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Testing a SSDI Benefit Offset:
An Evaluation of the Wisconsin SSDI Employment Pilot

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The descriptions and interpretations in this report are those of the authors and are not necessarily those of the either the Stout Vocational Rehabilitation Institute, University of Wisconsin - Stout or of the Office of Independence and Employment, Wisconsin Department of Health Services

Acknowledgements

Any evaluation of a pilot project requires that there be a project to evaluate. The Wisconsin SSDI Employment Pilot (SSDI-EP) was the culmination of many years of effort on the part of individuals and organizations both within and outside Wisconsin. We do not pretend to know the full story, but we are aware of the central role that individuals housed at the Wisconsin Department of Health Services (DHS), particularly at what is now known as the Pathways Projects, had in advocating for, designing, and then implementing a test of a SSDI benefit offset pilot. These efforts began in earnest in the late 1990s in preparation for Wisconsin's participation in the Social Security Administration funded State Partnership Initiative (SPI), but did not come to fruition until after the conclusion of that effort. By 2004, SSA had decided it would be important to have a preliminary test of a benefit offset and its associated implementation processes to inform the design of a congressionally mandated national demonstration of a SSDI benefit offset. SSA chose to site the effort in Wisconsin and three other states, reflecting both the interest and capacities those states had shown over the years.

There are many individuals who deserve explicit acknowledgement and too little space to do so. However, we want to explicitly mention Pathways staff who worked directly on the design and implementation of the project since 2004: Catherine Anderson, Joseph Entwisle, Kay Huisheere, Theresa Lannan, Malika Monger, John Reiser and Amy Thomson. John Reiser, the Director of the DHS Office of Independence and Employment, merits additional mention for a reason important to the authors. He committed to a fully independent evaluation and never deviated from that commitment.

Additionally, we acknowledge the critical contribution of our database manager, David Sage. The analyses presented in this report could not have been performed without his skill in organizing information having multiple time structures. Lastly, we think it important to mention by name two important contributors at SSA: Mark Green, the project manager in Baltimore and Robert Monahan, the Area Work Incentives Coordinator in Madison, WI.

We do not have space to identify by name the benefits counselors and other staff at the twenty-one community based agencies that recruited and enrolled participants, provided project services, and, helped to collect evaluation data. It would have been impossible for Pathways to operate the pilot on a statewide basis without their involvement and this evaluation would have been greatly impoverished.

Of course the final acknowledgement must go to the over five hundred individuals who volunteered for the SSDI-EP. Most of these individuals qualified for participation and remained involved in the project for several years. Though we think most participants benefited in some way from their participation, they gave back, perhaps in some cases, more than they got, in time, information, and their willingness to venture the sometimes negative consequences of the novel rules and procedures being tested.

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List of Acronyms

ACS	American Community Survey
ANOVA	Analysis of Variance
APPAM	Association for Public Policy Analysis and Management
AWIC	Area Work Incentives Coordinator
BOND	Benefit Offset National Demonstration
BPQY	Benefits Planning Query
CDR	Continuing Disability Review
CDSD	Center for Delivery Systems Development
CMS	Center of Medicare and Medicaid Services
COLA	Cost of Living Adjustments
COP	Community Options Program
CPI-U	Consumer Price Index for all Urban Consumers
DAC	Disabled Adult Child
DDB	Disability Determination Bureau
DDS	Disability Determination Services
DHFS	Department of Health and Family Services
DHS	Department of Health Services (formerly DHFS)
DVR	Department of Vocational Rehabilitation
DWB	Disabled Widow/Widower Benefits
DWD	Department of Workforce Development
EPE	Extended Period of Eligibility
ERI	Employment Resources Incorporated
FICA	Federal Insurance Contributions Act
GDP	Gross Domestic Product
GH	General Health Indicator
IRWE	Impairment Related Work Expenses
MANOVA	Mixed Model Analysis of Variance
MAPP	Wisconsin Medical Assistance Purchase Plan (WI Medicaid Buy-In)
MCO	Managed Care Organization
MCS	Mental Component Scale
MIG	Medicaid Infrastructure Grant
MPR	Mathmatica Policy Research, Inc.

MSA	Metropolitan Statistical Area
NCHSD	National Consortium for Health Systems Development
OASDI	Social Security’s Old-Age, Survivors, and Disability Insurance
OCO / SSA-OCO	Social Security Administration Office of Central Operations
OIE	Office of Independence and Employment
OOS	Order Of Selection
PAS	Personal Assistance Services
PASS	Plan to Achieve Self Support
PCP	Person Centered Planning
PCS	Physical Component Scale from SF-8 Survey
PIA	Primary Insurance Amount
QA	Quality Assurance
RFP	Request for Proposals
RWJ(F)	Robert Wood Johnson Foundation
SF-8	SF-8 Health Survey
SGA	Substantial Gainful Activity
SPI	State Partnership Initiative
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSDI-EP	Social Security Disability Insurance - Employment Pilot
SSI	Supplemental Security Income
SVRI	Stout Vocational Rehabilitation Institute
TA	Technical Assistance
TWP	Trial Work Period
UI	Unemployment Insurance
VFP	Vocational Futures Planning Model
VR	Vocational Rehabilitation
WDBN	Wisconsin Disability Benefits Network
WIPA	Work Incentive Planning and Assistance

Executive Summary

The Wisconsin SSDI Employment Pilot (SSDI-EP) has been one of four small state based projects authorized by the United States Social Security Administration (SSA) to begin testing a proposed benefit offset feature for the Social Security Disability Insurance (SSDI) program. The main purpose of the pilots was to inform the design of a national demonstration of the benefit offset feature by providing SSA with information about implementation and preliminary findings about whether a SSDI benefit offset would result in desired increases in employment related outcomes. The SSDI-EP was organized and operated through the Pathways Projects.

SSDI is one of the Title II programs of the Social Security Act. The main purpose of SSDI is to provide income support to disabled workers and, under some circumstances, their spouses and dependents. SSDI eligibility also establishes eligibility for Medicare after a two years waiting period. Access to SSDI requires that an individual have a medically determinable impairment that makes that individual incapable of performing substantial gainful work. In practical terms, this means that a claimant must not be able to earn at or above what SSA calls the Substantial Gainful Activity (SGA) level at any job in the national economy.[1]

However, Congress and SSA have increasingly encouraged those attached to the SSDI program ("beneficiaries") to work after entering the program. Initially, the purpose was to encourage some to leave benefit status. More recently, greater focus has been put on encouraging work effort without any expectation that beneficiaries would frequently leave the program. The hope has been that SSA would still be able to lower program outlays and that beneficiaries would reap a portion of the material and personal rewards associated with work. Given that SSA's disability definition would seem to preclude work at a "substantial level," Congress and SSA have faced the challenge of how to encourage work without changing the very basis of program eligibility. Moreover, even ignoring this seeming contradiction, the SSDI program includes a powerful disincentive to SGA earnings. Under current law, the SSDI benefit payment is reduced to zero dollars when monthly earnings exceed SGA, the so-called "cash cliff."[2]

The purpose of a benefit offset feature is to mitigate this disincentive and, as a result, to encourage SSDI beneficiaries to become employed and, once employed, to increase their earnings above the Substantial Gainful Activity (SGA) level. The version of the offset tested through the SSDI-EP and the other three pilots provided for a one dollar decline in the benefit level for each two dollars of earnings above the SGA level.

SSA specified that all of the benefit offset pilots utilize random assignment and that participants be volunteers. The SSDI-EP enrolled 529 participants between August

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[1] The 2009 SGA level was $980 per month, though the SGA level is always somewhat higher for those disabled because of a visual impairment. SGA, like SSDI benefits themselves, is indexed.

[2] In current law there is one exception to the complete loss of cash benefits when earnings go above SGA. SSDI benefits are unaffected by earnings during the nine month Trial Work Period (TWP).

2005 and October 2006; 496 of these individuals proved fully eligible to participate. The pilot continued full operations through December 2008, though follow-up activities will continue for some time to come. For several reasons, principally SSA mandated eligibility rules, the voluntary nature of participation, and how the pilot recruited participants, SSDI-EP enrollees were not a representative sample of the adult SSDI beneficiary population who, presumably, would be qualified to use a benefit offset provision should one be added to the Social Security Act. This fact did not negatively affect what could be learned from studying implementation. As the SSDI-EP sample included an unusually large proportion of beneficiaries already engaged in work, the SSDI-EP sample offered an opportunity to examine the effects of the offset and pilot provided support services on a subgroup that might be especially motivated to use the offset.

This report presents findings from both a process evaluation and the analysis of participant employment related outcomes. In brief, the SSDI-EP was able to organize and implement its activities much as had been planned, though not without some shortcomings. However, there were far more serious implementation problems at the Social Security Administration. These implementation problems tended to reinforce concerns about whether treatment group participants, especially those who had used the offset, would have a smooth transition back to regular program rules. In particular, concern has been raised as to how work performed above the SGA level during the pilot would affect the outcome of future continuing disability reviews.

The impact evaluation focused on whether the employment rates, average earnings, or the proportion of those with earnings above SGA of those assigned to the treatment group would increase relative to those assigned to the control group. In brief, there were no significant differences in employment outcomes over the two years following entry into the project. Nonetheless, both the treatment and control groups achieved some gains in aggregate employment outcomes. These were strongly associated with the amount and continuity of work incentive benefits counseling received after entering the project.

SSDI-EP structure and operations

The SSDI-EP was operated by the Pathways Projects, a collaborative entity housed in the Wisconsin Department of Health Services (DHS), which also includes partners from the University of Wisconsin-Madison and the University of Wisconsin-Stout. Pathways is best viewed as an entity with the mission of developing and then disseminating best practice for encouraging employment and better outcomes from employment for persons with serious disabilities. As a consequence, Pathways had a somewhat different perspective on the project than SSA. There was a greater focus on the offset as one tool amidst holistic efforts to achieve better employment outcomes, irrespective of whether those efforts resulted in SGA earnings.[3]

SSA chose the specific features of the benefit offset, established the eligibility rules, and determined how the offset itself would be administered. These features were essentially the same across all four pilots. Each state, however, was given substantial

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[3] Pathways is housed in its state Medicaid agency. It has been deeply involved in the design and evaluation of Wisconsin's Medicaid Buy-in program. Pathways coordinates efforts under the state's very large Medicaid Infrastructure Grant.

discretion to decide how the pilot would be organized and how activities such as recruitment, enrollment, service provision, and evaluation would be carried out.

SSA restricted participation to working age SSDI beneficiaries who did not also have SSI eligibility, who qualified for their benefit based solely on their own earnings records, and who were not more than seventy-two months past the completion of a Trial Work Period (TWP). Only those assigned to the treatment group would have the opportunity to use the offset and to be exempt from medical Continuing Disability Reviews (CDRs) for as long as they remained in the pilot.

Nonetheless, those assigned to the treatment group would not automatically get to use the benefit offset. The TWP would need to be completed first. Also, the offset would only be applied during those months when a beneficiary had earnings above the SGA level. Those in the treatment group effectively had their Extended Periods of Eligibility (when beneficiaries receive their full SSDI benefit when earnings fall under SGA) increased from thirty-six to seventy-two months. However, the EPE extension would be referenced to the TWP completion date, not the pilot enrollment date. Thus, while the maximum duration of offset use was seventy-two months, a member of the treatment group could have entered the SSDI-EP with as little as one month to use the benefit offset. Additionally, SSA made a critical change to the rules for offset use very late in the project. Only treatment group members who completed their TWP by the end of December 2008 would be allowed to use the offset; everyone else in the treatment group would be returned to regular program rules at the start of 2009. Those in the treatment group had enrolled with the understanding that they could use the offset whenever they completed their TWP, regardless of whether the active phase of the pilot had ended.

For the most part, Pathways organized the SSDI-EP similarly to the pilots outside Wisconsin. The SSDI-EP did not explicitly limit participation to participants who had completed or entered a TWP. In common with the other pilots, the SSDI-EP would provide access to work incentive benefits counseling and would do so irrespective of whether the participant was assigned to treatment or control. Pathways staff viewed benefits counseling as essential because it would provide individuals with accurate information about both opportunities and dangers, including how opportunities might be exploited and how dangers might be avoided or mitigated. Though Pathways staff felt that those using the offset would generally need benefits counseling services, so too would any SSDI beneficiary interested in becoming employed or increasing his earnings. This principle of equal access would apply to any service provided through the SSDI-EP. Indeed, it was thought that providing “equal access” would allow a better test of the offset because, theoretically, that would avoid any possibility of conflating the offset’s impact with that of benefits counseling or any other pilot provided services.

Among the four pilots, the SSDI-EP was distinctive in using a network of (largely) non-profit entities to work directly with participants. Based on past experience, Pathways staff thought it important to organize the pilot to enroll and serve participants on as local a basis as practicable. Pathways staff also felt that a decentralized delivery system would better model the context in which a statutory offset would have to be used. Given Pathways did not have any significant local presence for identifying and serving participants nor the resources to create one, it decided to use existing community based capacity to conduct recruitment and enrollment, provide or arrange for services, and collect participant information to both administer the offset and for evaluation purposes.

Twenty-one “provider agencies” enrolled participants; twenty of these have remained involved in the effort. Thus, Pathways was able to meet SSA’s requirement that the pilot would be available to beneficiaries throughout the state.

During the pilot, the SSDI-EP central office’s main role was to supply provider agency staff with needed training and technical assistance, to monitor compliance with pilot rules, and to serve as an intermediary between the SSA Office of Central Operations (OCO) and the provider agencies and participants. This final role became increasingly important over time due to the unforeseen challenges of offset administration.

Evaluation approach

As noted, this report presents findings from both a process and outcomes evaluation. The two are related. In the absence of evidence of adequate implementation, it is impossible to attribute results, good or poor, to the intervention. Good information about the intervention can also give insight into observed results and provide a firm basis for improving policy and program in the future.

In general, process evaluation activities sought to both describe the project and to account for change in it over time. We sought to understand how different stakeholders viewed or experienced the pilot, giving the most attention to participants, provider agency staff, and pilot staff housed at Pathways. We utilized multiple data sources including written records and communications, encounter data collected through the provider agencies, interviews, surveys, and focus groups. Additionally, as the evaluation team was located at the pilot’s central office, these data were augmented by our experiences as participant-observers. No single method was used to analyze data; in general we strived to work in conformance with recognized principles of historical and social science research.

Evaluation of participant outcomes was guided both by our understanding of an admittedly implicit intervention theory and our interest in whether and how pilot participation facilitated better employment outcomes, irrespective of actual use of the offset provision. The offset was expected to work because it substantially reduced the marginal tax rate at SGA and above from 100% to 50%.[4] Beyond this, experiencing the offset or hearing about the positive experience of others was hypothesized to reduce beneficiaries’ fear that work activity would result in the loss of income, threaten SSDI eligibility, or that for vital health care programs such as Medicare or Medicaid. Thus, the offset would also motivate improvements in employment outcomes through this second indirect path. In addition, benefits counseling was hypothesized to have a separate impact on fear reduction that might lead to improved outcomes for those in the control group and for treatment group members who did not use the offset as well as serve to reinforce the offset’s positive outcomes.

The evaluation concentrated on comparing the full treatment group and control group to each other. In a few cases, comparisons were limited to examining differences between those who had completed their TWP. Most analyses were designed to compare outcomes over a time period relative to each participant’s entry into the pilot. The main

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[4] Of course, once earnings were sufficiently high to “zero out” the amount of the offset user’s full SSDI payment, the marginal tax rate on the benefit would be 0%.

period examined began four calendar quarters before the quarter in which the participant enrolled and concluded with the eighth quarter following the enrollment quarter for a total of thirteen quarters.

SSA asked for a range of subgroup analyses based largely on demographic characteristics and pre-enrollment employment outcomes or program participation. In addition to these, we added our own subgroup analyses, including some focused on the effects of benefits counseling, Medicaid Buy-in use and participant attitudes.

SSA was most interested in examining three types of outcomes: employment rates, mean earnings and the proportions earning at least SGA. The primary outcome measures used in this paper are all constructed from Wisconsin Unemployment Insurance system records and thus reflect the strengths and limitations of such data. As these records are organized on a calendar quarter basis, so are most of our analyses.[5] All monetary amounts are inflation adjusted using the Consumer Price Index for Urban Consumers (CPI-U). We also examined additional outcomes including changes in participant attitudes and a proxy for individual income. We consider this last outcome especially important. It is our belief that from a participant's perspective there isn't much value in increasing earnings unless there is also an increase in income. After all, isn't that the point of reducing a marginal tax rate?

Readers will note that two different modeling approaches are used to analyze outcomes. One was mandated by SSA; the other approach reflects are own priorities. In our own case and, we believe, SSA's, the choice made reflects the relatively small number of cases available for analyses. SSA's approach was to specify and run separate regression models for each of nine calendar quarters beginning with the quarter in which the participant enrolled. Unfortunately, this approach does not support direct analysis of trends over time and greatly limits the use of control variables. As an alternative we used MANOVA (Mixed Model Analysis of Variance). This procedure allowed us to examine trends and to utilize more control variables, despite our relatively small sample size. However there is no free lunch; MANOVA has its own set of limitations that will be identified in the report.

This evaluation was designed and conducted solely by the authors with no direct involvement by Pathways management or the staff involved in implementing the operational aspects of the SSDI-EP. A document they provided summarizing their perceptions about the pilot, its accomplishments, and lessons learned can be found at the start of Section Four of this report.

Selected process findings

- The SSDI-EP was able to mobilize a network of partners to implement a benefit offset pilot on a statewide basis. The SSDI-EP provided the training, technical assistance, and program monitoring capacity that allowed a highly decentralized program to operate much as planned.
- This network, as desired, closely modeled Pathways' goal of operating the pilot in a context that would closely resemble that in Wisconsin should a statutory SSDI

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[5] SGA is an inherently monthly amount. As UI earnings are quarterly, we use three times SGA as a proxy for having SGA earnings in a calendar quarter.

benefit offset become available in the not distant future. Though similar to that of other states in that service provision is decentralized and funded through multiple public agencies, Wisconsin is distinctive in having an unusually large number of benefits counselors and a well developed training and technical support system to sustain benefits counseling and other employment related services.

- The SSDI-EP was able to use its technical assistance structure to meet unanticipated needs or to perform anticipated tasks at much higher levels of demand than originally expected. In particular, central office staff members were able to meet major challenges involved in ensuring successful completion of a large number of work reviews and responding to problems, such as delayed or inaccurate checks and/or resolving large overpayments.

- The SSDI-EP was able to insure the delivery of benefits counseling services at most provider agencies through most of the pilot. Still, about 22% of participants received no benefits counseling services after enrolling in the pilot. These individuals were disproportionately from the control group.

- Though great efforts were made to insure that benefits counselors were well trained and had access to good technical assistance, roughly a third of participants indicated through surveys that they had not received benefits counseling services that fit their needs. It is possible that negative assessments were related to the quantity of services received. The average number of hours of benefits counseling a participant received over the period starting with the enrollment quarter and ending with the eighth quarter thereafter (Q0-Q8) totaled less than eight hours.

- Nonetheless, in both surveys and focus groups, virtually all participants characterized benefits counseling as an important, even critical service. There was consensus that a statutory offset should not be implemented without the ready availability of benefits counseling services.

- Both staff and participants expressed substantial concern about the ability to obtain needed employment related services, especially given Order of Selection closures at Wisconsin’s Vocational Rehabilitation (VR) agency.

- There was close to unanimity among participants, pilot staff, key informants, and SSA itself, that the offset was poorly administered.

- Many of the problems in offset administration had roots in other processes either set up specifically for the pilots or moved to OCO for the duration of the pilots. An example of the first class of problems was SSA’s choice of using annual earnings estimates as the main source of information for determining the amount of SSDI checks once a treatment group member entered offset status. It proved difficult for treatment group members, even with the aid of benefits counselors, to complete estimates accurately and to know when and how to update them.

- OCO processes for performing activities normally done through SSA field offices often led to delays and frustration beyond those normally experienced by beneficiaries. In particular, already stressful and occasionally problematic activities such as reporting of earnings, associated reconciliation of SSDI payments, and work reviews were made more difficult because they were performed by initially inexperienced, largely inaccessible, and at times overworked staff at OCO.

- SSA letters to those in the treatment group appear to have been written to meet the agency's legal needs or to address fears of potential litigation. Both participants and staff reported that the letters were difficult to understand, often contained inaccuracies, and tended to reinforce existing fears.

- Most provider agencies did a reasonably good job of maintaining contact with participants over as much as a three and one-half year period. Severe problems were concentrated at only a few agencies. Still, there was a tendency to remain in better contact with participants assigned to treatment group.

- Attrition from the project was relatively modest, but voluntary withdrawals were concentrated in the control group.

Selected impact findings

- Only 21% of those in the treatment group had used the offset provision through mid-year 2009.

- There were no statistically significant differences between the employment outcomes trends for those in the treatment group compared to those for control group members during the primary post-entry analysis period of Q0-Q8.

- Participants in both study assignment groups achieved some gains in UI employment rates, average quarterly UI earnings, and the proportion of those with quarterly earnings at least three times the SGA level during the Q0-Q8 period. For example, those in the treatment group posted a three percentage point increase in their employment rate, a 21% increase in mean earnings, and a three percentage point increase in the proportion of those with earnings comparable with or exceeding the SGA level. The control group results were slightly less positive, but the differences were not statistically significant.

- Participants achieved much larger percentage gains in employment outcomes in the year prior to entering the pilot than in the two years following entry.

- There were decreases in the mean value of the income proxy variable (quarterly earnings plus the sum of SSDI payments in that quarter) over the Q0-Q8 period (2.5% for treatment and 4% for control). This is a highly undesirable result, given the substantial increases in average earnings (roughly 20% for both groups) over the same period. A main purpose of the offset feature and, for that matter, pilot services was to make it easier to convert earnings gains into higher incomes.

- Receipt of benefits counseling is strongly associated with increases in employment outcomes, especially earnings, in even relatively small dosages. Earnings growth in the Q0-Q8 period for those getting four to eight hours of benefits counseling was 37%; those getting more than eight hours witnessed a

30% increase. By contrast, Q0-Q8 earnings increased 7% for those who received less than four hours of benefits counseling and declined 7% for participants who received no benefits counseling following SSDI-EP enrollment.

- There is also evidence that receiving benefits counseling in multiple time periods rather than in a single time period was associated with stronger employment outcomes. Participants getting benefits counseling during four or more quarters during the Q0-Q8 period had Q8 earnings at least $700 more than participants in groups that received benefits counseling in three or fewer quarters or did not receive any benefits counseling.

- Those in the treatment group were significantly more likely to complete a trial work period after entering the pilot than those in the control group (27% versus 19%). This difference is especially noteworthy given the relatively small proportions of participants (3%) in TWP when they entered the pilot. It also suggests the possibility that the offset feature provides an incentive for TWP completion, an incentive likely to be stronger if the offset were not time limited.

- Earnings and income gains were strongly associated with completing a TWP, irrespective of study group assignment. However, gains in the treatment group were concentrated among those TWP completers who went on to make some use of the offset.

- Participation in the Wisconsin Medicaid Buy-in was associated with lower earnings and a reduction in the proportion of those earning three times SGA over the Q0-Q8 period. This finding appears related to the Wisconsin Buy-in premium structure.

- Nonetheless, those participating in the Medicaid Buy-in tended to suffer smaller reductions in income as their earnings increased. Treatment group members using the Buy-in actually posted increased income over the Q0-Q8 period. However, even in this case only a small proportion of increased earnings were converted into income.

- Survey results showed high levels of concern that work activity would either reduce SSDI benefits or threaten eligibility for SSDI, Medicare and/or Medicaid. Over the following two years fear levels for control group members increased. Meanwhile, response distributions for treatment group members tended to remain about the same.

- The interactions between benefits counseling, attitudinal change, and achieving better employment outcomes appear complex and, for those in the treatment group, counterintuitive. Those in the treatment group with higher levels of fear entering the pilot or who had increased fear over time had better outcome trajectories than those with the lowest levels of fear or who appeared to have become less fearful over time. These findings suggest the possibility that benefits counseling may not always need to reduce fears in order to be effective in supporting better employment outcomes.

- The MANOVA results were congruent with findings from previous studies that those who work and have relatively high employment outcomes after entering a disability program are likely to continue doing so. Covariates such as UI earnings in the year prior to entering the SSDI-EP explained far more of the variance in the models (sometimes as much as half) then the statistically significant indicators of benefits counseling, fear of benefit loss, or self-efficacy.

Project Timeline

1998

June 1998 – Wisconsin includes SSDI benefit offset feature in its State Partnership Initiative (SPI) proposal.

June 2000 – Wisconsin submits SSDI offset proposal to SSA for SPI project. Request never approved.

July 2002 – Wisconsin and other states submit initial unsolicited proposal for SSDI offset pilot

November 2003 – SSA declines subsequent unsolicited proposal but indicates that SSDI offset will be piloted.

March 2005 – Wisconsin, along with Utah, Connecticut, and Vermont, is awarded contract to conduct SSDI offset pilot.

March through June 2005 – Wisconsin identifies provider agencies for the SSDI-EP.

July 2005 – SSDI-EP “kick-off,” training and recruitment activities begin in earnest.

August 2005 – First participant enrolls.

May through July 2006 - DHS sends outreach mailings to Wisconsin MAPP and VR consumers.

October 2006 – SSDI-EP enrollment period ends.

December 2008 – Active phase of SSDI-EP ends. Treatment group members who did not complete TWP are returned to regular program rules

January through April 2009 – Intensive phase-out activities at provider agencies

Winter 2011 – Start of enrollment in Benefit Offset National Demonstration

December 2014 – Last month any SSDI-EP participant might use the offset

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SECTION ONE: INTRODUCTION AND PROJECT DESIGN

Most public policies seek to achieve multiple goals. In virtually all cases there will be tradeoffs, some diminishment in the ability to maximize the attainment of every goal. Sometimes these tradeoffs are modest, sometimes severe. These tradeoffs are most likely to be severe when policy seeks to achieve contradictory purposes.

In the United States, such is the case for national programs providing income support and/or health care for persons having severe disabilities. Eligibility for such programs was and largely remains based on the premise that program beneficiaries are unable to work, at least to an extent that would permit full or nearly full economic self-sufficiency. As a consequence, most efforts to encourage persons using such programs to work have been set up largely to encourage eventual separation from the benefit programs.

Over the last decade, federal policy makers have become progressively more interested in encouraging program beneficiaries to reduce their reliance on disability benefit programs without necessarily expecting them to leave the programs. This shift in emphasis coincided with changes in societal needs and attitudes, but also with intensified efforts by people with disabilities and their allies to push for policy changes more consistent with fuller social, economic and political inclusion. Not coincidentally, there have been ongoing changes in technology and medical care that have greatly increased the practicality of fuller inclusion, including labor force participation.

Thus, federal policies that provide income support and health care for persons with severe disabilities now incorporate contradictory principles. Increasing emphasis is placed on encouraging a level of work activity consistent with at least partial self-sufficiency. Nonetheless, initial program eligibility and, for the most part, continued attachment still depends on the incapacity to work. The rules governing eligibility are deeply embedded in statute, program regulations, and agency practice. These can be viewed as an essential structural feature of each of the disability benefit programs. By contrast, the rules and supports intended to encourage gainful work are better viewed as epiphenomena. Though not without importance, they are largely attempts to lessen the negative impact of the programs' structural features on work activity. Consequentially, program beneficiaries who make significant progress toward achieving economic self-sufficiency often feel they risk separation from needed benefits, either in the present or the future. Their concerns are justified.

Though there are tensions between eligibility rules and work incentives across all the federal income support and health care programs targeted to those with disabilities, the tradeoffs associated with the Social Security Disability Insurance (SSDI) program are extreme.[6] These will be described in greater detail later in this report. However the central contradiction is as follows: SSDI beneficiaries who earn above a certain amount immediately lose their entire cash benefit. Work activity, including activity that produced

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[6] For adults who have not reached the full Social Security retirement age, eligibility for Social Security disability benefits are directly tied to inability to engage in what is called substantial gainful work activity because of a medically determinable physical or mental impairment. SSDI benefits result from having earnings above a certain threshold for a minimum amount of time (the amount is age dependant). However, in some cases, benefits may go to a person with a disability based on the earnings record of a parent or a spouse.

earnings below the amount that terminates the cash benefit, may be used as evidence to sever eligibility for SSDI and eventually to end access to health care through the Medicare program.

Federal policy makers have been seeking ways to ameliorate the tradeoffs found in the SSDI program. In particular, Congress has directed the Social Security Administration (SSA) to test a cash benefit offset for the SSDI program. As conceptualized by SSA, the offset involves a gradual reduction in the SSDI benefit level as earnings increase and protection from losing SSDI eligibility because of a relatively "high" level of work activity. Prior to designing and implementing a congressionally mandated test of a cash benefit offset, SSA decided to pilot the effort in four states. SSA's purpose was to gain information that could inform the design of a larger national demonstration. Wisconsin was chosen as one of the pilot states. This report describes the Wisconsin pilot and its outcomes. It seeks to explain why those outcomes occurred and to explore what implications the pilot has for improving the national demonstration and public benefit programs such as SSDI.

CHAPTER I: INTRODUCTION

The Wisconsin SSDI Employment Pilot (SSDI-EP) was one of four pilot projects that the Social Security Administration authorized and funded to do preliminary testing of a benefit offset provision for the Social Security Disability Income (SSDI) program. In brief, the benefit offset provision involved a 50% reduction in the size of a beneficiary's monthly SSDI payment for every dollar of earnings above the Substantial Gainful Activity (SGA) level.[7] The offset was intended to provide a financial incentive to encourage better employment outcomes.

The SSDI-EP was operated through the Pathways Projects (Pathways for short). Pathways can be viewed as a collaborative involving three entities: the Office of Independence and Employment (OIE) in the Wisconsin Department of Health Services (DHS), the Stout Vocational Rehabilitation Institute (SVRI) at the University of Wisconsin – Stout and the Waisman Center at the University of Wisconsin – Madison.[8] OIE has been the dominant partner in Pathways. OIE/DHS was the party that entered into contracts with SSA to operate the pilot. OIE/DHS also holds the state's Medicaid Infrastructure Grant (MIG) which has been the principal source of Pathways funding in recent years. MIG funding, staff, and activities provided substantial support for the pilot.[9]

Pathways itself could be viewed as part of a broader network that had been concerned with issues of disability and work for more than a decade prior to the start of the SSDI-EP. Without attempting an exhaustive listing, network participants included various offices within DHS, the Division of Vocational Rehabilitation, other state and local government agencies, local SSA staff, a range of private community service and rehabilitation agencies, advocacy groups, consumers, and their families, and friends. Like many networks, the strength of both bilateral and group relationships has varied across issues and over time.

While SSA directed that the basic intervention approach and eligibility rules were essentially common across the four pilots, the SSDI-EP was different from the other

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[7] The SGA level is the method SSA uses to effect the statutory requirement that disability benefits be restricted to persons (of working age) not able to engage in substantial gainful work activity. Persons who apply for Social Security disability benefits but have monthly earnings at the SGA level will not be granted eligibility, irrespective of the severity of their medically determinable impairment. This standard is also applied in Wisconsin to Medicaid eligibility for reason of disability with the exception of the state's Medicaid Buy-in for disabled workers. In the case of the SSDI program, earnings above SGA are (after the Trial Work Period) incompatible with receiving a cash benefit. Earnings above SGA after the Trial Work Period may also result in removal from the program, depending on whether the work performed to obtain the earnings is viewed as evidence of medical improvement, that is, of the beneficiary's capacity to engage in substantial gainful work activity.

[8] Prior to July 1, 2008, the Wisconsin Department of Health Services (DHS) was called the Department of Health and Family Services (DHFS).

[9] The Medicaid Infrastructure Grant (MIG) is authorized by the Ticket to Work and Work Incentives Improvement Act of 1999. Administered by the Centers for Medicare and Medicaid Services (CMS), the main purpose of the MIG is to support state efforts to improve the overall system that can help Medicaid recipients by reason of disability, especially those who participate or may some day participate in Medicaid Buy-ins, return to work and, when possible, improve their employment related outcomes.

three pilots in having substantially more decentralized enrollment, service provision, and data collection processes. SSA also required that the pilots produce or arrange for both process and outcome evaluations, with the outcome evaluations utilizing experimental designs. Consequently, participants were randomly assigned to either a treatment group or a control group.

The SSDI-EP began enrolling participants in August 2005, about the same time as the other three pilots. We view the SSDI-EP's nominal end date as December 31, 2008. Though various phase out activities continued after that date and may do so for several years to come, SSA, in effect, ended the "active phase" of the pilots by requiring that all treatment group members who had not completed their Trial Work Period (TWP) be returned to standard program rules.[10] Those treatment group members who had completed their TWP would still be allowed to utilize the offset until their completion of an extended seventy-two month Extended Period of Eligibility.

A. Statement of Problem

In a narrow sense, the problem that a SSDI cash benefit offset is expected to address is straightforward. Current program rules, especially those pertaining to the thirty-six month Extended Period of Eligibility (EPE) produce a strong disincentive to work, especially to have monthly earnings above the SGA level.[11] Following the Trial Work Period (TWP), monthly earnings above the Substantial Gainful Activity (SGA) level result in the complete loss of the SSDI cash benefit, produce evidence that can lead to the loss of program eligibility, and, over a longer period, the loss of Medicare eligibility. The disincentive effects of SSDI rules would be troublesome irrespective of whether the primary goal of having work incentives is to encourage beneficiaries to attempt work in expectation of leaving SSDI permanently or simply to reduce dependence on and thus the cost of benefits. In either case, the potential reductions in program size and cost would not be realized nor would the economic benefits to beneficiaries, whether continuing or former.

To provide a concrete example, let us consider the situation of a beneficiary named "Joe." To keep the example simple, we'll assume that Joe has completed his Trial Work Period, does not participate in any benefit programs other than SSDI and

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[10] The Trial Work Period (TWP) is a standard SSDI provision that allows beneficiaries to earn above SGA for up to nine months over a five year period without losing any of their cash benefit. Although beneficiaries cannot lose their eligibility due to above SGA earnings during the TWP, it is possible that the work activity that generated those earnings can be used to assess medical improvement and thus continued eligibility. We do not have credible information about how frequently SSDI eligibility is lost due to work activity performed during TWP. We do know that it has been a concern for both pilot program staff and pilot participants and have seen some evidence that SSDI beneficiaries deliberately limit their earnings to levels well below SGA or even the substantially lower amount (approximately 70% of SGA) that signifies use of a TWP month. We would also note that uncertainty about the impact of "protected" SGA work activity is part of the environment of other "return to work" programs, for example Medicaid Buy-ins.

[11] The Extended Period of Eligibility (EPE) follows the successful conclusion of the Trial Work Period. During EPE the beneficiary retains SSDI eligibility, but receives no cash benefit if the beneficiary's earnings exceed SGA. If earnings are under SGA, the beneficiary receives the full cash benefit.

Medicare, does not have “special circumstances” such as Impairment Related Work Expenses (IRWE) or subsidies, and is subject to the standard SGA level.[12] We’ll also assume the year is 2009 and thus the SGA level for non-blind individuals is $980 per month. In this example, Joe receives a monthly SSDI check of (coincidentally) $980, a figure close to the national median for disabled workers.[13] Joe has no source of income aside from his SSDI benefit and any earnings.

In this example, Joe started the year working fifteen hours per week at a rate of $13 per hour. Using the convention of 4.3 work weeks in a month, this generates $838 in gross earnings. With Joe’s SSDI benefit, his total monthly earnings were $1,818. On an annual basis, Joe would have approximately $21,800 in earnings, roughly twice the 2009 poverty guideline ($10,830) for a single individual.

In the following month Joe increased his work effort to twenty hours a week. His monthly earnings were now $1,118. As this was above the $980 SGA level, Joe no longer received any SSDI cash benefit. His monthly income was solely his earnings. Despite increasing his earnings by approximately a third, Joe’s total income decreased by $700 (39%). His annualized earnings were now $13,416. Though this income is still approximately 125% of poverty level, it must be remembered that having a severe disability often entails substantial additional expenses. To achieve his previous monthly income level, Joe would now have to work nearly thirty-three hours per week. It is possible that Joe is not capable of doing so on a sustained basis. It is also possible that if he were, Joe would risk losing his SSDI eligibility and eventually his Medicare.[14]

Even without factoring in the risk to his continued attachment to SSDI and Medicare, the relatively modest difference ($138) between Joe’s monthly SSDI benefit and his higher earnings raises the issue of whether Joe should choose marginally higher earnings in preference to the twenty hours of what economists call “leisure” should he decide not to work at all. Alternatively, he could erase this income gap by working less than three hours per week at his current wage rate. To surpass the maximum income compatible with his benefit and the SGA level ($1,960), Joe would have to work thirty-

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[12] An IRWE (Impairment Related Work Expense) refers to the cost of items or services that enables someone on Social Security disability benefits to work. The IRWE is deducted from gross earnings before they are appraised for SGA. Subsidies refer to employer provided support that result in the employee receiving higher compensation than justified by the real value of the work. Special conditions refer to similar support from third parties. The value of both subsidies and special conditions are also deducted from gross earnings before any determination that earnings exceed SGA.

[13] The December 2008 median was $982.50. See Social Security Administration. 2009. Annual Statistical Report on the Social Security Disability Insurance Program, 2008. Baltimore, MD: SSA Publication 13-11826, p. 48.

[14] This example was taken from Smith, James, Porter, Amy, Chambless, Cathy, and Reiser, John. March 2009. “The Social Security Disability Insurance (SSDI) Program: A Proposed Policy Change to Make Work “Worth It” and Save the Social Security Trust Fund.” p. 3. The authors are the program directors for the benefit offset pilots in their respective states; the report would be available by contacting the lead author through the Vermont Division of Vocational Rehabilitation. The example was modified by increasing the SSDI benefit level from $900 dollars per month to $980 to more closely reflect the national median for disabled workers.

five hours per week at his current wage rate, a number of hours many would consider full time.

Leaving aside the issue of the objective impact of work activity on the probability of continued program eligibility, it should be clear that the 100% loss of SSDI cash benefits (aka the “cash cliff”) that results from having earnings above SGA is a powerful work disincentive. By penalizing work effort at barely the poverty level, current policy reduces beneficiaries’ economic welfare, decreases government tax revenue, and increases Social Security expenditures, as beneficiaries are less likely to seriously test their ability to leave benefits and/or risk behavior that may be interpreted as suggesting such capacity. Over time, it increases pressure on the Social Security Trust Fund and is also likely to contribute to the expected long term labor shortage. To the extent that the recent trends of increased morbidity within the large cohort of aging “baby boomers” and of the increasing average duration beneficiaries are in the SSDI program continue, most of these impacts will be exacerbated.[15] It would seem that, from admittedly different perspectives, these issues would constitute problems enough for beneficiaries, the Social Security Administration, and, more generally, society. One recent study of the employment rates of working age SSDI beneficiaries estimated that it was 9% for those in SSDI but not SSI, 11% for those with concurrent benefits. Though no one really knows what proportion of beneficiaries could perform compensated work at any time, these employment rates are approximately one quarter of the proportions of those who indicated interest in working.[16]

However for Pathways and the network of actors and stakeholders associated with it, the problems arising from the structure of SSDI program rules was part of a broader concern with the status of persons with disabilities, particularly those served by public benefit programs. In addition to the SSA administered SSDI and Supplemental Security Income (SSI) programs, these programs included state administered, funded, or regulated income and/or in kind transfer programs, health care programs, rehabilitation and training programs, and long term support programs. It was in this context that Pathways chose to become involved in implementing a benefit offset pilot. In point of fact, it was in this more holistic context that Pathways had lobbied for a test of a SSDI benefit offset since 1998.

Housed in the state agency that administered both Medicaid and the provision of long term support services, Pathways’ managers and those whom they reported to came from the perspective that many, perhaps most, SSDI beneficiaries would either continue to use or ultimately enter one or more of these DHS administered programs, irrespective of whether SSDI beneficiaries worked their way off benefits. Nonetheless, it is important to acknowledge that the increase in DHS’ interest in facilitating the employment goals of its consumers was gradual. Though perhaps DHS moved more rapidly than some other federal and state agencies to realizing that most consumers would need to make some

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[15] There are multiple factors involved in the increasing size and cost of SSA disability programs, including SSDI. See Wunderlich, Gooloo S., Rice, Dorothy P., and Amado, Nicole L, eds. 2002. The Dynamics of Disability: Measuring and Monitoring Disability for Social Security Programs. Washington, DC: National Academy Press. pp. 42-52.

[16] Livermore, Gina A. 2008, “Disability Policy Research Brief Number 08-01: Earnings and Work Expectations of Social Security Disability Beneficiaries.” Washington, DC: Center for Studying Disability Policy, Mathematica Policy Research, Inc. pp. 2-3. Estimates for having employment in the previous year were a little higher; at 13% for both the SSDI only and the concurrent groups.

permanent use of public benefits in order to work, this realization was not unique to DHS nor is it to this day complete. A similar evolution can be seen at federal agencies that serve persons with disabilities, including SSA.

We would argue that prior to the late 1990s SSA's concept of "return to work" strongly emphasized leaving benefit status permanently.[17] Nothing typifies this mind set more than the repeated use of a particular factoid in discussions of the issue: not more than one of every five hundred SSDI beneficiaries has left the rolls by returning to work.[18] Two events in this period both marked and facilitated a gradual shift in emphasis toward supporting increased employment outcomes for people with severe disabilities even if those outcomes were not often associated with an end to benefit status. One was the State Partnership Initiative (SPI). The other was the Ticket to Work and Work Incentives Improvement Act of 1999, including the Act's emphasis on Medicaid Buy-in options for working people with disabilities.

SSA, as co-sponsor of SPI, funded demonstration programs in twelve states to test innovative approaches for helping persons with severe disabilities enter or return to the workforce. At the start of SPI, the federal sponsors emphasized the potential of new work incentives and support programs to reduce the numbers of people who would maintain long term attachment to federal disability programs. Other stakeholders, including the state agencies operating SPI projects, tended to frame their arguments in this language to make it more likely that federal actors would take their interests, claims, and programmatic ideas more seriously. During SPI, SSA and other agencies gradually moved to the position that while relatively few persons who qualify for a Social Security program or Medicaid because of serious disabilities would ever be able to live without some form of public assistance, it would be in the public interest to assist them in achieving whatever level of self-sufficiency they might be capable of achieving. One factor in this process was the generally modest results produced through the SPI efforts, including Wisconsin's Pathways to Independence.[19]

The signature feature of Ticket to Work and Work Incentives Improvement Act was a voucher program that awarded vendors who were able to provide training and

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[17] The concept of "return to work" also includes initial efforts to work by those on Social Security disability benefits with no prior work history. The concept is also broad enough to subsume increased work effort and/or improved employment outcomes for SSDI beneficiaries and SSI recipients who are already working.

[18] Though still occasionally used, this statement or similar ones are used far less often today than a decade ago. This change does not so much reflect a positive empirical trend as how issues of return to work are thought about and debated. If anything, there is evidence that employment outcomes for persons with severe disabilities have decreased since the early 1990s. For example, see Stapleton, David C., and Burkhauser, Richard V. eds. 2003. The Decline in Employment of People with Disabilities: A Policy Puzzle. Kalamazoo, MI: W.E. Upjohn Institute.

[19] Pathways to Independence was the name of the Wisconsin SPI project. The name was later applied to the collaborative formed by DHS and the two University of Wisconsin units and was ultimately used to identify, in aggregate, Wisconsin's activities conducted under the Medicaid Infrastructure Grant.

other services that helped those on SSDI and SSI return to work. [20] Payouts were structured to reward work effort over SGA, that is, earnings that would lead to ending attachment to the SSA income support programs. In turn, two features of the Ticket to Work and Work Incentives Improvement Act, the authorization of a new, more flexible type of Medicaid Buy-in and an extension of the period of Medicare eligibility for former SSDI beneficiaries, were intended to address SSDI beneficiaries' fear of losing access to needed health care. Like SPI, the "Ticket," at least over its first decade, did not result in many people leaving benefit status. Ultimately the program was altered to give somewhat greater reward for helping those on Social Security disability benefits achieve more modest employment outcomes. Concurrently, the Centers for Medicare and Medicaid Services (CMS) gave greater attention to the use of Medicaid Buy-ins to support work efforts of persons who would retain long term attachment to income support programs, including through the use of Medicaid Infrastructure Grant (MIG) resources to support programmatic innovation and expanded work incentive benefits counseling services.[21]

B. Wisconsin's Efforts to Address the Problem

As noted, the problem that SSDI-EP addressed could be conceptualized in either the narrow sense of reducing the negative impact of the SSDI program rules on employment outcomes or the broader one of improving outcomes for persons with severe disabilities more generally, including SSDI beneficiaries. This account focuses on how Wisconsin addressed both characterizations, with the caveat that only the federal government could authorize efforts to change or test changes to SSDI program rules such as the cash cliff.

Additionally, this account concentrates on efforts associated with DHS, especially those that were designed, funded, or implemented through Pathways or linked to the entity's initial development. Little is said about efforts by other state agencies, most notably the Wisconsin Division of Vocational Rehabilitation (DVR), or of private entities or groups in the state. This concentration on DHS activities reflects the agency's primary mission in reference to working age adults with severe disabilities: providing health care and/or long term support services. Eligibility for such services has generally required that consumers meet the Social Security medical definition of disability. As most relevant DHS programs have been Medicaid related, SSDI beneficiaries were not automatically eligible for participation. Nonetheless, a substantial proportion of Wisconsin's adult SSDI

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[20] Though one goal of the Ticket was to elicit a greater supply and variety of service vendors (called "employment networks"), over 90% of vouchers have been deposited with state Vocational Rehabilitation agencies. Historically, less than 5% of those have received vouchers have used them. Thus the demand for employment network creation or expansion has been less than overwhelming. See http://www.socialsecurity.gov/work/tickettracker.html for the most recently updated information. (last accessed in August 2009).

[21] MIG funds cannot be used for direct service provision except benefits counseling. Up to 10% of a state's MIG award can be used for that purpose. Work incentive benefits counseling is intended to help consumers understand the potential impact of work activity on benefit programs eligibility and levels so they can make informed decisions.

In Wisconsin, as elsewhere, the term "consumer" has gradually replaced the term "client" as a descriptor of a participant in public benefit programs.

beneficiaries have participated in DHS administered programs and this proportion has expanded over the years with the creation of a Medicaid Buy-in and changes to Medicaid waiver programs.

We view 1981 as a useful starting point for reviewing the sequence of state based efforts that would result in Wisconsin hosting one of the four cash benefit offset pilots. At the federal level, Congress authorized the Medicaid 1915(c) Home and Community Based Services Waiver program. In Wisconsin, the legislature created the Community Options Program (COP). Both programs allowed funding of a much broader range of services for the purpose of helping persons with disabilities to remain in their communities than had been previously allowed. Both programs permitted services that were not “medical” in any immediate sense, including services that could support employment. The 1915(c) waivers, as part of the state’s Medicaid program, included limits on income and assets that could exclude many SSDI beneficiaries. This was not the case with the fully state funded COP, though as with many Medicaid waivers there were limits on the number of consumers who could be served and, as a consequence, long waiting lists.

Starting in the mid 1990s, DHS staff began to systematically explore whether consumers in COP and other long term support programs desired employment and, when so, what conditions facilitated or discouraged work activity. This exploration began with consumer interviews and surveys. The basic findings were that a majority of consumers wanted to at least test employment, but in most cases there were multiple factors that had a bearing on whether employment was a practical option and, more often than not, the barriers to work were more formidable than the incentives and supports. Disincentives stemming from program rules (including the SSDI cash cliff) or from undesirable interactions between the eligibility rules of different programs were identified as an important barrier to employment. For many consumers, the impacts of policy based disincentives interacted with and typically reinforced the effects of other types of barriers. While some of these combinations appeared more frequently than others, it became apparent that intervention strategies would need to address a wide range of needs and circumstances.

This period of needs assessment was soon followed by efforts to develop policy approaches that would address barriers and opportunities in a holistic and individualized manner. These efforts involved multiple actors, but the key entities were DHS and a non-profit entity, Employment Resources, Incorporated (ERI). Program development centered on two issues: developing ways to provide consumers better information about their situations and options and increasing consumers’ abilities to define and pursue their employment goals. Two primary techniques for responding to these issues soon emerged. The main strategy for improving both the availability of information and improving consumers’ ability to use it was what would become known as work incentive benefits counseling. The main approach for helping consumers identify and pursue goals was the approach now referred to as person centered planning (PCP). These two interventions were unified into a team based process which ERI coined the “Vocational Futures Planning Model” (VFP). The Robert Wood Johnson Foundation funded a feasibility study of the approach that was operated by ERI, but limited to one area of the state. Additionally, the feasibility study was restricted to persons with physical disabilities. The Wisconsin SPI project was based on the same general intervention approach, though the effort to take the approach statewide and to serve consumers with a wider range of disabilities resulted in the development of multiple variants of the “pure”

VFP. What was to become the Pathways entity had principal responsibility for managing the project and providing training and technical assistance to the approximately twenty organizations chosen to enroll participants and implement the intervention model. In short, much of the Wisconsin cash benefit offset's framework originated in SPI and the activities that preceded it. The SPI project enrolled its first participant in summer 1999 and continued serving participants through 2004.

These developments occurred within the context of a larger DHS effort to develop a capitated managed care system for providing long term support services for the frail elderly and those with severe disabilities. This effort resulted in what is now known as Family Care. The effort was intended to fulfill multiple purposes including containing costs, ending waiting lists, and, to the fullest practicable extent, allowing consumers access to those services most consistent with their preferences and goals. This final purpose was understood to include access to employment related services and supports. DHS created a specific entity, the Center for Delivery Systems Development (CDSD) to plan and test the managed care initiative. What was to become Pathways was also housed in CDSD.

In preparation for the Wisconsin SPI project, staff at CDSD began work on two fronts to ameliorate the policy barriers that project participants would face. The first of these was to fashion a proposal for a Medicaid Buy-in based on the provisions of the 1997 Balanced Budget Act. The Medicaid Buy-in, as a statutory change to the state's Medicaid Plan, would be available to anyone who met the eligibility requirements, not merely SPI participants. SSDI beneficiaries were viewed as the key constituency for the Buy-in, as it would provide a means to obtain affordable public health care coverage that would be independent of any termination of Medicare eligibility that might ultimately follow completion of EPE.[22] Those who designed the Wisconsin Buy-in were aware of empirical work documenting that many beneficiaries claimed they remained attached to SSDI primarily to protect access to health care, rather than to keep income support. The Buy-in also provided the additional benefit of services not covered under Medicare and potential eligibility for Medicaid funded long term care supports. The Wisconsin Medicaid Buy-in went into effect in March 2000, six months after the start of the SPI demonstration.

The second front was that of seeking temporary program rule waivers specifically for SPI participants. Though CDSD/Pathways explored the possibility of waivers to multiple federal and state programs, most effort focused on obtaining temporary changes to Social Security disability program rules. These included both a cash benefit offset for those in SSDI and an enhanced offset for those in SSI. Of these, Pathways

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[22] Historically, over 80% of those in the Wisconsin Medicaid Buy-in are thought to be SSDI beneficiaries. Estimates have been based largely on information about age and Medicare eligibility. One feature of Medicaid Buy-ins is that SGA earnings do not result in loss of eligibility. Thus, in theory, a SSDI beneficiary could engage in work effort that would result in leaving that program but retain access to Medicaid indefinitely. However, remaining in the Buy-in still requires that the consumer have a disability determination for Medicaid, which involves the same medical standard as the Social Security disability programs. Thus, those participating in the Buy-ins face the same issue of whether work activity (which is generally an eligibility requirement for Buy-in participation) might be used as evidence that the consumer is no longer disabled. In Wisconsin, any review of a Buy-in participant's disability status is made by the same agency that conducts reviews for SSI and SSDI eligibility.

staff viewed the proposed SSDI waiver as the far more important change, as the SSDI program had no feature equivalent to the existing 1619 provision of SSI.[23] Moreover, there was something of a consensus that SSDI beneficiaries, because of their previous labor market experience, would, in the absence of the "cash cliff," be in a generally better position to increase their work effort and earnings than SSI recipients.

The SSI waiver was implemented in May 2001, almost two years after project start-up. The SSDI waiver was never granted. Though the delay in obtaining the SSI waiver negatively affected the central Pathways office's relationships with its cooperating partners and other stakeholders, the failure to obtain the SSDI waiver had stronger and more persistent consequences. Pathways staff, especially its original Director, stressed the significance of the waivers in recruiting partners, especially the community agencies that would recruit and work directly with participants.[24] Partners generally believed that even if the waivers were not in place when SPI started enrollment in summer 1999, they soon would be. Little was done to temper this impression, though experienced DHS staff knew that obtaining such waivers is hardly quick work even when an agency, such as CMS, has standard procedures for processing waiver requests. SSA, by contrast, did not.

Staff at many of the SPI sites reported they had concentrated on recruiting and enrolling SSDI beneficiaries over the first year or so of the project in expectation of the waiver, a claim supported by an examination of actual enrollment patterns. Further, they conveyed their expectations about waiver availability to consumers. As the program progressed, staff members at the community agencies were increasingly disappointed. Some reported that they felt misled by Pathways. More importantly, by trusting that Pathways would obtain the proposed waivers, they had conveyed inaccurate information about the project to participants. They argued that this made SPI objectively less useful to many participants and, more importantly, negatively affected participant trust and motivation. There were also indications that other partners including staff at DVR and at least one DHS bureau, felt that Pathways had exaggerated its ability to obtain the waivers and, as a result, became more skeptical of SPI and other Pathways efforts.[25]

In addition to the service and policy initiatives already noted, the Wisconsin SPI project could be said to have created or increased institutional capacity to address issues of disability and employment, capacity that would be available for the benefit

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[23] The SSI 1619 provision trades one dollar in benefits for each two dollars of additional earnings. 1619 is implemented above $85 per month, rather than at SGA. Though SSDI allows beneficiaries to earn above SGA and keep their full SSDI benefit during a nine month Trial Work Period, the SSI 1619 provision remains in force as long as the recipient retains her/his disability status.

[24] The original Director was also the head of the Center for Delivery Systems Development (CDSD) which then housed both Pathways and the effort to develop Family Care. This individual left CDSD well before the conclusion of the SPI project.

[25] Material about the development and implementation of the Wisconsin SPI project, including the unsuccessful effort to obtain a SSDI waiver, was largely taken from See Delin, Barry S., Reither, Anne E., Drew, Julia A., and Hanes, Pamela P. 2004. Final Project Report: Wisconsin Pathways to Independence. Menomonie, WI: University of Wisconsin – Stout Vocational Rehabilitation Institute.

offset pilot. First and foremost, a substantial cadre of benefits counselors were trained and gained practical experience. SPI also resulted in the generation of some level of permanent demand for work incentive benefits counseling from consumers, community agencies and DVR.[26] In tandem, these conditions supported having an ongoing capacity to provide work incentive benefits counseling beyond the level SSA would support nationally through the Ticket to Work. The establishment of a permanent technical assistance and training center, the Wisconsin Disability Benefits Network (WDBN), would prove to be an important development, both for supporting a high level of benefits counseling capacity (relative to other states) and for providing an organizational model that could be utilized for developing and sustaining capacity in multiple areas.[27]

Though SPI did not lead to establishing VFP (or any of its variants) as a major component of the service delivery system, it contributed to the development of experience with person-centered employment approaches that would be available for Pathways, DVR, and others to exploit.[28] Roughly contemporary with the end of SPI, Pathways staff began to provide training and technical assistance for the community based entities that would be contracted through the managed long term care system (Family Care) to respond to the employment service needs of members. Gradually Pathways staff began to work directly with staff at the Family Care Managed Care Organizations (MCOs). More so than in SPI, this effort was interactive. In addition to having a stronger focus on responding to needs defined by community service providers and MCOs, Pathways sought to identify and expand good practice based, in part, on the reflections of front line staff about their use of person centered approaches.

Increasingly, this and other Pathways work was supported through the Medicaid Infrastructure Grant. As grant levels increased, Pathways designed or supported an ever greater number and range of efforts to address issues of disability and employment. Though, in our opinion, of varying quality, Pathways’ activities resulted in a range of practices, tools, informational products, and studies that could be and to a substantial degree were used to address issues of disability and employment.

C. How Benefit Offset Plays a Role Addressing the Problem

Wisconsin continued to seek authority from SSA to test a SSDI waiver even after the SPI project ended. It was never the only state involved in these efforts. Pathways, as Wisconsin’s primary agent, and the other petitioners repeatedly pressed the argument that a SSDI benefit offset would likely have beneficial effects on employment and earnings and thus merited testing. For Pathways and its in state allies, a SSDI offset was

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[26] DVR has tended to favor limiting intensive benefits counseling to when a consumer has indicated a clear commitment to work above the SGA level and to achieve that in a limited time period. Other organizations are more sympathetic to providing intensive benefits counseling as a way for consumers to frame goals, identify barriers, and then make informed choices.

[27] According to WDBN staff, it provides technical assistance to a cadre of about fifty active work incentive benefits counselors at any time. The number of trained benefits counselors is appreciably higher.

[28] The VFP approach has become permanent insofar as it is specifically listed among those services that can be authorized through DHS long term support programs. However, it is also clear that VFP as defined in DHS rules does not require the same levels of team based activity or process intensity that were required, at least theoretically, during SPI.

desired for other reasons than its hopefully positive impacts on beneficiaries. In particular, Pathways had growing interest in promoting an environment where persons with serious disabilities could define and make progress toward their employment goals, irrespective of their current program attachment. This tendency was strengthened as the Centers for Medicare and Medicaid Services (CMS) became Pathways most important federal partner. The Medicaid Infrastructure Grant was intended to build capacity that might serve people other than current Medicaid Buy-in participants. CMS signaled interest in potential Buy-in users, even to the point of supporting capacity building with the object of reducing the probability that some might need to enter a Medicaid Buy-in.

While it is arguable that Pathways never fully elaborated an intervention model, it appears that there was an expectation that an offset's beneficial effects would arise through two processes and the interactions between them. The first process would be that of a direct economic incentive, including the expectation that individual's behavior would strongly reflect the assumptions of economic rationality. The second process would be that of changing beneficiaries' perceptions and understandings of their situations and possibilities, especially in ways that reduced fears that employment would threaten access to essential public benefits. Though this second process does not preclude beneficiaries from acting in ways consistent with economic rationality, it does not require that economic rationality be the sole or even the predominant motivator of human action. Furthermore, perceptions, understandings, and, for that matter, behavioral orientations occur in a social context. It matters what other people say or do. Sometimes that may be one's immediate social contacts, sometimes what one learns through impersonal media sources.

If the problem a benefit offset is meant to address is conceptualized narrowly, that is dealing with the disincentive effects of the immediate loss of SSDI cash benefits when earnings go above SGA, then it is not difficult to identify one cause of potentially positive outcomes. To assert the obvious, reducing the 100% marginal tax rate on one income source as earnings increase above a threshold amount to a 50% rate should increase at least some beneficiaries' work effort and earnings. Having more income because of work is almost without exception considered better than having less income because of work. Still it is not obvious how big this incentive effect should be. In the American context, a 50% marginal tax rate is associated with the last dollars of income for the very affluent, not earnings levels that are roughly at the poverty level. Also, as previously noted, SSDI beneficiaries face other challenges to increasing their work effort than SSDI program rules, including the effects of their disabling conditions.

Moreover, the incentive effects of a cash benefit offset will likely be mediated by subjective factors such as beneficiaries' perceptions and concerns of how work activity will affect their ability to either retain or regain SSDI and other public program benefits. While we term these perceptions and concerns subjective, it is important to note that in most cases there is little reason to think these are arbitrary. They reflect beneficiaries' interpretations of their lived experience or of what they have learned about what happened to others. Of course in some cases these interpretations may be objectively false. However, interpretation may often be a matter of perspective. As we shall see later, an action that from SSA's perspective may be viewed as consistent with the principle of not harming a beneficiary may from the beneficiary's perspective be as reasonably viewed as an action that has caused harm or has the potential to do so in the future. Additionally, other subjective factors, including basic values or priorities, may well influence whether and how an economic incentive is used.

Despite these cautions about the factors that might reduce the effectiveness of an offset, Pathways and its partners generally expected the offset would have some beneficial effect. Many of those involved in the “network” expressed the view that the disappointedly modest gains in employment outcomes by SPI participants resulted, in large part, from the failure to address the cash cliff. Beyond this it also appears that many believed that obtaining the offset might provide strong signals that the system was moving in a desirable direction. Consumers, whether SSDI beneficiaries or not, would be encouraged. Of equal importance, the organizations, both public and private, that had been involved with SPI or had carefully observed it, would be encouraged to either participate in new efforts or to do so with more commitment. This was especially important at the front line. If a benefits counselor’s expert opinion were that increased work effort would be more likely to harm than to help a consumer, it would be far less likely that the consumer would undertake such effort.

Finally, few among the Pathways staff or its partners expected the offset to work as a proverbial silver bullet, even for beneficiaries who had some history of relatively high earnings following their initial entitlement for SSDI benefits. Too many persons with serious disabilities faced multiple barriers, including the possibility that their health might deteriorate either cyclically or permanently. Stakeholders repeatedly used the metaphor that overcoming any particular barrier to work resembled peeling an onion. It followed, then, that for most beneficiaries, an offset would have to be used as part of a broader and generally individualized strategy. So there was always a concern about what other conditions, including services and supports, would need to be in place for consumers to effectively use policy changes such as a SSDI offset. For Pathways, one consistent answer would be the availability of work incentive benefits counseling.

There was also concern about the provisions of the benefit offset provision itself. It was felt that the potential impact might reflect the slope of the offset. In general, Pathways staff favored a more gradual reduction of the SSDI benefit than 50%, especially given the likelihood that an offset incorporated into the Social Security Act would apply to concurrent beneficiaries who could already use the SSI 1619 option. Similar issues arose over whether the offset should be applied at SGA or at some level well below it. Most of all, there was an abiding concern about whether beneficiaries could be reasonably protected from having their work efforts used as evidence of medical improvement, especially in the case of cyclical disabilities, those where primary symptoms had strong subjective components, or those where medications might not be permanently effective. In the context of the benefit offset pilots, most of these issues were determined by SSA. As such, Pathways’ or its partners’ preferences on these issues have no further bearing on this narrative.

D. State Level Context/Environment in which Wisconsin Implemented the Pilot

The SSDI benefit offset pilots, as any policy initiative, were implemented in a wider social context. Given the complexity and variability of both individual and collective behavior, any test of a benefit offset would inevitably be a test within a limited set of contexts. Moreover, contexts change over time. As the benefit offset pilots were intended to inform both the design of a larger demonstration and of possible changes to the SSDI program, it is reasonable to ask whether what is learned in Wisconsin or any of the other pilot states is more broadly applicable.[29] We will not seek to analyze that issue directly. We only wish to note that Wisconsin (and for that matter the other pilot states) are part of a reasonably coherent national community and this, in our view, is sufficient basis for taking the pilots' results seriously.

Nonetheless, state level variations can have a significant impact on policy implementation and outcomes. Indeed, environmental characteristics must be taken into account in policy design if for no other reason to identify the boundaries of the practical. Though we can only assess contextual impacts on the SSDI-EP to a limited and often indirect extent, it is important to identify local conditions that we think had a large potential to affect either program implementation or outcomes. We think that three kinds of state level contextual factors are especially important: economic conditions, the policy environment, and the organizational infrastructure that was available or could be built to deliver or support the pilot. It is important to note that state level context is to some degree, shaped by external trends or events. External factors can even dominate. For example, short term economic conditions in Wisconsin are driven more by national and international trends than by anything that happens in the state. Yet this dominance is rarely, if ever, complete. Public and private choices within the state, for example about education and capital investment, will have a long term influence on Wisconsin's relative position in the national and world economies irrespective of the business cycle.

To use a benefit offset a beneficiary would need to participate in the labor market. It is reasonable to hypothesize that outcomes would be better in good economic times than in poor ones. It is also reasonable to think that it would be easier to assess the offset impacts over periods when economic conditions are relatively stable.

In some respects, economic conditions in Wisconsin can be characterized as benign and stable over the August 2005 through December 2008 period on which this evaluation concentrates. Annual inflation rates, as captured by the consumer price index for urban consumers (CPI-U) were modest, typically around 3%. More importantly Wisconsin seasonally adjusted unemployment rates were generally low, varying over a fairly narrow range of 4.4% to 5.9%. The maximum was reached in December 2008, heralding the rapid increase in unemployment rates that would occur in 2009.[30] However, this deterioration occurred after most enrollees had completed the nine quarter participation period analyzed in this report.[31]

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[29] We will delay consideration of an important type of contextual issue that affects any judgment of how well the Wisconsin pilot can inform policy development and implementation of an offset. Pilot eligibility rules and, secondarily, recruitment strategies meant that participant characteristics would not closely match those of the population of SSDI beneficiaries who would be eligible to use an offset provision if one were added to the Social Security Act.

[30] Wisconsin unemployment rates were generally equal to or slightly lower than national rates over most of the 2005-08. In the second half of 2008, national rates rose appreciably sooner and higher than Wisconsin's. Data are from the Economagic website: http://www.economagic.com. (accessed In August 2009).

[31] Enrollment in the SSDI-EP ended on October 31, 2006; only those enrolled in that month would have generated outcome data that included the fourth calendar quarter of 2008. For comparison, the analysis period for a participant who enrolled in the July-September period of 2006 would have ended with the third quarter of 2008. The September 2008 unemployment rate of 4.7% was typical of monthly values through the pilot.

As it is not inevitable that employment conditions for the general population correlate strongly with those faced by persons with disabilities, it may be helpful to review some information about employment rates for disability populations. While available data demonstrate that persons with disabilities are far less likely to be employed than the non-disabled population and to have less earnings when they are, persons with disabilities in Wisconsin appear to have better outcomes relative to national averages. For one indicator, the difference is impressive. Roughly twice the proportion of Wisconsin's blind and disabled SSI recipients report earnings than the proportion for the United States as a whole. This difference has been persistent; for example, in December 2005 the proportion was 12.1% in Wisconsin, 5.6% nationally.[32]

Looking at data from the American Community Survey (ACS), Wisconsin's advantage remains, but the differences from national figures are less pronounced. Though the ACS data does not identify SSDI or SSI, based on respondent answers it identifies a category of working age persons with an "employment disability."[33] Respondents in this category have much lower employment rates and are far less likely to report having full time employment than the larger sample of working age persons who are identified as "disabled." For example, in 2005 21.7% of those in Wisconsin with an employment disability reported employment compared to 17.7% nationally. However, Wisconsin's seemingly better labor market for persons with disabilities must be assessed in context. Wisconsin's labor participation rates for the non-disabled population have remained a bit higher than for the United States as a whole.[34]

Yet, economic conditions in Wisconsin were less favorable than might be inferred from employment and inflation statistics. Economic growth is a primary driver of job creation. This is especially important for populations, such as those with severe disabilities, who are not strongly incorporated into the labor force. Wisconsin's growth, relative to both the nation as a whole and to a rate likely to generate job growth, was low. For 2005, 2006, and 2007, Wisconsin's annual rate of increase in its Gross Domestic Product (GDP) was roughly 1% less than for the United States (e.g., 1.9% versus 3.1% in 2007). Admittedly the estimated rates for 2008 converged at .07% as the

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[32] Office of Research, Statistics, and Policy Analysis, Social Security Administration. 2007. "SSI Annual Statistical Report, 2005." Baltimore MD: Social Security Administration. http://www.ssa.gov/policy/docs. (accessed in August 2009). Data was drawn or calculated from Tables 9, 28, and 30.

[33] The ACS classifies persons as having an "employment disability" who report that because of a physical, mental, or emotional condition lasting six months or more they had difficulty in working at a job or business. See Rehabilitation Research and Training Center on Disability Demographics and Statistics. 2007. "2005 Disability Status Reports: United States." Ithaca NY: Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics. p. "P."

[34] ACS data were obtained from the Disability Status Reports prepared by the Rehabilitation Research and Training Center on Disability Demographics and Statistics (StatsRRTC) at Cornell University. For each of the annual American Community Surveys since 2004, StatsRRTC has prepared reports for each state as well as the United States. The 2005 data come from StatsRRTC. 2007. "2005 Disability Status Reports (Wisconsin & United States)." Ithaca NY: Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics. The reports are available online at http://www.DisabilityStatistics.org.

nation endured a financial crisis that induced an unusually severe recession in its wake.[35] While there is uncertainty about the relationship between GDP growth and job creation, a 3% growth rate is often viewed as the threshold for when net job growth will clearly exceed the number of jobs needed because of population increase.[36]

The second contextual factor we identified as potentially important to how effectively someone might use a benefit offset was the state's policy environment. By this we mean the programs, rules, and the grants of public authority that establish them that might either support or impede progress toward improved employment outcomes. Though analytically distinct from implementation, these constitute a framework through which the purposes and opportunities for program or service delivery are constrained. This is most immediately true for public entities, but also for private actors to the extent that their activities are publicly funded or regulated. In describing Wisconsin's policy context, the focus will naturally be on policies that directly impact persons with disabilities. Nonetheless, some consideration need be given to the wider circle of public commitments and limits that can touch on those.

We have previously identified much of the relevant policy framework. Wisconsin through Medicaid waivers and the Community Options Program had the programmatic authority to provide a broad range of services and supports for persons with disabilities who wanted to attempt work. However, as mentioned, available resources fell well short of what would be needed to meet programmatic goals, resulting in extensive waiting lists. It was hoped that Family Care would eventually ameliorate this problem. However when Pathways was planning the SSDI-EP in 2004-5, Family Care was operating in only five counties. One was Milwaukee County, by far the state's largest, but the Milwaukee County Managed Care Organization (MCO) did not serve persons with disabilities under age sixty.

By 2005 the Medicaid Buy-in had been operating for five years and had grown to nearly 10,000 participants by the end of that year. In turn, as the upper limit of a MIG award was 10% of the Medicaid expenses of Buy-in participants, the large Buy-in resulted in Pathways having substantial resources for its efforts.[37] While it is not clear how aware the Governor's office or the legislature was of this dynamic, neither showed much interest in limiting Medicaid Buy-in growth either to constrain spending or to

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[35] GDP data were obtained online from the U.S. Department of Commerce, Bureau of Economic Analysis website at http://www.bea.gov. (accessed in August 2009).

[36] This "rule of thumb" is supported by empirical data about the relationship between real GDP growth and employment. This relationship is usually expressed as an elasticity and, in most cases, treats employment change as occurring at some later point in time than the change in GDP as a lagged variable. For a brief review of pertinent literature see Seyfried, William. 2005. "Examining the Relationship between Employment and Economic Growth in the Ten Largest States". Southwestern Economic Review 32 (1), pp. 13-21. Additionally, the sluggish employment rebounds associated with recent economic downturns have suggested to some that structural changes to the economy have further loosened the relationship between economic growth and job creation.

[37] This funding maximum applies only to states that meet the criteria for receiving what is called a comprehensive grant.

reserve the program to persons making significant work efforts.[38] However, this unwillingness to tinker with eligibility requirements may have worked against those in SSDI, including those who would have access to a benefit offset through the pilot. For the purposes of premium calculation, the Wisconsin Buy-in treated earned and unearned income differently and defined the SSDI benefit as unearned income. Above a certain income threshold, the premium amount included 100% of the SSDI benefit.[39]

In fact, Wisconsin officials exhibited little or no interest in reducing the enrollment of any Medicaid program with the temporary exception of Family Care. Just the opposite, Wisconsin has been open to further expansion of Medicaid services and eligibility to children, low income workers, and the elderly as well as those with disabilities. Even in the case of Family Care, official resistance to its state wide expansion proved to be temporary.[40] This all occurred despite the state's structural deficit, one that motivated budget cutbacks in other areas (including reduction of staff to implement Medicaid related programs) even during good economic times.

Nonetheless, Wisconsin's structural deficit, especially as exacerbated by recession caused revenue declines, has certainly had an impact on the environment in which the SSDI-EP took place. Constraints on both local government revenue and state aid to local governments reduced local governments' capacity to provide a range of services that either directly or indirectly support persons with disabilities. To some extent, the same could be said for a range of DHS activities other than those funded through Medicaid.[41] However, it is likely that the greatest negative impact for SSDI beneficiaries and similar consumers with employment goals has been the constraint on Division of Vocational Rehabilitation (DVR) staffing and services.

The simple fact is that DVR is the most important source of services and supports for those consumers who are either seeking employment or trying to prepare for jobs that require better skills and pay more. DHS funded services are generally more crucial for maintaining employment, as DVR services typically end ninety days after a successful job placement. Though DVR operations are largely federally funded, access to that funding requires a state match. As vocational rehabilitation services, unlike Medicaid, are not an entitlement, state funding is far more likely to be cut or constrained

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[38] The Wisconsin Buy-in requires no minimum earnings level and, as a practical matter, any minimum hours of work. Work has to be compensated, but in-kind compensation is allowed.

[39] Premiums are set in ranges that reflect the total of an individual's unearned income, minus a living allowance and various disability related exclusions plus 3% of earnings. There is no premium as long as gross individual income, adjusted for family size, remains no more than 150% of the federal poverty level.

[40] This assertion applies to state government, especially the Governor who appeared to oppose further Family Care expansion in 2006. There continues to be resistance to expansion at the county level and among some stakeholder groups, but statewide expansion continued on schedule through 2009 to include most of the state. Further expansion will likely be slowed due to the severe budgetary problems arising from the current recession.

