that this factor is not considered in SSA’s program rules.

A long-term trend in the pattern of disability allowances has been an increase in the number of claims made on the basis of symptoms indicating severe disability. As the number of claims based on such conditions has increased, so has SSA and DDS (Disability Determination Services) dependence on functional and symptomatic evidence,<sup>126</sup> and these cases are more likely to be considered marginal. This trend underscores the urgent need for SSA to enhance research into functional capacity assessments.

As comprehensive as these rules are, they overlook personal and circumstantial differences such as inordinate motivation to overcome limitations, unpredictable episodic exacerbations and remissions of some medical conditions that are not usually subject to variability, availability of part-time work, heavily accommodated work conditions, and the availability of certain jobs in the local/regional economy that a person might be considered capable of performing.

## ***An Alternative Approach to a Disability Definition***

The SSI child determination process is a feasible alternative to the current process used for adults, because it is not work-centric; that is, it focuses on the full range of a person's functioning rather than the singular capacity to work. SSA has more than two decades of experience performing broad-based functional assessments under the child program's rules. The changes would require a paradigm shift from a definition based on work-related factors to one that considers the whole person. Admittedly, this will not be an incremental change; however, a disability definition that supports a whole person approach is much more likely to motivate substantial increases in employment outcomes.

The proposed definition is as follows:

A person over the age of 18 will be found to have a disability if a medically determinable physical or mental impairment(s) exists that results in substantial limitations in the full range of adult functioning, the impairment(s) being one expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months.

A revised sequential evaluation process can be developed that retains important elements of current SSA and DDS processes and practices. The determinants of what constitutes a marked or extreme limitation lie in the functional limitations resulting from all impairments, including their interactive and cumulative effects. Consideration would be given to all the relevant information related to functioning, including signs, symptoms, and laboratory findings, as well as functional descriptions from laypersons.

Table 1 compares the proposed changes in the process for initial adult disability determinations to both the sequential process for SSI child determinations and the proposed new adult process. For simplicity, Table 1 does not include information about continuing disability review processes. Additional information about CDRs is contained in Appendix B. Table 1 presents side-by-side questions that are used at each step of the eligibility determination process for the current SSI/SSDI adult process, SSI disabled child process, and proposed SSDI/SSI adult process.

**Table 1. Comparison of Initial Eligibility Determination Processes:  
Current Adult, SSI Child, and Proposed Adult**

<b>Step</b>	<b>Current SSI/SSDI Initial Adult Process</b>	<b>SSI Disabled Child Process</b>	<b>Proposed SSDI/SSI Initial Adult Process</b>
<b>1</b>	Is the claimant working at SGA? If yes, technical denial at SSA field office; if not, proceed to Step 2.	[SGA step does not apply to children]	Is the claimant working at SGA? If yes, technical denial at SSA field office; if not, proceed to Step 2.
<b>2</b>	Does the claimant have a severe impairment? If yes, proceed to next step; if not, the claim is denied.	Does child have a severe impairment? If yes, proceed to next step; if not, the claim is denied.	Does the claimant have a severe impairment? If yes, proceed to next step; if not, the claim is denied.
<b>3</b>	Does the claimant's medical impairment(s) meet or equal the intent of a Listed Impairment? If yes, the claim is allowed; if not, proceed to the next step.	Does the child's medical impairment meet or equal a Listed Impairment? If yes, an allowance is prepared; if not the process continues to Step 4.	Does the claimant's medical impairment(s) meet or equal the intent of a Listed Impairment? If yes the claim is allowed; if not, proceed to the next step.
<b>4</b>	After determination of residual functional capacity (RFC) for work, can the claimant perform past work either as actually performed or as is generally performed in the economy? If yes, the claim is denied; if not, proceed to the next step.	Does the child's impairment(s) <b>functionally</b> equal a Listed Impairment? If yes, a favorable determination ensues; if not, a denial of benefits is prepared.	Does the claimant's impairment(s) <b>functionally</b> equal a Listed Impairment? If yes, a favorable determination ensues; if not, a denial of benefits is prepared.
<b>5</b>	Can the claimant—on the basis of age, education, and elements of past work—perform any work that exists in substantial quantity in the regional or national economy? If yes, a denial of the claim is prepared; if not, an allowance is prepared.	[Does not apply]	[Does not apply]

We have a single overriding purpose in offering a revised Social Security disability definition that focuses on the full range of adult functioning rather than the specific capacity to work. That purpose is to create an environment that will encourage participants in the SSDI and SSI programs to attempt and to a greater extent succeed in work efforts consistent with economic self-sufficiency. This goal cannot be achieved unless a substantial portion of those who would qualify for benefits under the proposed disability definition can be diverted or, preferably, encouraged not to become permanently attached to a Social Security disability program.<sup>127</sup>

## **Recommendations (*numbering continues from previous chapter*)**

### ***Recommendation 11:***

Congress should authorize SSA to identify promising models of assessing adult functioning and select one for testing within a given time frame. SSA should be directed to convene a workgroup or task force, including stakeholders with disabilities, to identify the most promising models of assessing adult functioning. Begin with models mirroring the paradigm that underlies the nature and intent of the whole person approach to comprehensive assessment.

### ***Recommendation 12:***

SSA should use electronically stored cases to compare adjudication outcomes using the new definition with outcomes for previous claims.

### ***Recommendation 13:***

SSA should conduct pilot demonstration projects by adjudicating claims in a side-by-side manner. Experienced claims adjudicators trained in the new process should develop the evidentiary record as required by each definition (work-centric and non-work-centric) and then render simultaneous decisions to the workgroup or task force.



***Recommendation 14:***

SSA should conduct analyses of state experiences with applying a less work-centric definition in their Medicaid Buy-In (MBI) initiatives. For example, Wisconsin DDS employed a process for Title XIX and MBI claims based on the current SSA definition that involved multiple determinations using the same evidentiary materials.

***Recommendation 15:***

SSA should continue to expand its support for research on how to effectively and efficiently assess functional capacity. The International Classification of Functioning, Disability and Health can be used as the conceptual starting point in developing an assessment framework for adult adjudication.

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## CHAPTER 5. **Changing the Disability Definition: Impact on the SSDI/SSI Population**

### **Goal of Chapter**

An important issue to consider when contemplating any significant policy change is identifying the likely winners and losers among the beneficiary population if the policy change is implemented. This chapter responds to the question, “Given the extremely diverse populations served by the SSI and SSDI programs, how might the proposed SSA reform strategies disproportionately affect, either positively or negatively, particular segments of the disability community?” The goal of Chapter 5 is to speculate on the implications of the proposed definition of disability (described in the previous chapter) for people who are currently eligible for SSI and SSDI benefits, and those who are not currently eligible who might benefit.

### **Outline of Issue**

The previous chapter put forward a new definition of disability that does not use inability to work as its foundational criterion, so that other return-to-work supports and incentives (such as offsets and premiums) can be built around it. By implementing a definition of this type, it is hoped that, over time, the cultural understanding of what it means to have a disability will change from *a person with a disability cannot work* to *a person with a disability faces substantial barriers that limit functioning in multiple areas of living*. If a person wants to try working, there will be no penalty. Encouragement to work would be real.

There are many challenges in moving from the current definition to a radically different one. In this chapter we will discuss the potential harm to those who currently benefit from the programs, and the potential benefits to other people with disabilities.

First of all, to limit induced entry by people who would quit their jobs to apply for disability benefits, applicants would still have to meet the test of working below the SGA level to be eligible at initial application. This precaution is used in several state Medicaid Buy-In programs to limit the occurrence of what is sometimes referred to as “the woodwork effect.” Ideally, it is combined with a robust Work First policy, through which applicants are met with expectations and accompanying services and supports to maintain their workforce attachment.

The proposed new definition would not, on its own, result in dramatic changes to the primary outcome of the adjudication process; that is, the revised definition would not necessarily produce unfavorable decisions. There is nothing in the proposed definition that would render a currently eligible claimant ineligible or result in a favorable decision for a person who would not now be found eligible. The intent of the new definition is to remove the focus on inability to work as the primary standard for disability. To do this, we must eliminate the current vocational guidelines (the grids). However, we can create a different process using domains of adult functioning similar to those used in the SSI child program. The concept of “functional equals” of the Listing of Impairments would produce essentially the same results. Under the reform proposal, the assessment of functional equivalents of the Listings would rely on multiple domains of living and not just the domain of employment.

### ***Populations Likely to Be Affected***

Currently, the vocational grids are weighted toward a decision of “disabled” for applicants of advanced age who also have a lower educational level, lesser work skills, and limited work experience. If the grid were eliminated, this extra weighting would be lost to people who are older and less educated, and have fewer work skills or less experience. To compensate for this drawback, extra weight could be accorded findings of age (over 55), severity in limitations of function, combined with limited skills and experience. The Social Security Administration could evaluate how a new definition and corresponding process changes would affect eligibility decisions, by applying the new

criteria to the records of current beneficiaries. SSA should have sufficient information to conduct this kind of review, given its longstanding evidence-gathering policies that stress obtaining a full picture of claimant functioning. By modeling the effect of a new definition, SSA could make adjustments (if it wanted to) so that there would be no change in the relative proportions of allowance versus denial.

By itself, the proposed definition would not disadvantage particular groups on the basis of type of impairment, and the current Listings of Impairments would not require extensive changes. However, if other policies were implemented that required a serious return-to-work effort on the part of new beneficiaries, that part of the system could have a major impact on which individuals and groups would remain in beneficiary status. However, that would also be true if a stringent Work First policy were implemented under the current disability definition.

Owing to lower levels of education or job skills, many people with disabilities will not be well prepared to benefit from job preparation and supports. Others, who have been socialized into a “culture of low expectations,”<sup>128</sup> will not want to take advantage of a Work First environment. A similar argument could be made about the differential impacts on people with certain impairments if early intervention programs were instituted with people who have early signs and symptoms of impairment. The characteristics of applicants would change, but it is not possible to predict what those changes would look like.

The challenge in moving from the current definition to a revised definition and process is how to prevent substantial harm to current beneficiaries. A sudden change to a stricter definition could result in immediate personal and family hardship, as well as political backlash. Policy safeguards would have to be designed and piloted with gradual phase-in periods during which the new definition is applied over time through periodic medical reexaminations. For example, once a new policy is enacted, existing beneficiaries who undergo a continuing disability review (CDR) could be adjudicated under both the old and the new standards. If the beneficiary were found eligible under the old definition but not under the new, he or she would continue to receive benefits until the next CDR, at which

time the new definition would be applied. Thus, the first post-revision determination would provide a heads-up regarding the nature of subsequent eligibility reviews.

The primary component of an effective post-entitlement return-to-work program has to be a system to assess and support beneficiaries in the first year or two after they enter the disability program. It would have to be proactive but not punitive in the sense of disqualifying people who make reasonable attempts to work but are unable to do so. One of the potential benefits of the revised definition is that it is more likely than the current definition to show good results from a well-designed early intervention system. A more positive response would arise from potential applicants' expectations that work is not incompatible with disability.

### ***Advantages of a New Definition***

The proposed disability definition would offer multiple advantages. Not only would it greatly reduce the perceived barriers to increased workforce participation and employment outcomes, but it would do so in a manner that is highly consistent with values of fairness and consistency, and within the administrative capacities of SSA and the state Disability Determination Services (DDSs). These advantages can be summarized as follows:

- The definition and adjudicative process eliminates the emphasis on employment. Thus, it promises to greatly reduce both the psychological impediments and tangible disincentives experienced by claimants and beneficiaries that constrain work effort.
- The revised definition would not require significant and expensive changes in SSA infrastructure or inter-unit relationships, specifically those involving SSA field offices (FOs), state DDSs, and the SSA Office of Disability Adjudication and Review (ODAR). In particular, it would maintain the case development and preparation functions of the FOs and DDSs for administrative hearings.

- The proposed process and methodology are familiar to adjudicators, claimant representatives, and advocates.
- The disability definition provides for a less jarring transition between childhood benefits and adult programs by increasing the coherence of the meaning of disability and of the determination process across the lifespan.

People with disabilities who want to work and want the freedom to try working at an optimal level will be the winners under the revised definition. People who fear triggering a medical review because of their work efforts would no longer have to minimize their earning potential. By having an attachment to the Social Security program while they are working, people would be able to access health care and long-term supports at reasonable costs through the Health Care Marketplace. Under the revised definition, more people with disabilities would be living more independently and participating in their communities in valued roles.

## **Recommendations *(numbering continues from previous chapter)***

### ***Recommendation 15:***

SSA and the DDSs should continue to apply the substantial gainful activity (SGA) test as the first step for eligibility. Subsequent disability reviews would not use earnings level as the sole criterion for continued disability status.

### ***Recommendation 16:***

SSA should redesign the assessment process and give extra weight to findings of severity in limitations of function for older workers with limited skills and experience. For example, similar vocational adversities could be considered a “moderate” limitation for a claimant under age 55 and a “marked” limitation for a person 55 or older.

***Recommendation 17:***

If the revised definition of disability is adopted, SSA will have to design policy safeguards and pilot them with gradual phase-in and periodic reexaminations. For example, once a new policy is enacted, existing beneficiaries who undergo a continuing disability review (CDR) could be adjudicated under both the old and the new standards. If the beneficiary were found to be eligible under the old definition but not under the new one, he or she would continue to receive benefits until the next CDR, at which time the new definition would be applied.



