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Back to Work: Recent SSA Employment Demonstrations for People with Disabilities

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The Social Security Administration (SSA) recently implemented four large scale-demonstration projects designed to increase the economic self-sufficiency of Supplemental Security Income (SSI) recipients and Social Security Disability Insurance (SSDI) beneficiaries. Although the demonstrations' innovations and target populations differ substantially, all of the demonstrations use random assignment to allow for a rigorous assessment of impacts.

This brief summarizes short-term impacts from these four demonstrations. Some promising results have emerged, including modest improvements in employment. Questions remain, however, as to whether these interventions can encourage more substantial long-term employment. Although it is too early to fully assess the benefits and costs of each intervention, the demonstrations' short-term impacts provide valuable evidence on the potential of different intervention approaches to influence outcomes for people with disabilities. In addition, the findings provide insight on the key barriers people with disabilities face, including work disincentives and lack of health care access and impairment-specific supports, as they strive to live more independently.

SSA's Demonstration Authority

Over the past several decades, SSDI and SSI caseloads have grown considerably and beneficiary employment has decreased steadily. From 1980 to 2011, SSDI's caseload almost tripled from 2.8 to 8.0 million. The cost of such rapid growth is substantial—expenditures for SSDI and Medicare beneficiaries under age 65 represented 5.4 percent of all federal outlays in 2010.[1] Mamun et al. (2011) showed that the employment rate for SSA disability program beneficiaries in 2007 was 12 percent, compared to 80 percent for members of the general population without disabilities.

SSDI and SSI eligibility criteria require that eligible applicants have a medically determinable disability expected to last at least 12 months or result in death and be unable to engage in substantial gainful activity (SGA), which is currently defined as the ability to earn at least $1,010 per month in unsubsidized employment for non-blind beneficiaries ($1,690 for blind beneficiaries). SSDI also requires that applicants not engage in SGA for at least five months before applying for benefits.

Although some beneficiaries regain the capacity to perform SGA, prolonged detachment from the workforce and confusing work incentives create barriers to employment (Stapleton et al. 2006). Though both programs include work incentives, such as prolonged Medicare or Medicaid eligibility for those earning more than the SGA levels for an extended period, the program rules are complex and poorly understood by beneficiaries. Additionally, because the application process emphasizes an inability to perform SGA and can take months or even years, new beneficiaries may lose skills, grow accustomed to not working, and/or conclude they cannot work. SSDI beneficiaries also may have inadequate access to health care for a long period before they come eligible

[1] Data sources: Social Security Administration (2012) for SSDI expenditures; Centers for Medicare & Medicaid Services (2012) for Medicare Part A and B expenditures; Census Bureau (2012) for federal outlays.

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for Medicare, which occurs 24 months after SSDI award.[2]

Congress authorized the SSA to conduct demonstration projects to test strategies that could improve employment outcomes. Authorization was granted in 1980 to test SSDI demonstration projects over a five-year period and test SSI demonstration projects permanently (Szymendera 2011). SSA could use this authority to temporarily waive certain program rules and allocate trust fund dollars and appropriated funds to finance demonstration development. The authority required that the demonstrations have sufficient scope and scale to ensure a thorough evaluation of the program or policy change under consideration. The SSDI demonstration authority was renewed several times, most recently in the Ticket to Work and Work Incentives Improvement Act of 1999. That act directed SSA to conduct demonstration projects in several areas that were recently implemented, including altering the period that SSDI beneficiaries have to wait for Medicare and administering a sliding scale of benefit offsets for SSDI beneficiaries. SSA's demonstration authority expired in 2005, though the projects started before 2005 were allowed to continue.

Four Recent Demonstrations

Table 1 summarizes the characteristics of four demonstration projects that have been implemented since 2000 and have published evaluation results.[3] These demonstrations tested different intervention approaches that were generally targeted to specific subgroups of beneficiaries, including those who (1) are uninsured, (2) are working, (3) have mental impairments, and (4) lack health insurance. All of the demonstrations used volunteers and the service and incentive provisions continued for a specified period.[4] Although their specific goals varied, each demonstration aimed to improve beneficiary employment rates. The goals and performance of each demonstration are described in detail below.

Accelerated Benefits Demonstration

The Accelerated Benefits (AB) Demonstration, which was fully implemented in 2008 in 53 metropolitan areas nationwide, tested whether accelerated access to a health plan and other telephonic services would improve outcomes for new SSDI beneficiaries. Under current law, SSDI beneficiaries must complete a five-month waiting period before becoming entitled to cash benefits and most wait another 24 months before becoming eligible for Medicare. Some beneficiaries lack health insurance during the Medicare waiting period, which may cause them to delay obtaining health care and become more reliant on long-term SSDI benefits. To test the efficacy of providing health services to SSDI beneficiaries at least 18 months before Medicare eligibility, approximately 2,000 demonstration participants were randomized into one of three groups: (1) AB, which received a relatively generous health benefit plan; (2) AB Plus, which received the same health plan plus additional telephonic services to navigate the health care system and promote work; or (3) a control group.