[41] Pathways use of MIG funding to support some DHS work-related activities for persons with disabilities (other than prohibited direct service provision) and staffing associated with those activities has lessened this impact.

in a difficult fiscal climate. Over much of the offset pilot's duration, DVR was in either a total or partial Order of Selection (OOS) closure. Consumers, including SSDI-EP participants, without existing service authorizations often had to wait substantial periods to get desired services and supports.[42]

Finally, the SSDI-EP utilized, though not without modification, an organizational infrastructure that had been created for previous initiatives, mainly SPI, but also the expanding range of capacity building efforts pursued through MIG. Much of this infrastructure development has already been described in preceding material about Pathways efforts to address issues of disability and employment.

SPI was implemented at the "street level" through twenty-one community agencies. Pathways had used several methods to encourage appropriate implementation, but a combination of training, technical assistance, and monitoring activities were foremost among these. As the agencies participated under contract, there were also financial incentives and disincentives to provide Pathways staff with an additional source of leverage. As noted, Pathways training and technical assistance capacities were strengthened following SPI, principally through establishing a permanent training and technical assistance center (WDBN) to expand and improve the quality of benefits counseling and a less structured, more participatory effort to incorporate or improve practice of person centered employment services at both community agencies and Family Care MCOs. Concurrent with the pilots, MIG was used to build, expand, or improve capacity in other areas such as employer support, information sharing, assistive technology, school to work transition, and community development. Most of these efforts had at least the potential to support pilot operations.

Thus, while planning the offset pilot, Pathways had the advantage of having a program delivery and some elements of a quality assurance model in place. There was also a cadre of benefits counselors more numerous and more broadly experienced than that developed in other states through Social Security/Ticket to Work sponsored programs such as BPAO or its successor WIPA.[43] Many of these benefits counselors were already in place at the community agencies that would be asked to participate in the SSDI-EP. Pathways would not need to develop de novo capacity to deliver a program across the state. In any case, this would not have happened in a difficult state fiscal environment unless there had been massive federal funding to support this. As noted, DVR, which did have a state wide presence, did not have sufficient resources to take on frontline implementation of the pilot.[44]

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[42] Periods of complete OOS closure were relatively brief, but periods of partial closure were prolonged. Though one might think that most SSDI beneficiaries would be classified in OOS group 1 (most significant) and thus be largely unaffected during partial OOS closures, 59% of SSDI-EP participants who were DVR consumers had an OOS classification of 2 (significant) or 3 (non-significant). These consumers were far more likely to be negatively affected by a partial closure.

[43] BPAO stands for Benefits Planning Assistance and Outreach, WIPA for Work Incentive Planning and Assistance

[44] Through most of SPI, DVR had co-managed the project, but even then the agency was not directly involved in enrolling participants or delivering the intervention models. DVR was involved in training, TA and monitoring activities, but even then could not afford to commit staff effort comparable to that provided through the Pathways entity at DHS.

Consequently, it was extremely practical for Pathways to reconstitute the organizational infrastructure created for SPI as the foundation of the SSDI-EP. However, at least two other factors supported choosing this approach. The first was that Pathways viewed the offset pilot as a logical extension of SPI. It had sought a SSDI offset first as a feature of SPI and then as an extension of that effort. There was no clear dichotomy between the Wisconsin SPI project and the offset pilot. For instance, it was initially hoped that roughly half the pilot participants would be beneficiaries who had participated in SPI without benefit of an offset provision. The most obvious way to connect with these potential pilot participants was thought to be through the community agencies where they had enrolled in SPI.[45] Additionally, Pathways managers and staff felt that a decentralized enrollment and service system would more closely model a "natural" service delivery system, comparable to the way beneficiaries would access information or support should a benefit offset provision become law.

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[45] It was not only the expectation that the former SPI agencies would have better contact information about the former SPI participants, but there would be a higher level of trust between the organizations or, at least, their staff members and the former SPI participants than would be the case between DHS and the former SPI participants.

CHAPTER II: BENEFIT OFFSET PILOT DESIGN FEATURES

This section of the report concentrates on the design features of Wisconsin's benefit offset pilot, the SSDI-EP. Though intertwined in many ways, one can identify separate intervention and evaluation components. The intervention component can be viewed as a joint product arising out of decisions made by the Social Security Administration (SSA) and the Pathways Projects housed at the Office of Independence and Employment (OIE), Wisconsin Department of Health Services (DHS).[46] We characterize the intervention as a joint product rather than a joint design as SSA and Pathways each took a dominant role in planning different aspects of what, in a broad sense, could be termed the intervention. Though SSA certainly consulted Wisconsin and the other states chosen to conduct an offset pilot about the design features SSA would determine, there is little evidence that state input had meaningful influence on most of SSA's decisions. In contrast, though SSA was in a position to reject those design choices made by the state pilots, in Wisconsin, at least, SSA gave very substantial deference to Pathways' choices.

The SSDI-EP evaluation design was produced by staff from the University of Wisconsin – Stout Vocational Rehabilitation Institute (SVRI). Though both SSA and Pathways had authority to reject the design in either whole or part, neither party exercised that authority. SSA did specify research questions as part of the contracts with the four states chosen to implement the pilots. These questions provided substantial guidance for evaluation planning. However, SSA never commented on the original SSDI-EP evaluation design or its subsequent modifications. It was only in June 2009 that SSA took on a direct role in shaping the evaluation. SSA decided to have the evaluation reports for all four offset pilots follow a common format and to include a number of common analyses. Pathways, continuing its established practice, was committed to sponsoring an independent evaluation. However, as the researchers were housed at the Pathways office, there was continual interaction with Pathways management that likely had some impact on the evaluation design and its implementation.[47]

A. Intervention Design

If, in the context of an experimental design, an intervention refers to those aspects of an experiment that are purposively different for members of a treatment and control group, then the SSDI-EP's intervention was solely the temporary changes to SSDI rules that constituted the benefit offset.[48] SSA specified all of the essential features of the offset.

However if the concept of intervention is broadened to include structuring an environment in which the treatment can be effectively tested, then Pathways had a very

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[46] Though OIE/DHS held the contract to operate the Wisconsin pilot, most of the staff involved in designing the pilot, managing it, or responsible for central provision of training and technical assistance were employees of the University of Wisconsin – Stout Vocational Rehabilitation Institute.

[47] For example, Pathways managers and operational staff provided feedback on drafts of the evaluation plan, most data collections instruments, and research dissemination products. Evaluation staff attended the regularly scheduled meetings for SSDI-EP central office staff.

[48] In addition to the offset, this included the suspension of Medical CDRs and the extended EPE.

significant role in designing the intervention. Pathways staff strongly believed that certain support services, particularly benefits counseling, had to be in place for those in the treatment group to make effective use of a benefit offset provision. However, staff also thought that control group members deserved equal access to such services. This was needed to insure that observed differences in employment outcomes could be attributed to the offset, rather than to treatment group members receiving services unavailable to other pilot participants. In addition, there was concern among Pathways staff and potential stakeholders that those in the control group needed to have some incentive to remain in the pilot. This consideration was seen as being as much a matter of fairness as one of providing a tangible quid pro quo. Life can be challenging enough to individuals with serious disabilities; volunteering for the pilot indicated a potential commitment to working at earnings levels above SGA and the associated exposure to risks under existing public policies. Pathways did not wish to discourage consumers who wanted to attempt work at relatively high levels. Irrespective of the success of a SSDI benefit offset, Pathways' main charge, both from DHS and as the entity administering Wisconsin's Medicaid Infrastructure Grant, was to promote better employment outcomes for all persons with serious disabilities. This perspective appears to have been shared by those who designed and implemented the offset pilots in the other three states.

Additionally, SSA allowed states a large measure of control over the design of many key features of the pilots, including participant recruitment and enrollment processes, pilot staffing, service provision, and the means that would be used to maintain contact with participants for both facilitating use of the offset and collecting information needed for operational or evaluation purposes. SSA also indicated a strong preference that the pilots operate state wide. In Wisconsin, it is clear that the SSDI-EP designers' decisions had considerable impact as to who entered the pilot and, through that, observed outcomes. Though Pathways made choices in these areas, it is important to also remember that these choices had been constrained by SSA's decisions about participant eligibility, the offset provision's features, and that agency's decisions about how the offset would be implemented for those who actually used it.

1. SSA Intervention Parameters

SSA required that all of the pilots provide the same basic intervention to those participants randomly assigned to the treatment group. The benefit offset would apply only after completion of the Trial Work Period (TWP), as SSA indicated that it would not tolerate operating the pilot in any way that would disadvantage beneficiaries, particularly those assigned to the treatment group.[49] Under SSDI program rules, TWP beneficiaries receive their full benefit amount during TWP irrespective of how much they earn. If an offset was applied during TWP, affected beneficiaries would have a smaller SSDI check and less total income.

The benefit offset provision SSA tested through the pilots consisted of a reduction of one dollar in the monthly SSDI benefit amount for every two dollars of earnings over the Substantial Gainful Activity (SGA) level.[50] Access to the offset was

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[49] It is arguable whether this standard was met in anything except the most technical fashion. This issue will be discussed in some depth later in the material on project implementation.

[50] For the pilots, SSA decided not to apply the offset to any portion of the SSDI benefit for a treatment group member's dependents.

restricted to a period beginning three months after the completion of the Trial Work Period (TWP) through the seventy-second month following TWP completion. Functionally, this extended the Extended Period of Eligibility (EPE) from thirty-six to seventy-two months, though treatment group members who had completed their TWP before entering a pilot would retain access to the offset only through the seventy-second month following TWP completion. Originally, SSA specified that it did not matter whether or when those assigned to treatment completed the TWP and began the seventy-two month period of offset eligibility. SSA, in late 2008, limited this general assurance to include only treatment group members who completed their TWP by December 31 of that year, effectively revoking offset eligibility for those who had not achieved that milestone. Finally, treatment group members also received protection against loss of SSDI eligibility through suspending scheduled medical Continuing Disability Reviews (CDRs) and, for those past the end of their EPE (but still viewed as disabled), restoration of their SSDI cash benefit, subject to the application of the offset provision. However, a treatment group member who faced a scheduled CDR at the time of enrollment was not exempted from that review.

SSA also specified the basic eligibility requirements. Participants had to be volunteers and enrolled through an informed consent process that met SSA standards.[51] Enrollment would be limited to adult SSDI beneficiaries who were receiving their benefits as a consequence of their own earnings records.[52] Beneficiaries eligible for SSI (Supplemental Security Income) benefits were also excluded.[53] While starting or completing the TWP was not an eligibility requirement, a beneficiary who had completed his TWP seventy-two or more months prior to attempting enrollment would not be eligible to enroll. Finally, SSA precluded enrollment of beneficiaries within twenty-four months of an expedited reinstatement.

One effect of restricting pilot eligibility to a subset of adult beneficiaries was to guarantee that the characteristics of pilot participants would not closely resemble those of the population legally qualified to use any conceivable statutory offset, even within the states where the pilots were sited. Based on comments from the SSA project manager, decisions to restrict the pilot eligibility rules were made in the interest of administrative simplicity. Within these constraints, SSA permitted the pilots to have additional eligibility requirements to suit state goals or programmatic context.[54] Pathways did not establish

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[51] SSA wanted specific language describing the benefits, risks, and obligations associated with participation in the treatment group in each pilot’s consent forms.

[52] In particular, this meant that DACs (Disabled Adult Children) and those entitled to DWB (Disabled Widow/Widower Benefits) were excluded from the pilots. This eligibility exclusion was added to those SSA had previously stipulated relatively late in the planning process May 2005, less than two months prior to the nominal start date of the pilots.

[53] However, SSA did not exclude SSDI beneficiaries receiving a state SSI supplement. It left discretion to do so to the states. Wisconsin chose not to exclude otherwise eligible beneficiaries who still received the supplement. There were two such participants.

[54] For example, SSA allowed the state projects discretion in requiring enrollees to have started or completed a TWP, to finish the TWP within specified time limits, to remain state residents following enrollment, or to have a minimum earnings level.

any for the SSDI-EP beyond requiring participants to be state residents at the time of enrollment.

In addition to stipulating the offset pilots' basic features and eligibility rules, SSA set up the administrative process for confirming participant eligibility. Oddly, SSA chose to perform this function only for those assigned to the treatment group, having the decision made in its Office of Central Operations (OCO) in Baltimore. SSA was silent on whether, let alone how, the pilots should certify that those in the control group met the same eligibility criteria, seemingly a condition of implementing an experimental design.[55] Indeed, SSA staff in Baltimore seemed largely unmindful of the fact that control group members were also pilot participants, often conflating assignment with treatment with being in the pilot in both oral and written communications and not asking the pilots to identify those in the control group.[56]

SSA also established the processes administering the benefit offset, including identifying whether, for particular beneficiaries, an offset should be applied and, if so, to generate the appropriate reduction in the monthly SSDI payment. To do so SSA faced the challenge of how to operate under a substantially different set of procedures for a very small number of beneficiaries in the context of a highly routinized bureaucratic system. Informants have reported that these challenges were compounded by the inflexibilities, even instabilities, of SSA data systems. There are separate data systems for administering the SSDI and SSI disability programs. While the SSI system provided SSA with capacity to track monthly earnings and to implement an offset, the SSDI system did not. Everything would have to be done by hand.

SSA decided not to track treatment group members' earnings on a monthly basis. Instead, SSA decided that treatment group members would submit yearly earnings estimates with the option of amending them.[57] These estimates would be used to calculate the size of any reduction in the SSDI check, provided the beneficiary had completed their TWP and three month grace period. At the start of the following calendar year, the accuracy of the estimate and of actual payments would be assessed retrospectively. As SSA accepted the reality that a system based on estimates would result in some inaccuracies, the agency committed to forgiving relatively small overpayments.[58] Though subject to some subsequent modification, this system of yearly estimates and reconciliations has remained in force and is expected to continue.

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[55] The SSDI-EP arranged for the Madison area office to assume this function.

[56] SSA expressed no interest through most of the project, even when asked by the pilots. SSA finally acknowledged that any analyses utilizing individual level SSDI program data would need to use data for both those in treatment and control. It was only then that SSA (in Baltimore) was willing to receive identifying information for control group members.

[57] Early in the pilot, SSA wanted the updates amended within a month, but later backed away from this because of the workload involved.

[58] SSA indicated that it would automatically forgive any overpayment under the offset of up to $500 per year; later this amount was raised to $1,000. Beyond this SSA has a history of being receptive to requests to waive overpayments, especially when there is no evidence that a beneficiary deliberately sought to receive or continue an overpayment.

Given the small scale and atypical nature of the pilots, SSA decided to administer the offset through its Office of Central Operations (OCO).[59] A critical step in administering the offset was to determine whether and when a treatment group member had completed her TWP and whether, based on the work review this involved, the individual was qualified to enter the EPE.[60] It was only then that OCO, based on the earnings estimate, could actually apply the offset provision. Through much of the project, OCO did not designate specific staff members to handle these operations on a continuing fashion. It is also our understanding that the SSA project manager had no authority over who at OCO would perform these functions.

2. State Intervention Parameters

As described, SSA was far less prescriptive about how the states organized their recruitment, enrollment processes, service provision, and participant contact and tracking processes. Although, through the contracting process, SSA had the ultimate say as to how states organized their pilot projects, it left Pathways largely free to design the project infrastructure in these areas. The main exception would be in areas that touched upon offset administration, for example the language used in notices or the procedures used to gather earnings data at the end of each year. SSDI-EP staff members appear to have understood the legal basis for SSA's greater prescriptiveness on these matters.

a. Project decentralization and the role of Pathways

Pathways made a number of choices within the framework of the SSA requirements as to how to organize the SSDI-EP. In many respects they resembled those made by the other states. The one area in which the SSDI-EP was critically different was its choice to have outreach/recruitment, enrollment, service provision, and significant data collection performed through a network of, originally, twenty-two contracted provider agencies.[61] [62] Most of these agencies were private non-profit entities, though there were a small number of proprietary and governmental units as well. The key point is that Pathways had no direct authority over these agencies'

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[59] Local SSA offices were with one exception excluded from formal involvement with participants in the treatment group. Local offices had to be directly involved in the resolution of overpayments. However, the local offices continued to work directly with those in the control group. This resulted in some confusion and frustration for pilot participants, provider agency staff, and local SSA staff.

[60] We alternate the use of gender specific third person singular pronouns through the report, rather than use plurals or the s/he or he/she formulations.

[61] Twenty-one agencies enrolled participants. One of these agencies decided to discontinue its participation in the pilot after its first year. Participants who had enrolled at this agency were transferred to another in the same part of the state.

[62] After Wisconsin, the Utah pilot had the most decentralized structure. However, substantially fewer "partners" were involved and the relationships among them appear to be somewhat different. The Utah pilot appears to have adopted a network structure involving a substantial degree of co-management, though partners may have specific areas of responsibility. There is nothing comparable to the SSDI-EP system where twenty-two contracted agencies perform almost all of functions and activities involving direct contact with participants. To give a key example, all SSDI-EP agencies provided or arranged for benefits counseling; in Utah almost all benefits counseling was provided through the Utah Office of Rehabilitation.

operations. The basic relationship between Pathways and the provider agencies would be contractual. Yet, as these contracts involved performance of complex tasks with only an uncertain relationship between those tasks and desired outcomes, Pathways faced the difficult challenge of encouraging flexibility and experimentation while providing adequate guidance and oversight.

Though there were important Wisconsin specific reasons for choosing this approach, SSDI-EP's designers felt that a program delivered in a decentralized manner represented the most typical pattern for delivery of vocational and other social services in the United States and thus would better model the likely environment in which SSDI beneficiaries would use any statutory offset provision.

Nonetheless, the choice of this decentralized structure for the SSDI-EP reflected both the history of the Pathways Projects and considerations specific to the SSDI-EP. The single most important component of the SSDI-EP's service approach was the provision of work incentive benefits counseling. The Pathways Projects (and the antecedent working group housed in DHS) had been instrumental in training benefits counselors in the state, particularly in the context of Wisconsin's State Partnership Initiative (SPI) demonstration.[63] From 1999 through 2004, the Pathways Projects had supported training, technical assistance, and, to a significant degree, funding of benefits counseling through the twenty-one provider agencies that worked directly with SPI participants. In point of fact, there had been little capacity to provide work incentive benefits counseling in Wisconsin before SPI and the capacity that existed was concentrated at organizations that became SPI provider agencies. Because of SPI itself and, later, the training and technical assistance capacity that began in SPI, there had been substantial growth in the number of trained benefits counselors.[64] Much of this capacity had remained at those organizations that had served as SPI provider agencies and was later supported through the Wisconsin Disability Benefits Network, the technical assistance center Pathways had created and continued to support. It was simply more practical to utilize this existing capacity than to attempt to build it at the central project office in Madison, especially as SSA indicated that the pilots should be able to operate on a statewide basis.

Additionally, the provider agencies during SPI had delivered benefits counseling in the context of a broader person centered vocational planning process (PCP). While Pathways staff did not wish to mandate use of an often costly PCP approach for all SSDI-EP participants, they did want participants to have an opportunity to access such services as they might find useful. Again, this pointed toward giving community based agencies a major role in the pilot. First, the capacity to provide both PCP and benefits counseling was concentrated in such agencies, in particular those that had participated in SPI or had later hired staff who had worked at the SPI provider agencies. Though less formalized than that for benefits counseling, Pathways had continued to support

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[63] Wisconsin's SPI project was called "Pathways to Independence." To avoid confusion, this title will not be used again in this paper.

[64] The term "benefits specialist" is used in Wisconsin to denote a person who provides work incentive benefits counseling. We will use "benefits counselor" in this report as that appears to be the more commonly used term nationally.

technical assistance for PCP.[65] Moreover, many of the SPI provider agencies claimed that outcomes for SSDI beneficiaries in that project had been constrained by the lack of a SSDI offset provision. Pathways staff thought there might be value in looking at whether persons with substantial PCP experience might be in a better position than others to quickly exploit the offset without substantial additional services.

Another significant factor was that with the exception of some ability to fund benefits counseling services the SSDI-EP would have no ability to pay for participant services.[66] Community agencies, especially those with experience providing vocational services, had established working relationships with the government agencies that typically fund such services for persons with disabilities. Foremost among these is the Wisconsin Division of Vocational Rehabilitation (DVR), though the various Long Term Care programs in DHS are also an important funding source. Pathways anticipated that these agencies' experience would make it more likely that appropriate individualized service packages could be cobbled together. It also was hoped that these agencies' existing relationships with consumers and their more visible presence in their respective service areas would make it far easier to recruit potential participants than attempting to do so from a central project office housed in the state capital.

Furthermore, there was an additional contingency that supported use of community agencies as the setting for direct contact between the SSDI-EP and its participants. In brief, state rules made it easier to contract with entities with which Pathways had an existing contractual relationship than to either solicit new partners or to build the needed statewide capacity at Pathways itself. In most cases, Pathways could enter into contracts with agencies to become SSDI-EP provider agencies as essentially a continuation of the relationship established in SPI. Sixteen of the twenty-two entities that Pathways selected to help implement the SSDI-EP had been provider agencies during SPI. This represented about three-quarters of the agencies that had served SPI participants. The six new provider agencies were chosen through a competitive process.

Finally, the choice of utilizing community agencies, especially those that had participated in SPI, was connected to the Pathways recruitment strategy and goals for the pilot. The hope was to enroll up to 800 participants, approximately half of whom would be recruited from the 956 persons who had enrolled in Wisconsin's SPI project. Pathways anticipated that most of the other half, that is the "new participants," would be recruited from consumers who had a current or previous relationship with one of the provider agencies. Additionally, it was expected that the provider agencies would

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[65] Admittedly, in 2005, this support was directed more at developing PCP services at Family Care MCOs or the providers contracted to them. However, this technical assistance capacity could be made available to SSDI-EP provider agencies, some of which already served Family Care clients.

[66] These benefits counseling services were paid out of other monies available to OIE/Pathways, not through the SSDI-EP contract with SSA. Originally, these were mainly state funds. MIG funding of benefits counseling services became predominant as other funding sources, including Pathways (OIE's) state appropriation, were reduced or became less available. While no MIG funding was specifically earmarked for the pilot, SSDI-EP participants met the funding criteria.

Provider agencies did receive funding for reporting monthly encounter data to the evaluation team and for performing a variety of activities (many agency specific) intended to maintain participant involvement.

network with local DVR offices, other service providers, etc. to further publicize the pilot and to recruit potential participants.

However, Pathways neither required nor explicitly encouraged provider agencies to conduct recruitment activities in a manner that would result in enrolling roughly equal proportions of individuals with SPI experience and of those without. In fact, Pathways central placed almost no demands on how the agencies conducted their recruitment activities, especially in contrast to Pathways' detailed enrollment protocols. Pathways central office generated materials that could be used or distributed in the community. Pathways staff also met with the administrators and staff of statewide programs to discuss the pilot and to encourage their local offices to cooperate with the provider agencies. This rather "laissez-faire" approach to enrollment later changed, with the central project office arranging for mass mailings to those, at first, in Family Care, and, later, those in DVR and the Medicaid Buy-in thought to have a reasonable probability of being eligible for the offset pilot.

While this decentralized structure would appear to enhance the reach of the pilot and permit it to operate through the entire state, it also meant that there would be little direct contact between central SSDI-EP staff and participants. Provider agency staff would be the face of the project for the participants and the SSDI-EP would be highly dependent on agency staff members' understanding of project rules and on the performance of duties entrusted to them. As will be noted later, this condition also applied to the implementation of research tasks such as informed consent processes and the collection and submission of data on a monthly basis.

This decentralized structure placed great importance on the capacity of the Pathways staff involved in SSDI-EP operations to create and fine tune pilot procedures and to provide effective training, technical assistance, contract monitoring, and troubleshooting. The project design envisioned multiple reinforcing methods for accomplishing these tasks. There would be a dedicated office staff for this purpose who had already gained experience performing these types of tasks during SPI, implementing various MIG funded projects and/or involvement in the WDBN. Formal training for the provider agencies was designed and implemented, as well as outreach activities to key stakeholders such as local SSA offices, DVR, and Family Care. SSDI-EP operations staff at Pathways developed a procedures manual and standardized reports for the provider agencies to submit. There would be site visits and periodic meetings and conference calls including both SSDI-EP operations staff and provider agency personnel. Agency staff members were encouraged to contact central operations staff whenever they felt the need and central operations staff were expected to respond quickly and effectively.

As the availability and quality of benefits counseling were extremely important to successful implementation, a great deal of attention was given to integrating SSDI-EP technical assistance with that from the WDBN, both in terms of content and timing. Closely related to this effort, Pathways operations staff would serve as an intermediary between the participants and their benefits counselors on one hand and SSA staff in Baltimore on the other. In particular, the central Pathways operations staff would become deeply involved in the resolution of issues or conflicts involving eligibility, the initiation or end of the offset provision, and overpayments for those assigned to the

SSDI-EP treatment group.[67] Anticipating most of these needs, those involved in designing the SSDI-EP perceived that it would be necessary that this staff included persons who could function as benefits counselors.

Finally, in addition to the substantial decentralization represented by the use of provider agencies, the SSDI-EP was structured to strongly separate evaluation from other central operations. This was done to facilitate a genuinely independent evaluation. This separation was manifested in at least two important ways. First, data collected for research purposes was, with the exception of those data elements expressly released by participants for program administration purposes, unavailable for operational uses. Second, during enrollment, there were separate informed consent processes for the pilot and for the research, though to limit participant confusion these were administered concurrently. Though operations and research staff generally attempted to keep their provision of training, technical assistance, and other contacts with provider agency staff distinct, provider agency staff proved to have some difficulty understanding the division of responsibilities. Perhaps the fact that the research staff was also housed at the Madison office contributed to this, though the co-location with operations staff was intended to facilitate cooperation and to give research staff greater ability to observe the project and perform process evaluation activities.

b. Intervention and service provision

Pathways decided that it would structure the SSDI-EP so that the availability of the offset provision itself would be the only pilot based difference in what members of the treatment and control groups would experience following random assignment. This statement should not be interpreted as meaning that there was an expectation that their experiences would be the same in a literal sense. It was understood that treatment group members might well have more or better employment opportunities because of the offset and, thus, greater service needs. However, SSDI-EP sought ways to make sure that provider agencies would not deliberately give some participants either a better quality or greater quantity of services simply because of assignment to the treatment group.

The SSDI-EP had several policies or standards dealing with service provision designed to support achievement of this goal. The SSDI-EP, with one important exception, did not guarantee participants a specific service package. Provider agencies were expected to make the same effort to determine and arrange for needed services for all participants on an individualized basis that was consistent to the greatest extent possible with the participant's expressed preferences. As noted, funding or in-house resources for services had generally to be identified on a case by case basis. Agencies were expected to make good faith efforts to locate the resources needed to help all participants achieve their employment goals.

The one area where provider agencies were in some genuine sense required to insure service provision was benefits counseling. The SSDI-EP required all provider agencies to have or arrange for the capacity to provide work incentive benefits

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[67] Overpayments can occur for many reasons unrelated to participation in the SSDI-EP treatment group.

counseling.[68] However, though all participants were ensured access to needed benefits counseling, each provider agency was in the dominant position to interpret what this commitment meant. The SSDI-EP central office did not mandate a minimum amount of service, though pilot rules required that a participant have a full benefits summary when entering the pilot.[69] Additionally, provider agencies were expected to arrange for benefits counseling for any SSDI-EP participant when there was a significant change in that person's employment situation or life circumstances. The OIE work incentive benefits counseling grant (OIE grant) provided the means to realize this should there be no other funding source.[70]

Provider agencies were expected to enroll any eligible participant, except as limited by three factors. First, the provider agency was not required to enroll an otherwise eligible individual when the agency did not have the capability to serve a person with a particular combination of symptoms or impairments. Second, a provider agency was allowed to refuse potential participants who were not eligible for agency services because of state or pre-existing agency rules. Finally, provider agencies had designated geographic enrollment and service areas negotiated as part of their DHS contracts and could choose not to serve individuals who resided outside the boundaries.

In lieu of direct funding for services, the SSDI-EP funded provider agencies chiefly for providing data for both operational and evaluation purposes, but secondarily to support communication with and the involvement of participants and to allow agency staff to participate in pilot related training and technical assistance activities. It is inconceivable that this funding, while probably more than sufficient for its stated purpose, would have provided any meaningful subsidy for employment related services.

c. Project staffing

The SSDI-EP's decentralized structure had implications for the organization of the "project team." There was a clear division between the project central office at Pathways and the staff at each of the provider agencies. As noted, the central office's authority was ultimately contractual, though in practice largely exercised through a training and technical assistance regime. Within the SSDI-EP central office, there was a strong functional differentiation between operations and evaluation staff, though there

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[68] Pathways much preferred that provider agencies had a trained benefits counselor. To encourage this, Pathways put substantial resources into providing for training and ongoing technical assistance. With few exceptions, SSDI-EP provider agencies chose to have benefits counselors on staff, though several agencies went through periods when they either had no benefits counselor or an inexperienced one.

[69] This did not necessarily require doing an assessment de novo. For example, a participant with a full benefits summary completed within six months, sometimes a year, before enrollment would not be seen as automatically needing additional benefits counseling provided a benefits counselor determined that there had been no relevant changes in the consumer's situation.

[70] However, several provider agencies did not apply for the OIE grant until 2007. Until July 2007, there was no way to insure funding for all participants at these agencies unless the agency was willing to absorb the cost. These agencies could have easily qualified for the OIE grant at any time had they chosen to apply.

was no formal organizational separation.[71] The operations staff and overall project management are discussed in this section, the evaluation team in the next.

The provider agencies directly hired and supervised their staff who worked on the pilot, including benefits counselors. Pathways strongly preferred that benefits counselors be directly employed by the agency, but did allow agencies to use benefits counselors who were either employees at other entities or independent contractors. Nonetheless, provider agencies were required to utilize benefits counselors who had successfully completed WDBN training and who would be obliged to get follow-up training and technical assistance from that source.[72] Pathways also desired that benefits counselors conduct the enrollment process and maintain direct contact with participants to facilitate participants' employment goals and to collect information for both SSA and the evaluation team. However, Pathways permitted other arrangements.

Additionally, provider agencies needed to designate a person who would be the administrative contact with the SSDI-EP central office. Beyond this, a provider agency could assign additional staff (e.g., vocational service staff) to the project, but few did so. The more typical pattern was that pilot participants had access to services provided by other agency personnel. In practice, the extent to which this was true varied widely across provider agencies, reflecting agency rules, service philosophies, and the need for a source of external funding.

Initially, the SSDI-EP operations staff consisted of Pathways staff who had worked on the SPI project. These staff had been involved in the design of policy and procedures for that effort, in providing training and technical assistance to the agencies that took part, and/or monitoring contract compliance. These individuals performed similar functions in planning the pilot and helping provider agencies to become operational. As the provider agencies enrolled and then served participants, the operation team's emphasis shifted to supporting the benefits counseling activities at the agencies and serving as intermediaries between the benefits counselors working directly with participants and OCO in Baltimore. Consequently, after two of the initial operations staff members left Pathways, new hires were chosen more for their experience in providing benefits counseling and technical assistance to support it, then for expertise in policy or organizational design.

The SSDI-EP operations team had a manager who was more involved in contracting and global oversight of provider agencies than routine support of agency staff, though she provided backup for these as needed. This manger administered the Wisconsin pilot and served as the liaison with the project manager at SSA in conjunction with the Pathways/OIE Director.

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[71] Members of the central office staff included at various times DHS, UW-Madison, and UW-Stout employees, each subject to their own supervisory hierarchy. However, through most of the project, all members of both the operations and evaluation teams were employees of the UW-Stout Vocational Rehabilitation Institute.

[72] For some veteran benefits counselors other sources of initial training were acceptable.

B. Evaluation Design

The four pilots were required to conduct evaluations that would inform the design of the national demonstration as well as examine the outcomes of each pilot. SSA identified a number of research questions that evaluation designs were expected to answer and/or contribute to answers that SSA would derive from information provided from the four pilots. Beyond this, SSA gave the pilots considerable latitude to plan and conduct their evaluations. Though SSA could use the contracting process to limit the focus or scale of Wisconsin's evaluation it did not do so. Moreover, SSA staff expended considerable effort to make sure that the evaluators in Wisconsin and elsewhere would have access to individual level data from the SSA's administrative records. It was only late in the project that SSA became more prescriptive in its approach, imposing a common organization on the evaluation reports and requiring that a group of core analyses be performed and reported in the same way in all four evaluations. Even so, SSA encouraged evaluators to include additional material or analyses that might be of interest to SSA, the state pilots, or other stakeholders.

Pathways chose to have the SSDI-EP evaluation designed and conducted by the University of Wisconsin – Stout staff who authored this report. Though university employees, all had positions that were 100% funded through federal grants or contracts to the Pathways Projects. Notwithstanding this, Pathways management was fully committed to having a fully independent evaluation.[73] Key members of the team had previously worked on the evaluation of the Wisconsin SPI.

The authors of this report developed and, over time, modified an evaluation plan with both process and impact components. From the start, we had greater clarity about the primary goals for the process component of the evaluation. One aim was to examine how well the structures and processes set up to recruit and enroll participants, provide services, train and support provider agency staff, collect information, and maintain participant involvement worked. This information would have the potential to directly inform the design of the national demonstration. Secondly, the process component was intended to promote understanding of how the SSDI-EP's design, implementation, and the context in which that implementation occurred shaped participant outcomes. We knew that the characteristics of SSDI-EP participants would be unlikely to closely match those of national demonstration participants. Still, much could be learned about the relationships among project implementation, the environment in which it happened, and participant outcomes that might help SSA adopt better design decisions.

The ultimate purpose of the impact component, beyond the understanding that SSA was interested in the impact of a benefit offset on employment related outcomes, was less clear. Given that the pilots would operate in only four states, participants would be volunteers, enrollment numbers would be small, and, above all else, the "exclusionary" nature of pilot eligibility requirements, each pilot's sample characteristics would be substantially different from the population of adult SSDI beneficiaries either nationally or in any of the pilot states. We also expected that, at lest in Wisconsin, this "bias" would be increased because of Pathways' decision to conduct participant recruitment through the provider agencies. At best, any statistically significant

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[73] Members of the evaluation team were formally supervised by the Stout employee who directly managed the SSDI-EP operations team. This individual, despite having supervisory authority, did not attempt to exert any control over the evaluation.

differences between the treatment and control groups would be suggestive of what might occur in the different context of either a national demonstration or a change in the law. Positive findings might increase confidence that the national demonstration was worth doing or provide supporting evidence for those pressing Congress to adopt a benefit offset without having a national demonstration.

There was a second factor bearing on the goals and hence the design of the impact component. The pilots would operate for a limited and initially unknown duration. As those in the treatment group would not be able to utilize the offset unless they had completed the TWP, outcomes could not be directly assessed until a sufficient number in both the treatment and control group had completed their TWP and could have their employment outcomes monitored over some period lengthy enough to support useful analysis. Though we were aware of this issue from the outset of our involvement in evaluation planning, we did not initially grasp its full implications when we drafted the first version of our formal evaluation plan.

Thus, our original evaluation plan emphasized comparisons between study assignment groups or subgroups thereof, as do subsequent versions and the mandatory analyses that SSA first announced in mid-2009. In this structure, we think observed outcomes for the two study groups should not be interpreted as estimates of the benefit offset's direct effects, not even as formative estimates. We would argue that any differences are better viewed as formative estimates that capture differences in the behavior of persons randomly assigned to two similar sets of conditions with the only intentional difference being the ability to potentially use the offset. Those in treatment who have completed TWP have, in principle, the choice as to whether to use the offset. Those in treatment who haven't completed the TWP have, again in principal, the choice to take actions that would lead to TWP completion and through that subsequent offset usage.[74] Consequently, we believe this comparison structure retains value, especially in the context of planning for a national demonstration of limited duration.[75] Should the treatment group exhibit significant gains in employment related outcomes relative to the control group, it would provide evidence that, in combination, the offset's features and administration and the pilot's implementation were efficacious, if not necessarily optimal. The lack of outcome differences would still provide useful information in the sense that SSA and its agents might rethink how to design and operate a national demonstration of a benefit offset.

1. Key Research Questions

Both SSA and Pathways were interested in the same general research questions, though from somewhat different perspectives. For SSA, the primary focus of any evaluation was to help SSA prepare for a national demonstration of a SSDI cash

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[74] In principle, there are many factors, both exogenous and endogenous, that can constrain an individuals' ability to get and maintain employment that result in SGA earnings.

[75] One advantage of a large national demonstration is that it is likely that even if the rate of TWP completion is small there will be a sufficient number of completers in both the treatment and control groups to support analysis.

benefit offset.[76] Pathways managers were perhaps more interested in how the offset might contribute to the efficacy of other programmatic efforts (and visa versa) intended to encourage better employment outcomes for persons with serious disabilities. Given Pathways connection with the state health department, this interest in potential and hopefully positive interactions between changes to Social Security policy and state programs concentrated on those using Medicaid and/or long term support programs.

However, there was nothing about these differences in perspective that was likely to result in an evaluation plan that would not serve the interests of both parties. Both parties wanted to test whether a SSDI benefit offset would increase the employment rates and earnings of beneficiaries. Both parties had an interest in how to effectively administer a benefit offset and what auxiliary services and supports would encourage beneficiaries to take advantage of the offset provision.

In the 2004 solicitation for what was called the “Benefit Offset Pilot Demonstration Project,” SSA announced its research aims for the project and its expectations for the research questions the pilot evaluations would address. Based on that document, SSA appears to have had greater interest in generating information that could be analyzed across the four pilots than in assessing the impacts associated with each of the four pilots.[77] In particular, SSA hoped that the pilot evaluations would help answer the following questions and, by doing so, inform the design and implementation of a national demonstration. It is important to note that three of these four questions are explicitly framed in terms of designing a national demonstration. The fourth, though state specific, has a direct bearing on demonstration design.

- What are the most effective methods of keeping participants informed of project activities and of maintaining participation in the project?
- What are the most effective methods of informing participants about the demonstration and obtaining their consent to participate in the project?
- What are the most important problems and issues surrounding both the provision of the state-specific employment supports to project participants, i.e., benefits planning, and the integration of these services with the benefit offset, and the best solutions?
- For whom does each of the State-specific employment support interventions appear to be the most effective?[78]

SSA also specified a list of research questions that the agency hoped could be answered within the context of each of the pilot evaluations. These included comparison of differences between the treatment and control groups on a variety of employment

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[76] As of the time of completing this report, it appears that the national demonstration will begin operations in fall 2010 and begin informing beneficiaries of their participation in early 2011. The project is known as the Benefit Offset National Demonstration (BOND).

[77] To avoid any misunderstanding, we think the focus on questions that were better addressed by pooling information from across the pilots was fully appropriate given SSA’s desire to use the pilots to inform the design of the national demonstration project.

[78] Social Security Administration (SSA) Solicitation #SSA-RFP-05-1003 “Benefit Offset Pilot Demonstration Project” September 28, 2004, p. 7.

outcomes, in the proportion leaving SSDI cash benefits, and the impact of the service model.[79] SSA also specified goals for process evaluation activities, some paralleling those identified in the “cross-state” questions and additional ones focused on identification of within state implementation challenges, participant perceptions of the intervention, and the extent participants refused to cooperate with data reporting or left the pilots.[80]

In our evaluation planning we sought to address SSA’s questions and to explore areas relevant to Pathways efforts to develop employment supports and infrastructure, The research questions listed below are organized into groups based upon whether they are more closely aligned to identifying participant impacts or documenting and assessing project implementation. There have been some changes in these questions over the past four years reflecting differences between actual and anticipated enrollment patterns, limitations in data availability and quality, and new issues that have come to the fore as we observed the SSDI-EP’s development.[81]

Outcome Questions

- Do members of the treatment group exhibit, on average, higher employment rates, earnings, and income than members of the control group?
- Are there differences in other employment related outcomes such as sustaining employment, work effort, and/or the characteristics of jobs held?
- Do any differences between the study groups increase over the intervention period?
- Are there discernable patterns in the effectiveness of the intervention in regard to participant characteristics, including socio-demographic, work experience, program and disability characteristics?
- Do services received during the study period, especially work incentives benefits counseling affect employment related outcomes?
- Does participation in a Medicaid Buy-in affect employment related outcomes?
- Are there differences between the study groups in their perceptions of barriers to gainful employment? Do these change over time?

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[79] The Wisconsin evaluation plan never included an analysis of the rates participants would leave SSDI cash benefits. Indeed the rules of the offset provision allowed those in treatment who had completed their TWP to retain some portion of their cash benefit until they had earnings well over SGA. As an alternative, SSA ultimately suggested comparing the rates of treatment and control group members with earnings above the SGA level. As we argue elsewhere in this report, this type of analysis would be better if it were conducted separately based upon whether a participant had completed TWP. Prior to TWP completion, all participants can keep their full SSDI cash benefit and all earnings (though this may not be true for individuals in additional public programs). Still, it could be possible that there would be a higher proportion of above SGA earners in those assigned to the treatment group because of their expectations that the offset would be available following TWP completion.

[80] Social Security Administration (SSA) Solicitation #SSA-RFP-05-1003 “Benefit Offset Pilot Demonstration Project” September 28, 2004, pp. 9-10.

[81] For instance, a planned analysis of a subgroup of those who participated in the Wisconsin SPI project prior SPI participants was dropped because very few enrolled in the SSDI-EP. Similarly, planned analyses of the impact of Ticket to Work usage and of DVR service utilization were abandoned because of data availability and quality issues.

- Are there differences between the study groups in their attitudes regarding personal efficacy and work? Do these change over time?
- Are there differences between the study groups in their perceptions of health status? Do these change over time?
- Are there differences in employment outcomes between the treatment and control groups subsequent to the completion of the Trial Work Period?
- For those entering the Pilot before initiation or completion of the TWP are there differences in the proportion completing the TWP?
- Are there important differences in the characteristics and experiences of those in the treatment group who have used the offset and of those in the treatment group, qualified to use the offset, but who have not done so?

Though, for the most part, these outcome questions remained constant throughout the pilot, there was a gradual change in emphasis. By 2008 it was becoming apparent that outcome differences between the treatment and control groups would be small and probably not statistically significant. As such, somewhat greater focus was directed at examining the impact of "control variables" such as benefits counseling, participant attitudes, and Medicaid Buy-in participation. In part this was to address the possibility that the intervention might have significant if relatively small effects that were being masked by other variables. However, this shift in emphasis also reflected an expectation that Pathways would be interested in assessing the "independent" effect of programmatic efforts that would be in place irrespective of whether there was an offset.

Process Questions

- Is the program delivered as intended, including, but not limited to, participant recruitment, informed consent procedures, service provision, participant/staff communication, staff recruitment and retention, funding, technical assistance provision, and data reporting?
- Did the program recruit desired analytical subgroups in useful numbers?
- Did the program face any challenges in assessing the eligibility of potential participants?
- How do participants perceive program operations, including, but not limited to, recruitment, informed consent procedures, service provision, communication with program staff, and research burden?
- What is the extent of attrition (voluntary or forced) from the intervention and control groups? What factors are associated with attrition, especially any differences in attrition rates between the two study groups?
- What difficulties, if any, occur in collecting and utilizing the administrative, encounter, and survey data needed to estimate program outcomes?
- Did participants in both the treatment and control groups have access to and/or receive equivalent services?
- Does SSA make (or is perceived to make) adjustments to SSDI checks and records accurately and in a timely fashion?
- What adjustments were made to deal with implementation problems and how effective were those adjustments?

2. SSA Requirements

In addition to specifying or suggesting research questions, SSA also stipulated a number of requirements for the pilot evaluations. Many of these also applied to the structure and operation of the pilots themselves and have been discussed above in the material in the section titled "SSA Intervention Parameters."

As already noted participants had to be volunteers and could not agree to participate until they had been informed of the project's goals and rules and the potential benefits and risks that might result from participation. Participants had to provide written consent and had to be informed that they could withdraw without penalty at any time, though if in the treatment group they would again be subject to all SSDI program rules.

Necessarily, SSA insisted that all volunteers meet the eligibility rules it established and any that each pilot added. SSA also stipulated that the sample must be "…drawn from title II disability beneficiaries who are participating in statewide employment support programs." [82] SSA never specified what this meant. In the case of the SSDI-EP this requirement was observed by (1) operating the pilot on a statewide basis and (2) having the same service access rules for all participants.

As all the pilots had to randomly assign participants to a treatment and control group, impact evaluations would necessarily be experimental. SSA retained final say over how random assignment was implemented. In practice, SSA allowed the pilots significant discretion as to how each would implement random assignment. Pilots made choices as to the mechanics of assignment, the assignment ratio, and whether to formally stratify the sample.

Finally, SSA imposed a number of analytical requirements on the evaluations when it specified required content and organization for the final reports only months before their completion. In particular SSA specified a particular modeling approach that utilized separate regressions for each of nine quarterly time periods, instead of other alternatives such as directly analyzing trends across those time periods. However, it is also true that SSA made its choices with good knowledge of the decisions that each pilot had already made about data collection and the time structures of their analyses. It is our perception that these requirements were not burdensome.

3. Description of Data Sources

This evaluation makes use of administrative, encounter, survey, and interview data. It also utilizes documents produced by Pathways and the service provider agencies. Individual level data were collected for time periods relative to the calendar quarter in which a participant enrolled. No individually identifiable data were used from any period more than eight calendar quarters (nominally two years) prior to the quarter in which SSDI-EP enrollment took place. Under the terms of participants' signed consent forms data can be gathered through December 31, 2011 unless the participant withdraws from the study. Most of the data used in this report are for events prior to January 1, 2009.

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[82] Social Security Administration (SSA) Solicitation #SSA-RFP-05-1003 "Benefit Offset Pilot Demonstration Project" September 28, 2004, p. 8.

Only administrative data were available for periods prior to SSDI-EP enrollment and even then not for all data elements.[83] Encounter, survey, and focus group data pertaining to specific participants were available only after each participant's enrollment date. All of these data were collected for periods prior to January 2009.

Individual level administrative data were obtained from multiple state agencies and the Social Security Administration through agency specific data agreements. Unemployment Insurance (UI) data from the Wisconsin Department of Workforce Development (DWD) were especially critical, as these data serve as or are used to create the primary indicators of employment outcomes. Though UI data have some shortcomings, particularly the exclusion of some types of employment and employers, such data are reported in a standardized manner and could be obtained for time periods both prior to and after a participant's enrollment in the SSDI-EP. Moreover, employers are legally required to report the data and face substantial penalties if they fail to comply.

Data from the Wisconsin Department of Health Services (DHS) and the Division of Vocational Rehabilitation (DVR) in DWD provided useful information about public program participation and to lesser extent employment related service utilization and participant characteristics. SSA data provided information about participants' cash benefits, TWP and EPE usage, Medicare eligibility, and a range of disability related characteristics.

Encounter data about participants were collected through forms completed by provider agency staff and sent to the evaluation team by means of a secure web based application. Provider staff completed an enrollment form for each entering participant that provided basic identifying information for the participant as well as selected information about personal characteristics, employment history, and current employment.[84] Submitting this form initiated the random assignment process, though both enrollment and study group assignment were contingent upon receipt of signed consent materials. The evaluation team also provided some basic information from the enrollment form to SSDI-EP central operations staff at Pathways. This information was limited to that necessary for project administration at both the SSDI-EP central office and SSA in Baltimore.

Using a web based application, a staff member at each provider agency was required to submit two forms on a monthly basis for each participant. One form was used to report changes in a participant's employment and living situation. Completing it

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[83] In some cases, only the most recently entered data value was available or time series data had been purged for periods prior to some date. Such issues were especially frequent with data elements from the WI Division of Vocational Rehabilitation, but also affected administrative data from other sources including SSA.

[84] A deliberate effort was made to reduce the amount of participant information collected on the SSDI-EP enrollment form compared to that collected from a similar enrollment form used in SPI. Both staff and participants in that earlier project had expressed concerns about the length of the previous form. Consequently, we were more dependent on SSA administrative data for obtaining information about participant characteristics, particularly in the domains of disability and program participation. State data sources such as those at DVR or DHS were not useful for this purpose because SSDI-EP participants were not required to use programs or services administered by either of these two entities.

required that the staff member had monthly contact with the participant.[85] The second form was used to track service provision to the participant by the provider agency in nine different categories.[86] Irrespective of enrollment date, form submission was expected to continue for all participants through December 2008, excepting for those who withdrew, died, or had moved out of state.[87] The evaluation team also had access to additional individual level encounter data collected by the SSDI-EP operations staff. Among other things, SSDI-EP operations provided the evaluation team with additional information about participants' disabilities, receipt of benefits counseling, and benefit offset use.

Participants were expected to complete surveys at project entry and annually for two years after project entry. The baseline survey was administered as part of the enrollment process and in theory (but not in practice) should have been submitted for all participants. The two follow-up surveys were mailed to participants; participants were paid a small amount for completing the instrument.

The baseline survey included items about work motivation and expectations, employment support needs, barriers to employment, personal orientation to challenges, and health status. The follow-up surveys retained these items and added additional ones about participants' experience of the pilot, including service needs and adequacy, contact with provider agency staff, and the accuracy and timeliness of their SSDI checks.

The evaluation included two sets of participant focus groups. The first were held in spring 2007 approximately six months after the SSDI-EP finished enrolling new participants.[88] Topics discussed included participant perceptions of recruitment processes, enrollment/informed consent processes, and initial service provision. We held the second set in the autumn of 2008. These focus groups were restricted to treatment group members who had at least started their TWP. The questions asked during these focus groups concentrated on understanding participant decisions regarding TWP entry, completion, and offset use. Additionally, there were questions

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[85] As will be discussed in the implementation section of this report, there was substantial variation in how well provider agencies complied with this requirement.

[86] The form did not reliably capture services provided by entities outsider the provider agency. The form did not necessarily capture information about all services provided to the participant at the provider agency as in some cases those services were not directly related to SSDI-EP participation. This last point is important as, despite instructions, there appeared to be substantial differences across provider agencies as to when a service was considered to be directly related to pilot participation.

[87] In some cases of "out of state" moves, provider agencies maintained contact with participants and submitted encounter forms. These movers largely resided in adjacent areas of neighboring states.

[88] We did not utilize a panel design for focus groups. Due to resource limitations, only five or six focus groups were conducted in each set. Focus groups were hosted and usually located at provider agencies. These were selected to achieve some diversity in geography and agency service populations. Recruitment was through the provider agencies who were given guidelines aimed at insuring some diversity in whom was invited to attend and that invitees understood that their involvement in a focus group was voluntary and not part of their research reporting obligations. Focus group attendees received a modest payment.

intended to elicit information from offset users about any advantages or problems associated with using the benefit offset.

In addition to data collection from and about individual participants, the evaluation collected information about program operations in a variety of ways. Documents about program planning and activities were collected for a period beginning with the first discussions of the SSDI cash benefit offset in the context of the SPI project through the conclusion of this study. Most of these documents were from within Pathways or were communications between Pathways, especially SSDI-EP central office staff, and the provider agencies, SSA, or other Wisconsin state entities.

The evaluation team also conducted interviews with provider agency staff and a group of key informants. There were two sets of provider agency interviews where at least one staff member at each agency was interviewed. The first set of interviews took place in spring 2006 before the conclusion of the enrollment period. The emphasis was on early implementation including staffing, adequacy of training and technical assistance, outreach and recruitment, informed consent and enrollment processes, issues attendant to data gathering, and the availability of funding to support the delivery of benefits counseling and person-centered planning services. The second set was conducted in spring 2008. We limited participation to benefits counselors working at provider agencies with at least 10 participants.[89] The second set of interviews concentrated on the provision of benefits counseling and how it might vary according to study group assignment, TWP status, and/or offset use.

We conducted key informant interviews in spring 2009 after the “active phase” of the pilot was over. Key informants included both SSDI-EP/Pathways staff and persons outside the project in a position to observe the Wisconsin pilot.[90] The goal of these interviews was to get informants’ overall assessment of the SSDI-EP’s implementation, its accomplishments and shortcomings, and what was learned through the experience that might be applied to either a national demonstration project or SSA operations should the Social Security Act be amended to include an offset provision.

The evaluation team’s co-location with SSDI-EP central operations staff provided additional opportunities for data collection. We were able to attend internal meetings, observe staff interactions, and to be copied in on much of the e-mail traffic both within Pathways and with SSA, provider agencies, and other external stakeholders. Access was provided to some data collected for strictly operational purposes. We also had substantial opportunities to attend training and TA events for provider agencies. However we were understandably excluded from bilateral meetings between SSDI-EP central staff and provider agencies and there was no direct observation of the interactions between participants and provider agency staff.

Finally, we collected documents and aggregated data about changes in economic conditions, public policies, and other contextual factors that may have affected

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[89] Our intention was to interview benefits counselors who had large enough caseloads to make it likely that they had served some participants who were in or had completed TWP.

[90] Our hope was that that there would be a key informant from SSA in Baltimore, but for whatever reason(s) no one at national office agreed to be interviewed.

implementation and participant outcomes. Most of this information was obtained from public sources, though Mathematica Policy Research (MPR) provided aggregated data comparing SSDI-EP participants in the Medicaid Buy-in to those of two groups of Wisconsin Buy-in participants: adult SSDI beneficiaries and, within that category, those beneficiaries who appeared to meet pilot eligibility requirements.[91]

4. State Specific Evaluation Design

From the standpoint of the evaluation team there was no SSDI-EP evaluation design distinct from that intended to meet SSA requirements and expectations. There was, as noted, a difference in perspective rooted in Pathways' concern with the efficacy of certain support services, particularly work incentive benefits counseling and person centered planning, and public programs, most notably the Medicaid Buy-in. Though we look at these factors as controls that might mediate differences between those receiving the intervention and those in the control group, we also, albeit to a lesser extent, attempt to assess the power of these services and programs as important intervention approaches in their own right.

We would argue that Pathways had a more immediate and concrete concern with how participants viewed the program than SSA. It was not that SSA lacked interest in how participants experienced the pilots. Nevertheless, as indicated by the research questions in SSA's solicitation document, this interest centered on whether that experience would affect such issues as beneficiaries' potential willingness to enroll or stay in a national demonstration or whether any experiential differences between the treatment and control groups would affect the size of differences in employment outcomes. These interests are fully legitimate and were of comparable significance to Pathways and its within state stakeholders. Yet, there was also a more explicit concern with whether the consumers who participated thought they were better off, whether materially or subjectively as a result of their participation. Particularly on the operations side of the pilot there was a concern about the potential for participation, especially for those in the treatment group, to lead to either short or long term injuries not directly attributable to either SSA's or Pathways' administration of the pilot. These included, but were not limited to, potential threats to the eligibility or receipt of needed public benefits aside from SSDI, the potential of losing one's SSDI eligibility after the pilot because of work activity during the pilot, and further discouragement among a population where many already questioned whether "the system" was rigged against their return to work on terms that would leave them economically, physically, and/or mentally better off.

While this difference in perspective changed the evaluation goals and design mainly on the margins, we do not think the differences were insignificant. For example, the reason we include an income proxy as one of our outcome variables is that we desired some method of assessing whether participants were economically better off. It is also a reason that we gave significant attention to tracking participant fears about potential loss or reduction of SSDI benefits should they seek to work or to appreciably increase their earnings.

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[91] MIG states can apply through a CMS sponsored TA entity called MIG-RATS for customized data extracts from an integrated data set of all Buy-in participants maintained by MPR. Unfortunately, these data arrived too late for use in this report.

Evaluation planning and conduct were also shaped by our observations of how the pilot unfolded over time. We already noted our gradual realization of the importance of directly comparing differences between those members of the treatment and control groups who had completed their TWPs. Another “post design” issue was the lack of operational information about the quality of delivered benefits counseling and employment services. While we were able to devise an approach to looking at variation, at least at the provider agency level, we would not characterize our response as fully satisfactory. Lastly, the evaluation design also was affected by issues brought to our attention by the evaluators of the other pilots. For example, in our early planning we did not consider there would be an explicit need to examine whether the SSDI-EP’s design and implementation were adequate for a meaningful evaluation of the benefit offset.[92]

a. Process evaluation

In general, process evaluation activities and analyses were undertaken in a manner that sought to describe and account for change over time. We sought to understand the multiple perspectives of different stakeholders as these perspectives, informed actions and structured perceptions.[93] Nonetheless, priority was given to tracking issues of concern to SSA and that may inform the operation of the national SSDI benefit offset demonstration project. We have already identified the main questions and data sources for the process component of the SSDI-EP evaluation earlier in this chapter. The remainder of the material in this section emphasizes the analytical methods and types of evidence used to examine process issues. As far as possible we use multiple data sources and methods in these analyses. Nonetheless, for most issues particular data sources and the analytical methods associated with their use will be primary. For most questions, we credit data from respondents reporting their own perceptions and experiences with greater purchase than that reported second hand, though veracity can never be assumed to be absolute. We have greater confidence in process findings when they are based on reasonably consistent information from multiple informants and/or data sources.

Information about participant satisfaction and perceptions of the informed consent and project communication processes were drawn from survey items. We also used information from the focus groups to elucidate these areas, especially when survey responses and/or attrition rates suggested significant dissatisfaction or implementation problems. Additionally, interview data from provider agency staff and key informants also contributed to our analyses of these topical areas.

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[92] For our initial and generally positive assessment of this issue see Delin, Barry S., Sell, Christopher, W. and Reither, Anne. E. 2007. “Challenges in Conducting Randomized Field Trials: The Experience of the Wisconsin SSDI Employment Pilot,” Baltimore MD: American Evaluation Association Annual Meeting, November 2007.

[93] Perspective in many cases can have an organizational or social dimension as well as an individual one. In those cases, where an individual is acting in an organizational role (e.g. as an employee) the organizational perspective will usually be paramount. However, even when a person is speaking or acting in an individual capacity, she may still perceive or act from an organizational or social framework, whether by choice or because of socialization.

The primary sources of information about service provision included both encounter data and administrative documents and data.[94] Analyses utilize both measures of central tendency and variation. The emphasis is on identifying pilot wide patterns of service provision, with emphasis on benefits counseling delivery and any differences between the treatment and control groups. Some attention is paid to understanding differences related to the number of participants served by a provider agency.[95] Our analyses were enriched by information drawn from key informant interviews and participant surveys and focus groups, especially when addressing questions of service needs and the perceived value of the services provided.

Our examination of SSDI-EP program operations, including coordination between the program and service provider agencies and between the program and entities such as DVR, SSA, and other DHS based entities, relies heavily on information drawn from administrative documents. We also use information drawn from key informant and provider agency staff interviews. What we learned through these information sources was supplemented by our direct observation of staff and stakeholder interactions at the Pathways' office, at pilot training and technical assistance events, and at other external meetings.

Our analysis of the adequacy of data collection processes utilizes information about the completion rates of surveys and encounter forms and of experience in obtaining or amending administrative data agreements. Again, additional information was drawn from key informant interviews and the participant focus groups.

Finally, documenting and understanding participant attrition was an important part of the process evaluation, especially as participants were volunteers and their numbers were fairly small. Particular attention was given to identifying any differences in the rates of and reasons for attrition between the study assignment groups. Originally, we hoped that most of those who left the pilot would complete an exit survey. As this did not occur, our analysis relied heavily on data from the enrollment form and the baseline survey. This was supplemented by information from agency staff and key informants.

b. Impact evaluation

The SSDI-EP's impact evaluation focuses on the participants as the primary unit of analysis. The outcomes of primary interest are employment and, especially, various indicators of earnings and income associated with employment. Prior material has identified the key questions the impact evaluation was intended to answer, how those questions changed over time, and the data sources that would be used. In this section, we focus on issues pertaining to random assignment, our understanding of the intervention model, and the time structure and methods that would guide the impact analysis.

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[94] This analysis concentrates on the range of services captured through the monthly participant level reports of service provision to the evaluation team. This report is called the "Case Noting Form." The nine service categories include benefits analysis and counseling, two planning and assessment service categories and six employment related service categories. There was no systematic tracking of employment related services from other sources.

[95] Half of the provider agencies enrolled twenty or fewer participants, effectively precluding looking at whether any service provision differences were related to study group assignment.

i. Random assignment

As SSA required that the impact evaluation utilize an experimental design, the pilots had to establish principles to guide the implementation of the random assignment process. In the case of SSDI-EP these decisions were made by the project managers, but these decisions largely reflected the evaluators' advice. One key decision was to have study assignment follow the completion of all other parts of the formal enrollment process.[96] Other fundamental choices included having assignment performed at the central office, having the assignment generated using a computer algorithm and communicating the result to the new enrollee in real time.[97]

Additional decisions include those relevant to the structure of the sample(s) available for analysis. In general, these decisions reflected a desire for avoiding additional complexity, both for technical reasons and to hopefully decrease confusion and distrust among consumers and provider agency staff.[98] The SSDI-EP chose not to formally stratify the sample and to implement random assignment on that basis, although there was an expectation that roughly half the participants would be former SPI project participants. Similarly, the SSDI-EP chose to apply random assignment across the pilot, rather than to apply it separately within each provider agency.[99] Finally, it was agreed that the assignment algorithm would be designed to give each enrollee an equal chance of assignment to the treatment and control groups and, thus, to result in study assignment groups of essentially equal size.[100]

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[96] The formal enrollment process included the completion of the enrollment form and the baseline survey and signing the informed consent forms.

[97] At the end of the enrollment session at the provider agency, the staff member who conducted the enrollment would electronically submit the enrollment form. This action automatically triggered the assignment process and a message with the assignment information was sent back to the provider agency almost immediately. This was followed with letters to both the participant and the provider agency confirming the assignment.

[98] There was some distrust of random assignment. In part this reflected concerns about whether it would be done fairly; i.e. that there would be "favoritism." In other cases, there was a desire to insure that those beneficiaries who were best prepared and most motivated to use the offset would get access to it. However, the greater concern (and which was expressed in both the interviews and focus groups we conducted) was that there was no reason to have random assignment. Their view, when made explicit, was that the current "average" value of employment outcomes should be viewed as a baseline against which changes among project participants should be compared.

[99] Based on the SPI experience, it was thought that enrollment at many agencies would be quite small (e.g. thirty or less), so it was thought unlikely that randomization within provider agencies would have much research value.

[100] This decision was reached without foreknowledge of the relatively small proportion of treatment group members (roughly 20%) who would actually use the offset during the "active" phase of the pilot. Had we anticipated this result and the somewhat smaller than expected total enrollment, we might have recommended that a larger proportion of the sample be assigned to treatment. SSA had indicated it would accept assignment ratios of up to 2:1 in favor of treatment.

ii. Intervention theory

Though Pathways did not formally articulate an intervention theory for the SSDI-EP, the core elements of one have been in place since discussions of a SSDI benefit offset began during planning for SPI. The primary effect of the benefit offset feature is hypothesized to be directly economic. The offset is by definition a substantial reduction in the marginal tax rate, in theory, 50%.[101] Thus, members of the treatment group were expected, given their generally low incomes, to respond by increasing work effort and thus, on average, earnings and income.

Pathways staff also thought it likely that the offset would have secondary impacts that might be classified as attitudinal but would make it more likely that potential economic benefits might be realized. The very existence of an offset feature might help convince beneficiaries and those with whom the beneficiaries regularly interacted, whether socially or to access support services or public benefits, that work activity would be more likely to bring benefit than harm. Further, such changes in expectations could be increased or, perhaps more importantly, more fully trusted if the offset was well administered and/or did not, as SSA promised, disadvantage or harm any consumer.

Additionally, it was understood that an offset might have economic effects prior to treatment group members' actual utilization of the feature. For example, there might be a higher probability that those in the treatment would start or complete the TWP than otherwise would have been the case. If this were true, it would be reflected in higher employment rates and average earnings, irrespective of the impact of the offset feature itself.

However, even with a well implemented offset, there was no theoretical reason why improved outcomes were inevitable. In principle, an offset could be used by employed beneficiaries to reduce work effort while maintaining income. For those in the treatment group entering the pilot prior to the end of their TWP, the implementation of the offset at SGA obviates this possibility relative to the time of study entry.[102] Still, for

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[101] However, the actual reduction in the marginal tax rate was certainly less than 50% for some treatment group members who used the offset. Additional earnings can result in the loss of benefits from other public programs such as food stamps and Section 8 public housing or increases in premium amounts for programs like a Medicaid Buy-in. Thus the application of the offset would in some cases result in more than the loss of one dollar of income for each dollar of earnings above SGA. In an extreme case, it would be possible for a beneficiary using the offset to lose more than one dollar of income for each additional dollar of earnings.

This is one reason why the pilot required that all study participants had access to benefits counseling. Better information about the nature of both barriers and opportunities was expected to facilitate making informed choices about employment and work effort. If the "system" was in fact being changed in ways that incentivized the choice to work more, then, on average, it would be reasonable to expect consumers to make choices that would increase employment related outcomes.

[102] Recall that the SSDI offset cannot be applied until after the end of the TWP, plus the three month grace period. At that point in time, under normal SSDI program rules, any individual earning at or above SGA would lose their entire SSDI cash benefit for that month. Thus, at study entry, it is impossible to trade earnings above SGA for additional "leisure" time. This situation can change after a member of the intervention group raises her/his earnings above SGA while utilizing the offset. It is now "rational" according to economic theory to trade some portion of

treatment group members entering the pilot during the thirty-six month EPE and for those (i.e., with earnings above SGA) entering post-EPE, there was a potential choice between additional income and leisure.[103]

In any case, Pathways staff believed that an offset implemented without certain support services was likely to be ineffective or even counterproductive to the extent that it might increase the risk of harm to beneficiaries. In fact, it was expected that different service and support packages might have an impact on individuals' willingness to use the offset provision by reducing uncertainties or fears regarding the impact of work or increased earnings on income, access to health care and other needed services, and perceptions of overall welfare. Benefits counseling was seen as the most important of these support services as, provided it was of satisfactory quality, it would directly augment beneficiaries' capacities to make informed choices. Pathways staff also favored integrating benefits counseling into a person centered planning (PCP) approach that would explicitly link benefits counseling and employment services in support of a consumer's employment goals. However, despite this preference, Pathways did not have the resources to insist that provider agencies deliver PCP to all participants.

Indeed, the principle of facilitating informed choices by consumers has been deeply embedded in Pathways activities and increasingly in DHS programs, especially managed long term care. Thus, Pathways insisted that all participants, irrespective of their assignment to treatment or control, had equivalent access to work incentive benefits counseling. While Pathways was in no position to make the use of PCP mandatory, it could insist that PCP be equally available to pilot participants enrolled at the same agency. One consequence of the decision that all SSDI-EP participants have "equal access" to services was there could not be a direct test of the impact of a combined offset and service intervention, though the evaluation could still examine the impact of benefits counseling and other services as control variables.

iii. Analysis structure and methods

To have substantial value for beneficiaries, the government, and the public, a SSDI benefit offset would need to support better employment outcomes over time. In particular, the value of an offset would be enhanced to the extent that it facilitated earnings growth over an extended time beyond the initial months or quarters of use. It then follows that any impact analysis needs to look at differences between the treatment and control groups or of relevant subgroups over a substantial time period.

Nonetheless, choice of the relevant time period was constrained by several considerations. The first was that pilot projects are limited in length. Participant contact activities, service provision, and direct data gathering were reduced or ended in 2009 following the end of the active phase of the project at the end of 2008.[104] The second is

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above SGA earnings for additional "leisure" time, provided the individual places a higher value on that time compared to net income that will be lost.

[103] Potential, as employers may not allow participants to reduce their hours or, if they do, may not provide the same package of health insurance and other benefits.

[104] Provider agencies remain responsible for collecting earnings estimates and retrospective documentation of earnings for treatment group members qualified to use the offset. This implies a continued obligation to provide benefits counseling. A SSDI-EP operations staff member reported

that SSA and its partners needed findings to help finalize their decisions about the national demonstration.

Third, SSA's decision to return treatment group members who had not completed their TWP by the end of 2008 to regular program rules as of January 1, 2009 effectively divided the treatment group into two distinct groups. One group consists of those who are either using or are entitled to use the offset. The second group is composed of those who have had the promise of eventual access to the offset taken away. There is no longer a cogent reason for lengthening the analysis of the full treatment group. A final consideration was the fact that beneficiaries became SSDI eligible at different dates relative to their entry to the pilot. As one expands the length of the pre-enrollment period included in the analysis, one increases the proportion of those with pre-entitlement employment outcomes included in the analysis.

As our primary outcome data, UI records, would be available on a calendar quarter basis, we chose to structure our analyses on this basis. We decided to perform most analyses in participant time, where irrespective of a participant's enrollment date, we would examine a time series of outcome data from a constant number of calendar quarters prior to and after the calendar quarter of pilot enrollment. Most of our chosen analyses are performed over a thirteen quarter period starting four quarters before the enrollment quarter and ending with the eighth quarter following enrollment. The eighth quarter was the maximum possible for all SSDI-EP participants without going beyond the end of 2008. The decision to limit the pre-enrollment period to four quarters was taken to insure that there would be outcomes data from before SSDI entitlement for only a few cases included in the analysis.

Though we found it useful to begin our analysis descriptively using graphs, plots, and simple univariate and bivariate statistical procedures, our intention was to undertake a time series analyses that would allow looking at multiple control variables and estimating the rates of change in employment outcomes for both study groups.[105] Initially we hoped to utilize a hierarchical (mixed) regression modeling approach that would enable examining both individual variation and group effects. Unfortunately, the limited size of our sample (less than 500) would have greatly limited the number of control variables that could be included in the regression models.[106] It might have been impossible to run models for smaller subgroups at all.

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that there is some confusion at the provider agencies as to the extent, if any, of their continued obligations to other SSDI-EP participants. However, as a practical matter, the MIG provides a funding mechanism for continued access to benefits counseling for those who were in the control group or were returned to regular program rules.

[105] SSA has required pilot evaluators to use separate regressions for each quarter for the mandatory analyses. This approach makes it straightforward to assess results within any particular quarter and can be implemented with very small sample sizes. However, the method is not well suited for either examining trends across time for either the intervention or potential control variables. There is also no standard for assessing whether overall results are significant or not. We will discuss this issue in greater detail when we present the impact evaluation data in Part III of this report.

[106] Regression models using repeated measures tend to utilize many degrees of freedom due to the use of time interaction variables. This makes the use of such techniques problematic with

As an alternative to hierarchical modeling we decided to utilize repeated measure MANOVA (Mixed Model Analysis of Variance). [107] This method shares many of the advantages of hierarchical modeling allowing comparison of both between and within subject effects. It had the distinct advantage of allowing us to run time series with multiple control variables with a relatively small sample size. However, using MANOVA also has some disadvantages. Independent variables have to be categorical.[108] As a consequence, some of the information available when a variable is in continuous form is lost and, in some cases, results can be sensitive to rather small differences in how the boundaries between categories are set. Additionally, MANOVA does not produce a direct equivalent to the beta coefficients available from regression analyses. Though it is still possible to identify the rate of change over a particular time period, this needs to be separately calculated using the categorical (marginal) means.

We have identified our particular interest in examining the impact of benefits counseling, Medicaid Buy-in participation and participant attitudes in two domains, (1) fears about the loss of Social Security or healthcare benefits and (2) self-efficacy. These analyses were performed using MANOVA and the same time structure as the general outcome analyses. However, as we are interested in the impact of these factors independent of the offset itself, we have also been willing to run models where these variables are treated as the primary independent variable and the study assignment variable is removed from the model.

The comparison of outcomes between treatment and control group members who completed their trial work period raised some challenges that required alterations to our modeling strategy. As participants could finish their TWPs well after their enrollment dates, we needed to make choices about the minimum amount of time we were willing to examine. The longer the period examined the fewer cases there would be in the analysis. Our compromise was to restrict the analysis to six quarters of post TWP completion time.[109]

The TWP analyses were conducted in participant time. For those who completed their TWP during the pilot, the first post-completion quarter was set in real time. However, participants who completed their post TWP prior to SSDI-EP enrollment presented a problem. Within this category, participants had completed the TWP at different times relative to enrollment. One individual might have completed his TWP in the quarter immediately prior to enrollment, another might have completed it five years earlier. In these cases we chose to use the enrollment quarter as first post-TWP quarter

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small samples as the available degrees of freedom are never more than the sample size minus one.

[107] MANOVA was implemented using the GLM Repeated Measures options in version 14 of SPSS for Windows statistical software.

[108] MANOVA allows multiple independent variables. The procedure allows examination of the variables' impact on both within and between subject variation. Independent variables must be entered into the model in categorical form. However, other covariates can be entered as continuous variables.

[109] The resulting subgroup contains just over 200 cases, i.e. just over 40%of the total sample. Additionally, it required us to utilize UI data from the first calendar quarter of 2009 for those participants who enrolled between October 1 and October 31 2006.

in our analysis no matter when TWP was completed. Additionally, instead of looking at outcomes data from before the nominal TWP completion quarter as dependent variables, we entered a prior earnings variable into the model as a covariate.

SECTION TWO: PROCESS EVALUATION

This section of the report focuses on the SSDI-EP's implementation. It seeks to answers such questions as what actually occurred, how close that was to what had been planned, what challenges arose in implementation, how those challenges were responded to, and whether those responses helped the pilot and its sponsors to attain their goals. Yet even this broad specification is too restrictive. There can be circumstances in which project goals change; one possible reason for this happening is what has been learned through experience about the practicality or even the value of the project's original aims. Small scale or preliminary efforts such as the benefit offset pilots are often valuable for this reason alone.