## CHAPTER 6. Reenvision the Ticket to Work Program

### Goal of Chapter

Chapter 6 assesses whether the Ticket to Work program has achieved its intended objectives and what actions, if any, might reinvigorate the program. This chapter responds to the following questions: “To what extent has the Ticket to Work initiative been evaluated? What lessons can be drawn from the challenges the program has faced in achieving its intended goals? If sufficient information is available to make a determination, what reforms to the Ticket to Work program are recommended?” The goal of this chapter is to summarize the results of a series of program evaluations of the Ticket to Work program conducted by numerous researchers over 12 years.

### Outline of Issue

The Ticket to Work (TTW) program was designed to increase employment and earnings of SSI and SSDI beneficiaries by expanding choice and diversity of rehabilitation and employment service providers using a market-driven approach. The assumption was that providing payments directly to service providers (called Employment Networks) for employment outcomes of beneficiaries would produce greater choice for beneficiaries and competition among providers. The ultimate result would be that more beneficiaries would become financially self-sufficient and able to go off benefits. One aim of the 1999 Ticket to Work and Work Incentives Improvement Act (TW-WIIA), the authorizing legislation for TTW, was to reduce disability program costs. The following questions address the effectiveness of this program: Has the Ticket to Work increased choice and diversity of providers? Are beneficiaries who otherwise would not have been employed now working? Has the program resulted in net savings to the U.S. Treasury?

## **Research Review Findings**

Although the TTW program has been in place for 12 years, the program rules have evolved significantly, and other changes have occurred since the initial rollout in 2002. Under the original rules, participation was low (about 2%), and only about 9 percent of the participants used the new providers; instead, most participants assigned their tickets to State Vocational Rehabilitation Agencies (SVRAs).<sup>129</sup> In 2008, the Social Security Administration implemented major regulatory changes that significantly increased incentives for Employment Networks (ENs) to participate. In 2011, SSA responded to findings from the Government Accountability Office (GAO)<sup>130</sup> that were critical of program oversight, introducing administrative changes that tightened requirements for organizations seeking to become ENs. This NCD research review compares outcomes of the original Ticket to Work program that began in 2002 with outcomes after the reforms in 2008 and later.

### ***Beneficiary Participation***

Participation is measured by the number of “tickets” assigned to an Employment Network or to an SVRA acting as an EN. Beneficiaries assign their tickets when they seek rehabilitation or employment assistance. In December 2005, the participation rate for beneficiaries ages 18 to 40 years was 3.6 percent, compared with 1.9 percent for beneficiaries ages 40 to 49, and just 0.6 percent for those 50 and older.<sup>131</sup> The size of the participant pool from January through December 2005 was 45, 257.<sup>132</sup>

Compared with earlier reports, the 2010 evaluation showed an increase in the proportion of younger participants (ages 18 to 24), as well as increases in the number of participants who had a psychiatric disability, those who were more likely to be dependent on other benefits, and those who were less likely to have ever worked. These findings suggest that ENs were beginning to serve people who are perceived as harder to serve.

## ***Employment Network Participation***

The number of ENs that accepted at least one ticket doubled, from 305 as of June 2008 to 639 as of December 2009.<sup>133</sup> The number that accepted five or more tickets increased from 147 in June 2008 to 344 in December 2009, and 40 ENS had accepted 100 or more tickets. The 2008 regulations did attract more private ENs into the market, which had been dominated by SVRAs. However, there is room for private ENs to participate in the program at a more substantial level.

## ***SVRA Participation***

There also is need for additional SVRAs to embrace the TTW, either as ENs or through Partnership Plus or other options. Under Partnership Plus, both SVRAs and ENs can receive payment for serving a beneficiary sequentially. SSA and its contractors heavily marketed the Partnership Plus model for SVRAs as the preferred method of participation in 2008; however, early data suggested low participation, with only 786 beneficiaries being served under Partnership Plus as of December 2009.<sup>134</sup> Only a small number of SVRAs seem to have embraced the approach in a substantial way. Altshuler et al. (2009) found multiple barriers to implementation of Partnership Plus, including a lack of ENs to partner with, SVRA staff challenges, and a perception that SVRA and EN interests are in conflict.<sup>135</sup>

## ***Impact of TTW on Employment Outcomes***

TTW employment outcomes thus far have been less than promising. Between 2002 and 2006, between 2 percent and 4 percent of participants left the rolls for one year because of employment, compared with 5 percent of nonparticipants. Participants served by private ENs were more likely to leave the rolls than beneficiaries served by SVRAs.<sup>136</sup> However, this difference can be attributed to the different mandate of the SVRA system, which has a statutory requirement to serve beneficiaries and not screen out individuals who are unlikely to work at the substantial gainful activity (SGA) level. The same

evaluation was not able to identify any significant impact of the TTW on beneficiary earnings or benefit status. The beneficiaries who did work above SGA may have achieved this outcome without the benefit of the TTW. The evaluation noted that 79 percent of beneficiaries who left the benefit rolls because of employment did so without enrolling in TTW or an SVRA. In impact analyses as recent as 2013, researchers have found no consistent evidence of impact on employment outcomes of beneficiaries.<sup>137</sup> Any reduction of benefits paid to TTW participants has not offset the costs of operating the TTW program to result in savings to the U.S. Treasury.

Twelve years after the launch of the TTW program, it appears that the program has fallen short of achieving its objectives and has had little impact on the service system for people with disabilities. The original hope was that a market-based approach would bring new employment service providers into the system; however, few new providers started serving beneficiaries as a result of the TTW..

A significant historical challenge for the TTW program was its implementation at the federal level primarily through contractors working directly with beneficiaries and local ENs. Under the federal statute, the state governments are not mandated to have a role in the TTW program. However, most employment services for people with disabilities are administered at the state level through entities such as SVRAs, state mental health agencies, state developmental disability agencies, and state departments of labor. As federal partners continue working to boost state-level and EN participation, SSA can share more recent data about any progress being made.

## **Recommendations (*numbering continues from previous chapter*)**

### ***Recommendation 18:***

Congress and SSA should identify and implement appropriate ways to engage the states directly in the TTW program. One option would be to test alternative partnership options that might blend TTW more effectively with state funding sources. Partnership Plus is a start, but it needs to be improved by encouraging

partnerships between SVRAs and ENs that are collaborative rather than competitive.

***Recommendation 19:***

SSA should explore collaborative strategies with the states to more broadly support the return-to-work efforts of SSI/SSDI beneficiaries. Currently, state and county governments have very little reason to align their efforts with SSA's efforts to help people return to work at substantial levels. The states could potentially have a huge influence on how state programs either support or undermine return-to-work efforts of SSI/SSDI beneficiaries.

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# CHAPTER 7. **Expand Other State and Federal Programs That Positively Affect SSA Beneficiaries and Work Opportunities**

## **Goal of Chapter**

This chapter responds to NCD's question, "What changes, if any, did the research reveal to other federal programs that would have a positive impact on the health and effectiveness of the Social Security programs and work opportunities for SSDI and SSI beneficiaries?" Chapter 7 examines system strategies that have been used to support particular subgroups of people with disabilities: youth in transition from high school to adult living, and people with mental illnesses/psychiatric disabilities. The chapter also examines a system improvement strategy that has been used to facilitate infrastructure changes in states to improve outcomes for all people with disabilities. The goal of Chapter 7 is to identify effective workforce participation practices that should be considered for expansion nationally to target specific populations and benefit people with disabilities generally.

## **Outline of Issues**

Youth and young adults with disabilities require particular attention because of the challenges they face during the transition into adult living. One issue is the ongoing crisis of persistently low labor force participation rates of people with disabilities. Senator Tom Harkin (D-IA) referred to the generation of people with disabilities who have come of age since the passage of the American with Disabilities Act (ADA) as "the ADA Generation."<sup>138</sup> While some people of the ADA Generation have attained unprecedented educational levels in inclusive settings, not all young people with disabilities have had access to the general education curriculum and opportunities. Yet, all have a right to be included as valued members of the American workforce. The

United States is failing to ensure training for all to encourage full inclusion, workforce readiness, employment access, appropriate accommodations, and supports for job retention. This failure jeopardizes the civil rights of the ADA Generation and does not fully leverage their talents.

Another population group to consider when proposing changes to Social Security is people with mental illnesses/disorders or psychiatric disabilities. On the basis of available raw data for fiscal year 2008,<sup>139</sup> over one-third of all SSDI beneficiaries under the age of 50 have mental health disabilities as their primary disability.<sup>140</sup> These beneficiaries tend to stay on the rolls longer because they are younger when they first receive SSDI; therefore, the lifetime costs are greater than for other beneficiary groups.<sup>141</sup> The data on these beneficiaries from 14 and 25 years ago also shows a low rate of employment earnings: only 1 percent had any earned income.<sup>142</sup> Clearly, more current evidence-based research is needed for informed policy and decision making. Health care coverage is critical for people with psychiatric disabilities to fund medications, therapy, counseling, and links to supports such as rehabilitation and other services that will help them maintain the functioning essential to participate in the workforce. People with psychiatric disabilities are often among the applicants/claimants to Social Security disability programs who present the most complex cases.<sup>143</sup> Beneficiaries with mental health needs also may be seen by the labor market and service providers as hard to serve.<sup>144</sup>

The third and final topic in this chapter is a systems change process—the Medicaid Infrastructure Grant (MIG) program. Fragmentation in health and human service delivery at the community level has long been recognized as a problem for service beneficiaries. Multiple sources of funding for health and employment programs for people with disabilities create a “silos syndrome.”<sup>145</sup> The silo metaphor is used to suggest that agencies interact primarily within their own tower, leading to insular thinking, separate organizational cultures, and redundancies. This can be frustrating, time-consuming, and discouraging for beneficiaries, especially when services cannot be obtained elsewhere. The solution to the silo syndrome is to adopt a collaborative



culture, including interactive processes and tools. The MIG initiative was an attempt to address the problem of silos while improving systems of support for people with disabilities.

## **Research Review Findings**

### ***Youth in Transition***

To further the goal of increasing employment of people with disabilities,<sup>146</sup> the SSA Youth Transition Demonstration (YTD) project was designed to coordinate the fragmented transition support system; address low individual, family, and employer expectations; and raise awareness about available incentives.<sup>147</sup> One employment barrier is lack of information about the effect of earnings on SSI payments. It was anticipated that YTD projects could “provide youths and their families with the skills and knowledge necessary to achieve independence and self-sufficiency. In turn, participants would become less reliant on SSI and other assistance programs, such as Medicaid, thus lowering public costs.”<sup>148</sup>

According to interim reports, the intensity of service and focus on employment was high in four of the six completed YTD projects. “Three of those projects had positive and statistically significant impacts on paid employment during the year following random assignment, and two of them also had significant positive impacts on annual earnings. [SSA’s evaluation] found no impacts on employment and earnings for the two projects in which the intensity of services and focus on employment were low.”<sup>149</sup>

According to SSA data, total SSI payments of \$7.8 billion in 2010<sup>150</sup> and nearly \$7.5 billion in 2009 were made to more than a million youth ages 13 to 25. Another 196,000 people ages 25 and under received SSDI with an aggregate value in excess of \$1 billion.<sup>151</sup> Using SSA records and results from the National Survey of Children and Families, researchers found that 41 percent of those who received SSI were employed

at age 19, and only 14 percent were earning more than their annual SSI payment at 17 years of age.<sup>152</sup>

Approximately one-third of childhood SSI recipients lose benefits when they turn age 18 because they do not meet the adult eligibility criteria or they leave the program for other reasons.<sup>153</sup> Only 61 percent of people in this category were working at age 19, compared with 29 percent of those working who were on SSI. Just 25 percent of the 19-year-olds earned enough to replace their childhood SSI benefits.<sup>154</sup> Also, 39 percent of youth ages 19 to 23 had dropped out of high school. Approximately one-fifth of these dropout youth had been arrested, and 57 percent did not participate in any postsecondary school, vocational rehabilitation program, or employment activity. Of the 19- to 23-year-olds who no longer received SSI, only 41 percent were employed.<sup>155</sup>

Reported problems were especially high among the 19- to 23-year-olds with mental health needs and behavioral disorders: 45 percent had dropped out of school, 52 percent reported being expelled or suspended from school, and 28 percent reported a previous arrest.<sup>156</sup> On the positive side, 49 percent of this age group was employed, but only 10 percent earned more than \$2,000 per year. Conversely, people with sensory impairments had an employment rate of only 31 percent, and 17 percent of them earned over \$2,000 a year.<sup>157</sup>

A systematic review was conducted of 22 studies to identify predictors of improved post-school education, employment, or independent living outcomes for young people with disabilities.<sup>158</sup> Results showed 16 indicators that correlated with increased success in one or more of those three areas: career awareness, community experiences, exit exam requirements/high school diploma status, inclusion in general education, interagency collaboration, occupational courses, paid work experience, parental involvement, program of study, work study, work experience/paid employment, vocational education, self-advocacy/self-determination, self-care/independent living, social skills, and student support. In terms of employment, all 16 indicators predicted improvement in post-school outcomes. The five indicators associated with improved outcomes in employment only were community experiences, exit exam requirements/high school diploma status,

parental involvement, program of study, and work study. Finally, four factors showed strong correlation with improved employment outcomes: inclusion in a regular education classroom, work experience/paid employment, vocational education, and work study.<sup>159</sup>

The four factors are confirmed and expanded upon by analysis of the National Longitudinal Transition Study-2.<sup>160</sup> These results showed that holding a community-based job in high school, having more independence in self-care, better social skills, more household responsibilities during adolescence, and higher parental expectations related to future work were all associated with increased odds of employment after school for young adults with severe disabilities. Hemmeter et al. (2009) also found that early work experience appears to correlate with post-age-18 employment outcomes. High earners at age 19 were most likely to have had high earnings before age 18, while those who were not employed were least likely to have had high earnings before age 18.<sup>161</sup>

Beginning in 2013, Congress and the White House agreed to fund PROMISE (Promoting the Readiness of Minors on Supplemental Security Income) grants to states.<sup>162</sup> The funding focus is on developing and implementing model demonstration projects that promote positive outcomes for youth with disabilities who receive SSI. PROMISE is a joint initiative of the Social Security Administration and the U.S. Departments of Education, Labor, and Health and Human Services.<sup>163</sup> The grants were awarded to five large-population states and a consortium of six smaller states. These five-year projects are required to use an experimental design and develop comprehensive family-focused interventions founded on the best evidence-based practices. Each demonstration project must enroll a minimum of 2,000 youth ages 14 to 16. The projects represent a huge investment in applying the lessons learned from the Youth Transition Demonstrations and the Longitudinal Transition Surveys.

