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The Demonstration to Maintain Independence and Employment: Implications for National Health Care Reform

By Noelle Denny-Brown, Boyd Gilman, Gilbert Gimm, Henry Ireys, and Sarah Croake

Individuals with potentially disabling conditions have distinct health care needs, which if left unmet, can lead to the onset of a disability and enrollment in a federal disability benefit program. The Demonstration to Maintain Independence and Employment (DMIE), a grant program administered by the Centers for Medicare & Medicaid Services (CMS) and authorized under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), awards funds to states to develop, implement, and evaluate interventions for workers with potentially disabling conditions. For instance, states may provide Medicaid-equivalent coverage or "wrap-around" coverage to supplement an individual's existing health insurance. They may also offer employment-support and case-management services that increase the likelihood of sustained employment and reduced use of federal disability benefits. Four states received DMIE funding under the 2004 and 2006 solicitations—Hawaii, Kansas, Minnesota, and Texas. Federal funding for DMIE services expired on September 30, 2009.

This issue brief, the tenth in a series on workers with disabilities, describes the four DMIE interventions and discusses what they might tell us about designing policy initiatives for workers with potentially disabling conditions in the context of national health care reform.

What Was the Impetus for the DMIE?

The DMIE arose out of congressional interest in providing medical services and employment supports to working adults with potentially disabling conditions to improve their health, prolong their employment, and promote independence from federal disability benefit programs.[1] Many working-age people with potentially disabling conditions face major barriers to obtaining adequate medical care, such as coverage restrictions for pre-existing conditions, navigating through many different clinics and agencies, or finding appropriate health care providers. They also encounter financial barriers such as high health insurance premiums and steep out-of-pocket costs, which can cause them to delay or forgo needed medical services (Drainoni et al. 2006). As a result, their health condition may deteriorate, which can lead to loss of employment and entrance onto the federal disability rolls.

If the DMIE—or an ongoing program like it—could help workers with potentially disabling conditions maintain their health, stay employed, and prevent or

[1]Potentially disabling conditions include diabetes, severe mental illness, cardiovascular conditions, and physical impairments that require ongoing medical care and have the potential for deteriorating to the point where consistent employment is impossible.

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delay their impairment from becoming a disability, then workers could remain productive and independent. Such an "early intervention" effort could also save federal dollars that would otherwise have been spent on disability benefits or high-cost medical services. As national health care reform proposals continue to evolve, the DMIE could inform future policies and programs that address the needs of underinsured workers with potentially disabling conditions.

What Services Did the DMIE Offer and to Whom?

Working adults with chronic, potentially disabling conditions need more comprehensive health care services and work supports than do other adults. Compared with the general population, persons with disabilities tend to be in poorer health, are more likely to have a lower household income, and are less likely to work. In fact, the employment rate among non-institutionalized working-age persons with a disability is 36.9 percent compared with 79.7 percent among the general working-age population (Erickson and Lee 2007).

To address these special needs, the states designed their DMIE programs to have comprehensive models of coverage with two main components: enhanced access to medical services, or "wrap-around" coverage, and employment supports consisting of case management and vocational rehabilitation services (Table 1). Both components were designed to address the special needs of workers with potentially disabling conditions who currently are, or may soon be, at risk of being underinsured because of their complex health conditions. All participants were randomly assigned to either a treatment group, which received existing services and DMIE services, or to a control group, which received only existing services.

Enhanced Medical Services. Access to medical services was enhanced by broadening the medical benefits for which participants were eligible. Kansas and Texas offered dental and vision care, and other services such as durable medical equipment and chemical dependency treatment. Hawaii provided medication therapy and disease management services to help participants better manage their diabetes. Hawaii, Kansas, Minnesota, and Texas also enhanced access to medical services by paying for all or part of their participants' premiums, copayments, or deductibles, with the goal of making coverage more affordable and reducing financial barriers to obtaining needed medical care.

Employment Supports. In addition to vocational rehabilitation services, employment supports included one-on-one "case managers" or "service navigators," who helped participants assess their health and employment needs, develop a person-centered plan for meeting their needs, and identify concrete steps for making use of available services and supports. In Minnesota and Texas, service navigators also provided other support services including employer education, accommodation assessments, resume and interview skill building, and assistance in identifying job leads. Service navigators also helped participants become better informed consumers of health care who can participate more fully in decisions about their medical care and employment opportunities. Navigators have the potential to improve health outcomes in two ways: by helping workers navigate the health care

TABLE 1. DMIE MEDICAL SERVICES AND EMPLOYMENT SUPPORT INTERVENTIONS

	Enhanced Medical Services				Employment Supports		
DMIE State	Dental and vision services	Mental health & substance abuse services	Medication therapy/disease management	Financial assistance	Vocational rehabilitation and supports	Case manager/ navigator/life coach	Service coordination
Hawaii			X	X	X	X	
Kansas	X	X		X	X	X	X
Minnesota	X	X		X	X	X	X
Texas	X	X		X	X	X	X

system effectively and ensuring that care is adequate, appropriate, and coordinated.