The SSDI-EP and the other three offset pilots were conceived and implemented as social experiments. Experimental designs utilizing random assignment have often been characterized as the gold standard for social research, mainly because random assignment, if well implemented, should insure that anything that occurred prior to the start of the experiment will not bias any differences observed between the treatment and control groups.

However, the lack of such bias does not mean that prior characteristics and events will not affect an experiment's results. This point is critical for thinking about the meaning of both process and impact findings from pilot projects and their application to larger or different settings. We have already noted that both the offset pilots' eligibility requirements and the voluntary nature of participation virtually insured that the characteristics of the pilot samples would not closely match those of the adult SSDI beneficiary population on either a national basis or in the states that hosted the pilots. The recruitment and enrollment processes described in the following chapters also had potential to increase differences between the sample and the relevant populations for either a national demonstration or a statutory offset. Given this, we think it important to give readers our informed judgment about the applicability of our findings outside of their immediate context.

The issues just discussed may affect the applicability of results, but do not directly diminish their validity. There are, nonetheless, other issues that potentially challenge the authenticity of what is learned through social experiments. Perhaps the most important class of these is the implementation problems that can afflict both the conduct of an experiment and its evaluation. This is especially true for pilot projects, as such efforts tend to involve novel policies, processes, and/or methods, at least to those implementing them. Thus, process evaluations are often designed and conducted in concert with outcomes evaluations to learn (among other things) whether the intervention was sufficiently "present" to allow meaningful evaluation of outcomes. If the intervention is not adequately implemented, random assignment by itself will not provide useful information about the intervention's role in producing observed outcomes.[110]

Within the general issue of whether the SSDI-EP (or any other of the offset pilots) was implemented well enough to support accurate estimates of outcome differences between the treatment and control groups, there is a more specific concern about

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[110] Failure to properly implement random assignment is itself an important type of implementation problem.

implementation quality that has proven salient precisely because the SSDI-EP is a pilot. Because such efforts utilize novel implementation approaches, it is important to assess the pilot's "evaluability," that is whether the intervention itself and the theory as to why that intervention is expected to work are well enough developed so that meaningful outcomes measurement can take place.[111]

In a 2007 paper, we argued that while important elements of the SSDI-EP had not been fully developed and that some of those deficiencies were of a character to threaten the capacity to fulfill evaluation goals, we felt that, with one exception, implementation problems would not seriously threaten our ability to complete a meaningful evaluation of participant outcomes. That exception was the problems arising in the administration and tracking of the benefit offset usage. We also noted that there was still sufficient time to mitigate observed problems so they would not constitute a serious threat to evaluability.[112] In this section of the report, we will reconsider the preliminary assessment rendered two years ago.

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[111] For a general discussion of the issues involved, see Wholey, Joseph, F. 2004. "Evaluability Assessment" in eds. Wholey, Joseph S., et al. Handbook of Practical Program Evaluation: Second Edition. San Francisco, CA: Jossey-Bass, pp. 33-62. For a more targeted discussion of the issue of when policy or program can be judged as ready for meaningful evaluation, see Julnes, George and Rog, Debra J. 2007. "Pragmatic Support for Policies on Methodology," New Directions for Evaluation, No. 113, pp. 129-147.

[112] See Delin, Barry S., Sell, Christopher, W. and Reither, Anne. E. 2007. "Challenges in Conducting Randomized Field Trials: The Experience of the Wisconsin SSDI Employment Pilot," Baltimore MD: American Evaluation Association Annual Meeting, November 2007, especially pp. 2-3 and 38-44.

CHAPTER III: RECRUITMENT PROCESS AND FINDINGS

SSDI-EP participants were volunteers. This fact required that the SSDI-EP had processes to elicit volunteers in numbers sufficient to meaningfully assess both the project's delivery and impact on participant outcomes. Additionally, though SSA's eligibility requirements would be the primary factor determining sample characteristics, the SSDI-EP's choices as to recruitment strategies would have considerable potential to shape the sample. In particular, it would be a contributing factor to how closely the pilot sample would be representative of the adult SSDI population in Wisconsin who would meet the pilot eligibility requirements, had this been either SSA's or Pathways' intention.

In fact, SSA did not require that the offset pilots seek to attract volunteers that would constitute a representative sample of the pilot eligible in the state, only that program enrollment be statewide and that each pilot project meet a vague admonition that enrollees be attached to statewide employment support programs.[113] SSA did permit states to add additional eligibility requirements that would, by their nature, imply differences in recruitment purposes. For example, a pilot could have restricted participation to those who had already started or completed their Trial Work Periods in order to increase the proportion of treatment group members who would be qualified to use the offset at or soon after enrollment. Recruitment process could then be designed to increase the probability of outreach to this particular component of the SSDI population.

However, a pilot could still seek to enroll a sample to achieve a policy or evaluation goal without having an explicit eligibility requirement. While not as efficient in the absence of explicit eligibility requirements, it is possible to use recruitment methods alone to shape sample characteristics. Consider a pilot that wanted to test the intervention in a context where enrollees had a much higher probability of employment than in the state's beneficiary population. That pilot could design its recruitment approach to target outreach to groups such as Vocational Rehabilitation consumers who had recently achieved successful case closures or those participating in a Medicaid Buy-in program.[114]

Though recruitment approaches most often involve deliberate targeting strategies, choices about where recruitment and enrollment activities are conducted and who performs them are another, potentially important, aspect of project recruitment. It is not necessary that these choices be made explicitly to shape enrollment; unintentional results can matter as much as intentional ones. However, in the case of the SSDI-EP, decisions about program delivery were consciously made in order to influence who would enroll in the pilot.

In addition to recruiting participants, the SSDI-EP faced a need to conduct another type of recruitment, that for the provider agencies that would enroll and serve participants. Pathways did not have the resources to create a statewide infrastructure to

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[113] The SSDI-EP met this criterion, at least in spirit, by insuring that all participants would have access to benefits counseling.

[114] In this context, Medicaid Buy-in refers to programs that are designed to allow persons who meet Social Security disability standards and who are gainfully employed to get or maintain Medicaid eligibility, even when having earnings or assets that would otherwise preclude eligibility.

set up the project and there was no expectation that any entity in Wisconsin state government could do so without massive infusions of external resources.[115] As previously noted, the available solution was to utilize community based disability service providers that already had some capacity to provide relevant services, especially benefits counseling. As a practical matter, much of the capacity to provide benefits counseling was concentrated at the twenty-one providers who had been involved in Wisconsin's SPI project. Additionally, as will be described in more detail below, the SSDI-EP wanted to generate a significant proportion of its enrollment from those who had participated in Wisconsin's SPI demonstration project. It was believed that the agencies who had participated in SPI would provide the best setting for recruiting the former SPI participants. Finally, it was possible to contract with these organizations without going through an extensive selection process. This would considerably reduce project start-up time.

According to a SSDI-EP manager, it was relatively easy to recruit the SPI agencies; sixteen initially agreed to participate. The availability of the offset was, by itself, a powerful inducement; staff at many of these organizations had felt that the SPI project's effectiveness had been severely limited by Pathways' inability to obtain the promised SSDI waiver. It also helped that the former SPI provider agencies needed to do little more than submit a letter of intent to be designated as a SSDI-EP site.

The five organizations that demurred did so for a variety of reasons. Some expressed the view that excluding concurrent beneficiaries from eligibility would exclude too large a portion of their service populations from the pilot.[116] In other cases, the agencies no longer had the capacity to offer benefits counseling and did not wish to restore it. In any case, as a group these agencies had enrolled a smaller proportion of SPI participants than implied by their having constituted about 25% of SPI agencies.

The remaining six SSDI-EP providers were recruited through a competitive process that placed emphasis on organizational experience in providing benefits counseling and coordinating employment services. This recruitment was particularly important to insure that the SSDI-EP would operate statewide. Interestingly, these agencies would ultimately enroll a disproportionately large share of pilot enrollment. Figure III.1 shows the county where the provider agency had its primary office for the purpose of implementing the pilot.[117]

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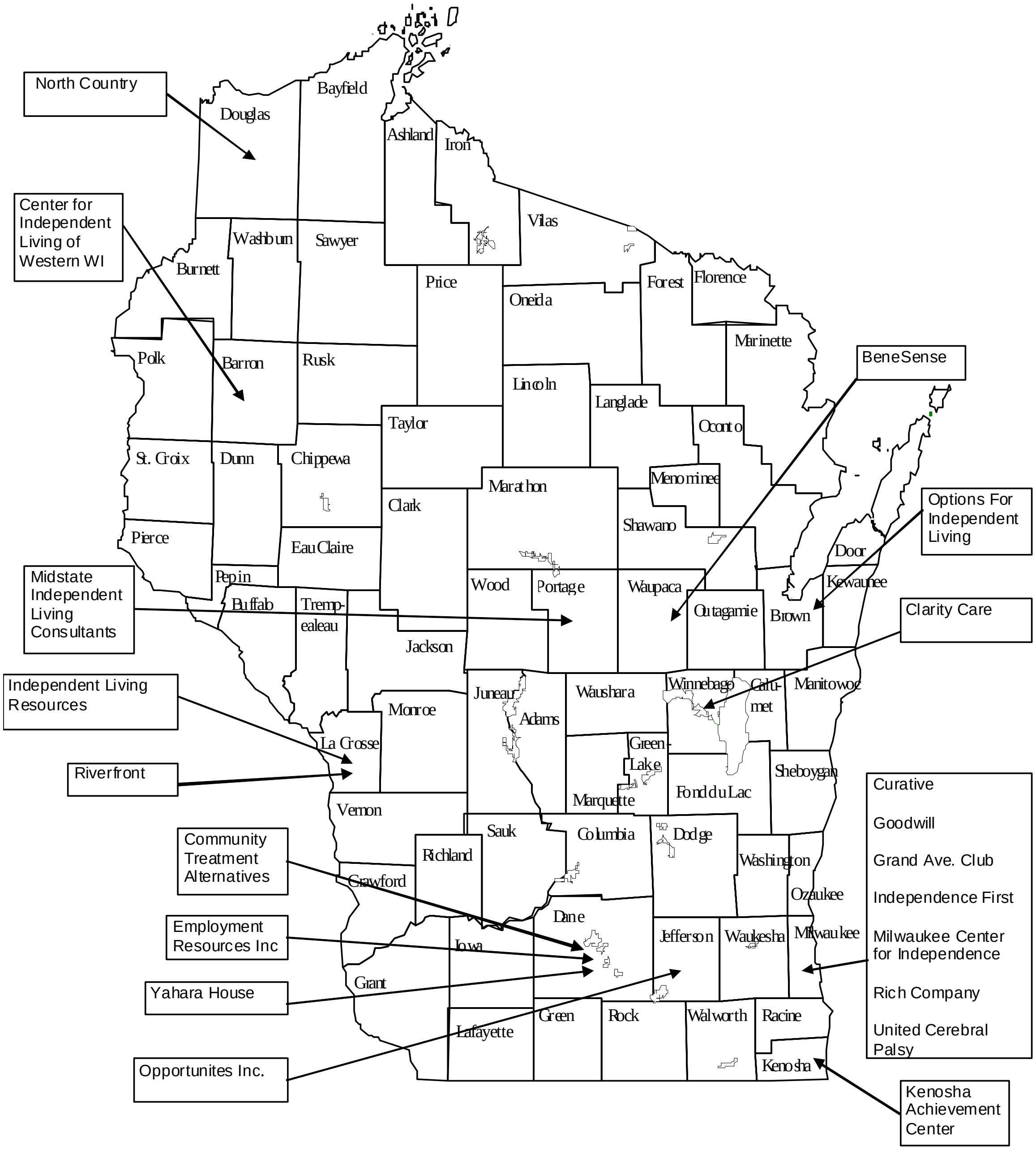
[115] Two of the four pilots were housed in their state's Vocational Rehabilitation agency and used their field networks to implement the pilots. This was never a likely possibility in Wisconsin. DVR simply did not have spare resources to do much more than to meet its own programmatic obligations. This did not preclude DVR from cooperating in referring consumers to the pilot or in funding employment-related services for consumers who had enrolled in the SSDI-EP.

[116] One of the sixteen former SPI agencies that agreed to enroll SSDI-EP participants never enrolled a single person. SSA made additional and largely exclusionary changes to eligibility requirements almost to the start date of the offset pilots. The agency in question argued that after these later changes there was almost no one in their service population who would qualify for the SSDI-EP. As a particular type of state certified mental health provider, the agency claimed that it could not recruit and did not have the resources to serve new consumers who would meet pilot eligibility requirements.

[117] Some provider agencies had multiple locations, usually in multiple counties. Provider agencies varied widely in their willingness to serve participants in the field. Generally, the larger an

Figure III.1[118]

Primary Locations of SSDI-EP Provider Agencies by County



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agency's catchment area, the more likely it was to provide services in the field instead of requiring a participant to go to a agency office when face to face contact was needed or desired.

[118] Two of the original twenty-two providers are not on this map. Rock County CSP never enrolled anyone. Aurora Community Services, operating out of Eau Claire County, ended its participation in the SSDI-EP in June 2007. Its five enrollees transferred to another provider agency.

A. Identification of the target population

The SSDI-EP hoped to enroll up to 800 participants, though it specified 500 as an acceptable lower limit. No global estimate was made as to either how many consumers would need to gain some awareness of the pilot or would have to seriously discuss the opportunity to enroll with a provider agency staff member in order achieve the enrollment goal. There was also an expectation that each provider agency would enroll at least fifteen participants.[119]

In a status report to SSA, the SSDI-EP reported that "Wisconsin designed the pilot under the premise that it was better to cast the net widely in targeting potential participants for the pilot."[120] This statement is accurate in the sense that the pilot encouraged any beneficiary who was potentially eligible and interested in utilizing an offset, whether immediately or the future, to explore participation. Yet, the claim is not fully accurate. To a large degree, it reflects what happened rather than what was intended. The choice to use the provider agencies as the pilot's chief agents for performing recruitment and enrollment activities can be viewed as a form of targeting. It reflected expectations about how interested beneficiaries could be more efficiently reached and how they could be more easily connected to relevant services. It also reflected an expectation that consumers already attached to a provider agency would have a higher probability of being employed and able to use the offset in a reasonable time period. [121]

Moreover, those planning the SSDI-EP hoped to target members of one very specific group of beneficiaries and seriously explored another. The SSDI-EP hoped that approximately half of the participants could be recruited from the 956 persons who had enrolled in Wisconsin's SPI project. These consumers had presumably received both work incentives benefits counseling and person centered planning (PCP) services during SPI. Though gains in employment outcomes through that project had been modest (though statistically significant), it was hypothesized that one reason the gains were not larger was that SSDI beneficiaries enrolled in SPI had been subject to the cash cliff. On paper, these former participants seemed well positioned to successfully exploit the offset. Additionally, having a large subgroup of former SPI participants would allow study of the potential value of getting benefits counseling and PCP over an extended period.

Based on self-report, approximately 620 SPI participants had claimed to be SSDI beneficiaries, about 400 of which reported that they did not get concurrent SSI benefits.[122] Given that in the early planning for the offset pilot, including the period when

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[119] No effort was made to enforce this expectation.

[120] Reiser, John, et. al. 2008. "Wisconsin SSDI Employment Pilot: Wisconsin Year 3 Report" Madison: WI: Wisconsin Pathways to Independence Projects, p. 5.

[121] This expectation was accurate. 53% of SSDI-EP enrollees reported that they were employed when they enrolled; nearly 60% of those reporting employment claimed to be working at least twenty hours per week.

[122] There figures were calculated from the de-identified Wisconsin SPI participant data set. Similar numbers were implied by estimates made from SSA sourced data supplied by Mathematical Policy Research, Inc. to the Wisconsin SPI project

Wisconsin, Connecticut, and Vermont were trying to persuade SSA to pilot the offset, it was not clear whether concurrent beneficiaries would be excluded, Pathways staff thought it might be possible to recruit large numbers of SPI participants. A 50% take-up rate was viewed as realistic and, if achieved, would generate over 300 participants if concurrent beneficiaries were eligible, about 200 if they were not.

However, Pathways never considered establishing targets for enrolling former SPI participants at the provider agencies that had served them. It was thought that achieving something close to equal proportions between those who had participated in SPI and those who did not would be a likely consequence of the primary role that the provider agencies would take in engaging in outreach and recruitment. While provider agencies would be prohibited from giving enrollment preference to individuals with which they had current or past relationships, Pathways anticipated that, as in SPI, the very fact of a relationship between the agency and a potentially eligible consumer would greatly increase the probability of enrollment. It was thought that most of the SPI participants either had a continuing relationship with the agency where they had participated or that the agencies would find it relatively easy to contact them. As the sixteen SPI provider agencies that agreed to participate in the SSDI-EP had enrolled over 80% of SPI participants, SSDI-EP staff generally felt confident that there would be effective outreach to the SPI subgroup. In turn, it was also felt that many consumers, based on their SPI experiences, would consider themselves good candidates for the SSDI-EP and agree to enroll. These expectations would prove to be wrong. The likely reasons will be explored later in this chapter.

Prior to the project, Pathways had considered targeting individuals enrolled in Family Care, Wisconsin’s effort to provide long term support services for both those with severe disabilities and the frail elderly. Though Family Care “members,” unlike the SPI participants, were never viewed as a subgroup for analytical purposes, there was interest in outreach to this group for two reasons. Family Care was a DHS program that emphasized consumer choice; Pathways hoped to encourage the provision of benefits counseling and PCP within Family Care for those members who wished to pursue employment goals. Second, there was interest in using Family Care as a source of funding for SSDI-EP participants. This would be especially important when participants were not eligible for VR services or DVR, because of Order of Selection closures, could not fund services for all of its current consumers.

Unfortunately, in 2004-05, Family Care operated in only a handful of the state’s counties. Wisconsin had not yet made a commitment to expand the program statewide.[123] A DHS staff member provided Pathways with an estimate of the number of SSDI beneficiaries served through Family Care: approximately 550.[124] There was no guess as to the possible take-up rate for this group other than it was expected to be much lower than for the former SPI participants. In any case, it was believed that the Family Care group would, on average, be less likely to be currently employed or likely to

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[123] The final commitment to expand Family Care statewide was made in 2006. At the time the SSDI-EP was being planned, there were indications that the Governor’s office would oppose further expansion.

[124] DHS does not maintain information about SSDI participation in its administrative databases. SSDI participation must be imputed from other information such as Medicare eligibility.

be interested in earning above SGA due to greater health problems and the need to stay within Medicaid waiver income limits. For these reasons, Pathways decided not to target Family Care members.

Nonetheless, this exploratory effort eventually had an impact on how the SSDI-EP recruited participants. Enrollments rate over the first months of the pilot were insufficient to meet even the lower enrollment target of 500. In response, the SSDI-EP began to augment provider agency recruitment by sending letters directly to consumers served by state programs that provide services or supports used by those seeking to "return-to-work." Due to the prior work that had been done to explore targeting Family Care members, a direct mailing strategy could be quickly implemented for that audience. In turn, this mailing would serve as a trial run for the far larger future mailings to selected consumers enrolled in the Medicaid Buy-in or receiving DVR services. In combination, these mailings constituted a targeting strategy, albeit it a largely passive one.

B. Methods Used to Provide Target Populations with Information about the Pilot

SSA authorized the SSDI-EP to begin enrolling participants as of August 12, 2005. Recruitment activities necessarily began prior to this date and continued through October 31, 2006, the last date of enrollment. In practice, the boundary distinguishing information provided to interest a consumer in the pilot and that provided to help a consumer to make an informed choice to enroll is not a sharp one. Nonetheless, we view recruitment activities as those intended to get potential participants aware of and interested in the offset pilot. Conceptually, the transition to enrollment activities occurred when the consumer began to seriously consider enrollment.

The SSDI-EP used recruitment activities that were aimed at directly reaching potential participants. The project also conducted activities to provide information to organizations and professionals that were likely to have regular contact not only with persons with disabilities, but with those in this population who were more likely to be interested in working and to meet pilot eligibility requirements. In the period leading to the first date consumers could enroll in the SSDI-EP and for several months thereafter, recruitment activities directly aimed at potential participants were conducted almost exclusively through the provider agencies. Outreach activities, intended to inform organizations and professionals about the pilot and to elicit referrals to the provider agencies were conducted by both the agencies and SSDI-EP central office staff. In general, the provider agencies performed this function locally and the central office staff concentrated on statewide audiences or the executives and staff at the main offices of relevant state agencies. For example, a provider agency might conduct outreach to Division of Vocational Rehabilitation staff in its area, while the SSDI-EP staff might brief managers and support staff at the agency headquarters in Madison.[125]

As the project progressed, the SSDI-EP central office took an increasing role in organizing direct outreach to potential participants, mainly through arranging mass mailings to selected groups of consumers. Nonetheless, this involvement only modestly

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[125] The SSDI-EP central office was especially concerned with conducting effective outreach to the Division of Vocational Rehabilitation (DVR), Family Care and other Medicaid funded long-term care programs, the Disability Program Navigators, SSA field offices, and county human service agencies.

altered the central office's original emphasis on having consumer outreach performed locally through the provider agencies.[126] The mailing included a brochure providing an overview of the pilot and referred consumers to agencies in their areas to get additional information. Provider agencies were still expected to continue recruitment activities in their catchment areas.[127]

Provider agencies were expected to contact their current or previous consumers who were likely to meet the pilot eligibility criteria. Agencies were also encouraged, when possible, to seek out new consumers who might enroll.[128] Although outreach could be performed through face to face contact with potential enrollees, provider agencies also employed techniques such as holding group meetings and distributing brochures, posters, and other promotional materials. These were usually developed by the SSDI-EP central office, but sometimes were customized for the provider agency's intended audiences. Provider agencies, in performing outreach to government offices, stakeholder organizations, and area professionals, also used or modified materials from the central office. A standardized Power Point presentation was a particularly valuable resource; it was also used by SSDI-EP central staff in their outreach activities. Additionally, though the SSDI-EP did not provide provider agency staff explicit training on how to conduct outreach, substantial effort was given to training agency staff about what information would need to be discussed with consumers prior to enrollment. SSDI-EP operations staff followed this up with technical assistance intended to encourage provider agencies to increase or improve their outreach efforts.

Within four months of when provider agencies started to enroll participants it became apparent that overall pilot enrollment targets would not be met unless the pace of enrollment quickened.[129] In response, the SSDI-EP sought to augment local recruitment activities with direct mailings to individuals presumed to be SSDI beneficiaries who were receiving services through Family Care, enrolled in the Medicaid Buy- In, and/or accessing services through the state Vocational Rehabilitation program. The Family Care mailing was initiated in January 2006, but was sent to only a few

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[126] It is our observation that there was substantial variation in the degree that provider agencies still conducted recruitment activity following the mailings. In some cases it is not clear whether an agency had made a decision to rely on others to perform recruitment or whether the agency's enrollment had reached the limit of what the agency was willing or able to serve.

[127] Provider agencies had contractually defined geographic areas where they were allowed to enroll SSDI-EP participants. These did not necessarily coincide with agency service areas for other purposes. These boundaries were never tightly enforced. As long as a provider agency was able to serve and stay in contact with a consumer who lived outside the nominal catchment area, the SSDI-EP had no objection to the agency doing so.

[128] Some agencies faced constraints in their ability to recruit new consumers expressly for the purpose of entering the SSDI-EP. In some cases the constraints were external, as in the case of state regulations limiting who could be served by an agency designated as a Community Support Agency for those with severe and persistent mental health problems. In other cases, the constraint was a matter of the agency's own rules. For example Clubhouses (there were two SSDI-EP provider agencies in this category) required consumers to be involved in Clubhouse activities in addition to those that were strictly part of the offset pilot.

[129] As the enrollment period was originally set as one year, a straight line projection of enrollment trends at this point would have resulted in a final total of about 320 enrollees (or 400 over the actual fifteen month enrollment period).

hundred persons in the six counties then served by the program. Mailings to subgroups of over 8,000 Medicaid Buy-in participants and about 2,200 DVR consumers started in May 2006. The pace of SSDI-EP enrollment markedly increased following these mailings, though one should not conclude that all or even most entrants in the last months of the enrollment period were recruited through the letters. To a greater or lesser extent, provider agencies continued their local outreach to potential participants and, in any case, the deal had to be closed by provider agency staff.

Provider agency staff informed the SSDI-EP central office that many of the consumers who contacted their agency following receipt of the mailing had already talked to them about the pilot. In many cases, it was said that the letter acted as a reminder and perhaps reinforced the credibility of the SSDI-EP by associating it with established state programs. It is certain the mailings resulted in a high number of phone calls to both the pilot's central office and the provider agencies. Frequently an initial phone call to the SSDI-EP central office resulted in a series of calls back and forth to adequately answer all questions. There is no reason to think that the experience at the provider agencies was substantially different.[130]

C. Outcomes of the recruitment process

The only documentation of the number of consumers contacted is that of the over 10,000 letters sent to probable SSDI beneficiaries identified among those attached to the Medicaid Buy-in, DVR, and Family Care. The actual number of distinct individuals reached through these mailings is unknown. There is also reasonable evidence that the pilot's central office and most provider agencies contacted all or most of the government offices and stakeholders groups they were expected to, though the depth and persistence of such outreach by the local agencies is uncertain.

We think the best criterion of whether recruitment activities were successful is whether enough consumers enrolled in the pilot for it to serve its primary purpose: providing SSA with useful information to inform the design of a national demonstration of a SSDI cash benefit offset. Enrollment would need to be sufficient to allow meaningful assessment of project operations and formative estimates of participant outcomes. Though neither SSA nor the SSDI-EP set an explicit standard, the SSDI-EP's enrollment targets (which SSA agreed to) provide benchmarks.

The SSDI-EP enrolled 529 individuals. However, as some enrollees were later found not to meet all eligibility requirements, there were actually 496 SSDI-EP participants. Consequently, the SSDI-EP basically achieved its lower enrollment target of 500, but fell far short of the upper target of 800.

However, recruitment processes failed to meet one important goal of those who designed the Wisconsin pilot. It was hoped that roughly half the participants would be former SPI participants who had already received significant amounts of benefits counseling and person centered employment services. Half of the 800 person target is 400; half of actual enrollment would be 248. Only twenty-two SPI participants entered

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[130] The description provided in this segment of Chapter III was informed by that in Reiser, John, et. al. 2008. "Wisconsin SSDI Employment Pilot: Wisconsin Year 3 Report" Madison: WI: Wisconsin Pathways to Independence Projects, p. 6.

the SSDI-EP. We will discuss the probable reasons for this poor result in the material about which aspects of the recruitment processes did not work well. Nonetheless, we do not want to exaggerate the negative consequences of the pilot's inability to enroll a number of former SPI participants large enough to support the intended analyses of the differences between those with long term exposure to benefits counseling and PCP services to those with shorter exposure. The inability to perform this type of analysis did not impede the process evaluation in the least, as it dealt with issues that were relatively insensitive to the sample size. Though the limits on sample size did affect the evaluation's choice of method for the impact analysis, it did not prevent us from obtaining formative estimates of participant outcomes.[131]

By contrast, the pilot succeeded in attracting more "original participants" than anticipated. Recruitment processes generated 474 valid enrollments of participants who had no attachment to SPI; that is, nearly 20% above the number implied by an equal division of the upper enrollment target. We note in passing that most of the provider agencies with the largest enrollments had not participated in SPI. This fact is examined in more detail in the chapter describing pilot enrollment processes.

Finally, there is only limited evidence about take-up rates; that is the number of contacts that had to be made in order to convince one individual to enroll. Indeed, the concept of take-up rate is somewhat fuzzy. Should the numerator of the take-up rate be the number of consumers that provider agency staff had serious discussions concerning enrollment with, or the number staff provided any information to, or even the number who received information from any source?

In interviews held in spring 2006, we asked provider agency staff to indicate what percentage of (apparently) eligible consumers decided not to enroll. About 70% reported that no more than one out of every four "eligible consumers" chose not to enroll. Only one respondent said that more than 50% refused. Although these responses are supportive of a conclusion of reasonably efficient outreach, they still need to be treated cautiously as indicators of the take-up rate. It is unlikely that staff would always be in a position to assess eligibility until there had been a fairly serious conversation about enrollment, at least not for consumers who were not already attached to their agency. So staff perceptions, even if accurate, reflected results for a subset of consumers who had received information about the pilot. Perhaps the information that SSDI-EP operations staff obtained from provider agency staff in August 2006 provides a better indicator. Provider agency staff reported that "…approximately 30-50% of the calls they received were appropriate referrals…"[132] The percentage of these who actually enrolled is unknown, but if, as reported in spring 2006, about three quarters of those thought to be eligible enrolled, it suggests a take up rate of between 20% and 40% at most agencies.

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[131] As a consequence of the limited sample size, we chose to use MANOVA instead of a hierarchical regression approach to estimate participant outcomes. See Chapter II, section B4b of this report for further discussion.

[132] Reiser, John, et. al. 2008. p. 7. It is not clear whether these calls were strictly inquiries from potential participants or also included referrals from third parties.

D. Consumers' experience with the recruitment process

Neither the evaluators nor SSDI-EP operations staff collected information from individuals who did not enroll in the pilot. Relevant information was collected only from those who actually enrolled and most of that information pertains to the enrollment process itself. However, the two participant follow-up surveys administered, respectively, about one and two years after the participant's enrollment date included a question that asked where the participant heard about the offset pilot before they enrolled. Though we have no way of knowing whether non-enrollers would have provided a different distribution of answers had they been surveyed, we are not aware of any reason why those who did not enroll typically learned about the SSDI-EP in ways fundamentally different than those who enrolled.[133]

The most frequent answer to the question in the year one survey about the original source of information about the pilot was the state's vocational rehabilitation agency DVR (31%). The next most frequent responses included those indicating the SSDI-EP's primary approaches to direct recruiting activities. 19% of those responding to this question on their first follow-up survey reported they had learned about the pilot from the agency where they had enrolled, 14% answered they first learned about the SSDI-EP through a letter mailed to them. Response patterns for the year two follow-up survey were very similar. In both surveys the proportion of "don't know" answers was less than 10%, though understandably (given the passage of time) a bit higher in the later survey.

What we find interesting about these findings is what they suggest about which forms of outreach consumers found particularly salient. Those who completed the surveys were as likely to recall that they heard about the pilot through DVR as through provider agency activities and the mailings combined. DVR was certainly an important target of the SSDI-EP's indirect recruitment activities, but survey respondents mention hearing about the pilot at least five times more often through DVR than through any of the other main categories of organizations or professionals that either the project central office or provider agency staff had performed outreach to.[134] Lest it be thought that DVR personnel as a whole were highly enthusiastic about or even knowledgeable about the pilot, responses from both staff interviews and participant focus groups present a decidedly mixed picture. Some informants had strong praise for DVR staff, almost as many reported that DVR staff was poorly informed about the pilot or did little or nothing to either encourage enrollment or to help those consumers who participated get appropriate services.

Based on our interviews and focus groups for this and other research projects, we are willing to hypothesize why survey respondents emphasized DVR's importance in publicizing the offset pilot far beyond its expected importance to SSDI-EP outreach efforts. To begin with DVR is a natural contact point for SSDI beneficiaries hoping to return to work or achieve better employment outcomes. It is by far the most important

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[133] Nonetheless, it is possible that how one learned about the pilot might affect one's decision to enroll. It is conceivable that different sources of information were viewed as more trustworthy or offered messages that proved better aligned with consumer interests.

[134] Examples of these include SSA, community agencies other than the provider agencies, and county economic support workers.

source of funding for vocational services, including those provided through most of the community based agencies taking part in the pilot. Though SSDI-EP participants need not have any connection to DVR, approximately 55% were open DVR cases either during the pilot or in the two years prior to entry. Many of the DVR consumers enrolled in the SSDI-EP and other return to work efforts we've studied have indicated that they greatly value and trust their counselor's input. Given these factors, we would not be surprised if many consumers simply found what their DVR counselor said more salient than other sources, especially when being asked to recall events that, at minimum, occurred one year earlier.

In addition to the limited survey information presented, during the 2006 provider agency staff interviews we asked staff about their impressions of why consumers they had believed to be eligible had not enrolled. Besides constituting "hear say" evidence, these reports are about a subset of consumers who were apparently making a conscious decision as to whether to enroll. Still, we think the results provide some insight as to why those in the larger audience of the "recruited" did not seriously pursue the offer to join the pilot.

Our informants most often mentioned consumer fears about losing eligibility for public benefits, reductions in benefit levels, and/or inability to regain access to benefits if needed in the future. Moreover, these fears were most often focused on SSDI and associated health care programs.[135] Staff reported there was particular concern as to how SSA would treat earnings, especially earnings above SGA, after the offset pilots.

However, provider agency staff identified other reasons for non-enrollment. The most commonly identified of these was that consumers did not feel the time was right to participate. A consumer might have a health problem or need to manage some family issue. In some cases a consumer was completing a degree or training program for the purpose of achieving better employment in the future and did not wish to interrupt that process.

Some consumers, according to the staff members interviewed, had concerns about the pilot itself. Consumers were reported to have privacy concerns, to view the informed consent/enrollment process as too complex and/or research reporting as too demanding, or had concerns about SSA's ability to implement the project (especially accurately processing checks). Finally, some staff asserted that some consumers' decisions not to enroll were manifestations of their mental illnesses, for example paranoia or the incapacity to make a decision due to serious depression.

E. What worked well (recruitment)

As the SSDI-EP achieved its lower enrollment target, the recruitment process must be judged to have been satisfactory. However, it is unlikely that the original emphasis on having the provider agencies recruit prior or current clients would have been sufficient to generate an acceptable number of participants. Though it is possible that the central office's and the provider agencies' outreach to the organizations and

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[135] This included access to Medicaid and Medicaid waiver programs as well as Medicare. Though SSDI only beneficiaries have no entitlement to Medicaid, they often established categorical eligibility. These beneficiaries would lose categorical eligibility if they did not continue to meet the Social Security disability criteria that also applied to the relevant Medicaid programs.

professionals serving disability populations had a cumulative impact, it appears that the mass mailings to those served by the Medicaid Buy-in and DVR was the action that made the most difference. Before the mailings began in earnest, valid enrollments averaged about twenty-four per month. After the mailings, valid enrollments averaged fifty-one per month, more than twice the previous rate.

Though this finding can be interpreted to suggest that the SSDI-EP should have started the mass mailings far earlier, it is not certain that doing so would have massively increased final enrollment. Provider agency staff noted that the letters often worked as a reminder to consumers who had already been contacted. There are also indications that for some consumers getting a letter from DVR or DHS served to give the pilot more credibility. Lastly, there is the fact that after the SSDI-EP made the decision to utilize large scale mailings, it delayed implementation to make sure the recruitment letters would reach consumers well after a DHS mailing about the then new Medicare D program. Even so, provide agency staff reported to the pilot operations staff that the ongoing roll-out of Medicare D made the pilot recruitment process more difficult. Many consumers had questions about Medicare Part D and placed a high priority on having them answered. This reduced the time that staff could spend explaining the pilot. Some consumers were reported to have said that they couldn't consider enrolling in the SSDI-EP because they were confused and concerned about Medicare Part D.[136]

One unexpected finding is that the provider agencies that had not been involved in SPI typically had larger enrollments then those that had. The new agencies averaged about forty-one participants, compared to nineteen for the ones involved in SPI. Median enrollments figures were about the same as the mean, though every provider agency with less than twenty participants had been among those brought forward from the earlier project.[137] As there is no evidence that the new agencies had more staff devoted to pilot activities, we think the enrollment data suggest that the agencies that went through the "competitive" selection process more aggressively or effectively performed their recruitment activities than the agencies that had been selected for the pilot because of their existing relationships with Pathways. We do not know a great deal about the causes of these differences; we will discuss what we know or hypothesize in Chapter IV.

F. What didn't work (recruitment)

The SSDI-EP did not succeed in enrolling an analytically useful number of participants who had also participated in the Wisconsin SPI project. As the service package for those in SPI was conceptually similar and typically more intensive than what was planned for the SSDI-EP, the hope was that recruiting SPI participants would result in a sample with a larger proportion of treatment group members ready to use the offset and would also permit researchers to examine the effects of long term exposure to benefits counseling and person centered planning. The expectation at Pathways was that the former SPI provider agencies would be able to contact most of the SSDI

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[136] Reiser, John, et. al. 2008. p. 6.

[137] The provider agency that discontinued its relationship with the SSDI-EP had enrolled only five participants and was one of those that had been selected through the RFP process. Their participants were transferred to a former SPI agency, increasing its enrollment from fifteen to twenty.

beneficiaries the agencies had served during the earlier project and that many of these individuals would want access to the offset feature. Indeed, this was a primary reason these organizations were given almost automatic entrée to the SSDI-EP.

Based on our interviews and what we heard from central office staff, these provider agencies did concentrate on recruiting current or former consumers, particularly in the first months of enrollment period.[138] Over 90% of the staff interviewed from the agencies involved in SPI said that they were able to identify and contact former consumers. If so, why did only twenty-two SPI participants enter the SSDI-EP?

One possible answer is that most qualified SPI participants were unwilling to enroll in the offset pilot. Aside from the low number of such enrollees, there isn't much evidence to support this. Recall that most provider agency staff reported that at least three out of four consumers thought eligible had entered the SSDI-EP. Nonetheless, we would not dismiss the possibility that some SPI participants declined to participate in the SSDI-EP because of their disappointments with the earlier project or of what might be termed participation fatigue.

A more satisfying answer is that Pathways staff greatly overestimated the number of SPI participants likely to be eligible for the pilot. We previously mentioned that the estimated number of SSDI only participants in SPI was 400. Some of these individuals would have been ineligible because they received benefits based on another person's earnings record. Additionally, some of these individuals would have been more than six years beyond their TWP completion date. Even had the provider agencies been able to contact most of the presumptive eligibles among the former SPI participants and then most of them had chosen to enroll, the number of these participants would have been far less than the original target of 400.

Nonetheless there is another factor that helps explain why so few of the former SPI participants enrolled. Most of the relevant provider agencies had not maintained records of which consumers had participated in SPI and staff that had worked with SPI participants had either left the agencies or may have forgotten which of their consumers had participated. The SSDI-EP operations staff did not have records either. Only the researchers who had evaluated SPI had access to this information and under terms of the consent agreements they could not provide it to the SSDI-EP operations staff.[139]

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[138] In our spring 2006 interviews, about half of those we talked with identified a gradual shift in recruitment and outreach activities. Most frequently, the emphasis shifted toward recruiting consumers that had no previous involvement with the agency. There was also, to a lesser degree, a tendency to reduce outreach to government entities, community organizations, and area professionals. We do not know whether this reflects reaching a point where staff felt there were diminishing returns or the expectation that the mass mailings made these activities less important. It is important to note that these trends applied to both the old SPI agencies and the agencies specifically enlisted for the SSDI-EP.

[139] The informed consent agreements for SPI would have allowed the researchers to provide the identities of participants to the organizations at which those participants had enrolled had the agencies requested it. No one remembered this possibility until after the enrollment period was over.

Thus, most of the former SPI agencies were in no position to perform targeted outreach to those who had been in SPI.[140]

Based on information gathered from SSDI-EP operations staff, provider agency staff, and participants, we can identify a second factor that may have reduced the effectiveness of recruitment activities. SSA amended rules about pilot eligibility and offset use almost up to the date of the first enrollment. These changes were not always immediately or fully understood by staff at either the SSDI-EP central office or at the provider agencies. In particular, one member of the operations staff had presented obsolete information at early training events. Indeed, the SSA project manager had attended one of these events and had not caught the mistake. [141] As late as the end of 2005, project operations staff members were still working to correct misunderstandings rooted in “last minute” changes in SSA rules for the offset pilots.[142]

Provider agencies were largely recruited in the first half of 2005. Training and technical assistance activities commenced in earnest at mid-year, about seven weeks before the date SSA had set to begin enrollment. During this period SSA changed its mind about allowing Disabled Adult Children (DACs) and those receiving benefits as widows/widowers to enroll in the pilot. SSA also changed its position on how long those assigned to the treatment group would be able to use the offset. Initially Pathways and the provider agencies were informed that the offset would be available as long as a treatment group member remained in the SSDI program. Then, SSA limited the usage period until seventy-two months past the conclusion of the TWP, but those in the treatment group who had completed EPE would have thirty-six months in which to use the provision. This was changed once more. The amended rule was an absolute limitation of offset usage to within the seventy-two month period. If someone enrolled in the seventy-first month following TWP completion, she would have a maximum of one month in which to use the offset.

These rule changes substantially reduced the size of the eligibility pool. In turn, it created informational demands on those attempting to identify potential enrollees, whether at the provider agencies or external entities such as DVR, that were almost impossible to meet without access to confidential materials such as the SSA generated Benefits Planning Query (BPQY).[143] Moreover, our informants reported that the ongoing rule changes reinforced existing doubts about whether SSA could effectively administer

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[140] Again, it is important to note that Pathways had hoped to implement a benefit offset as a continuation of SPI. It probably would have been easier to convince SPI participants to stay in order to utilize a project feature which, if not explicitly promised, had been mentioned during SPI recruitment than to convince them to enroll in a new project.

[141] This was the final change in the interpretation of the seventy-two month rule. See the next paragraph for further information.

[142] However, there were instances where provider agency staff held misconceptions about eligibility requirements that were completely unrelated to anything that SSA had ever required, let alone changed. As late as three months after enrollment commenced, staff at one provider agency still believed that a consumer had to be employed to be eligible for the pilot.

[143] In many cases information on the BPQY would prove inaccurate. This resulted in several enrollees who appeared to be pilot eligible based on their BPQYs being removed from the pilot after they enrolled.

the pilot and abide by its pledge that no beneficiary would be disadvantaged by his participation in the offset pilot. Staff would necessarily be more guarded in their description of the benefits of participation and because of worries that if SSA again changed the rules their credibility would be on the line as much as SSA's. Finally, in some cases, these changes made the pilot less attractive to those who might be eligible to enroll. For example, the final interpretation of the seventy-two month rule would make the pilot less attractive to potential enrollees well past their TWP completion date.

Beyond this, some in Wisconsin perceived a deeper contradiction in the pilot stemming from SSA's decision to limit offset use to a maximum of seventy-two months. They observed that an effective benefit offset (at least in conjunction with continued access to public health care programs) should encourage some individuals to make the full transition from "beneficiary" to "worker." The decision to time limit the offset meant that offset users would be administratively returned to active "beneficiary" status and thus would have a strong incentive to be mindful of the need to meet the requirements of maintaining that status. As such, according to those holding this perspective, the pilots included a significant disincentive for taking full advantage of the offset provision.

G. Summary of lessons learned for informing BOND (recruitment)

We think it unlikely that much about SSDI-EP participant recruitment processes has purchase for the Benefit Offset National Demonstration (BOND). Our understanding is that BOND will identify potential participants directly from SSA administrative records. Those in the primary treatment group will be informed, probably by mail, that they can use the offset. Those in the primary control group will never be informed of their status.

Our understanding is that BOND will include secondary and substantially smaller treatment and control groups, mainly for the purpose of testing various combinations of the offset and support services. Members of these groups will be volunteers. Though potential volunteers will still be identified based on inclusion in a sample drawn from SSA records, one can argue that they will need information that will elicit their interest in participation. This initial information provision can be viewed as analogous to recruitment.

Our main advice, based on the SSDI-EP experience, is that SSA waits until project features and rules are set before communicating them to potential volunteers. Our view is that many beneficiaries do not fully trust SSA. Inconsistent messages tend to reinforce such lack of trust. We would also advise that SSA find credible local intermediaries to do much or most of this contact. We understand there is the danger that such intermediaries may act in ways that make it less likely that volunteers will reflect the overall beneficiary population, but the fact that SSA draws the sample from which volunteers will come will help mitigate such problems. So too can effective training and monitoring.

The development of trust or lack thereof may actually have greater implications for the recruitment of local capacity to help enroll volunteers or to provide them or the broader sample of BOND participants with support services such as benefits counseling. This is particularly true if, as expected, some of the states that had offset pilots will also be included in BOND. Relatively few in the adult SSDI population in the pilot states will be aware of what happened during the pilots. By contrast, executives and staff at most of the entities that could provide services such as benefits counseling will know or will be members of networks that will allow them to find out. Earning their trust is important, both for gaining their cooperation with BOND and because the consumers they serve often act on the basis of information or cues they provide. In particular, it will be remembered that SSA had made an important change affecting future offset use near the end of the project, effectively negating what consumers had been told during and since enrollment.[144]

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[144] We are specifically referring to the decision to return all treatment group members who did not complete their TWP by the end of 2008 to regular SSDI program rules on January 1, 2009.

CHAPTER IV: ENROLLMENT PROCESS AND FINDINGS

From August 12, 2005 through October 31, 2006, 529 individuals volunteered for the SSDI-EP. As thirty-three enrollees were later determined not to meet all eligibility requirements, there were a total of 496 participants in the SSDI-EP. This number was more than sufficient for the purpose of examining how well pilot processes and procedures worked. Enrollment was also adequate for the purpose of looking at differences in outcomes between the treatment and control groups, though sometimes marginal or insufficient for examining important subgroups.[145]

In this chapter we describe the enrollment process and a broad range of participant characteristics. While the distributions of participant characteristics provide evidence of how successfully random assignment was implemented, it can serve other purposes as well. In particular, these distributions can help establish how representative SSDI-EP participants are of either the adult SSDI population or that portion that would have qualified for the offset pilot.

We also report on what participants and staff members at the provider agencies told us about their perceptions and experiences of the enrollment process. This information is directly pertinent to a question that SSA wanted the pilot evaluations to address: What are the most effective methods of obtaining consent to participate in the projects? Finding a satisfactory answer to this question is important for designing the national demonstration, especially if SSA and its partners go forward with the current plan to enroll volunteers into experimental groups intended to test the effectiveness of various combinations of a benefit offset and service provision.

A. Description of Enrollment Process and the Informed Consent Process

Most of the enrollment process took place at the provider agencies, a direct consequence of how Pathways decided to organize the pilot. It was staff at these agencies that explained the details of the pilots to potential enrollees, assessed whether consumers appeared to meet pilot eligibility requirements, engaged in “ability to benefit” discussions with them, and then, following a decision to enroll, facilitated the completion of all enrollment materials, including informed consent forms. It was agency staff who informed new enrollees of their assignment to either the treatment or the control group.

The SSDI-EP central office was also involved in the enrollment process, but had no direct contact with enrollees beyond mailing participants a letter confirming enrollment and their assignments to a study group. Random assignment was performed at the SSDI-EP central office and was automatically triggered when a provider agency electronically submitted the enrollment form. Central pilot staff would follow-up on problems that arose, such as difficulties establishing eligibility or the failure of consent forms and other enrollment materials to arrive on a timely basis. These exchanges were almost always with provider agency staff who would then contact participants as needed.

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[145] In particular, we are referring to the very low number in the former SPI participant subgroup. Though it is true that the pilot enrolled an insufficient number of persons who had completed or would soon be able to complete a TWP to support a comparison between treatment and control group members in this subgroup over the full Q0-Q8, this issue could have been addressed by extending the pilot another year.

Though provider agency staff conducted enrollment, they did so based on following rules and procedures designed by the SSDI-EP central office. Crucially, the central office provided substantial training and then technical assistance as needed. Responsibilities for performing enrollment related training, TA, and troubleshooting were divided between operations and evaluation staff and reflected Pathways choice to have a fully independent evaluation. There would be separate consent forms for research and operational purposes and a need for provider agency staff to comprehend and then be able to explain to interested consumers the purpose of the separate forms and the differences in data collection for research and operational purposes. SSDI-EP managers made another choice, to have most data elements collected during the enrollment process flow directly into the research domain and thus be unavailable to operations staff unless the informed consent materials specified that a data element would be shared.[146] This choice was made, in part, because of the evaluators' superior capacity for performing data collection and management tasks and, in part, to help reassure participants who might be concerned that confidential data collected for research purposes would find its way into DHS administrative records.[147] The evaluation team, being housed at DHS, argued that a strong separation between research and operations functions would make promises of confidentiality more credible. One consequence of this was that the evaluation team would have the larger role in providing training and TA to provider agency staff as to how to implement the nuts and bolts of the enrollment process.[148] Even so, operations staff was the sole source of guidance on many issues, especially when a rule needed to be applied to individual circumstances. Examples include eligibility assessment and whether an existing benefits analysis was acceptable.

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[146] Some operations staff later said that it would have been better had all encounter data from the provider agencies been collected in the operations domain and then transferred to the evaluation. They argued that having direct access to the encounter data would have allowed better identification of and response to both agency and participant problems. They noted that some provider agency staff members were surprised that operations staff did not get the encounter data from the evaluation team, calling into doubt how well the separation of research and operation functions were understood in the field or even whether the separation mattered.

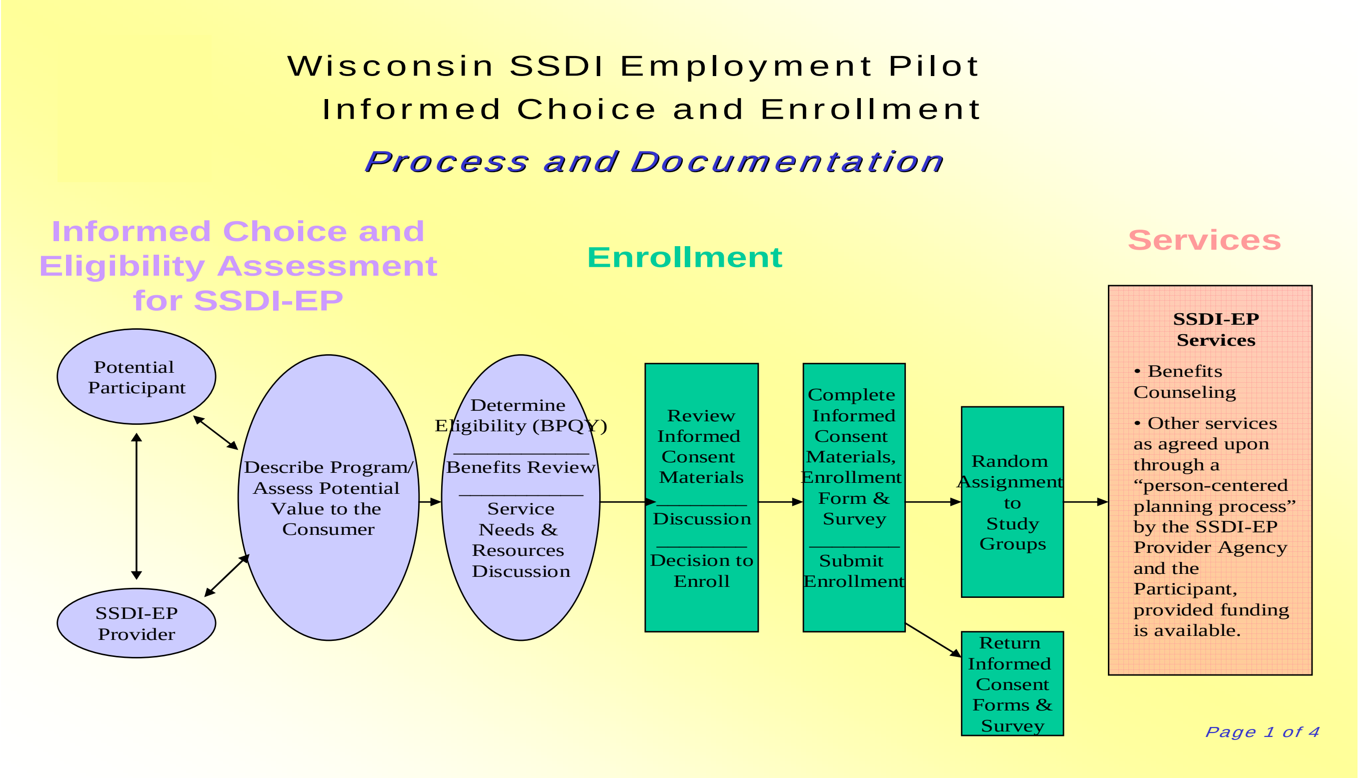
Nonetheless, granting the purchase of these concerns, we think there would have been significant costs to having the encounter data needed for evaluation purposes collected in the operations domain. If the framing of the questions and instructions had been predominately in the operations domain, there would have been a danger that the data would not have been usable for evaluation purposes. This is not a theoretical argument, but reflects the limitations of certain data collection activities designed and implemented by operations staff during the SSDI-EP. However, even if the items and instructions met evaluation needs, it is unlikely that operations staff would have had the resources to engage in the level of data cleaning activity that the evaluation team felt was minimally necessary. These activities required considerable effort on both a weekly and an annual basis. Despite our considerable efforts, we doubt the encounter data are fully accurate.

[147] Additionally, for consistency and convenience, certain forms and information with strictly operational purposes were routed and stored by the evaluation team. Examples include project, as distinct from research, consent forms and the annual earnings estimates.

[148] The online system for submitting the enrollment form and the monthly encounter data forms was in the research domain. Provider agency staff could get access to the system only after they received training from the evaluation team in its use. Because of this, it was more efficient for the evaluation team to provide substantive information about most aspects of the enrollment process during training.

Figure IV.1 displays the main steps of the enrollment process as conducted at the provider agencies. The formal enrollment process was preceded by a period in which the consumer and the staff involved in the enrollment process were expected to have a targeted discussion about whether the pilot would be of value to the consumer. This discussion often involved considering what services would help a consumer achieve his employment goals and how those services might be accessed and funded. At approximately the same time, agency staff needed to perform two other critical tasks. The first task was to review the consumer's eligibility - generally using the SSA generated Benefits Planning Query (BPQY) as the primary source of information. The second task was to determine whether the consumer had a recent comprehensive benefits analysis (i.e., "benefits review" in figure IV.1) that could be used or whether an initial or updated one was needed.[149] A benefits analysis involves documenting the individual's use of public benefits and the use or availability of work incentives. The benefits analysis can then be used as a basis for forecasting the consequences of various levels of earnings and for identifying useful work incentives and supports. The expected result is that the consumer has adequate information to support informed decision making.

Figure 1V.1: Sequence of Informed Choice and Enrollment Process



Provider agency staff reported substantial case to case variation in how long it took to complete these activities and start the formal enrollment process. In some cases, these activities and enrollment itself were completed in less than a day. Occasionally, these activities could take weeks.

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[149] A comprehensive benefits analysis was considered current for up to one year, provided there haven't been significant changes in the consumer's benefits or employment situation.

Generally, when a consumer did not have a current BPQY, benefits counselors at most provider agencies could obtain the document quickly from a local SSA office. In large part, this rapid response reflected ongoing relationships between agency and SSA staff that in many cases had their origin in the SPI project. Where such relationships did not yet exist or proved ineffective, the SSA Area Work Incentive Coordinator (AWIC) in Madison expedited BPQY delivery. More seriously, the BPQY sometimes lacked accurate information, especially about TWP usage or completion. This information was critical for determining whether a TWP had been completed within the prior seventy-two months and, thus, whether an otherwise eligible consumer could participate in the SSDI-EP.[150] While this information could sometimes be updated in a reasonable time period, it was not unusual for a provider agency to enroll a participant without having absolute proof of eligibility.

Similarly, there could be delays in completing benefits analyses. In addition to obtaining BPQYs or getting other Social Security related information, a benefits counselor often needed to obtain information about the use of other public programs and the consumer's personal circumstances. Sometimes delays resulted from the size of the benefits counselor's overall workload, especially when the benefit counselor was responsible for providing services to agency consumers not participating in the pilot. Lastly, "pilot eligible" consumers made the final decision as to whether to proceed to the formal enrollment process. Some consumers prolonged making their enrollment decision until long after their eligibility had been established and their benefits analyses finished.

The formal enrollment process was typically completed in one day. First, informed consent materials would be reviewed. Consumers were encouraged to ask any questions they had before signing. There were two consent forms that anyone entering the pilot had to sign.[151] The first was for the pilot itself and included a detailed description of the benefits, and obligations of those assigned to the treatment group. The second form identified what information would be collected for evaluation purposes and how the confidentiality of those data would be protected. By signing this form the enrollee was giving permission to access individually identified data in various administrative data bases as well as use of data collected specifically for the SSDI-EP. Enrollees were required to sign both forms as project participation was conditional on research participation.

Next, the staff member conducting enrollment asked the consumer to provide or verify the information needed to complete the enrollment form. At this time, the enrollee was asked to complete the baseline survey as the evaluators did not want responses

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[150] The SSDI-EP central office processed any enrollment submitted by staff at a provider agency. The expectation was that staff would always make a good faith effort to establish eligibility using the BPQY. In thirty-three cases (approximately 6% of the 529 enrolled) this expedited process "failed." The SSDI-EP's decision to enroll participants without full verification of eligibility reflected a judgment that it was better to involve willing beneficiaries in the pilot as soon as possible, rather than to have a significant delay dampen interest in participating. It sometimes took months for SSA to identify ineligibility, especially for those assigned to the treatment group.

[151] There was a third form that former SPI participants could sign allowing the evaluators access to data collected for that project and allowing those data to be linked to that collected during the SSDI-EP. Former SPI participants were not required to sign this form to enroll in the pilot. Additionally, prospective enrollees were given material summarizing the informed consent documents, the purposes of the evaluation, and describing the annual participant surveys.

influenced by whether or not the enrollee was assigned to the treatment group. The enrollee also completed her earnings estimate for the current calendar year at this stage of the process.

Once these tasks were completed, the staff member submitted the enrollment form. Within seconds, notification of assignment to either the treatment or control groups would be received from the SSDI-EP central office and shared with the new participant. The provider agency staff member would then mail the completed informed consent forms and the earnings estimate to the SSDI-EP. Participants would send their baseline surveys separately from other enrollment materials using prepaid envelopes. For the most part, materials were received promptly. However, there were cases when there were delays in sending informed consent forms and, in approximately thirty cases, surveys were never returned.[152]

Finally, provider agencies were allowed some flexibility to implement enrollment processes differently in special situations, most typically when a consumer could not travel to the agency. Field enrollments were permissible, but resulted in delays in submitting enrollment forms and in notifying the enrollee of his study group assignment. More seriously, it appears that staff at some agencies allowed participants to complete their surveys after they had been informed of the results of random assignment. Though provider agency staff members were allowed to do this “at need,” there is evidence that this became a common practice at some providers.[153]

B. Characteristics of Enrollees

Tables IV.1 through IV.12 provide information about participant characteristics. This information, with a few exceptions, describes participant characteristics at the time of pilot entry or for the most recent available time period prior to the enrollment date. All of the tables, with the exceptions of IV.11 and IV.12 provide information for both the treatment and control groups. Despite random assignment, there were three comparisons out of sixty-nine (4%), where there was a statistically significant difference (p-value = or < .05) and one more where the p-value was less than .1.

Accordingly, we had some concerns as to whether the random assignment produced an appropriate sample and so directly checked whether there was a significant difference in the proportions assigned to the two study groups.[154] Of the 496 valid participants, 266 (53.6%) were assigned to the treatment group, 230 (46.4%) to the

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[152] Though participants were required to complete surveys, failure to do so did not result in any sanction.

[153] Surveys were logged upon receipt. Thus, it was possible to calculate the difference between the enrollment date and the receipt date. Though there is no certain method to ascertain that a baseline survey was completed after the participant was informed of her study group assignment, we think the probability this was the case grows rapidly when the difference between the enrollment and survey receipt dates is more than a week.

[154] We do not think there was a problem with either the mathematical algorithm used or its implementation, as it was thoroughly tested before enrolling participants. With one exception (the proportions entering the pilot five to eight years after SSDI entitlement) significant differences occur only when there are very small proportions in one category of a distribution.

control group. The associated p-value is .106. However, if one then scrutinizes the distribution for the sample who were actually enrolled at the provider agencies (529, 279 (52.7%) in treatment, 250 (47.3%) in control), the associated p-value is .206.[155]

Table IV.1 (also known as SSA table 2) presents information about a group of twelve characteristics that SSA wanted all four pilots to report in the same way. Though there are no significant differences based on random assignment, the sample suggests that the SSDI-EP sample characteristics are distinctive in a number of ways that may differ from those for the general adult population, for adult SSDI beneficiaries, and for those beneficiaries that met pilot eligibility criteria, whether for the United States or Wisconsin. Additionally, the material in table IV.1, allows SSA and others to identify salient differences between the samples in the four offset pilots.

While we will not extensively review the data presented in table IV.1, we want to identify a number of salient findings. The SSDI-EP sample was heavily male (54.3%) compared to the general population, though not much different from that of disabled workers in current pay status in either Wisconsin (55%) or nationally (56%).[156] However, in many other respects the SSDI-EP sample was quite dissimilar from the disabled workers group either in Wisconsin or nationally. As proportions were similar for Wisconsin and the national group, we use the former in the following comparisons.

The SSDI-EP sample included a much larger proportion of younger beneficiaries. About 16% of SSDI-EP participants were younger than thirty-four years and 27% were between ages thirty-five and forty-four. The comparable proportions for Wisconsin were, respectively 5% and 14%. Additionally, SSDI-EP participants typically had far higher levels of educational attainment than those reported for disabled workers in current pay status. Two thirds of the pilot sample reported at least some education beyond a high school diploma, compared to 15% for Wisconsin. Finally, there were large differences in the distribution of SSDI-EP participants across Social Security impairment groups and those of the reference population in Wisconsin. Pilot participants were far more likely to be identified as having a mental disorder other than retardation (44%) than disabled workers in Wisconsin (29%). By contrast, the proportions in the SSDI-EP reported having impairments of the musculoskeletal system (14%) or in the broad “other” category (21%) was notably less than for the Wisconsin reference group (approximately 25% and 29%).

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[155] Twenty of the thirty-three enrollees later found ineligible had been assigned to the control group. The SSA Office of Central Operations in Baltimore only checked the eligibility of treatment group members. In order to insure ineligibles were removed from the control group, we asked staff at the SSA office in Madison to vet these cases. We believe the same criteria were used to identify ineligibles at both offices, though OCO took much longer to make its determinations. Using enrollment form information, we observed no suspicious differences between the characteristics of those determined ineligible in Baltimore and those so determined in Madison. The numbers were too small for meaningful statistical analysis.

[156] Data tables prepared by SSA (ODPR, ODA) for the benefit offset pilots. Data was from July 2007. The age, educational attainment, and impairment data identified in the following paragraph are also from this source.

Table IV.1: Participant Characteristics in Percentages by Study Assignment (a.k.a. SSA Table 2)

	Treatment		Control		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Gender								
Female	44.7%	3.05	45.7%	3.28	-1.0	4.48	0.823	45.2%
Male	55.3	3.05	54.3	3.28	1.0	4.48	0.823	54.8
Age								
34 and younger	18.0	2.36	13.9	2.28	4.1	3.28	0.211	16.1
Ages 35 to 44	27.8	2.75	26.1	2.90	1.7	3.99	0.670	27.0
Ages 45 to 54	36.8	2.96	41.3	3.25	-4.5	4.39	0.305	38.9
Ages 55 and up	17.3	2.32	18.7	2.57	-1.4	3.46	0.686	17.9
Race								
Non-White	14.3	2.15	10.4	2.01	3.9	2.94	0.185	12.5
Years Since Entitlement								
2 or less	14.7	2.17	12.2	2.16	2.5	3.06	0.414	13.5
More than 2 and less than 5	33.8	2.90	34.3	3.13	-0.5	4.27	0.907	34.1
5 to less than 8 years	15.8	2.24	23.5	2.80	-7.7	3.58	0.031	19.4
8 years or more	35.7	2.94	30	3.02	5.7	4.21	0.176	33.1
Impairment								
Musculoskeletal	13.9	2.12	15.2	2.37	-1.3	3.18	0.683	14.5
Neurological	15	2.19	10.4	2.01	4.6	2.97	0.122	12.9
Mental-Mental Retardation	5.6	1.41	3	1.12	2.6	1.80	0.149	4.4
Mental-Not Mental Retardation	44.0	3.04	48.7	3.30	-4.7	4.49	0.295	46.2
All Others	21.4	2.51	22.6	2.76	-1.2	3.73	0.748	22.0
Education								
Less than HS	4.5	1.27	6.5	1.63	-2.0	2.06	0.332	5.4
HS	27.8	2.75	27	2.93	0.8	4.01	0.842	27.4
More than HS	67.7	2.87	66.5	3.11	1.2	4.23	0.777	67.1

Table IV.1 (cont.): Participant Characteristics in Percentages by Study Assignment

	Treatment		Control		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
High Earner								
$1200 in at least one of 4 quarters before enrollment	37.6%	2.97	40.4%	3.24	-2.8	4.39	0.524	38.9%
TWP								
Completed before enrollment	27.4	2.73	29.4	3.00	-2.0	4.06	0.622	28.4
Medicaid Buy-in								
Participant before enrollment?	32.0	2.86	31.3	3.06	0.7	4.19	0.867	31.7
Employment Rate								
Any Earnings t-4	36.8	2.96	38.3	3.21	-1.5	4.36	0.731	37.5
Any Earnings t-3	35.7	2.94	39.6	3.22	-3.9	4.36	0.371	37.5
Any Earnings t-2	38.3	2.98	42.2	3.26	-3.9	4.41	0.377	40.1
Any Earnings t-1	43.2	3.04	44.3	3.28	-1.1	4.47	0.805	43.8
3X SGA								
SGA Earnings t-4	9.8	1.82	9.6	1.94	0.2	2.66	0.940	9.7
SGA Earnings t-3	10.5	1.88	9.6	1.94	0.9	2.70	0.739	10.1
SGA Earnings t-2	9.8	1.82	7.8	1.77	2.0	2.54	0.431	8.87
SGA Earnings t-1	12	1.99	9.1	1.90	2.9	2.75	0.292	10.7
Earnings								
Mean Earnings t-4	$810.73	107.63	658.17	80.21	152.56	134.23	0.256	739.99
Mean Earnings t-3	$813.23	116.16	729.19	91.28	84.04	147.73	0.569	774.26
Mean Earnings t-2	$726.38	79.79	754.63	118.83	-28.25	143.13	0.844	739.48
Mean Earnings t-1	$886.68	96.61	881.80	107.96	4.88	144.88	0.973	884.42

Data Source(s): SSDI-EP Encounter Data; SSA records, WI Unemployment Insurance records, & WI DHS records Sample Sizes: 496, Treatment=266, Control=230

We also interpret the data presented in table IV.1 as suggesting that SSDI-EP participants, at the time of enrollment, were better poised than other adult beneficiaries to use an offset. There are some studies that suggest that no more than 10% of SSDI-only beneficiaries are employed at any given time.[157] When the reported average monthly wage and percentage earning above SGA for employed individuals in one of these studies is converted into a quarterly framework and adjusted to include the non-employed members of the subgroup, the resulting quarterly mean earnings are about $175 and the proportion earning above SGA about 2%.[158] Though the figures exhibited in table IV.1 for the employment rate, mean earnings and 3x SGA variables are calculated from different data sources and from a slightly later time period, the differences in magnitude are so stark as to render methodological differences irrelevant. Employment rates are three or four times greater; the ratio between mean earnings and proportions earning over SGA are somewhat greater.[159] The use of work incentives also appears unusually high among SSDI-EP enrollees. Over a quarter of enrollees had completed their TWP and almost a third was participating in the Medicaid Buy-in.

In addition to the descriptive characteristics required by SSA, the SSDI-EP evaluation sought a fuller range of information about who chose to enroll in the pilot and to provide a greater range of options for statistical modeling. Table IV.2 displays the distributions for several additional socio-demographic variables. First we include an alternative presentation of educational attainment to make the point that the study sample, while having smaller proportions in the higher attainment categories than Wisconsin's general adult population, was not radically different. For example 22.5% of participants had at least a bachelor's degree compared to 28.1% for the general population.[160] Based on this it would not be unreasonable for most SSDI-EP participants to aspire to jobs that required some post-secondary education. Another important finding is that almost half of participants lived alone, suggesting both greater dependence on their own incomes, whatever the source, and getting non-financial assistance or support from sources external to their households.

We include a different presentation of the racial identification variable. While the proportion of "non-whites" is comparable to that in the state population, we wanted to give the reader some information suggesting the ratios between those who identify themselves as black and those giving other racial identifications than white. Surprisingly, we found that the proportion of blacks in the treatment group (11.3%) was nearly twice

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[157] Livermore, Gina A. 2008. "Disability Policy Research Brief Number 08-01: Earnings and Work Expectations of Social Security Disability Beneficiaries." Washington, DC: Center for Studying Disability Policy, Mathematica Policy Research, Inc. and Kennedy, Jae, and Olney, Marjorie F. 2006. "Factors Associated with Workforce Participation among SSDI Beneficiaries, <u>Journal of Rehabilitation,</u> 72 (4). pp. 24-30.

[158] Livermore, Gina A. 2008. pp. 2-3.

[159] As earnings data from unemployment insurance records are reported on a quarterly basis it is impossible to directly calculate the proportion with SGA earnings in any month. Though a proxy, the three times SGA variable logically requires that there were SGA earnings in at least one month during the quarter.

[160] StatsRRTC. 2007. "2005 Disability Status Reports (Wisconsin & United States)." Ithaca NY: Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics. Status Report Section #13.

that in the control group (6.1%). This difference proved statistically significant. As will be discussed later, this finding appears related to the unexpectedly high proportion of Milwaukee area participants assigned to the treatment group. Unfortunately the number of black enrollees (forty-four) is too small to support a subgroup analysis.

Table IV.2: Various Socio-demographic Variables in Percentages by Study Assignment Group at Project Entry

	Treatment Group		**Control Group**		**Difference**			**All**
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Education (WI recode)								
High School or less	32.3%	2.87	33.5%	3.11	-1.2	4.23	0.777	32.9%
More than High School, but less than 4-yr College degree	46.7	3.06	42.1	3.26	4.6	4.47	0.303	44.6
4-yr College degree or more	21.0	2.50	24.3	2.83	-3.3	3.77	0.382	22.5
Living Situation								
Alone	47.0	3.06	50.9	3.30	-3.9	4.50	0.386	48.8
With Spouse or Significant Other	25.6	2.68	27.8	2.95	-2.2	3.99	0.581	26.6
Other Family	12.0	1.99	10.9	2.05	1.1	2.86	0.701	11.5
All Others	15.4	2.21	10.4	2.01	5.0	2.99	0.095	13.1
Race (WI Recode)								
Black	11.3	1.94	6.1	1.58	5.2	2.50	0.038	8.9
White	85.7	2.15	89.6	2.01	-3.9	2.94	0.185	87.5
Other	3.0	1.05	4.1	1.31	-1.1	1.67	0.511	3.6
Ethnicity								
Hispanic	2.6	0.98	3.9	1.28	-1.3	1.61	0.418	3.2
Other	97.4	0.98	96.1	1.28	1.3	1.61	0.418	96.8

Data Source(s): SSDI-EP Encounter Data
Sample Sizes: 496, T=266, C=230

Table IV.3 displays additional program participation information. As expected, the vast majority of pilot entrants had Medicare coverage; a surprisingly high proportion of these SSDI-only individuals were also enrolled in a Medicaid program (about half in the Buy-in). Notwithstanding this, only 6% were enrolled in a long term support program, all of which, with one exception, are Medicaid waiver programs. These programs are the predominant funder of personal assistance and supported employment services.

Table IV.3: Various Program Participation Variables in Percentages by Study Assignment Group at Project Entry

	Treatment Group		**Control Group**		**Difference**			**All**
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Medicaid								
Yes	63.2%	2.96	57.4%	3.26	5.8	4.40	0.188	60.5%
No	36.8	2.96	42.6	3.26	-5.8	4.40	0.188	39.5
State Long Term Support Programs								
Yes	5.6	1.41	6.1	1.58	-0.5	2.12	0.813	5.8
No	94.4	1.41	93.9	1.58	0.5	2.12	0.813	94.2
Medicare A								
Yes	85.7	2.15	87.8	2.16	-2.1	3.04	0.490	86.7
No	14.3	2.15	12.2	2.16	2.1	3.04	0.490	13.3
Primary Insurance Amount								
Low	44.0	3.04	48.2	3.31	-4.2	4.50	0.350	46.0
Medium	41.0	3.02	38.2	3.22	2.8	4.41	0.525	39.7
High	15.0	2.19	13.6	2.27	1.4	3.15	0.657	14.4
In TWP								
Yes	1.5	0.75	4.8	1.41	-3.3	1.59	0.038	3.0
No	98.5	0.75	95.2	1.41	3.3	1.59	0.038	97.0
Prior Benefits Counseling								
Yes	33.5	2.89	36.1	3.17	-2.6	4.29	0.544	34.7
No	66.5	2.89	63.9	3.17	2.6	4.29	0.544	65.3
Successful VR Closure								
Yes	4.9	1.32	8.3	1.82	-3.4	2.25	0.131	6.5
No	95.1	1.32	91.7	1.82	3.4	2.25	0.131	93.5

Data Source(s): SSDI-EP, WI DHS and DVR administrative records, and SSA administrative records

Sample Sizes: 496, T=266, C=230 except for PIA 494, T=266, C=228

Notes: Primary Insurance Amount categories defined by Low = $829 or Less; Medium = $830 to $1199; High = $1200 or More. The indicator for benefits counseling prior to SSDI-EP entry combines information from provider agencies and records from the Wisconsin SPI project.