### ***Mental Illnesses/Psychiatric Disabilities***

SSA sponsored the Mental Health Treatment Study (MHTS) in which more than 2,200 SSDI beneficiaries from 23 research sites were studied over two years in a

random-assignment experimental design.<sup>164</sup> Study participants were recruited from a list of SSDI beneficiaries provided by the Social Security Administration. Compared with previous studies, a very high percentage of participants had serious physical health problems and medical conditions. Researchers found that many of them were not receiving mental health services before they enrolled in the study.<sup>165</sup> The researchers expected to see worse employment outcomes than previous studies of individual-placement-supported employment.

The study provided intervention group participants with a comprehensive package of employment services and health benefits. The package included supported employment using the Individual Placement and Support (IPS) model, systematic medication management (including facilitation by a care coordinator), behavioral health services (such as therapy and substance abuse counseling), benefits counseling, and insurance coverage for medication and co-pays. SSA suspended medical CDRs for the intervention group for three years from the date of enrollment. In addition, whenever possible the supported employment services were provided by the same organization that provided the mental health services and thus were well coordinated. The package of services was designed to reflect the most effective evidence-based practices at the time.<sup>166</sup>

The outcomes of the MHTS were unequivocally positive. The intervention group had significantly better employment outcomes than the control group in terms of average time in employment, weekly earnings, hours per week, and hourly wages.<sup>167</sup> Also, the intervention group showed significant improvements in mental health status and self-reported quality of life, lower inpatient hospital use, and greater use of outpatient clinic services than the control group. Despite greater increases in employment and wages for the intervention group, there was no difference between the groups in the percentage of participants that earned more than the current SGA level (8%).<sup>168</sup> The outcomes provide strong evidence for the effectiveness of a comprehensive set of services, including health care subsidies for those who do not have insurance. The implications are that significant improvement in employment, mental health, and quality of life is possible for SSDI beneficiaries with serious psychiatric disabilities who want to work.

The MHTS added to knowledge about the potential for outcomes that can be achieved with access to health care, access to evidence-based supported employment, and management of complex, co-occurring physical and mental conditions.<sup>169</sup>

### ***Medicaid Infrastructure Grants***

The Medicaid Infrastructure Grant (MIG) program was established by Section 203 of the Ticket to Work and Work Incentives Improvement Act (TW-WIIA).<sup>170</sup> The funding was intended to support enhancements to state Medicaid programs and services that would result in increased employment for people with disabilities. Funding was initially targeted toward implementing Medicaid Buy-In programs and increasing the availability of attendant services for workers with disabilities.<sup>171</sup> After reaching these goals, states were eligible to request funding to support comprehensive employment initiatives that bridged services across a wide range of agencies and programs. MIG funding was available between 2000 and 2011.

The amount of MIG funds awarded during the initial phase was approximately \$500,000 per state.<sup>172</sup> Once a state had a Medicaid Buy-In (MBI) program, subsequent MIG funding was based on the yearly service expenditures. Thus, states that invested early in growing their MBIs were rewarded with larger grants for infrastructure development. For example, in 2008, MIG funding to 21 states ranged from a minimum of \$500,000 per year to a high of \$6.7 million awarded to the state of Wisconsin.<sup>173</sup> Overall, 49 states plus the District of Columbia and the Virgin Islands received MIG funding for at least one year.<sup>174</sup> Funding for the MIG program ended in 2011.

Comprehensive MIG funds gave states the opportunity to innovate in removing barriers to employment identified through a state-based strategic planning process. The grants encouraged states to build partnerships and interagency collaboration, to foster leadership among people with disabilities, and to test innovative approaches to employment for adults and youth with disabilities.<sup>175</sup> States used MIG funds to support and enhance other federal and state employment initiatives such as Ticket to Work,

benefits counseling, employer partnerships, and education and outreach to stakeholders. MIG funding was also used for formative evaluation of demonstration projects and for piloting new state-driven initiatives. For examples of state innovations developed through MIG funding, see Appendix C—Medicaid Infrastructure Grants in Three States.

A long-term outcome measure used to evaluate the overall MIG initiative was the employment rate of people who receive federal disability benefits. An independent evaluation of all states showed slightly higher rates in 2009 for SSDI beneficiaries who had their benefits withheld or terminated because of substantial work in MIG states (1%) compared with non-MIG states (0.7%). The differences were not statistically significant. For SSI recipients, the employment rate in 2009 was significantly higher in MIG states (7.3%) than in non-MIG states (4.6%). However, because of the wide variability in supports for people with disabilities across states, it is not possible to attribute these differences to the MIG programs.<sup>176</sup> Although there does not appear to be a relationship between MIG projects and the rates at which beneficiaries return to work, there are myriad examples of concrete structural and policy changes brought about as a result of long-term investment by CMS. These mechanisms allowed the states to choose the paths that worked best in their environments.

## **Recommendations (*numbering continues from previous chapter*)**

### ***Recommendation 20:***

The Social Security Administration and U.S. Departments of Education, Labor, and Health and Human Services should issue a joint report on the results of an evaluation of the PROMISE initiative, expanding evidence-based practices for youth in transition from school to adult living.

### ***Recommendation 21:***

Congress and the White House should initiate a national demonstration of evidence-based practice to benefit people with psychiatric disabilities/mental

illnesses. Begin by using a funding approach similar to PROMISE that would replicate the Mental Health Treatment Study model. The Substance Abuse and Mental Health Services Administration could be the lead agency in ensuring that interventions are based on evidence-based practices.

***Recommendation 22:***

CMS should assist reform by reinstating the Medicaid Infrastructure Grant (MIG) approach to funding strategic state-level system improvements.

***Recommendation 23:***

CMS should work with states to incorporate benefits counseling within state home- and community-based services waivers.

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## CHAPTER 8. SSI State Supplementation

### Goal of Chapter

Chapter 8 reviews the interaction of federal and state policies regarding state supplemental payments to the SSI program. The question posed by NCD was, “Could an incentive mechanism be developed to encourage states to supplement the SSI program with state funds? If so, describe the mechanism.” The goal of this chapter is to explore the question of whether changes in policies for state SSI supplement payments would encourage employment. An unanticipated finding of this research produced a recommendation for further study.

### Outline of Issue

A focus on state SSI supplements is germane to a discussion about work incentives for people receiving federal SSI and SSDI benefits. State supplements not only affect recipients of SSI but also have the potential to affect the receipt of SSDI benefits, because beneficiaries whose SSDI benefit amount is below the minimum SSI benefit level can access SSI. State supplements increase the total SSI benefit amount and raise the threshold for losing benefits. A person with earnings continues to receive a declining amount of SSI payment as his or her earnings increase. Because of the state SSI supplement, this person will continue to receive some SSI up to a higher earnings level than if the state’s SSI benefit standard were the same as the federal standard. If the total SSI benefit amount were increased through supplementation, SSI recipients and dual SSI/SSDI beneficiaries would have a stronger incentive to work at higher levels.

### Research Review Findings

When they created the Supplemental Security Income program in 1972, Congress and the Nixon Administration sought to establish a minimum level of subsistence across the

country for low-income people who were aged, blind, and disabled. This program was designed to replace the patchwork of public benefits operated by states.<sup>177</sup> Thus, the SSI program replaced individual state-run programs of assistance. State supplemental payments can trace their origins back to the authorizing legislation of the SSI program. Before that time, individual states provided widely varying amounts of cash assistance for people with disabilities and the elderly, with various income and asset limits. The SSI legislation provided for two types of state supplementation: mandatory and optional. Mandatory supplements were required for states whose benefit amounts were greater than the federal minimum at that time, to ensure that recipients under the new federal system would not receive a lower benefit than they had received before federalization. Optional supplements allowed a state to provide benefits in excess of the minimum federal benefit amount. Increases in federal benefits over the years have left only a few SSI beneficiaries receiving mandatory payments today.<sup>178</sup>

Forty-six states and the District of Columbia offer some type of optional SSI state supplement.<sup>179</sup> Even though a large majority of states provide the optional benefits, a number of factors diminish the significance of these supplemental programs. First, only 23 states provide supplemental payments to the approximately 90 percent of SSI recipients who live independently in their own homes.<sup>180</sup> The remaining states provide supplements to the less than 10 percent of SSI recipients who live in congregate housing.<sup>181</sup> In 22 states, the SSI supplementation is only for group living arrangements—primarily relatively large nonmedical facilities.<sup>182</sup>

State supplements also have a decreased impact because states do not adjust supplements for inflation.<sup>183</sup> Over the years, there have been few changes to the means test criteria and no adjustment for inflation in these criteria, meaning that the amount of income that will disqualify a person for SSI has fallen in real terms. Simply put, the means test has become more restrictive. The real value of the median state supplemental payment to people who are living independently declined by about 60 percent between 1975 and 1997.<sup>184</sup> Meanwhile, the state share of payments to individuals declined from approximately 27 percent of total SSI payments in 1975 to

about 11 percent of annual SSI expenditures in 2001.<sup>185</sup> State supplement payments have not been a high priority policy focus for disability advocates because the payments support people who are living in provider-owned, less independent settings, and the supplements are less and less valuable in real dollars.<sup>186</sup>

The SSI law was amended in 1974 to provide for an annual cost of living adjustment (COLA) in the federal benefit. At the same time, the law prohibits states from decreasing their own SSI supplementation benefit levels or total expenditures in response to a cost of living increase in the federal benefit. This is referred to as the “maintenance of effort” requirement.

### ***Fees for SSA to Administer State Supplements***

The SSI legislation permits states to develop an agreement with the Social Security Administration (SSA) to administer a state’s SSI supplement; alternatively, states may administer the supplement themselves. In the mid-1990s, Congress allowed SSA to begin charging a fee for administering state SSI supplements. This has added to the cost for states and created a disincentive for them to have an SSI supplement. The SSA administers state supplements in 13 states and the District of Columbia.<sup>187</sup>

### ***State Supplements and Medicaid Eligibility***

Existing SSI and Medicaid laws include numerous work incentives designed to achieve the overall policy objective of enhancing the level of economic self-sufficiency of people with significant disabilities by ensuring their ongoing eligibility for health care. The work incentives are intended to provide an integrated and seamless package of income and health services and supports for a person who attempts to work despite a significant disability. Specifically, the work incentive provisions in Section 1619 of SSI law and Section 1905(q) of Medicaid law are intended to reduce the uncertainty and risks felt by people with disabilities by enabling them maintain a connection to both the SSI income

assistance program and the Medicaid program when they work or increase their level of earnings.

To integrate income assistance and Medicaid programs, Congress enabled states to provide automatic eligibility for Medicaid to people who receive an SSI payment from SSA. An SSI beneficiary can be eligible for Medicaid without having to make a separate application to the state or local agency that administers the Medicaid program. A state can choose to enter into an agreement with SSA to administer the state SSI supplementation program and provide automatic Medicaid eligibility for people who are not eligible for cash benefits under the federal SSI program but who receive cash benefits under the state SSI supplementation program. If a state enters into such an agreement, it must use the same income disregards and asset criteria for its supplement as the federal SSI program uses.

SSI recipients retain their eligibility for Medicaid even when they no longer receive any federal SSI cash benefits because of higher earnings. There is a seamless continuation of Medicaid eligibility without requiring a new application for Medicaid. This automatic eligibility for Medicaid occurs by means of an electronic transfer of information from SSA to the state Medicaid agency.

In states without automatic Medicaid eligibility for SSI recipients, the person must make a separate application to the Medicaid agency to be determined eligible. A high level of communication and cooperation among those who administer these programs at the federal, state, and local levels is required to ensure that people with significant disabilities receive integrated and ongoing benefits and supports.

The policy issue facing states is whether the methods chosen for administering the state SSI supplementation and the Medicaid program facilitate or impede access to and use of work incentives designed to increase the level of economic self-sufficiency of people with significant disabilities. A recommendation in Chapter 1 favors separating the application for cash benefits from that for health care benefits in order to make health care benefits available to those who would prefer to forgo cash assistance.

Should people with disabilities be expected to work? If yes, then policies targeting people with disabilities—particularly the young—would be better focused on education, rehabilitation, job training, and accommodation than on increasing or expanding transfers. Likewise, for children with disabilities, investing more time, energy, and resources to enhance their education and development might be more effective than focusing solely on supplementing the income of their households.<sup>188</sup>

## **Recommendations (*numbering continues from previous chapter*)**

### ***Recommendation 24:***

Congress should repeal the current provision in federal law that requires SSA to charge states a fee to administer their SSI supplements. This action would encourage an increase in state supplementation and simplify access for SSI beneficiaries.