The early demonstration findings provided important insights on the characteristics of uninsured beneficiaries and their demand for health services (Michalopoulos et al. 2011). Of the new SSDI beneficiaries screened for the demonstration, approximately 13 percent were eligible because they lacked health insurance. Interest in the demonstration was high and 99 percent of eligible SSDI beneficiaries participated, underscoring this population's demand for health services. When the demonstration began, many participants reported severe health problems and several unmet needs for medical care and prescription drugs. Not surprisingly, once the demonstration began, participants used the health plan extensively to address these needs; average costs were approximately $19,000 per participant in the first year. Although nearly all AB and AB Plus participants used some health plan services, the majority of costs were for a minority who had $50,000 or more in claim payments. These findings underscore the high expenses associated with providing

[2] Under the Affordable Care Act, starting in 2014, SSDI beneficiaries in the Medicare "waiting period" who meet certain household income thresholds will be eligible for either Medicaid coverage or subsidies to buy health insurance on their state's health insurance exchange.

[3] Szymendera (2011) notes that SSA had undertaken 10 projects since the Ticket to Work Act, of which 4 had been completed, 2 were ongoing, and 2 were cancelled. Of the 6 ongoing or completed projects, only 1 (the Benefit Offset National Demonstration) does not have a set of reported findings, though an evaluation plan is available. Szymendera (2011) also reports detailed findings from the evaluations summarized here, including information on the State Partnership Initiative evaluation, which was completed in 2005.

[4] The Benefit Offset Pilot Demonstration offset was available for a six-year period that began after the beneficiary completed an SSA work milestone referred to as the grace period. The offset was applied for earnings above the SGA level in all months following the grace period.

Table 1.

SUMMARY OF FOUR RECENT SSA PROJECTS USING RANDOM ASSIGNMENT

Demonstration	Target Population	Intervention
Accelerated Benefits (AB) Demonstration	Uninsured new SSDI beneficiaries	Health plan and other health, employment, and behavioral supports
Benefit Offset Pilot Demonstration (BOPD)	SSDI beneficiaries	Work incentive that replaces "cash cliff" with gradual benefit reduction and access to work incentive counseling services
Mental Health Treatment Study (MHTS)	SSDI beneficiaries with a primary impairment of schizophrenia or affective disorder	Integrated mental health and employment support services
Youth Transition Demonstration (YTD)	Youth and young adults with disabilities receiving or at risk of receiving SSI or SSDI	Customized employment supports, benefits counseling, and program waivers

health services to an uninsured population with significant health needs.

The one-year impact findings indicate that the demonstration made some progress toward its initial goals of promoting access to health care and improvements to health, though more time is needed to assess whether it will have long-term impacts related to SSDI participation, Medicare, and employment. The impact findings indicate that the AB and AB Plus participants increased their health care use and reported fewer unmet medical needs relative to the control group. Additionally, AB and AB Plus participants reported they were in better general health relative to the control group, though there were no measured impacts in functioning (such as activities of daily living). AB Plus participants were more likely to look for work than members of the AB and control groups, but there were no overall impacts of AB Plus (or AB) on employment. Finally, AB and AB Plus participants reported fewer difficulties paying for basic necessities, which indicates that treatment group members incurred fewer out-of-pocket health expenses. Although these findings are promising, the benefits' effects must be weighed against the large per-participant spending on health claims noted above, which underscores a need for a continued tracking of long-term demonstration impacts to provide a full-scale assessment on all outcomes.

Benefit Offset Pilot Demonstration

In 2005, SSA implemented the Benefit Offset Pilot Demonstration (BOPD) in Connecticut, Utah, Vermont, and Wisconsin. BOPD's purpose was to test the administrative processes needed for the Benefit Offset National Demonstration (BOND), which is now under way. The benefit offset allows SSDI beneficiaries to earn more than the SGA amount without necessarily losing all of their benefits, as under current law. Instead, their benefits are reduced by $1 for every $2 of additional earnings. Each state recruited between 250 and 600 participants for the pilot before conducting random assignment. The treatment group received the benefit offset; the control group did not. Both groups were offered work incentive counseling services.

Although all BOPD sites adhered to broad participation and recruitment requirements, the target population and outreach methods for BOPD varied considerably by state. In all sites, the target population included only SSDI beneficiaries who did not receive SSI (which has its own work incentive provisions), and excluded those receiving benefits as a disabled adult dependent or widow(er) of a Social Security beneficiary. Beyond these general guidelines, states had considerable freedom in choosing sample members. Specific target populations, outreach methods, and recruitment methods varied considerably across states.