The four DMIE states—Hawaii, Kansas, Minnesota, and Texas—reached out to working adults with different types of potentially disabling conditions and used different program designs (Table 2). Hawaii targeted adults with diabetes, Kansas drew participants from its high-risk insurance pool, and Texas and Minnesota focused on workers with mental illness. Three of four states exceeded their enrollment targets, demonstrating the substantial interest in this type of program.

What Do We Know About DMIE Program Participants?

DMIE participants are diverse with respect to age, race, education, health status, and personal

TABLE 2. DMIE POPULATION AND INTERVENTIONS, BY STATE

Target Population	# Enrolled (% of Target)	DMIE Intervention
		Hawaii
Working adults (age 18-62) with diabetes living in the city and county of Honolulu.	N = 190 (36%)	**Enhanced Medical Services:** Included medication therapy, disease management, and support services to address issues related to diabetes management. The intervention also offered financial assistance for diabetes-related physician visits, medications, and supplies. The uninsured had access to the state's Medicaid plan; participants working more than 20 hours a week had employer-based coverage; additional health supports included access to certified diabetes educators, registered dietitians, and fitness memberships. **Employment Supports:** Included individualized life-coaching.
		Kansas
Working adults (age 18-64) enrolled in the Kansas Health Insurance Association (KHIA) high-risk insurance pool.	N = 500 (125%)	**Enhanced Medical Services:** Included coverage of services that augmented the existing KHIA high-risk pool benefits, and also enhanced services such as dental and vision care. It also offered premium subsidies, the elimination of deductibles, and lower copayments. **Employment Supports:** Included case management and vocational rehabilitation services.
		Minnesota
Working adults (age 18-60) with severe mental illness from eight counties.	N = 1,793 (120%)	**Enhanced Medical Services:** Included access to an expanded Medicaid-like benefit package—comprising mental health and substance abuse services—as well as financial assistance through premium subsidies, lower copayments, and elimination of annual spending limits. **Employment Supports:** Included a wellness navigator and employment supports.
		Texas
Working adults (age 21-60) enrolled in the Harris County Hospital District medical program for uninsured residents with either severe mental illness or behavioral health diagnoses co-occurring with a physical diagnosis.	N = 1,616 (113%)	**Enhanced Medical Services:** Included access to an expanded set of services including enhanced behavioral, medical, and dental services in addition to the Medicaid-like services that participants could receive through the local hospital district; improved access to mental and physical health services; and elimination of copayments for prescription drugs and services. **Employment Supports:** Included case management and employment supports.

earnings (Table 3). This variation is due in large part to differences in the program designs, and it shows that early intervention supports can be applied to different settings with different populations.

- ***Demographic Characteristics.*** DMIE participants are predominantly middle-aged adults, ranging from an average of 39 years in Minnesota to 51 years in Kansas. Variations in mean age across programs reflect differences in the target populations; Hawaii targeted participants with diabetes, which is more prevalent among older adults. In Kansas, many participants have chronic physical impairments which are reflected in the higher concentration of older adults. Most participants are unmarried and do not have the option of obtaining employer-sponsored coverage through a spouse and do not qualify for Medicare because they are under the age of 65.
- ***Health Characteristics.*** Most DMIE participants have more than one chronic condition, underscoring the complexity of their service needs. The average number of medical conditions among participants is 3.7 in Kansas, 1.7 in Minnesota, and 4.9 in Texas.[2]
- ***Employment and Income Characteristics.*** Despite having multiple conditions, nearly 60 percent of all participants on average reported that they worked full time (that is, at least 160 hours during the four weeks before enrolling in the demonstration). This suggests that many DMIE participants are willing and have the capacity to work when appropriate supports are provided. DMIE participants in Hawaii and Kansas have higher rates of employment and personal earnings than participants in Texas; this is likely due to the fact that Hawaii and Kansas' DMIE programs have higher proportions of college graduates. Participants' average earnings in Minnesota and Texas are under $15,000, or less than 150 percent of the federal poverty level.[3]

How Can the DMIE Inform the Debate on National Health Care Reform?

The DMIE offers several lessons for policymakers as they attempt to expand coverage to uninsured individuals and also to ensure that coverage is affordable. The issue of affordability is especially relevant to underinsured adults with potentially disabling conditions, many of whom need a comprehensive package of services and help navigating the health care system. Burdensome cost-sharing requirements

[2]Because the Minnesota DMIE program collects data on a maximum of two co-occurring conditions, the number of reported comorbidities may be underestimated among these participants.