### ***Recommendation 25:***

Consistent with the Supreme Court's 1999 decision in *Olmstead v. L.C.*, Congress should ensure that SSA prohibits the use of SSI supplement programs that incentivize congregate or institutional living environments and work with states to shift existing arrangements with minimal disruption to remove incentives for congregate care in the operation of SSI supplements.

### ***Recommendation 26:***

SSA should develop policy that provides waivers permitting states to increase their SSI supplements—including pass-through of COLAs—when a state describes a plan for using supplements to support beneficiaries in least restrictive settings. For example, states could coordinate increases in SSI supplements with Money Follows the Person projects.

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# Appendix A. State-by-State Comparison of Medicaid Buy-In Provisions<sup>189</sup>

## Table A-1. Medicaid Buy-In Program: Income Eligibility Criteria

- Whose income is counted?
- What is the countable income eligibility limit?
- What disregards apply in determining countable Income?
- Is there a separate unearned income limit?

## Table A-2. Medicaid Buy-In Program: Authority, Resource Limits, and Exclusions

- What is the resource limit?
- Are retirement accounts excluded from countable assets?
- Are medical savings accounts excluded from countable assets?
- Are approved accounts for employment or independence excluded?

## Table A-3. Cost-Sharing Policies: Minimum Income Level and Premium Method

- Income level at which premiums or cost shares start
- Premium is a percentage of income
- Payment based on income bracket
- Separate premiums or cost share for earned and unearned income

## Table A-4. Work-Related Policies and Protections

- Work requirements
- Protections for temporary loss of employment
- Protections when returning to other eligibility categories

**Note:** Data for the four tables were compiled by Allen Jensen, George Washington University Center on Study of Disability Policy, and updated in October 2013 by Julie Delong, University of Utah Center for Public Policy and Administration.

**Table A-1. Medicaid Buy-In Program: Income Eligibility Criteria**

<b>State</b>	<b>Whose Income Is Counted?</b>	<b>What Is The Countable Income Eligibility Limit?</b>	<b>What Disregards Apply in Determining Countable Income?</b>	<b>Is There a Separate Unearned Income Limit?</b>
<b>Alaska</b>	Individual and spouse for total income Individual for unearned income	Family net income <250% FPL	Standard SSI disregards	Yes Unearned income ≤\$1,252/month
<b>Arizona</b>	Individual	250% FPL	Disregard unearned income and standard SSI disregards, including disregarding IRWEs	No
<b>Arkansas</b>	Individual	250% FPL	Standard SSI disregards	Yes Unearned income must be less than SSI standard plus \$20
<b>California</b>	Individual and spouse	\$2,000 individual \$3,000 couple for entry into program	Standard SSI disregards	No cap on assets once enrolled Funds must be in separate identified account
<b>Colorado</b>	Individual	450% FPL	Standard SSI disregards	No
<b>Connecticut</b>	Individual	Up to \$75,000/year	Standard SSI disregards	No
<b>Georgia</b>	Individual	300% FPL	Standard SSI disregards	\$699/month



**Table A-1 (continued)**

<b>State</b>	<b>Whose Income Is Counted?</b>	<b>What Is The Countable Income Eligibility Limit?</b>	<b>What Disregards Apply in Determining Countable Income?</b>	<b>Is There a Separate Unearned Income Limit?</b>
<b>Idaho</b>	Individual	≤500% FPL (excludes retirement accounts, life insurance) earned income >15% of total earned and unearned income	Standard disregards under state Aid to the Aged, Blind, and Disabled	No
<b>Illinois</b>	Individual and spouse	200% FPL net after taxes Increased to 350% in February 2009	Standard SSI disregards and work-related expenses	No
<b>Indiana</b>	Individual	350% FPL	Standard Medicaid income disregards including IRWE	No
<b>Iowa</b>	Individual and spouse	250% FPL for family size	Standard SSI disregards	No
<b>Kansas</b>	Individual and spouse	300% FPL	Standard SSI disregards plus IRWEs	No
<b>Kentucky</b>	Individual, but married if >\$45,000	250% FPL	SSI Federal Benefit Rate plus the standard \$20 exclusion	Yes
<b>Louisiana</b>	Individual	250% FPL	Standard SSI disregards	No

**Table A-1 (continued)**

State	Whose Income Is Counted?	What Is The Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
<b>Maine</b>	Individual and spouse	Up to 250% FPL on total income Up to 100% FPL on unearned income	Standard SSI disregards, plus additional state disregard on unearned or earned income of \$55.	Yes Unearned income limit is 100% FPL plus \$75
<b>Maryland</b>	Individual and spouse	300% FPL	Standard SSI disregards	No
<b>Massachusetts</b> Sec. 1115 Medicaid Waiver	N/A	No income eligibility maximum	N/A	N/A
<b>Michigan</b>	Individual	Pre-enrollment total countable income Unearned may not exceed 100% FPL using the SSI methodology	Standard SSI disregards	Yes Unearned income limit is 100% FPL
<b>Minnesota</b>	Individual	No income limit Must have monthly wages or self-employment earnings of >\$65	1902(r)(2). All earned and unearned income ignored	No

**Table A-1 (continued)**

State	Whose Income Is Counted?	What Is The Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
<b>Mississippi</b>	Individual and spouse	250% of FPL Individual limit - \$4,929/month (meaning an unmarried individual) Couple limit - \$6,619/month (meaning either one or both members of the couple are disabled and applying for Medicaid)	Standard SSI disregards and IRWEs	135% of FPL Gross unearned income cannot exceed: Individual limit - \$1,363/month Couple limit - \$1,820/month

**Table A-1 (continued)**

State	Whose Income Is Counted?	What Is The Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
<b>Missouri</b>	Individual and spouse	300% FPL	<p>All earned income of the disabled worker</p> <p>Standard \$20 income disregard</p> <p>Standard SSI disregards of nondisabled spouse's earned income</p> <p>All SSI payments</p> <p>Health insurance premiums</p> <p>Up to \$75 of dental and optical insurance</p> <p>Impairment-related expenses up to 1/2 of earned income</p>	<p>Yes</p> <p>85% FPL after disregarding \$50 of SSDI</p> <p>Standard \$20 income disregard</p> <p>Standard SSI disregards of deemed income from non-disabled spouse</p> <p>All SSI payments</p> <p>Health insurance premiums</p> <p>Up to \$75 of dental and optical insurance</p> <p>After taking all the disregards in determining countable income, the net income may not exceed the net income for non-spend-down eligibility in Missouri Health Net, which is 85% FPL.</p>

**Table A-1 (continued)**

State	Whose Income Is Counted?	What Is The Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
<b>Montana</b> Effective July 1, 2010	Individual and deemed income as provided under SSI	250% FPL	Standard SSI disregards + PASS	No
<b>Nebraska</b>	Individual and spouse	Two-part test: (1) Sum of spouse's earned income and applicant's unearned income must be less than SSI standard (\$698 for an individual and \$1,048 for a couple in 2012) (2) countable income up to 250% FPL (includes spousal income)	Standard SSI disregards Individual's earned income disregarded in part 2 of eligibility test Individual's unearned income if from trial work period	Yes Unless an individual is in a trial work period or extended period of eligibility, SSDI income (minus disregards) must be less than SSI income standard.
<b>Nevada</b>	Individual	250% FPL earned income \$699 on unearned income	Taxes Some income disregards (not all SSI)	No (effective October 1, 2007) Yes (before that, \$699/month)
<b>New Hampshire</b>	Individual and spouse	450% FPL on earned income	Standard SSI disregards	No

**Table A-1 (continued)**

State	Whose Income Is Counted?	What Is The Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
<b>New Jersey</b>	Individual and spouse	250% FPL on earned income Up to 100% FPL on unearned income disregarding SSDI benefits received under individual's account (SSN, not survivor's SSN)	Standard SSI disregards	Yes Unearned income other than SSDI or SSI Limit is 100% FPL
<b>New Mexico</b>	Individual	250% FPL on earned income Up to \$1,226/month on unearned Must earn at least \$970/quarter	Standard SSI disregards and IRWEs and work-related expenses, including cost of health insurance	Yes Unearned income <\$1,090/month
<b>New York</b>	Individual and spouse	250% FPL	Standard SSI disregards	No
<b>North Dakota</b>	Family	225% FPL	Standard SSI disregards	No
<b>North Carolina</b>	Individual	450% FPL phased implementation open to people up to 150% FPL by December 2009	Standard SSI disregards	No

**Table A-1 (continued)**

<b>State</b>	<b>Whose Income Is Counted?</b>	<b>What Is The Countable Income Eligibility Limit?</b>	<b>What Disregards Apply in Determining Countable Income?</b>	<b>Is There a Separate Unearned Income Limit?</b>
<b>Ohio</b>	Individual	250% FPL (countable income limit is 250% FPL Income above FPL is disregarded up to \$20,000)	Standard SSI disregards	No
<b>Oregon</b>	Individual	250% FPL on adjusted earned income	All unearned income, standard SSI disregards, and employment and independence expenses	No
<b>Pennsylvania</b>	Individual	250% FPL	Standard SSI disregards	No
<b>Rhode Island</b>	Individual	250% FPL	Standard SSI disregards including IRWEs	Yes Unearned income no >100% FPL or would meet the eligibility requirements under the state's Medically Needy program
<b>South Carolina</b>	Individual	250% FPL	Standard SSI disregard	Yes Unearned income no more than federal SSI standard

**Table A-1 (continued)**

<b>State</b>	<b>Whose Income Is Counted?</b>	<b>What Is The Countable Income Eligibility Limit?</b>	<b>What Disregards Apply in Determining Countable Income?</b>	<b>Is There a Separate Unearned Income Limit?</b>
<b>South Dakota</b>	Individual	250% FPL	Standard SSI disregards	No
<b>Texas</b>	Individual	250% FPL (excludes spousal income; must earn \$1,090 in qualifying SSA quarter before application date)	No information	No
<b>Utah</b>	Individual and spouse	250% FPL	Standard SSI disregards	No
<b>Vermont</b>	Individual and spouse	<p>Before July 1, 2005: two-part test.</p> <p>1. Family net income &lt;250% FPL</p> <p>2. Family net income does not exceed either Medicaid's protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings, SSDI benefits, and any veterans disability benefits</p>	<p>Standard SSI disregards. Disregard all earnings and \$500 of SSDI for part 2 of eligibility test.</p> <p>Effective July 1, 2005: SSDI and veterans benefits no longer count toward unearned income limit</p>	<p>Yes</p> <p>Unearned income limit is the Medically Needy Program's protected income level plus \$500.</p> <p>No</p> <p>Effective July 1, 2005, SSDI and veterans benefits no longer counted toward unearned income limit</p>



**Table A-1 (continued)**

State	Whose Income Is Counted?	What Is The Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
<b>Virginia</b>	Individual and spouse	80% FPL	Standard SSI Disregards, including IRWEs	Yes Unearned income limit is 80% FPL
<b>Washington</b>	Individual and spouse, but only individual income if spouse's income is equal to or less than 1/2 of the SSI standard	220% FPL	Standard SSI disregards and IRWEs	No
<b>West Virginia</b>	Individual	250% FPL. Unearned income must be equal to or less than SSI benefit plus \$20	Standard SSI disregards, including IRWEs	Yes The individual's unearned income that does not exceed the SSI federal benefit standard plus the general income exclusion (\$20)
<b>Wisconsin</b>	Individual and spouse	250% FPL	Standard SSI disregards	No

**Table A-1 (continued)**

State	Whose Income Is Counted?	What Is The Countable Income Eligibility Limit?	What Disregards Apply in Determining Countable Income?	Is There a Separate Unearned Income Limit?
<b>Wyoming</b>	Individual	\$2,022 (applicant's gross countable income only)	No disregards	No information

**Note:** AABD – Aid to the Aged, Blind and Disabled  
 FPL – Federal Poverty Level  
 IRWE – Impairment Related Work Expense  
 MNIL – Medically needy income level  
 N/A – Not applicable  
 SSDI – Social Security Disability Insurance  
 SSI – Supplemental Security Insurance

**Table A-2. Medicaid Buy-In Program: Authority, Resource Limits, and Exclusions**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Alaska</b>	Balanced Budget Act of 1997	\$10,000 Individual \$15,000 couple	No	No	No
<b>Arizona</b>	TW-WIIA Basic + Medical Improvement	No resource limit	Yes	Yes	Yes
<b>Arkansas</b>	TW-WIIA Basic	\$4,000 individual \$6,000 couple	No	No	Yes Up to \$10,000 in an approved account Interest on account not counted toward limit
<b>California</b>	Balanced Budget Act of 1997	\$2,000 individual \$3,000 couple	Yes	No	Individual development accounts (IDAs) and deferred compensation plans
<b>Colorado</b>	TW-WIIA Basic	None	Yes	Yes	Yes

**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Connecticut</b>	TW-WIIA Basic, Medical Improvement, BBA (added October 2006)	\$10,000 individual \$15,000 couple	Yes	Yes	Yes
<b>Delaware</b>	Insufficient information available				
<b>Georgia</b>	TW-WIIA Basic	\$2,000 individual \$3,000 couple	Yes	Yes	Yes
<b>Idaho</b>	TW-WIIA Basic	\$10,000 individual \$15,000 couple	Yes	No	No
<b>Illinois</b>	TW-WIIA Basic	\$10,000 (includes spousal resources)  Increased to \$25,000 and exempts retirement and medical savings accounts	No	No	No

