MEMORANDUM

A FRAMEWORK FOR PREPARING COST ESTIMATES FOR SSDI $1 FOR $2 GRADUAL REDUCTION DEMONSTRATION PROPOSALS

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DECEMBER 14, 2005

The work presented here was performed pursuant to a grant (10-P-98360-5-047) from the U.S. Social Security Administration (SSA) funded as part of the Disability Research Institute. The opinions and conclusions expressed are solely those of the author(s) and should not be construed as representing the opinions or policy of SSA or any agency of the Federal Government.

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INTRODUCTION AND OVERVIEW

Section 302 of the Ticket to Work and Work Incentives Improvement Act (TWWIIA) directs the Commissioner of the Social Security Administration (SSA) to conduct $1 for $2 gradual reduction demonstrations to address the Social Security Disability Insurance (SSDI) "cash cliff" work disincentive. Prior to publishing in the *Federal Register* the parameters of such demonstrations, a cost estimate will be prepared by SSA's Office of the Actuary. On June 13, 1994, a cost estimate was prepared by the Office of the Actuary regarding SSDI $1 for $2 gradual reduction proposals under consideration at that time.

This 1994 SSA Actuarial Report (attached) was used by The Disability Policy Panel of the National Academy of Social Insurance (NASI) in developing it's 1996 report "*Balancing Security and Opportunity: The Challenge of Disability Income Policy."* The 1994 Cost Estimate was also used by the Office of Management and Budget (OMB) and Congressional Budget Office (CBO) in 1999 when Congress was considering making a permanent change to the SSDI program to include a $1 for $2 gradual reduction policy as part of TWWIIA. Note, instead of making a permanent change, Congress directed the Commissioner of SSA to conduct $1 for $2 demonstrations (Section 302 of TWWIIA).

The purpose of this memorandum is to propose assumptions, factors and indicators to use for purposes of preparing a cost estimate for contemporary SDDI $1 for $2 gradual reduction proposals, including demonstration projects to be conducted under Section 302 of TWWIIA. This analysis will include a discussion of whether and how to use the 1994 Actuarial Report (including its underlying data, assumptions and assertions) for purposes of estimating the cost of a SSDI $1 for $2 gradual reduction policy proposal. The following are the key **assumptions** set out in the 1994 SSA Actuarial Report. There would be:

1. A decrease in costs to the SSDI program due to the offset of certain disability benefits that would not be paid because of increased earnings (reduced benefits resulting from increased earnings);

2. An increase in costs due to the inducement of some persons (who currently have significant impairments, but who do not now receive SSDI benefits) to apply for and receive SSDI benefits (induced entry); and

3. An increase in costs due to the continued payment of a portion of certain SSDI benefits that would terminate under present law (reduced exit).

This memo includes five sections. The first section describes the data used by and key assumptions and assertions made by the Office of the Actuary in 1994. The second section describes the changing realities and the limitations of the data. The third section provides data and analysis related to developing projections of the number of SSDI beneficiaries who may increase their work effort and have increased earnings and

reduced benefits under a SSDI $1 for $2 gradual reduction policy (including a discussion of the experience under the SSI and Section 1619 $1 for $2 gradual reduction policy and continued attachment, the experience of SSI/SSDI concurrent beneficiaries, and the experience of participants in the Medicaid Buy-In programs). The fourth section includes detailed comments on and analysis of the Actuary's assumptions and assertions related to induced entry and reduced exit, including a discussion of the impact of policy changes to the SSDI program since 1994 (e.g., increases in SGA, expedited reinstatement, Continuing Disability Reviews (CDRs) related to impact of work). The final section summarizes our conclusions.

SUMMARY OF MAJOR ASSUMPTIONS AND ASSERTIONS INCLUDED IN 1994 ACTUARIAL REPORT

1. The 1994 SSA Actuarial Analysis was based on an SGA of $500.

2. Assertion by the Actuary: The $1 for $2 proposal would eliminate the Trial Work Period (TWP) and Extended Period of Eligibility (EPE).

3. Assertion by the Actuary: The $1 for $2 gradual reduction proposal could be interpreted by the disabled population as a de facto change in the definition of disability under the SSDI program. Such an interpretation could induce significantly disabled workers and others who are not currently on the rolls to apply for SSDI benefits, i.e., “change their behavior.”

4. Assumption by the Actuary: The $1 for $2 gradual reduction proposal would induce additional disabled individuals to apply for and receive SSDI benefits.

5. Assumption by the Actuary: Certain of these new beneficiaries would perceive the need for only a specific absolute level of income and would reduce their work effort in light of the additional benefits they would receive. In other words, people would reduce earnings in light of benefits so a person previously earning $1000 would only earn $500 believing he or she can make up the difference ($500) from benefits.

6. Assumption by the Actuary: The $1 for $2 gradual reduction proposal would induce current beneficiaries to increase their work effort (i.e., no longer park under SGA). Estimate by Actuary: However, the proposal would provide relatively little net inducement for increased work among current beneficiaries in the short range.

7. Assumption by the Actuary: Some beneficiaries who might have worked and left the SSDI rolls would now reduce their work effort to avoid a decrease in their cash benefits (reduced exit).

8. Net cost of proposal:

    - Decrease in costs due to the offset of certain disability benefits that would be paid under current law;
    - An increase in costs due to the continued payment of a portion of certain SSDI benefits that would terminate under present law (reduced exit);
    - An increase in costs due to induced entry.

9. Assumption by the Actuary: 25,000 present SSDI beneficiaries will have reduced benefits.

10. Assumption by the Actuary: 10,000 SGA terminations due to work would not occur.

11. Estimate Regarding Induced Entry: Using 1978 SSA "Survey of Disability and Work" project a total population of 13 million meeting the following criteria: (1) non-beneficiary, (2) aged 18-64, and (3) severely disabled. (4) Total reduced to about 2 million who also are: (5) "insured", (6) have earnings over $500 (SGA), and (7) could meet SSA's definition of disability if they stopped working. Two million reduced to 400,000 who: (8) could satisfy a 5-month waiting period at least once during the 10-year period after the onset of disability and (9) would apply for benefits i.e., 40,000 per year over the 10 year period.

12. Limitations of Data and Effect on Estimates: The Actuary recognized that the data had substantial limitations (validity and reliability) in many respects e.g., self-reported which was supposed to imply that the respondent was unable to work altogether or unable to work regularly. The Actuary further states that the data may underestimate the size of the disabled and working population because people who are working may not consider themselves to be severely disabled. He then asserts that given the uncertainties, the actual effect could be substantially different from the estimates.

13. Expectation: The Actuary recognized that there is considerable uncertainty of how many persons will fit under the criteria in paragraph 11. However, the actuary states that it is "reasonable to expect that a significant number of these persons would apply for and receive benefits" by the end of the fifth year (40,000 x 5= 200,000).