[3]The 2009 federal poverty level is $10,830 for a single person (U.S. DHHS).

TABLE 3. DEMOGRAPHIC, HEALTH, AND EMPLOYMENT CHARACTERISTICS OF DMIE PARTICIPANTS

	Hawaii	Kansas	Minnesota	Texas
Demographic and Health Characteristics				
Age (mean years)	48.5	50.7	38.6	46.9
% Female	62.6	50.6	60.9	76.5
% Currently married	52.6	54.6	20.6	25.2
% White and non-Hispanic	17.4	96.0	76.7	23.0
% At least four-year college graduate	50.6	44.4	18.1	8.5
Number of co-occurring conditions (mean)	1.0[a]	3.7	1.7[a]	4.9
Employment Characteristics				
% Working full-time	54.7	49.0	87.4	30.9
2007 Personal earnings (mean dollars)	$46,337	$29,998	$14,762	$14,140

Source: Uniform data sets submitted by Hawaii, Kansas, Minnesota, and Texas. Personal earnings data are from the DMIE National Finder File and Social Security Administration (SSA) Master Earnings File (MEF) 2007. Personal earnings data are for 2007 and include self-employment income. Figures are based on the total number of DMIE participants who enrolled at baseline, and include individuals who disenrolled during the demonstration.

[a]Minnesota collects information on a maximum of two co-occurring conditions, and Hawaii collects information on a maximum of only one condition. As a result, the number of reported comorbidities may be underestimated for these states.

can discourage low-income workers with potentially disabling impairments from seeking the medical care they need, which can lead to declines in health (Hall and Moore 2008). Moreover, lack of affordability places workers with potentially disabling conditions at greater risk of being underinsured. Addressing the problem of underinsurance is particularly important for workers with chronic conditions who are at greater risk of developing a disability and exiting the workforce than other workers. Were coverage made more affordable, workers with potentially disabling conditions would be more likely to seek the care they need, which in turn could improve their overall health, prolong their employment, and reduce dependence on federal disability benefits.

Although the national evaluation of the DMIE program will not be complete until 2011, early results are promising and suggest that the DMIE is a model of early intervention supports that can be tailored to meet the specific health care needs of different populations in different settings. Three states targeted specific impairment groups (Hawaii, Minnesota, and Texas), and one state (Kansas) drew from its high-risk insurance pool. While the general principle of providing early intervention services was the same across all programs, variations in the program designs illustrate the potential for implementing DMIE-like interventions in other settings.

Early results also suggest that the DMIE might reduce the rate at which individuals apply for federal disability benefits or delay their entrance onto the federal disability rolls. For example, the Minnesota state evaluators conducted a preliminary analysis of self-reported application rates for Social Security disability benefits. An analysis of a subgroup that included 45 percent of all participants showed that 3 percent of the treatment group reported applying for federal disability benefits in the past year compared with 12 percent of the control group (Linkins et al. 2009). In addition, the 12-month findings in Texas indicate that, for the majority of participants, rates of self-reported receipt of disability payments were significantly lower in the treatment group than in the control group (UT ARI 2009). The final results from the national evaluation will be documented in an upcoming issue brief.

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DATA AND METHODS

The information reported in this issue brief is part of a larger database that Mathematica is using for the national DMIE evaluation. The database, which includes information from the state DMIE projects and selected federal sources, has been assembled according to specifications in data use agreements between Mathematica and CMS. The data on participant characteristics in Table 3 come from a Uniform Data Set (UDS) submitted to CMS by Hawaii, Kansas, Minnesota, and Texas. The UDS contains participant data on health status, demographic and employment characteristics, diagnostic conditions and functional status, self-reported health care utilization, number of hours worked, and participation in public programs. Personal earnings data in Table 3 come from SSA's Master Earnings File (MEF) for 2007. The MEF data provide an aggregate-level measure of total annual earnings based on income reported to the Internal Revenue Service.

In addition to the national evaluation, each state is conducting its own evaluation, which, at the urging of CMS, is based on a randomized design. The state evaluation teams have produced a variety of reports based on their data, and readers may obtain a list of these reports by contacting the authors of this brief or key individuals in each state (whose names are noted elsewhere in this brief). For detailed descriptions of each state's intervention as well as additional information pertaining to the data used in the national DMIE evaluation, readers may refer to Gimm et al. (April 2009).

the content and clarity of the brief. The accuracy of all statements remains the responsibility of the authors.

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For further information on this issue brief or to access it in an alternative format, contact Gilbert Gimm at 202-264-3460 or at ggimm@mathematica-mpr.com.

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