**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Indiana</b>	TW-WIIA Basic	\$2,000 (excludes spousal resources)	Yes	No	Yes Up to \$20,000 as approved by state
<b>Iowa</b>	Balanced Budget Act of 1997	\$12,000 individual \$13,000 couple	Yes	Yes	Yes Assistive technology accounts
<b>Kansas</b>	TW-WIIA Basic + Medical Improvement	\$15,000 (includes spousal resources)	Yes	No	IDA accounts excluded
<b>Kentucky</b>	TW-WIIA Basic	\$4,000 personal assets	Yes Any employer or individual retirement plan approved by the Internal Revenue Code is permissible under the program (for example, an individual retirement account)	No	—

**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Louisiana</b>	TW-WIIA Basic	\$25,000 Individual	Yes	Yes	No
<b>Maine</b>	Balanced Budget Act of 1997	\$12,000 (includes spousal resources)	No	No	No
<b>Maryland</b>	TW-WIIA Basic	\$10,000 (includes spousal resources)	Yes First \$4,000 does not count toward resource limit	No	No
<b>Massachusetts</b>	1115 Demonstration Waiver	No limit	N/A	N/A	N/A
<b>Michigan</b>	TW-WIIA Basic	\$75,000 individual	Yes	No	No
<b>Minnesota</b>	Balanced Budget Act (before 10/2000) TW-WIIA Basic (as of 10/2000)	\$20,000 individual	Yes	Yes	No
<b>Mississippi</b>	Balanced Budget Act of 1997	\$24,000 Individual \$26,000 Couple	No	No	No

**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Missouri</b>	TW-WIIA Basic + Medical Improvement	\$999.99 for individual \$2,000 for couple	No	Yes Up to \$5,000 if deposited from earned income while an individual is in the Medicaid Buy-In program Interest on these accounts is also excluded	Yes Up to \$5,000 deposited from earned income while an individual is in the Medicaid Buy-In program Interest on these accounts is also excluded
<b>Montana</b>	Balanced Budget Act of 1997	\$8,000 individual \$12,000 couple	Yes	No	PASS accounts excluded
<b>Nebraska</b>	Balanced Budget Act of 1997	\$4,000 individual \$6,000 couple	No	No	No
<b>Nevada</b>	TW-WIIA Basic	\$15,000 individual	—	—	—
<b>New Hampshire</b>	TW-WIIA Basic	\$24,991 individual \$37,487 couple	No	No	Yes

**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>New Jersey</b>	TW-WIIA Basic	\$20,000 individual	Yes	No	No
<b>New Mexico</b>	Balanced Budget Act of 1997	\$10,000 individual	Yes	No	No
<b>New York</b>	Balanced Budget Act of 1997	\$13,800 individual \$20,100 couple	No	No	No
<b>North Carolina</b>	TW-WIIA Basic + Medical Improvement	\$20,880 couple	No	No	Yes
<b>North Dakota</b>	TW-WIIA Basic	\$13,000 couple	No	No	Yes Up to \$10,000 from earnings in approved plan for achieving self-support
<b>Ohio</b>	TW-WIIA Basic + Medical Improvement	\$10,580 couple	No	No	No
<b>Oregon</b>	Balanced Budget Act of 1997	\$5,000 individual	Yes	Yes	Yes



**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Pennsylvania</b>	TW-WIIA Basic + Medical Improvement	\$10,000 couple	No	No	No
<b>Rhode Island</b>	Balanced Budget Act of 1997	\$10,000 individual \$20,000 couple	Yes	Yes	Yes Approved items necessary due to disability for employment (e.g., a wheelchair-accessible van) are not counted as assets
<b>South Carolina</b>	Balanced Budget Act of 1997	\$2,000 individual \$3,000 couple	No	No	No

**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Texas</b>	Balanced Budget Act of 1997	\$5,000 individual 1/2 of any jointly owned (with spouse) assets considered	Yes	No	Yes  Individual may deposit up to 50% of gross earned income during a SSA qualifying quarter into the account. Funds in this account may only be used for health care or work-related expenses.
<b>Utah</b>	Balanced Budget Act of 1997	\$15,000 couple	Yes	No	No
<b>Vermont</b>	Balanced Budget Act of 1997	\$5,000 individual \$6,000 couple  Disregards assets accumulated from earnings since enrollment	Yes, if from earnings after enrollment	Yes, if from earnings after enrollment	Yes, if from earnings after enrollment

**Table A-2 (continued)**

<b>State</b>	<b>Federal Authority</b>	<b>What Is the Resource Limit?</b>	<b>Retirement Accounts Excluded from Countable Assets?</b>	<b>Medical Savings Accounts Excluded from Countable Assets?</b>	<b>Approved Accounts for Employment or Independence Excluded?</b>
<b>Virginia</b>	TW-WIIA Basic	\$2,000 individual \$3,000 couple	Yes, if from earnings after enrollment	Yes, if from earnings after enrollment	Yes, if from earnings after enrollment
<b>Washington</b>	TW-WIIA Basic + Medical Improvement	No resources test	No resources test	No resources test	No resources test
<b>West Virginia</b>	TW-WIIA Basic + Medical Improvement	\$2,000 (\$5,000 liquid asset exclusion)	Yes	No	Yes Independence accounts from a recipient's earnings
<b>Wisconsin</b>	Balanced Budget Act of 1997	\$15,000 individual	Yes Retirement accounts initiated after Buy-In enrollment are not counted Retirement accounts existing before Buy-In enrollment are counted	No	Yes Independence accounts

**Table A-2 (continued)**

State	Federal Authority	What Is the Resource Limit?	Retirement Accounts Excluded from Countable Assets?	Medical Savings Accounts Excluded from Countable Assets?	Approved Accounts for Employment or Independence Excluded?
<b>Wyoming</b>	TW-WIIA Basic	\$2,022 individual gross countable income only	No	No	No

**Note:** IDA – Individual Development Account  
 MBI – Medicaid Buy-In  
 N/A – Not applicable  
 PASS – Plan to Achieve Self Support  
 SSA – Social Security Administration  
 TW-WIA – Ticket to Work-Workforce Incentive Act

**Table A-3. Cost-Sharing Policies:  
Minimum Income Level and Premium or Cost-Share Method**

<b>State</b>	<b>Income Level at Which Premiums or Cost Shares Start</b>	<b>Premium Is a Percentage of Income</b>	<b>Payment Based on Income Bracket</b>	<b>Separate Premiums or Cost Share for Earned and Unearned Income</b>
<b>Alaska</b>	100% FPL	A sliding scale premium as a fixed percentage of income  Maximum premium is 10% of net family income	No	No
<b>Arizona</b>	\$500 of monthly earned income	Sliding scale premium not to exceed 2% of net earned income	Yes  Not in institution \$10/mo. at \$500–\$750  Countable earnings after SSI disregards increasing by \$5 for each \$250 of earnings until \$35/mo. at \$1,750–\$1,846 of earnings	No
<b>Arkansas</b>	No premium required  Co-payments higher than those for regular Medicaid are required when income is above 100% FPL	N/A	No	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>California</b>	200% FPL	A sliding scale premium based on net countable income  For income from \$1–250% FPL, premiums from:  \$20–\$250 for an individual  \$30–\$375 for a couple	Yes  \$20/month to a maximum of: \$250/month for an individual \$25–\$375 for a couple	No
<b>Colorado</b>	41% FPL	No	Yes  41%–133% FPL, \$25 134%–200% FPL, \$100 201%–300% FPL, \$225 301%–450% FPL, \$400	No
<b>Connecticut</b>	200% FPL	Yes  10% of family income	No	No
<b>Georgia</b>	A minimum of \$35/month	No	No	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Illinois</b>	\$250 income/month	Yes Premium payment categories are calculated using a premium table (table is based on the sum of 7.5% of unearned and 2.5% of earned income)	Yes	Yes Premiums are calculated on approximations of 7.5% of unearned and 2% of earned income
<b>Idaho</b>	133% FPL	Income 133%–250% FPG, \$10 250%–500% FPG, greater of \$10 or 7.5% of income above 250% FPG	Income 133%–250% FPG, \$10 250%–500% FPG, greater of \$10 or 7.5% of income above 250% FPG	No
<b>Indiana</b>	When individual and spouse gross income exceeds 150% FPL	Based on percentage of applicant's and spouse's gross income according to family size	Yes Six brackets with a maximum of \$187/month when over 350% FPL	No
<b>Iowa</b>	150% FPL gross individual income	Based on sliding scale premium schedule with 18 premium brackets, ranging from \$34–\$660	Yes Eleven brackets with monthly range from \$20–\$207	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Kansas</b>	100% FPL	Sixteen premium amounts based on income brackets from: \$55–\$152 for individual \$74–\$205 for two or more May not exceed 7.5% of income	Yes Eight brackets	No
<b>Kentucky</b>	139%–400% FPL	Not more than 9.5% of income <400% of FPL	Yes	—
<b>Louisiana</b>	150% FPL	\$80 for 150%–200% FPL \$110 for 200%–250% FPL	Yes 150%–200% FPL net income, \$80/mo. 200%–250% FPL net income, \$110/mo.	No
<b>Maine</b>	150% FPL net family income No premium if paying Medicare Part B	\$10 premium for 150%–200% FPL \$20 for 200%–250% FPL	Yes 150%–<200% FPL, \$10 monthly 200%–<250% FPL, \$20 monthly	No



**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Maryland</b>	100% FPL	<p>Countable income to 100% FPL, no premium</p> <p>Over 101% FPL–200% FPL, \$25/month</p> <p>201%–249% FPL, \$40/month</p> <p>250%–300% FPL, \$55/month</p>	<p>Yes</p> <p>Countable income up to 100% FPL, no premium</p> <p>Over 100% FPL–200% FPL, \$25/month</p> <p>Over 200% FPL–250% FPL, \$40/month</p> <p>Over 250% FPL–300% FPL, \$55/month</p>	No
<b>Massachusetts</b>	150% FPL	<p>Premiums based on two sliding scales—one for enrollees with other health coverage and one for enrollees without it</p> <p>Premiums begin at 100% and increase in increments of \$5–\$16 based on 10% increments of FPL</p>	<p>Premiums are based on one of two different sliding scales, one for those with and one for those without other insurance.</p> <p>Premiums begin at 100% FPL and increase in increments of \$5–\$16 based on 10% increments of FPL, and ranging from \$15–\$912/month (the upper range is at 1000% FPL)</p>	—

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Michigan</b>	250% FPL using SSI methodology	Based on sliding scale ranging from \$50–\$920/month	Yes \$50/month up to \$33,000 income \$190/month up to \$47,868 income \$460/month up to \$75,000 income Countable earned income is gross earned income less allowable disregards	No
<b>Minnesota</b>	All enrollees must pay a minimum premium of \$35	Premiums based on a minimum of \$35 or a sliding fee scale based on income and household size Premium gradually increases to 7.5% of income at or above 300% FPL Must also pay 0.5% of unearned income No maximum premium amount	No	Yes Effective in 2014 MN has an active Assisters network to help the population address cost share and related matters. <a href="https://www.mnsure.org">https://www.mnsure.org</a>

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Mississippi</b>	For working disabled: \$2,983 gross earnings for an individual or \$3,999 for a couple	The premium is equal to 5% of the amount Medicaid considers to be “countable” earnings  Countable earnings are less than 1/2 of the gross earned income amount × 5%	No	No
<b>Missouri</b>	When gross income exceeds 100% FPL	No	>100% but <150% FPL pays 4% of 100% FPL  150%–199% FPL pays 4% of 150% FPL  200%–249% FPL pays 5% of 200% FPL  250%–299% FPL pays 6% of 250% FPL	No
<b>Montana</b> Effective July 1, 2010	All must pay some premium	No	Yes  100% FPL or less, \$35  Up to 150% FPL, \$67  Up to 200% FPL, \$100  Up to 250% FPL, \$135	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Nebraska</b>	200% FPL net family income	Sliding scale based on income ranging from 2% of income (if income is 200%–210% FPL) to 10% of income (if income is 240%–250% FPL)	Yes Five income bands with premiums from 2%–10%	No
<b>Nevada</b>	All enrollees pay at least 5%	Combined net income <200% FPL, pay a monthly premium of 5% of combined net income  Combined net income between 200% and 250% FPL, pay a monthly premium of 7.5% of combined net income	Yes	No
<b>New Hampshire</b>	150% FPL net family income	Six brackets from \$102–\$271 for individuals  Those with gross income (including spousal income) that exceeds \$75,000 are required to pay the full premium	Yes  Six income bands from \$80–\$220 (2002 figures)	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>New Jersey</b>	150% FPL Flat rate: \$25 individual \$50 couple	Flat rate: \$25 individual \$50 couple	No	No
<b>New Mexico</b>	Co-pays required at all income levels No co-pays for Native Americans	No premium required Co-pays higher than those for regular Medicaid are required at all income levels Clients are responsible for keeping track of co-pays	No	No
<b>New York</b>	150% FPL of net income	Yes	No	Yes 7.5% of unearned income, plus 3% of earned income Moratorium on premiums until automated premium collection and tracking available