14. Derivation of Assumption: Assumption by the Actuary of induced entry of 200,000 in five years is derived in large part from the fact that this proposal would imply a very significant change in the concept of disability. The Actuary asserted that the proposal would allow individuals who have the ability to do SGA to remain on the rolls once they had qualified for benefits due to medical impairment in combination with a one-time period of earnings inactivity. Once on the rolls, individual could resume earnings.

15. Effect of Proposal on Particular Categories of Workers: The Actuary asserted that certain beneficiaries e.g., disabled workers in seasonal industries such as construction, agriculture, or education could draw full benefits during their off months no matter ho high their yearly earnings might be.

CHANGING REALITIES AND LIMITATIONS OF DATA

A cost estimate prepared in 2005 by an actuary should reflect changing realities and should utilize the best data available, while recognizing the limitations of existing data sources.

First, the 1994 SSA Actuarial Report used an estimate of 13,000,000 persons with significant disabilities as the beginning point for calculating the estimated number of persons that will be induced to enter the SSDI program as a result of the $1 for $2 gradual reduction proposal. This estimate was based on a 1978 Survey. Any new actuarial analysis should use more current surveys to calculate an estimate in 2005.

Second, the 1994 SSA Actuarial Report used an SGA of $500 as one of the assumptions for estimating the number of persons that will be induced to enter the SSDI program. Obviously, the current SGA ($830 for 2005) should be used.

Third, given the limitations of the data identified by the SSA Actuary in the 1994 Report and the fact that these and comparable limitations of data are still in place today, it is reasonable that any cost estimate include a margin of error and an estimated range rather than a single absolute number.

REDUCED BENEFITS RESULTING FROM INCREASED EARNINGS

The 1994 SSA Actuarial Report assumes that only 25,000 beneficiaries will have reduced benefits because of increased work effort and earnings under a gradual reduction policy. The 25,000 number was the equivalent of six-tenths of one percent (.6%) of the 3,962,954 SSDI beneficiaries in December 1994.

Experience under the SSI and Section 1619 programs should be considered in conducting contemporary cost estimates of SSDI $1 for $2 gradual reduction policy proposals. The SSI and Section 1619 work incentive policies include gradual reduction in benefits as earnings increase, continued eligibility after SGA, and continued attachment to SSI after earnings reduce benefits to zero.

We also suggest that contemporary cost estimates of SSDI $1 for $2 gradual reduction policy proposals take into consideration, among other things, the likelihood that as a result of the experience of SSI/SSDI concurrent beneficiaries (a higher percentage of work effort than SSI-only beneficiaries) and the new interventions authorized by TWWIIA (including Medicaid Buy-In programs and Benefits Planning Assistance and Outreach, BPAO programs) a greater number of SSDI beneficiaries will increase their work effort and have increased earnings and reduced benefits or move into nonpayment status than SSI beneficiaries under the SSI and Section 1619 programs.

In sum, the experience under the SSI and Section 1619 programs, in combination with the Medicaid Buy-In data and survey results (see below), can provide valuable insight and data in developing actuarial estimates relating to the possible effect of a SSDI $1 for $2 gradual reduction proposal, including a proposal that incorporates or expands the concepts of continued eligibility and continued attachment.

The SSI experience, in general. Based on the most recent data from SSA (*SSI Disabled Recipients Who Work, 2004* (July 2005), in December 2004, the number and percentage of SSI recipients that work (**all age groups**) is as follows [page 9]:

- 5,850,359 is the number of all SSI recipients.
- 328,204 is the number of SSI recipients that work.
- **5.6** is the percentage of SSI recipients that work.

The number and percentage of SSI recipients that work (**aged 18-64**) is as follows [page 11]:

- 4,017,108 is the number of SSI recipients (aged 18-64).
- 313,005 is the number of SSI recipients (aged 18-64) who work.
- **7.8** is the percentage of SSI recipients (aged 18-64) that work.

The percentage distribution of SSI recipients (all) who work by level of earnings [page 17, 20]**:**

- **40.7%** of all SSI recipients who work earn more than $400 per month.
- **6.7%** of all SSI recipients who work earn between $400-$499.
- **34%** of all SSI recipients who work earn more than $500 per month.
- **20%** of all SSI recipients who work earn between $500-$999.
    - $500-$599 is 6.2%
    - $600-$699 is 5%
    - $700-$799 is 3.5%
    - $800-$899 is 3.2%
    - $900-$999 is 2.1%
- **14%** of all SSI recipients who work earn $1000 or more.

The following chart shows the average earnings of SSI recipients (by age) that work [page 20]:

Age	Number of Beneficiaries in Age Group	Average Earnings	Number of Earners in Age Bracket	Percent of All SSI Earnings
18 – 21	**269,246**	**$439**	**30,392**	**9.3%**
22- 29	**486,771**	**$523**	**75,465**	**23%**
30 – 39	**676,356**	**$504**	**77,329**	**23.6%**
40 – 49	**1,038,253**	**$484**	**72,536**	**22.1%**
50 – 59	**1,065,211**	**$431**	**44,483**	**13.6%**
60 – 64	**481,271**	**$380**	**12,800**	**3.9%**

Using the SSI experience to project <u>minimum</u> numbers of SSDI beneficiaries with increased earnings and reduced benefits under a $1 for $2 gradual reduction policy.

Based on this most recent data from SSA (*SSI Disabled Recipients Who Work, 2004* (July 2005), in December 2004:

- 4,017,108 is the number of SSI recipients (aged 18-64).
- 133,985 SSI beneficiaries had earnings in excess of $400 (which is approximately one-half of SGA).
- 63,516 beneficiaries had earnings in excess of $800 (which is approximately the SGA level).
- 46,334 beneficiaries had earnings in excess of $1,000.

The percentage of SSI beneficiaries (aged 18-64) with earnings in excess of one-half of SGA is **3.33%** of the total number of SSI beneficiaries aged 18-64 (133,985 divided by 4,017,108).

The percentage of SSI beneficiaries (aged 18-64) with earnings in excess of SGA is **1.58%** of all SSI beneficiaries aged 18-64 (63,516 divided by 4,017,108).

From the SSI experience, it is reasonable to assume that at a **minimum** between 1.58% and 3.33% of SSDI beneficiaries would have significant earnings resulting in reduced benefits and significant numbers would be in zero payment status. The total number of SSDI beneficiaries is 7,166,910.[1] This translates into a possible range of between:

- **113,237** SSDI beneficiaries (1.58% x 7,166,910) with earnings in excess of SGA and
- **236,508** SSDI beneficiaries (3.33% x 7,166,910) who would have earnings in excess of one-half of SGA.

Also, based on the SSI experience, a significant number of these beneficiaries would be paid minimal benefits. For example, of SSI recipients who work, 14% earn $1000 or more.

The projected percentage of SSDI beneficiaries with earnings are expected to be substantially greater than the percentage of SSI beneficiaries with earnings.