Additionally, table IV. 3 provides information about TWP usage, successful closure from vocational rehabilitation services after 2002, and the receipt of benefits counseling prior to pilot entry.[161] Only a small proportion of participants were in their TWP when they enrolled in the SSDI-EP (3%).[162] The importance of these data comes from the fact that almost 70% of those entering the pilot had not used a single TWP month. Even if one of these participants started a TWP immediately after enrollment it would be at least a year into their participation period before any of them could use the offset.[163]

The fact that only 6.5% of enrollees were discovered to have a recent successful closure was unexpected given the relatively high employment rates and earnings observed in the four quarters prior to the quarter in which participants enrolled (see table IV.1 above). The relatively high proportion with prior benefits counseling (34.7%) reflected the fact that enrolling participants were supposed to get a comprehensive benefits analysis prior to enrollment, if there wasn't an up to date one available.[164]

We were interested in the distribution of primary insurance amounts (PIA) as an indicator of whether a participant had a relatively high or low SSDI benefit and, thus, also as an indicator of their relative earning capacity before disability. We wondered whether a high PIA would be associated with greater or lesser use of the offset provision, as we could think of reasons why one might hypothesize either greater or less utilization.[165] We also were curious whether the result would be influenced by participation in other public programs, such as the Medicaid Buy-in.[166] The "medium" category includes the mean and median PIA amounts for the years in which pilot enrollment was conducted.[167]

The type and severity of a person's disability may affect both the probability that one can exploit the offset and the types of services and support that might facilitate a successful return-to-work. Table IV.1 includes information about the distribution of

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[161] A successful closure generally requires employment for at least ninety days.

[162] The difference between the treatment group and control group is significant, though the number of cases is small.

[163] The offset could not be applied until after the three month grace period that followed the completion of the nine month TWP.

[164] A comprehensive benefits analysis indicates that there had been "serious" benefits counseling that examined an individual's specific situation and required verification of public benefits.

[165] A high PIA would indicate having skills and experience that would support the ability to obtain employment well above the SGA level. However, if a participant feared the consequences of using the offset on future eligibility for SSDI or other public programs, the participant might be more cautious about risking a relatively high benefit level.

[166] The Wisconsin Buy-in's premium structure disadvantages unearned income relative to earned income. SSDI is classified as unearned income. An individual with earnings above SGA and who retained any significant proportion of a large SSDI benefit could face a very large premium that in extreme cases would lower total income to less than the participant would have had if they had decided not to work at all.

[167] PIA amounts, as all monetary data used in our participant analyses, were inflation adjusted using the 1982-84 CPI-U adjusted so that August 2005 would equal 100.

participants across SSA impairment categories. However, these categories are not widely used among SSDI-EP participants, the provider agencies or the range of government and non-governmental entities in Wisconsin with which persons with disabilities regularly interact. The terms “physical,” “cognitive,” and “affective” are in more common usage. The distribution presented in table IV.4 is based on information from provider agency staff; it is possible the results might have been different if based on participant self-report or the judgments of medical professionals. According to provider agency staff almost half of participants’ had a primary disability that was best categorized as “physical.” The next largest group was that of persons reported as having an “affective” disability. By contrast, only about 7% of participants were assigned to the “cognitive” disability category. Given that Pathways had recruited a number of provider agencies that specialized in working with persons with cognitive impairments, this result was unanticipated.

Table IV.4: Various Disability Related Variables in Percentages by Study Assignment Group

	Treatment Group		Control Group		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Primary Disability Status								
Physical	47.8%	3.06	48.1%	3.29	-0.3	4.50	0.947	48.0%
Cognitive	8.2	1.68	6.1	1.58	2.1	2.31	0.363	7.2
Affective/Mental Health	37.3	2.97	36.9	3.18	0.4	4.35	0.927	37.1
Sensory	4.7	1.30	5.1	1.45	-0.4	1.95	0.837	4.9
Other	2.0	0.86	3.7	1.24	-1.7	1.51	0.261	2.8
OOS category								
Most Significant (1)	38.9	2.99	44.5	3.28	-5.6	4.44	0.207	41.4
Significant (2)	60.1	3.00	54.3	3.28	5.8	4.45	0.192	57.5
Not Significant (3)	1.0	0.61	1.2	0.72	-0.2	0.94	0.832	1.1

Data Source(s): SSDI-EP administrative records and WI Division of Vocational Rehabilitation administrative records
Sample Sizes: Primary Disability Status 469, T=255, C=214; OOS 367, T=203, C=164
Note: These data do not necessarily represent status at SSDI-EP enrollment.

Admittedly, assignment to a vocational rehabilitation Order of Selection (OOS) category is a rough assessment of severity, but it is one that directly reflects a trained professional’s evaluation of how difficult it will be for a consumer to return to work. Though all pilot participants necessarily met the criteria for SSDI eligibility, only two-fifths were assigned to the “most significant” (OOS 1) category. This is important as the Wisconsin DVR is required to serve the most severely impacted consumers first. The nearly 60% of SSDI-EP participants who were not assigned to the OOS 1 category were likely to have been negatively affected by protracted (though often partial) OOS closures that occurred during the pilot. Services that might have helped pilot participants were either delayed or unavailable. It is also possible that in the absence of OOS closures a larger proportion of pilot participants would have sought DVR services.

The purpose of table IV.5 is to examine overlap in the distributions based on SSA impairment classifications and those resulting from provider agency reports to the SSDI-EP central office. The chi-square of the cross-tabulation (p-value <.001) suggests the two distributions are unrelated. Yet a visual examination of the table makes it clear that a majority of participants had a disability that was identified as a “mental illness” in either or both of the classifications. Based on experience, some Pathways staff thought that persons without clearly visible impairments might find it more difficult to maintain SSDI (or Medicaid) eligibility after using the offset. The concern was that work activity that resulted in earnings above SGA might be viewed as an indicator of medical improvement by Disability Determination Services (DDS) adjudicators, especially when the disabling condition was chiefly manifested through a consumer’s behavior.[168]

Table IV.5: Cross-tabulation of SSA Impairment Classifications with Primary Disability Status reported to SSDI-EP Staff (% within Primary Disability Status)

	Musculoskeletal	Neurological	Mental Retardation	Mental Other	All Others
Physical	59 (26.2%)	52 (23.1%)	4 (1.8%)	46 (20.4%)	64 (28.4%)
Cognitive	0 (0%)	4 (11.8%)	10 (29.4%)	16 (47.1%)	4 (11.8%)
Affective/Mental Health	7 (4.0%)	3 (1.7%)	5 (2.9%)	149 (85.6%)	10 (5.7%)
Sensory	1 (4.3%)	1 (4.3%)	1 (4.3%)	1 (4.3%)	19 (82.6%)
Other	0 (0%)	4 (30.8%)	1 (7.7%)	3 (23.1%)	5 (38.5%)

Data Source(s): SSDI-EP administrative records and SSA administrative records
Sample Sizes: 469, T=255, C=214
Note(s): Pearson Chi-Square = 302.37; df = 16; p-value < 0.001

Tables IV.6 and IV.7 display employment related information to supplement that provided in table IV.1. In these tables data are from participant reports rather than UI data. The first item in table IV.6 is the proportion of participants reporting some employment between when they became eligible for Social Security benefits and pilot entry. Over three-quarters reported some employment. Though we lack comparable data for the larger SSDI population, these data would support a claim that pilot participants, as a group, have demonstrated a strong behavioral orientation toward work.

As Wisconsin UI records do not capture certain types of employment, including self-employment, employment at out of state locations, and jobs at certain categories of non-profit employers, it is likely that the UI employment rates underestimate employment. The employment rate, based on self-reports, ranges from approximately 10% to 15% higher then the rates reported in table IV.1 for the four quarters prior to the quarter of pilot enrollment. Though it is likely the rate based on self-report is an over-

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[168] The Wisconsin DDS is known at the Disability Determination Bureau (DDB). DDB is housed within the WI Department of Health Services (DHS).

estimate, we doubt that much of any overestimate reflects inaccuracies in what participants reported.[169]

Table IV.6: Various Employment Related Variables in Percentages by Study Assignment Group at Project Entry

	Treatment Group		Control Group		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Employment between entering SSDI and Pilot								
Reported Employment	76.7%	2.59	77.8%	2.74	-1.1	3.77	0.771	77.2%
Did not Report Employment	23.3	2.59	22.2	2.74	1.1	3.77	0.771	22.8
Employed at Project Entry (self-report)								
Yes	50.4	3.07	53.9	3.29	-3.5	4.49	0.436	52
No	49.6	3.07	46.1	3.29	3.5	4.49	0.436	48

Data Source(s): SSDI-EP Encounter Data
Sample Sizes: 496, T=266, C=230

Table IV.7 exhibits hour and wage data from positions reported on the pilot enrollment form. The values provided were calculated only for those who reported employment. Mean and median hours are consistent with having roughly “half-time” employment. Mean earnings were estimated at $9.82 per hour and were a bit higher for those in the control group.[170] Though this value is above minimum wage, it implies monthly gross earnings of only $819 (about $9825 annually). By comparison, Livermore’s 2008 MPR research brief, reported somewhat lower hourly wages ($7.58) and monthly pay ($644) in her sample of employed SSDI-only beneficiaries.[171]

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[169] During the pilot we noticed that many of the monthly update forms that reported a participant had started a new business also reported there were no gross earnings for the month. When asked about this, provider agency staff often pointed out that the participant was involved in start-up activities. Additionally, participants’ UI employment rates and average earnings were rising during the period approaching enrollment and in the enrollment quarter. SSA asked that the employment rates and earnings for the enrollment quarter not be included in table IV.1 (a.k.a. SSA table 2).

[170] The monthly convention for full time employment depends on both the weekly convention (e.g. thirty-five hours, forty hours) and the number of work weeks (e.g., 4 or 4.3). Our interpretation reflects forty hours and four weeks.

[171] Livermore, Gina A. 2008. p.3.

Table IV.7: Various Employment Related Variables in Means and Medians by Study Assignment Group at Project Entry

	Treatment Group		Control Group		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Hours employed per Month for those Self-Reporting Employment								
Mean Hours	84.0	4.25	82.8	4.23	1.2	6.00	0.838	83.4
Median Hours	80.0		80.0		0.0			80.0
Implicit Hourly Wage								
Mean	$9.49		$10.19		-0.75			$9.82

Data Source(s): SSDI-EP Encounter Data
Sample Sizes: 258, T=134, C=124
Notes: Data for participants who had more than one job were pooled.

Tables IV.8 through IV.10 display attitudinal data from the baseline survey. Three areas are explored: participant fears about loss of Social Security and other public program benefits, self-efficacy, and information about how participants perceived their health status. Besides providing insight into participant perceptions at enrollment, these data also serve as a baseline against which to assess later change in these domains.

The first item displayed in table IV.8 is the average value for an index intended to elicit the level of concern that increased work activity might result in the loss of eligibility for benefits, reductions in benefits or income levels, or make it more difficult to regain eligibility if needed.[172] Scores range from one to five, with higher scores representing greater levels of fear.[173] As 3.0 is the midpoint, a mean score of 2.2 (and slightly lower

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[172] We use the term index rather than scale, as the psychometric properties are unknown.

[173] The index score represents the average of six survey items including:

- Working for pay will affect my ability to keep my Social Security Cash benefits
- If I work for pay, it will be hard to earn enough money to make up for lost Social Security benefits
- I worry that I may lose my eligibility for my Social Security Benefits if I work for pay
- I worry that working for pay will trigger a review of my eligibility for my Social Security benefits
- If I work for pay, it will be difficult to re-qualify for Social Security disability benefits in the future
- I worry that I will not be eligible for Medicare or Medicaid if I’m working

medians) indicates a substantial degree of concern about the potential for benefits loss. The data also indicate that those assigned to the treatment and control groups expressed equivalent levels of fear when they entered the pilot.

Table IV.8: Participant Attitudinal Data in Means and Medians by Study Assignment Group at Project Entry

	Treatment Group		Control Group		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Fear of SSA Benefit Loss Index								
Mean	2.3	.07	2.2	.07	0.1	0.1	0.222	2.2
Median	2.0		1.9		0.1			
Self-Efficacy Index								
Mean	3.6	0.06	3.6	0.06	0.0	0.08	0.700	3.6
Median	3.7		3.8		-0.1			3.7
SF-8 Physical Component Scale								
Mean	41.9	0.69	43.4	0.72	-1.5	1.00	0.133	42.7
Median	42.3		43.8					42.8
SF-8 Mental Component Scale								
Mean	42.5	0.77	42.7	0.77	-0.2	1.09	0.867	42.6
Median	44.0		44.4					44.2
General Health (GH)								
Mean	44.2	0.50	44.3	0.53	-0.1	0.73	0.843	44.3
Median	46.4		46.4					46.4

Data Source(s): SSDI-EP Survey Data

Sample Sizes: Fear 452, T=240, C=212; Self-Efficacy 454, T=244, C=210; SF-8 433, T=223, C=210

Notes: Both the Fear of Benefit Loss Index and the Self-Efficacy Index represent averages of items on the SSDI-EP participant surveys. US population averages and standard deviations for SF-8 scales are: PCS Mean=49.20, SD=9.07; MCS Mean=49.19, SD=9.46; and GH Mean=49.44, SD=7.45.

Subjective self-efficacy refers, in the broadest sense, to an individual’s beliefs in her ability to act in ways that increase the probability of achieving her goals. Although

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The response set ranged from “strongly agree” to “strongly disagree” with respondents having the option of answering “not sure.” Responses other than “not sure” were averaged. The case was excluded unless there were at least two useable answers for the six items.

the linkage between belief and behavior and, in turn, that between behavior and goal attainment is far from perfect, high self-efficacy is associated with goal attainment. In the context of the SSDI-EP, this should result in participants with high self-efficacy having a higher probability of employment and higher earnings, including a greater likelihood of earnings above the SGA level. Moreover, it is reasonable to hypothesize that high self-efficacy would reinforce any positive effects of the benefit offset.

The self-efficacy index represents the average score of participants' responses to six survey questions. Scores can range from one to five. Scores approaching five, indicate that the participant has provided answers that are consistent with having a high level of self-efficacy.[174] The mean score of 3.6 is a bit above the index midpoint and suggests the typical participant was reasonably confident that their actions would lead to desired results. Once again, the mean and median values for the treatment and control group are comparable.

Table IV.8 also displays mean and median scores on three measures from the SF-8^{TM} Health Survey: the Physical Component Scale (PCS), the Mental Component Scale (MCS), and a General Health (GH) Indicator.[175] As SSDI beneficiaries qualify for benefits because they have medical conditions that negatively affect the capacity to work, it was not surprising that the mean scores are somewhat below those for the general population (approximately fifty).[176] Medians are a bit higher than means, suggesting that the means are lower due to a minority of participants reporting more severe health problems. Results for the two study groups are basically identical for the MCS and GH, though treatment group members, on average, report somewhat greater physical problems.[177]

Additional information about how enrolling participants perceived their health status appears in tables IV.9 and IV.10. A clear majority (57%) rated their health as at least "good" at the time of enrollment. By contrast only 11% reported that their health was poor or very poor. When asked to compare their health status to that of a year

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[174] The six survey items included:

- If something looks too complicated I will not even bother to try it
- I avoid trying to learn new things when they look too difficult
- When I make plans, I am certain I can make them work
- When unexpected problems occur, I don't handle them very well
- I do not seem capable of dealing with most problems that come up in my life
- I feel insecure about my ability to do things

The response set ranged from "strongly agree" to "strongly disagree" with respondents having the option of answering "not sure." Responses other than "not sure" were averaged. The case was excluded unless there were at least two useable answers for the six items.

[175] SF-8^{TM} is a trademark of QualityMetric, Inc. For detailed information see Ware, John, E. Jr., et al. 2001. <u>How to Score and Interpret Single-Item Health Measures: A Manual for Users of the SF-8^{TM} Health Survey</u>. Lincoln, RI: QualityMetric Incorporated

[176] Differences approach, but do not exceed, one standard deviation from the general population means.

[177] However, these differences are not statistically significant.

earlier, about twice as many participants offered that it had improved (46%) as said that it had declined (24%). On the whole, pilot entrants gave an upbeat assessment of their health, at least relative to their recent experience. A positive assessment would seem consistent with a decision to enter a program intended to facilitate increased work effort.

Table IV.9: Participant Responses to "Overall, how would you rate your health during the past 4 weeks" in Percentages at Project Entry

	Treatment	Control	All
Excellent	5.2%	5.6%	5.4%
Very Good	18.0	21.1	19.5
Good	35.2	29.1	32.3
Fair	30.0	33.3	31.6
Poor	10.7	10.3	10.5
Very Poor	0.9	0.5	0.7

Data Source(s): SSDI-EP Survey Data
Sample Sizes: 446, T=233, C=213
Note(s): Item from SF-8. Valid responses only

Table IV.10: Participant Responses to "Compared to one year ago, how would you rate your health in general now" in Percentages at Project Entry

	Treatment	Control	All
Much better	19.3%	21.5%	20.3%
Somewhat better	27.5	22.8	25.3
About the same	30.3	30.6	30.5
Somewhat worse	21.3	20.1	20.7
Much worse	1.6	5.0	3.2

Data Source(s): SSDI-EP Survey Data
Sample Sizes: 463, T=244, C=219
Note(s): Valid responses only

The final tables in this section examine differences between early and late enrollees. Early enrollers entered the pilot before May 1, 2006; late enrollers thereafter. The division reflects the approximate time that recruitment letters went out to those in the Medicaid Buy-in or served by DVR thought reasonably likely to meet pilot eligibility requirements. Table IV.11 shows some interesting differences between early and late enrollees. For example, the proportion of females in the late enrollee group is 6% higher than in the early enrollee group. However, this and most of the other differences did not reach the level of statistical significance. The one difference between early and late enrollees that did was the difference in the proportion of participants who had worked after gaining SSDI eligibility. The proportion of those who reported being employed at some point after qualifying for benefits was over 8% higher among those who enrolled in the earlier period. This is an important difference, as work after becoming disabled is one of the best predictors of future work activity.[178]

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[178] This is one of the rationales for encouraging return to work as early as possible. For example see Sim, Joanne. 1999. "Improving Return-to-Work Strategies in the United States Disability Programs, with Analysis of Program Practices in Germany and Sweden." Social Security Bulletin. 62 (3) pp. 41-50.

Table IV.11: Various Participant Characteristics in Percentages by Time of Project Entry

	Early Enrollees		Late Enrollees		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Assignment								
Treatment	52.3%	3.37	54.7%	3.00	-2.4	4.51	0.594	53.6%
Control	47.7	3.37	45.3	3.00	2.4	4.51	0.594	46.4
Gender								
Female	41.8	3.33	47.8	3.01	-6.0	4.48	0.181	45.2
Male	58.2	3.33	52.2	3.01	6.0	4.48	0.181	54.8
Age								
44 or younger	43.6	3.34	42.8	2.98	0.8	4.48	0.858	43.1
45 or older	56.4	3.34	57.2	2.98	-0.8	4.48	0.858	56.9
Education (WI recode)								
High School or less	33.2	3.18	32.6	2.82	0.6	4.25	0.888	32.9
More than High School, but less than 4-yr College degree	43.2	3.34	45.7	3.00	-2.5	4.49	0.578	44.6
4-yr College degree or more	23.6	2.86	21.8	2.49	1.8	3.79	0.635	22.5
Employment between SSDI Entry and Project Enrollment								
Reported Employment	81.8	2.60	73.6	2.65	8.2	3.72	0.027	77.2
Did not Report Employment	18.2	2.60	26.4	2.65	-8.2	3.72	0.027	22.8

Data Source(s): SSDI-EP Encounter Data
Sample Sizes: 496, Early=220, Late=276

Similarly, there were large differences in employment outcomes for early and late enrollees for the calendar quarter immediately prior to entering the SSDI-EP. The UI employment and earnings data in table IV.12 shows there were large and significant differences between the two groups. The employment rate is 15% higher for early enrollees. Mean quarterly earnings are almost $500 greater. These data are consistent with what one would expect from a cohort of participants with greater post-disability attachment to the work force.

Table IV.12: Various Participant Employment Characteristics in Percentages and Means by Time of Project Entry

	Early Enrollees		Late Enrollees		Difference			All
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
Employment Rate in the Calendar Quarter before Enrollment	52.3%	3.37	37.0%	2.91	15.3	4.45	0.001	43.8%
Mean Earnings in the Calendar Quarter before Enrollment	$1158.03	128.36	$666.32	76.85	491.71	149.61	0.001	884.42

Data Source(s): WI Unemployment Insurance administrative records
Sample Sizes: Early=220, Late=276

C. Enrollment Process Data (Pace and Distribution)

The pace of enrollment during the early months of the SSDI-EP was relatively slow and would not have been sufficient to reach the lower enrollment target of 500, even after the enrollment period had been extended from twelve to fifteen months. On average, twenty-four valid enrollees entered the pilot each month.[179] As noted in Chapter III, the SSDI-EP expected most participants to either be individuals currently or formerly associated with one of the provider agencies or to seek out the pilot as a result of the agencies' local outreach efforts. Additionally, several provider agencies did not begin outreach or enrollment activities in August 2005. One agency did not enroll its first participant until early 2006. Enrollment after the mass recruitment mailings proceeded at a faster pace, averaging nearly fifty-one valid entrants over the final five months of the enrollment period.

Figure IV.2 displays the cumulative enrollment trend. One can readily see the inflection point after which enrollment grew more rapidly. The lower line represents actual participants; the upper line includes the additional thirty-three enrollees who were later removed from the pilot because they did not fully meet eligibility requirements. Despite the increased pace of enrollment and that later enrollees were less likely to have existing ties with their provider agency, the proportion of invalid enrollments was actually slightly lower over the last five months of the enrollment period than during the first ten.

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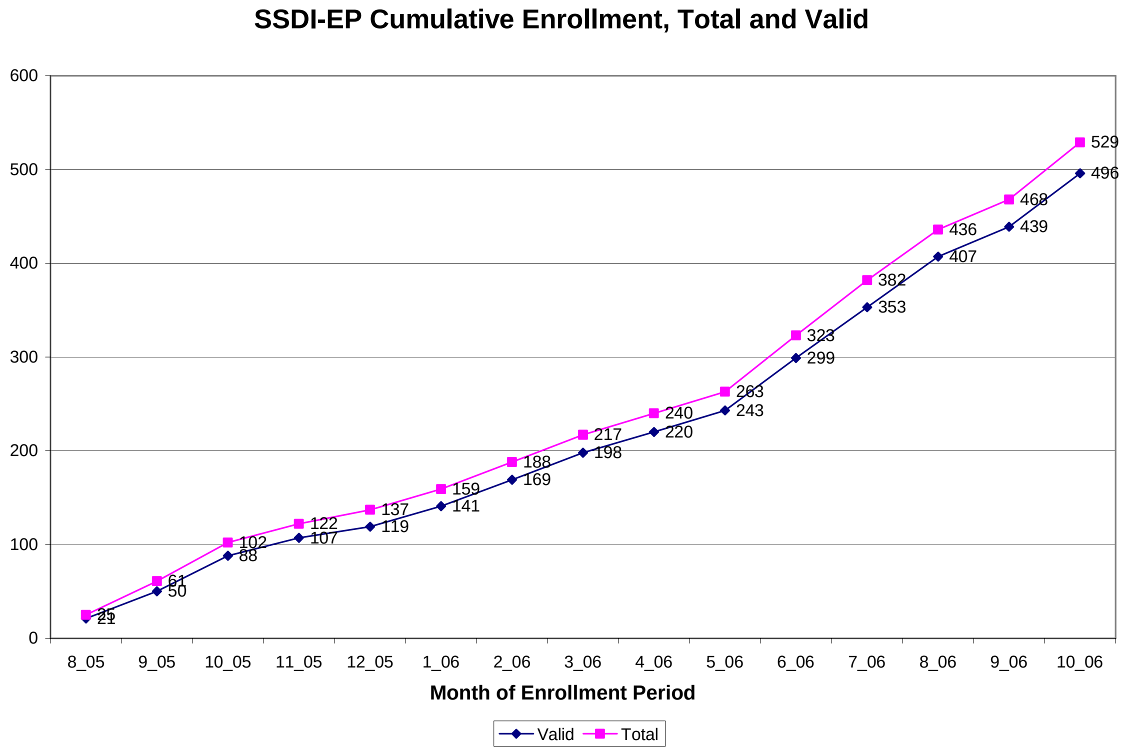
[179] A valid enrollee was one who was not disqualified from the pilot after SSA had checked eligibility.

Figure 1V.2: Cumulative Enrollment, by Month, over SSDI-EP Enrollment Period



Of the thirty-three individuals found ineligible after enrollment, twenty (61%) were from the control group. Additionally, those disqualified from the treatment group often learned about their disqualification months after enrollment, in one case as OCO was in the process of applying the offset to the participant's benefit check.[180] As ineligibility for the pilot was determined by different offices depending on which study group the enrollee had been assigned to, we checked the limited encounter and administrative we had to explore the possibility that standards were being interpreted differently in the SSA offices in Baltimore and Madison. We found nothing beyond the numbers and the timing of decisions that would suggest any difference.

As indicated in chapter III, there was substantial variation across provider agencies in the number of participants enrolled. Valid enrollment totals ranged from four to seventy-eight. Mean enrollment was just under twenty-five; the median was slightly lower at twenty-two.[181] These numbers gain potential significance from two circumstances. Agency staffing levels devoted to the pilot did not vary as much as enrollment. Most agencies, large or small, assigned a single benefits counselor to serve their SSDI-EP participants. Second, the provider agencies that had not been involved in SPI generally had larger enrollments. These "new" agencies averaged about forty-one participants, compared to nineteen for the others.

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[180] Internal Pathways communication, May 18, 2006.

[181] This excludes the provider agency that had no enrollment. Enrollment at the agency that severed its relationship with the project is assigned to the agency where all those participants transferred.

We have identified several factors we think provide insight into why enrollment levels were higher at the "new" provider agencies. During SPI, provider agencies had direct funding to support staff and provide both benefits counseling and vocational services. We conjecture, with support from agency staff interviews, that the former SPI agencies exhibited some reluctance to aggressively recruit participants because the SSDI-EP could not provide direct support for participant services other than for benefits counseling.[182] The only direct income flow would be for research reporting and encouraging continuing participant involvement. By contrast, the "new" agencies made their decisions to participate without direct experience of the former, more generous funding environment. We hypothesize that most of the non-SPI agencies sought higher enrollments as part of their "business plans." They appear to have been more willing to take advantage of economies of scale and to spread potential risk from any participants with higher service costs. It is suggestive that participant to staff ratios appear higher at the agencies that did not participate in SPI.[183]

Still, there is a remaining puzzle. When provider agency staff were interviewed in the spring of 2006, respondents from both types of agencies were equally likely to report they actively recruited from both their current and past caseloads. Even though there were large differences in the average number of pilot participants served between the new and old agencies, the typical client population of the former SPI agencies was, if any thing, larger. It appears likely that both Pathways central operations and evaluation staff overestimated the proportion of enrollment that would be generated from agencies' own caseload, an assertion that is supported by participant survey data indicating only about a fifth of enrollees first learned about the pilot from the organization where they enrolled.

Additionally, though provider agency staff generally could not identify former SPI participants, they were frequently able to identify consumers they had worked with who had significant post-disability work histories. [184] Staff thought these consumers would benefit most from access to a SSDI benefit offset and their participation would help build evidence for the efficacy of an offset provision. However provider agency staff claimed that a large proportion of these consumers had already passed the seventy-second month following TWP completion or would have done so shortly after enrollment had they entered the SSDI-EP.[185] Provider agency staff and, to some extent, Pathways staff, external informants, and, in focus groups, participants themselves have all asserted that

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[182] Technically, the funding for benefits counseling was available through a Pathways grant separate from the SSDI-EP. However, provider agencies faced no significant barriers to getting these funds.

[183] Nevertheless, it is important to remember that agencies can differ in service philosophies. This can be a result of legal requirements, organizational choice, and/or needs that arise from the characteristics and circumstances of an agency's consumers.

[184] See section F of chapter III for information about the challenges that provider agencies that had taken part in SPI faced in identifying SPI participants.

[185] In particular, provider agency staff reported that about 40% of the consumers indicating a serious interest in entering the pilot were determined ineligible before they could enroll. The main reason for ineligibility was reported to be the "seventy-two month rule."

the “seventy-two month rule” depressed enrollment in two ways.[186] First, it excluded persons who have strong continuous work histories, even when beneficiaries had disabling conditions that unequivocally met SSA listings. Some argued that these were the very people in the best position to make gains under an offset provision. Second, some individuals approaching the seventy-two month limit may not have enrolled because they feared that they would incur high transaction costs during the short period between entrance and exit.[187]

Finally, we observed unexpected geographic variation in enrollment patterns. Table IV.13 displays information about the distribution of participants across Wisconsin’s three largest metropolitan areas/labor markets at the time of their enrollments. There is also a residual “other” category that combines data from all other Wisconsin locations.[188]

Table IV.13: Distribution of Participants by Geographical Area at Enrollment

	Treatment Group	**Control Group**	**All**	**% of State Population**
Area of Residence				
Milwaukee Area	26.7%	14.3%	21.0%	30.7%
Madison Area	12.0	18.7	15.1	9.8
Green Bay / Fox Valley	10.2	11.7	10.9	14.0
Other	51.1	55.2	53.0	45.5

Data Sources: SSDI-EP encounter data and 2006 U.S. Census Estimates
Sample Sizes: 496, Treatment=266, Control=230

The Green Bay/Fox Valley area (11% of enrollment) and, especially, the Milwaukee area (21%) have a smaller proportion of SSDI-EP participants than would be implied by their share of the state’s population. The difference is especially noticeable in the Milwaukee area where the proportion of pilot participants is barely two thirds of what might be expected and almost half the provider agencies were located. By contrast, a somewhat greater proportion of enrollment came from the Madison area (15%) and elsewhere in the state (46%).

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[186] It is important to note that observers are not necessarily or even mainly talking about persons with histories of lengthy spans of above SGA earnings following their TWP. In many cases they are talking about persons with earnings relatively close to SGA on a persistent basis. This is sometimes called “parking,” especially when it is a conscious strategy.

[187] While such costs can be directly financial, they can also be incurred in time, effort, and anxiety. While such costs might have been viewed as hypothetical during the SSDI-EP’s enrollment period, ongoing difficulties in administration of the benefit offset have made these costs real.

[188] Areas are composed of county units. The three metropolitan areas reflect Metropolitan Statistical Areas (MSA) as defined in 2005. The Milwaukee area includes the Milwaukee-Waukesha-West Allis MSA and the Racine MSA. The Green Bay/Fox Valley area includes the Green Bay, Appleton, Oshkosh-Neenah, and Fond du Lac MSAs.

It is not likely that this distribution had a major effect on pilot outcomes. Though, it could be argued that employment options are more constrained in rural areas, the “other” category includes all or parts of eight MSAs including portions of the Chicago and Minneapolis-St. Paul metropolitan complexes. The geographical “irregularities” that had greater potential to affect pilot outcomes were the differences in the proportions assigned to the study groups within geographical areas. Almost twice as many participants in the Milwaukee area were assigned to the treatment group than to the control group. By contrast, Madison area enrollees were about 50% more likely to have been assigned to the control group. To the extent that labor market conditions and/or human capital characteristics differed across regions, there would be a chance that the offsets’ estimated impacts could be either exaggerated or suppressed.[189]

D. Participants Experience with Enrollment Process

This section of chapter IV examines the participants’ experience of the enrollment process. We begin by presenting information obtained directly from participants through surveys or focus groups. As this information is limited in scope and was collected well after enrollment, we supplement this with what provider agency staff conveyed about feedback they received from the participants they worked with. Additionally, we present information about how provider agency staff viewed the enrollment process and the challenges they faced implementing it.

1. Feedback from Participants

Relatively little information about participant perceptions of the enrollment process was collected through surveys and only then through instruments administered, respectively, one and two years following enrollment. Most participants completed the follow-up surveys.[190]

Table IV.14 displays responses for a question intended to measure participants’ opinions about whether the pilot had been well explained to them. This item is a global assessment and does not allow us to look at participants’ views about how well specific aspects of the pilot were explained.

Four-fifths of those who responded to this item agreed that the project had been well explained. Those assigned to the treatment group were somewhat more likely to report that they strongly agreed than those assigned to the control group (58% vs. 42%). Additionally, there was substantial variation across provider agencies in how well participants thought the project had been explained. In general, participants at agencies with smaller enrollments were more likely to say the pilot had been well explained; the

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[189] Economic conditions were significantly better in the Madison area than the Milwaukee area through the study period. Additionally, the Milwaukee area, particularly within the City of Milwaukee, had higher poverty levels and generally lower levels of educational attainment and other indicators of human capital development. However, we have not yet looked for differences in “human capital” variables across geographical areas for those in the SSDI-EP sample.

[190] The year one return rate was 82%, the year two rate 77%. Return rates for the two study groups were almost identical for the first follow-up survey, though the proportion of those completing the second survey was almost 5% lower for the control group than for the treatment group.

percentage of answers in the positive categories was about 13% higher.[191] We do not show the response distribution for the second follow-up survey as they were similar to the result shown in table IV.14. The main difference were increases in the proportions of control who either strongly agreed that the pilot had been well explained or indicated that they felt it had not.

Table IV.14: Participant Perceptions of How Well Provider Agency Staff Explained Pilot

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Staff explained the Pilot in ways I could understand					
Treatment	6.2%	5.7%	5.2%	25.2%	57.6%
Control	5.7	9.1	7.4	36.4	41.5
All	6.0	7.3	6.2	30.3	50.3

Data Source: SSDI-EP Year One Participant Survey
Sample Sizes: 386 (78%), Treatment=210 (79%), Control=176 (77%)
Note: Valid answers only

However, additional information from focus groups suggested that the survey data may gloss over important nuances in how participants experienced the enrollment process. In turn, only a small number of SSDI-EP participants attended the focus groups and their responses cannot be assumed to be representative of the full sample.

Attendees at the spring 2007 focus groups were asked whether they felt they had a good understanding of the pilot when they enrolled. Responses were decidedly bimodal. About as many attendees felt that they had an inadequate understanding of the pilot when they enrolled as the number that indicated they had understood the pilot very well. Relatively few of those attending the focus groups expressed a “middle” position, for example that they had enrolled with some understanding of the SSDI-EP, but lacked information or felt confusion about one or more aspects of the project.

When focus group participants offered specific comments about what aspects of the pilot were not well enough explained during the enrollment process, the emphasis was on the financial aspects of the project. Some said they did not receive a good explanation of how or when the offset would be applied. Others expressed having uncertain comprehension of how their earnings would be tracked, including the purpose of the earning estimates.

The spring 2007 focus groups elicited other information about how participants viewed the enrollment process. For the most part, attendees didn’t have strong feelings about the process. Some were bothered by the amount of paperwork, but for the most part saw it as something to be endured in order to get a chance to use the offset. Similarly, there was relatively little concern with the need to give the SSDI-EP personal

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[191] Smaller provider agencies were those with less than twenty-five participants.

information. Several individuals indicated that the requirement to do so was a sign of the project's authenticity.

Though the majority of focus group participants seemed accepting of random assignment, some expressed dissatisfaction. Though, in some cases, this feedback reflected disappointment with not being assigned to the treatment group, several attendees had more generalized objections to random assignment. In particular, some argued that all volunteers should have access to the offset as the current level of employment outcomes among SSDI beneficiaries were so low as to allow those outcomes to serve as an adequate "natural" comparison.

Indeed, it is not surprising that those volunteering for a study would have an interest in how the random assignment worked. After all, it is reasonable to assume that most participants joined the SSDI-EP because they wanted access to the offset feature. It would seem to follow that each participant would want to know whether he had been assigned to the treatment group and would tend to remember that information. That would appear to be particularly true for those assigned to the treatment group. Beyond any actual use of the offset, the need to update earnings estimates and to provide the pilot with pay stubs, W2 forms and/or other confirmations of earnings would appear to serve as periodic reminders of assignment to the intervention.

Table IV.15 presents information about how well participants recalled their study group assignments, respectively, a year and two years following enrollment. On the positive side, only a small proportion of survey respondents mistook their assignment. In no case was the proportion over 3% and these proportions were even smaller in the second year.[192]

Table IV.15: Participant Self-Report of Study-Group Assignment

	Responded "Assigned to Treatment"	**Responded "Assigned to Control"**	**Didn't Know**
Responses, one year after entry			
Treatment	58.1%	2.9%	39.0%
Control	2.3	60.8	36.8
Responses, two years after entry			
Treatment	54.2	.5	45.3
Control	.7	60.0	39.3

Data Source: SSDI-EP Year One and Year Two Participant Surveys
Sample Sizes: Year One, Treatment=210 (79%), Control=171 (74%) Year Two, Treatment=190 (71%), Control=145 (63%)
Note: Valid answers only

Nonetheless, a large minority of participants, usually approaching 40%, reported not recalling which study group they had been assigned to. This finding is not necessarily surprising for the control group who in many cases may have had little

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[192] As the proportion of survey respondents decreased over time, it is likely that respondents were disproportionately those with ongoing involvement with the project.

contact with the pilot after their first months beyond that for collecting information for evaluation purposes. Yet the proportion of "don't know" responses was actually higher in both time periods for the treatment group.

Unfortunately neither the surveys nor the 2007 focus groups included a question that would identify why participants enrolled in the pilot. The 2008 focus groups did.[193] Attendees responded much as expected, with the most frequent answer being that they hoped to use the offset to increase their earnings without losing all of their SSDI benefit. Another frequent response was that while there was no immediate expectation of using an offset, the participant wanted the opportunity to use it in the future.[194] However, one frequent response, at least if taken literally, was inconsistent with what the pilot offered. Some participants said that they expected that the SSDI-EP would provide direct help in placing them into jobs.

2. Feedback from Provider Agency Staff

We now turn to the information that provider agency staff gave us about consumers' feedback about the enrollment process. This feedback includes reports of what consumers told staff and the staff members' observations of the behavior of those consumers. For the most part this information was gathered through formal interviews in spring 2006. Thus, this information applies most to the period before recruitment letters were sent directly to those using the Medicaid Buy-in or DVR services.

Agency staff recalled a wide range of questions and comments consumers made during the enrollment process. Nonetheless, the most frequent themes closely matched those identified by the participants who attended focus groups. There was occasional and largely negative feedback about random assignment, chiefly after assignment and from those placed into the control group. Some staff reported consumer concerns about the amount of paperwork or the loss of privacy. There were also reports of consumers expressing satisfaction with the enrollment process, particularly that they would be informed of the results of random assignment almost immediately. However, no staff member reported that any participant complained that the staff member hadn't adequately explained the pilot.

These interviews also provided valuable information about how agency staff viewed the enrollment process. Their comments emphasized issues pertaining to eligibility determination and requirements.

Though almost all provider agency staff interviewed said that the BPQY (Benefits Planning Query) was the single most important information source for assessing pilot eligibility, about 60% of respondents also said that they often needed to obtain additional information to make even a tentative judgment of a consumer's eligibility. Most frequently, the main challenge was identifying whether a prospective participant had completed the TWP and, if so, when that had occurred. Given this, it is not surprising

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[193] Participation in these focus groups was limited to those in the treatment group who had at least started a TWP. Though we see no reason why their motivation for enrolling would be different than for other participants, we acknowledge that possibility.

[194] Enrollees were told that if assigned to the treatment group the offset would be available for their use in the future, no matter when they completed their TWPs.

that agency staff most often contacted a local SSA field office or the Social Security Area Work Incentive Coordinator (AWIC) for Wisconsin for additional information. Staff also reported obtaining eligibility relevant information directly from consumers, existing agency records, and occasionally caseworkers at other organizations or employers. Other challenges to determining pilot eligibility included issues around possible SSI participation (including use of a PASS), whether consumers received checks reflected their own FICA payments, or whether there had been expedited reinstatements to SSDI.[195]

About three-quarters of those we interviewed said that they either never or rarely encountered problems establishing eligibility. Those who reported having more frequent problems generally attributed them to either incomplete or inaccurate information on the BPQY. As already noted, once such issues were identified, the typical response was to seek information from other sources, most frequently from local SSA offices or the AWIC.

Provider agency staff also noted challenges about understanding and interpreting pilot eligibility rules. Almost all reported talking to staff at Pathways for clarification. Usually agency staff initiated the contact, though SSDI-EP central staff made the first inquiry about a third of the time, usually after a problem had been brought to their attention. By far, the most frequently discussed issue was how to interpret the seventy-two month rule and its implications for how long a potential enrollee would have access to the offset.[196]

Finally, a significant minority of provider agency staff made it very clear that they considered the seventy-two month rule a serious mistake.[197] They argued that the rule either excluded or greatly discouraged participation of the best candidates for testing the value of the offset: those past the end of their EPE and having continuing employment. The argument was that many of these individuals were deliberately keeping their earnings under SGA to retain their benefit check and would not do so if they had access to a benefit offset.

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[195] PASS stands for Plan to Achieve Self Support. This work incentive, among other things, allows those receiving Social Security disability benefits to save for or spend money on employment related training, equipment, or services without running afoul of earnings, income, or asset limits that would otherwise apply. When a SSDI only beneficiary uses PASS, she must devote enough of her personal income to also qualify for SSI. By starting a PASS an otherwise eligible beneficiary becomes ineligible for the offset pilot.

[196] Until shortly before enrollment began, the draft policy was that enrollees assigned to treatment and who had completed their EPE but had not reached the seventy-second month after TWP completion would get thirty-six months in which they could potentially use the offset. Though by the time the pilots started SSA had changed this policy to a hard and fast limit on eligibility to the end of month seventy-two, provider agency staff was initially trained as if the prior expectation had remained in effect.

[197] Provider agency staff offered these remarks at the end of the interview when asked to bring up any important topic they felt had not been raised before or adequately discussed. Since we did not seek to elicit comments on the issue, we take the relatively large number of unsolicited comments as indicating the concern about the implications of the seventy-two month rule was a highly salient one.

E. What worked well (enrollment)

Two important indicators of the success of the enrollment process were exactly the same as for the recruitment process. There were a sufficient number of volunteers to assess pilot processes and to conduct a formative impact evaluation. As noted before, the first benchmark was easily met, though the second was only marginally achieved, if the criterion was the minimum recruitment target of 500. Study groups were of acceptable size and baseline characteristics were consistent with a successfully implemented random assignment process.

Additionally, it is clear that enrolling participants at geographically removed locations using organizations and staff not directly under SSDI-EP central office control worked adequately. Training and technical assistance activities, data collection, and random assignment processes all appear to have worked well enough. Though there were some problems around eligibility determination, the problems could not be characterized as severe. Provider agency staff was able to obtain BPQYs with reasonable ease and more often than not these proved adequate for determining pilot eligibility. When information was incomplete, agency staff could generally obtain what they needed, especially from SSA local offices or the state AWIC.

For the most part, enrollees felt the pilot had been well explained, albeit with some later reports that important issues, such as how the offset would be implemented, were not as well covered as they might be. Though participant understanding of their assignment to the treatment or control group was far from complete, few participants incorrectly identified their assignment. In general, participants tolerated the paperwork, the need to provide personal information, and the use of random assignment. They liked learning their assignment in real time. Attrition immediately following enrollment was slight and (excluding deaths) was relatively modest over the course of the pilot.[198] Finally, as will be documented in chapter V, most enrollees proved willing to stay in contact with the pilot and to cooperate with data collection for both administrative and research purposes, in some cases for more than three years.

F. What didn’t work (enrollment)

Though relatively few participants were affected, there were some serious problems with determining eligibility in specific cases. Though these cases occurred in both the treatment and control groups, the ramifications were quite different.

Eligibility problems for those in the control group were determined rather quickly through the cooperation of the AWIC. Though loss of pilot eligibility could mean that the former participant would lose access to benefits counseling and other services, available evidence suggests that this rarely happened. By contrast, being declared ineligible following enrollment would deprive a treatment group member of potential access to the offset and of suspension of the medical CDR during the pilot. As these eligibility determinations were made at Office of Central Operations in Baltimore, enrollees and their provider agencies sometimes learned about enrollees’ ineligibility months after enrollment. This problem appears to have been exacerbated by the fact that OCO did not assign designated staff to pilot duties during the first year of the effort.

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[198] Six participants voluntary withdrew before completing the first quarter following the enrollment quarter. All had been assigned to the control group.

This is not to say that implementation of enrollment processes in Wisconsin whether by the central project office or at the provider agencies was without fault. We have noted that the SSDI-EP central staff disseminated some incorrect information in its initial training of agency staff. Not all provider agencies were equally effective in explaining the pilot. Indeed, we are especially troubled that well over a third of participants did not know their assignment to treatment or control irrespective of assignment. This is especially troubling in the case of the treatment group.

Finally, there are important aspects of the enrollment process for which we have little information. The most important of these is whether and how well the "ability to benefit" discussions were performed. Though the fact that most participants reported that the pilot had been well explained, we have anecdotal reports, including from provider agency staff, that such discussions were often brief and shallow. Nonetheless, the need for extensive discussions may have been reduced because some level of trust had been developed between the enrollee and the staff member conducting the enrollment. In many cases the enrollee may have already had a long term relationship with the provider agency and/or the staff member. More often than not, the staff member was a benefits counselor. As benefits reviews were often updated or performed de novo prior to formal enrollment, this activity may have encouraged the consumer to at least provisionally extend her trust.

G. Summary of lessons learned for informing BOND (enrollment)

Our thoughts about the applicability of what we learned about the SSDI-EP's enrollment process rests on our current understanding of the Benefit Offset National Demonstration (BOND), an understanding that is certainly incomplete and possibly inaccurate. To the best of our knowledge, SSA expects several hundred thousand beneficiaries to be included in the project. Most of these will be in a control group and will almost certainly never be informed of their "involvement."[199] Those in the primary treatment group will be informed, probably by mail, of the availability of the offset and the rules for its use. Our understanding is that there will be no formal enrollment process for these individuals, though it is likely they will be given contacts for more information about BOND and, perhaps, how to access benefits counseling and other support services.[200]

However, the BOND design appears to include a number of smaller participant groups to test various combinations of services and support, both in conjunction with the offset and without it. Though, unlike the SSDI-EP, these individuals will be pre-selected through a sampling procedure, they still must volunteer for the project. Therefore, it would appear that BOND must design and implement processes to explain the pilot and gain informed consent from the volunteers participating in so-called "tier two" groups.

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[199] "Involvement" in this context refers to BOND's use of data about control group members from SSA and possibly other federal agency databases.

[200] Managers and operational personnel from the four offset pilots have all argued that those in the primary treatment group will need access to benefits counseling and perhaps other services to effectively use the offset and/or to avoid inadvertently doing things that might negatively affect their eligibility or benefits for public programs. See Jensen, Allen and Silverstein, Robert. 2007. "Significant Lessons Learned from the Benefit Offset Pilot Demonstrations: Summary of the March 2007 Conference (draft)." Cambridge: MA: Abt Associates, Inc. pp. 11-12 and 18.

If it is correct that these volunteers will be drawn from ten geographically distinct areas, the BOND will need local capacity to conduct tier two enrollment. In some respects those operating BOND will face the same need to locate, train, support, and monitor local capacity as the SSDI-EP did and can learn much from the SSDI-EP’s experience. BOND presumably will have the advantage of having eligibility confirmed before approaching potential tier two volunteers. However, BOND may face two disadvantages. The first arises from general distrust of SSA, whether resulting from the often arduous process of establishing SSDI eligibility or that many beneficiaries find communications from the agency difficult to understand. Moreover, even when the content can be understood, a sizable proportion of beneficiaries are said to hold the view that any communication from SSA portends “trouble.” Second, even if BOND engages local organizations to perform enrollment, it will not necessarily be the ones that most prospective enrollees already have relations with. It is not that we fear that SSA and BOND will make poor choices, but that they are likely to contract with a relatively small number of entities to provide services in ten relatively large geographical areas. As such, we would expect that the presence of existing trust relations will be relatively infrequent compared to the SSDI-EP and the other pilots.

CHAPTER V: ADMINISTRATION OF THE PILOT

This section of the report concentrates on the SSDI-EP's implementation, save for the recruitment and enrollment processes already discussed in previous chapters. Nonetheless, this chapter inevitably looks at some events that occurred before any beneficiary was either recruited or enrolled. The pilot had to be staffed and, in turn, those engaged to staff the pilot had to be prepared to fulfill their responsibilities.

The core of this chapter is the material about service provision and the implementation of the benefit offset provision. We conceptualize offset administration broadly. It is not just identifying which participants would be using the offset at any particular time and then processing the reduction of their SSDI checks by one dollar for each two dollars of earnings beyond SGA. We also include the processes for estimating earnings, confirming earnings, suspending medical Continuing Eligibility Reviews (CDRs), and conducting work CDRs at the end of the Trial Work Period (TWP). While material concerning service provision applies to all SSDI-EP participants, material about the other topics applies only to members of the treatment group.

As service provision was implemented wholly in Wisconsin, we had opportunities to gather information from all relevant parties and, to a lesser extent, directly observe project activities. On the other hand, the processes associated with offset administration were largely in the hands of SSA staff in Baltimore. While we had limited contact with the project manager, there was essentially none with Office of Central Operations (OCO) staff who carried out many of these activities. What we know about how OCO implemented the offset is largely through the reports of third parties.

Since the offset pilot involved an interorganizational division of labor, significant attention is given to how staff located in multiple entities interacted to manage and deliver a project. This includes the relationship between the SSDI-EP central office and SSA, but given the decentralized structure of the Wisconsin pilot at least as much effort goes to describing the relationships between the SSDI-EP central office and the twenty-one provider agencies that directly worked with participants.[201]

Chapter V also presents material about participants' experience of the pilot, with an emphasis on what was learned through surveys and focus groups. In some respects, information about how participants perceived the offset pilot may prove more important than reports or assessments from project staff. After all, it will be beneficiaries who will make the decision as to whether to make use of a benefit offset should one become available. We would further argue that the participant perspective is vital for making good design decisions for the national demonstration (BOND). For example, SSA hoped that the pilots would provide useful information about effective methods of keeping participants informed and for encouraging them to remain actively involved in the project. This is not to say that useful information about these issues cannot be obtained from project staff and records. Yet, who was in a better position than the participants themselves to indicate what worked in these areas?

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[201] Twenty agencies after June 30, 2007

A. Implementation of Pilot Components

To either describe or assess the implementation of the Wisconsin offset pilot requires providing relevant information about those who staffed the project. It is important to ask whether project staffing was both quantitatively and qualitatively adequate. It is also important to know whether staff attrition was of a character to seriously impede project implementation. For the SSDI-EP, staff critical to implementing the pilot were housed in three different settings: SSDI-EP central operations at Pathways, the provider agencies, and at SSA in Baltimore. Pathways had only partial authority over who staffed the pilot at the provider agencies and how they performed their functions. Pathways had no control whatsoever over staffing at SSA.

Over most of the project, eight individuals at Pathways devoted substantial time to the SSDI-EP.[202] Collectively, they constituted the SSDI-EP central office. The Director of the DHS Office of Employment and Independence (OIE) was viewed as project lead at SSA. While he had been deeply involved in early planning and implementation, in later years his internal role was to exercise general oversight. The OIE Director continued to take a leading role in representing the SSDI-EP to SSA, the other pilots, and other units in Wisconsin state government. The personnel who carried out the day to day work of the central SSDI-EP office were divided into two functionally distinct groups: an operations team and an evaluation team.

The operations team's activities were diverse but could be viewed as having two major components. The first was to make sure that field operations (e.g. enrollment, service provision, etc.) would be performed as intended. To a large extent this meant making sure that provider agencies had adequate capacity, monitoring provider agency performance, and figuring out how to respond to any problems that were observed. Secondly, the operations team acted on behalf of SSA to collect information needed to administer the offset itself or related procedural tasks. Often these functions overlapped. The operations staff might need to act as an intermediary between the provider agencies and SSA, for example to clarify a policy or to "troubleshoot" individual participant problems. Generally, there were three individuals assigned to this team. Two members had primary responsibility for performing these functions on an ongoing basis. The third member focused more on overall project management and coordination, but was still involved in day to day support activities.

The evaluation team was also housed at the SSDI-EP central office. Their role in administering the pilot itself was restricted to information collection, especially training and technical assistance for provider agency staff. The team was composed of four members, three researchers and a data manager. The data manager also served the operations team.

The SSDI-EP central office experienced relatively little attrition. It is even arguable that the attrition that occurred might have actually improved the SSDI-EP's capacity to administer the project. Two of the three original members of the operations team left the project less than a year after enrollment began. Though one of these individuals was an experienced benefits counselor, these individuals involvement in the pilot had been mainly in the areas of policy development and process design. Both of the replacements were experienced benefits counselors. Moreover both had been involved

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[202] Pathways also devoted a substantial part of a clerical employee's time to the project.

in the training and mentoring of new counselors through the Wisconsin Disability Benefits Network (WDBN) and had worked at provider agencies involved in both SPI and the SSDI-EP. Whether by foresight or fortune, the SSDI-EP would be in a better position to help provider agency staff and pilot participants troubleshoot the increasing issues that arose around work CDRs and either late or inaccurate payments to those in the treatment group.

As noted in chapter II, provider agencies were given substantial latitude on how to staff the project. In reality, there were only two requirements. The provider agency had to be able to provide SSDI-EP participants with benefits counseling that was acceptable to Pathways. In most cases this requirement was met by having one or more benefits counselors who had been trained by the WDBN on staff. However, it was also acceptable to obtain benefits counseling services by contracting with another organization or a qualified independent contractor. In either case, Pathways specified that no full time benefits counselor should have a caseload of more than thirty.

Secondly, each provider agency needed to designate an administrative contact, sometimes called the "site coordinator," to handle contract issues and to be responsible for assuring that necessary operational and research reporting was done. Sometimes, this function was added to an agency administrator's work load. More often, the site coordinator duties were handled by a benefits counselor or another individual who provided services directly to pilot participants.

Although the SSDI-EP expected provider agencies to help participants to identify and then access needed employment services, this expectation did not generate an explicit staffing requirement.[203] There was substantial variation in how and in what quantities provider agencies engaged in employment related service coordination and provision. Our observation is that variation reflected the provider agency's overall service philosophy and capacity. If a provider agency had already heavily invested in the ability to provide some range of employment related services to its consumers, those enrolled in the pilot would also be likely to have good access to those services. In those cases where capacity did not exist, the benefits counselor would have to take on the employment service planning/coordination duties if they were to be performed at all.

Thus, when assessing whether provider agencies were adequately staffed, the bottom line is whether there was sufficient benefits counseling capacity. In interviews held less than a year after project start-up, site coordinators reported that they had little difficulty identifying capacity. In most cases this assertion was true. Experienced benefits counselors were already working at most agencies. In other cases, newly hired staff would need to go through the WDBN training and then acquire some job experience. This process, at best, would take several months.

The greater danger to provider agency capacity would be attrition of benefits counselors, especially when there was only a single counselor at an agency. Such losses were compounded by the fact that a new benefits counselor had to earn the trust

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[203] The SSDI-EP recommended that for each fifteen participants there should be one staff member to help plan and coordinate employment related services. We are not aware of any serious effort to encourage provider agencies to meet this standard. Indeed, in contrast to benefits counseling, there was little besides providing access to training that the SSDI-EP could do to help provider agencies to build or maintain capacity to provide employment related services.

of her consumers. Fortunately, most provider agencies were able to keep benefits counselors in place over long periods of time. However, there were exceptions. On the basis of project records, reports from central operations staff, and participant focus groups, it is clear that at least four provider agencies went through protracted periods of time without providing participants with adequate access to benefits counseling services.[204] The positive news is that in three of these four cases, problems were ultimately resolved or substantially reduced. As such, we think the evidence supports a judgment that the SSDI-EP developed and maintained the basic capacity needed to guarantee the delivery of required benefits counseling services.[205]

The SSA staff directly involved in administering the offset pilot all worked in the agency's headquarters in Baltimore, MD. The staff performed activities relevant to all four pilots, not just the SSDI-EP. However, these staff cannot be viewed as constituting a central project office. The project manager was located in the Office of Program Development and Research. The individuals who administered the offset and related processes were located in the Office of Central Operations (OCO).

Our ability to observe or to obtain reports about the project manager's activities was largely limited to his efforts as a contract manager and/or as a liaison between the four pilots and his agency. In our view he preformed these functions effectively; neither the SSDI-EP nor this evaluation would have been possible without his efforts.[206] However, the project manager did not have direct control over how OCO organized or performed offset administration. Though we have reports that the project manager encouraged changes in how OCO conducted offset administration, we are not in a position to identify his actual role.

OCO was responsible for both applying the offset to SSDI checks and ascertaining when those in the pilots' treatment groups would be eligible to use the offset provision. In many respects these tasks were non-routine, either requiring application of different rules or the need to record information "by hand." Until spring 2008, OCO did not constitute a unit with designated staff to perform these duties.[207] Even after designated staff was assigned to offset administration, their tenure was limited due to SSA's staff rotation policies. It is reasonable to ask whether OCO's performance of pilot related tasks were affected by insufficiently developed organizational capacity early in the pilots and staff turnover later on. The evidence appears to be yes. When SSA

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[204] In three of these cases the problem was either the lack of internal capacity or the unwillingness or inability to use existing capacity for the pilot participants. The fourth case combined unwillingness to use internal capacity on behalf of the pilot with an inability to get an external organization that had been contracted to provide benefits counseling to fulfill its obligations.

[205] This assertion is not a claim about the quality of benefits counseling services. It is also not an assertion that all provider agencies provided one full time benefits counselor for every thirty pilot participants. These matters will be examined later in this chapter.

[206] For example, the project manager was chiefly responsible for assuring that SSA administrative data would be available for evaluating the pilots. Getting this accomplished in a manner that addressed legal requirements and all parties' needs and interests proved to be a major effort.

[207] However, it does appear that OCO utilized a small group of disability examiners to do the work CDRs through most of the period the offset pilots operated.

decided to end the “active phase” of the pilots and return treatment group members who had not completed their TWP to regular SSDI rules as of the start of 2009, SSA cited the difficulty of administering the offset as the major reason for taking those actions.[208]

1. Benefit Counseling and Other Program Services

The SSDI-EP assured participants that they would have access to work incentive benefits counseling as needed and without distinction based on assignment to the treatment or control group. This commitment was backed with a funding source (albeit initially one of last resort) and substantial training and technical assistance capacity through the WDBN and the pilot itself. Participants were also told that their provider agency would help them identify employment goals and what services and supports would be needed to achieve them. However, the provider agency was not required to supply or pay for those services and supports. The obligation was to make a good faith effort to help the participant obtain access.

a. Benefits counseling

Table V.1 displays information about the amount of benefits counseling pilot participants received in the nine quarters that constitute the primary analytical period for this study. Q0 designates the calendar quarter in which the participant entered the SSDI-EP. Service hours represent the hours of benefits counseling activity reported by the provider agency. It can include time spent on gathering information or engaging in troubleshooting with public agencies, as well as direct contact with consumers.[209]

Table V.1: Benefits Counseling Services Provided to Participants, Q0-Q8

	Treatment	Control	Difference	All
Mean Hours	8.9	6.5	2.4	7.8
Median Hours	5.0	2.5	2.5	4.0
Standard Deviation	12.8	10.3	2.5	11.7
% getting no benefits counseling	16.2%	29.6%	- 13.4%	22.4%
% getting > 0 hours but < 4 hours	27.1%	26.1%	1.0%	26.6%
% getting 4 to 8 hours	21.4%	17.4%	4.0%	19.6%
% getting > 8 hours	35.3%	27.0%	8.3%	31.5%

Data Source: SSDI-EP Encounter Data
Sample Sizes: 496, Treatment = 266, Control = 230

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[208] Federal Register Online, December 11, 2008. Washington DC: GPO Access, wais.access.gpo.gov. 73 (239) pp. 75492-4. E-mail forward to SSDI-EP central office December 12, 2008.

[209] However it excludes gathering or recording information specifically for administrative or research reporting.

The data presented in table V.1 suggest that the typical participant received relatively little benefits counseling in the roughly two years following enrollment. The average value was approximately eight hours, the median only four. We were surprised by this finding, as we were by the fact that 22% of participants received no benefits counseling subsequent to enrollment.

Yet, the relatively small number of service hours most participants received is only problematic if not having more service was injurious to their ability to make progress toward their employment goals. About 90% of benefits counselors serving the project claimed that participants, irrespective of study assignment, received service that at least adequately met their needs.[210] As will be described later in this chapter, most participants thought so too, though not by such an overwhelming margin.

In chapter VI, we present evidence that even relatively small amounts of service (four hours or more) were associated with increases in employment outcomes. Additionally some benefits counselors did not record all service hours that they might have, though we cannot quantify the extent to which this happened.[211] Finally, it is possible that at least some participants received sufficient benefits counseling prior to pilot entry. For example, the SSDI-EP did not require a new or updated benefits analysis when one had been completed within a year of enrollment and there had been no important changes in the participant’s circumstances or employment goals.

Table V.1 also provides a basis for asking whether those in the control group had equal access to benefits counseling services. The information suggests this cannot be assumed to have occurred. Both mean and median service hours are less for the control group than for the treatment group. Still, the more disturbing piece of information is the difference between the two assignment groups in the percentages receiving no benefits counseling in the Q0-Q8 period. The proportion in the control group is 30%, compared to only 16% in the treatment group. Similarly, the percentage in the treatment group who got the amount of service that is associated with positive employment outcomes was about 12% higher than for the control group.

Though these differences are real, they must be put into context by remembering that it was expected that the typical participant would get more benefits counseling soon after enrollment than later, in large part due to the need to produce new or updated comprehensive benefits analyses. It was also hypothesized that those in treatment might, on average, get more benefits counseling over the course of the pilot as they used the offset to achieve ongoing monthly earnings above SGA.

Table V.2 presents information about the receipt of benefits counseling services in two time periods shortly after pilot entry. The first time period is limited to the enrollment quarter and the first quarter thereafter. The second time period adds Q2.[212]

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[210] Spring 2008 provider agency interviews were held exclusively with benefits counselors and concentrated on topics related to service provision and offset usage.

[211] For example, during our 2008 interviews with benefits counselors we learned that some did not record the hours they spent troubleshooting problems stemming from offset administration problems such as incorrect or late SSDI checks.

[212] Encounter data for benefits counseling and other services delivered by the provider agency was recorded from enrollment forward. Therefore, there can be significant variation in the amount

There is no difference in the mean hours of service received between the treatment and control groups, though the typical treatment group member still gets somewhat more benefits counseling. The proportions getting services in each group is similar, though almost 40% in both have no reported hours. Finally, the results for the alternative Q0-Q2 analysis are comparable to those for the Q0-Q1 period. All in all, these data suggest that most of the treatment group's additional service comes after Q2. The data also make it clear that those who get their first benefits counseling after Q2 are over twice as likely to be treatment group members.

Table V.2: Benefits Counseling Services Provided to Participants, Q0-Q1

	Treatment	Control	Difference	All
Q0-Q1				
Mean	3.8	3.8	0.0	3.8
Median	2.0	1.3	0.7	1.8
Standard Deviation	5.2	5.3	-0.1	5.2
% getting service	62.4%	60.9%	1.5%	61.7%
Q0-Q2				
Mean	4.6	4.3	0.3	4.4
Median	2.0	1.6	0.4	2.0
Standard Deviation	6.4	5.8	0.6	6.1
% getting service	66.5%	62.6%	3.9%	64.7%

Data Source: SSDI-EP Encounter Data
Sample Sizes: 496, Treatment = 266, Control = 230

Although the findings exhibited in table V.2 imply that differences between the treatment and control groups in the amounts of benefits counseling services received shortly after entering the SSDI-EP are modest, they do little to explicate why so many participants did not receive any benefits counseling in the months following enrollment. Is it possible that an appreciable portion of the 35% who had not gotten any benefits counseling by the end of Q2 had received services prior to enrollment and needed no more? The available information suggests otherwise.

We have identified 172 SSDI-EP participants that we have strong reason to think had meaningful benefits counseling prior to enrollment.[213] A small number of these participants had also been in SPI, but most were identified from information that the SSDI-EP operations staff collected from provider agencies in early 2008.[214] Participants

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of time included in Q0, ranging from a maximum of three months to a minimum of a single day. We offer data for the Q0-Q2 period to more nearly equalize the comparisons across participants. However, the variation in the lengths of Q0 periods included in these data should not have any impact on differences between study assignment groups.

[213] Meaningful benefits counseling is understood as that producing or utilizing a comprehensive benefits analysis.

[214] It is likely this number includes errors of both inclusion and exclusion. There are cases of recall error that can be clearly identified using the monthly encounter data reported to the

for which there was a report of prior benefits counseling received a mean of 10.5 hours of service and a median of 5.4 hours over the Q0-Q8 period. These figures are greater than the comparable values for all participants or even those assigned to the treatment group (see table V.1). Consequently, it follows that most of those who did not get benefits counseling services during the pilot were unlikely to have received meaningful services prior to entry.

However, none of this suggests why over the course of the pilot those in the control group received less benefits counseling. Random assignment suggests that there should not have been major differences between the study groups in their receipt of benefits counseling prior to entering the pilot.[215] One plausible explanation has already been mentioned. It is possible that access to the offset resulted in large enough differences in employment opportunities and outcomes that those in the treatment group had far greater incentive to use benefits counseling later in their pilot experience even if they had not used the service earlier. The problem with this hypothesis is that it doesn't conform to actual trends in employment and earnings. Without going into details that are found in chapter VI, there simply aren't statistically significant differences in employment and earnings trends between the treatment and control groups over the first two years of participating in the SSDI-EP. While it is true that towards the end of the study period there were increases in outcomes within the treatment group relative to the control group, employment outcomes for the control group had generally been a little better over the first year of SSDI-EP participation.

Another candidate for explaining differences between the treatment and control groups is that provider agencies found it easier to get benefits counseling funded if the participant was assigned to the treatment group. The SSDI-EP did not directly fund services. Though provider agencies could arrange for payment through another Pathways effort, the MIG funded "OIE grant," at least initially Pathways was suppose to be the funder of last resort. The most probable source of support outside Pathways was DVR. As DVR policy was to financially support benefits counseling when a consumer indicated he intended to earn above SGA, some thought that DVR would give preference to consumers who had access to the benefit offset. However, we found no evidence in support of this claim or that anyone in DVR made affirmative efforts to identify who was assigned to the treatment group. In any case, even within the first year of the pilot most benefits counseling was funded through the OIE grant. By 2008, virtually all was.[216]

To attempt to understand reasons for variation in the provision of benefits counseling to the two study groups, we examined differences at the provider agency level. Nearly half of the agencies exhibited results consistent with overall findings: those

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evaluation team. There may be cases where reporting staff were not aware of service that had been provided by benefits counselors at other organizations or even at their own agency that had been unrelated to pilot participation.

[215] We have not yet confirmed this directly. However, material in chapter IV supports the claim that there are no differences in pre-enrollment characteristics incompatible with that expected with random assignment.

[216] During the pilot's first two years several provider agencies chose not to utilize the OIE grant, in one case by unaccountably not being aware of the opportunity. There was no effective barrier to receiving the grant. By 2007 all but one SSDI-EP provider agencies used the grant, by 2008 all.

in the treatment group received slightly more benefits counseling than those in control, with differences growing after Q2. There were even a couple of agencies where those in the control group received more services.

Nonetheless, we found that at half (ten) of the provider agencies the typical treatment group member received at least 50% more hours of benefits counseling than those in control. At six of these agencies the median was at least twice as high for the treatment group. Furthermore, at four provider agencies the median amount of benefits counseling received by those in the control group was zero hours. Lastly, at most of these provider agencies the proportion of control group cases that received no benefits counseling in the Q0-Q8 period was at least 20% higher than the proportion in the treatment group.[217]

With one exception we could not find any common thread among the ten agencies where there were large proportional differences in the amounts of benefits counseling provided associated with study assignment. All four of the agencies where there had been protracted deficiencies in their capacity to deliver benefits counseling are included in the group of ten. Additionally, three of these agencies are among the four where the control group median was zero hours. It is possible that staff at these agencies engaged in a form of triage favoring those in treatment, though we do not have additional evidence to support that view.

We also want to recognize an additional factor that might explain at least some of the greater amount of service that those in the treatment group received. In discussing our doubts about whether all relevant benefits counseling hours had been captured in the encounter data, we mentioned that some benefits counselors said they had not reported time working on the problems of treatment group members related to actual utilization of the offset. Still, it is likely that some benefits counselors reported such activity as benefits counseling hours. Moreover, given the relatively small proportion of offset users among all participants (roughly 11%) it is likely that the burden of dealing with such cases fell disproportionately on some benefits counselors.

Another important factor in assessing service provision is variation across the provider agencies. When we compared the hours of benefits counseling across twenty provider agencies, we saw large inter-agency variation. Two agencies averaged more than thirty hours, four less than three hours. Further, though the four agencies with long periods of diminished service capacity were grouped toward the lower end of the distribution, so too were several agencies with strong reputations for providing benefits counseling and/or major roles in WDBN activities. Another relevant factor may have been having caseloads well above the recommended thirty to one ratio.[218] Three of the four agencies in this category had average service levels well under the average for the twenty agencies. Then again, there is an exception. The fourth agency with a benefits

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[217] Such differences in proportions need to be viewed with caution for the provider agencies with smaller enrollments, especially when random assignment resulted in a disproportionate share of participants at that location being assigned to one of the study groups.

[218] The most extreme case was a caseload ratio of 78:1, 2.6 times the recommended load. This benefits counselor faced the additional challenges of needing to be trained after he began work on the pilot and working at an agency that did not have an experienced benefits counselor who, though not assigned to the pilot, might have provided useful backup or mentoring.

counselor serving a very large caseload posted the third highest mean and median service level.

To the extent that we can discern a pattern in the group of agencies that had means well above the average for the pilot, there is a tendency for their service populations to have large proportions of consumers with cognitive and/or affective conditions. Nonetheless, there are agencies that serve similar populations which have mean and median hours of benefits counseling that are much lower.

Lastly, service quality can be just as important as service quantity. Unfortunately, we did not have data that would support a direct assessment of the quality of benefits counseling delivered through the pilot. Indeed, the issue of how to do this is of great concern to those seeking to expand and improve benefits counseling practice both in Wisconsin and nationally. SSDI-EP operations staff has characterized quality across provider agencies as variable but generally acceptable or better. They reached this judgment through input from those at WDBN who train and monitor the performance of new benefits counselors and their own interactions with provider agency staff.[219] Persistent concerns about unacceptable quality (as opposed to availability) focused on only two agencies. We will now leave the topic of benefits counseling until later in this chapter when we report information about both participant and provider agency staff perceptions of their respective experiences receiving or providing the service.

b. Employment related services

Provider agencies were not under any specific obligation to provide employment related services to participants. There was an expectation, consistent with Pathways' and the SSDI-EP's commitment to person centered planning approaches, that provider agency staff would seek to identify participants' employment goals and what services and supports might be needed to achieve them. As the SSDI-EP (or Pathways) did not fund such services, the provider agency would need to find some entity that would pay for them.

Those planning the SSDI-EP hoped that the Wisconsin Division of Vocational Rehabilitation (DVR) would be the main source of payment. Pilot staff, at both the central office and the provider agencies, indicated that DVR purchased limited amounts of employment related services for participants, chiefly due to the full and partial Order of Selection closures that were concurrent with the pilot. We do not have data that will confirm or refute this claim, though a substantial majority of SSDI-EP participants were open DVR cases either during the pilot or in the period leading up to their enrollment.[220] The pilot's designers also anticipated that DHS long term care programs might be a significant source of resources for employment related services. Though this might have

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[219] The central operations staff's role as intermediaries between the participants and provider agencies on one hand, and OCO on the other, allowed them a particularly good window to assess many aspects of benefits counselors activities related to the pilot.

[220] Though DVR may have expended fewer dollars than it might have under better fiscal conditions, it is still probable that DVR provided a large proportion of external funding for participant's employment related services, especially when delivered through entities other than the provider agency.

been true for individual cases, only 8% of SSDI-EP participants took part in one of these programs.

More generally, we caution readers not to conclude that all or even most of the employment related services that a participant received were delivered by provider agency staff assigned to the SSDI-EP. In some cases services might have been delivered by others in the organization. It is possible that the provider agency staff working with the participant either did not know about the service provision or did not consider it relevant to the pilot.[221] The participant may also have received services directly from other sources. Even if the staff working with the participant had full knowledge of this service delivery, it would not have been reported to the evaluation team using the monthly case-noting form.

Table V.3 presents encounter data about employment related services delivered through the provider agencies that staff considered relevant to making use of the pilot. The data are again for the Q0-Q8 period. Two facts stand out. Whatever the funding challenges, on average, pilot participants received four times more hours of employment related services than benefits counseling (31.3 versus 7.8). Table V.3 also indicates that a majority of participants received no employment related services whatsoever. Moreover, the standard deviations are at least three times larger than the means, indicating that the lion's share of services went to relatively few individuals among those who received any.

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[221] Provider agency staff made the decision as to which services provided to a participant through their organization were relevant to someone's participation in the pilot. There was no guidance beyond this broad standard and the definitional material for the service categories reported to the evaluators using the monthly case-noting forms.

Table V.3: Employment Related Services Provided to Participants through SSDI-EP Provider Agencies, in Hours, Q0-Q8

	Treatment	Control	Difference	All
Assessment & Service Coordination				
Mean	17.3	25.3	-8.0	21.1
Median	0.0	0.0	0.0	0.0
Standard Deviation	74.0	113.4		94.3
Employment Support Services				
Mean	7.7	4.2	3.5	6.1
Median	0.0	0.0	0.0	0.0
Standard Deviation	23.0	15.3		19.9
Job Coaching and Natural Supports				
Mean	5.8	2.3	3.5	4.2
Median	0.0	0.0	0.0	0.0
Standard Deviation	20.3	9.5		16.3
All Services				
Mean	30.8	31.8	-1.0	31.3
Median	0.6	0.0	0.6	0.0
Standard Deviation	86.6	119.0		102.8

Data Source: SSDI-EP Encounter Data
Sample Sizes: 496, Treatment = 266, Control = 230
Note: The “employment support services” category excludes “job coaching and natural supports” data.