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>North Dakota</b>	\$3,006	Must pay a premium Beginning July 1, 2009, premiums and enrollment fees are not charged to Native Americans due to federal statute	No	No
<b>North Carolina</b>	Annual enrollment fee	No	Premiums based on a sliding scale	No
<b>Ohio</b>	Premiums when total family income exceeds 150% FPL	Premium charged is 10% of the difference between 150% FPL and total income	No	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Oregon</b>	\$651	Premium based on sliding scale	Yes Participant fees Countable income \$651–\$866.99, \$50 \$867–2167.99, \$100 \$2,168 and above, \$150	Yes Cost share is all unearned income above SSI income standard and special maintenance allowance, cost of mandatory taxes and cost of approved employment and independence expenses Premium is on earned income—between 2% and 10% of individual’s earned income above 200% of FPL and remaining unearned income
<b>Pennsylvania</b>	All participants pay a premium (5% of countable income) Premiums of <\$10 are waived	Yes Premium of 5% of countable monthly income Option for payroll deduction to pay the monthly premium Premiums of <\$10 are waived	No	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Rhode Island</b>	<p>Premiums begin at 100% FPL</p> <p>All unearned income over the state's Medically Needy Protected Income Level is owed as premium</p> <p>Based on formula counting individual's or couple's earned income</p>	<p>Sliding scale in accordance with a monthly payment or payment formula counting a portion of an individual's or couple's earned income</p>	<p>Yes</p> <p>Countable earned income with premium:</p> <p>100%–149% FPL, \$42</p> <p>50%–184% FPL, \$62</p> <p>185%–199% FPL, \$82</p> <p>200%–250% FPL, \$100</p>	<p>Yes</p> <p>All unearned income over the state's Medically Needy Protected Income Level is owed as premium</p>
<b>South Carolina</b>	<p>No premiums or cost sharing</p>	<p>No</p>	<p>No</p>	<p>No</p>
<b>South Dakota</b>	<p>No premiums or cost sharing</p>	<p>No</p>	<p>No</p>	<p>No</p>



**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Texas</b>	Unearned income above federal SSI benefit standard  Earned income above 150% FPL	All unearned income above SSI federal benefit rate (\$674 in 2009), plus \$20–\$40/month depending on FPL category of earned income, with a cap of \$500/month  \$20–\$40 maximum with no unearned income based on FPL category of earned income	Yes  Earnings. premiums: 150%–185% FPL, \$20 186%–200% FPL, \$25 201%– 250% FPL, \$30 Above 250% FPL, \$40	Yes  All unearned income over the SSI benefit rate
<b>Utah</b>	100 % FPL	Yes  100%–110% FPL, 5% premium  111%–120% FPL, 10% premium  Over 120% FPL, 15% premium	No	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Vermont</b>	No premiums due to administrative cost to states	No Premium eliminated in June 2004	No Discontinued premiums due to administrative cost to state Previously were as follows: 185%–225% FPL, \$10 225%–250% FPL, \$12 with private insurance or \$25 with no private insurance	No
<b>Virginia</b>	No premiums for first six months of program (Jan. 1– June 30, 2007) Premium schedule will be established on a sliding scale based on individual enrollee income	Must receive minimum wage at the prevailing wage rate in the community and must provide documentation that payroll taxes are withheld Self-employment must be documented through a federal income tax return or business records The applicant’s signed allegation is acceptable if no other evidence can be obtained	A premium schedule will be established on a sliding scale based on individual enrollee income	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Washington</b>	\$65 earned income \$623 unearned income	Yes The lesser of 7.5% total income or a total of the following: 50% unearned income above MNIL plus 5% total unearned income plus 2.5% earned income after deducting \$65	No	Yes 50% of unearned income above MNIL (\$571) plus 5% of total unearned income plus 2.5% of earned income after first deducting \$65 Total premium may not exceed 7.5% of total income
<b>West Virginia</b>	All participants pay a \$50 enrollment fee, which includes the first month's premium Minimum monthly premium of \$15	Yes 3.5% of monthly gross income with a \$15 minimum amount Must also pay an enrollment fee of \$50, which includes the first month's premium	No	No

**Table A-3 (continued)**

State	Income Level at Which Premiums or Cost Shares Start	Premium Is a Percentage of Income	Payment Based on Income Bracket	Separate Premiums or Cost Share for Earned and Unearned Income
<b>Wisconsin</b>	Gross individual income below 150% FPL for enrollee's family size	Equal to the sum of 3% of an individual's earned income and 100% of unearned income, minus certain needs and expenses and other disregards  If the second calculation is <\$25, this component of the premium is zero	No	Yes  100% of the individual's unearned income minus standard living allowance, work expenses, and medical and remedial expenses  3% of individual's earned income  Minimum premium is \$25  If calculation is <\$25, the person pays nothing
<b>Wyoming</b>	All participants pay a premium	Yes  Premium is 7.5% of total gross earnings from work, less a \$50 deduction from unearned income	No	Yes  7.5% of unearned income in excess of \$600/year (data may be impacted by the Affordable Care Act  WY had no state marketplace at the writing of this report)

**Note:** FPG – Federal Poverty Guidelines  
 FPL – Federal Poverty Level  
 MNIL – Medically needy income level  
 N/A – Not applicable

**Table A-4. Work-Related Policies and Protections**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>Alaska</b>	Must have earned income	None	None
<b>Arizona</b>	Paid for working and paying FICA taxes	Guaranteed six months of eligibility the first time approved for program unless in institutional living arrangement	None
<b>Arkansas</b>	“Working” means employed in any ongoing work activity for which income is reported to the IRS  Employment must be verifiable with paycheck stubs, tax returns, 1099 forms, or proof of quarterly estimated tax	Yes. Up to six months and states that he/she intends to return to work	No
<b>California</b>	Provide proof of employment (e.g., pay stubs or written verification from the employer)  Self-employed, or contractor provide records (e.g., W-2 forms, 1099 IRS form)	No	No
<b>Colorado</b>	Has earned income and is working part time or full time, or is self-employed	No	No
<b>Connecticut</b>	Must make FICA contributions	May continue Buy-In for one year after losing employment	Assets in retirement, medical savings accounts, and approved accounts not counted during the individual’s lifetime

**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>Georgia</b>	<p>“Working” is defined as activity for which income is reported to the IRS</p> <p>Earnings must be verified by paycheck stubs, tax returns, 1099 forms, etc.</p>	N/A	N/A
<b>Idaho</b>	Is employed, including self-employment, and has provided the Department of Health and Welfare with satisfactory written proof of employment	N/A	N/A
<b>Illinois</b>	Employment must be verifiable by pay stubs and employer documents that show income is subject to income tax and FICA	No	No
<b>Indiana</b>	Employment must be verifiable by pay stubs and employer documents that show income is subject to income tax and FICA	<p>Yes</p> <p>May continue Buy-In for one year after losing employment</p>	None
<b>Iowa</b>	Must have earned income	<p>Yes</p> <p>May remain eligible for six months after work stoppage</p>	None

**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>Kansas</b>	Employment must be verifiable by pay stubs and employer documents that show income is subject to income tax and FICA	Yes May remain eligible for six months after work stoppage	None
<b>Kentucky</b>	Employed or self-employed	Yes May remain eligible for six months after work stoppage	None
<b>Louisiana</b>	Employed	Yes May remain eligible for six months after work stoppage	No
<b>Maine</b>	Must have earned income	None	None
<b>Maryland</b>	Employed. Must provide W2, paystubs, business ledgers, or other evidence of employment	Yes Remains eligible for up to four months after loss of employment due to illness or reasons beyond the individual's control	No
<b>Massachusetts</b>	Must be employed at least 40 hours per month, if less must have been employed 240 hours in the past 6 months	Continued eligibility for up to 3 months after termination of employment if they continue to pay premiums	—

**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>Michigan</b>	Is employed on a regular and continuing basis	Up to 24 months if unemployment is the result of an involuntary layoff or determined to be medically necessary	No
<b>Minnesota</b>	Must document earned income tax withholding and FICA tax withheld  Must have sufficient monthly gross earning to qualify for initial earned income disregard of \$65/month to be eligible	If loss of employment is not attributable to the enrollee, may continue for four months, but must pay premiums	—
<b>Missouri</b>	Document that Medicare and Social Security taxes paid on income	None	None
<b>Mississippi</b>	40 hours each month at some type of paid activity	—	—
<b>Montana</b>	Require proof of FICA or, if self-employed, other proof of a business	No	None
<b>Nebraska</b>	Must have earned income	None	None



**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>New Hampshire</b>	Be working—proven with a pay stub or 1099 estimated tax statement if the individual is self-employed	Yes Buy-In recipients who lose their jobs through no fault of their own can remain on Buy-In for 12 months, as long as they intend to go back to work within the next 12 months	Yes Earned income accounts—resources from earnings that a person puts into a special account will not be counted toward any Medicaid eligibility for the person’s lifetime
<b>New Jersey</b>	Be employed either full or part time	None	None
<b>New Mexico</b>	Proof of wages to show that the applicant has earned or expects to earn a sufficient amount in the current calendar quarter or in the last quarter of the previous year to have that quarter count toward Social Security coverage (\$970/quarter in 2006)  Work requirement waived during two year waiting period for Medicare for SSDI recipients	None	—

**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>New York</b>	Be working	<p>A grace period can be for up to six months in a 12-month period</p> <p>Multiple grace periods may be granted as long as the sum of the grace periods does not exceed six months in a 12-month period</p> <p>Grace periods may be for medical reasons or job loss through no fault of the participant, and he or she intends to return to work</p>	No
<b>North Dakota</b>	Gainfully employed	No	No
<b>Ohio</b>	Must be working and earning income	<p>Program participants will be allowed a six-month grace period if they lose their job or their disability improves</p> <p>Intention is to allow the person to find another job, plan for a transition back to regular Medicaid, or (in the case of medical improvement) plan for a transition off Medicaid</p>	—
<b>Oregon</b>	Must be attached to the workforce (defined as earning at least \$920/calendar quarter)	None	None

**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>Rhode Island</b>	Have proof of active, paid employment such as a pay stub or—for those who are self-employed—a quarterly IRS tax statement	Yes People who lose employment may retain eligibility for up to four months by paying a premium equal to all of their unearned income over the Medically Needy Income Level	Yes
<b>Pennsylvania</b>	Employed and receiving compensation	Yes Two months	No
<b>South Carolina</b>	Earning at least \$830/month	None	—
<b>South Dakota</b>	Must pay Social Security/FICA taxes	None	No
<b>Texas</b>	A person's earnings and FICA contributions must be enough in a calendar quarter to count as a Social Security Administration qualifying quarter	None	No
<b>Utah</b>	Pay stubs or a business plan needed to verify employment	Yes A person may continue to qualify under the increased assets limit for 12 months following job loss	No
<b>Vermont</b>	Must have earned income	None	None

**Table A-4 (continued)**

State	Work Requirements	Protections for Temporary Loss of Employment	Protections When Returning to Other Eligibility Categories
<p><b>Virginia</b></p>	<p>Applicant/enrollee must be engaged in competitive employment in an integrated setting and receive compensation at or above the minimum wage from which payroll taxes are withheld (documentation required)</p> <p>If self-employed, earnings must be demonstrated through documentation of IRS filings, quarterly estimated taxes, business records or a business plan</p>	<p>Yes</p> <p>Enrollees who are unable to maintain employment due to illness or unavoidable job loss can remain in the program as unemployed for up to six months with the continued payment of any required monthly premium</p> <p>Enrollees who are unable to sustain employment and must terminate from the program will be evaluated expeditiously by the local Department of Social Services to determine whether they meet the eligibility requirements for any other Medicaid covered groups</p> <p>This evaluation will be completed before an enrollee is terminated from the program</p>	<p>Resources accumulated after enrollment in the Medicaid Buy-In program from enrollee earnings that are held in WIN accounts and are no greater than the WIN limit will not be counted in the eligibility determination for other Medicaid covered groups</p> <p>If found eligible and enrolled in another Medicaid covered group, the individual will have up to one year to dispose of these funds before they are counted toward ongoing Medicaid eligibility</p> <p>Resources accumulated after enrollment from earnings held in the following IRS-approved accounts that have been designated as I WIN accounts will not be counted in any future eligibility determinations: retirement, medical savings, education and independence accounts</p>

**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>Washington</b>	<p>Get paid for working; have earnings that are subject to federal income tax; and have payroll taxes taken out of wages, unless self-employed</p> <p>If self-employed, must provide tax forms such as IRS Schedule SE form or legitimate business records</p>	<p>If enrollee loses job after enrolling in the state HWD program he or she may choose to continue enrollment in the HWD program through the end of their current certification period (up to 12 months), if loss of employment is due to a health crisis or involuntary dismissal, they intend to return to work after the health crisis has passed or continue looking for new employment, and they continue paying the monthly premium based on their remaining income</p>	None
<b>West Virginia</b>	<p>Engaged in competitive employment, including self-employment or nontraditional work, and the work results in remuneration at or above the minimum wage in an integrated setting</p>	<p>Yes</p> <p>Up to six months from the involuntary loss of employment</p> <p>Individual must maintain a connection to the workforce</p>	None

**Table A-4 (continued)**

<b>State</b>	<b>Work Requirements</b>	<b>Protections for Temporary Loss of Employment</b>	<b>Protections When Returning to Other Eligibility Categories</b>
<b>Wisconsin</b>	Must be working or enrolled in an employment counseling program. May remain in employment counseling for up to one year	May enroll in health and employment counseling (time-limited and restricted to twice in a five-year period)  Work requirement may be waived for six months due to a health setback	None
<b>Wyoming</b>	No specific provision in state legislation	None	None

**Note:** FICA – Federal Insurance Contributions Act  
HWD – Healthcare for Workers with Disabilities  
IRS – Internal Revenue Service  
MNIL – Medically Needy Income Level  
N/A – Not applicable  
WIN – Work Incentive account(s)

## **Appendix B. Continuing Disability Review**

This appendix describes the continuing disability review (CDR) process which SSA uses for periodic reconsiderations of a beneficiary's disability status. The CDR includes eight steps that address whether a person remains eligible to receive federal benefits. For adult beneficiaries the notion is that sometimes medical improvement may lessen the vocational impact of a person's disability. However, the presumption is that the beneficiary remains unable to work unless the converse is documented.