In general. It is important to understand that in general SSI beneficiaries, who are not currently eligible for SSDI, have very limited or no work experience compared to SSDI disabled workers. This point was made by CBO in costing out a previous SSDI $1 for $2 gradual reduction proposal. As indicated by CBO "the significant earnings histories of the SSDI population may indicate that disabled worker beneficiaries would

[1] Social Security Administration, *Annual Statistical Supplement, 2005* (December 2005), Table 5A.

be more likely than SSI recipients to obtain employment." (CBO Cost Estimate Accompanying H.R. 4680, July 25, 1988).

This reality and the following additional factors suggests that the projected number of SSDI beneficiaries that would have significant earnings and reduced benefits would be substantially greater than the experience of SSI beneficiaries under SSI and Section 1619.

- There are a significantly higher than average percentage of disabled SSI beneficiaries with earnings in some states compared to other states;

- The work effort and earnings of concurrent SSI/SSDI beneficiaries is 1.5 times as high as SSI only beneficiaries; and

- The Disabled Adult Children population that are SSDI-only are like the SSI population with mental disabilities who have higher levels of work activity than the average SSI disabled population.

In addition, significant potential for increased work activity and earnings by SSDI beneficiaries participating in SSDI $1 for $2 gradual reduction demonstrations is indicated by the experience of individuals participating in Medicaid Buy-In programs and BPAO programs.

Variation among states in work effort and earnings under SSI. An analysis of detailed state-by-state data on the number and level of earnings by SSI beneficiaries shows a wide variation among the states and the potential for major expansion of work activities based on the relatively high percent with earnings in a few states. This has significant implications in making projections of the potential number of SSDI beneficiaries who could have significant earnings under a SSDI $1 for $2 gradual reduction policy.

The Table in Appendix 1 provides data from several states regarding the percent and number of SSI beneficiaries ages 18 – 64 with earnings and detailed data on the percent and number with earnings between $400 - $800 a month and for those with earnings over $800. While nationally only 7.8 percent of the SSI beneficiaries ages 18 – 64 have earnings, in three states, for example (North Dakota, Minnesota and Iowa) the percentage with earnings exceeds 20 percent. In contrast, in several states the percent with earnings is less than six percent (Florida, Texas, and Tennessee).

Some, but a relatively small percent, of the difference among the states can be attributed to the age of the SSI beneficiaries with national data showing that younger SSI beneficiaries are more likely to have earnings. For example, in Florida 38.6 percent of the disabled ages 18 – 64 are over the age of 50 compared to a younger population in Minnesota where 32.4 percent are over the age of 50. However, this is a difference of only 4.2 percent whereas the difference in the percent of SSI beneficiaries working is nearly 15 percent.

In looking at other possible reasons for the difference in the level of earnings, data was developed which looked at specific groups within the SSI population ages 18–64 based on their disability diagnosis. The Table in Appendix 2 shows the percentage of SSI beneficiaries with mental retardation or mental illnesses compared to the percent with earnings. The variation of the percent of beneficiaries with earnings generally follows the same pattern in comparisons among the states as the percent with earnings of all SSI beneficiaries ages 18-64.

It should be noted that there are exceptions to the "ranking" of the states in terms of the percent of SSI beneficiaries with earnings. For example, in Vermont the percent of SSI beneficiaries with earnings with a diagnosis of mental illness is higher than any state. As part of the State Partnership Initiative (SPI) project and continuing now, an intensive effort was and is being made to provide benefits counseling and employment related services in a joint effort between the state Vocational Rehabilitation agency and the community mental health centers and other employment service providers in the state.

It is not known for certain the reasons for the variations among the states in the percent of SSI beneficiaries with earnings. The list of tangible and intangible variables set out in our paper entitled "*Gradual Reduction Choice Option and Related Policy Proposals*" (December 2005) may provide some insight. Among the tangible variables we identified are the variations among the states in the availability and use of comprehensive employment related services and ongoing support services. In addition, the intangible variables related to the level of encouragement and attitudes toward employment by both public and private service providers in combination with the level of encouragement and value placed by families and friends (which make up an individual with a disability informal support system) may prove to be key factors.

Work effort and earnings of concurrent beneficiaries in comparison to SSI only beneficiaries. There are 1,243,356 beneficiaries (aged 18-64) that receive benefits under both the SSI and SSDI programs.[2] These individuals are referred to as concurrent beneficiaries. At least 75% of these concurrent beneficiaries have sufficient work history to qualify them for SSDI benefits; the remaining estimated one-quarter are eligible because they are disabled adult children (DACs) of retired disabled or deceased workers or spouses of deceased workers. According to SSA, there are approximately 313,000 SSI beneficiaries (aged 18-64) with earnings. Of this number, 143,214 also receive SSDI benefits (concurrent beneficiaries).[3] The 143,214 concurrent beneficiaries with earnings is 11.5 percent of the 1,243,356 SSI/SSDI concurrent beneficiaries in comparison to 7.8% of SSI beneficiaries (aged 18-64) that work. In other words, the percentage of concurrent beneficiaries with earnings is approximately 1.5 times the percentage of all SSI beneficiaries that work (11.5% divided by 7.8% equals 1.5).

[2] See *SSI Annual Statistical Report 2004,* Table 7. This report can be found at http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2004/sect04.html.

[3] It should be noted that this number includes a de minimis number of beneficiaries over the age of 64.

Many of these concurrent beneficiaries are more like SSDI-only beneficiaries because they have a work history. It is reasonable to assume that if a SSDI $1 for $2 gradual reduction policy were to be adopted, the percentage working of the concurrent beneficiaries under the SSI work incentives would be more appropriate to use than the percentage of all SSI beneficiaries working. Thus, the projected percent and number of SSDI beneficiaries likely to increase their earnings, thereby reducing their benefits would be as follows:

- The lower range percent would increase from 1.58% to **2.37%** (1.58% x 1.5 = 2.37%). The lower range number of SSDI beneficiaries would increase from 113,237 to **169,856** SSDI beneficiaries (2.37% x 7,166,910 = 169,856 OR 113,237 X 1.5 = 169,856).
- The upper range percent would increase from 3.33% to **4.95%** (3.33% X 1.5 = 4.95%). The upper range number of SSDI beneficiaries would increase from 236,508 to **354,762** SSDI beneficiaries (4.95% x 7,166,910 = 354,762 OR 236,508 x 1.5 = 354,762).

It should be noted that there is wide variation among the states regarding the percentage of concurrent beneficiaries with earnings. (See Table in Appendix 3). The implication from this table is that there is a significant potential for average and below average states to increase the number and percentage of beneficiaries who work and have significant earnings and thus experience reductions in benefits.

