WORKING HEALTHY
Making health care work

Policy Brief

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EARLY ENROLLMENT IN WORKING HEALTHY: PROGRAM FEATURES MAKE A DIFFERENCE

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Working Healthy allows persons with disabilities the opportunity to increase their earnings and assets without jeopardizing their Medicaid health insurance coverage. Working Healthy has been in operation in Kansas for almost a year now. In that time, enrollment has steadily increased and premium payers continue to constitute more than half of all enrollees. The initial accomplishments of Working Healthy are especially gratifying in the current depressed economic setting. Through their enrollment, many people with disabilities are now working more, paying taxes, and putting money into the state's economy by virtue of having additional disposable income—all without fear of losing their health insurance coverage.

Despite these successes, however, Working Healthy also has a few areas of concern in its early stages. One of the most notable findings in reviewing early enrollment patterns is that people with mental illness are disproportionately over-represented relative to the entire population of people with disabilities who are eligible for Working Healthy. This situation is not unique to Kansas. Hanes, Edlund and Maher (2002) of the Oregon Health Policy Institute (OHPI) conducted an extensive study of work incentives for persons with disabilities in Oregon, Vermont, and Wisconsin. All three of these states have Medicaid buy-in programs. The study specifically targeted buy-in participants in Oregon and those making use of other broader work incentives, including Medicaid buy-ins, in Wisconsin and Vermont. The OHPI researchers found significant differences in enrollment trends by different disability groups in different states: in Oregon and Wisconsin, people with physical disabilities were over-represented while in Vermont, people with severe and

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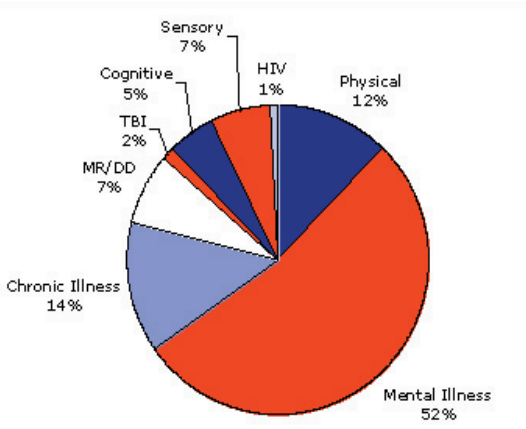
>
> - Hanes, Edlund & Maher (2002)

persistent mental illness were over-represented. As the authors noted, "Whether the targeting strategy was implicit or explicit, it appears that program design, outreach, and recruitment have resulted in programs in each state that disproportionately reached one disability group over others" (p. 12).

Disability Types of Working Healthy Enrollees*



*n=128; Enrollment status as of November 2002

Source: KU 2002 Baseline Survey of WH Eligibles Identified by Kansas SRS

In Kansas, the over-representation of people with mental illness can likely be traced to how the benefits structure for Working Healthy is designed. Currently, Working Healthy does not have personal care services available to program participants. Because many people with physical disabilities, chronic illnesses, mental retardation / developmental disabilities (MR/DD), and head injuries rely on personal care attendants to support their daily activities, persons with these characteristics may be discouraged from participating in Working Healthy. Kansas SRS is currently working to secure an Independence Plus waiver to begin Personal Care Services to Support Employment (PCSE) for enrollees in Working Healthy.

EXPERIENCES IN WORKING HEALTHY: DISABILITIES MAKE A DIFFERENCE

Enrollees with mental illness have different experiences than enrollees with other disabilities in Working Healthy. University of Kansas (KU) research and management support staff sent baseline surveys to people eligible for Working Healthy in June 2002 and repeated the surveys in January 2003. The surveys asked respondents to rate themselves across four personal domains: self-esteem, quality of life, work attitudes, and health status.

Findings from these surveys demonstrate that enrollees with mental illness experienced improvements in all four of these domains over time, with significant increases in their scores for quality of life and health status. In contrast, people with other disabilities, including physical, chronic illness, MR/DD, head injury, cognitive, sensory and HIV, did not experience consistent improvements in the domain measures, showing no increases that were statistically significant (see Table 1).