Data presented in table V. 3 also indicate that members of the treatment and control groups received about the same mean hours of employment related services. However, when overall service hours are disaggregated, the profiles for those assigned to treatment and control become more distinct.

The first category “assessment and service coordination” would include most of the goal identification and planning activities associated with a person centered planning approach. “Employment support services” group a range of services (e.g. job development, placement, planning job accommodations, planning for self-employment, etc.) pertinent to obtaining or upgrading employment. We have separated “job coaching and natural supports” from the general “employment support services” category due to the historical association of job coaching with supported employment programs and the disability populations that most frequently use those programs.

Those in the control group received an average of about eight more hours of “assessment and service coordination.” This represents nearly a 70% difference. Those in the treatment group received somewhat more “employment support services” and “job coaching and natural supports” than those in the control group. The absolute difference in both cases is about 3.5 hours. We have no clear explanation for the differences. Had the employment outcomes for treatment group members been better than for those in the control group, the additional increments of employment support services for those having potential use of the offset would have been intelligible. Yet as will be documented in chapter VI, employment outcomes for the two assignment groups were not significantly different. Similarly, several agency staff members indicated giving somewhat more attention to control group members they felt would have been in a good position to benefit from an offset had they been assigned to the treatment group. However, we have no evidence to suggest this was a common orientation among provider agency staff.

Table V.4 provides additional information about provision of employment related services through the pilot. The table displays information about the percentages of participants who received services in each of the categories along with mean hours for services for those who actually received the services. Some patterns emerge that could not have been discerned from table V.3. Most importantly, it appears that while control group members who got assistance in “assessment and service coordination” area received much more (sixty-nine versus thirty-eight hours) than those in the treatment group, those in the treatment group were far more likely to receive some service.[222] About 46% of treatment group members received some services from this category compared to 36% for those in the control group. Table V.4 also shows that while both assignment groups received the majority of their hours of employment related services in the “assessment and service coordination” category, a much higher proportion of the total employment related service hours received by control group members (79.5%) came from this category than for treatment (56.2%).

Participants in the treatment group were also more likely to get “employment support services” and/or job coaching through the pilot. Close to 10% more of those assigned to treatment had reported hours in these service categories than those in control. Those in the treatment group who received a service also, on average, received more hours of that service. The difference is especially notable for the “job coaching/natural supports” category where those in treatment got almost twice the service hours as those in the control group.

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[222] This pattern is also reflected in the summary figures for “employment related services.” When a control group member got service he averaged nearly fifteen hours more than those in the treatment group. Yet only 43.7 % received any service, compared to 53.6% for those in treatment.

Table V.4: Employment Related Services Provided to Participants through SSDI-EP Provider Agencies, Data for Those Receiving Services, Q0-Q8

	Treatment	**Control**	**Difference**	**All**
Assessment & Service Coordination				
% who received service	46.4%	36.4%	10.0%	41.7%
Mean Hours	37.5	69.1	-31.6	50.3
% of Total Employment Services Hours	56.2%	79.5%	-23.3%	67.2%
Employment Support Services				
% who received service	33.6%	24.2%	9.9%	29.2%
Mean Hours	22.9	17.2	5.7	20.7
% of Total Employment Services	24.9%	13.2%	11.7%	19.4%
Job Coaching and Natural Supports				
% who received service	29.1%	19.9%	9.2%	24.8%
Mean Hours	20.2	11.5	8.7	16.9
% of Total Employment Services	18.9%	7.3%	11.6%	13.4%
All Services				
% who received service	53.6%	43.7%	9.9%	49.0%
Mean Hours	57.7	72.3	-14.6	63.8
% of Total Employment Services	100.0%	100.0%	0.0%	100.0%

Data Source: SSDI-EP Encounter Data
Sample Size: 496, Treatment = 266, Control = 230
Note: The “employment support services” category excludes “job coaching and natural supports” data.

It is common for community agencies to concentrate on providing a particular menu of services and supports. Choices may reflect organizational preferences or legal requirements related to access to public funds; often choices are correlated with the predominant characteristics and needs of the organization’s primary service population. Thus, we decided to examine the average number of hours delivered by each provider agency for, respectively, the assessment and service coordination, employment support services, and the job coaching/natural support categories over the active phase of the pilot. We would then see if there were patterns that coincided with our understandings of the service philosophies and core consumer populations of the SSDI-EP provider agencies.

In table V.5, we try to give a sense of how delivery patterns of categories of employment related services varied across provider agencies. The primary finding is that service delivery for each category is concentrated at relatively few of the provider agencies. Indeed only for the "employment support services" category did the typical agency approach the mean values. Meanwhile the provider agencies with the highest means exhibit values many times higher than the group mean, in the most extreme case over seventeen times higher than the group mean.

Table V.5: Mean (Per Capita) Hours for Three Categories of Employment Related Services by Provider Agency, Pilot Start-up through December 2008

	Assessment & Service Coordination	**Employment Support Services**	**Job Coaching and Natural Supports**
Mean for All Twenty Provider Agencies	31.3	6.8	3.2
Mean, Highest Provider Agency	544.5	57.3	37.1
Mean, Second Highest Provider Agency	218.2	46.2	32.3
Mean, Third Highest Provider Agency	56.7	35.5	7.8
Mean, Tenth Highest Agency	1.9	5.2	0.0

Data Source: SSDI-EP Encounter Data
Sample Size: 496, Treatment = 266, Control = 230
Note: Rank in one service category does not denote rank for any other category
Note: The "employment support services" category excludes "job coaching and natural supports" data.

In every case, the agencies with extremely high means are those that both offer a full service model and served persons with cognitive and/or affective impairments. However, this description must be qualified in two ways. First, it does not appear that there is a strong association between providing large amounts of an employment related service and the reputed severity of the agency's general service population. Second, and perhaps more important, while the agencies providing the most per capita employment related services predominately served consumers with cognitive and/or affective impairments, it does not follow that all provider agencies that have this profile delivered higher than average hours of employment related services.

Later in this chapter we return to the topic of service provision, but from the perspective of participants and provider agency staff. For participants the focus is on satisfaction, especially whether services met their needs as they perceived them. For staff the presentation centers on the challenges they faced in service delivery and whether they thought support from the SSDI-EP central office was adequate to their needs.

2. CDR waivers

Though the benefit offset itself was the main feature of the intervention, those in the treatment group were not subject to undergoing medical continuing disability reviews (CDR) during their participation in the SSDI-EP.[223] [224] These periodic reviews are important as they determine whether a beneficiary will retain SSDI eligibility. In Wisconsin, as in most states, medical CDRs are performed by state entities called Disability Determination Services (DDS) rather than directly by SSA.[225] Each DDS assesses whether a beneficiary remains disabled following a sequential process and standardized criteria. Given the definition of disability used, having a medically determinable impairment does not by itself establish SSDI eligibility. The individual must be incapable of performing any kind of substantial gainful work. DDS personnel look at work activity in several ways: whether an individual is earning over SGA, whether there is an impairment that interferes with the ability to perform basic work activities, and, in some circumstances, whether there is residual functional capacity. While true that once a beneficiary has established eligibility the burden passes to the DDS to prove that the beneficiary is no longer eligible, it is understandable that those encouraged to earn over SGA might, in anticipation of a future CDR, be reluctant to do so. SSA suspended medical CDRs for those in the pilot treatment groups to obviate these concerns.[226]

However, the CDR waiver did not apply to a scheduled medical CDR that had been initiated by the time of enrollment. Thus a small number of those assigned to the treatment group had to undergo a CDR while in the study. While this caused some uncertainty and dissatisfaction on the part of both participants and pilot staff, no member of the treatment group lost SSDI eligibility because of these reviews.

The CDR waiver appears to have been well implemented during the pilot. Though we cannot directly confirm this, it seems reasonable to infer that SSA has provided DDSs with sufficient information to recognize when a scheduled CDR should be suspended. However, central project staff, provider agency staff, and, through focus groups, participants have all raised the issue of what will happen following the end of the pilot when treatment group members are again subject to medical CDRs. In particular, they have expressed concern that a DDS, following normal processes and rules, will use the work activity and above SGA earnings of the more successful members of the

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[223] The length of time between medical CDRs is set at the time of the prior eligibility review and reflects a judgment about the likelihood of medical improvement.

[224] This protection ended with the seventy-second month following TWP completion, even though affected individuals would remain in the pilot in terms of access to benefits counseling and for evaluation purposes.

[225] The Wisconsin DDS is called the Disability Determination Bureau (DDB). It is located within DHS though, like all DDSs, it is subject to substantial SSA oversight and supervision.

[226] Those involved in planning the SSDI-EP had argued that the waiver should also apply to those in the control group. From a strictly evaluation perspective not doing so made it more difficult to isolate the effect of the benefit offset itself.

It is likely that some control group members had suspended CDRs due to their use of the Ticket to Work. Similarly some of those in the treatment group who were returned to regular program rules in January 2009 may be similarly protected.

treatment group to terminate their SSDI eligibility and, indirectly, that for other programs such as the Medicaid Buy-in. Concern was greatly elevated in those cases where the beneficiary's medical condition is not included in SSA's "impairment listings" or assessing its severity depends on the interpretation of reported behavior and/or subjective states (e.g., pain) rather than direct physical evidence.[227] Pathways staff discussed this issue with a Wisconsin DDS manager in September 2009. Though the DDS staffer thought that serious problems were fairly unlikely, he did not discount the possibility that some problems might occur and, though correctable, might well result in stress and material hardship for some individuals.[228]

Ironically, a different type of CDR played a far more important role in administering the SSDI-EP, the work CDR. In a work CDR, the beneficiary's earnings are looked at to determine whether she remains eligible to receive monthly benefits. A variety of events can trigger a work CDR, but in the context of the offset pilots the critical events were TWP completion and/or initiating offset usage. Unlike medical CDRs, work CDRs are performed directly by SSA staff. Generally, this means local SSA staff, but for those in a pilot's treatment group responsibility was shifted to OCO in Baltimore.

Though any SSDI beneficiary may face a work review, the reviews can be viewed as an integral part of offset administration as there could be no application of an offset until the work record had been developed and TWP and SGA determinations made. Therefore, expediting work CDRs involved significant effort at both the provider agencies and the central office. Delays in completing work reviews resulted in problems in the timely application of the offset in individual cases. Thus problems experienced in this area were perceived to be associated with the increased incidence of both overpayments and underpayments. Further discussion of work CDRs occurs in the next section of this chapter.

3. Benefit offset waivers

The benefit offset was the central feature of the intervention tested through the four pilots. The offset involved a one dollar reduction in the SSDI check for every two dollars in earnings above the SGA level. As already noted, the offset is applied only following TWP completion and a three month grace period. The offset could not be applied once a beneficiary reached his seventy-second month following TWP completion.

The benefit offset, in the most literal sense, was administered entirely by SSA's Office of Central Operations. As already noted, the evaluation team did not have the opportunity to directly observe how the offset was implemented. Indeed, we have only

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[227] See Office of Disability, U.S. Social Security Administration. Disability Evaluation Under Social Security. 2001. Baltimore MD: SSA Publication 64-039. pp. 18-142.

[228] The DDS staffer offered several reasons for his opinion. The most important of these was that the DDS would have to show there had been improvement in the medical condition underlying impairment; it would not be enough to show there had been greater work activity. He also made a distinction between "control" and "remission." For example an individual with severe mental illness whose symptoms were controlled through medication would not be viewed as having achieved medical improvement. Nonetheless, the staffer conceded this practice is not explicitly found in the written rules for the disability determination process.

fragmentary information from SSA about which SSDI-EP participants ever used the offset, the periods of time they did so, and the adjustments made to their benefit checks. The information used in this account is from reports from various stakeholders, including reports about the consequences of OCO actions.

This is not to say that SSDI-EP staff, whether at the central office or the provider agencies, did not contribute to the process of offset administration in important ways. They did so in areas such as obtaining and amending earnings estimates, monitoring or collecting earnings information for OCO, facilitating work CDRs, engaging in troubleshooting to deal with delays and inaccuracies in SSDI checks and/or to resolve overpayments and underpayments related to offset use, and resolving problems with other public benefits stemming from offset use. As such, we have organized this section of chapter V around the performance of these activities. It should also be noted that some of these activities, most notably facilitating work CDRs and dealing with over- and underpayments, were performed on behalf of those in the control group. Doing so was part of the SSDI-EPs commitment to facilitate the employment goals of all its participants, not just those assigned to the treatment group.

It should also be noted that relatively few members of the treatment group ever used the offset feature and that we do not know the number with certainty. The SSDI-EP operations staff has told us that a total of fifty-five participants (21% of the treatment group) had made use of the offset by summer 2009. They could not provide information as to when each of these individuals had first used the offset or whether they had done so continuously.[229] However, operations staff once again noted something they and provider agency staff had told us throughout the project. If one used the offset, there was a near certainty that SSDI checks would be delayed or inaccurate.

However, it is important to remember that the difficulties of benefit offset administration were not limited to problems of getting the right check to the right person at the right time. All areas of offset administration involved serious and persistent difficulties. Every month, SSDI-EP operations staff sent the SSA project manager a status report which, among other things, listed current staff and participant concerns.[230] Following the first months of the pilot, every monthly report identified the same seven concerns:

- Problems reporting/estimating earnings on an annual basis
- Problems related to completing forms needed for SSA work reviews
- Delays in OCO applying the benefit offset
- Incorrect offset amounts
- Delays in getting Impairment Related Work Expenses (IRWE) approved
- Incorrect or confusing notices
- Overpayments and/or requests for information about how to apply for waivers of overpayments

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[229] SSA supplied some data regarding offset usage but the numbers of cases we could identify from what are essentially appended notes appear about 20% less than the number of cases identified by central operations staff. As the central pilot staff's count is based on working with these cases, we think it is more credible.

[230] These monthly reports are identified as "Task 8" in SSA's contracts with the four pilot states.

As will be described below, all seven concerns, though not always exclusive to offset administration, arise from that process.

a. Earning estimates

SSA decided to implement the offset on an annual basis. Those in the treatment group would provide the pilot with an annual earnings estimate at the time of enrollment and then update it on an annual basis.[231] The pilot would then forward the estimate to OCO, with amended estimates sent on a quarterly basis. Once a member of the treatment group was determined to be qualified to have the offset applied to his SSDI check, the estimate would be used to determine the monthly SSDI amount (if any) for the rest of the year.[232] Those in the treatment group were expected to amend the estimate whenever there was a major change in earnings. If a beneficiary was in "offset status," OCO would presumably change the amount of the monthly SSDI check accordingly. SSA also agreed to ignore minor overpayments that would result, especially when there were large increases in estimates late in a calendar year.[233]

In practice, the earnings estimate proved difficult to implement well. In Wisconsin, both participants and provider agency staff found it difficult to understand how to fill out the form.[234] Among the more frequent issues that came up were how to treat an IRWE or subsidy, how to report earnings when they were highly variable, and how to merge information about actual earnings and expected earnings from different time periods into annualized estimates for the current year. Seemingly simple issues proved surprisingly difficult to resolve. For example, just when should someone in the treatment group amend the earnings estimate? It wasn't until January 2007 that this issue was settled; that is, nearly one and one-half years after the first participant entered the SSDI-EP. The final rule was that an estimate, even one from a previous year, only needed to be amended if the annual change from the previous estimate was at least $1000.

Getting earnings estimates "right" was complicated by the multiple stakeholders involved. The form and its instructions had to make sense to participants and provider agency staff. Though SSA was initially comfortable with some state to state variation in these materials, staff at OCO also had a need to make sure that they could interpret estimates from different pilots in the same way. In Wisconsin, the estimate form went through multiple revisions with the final version implemented in 2007. Every amended

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[231] The initial estimates were collected prior to random assignment; thus all SSDI-EP participants made an earnings estimate at enrollment.

[232] In this context, being qualified meant having earnings greater than SGA as well as having completed the TWP and the three month grace period. Additionally, if earnings were high enough (essentially SGA plus twice the monthly benefit amount) applying the offset would result in a monthly benefit of $0.

[233] This amount was initially set at $500; it was later increased to $1000. Though participants were responsible for paying back larger overpayments, SSA could waive payment. Our understanding is that generally such requests were approved except when there was evidence of fraud or other misconduct on the beneficiary's part.

[234] It is likely these difficulties were greater in Wisconsin because of the decentralized structure of the project.

version meant there was some need for SSDI-EP central staff to provide additional technical assistance.

We cannot directly assess how well OCO utilized earnings estimates or how the quality of utilization changed over time. Reports from SSDI-EP operations staff suggest that offset users who conscientiously amended their estimates still faced substantial delays and inaccuracies in their checks. What we cannot tell is whether and to what degree these problems arose from unresolved problems in the forms and instructions leading to "user error" by participants, agency staff, or OCO staff, from deficiencies resulting from guesstimates rather than retrospective information, or from a combination of both.[235]

b. Reporting earnings/reconciliation

All SSDI beneficiaries have an obligation to report earnings to SSA. Those in the control group met this obligation through normal reporting mechanisms. Those in the treatment group did so through the pilot to OCO. The principal means for doing this was through retrospective annual reporting that was expected to be performed relatively early in the new calendar year. In many cases, retrospective reporting stretched over months. As OCO needed to reconcile actual SSDI payments with the retrospective reports, the full reconciliation process took additional months, sometimes into the next calendar year.

An additional factor lengthened the process in Wisconsin compared to the other pilots. Provider agency staff needed to collect participant information and then transfer it to the central project office so that it could be conveyed to Baltimore. If OCO (or the SSDI-EP project office) had questions requiring follow-up action, it generally required contacting agency staff who would then need to contact participants. Then the information would have to be moved back up the chain to OCO.

Early in the pilot there was some confusion as to whether retrospective earnings reporting should be done using the W2 form or pay stubs.[236] SSA's preferred documentation proved to be pay stubs: always the last in a calendar year, though sometimes the first in the following year if it included earnings from the previous year. This method was prone to errors in specific cases, e.g., where cumulative earnings were not reported on the pay stub. According to our informants, such errors could lead to serious overpayments or underpayments, especially for the minority of treatment group members who actually used the offset.

Furthermore, there was some confusion among participants, provider agency staff, and even at SSA field offices as to whether those in the treatment group still needed to provide earnings information to staff at the field offices. There was also a

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[235] It also appears that many treatment group members did not submit amended earnings estimates on a yearly basis or, in some cases, at any time subsequent to enrollment. For some this might reflect either persistent non-employment or stable earnings. Still, even if the failure to amend was purposeful, such action would not have resulted in either an overpayment or underpayment as long as these individuals were not using the offset.

[236] The original instructions to the provider agencies emphasized the use of W2s. See Pathways to Independence. "Wisconsin SSDI Employment Pilot Policy and Operations Guide". 2005. Madison, WI: Office of Independence and Employment, WI Department of Health and Family Services. Section I.9 "Processing the Cash Benefit Offset."

mistaken belief at a few provider agencies that reports to the evaluators of the earnings associated with new jobs qualified as earnings reporting for administrative purposes.

Finally, there were two additional issues about reporting earnings that were important for some individuals within the treatment group. Those currently in their TWP needed to report their earnings on a monthly basis to OCO. This involved the same basic procedures as described for annual reporting and, though to a lesser degree, involved delays for the same reasons. The second issue involved the processing of IRWEs and work subsidies. OCO had to approve IRWEs and subsidies for those in the treatment group, including those already approved by SSA field offices.[237] Once again this increased the probability of delays and that the delays would be longer.

c. Facilitating work CDRs

All SSDI-EP participants remained subject to work CDRs irrespective of their assignment to one of the study groups. Though work CDRs can be conducted for multiple reasons, the ones associated with TWP completion were the most important in the context of the offset pilots. The review would provide necessary evidence as to whether the offset could be applied to the benefit checks of those in the treatment group. Additionally, work CDRs would become important for identifying who would be able to begin use of the offset after the end of 2008. Treatment group members who had not completed their TWP before the start of 2009 would never get an opportunity to do so.[238]

Work reviews for those in the control group were conducted by staff at SSA field offices. These reviews, participants' experiences with them, and their impact on pilot operations are not directly examined in this report. Still, these reviews have some relevance for understanding how the pilot operated. First, SSDI-EP staff, consistent with program "equal access" rules, helped control group members understand what was expected of them, facilitated the submission of required paperwork, and, when requested, acted as mediators when problems arose during or following the review. Second, these work CDRs provide a benchmark against which to assess the performance of work CDRs for those in the treatment group. By benchmark, we mean typical, not exemplary, performance. Pilot staff, participants, and external informants have all noted that work reviews for SSDI beneficiaries are often late, even when work activity and earnings are reported in a timely manner. Delays, whether at SSA or stemming from beneficiary or employer failure to submit forms and other documentation, often result in incorrect payments and subsequent work to resolve problems.[239] To the

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[237] IRWEs and subsidies were not counted as earnings in calculating the offset. As the offset was calculated from the earnings estimate it was important that treatment group members have accurate information about whether an IRWE or subsidy had been approved.

[238] However, SSA did not need to finish the work review confirming TWP completion by December 31, 2008. Thus, the final status of a number of treatment group members would not be clear for some time thereafter.

[239] Informants claim that SSA is the predominant source of delay, saying that SSA is very slow to respond to earnings reports and thus initiating work reviews, especially at the end of a TWP. This leads to a higher probability of overpayments. The eWork reporting system has not, as hoped, resolved these problems, though our informants report that it has helped insofar as lost documentation has become less of an issue for those in the control group. SSDI-EP operations

extent a process tends to increase the length of delays, the result will be a larger number of incorrect checks and, thereby, increases in the size of the payment errors.

Work CDRs for treatment group members were performed at OCO. Though from early on reviews from the four state pilots were handled by specific disability examiners, our informants have told us that it took considerably longer to conduct reviews compared to the time it took at SSA field offices. Several factors appear to have been at work. For instance, having designated disability examiners at OCO did not, by itself, fully ameliorate the negative effects of frequent staff rotation.[240] We have also been told that disability examiners at OCO often had little experience in performing work, as opposed to medical, reviews. Finally, reflecting SSA's general tendency of having some backlog in conducting work reviews, there was a large number of reviews on treatment group members that needed to be conducted almost immediately following enrollment into the pilot.[241] Indeed, the workload problem was compounded by OCO's charge to conduct reviews for all treatment group members currently in TWP.[242]

However, the most important factor in delaying work reviews throughout the pilot may have been the additional distance, both physical and social, between OCO, pilot staff, and treatment group members. We think it probable that this "remoteness" was of greater consequence for the Wisconsin pilot than for the others, due to the SSDI-EP's more decentralized structure.

Through most of the project OCO staff would respond directly to only central pilot staff, not at all with treatment group members. OCO, for understandable reasons, did not want to communicate directly with benefits counselors and other staff at the SSDI-EP provider agencies.[243] Relevant notices and paperwork would be mailed to the participant with copies sent to central pilot staff who, in turn, would fax these to benefits counselors at the provider agencies. Though a beneficiary could in theory complete and return paperwork to OCO, few did. Typically, agency staff would work with participants to complete materials, though in some cases SSDI-EP central staff would need to become involved. Typically, the staff in Madison would send documentation to OCO after getting it from the provider agency and/or participant. Doing so increased the likelihood that the material was complete and accurate and, as effective follow-up was insured, lessened

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staff have pointed out that OCO, which performs the reviews for those in the treatment group, appears to make little or no use of eWork.

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[240] The standard rotation period is 120 days.

[241] As indicated in chapter IV, SSDI-EP participants entered the pilot far more likely to be employed or to have completed a TWP than the general beneficiary population. We have been told that this was also true for the other three pilots.

[242] Central project staff indicated there were yearly backlogs in conducting work reviews, though the greatest delays were experienced in the first full years of the pilot.

[243] We speculate that OCO, in addition to wanting to limit the number of state level individuals it would need to interact with, wanted to limit access to the secure e-mail system that it had set up to facilitate the flow of confidential information to and from the pilots.

the probability that the material would be misplaced at OCO.[244] In some cases, pilot staff needed to contact employers to complete alternative documentation. Participants did not always provide required information for a work review.

By itself, this process suggests delays relative to what would have occurred at a SSA field office. However, in the SSDI-EP, there was an additional party that needed to be involved, the benefits counselors at the provider agencies who worked directly with the participants. This additional layer added to the time needed to gather information or to respond to problems. It also added to the potential for miscommunication, which in turn tended to contribute to delays and errors. Finally, beyond the difficulties arising out of longer and more complex communication networks, there is also the possibility that the lack of continuing interactions between provider agency and OCO staff may have also contributed to delays in processing work CDRs. Familiarity and trust often increase the efficiency of bureaucratic processes. Benefits counselors at the provider agencies often have good working relationships with SSA field staff; there was no opportunity to reduce the social distance with OCO staff. This same point could be made for some beneficiaries who have developed working relationships with staff at SSA field offices.

In an effort to reduce delays, SSDI-EP central staff in early 2007 began to collect information from provider agencies in order to prompt OCO to conduct needed work reviews. Whether for this reason, the creation of a dedicated unit at OCO to administer the offset, or others, the number of serious delays decreased late in the project. Another helpful change was implemented in late 2007, when OCO started to consistently report to pilots the TWP and EPE status of those in the treatment groups. OCO also started to provide the pilots with copies of letters sent to participants who had reached their seventy-second post TWP month. Previously, these kinds of information had been provided on an intermittent and incomplete basis.

d. Troubleshooting offset problems

While we know little about the process of offset calculation at OCO and its attendant challenges, it is clear that SSA had enormous difficulty in administering the offset. Staff at the provider agencies indicated that virtually every offset user experienced either substantial delays in receiving her SSDI checks and/or that the amount was wrong. Though these problems could occur at any time, agency staff reported that errors most often happened when offset use was first initiated.[245] Staff at Pathways corroborated these reports, as program participants did to a lesser extent.[246] It is unlikely these reports were seriously exaggerated; SSA itself cited deficiencies in administering the offset as a principal reason for returning those in the treatment group who had not completed a TWP back to regular program rules at the start of 2009.

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[244] SSDI-EP staff reported that only a handful of treatment group members sent work review materials directly OCO. In most cases these materials were misplaced and had to be resubmitted by staff at the pilot's central office.

[245] It is almost certain that delays or mistakes in completing work CDRs were important contributing factors to delays or inaccuracies in the first application of the offset.

[246] See section E below for more detailed information about participant perceptions.

The negative effects of not having a dedicated unit for offset administration at OCO, as well as those arising from the staff rotation policy have already been identified. There was an additional difficulty in the area of check calculation. While specific disability examiners worked on the offset cases, through most of the project offset cases were not given to a benefit authorizer (the position responsible for calculating check amounts) specifically trained and assigned for that responsibility. Further, as checks were calculated and recorded manually, there was additional potential for mistakes.[247]

Beyond implementation problems involved in either confirming that offset use could be initiated or adjusting the SSDI check, SSA's communications to participants, especially about the offset, were problematic. Often there were notices which contained information inconsistent with the checks sent out or decisions actually taken at SSA. The use of preapproved blocks of information "borrowed" from other SSA letters and apparently used for legal purposes tended to obscure rather than enlighten. Based on remarks offered by pilot participants during focus groups, the language used could reinforce existing fears about how work activity might lead to the loss of benefits. Even language intended to reassure, such as the description of appeal rights, was reported to be difficult to understand and, because of its context, as likely to heighten as to reduce fears. Though SSDI-EP operations staff offered to draft language for letters that pilot participants would find easier to comprehend and/or would be less likely to induce fear, SSA refused the offer.

These impacts were exacerbated because OCO did not always send copies of the letters sent to treatment group members to SSDI-EP central staff. As such, benefits counselors at the provider agencies, who might otherwise have been in position to assuage unnecessary participant concerns, were not in a position to be proactive in doing so. Over time OCO did a better job in making sure copies of participant notices reached the SSDI-EP central office. However, staff in Madison still lacked anything resembling real time information about which participants were using the offset, which had (at least temporarily) stopped using it, and the size of actual adjustments

Problems with offset administration were reflected in the very significant time that both central SSDI-EP staff and agency benefits counselors put into troubleshooting problems with delayed or inaccurate benefit payments for those actually using the offset. SSDI-EP central office staff acted as liaison between affected participants and their benefits counselors and OCO. In addition to performing this function, central office staff, as experienced benefits counselors, provided their agency based colleagues with either direct technical assistance or referral to other sources (such as the Wisconsin SSA AWIC). Even OCO's efforts to be responsive to problems could result in additional difficulties. Efforts to resolve overpayments could, according to staff reports, result in a fluctuating series of over- and underpayments that made it difficult for those affected to budget their modest resources. Finally, OCO did not have an internal process for resolving overpayments that were above the $500 (later $1000) automatic forgiveness level. Consequently SSA field offices had to be involved in any appeals and subsequent forgiveness of all or part of an overpayment. We have no certain information about

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[247] Both the disability examiner and benefits authorizer were involved in calculating check amounts. The benefits authorizer had the particularly difficult job of reconciling the offset amount with what the beneficiary had received earlier in the year before entering offset status.

whether this advantaged or disadvantaged offset users, though informants reported that it added another layer of confusion and delay.

Finally, there were reports from provider agency staff and participants that application of the offset to SSDI checks occasionally affected eligibility or cost share for other benefit programs. Most reports concerned increases in premiums for the Medicaid Buy-in where, in Wisconsin, the combination of significant earnings and unearned income like SSDI can result in the net loss of income that the benefit offset was intended to prevent.

B. Attrition from the Pilot

Measuring the amount of participant attrition from the pilot and understanding the reasons for it is important for at least two reasons. As attrition increases, the reliability of even formative estimates of project impacts decreases. This is especially true if there was substantially more attrition from one of the study assignment groups than from the other. The second reason is that participant attrition may indicate intervention problems that were pernicious enough to seriously affect project outcomes. In the context of the current project this kind of information can inform understanding of what occurred. In the context of future policy and program planning, problems can be anticipated and past mistakes corrected.

From August 2005 through the end of 2008 a total of thirty-eight individuals left or were removed from the pilot.[248] There were a total of eleven deaths and twenty-two voluntary withdrawals. All the voluntary withdrawals, save one, were from the control group. An additional five individuals were terminated from the pilot in fall 2008 for failure to provide SSA with information about their earnings. All five of these individuals were from the treatment group.

As we generally examine participant outcomes during the pilot using a period starting with the calendar quarter of enrollment and concluding with the eighth full quarter thereafter (Q0-Q8), it is especially important to understand attrition levels over this time span. The total number of attritors over this period was twenty-eight. Seven participants died (three from control, four from treatment). Twenty-one participants chose to withdrawal (20 from the control group). All of the participants who were administratively terminated completed Q8. Consequently, total attrition over the Q0-Q8 period was 5.6%. The reduction in the size of the control group (10.0%) was considerably greater than for the treatment group (1.5%).

The substantially greater attrition from the control group is hardly surprising. After all, most participants volunteered in hope of getting access to the offset, even when they had no ability or intention to utilize it in the near future. Though many took advantage of benefits counseling and other services through the pilot, some received little or nothing from the project except monthly contacts for encounter data and annual surveys from the

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[248] A provider agency could refuse to work with a participant for cause. In such cases it was the responsibility of the SSDI-EP central office to find an agency to which the participant could transfer or to serve the participant directly. There were several such cases, all but one (which ended with a participant withdrawal) were resolved satisfactory. None of these cases constituted a removal from the project.

evaluators. Our limited information about the reasons participants withdrew is mainly from three sources: anonymous attrition surveys, unsolicited calls and letters from those who withdrew (or threatened to do so), and comments made by provider agency staff (both in our interviews and unsolicited).[249]

This input suggests that most early withdrawals reflected disappointment with not being assigned to the treatment group. Later withdrawals seem to be associated with a broader range of reasons, though most often the issue was one of a negative “benefit-cost ratio” from the participant’s perspective. This generally involved not getting enough from the pilot (usually services or a job) and/or being asked to do too much (providing information on a regular basis). Except for a concentration of withdrawals shortly after enrollment, withdrawals seem randomly distributed over both the Q0-Q8 period and through December 2008.[250]

Given that all except one of the voluntary withdrawers left the control group, it was important to learn how closely the attritors resembled participants who remained in the study. The comparison was made on a group of demographic and experiential characteristics. Of course, the small number of withdrawals meant that any but the largest of observed differences might be a product of chance. The two groups were similar in terms of their demographic characteristics. The largest difference was gender. About 57% of those who withdrew were female compared to only 43% for those who remained in the study. The primary experiential differences were in the area of employment. Although the withdrawers’ average quarterly earnings over the four quarters prior to pilot entry were only marginally higher than those of other participants, their median earnings were considerably greater ($523 per quarter compared to $59). This finding would appear to be consistent with the feedback that some withdrew because the pilot could not offer them much to improve their situation.

In addition to attrition from the pilot itself, a second type of participant “loss” had the potential to affect the quality of any comparison of outcomes between the two study assignment groups. While those in the treatment group more than seventy-two months past TWP completion could remain in the pilot, they would not be able to use the offset. While eleven members (4.1%) of the treatment group reached month seventy-two before the end of the Q0-Q8 period, this number is unlikely to have had a consequential impact. However, the proportion of such cases will grow over time and may need to be controlled for in any examination of outcomes over periods much longer than two years.[251]

All in all, we found no basis for concluding that participant attrition had a significantly negative impact on the pilot or on our ability to evaluate participant outcomes. However, there are other ways that participant dissatisfaction might manifest itself than through “voting with one’s feet.” Attrition is but one indicator of the pilot’s

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[249] Only a third of those who voluntarily withdrew returned attrition surveys, mostly in the first year or so of the pilot.

[250] The fall 2008 announcement that treatment group members who had not completed their TWP by the end of the year would be returned to regular rules did not generate any withdrawals.

[251] The proportion more than doubled by the end of 2008 to 9.4%. By that time the first entrants to the pilot had completed twelve post-enrollment quarters.

ability to involve or maintain contact with participants. We will look at other indicators later in this chapter.

C. Relationships among SSA, State Pilot, and Local Pilot Staff during Administration of the Intervention

The SSDI-EP, particularly after the design phase, involved ongoing interaction among multiple parties. Two classes of relationships were of particular importance. The first was that between the SSDI-EP central office housed at Pathways and those in the Social Security Administration national office with responsibilities for the offset. The second class was between the SSDI-EP central office and the approximate score of provider agencies that enrolled and served participants.

In an important sense, the SSDI-EP can be viewed as two separate communication networks with the pilot's central office serving as the bridge between the two. Both the SSA project officer and OCO staff chose to avoid direct interactions with the SSDI-EP's provider agencies. To the best of our knowledge, this practice simply reflected SSA's desire to work with all four offset pilots on consistent terms. Nonetheless, as indicated in the previous material focusing on earnings reporting, work reviews, and offset administration, this approach tended to slow the flow of information and the ability to identify and respond to errors.

Another important element of these relationships is that the three key parties were hardly unitary actors. This is obvious for the provider agencies. However, those at OCO who implemented the offset were not directly responsible to the project manager at Office of Program Development and Research. Operations and evaluation staff housed at Pathways had largely separate interactions with staff at the provider agencies.[252]

Lastly, it should be noted that the within state environment included multiple actors that had relationships with Pathways, the provider agencies, and consumers that will not be discussed in the following material. Among the most important of these were DVR, because of its central role in funding employment related services, DHS (external to OIE), because of its role in providing access to health care and long term supports, and local SSA staff. All three of these entities made some positive contribution to implementing the SSDI-EP. Particular credit should go to the Wisconsin AWIC due to his efforts to expedite resolution of overpayments and other participant problems and to insure that SSA field staff had sound information about the pilot.

1. The SSDI-EP central office and SSA

Relationships between overall project management at SSA and the central project office are best described as productive. Interactions tended to focus on relatively broad issues of management, policy, and evaluation. In general, the project manager treated input from the SSDI-EP seriously and, subject to SSA rules and resource limitations, was responsive to issues raised by the SSDI-EP and the other pilots. The project manager made it clear that he valued honest information and counsel from the

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[252] The evaluators had a strong interest in maintaining a separate identity in order to protect the independence of the evaluation. Some provider agency staff appeared to fully understand the separation between operations and research. Others never did, despite the evaluators efforts to stress independence in training and communications.

pilots and he conducted himself in the same spirit. He did not hedge or misrepresent. Instead he would straightforwardly identify when he could not speak to an issue. The project manager moved on to other duties in early 2009, his successors operated in the same spirit of cooperation.

Nonetheless, there were areas of friction, particularly just before the pilot began enrollment in 2005 and again in summer/fall 2008. What was most problematic in the relationship was SSA's tendency to make changes in pilot rules that had the effect of reducing the pilot's credibility with recruits, participants, and provider agencies. SSA announced its final change in the interpretation of the seventy-month rule essentially concurrent with provider agency staff training. Some at the pilot's central office felt that this final announcement significantly lessened provider agencies' trust in the pilot and of the pilot's potential value for their consumers. There had already been some concern over the gradual constriction of eligibility requirements, but now an important change had occurred after most of the provider agencies had committed to the project. Similarly, when SSA, during an August 2008 call with the four pilots, announced its plan to return treatment group members who had not completed a TWP by the end of the year to standard program rules, the primary concern was the loss of credibility rather than the potentially negative impacts of the change on some participants' future employment outcomes.[253] Those assigned to the treatment group had, through the informed consent materials they signed, been promised access to the offset whenever they completed their TWPs. Given existing distrust of SSA, there was concern that SSA's actions would make it less likely that affected individuals would engage in serious return to work activity in the future. A second set of concerns arose from Pathways' continuing efforts to encourage and support employment initiatives for persons with disabilities irrespective of SSA involvement. Credibility is an important resource for effective action when there are continuing transactions among stakeholders.

Most of the interactions between the SSDI-EP central office and OCO focused on the details of offset administration, including those involving the reporting and reconciliation of earnings, work reviews, as well as offset administration per se. In many cases, there was an exchange of information or notification of action regarding specific individuals. These interactions entailed some frustration due to the sheer time necessary to resolve issues, a condition exacerbated by the OCO staff rotation and the lack of a dedicated unit for offset administration until fairly late in the project. Moreover, through much of the project there were problems in making sure that pilot staff, both at the central office and provider agencies, had access to notices sent to participants. Both types of problems diminished as OCO instituted changes in staffing and procedures to build a more stable infrastructure for administering the pilots. However, these problems were never fully resolved.

Finally, it should be mentioned that the relationship between the SSDI-EP and SSA were supported by the mediation of third parties and/or the creation of informal groups, including both pilot and SSA staff, to work on specific problems. Of the former, the most important intermediary was the National Consortium for Health Systems

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[253] Nonetheless, both central and provider agency staff thought some treatment group members returned to old rules would be harmed, particularly those who had intentionally delayed TWP completion to get education or training before utilizing the offset or because of medical or family problems. However, not all shared this opinion. A few argued that by late 2008 almost anyone who had genuinely intended to use the offset had ample opportunity to have completed a TWP.

Development (NCHSD) which convened conference calls and occasional meetings. The NCHSD also aided the formation of specific multi-state work groups, including those focused on policy and operations and on evaluation issues. The four offset pilot directors also conferred regularly, both among themselves and with the SSA project officer.

2. The SSDI-EP central office and provider agencies

The "street level" operations of the SSDI-EP were conducted by twenty (initially twenty-one) provider agencies, all of which were organizationally independent of Pathways. Pathways could persuade, or contractually incent or sanction, but it was in no position to order. Thus one prerequisite of adequate implementation would be the quality of the relationships between the central office and these agencies. Provider agencies also played an important and ultimately voluntary role in the pilot's evaluation, as agency staff collected and submitted encounter data and facilitated other research tasks.

a. Central operations staff and provider agencies

The SSDI-EP's decentralized structure placed great importance on the capacity of the central operations staff at Pathways to create and fine tune the pilot's working procedures and to provide effective training, technical assistance, oversight, and troubleshooting. This last activity involved both helping provider agencies ameliorate deficiencies in their performance of pilot activities and responding to participant problems, especially those that required interaction with OCO. Earlier in this report, we discussed the general approaches and methods used by the operations staff in their work with provider agencies. These included formal training and technical assistance, responding to agency specific initiated requests for technical assistance and support, site visits/direct inquiries, and responding to agencies' periodic status reports. It also, de facto, included training and technical assistance through the WDBN, which was Pathways funded and in which some SSDI-EP central operations staff actively participated.[254]

To understand the typical relationship between central operations staff and provider agencies, it is important to know that in most cases the key (and often the only) staff member assigned to the pilot at a provider agency was a work incentive benefits counselor. In part this was because benefits counseling was the single mandatory service associated with the pilot. As the SSDI-EP did not directly fund either staffing or service provision, most provider agencies could only afford to assign one person to the pilot. This also reflected that a benefits counselor would generally have the skills needed to help a potential enrollee explore whether she was likely to benefit from participation. The central operations personnel, especially after the first year of the pilot, who interacted most with provider agency staff, were themselves experienced benefits

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[254] The WDBN (Wisconsin Disability Benefits Network) is an entity created to support the provision of benefits counseling. Its main activity has been in the areas of training and technical assistance, though it has become increasingly involved in standard setting and exploring how to perform quality assessment. It is a major reason that Wisconsin has substantial benefits counseling capacity beyond that provided through the SSA WIPA program.

As the SSDI-EP required new benefits counselors to be trained by the WDBN and strongly urged that experienced benefits counselors make use of WDBN resources, functionally the WDBN provided a significant addition to the pilot's training, TA, and performance monitoring regime.

counselors. As such, the “frontline” members of the central operations staff were fellow professionals and contract administrators at the same time. Our interviews with provider agency staff suggest that the operations staff were viewed more in the first role than in the second, a tendency that was reinforced by their role as necessary intermediaries between provider agency staff and OCO.

Provider agency staff, on the whole, greatly appreciated the availability of central operations staff for technical assistance and as intermediaries with OCO. In our 2006 interviews, agency staff indicated by a ten to one margin that their contacts with operations staff were very useful. No respondent offered a predominately negative assessment and most criticism centered on use of group settings, such as in-person meetings and conference calls, that were not specifically focused on their agency’s needs. Another indicator of the value staff put on these contacts is that agency staff reported being more than twice as likely to initiate contact with the central office as to wait to be contacted. Given that the SSDI-EP central office, especially during the first two years of the pilot, was itself proactive in scheduling meetings and site visits, the fact that agencies sought out additional contact and assistance speaks to the general strength and mutual utility of the central SSDI-EP/provider agency relationship.

This impression was strengthened by what benefits counselors told us in 2008.[255] By that time, about 80% of the benefits counselors we interviewed had substantial interactions with central operations staff about participant problems arising from one of the processes constituting offset administration. There was nearly uniform praise for the help operations staff provided, including in some cases that involving direct contact with participants. Though some respondents offered that central staff’s efforts were not always as effective as needed, the responsibility for what benefits counselors viewed as either inadequate resolution of issues or the lack of resolution in an acceptable time period was attributed to SSA, especially the process SSA had set up.[256]

Thus the overall relationship between provider agencies and central operations staff can be characterized as cordial and, more importantly, supportive of good implementation of the pilot. Nonetheless, there were exceptions to this pattern. Though relationships remained at least civil, civility or cordiality they did not always lead to effective performance of pilot responsibilities.

In particular, these exceptions involved two core issues. The first was maintenance of staffing needed to provide benefits counseling services. Though any provider agency could face a temporary diminishment of capacity due to illness, family needs, or attrition, a small number of agencies chose, for extended periods, to either not hire a new benefits counselor or to arrange for an external contractor to provide service.[257] A second problem, often correlated with the first, was that a small number of

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[255] In 2008 we limited staff interviews to those who were benefits counselors as we wanted to focus on issues related to the provision of benefits counseling and how problems arising from the use of the TWP or offset administration were handled.

[256] The benefits counselors, with few exceptions, would have preferred involvement by local SSA staff. Less frequently, benefits counselors would have liked the option of talking directly with OCO staff. Many, however, preferred that the pilot’s central staff make those contacts.

[257] The pilot greatly preferred that provider agencies had internal benefits counseling capacity as that facilitated communication for service coordination and data collection. The value of this

agencies were extremely slow to report information needed for work reviews or for earnings reporting and reconciliation. Though each case had its own evolution, key informants generally attributed difficulties to agency culture, especially an agency's lack of commitment to providing benefits counseling and/or encouraging the use of available work incentives and supports. In some cases, agencies backed away from their commitment to the pilot because of resource limitations that in its management's view required greater attention to traditional priorities.[258] In other cases, agencies did not seem to have developed a concrete interest in implementing the pilot or in providing benefits counseling. The concept of a benefit offset was attractive enough to get these agencies to "sign up" for the project, but not enough to generate faithful or consistent effort to implement the project well.

Given the lack of specific funding to support staffing should one be surprised that some provider agencies, whatever their original motivations for attaching themselves to the project, would back away from that commitment? Our response is that while the pilot did not provide direct funding to support benefits counseling, Pathways did. Moreover, this funding was offered readily as long as the agency would agree to hire or contract with a WDBN trained benefits counselor.[259] Therefore, we find little purchase to any claim that the benefits counseling requirement was an unfunded obligation.

Why then did the SSDI-EP tolerate a serious lack of performance at a handful of provider agencies? In part there was the not unreasonable hope that improvement was possible. Some provider agencies exhibited marked improvement in implementing the pilot after working with central project staff. Another factor was simply time and the uncertainty about when the active phase of the pilot would be completed. This issue will be taken up in section D of this chapter.

In any relationship, there is a balance of power, though formal authority, whether as in the case of the SSDI-EP chiefly contractual in nature or manifested in some other form, may sometimes obscure less formal sources and applications of power. One of the co-authors of this report was involved in an analysis of this issue in the context of several Pathways projects, one of which was the SSDI-EP. Those interviewed, some from Pathways, some from provider agencies and other external entities, agreed that Pathways held the dominant position. However there was less consistency in responses about the influence that can be exerted through implementation. In short, informants from provider agencies never offered that their role in implementing the pilot was at least a potential source of power. For the most part, other informants, whether or not from Pathways, were aware that provider agencies had made decisions that had both aided and impeded faithful implementation of the project. Still, as participant observers, our

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preference was confirmed throughout the pilot. Not only did the anticipated problems arise, but contracting out benefits counseling was associated with a higher percentage of participants getting no hours of benefits counseling over the Q0 through Q8 analysis period.

[258] Indeed this is the main reason the "twenty-first" provider agency ended its participation in the project. This agency acted responsibly, cooperating with the central office to transfer participants to another pilot agency, rather then leaving them in limbo.

[259] We are referring to the MIG funded OIE grant. Some provider agencies did not apply for the grant until rather late in the project. In one case an agency claimed it was unaware of the grant's existence.

view is that at more project sites than not, agency and central staff, despite differences in perspective and organizational needs, worked together to achieve credible implementation.[260]

b. Evaluation staff and provider agencies

There was also frequent contact between evaluation team members and provider agency staff throughout the pilot. Interactions were primarily in the context of data collection. Any staff member at a provider agency responsible for collecting encounter data was required to complete a two hour training session before being allowed to use the online data transfer system. In addition to instruction on using the data system, this training included information about the purpose of the evaluation, how data elements were defined, and, as long as participants could be enrolled, a substantial component about informed consent materials and the enrollment process. Subsequent contact focused on two issues, requests from provider agencies for technical assistance (most often clarification of research definitions and protocols) and inquiries by the evaluators to obtain missing data or to confirm or correct data that had been submitted. Provider agency staff was also asked to help arrange research activities such as participant focus groups and to participate in interviews.

With few exceptions, agency staff cooperated with the evaluation effort. Some made it clear that they or their participants thought the monthly data collection was too burdensome and/or that random assignment excluded too many consumers who would have benefited from having access to the offset. Nonetheless, most were aware that SSA was only willing to offer the offset in states committed to implementing an experimental design. Moreover, most of the direct funding provider agencies received for implementing the pilot was for research reporting.[261]

When asked whether they understood research protocols, every staff member interviewed claimed to have a good overall understanding. Still, about 40% conceded that there were details they did not understand. As those aspects of the evaluation that utilized encounter data were dependent on how well provider agency staff performed their research related duties, it is important to have a sense of the completeness and accuracy of the data they provided.

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[260] Delin, Barry S. and Anderson, Catherine A. 2008. “Experimentation and Collaboration to Enhance Employment for Persons with Disabilities: Assessing the Wisconsin Pathways Projects’ Efforts to Explore Systems Change. Los Angeles, CA: Association of Public Policy Analysis and Management annual conference. pp. 35-36.

[261] Provider agencies received $50 for processing an enrollment and for each pair of monthly case-noting and participant update forms it submitted. The main purpose of the payment was to compensate the agencies for the time spent contacting participants. Though payments were expected to more than cover that purpose, there was no expectation that any surplus would compensate provider agencies for any significant amount of services provided for participants.

Provider agencies could also receive direct SSDI-EP funding to compensate efforts to communicate with participants or to hold activities that would more fully involve participants in the project. This included some support for the evaluation effort, for example providing transportation to and refreshments at a participant focus group.

At most agencies, staff submitted encounter data on a reasonably prompt basis. Over the course of the pilot, 99% of encounter forms were submitted. This figure is exaggerated because it includes forms submitted in the context of a yearly data cleaning exercise that, among other functions, was intended to get agencies to send in forms that had not been previously submitted. Though not all participants responded to agency contacts for information, in each year only a few agencies had large numbers of missing forms. In most cases having significant numbers of missing reports reflected staff attrition or protracted absence. Most problems were resolved with a new hire or a return to work, though with some likely loss in data quality related to the passage of time and the limits of participants' memories. However, there were more serious problems at several provider agencies; generally ones that had protracted difficulties offering services and providing operations staff with needed information.

We are more concerned with data quality problems that occurred because of the inherent difficulty of applying data definitions, lack of care or attention in their application, or, possibly, deliberate decisions to ignore the definitions. One example of the first phenomenon would be that of a benefits counselor who had difficulty understanding which of two case-noting form categories to use to capture a range of "case management" services his agency provided. He asked a SSDI-EP operations staff member, instead of a member of the evaluation team for advice. The response he was given and which he faithfully followed thereafter was to assigned hours to the categories in a two to one ratio. Though this decision "spoiled" the data, the deeper significance was that the evaluation team would not have been able to have offered unambiguously better advice as the definitions overlapped considerably.[262]

Even when data definitions were clearer, there was no guarantee that they would be correctly used. Table V.6 provides evidence of one significant deficiency in agency staff application of encounter form instructions, one that appears to have been intentional in some cases. When a participant first reports a job, the staff member assigns the position to one of seven job classification categories. The categories are subject to some interpretation, but two of the categories have definitions that include clear educational requirements. To code a position as "professional" the expectation is that the job holder has at least a baccalaureate degree. Jobs assigned to the "technical/paraprofessional" category are expected to require at least a two year or technical degree.[263]

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[262] The further irony is that the definitions for these two data elements were written based on operations staff input. These definitions represented the most important change from the case-noting form categories used during SPI. We had wrongly assumed that the new definitions captured what operations staff viewed as a meaningful distinction.

[263] The definition does allow for equivalent on-the job-training.

Table V.6: Job Classification by Educational Attainment in Percentages, Selected Categories			
	Bachelors Degree or beyond	Completion of Vocational or Technical Training or Two Year Degree	All Other Educational Attainment
Professional	51.9%	25.9%	22.2%
Technical/paraprofessional	33.0%	36.0%	31.0%
Data Source: SSDI-EP Encounter Data Sample Size: 181 Professional Jobs=81 Technical/Paraprofessional Jobs=100 Note: Unit of analysis is relevant positions, not participants			

Almost half of the professional jobs reported were held by participants with less that a bachelor's degree and almost a third of technical/paraprofessional positions are held by those not having the expected educational qualification. It is not that exceptions occur that concerns us, but the sheer frequency of them for a population where there has been ongoing concern that educational achievement has not been rewarded by getting employment typically associated with that achievement.[264] At the least, the data in table V.6 suggests a lack of attention on the part of agency staff. Staff should have been aware of the definitions and of participants' educational attainment and thus prepared to ask clarifying questions.

However, reporting problems, such as implied by table V.6 can have other sources. In conversations, some agency staff conceded that they wanted to place the best possible face on a participant's progress, so when in doubt they chose to code a position "optimistically." This kind of practice appears to have affected data quality in some degree in other areas, most notably information about how jobs ended. Some agency staff indicated that they did not want to characterize job loses as terminations for cause. Though there is no evidence of outright dishonesty, staff admitted that they used a less pejorative category (resignation, temporary suspension) whenever there was the slightest evidence to support its use. Despite the evaluation team's efforts to describe how confidentiality was protected, there appears to have been residual concern that negative information would be shared with SSDI-EP central operations staff and SSA or would somehow later appear in the permanent records of state agencies such as DHS or DVR.

It also appears that quality problems with some of the encounter data stemmed from an operational expedient adopted at several provider agencies. Encounter data, especially for the participant update form, was supposed to be collected by staff who worked directly with the participant; that is, a staff member who provided benefits counseling and/or was involved in coordinating person centered employment services. Given a choice between having such staff spend time delivering professional services to pilot participants or other agency consumers or to make phone calls or send e-mails to

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[264] As educational attainment was measured at enrollment, it is likely that some participants increased their educational attainment during the pilot. However, there is no evidence suggesting that a significant proportion of participants did so. Moreover, the pilot took place in a time period where DVR had become extremely cautious about funding extended periods of post-secondary education.

gather research data, some agencies decided that it would be more cost effective to turn over data collection to clerical staff or interns.[265] When this expedient was used, data quality clearly suffered; one indicator was the increased number of calls that evaluation staff needed to make to correct evident errors on submitted forms. Unfortunately, not all errors were easy to detect.

We do not wish to exaggerate the gravity of these problems. The encounter data elements most vital to conducting impact analyses are those for common and generally straightforward demographic information such as age, gender, and education. There is no doubt that the demographic information collected at enrollment is accurate for almost all participants. Variables expressing employment related outcomes use or are derived from administrative data.

D. Pilot Phase-out

During an August 2008 conference call with the pilots, SSA indicated its intention to end of the "active phase" of the project before the end of the year. After a short period of consultation with the pilots as to how and when to do this, SSA announced its decision to return treatment group members who had not completed a TWP by year's end to regular SSDI program rules as of January 1, 2009.[266] Those in the treatment group, especially those who had not already qualified for offset use, would need to be notified. OCO would need to ascertain who in the treatment group had in fact completed TWPs by the cutoff date. Finally, though the pilots would need to ramp down their activities, there would still need to be adequate residual capacity to insure that individuals who were using the offset or would be qualified to do so in the future would have both the means and necessary support to submit earnings estimates, retrospective earnings reports, and whatever other documentation SSA might want. Additionally, there was no reason to think that delays or inaccuracies in offset users' checks and, as a consequence, overpayments would no longer occur. There would need to be continued capacity to address these problems too. Lastly, there would be a need to have a reliable means to identify when participants with continuing access to the offset would reach their seventy-second month. Without that, it would be difficult to inform former pilot participants soon enough so that they could take whatever actions would be consistent with their employment goals and personal situations.

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[265] In some cases these individuals did get research training so they would be able to directly enter data into the online system. Nonetheless, these individuals tended to misapply research definitions and protocols more often than benefits counselors or those providing employment services. We cannot speak to issues of motivation or capacity. What is clear is that these individuals, not really working with the participants they contacted, did not have a context in which to make sense of answers and to know when to ask a clarifying question.

[266] The fact there was an opportunity to provide suggestions to SSA does not mean that the SSDI-EP or any of the other pilots found the conditions under which the project would be concluded satisfactory. They did not. For Wisconsin, a particular concern was the lack of adequate time for those who in good faith had started a TWP but could not possibly complete it before SSA's proposed cutoff date. There was particular concern for treatment group members who had delayed TWP completion to undertake a course of education or vocational training that might lead to a well compensated job or career. For whatever reason(s), SSA made a small adjustment in the cutoff date, delaying it to December 31, 2008. However, the deadline would have needed to have been extended to at least mid-2009 to meet the SSDI-EP's concern.

Though SSA's decision to return treatment group members who had not completed the TWP to regular rules had been a surprise, the fact that the benefit offset pilots would conclude was not. With SSA's plans to initiate BOND, the SSDI-EP and the other pilots had already engaged in phase out planning as one of the deliverables (task 15) under their SSA contracts. In Wisconsin, the contracts offered to the provider agencies in spring 2008 identified March 31, 2009 as the pilot's likely end date. The accompanying materials indicated that SSDI-EP central staff would be working with provider agency staff to develop detailed plans for both phase-out and how to provide support for those who would continue to have access to the offset.

Wisconsin was in a fortunate position as its large Medicaid Infrastructure Grant would, at least through 2011, insure that provider agencies that maintained benefits counseling capacity could be paid for supporting those still eligible to use the offset. In fact, the MIG funded OIE grant for benefits counseling would allow provider agencies to continue serving many of their pilot participants, irrespective of study group assignment or continued offset eligibility.[267] Should a provider agency be unable or unwilling to provide follow-up support for those who remained offset eligible (including those who had moved out of the state), Pathways staff would provide needed benefits counseling services. Finally, Wisconsin's SSA AWIC volunteered to facilitate and monitor cooperation at SSA field offices. However, there could be no firm plans for 2012 or beyond.

SSDI-EP staff had greater concerns about how well the offset would be administered at SSA. It had taken three years to create a dedicated unit to administer the offset. SSA has not been willing to indicate precisely how long this unit would continue. (The "last" offset user from the pilots may not return to regular program rules until January 2015.) Though opinions, whether of pilot staff or other informants, are divided as to whether residual offset administration would be better handled if performed in Baltimore or at the field offices, all agreed that it is crucial to have a plan in place and communicated to affected participants while provider agency staff still have reasonably frequent contact with most of those in the treatment group.

At the time of writing this material (late 2009) it was still too early to assess how smoothly phase out has proceeded, though there was no indication at that time of pervasive problems. Affected participants were sent letters informing them of their situation. Reactions were muted. Most of the treatment group members who contacted the SSDI-EP central office after receiving notification about being returned to regular SSDI rules indicated they didn't remember being in the project. Participants who completed their TWP late in 2008 were in limbo for some months until OCO completed the necessary work CDR. There is no indication that these reviews, as a group, were

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[267] None of the MIG sourced OIE grant funds were earmarked for the SSDI-EP. Qualified entities or individual benefits counselors could apply for funding benefits counseling for specific individuals. SSDI-EP provider agencies were originally expected to seek OIE grant funding if another source for funding a pilot participant's benefits counseling services was not available. Gradually the OIE grant became the primary source for funding participants' benefits counseling services.

conducted more expeditiously than those conducted earlier in the pilot. Nonetheless, at the time of writing, OCO has completed its review of all known cases.[268]

Despite the relative infrequency of participant problems related to phase-out, it is too early to be confident that the future will be smooth. The last round of earnings reporting (that for 2008) took place when provider agencies had designated staff for the pilot. This will not be the case when those who remain offset eligible need to report their 2009 earnings early in 2010.[269] There are also unanswered questions as to how well the transition to regular program rules will go for the 118 treatment group participants returned to old rules. As already noted, both staff and participants themselves have expressed concern about how work activity performed during the pilot will affect future medical CDRs. These concerns will also apply, if anything with greater force, to those who used the offset and ultimately returned to regular SSDI program rules following their extended EPE.

E. Participants' experience with administration of intervention

Though the benefit offset pilots were intended, in part, to obtain information about participant outcomes, the pilots were never viewed as miniature versions of the Benefit Offset National Demonstration (BOND). The purpose of gathering outcome information was to inform BOND's design process, with potentially the additional benefit of providing information relevant to facilitating beneficiary use of any future statutory offset. Thus, it is important to examine how participants' viewed the project, preferably, when possible, through their own eyes.

During the offset pilots, SSA staff in Baltimore demonstrated a marked tendency to conflate inclusion in a treatment group with participation in a pilot. We think it fair to argue that for many at SSA the only value a control group had was to provide the basis for an unbiased comparison. Unlike the upcoming national demonstration where it would be possible to assign beneficiaries to either treatment or a control group from a sample identified from SSA records, those in the pilot treatment groups were volunteers and needed to be enrolled following an informed consent process.[270] Consequently, control groups had to be recruited and enrolled on the same voluntary basis prior to random assignment.

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[268] Unfortunately, (as of December 2009) one provider agency had still not provided information that would allow central pilot staff to determine whether there are participants at this agency who needed a work review to confirm TWP completion.

[269] In its response to our December 2009 draft report, SSA noted that there would be dedicated staff at OCO to work with these cases as long as any treatment group member remained eligible to use the offset. This is certainly desirable, but largely misses the point. Most participants place great value on being able to work with a benefits counselor they trust. Many are not comfortable working with local SSA staff for a variety of reasons identified elsewhere in this report. During the pilot, few, if any, had any personal contact with OCO personnel. If anything, it is reasonable to expect there would be even less comfort or trust working with a person where there would be no opportunity for face to face contact.

[270] Unless preliminary design decisions are revised, those assigned to BOND's primary control group will never be informed of their participation.

This provided the pilots with an opportunity to utilize the control group, as well as the treatment group, to investigate a range of issues pertaining to state specific efforts to facilitate employment for those with serious disabilities. Moreover, all four of the states where the offset pilots were sited were also Medicaid Infrastructure Grant (MIG) awardees and thus had an interest in what might be learned through the pilots that would be applicable to serving those enrolled in a Medicaid Buy-in and other employment support programs. For Wisconsin, where Pathways coordinated all MIG sponsored activities, there was a strong commitment to building a sustainable training and technical assistance capacity that would support the provision of benefits counseling, person centered planning, and other services through a decentralized system of private and public entities. Though the SSDI-EP was not part of MIG activities per se, the pilot's organization reflected the general infrastructure development approach being developed. Thus what could be learned about how all SSDI-EP participants viewed their experience in the offset pilot, not just those in the treatment group, might contribute to the improvement and sustainability of the more general employment support infrastructure being developed under MIG.

1. Public Program Usage during Pilot

Chapter IV included data about participant public program participation at enrollment. As a group, public benefit and service programs, other than SSDI, can make important contributions to return to work efforts. Thus changes in the proportions of participants in these programs can have implications for the likelihood that average levels of relevant outcomes such as employment rates, earnings, or the proportion of individuals with SGA earnings will change. Table V.7 provides information about the proportions of those in the SSDI-EP who had some span of participation in these health care and long term care programs during the period following pilot enrollment that is included in the longitudinal outcome analyses presented in chapter VI.

More than two-thirds of participants had some span of Medicaid coverage in the Q0-Q8 period, with just over half having some period of Medicaid Buy-in participation (i.e., over 70% of those with Medicaid coverage). This is important as the Buy-in is intended to serve as a work incentive, not merely an additional Medicaid eligibility category.[271] The DHS administered long term support programs are the most important source of funding services that can be important for maintaining employment such as personal assistance services (PAS) or supported employment services.[272] Relatively few pilot participants (8%) used those programs. Finally, by the end of Q8 all participants had been in SSDI long enough to qualify for Medicare and can be presumed to be enrolled in at least the Medicare "A" (hospitalization) component of the program.

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[271] The interaction between Buy-in participation, study group assignment, and employment outcomes is examined in chapter VI.

[272] Though other agencies, such as DVR, can fund such services for limited time periods, more or less permanent funding is dependent on participation in DHS administered programs, especially those authorized through Medicaid waivers.

Table V.7: Health and Long Term Support Program Usage, Anytime during Q0-Q8 Period

	Treatment	Control	Difference	All
Medicaid Buy-In				
Yes	53.0%	48.3%	4.7%	50.8%
No	47.0%	51.7%	-4.7%	49.2%
Medicaid				
Yes	71.1%	67.8%	3.3%	69.6%
No	28.9%	32.2%	-3.3%	30.4%
State Long Term Support Programs				
Yes	7.1%	9.6%	-2.5%	8.3%
No	92.9%	90.4%	2.5%	91.7%
Medicare A				
Yes	100.0%	100.0%	0.0%	100.0%
No	0.0%	0.0%	0.0%	0.0%

Data Source: DHS administrative records
Sample Size: 496, Treatment = 266, Control = 230
Notes: Medicaid includes Medicaid Buy-In participants. Long Term Care refers to participation in relevant Medicaid waiver programs or the state funded Community Options program. Medicare A eligibility based on Date of Initial Entitlement

Table V.7 also indicates there were only modest differences in health and long term program participation associated with study group assignment. Those in the treatment group had a nearly 5% greater participation rate in the Buy-in. By contrast those in the control group were a little more likely to participate in a long term support program. These differences are not large enough to denote significance, though it is possible that on the margins participants are choosing options based on expectations about programmatic restrictions on earnings. Both the Buy-in and the benefit offset are designed to be less restrictive of earnings and income than Medicaid waiver based long term care programs.

Information about baseline participation levels in these programs can be found in chapter IV (specifically tables IV.1 and IV.3). As the data in table V.7 are for an approximately two year period and those in the chapter IV tables are essentially in a “point in time” structure, the reader should be careful to not overestimate the differences. Nonetheless, the differences are meaningful as individuals with permanent disabilities tend to maintain eligibility for these programs for lengthy periods.

Between the calendar quarter of pilot entry and the end of the eighth quarter thereafter, the cumulative percentage of participants in Medicaid grew by nine percentage points. Growth in the cumulative participation rate in the Medicaid Buy-in was nineteen percentage points (from 32% to 51%) suggesting that an appreciable share of the increase can be attributed to movement from other Medicaid eligibility categories. By contrast, the proportion attached to long term support programs grew less than three percentage points (5.8% to 8.3%). This finding may reflect the distribution of primary impairments among pilot participants. It is likely that those enrolling had greater functional capacity and better health than those in the working age population involved in DHS administered long term support programs.[273]

One consequence of the small proportion of participants in long term care programs was that those programs would not be a significant source of funding for benefits counseling or other employment services. As already discussed, Pathways would serve as the primary source of benefits counseling funding because of the availability of MIG monies.[274] Provider agencies would have to fund other employment related services from different revenue streams. In some cases, a provider agency might simply absorb the cost of service provision. In our 2006 staff interviews every respondent who answered a question about this reported that at least on occasion their organization provided uncompensated services.[275]

It is no secret that the Wisconsin Division of Vocational Rehabilitation (DVR) is by far the most important funding source for services that will help those with serious disabilities return to work or to enter the competitive labor market for the first time. Both central office staff and those at provider agencies have reported that DVR appeared to have provided relatively little funding for employment services delivered or arranged through the provider agencies, in large part attributing problems to the Order of Selection Closures that were nearly continuous through the project. In focus groups, some participants expressed frustration and disappointment about the level of support received through DVR, though it is important to note that more participants praised the agency or their VR counselor than offered criticism. It may be useful to take another look at DVR's contribution to service provision even if it occurred largely outside the formal structure of the pilot.

Table V.7 provides information about participants' experience with DVR. Though the data do not allow us to clearly distinguish whether a participant started or continued a span of involvement with DVR in either the Q0-Q8 analysis period or between enrollment and December 31, 2008, about 55% of participant had at least one span of involvement during the 2003 to 2008 interval. Nonetheless, an active case does not always receive employment related services. Still it would seem reasonable to expect

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[273] Relevant data can be found in tables IV.1 and IV. 4. Relatively small proportions were reported as having established SSDI eligibility due to "mental retardation" (4%) or, by provider agency staff, as having a cognitive impairment (7%) as their primary disabling condition. Such individuals constitute a much larger proportion of working age adults served through the long term support programs. Additionally, though all pilot participants meet Social Security disability standards, they may, as a group, have greater capacity to perform activities of daily living than most consumers served by the long term support programs. The Order of Selection information in table IV.4 (where a higher proportion of participants are classified in the "significant" than in the "most significant" category) is suggestive of this possibility, as are the relatively high employment rates and mean earnings level that participants had in the year prior to project entry.

[274] MIG funding cannot not be used to provide direct services with the one exception of benefits counseling.

[275] These uncompensated services probably should be viewed as being compensated through the funding streams used to cover general overhead costs. If they were truly uncompensated it is unlikely that the average number of employment related service hours reported in the Q0-Q8 period (thirty-one) would have been almost four times greater than the average for benefits counseling (eight).

that a successfully closed case would involve some funding of such services. DVR records did allow us to identify the date of a successful closure.

Table V.7: Vocational Rehabilitation Program Usage, VR Successful Closures, and TWP Completion

	Treatment	Control	Difference	All
Active case 2003-08				
Yes	58.6%	51.7%	6.9%	55.4%
No	41.4%	48.3%	-6.9%	44.6%
Successful VR Closure, Q0-Q8				
Yes	31.2%	21.7%	9.5%	26.8%
No	68.8%	78.3%	-9.5%	73.2%
Successful VR Closure, Q0-12/31/08				
Yes	32.3%	25.2%	7.1%	29.0%
No	67.7%	74.8%	-7.1%	71.0%
TWP Completion by 12/31/08				
Yes	53.0%	48.7%	4.3%	51.0%
No	47.0%	51.3%	-4.3%	49.0%

Data Source: DVR and SSA administrative records
Sample Size: 496, Treatment = 266, Control = 230
Notes: In general, DVR data provided to the evaluation team did not support identifying precisely when participants were active clients and the pace they moved through the rehabilitation process. For some data elements, previous values were overwritten when information was updated. An important exception to this is the case closure date. Successful closures are denoted by case status codes 26 and 34.

About 27% of pilot participants achieved a successful closure at some point in their Q0-Q8 participation period; this increased to 29% if referenced to the end of the pilot's active phase. Additionally, the proportion of those in the treatment group having a successful closure in the first two years of pilot participation is almost 10% higher than in the control group. Much of this difference would be attributable to the larger proportion of treatment group members reported as active cases. Unfortunately, we cannot tell the extent this difference reflects post-enrollment behavior by the participants or possible favoritism by DVR staff members.

One might hypothesize that treatment group members seeking to take advantage of the opportunity the offset provided were more likely to pursue access to DVR services, more likely to use them effectively (i.e., to achieve a successful closure), or both. Two factors make us cautious about accepting this conclusion in the absence of better evidence. First and foremost, despite the higher successful closure rate there were no significant differences in employment between the treatment and control groups.[276] Though less compelling in isolation from the preceding information, provider agency staff indicated they observed no difference in the proportion of those in the treatment or control groups that received DVR services.[277]

Finally, it is important to note that by the end of the pilot's active period 51% of participants had completed a TWP, an increase of almost twenty-three percentage points relative to enrollment. This gain looks even more impressive given that only 3% of participants were within a TWP at enrollment.[278] The final TWP completion rate was somewhat higher for the treatment group (53.0%) than for the control group (48.7%), suggesting those who had potential access to the offset did see additional value in completing a TWP. Completion rates had been essentially equal at enrollment.

2. Participant Perceptions about Services

Earlier in this chapter, information was presented about service provision through the SSDI-EP provider agencies. Key points include that, on average, participants received relatively modest amounts of service, especially of the theoretical critical service of work incentive benefits counseling. In fact, substantial proportions of participants appear to have received no hours of benefits counseling (22%) or employment related services (51%) related to the pilot through their provider agency. Though it appears that those in the treatment group received somewhat more service, other factors seem more strongly associated with variation. We presume much of the variation reflected individual need or demand, but there were also very substantial inter-agency differences in service delivery patterns.

Unfortunately, we did not have a method for directly assessing service need or quality. However, one way of exploring these issues is to look at participant perceptions in this domain. On the two annual follow-up surveys we asked participants to indicate whether they thought they needed benefits counseling or some type of employment related service to benefit from the pilot and whether they received what they needed.[279] Readers should note that the same questions were asked for all participants. The context was not specifically that of access to the benefit offset, but of the SSDI-EP as a project intended to help all participants return to work. In addition to the survey data, some information about participants' perceptions of service delivery was obtained in focus groups held in 2007 and 2008.

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[276] Nonetheless, there were observed differences in when the treatment and control groups achieved the strongest outcomes relative to each other. The performance of the control group was stronger early on, the treatment group later in the Q0-Q8 period. Thus it is possible that differences in successful VR closure rates either contributed to or reflected these differences.

[277] We have already mentioned that provider agency staff also reported that they saw no indication of favoritism on the part of DVR counselors and that DVR staff did not seek information about who had been assigned to treatment and control.

[278] See table IV.3.

[279] Questions about expectations about service needs had not been asked on the survey completed at enrollment.

a. Benefits counseling services

One year following pilot entry, about two thirds of participants agree or strongly agree that they needed benefits counseling services. Those in the treatment group were slightly more likely to indicate having a need. Unexpectedly, about a fifth of participants indicated that access to benefits counseling was not particularly central to their progress. The results from the year two survey were very similar. The most important difference was a noticeable decline from 21% to 15% in the percentage of those who felt little or no need for the service.

Table V.8: Participant Perceptions about the Need for Benefits Counseling Services, One Year After Pilot Entry

To be able to use the SSDI-Employment Pilot, I need(ed) counseling to help me understand my benefits and what will happen to them when I work.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Treatment	42.7%	25.6%	11.8%	9.5%	10.4%
Control	36.0%	27.4%	14.3%	8.6%	13.7%
All	39.6%	26.4%	13.0%	9.1%	11.9%

Data Source: Year One Follow-Up Survey
Sample Size: 386 valid responses, Treatment = 211, Control = 175
Note: 22.2% of participants either had missing or invalid answers or failed to return a survey.