Weathers and Hemmeter (2011) found that the impacts of BOPD varied, depending on beneficiaries' employment history. In general, BOPD did encourage more people to earn more than the SGA level in two demonstration states—Connecticut and Utah—though it also led to a reduction in earnings among those who had previously been earning above the SGA amount. The former finding shows that people responded to an enhanced work incentive and that the current cash cliff reduces the earnings of some beneficiaries. However, the latter finding indicates that those who earn more than the SGA amount might reduce their earnings to obtain a higher benefit. Weathers and Hemmeter (2011) also found that BOPD increased the mean payout to beneficiaries, which translates to an increase in overall program costs.

A caution in drawing any definitive conclusions from these results is that problems with the processing of the benefits, which was done manually in BOPD, may have influenced outcomes. Consequently, Weathers and Hemmeter (2011) conclude that BOPD likely establishes a lower bound estimate of benefit offset usage for those targeted. Finally, BOPD provided valuable information that influenced the implementation design of BOND, particularly in benefit administration. BOND uses a more automated benefit offset payment process.

Mental Health Treatment Study

Over the past decade, the number of SSDI beneficiaries with psychiatric disorders has grown steadily. Although a large proportion of this subgroup indicates an interest in returning to work, employment of beneficiaries with psychiatric disorders has remained very low. To encourage certain members of this subpopulation to return to work, SSA conducted the Mental Health Treatment Study (MHTS) from 2006 to 2010. MHTS provided integrated supported employment (SE) and systemic medication management services (MMS) over a 24-month period to treatment SSDI beneficiaries with schizophrenia or an affective disorder.[5]

Participation in MHTS was voluntary and assignment to the treatment and control groups was randomized. As has been shown in previous SSA demonstrations, recruiting volunteers is challenging: about 14 percent of beneficiaries who were asked agreed to participate (Wittenburg et al. 2008). Program volunteers were more likely than others to have had prior work history in the SSA administrative records and be in good physical health. In total, 2,238 beneficiaries were recruited. SE and MMS services were provided at 23 sites across the country. On average, each treatment group member received $6,986 worth of services each year, excluding services that were not paid for by MHTS, such as standard mental and physical health services covered by Medicare and Medicaid.

Frey et al. (2011) found that the MHTS successfully improved many employment and health outcomes for treatment group members. Most notably, after 24 months, 61 percent of those who received MHTS services were employed, compared to just 40

[5] MHTS treatment subjects also were ineligible for medical Continuing Disability Reviews for three years.

percent of those who did not receive the services. However, overall average earnings remained relatively low for treatment group members who were employed ($251 a month) and there was no significant difference between the proportions of treatment and control group members earning more than the SGA amount. Treatment subjects were more likely than control subjects to use vocational services. Hospitalizations (both admissions and numbers of days) and psychiatric visits decreased among treatment subjects. The treatment group also reported improvements in mental health status and quality of life.

The findings from MHTS indicate that SE services and additional work incentives can improve employment participation of a select group of SSDI beneficiaries with psychiatric impairments over a one-year period, though the demonstration found no impact on the proportion of workers engaging in SGA. The low employment participation of the control group also indicates that relatively few current SSDI beneficiaries with psychiatric impairments will work without additional supports. In part, this finding is potentially related to another MHTS finding: that many SSDI beneficiaries with psychiatric disorders also have other comorbidities that further complicate their ability to return to work. The study does not, however, measure the long-term impacts of the intervention, so it is not possible to assess whether the additional effects of SE and work incentives will be cost beneficial to SSA or, more broadly, to society.

Youth Transition Demonstration

The SSA initiated the Youth Transition Demonstration (YTD) projects in an attempt to develop services and supports to assist youth in becoming self-sufficient adults. Implemented at several sites across the country from 2003 through 2008, the YTD projects had flexibility in developing partnerships, specifying intervention services, and serving target populations of youth with disabilities. All YTD projects serve a target population of youth ages 14 to 25 who receive SSA disability benefits or are at risk of receiving these benefits after leaving school. The types of services vary by project, but all projects include a core set of components that emphasize employment services as part of the intervention and as a key outcome. Additionally, the services are tailored to address the unique needs of youth who receive SSA disability benefits (Luecking and Wittenburg 2009).

The YTD evaluation will include findings from 10 YTD projects, including six sites that will be rigorously evaluated using random assignment. Relative to other YTD sites, the six random assignment sites include much larger samples of youth. Their outcomes will be tracked over a four-year period using a combination of survey and administrative data to measure program impacts and assess overall benefits and costs. The six random assignment sites each recruited approximately 880 youth, of whom 480 are randomly assigned to YTD services and the rest are assigned to a control group. The evaluation of YTD will continue through 2014.[6]

The six random assignment sites were selected in two phases. In the first phase, three of the original seven YTD projects funded by SSA in 2003 were selected to participate in the national impact study. In the second phase, three new projects were identified, piloted, and eventually selected for full implementation.[7] All six sites received technical assistance. Because of the later start date, the sites in the second phase had the relative advantage of learning implementation lessons from the first phase sites and from the YTD sites that did not use a random assignment design.