For example, if the Nation were able to duplicate Minnesota's experience (36.7% of concurrent beneficiaries have earnings in contrast to the national average of 7.8%), the range of SSDI beneficiaries that would have reduced benefits because of earnings would be **341,862** (4.77% x 7,166,910) to **913,781** (12.75% x 7,166,910).These calculations are based on the following assumptions. Assuming the same distribution of earnings levels for concurrent beneficiaries as for all SSI beneficiaries, 4.77% (36.7% divided by 7.8% equals 4.77%) of concurrent beneficiaries (instead of 1.58%) would have earnings above $800 (1.7 times the national average) and 12.75% of concurrent beneficiaries (instead of 3.33%) would have earnings above $400 (3.8 times the national average).

Work Effort of Disabled Adult Children. Title II of the Social Security Act, in addition to covering disabled workers, also provides benefits for disabled adult children of retired, deceased, or disabled workers who are eligible to receive Social Security benefits if the child has a permanent disability originating before the age of 22. A high percentage of these disabled adult children have mental retardation as their primary disability category. Such disabled adult children of retired or disabled workers receive 50% of the amount of benefits that their parent receives. Such children of deceased workers receive 70% of the amount of benefits that their parent would have received. In December 2003, 682,216 disabled adult children (aged 18-64) received benefits under this program.[4] Their average monthly benefit was $567. In December 2003, the federal

[4] Social Security Administration. *Annual Statistical Report on the Social Security Disability Insurance Program, 2003,* Table 58.

SSI benefit standard was $552. Therefore, over one-half of the disabled adult children have benefits less than the SSI benefit standard. Based on their benefit levels, about half of such disabled adult children are potentially concurrently eligible for SSI. However, it cannot be expected that all of those with SSDI benefits as a disabled adult child with benefits less than the Federal SSI standard would be eligible for SSI. The reason is that some disabled adult children have assets in excess of the SSI asset limitations and some live with families and the applicable benefit standard is reduced by one-third.[5] SSA data indicates that 407,985 were SSDI only and 274,231 were concurrently eligible for SSI and SSDI.[6]

As we explained in the previous section, even though as a general proposition, the SSI population is less likely to work than the SSDI population, there is a subgroup of SSI beneficiaries in which a high percentage work. This subgroup is made up of individuals who are SSI/SSDI concurrent beneficiaries, many of whom have mental retardation as their primary disability category. Similarly, there is a subgroup of the SSDI-only population in which a higher than average percentage could potentially work. This group consists of disabled adult children (334,015 or 44.4% of the 752,813 (of all ages) in December 2003 were mentally retarded)[7], especially those who are children of deceased workers who receive the higher benefit percentage. We believe that twice the percentage of disabled adult children (15%) will have earnings compared to the general population of SSDI beneficiaries (7.8%). Thus, the overall projections should be increased to reflect this reality.

Medicaid Buy-In and BPAO programs. When Congress enacted TWWIIA, it assumed that the Ticket to Work and Self-Sufficiency Program[8], the Medicaid Buy-In program, and Benefits Planning Assistance and Outreach (BPAO) program would serve as complementary work incentives to the SSDI $1 for $2 demonstration authority. The experience under the Medicaid Buy-In program, BPAO program, and SSA's State Partnership Initiatives (SPI) can be used as indicators, in combination with other data and survey results, to make a range of estimates of beneficiaries likely to attempt to work and to increase their earnings, thereby reducing their dependency on cash benefits. It is assumed that any SSDI $1 for $2 gradual reduction demonstration project would have integral to its implementation a comprehensive infrastructure of tangible services and ongoing support services but also the presence of intangible encouragement and support exhibited by providers and the informal support system.

[5] SSI law and regulations provide that if an individual is living in the household of another and receiving support and maintenance in kind (i.e. not contributing a pro rata share to household expenses) that such in kind assistance is presumed to be equal to one-third of the Federal SSI benefit standard.
[6] Social Security Administration. *Annual Statistical Report on the Social Security Disability Insurance Program, 2003,* Table 58.
[7] Social Security Administration. *Annual Statistical Report on the Social Security Disability Insurance Program, 2003*, Table 6.
[8] As of December 2005, The Ticket to Work and Self-Sufficiency Program has played a limited role in reducing benefits paid to SSDI beneficiaries. Current proposals by SSA to change the reimbursement payment system, in conjunction with changes to the SSDI cash cliff, may transform this program into a significant component of a national work incentive policy.

Medicaid Buy-In programs as complementary work incentives. The current Medicaid Buy-in program (not in effect in 1994 but in effect today in 31 states) has increased the numbers of SSDI beneficiaries that work and have increased earnings (75% of Buy-In participants are SSDI beneficiaries). It can be assumed that the Medicaid Buy-In program as a complementary work incentive to the SSDI $1 for $2 gradual reduction proposal will have the effect of increasing the number of persons that will have reduced benefits due to earnings.

There has been a gradual but significant increase in enrollment in Medicaid Buy-In programs. The first Medicaid Buy-In program began in 1999. By December 2002 there were approximately 37,000 individuals enrolled in Medicaid Buy-In programs. By June 2005 that number had increased to 72,032. For example, in Iowa, the program began in June 2000. By June 2001 Iowa had an enrollment of 2105 participants and by June 2005 had an enrollment of 8,610. In Connecticut, in June 2001 there were 919 participants and by June 30, 2005, there were 3,711 participants. This enrollment increase may be viewed as an indicia of increased interest by SSDI beneficiaries (the primary participants in the Buy-In programs) in working when certain barriers to work (e.g., concern about loss of health care) are addressed, notwithstanding the continued existence of other barriers to work (e.g., the SSDI "cash cliff"). [See the Table in Appendix 4 of state examples of recent increases in enrollments]

In a survey of Vermont Medicaid Buy-In participants, 80% indicated that the Medicaid Buy-in program was very important in enabling them to keep working. In Kansas, 61% of survey respondents indicated that their level of independence has increased since enrolling and 58% said their mental health had improved since enrolling. In Minnesota, 72% of participants said that they would not be able to work without the Medicaid Buy-In program. Ninety-two percent (92%) of participants in the Medicaid Buy-In program reported that working because of the Medicaid Buy-In program improved their quality of life.

Impact of Medicaid Buy-In programs on work effort, earnings, and disposable income. There is anecdotal information that some persons in the Medicaid Buy-In program who were on SSDI and who have chosen to work sufficient amount that they have become ineligible for SSDI because of earnings (and are possibly in their EPE) but remain in the Medicaid Buy-In program. Similarly, the impact of the Medicaid Buy-In program has also removed a work disincentive by providing for a premium to be paid instead of a major spend-down of earnings under the Medicaid medically needy program.[9] The effect has been

[9] States have the option to provide Medicaid eligibility for individuals with significant disabilities who have income too high to be eligible for SSI but low enough, after paying some of their health care bills, to meet an income standard under the state's medically needy category of eligibility for Medicaid. The income standard is generally called the "protected income level" (PIL). In many states the protected income level is less than the Federal SSI standard. According to Mathematica researchers in a recent study "Explaining Enrollment Trends at Participant Characteristics of the Medicaid Buy-In Program, 2002-2003 (January 14, 2005), 73% of those participants new to the Buy-in program in calendar year 2003 had previously been enrolled in Medicaid (page 34). In 2003 the medically-needy or spend-down categories

that a significant number of SSDI beneficiaries have increased their earnings and have more disposable income.