Tables V.9 and V.10 present information about how participants viewed the quality of the benefits counseling services they received. Responses were limited to those who claimed they received benefits counseling services.[280] In both survey periods almost two-thirds of respondents agreed that the benefits counseling received had met their needs. Nonetheless, more than a third indicated that the service they received did not, in any positive sense, meet their needs, with about 15% offering a clearly negative assessment.

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[280] Participant recall did not fully match encounter records. It is likely that some participants with zero hours reported on encounter forms were recalling either service prior to enrollment or an informal or general discussion of benefits or work incentives later. More puzzling were the cases who answered they had not received benefits counseling on the survey, but had hours of service reported through the monthly update forms. It is likely that in many cases the objectively false answers represent simple recall error. However, especially for those who received large amounts of services at multiple time points, we must consider the possibility that they conceptualized “benefits counseling” quite differently from project staff.

Table V.9: Participant Perceptions about the Value of Benefits Counseling Services, One Year After Pilot Entry

The benefits counseling I received as a part of the SSDI-Employment Pilot fit my needs.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Treatment	46.1%	26.7%	14.1%	4.2%	8.9%
Control	24.8%	32.0%	21.6%	13.7%	7.8%
All	36.6%	29.1%	17.4%	8.4%	8.4%

Data Source: Year One Follow-Up Survey
Sample Size: 344 valid responses, Treatment = 191, Control = 153
Note: 22.4% of participants either had missing or invalid answers for this question or did not return a survey. 8.3% of all participants answered they did not receive benefits counseling as part of the project. These cases were not included in this analysis.

There were not major differences between how those in the treatment and control groups perceived the value of benefits counseling delivered through the pilot. The most notable difference was within the control group, where opinions became somewhat more extreme over time. The proportion of control group members who strongly agreed that the benefits counseling services met their needs rose 25% to 32%. The proportion with the most negative assessment of quality increased from 8% to 14%.

Table V.10: Participant Perceptions about the Value of Benefits Counseling Services, Two Years After Pilot Entry

The benefits counseling I received as a part of the SSDI-Employment Pilot fit my needs.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Treatment	39.3%	31.2%	16.2%	6.9%	6.4%
Control	31.5%	23.1%	22.3%	9.2%	13.8%
All	36.0%	27.7%	18.8%	7.9%	9.6%

Data Source: Year Two Follow-Up Survey
Sample Size: 303 valid responses, Treatment = 173, Control = 130
Note: 32.4% of participants either had missing or invalid answers for this question or did not return a survey. 6.5% of all participants answered they did not receive benefits counseling as part of the project. These cases were not included in this analysis.

Assessments of service quality may also be related to the amounts of service received. Table V.11 exhibits a cross-tabulation of four ordinal categories of the amount of benefits counseling service delivery reported by provider agency staff and participant responses about the value of the service on the first annual follow-up survey.[281] As results from the year two survey were quite similar to those displayed in table V.11 we have not displayed them. Though it is possible for perceptions of service quality to change over time, they did not do so appreciably at the aggregate level.

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[281] The categories displayed in table V.11 are the same as used for the MANOVA analyses appearing in chapter VI. It is important to observe that a participant's inclusion in one of the service quantity categories reflects what was reported for the Q0-Q8 period, not what had been delivered by the time the survey was administered.

Table V.11 Categorical Amounts of Benefits Counseling Hours Provided by Provider Agencies Q0-Q8 by Participants' View of Benefits Counseling through the SSDI-EP, on Year One Survey

The Benefits Counseling I Received as part of the Pilot fit my needs.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
0 hours	27.4%	29.0%	16.1%	12.9%	14.5%
0.1 to 3.9 hours	36.7%	28.9%	22.2%	7.8%	4.4%
4.0 to 8.0 hours	37.5%	23.6%	18.1%	9.7%	11.1%
8.0+ hours	40.8%	32.5%	14.2%	5.8%	6.7%

Data Sources: SSDI-EP Encounter Data and Year One Follow-Up Survey Data
Sample Sizes: Total = 344, 0 Hours = 62, 0.1 to 3.9 Hours = 90, 4.0 to 8.0 = 72, Over 8 Hours = 120
Note: Participants who responded on the survey that they had not received benefits counseling as part of this pilot were excluded from this analysis.

The information in table V.11 is consistent with that in earlier tables suggesting that a large, but not overwhelming, proportion of participants felt the benefits counseling services they received were helpful. The data also supports an interpretation that those who received more service generally felt more positive about what they had received, though the differences are fairly modest. For example, 73% of those who received or ultimately would receive more than eight hours of service agreed their needs had been reasonably met. The comparable values for the other groups were lower. Indeed, those in the middle group (four to eight hours of service) were somewhat less satisfied with service received then those who received less than four hours of services.

The data for the group who received no benefits counseling after enrollment are inherently ambiguous; just what does it mean to assert that a service one did not receive fit one's needs? 56% of survey responses were positive. It is possible that some of these participants felt they had no particular need for benefits counseling. Perhaps some were satisfied with their employment and earnings at least for the moment and perceived no current need for the service. Perhaps some were making reference to benefits counseling received prior to enrollment. By contrast, it is probably easier to make a defensible inference about the nearly 30% among those who no reported benefits counseling who offered that they had not received benefits counseling that had met their needs. These answers suggest there was a considerable level of unmet need for benefits counseling, even though all pilot participants were suppose to have access to the service. Recall that about 35% of participants had no post entry benefits counseling by the end of Q2 of their participation or 22% by the end of Q8.

Lastly, we looked at differences in participant perceptions of benefits counseling quality in relation to provider agency size. Generally, provider agencies had only a single benefits counselor assigned to the pilot. Thus agencies with larger enrollments were less likely to meet the SSDI-EP's recommendation that there be a full time benefits specialist for every thirty participants. Table V.12 displays participants' perceptions about whether benefits counseling services met their needs based on the size of the agency in which they enrolled.

Table V.12: Participant Perceptions about the Value of Benefits Counseling Services by Provider Agency Size, One Year After Pilot Entry

The benefits counseling I received as part of the SSDI-EP fit my needs

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Smaller Agencies	44.8%	28.4%	15.5%	4.3%	6.9%
Larger Agencies	33.8%	29.6%	17.8%	9.9%	8.9%

Data Source: Year One Follow-Up Survey
Sample Sizes: 329 = Total, Smaller Agencies = 116, Larger Agencies= 213
Notes: Larger agencies were defined as having at least 25 participants enrolled. Two provider agencies serving 4.4% of participants were excluded from this analysis because of lacking the ability to provide benefits counseling over most of the study period.
Also excluded from this analysis were participants who did not return surveys, had missing or invalid answers to this question, or were among the 10.6% of participants who answered that they had not received benefits counseling as part of the pilot.

Though response patterns are strongly positive for both agency size categories, 11% more of the responses from the smaller agencies indicate strong agreement that benefits counseling services fit perceived needs. Differences between smaller and larger agencies were more modest in year two survey results (not shown), perhaps reflecting reduced service delivery during the later quarters.[282]

b. Employment related services

Provider agencies were not required to supply participants with employment related services. Instead the obligation was to make good faith efforts to arrange access and to identify funding sources. Agencies reported hours of employment related services for only about half of participants, with about 10% more treatment group members (54%) having reported hours than control group members (44%). Service hours were concentrated in the areas of assessment and case management, rather than in categories that captured activities specifically targeted to preparing, finding, or keeping a job. As noted elsewhere in this chapter, many participants probably received employment related services through DVR and other sources, though we lack detailed information about the types, quantity, or cost of these services.

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[282] 78% of all hours of benefits counseling services reported during the Q0-Q8 period had been delivered by the end of Q2. This value is computed from data in tables V.1 and V.2.

Table V.13: Participant Perceptions about the Need for Employment Related Services, One Year After Pilot Entry

To be able to use the SSDI-EP, I needed access to services to help me build my job skills and/or find a job

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Treatment	38.8%	19.6%	22.5%	5.7%	13.4%
Control	27.7%	20.2%	20.8%	8.7%	22.5%
All	33.8%	19.9%	21.7%	7.1%	17.5%

Data Source: Year One Follow-Up Survey
Sample Size: 382 valid responses, Treatment = 209, Control = 173
Note: 23.0% of participants either had missing or invalid answers for this question or failed to return a completed survey.

Unlike benefits counseling, where the response distributions for treatment and control group members were similar, after one year in the pilot those in treatment indicated a much stronger need for employment related services. The differences can be readily seen at both tails of the distribution. Those in the treatment group were 11% more likely to answer that they had a strong need for employment services. By contrast, 9% more of the control group responded that they strongly disagreed that they needed such services.

Nonetheless, when responding to an item about whether the employment services they received had met their needs, the distributions for the two groups (after excluding those who claimed to have received no employment related services) were actually fairly similar.[283] The percentage of positive responses (46%) was substantially higher than of negative responses (30%). This information can be found in table V.14.

Table V.14: Participant Perceptions about the Value of Employment Related Services, One Year After Pilot Entry

Yr1 Q8: The job-related services I received as a part of the SSDI-EP fit my needs.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Treatment	24.1%	25.3%	24.7%	10.8%	15.1%
Control	20.8%	20.0%	24.6%	15.4%	19.2%
All	22.6%	23.0%	24.7%	12.8%	16.9%

Data Source: Year One Follow-Up Survey
Sample Size: 296 valid responses, Treatment = 166, Control = 130
Note: 22.6% of participants either had missing or invalid answers or failed to return a survey. 17.7% of all participants answered they did not receive job-related services as part of the project. These participants are not included in this analysis

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[283] The relatively small proportion of respondents reporting getting no employment related services (18%) probably reflects the fact that there were sources of getting employment related services that would not have been captured in the encounter data. By contrast, it was highly unlikely that a participant would have received significant work incentive benefits counseling services outside the pilot (though there would have been alternative but generalized sources of benefits information).

Still, about 10% more of participants in the treatment group indicated that they agreed or strongly agreed that services had met their needs. About 10% more of those in the control group offered negative assessments. Unfortunately, we have no basis for determining whether the greater dissatisfaction among the control group only reflects their interactions with the provider agency or also signals problems accessing services from other sources.

Finally, given differences in the distributions of participant assessments of benefits counseling services related to provider agency size, we also looked at the differences in responses to the survey item: “The job-related services I received as part of the SSDI-EP fit my needs”. While respondents from the smaller provider agencies were slightly more likely to make a positive assessment (44% versus 40% at the larger agencies), the percentage who “strongly agreed” was more than twice as high among participants at smaller agencies (35%) as at larger agencies (16%). For whatever reasons, these differences were noticeably smaller in the year two survey results.

c. Additional feedback from participant focus groups

Two sets of focus groups provided an additional opportunity to obtain information about how participants viewed the services they received through the pilot.[284] Though it is unlikely that those who attended focus groups were representative of the participant sample, we learned more about the details of at least some participants’ experiences. Because provider agencies helped to recruit attendees, it is likely that these participants were somewhat more likely to have had been in ongoing contact with pilot staff than the typical participant. Based on attendees own comments, they were slightly more likely to have received benefits counseling services during the pilot, but much more likely to have received employment related services from some source.

Participants in the 2007 focus groups indicated that after there had been a written benefits review, the single most frequent reason for contacting their benefits counselor was to assess how their benefits would be impacted by changes in employment, both actual and potential. Though there was great concern with impacts on SSDI benefit amounts and eligibility and/or access to Medicaid related programs, discussions with benefits counselors also focused on how changes in employment or family situations would affect access to benefits for a wide range of federal, state, and local programs. Somewhat less frequently, focus group participants reported talking about the use of work incentives or seeking aid to resolve overpayments. It is important to note that in the 2007 focus groups, the issue of dealing with overpayments was reported about as often by control group members as those in the treatment group. Benefits counselors were also relied upon to as one person put it “…translate SSA’s letters into English.” However, one type of issue was only mentioned by those in the treatment group: completing earnings estimates and or complying with earnings reporting requirements. Participants felt it was important to have a benefits counselor’s assistance. Some participants viewed making estimates or reporting earnings as an inherently difficult task. Others said their difficulties were situational, for example making their living through multiple short term contracts or figuring out how to apply an IRWE or subsidy to the estimate.

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[284] Focus groups were held in both 2007 and 2008. Participation in the 2008 focus groups was restricted to treatment group members who had at least started a TWP.

When asked how well benefits counselors provided information, most focus group participants indicated that the benefits counselors did a satisfactory job. A common response was that the participant would usually be able to achieve a reasonable grasp of the material, but would not necessarily understand all the details. Many conceded that their understanding decreased as weeks and months went by, so review and reinforcement was important.

For the most part, those at the focus group felt that their benefits counselors were extremely good at responding to specific questions or tracking down needed information. It appeared that participants had greater difficulties making use of information describing contingencies and the likely implication of choices. Many focus group attendees made it clear that it was important that they be able to trust their benefits counselor as participants rarely had the capacity to immediately assess the quality of information or advice they had been given. Proof of performance would only become apparent with time, but in the meantime, in those cases where there wasn't yet a long relationship with a benefits counselor, attention and responsiveness provided a provisional basis for extending trust.

In the 2008 focus group the discussions of benefits counseling services were framed in a narrower context, use of the TWP, EPE, and of the offset provision. Attendees reported some difficulty understanding how the TWP and the EPE work and their reporting obligations to SSA. The range of issues discussed with benefits counselors was similar to that reported in 2007. However, resolving overpayments was an even more salient issue as were problems associated with offset use. Almost two-thirds of attendees who responded to a query about whether TWP or offset use had increased their personal need for benefits counseling answered yes. Not a single person answered that their level of need for the service had lessened. Unanimity is rare in any group, but virtually every participant at every one of the 2008 focus groups said that having good access to benefits counseling would be important if a benefit offset was ever implemented nationally. Many on their own initiative added that it would either be very important or absolutely necessary.

Participants at the 2007 focus groups provided information about the range of entities where they obtained employment related services in addition to or instead of the provider agency. Though the number of focus group participants was small, there was substantial diversity in the sources method, suggesting that a full list would be very long indeed.[285] However, a second impression was that there was a great deal of variation across the state in the availability of useful sources of information or services to facilitate return-to-work goals.

Not surprisingly DVR was the entity most often identified as a source of employment related services. As noted earlier, there was great variation in how well those attending focus groups thought they had been served. Nonetheless, responses were clearly more positive than negative. Moreover, participants tended to see variation resulting less from agency policy than from the sensibilities and performance of the DVR staff member a participant had worked with.

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[285] In addition to the usual suspects of community based rehabilitation organizations and public agencies, examples included Alcoholics Anonymous, Habitat for Humanity, various disability advocacy groups, MDs and other health personnel, technical colleges, libraries, and general community service organizations.

One thing that both DVR and the SSDI-EP were criticized for was not directly placing individuals into jobs. In fact, several focus group participants reported that they had been told that they would be given a job when they enrolled in the pilot. Although we cannot prove that a provider agency staff member never offered a guarantee of placement, we would be surprised if there was any truth to the claim. Nonetheless, the participants appeared to sincerely believe they had been promised employment. This speaks both to the necessity and difficulty of clearly explaining what a program or demonstration project offers.

3. Participant Satisfaction and Involvement

Among SSA's goals for the offset pilots was to learn whether study participants would remain involved with the project on an extended basis and what might be done to encourage that. While the second half of the question would be best approached by utilizing information from across the four pilots, a within pilot analysis still provides useful information about trends over time and differences between the treatment and control groups. Though it appears that those in the national demonstration project's primary control group will have no contact with demonstration staff, SSA plans for there to be smaller control groups for the purpose of assessing various combinations of service provision and access to a benefit offset. Thus, differences in the level of involvement with the pilots that are associated with study group assignment have some importance to SSA and those implementing BOND.

The information about attrition presented in section B of this chapter provides a useful starting point for examining these issues. Voluntary attrition was modest (4%) but almost entirely from the control group. However, this information indicates nothing about the relative level of involvement of those who remained in the project, especially those in the control group.

Most of the pertinent information we have comes from the surveys participants were asked to complete at enrollment and annually after the first two years of participation. Survey return rates are themselves indicators of the degree of participant involvement. Table V.15 exhibits return rates for each of the three waves of surveys.

Table V.15: Survey Return Rates: At Enrollment, for Year One Follow-up Survey, and Year Two Follow-up Survey

	At Enrollment	Year One	Difference, Yr1 - Enrollment	Year Two	Difference, Yr2 - Enrollment
Treatment	94.7%	81.9%	-12.8%	79.2%	-15.5%
Control	92.4%	82.4%	-10.0%	74.8%	-17.6%
All	93.5%	82.1%	-11.4%	77.3%	-16.2%

There clearly was some reduction in survey return rates over the three survey waves. The year two return rate was 16% lower than that for the baseline survey. Nonetheless, we consider the reduction modest, especially given differences in how the surveys were administered. Most of the baseline surveys were completed in the same session as other enrollment activities and were, with provider staff assistance, usually mailed to the evaluation team that day or the next. By contrast the follow-up surveys were mailed directly to participants, though, unlike the initial survey, participants were paid ($20) for a returned survey.

Additionally, differences in return rates between the treatment and control groups did not emerge until the second follow-up survey. As might be expected, the control group's return rate declined relative to the treatment group's rate as well as absolutely. Even so the difference remained modest; the control group's return rate of 75% was still less than 5% below that for the treatment group.

Satisfaction with a program is generally highly correlated with program involvement. Both follow-up surveys contained a question intended to elicit participants' overall level of satisfaction with SSDI-EP. These data are summarized in Table V.16. The most notable result is that the distribution of responses remains nearly constant across the two surveys. In both survey waves, the ratio of the satisfied to the dissatisfied is better that two and one-half to one.

However, the data indicates a somewhat higher level of dissatisfaction among participants in the control group. This is hardly surprising given that these participants had volunteered for the project mainly to have access to the offset. Even so, those in the control group were about 10% more likely to report being satisfied with their experience than dissatisfied. Indeed, the year two survey results suggest an increasing bifurcation in how control group members perceived their experience. The proportions in both the very dissatisfied and very satisfied groups increased, mirroring the results already presented as to whether the benefits counseling services received had met participants' needs.

Table V.16: Participant Satisfaction with the SSDI-EP, One and Two Years After Pilot Entry

Overall, how satisfied are you with your experience in the SSDI-EP?

	Very Satisfied	**Somewhat Satisfied**	**Neither Satisfied or Dissatisfied**	**Somewhat Dissatisfied**	**Strongly Dissatisfied**
Year One					
Treatment	38.8%	24.9%	22.0%	8.1%	6.2%
Control	14.8%	24.4%	34.1%	12.5%	14.2%
All	27.8%	24.7%	27.5%	10.1%	9.9%
Year Two					
Treatment	37.7%	27.2%	23.6%	5.2%	6.3%
Control	17.1%	23.3%	28.8%	13.7%	17.1%
All	28.8%	25.5%	25.8%	8.9%	11.0%

Data Source: Year One and Year Two Follow-Up Surveys
Sample Sizes: Year One = 385, Treatment = 209, Control = 176; Year Two = 337, Treatment =191, Control =146.
For year one 22.4% of participants did not return a survey or had missing or unusable responses to this question. For year two the comparable percentage is 32.1%

In addition to the questions about general satisfaction and whether pilot provided services had met participant's needs, the follow-up survey included one additional item intended to gauge the level of participant involvement. The SSDI-EP expected provider agency staff to be in contact with all the participants they worked with on a monthly basis. One reason for this obligation was to make sure that provider agencies would be able to collect and submit data for the monthly participant update form. Though this encounter data was available only to the evaluators, the monthly contacts were also meant to serve programmatic purposes. It would allow provider staff to check in with participants about possible changes in their situations that might suggest a need for benefits counseling, employment service planning, or the need to prepare documentation for SSA (e.g., earnings estimates, 821s and other forms for work reviews).

In interviews, about half of provider agency staff members reported at least occasional difficulties in keeping in touch with participants. Moreover, agency staff characterized the difficulties as more severe in the 2008 interviews than in the 2006 interviews. Though many staff members noted that there was a strongly positive association between the level of (perceived) trust participants had developed with a staff member and the regularity of contact, staff members, with few exceptions those interviewed said that they had faithfully attempted to make contact with any participant for which they had a current address, phone number, or e-mail.[286] Failure to maintain contact was usually characterized as a participant choice.

However, in focus groups, participants suggested that there was significant inter-agency variation in actual practice. In most focus groups, the majority of attendees confirmed that agency staff regularly initiated contact on roughly a monthly basis. However, a minority, enrolled at a subset of provider agencies, reported that agency staff contacted them on a very irregular basis and in some cases, regular contact occurred only because the participant initiated it. Of course, it is probable that most focus group participants were strongly attached to the project and thus might have been more motivated to seek out frequent contact with project staff. An item on the follow-up survey can be used to infer how pilot participants as a whole perceived how regularly agency staff checked in on their situations.

Tables V.17 and V.18 exhibit distributions of participant responses to the statement: “Staff from the agency where I enrolled in the SSDI-EP talks to me on a regular basis about my job-related activities”*.* Table V.17 displays data for the first annual follow-up survey, table V.18 for the year two survey. Though the differences in response patterns are minor, we display both years as the passage of time can often be strongly related to decreased involvement in a research study.

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[286] Several of those interviewed indicated that they refrained from monthly contact when participants explicitly said that they did not want to be contacted that often. Only one interviewee indicated that he attempted to infer participants’ tolerance for contact from past interactions.

Table V.17: Regularity of Contact between Provider Agency Staff and Participants, One Year after Pilot Entry

Staff from the agency where I enrolled in the SSDI-EP talks to me on a regular basis about my job-related activities.

	Strongly Agree	Agree	Neither Agree of Disagree	Disagree	Strongly Disagree
Treatment	41.2%	18.0%	10.4%	13.3%	17.1%
Control	29.7%	21.7%	10.9%	15.4%	22.3%
All	36.0%	19.7%	10.6%	14.2%	19.4%

Data Source: Year One Follow-Up Survey
Sample Size: 386 Treatment =211 Control =175
Note: 22.2% of participants did not return a survey or had missing or unusable responses to this question

Table V.18: Regularity of Contact between Provider Agency Staff and Participants, Two Years after Pilot Entry

Staff from the agency where I enrolled in the SSDI-EP talks to me on a regular basis about my job-related activities.

	Strongly Agree	Agree	Neither Agree of Disagree	Disagree	Strongly Disagree
Treatment	41.7%	21.9%	11.2%	8.0%	17.1%
Control	34.9%	22.6%	10.3%	15.1%	17.1%
All	38.7%	22.2%	10.8%	11.1%	17.1%

Data Source: Year Two Follow-Up Survey
Sample Size: 333. Treatment =187 Control = 146
Note: 32.9% of participants did not return a survey or had missing or unusable responses to this question

In both years, only a slight majority of surveyed participants agreed that agency staff had been in contact with them on a regular basis. About a quarter of participants disagreed with the statement at both time points. Interestingly, the distribution was slightly more positive for the second time period. It is possible that agency efforts in this area increased as there was less delivery of benefits counseling services in the later years of the pilot. It is just as possible that participants who continued to complete the survey in year two “oversampled” those participants who remained committed to the project.

However, in both survey waves there were evident differences between the study groups. Those in the control group were much less likely to report regular contact. For example, in the first year follow-up surveys, 8% fewer control group members than treatment group members provided an answer suggesting regular contact. By contrast, 7% more in the control group indicated disagreement with the statement that there had been regular contact. It is not clear to what extent these differences reflected intentional behavior by provider agency staff.

Certainly, there was a program related factor that would provide a strong incentive to make additional efforts to contact treatment group members. OCO required information from treatment group members not required from those in the control group:

earnings estimates, annual earnings reports, and forms required to complete work CDRs. Problems arising from offset usage no doubt motivated additional contacts. Given these stimuli, the differences between the control group and treatment group distributions can be characterized as marginal.

As we had seen some differences in participant perceptions of service delivery that were to the advantage of smaller agencies (especially in the year one survey results), we were curious whether lower staff to participant ratios would also be associated with participant perceptions of whether there had been regular contact with agency staff. The answer is no. For the first follow-up survey the response distributions are essentially the same; 58% in both study groups indicated that there had been regular contact. The year two results told the same story, though the proportion of those enrolled at larger agencies who strongly agreed that there was regular contact was 6% higher than at the smaller agencies.

Another indicator of participant involvement is whether the monthly participant update forms were submitted on a timely basis. Provider agencies had a strong incentive to submit these forms as it was the only regular direct source of financial support for the SSDI-EP. Though payment would be the same no matter how late a pair of forms were submitted, the evaluators favored submission in the month following the events reported on to reduce the likelihood of recall error. Beginning in fall 2006, an item was added to the form so that provider agency staff could clearly indicate that they had been unable to contact a participant and, consequently, the required information on the update form.

We examined the frequency which agencies submitted forms using the “could not contact” option in each of the full calendar years it was available. The option was used on 11.7% of forms in 2007 and 14.9% in 2008.[287] More importantly, there was a substantial difference in each year in how often the “could not contact” option was used related to study group assignment. In 2007, 9.4% of the forms from the treatment group used the option. By comparison, the 2007 rate for the control group was 14.5%. Though the 2008 rate for the treatment group increased to 10.8%, the rate for the control group ballooned to 20%.

This information suggests a less sanguine assessment of how well the pilot retained participant involvement toward the end of the project, especially for those in the control group. Still, in the post-pilot environment this may matter little. Continued involvement and contact is a far more important issue for those members of the treatment group who can still make use of the offset rules for some time to come.

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[287] On the surface, these rates would suggest massive loss of encounter data, especially about participant employment and employment characteristics not available through Unemployment Insurance data. Two factors reduce the scope of these problems, without eliminating them completely. First, the evaluators conducted yearly data cleaning exercises that resulted in provider agency staff contacting participants for missing information. Though, the vast majority of missing forms were ultimately completed, the price was data more likely to be negatively affected by recall error. A second “compensating” factor was that the primary analysis period was limited to the end of the eighth calendar quarter after the enrollment quarter. For many participants, some or all of the 2008 data was from a period after their individual Q8.

4. Participant Perceptions about SSA and Offset Administration

Pilot participants entered the SSDI-EP having some experience with Social Security Administration operations whether performed by SSA or its agents such as a Disability Determination Service. All pilot participants had undergone an eligibility determination process at least once, many had subsequently gone through medical CDRs. Many also had experience with work reviews; almost 30% had completed a TWP by the time they had entered the SSDI-EP. From focus groups we leaned that some participants had experienced overpayments and other difficulties using SSDI before entering the pilot.

It is widely believed that work activity and outcomes for SSDI beneficiaries and other persons with disabilities who use any public program for income support, health care, or other services, are diminished because of fears of eligibility loss and/or reduction in benefit levels. While the main thrust of the piloted SSDI benefit offset was to remove the objective barrier of facing a 100% marginal tax rate on SSDI benefits when monthly earnings reached SGA, SSA also hoped that the pilots would reduce fears about the negative consequences of work activity. This was to be accomplished both explicitly and indirectly. Suspension of medical CDRs for those in the treatment group represents an explicit feature aimed at reducing beneficiary fears. However, it is also likely that SSA hoped that detailed information about the terms and conditions of participation communicated in the recruitment and enrollment processes would at least provisionally assuage fears. Still, experience matters. Nothing would reduce fears more than if those in the treatment group were able to use the offset to increase their earnings without losing income or program eligibility or experiencing collateral problems stemming from participation in the pilot, including offset administration in the strictest sense.[288]

In Wisconsin, Pathways hoped that all pilot participants would feel somewhat greater comfort increasing their work activity. The primary mechanism for accomplishing this would be benefits counseling; though increased access to a person centered employment planning process was also expected to help. Nonetheless, the expectation was that in combination a good experience with offset use and program services would more effectively address participant concerns than services alone.

This section of chapter V is divided into two parts. The first looks at the issue of whether participation in the SSDI-EP had a favorable influence on participant fears about loss or reduction of SSDI and associated health care benefits. The second section concentrates more directly on the experiences of those in the treatment group with the offset and associated processes such as work CDRs.

a. Fear of Benefit Reduction or Loss of Eligibility

In all three participant surveys, respondents were asked a series of questions aimed at eliciting their level of concern about potential policy and situational barriers to

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[288] SSA initiated the pilots on the stipulation that no harm would occur to participants, with participants primarily understood as those assigned to the treatment group. It appears that "harm" was conceptualized as loss of the opportunity to use a TWP (and benefiting from the 0% marginal tax rate on benefits for those nine months) or losing SSDI eligibility. At that time it appears that no thought was given to adverse consequences that might arise from offset administration or delays attendant to OCO taking on the task of conducting work reviews.

employment or increasing earnings. Six of the items were intended to elicit participants' level of concern about loss or reductions of SSDI benefits or of access to Medicare or Medicaid. These items were combined into a single "fear of benefits loss" index that is used in the impact analyses presented in chapter VI. In this material we limit the presentation to descriptive results for three of the six items.

Table V.19 displays survey results for an item that directly focuses on the main promise of the benefit offset: that one can benefit economically from work once earnings rise above SGA. Readers should note that we have reversed the ordering of column categories on this and the following two tables. The "strongly disagree" category is now on the left. This is done as the category represents the "most desirable" condition from the perspective of both SSA and the SSDI-EP. That is, the participants who "strongly disagree" with these survey items are indicating the least fear of negative consequences to their benefits from work activity.

Table V.19: Treatment and Control Group Perceptions about Benefit Loss or Reduction, Work Resulting in Income Loss, at Enrollment and One and Two Years after Enrollment

If I work for pay, it will be hard to earn enough money to make up for lost Social Security Benefits.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Not Sure**
Baseline						
Treatment	9.0%	7.8%	18.0%	17.1%	35.5%	12.7%
Control	9.3%	10.3%	15.9%	16.8%	39.3%	8.4%
Year One						
Treatment	9.4%	11.3%	14.6%	14.6%	41.3%	8.9%
Control	11.1%	2.2%	8.3%	14.4%	56.7%	7.2%
Year Two						
Treatment	6.3%	8.5%	20.6%	16.4%	40.2%	7.9%
Control	10.9%	6.1%	12.2%	12.9%	53.1%	4.8%

Data Source: SSDI-EP participant surveys.
Sample Sizes: *Baseline* = 459, Treatment = 245, Control =214. *Year One* = 393, Treatment = 213, Control = 180. *Year Two* = 336, Treatment = 189, Control = 147.

The key findings from table V.19 are that the fear that increasing earnings will result in overall income loss is not only strong at pilot entry, but did not change a great deal over the next two years.[289] At every time period, majorities in both the treatment and control groups indicate agreement or strong agreement with the proposition that it is hard to earn enough to make up for lost benefits. The most positive thing that can be said is that the proportion of those in the treatment group with substantial concerns remained pretty much the same across the three time periods, while concern increased considerably in the control group (56% in the "agree" and "strongly agree" categories at baseline, 71% and 66% in the subsequent years).

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[289] Careful readers will note that control group responses consistently indicate slightly higher levels of fear than those for treatment. It is very likely that some surveys, against protocol, were completed after participants learned the results of random assignment. We have no basis for directly identifying such surveys, but note that over 10% of surveys reached the evaluation team ten days or more after the enrollment date. Thus we infer that at least some participants answered baseline survey questions knowing their assignment.

At the SSDI-EP central office and Pathways more generally, an ongoing concern was the possibility that work, especially that which resulted in SGA earnings, might result in some participants losing or facing serious difficulty in retaining eligibility for SSDI benefits or those that depended on having an allowance. Table V.20 shows results for one of two survey items intended to assess the level of participant concern about this issue. Survey results from the time of enrollment suggest considerable concern with 49% of those in the treatment group and 55% in the control group offering responses suggesting substantial concerns.

Table V.20: Treatment and Control Group Perceptions about Benefit Loss or Reduction, Work Triggering Eligibility Reviews, at Enrollment and One and Two Years after Enrollment

I worry that working for pay will trigger a review of my eligibility for my Social Security benefits

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Sure
Baseline						
Treatment	13.5%	10.2%	19.6%	14.7%	34.3%	7.8%
Control	13.6%	10.3%	14.6%	20.2%	35.2%	6.1%
Year One						
Treatment	14.6%	12.3%	10.4%	16.5%	38.2%	8.0%
Control	12.2%	4.4%	12.8%	14.4%	48.9%	7.2%
Year Two						
Treatment	12.2%	11.1%	19.0%	18.0%	31.7%	7.9%
Control	18.4%	7.5%	10.9%	15.0%	44.9%	3.4%

Data Source: SSDI-EP participant surveys
Sample Sizes: *Baseline* = 458, Treatment = 245, Control =213. *Year One* = 392, Treatment = 212, Control = 180. *Year Two* = 336, Treatment = 189, Control = 147.

The overall pattern is one where the level of concern starts high and stays high. Again, it is arguable that the treatment group more or less remains at the level of fear it had at the time of random assignment. The proportion of responses in the control group associated with strong fears are at least 5% higher in the out years than at baseline, though the case for actual growth in fear levels is less clear than for the previous item focused on income loss.

The final table in this group of three (V.21) displays responses to a survey item about the potential loss of Medicare or Medicaid eligibility because of employment. Many persons with disabilities have reported that access to health care and long term support programs is more vital to them than continued participation in income support programs like SSDI. Yet, objectively, fear about eligibility loss for federally funded health care programs should be relatively modest for those in the SSDI-EP, irrespective of study assignment. The Ticket to Work Act provides for attachment to Medicare for almost a decade for former SSDI beneficiaries who work. While most categories of Medicaid eligibility involve tight financial limits, the Medicaid Buy-in provides an option that should allow most individuals earning more than SGA to retain Medicaid eligibility indefinitely. Over 50% of SSDI-EP participants have been in the Buy-in.

Table V.21: Treatment and Control Group Perceptions about Benefit Loss or Reduction, Work Triggering Loss of Health Care Eligibility, at Enrollment and One and Two Years after Enrollment

I worry I will not be eligible for Medicare or Medicaid (Medical Assistance) if I'm working.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Not Sure**
Baseline						
Treatment	13.1%	7.3%	13.1%	18.4%	42.0%	6.1%
Control	10.3%	10.8%	12.2%	13.1%	47.4%	6.1%
Year One						
Treatment	15.5%	8.9%	13.6%	15.0%	43.7%	3.3%
Control	11.7%	8.3%	8.9%	11.1%	54.4%	5.6%
Year Two						
Treatment	10.0%	10.6%	17.5%	15.9%	37.6%	8.5%
Control	11.7%	12.4%	7.6%	15.2%	48.3%	4.8%

Data Source: SSDI-EP participant surveys.
Sample Sizes: *Baseline* = 458, Treatment = 245, Control =213. *Year One* = 393, Treatment = 213, Control = 180. *Year Two* = 334, Treatment = 189, Control = 145.

If anything, the level of fear about loss of public health care benefits through work activity is greater at baseline than for the items more directly focused on SSDI benefits. More than 60% of both study groups agreed or strongly agreed with the survey item. This finding is consistent with reports that many with severe disabilities place more importance on maintaining access to health care than on retaining income support. Once again, the proportion of responses indicating substantial fear increases after enrollment in the control group, though a smidgen less compared to the preceding two items. The trend for the treatment group is more salutary. The percentage of "high concern' answers declines over 6% relative to the percentage at enrollment. Still, on the year two surveys a majority of those in the treatment group believe that engaging in work activity poses a significant risk of losing health care benefits.

Lastly, we checked what focus groups attendees had said about their concerns about how work activity might affect benefits loss and whether their remarks were consistent with survey results. Though we did not ask questions specifically about this topic during either the 2007 or 2008 focus groups, participants raised the issue both in the context of questions about benefits counseling and during the open-ended discussions at the conclusion of every focus group. Many participants at the 2007 events mentioned having very significant concerns about the possibility of losing benefits because of work activities, closely paralleling those found in the survey responses. In particular, there was a high level of fear about the negative implications of increased earnings on the ability to retain eligibility for public health care programs.

A secondary, but still important, theme raise by the 2007 focus group participants was concerns about the ability or willingness of SSA staff to respond to requests for information or to be responsive to circumstances that might impact benefit levels or eligibility. Some attendees claimed that local SSA staff often gave them inaccurate information, but more frequently concerns were raised about SSA's ability to maintain accurate records. These problems were said to have, at minimum, resulted in the inconvenience of needing to resubmit paperwork but had also led in some cases to serious problems such as overpayments, suspension of benefits, or unwarranted notices of termination. Multiple participants cited cases where SSA staff loss records submitted for either confirmation of TWP month usage or work reviews. Thus, some participants feared that poor record keeping rather than work activity itself might threaten continued eligibility or receipt of one's full benefit long after the pilot had ended.[290]

These concerns about SSA's long term capacity to maintain records and thereby avert future harm to pilot participants were even more salient at the 2008 focus groups. However this time the remarks arose out of a context of negative experiences attributed to participating in the treatment group, whether from use of the benefit offset or related to the work CDR that preceded its use.

b. Experience preparing for or using the benefit offset

For much of the pilot, both central office operations staff and every agency based benefits counselor we interviewed reported that every single offset user had experienced a problem using the offset. Sometimes, the issue was delay. Sometime the issue was the accuracy of the payment. Overpayments were frequent and there were multiple reports of offset users oscillating between overpayments and underpayments. Even experienced benefits counselors reported finding it difficult to understand OCO's calculations. By mid 2009, pilot staff rephrased their assessment, saying almost all, rather than literally all, offset users had experienced problems. Though SSA has never provided a public estimate of the frequency of problems in offset administration, multiple staff members in Baltimore have acknowledged the serious nature of the problems and the need to address them prior to implementing BOND.

However, how did participants experience this situation? On both of the follow-up surveys, those in the treatment group were asked to report whether there had been a problem with their SSDI checks, including its accuracy or getting it on schedule.[291] The results from the year two follow-up survey are shown in table V.22. We have chosen to present the later data as it is probable that a higher proportion of the fifty-five known offset users had actually initiated their first use of the provision by the time they completed the second follow-up survey.[292] [293] It is important to note that problems with SSDI checks are not exclusive to offset users. Thus the differences in the pattern of reports between offset users and others in the treatment group should give an indication of the incidence of additional problems beyond "background" levels that resulted from offset use. In this case the background rate is for a group of beneficiaries much more likely to be employed and to be using or having completed TWP compared with the overall SSDI beneficiary population.

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[290] No 2007 focus group participant specifically mentioned loss of a record related to getting an offset payment. The concerns were directed at SSA generally, without any clear distinction being made between local offices and OCO in Baltimore.

[291] This item was the only difference between the versions of the follow-up surveys sent to the treatment and control group members. All participants were given the same baseline survey.

[292] One indicator that not all known offset users had used the offset by the time of the second follow-up survey was that almost 16% of respondents claimed there had not been a problem simply because there had been no need to change the benefit amount.

[293] It is also possible that some had not used the offset feature for some protracted period, thus increasing the probability of recall error.

Table V.22: Reports of Problems with Treatment Group Members SSDI Checks, by Percentage of Incidence, from the Year Two Follow-up Survey

Have you had any problems with your SSDI benefit check? (Respondent can check multiple categories)

	Offset Users	Other Treatment	All Treatment
No problems, there should not have been any changes to the SSDI check	15.6%	59.1%	48.4%
No problems, changes were made accurately and on time	20.0%	29.9%	27.5%
Problem, check amount was inaccurate.	11.1%	0.7%	3.3%
Problem, check was delayed or did not resume on time	13.3%	2.2%	4.9%
Other problems	17.8%	6.6%	9.3%
Multiple Problems	22.2%	1.5%	6.6%
All reports with no problems	35.6%	89.0%	75.9%
All reports with problems	64.4%	11.0%	24.1%

Source: SSDI-EP participant follow-up survey
Sample: Number of Reports = 182 From offset users = 45 From others =137
Note: Offset users include all known offset users. It is not known how many had used the offset by the time of survey completion

The most striking difference between the reports from offset users and other treatment group members is in the overall incidence of problems. Almost 65% of offset users who responded to this item reported problems, about a fifth reported two or more different types of problems. Treatment group members who never used the offset were only about one sixth as likely to report a problem. The percentage of non-offset users reporting problems (11%) was not dissimilar to that from the year one follow-up survey (15%). By contrast there was a marked increase in the proportion of those who were or would become offset users reporting problems from that in the year one survey (46%). We think it unlikely this increase reflects a disintegration in OCO's performance, especially as pilot staff generally indicated that OCO's performance gradually improved as specific SSA staff were assigned pilot cases and, ultimately, the designated unit was formed. More likely, the roughly 40% growth in the incidence of survey reported problems reflects an increase in the number of offset users.

We were at first surprised by the relatively low rate of offset user reports of inaccurate or delayed checks (11% and 13% respectively), but soon found that this was explained by the 22% of respondents who checked multiple categories. In most cases this was the combination of having delays as well as inaccurate checks. When the “other” category was used, the respondent was asked to describe the problem. In many cases the problem described could have easily fit into either the “delay” or “inaccuracy” categories, but the respondent apparently wished to provide more detailed information. Other respondents used the category to talk about other issues of SSA performance and/or pilot administration including CDRs, earnings estimates, processing of IRWEs and subsidies, problems understanding SSA communications, and poor treatment, including failure to reply to phone calls and letters, failure to follow through on promised actions, and outright discourtesy by SSA staff.

Still, even the year two data is inconsistent with the common assertion at both Pathways and the provider agencies that virtually everyone who used the offset experienced a late or inaccurate check. What might explain the differences in perception? We have already raised two possibilities: some of our group of fifty-five known offset users probably did not start using the offset until after they had completed the second follow-up survey and the greater probability of recall error as time passed. Based on feedback from the 2008 focus groups, there is another possibility. The stress and economic harm attendant to check delays and error vary with participants circumstances. Those who thought they had suffered harm because of a perceived SSA error, remember the incident vividly. Moreover, in a focus group, the reports of one participant can prompt the memories of others. Indeed, focus group attendees who had used the offset reported exactly the same rate of problems as reported by provider agency staff, that is, 100%.

It should also be noted that staff perceptions about the issues and delays involved with work reviews and completion of TWP were collaborated by attendees at the 2008 focus groups. About three-fifths of focus group attendees indicated that did not understand the TWP well, with 39% indicating they had little or no understanding of that work incentive. Yet those in the treatment group were aware that successfully completing the TWP and the work CDR that followed were the gateway to offset use. As such, they found the challenges and delays in getting TWP completion confirmed vexing. Yet it is instructive that most of those who had or sought to complete their TWP after entering the pilot stated that their main interest was having a good job with decent earnings. The opportunity to use the offset was, at most, a secondary motivation.

5. Characteristics Associated with Participant Jobs

The SSDI-EP was intended to see whether access to a benefit offset and services such as benefits counseling and person centered planning had the potential to improve employment outcomes. Though analysis of program impacts on employment, earnings, the likelihood or earnings, and beneficiary income are presented in chapter VI, we think it useful to prepare for discussion of these analyses by providing descriptive information about the characteristics of the jobs participants held.

In general the material will look at the characteristics of participant jobs “en masse,” only seeking to identify differences between the treatment and control groups. While it would be a desirable result if the “quality” of jobs that participants took, whether defined in terms of inflation adjusted hourly earnings, benefits, or, most importantly, career advancement, had increased during their time in the pilot, our initial analysis at the aggregate level showed little or no improvement over the pilot’s limited time span.

For the most part, data presented in this section was collected by provider agency staff at enrollment and on a monthly basis through the participant update form. As already noted, we have some concern about the overall quality of the data, but think that efforts to follow-up on evident shortcomings resulted in the data being adequate for giving a general picture of the types of jobs participants held, why those jobs ended, and, particularly, of any differences between those in treatment and control groups.[294]

a. Job classification, health benefits, and employer characteristics

Whenever provider agency staff identified a new job, the staff member was asked to classify the position into one of several categories. These categories were intended to capture differences in the level of responsibility, function, or typical education or preparation associated with a given job category. In particular, there was interest in finding out whether those in the treatment group would have greater access to the types of positions usually requiring significant education, training, or experience. Though the data could be looked at for different periods relative to pilot enrollment, the current analysis looks at all reported jobs. These data are presented In table V.23. Readers are alerted that percentages in this table and most of those that follow are calculated based on the number of unduplicated jobs, not the number of participants.

Table V.23: Job Classifications of Positions Held by Participants, Enrollment through December 2008

	Treatment	**Control**	**All**
Job Classifications			
Executive/managerial/ administrative	2.3%	4.8%	3.4%
Professional	11.3%	9.8%	10.6%
Secretarial/clerical	15.7%	14.5%	15.2%
Technical/paraprofessional	13.6%	12.1%	13.0%
Skilled Craft	3.8%	3.6%	3.7%
Service Maintenance	51.4%	54.9%	53.0%
Unable to classify	1.9%	0.3%	1.2%

Data Source: SSDI-EP Encounter Data
Sample Sizes: 763 reports, Treatment=426, Control=337
Note: Percentages reflect proportions of jobs held by participants, not the percentage of participants holding such jobs.

Overall differences between treatment and control appear modest and almost certainly the result of chance. A majority of positions are in the service maintenance category which generally involve little training or experience and tend to be low paying. These data seem generally consistent with the conventional wisdom that persons with disabilities are largely employed in positions involving less responsibility, skill, and compensation than the general population. Two thirds of participants had more than a high school education at enrollment, 23% at least a baccalaureate degree.[295]

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[294] The job characteristics variables reported (job classification, heath insurance, industry, sector, and reasons for jobs ending) had their origins in SPI and were used with only minor modifications. The original intent had been to facilitate linking SPI and SSDI-EP encounter data.

[295] See table IV.2.

Benefits are an important aspect of job quality. For many people, the single most important job benefit is access to health insurance. Moreover, health insurance availability and quality are strongly correlated, even when employment is full time, with higher paying positions or the career ladders that lead to such jobs. While few pilot participants were ever without access to some form of public health insurance, good private insurance could provide useful wrap-around coverage, facilitate departure from the Social Security rolls, and, thus, from a governmental perspective, reduce expenditures. However, the proportion of participant jobs that included health care coverage was only 11.4% (12.4% for treatment group members, 10.1% for those in control). We have no useful information about the proportions of participants who actually had private coverage or about the quality of that coverage. Nonetheless, the 11.4% represents an upper bound, the real number with coverage is almost certainly somewhat less.[296] Thus, it is unlikely, at least in the current environment, that beneficiaries motivated to work are likely to obtain positions with health insurance, let alone insurance that meets an often heighten level of service needs and cost.

The next table, V.24, displays information about the industries in which most participant jobs were concentrated (roughly 70%). Jobs tend to be concentrated in expected categories such as human services, health care and hospitality. Most of these jobs are relatively low skill (service maintenance) but we lack sufficient information as to the degree these positions in these industries meet the “food, filth, and folding” stereotype. The “other” category includes enough jobs in transportation, agriculture, and financial services as to have suggested that these categories should have been coding options, though none would have included more than 5% of participant jobs. Again, there appears to be no meaningful differences between the distributions for those in the treatment and control groups.

Table V.24: Most Frequently Reported Industry Categories for Positions Held by Participants, Enrollment through December 2008

	Treatment	**Control**	**All**
Industry Type			
Human Services	20.0%	22.0%	20.8%
Retail Sales	16.0%	15.1%	15.1%
Other	11.7%	10.7%	11.3%
Health Care	8.0%	9.8%	8.8%
Hospitality (Food only)	8.0%	7.7%	7.9%
Government (not Education)	5.9%	7.1%	6.4%

Data Source: SSDI-EP Encounter Data
Sample Sizes: 763 reports, Treatment=426, Control=337
Note: Percentages reflect proportions of jobs held by participants, not the percentage of participants holding such jobs.

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[296] It is likely that many who were eligible for coverage could not afford to take it. Those who could have would have had to consider whether their primary health needs would have been classified as excluded pre-existing conditions.

Table V.25 displays information about whether positions were in organizations located within the for-profit, non-profit, or government sectors of the economy. Self-employment/participant ownership was set up as a separate category.[297]

Table V.25: Economic Sector of Positions Held by Participants, Enrollment through December 2008

	Treatment	**Control**	**All**
Sector			
Private non-profit	21.6%	25.8%	23.5%
For-profit business	62.4%	56.1%	59.6%
Participant owned	5.2%	5.0%	5.1%
Government	10.9%	13.1%	11.8%

Data Source: SSDI-EP Encounter Data
Sample Sizes: 763 reports, Treatment=426, Control=337
Note: Percentages reflect proportions of jobs held by participants, not the percentage of participants holding such jobs.

The treatment and control groups exhibit similar patterns. Treatment group members appear to have a slightly higher proportion of jobs in the for-profit sector. Those in the control group have a slightly higher proportion of jobs in the non-profit and government sectors. The proportion of jobs that were identified as involving “self-employment” was basically the same for the treatment and control groups. We will provide additional information about self-employment later in this chapter.

b. Job changes

Staff at provider agencies was asked to provide a reason every time a job ended or there was an interruption in employment or a significant (20%) change in monthly work hours. Table V.26 displays the most frequently reported reasons for job changes when a participant was already employed. Changes are not always negative. Available categories included promotions or major changes in job duties at an existing employer and resignations in order to take a new and, hopefully better, position at another employer. Unfortunately reports of these types of changes were quite infrequent. Moving into a new position at the same employer constituted less than 2% of reported changes. Resigning to take a new position with another employer was more common, amounting to almost 7% of reported job changes.

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[297] These positions cannot be assumed to be “for profit,” several were classified as non-profit.

Table V.26: Most Frequently Reported "Job Changes" for Positions Held by Participants, Enrollment through December 2008			
	Treatment	**Control**	**All**
Reason for Job Change			
Increases in Hours (not disability or health related)	21.4%	15.2%	18.9%
Decreases in Hours (not disability or health related)	16.8%	14.1%	15.7%
Resignation – didn't start new job or keep second job	11.7%	17.1%	13.8%
Conclusion of temporary job	11.3%	12.5%	11.7%
Decreases in Hours (not disability or health related)	8.8%	10.0%	9.3%
Termination	8.1%	10.0%	8.9%
All changes associated with "permanent" job loss	36.2%	43.4%	39.1%
Data Source: SSDI-EP Encounter Data Sample Sizes: 935 reports, Treatment=566, Control=369 Note: Percentages reflect proportions of jobs held by participants, not the percentage of participants holding such jobs.			

Though the overall patterns for those in the treatment and control groups are similar, there are some differences. Both the percentage of jobs ending in either a resignation without a new job and the percentage ending with a termination were a little higher for the control group. These differences are then reflected in the total of proportion of changes referring to permanent job loss (that is not involving temporary layoffs, medical leaves, etc.). For the control group the proportion of such reports (43.4%) was about seven percentage points higher than for the treatment group (36.2%). Another salient difference was the larger number of job changes associated with being in the treatment group (2.1 per participant) compared to being in the control group (1.6). It is possible this indicates greater job churning in the treatment group, though it could also result from staff engaging in more intensive tracking of these participants because of the requirements of offset administration.

In addition to reporting information about the reasons for job changes, agency staff was asked to supply additional information for those cases where a job change resulted in the participant no longer having employment.[298] Table V.27 presents the most frequent reasons for non-employment after jobs had ended and participants had not reported having other employment. Again, there are few differences between the distributions for the treatment and control groups, with the largest differences related to medical or impairment related job losses.

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[298] Interruptions in employment such as temporary layoffs or medical leaves were not treated as denoting an end of employment until there was a later report of permanent separation from a job. Similarly, a participant was not viewed as entering "non-employment" status if there was a known or expected start date for a new position.

Table V.27: Most Frequently Reported "Reasons for Non-Employment" following Reported Job Endings Without New Employment Reported, Enrollment through December 2008

	Treatment	Control	All
Reason for Job Change			
Worsening of Disability, Hospitalization or Other Health Problems	20.1%	15.6%	17.1%
Problems with Job Demands	20.6%	20.1%	20.4%
Problems with Supervisors or Co-workers	6.5%	6.5%	6.5%
Temporary Job Ended	29.7%	26.6%	28.3%
Other	15.1%	21.9%	18.2%
Employer ceased operations, moved, or reduced size of operations	7.0%	4.7%	6.0%

Data Source: SSDI-EP Encounter Data
Sample Sizes: 368 reports, Treatment=199, Control=169
Note: Percentages reflect proportions of reasons given for non-employment following a job loss.

For both study groups, the most common reason for moving from employment to non-employment status was the end of a temporary job. This category included nearly 30% of all reports. This finding is important as it suggests a lower bound for the proportion of employed participants working in temporary positions rather than putatively permanent ones. While this reflects an important labor market trend for the entire workforce, it also raises the issue of whether participants had access to jobs likely to be compatible with career development. Other circumstances most frequently associated with moving from employment to non-employment status were problems related to job performance (problems with job demands, supervisors, and co-workers) and, as already noted, the worsening of a disabling condition or other health related problem.

c. Other job relevant information

Many in the labor market view self-employment as an attractive option. There is no reason to think that those with serious disability are markedly different and, in some cases, self-employment may be advantageous in the sense of mitigating transportation difficulties, allowing more flexible scheduling, and avoiding possible discrimination. The Pathways Projects, especially in the context of MIG, has made substantial efforts to facilitate greater use of the self-employment option.

Nonetheless, relatively few pilot participants were self employed, with no discernable differences between the treatment and control groups. There was, however, a little growth in the percentage of participants reporting self-employment over the primary Q0-Q8 analysis period. In the enrollment quarter 4.6% reported self-employment. By the conclusion of the analysis period 6.0% reported being self-employed.

In thinking about employment of those with serious disabilities, it is important to remember that the disabling condition remains a potentially huge barrier to employment or improving employment outcomes. Though SSDI-EP participants, even before entering the pilot, were much more likely to be employed or to have completed a TWP than the overall population of adult SSDI only beneficiaries, every single one had met the stringent definition of disability that permits SSDI eligibility.[299] The information in table V. 28 confirms that a majority of participants see their disability and/or health problems as a serious impediment to work effort and that these perceptions did not change appreciably over time.

Table V. 28: Treatment and Control Group Perceptions about the Impact of Disability and Health Problems on Ability to Work, at Enrollment and One and Two Years after Enrollment

I am limited in my ability to work because of my disability or health problems.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Sure
Baseline						
Treatment	8.6%	5.7%	23.7%	17.1%	42.4%	2.4%
Control	6.5%	6.1%	18.7%	17.8%	48.1%	2.8%
Year One						
Treatment	8.0%	4.7%	16.0%	20.7%	48.4%	2.3%
Control	7.8%	4.4%	12.2%	13.9%	60.6%	1.1%
Year Two						
Treatment	6.3%	8.4%	15.7%	22.0%	47.1%	0.5%
Control	8.9%	7.5%	14.4%	18.5%	47.9%	2.7%

Data Source: SSDI-EP Participant Surveys
Sample Sizes: *Baseline* = 459, Treatment = 245, Control =214. *Year One* = 393, Treatment = 213, Control = 180. *Year Two* = 337, Treatment = 191, Control = 146.

Table V. 29 displays information about how participants viewed their general health status at different time points. Despite the information presented in table V.28, a majority of those entering the study, whether assigned to treatment or control, rated their recent health status as good or better. Though the general pattern of these results continues after enrollment, there is growth in the proportions reporting poor or very poor health. This is particularly striking in the control group where the proportions reporting poor health more than double in the follow-up surveys. We do not know whether this is a chance result or whether there was something about the experience of being in the

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[299] At the November 2009 Association for Public Policy Analysis and Management annual research conference, Gina Livermore and Su Liu of Mathematica Policy Research, Inc. each made presentations about the work related behavior of SSDI beneficiaries. Livermore's presentation was titled "SSI and DI Beneficiaries with Work Goals and Expectations." Liu's was titled "Cohort Trends in Employment and Use of Work Incentives in the Social Security Disability Insurance Program." Their separate work was presented in draft form and awaits publication.

We particularly look forward to the publication of Dr. Livermore's research. It appears that there is an employment motivated segment in the beneficiary population which have employment related characteristics quite similar to those of the SSDI-EP sample. It will be interesting to learn whether their demographic, experiential, and program use characteristics are also similar. If so, it would give greater purchase as to the broader applicability of our findings.

treatment group that facilitated better health and/or encouraged members to see and/or report themselves as having better health.

Table V. 29: Treatment and Control Group Perceptions about Health in Recent Weeks, at Enrollment and One and Two Years after Enrollment

Overall, how would you rate your health during the past 4 weeks?

	Excellent	**Very Good**	**Good**	**Fair**	**Poor**	**Very Poor**
Baseline						
Treatment	6.2%	18.3%	32.8%	30.7%	11.6%	0.4%
Control	4.4%	20.9%	31.6%	33.0%	9.2%	1.0%
Year One						
Treatment	4.3%	17.1%	30.3%	28.4%	14.7%	5.2%
Control	9.1%	10.9%	20.0%	34.9%	20.0%	5.1%
Year Two						
Treatment	6.0%	16.4%	25.7%	31.1%	15.3%	5.5%
Control	8.9%	8.2%	21.2%	37.7%	21.9%	2.1%

Data Source: Baseline, Year One, and Year Two Follow-Up Surveys.
Sample Sizes: *Baseline* = 447, Treatment = 241, Control =206. *Year One* = 386, Treatment = 211, Control = 175. *Year Two* = 329, Treatment = 183, Control = 146.

In any case, it does seem reasonable to think that those who feel they are in better health would be more willing to pursue better employment outcomes and to agree to enter a project to pursue such goals. The data provide a sobering reminder that many disabilities are cyclical or can worsen and can result in reductions in the capacity to work. Indeed, descriptive data presented in the next chapter show that employment outcomes for those in the control grow were better than those for treatment group members in the first quarters following enrollment (though the overall trends were not significantly different). Differences in health status may have played a role in motivating this finding.

F. What Worked Well (Pilot and Offset Administration)

It is rare that pilot projects work perfectly. After all, the purpose of a pilot is to undertake and assess the novel. The SSDI-EP's implementation represents a mixture of reasonable success, considerable failure, and, most often, conditions somewhere between the two. Though we would characterize the overall implementation quality of the pilot as mixed, including many aspects under at least the nominal authority of the SSDI-EP central office at Pathways, we would argue that overall implementation was "good enough" to say that something approximating the project's intent actually took place. This is important, as it is a necessary condition for identifying and applying lessons learned through either practitioners' observations and reflections upon events or the through the more formal methods of process and impact evaluation.

Surely, one major accomplishment was creating and operating the project. This is especially true as Pathways had no direct capacity to recruit, enroll, or serve eligible beneficiaries on a statewide basis nor the resources to create the internal capacity to do so. It had to recruit and gain the cooperation of a network of autonomous community agencies. Fortunately, Pathways had several resources that helped to make this possible. The prospect of access to a SSDI benefit offset was attractive enough to interest partners. Pathways, through SPI and various MIG endeavors, had established working relationships with a significant number of potential partners who might decide to join the project as “provider agencies.” Within Pathways and the technical assistance entities it had helped to establish (especially WBDN), there was sufficient and experienced staff to aid in the ongoing implementation of the project. Finally, due to the OIE grant funded through the Medicaid Infrastructure Grant, Pathways maintained the ability to fund, exclusively if necessary, the core service the Wisconsin pilot would offer: work incentive benefits counseling. In our judgment, these resources were used skillfully enough to organize the project in less than a year and to operate it with reasonable fidelity for more than three years.

The SSDI-EP also proved quite responsive in helping provider agencies deal with unanticipated challenges arising from offset administration and/or the conduct of work reviews, especially related to TWP completion. This success is principally to the credit of the pilot operations staff members who were highly experienced benefits counselors. They served as critical intermediaries between OCO, the provider agencies, and often participants. Though problems could rarely be prevented, they could be managed and mitigated. This was done with considerable success as well as creating procedures to inform OCO of upcoming events (e.g., the need to conduct a work review) that probably served to prevent some problems from happening.

G. What Didn’t Work Well (Pilot and Offset Administration)

There were problems and shortcomings in implementing pilot activities at both SSA and in Wisconsin. Though to some extent intertwined, we will look at problems at SSA, particularly OCO first.

As mentioned ad nauseam, many observers believe that OCO did not administer any beneficiary’s use of the benefit offset without there being a problem. Participant feedback confirms the basic, if not necessarily the absolute, accuracy of this assertion. So too did SSA, when it chose to return treatment group members who had not completed their TWP before the start of 2009 to regular program rules - ignoring what participants had been promised at enrollment. Perhaps SSA was wise to renege on the commitment, as it is possible that for most of these participants it will allow SSA to fulfill its commitment to do no harm. Somewhat unexpectedly, there were also significant problems and delays in conducting work reviews for treatment group members at OCO. Though there are often problems related to work reviews conducted by SSA field offices, having them performed by OCO staff said to be inexperienced in conducting such reviews appears to have compounded the problems. So too did factors such as not having OCO staff specifically trained for and assigned to offset administration or a structure to coordinate their activities for much of the pilots’ durations. These problems were compounded by rapid rotation of staff and apparent deficiencies in SSA data systems that required manual tracking and check calculation. Finally, the content and tone of SSA communications to those in the treatment group also compounded problems. Though it is clear that SSA was concerned that communications meet legal requirements, it is unfortunate that SSA was largely unwilling to use input from SSDI-EP staff and those of the other offset pilots to improve those materials.

Though none of these problems were fully rectified by late 2009, SSDI-EP staff thought that OCO’s performance had improved over time. Indeed, pilot staff, key informants, and even participants expressed concern about the possible dismantling of the modest infrastructure SSA had created for the pilots. These concerns include expectations of an increase in the incidence of problems associated with offset use and that treatment group members returned to standard program rules, especially after offset use, will face problems during future medical CDRs.

Another aspect of the SSDI-EP that did not go well was the design and implementation of earning estimates. Both SSA and the SSDI-EP bear some responsibility for the difficulties that treatment group members and provider agency staff had in completing them. Though the SSDI-EP tried to respond quickly to problems with the forms as they were identified, in retrospect it is probable that more should have been done to pre-test the forms. However, the deeper problem was the SSA decision to use earnings estimates to implement the offset. It is likely that some system of retrospective reporting would have been better.[300]

In our view, it is likely that the most important shortcoming in Wisconsin's implementation of the "intervention" was the variation in the amount and quality (at least from the participants' perspective) of work incentive benefits counseling. This happened despite the considerable attention placed on training, technical assistance, and having funding available for the service. Though as will be indicated in chapter VI even relatively small number of hours of benefits counseling were associated with positive employment outcomes, survey data suggests that many participants did not get the services they felt they needed. The most severe problems were concentrated at a small group of provider agencies, though high staff to participant ratios may have contributed to problems at some of the larger provider agencies. It is unclear what additional steps operations staff could have taken. However, as some on the operations staff have noted, there is a pressing need to have a method for assessing benefits counseling quality, a task that WDBN and Pathways, among others, are currently working on.

From an evaluation standpoint, we are concerned about the quality of encounter data. Though the deficiencies we reported will not compromise the impact evaluation (which utilizes UI data), they do affect the quality of some descriptive analyses of employment dynamics. Our training and technical assistance should have placed more emphasis on data interpretation issues, perhaps through working through concrete examples, and on research ethics as it touched on data reporting. We would also have looked for better ways to encourage prompt data submission; the payment system used had no disincentive for late reporting.

H. Lessons Learned for Informing BOND or Future SSA Policy (Pilot and Offset Administration)

It is our understanding that SSA has learned a great deal from the offset pilots about how to administer a benefit offset. Our understanding is that SSA has delayed start up until it has an automatic data system capable of tracking information and making payments. This is good start, but SSA should also consider the need for an adequate human infrastructure to process work reviews, especially at the conclusion of TWP. Even if SSA approaches perfection in calculating offset check amounts, delays in work

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[300] A number of informants have suggested something like the annual retrospective system used for early Social Security retirees who return to the workforce before full retirement age as a useful model.

reviews will inevitably mean delays in applying the offset and make overpayments more likely. Indeed, should Congress amend the Social Security Act to authorize a SSDI benefit offset, problems with conducting work CDRs are likely to become a major barrier to its effective use.[301]

Second, what we heard from staff and participants suggest that high quality benefits counseling needs to be available to everyone in BOND or, for that matter, for anyone with eligibility to use a statutory offset, should one ever become available. At the start of the pilot we would have recommended these as a precondition for informed decision making. Given the range of substantive problems we've observed, we now believe that benefits counseling is a necessary condition for avoiding inadvertent harm. Even if all of the problems in offset administration, narrowly construed, observed during the pilot were corrected and no new ones arose, we would still argue that those undergoing work reviews (or making earnings estimates) will usually need help. This is hardly an original suggestion. It has been made by the management and operations staff of all four offset pilots.

However, our analysis of SSDI-EP operations has demonstrated to us that it can be difficult to insure quality delivery of benefits counseling services, especially when one contracts for rather than directly controls service provision. We do not know the extent or manner in which BOND will provide benefits counseling services. To the extent that the entity implementing the demonstration contracts with local providers or decides to expand existing WIPA capacity, there will be a need to effectively tackle the issue of providing high quality service across multiple locations and over an extended length of time.

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[301] Some observers argue that the TWP as it now stands should be eliminated and replaced by something akin to the 1619 options associated with the SSI program. We take no position on the desirability of doing so.

SECTION THREE: IMPACTS OF BENEFIT OFFSET ON BENEFICIARY BEHAVIOR

The focus of section three is on participant outcomes, particularly reporting estimates of net impacts. It is important to understand that these findings are from one relatively small study and do not, by themselves, settle the issue of whether a SSDI benefit offset is effective in motivating increases in employment related outcomes. Besides its modest size, the SSDI-EP recruited a participant sample that was not representative of the adult beneficiary population. As documented in chapter III, the pilot sample had much higher rates of employment, mean earnings, and TWP completion when they entered the pilot than typical SSDI beneficiaries and these higher levels of employment outcomes persisted as far back as we have data. Participant outcomes may, in part, reflect the distinctive structure of the Wisconsin pilot and the problems that arose in administering the intervention, especially at the SSA Office of Central Operations. Finally, no assessment of impacts can be made without remembering that both program staff and treatment group members understood that access to the intervention was temporary. Treatment group members would be eventually returned to regular program rules and, thus, face the possibility that offset use might suggest to a DDS adjudicator that they no longer met the SSDI program's definition of disability.

In this section, we address five broad questions that are of interest to Pathways and its stakeholders in Wisconsin. Our expectation is that the answers are also pertinent to SSA's needs for information about pilot impacts, though the questions may not be framed quite as SSA might prefer. Though, these questions are of national interest, the material presented in chapter VI is necessarily limited to the context of the benefit offset pilot implemented in Wisconsin.

- What were the effects of study group assignment (treatment vs. control) and thus, the availability of the offset, on employment rates, earnings, the probability of working at the substantial gainful activity (SGA) level, and individual income?
- What characteristics of treatment group members and benefit offset users appear to influence an increase in employment related outcomes?
- What aspects of the experience of being a treatment group member or a benefit offset user influenced the levels of employment related outcomes achieved?
- What services or supports, other than a benefit offset, aided participants in their efforts to improve their employment related outcomes?
- What do these findings tell us about what changes to policy or programs may be useful for promoting work for SSDI beneficiaries (or others with serious disabilities)?

As elsewhere in this report we have attempted to take into consideration the differing interests and needs of two audiences. The first is SSA and those it will entrust with the design and operation of BOND. The second audience is Pathways, the network of entities involved in the SSDI-EP, and other Wisconsin based stakeholders concerned with issues of disability and employment. Of course, both SSA and Wisconsin stakeholders have a primary interest in whether the benefit offset proved effective. Yet even on this point there are differences in emphasis. SSA seems to be most focused on impacts at the population level that might lower SSA costs. Perhaps it was assumed that increases in earnings and other employment outcomes would automatically be reflected in beneficiaries' economic welfare. By contrast, staff at Pathways and those working at the state and community entities the Pathways staff interacts with have long observed that programs and work incentives intended to encourage greater earnings can, in some circumstances, have negative effects on actual income (or program eligibility). In order to respond to this “Wisconsin based” perspective, we decided to conduct many of the same analyses for an income outcome variable as we did for the three economic outcomes of primary concern to SSA.

Another divergence in perspective is addressed by expanding our impact analyses into areas beyond SSA’s primary focus on the net effects of the offset feature. Pathways and its stakeholders had a strong interest in what could be learned from operating the pilot that could be applied to efforts to improve policy and program for persons with serious disabilities who are not SSDI beneficiaries. Given this shift in emphasis, it became important to look at effects on all participants as well as differences between those assigned to the treatment and control groups.

For example, it was important to Pathways to learn more about which services and supports might motivate better employment outcomes and how to deliver them to those in Wisconsin’s Managed Long Term Care programs, Medicaid Buy-in, or even to those who might ultimately enter such programs. Given our understanding of the interests of Pathways and its stakeholders, we conducted analyses specifically aimed at assessing the influence of benefits counseling and of Buy-in participation on participant outcomes. Similarly, as such services or programs, as well as the offset itself, are intended to have beneficial effects through reducing fears, we give substantial attention to looking at the intermediate effects of attitudinal variables on employment related outcomes. We also conceptualize attitudinal variables such as fear of losing SSA or medical benefits and self-efficacy as outcomes worthy of investigation.

Due to these somewhat different perspectives and goals, we included several types of analyses in chapter VI. Of course the analyses most directed at meeting SSA needs are conducted as per that agency’s instruction to the evaluators of the four pilots. These analyses are performed separately for each quarter in the Q0-Q8 period. The only control variables are the values for the relevant employment outcome in the four quarters immediately prior to enrollment in the pilot. By contrast, given our understanding of Wisconsin stakeholder needs and our own views about good evaluation practice, we wanted to control for multiple factors, including some that change over time and that capture events occurring after enrollment. In particular, we think it is critical to look directly at outcome trends, something the SSA analysis approach did not allow.

Finally, our decisions about which “state specific” analyses to perform reflect our view that restricting outcome comparisons to those between the entire treatment and control groups or, as SSA suggested, to subgroups based on pre-enrollment characteristics, was too limiting. In order to use the benefit offset, one had to first complete a TWP. Thus, we were interested in examining whether study assignment had an impact on whether a participant completed a TWP during the pilot. Similarly, we chose to look at the employment outcome trends of those who completed a TWP in reference to that completion date. Though preliminary and including a quite small number of cases, these analyses are conceptually important as they removed the conflating effects of TWP participation on earnings and on the likelihood of earning at or above SGA.

CHAPTER VI: NET IMPACT EVALUATION ESTIMATES

There were a total of 496 eligible participants in the Wisconsin pilot, 266 in the treatment group and 230 in the control group. By the eighth quarter following enrollment into the study, twenty eight participants had withdrawn or died, leaving an effective total of 468 participants whose outcomes trends could be analyzed for either a nine calendar period (Q0-Q8) beginning with the calendar quarter of enrollment or a thirteen quarter period (Q-4 through Q8) that would include the year prior to entering the pilot. In fact, all subgroup analyses would exacerbate this issue, as they had to be completed with an even smaller number of cases. Sample size is vitally important to the ability ("power") to detect statistically significant differences; this ability shrinks as sample size decreases. Therefore, with small samples, an effect has to be particularly large in order to be found statistically significant. For this reason, differences that approached statistical significance in this chapter are given special consideration due to the fact that with a larger sample size, these differences may (or may not) have proved to be statistically significant.

Due to the relatively small and diminishing size of the SSDI-EP participant sample, any approach for estimating net impacts entails limitations. The regression approach SSA mandated for insuring the separate pilot evaluations would produce comparable estimates limits the use of control variables and lacks clear standards for identifying the existence and significance of outcome trends. The approach we chose for performing most of our "state specific" analyses avoids these shortcomings, but at the cost of requiring that all independent variables be transformed into a categorical form and of making it more difficult to calculate effect sizes.

Obviously, the independent variable of greatest interest was study group assignment and through that potential access to the benefit offset. Those treatment group participants who had completed their TWP would have their SSDI benefit checks reduced $1 for every $2 of earnings over SGA. Effectively, their extended period of eligibility (EPE) was increased to seventy-two months after which time the offset would no longer be available to them.[302]

Nonetheless, it is essential to understand that none of the comparisons presented in this chapter compare offset users to any other group of participants with the exception of some descriptive information. In all but a few analyses, comparisons of net impact estimates examine differences between all or selected subgroups of treatment group members and, respectively, all or selected subgroups of control group members. These comparisons almost always mix information from periods of time before, during, and after TWP use. In the case of the treatment group, information for periods of offset use is added to the mix for some participants. Moreover, when or whether any particular participant is in any of these situations is specific to that participant's personal history. While we think the use of treatment and control comparisons is appropriate for examining sample differences for variables such as starting or completing a TWP or for estimating potential savings or costs, we think it is a fairly weak proxy for estimating

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[302] If a treatment group member entered the pilot having completed a TWP, the final month of the extended EPE would be calculated in reference to the TWP completion date, not when the participant entered the pilot. If a participant in the treatment group had not completed a TWP by the end of 2008, the individual would be returned to regular rules and the extended EPE would not apply.

differences in employment outcomes caused by having access to a benefit offset. The main justification for using the approach is the small sample size and the limited duration of the pilot. As a supplement, rather than a true alternative, we estimated some net outcome differences between those in the treatment group and control group who had completed their TWP. As these control group participants would have been able to use the offset had they been assigned to treatment, this is a conceptually stronger basis for comparison. Still, these estimates are not without limitations due to their even smaller sizes and the technical difficulties involved in analyzing outcomes for those who completed the TWP at different times prior to entering the pilot.