Initial findings are available from the sites that were first implemented in 2003, including the first three random assignment sites. The early implementation findings emphasized the importance of developing clear communications among project staff and partners, especially in tracking and monitoring key service delivery and participant outcomes, such as employment service delivery and competitive employment placements (Martinez et al. 2010). Partly in response to these findings, the three sites selected in the second phase of the study developed formal strategies for sites to report ongoing benchmarks for service delivery and competitive employment placements to SSA on a monthly basis. The implementation findings also noted that challenges exist in integrating multiple partners who may not all have a clear emphasis on promoting employment as the primary outcome. Finally, the one-year follow-up findings in the three sites included in the first phase of random assignment indicate that all three YTD projects led to increased use of employment-related services, such as vocational rehabilitation, though only one project had impacts on paid competitive employment. One key early finding: the one site that had employment impacts also had much higher levels of recorded employment service delivery relative to the other two sites (Fraker 2011). In a follow-up study at two years using administrative data, two sites had positive earnings impacts, though one of the sites guaranteed a summer job to all youth, which likely affected impacts (Hemmeter 2012). It will be important to track the ongoing relationship between employment service intensity and ultimate employment outcomes in longer-term follow-ups, as well as in the short-term follow-ups for the phase 2 random assignment sites (report expected in 2012).

[6] The implementation of YTD began in a select number of small sites in 2003 before the start of the evaluation; all six of the large random assignment sites began after 2005 (Fraker and Rangarajan 2009).

[7] Originally, five sites participated in the pilot and three of the five sites were selected for the national evaluation based on their potential for promising impacts. (Martinez et al. 2008)

Conclusion

Although it is still too early to generalize the findings from the recent SSA demonstrations, preliminary findings show mixed results (Table 2). All of the demonstrations reported modest positive impacts on employment or use of employment services and show potential for influencing other participant outcomes, such as health and unmet medical needs. However, none of the findings reported to date show that the demonstrations tested would likely lead to a substantial reduction in caseload sizes.[8] The demonstrations' potential to influence outcomes is limited because their interventions only affect individuals after they enter a disability benefit program. Nonetheless, these demonstrations provide lessons for developing further innovations that could result in improved outcomes for beneficiaries.

A major challenge in developing future innovations is that relatively few have been tested among SSA beneficiaries and populations with disabilities more generally. The lessons here indicate that providing additional supports could improve employment, though it is unlikely that making such changes for existing beneficiaries will reduce caseload size. As policymakers struggle to address growing caseloads, they may need to consider making supports available to people before they receive benefits. Unfortunately, there is little information on how such supports would affect outcomes of people with disabilities. Gathering such information will help determine whether policy changes can substantially improve the lives of people with disabilities.

[8] The three final random assignment sites from the YTD demonstration have yet to report impacts, so it is possible that negative effects for caseload size might still be observed in this demonstration.

Table 2.

KEY FINDINGS FOR RECENT SSA DEMONSTRATION PROJECTS

Demonstration	Key Short-Term Findings
Accelerated Benefits (AB) Demonstration	• **Health and unmet need impacts:** Increased use of health care, decreased unmet medical needs (e.g., not going to the doctor), and improved health relative to control group; no impacts on employment, but AB Plus participants were more likely to use employment-related services (e.g., vocational rehabilitation). • **Extensive use of health plan:** Average cost per participant was more than $19,000.
Benefit Offset Pilot Demonstration (BOPD)	• **Employment impacts:** Increased percentage with earnings above the SGA amount for some, but did not increase overall employment. • **Benefit increases:** Annual SSDI program expenditures increased by about $500 per beneficiary. • **Processing problems for offset usage:** Problems processing benefit adjustment may have adversely influenced subjects' perceptions of the pilot.
Mental Health Treatment Study (MHTS)	• **Employment and earnings:** Increased the percentage of beneficiaries with positive earnings, but did not increase the proportion of workers earning more than the SGA amount. • **Health effects:** Treatment group members reported improved physical and mental health. • **Role of comorbidities:** Findings suggest that many beneficiaries with psychiatric disorders also have other comorbidities that further complicate their ability to return to work.
Youth Transition Demonstration (YTD)	• **Impact findings for three sites:** Findings indicate one-year impacts on employment service use in all sites. However, only one site (in New York City) had one-year impacts on competitive employment; that site also had higher intensity service delivery than the other two sites. • **Final three random assignment sites:** One-year impacts in final three sites will be available in 2012.

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