Table 1.
Comparison of Changes in Domain Scores for Enrollees with Mental Illness versus Enrollees with Other Disabilities based on Survey Responses

	Mental Illness (N=40)				Other Disabilities (N=35)		
Domain Area	June 2002	January 2003	*p*		June 2002	January 2003	*p*
Self-Esteem	3.4143	3.5179	ns		3.5388	3.3912	ns
Quality of Life	3.2071	3.4679	<.01		3.2694	3.3593	ns
Work Attitudes	3.3357	3.4036	ns		3.2408	3.2136	ns
Health Status	3.2506	3.5036	<.01		3.2061	3.3952	ns

Note: The "other" disabilities category includes physical, chronic illness, MR/DD, head injury, cognitive, sensory, and HIV. Values for each domain are measured on a scale of 1 to 5, with higher scores representing more positive responses.
*Statistical significance tested using paired sample t-tests. NS = not statistically significant

KU staff members also mailed a Working Healthy Satisfaction Survey to program enrollees in January of this year. People with mental illness showed a somewhat higher level of overall satisfaction with the Working Healthy program compared to enrollees with

other disabilities (Table 2). Although monthly premium levels were similar for people with mental illness (mean = $38.67) and enrollees with other disabilities (mean = $33.19), people with mental illness were more likely to feel the amount paid was reasonable (Table 2).

Table 2.
Comparison of Satisfaction Survey Mean Scores for Enrollees with Mental Illness versus Enrollees with Other Disabilities

Survey Items	Mental Illness		Other Disabilities	
	N	Mean	N	Mean
Satisfaction with the Program	40	3.72	34	3.44
Premium Amount is Reasonable[a]	29	3.97*	21	3.33*

Note: Scores are on a scale of 1 to 5, with higher scores representing more positive responses.
[a] Not all respondents pay a premium.
*$p < .05$ using ANOVA

IRONING OUT THE DIFFERENCES

Though the program is still in its infancy, these preliminary findings indicate that Working Healthy is more attractive to people with mental illness. This population is over-represented among enrollees, is more likely to report improvements in quality of life and health status subsequent to enrollment, and is more satisfied with the program and the premiums. At present, Working Healthy is generally more responsive to the needs of people with mental illness because it covers prescription drugs and both inpatient and outpatient mental health services.

Many people who are currently eligible for Working Healthy—i.e., have earnings and qualify for Medicaid—are people with disabilities other than mental illness who participate in one of the state's Home and Community Based Services waivers. These waivers include coverage for personal attendant services that Working Healthy currently does not. Future changes in the availability of attendant services through Working Healthy may increase the enrollment of people with other disabilities and also increase their satisfaction and personal levels of self-esteem, quality of life, and health status.

People with mental illness showed a somewhat higher level of overall satisfaction with the Working Healthy Program compared to enrollees with other disabilities.

In the mean time, evaluating the success of Working Healthy remains an ongoing challenge due to the confounding nature of selection bias with regard to disability type. Because people with mental illness are over-represented and also are more satisfied, the overall satisfaction measures are high. Similarly, longitudinal changes in factors such as earnings, health status, and health care costs and utilization are also influenced by disability type. Until enrollment in Working Healthy more closely reflects the make-up of the entire eligible population, the true effectiveness of this effort to extend work opportunities while maintaining insurance coverage for Kansans with disabilities will be difficult to gauge.

Although enrollment has steadily increased and now exceeds 500 people, trend analysis reveals that approximately 90 people have also dis-enrolled from Working Healthy since its inception. Some reasons for disenrollment include job loss, inability to pay premiums, health problems and attainmentof employer-based health insurance. Efforts will be made to contact these individuals, via phone and survey, which may reveal other participant characteristics that are associated with levels of program satisfaction or the decision to dis-enroll.

REFERENCE

Hanes, P., Edlund, C., & Maher, A. (2002). Three-state work incentives initiative: Oregon, Vermont, and Wisconsin. Portland, OR: Oregon Health Policy Institute.

WORKING HEALTHY

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