According to Mathematica researchers in a recent study "Explaining Enrollment Trends at Participant Characteristics of the Medicaid Buy-In Program, 2002-2003 (January 14, 2005) of those Medicaid Buy-In participants who are working and contributed to the unemployment insurance system (UI), approximately 29% had earnings in 2003 in excess of $800 and 21% had in excess of $1,000 (page 54). According to a recent Kansas survey of Medicaid Buy-In participants, 59% indicated that their financial status had improved." In Iowa, a recent survey of Medicaid Buy-In participants found that 40 percent of the participants indicated that they would like to increase the amount they are working over the next 12 months. In Wisconsin, one-third of the participants reported that they wanted to work more hours.

At the same time, it is important to note that the data from four state surveys of participants in Medicaid Buy-In programs indicate that from 25 to nearly 40 percent of the participants in the Buy-In programs were adjusting their work activities to protect themselves against loss of SSDI benefits because of exceeding SGA. In a random sample survey of the Medicaid Buy-In participants in Iowa, 62 percent stated that they were limiting their work activity for various reasons. The primary reason for limiting their work activity was the severity of their physical or mental disabilities. However, 53 percent of those limiting their work effort stated that they were doing so because of concern about jeopardizing their social security benefits. In a random sample survey of Medicaid Buy-In participants in Kansas, 23 percent turned down an increase in hours of work because it might risk their SSDI; 7.5 percent turned down a job because it might affect their SSDI; and 9 percent turned down a raise to prevent risking their SSDI. A Utah survey of Medicaid Buy-In participants indicated that of those continuously enrolled in the Buy-In program, 29.6 percent were worried about losing their SSDI benefits.

Impact of BPAO programs. Preliminary evaluations of BPAO programs indicate, among other things, that increased knowledge of work incentive options has resulted in more persons with significant disabilities participating in the Medicaid Buy-In program and significant increases in their earnings levels.

Data for the Minnesota State Partnership Initiative Benefits Planning program indicates that of those they provided assistance to and tracked in a research program, after 6 months there was a 47 percent increase in earnings and a 25 percent increase in hours worked. Further, 20 percent were working after a 12 month period at a level over SGA and 27 percent were working between the Trial Work Period Level and SGA.

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were the most common categories of Medicaid coverage prior to enrollment in the Buy-In program in 9 states (page 38).

The main finding of an analysis of the Vermont BPAO project was that significant increases in mean earnings for SSDI beneficiaries are associated with the receipt of benefits counseling services, even after controlling for pre-existing earnings advantages, and even after controlling for key demographic predictors of earnings such as age, sex, disability type, and Social Security beneficiary type. The significance of this finding is that benefits counseling as an employment intervention adds value in terms of earnings outcomes for participants, above and beyond whatever increments might be attributed to services from Vocational Rehabilitation and/or the local Community Mental Health Agency. In other words, the earnings increased with time and with longer exposure to vocational services, but benefits counseling enrollees achieved a greater increase in earnings in relation to the new intervention.

Importance of well-established infrastructures. A key finding from data from Medicaid Buy-In states is that the existence of a well-established infrastructure (i.e., intensive training of eligibility workers, educational and outreach efforts to the general population of beneficiaries, combined with one-on-one benefits planning in conjunction with a Medicaid Buy-In program) can result in a significant percentage of SDDI beneficiaries having earnings above one-half of SGA. For example, such an infrastructure is in place in Minnesota where nearly 5.2 percent of all SSDI beneficiaries in the state above the SSI standard have earnings in a particular month in excess of one-half of SGA. This percentage is 50% higher than the percentage we identified using the SSI and Section 1619 experience (3.33%). This finding is particularly compelling in light of the fact that these beneficiaries were faced with the SSDI cash cliff.

INDUCED ENTRY AND REDUCED EXIT

The SSA Office of the Actuary based its cost estimate of the 1994 $1 for $2 SSDI gradual reduction proposal in part on the following premise--the $1 for $2 proposal "could be interpreted by the disabled population as a de facto change in the definition of disability under the SSDI program." Based on this premise, he then asserts that "such an interpretation could induce persons who currently have significant impairments, but who do not now apply for SSDI benefits, to change their behavior and attempt to collect disability benefits" (induced entry). He also asserts that the behavior of current SSDI beneficiaries will also change i.e., current SSDI beneficiaries who typically would leave the rolls because of earnings will instead remain on the rolls (reduced exit). Based on these assumptions and assertions, the Actuary found that 40,000 persons per year for 10 years would be induced to enter the program and 10,000 beneficiaries would not exit the SSDI program.

It is critical to review the assumptions, assertions and conclusions reached by the actuary in 1994 related to induced entry and reduced exit for purposes of conducting a contemporary actuarial estimate of a SSDI $1 for $2 gradual reduction proposal. Key elements of the review should include current realities and policy changes to the SSDI program since 1994. Any cost estimate of a SSDI $1 for $2 gradual reduction proposal should be viewed in the context of present or current disability policy and only include additional costs resulting from new or additional policy changes. In other words, a contemporary fiscal estimate should discount the fiscal implications of policy changes (administrative and statutory) that have taken place since 1994 and are now part of current law.

Length of the waiting period to qualify for SSDI

An assumption used to estimate the number of persons that will be induced to enter the SSDI program is the number of persons who are willing to forego earnings for five months (waiting period). Based on current information, we believe the actual period is more than five months. According to GAO (GAO-04-656, July 2004), the average amount of time from application to initial determination is 97 days. For those who appealed their denial to an administrative law judge, the time period that they waited for a decision was an additional 344 days. Thus, the actual average time for a determination is between 8 and 20 months.

The SSA Commissioner recently reported the research findings of a Service Delivery Assessment Team regarding the current disability determination process.[10] The team's research revealed that:

[10] Social Security Administration. Preamble to Notice of Proposed Rulemaking regarding Administrative Review Process for Adjudicating Initial Disability Claims 70 *Federal Register* 43590, 43591 (July 27, 2005).

- State Disability Determination Services (DDS) generally made an initial eligibility determination within three and a half months of a claimant's application;
- Forty percent of disability claimants were determined to be eligible for benefits at this initial stage; and
- It took an average of 1153 days to pursue a disability claim through all stages of administrative appeal to obtain a final Agency decision.

Changes to public policy, in general.