### **Continuing Disability Review**

For adults in disability status, periodic reviews are triggered by (a) a presumption that from a year to three years post-entitlement, medical improvement related to the ability to work may have occurred or (b) the passage of time (three to seven years post-entitlement) makes it prudent to review the factors that led to disability and determine whether they are still present. The process assumes that the person is still under a disability; thus, the burden of proof to show that the disability no longer exists lies with the SSA decision maker.

Although beneficiaries are presumed to still have a disability, the CDR process requires them to attest that they cannot work substantially; in other words, that their work capacity is so limited as to be negligible. The adjudicator must make a two-part assessment: (1) Has there been improvement in the impairment(s) that was originally the basis for finding that work was not possible? (2) Is/are the change(s) related to the ability to work? This step involves the Medical Improvement Review Standard (MIRS). This element of the process adds several steps to those applied in initial adjudication, stretching the process from five to eight steps.

Exceptions to MIRS can be applied at several steps in the CDR sequential process, but these will not be included in this discussion for sake of simplicity. The adult CDR process is as follows.

#### **Step 1**

Is the individual engaging in SGA? If not, the adjudicator moves to Step 2. If yes, is the individual using an SSA work incentive provision known as "trial work"? If not, disability has ceased. If the individual is doing trial work, the performance of SGA itself cannot be the basis for loss of benefits, and the work itself cannot be considered as past work for application of the step concerned with ability to do any past work. However, the activities required to perform even trial work can be brought to bear by the decision maker. See Step 6.

## **Step 2**

Does the individual have a current impairment(s) that meets or equals a Listed Impairment? If yes, disability continues. If not, the process moves to the next step.

## **Step 3**

Has there been medical improvement in the individual's condition? If no, disability continues. If yes, the decision maker moves to the next step.

## **Step 4**

Is the individual's medical improvement related to his or her ability to work? If not, disability continues. If yes, the decision maker moves to the next step.

## **Step 5**

Determine whether any of the exceptions apply. If exceptions from 20 C.F.R. 416.994(b) (3) apply, go on to step 6. If any exceptions from 20 C.F.R. 416.994(b) (4) apply, disability ends.

## **Step 6**

Are the individual's current impairments severe? If not, disability ends. If yes, a determination is made of the individual's residual functional capacity.

The activities demonstrated in doing trial work can be used in the formulation of medical severity. This is particularly critical for impairments that lack strictly objective findings (e.g., EKGs, pathology or surgical findings, X-rays, CT or MRI findings) but instead rely on subjective observations relating to such factors as pain, fatigue, anxiety, or depression. This element of the disability determination process has a particularly negative effect on return-to-work outcomes. Although many beneficiaries know that SSA regulations allow SGA without loss of benefit access under the trial work provisions and that work well below the SGA limit will not in itself disqualify them from ongoing benefits, the many attestations of inability to work they have been required to make haunt employment-related decision making. The fear of inadvertently providing evidence of medical improvement through the use of SSA work incentives or less than SGA-level employment effectively creates a barrier to employment apart from impairment itself.

## **Step 7**

Can the claimant return to his or her past relevant work, either as he or she performed it or as it is performed in the economy? If yes to either question, disability ends. If return to past work is not possible, move to Step 8.



## **Step 8**

Can the beneficiary do any other work that exists in “substantial numbers” (loosely and variously defined) in the local or national economy? If yes, disability ends; if not, disability continues.

It is the thesis of this presentation that the eventuality of the CDR reinforces beneficiaries’ reluctance to reenter the workforce. All the stress, fear, and uncertainty experienced during initial adjudication—with its foundation in the definition of disability—recur in the review process. While SSA encourages beneficiaries to test out working by holding them harmless as far as earnings and SGA issues are concerned, any work-related functioning they exhibit during these efforts can be used to support a finding that medical improvement related to the ability to work has been, at least in part, documented and the disability standard is no longer met. It is not surprising that a beneficiary who has previously attested to an inability to work and who is facing the dire consequences of an adverse CDR decision—both financially and in terms of health care access—might avoid work to preserve the benefits already in hand.

Many people believe that negative interactions with SSA—especially regarding reporting earnings, over- and underpayments, and attempting to understand and use available work incentives—have tended to decrease beneficiaries’ aspirations for work and increase their fears of negative consequences, further strengthening the value placed on continued attachment to SSDI or SSI.<sup>190</sup>

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## **Appendix C. Medicaid Infrastructure Grants in Three States**

To illustrate the types of changes in state support systems that have been facilitated by the Medicaid Infrastructure Grant (MIG) projects, we describe a few exemplary initiatives in three states: New York, Connecticut, and Utah.

### **New York**

The MIG in the state of New York was named New York Makes Work Pay (NYMWP). This project is a good example of how a large state with a very complex and fragmented disability employment service system has attempted to streamline services to improve employment outcomes for people with disabilities. Three key problem areas on which the NYMWP project focused its efforts were (1) the barriers created by fragmentation in policies and service delivery across agencies, (2) low workplace demand for employees with disabilities owing to employers' lack of knowledge, and (3) low participation in asset-building strategies by people with disabilities. The strategies New York is using to address these barriers are a redesigned data system to allow sharing across agencies, increasing and incentivizing positive relationships with businesses, and strategies to improve the economic self-sufficiency for New Yorkers with disabilities.<sup>191</sup>

### ***Integrated Data Management System***

New York State has seven primary state agencies that provide employment services for people with disabilities. Each agency tracks program participation, earnings, and health-related data, but there is no tool in place to coordinate employment service delivery across multiple public and private agencies and populations. NYMWP developed a disability services portal as part of New York's comprehensive New York Employment Services System's (NYESS) employment case management data system.<sup>192</sup> By creating a cross-agency data warehouse to manage the data and measure key outcomes and indicators, NYESS is attempting to create a virtual "no wrong door" to jobseekers and employers. The system will provide the information that decision makers need, such as connecting jobseekers to available jobs, generating useful statistics linking data to policies and funding, and improving coordination and communication across agencies.<sup>193</sup>

### ***Information Tools for Employers and Employment Support Providers***

Businesses need supports to help people with disabilities meet their workplace demands; conversely, suppliers of workforce resources need to understand employers' perspectives and needs. The NYMWP concluded that workplace demand for employees with disabilities was low because of employers' limited knowledge about or access to the largely untapped pool of jobseekers and workers with disabilities. The project

partnered with the U.S. Business Leadership Network (USBLN) and regional BLNs in New York State to develop information tools and disseminate information relevant to businesses. Training strategies incorporating online resources include a “Disability as Diversity” training series, employer/service provider forums, and just-in-time training for businesses provided by Cornell University.<sup>194</sup>

### ***Asset-building Strategies***

A full 28 percent of New Yorkers with disabilities live at or below the poverty line (2007 data), and yet very few participate in asset-building strategies to improve their economic situation. Earned income tax credits, individual development accounts (IDAs), micro-loans for entrepreneurship, and other sources of capital are available and can improve economic self-sufficiency, but these programs only work if people know about and participate in them. Work incentives planning, Medicaid Buy-In for Working People with Disabilities (MBI-WPD), and asset accumulation strategies will create new opportunities for New Yorkers with disabilities by helping them build resources to improve their economic self-sufficiency. Key implementation activities have been to expand the number of credentialed benefits and work incentive counselors and increase participation in programs to strengthen the economic position of people with disabilities, including earned income tax credits, IDAs, and micro-loans.<sup>195</sup>

## **Connecticut**

### ***Employment Services Maps***

The Connect-Ability project in Connecticut used Medicaid Infrastructure Grant funds to conduct a needs assessment in 2006 as part of a strategic planning effort. The assessment found that a major barrier to effective employment outcomes was lack of understanding by providers and consumers of the range of programs and pathways of service delivery. Thus, the project developed and updated employment services maps for four state agencies (vocational rehabilitation, blind, mental health, and developmental services). These maps identify service gaps, overlaps, and points of access for consumers to improve coordination across the system. The partnerships created as a result of the Connect-Ability project led to enhancement in employment processes in all four agencies, most significantly in mental health and developmental services, where employment was not a focus before the MIG.<sup>196</sup> Connecticut also used MIG funding to support data integration across multiple agencies within the Bureau of Rehabilitation Services, which has enabled the state to collect and analyze information on Medicaid Buy-In participants, consumers of vocational rehabilitation (VR) services, and the use of benefit counseling services to improve the employment outcomes of people with disabilities.<sup>197</sup>

## Utah

### ***Single Point of Contact for Employers in VR***

The Work Ability Utah project (the state's Medicaid Infrastructure Grant) provides an example of how a small state with large expanses of rural areas has addressed challenges in employment for people with disabilities. In its attempt to improve employment outcomes for people with significant disabilities, the Work Ability project decided to focus on the disconnect between the labor supply of people with disabilities and employer demand for employees. In collaboration with the Vocational Rehabilitation program in Utah, Work Ability created the job network called PWDNET to serve both businesses and jobseekers with disabilities. It was felt that the VR agency needed a person internally to provide a "business perspective," so the agency created a position for a business relations specialist to serve as the single point of contact for employers to connect with qualified candidates with disabilities who are seeking employment.<sup>198</sup> The business relations specialist conducts regular job fairs at which employers and jobseekers can meet and connect. Businesses are provided with individualized support and training on disability issues, accommodations in the workplace, effective recruitment strategies, assistive technology, retention practices, tax credits, and the Americans with Disabilities Act. Customized workshops are held at employers' request, and consultation on individual workplace accommodations is provided. On the supply side, benefits counseling is provided to jobseekers, and job openings are sent via email to a statewide list of employment providers. Employers who use these services are highly satisfied. More than 350 Utah businesses participate in PWDNET, and the number is increasing steadily.<sup>199</sup> The local offices of several international corporations have adopted these practices at the corporate level. Both Convergys and United Parcel Service (UPS) are examples of this Utah-to-national practice.

The Utah business relations model is being replicated in many other states, with the help of the National Employment Team (the NET) of the Council for State Administrators of Vocational Rehabilitation (CSAVR). This national office coordinates with business consultants in 80 SVRAs in the United States. The NET supports a "dual customer" approach to meeting the employment needs of businesses. For VR consumers, the NET provides access to national employment opportunities; for businesses, it provides access to job applicants and to support services from the SVRAs and partners. The national office also facilitates the sharing of employment resources, best practices, and business connections among the states.<sup>200</sup> This collaborative effort is another example of an initiative begun with MIG funds that has become an ongoing program.

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## Endnotes

<sup>1</sup> National Council on Disability, “Transition and Post-School Outcomes for Youth with Disabilities: Closing the Gaps to Post-Secondary Education and Employment” (2000), <http://www.ncd.gov>.

<sup>2</sup> Social Security Advisory Board, “Aspects of Disability Decision Making: Data and Materials” (2012), [http://www.ssab.gov/Publications/Disability/GPO\\_Chartbook\\_FINAL\\_05212012.pdf](http://www.ssab.gov/Publications/Disability/GPO_Chartbook_FINAL_05212012.pdf).

<sup>3</sup> National Council on Disability, “The Social Security Administration’s Efforts to Promote Employment for People with Disabilities: New Solutions for Old Problems” (2005), <http://www.ncd.gov>.

<sup>4</sup> Organization for Economic Co-operation and Development, “Sickness, Disability and Work: Breaking the Barriers. A Synthesis of Findings across OECD Countries” (2010), [http://ec.europa.eu/health/mental\\_health/eu\\_compass/reports\\_studies/disability\\_synthesis\\_2010\\_en.pdf](http://ec.europa.eu/health/mental_health/eu_compass/reports_studies/disability_synthesis_2010_en.pdf).

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<sup>114</sup> John Gettens *et al.*, "The Prospect of Losing Benefits and the Work Decisions of Participants in Disability Programs: A Cross-Program Comparison," *Journal of Disability Policy Studies* 23, no. 3 (2012): 186–89, doi:10.1177/1044207311429345; Mary B. Killeen and Bonnie L. O'Day, "Challenging Expectations: How Individuals with Psychiatric Disabilities Find and Keep Work," *Psychiatric Rehabilitation Journal* 28, no. 2 (2004): 152, doi:10.2975/28.2004; Pamela Loprest and Elaine Magg, Urban Insitute, "Barriers to and Supports for Work Among Adults with Disabilities: Results from the NHIS-D" (Washington, D.C.: U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy, 2001), <http://aspe.hhs.gov/daltcp/reports/barriers.htm>; Kim L. MacDonald-Wilson *et al.*, "A Study of the Social Security Work Incentives and Their Relation to Perceived Barriers to Work among Persons with Psychiatric Disability," *Rehabilitation Psychology* 48, no. 4 (2003): 48, doi:10.1037/0090-5550.48.4; Judith Barfield and Pamela Hanes Spohn, "Employment Experiences of Working-Age Adults with Severe Physical Disabilities in Dane County, Wisconsin" in *Employment Initiatives for Persons with Physical Disabilities* (Madison, WI: Employment Resources, 1993), 24, 34; Olney and Lyle, "Benefits Trap," 205–6.

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<sup>116</sup> Barfield and Spohn, "Employment Experiences," 39–40.



<sup>117</sup> Gettens *et al.*, “Prospect of Losing Benefits,” 187; Fear of benefits loss can be viewed as a complex concept with multiple components. The material here focuses on three types: getting or keeping benefit eligibility, getting reinstatement if the benefit is lost (for example because of a successful return-to-work effort), and concern about benefit loss at a particular earnings level (in this case the SGA “cash cliff” for those in SSDI). However, other fears may be pertinent depending on the features of a given program. *Ibid.*, 179–80.