As suggested, there are additional independent variables used in many of what SSA chooses to call "state specific" analyses. Most important among these are measures of benefits counseling services, Medicaid Buy-in participation, and attitudinal variables such as fear of loss of public program benefits and self-efficacy. Although, because of the requirements of the MANOVA modeling approach we use, these variables are distinguished from what in a regression framework might be identified as "control variables," the distinction has substantive meaning given Pathways' interest in how these factors may encourage or depress employment outcomes irrespective of study group assignment.

Most analyses in this chapter looked at time as it relates to the date that the participant enrolled in the project.[303] In principle, three general categories of time can be looked at, a pre-enrollment period, the enrollment quarter, and a post-enrollment period. The analyses, sometimes descriptively and other times statistically, looked at change over time across and within these three time periods. To do this the time periods were broken up into units, most often quarters (three month increments), reflecting the time structure of most of the outcome variables. In our descriptive and state-specific (MANOVA) analyses, we most often analyzed trends over either a thirteen quarter or a nine quarter period. The thirteen quarter period started with the fourth quarter prior to the quarter of study entry and ended the eighth quarter following enrollment (i.e. Q-4 through Q8).[304] The start of the nine quarter period was the enrollment quarter; the end was again the eighth quarter following the enrollment quarter. The use of the Q0-Q8 period generally reflected the absence of data for the pre-enrollment period.

Employment rates, mean earnings, and the percentage of participants with earnings at or above SGA are the outcomes of primary interest to both SSA and the SSDI-EP evaluation team and thus their indicators serve as the main dependent variables examined in our analyses. In addition, we thought it important to study individual income as a fourth employment related outcome. To measure these outcomes, the evaluation utilized Wisconsin Unemployment Insurance (UI) records as the primary source of information about participant employment and earnings. These data are available on a quarterly basis and are maintained in a consistent and reliable fashion over time. However not all employment is required to be reported to the UI

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[303] The key exception is with the TWP completers' subgroup analysis that was performed relative to the time of TWP completion (unless completion occurred prior to SSDI-EP enrollment). This is discussed in more detail later in this chapter.

[304] Though we had administrative data going back to Q-8, we chose to limit the analysis period to four quarters prior to the enrollment quarter. By doing so we greatly reduced the number of cases that included some data from before an individual's original entitlement to SSDI.

system. The most important exclusions likely to impact estimates of employment rates and earnings are self-employment and work for entities located outside Wisconsin. Additionally, the UI system provides no information about the proportion of any quarter an individual is employed.[305] Thus the employment rates and earnings calculated from UI records are best understood as useful indicators of actual employment rates and earnings.

To convert Wisconsin UI earnings records into employment rates, participants with UI earnings of $0 or not appearing in UI records in a given calendar quarter were coded as not having employment in that quarter. Participants with earnings greater than $0 were always coded as employed. The employment rate was computed as the total of those with positive UI earnings within any relevant group of participants divided by the number of participants in that group.

Quarterly earnings were also based on the Wisconsin UI records. Like employment, participants with no earnings or records were recorded as having $0 in earnings. If an earnings value was recorded, that value was deflated using the CPI-U (1982-84 = 100), but adjusted so that the August 2005 index value served as the 100 value (when current dollars equal constant dollars). Mean earnings for any group was calculated in the standard manner.

Because UI records are quarterly, we created a proxy variable to indicate a strong likelihood of having earnings that met the SGA criterion. If quarterly UI earnings, once deflated, equaled or exceeded $2,490, that participant was imputed to have SGA earnings, though we often identify this by the more accurate phrase of having quarterly earnings at least three times higher than SGA.[306] The proportion of participants in any group imputed to have SGA earnings was the number with deflated UI earnings equal to or greater than $2,490 in a quarter divided by the number of participants in that group.[307]

The quarterly income proxy was calculated by adding quarterly UI earnings to the total SSDI benefit payments the participant received within the same quarter. This income proxy is a simplistic measure of a participant's economic well being as it does not take into account other possible sources of individual income or the potential benefit

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[305] The exclusions depress employment rates and earnings. However the lack of information about whether an individual was employed throughout the quarter suggests that the UI employment rate is somewhat higher than one based on otherwise comparable data for shorter durations or a single a point in time.

[306] The 2005 SGA amount for most participating in a Social Security disability program was $830 per month. Since shortly after the passage of the "Ticket to Work" Act, SGA is inflation adjusted on an annual basis. Those beneficiaries and SSI recipients who are disabled because of a visual impairment have a somewhat higher SGA. As we did not have information that would have allowed us to accurately identify each individual's SGA level (and relatively few participants were identified as having a sensory impairment) we chose to perform our analyses as if everyone had the same SGA level in any year.

[307] It is possible that the proxy excludes some individuals who earned above SGA in either one or two months in a particular quarter. There may also be cases which where a participant had UI earnings greater than the SGA level in every month of the quarter, but which SSA would not view as meeting the SSA criterion because of an IRWE, an employer subsidy, and/or a special condition (a subsidy from a source other than the employer).

that the participant derives from the income of other members of a family or household unit. The proxy also ignores variation in the costs of fulfilling basic needs that may vary for many reasons including the type and severity of one's disabling condition(s). In aggregate analyses, we generally used the quarterly mean of the income proxy.

We begin our discussion of participant employment outcomes by presenting descriptive trend data. Findings are presented for both treatment and control groups as well as subgroups drawn from these. This material is followed by the single quarter regression analyses required by SSA. After this we turn to our "state specific" analyses utilizing the MANOVA technique. This material begins by looking at findings where study group assignment is the only independent variable examined. This is followed by material presenting results for models utilizing other independent variables, with and without the study assignment variable. Particular emphasis is placed on findings from a "combined model" that seeks to assess the contributions of benefits counseling, Medicaid Buy-in participation, fears of losing SSDI and other public benefits and self-efficacy. This is followed by a number of specialized analyses, most importantly our examination of the impact associated with completing a TWP.

Finally, this chapter concludes with a summary of overall patterns observed in the results from all the analytical methods utilized. To preview, overall results indicate that although, on average, the full participant group had gains in quarterly earnings, employment rates, and the proportion of those with earnings three times SGA, these increases were not significantly different between the treatment and control groups. Further, greater increases in the outcomes were observed prior to enrollment (Q-4 through Q0) than during the pilot (Q0 throughQ8). As for the income proxy, both study groups experienced similar income trends during both the pre- and post-enrollment periods, though by Q8 those in the treatment group averaged a slightly (but not significantly) higher income than did control group participants. Perhaps more consequentially, neither study group's post-enrollment earnings growth resulted in any income growth.

The one outcome where there is a statistically significant difference between the study groups is the rate of trial work period (TWP) completion. Those in the treatment group posted higher completion rates following study entry, consistent with the expectation that the offset's availability would provide a strong incentive for completion. Our examination of the employment outcomes of those who completed a TWP, exhibited a similar result. While we observed declining trajectories in employment outcomes for both treatment and control group members subsequent to completion, the declines were somewhat less for treatment participants.

Much of the variance observed in employment related outcomes after entering the pilot can be attributed to participants' work behavior in the year prior to enrollment, most notably differences in pre-enrollment earnings. Benefits counseling, Medicaid Buy-in participation, changes in one's fear of losing benefits, and self-efficacy were also related to employment outcomes. Greater or more continuous receipt of benefits counseling services were related to more positive employment outcomes, whereas Medicaid Buy-in participation was related to poorer employment related outcomes (specifically the probability of having UI earnings indicating that the SGA level had been reached). Nonetheless, among study participants enrolled in the Buy-in, treatment group members averaged slightly higher (but non-significant) income levels than control group members. Attitudinal variables appeared to have more complex relationships with employment outcomes. In particular, increases in fears that work would result in benefit loss and low self-efficacy were related to better outcomes for treatment participants.

A. Simple Comparisons between Treatment and Control Groups

Simple t-tests between treatment and control groups were performed comparing mean earnings, employment rates, the proportions with "SGA" earnings, and the income proxy means for the four pre-enrollment quarters, the enrollment quarter, and the eight post-enrollment quarters. All significance tests in chapter VI use a two tailed p-value of 0.05. In the tables, significant p-values of less than 0.05 are highlighted in yellow and near significant p-values, 0.05 to 0.10, are highlighted in blue. There were no statistically significant differences ($p > 0.05$) between treatment and control participants on earnings, employment, SGA, and income in any of the thirteen quarters.

1. Earnings

The average UI earnings of treatment and control participants for pre-enrollment (Q-4 to Q-1), enrollment (Q0), and post-enrollment (Q1 to Q8) quarters are shown in table VI.1 and figure VI.1. Also, included in table VI.1 is the difference between treatment and control average earnings during each quarter and the associated probability value (p-value). All p-values are greater than 0.05, so none of the difference values meet our criterion for statistical significance.

Table VI.1: Beneficiaries Quarterly UI Earnings, By Group (a.k.a. SSA Table 1a)

	Treatment Group			**Control Group**			**Difference**	
	N	Estimate	Std. Err	N	Estimate	Std. Err	Estimate	P-Value
Q-4	266	810.73	107.63	230	658.17	80.21	152.56	0.268
Q-3	266	813.23	116.16	230	729.19	91.28	84.04	0.578
Q-2	266	726.38	79.79	230	754.63	118.83	-28.26	0.840
Q-1	266	886.68	96.61	230	881.80	107.96	4.88	0.973
Q0 (Enrollment)	266	1053.55	108.27	223	1052.89	119.30	0.66	0.997
Q1	264	1083.39	106.01	220	1291.81	136.72	-208.42	0.222
Q2	263	1078.71	101.56	220	1341.42	174.59	-262.71	0.177
Q3	263	1216.24	111.05	219	1307.62	161.71	-91.38	0.633
Q4	263	1245.10	117.46	217	1380.84	163.86	-135.74	0.491
Q5	263	1288.92	121.78	214	1373.22	166.59	-84.31	0.677
Q6	262	1265.28	116.93	212	1272.75	178.09	-7.47	0.971
Q7	262	1224.06	111.76	207	1330.22	164.50	-106.16	0.582
Q8	262	1270.42	115.95	206	1239.09	170.60	31.33	0.876

Most increases in mean earnings occurred in the pre-enrollment period, with control group gains concentrated in the Q-2 to Q0 period.[308] Though the two groups started the year prior to enrollment with somewhat different average earnings, by Q-2 average earnings for the two groups were comparable and, as might be expected with

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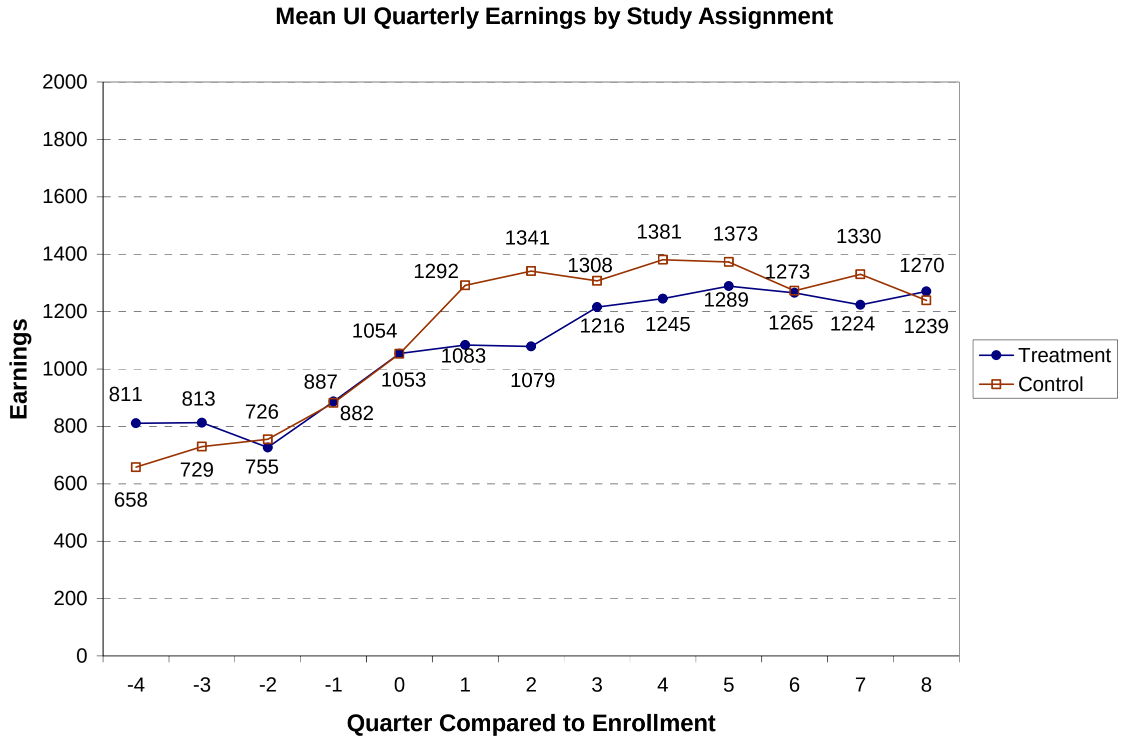
[308] Readers are reminded that participants entered the pilot with far stronger employment outcomes than would be expected of a representative sample of SSDI beneficiaries and that these differences are apparent in UI data even earlier than Q-4.

random assignment, remained so through the enrollment quarter. Nonetheless, it is important to note the non-trivial earnings growth in the year prior to pilot enrollment. By the enrollment quarter both groups had mean earnings of just over $1,050. Thus, relative to Q-4, the treatment group achieved a mean growth of $61 per quarter, the control group $99 per quarter.

Treatment and control group earnings trends differed following enrollment. Most of the post-enrollment earnings gains in the control group occurred in the first two quarters. These initial earnings gains far exceeded those of the treatment group. As a result, control group members continued to have higher average earnings through the post-enrollment period until Q8 when the average for the treatment group finally exceeded that for the control group. Following Q3, the earnings growth of control group members slowed, stopped, and even decreased, so that by quarter eight control group participants earned on average $186 (18%) more than they did in the enrollment quarter. Treatment group participants, on the other hand, had a more continuous increase in their average earnings across the post-enrollment period (with the exception of quarter seven), so that by quarter 8 they were earning on average $216 (20%) more than they were in the enrollment quarter and $31 more than the control group participants. Also, the rates of growth for both study groups were much slower than those observed during the pre-enrollment period, averaging only $27 per quarter for the treatment group and $23 for the control group.

Figure VI.1: Mean UI Earnings, by Quarter, by Study Assignment



2. Employment Rates

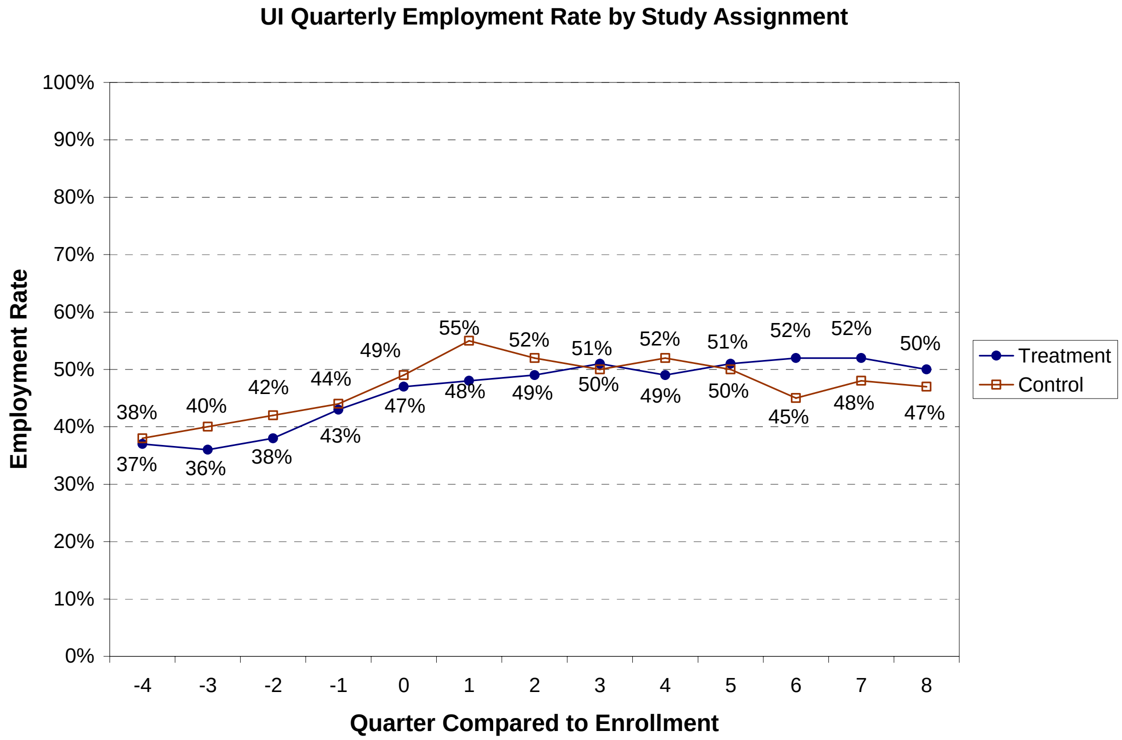
The UI employment rates for treatment and control group participants are included in table VI.2 along with employment rate differences and the probability (p-value) that these differences are statistically significant. All p-values were less than 0.05, so no differences between the treatment and control employment rates were statistically significant in any quarter. There is also a visual depiction of the employment rates in figure VI.2.

Table VI.2: Beneficiaries Quarterly UI Employment Rates, By Group (a.k.a. SSA Table 1b)

	Treatment Group			**Control Group**			**Difference**	
	N	Estimate	Std. Err	N	Estimate	Std. Err	Estimate	P-Value
Q-4	266	0.37	0.03	230	0.38	0.03	-0.01	0.745
Q-3	266	0.36	0.03	230	0.40	0.03	-0.04	0.378
Q-2	266	0.38	0.03	230	0.42	0.03	-0.04	0.387
Q-1	266	0.43	0.03	230	0.44	0.03	-0.01	0.803
Q0 (Enrollment)	266	0.47	0.03	223	0.49	0.03	-0.02	0.619
Q1	264	0.48	0.03	220	0.55	0.03	-0.07	0.127
Q2	263	0.49	0.03	220	0.52	0.03	-0.03	0.602
Q3	263	0.51	0.03	219	0.50	0.03	0.01	0.875
Q4	263	0.49	0.03	217	0.52	0.03	-0.03	0.635
Q5	263	0.51	0.03	214	0.50	0.03	0.01	0.982
Q6	262	0.52	0.03	212	0.45	0.03	0.07	0.177
Q7	262	0.52	0.03	207	0.48	0.03	0.04	0.427
Q8	262	0.50	0.03	206	0.47	0.03	0.03	0.418

The employment rates follow a similar pattern to the mean earnings with the steepest growth for both treatment and control participants occurring during the pre-enrollment period. Again, during the post-enrollment period, the growth was steepest for control group participants very early on, reaching a peak employment rate of 55% in quarter one before subsequently decreasing to 47% by quarter eight. Like mean earnings, the employment rate growth for treatment group participants was slower, but continued through quarter seven, peaking at 52%, and then dropping slightly at quarter eight to 50%. Due to the decrease in employment rates for the control group and increase in employment rates for treatment group participants, treatment group participants had a higher employment rate during quarter eight at 50% compared to the control group's employment rate of 47%. Again, the rate of growth of treatment group participants' employment rate during post-enrollment (a three percentage point increase or an average increase of almost 0.4 percentage points per quarter) did not exceed the rate of growth during the pre-enrollment period, which was a ten percentage point increase (i.e., an average increase of two and one-half percentage per quarter).

Figure VI.2: Employment Rates, by Quarter, by Study Assignment



It is not unexpected that mean earnings and employment rates show similar patterns across time, as changes in mean earnings often reflect changes in employment rates. Yet, this increase could also reflect changes in wage rates or hours of work.

Though observed trends in UI mean earnings and employment rates generally followed the same patterns, there were some minor differences. When comparing treatment mean earnings and employment rate outcomes relative to those for control, increases in treatment employment rates do not seem to increase mean earnings to the same extent that gains in control employment rates do. For example, a three percentage point increase in the treatment group's employment rate over the Q0-Q8 period netted a gain of $216 in quarterly earnings. Though the control group's gain was less at $186, this gain came despite a two percentage point drop in the employment rate. This finding strongly suggest that control group members, on average, either had higher hourly earnings, worked more hours or both. It is not clear whether this difference is motivated more by small differences spread across many employed control group members or results more from the influence of a small number of extreme cases.

3. SGA Proxy

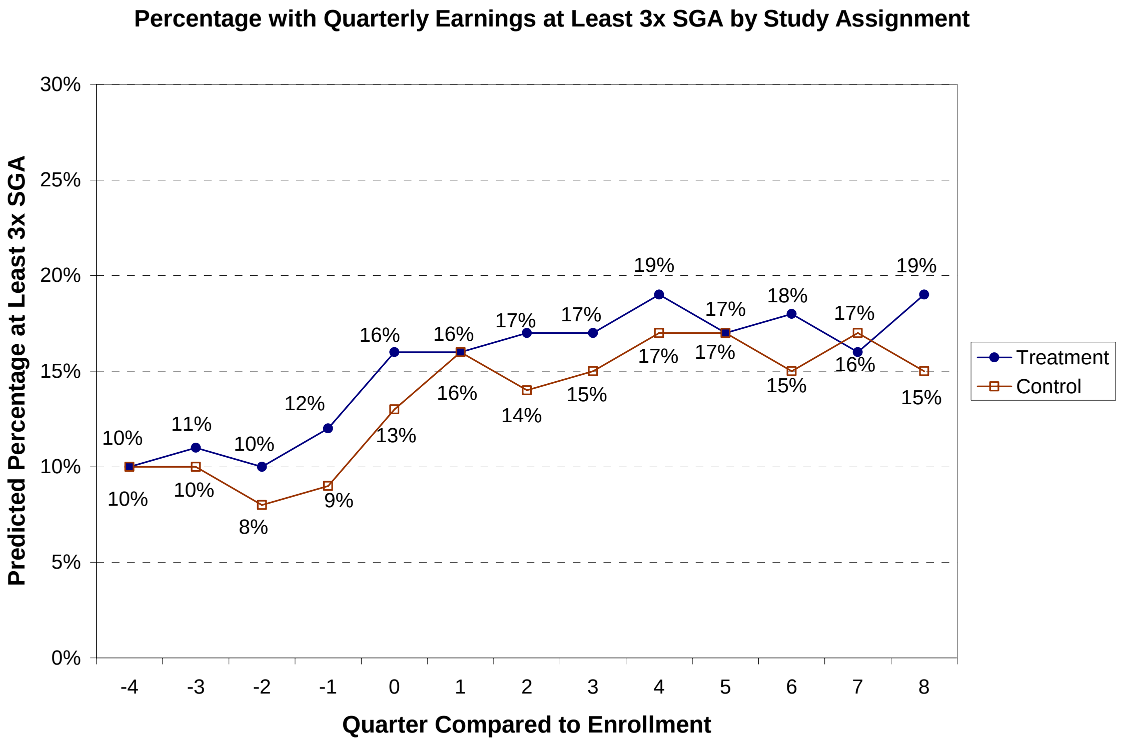
Table VI.3 and figure VI.3 exhibit the proportion of treatment and control participants with quarterly UI earnings at least three times SGA. In all but four of the thirteen quarters, treatment group members had a higher percentage of individuals with earnings at least three times the monthly SGA than did the control group. This difference was never statistically significant.

Table VI.3: Beneficiaries Quarterly UI 3X SGA Rates, By Group (a.k.a. SSA Table 1c)

	Treatment Group			**Control Group**			**Difference**	
	N	Estimate	Std. Err	N	Estimate	Std. Err	Estimate	P-Value
Q-4	266	0.10	0.02	230	0.10	0.02	< 0.01	0.938
Q-3	266	0.11	0.02	230	0.10	0.02	0.01	0.724
Q-2	266	0.10	0.02	230	0.08	0.02	0.02	0.448
Q-1	266	0.12	0.02	230	0.09	0.02	0.03	0.298
Q0 (Enrollment)	266	0.16	0.02	223	0.13	0.02	0.03	0.260
Q1	264	0.16	0.02	220	0.16	0.02	0.00	1.000
Q2	263	0.17	0.02	220	0.14	0.02	0.03	0.426
Q3	263	0.17	0.02	219	0.15	0.02	0.02	0.545
Q4	263	0.19	0.02	217	0.17	0.03	0.02	0.510
Q5	263	0.17	0.02	214	0.17	0.03	< 0.01	0.848
Q6	262	0.18	0.02	212	0.15	0.02	0.03	0.334
Q7	262	0.16	0.02	207	0.17	0.03	-0.01	0.886
Q8	262	0.19	0.02	206	0.15	0.02	0.04	0.198

The largest difference was in quarter eight, with 19% of treatment participants earning at least three times SGA and 15% of control participants earning at least three times SGA, a difference of four percentage points, but this difference is only a point greater than the one observed in Q-1. Similar to the other outcomes, the largest increases in those earning at least three times SGA occurs during the pre-enrollment period, a six percentage point increase for the treatment group and a three percentage point increase for the control group. During the post-enrollment period, the percentage of control group participants earning at least three times SGA continues to grow (another three percentage points) through Q1, but then remains between 14% to 17% for the rest of the quarters, ending at 15% during Q8. The treatment group percentage continues to grow for a longer period up through the first year following enrollment (until Q4), but the SGA rate dips again during Q5 to Q7 before returning to the 19% peak at Q8.

Figure VI.3: UI 3X SGA Rates, by Quarter, by Study Assignment



4. Income Proxy

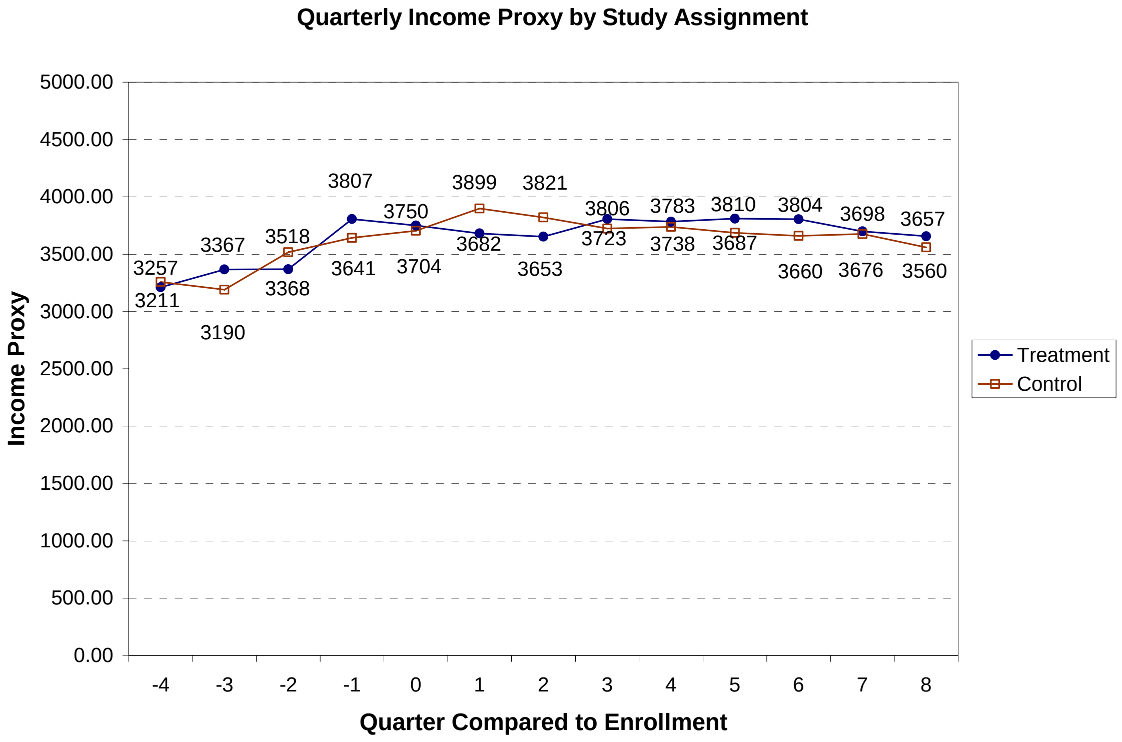
An income proxy was calculated for each quarter by adding the individual's quarterly UI earnings to the individual's actual SSDI payments for the three relevant months. The income proxy data for both treatment and control participants are shown in table VI.4 and figure VI.4. The difference between the income proxy for treatment group participants and control group participants was never statistically significant.

Table VI.4: Beneficiaries Quarterly Income Proxy, By Group

	Treatment Group			**Control Group**			**Difference**	
	N	Estimate	Std. Err	N	Estimate	Std. Err	Estimate	P-Value
Q-4	266	3210.97	2329.42	230	3256.73	2211.37	-45.77	0.823
Q-3	266	3367.32	2798.95	230	3190.07	1810.25	177.24	0.411
Q-2	266	3368.36	2708.44	230	3517.51	3442.67	-149.15	0.590
Q-1	266	3807.00	3204.84	230	3641.47	2564.69	165.53	0.530
Q0 (Enrollment)	266	3750.35	2455.07	223	3704.26	2533.54	46.08	0.839
Q1	264	3682.02	1959.39	220	3899.11	2336.02	-217.09	0.267
Q2	263	3652.56	1827.35	220	3821.13	2527.30	-168.57	0.397
Q3	263	3806.16	2009.88	219	3723.17	2273.71	82.99	0.671
Q4	263	3782.69	2016.37	217	3737.60	2246.46	45.09	0.817
Q5	263	3809.78	2181.31	214	3686.66	2264.43	123.11	0.547
Q6	262	3804.03	2122.05	212	3659.65	2423.57	144.38	0.490
Q7	262	3698.02	1998.66	207	3676.04	2149.40	21.97	0.909
Q8	262	3656.92	1951.04	206	3559.62	2233.65	97.31	0.616

As previously noted, the income trends for the study groups were not significantly different. Moreover, as observed with the previous employment outcomes, substantial gains in the income proxy can be observed during the pre-enrollment period. Over this period, the income proxy for treatment participants increased from $3,211 in Q-4 to $3,750 in Q0, a $539 increase, whereas the income proxy for control participants increased from $3,257 in Q-4 to $3,704 in Q0, a $447 increase. Thereafter, the similarity ends. While other employment outcomes either tended to grow slowly or to be flat when observed over the entire Q0 through Q8 period, the average for the income proxy actually declined for both study groups, decreasing $93 (2.5%) relative to Q0 for treatment and $144 (5.7%) for control. Given, the approximately 20% increases in earnings reported over the post-enrollment period for both study groups, this is a discouraging finding, especially for the treatment group which had access to an offset intended to insure that half of earnings above SGA would be translated into income. It is possible that the less precipitous decline for the treatment group reflects offset use, but we do not have adequate evidence to either confirm or refute that possibility.

Figure VI.4: Income Proxy, by Quarter, by Study Assignment



B. Regression Adjusted Impact Estimates

Although a simple t-test is entirely appropriate when comparing the differences when a study includes random assignment, a simple t-test does not take into account the potential influence of pre-enrollment levels of employment outcomes on post-enrollment outcomes. This is a potential problem if one is interested in isolating the net effect of the intervention, especially as most of the increases in employment related outcomes occurred in the quarters leading up to enrollment. Therefore, all of the statistical models presented in this chapter, attempt to control for pre-enrollment employment outcomes.

In the following material, we present findings for the regression analyses that SSA required be performed for all four pilot evaluations. To insure that the pilot evaluation reports contained a common set of core analyses, SSA specified that the required regression analyses should not include any control variables beyond the Q-4 through Q-1 values of the outcome being modeled. SSA asked pilot evaluators to conduct a separate regression analysis for each quarter, starting with the enrollment quarter and for each of the eight quarters that followed. Further, SSA asked that models be run for each of three dependent variables: earnings, employment, and having SGA equivalent earnings. We added the income proxy to this group. Because employment and having SGA earnings are dichotomous variables, logistical regression analyses were conducted for these two dependent variables. Linear regression analyses were conducted for earnings and the income proxy.

An advantage of regression methods, including that chosen by SSA for this report, are that they provide predictive adjusted impact estimates, which make the comparison between groups more informative than simply reporting whether differences are statistically significant. However, a disadvantage of SSA's specific approach is that it does not allow one to straightforwardly analyze trends over time.

1. The Quarterly Models for Treatment vs. Control

A summary of the overall results, specifically the study assignment coefficient, standard error, p-value, and effect size or odds ratio, are given in table VI.5. Because results are given by quarter, there is no inherent standard to assess the significance of quarter to quarter differences. Receiving no guidance from SSA, we discussed various standards for interpreting the meaning of "trends" based on whether there were any series of significant differences over a series of consecutive quarters associated with one study group having consistently higher and/or increasing outcomes relative to the other. No such patterns were observed, so the matter was, at least for the evaluation of the Wisconsin pilot, moot.

Like the t-test, the regression analyses found no statistically significant differences between treatment and control participants. Earnings differences within the SSDI-EP participant sample were generally higher for the control group in the enrollment and post-enrollment quarters, whereas three times SGA rate and income proxy (with exception of Q1 and Q2) was higher for the treatment group. Employment rate was higher for the control group in the earlier quarters (enrollment, Q1, Q2, Q4, and Q5), but higher for the treatment group in the later quarters (Q3, Q6, Q7, and Q8). Again, although differences were observed in the Wisconsin sample, these differences were not statistically significant. Some values did near significance and were highlighted in blue within table VI.5, but these differences did not persist or increase over time.

Table VI.5: Linear Regression Adjusted Impact Estimates – By Study Assignment

	Enroll-ment Quarter 0	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Quarter 8
Sample Size Treatment	266	264	263	263	263	263	262	262	262
Control	223	220	220	219	217	214	212	207	206
Earnings Estimate	-19.81	-201.59	-247.07	-81.84	-128.91	-93.09	4.26	-116.60	25.47
Standard Error	89.58	119.92	145.66	164.06	170.73	172.26	177.95	167.39	177.99
P-Value	0.825	0.093	0.090	0.618	0.451	0.589	0.981	0.486	0.886
Squared Part Correlation	< 0.001	0.003	0.003	< 0.001	0.001	< 0.001	< 0.001	0.001	< 0.001
Employ-ment Estimate	-0.12	-0.36	-0.07	0.09	-0.06	0.06	0.37	0.23	0.24
Standard Error	0.24	0.22	0.21	0.21	0.21	0.21	0.21	0.21	0.21
P-Value	0.607	0.113	0.748	0.667	0.776	0.765	0.078	0.266	0.260
Odds Ratio	0.884	0.700	0.934	1.094	0.943	1.064	1.453	1.261	1.270
SGA Proxy Estimate	0.24	-0.22	0.10	0.05	0.07	-0.05	0.15	-0.15	0.27
Standard Error	0.32	0.31	0.30	0.29	0.26	0.27	0.27	0.27	0.27
P-Value	0.451	0.472	0.746	0.861	0.786	0.843	0.572	0.573	0.325
Odds Ratio	1.275	0.801	1.101	1.052	1.074	0.948	1.166	0.858	1.306
Income Proxy Estimate	6.15	-241.67	-194.63	69.06	35.13	89.18	116.40	-18.67	67.12
Standard Error	203.36	170.01	170.68	175.53	178.05	183.27	188.61	172.16	177.55
P-Value	0.976	0.156	0.255	0.694	0.844	0.627	0.537	0.914	0.706
Squared Part Correlation	< 0.001	0.003	0.002	< 0.001	< 0.001	< 0.001	0.001	< 0.001	< 0.001

a. Earnings

The regression model for the enrollment quarter for the earnings outcome is

$$Q0\hat{E}arnings = B_0 + B_1 Q-1Earnings + B_2 Q-2Earnings + B_3 Q-3Earnings + B_4 Q-4Earnings$$

$+ B_5 Assignment$. The other eight regression models followed a similar form, and varied only by the predicted quarter on the left side of the equation. The regression results for the enrollment and eight post-enrollment quarters for the dependent variable, UI earnings, are given in table VI.6. This table includes the sample sizes, the constant estimate, the study assignment coefficient (where treatment = 1 and control = 0), and the coefficients for each of the pre-enrollment quarters. Also included in table VI.6 are the standard errors for each estimate and p-values indicating whether the constant or a coefficient is statistically significant, along with the effect size for each coefficient. This information is summarized in two subsequent graphs. The first graph, figure VI.5, plots the regression predicted quarterly means for UI earnings, whereas the second graph, figure VI.6, shows the difference between treatment and control predicted quarterly means for earnings via bars that appear either above (treatment group prediction was higher) or below (control group prediction was higher) the indifference point (0)[309]. This is when the predicted mean is the same for both the treatment and control groups.

Table VI.6: Linear Regression Adjusted Impact Estimates – UI Earnings (a.k.a. SSA Table 3)

	Enrollment Quarter 0	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Quarter 8
Sample Size Treatment	266	264	263	263	263	263	262	262	262
Control	223	220	220	219	217	214	212	207	206
Constant Estimate	244.87	569.16	608.63	734.07	787.27	705.56	633.93	729.58	688.92
Standard Error	70.99	95.27	115.63	130.43	136.12	137.42	141.95	134.09	142.62
P-Value	0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Treatment Estimate	-19.81	-201.59	-247.07	-81.84	-128.91	-93.09	4.26	-116.60	25.47
Standard Error	89.58	119.92	145.66	164.06	170.73	172.26	177.95	167.39	177.99
P-Value	0.825	0.093	0.090	0.618	0.451	0.589	0.981	0.486	0.886
Squared Part Correlation	< 0.001	0.003	0.003	< 0.001	0.001	< 0.001	< 0.001	0.001	< 0.001
Outcome (t-1) Estimate	0.97	0.69	0.56	0.52	0.55	0.57	0.42	0.49	0.38
Standard Error	0.05	0.06	0.08	0.08	0.09	0.09	0.09	0.09	0.09
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Squared Part Correlation	0.272	0.127	0.063	0.057	0.060	0.063	0.033	0.052	0.029

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[309] When the treatment and control predicted mean UI earnings are the same, the bar will fall at zero on the x-axis. If the treatment predicted mean UI earnings are higher than the control predicted mean UI earnings, the bar will appear from zero to a positive value on the x-axis. The further the positive value is from zero the larger the difference is between treatment and control participants. If the treatment predicted mean UI earnings are lower than the control predicted mean UI earnings, the bar will appear from zero to a negative value on the x-axis. The further the negative value is from zero the larger the difference is between control and treatment participants.

Outcome (t-2) Estimate	-0.12	0.18	0.46	0.24	0.20	0.13	0.32	0.15	0.29
Standard Error	0.05	0.07	0.09	0.10	0.10	0.10	0.10	0.10	0.10
P-Value	0.027	0.011	0.000	0.012	0.051	0.194	0.003	0.134	0.006
Squared Part Correlation	0.003	0.007	0.032	0.010	0.006	0.003	0.014	0.004	0.013
Outcome (t-3) Estimate	0.11	0.00	-0.14	-0.10	-0.11	0.01	0.04	-0.01	-0.11
Standard Error	0.05	0.06	0.08	0.09	0.09	0.09	0.09	0.09	0.09
P-Value	0.017	0.969	0.066	0.228	0.220	0.874	0.664	0.897	0.232
Squared Part Correlation	0.004	0.000	0.004	0.002	0.002	< 0.001	< 0.001	< 0.001	0.002
Outcome (t-4) Estimate	-0.04	-0.04	0.00	0.01	0.05	0.07	-0.02	0.09	0.12
Standard Error	0.05	0.06	0.08	0.08	0.09	0.09	0.09	0.09	0.09
P-Value	0.422	0.542	0.989	0.950	0.546	0.404	0.862	0.283	0.182
Squared Part Correlation	< 0.001	< 0.001	< 0.001	< 0.001	0.001	0.001	< 0.001	0.002	0.003

Figure VI.5: Mean Predicted UI Earnings, by Quarter, by Study Assignment

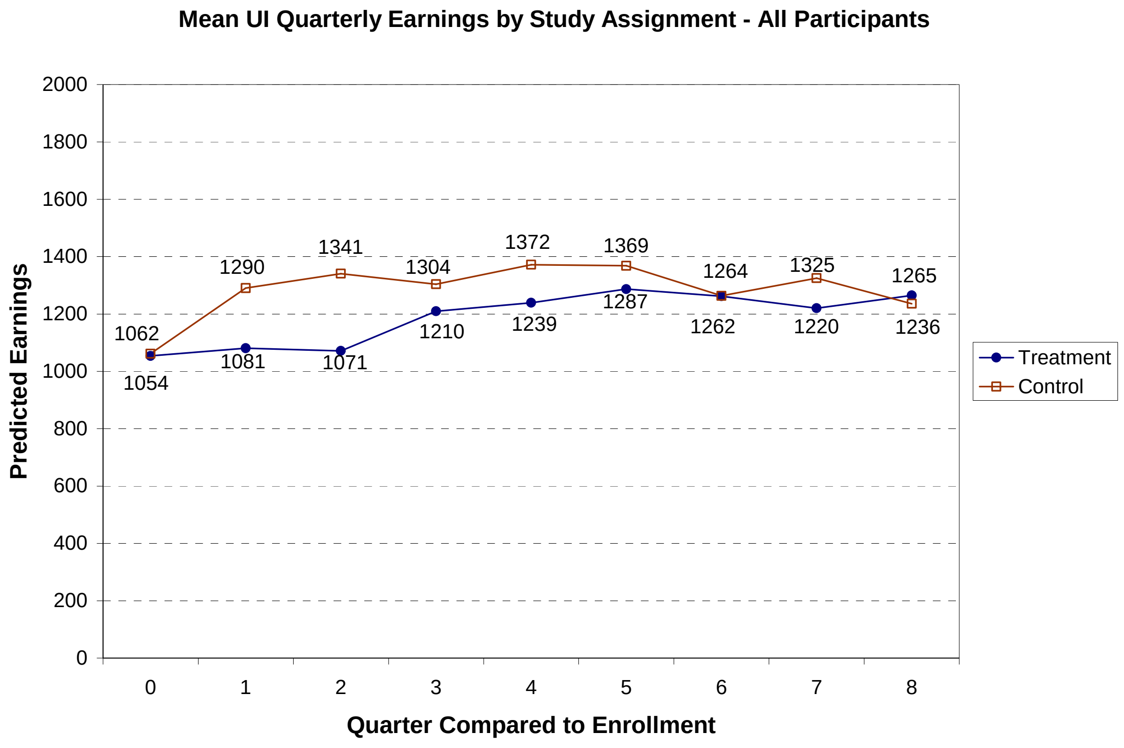
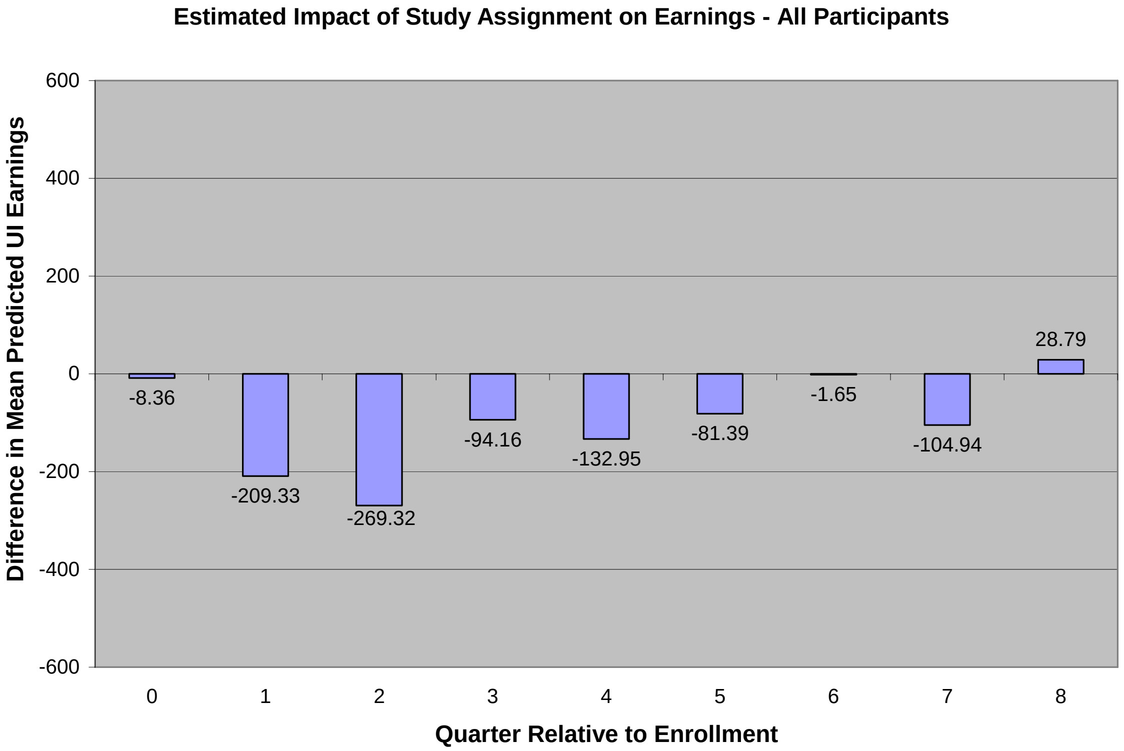


Figure VI.6: Mean Predicted Difference in UI Earnings, by Quarter, by Study Assignment



Both groups had an increase in predicted earnings during the post-enrollment period. There was a $211 (20%) predicted increase for treatment group members and a $174 (16%) increase for control group members. Despite the higher increase predicted for treatment group members, the predicted difference between treatment and control participants was typically to the advantage of the control group in all but quarter eight (though never reaching statistical significance). This is shown in figure VI.6 by the bars appearing below zero for Q0 to Q7 and above zero for Q8. The difference in Q2 neared statistical significance with higher predicted values for the control group with a p-value of 0.09. After Q2, the different between treatment and control participants continued to decline with the steeper increase in predicted earnings for the treatment group. By Q8 the treatment group had higher predicted mean earnings, but only by less than $30.

b. Employment Rates

The logistical regression model for the enrollment quarter for the employment outcome is

$$\Pr ob(Q0Employment) = \frac{1}{1+e^{-\left(B_o + B_1 Q{-}1Employment + B_2 Q{-}2Employment + B_3 Q{-}3Employment + B_4 Q{-}4Employment + B_5 Assignment\right)}}$$

The other eight logistical regression models followed a similar form, and varied only by the predicted quarter on the left side of the equation. The regression results for the enrollment and eight post-enrollment quarters for the dependent variable, UI employment rate, are given in table VI.7. This table includes the sample sizes, the constant estimate, the study assignment coefficient (where treatment = 1 and control = 0), and the coefficients for each of the pre-enrollment quarters (where any UI earnings = 1 and no UI earnings = 0). Also included in table VI.7 are the standard errors for each estimate and p-values indicating whether the constant or coefficient is statistically significant, along with the odds ratio for each coefficient.[310] This information is summarized in two subsequent graphs. The first graph, figure VI.7, plots the regression predicted quarterly UI employment rate, whereas the second graph, figure VI.8, shows the difference between treatment and control predicted quarterly UI employment rate via bars that appear either above (treatment group prediction was higher) or below (control group prediction was higher) the indifference point (0).

Table VI.7: Logistical Regression Adjusted Impact Estimates – UI Employment Rate (a.k.a. Table 3)

	Enrollment Quarter 0	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Quarter 8
Sample Size Treatment	266	264	263	263	263	263	262	262	262
Control	223	220	220	219	217	214	212	207	206
Constant Estimate	-1.48	-0.98	-0.98	-0.99	-0.91	-0.94	-1.25	-1.01	-1.13
Standard Error	0.21	0.19	0.18	0.18	0.18	0.18	0.19	0.19	0.19
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Odds Ratio	0.227	0.376	0.375	0.373	0.404	0.391	0.287	0.363	0.322
Treatment Estimate	-0.12	-0.36	-0.07	0.09	-0.06	0.06	0.37	0.23	0.24
Standard Error	0.24	0.22	0.21	0.21	0.21	0.21	0.21	0.21	0.21
P-Value	0.607	0.113	0.748	0.667	0.776	0.765	0.078	0.266	0.260
Odds Ratio	0.884	0.700	0.934	1.094	0.943	1.064	1.453	1.261	1.270
Outcome (t-1) Estimate	2.57	1.83	1.39	1.57	1.25	1.04	1.34	1.09	1.22
Standard Error	0.30	0.28	0.27	0.28	0.27	0.27	0.28	0.28	0.28
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Odds Ratio	13.122	6.228	4.033	4.796	3.476	2.820	3.808	2.982	3.370
Outcome (t-2) Estimate	0.93	0.70	0.72	0.53	0.98	0.72	0.35	0.37	0.42
Standard Error	0.39	0.36	0.35	0.35	0.35	0.35	0.35	0.35	0.35
P-Value	0.018	0.055	0.038	0.132	0.005	0.038	0.322	0.298	0.237
Odds Ratio	2.533	2.006	2.061	1.701	2.657	2.054	1.420	1.443	1.519

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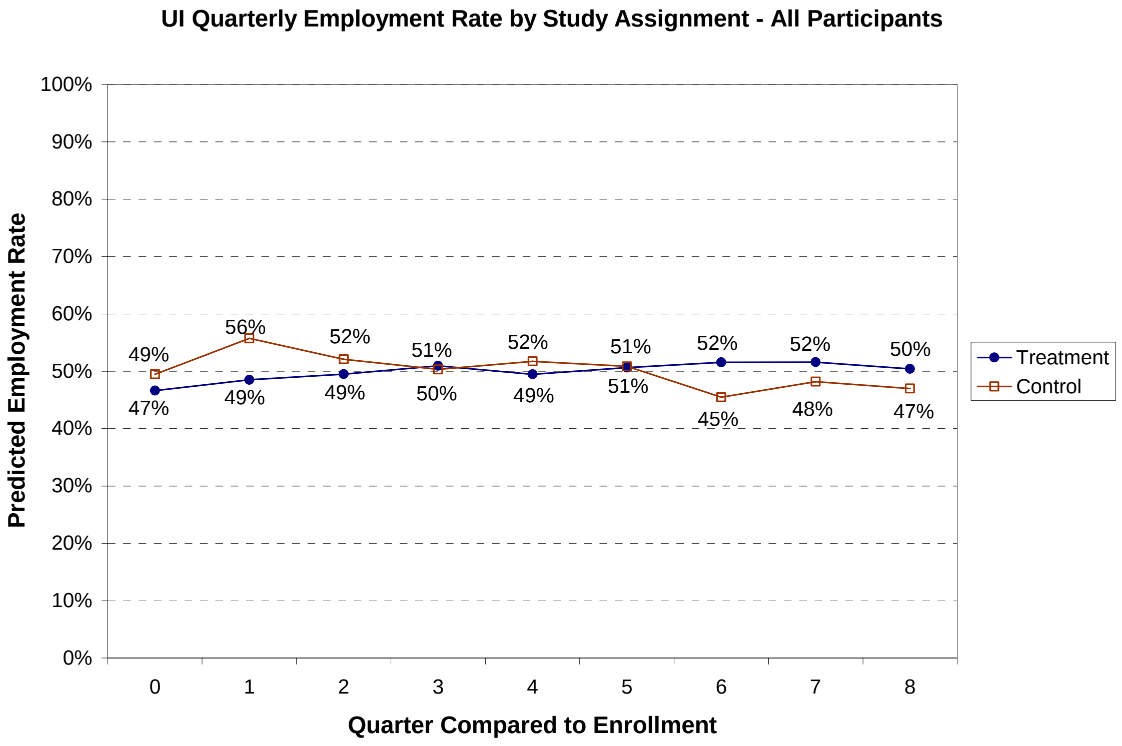
[310] The odds ratio is the ratio of the odds of an event occurring in one group to the odds of it occurring in another group. In this case the odds ratio of greater than one for the treatment assignment variable indicates a higher employment rate for treatment group participants, whereas an odds ratio less than one would indicate a higher employment rate for control group participants.

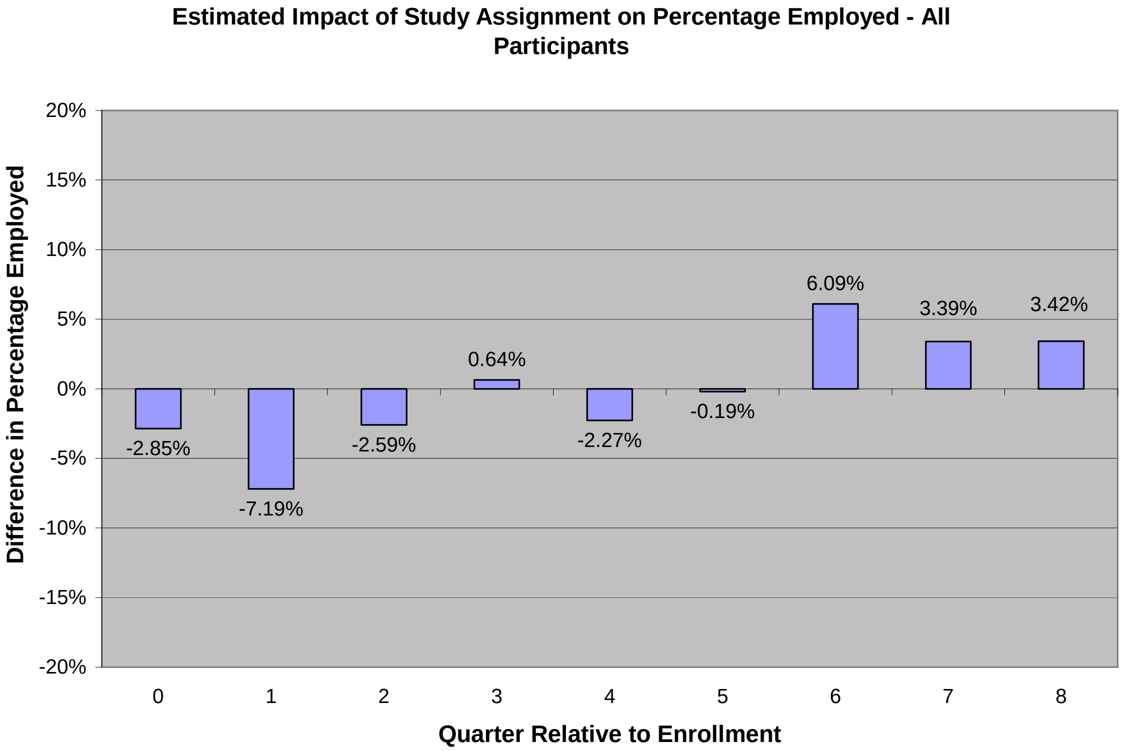
Outcome (t-3) Estimate	-0.21	0.28	0.49	0.39	-0.11	0.71	0.51	0.80	0.67
Standard Error	0.43	0.39	0.37	0.37	0.38	0.37	0.37	0.37	0.37
P-Value	0.619	0.466	0.182	0.298	0.770	0.055	0.163	0.029	0.071
Odds Ratio	0.808	1.325	1.639	1.475	0.896	2.026	1.671	2.233	1.945
Outcome (t-4) Estimate	0.23	0.44	0.03	-0.11	0.26	-0.09	0.25	-0.03	0.07
Standard Error	0.35	0.32	0.31	0.31	0.31	0.32	0.31	0.31	0.31
P-Value	0.516	0.167	0.932	0.722	0.387	0.784	0.421	0.932	0.813
Odds Ratio	1.252	1.553	1.027	0.894	1.303	0.917	1.283	0.974	1.077

Figure VI.7: Mean Predicted UI Employment Rate, by Quarter, by Study Assignment



The predicted employment rate for treatment group members increased during the post-enrollment period from 47% to 50%. In contrast, the predicted employment rate for control group members decreased during the post-enrollment period from 49% to 47%. The predicted difference between treatment and control participants was never statistically significant, but, as can be inferred by the opposing trends, the control group had higher predicted employment rates in the earlier quarters and the treatment group had higher predicted employment rates in the later quarters. By quarter eight, half of the treatment group participants had predicted UI earnings, whereas slightly less than half of control group participants did.

Figure VI.8: Mean Predicted Difference in Employment, by Quarter, by Study Assignment



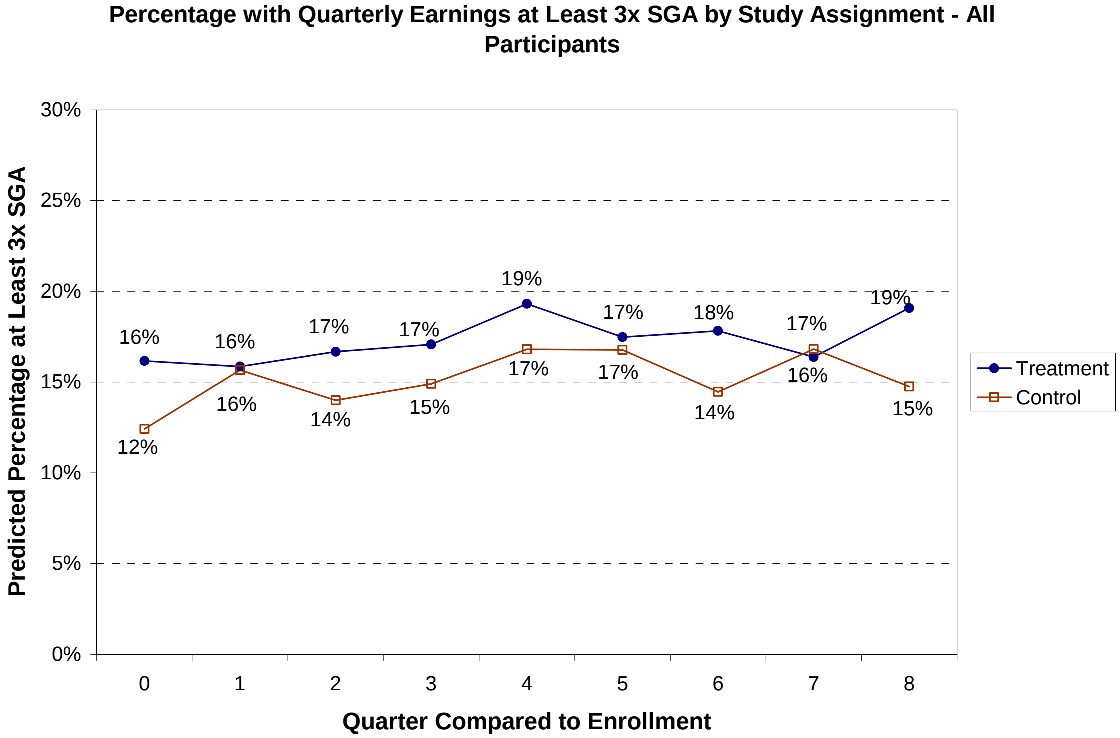
c. SGA Proxy

The logistical regression model for the enrollment quarter for the SGA outcome is $\Pr ob\left(Q0SGA\right) = \frac{1}{1+e^{-\left(B_o + B_1 Q-1SGA + B_2 Q-2SGA + B_3 Q-3SGA + B_4 Q-4SGA + B_5 Assignment\right)}}$. The other eight logistical regression models followed a similar form, and varied only by the predicted quarter on the left side of the equation. The regression results for the enrollment and eight post-enrollment quarters for the dependent variable, UI earnings at least three times SGA, are given in table VI.8. This table includes the sample sizes, the constant estimate, the study assignment coefficient (where treatment = 1 and control = 0), and the coefficients for each of the pre-enrollment quarters (where inflation adjusted UI earnings of at least $2,490 = 1 and UI earnings less than $2,490 = 0). Also included in table VI.8 are the standard errors for each estimate and p-values indicating whether the constant or coefficient is statistically significant, along with the odds ratio for each coefficient. This information is summarized in two subsequent graphs. The first graph, figure VI.9, plots the regression predicted proportion of those with quarterly UI earnings at least three times SGA, whereas the second graph, figure VI.10, shows the difference between the percentages of those in the treatment and control groups imputed to have earnings at or above SGA. Results are again displayed via bars that appear either above (treatment group prediction was higher) or below (control group prediction was higher) the indifference point (0).

Table VI.8: Logistical Regression Adjusted Impact Estimates – SGA Proxy (a.k.a. SSA Table 3)

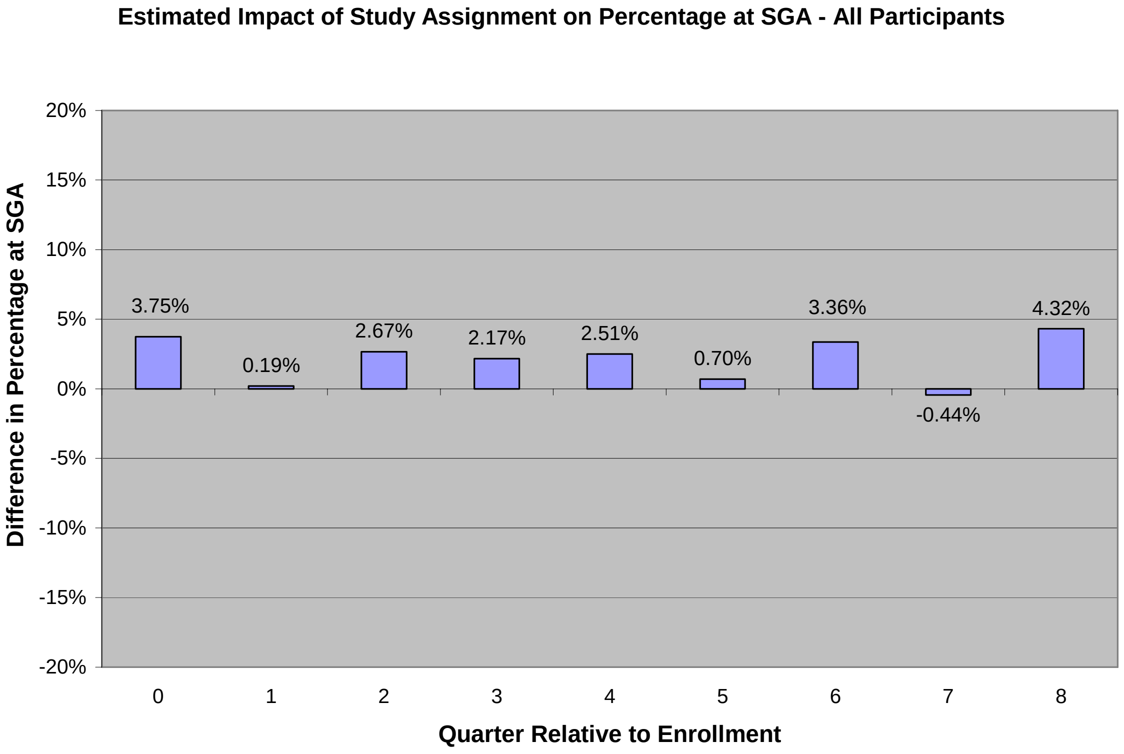
	Enrollment Quarter 0	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Quarter 8
Sample Size									
Treatment	266	264	263	263	263	263	262	262	262
Control	223	220	220	219	217	214	212	207	206
Constant									
Estimate	-2.79	-2.35	-2.44	-2.33	-2.02	-2.04	-2.14	-2.02	-2.18
Standard Error	0.27	0.24	0.24	0.23	0.21	0.21	0.22	0.21	0.23
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Odds Ratio	0.061	0.095	0.087	0.097	0.132	0.130	0.117	0.133	0.113
Treatment									
Estimate	0.24	-0.22	0.10	0.05	0.07	-0.05	0.15	-0.15	0.27
Standard Error	0.32	0.31	0.30	0.29	0.26	0.27	0.27	0.27	0.27
P-Value	0.451	0.472	0.746	0.861	0.786	0.843	0.572	0.573	0.325
Odds Ratio	1.275	0.801	1.101	1.052	1.074	0.948	1.166	0.858	1.306
Outcome (t-1)									
Estimate	3.07	2.97	2.18	2.36	2.12	2.11	1.72	1.59	1.25
Standard Error	0.41	0.40	0.39	0.38	0.37	0.38	0.38	0.37	0.38
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	0.001
Odds Ratio	21.648	19.588	8.889	10.600	8.325	8.276	5.559	4.925	3.475
Outcome (t-2)									
Estimate	0.04	1.09	1.69	0.87	0.84	-0.01	0.99	0.68	1.17
Standard Error	0.52	0.50	0.47	0.47	0.46	0.48	0.46	0.45	0.45
P-Value	0.933	0.031	0.000	0.063	0.067	0.981	0.032	0.136	0.009
Odds Ratio	1.045	2.967	5.438	2.390	2.321	0.989	2.694	1.967	3.220
Outcome (t-3)									
Estimate	0.62	0.31	-0.32	-0.07	0.02	0.59	0.50	0.59	-0.27
Standard Error	0.51	0.53	0.53	0.50	0.48	0.46	0.47	0.45	0.48
P-Value	0.226	0.561	0.546	0.886	0.962	0.196	0.291	0.188	0.582
Odds Ratio	1.854	1.357	0.727	0.931	1.023	1.802	1.651	1.801	0.767
Outcome (t-4)									
Estimate	0.90	0.16	0.50	0.76	0.09	0.37	-0.62	0.32	0.94
Standard Error	0.52	0.55	0.51	0.49	0.49	0.48	0.54	0.48	0.46
P-Value	0.081	0.767	0.325	0.118	0.853	0.446	0.248	0.505	0.042
Odds Ratio	2.458	1.177	1.651	2.142	1.096	1.446	0.535	1.377	2.557

Figure VI.9: Mean Predicted UI $ 3X SGA Rate, by Quarter, by Study Assignment



The predicted percentage with earnings at least three times SGA in a quarter increased for both treatment and control group members during the post-enrollment period, both by three percentage points. Throughout this period, treatment group members typically had a higher predicted three times SGA rate. In the enrollment quarter, the model predicted that 16% of treatment group members would have quarterly earnings three times SGA, whereas only 12% of control group members were predicted as having earnings that would meet the SGA standard. By quarter eight, the logistical regression analysis predicted that 19% of the treatment group participants would have quarterly earnings at least three times the monthly SGA level, whereas the predicted proportion of control group participants with SGA equivalent earnings was 15%. Though the results in the later quarters of the Q0-Q8 period are not statistically significant, they are consistent with an expectation that, because of the offset, treatment group members would have a greater incentive to achieve SGA earnings.

Figure VI.10: Mean Predicted Difference in the SGA Proxy, by Quarter, by Study Assignment



d. Income Proxy

The regression model for the enrollment quarter for the income outcome is

$$\widehat{Q0Income} = B_0 + B_1 Q - 1Income + B_2 Q - 2Income + B_3 Q - 3Income + B_4 Q - 4Income$$
$$+ B_5 Assignment$$

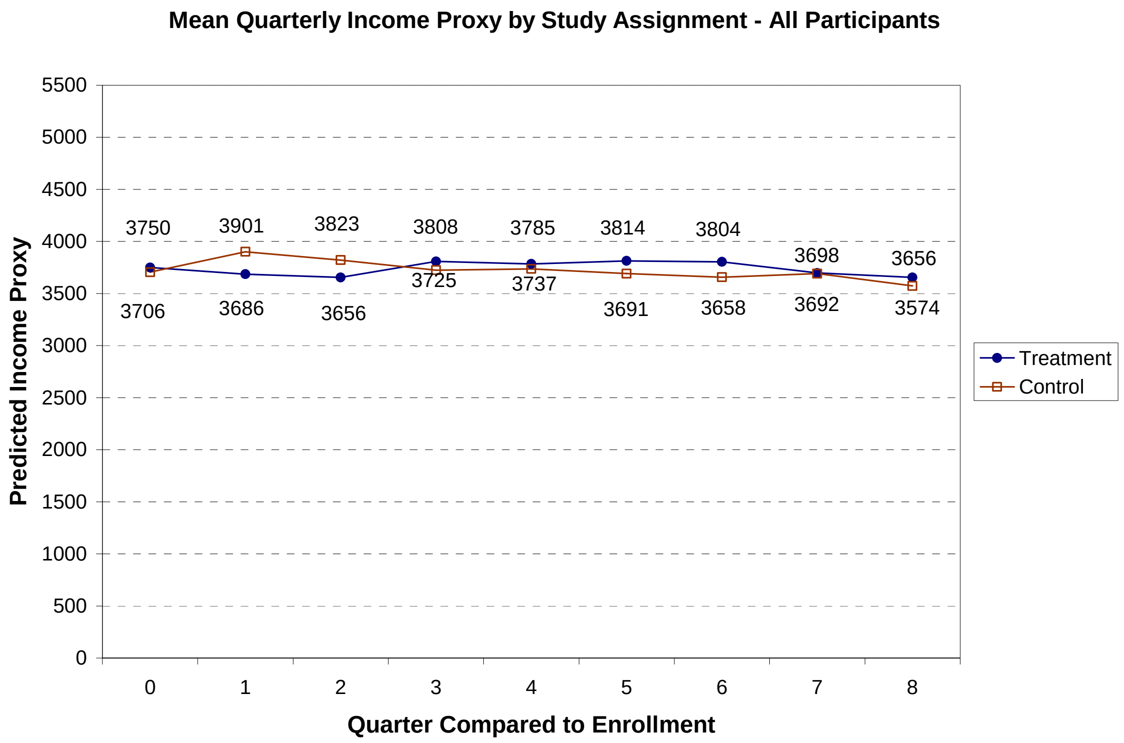
. The other eight regression models followed a similar form, and varied only by the predicted quarter on the left side of the equation. The regression results for the enrollment and eight post-enrollment quarters for the dependent variable, income proxy, are given in table VI.9. This table includes the sample sizes, the constant estimate, the study assignment coefficient (where treatment = 1 and control = 0), and the coefficients for each of the pre-enrollment quarters. Also included in table VI.9 are the standard errors for each estimate and p-values indicated whether the constant or coefficient is statistically significant, along with the effect size for each coefficient. This information is summarized in two subsequent graphs. The first graph, figure VI.11, plots the regression predicted mean value for the quarterly income proxy, whereas the second graph, figure VI.12, shows the difference between the predicted means for the treatment and control groups. These differences are displayed using bars. Bars can appear either above (treatment group prediction was higher) or below (control group prediction was higher) the indifference point (0).

Table VI.9: Linear Regression Adjusted Impact Estimates – Income Proxy (a.k.a. SSA Table 3)

	Enrollment Quarter 0	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Quarter 8
Sample Size Treatment	266	264	263	263	263	263	262	262	262
Control	223	220	220	219	217	214	212	207	206
Constant Estimate	1601.59	1854.24	1669.27	1897.47	2032.36	1725.12	1735.90	1841.59	1901.14
Standard Error	251.03	209.89	210.52	216.40	219.52	225.55	232.40	211.61	218.09
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Treatment Estimate	6.15	-241.67	-194.63	69.06	35.13	89.18	116.40	-18.67	67.12
Standard Error	203.36	170.01	170.68	175.53	178.05	183.27	188.61	172.16	177.55
P-Value	0.976	0.156	0.255	0.694	0.844	0.627	0.537	0.914	0.706
Squared Part Correlation	< 0.001	0.003	0.002	< 0.001	< 0.001	< 0.001	0.001	< 0.001	< 0.001
Outcome (t-1) Estimate	0.24	0.21	0.22	0.18	0.15	0.18	0.18	0.17	0.15
Standard Error	0.04	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Squared Part Correlation	0.076	0.081	0.081	0.058	0.042	0.058	0.054	0.049	0.040
Outcome (t-2) Estimate	0.15	0.15	0.17	0.15	0.14	0.11	0.13	0.12	0.12
Standard Error	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03
P-Value	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Squared Part Correlation	0.029	0.043	0.051	0.041	0.036	0.021	0.030	0.027	0.029
Outcome (t-3) Estimate	0.14	0.11	0.12	0.07	0.08	0.14	0.14	0.12	0.08
Standard Error	0.05	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
P-Value	0.005	0.006	0.003	0.088	0.059	0.001	0.002	0.004	0.065
Squared Part Correlation	0.013	0.012	0.014	0.005	0.006	0.018	0.017	0.014	0.006

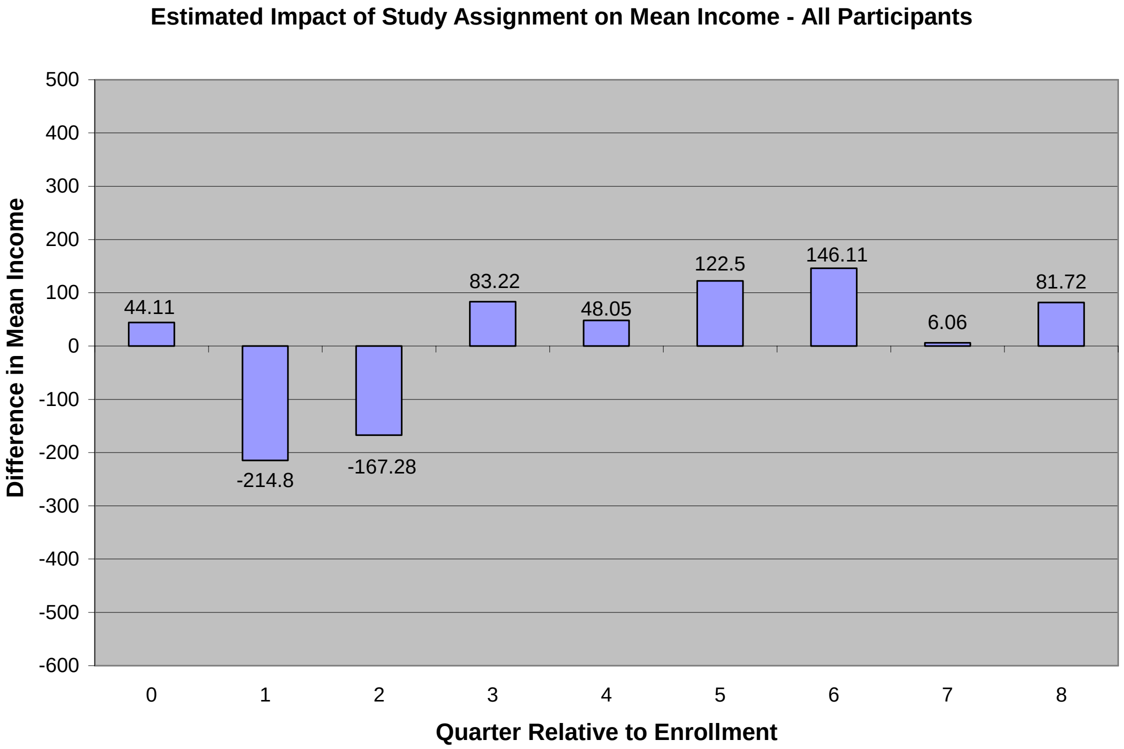
Outcome (t-4) Estimate	0.09	0.12	0.12	0.13	0.13	0.14	0.11	0.14	0.14
Standard Error	0.05	0.04	0.04	0.04	0.04	0.04	0.05	0.04	0.04
P-Value	0.079	0.004	0.005	0.002	0.004	0.002	0.019	0.001	0.002
Squared Part Correlation	0.005	0.013	0.012	0.016	0.015	0.017	0.009	0.018	0.017

Figure VI.9: Mean Predicted Income Proxy, by Quarter, by Study Assignment



There was a predicted decline in the income proxy for both treatment and control participants, consistent with the pattern seen in the raw data. This decline was steeper for control group participants, with an overall post-enrollment decline of $132 (3.6%). In comparison, treatment group participants had an overall post-enrollment decline of $94 (2.5%). The predicted difference between treatment and control participants was never statistically significant. With the exception of Q1 and Q2, treatment participants had a higher predicted mean quarterly income proxy than did control participants. The predicted mean income proxy of treatment participants peaked at Q5 at $3,814 and decreased to $3,656 by quarter eight. The control participants' predicted income did peak during Q1 at $3,901, but did decrease to $3,574 in Q8. At Q8 the predicted treatment income proxy was $82 more the mean predicted income for control group participants.