The purpose of a fiscal estimate is to calculate the cost implications of changes to public policy. Thus, the policy in existence at the time of the analysis is the base for purposes of conducting the cost analysis (present or current law). It is important to note that the SSDI $1 for $2 gradual reduction proposals (1994 and current) do not in any way change the definition used for determining **initial** disability; rather they modify the criteria for **continuing** disability.

Significant changes have been made to disability employment policy (entitlements and employment services interventions) since 1994. Examples of changes include increases in the SGA and enactment of TWWIIA (which authorized Medicaid Buy-in programs, the expedited reinstatement ("easy back on" policy), exclusion of work activity when conducting CDRs for beneficiaries on the rolls for more than two years, the Ticket to Work program, and Benefits Planning Assistance and Outreach, BPAO).

Changes to substantial gainful activity (SGA)

SGA has increased from $500 in 1994 to $830 in 2005 (plus COLA increases in the future) which is a higher percentage increase than the average SSDI benefit between those years. More specifically, the average benefit for disabled workers in December 1994 was $732 for men and $535 for women. In December 2003, the averages were $965 for men and $734 for women. This was a 32% increase for men and a 27% increase for women. In contrast, the increase in the SGA level was from $500 in 1994 to $810 in 2003, which is an increase of 62%.

This increase in the SGA level may have the effect of reducing induced entry because individuals with earnings less than the higher SGA are already eligible for the SSDI program without having to quit their job. In other words, the increase in SGA could have the effect of reducing the potential number of additional persons who may be "induced" to enter the program because of the SSDI $1 for $2 gradual reduction proposal.

The increase in SGA also could have the effect of reducing the impact of a SSDI $1 for $2 gradual reduction proposal by reducing the number exiting the program due to earnings above SGA. When there is an increase in SGA, SSA data shows that there are fewer people who are in the Section 1619(a) and (b) programs.[11] In other words, a relatively higher SGA level already is having the effect of reducing

[11] Social Security Administration. *SSI Disabled Recipients Who Work, 2004* (July 2005), Table 1.

the number of persons exiting the rolls because they can earn more and remain in the program.

Expedited reinstatement (easy back on) policy and changes to the CDRs related to impact of work

Expedited reinstatement ("easy back on") and the policy that CDRs will not look at work after a beneficiary is on the rolls for more than two years are variations on the work incentive policy of extended period of eligibility (i.e., continued attachment to the program even when earnings are above SGA). These existing continued attachment policies should be taken into consideration by actuaries in current estimates of induced entry and reduced exit compared to 1994.

As explained, above, the 1994 estimate by the actuaries is that 40,000 persons per year would be induced to enter the SSDI program and 10,000 beneficiaries per year would not exit the SSDI program because of the 1994 $1 for $2 gradual reduction proposal compared to the cash cliff. A contemporary cost estimate of a new $1 for $2 proposal should "discount" the cost of existing policy i.e., "easy back on" policy and the new policy of CDRs not looking at employment after 2 years in determining induced entry and reduced exit. In other words, it could be said that existing policy already has a significant impact on a prospective applicant's decision whether to stop working and apply for benefits and a beneficiary's decision not to leave the program. Note: In enacting TWWIIA, CBO "costed" out the fiscal implications of the "easy back on" policy change. This estimate should be reviewed to determine the actual experience compared to the actuary's estimate.

Reduced benefits and health costs for those induced to enter the program.

Whatever the number of persons the Actuary asserts will be induced to enter the program, it is still important to take into consideration the likelihood that a significant number would be at or near nonpayment status for a significant amount of time. By allowing increased hours of work resulting in increased earnings and access to employer-based health insurance, it can be assumed that there will be reduced dependence on Medicare and Medicaid.

De facto change in the definition and the SSI experience.

There is no data to indicate that the presence of the $1 for $2 disregard under the SSI program and the Section 1619 provisions has had the effect of being interpreted by people with disabilities as a de facto change in the definition of disability under the SSI program. There is no reason to assume that the experience under SSDI would be any different than the Section 1619 experience.

Induced entry and the SSI experience.

There is no data to indicate that the existence of the SSI gradual reduction policy or the Section 1619 program has induced entry into the SSI program. There is no reason to assume that the experience under SSDI would be any different than the Section 1619 experience.

Reduced work effort and SSI experience.

There is no indication under the SSI program or the Section 1619 program that certain beneficiaries perceive the need for only a specific absolute level of income and are reducing their work effort in light of the additional benefits they are receiving. There is no reason to assume that the experience under SSDI would be any different than the Section 1619 experience.

SUMMARY OF ANALYSIS AND CONCLUSIONS

The following is a summary of our analysis of the SSA 1994 Cost Estimate (including assumptions and assertions made by the Office of the Actuary) of a gradual reduction policy and our conclusions regarding the assumptions, factors, and indicators that should be taken into account in developing a **contemporary** fiscal impact estimate of a gradual reduction policy.

First, regarding **changing realities and limitations** of the data we suggest that:

- Demographic data from contemporary surveys should replace old demographic data (1978 surveys).
- The updated SGA level should be used ($830 for 2005 up from $500 in 1994).
- The assumption regarding the time period during which a person must quit work and forego earnings and await approval for DI benefits should be modified from 5 months (waiting period from onset of disability) [1994 actuarial report] to between 8 months (5 month waiting period plus 3 months for initial determination) and 1153 days (according to SSA researchers) or according to GAO 20 months (5 month waiting period plus 3 month initial determination plus 12 months after appeal to ALJ).
- Given the limitations of the data from the available surveys it is reasonable to expect that any cost estimate should include a margin of error and an estimated range rather than a single absolute number.

Second, with respect to the assumption that there would be **increased earnings resulting in decreased benefits,** we suggest that:

- Experience under the SSI and Section 1619 programs should be considered in evaluating the fiscal impact of a SSDI $1 for $2 gradual reduction proposal. The SSI and Section 1619 work incentives include gradual reduction in benefits as earnings increase, continued eligibility after SGA, and continued attachment after earnings reduce benefits to zero.
- From the SSI experience, it is reasonable to assume that at a **minimum** (a very conservative estimate in light of other points made in this memo) between 1.58% and 3.33% of SSDI beneficiaries (**113,237 and 236,508**) under the $1 for $2 gradual reduction policy would have significant earnings resulting in reduced benefits and significant numbers would be in zero payment status (compared to the 25,000 assumed in the 1994 Actuarial Estimate).
- The potential to exceed the minimum described in the previous bullet is evident by recognizing the ability of a number of states to have nearly twice the percentage of their SSI beneficiaries working than the national average.
- The potential to exceed the minimum described above is also evident by recognizing that the level of work activity by concurrent SSI/SSDI beneficiaries (1.5 times the level of SSI beneficiaries) is a more accurate indicator of the potential level of work activity by SSDI beneficiaries than work activity by the entire SSI population. Using the experience of SSI/SSDI concurrent

beneficiaries, it is reasonable to assume that between 2.37% and 4.95% of SSDI beneficiaries (**169,856 and 354,762**) under the $1 for $2 gradual reduction policy would have significant earnings resulting in reduced benefits and significant numbers would be in zero payment status (compared to the 25,000 assumed in the 1994 Actuarial Estimate).