<sup>118</sup> Bonnie O’Day and Mary Killeen, “Does U.S. Federal Policy Support Employment and Recovery for People with Psychiatric Disabilities?” *Behavioral Law and the Sciences* 20 (2002): 567–68, doi:10.1002/bsl.514; Killeen and O’Day, “Challenging Expectations,” 159; Olney and Lyle, “Benefits Trap,” 205–6.

<sup>119</sup> Barfield and Spohn, “Employment Experiences,” 24; Loprest and Magg, “Supports for Work,” 7.

<sup>120</sup> O’Day and Killeen, “Employment and Recovery for People with Psychiatric Disabilities,” 575; Williams *et al.*, “Waiting for Medicare,” 12–14.

<sup>121</sup> 20 C.F.R. §§ 404.1562, 1569; 20 C.F.R. Part 404 Appendix 2.

<sup>122</sup> Current processes are defined at 20 C.F.R. § 404.1501 for SSDI and 20 C.F.R. § 416.960 for SSI.

<sup>123</sup> 20 C.F.R. § 404.1525; 20 C.F.R. Part 404 Appendix 1.

<sup>124</sup> 20 C.F.R. Part 404 Appendix 1.

<sup>125</sup> Kalman Rupp, “Factors Affecting Initial Disability Allowance Rates for the Disability Insurance and Supplemental Security Income Programs: The Role of the Demographic and Diagnostic Composition of Applicants and Local Labor Market Conditions,” *Social Security Bulletin* 72, no. 4 (2012): 12, 20–1, <http://www.ssa.gov/policy/docs/ssb/v72n4/v72n4p11.html>.

<sup>126</sup> Jennifer Erkulwater, *Disability Rights and the American Social Safety Net* (Ithaca, N.Y.: Cornell University Press, 2006), 177–81.

<sup>127</sup> Generally, controlling the rates of entry to public programs is more effective, in terms of lessening both administrative costs and the use of overt coercion. Moreover, such gatekeeping is usually more effective when potential applicants have alternatives they value and positive incentives to choose not to apply to or remain in the programs. Burkhauser and Daly, “Declining Work and Welfare.”

<sup>128</sup> D. Stapleton *et al.*, “Poverty Trap.”

<sup>129</sup> Norman Altshuler *et al.*, Mathematica Policy Research, “Provider Experiences under the Revised Ticket to Work Regulations” (2011), [http://www.mathematica-mpr.com/~media/publications/pdfs/disability/ttw\\_process.pdf](http://www.mathematica-mpr.com/~media/publications/pdfs/disability/ttw_process.pdf).

<sup>130</sup> U.S. Government Accountability Office, “Ticket to Work Participation Has Increased, but Additional Oversight Needed” (2011), <http://www.gao.gov/products/GAO-11-324>.

<sup>131</sup> David Stapleton, Cindy Gruman, and Sarah Prenovitz, Mathematica Policy Research, “Work Activity and Use of Employment Supports under the Original Ticket to Work Regulations Participation in Ticket to Work Continues to Grow but Assignments under the Traditional Payment System Still Dominate Final Report” (2009), [http://www.mathematica-mpr.com/publications/PDFs/disability/TTW\\_participation.pdf](http://www.mathematica-mpr.com/publications/PDFs/disability/TTW_participation.pdf).

<sup>132</sup> Jody Schimmel and David C. Stapleton, “Disability Benefits Suspended or Terminated Because of Work,” *Social Security Bulletin* 71, no.3.(2011). <http://www.socialsecurity.gov/policy/docs/ssb/v71n3/v71n3p83.html>.

<sup>133</sup> Altshuler *et al.*, “Provider Experiences.”

<sup>134</sup> Ibid.

<sup>135</sup> Ibid.

<sup>136</sup> Stapleton *et al.*, “Work Activity and Use of Employment Supports.”

<sup>137</sup> Jody Schimmel *et al.*, Mathematica Policy Research, “Participant and Provider Outcomes since the Inception of Ticket to Work and the Effects of the 2008 Regulatory Changes” (2013), [http://www.mathematica-mpr.com/~media/publications/pdfs/disability/ttw\\_part\\_provid\\_outcomes.pdf](http://www.mathematica-mpr.com/~media/publications/pdfs/disability/ttw_part_provid_outcomes.pdf).

<sup>138</sup> U.S. Senate Committee on Health, Education, Labor, and Pensions, “High Expectations: Transforming the American Workforce as the ADA Generation Comes of Age” (2013), <http://www.help.senate.gov/newsroom/press/release/?id=8c890e1c-27fd-4599-b040-0e2631a96212&groups=Chair>.

<sup>139</sup> The raw data permits research of age breakdown for diagnostic groups. Other related SSA data such as in the *Annual Statistical Report on the Social Security Disability Insurance Program 2008*, stops at the end of December 2008—a period of time different from the fiscal year—and are not disaggregated. Social Security Administration, Office of Retirement and Disability Policy, Office of Research, Evaluation, and Statistics, “Annual Statistical Report on the Social Security Disability Insurance Program, 2008” (2009), [http://www.ssa.gov/policy/docs/statcomps/di\\_asr/2008/di\\_asr08.pdf](http://www.ssa.gov/policy/docs/statcomps/di_asr/2008/di_asr08.pdf).

<sup>140</sup> C. L. Barrett, “Number of SSDI Beneficiaries under Age 50 with a Primary Impairment of a Mental Disorder in Payment in July 2006, from the Social Security Administration Continuing Disability Review Selection File FY 2008” (unpublished raw data).

<sup>141</sup> Donna D. McAlpine and Lynn Warner, Rutgers State University, Institute for Health, Health Care Policy and Aging Research, Center for Research on the Organization and Financing of Care for the Severely Mentally Ill, “Barriers to Employment Among Persons with Mental Illness: A Review of the Literature” (2000), [http://www.dri.illinois.edu/research/p01-04c/final\\_technical\\_report\\_p01-04c.pdf](http://www.dri.illinois.edu/research/p01-04c/final_technical_report_p01-04c.pdf); John C. Hennessey and Janine M. Dykacz,

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<sup>142</sup> Monroe Berkowitz, “The Ticket to Work Program: The Complicated Evolution of a Simple Idea,” and Chad Newcomb, Suzanne Payne, and Mikki D Waid, “What Do We Know About Disability Beneficiaries’ Work and Use of Work Incentives Prior to Ticket?” in *Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work?*, ed. Kalman Rupp and Stephen H. Bell (Washington, D.C.: Urban Institute, 2003).

<sup>143</sup> Kalman Rupp and Stephen H. Bell, “A Ticket to Work? A Preliminary View of Provider Incentives and Access to Services in the Ticket Program,” in *Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work?*, ed. Kalman Rupp and Stephen H. Bell (Washington, D.C.: Urban Institute, 2003) <http://www.urban.org/url.cfm?ID=310603&renderforprint=1>.

<sup>144</sup> Ibid.

<sup>145</sup> Evan Rosen, “Smashing Silos,” *Bloomberg Business Week*, February 5, 2010, [http://www.businessweek.com/managing/content/feb2010/ca2010025\\_358633.htm](http://www.businessweek.com/managing/content/feb2010/ca2010025_358633.htm).

<sup>146</sup> Social Security Administration, Office of Retirement and Disability Policy, “2012 Red Book: A Summary Guide to Employment Supports for Persons with Disabilities under the Social Security Disability Insurance and Supplemental Security Income Programs” (2012), [http://www.socialsecurity.gov/redbook/eng/The%20Red%20Book%202012.\(F\).pdf](http://www.socialsecurity.gov/redbook/eng/The%20Red%20Book%202012.(F).pdf).

<sup>147</sup> Christa Bucks Comacho and Jeffrey Hemmeter, “Linking Youth Transition Support Services: Results from Two Demonstration Projects,” *Social Security Bulletin* 73, no. 1 (2013), <http://www.socialsecurity.gov/policy/docs/ssb/v73n1/v73n1p59.html#mt1>.

<sup>148</sup> “That goal [to increase the self-sufficiency of transition-age youth with disabilities], which may not be realized until many years after YTD participation, generally takes the form of increased employment and decreased dependence on public benefits, along with improved quality of life.” Ibid., 60.

<sup>149</sup> Comacho and Hemmeter, “Linking Youth Transition Support.”

<sup>150</sup> Mathematica Policy Research, “Youth Transition Demonstration: Helping Youth with Disabilities Become Employed 2005–2014,” <http://www.mathematica-mpr.com/our-publications-and-findings/projects/youth-transition-demonstration>.

<sup>151</sup> Thomas Fraker, Mathematica Policy Research, Center for Studying Disability Policy, “The Youth Transition Demonstration: Interim Findings and Lessons for Program Implementation” (2011), [http://www.mathematica-mpr.com/~media/publications/pdfs/disability/ytd\\_brief11-04.pdf](http://www.mathematica-mpr.com/~media/publications/pdfs/disability/ytd_brief11-04.pdf); Livermore, “Social Security Disability Beneficiaries with Work-Related Goals.”

<sup>152</sup> Jeffrey Hemmeter, Jacqueline Kauff, and David Wittenburg, “Changing Circumstances: Experiences of Child SSI Recipients before and after Their Age-18 Redetermination for Adult Benefits,” *Journal of Vocational Rehabilitation*, 30 (2009): 201–21, doi:10.3233/JVR-2009-0462.

<sup>153</sup> Ibid.

<sup>154</sup> Ibid.

<sup>155</sup> Pamela Loprest and David Wittenburg, Urban Institute, “Choices, Challenges, and Options: Child SSI Recipients Preparing for the Transition to Adult Life” (2005), [http://www.urban.org/UploadedPDF/411168\\_ChildSSIRecipients.pdf](http://www.urban.org/UploadedPDF/411168_ChildSSIRecipients.pdf).

<sup>156</sup> Ibid.

<sup>157</sup> Ibid.

<sup>158</sup> David W. Test *et al.*, “Evidence-Based Secondary Transition Predictors for Improving Postschool Outcomes for Students With Disabilities,” *Career Development for Exceptional Individuals*, 32, no. 3 (2009):160–81, 170, doi: 10.1177/0885728809346960.

<sup>159</sup> Ibid.

<sup>160</sup> Erik W. Carter, Diane Austin, and Audrey A. Trainor, “Predictors of Postschool Employment Outcomes for Young Adults With Severe Disabilities,” *Journal of Disability Policy Studies*, 23, no. 1 (2011): 50–63, doi: 10.1177/1044207311414680.

<sup>161</sup> Hemmeter, Kauff, and Wittenburg, “Changing Circumstances: Experience of Child SSI Recipients.”

<sup>162</sup> U.S. Department of Education, Office of Special Education Programs, Office of Special Education and Rehabilitative Services, “Fiscal Year 2013 Applications for New Awards” (August 2013), <http://www2.ed.gov/programs/oseptad/2013-326s.doc>.

<sup>163</sup> Applications for New Awards; Promoting the Readiness of Minors in Supplemental Security Income (PROMISE), 78 Fed. Reg. 98 (Sept. 2013).

<sup>164</sup> William Frey *et al.*, Social Security Administration, “Mental Health Treatment Study Final Report” (2011), [http://socialsecurity.gov/disabilityresearch/documents/MHTS\\_Final\\_Report\\_508.pdf](http://socialsecurity.gov/disabilityresearch/documents/MHTS_Final_Report_508.pdf).

<sup>165</sup> Ibid.

<sup>166</sup> Ibid.

<sup>167</sup> Ibid.

<sup>168</sup> Ibid.

<sup>169</sup> Ibid.

<sup>170</sup> Croake and Liu, “GPRA Medicaid Infrastructure 12/31/08.”

<sup>171</sup> Ibid. In order to qualify for progressive steps in the Medicaid Infrastructure Grant program, states needed to first demonstrate a basic level of Medicaid services that focused on assisting people with disabilities to work: (a) a Medicaid Buy-In program and (b) personal assistance services that could be used to support eligible individuals in employment either at home or at work. States that met these benchmarks set by CMS were then eligible for additional MIG funding. Ibid.

<sup>172</sup> Ibid.

<sup>173</sup> Ibid.

<sup>174</sup> Matthew Kehn, Sarah Croake, and Jody Schimmel, Mathematica Policy Research, “A Government Performance and Results (GPRA) Report: The Status of the Medicaid Infrastructure Grants Program as of 12/31/09” (2010), [http://www.mathematica-mpr.com/~media/publications/PDFs/disability/GPRA\\_09.pdf](http://www.mathematica-mpr.com/~media/publications/PDFs/disability/GPRA_09.pdf).

<sup>175</sup> American Public Human Services Association, Center for Workers with Disabilities, “Medicaid Infrastructure Grants: Impacts and Outcomes” (2010), <http://nasuad.org/hcbs/article/medicaid-infrastructure-grants-impacts-and-outcomes>.

<sup>176</sup> Kehn, Croake, and Schimmel, “GPRA Medicaid Infrastructure 12/31/09.”

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<sup>178</sup> Mary C. Daly and Richard Burkhauser, “The Supplemental Security Income Program,” in *Means-Tested Transfer Programs in the United States*, ed. Robert A. Moffitt (Chicago, IL: University of Chicago Press 2003), 97.

<sup>179</sup> Social Security Administration, “A Guide to Supplemental Security Income (SSI) for Groups and Organizations” (2014), <http://www.ssa.gov/pubs/EN-05-11015.pdf>.

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- <sup>188</sup> Daly and Burkhauser, “Supplemental Security Income Program.”
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