WORKING HEALTHY
Making health care work

Policy Brief

UNIVERSITY OF KANSAS MEDICAID INFRASTRUCTURE CHANGE EVALUATION PROJECT

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WORKING HEALTHY: GETTING THE JOB DONE

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> *"The reality facing many persons with significant disabilities is that too often they are unable to obtain health insurance in the private sector that provides coverage of the services and supports that enable them to live independently and enter, remain in, or rejoin the workforce. Thus, there is a need to supplement private insurance or rely on Medicaid for necessary services and supports."*
> *- Jensen, Silverstein, Folkemer & Straw (2002)*

When the Ticket to Work/Work Incentives Improvement Act (TW-WIIA) was passed in 1999, Congress acknowledged that the potential loss of Medicaid and/or Medicare coverage for people with disabilities who attained or increased employment was a serious disincentive to their meaningful participation in work. Medicaid Buy-In programs were offered as an option to states to extend Medicaid coverage to people with disabilities who wanted to work. Evaluation activities of the Kansas Medicaid Buy-In, Working Healthy, have demonstrated that Medicaid remains a critical element in the ability of Kansans with disabilities to work.

Satisfaction surveys sent to Working Healthy participants in June 2003 indicate that only 9% were offered health insurance through their employers in the last year and only 6% actually had any health insurance coverage through their employers (n = 182). For survey participants for whom we have information about their job types (n = 67), we know that about two-thirds have jobs within the service or maintenance sector and an additional 15% have secretarial or clerical jobs. The great majority (84%) of participants work 29 hours per week or less, and more than half work 19 hours per week or less.

> Nationally, only about 25% of companies with less than 1,000 employees offer any type of health insurance coverage to their part-time employees.
> - Gabel, Rickreign, Whitmore & Schoen (2001)

These statistics are remarkable because they underscore the critical gap in insurance coverage that Working Healthy fills for people with disabilities who want to work. Nationally, only about 25% of companies with less than 1000 employees offer any type of health insurance coverage to their part-time employees (Gabel, Pickreign, Whitmore & Schoen, 2001). Moreover, other research demonstrates that less

than half as many low-paid workers ($7 per hour or less) have employer-sponsored health care as higher-paid workers ($15 per hour or more; Kaiser Family Foundation, 1999). In contrast to the general public, one hundred percent of enrollees in Working Healthy have access to health insurance through Medicaid.

The Medicaid coverage provided by Working Healthy is generally much appreciated by participants; 83% of respondents agreed or strongly agreed with the statement "I am able to get the medical services I need through Working Healthy." Twenty-two percent of respondents stated that they were *better* able to get the medical services they needed since enrolling in Working Healthy.

A final illustration of the impact of Working Healthy participation is the contrast of employment rates for enrollees versus non-enrollees. Forty-seven percent of the control group of people who had earned income in June 2002 but never enrolled in Working Healthy are no longer employed. In comparison, the great majority (> 90%) of people who have ever been enrolled in Working Healthy are still employed.

Respondents to the Satisfaction Survey did indicate that their Medicaid coverage through Working Healthy still has some weaknesses compared to many private employer-based plans. For example, 15% of respondents reported that they had difficulty finding doctors, therapists or pharmacies who accept Medicaid. Others pointed out that they are unable to purchase coverage for their spouses, as many employer-based plans allow, and that coverage for most dental and optical services is not available.

Overall, though, Working Healthy is getting the job done. It is empowering Kansans with disabilities to work without the fear of losing a vital source of health insurance and moving them toward the goal of self-sufficiency.

WHY DO PEOPLE LEAVE WORKING HEALTHY?

KU staff mailed surveys in June and September 2003 to 100 people who had dis-enrolled from Working Healthy to learn about their experiences with the program and their reasons for leaving it. Thirty people returned surveys. No racial, disability or age group was over-represented among the sample of dis-enrollees as compared to enrollees in Working Healthy.

Spenddown

Prior to the availability of Working Healthy, many people with disabilities had to incur substantial medical expenses before qualifying for Medicaid coverage. This requirement is called a "spenddown," and had been a disincentive to working because additional earnings generally had to be applied to the spenddown amount.

About two-thirds (62.1%) of dis-enrollees had spenddown obligations before enrolling in Working Healthy, but only 44% of them had spenddowns after leaving it, probably due to a decrease in their earned income. Even though people with prior spenddown obligations often had to pay a premium for Working Healthy, the premium was typically much less than

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their spenddown obligation had been, giving them more disposable income for other living expenses.

Premiums

Forty-seven percent of dis-enrollees had paid a premium for their Working Healthy coverage, with an average monthly premium amount of $73.00. Fifty percent of respondents said they thought the premium they paid was about the right amount and 43% thought it was too much. In comparison, about three-fourths of respondents to the Satisfaction Survey—people who are still enrolled in Working Healthy—agreed or strongly agreed that the monthly premium they pay is reasonable. Sixty-one percent of these enrollees pay a premium, with an average of $69.00 per month.

Work and Insurance Status

Forty percent of respondents are no longer working and are therefore not eligible for Working Healthy. Of note is the fact that only 12.5% of respondents indicated they had stopped working because their disabilities had gotten worse. About 40% of dis-enrollees have access to insurance other than Medicaid, primarily through Medicare.

Other Findings

One person who dis-enrolled was working for a parent and did not pay FICA taxes, an eligibility requirement. Another dis-enrolled because he or she quit work to go back to school. Other reasons cited for dis-enrollment included spousal benefits issues and frustration with required paperwork. No single programmatic feature or system shortcoming was consistently identified as a reason for leaving the program. KU staff will continue to survey dis-enrollees to discern whether certain groups become more likely to leave the program or if particular reasons for leaving become more prevalent. Currently, however, it seems that the loss of a job—whether by choice, circumstances, or disability—is the single most common reason for leaving the program.

Overall, the dis-enrollment rate for Working Healthy through September 2003 is 14%. Data regarding dis-enrollment from other states' buy-in programs are limited, but Wisconsin reports a dis-enrollment rate of about 20% (Innovative Resource Group, 2002) and approximately 40% of enrollees in Maine's Buy-In have left the program (Salley & Glantz, 2002). In these states, high premiums, restrictive asset limits, and paperwork difficulties were frequently cited by participants as reasons for dis-enrolling.

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