- In general, contemporary cost estimates should take into consideration the impact of changes to Medicaid and employment services interventions that are having the effect of increasing beneficiaries' work effort and increasing their earnings.

    - The Medicaid Buy-In program (not in effect in 1994 but now in effect in 31 states) would serve as a complementary work incentive and result in an increase in the number of persons with reduced SSDI benefits due to earnings.
    - Some SSDI beneficiaries who enrolled in the Medicaid Buy-In program have chosen to work sufficient amount to become ineligible for SSDI and this experience should be taken into consideration.
    - Preliminary evaluations of the impact of benefits counseling under SSA's BPAO program indicate that increased knowledge of work incentive options have resulted in more persons with significant disabilities participating in the Medicaid Buy-In program and they have significant increased earnings.
    - It is assumed that integral to any SSDI $1 for $2 gradual reduction demonstration project would be the implementation of a comprehensive infrastructure of tangible services and ongoing support services and the presence of intangible encouragement and support exhibited by providers and the informal support system.

Third, with respect to assumptions regarding **induced entry and reduced exit,** we suggest that:

- The increase in SGA (from $500 in 1994 to $830 in 2005) will have the effect of reducing induced entry because individuals with earnings less than the higher SGA are already eligible for the SSDI program without having to quit their jobs.
- The increase in SGA will also reduce the number exiting the program due to earnings above SGA compared to the SGA level in 1994 because they can earn more and remain in the program.
- Any cost estimate should be viewed in the context of current or present SSDI disability policy (compared to 1994) and thus should discount the fiscal implications of policy changes (administrative and statutory) that have taken place since 1994 such as the increase in the SGA level and policies included in TWWIIA i.e., expedited reinstatement ("easy back on" policy) and exclusion of work experience as part of CDRs for beneficiaries who have been on the rolls for more than 2 years. In other words, these policies should be considered part of the base (present law) for purposes of preparing current estimates of induced entry and reduced exit.

- If some persons with significant disabilities cease working, are induced to apply and become eligible for the SSDI program, and subsequently return to work, many of such persons likely will be at minimal or nonpayment status for a significant amount of time.
- By allowing increased hours of work resulting in increased earnings and access to employer-based health insurance, it can be assumed that there is likely to be reduced dependence on Medicare and Medicaid.
- Estimates and actual experience from the 2000 SGA changes should be taken into consideration.
- There is no indication that the existence of the $1 for $2 provision in SSI and the Section 1619 program has induced entry into the SSI program.
- There is no indication under Section 1619 program that certain beneficiaries perceive the need for only a specific absolute level of income and are reducing their work effort in light of the additional benefits they are receiving.

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APPENDIX 1
Examples of States with Percentages of SSI Beneficiaries with Earnings
Data Source: SSI Work Incentive File and Revised Management Information Counts System (REMICS)

State	Total SSI Disabled 18 - 64	Percent and Number SSI 18 -64 Disabled with Earnings	Percent and Number of SSI Beneficiaries with earnings $400 - $800	Percent and Number of SSI Beneficiaries with earnings above $800
Examples of States with 11% and more of SSI beneficiaries with earnings				
North Dakota	5,135	26.7% 1,373	4.7% 243	3.1% 161
Iowa	28,977	22.8% 6,614	4.4% 1,281	2.6% 747
Minnesota	44,793	21.7% 9,725	4.9% 2,180	2.6% 1,172
Kansas	25,130	16.1% 4,046	3.4% 849	2.5% 619
Wisconsin	58,128	17.6% 10,236	3.5% 2,048	2.4% 1,407
Vermont	8,831	13.6% 1,200	3.7% 330	3.0% 267
Utah	13,999	15.2% 2,140	3.2% 454	2.3% 325
Examples of States with more than 9% and less than 11% of SSI beneficiaries with earnings				
Massachusetts	104,301	9.2% 9,647	2.4% 2,484	2.4% 2,504
New York	334,873	9% 30,195	1.9% 6,292	1.8% 5,861
Maryland	53,781	10.6% 5,694	2.3% 1,211	2.1% 1,126
Oregon	38,446	10.1% 3,885	2.1% 814	1.6% 628

State	Total SSI Disabled 18 - 64	Percent and Number SSI 18 -64 Disabled with Earnings	Percent and Number of SSI Beneficiaries with earnings $400 - $800	Percent and Number of SSI Beneficiaries with earnings above $800
Examples of States with more than 7% and less than 9% of SSI beneficiaries with earnings				
Washington	72,661	7.9% 5,785	1.9% 1,369	2.3% 1,638
California	578,944	7.5% 43,666	1.6% 9,457	1.7% 9,674
Pennsylvania	199,599	7.6% 15,137	1.7% 3,402	1.6% 3,086
North Carolina	110,939	7% 7,772	1.3% 1,474	1.2% 1,344

Examples of States with less than 7% of SSI beneficiaries with earnings				
Michigan	146,604	6.6% 9,647	1.9% 2,851	1.6% 2,381
Florida	197,811	5.8% 11,470	1.4% 2,921	1.5% 2,929
Texas	238,539	5.7% 13,560	1.3% 3,108	1.1% 2,698
Tennessee	101,866	5.1% 5,229	.9% 935	1.% 1,081
Georgia	116,203	6% 7,036	.9% 935	1.1% 1,322
Kentucky	118,946	4% 4,708	.8% 939	.9% 1,002

APPENDIX 2
SSI Beneficiaries with Earnings and
SSI Beneficiaries with Mental Retardation or Mental Illnesses with Earnings

Data Source: SSI Work Incentive File and Revised Management Information Counts System (REMICS)

Examples of States with 11% & more of SSI beneficiaries with earnings

State	Total SSI Disabled 18 - 64	Number and Percent SSI 18 -64 Disabled with Earnings	Number and Percent of SSI with Mental Retardation with Earnings	Number and Percent SSI with Mental Illnesses with Earnings
North Dakota	5,135	26.7% 1,373	44.7% 664	17% 295
Iowa	28,977	6,676 23%	3,145 38.4%	1,609 16%
Minnesota	44,793	21.6% 12,029	43.8% 4,184	12.1% 2,586
Wisconsin	58,128	17.6% 10,236	29.6% 4,058	11.3% 2,555
Kansas	25,130	16.1% 4,046	28.9% 1,996	9.4% 761
Utah	13,999	15.3% 2,142	28% 988	9.1% 475
Vermont	8,831	13.6% 1,200	20.7% 359	16.6% 627

Examples of States with more than 9% and less than 11% of SSI beneficiaries with earnings

State	Total SSI Disabled 18 - 64	Number and Percent SSI 18 -64 Disabled with Earnings	Number and Percent of SSI with Mental Retardation with Earnings	Number and Percent SSI with Mental Illnesses with Earnings
Massachusetts	104,301	9.2% 9,647	22.2% 3,075	6.4% 3,323
New York	334,873	9% 30,195	18.7% 10,944	6.6% 8,066
Maryland	53,781	10.6% 5,694	10.9% 2,526	7.5% 1,245
Oregon	38,446	10.1% 3,885	2.3% 1,613	6% 901

Examples of States with more than 7% and less than 9% of SSI beneficiaries with earnings				
State	**Total SSI Disabled 18 - 64**	**Number and Percent SSI 18 -64 Disabled with Earnings**	**Number and Percent of SSI with Mental Retardation with Earnings**	**Number and Percent SSI with Mental Illnesses with Earnings**
Washington	**72,661**	**7.9% 5,745**	**17.3% 2,129**	**5.4% 31,905**
California	**578,944**	**7.5% 43,666**	**20% 15,876**	**4.4% 10,561**
Pennsylvania	**199,599**	**7.6% 15,137**	**13.3% 6,193**	**5.2% 3,688**
North Carolina	**110,939**	**7% 7,772**	**10.9% 3,637**	**4.4% 1,282**

Examples of States with less than 7% of SSI beneficiaries with earnings				
Michigan	**146,604**	**6.6% 9,647**	**14.7% 5,232**	**6.5% 3,572**
Florida	**197,811**	**5.8% 11,470**	**11.3% 4,203**	**3.8% 2,686**
Texas	**238,539**	**5.7% 13,560**	**11.7% 5,422**	**3.8% 2,579**
Tennessee	**101,866**	**5.1% 5,229**	**7.8% 2,194**	**2.7% 904**
Georgia	**116,203**	**6% 7,036**	**9.9% 3,115**	**3.7% 1106**
Kentucky	**118,946**	**4% 4,708**	**5.4% 1,710**	**2.5% 1,065**

APPENDIX 3

Percent of Concurrently Eligible SSI/Title II Social Security Disabled Beneficiaries with Earnings Compared to All SSI Disabled Beneficiaries with Earnings

Data Sources: SSI Work Incentive File and Revised Management Information Counts System (REMICS)
SSI Disabled Recipients Who Work December 2004, Table 3
SSI Annual Statistical Report 2004, Table 7
December 2004

	Total SSI Disabled 18 - 64	Number and Percent All SSI 18 -64 Disabled with Earnings	Number of SSI Beneficiaries with Title II Social Security Disability Benefits: (Disabled Workers, Disabled Adult Children and Disabled Widows(ers)	Number and Percent of SSI Disabled 18 – 64 with Title II Social Security Benefits with Earnings
National	**4,017,108**	**313,005 7.8%**	**1,243,356**	**143,214 11.5%**
State	**Total SSI Disabled 18 - 64**	**Number and Percent All SSI 18 -64 Disabled with Earnings**	**Number of SSI Beneficiaries with Title II Social Security Disability Benefits: (Disabled Workers, Disabled Adult Children and Disabled Widows(ers)**	**Number and Percent of SSI Disabled 18 – 64 with Title II Social Security Benefits with Earnings**
Examples of States with 11% & more of SSI beneficiaries with earnings				
North Dakota	**5,135**	**1,373 26.7%**	**2,063**	**772 37.5%**
Iowa	**28,977**	**6,676 23%**	**10,517**	**3,291 31.6%**
Minnesota	**44,793**	**12,029 21.6%**	**13,663**	**4,809 36.7%**
Wisconsin	**58,128**	**10,236 17.6%**	**19,718**	**5,194 26.3%**
Kansas	**25,130**	**4,046 16.1%**	**8,710**	**1,889 22.1%**
Utah	**13,999**	**15.3% 2,142**	**4,212**	**914 21.7%**
Vermont	**8,831**	**13.6% 1,200**	**3632**	**632 17.4%**
Examples of States with more than 9% and less than 11% of SSI beneficiaries with earnings				
Massachusetts	**104,301**	**9.2% 9,647**	**32,870**	**4,425 13.6%**
New York	**334,873**	**9% 30,195**	**85,769**	**14,938 17.6%**
Maryland	**53,781**	**10.6% 5,694**	**13,217**	**2,136 16.2%**
Oregon	**38,446**	**10.1% 3,885**	**12,157**	**1,872 15.4%**

State	Total SSI Disabled 18 - 64	Number and Percent All SSI 18 -64 Disabled with Earnings	Number of SSI Beneficiaries with Title II Social Security Disability Benefits: (Disabled Workers, Disabled Adult Children and Disabled Widows(ers)	Number and Percent SSI Disabled with Title II Social Security Benefits with Earnings
Examples of States with more than 7% and less than 9% of SSI beneficiaries with earnings				
Washington	**72,661**	**7.9% 5,745**	**19,148**	**2,181 11.8%**
California	**578,944**	**7.5% 43,666**	**180,433**	**19,779 11.2%**
Pennsylvania	**199,599**	**7.6% 15,137**	**52,123**	**6,186 11.9%**
North Carolina	**110,939**	**7% 7,772**	**38,301**	**3,296 8.6%**

Examples of States with less than 7% of SSI beneficiaries with earnings				
Michigan	**146,604**	**6.6% 9,647**	**41,084**	**6,640 16.7%**
Florida	**197,811**	**5.8% 11,470**	**58,018**	**4,641 8%**
Texas	**238,539**	**5.7% 13,560**	**65,943**	**4,791 7.3%**
Tennessee	**101,866**	**5.1% 5,229**	**31,174**	**2,265 7.3%**
Georgia	**116,203**	**6% 7,036**	**34,395**	**2,976 8.7%**
Kentucky	**118,946**	**4% 4,708**	**32,870**	**2,032 6.2%**

Appendix 4

State Medicaid Buy-In Programs
State Examples of History of Enrollments
December 1999 through June 30, 2005

X = Year Medicaid Buy-In Program Began in State
Data Source: States' Medicaid Infrastructure Grant Reports to CMS

	Enrolled Dec 1999	Enrolled June 2000	Enrolled June 2001	Enrolled June 2002	Enrolled June 30, 2003	Enrolled Dec 31, 2003	Enrolled June 30, 2004	Enrolled June 30, 2005
Connecticut		X			2,663	2,908	3,073	3,711
Indiana				X	4,560	5,186	5,674	5,580
Iowa		X	2105		5,496	6,231	6,941	8,610
Kansas				X	563	672	750	930
Minnesota	X 3674	5173	6473	6048	6,510	6,221	6,209	6,458
New Hampshire				X	1,122	1,237	1,339	1,308
New Jersey			X		665	951	1,186	1,771
Pennsylvania				X	1,761	2,466	3,263	5,693
Vermont		X 160			456	468	508	557
Wisconsin		X			4,655	5,684	6,511	8,602