Figure VI.10: Mean Predicted Difference in Income Proxy, by Quarter, by Study Assignment



2. Subgroup regression analyses

In addition to the regression analyses for the overall comparison between treatment and control participants, SSA required each state to conduct comparable regression analyses for twelve different subgroups. SSA wanted to answer two important questions: 1) Are there any of the twelve subgroups for whom participation in the treatment group seems to motivate an increase in earnings or the probabilities of employment and/or achieving earnings at or above SGA? 2) Are there differences among the twelve subgroups that influence earnings levels, the probability of employment and/or the likelihood of having above SGA earnings? As these questions are just as relevant for understanding how pilot participation and study group assignment affect participants' economic welfare, we have added the income proxy to SSA's list of outcome variables that will be examined.

The regression analyses that were completed comparing the whole treatment group to the whole control group were repeated for each of the twelve different subgroups of SSDI-EP participants.[311] These twelve subgroups used are 1) participants who were enrolled in the Wisconsin Medicaid buy-in program prior to study enrollment, 2) participants who were not enrolled in the Wisconsin Medicaid Buy-in program prior to enrollment, 3) participants ages forty-four and under at enrollment, 4) participants ages forty-five and over at enrollment, 5) males, 6) females, 7) participants who had completed their trial work period (TWP) prior to enrollment, 8) participants who had not yet completed their TWP prior to enrollment, 9) participants who did not have any

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[311] The comparisons made in this section are between treatment and control participants within different subgroups. These analyses say nothing about the differences across subgroups.

earnings (as reported via UI records) in the quarter prior to enrollment, 10) participants who had earnings in the quarter prior to enrollment, 11) participants who had earnings of at least $1,200 in at least one of the four quarters prior to enrollment, and 12) participants whose earnings were less than $1,200 in all of the four quarters prior to enrollment. Though we created tables and graphs for each model fully equivalent to those for the overall regression analyses presented earlier in this chapter, they are not included in this chapter. The material can be found in Appendix B of this report; these tables and graphs are organized in the order subgroup results are presented in this chapter. In lieu of presenting the full set of tables and graphs, we display summary tables for each of the four outcome variables that combine data for all twelve subgroups. Graphs also provide information for multiple subgroups, but to lessen visual confusion for no more than four subgroups at one time.

a. Earnings

As reported, control group members had both higher actual and regression estimated earnings than those in the treatment group in most of the post-enrollment quarters, though differences decreased over time and the treatment group's average earnings exceeded those of the control group in Q8. In any case, none of the differences were statistically significant. This is again confirmed by the p-values displayed in table VI.10. This table also displays the quarter by quarter p-values for the twelve subgroups and, as a reference category, for the full participant group ("all"). Only one of the 117 cells illustrates a statistically significant result (Q1 earnings for females).[312]

Nonetheless, there are a total of seven cells with p-values of less than 0.1. All of these cells are for models run for either Q1 or Q2. These are the quarters in which control group members experienced the most post-enrollment earnings growth, which in turn resulted in the control group's greatest advantage in this outcome relative to the treatment group. The subgroup results are pertinent in that they can identify which subgroups made strong progress in the period just after entering the pilot.

In particular, females in the control group had significantly (p = 0.048) higher mean UI earnings in Q1 than did comparable treatment group participants during the first quarter following enrollment. This difference also neared significance for three other subgroups: those not in the Medicaid Buy-in the quarter prior to enrollment (p = 0.092), those with earnings reported for Q-1 (p = 0.093), and those who did not have earnings of at least $1,200 during at least one of the pre-enrollment quarters (p = 0.068). In the following quarter (Q2), the difference also neared significance for the whole group (all participants, p = 0.090) and the subgroup of those who did not have any pre-enrollment (Q-4 to Q-1) quarter earnings of at least $1,200 (p = 0.075). There were no other quarters where differences between treatment and control group earnings, whether for a subgroup or the all participant group, were statistically significant or the p-value was equal or less than 0.1.

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[312] Table VI.10 displays the p-values for the linear regression ran for all the participants and each subgroup for the enrollment quarter and the eight post-enrollment quarters.

Table VI.10: P-Value for Linear Regression Adjusted Impact Estimates on Study Assignment for Subgroups – Earnings

	Enrollment Quarter 0	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Quarter 8
All	0.825	0.093	0.090	0.618	0.451	0.589	0.981	0.486	0.886
Medicaid Buy-In	0.349	0.573	0.442	0.964	0.659	0.538	0.720	0.869	0.858
No Medicaid Buy-In	0.861	0.092	0.131	0.533	0.483	0.694	0.775	0.394	0.914
Ages 44 or Less	0.579	0.131	0.277	0.600	0.288	0.239	0.426	0.500	0.566
Ages 45 or More	0.883	0.382	0.362	0.958	0.826	0.533	0.184	0.941	0.349
Male	0.346	0.929	0.745	0.587	0.451	0.567	0.274	0.614	0.113
Female	0.256	0.048[313]	0.104	0.256	0.152	0.327	0.554	0.281	0.448
TWP Completed	0.972	0.355	0.423	0.732	0.501	0.963	0.804	0.628	0.820
TWP not Completed	0.964	0.176	0.214	0.846	0.840	0.563	0.894	0.714	0.752
Pre-Enrollment Earnings	0.891	0.093	0.128	0.358	0.174	0.382	0.704	0.430	0.897
No Pre-Enrollment Earnings	0.505	0.544	0.341	0.854	0.791	0.842	0.708	0.889	0.922
$1200 Pre-Enrollment Earnings	0.718	0.612	0.445	0.932	0.609	0.800	0.897	0.426	0.960
No $1200 Pre-Enrollment Earnings	0.318	0.068	0.075	0.581	0.572	0.649	0.954	0.846	0.769

Though, with the single exception, differences in subgroups' mean earning were not statistically significant, the level and direction of differences did vary from subgroup to subgroup. In some subgroups the control group had higher average earnings within a given quarter, whereas in other subgroups the treatment group had higher average earnings in the same quarter. These differences are displayed in three subsequent bar graphs. These graphs simply display differences between treatment and control participants within subgroups and include, for reference, those for the full participant group. Each bar represents the difference between treatment and control participants in the mean UI regression predicted earnings. When this difference is statistically significant ($p < 0.05$), an asterisk is placed either under or above the bar.

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[313] All significant p-values (those equal to or less than 0.05) are highlighted in yellow.

Figure VI.11: Study Assignment Difference in Mean UI Predicted Earnings, All Participants Compared to Gender and Age Subgroups

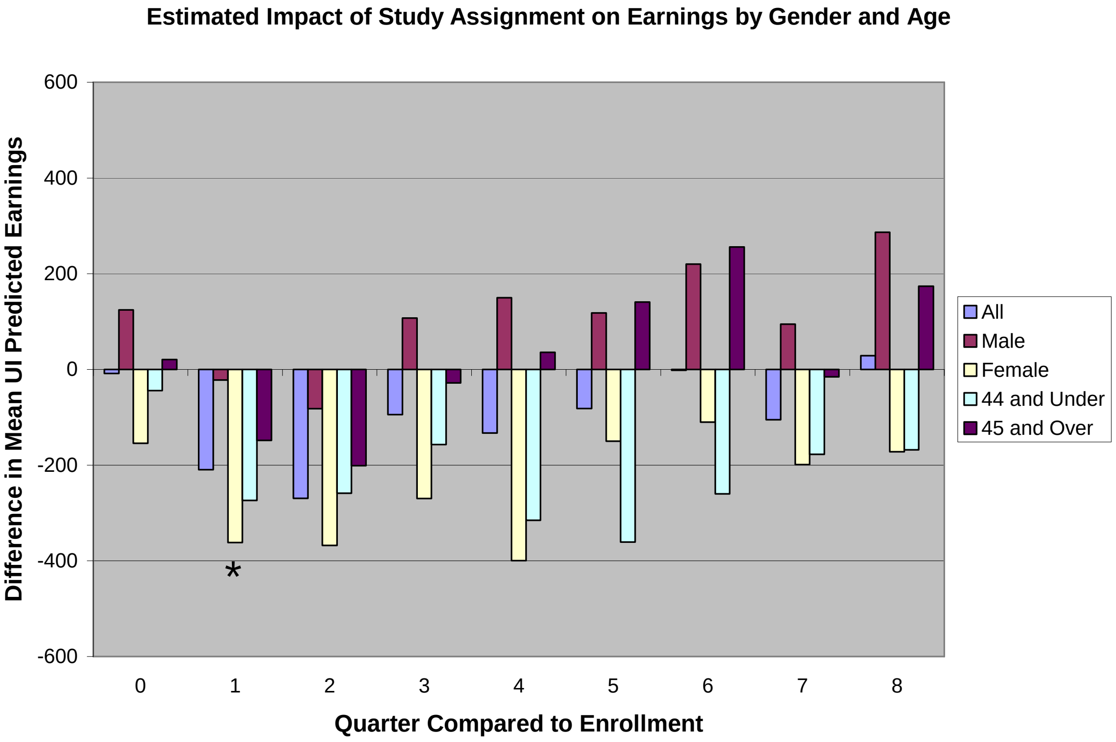

Figure VI.11 compares the treatment and control regression predicted differences in mean UI earnings for all participants and for the following four subgroups: males, females, participants no more than forty-four years old, and those forty-five years or older. For female participants and participants ages forty-four years and younger, the control group participants averaged more earnings than treatment group participants during every quarter (Q0 to Q8). This difference (favoring the control group participants) was always larger than what was observed for all participants and was statistically significant in Q1 for the female subgroup.[314] Almost the opposite pattern was observed for the male participants and the participants who were forty-five years or older. Male treatment participants earned on average more than male control participants in all quarters with the exceptions of quarters one and two. This difference seemed to grow over time and was largest in Q8, but was still not statistically significant. A similar pattern was observed for participants forty-five years and older, but the predicted difference was usually smaller.

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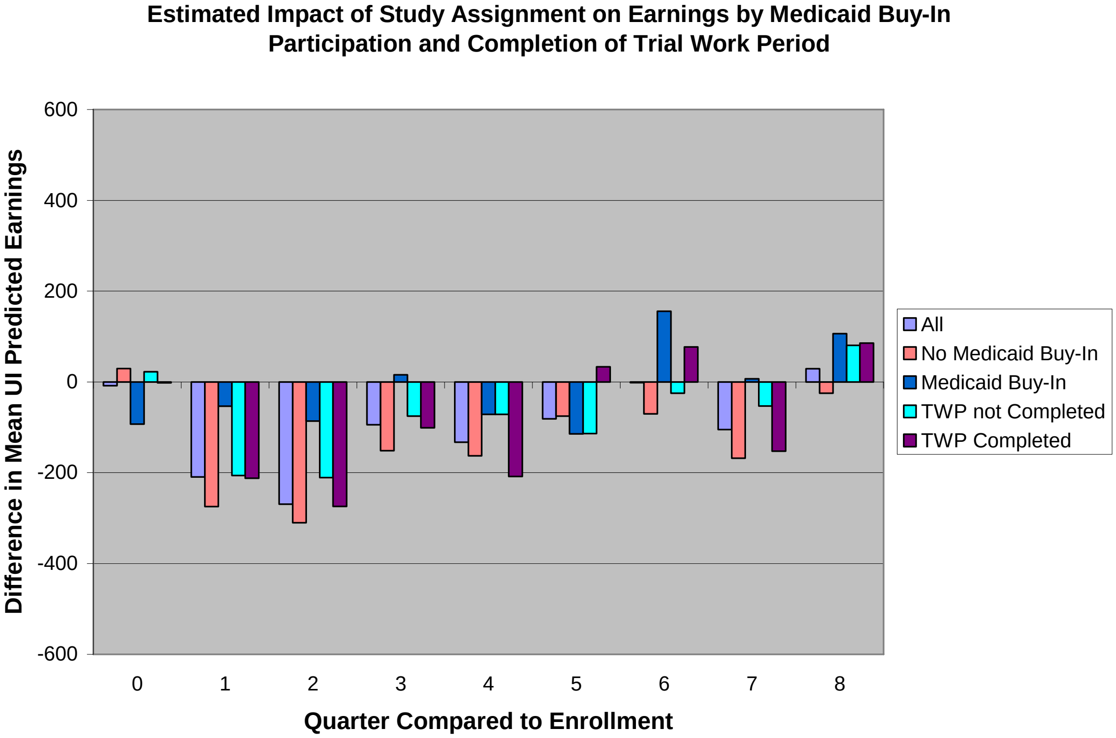
[314] In this chapter, the statement of a difference favoring one group or another refers to which group had the higher value for an employment outcome.

Figure VI.12: Study Assignment Difference in Mean UI Predicted Earnings, All Participants Compared to Buy-in and TWP Subgroups



The differences between those assigned to treatment and control groups for the other subgroups are not as pronounced as those observed for the full participant group. Still, differences are present, albeit never achieving statistical significance. These are displayed in figures VI.12 and VI.13. The pattern of differences observed between treatment and control participants who were not in the Medicaid Buy-In and participants who had not completed their TWP at the time of enrollment was very similar to what was observed for the all participant group. Control group participants generally earned more than treatment group participants. Nonetheless, this difference tended to decrease over time. In contrast, the difference in favor of the control group is typically smaller and at times even favored treatment group participants who were enrolled in the Medicaid Buy-In at Q-1, those who completed their TWP at the time of enrollment, and those with no earnings in the quarter immediately prior to pilot enrollment.

Finally, for participants with earnings in the quarter (Q-1) immediately preceding enrollment, differences favored the control group participants to a greater extent than what was observed for all participants. For those participants with no earnings in Q-1, figure VI.13 displays mean UI earnings greater for the treatment group during Q3, Q4, Q5, Q6, and Q8. For those participants with “pre-enrollment” (Q-1) earnings the same figure displays UI earnings greater for the control group during Q1 to Q7.[315]

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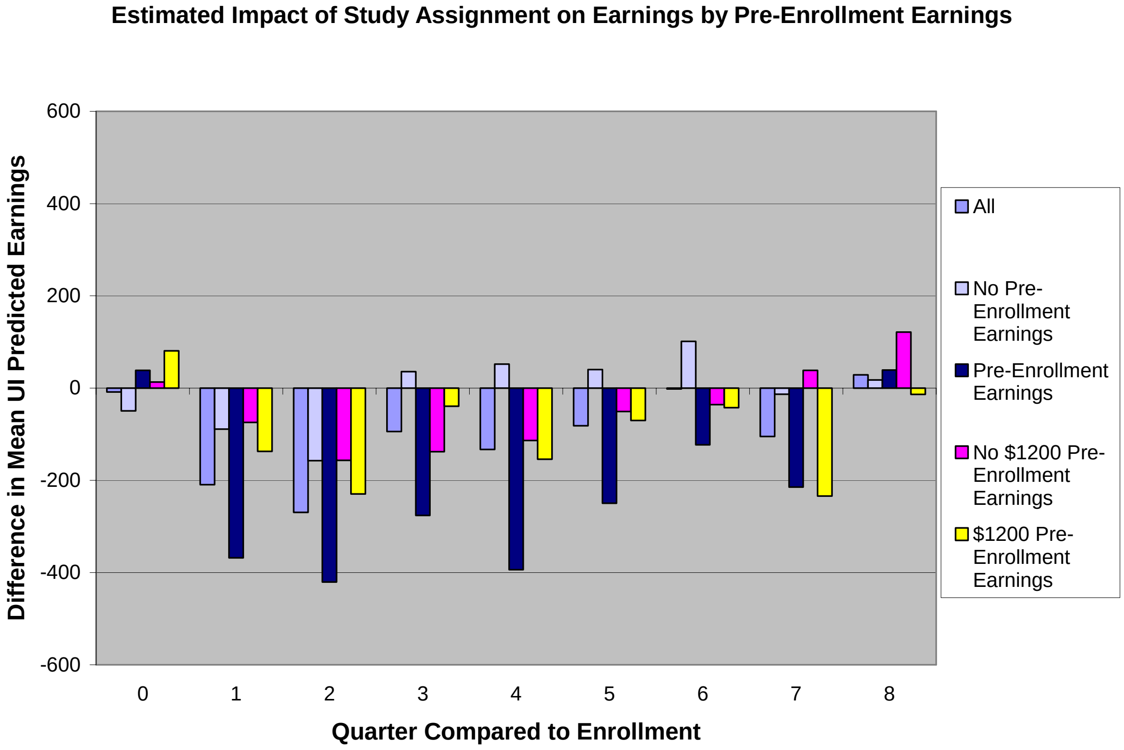
[315] This means that within the no pre-enrollment (Q-1) earnings subgroup, the treatment group participants often averaged more earnings than the control group participants. This does not mean that participants with no earnings for Q-1 earned more than participants with earnings for that quarter. Those with earnings in the last quarter of pre-enrollment period always earned more than participants with no pre-enrollment earnings. These graphs simply display differences

Figure VI.13: Study Assignment Difference in Mean UI Predicted Earnings, All Participants Compared to Pre-Enrollment Earnings Subgroups



b. Employment rates

As reported previously, the differences in UI employment rates favored the control group in the earlier post-enrollment quarters, but favored the treatment group in later quarters. None of these differences in the all participant group were significant, though the difference in Q6 favoring the treatment group generated a near significance p-value of 0.078. The p-values of the treatment and control group differences for the subgroups are reported in table VI.11. For Q1, the difference always favored control group participants and was statistically significant for pre-enrollment earners (p = 0.023) and neared significance for the non Medicaid Buy-in and the TWP not completed subgroups (p < 0.10). For Q6, the difference always favored treatment group participants and was statistically significant for the Medicaid Buy-in subgroup (p = 0.036) and neared significance for the male, TWP completers, and $1,200 earners subgroups.

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between treatment and control participants within subgroups. They show nothing of the differences between subgroups (e.g., pre-enrollment earners vs. no pre-enrollment earners).

Table VI.11: P-Value for Linear Regression Adjusted Impact Estimates on Study Assignment for Subgroups – Employment

	Enrollment Quarter (t)	Quarter (t+1)	Quarter (t+2)	Quarter (t+3)	Quarter (t+4)	Quarter (t+5)	Quarter (t+6)	Quarter (t+7)	Quarter (t+8)
All	0.607	0.113	0.748	0.667	0.776	0.765	0.078	0.266	0.260
Medicaid Buy-In	0.670	0.616	0.639	0.191	0.507	0.255	0.036	0.207	0.509
No Medicaid Buy-In	0.437	0.099	0.918	0.777	0.446	0.665	0.466	0.635	0.389
Ages 44 or Less	0.159	0.277	0.660	0.881	0.771	0.683	0.303	0.210	0.620
Ages 45 or More	0.550	0.196	0.373	0.704	0.795	0.565	0.171	0.768	0.389
Male	0.947	0.258	0.699	0.903	0.747	0.460	0.068	0.160	0.287
Female	0.417	0.274	0.946	0.456	0.989	0.754	0.468	0.831	0.590
TWP Completed	0.401	0.891	0.113	0.253	0.243	0.223	0.098	0.097	0.801
TWP not Completed	0.378	0.076	0.227	0.913	0.445	0.957	0.194	0.574	0.198
Pre-Enrollment Earnings	0.124	0.023	0.173	0.251	0.252	0.865	0.182	0.510	0.938
No Pre-Enrollment Earnings	0.561	0.799	0.481	0.108	0.543	0.826	0.205	0.387	0.119
$1200 Pre-Enrollment Earnings	0.368	0.847	0.686	0.827	0.759	0.218	0.051	0.238	0.824
No $1200 Pre-Enrollment Earnings	0.920	0.133	0.946	0.633	0.978	0.683	0.439	0.610	0.236

Figure VI.14: Study Assignment Difference in Percentage Employed, All Participants Compared to Gender and Age Subgroups

As depicted in figure VI.14, the male, female, forty-four and under, and forty-five and over subgroups have treatment/control difference patterns similar to those predicted for all study participants with employment rates favoring the control group in earlier quarters and the treatment group in later quarters. Further, the magnitude of these differences does not seem to be increased or decreased within these subgroups. Similar patterns can also be observed in figure VI.15 for those who were not Medicaid Buy-in participants and TWP non-completers. By contrast, differences in favor of the treatment group are much larger for the Medicaid Buy-in and TWP completer subgroups. Similar to the differences in earnings, those with no pre-enrollment (Q-1) earnings had differences that were more likely to favor treatment group participants, whereas those with pre-enrollment earnings had differences that were more likely to favor control group participants (see figure VI.16).

Figure VI.15: Study Assignment Difference in Percentage Employed, All Participants Compared to Buy-in and TWP Subgroups

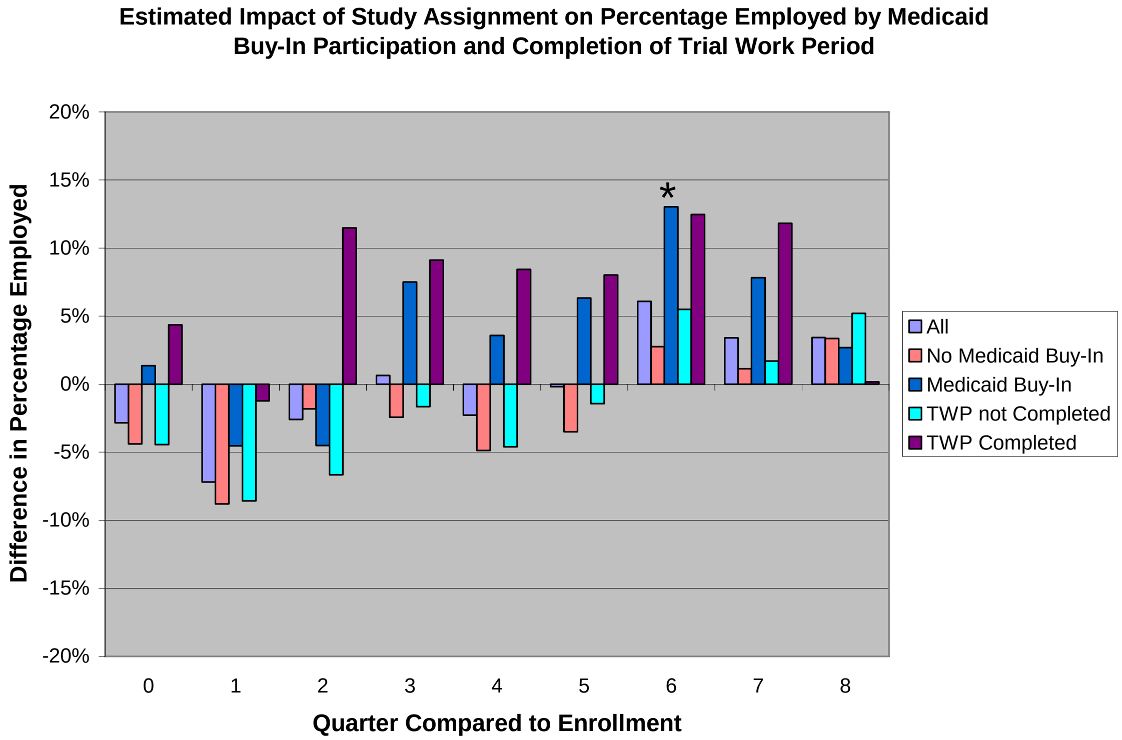
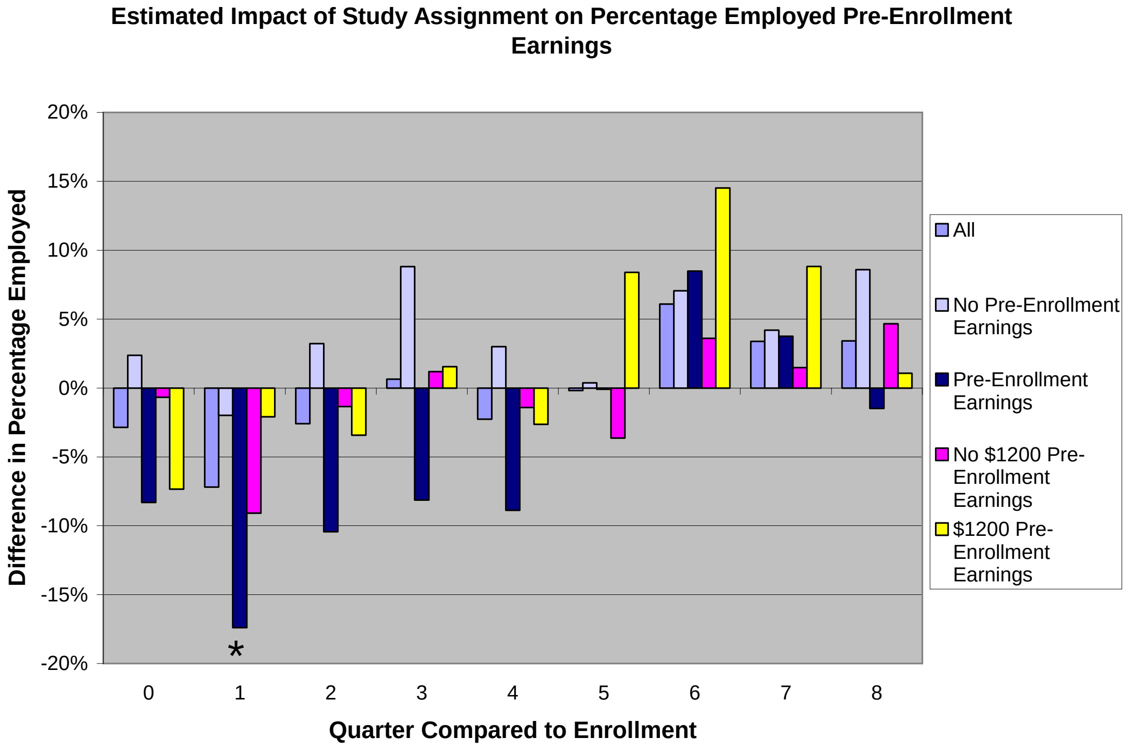


Figure VI.16: Study Assignment Difference in Percentage Employed, All Participants Compared to Pre-Enrollment Earnings Subgroups



c. SGA proxy

The general pattern for all participants was that a higher proportion of treatment group participants had earnings imputed to be at or above SGA than participants assigned to the control group. This was true for the enrollment quarter and the eight post-enrollment quarters. However, the difference was not statistically significant for any quarter. The p-values for this difference for the subgroups are displayed in table VI.12. This difference favoring the treatment group neared significance ($p < 0.10$) for the male subgroup in Q1 and Q8 and the $1,200 pre-enrollment earnings subgroup in Q1. The subgroup with no pre-enrollment quarter with $1,200 in earnings had a difference that favored the control group that in Q2 neared significance ($p < 0.10$).

Table VI.12: P-Value for Linear Regression Adjusted Impact Estimates on Study Assignment for Subgroups – SGA

	Enrollment Quarter (t)	Quarter (t+1)	Quarter (t+2)	Quarter (t+3)	Quarter (t+4)	Quarter (t+5)	Quarter (t+6)	Quarter (t+7)	Quarter (t+8)
All	0.451	0.472	0.746	0.861	0.786	0.843	0.572	0.573	0.325
Medicaid Buy-In	0.782	0.852	0.164	0.496	0.922	0.940	0.947	0.870	0.420
No Medicaid Buy-In	0.488	0.264	0.343	0.720	0.870	0.580	0.502	0.414	0.690
Ages 44 or Less	0.944	0.476	0.907	0.993	0.870	0.353	0.565	0.339	0.678
Ages 45 or More	0.351	0.472	0.755	0.796	0.531	0.525	0.131	0.826	0.319
Male	0.057	0.679	0.399	0.250	0.215	0.769	0.261	0.942	0.055
Female	0.456	0.190	0.619	0.306	0.323	0.551	0.755	0.416	0.674
TWP Completed	0.261	0.469	0.263	0.880	0.560	0.851	0.716	0.735	0.144
TWP not Completed	0.536	0.408	0.943	0.555	0.697	0.953	0.505	0.788	0.521
Pre-Enrollment Earnings	0.191	0.941	0.191	0.866	0.647	0.895	0.566	0.232	0.208
No Pre-Enrollment Earnings	0.534	0.246	0.257	0.803	0.981	0.966	0.747	0.616	0.805
$1200 Pre-Enrollment Earnings	0.098	0.540	0.172	0.792	0.801	0.766	0.659	0.177	0.279
No $1200 Pre-Enrollment Earnings	0.329	0.092	0.329	0.978	0.878	0.616	0.610	0.574	0.733

While overall rates for having SGA or higher earnings favored the treatment group, this difference was magnified (in favor of the treatment group) for some subgroups and reversed for other subgroups. As shown in figures VI.17 and VI.18, males, those forty-five years and older, and those who completed their TWP prior to enrollment generally had larger differences favoring the treatment group compared to those estimated for the overall group (all participants). By contrast, the difference was either smaller or favored control group participants for both female participants and those forty-four years and younger.

Figure VI.17: Study Assignment Difference in Percentage at SGA, All Participants Compared to Gender and Age Subgroups

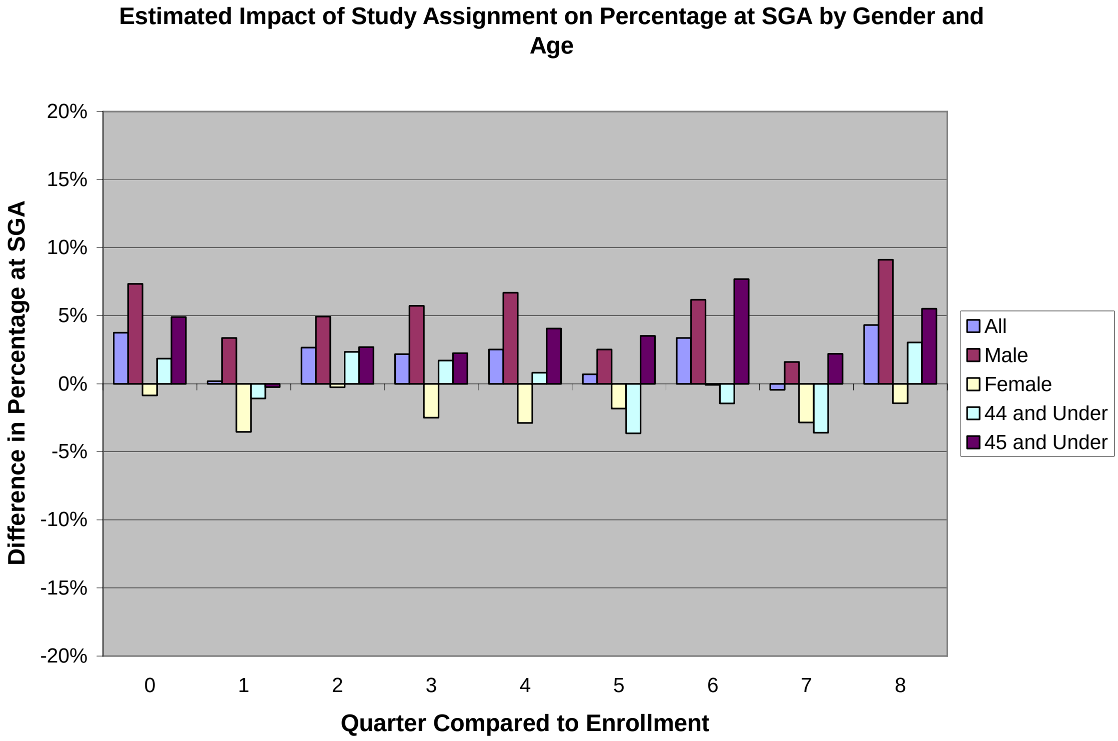


Figure VI.18: Study Assignment Difference in Percentage at SGA, All Participants Compared to Pre-Enrollment Earnings Subgroups

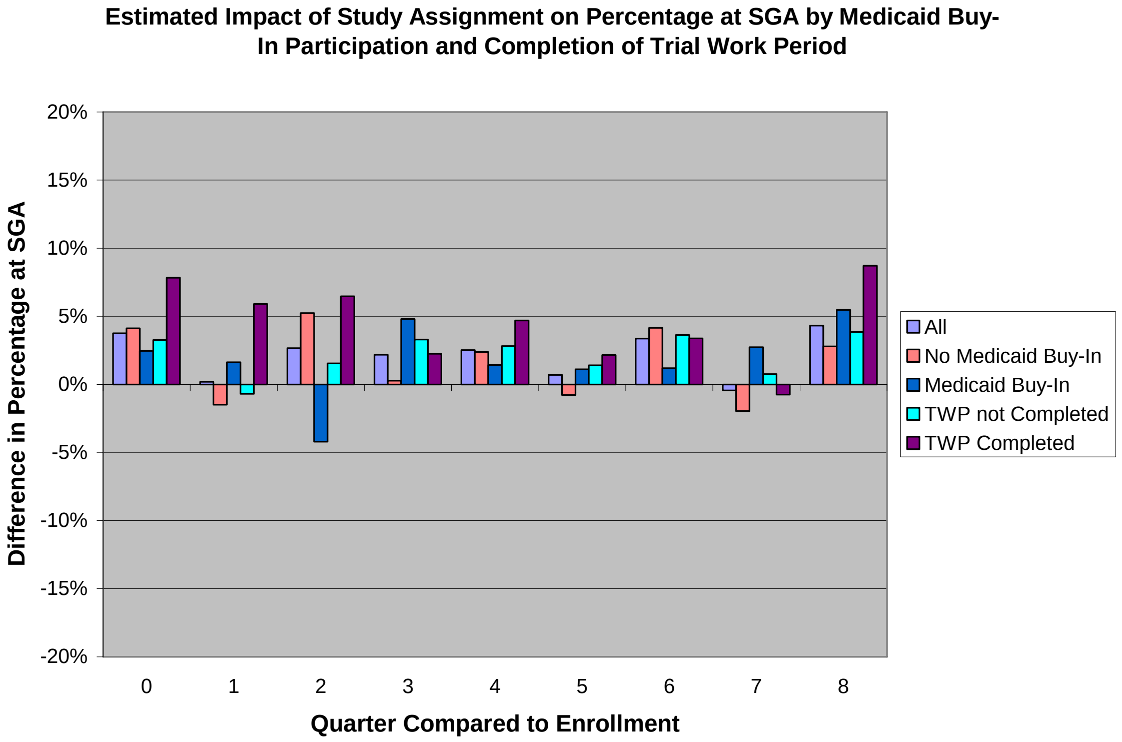
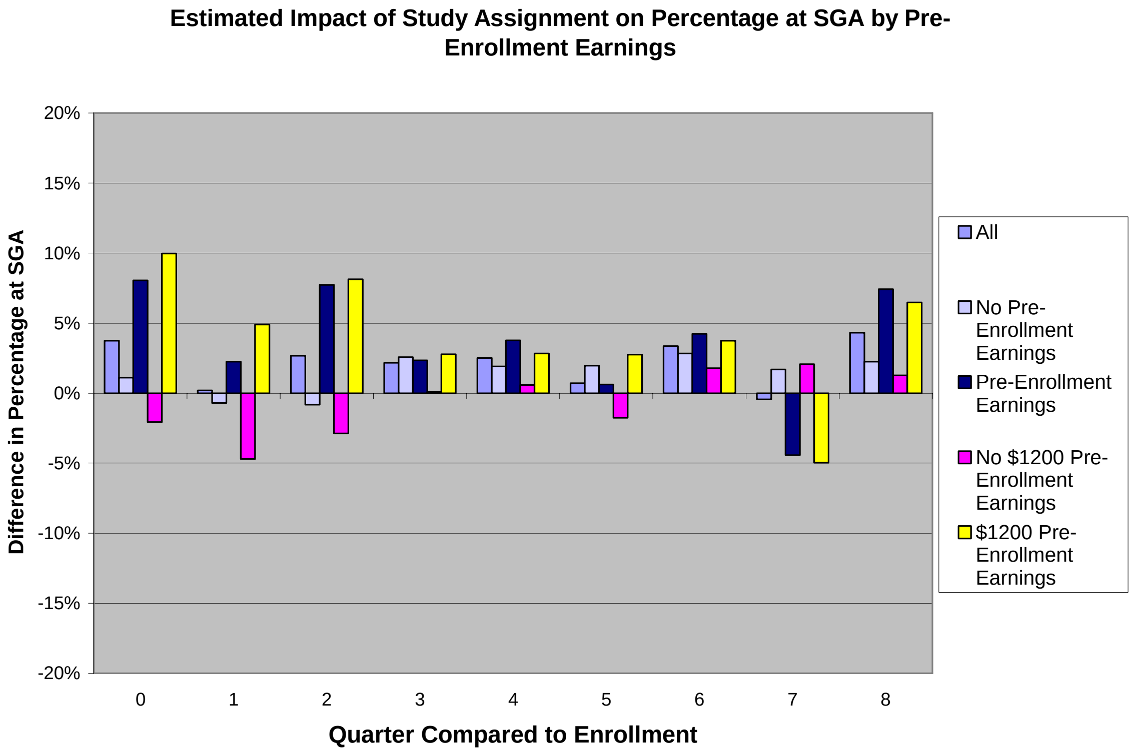


Figure VI.19: Study Assignment Difference in Percentage at SGA, All Participants Compared to Pre-Enrollment Earnings Subgroups



There are less consistent findings for the different earners subgroups. This information appears in figure VI.19. For the most part, the difference favored treatment group members at a higher magnitude than was observed for the all participant group, for those with UI earnings in Q-1 or those having at least one quarter in the Q-4 through Q-1 period with at least $1,200 earnings. By contrast, those without earnings in Q-1 or at least one pre-enrollment period quarter with $1,200 in earnings revealed differences that either favored the control group or favored the treatment group less than what was observed for the full participant group (with the exception of Q7).

d. Income Proxy

Table VI.13 displays p-values for the quarter by quarter regression models run for the income proxy. For most post-enrollment quarters, the all participant models generally estimated higher average incomes (using the income proxy variable) for the treatment group than for the control group. The only exceptions are Q1 and Q2. Though differences after Q2 are in a consistent direction, in no case do the p-values come close to statistical significance.

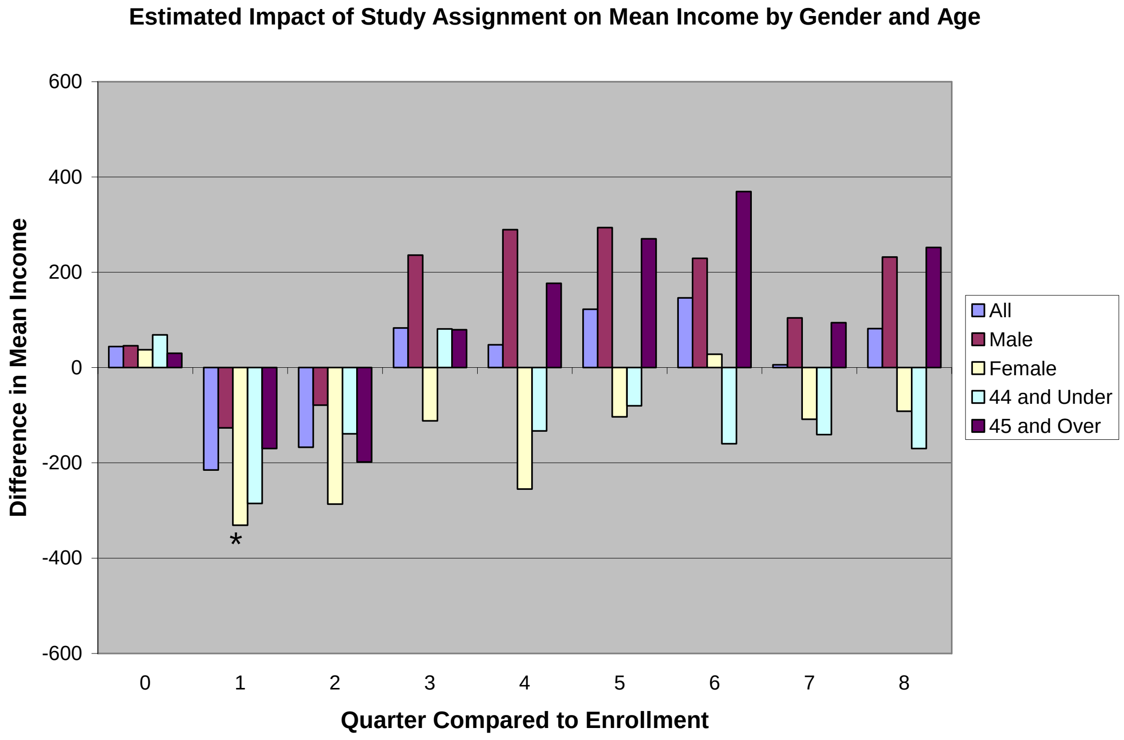
A similar pattern is observed for most of the subgroups. The income proxy consistently averaged higher for control participants in Q1 and Q2 and just missed significance in Q1 for the female subgroup (p = 0.05 rounded). Following Q2, the income proxy was typically higher for treatment participants across most subgroups. This difference approached significance in Q4 for the male subgroup and in Q6 for the forty-five and older subgroup. Again the results are suggestive, but not strong enough to confirm that the overall pattern isn't a chance result.

Table VI.13: P-Value for Linear Regression Adjusted Impact Estimates on Study Assignment for Subgroups – Income Proxy

	Enrollment Quarter (t)	Quarter (t+1)	Quarter (t+2)	Quarter (t+3)	Quarter (t+4)	Quarter (t+5)	Quarter (t+6)	Quarter (t+7)	Quarter (t+8)
All	0.976	0.156	0.255	0.694	0.844	0.627	0.537	0.914	0.706
Medicaid Buy-In	0.703	0.745	0.672	0.737	0.964	0.887	0.454	0.653	0.501
No Medicaid Buy-In	0.810	0.219	0.405	0.798	0.726	0.474	0.626	0.810	0.925
Ages 44 or Less	0.830	0.223	0.638	0.686	0.762	0.864	0.693	0.786	0.681
Ages 45 or More	0.903	0.554	0.476	0.575	0.250	0.176	0.053	0.499	0.161
Male	0.758	0.857	0.954	0.155	0.071	0.132	0.191	0.337	0.106
Female	0.739	0.050	0.126	0.375	0.225	0.432	0.825	0.427	0.495
TWP Completed	0.767	0.536	0.613	0.582	0.693	0.210	0.252	0.740	0.496
TWP not Completed	0.947	0.250	0.358	0.766	0.806	0.996	0.892	0.897	0.835

Pre-Enrollment Earnings	0.822	0.181	0.453	0.770	0.968	0.701	0.679	0.841	0.478
No Pre-Enrollment Earnings	0.760	0.707	0.524	0.515	0.449	0.411	0.332	0.729	0.736
$1200 Pre-Enrollment Earnings	0.112	0.804	0.671	0.128	0.240	0.174	0.260	0.519	0.502
No $1200 Pre-Enrollment Earnings	0.549	0.204	0.135	0.780	0.846	0.916	0.766	0.969	0.674

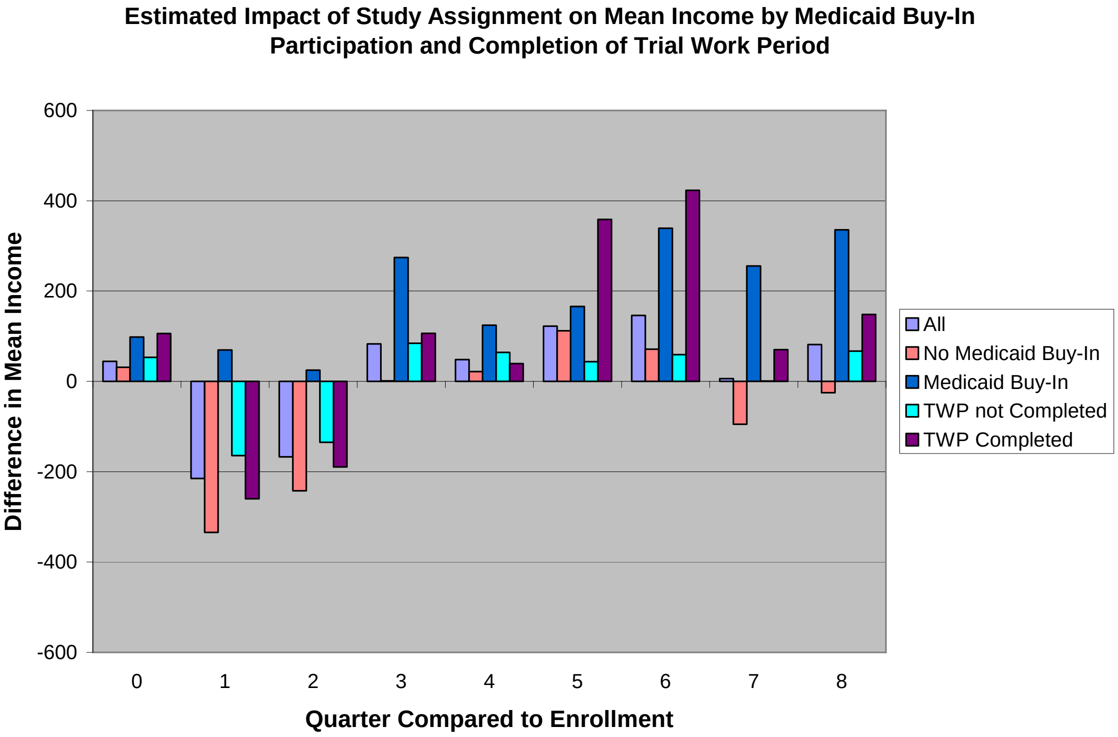
Figure VI.20: Study Assignment Difference in Income Proxy, All Participants Compared to Age and Gender Subgroups



Differences in mean income between treatment and control participants appear in the results for multiple subgroups in quarters three through eight. During these quarters, income was generally larger for treatment participants as compared to control participants for those individuals who were male and for those at least forty-five years old. In contrast, income was generally larger for control participants, as compared to treatment participants, for those individuals who were female or were in the forty-four and under age group. These differences are visually depicted in figure VI.20.

Figure VI.21 exhibits differences for the subgroups based on Medicaid Buy-in and TWP completion statuses prior to enrollment. Again, differences between treatment and control participants in the estimated means for the Q3 through Q8 period generally favored treatment participants for all four of the included subgroups. These included both those who were in the Medicaid Buy-in utilization and non-utilization subgroups. Similarly, it included both TWP completers and non-completers. However, the differences favoring the treatment group were much larger for the Medicaid Buy-in participants and the TWP completers.

Figure VI.21: Study Assignment Difference in Income Proxy, All Participants Compared to Buy-in and TWP Subgroups



Given the Buy-in related results shown in figure VI.21 and that Pathways both administers a Medicaid Infrastructure Grant and is deeply involved in ongoing policy development for Wisconsin's Medicaid Buy-in, we had an interest in identifying any joint impact of pilot participation and of utilization of the state's Medicaid Buy-in program on participants' incomes, especially of treatment group members who might be able to use the pilot's offset provision. Ideally, these two work incentives would reinforce each other. One indicator of positive joint effect would be if utilization of both resulted, on average, in higher income.

The regression results for the Medicaid Buy-in subgroup analysis provide a way to explore this possibility, albeit with limitations. First, this subgroup consists of individuals identified as participating in the Medicaid Buy-in prior to enrolling in the pilot. It says nothing about the whether a given individual participated in the Buy-in during the enrollment quarter or any portion of the Q0-Q8 period. Second, even though treatment group members could potentially use the benefit offset (once they completed their TWP), only a small group of treatment participants utilized the benefit offset. Further, they did not do so in either every post-enrollment quarter or every quarter following TWP completion, if that event occurred during the study period. In any case, the analysis would always be subject to the inherent limitations of the proxy measure itself.

Given these limitations, it is still interesting to note that the mean predicted income proxy for the Medicaid Buy-in subgroup was higher for the treatment participants than for control participants especially during the later post-enrollment quarters. This difference is illustrated in figure VI.22. Moreover, the pace of increase was faster for the treatment group. For those assigned to treatment, the average predicted mean for the income proxy increased by $219 (nearly 7%), from $3,326 in Q0 to $3,545 in Q8. By contrast, the average predicted income proxy for control participants decreased by $18 (0.6%); from $3,227 in Q0 to $3,209 in Q8. Also, within quarter differences tended to increase over time in favor of the treatment group. These trends can be discerned by examining figure VI.23. In Q0 the mean difference was $98, by Q8 it was $335.

Figure VI.22: Mean Predicted Income Proxy, by Quarter, by Study Assignment for Medicaid Buy-in Subgroup

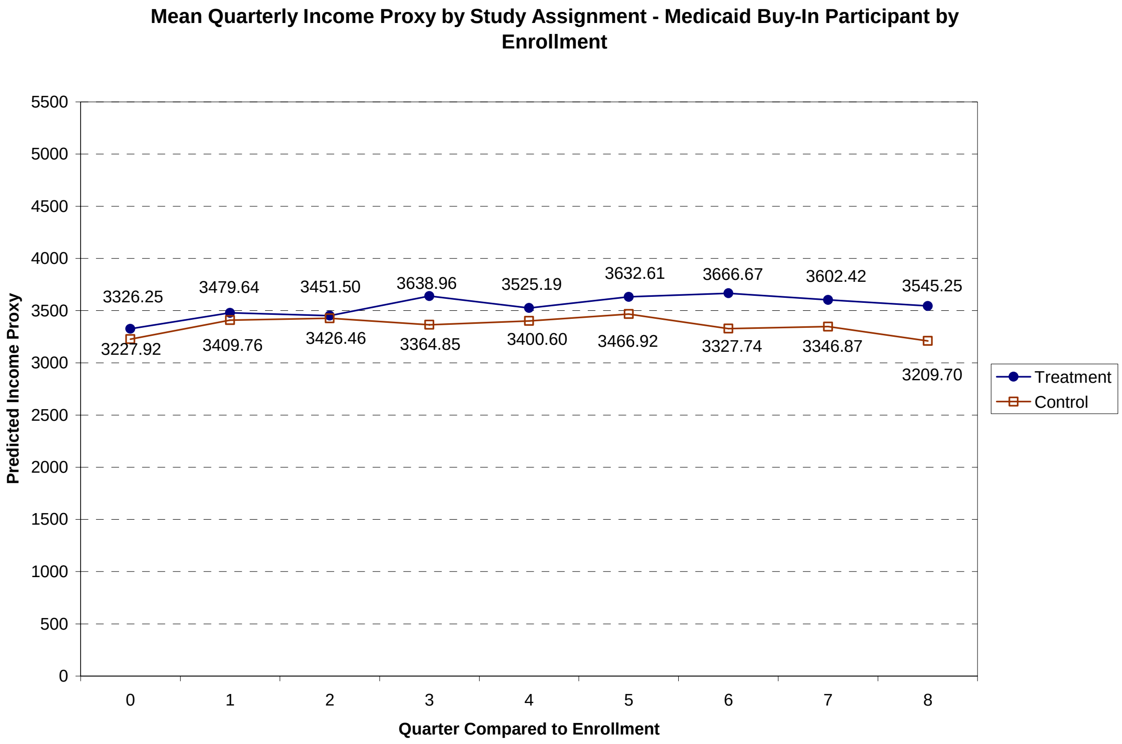
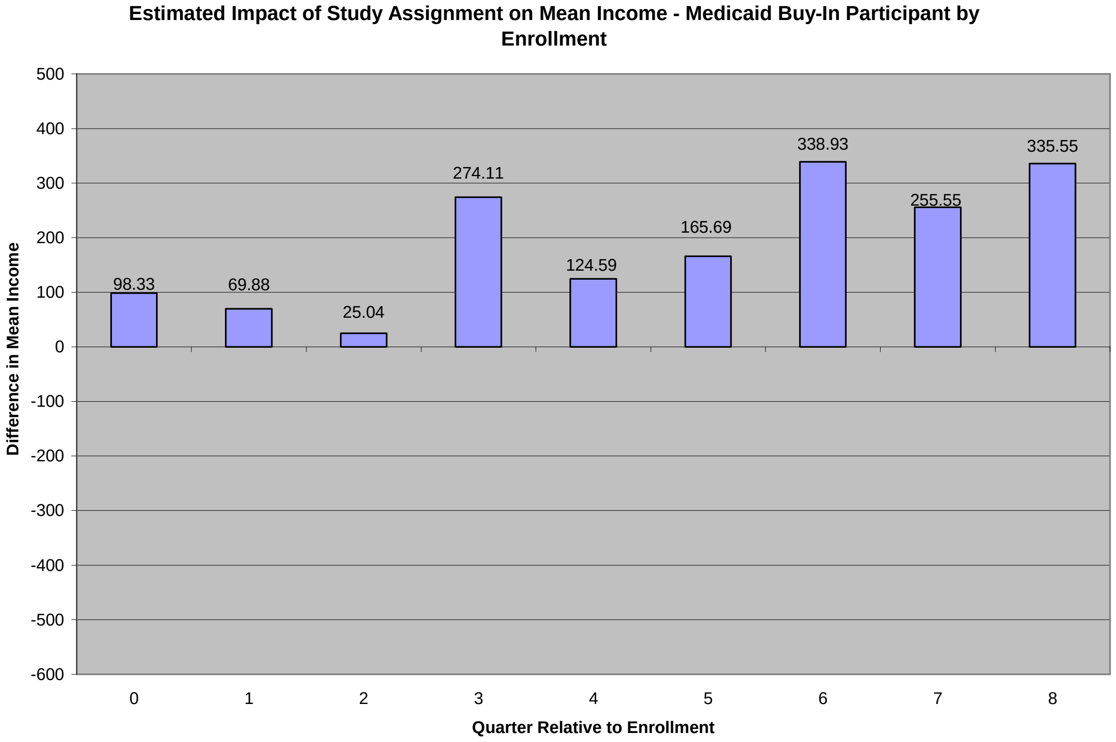


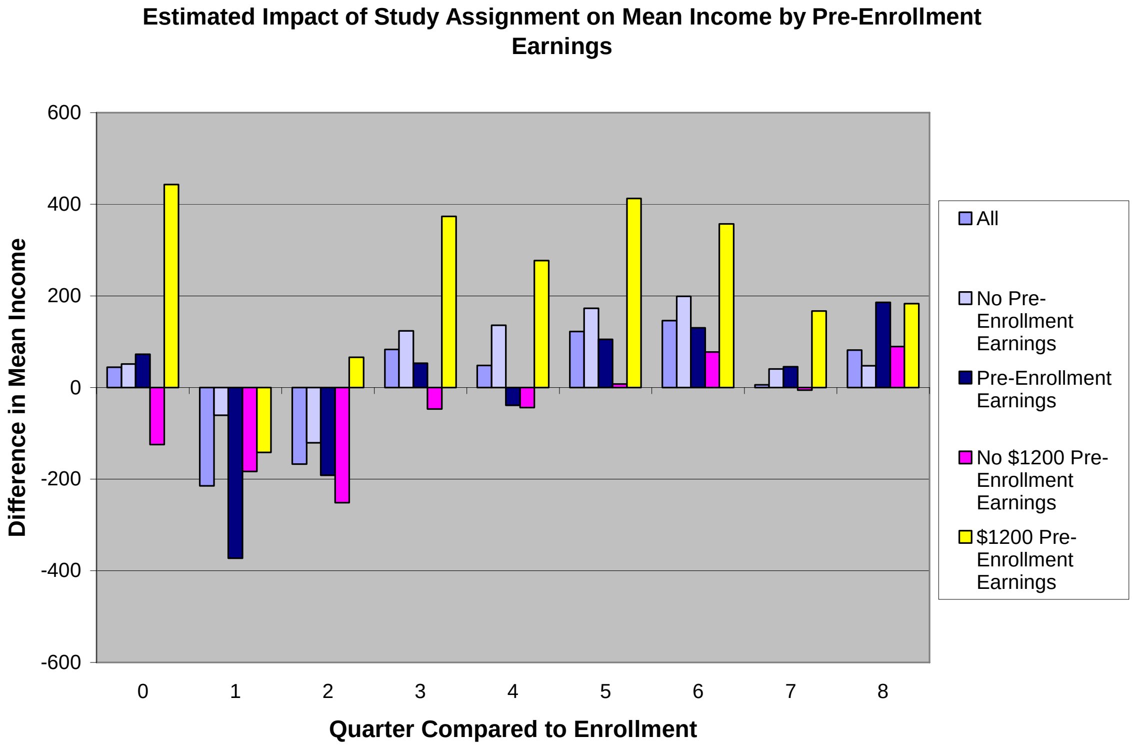
Figure VI.23: Study Assignment Difference in Income Proxy, Medicaid Buy-in Subgroup



Additionally, it is worth comparing the results displayed in figures VI.22 and VI.23 with those for both the actual and estimated income trends presented earlier in this chapter. For instance, between Q0 and Q8, the actual mean values for the income proxy declined $93 for the treatment group and $144 for the control group. The decreases calculated from the regression estimates were nearly identical. Clearly those in the Buy-in subgroup did better in converting increases in earnings into increases in income as measured through the income proxy. Those assigned to the control group almost broke even, while those in the treatment group came out ahead. What isn't clear is whether or how Buy-in participation contributed to these results.

Finally, figure VI.24 provides information about the four subgroups defined by pre-enrollment earnings or lack thereof, whether defined by having Q-1 earnings or having at least one quarter with earnings of at least $1,200 during the Q-4 through Q-1 period. Again, the differences observed from Q3 onward favor the treatment group and often more strongly than the comparable data for the full participant group. The effect is strongest for the subgroup of those who had at least $1,200 in earnings in one or more of the pre-enrollment quarters.

Figure VI.24: Study Assignment Difference in Income Proxy, All Participants Compared to Pre-Enrollment Earnings Subgroups



C. State Specific Analyses: Repeated Measures MANOVA

Unfortunately, calculating a regression model for each quarter made it difficult to identify trends over time. Though it was possible to estimate the size of differences for each of the nine quarterly models associated with each outcome variable and whether those differences were statistically significant, there was no explicit standard for assessing results across each series of nine quarterly models. Nonetheless, had significant and generally increasing differences in favor of the treatment group been observed consistently across the later quarters in the series we would have argued that it was convincing evidence of the benefits associated with being assigned to the treatment group.[316] Additionally, SSA prohibited the use of additional control variables in the mandatory models as it wanted to insure that these models were implemented consistently by those evaluating the four pilots. Though there was no barrier to running additional models that added control variables of interest, in any event, doing so was tightly constrained by sample sizes.[317]

Indeed it was small sample size that required us to abandon our original plan to utilize a hierarchical (mixed) regression modeling approach for the SSDI-EP evaluation.

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[316] The number of known offset users was so small (fifty-five) that it would have been difficult to demonstrate that any difference to the treatment group's benefit resulted directly from offset use.

[317] This was particularly true for the subgroup analyses where sample sizes were but a modest fraction of the theoretically available 496.

As an alternative to hierarchical modeling we decided to utilize repeated measure MANOVA (Mixed Model Analysis of Variance).[318] This method shares many of the advantages of hierarchical modeling allowing comparison of both between and within subject effects. Further, repeated measures MANOVA has the distinct advantage of allowing us to run time series with multiple control variables with a relatively small sample size.

However, using MANOVA also has some disadvantages. Independent variables that are examined for both differences between groups and within the groups over time have to be categorical.[319] As a consequence, some of the information available when a variable is in continuous form is lost and, in some cases, results can be sensitive to rather small differences in how the boundaries between categories are set. Additionally, MANOVA does not produce a direct equivalent to the beta coefficients available from regression analyses. Though it is still possible to identify the rate of change over a particular time period, this needs to be separately calculated.

As MANOVA statistics are less familiar than those for standard linear or logistic regression, we will identify those we use most. The significance of a variable for between subject comparisons is a straightforward probability value. The significance of a variable for within subject comparisons is the probability value for the Wilks' Lambda statistic. In both cases, we use the standard .05 level to denote statistical significance. The effect size of the variable (i.e. the amount of variation explained) is estimated by the Partial Eta Squared for both within subject and between subject effects. This is estimated separately for each effect type. Unfortunately, no statistic captures the overall effect of the model, though it is possible to provide estimated values of group differences and calculate the disparity between any pair.

1. Study assignment repeated measures MANOVA models

Due to the small differences and the lack of statistical significance in previously run models, we did not expect treatment group participants to be significantly different from control group participants in basic repeated measures MANOVA models when study assignment was the sole independent variable. We were, however, interested in how the predicted trends from these analyses might vary from those predicted from other models before adding other independent variables. A variety of covariates were used in all of our models, irrespective of which independent variable(s) were included. These were measured either at enrollment into the pilot or for some period prior to enrollment and included age, gender, race (white, non-white), education, TWP completion prior to enrollment, disability type, receipt of benefits counseling prior to study enrollment, average quarterly UI earnings in the year before enrollment, any reported employment subsequent to establishing SSDI eligibility and prior to study enrollment, and the SSDI primary insurance amount (PIA) at enrollment.[320] As with the

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[318] MANOVA was implemented using the GLM Repeated Measures options in version 14 of SPSS for Windows statistical software.

[319] In this framework, variables that might be called control variables in a regression framework are conceptualized as additional independent variables as long as they are examined for both between and within subject effects. The term covariate is used to identify all other "control" variables appearing in our MANOVA models.

previous models, the repeated measures MANOVA for study assignment was conducted separately for each of the four employment related dependent variables, UI earnings, UI employment, having quarterly earnings at least three times SGA, and the income proxy.

The results of the repeated measures MANOVA for study assignment earnings model were indeed non-significant when comparing treatment versus control (see table VI.14). The covariates included in this model were age, PIA, and average quarterly UI earnings in the year before enrollment ("pre-enrollment mean earnings"), with these earnings accounting for the largest proportion of variance within the model, 0.527 of the between subject variance and 0.162 of the within subject variance. In other words, much of the variance in the mean UI quarterly earnings in the Q0-Q8 period can be explained by the mean value for each participant's pre-enrollment (Q-4 through Q-1) earnings. Figure VI.25 graphs the model's predicted earnings. Not unlike the descriptive means and the regression predicted means, there is little difference between treatment and control predicted earnings until quarters one and two when the control group has higher predicted mean earnings, but this difference decreases over time and is almost non-existent by the eighth quarter following enrollment.

Table VI.14: Repeated Measures MANOVA – Assign – Earnings

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Assign	*Quarter	0.392	0.027	0.274	0.003
Age	*Quarter	0.058	0.044	0.003	0.019
PIA	*Quarter	0.013	0.054	0.017	0.012
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.162	<0.001	0.527

Sample Size = 467 Treatment = 262; Control = 205
ES = Effect Size = Partial Eta Squared

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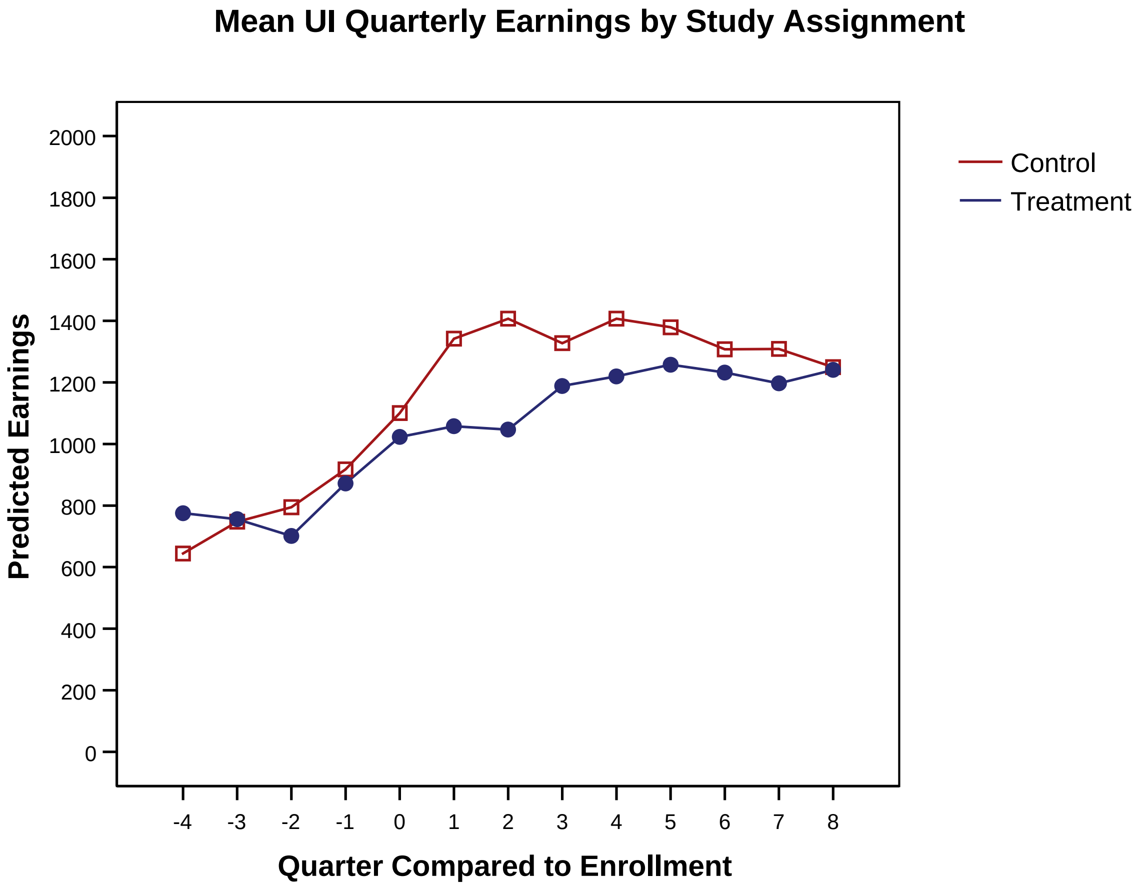
[320] Education included nine categories: less than seven years, seven to nine years, ten to twelve years without diploma, high school diploma, high school diploma equivalent, some college, voc/tech training or two year degree program, four year college degree program, and graduate school.

Disability type categories were defined by SSA with input from the pilot evaluators and were based on SSA body system categories. In some cases, a category is simply the SSA category. In other cases, the categories are created by either combing or splitting body system categories. The five resulting categories are: musculoskeletal, neurological, mental retardation, other mental, and all others.

Unless a covariate had a p-value of at least 0.10 for either within subject or between subject effects it was removed from the model's specification. More detailed information about how these variables are defined can be found in Delin, Barry S, Hartman, Ellie A. and Sell, Christopher W. 2009. "Countervailing Factors Impacting Employment Outcomes in the Wisconsin Pilot of the SSDI Cash Benefit Offset." Washington, DC: Association of Public Policy Analysis and Management annual conference. pp. 60-62.

Figure VI.25: Predicted Mean UI Earnings, by Quarter, by Study Assignment for the Repeated Measures MANOVA for Study Assignment Model



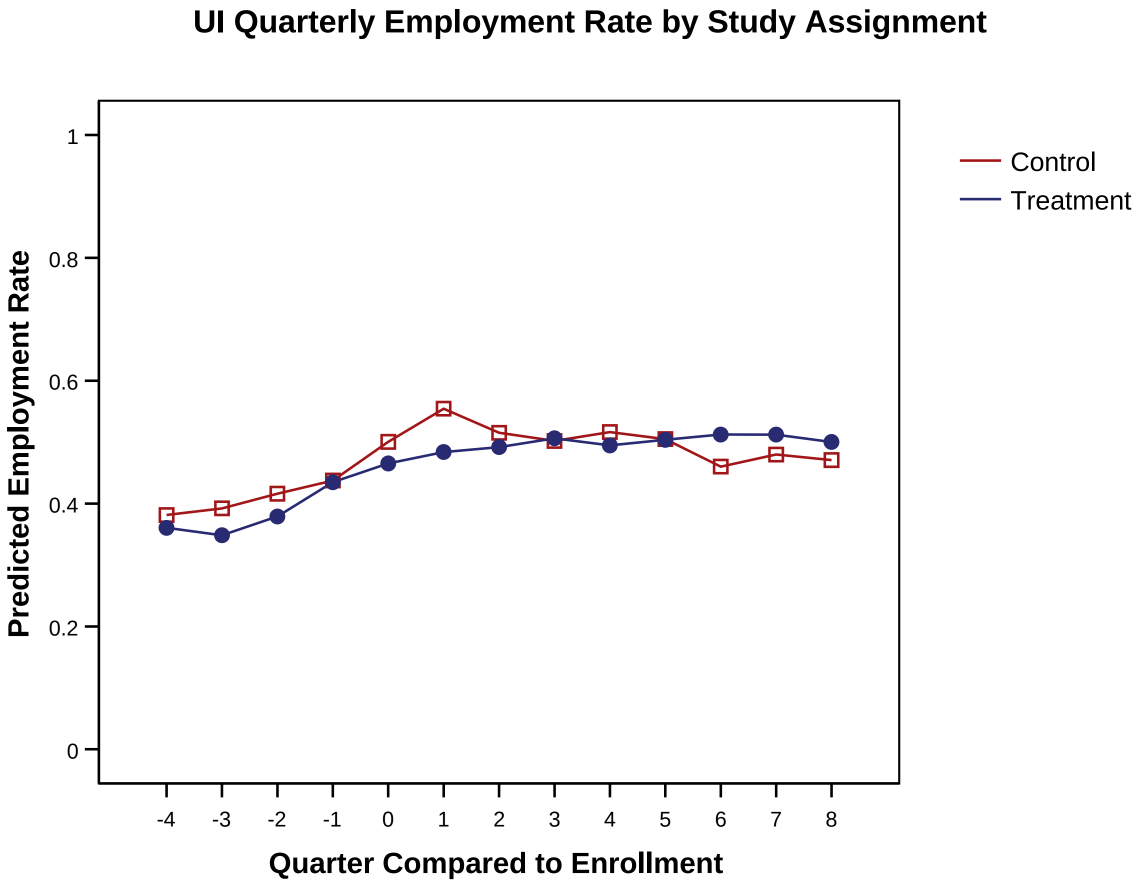
Similar to the earnings model, study assignment differences in employment rates were also not significant in the repeated measures MANOVA for study assignment model (see table VI.15). Further, age and pre-enrollment mean earnings were also included in this model as covariates, with pre-enrollment mean earnings again accounting for the largest amount of variance, although not to the degree it did for the earnings model. PIA was not a covariate in the "final" employment rate model, but gender, employment post SSDI eligibility, and TWP completion prior to enrollment were. As shown in figure VI.26, there was much overlap between the model's predicted treatment and control employment rates, with slightly larger employment rates for control participants in the earlier quarters and slightly larger employment rates for treatment participants in the later quarters.

Table VI.15: Repeated Measures MANOVA – Assign – Employment Rate

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Assign	*Quarter	0.611	0.022	0.685	< 0.001
Age	*Quarter	0.052	0.045	0.010	0.014
Gender	*Quarter	0.051	0.045	0.718	< 0.001
Employment Post SSDI Eligibility	*Quarter	0.005	0.060	< 0.001	0.082
TWP Completion Pre-Enrollment	*Quarter	0.153	0.036	0.005	0.017
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.083	< 0.001	0.216

Sample Size = 468 Treatment = 262; Control = 206
ES = Effect Size = Partial Eta Squared

Figure VI.26: Predicted UI Employment Rate, by Quarter, by Study Assignment for the Repeated Measures MANOVA for Study Assignment Model

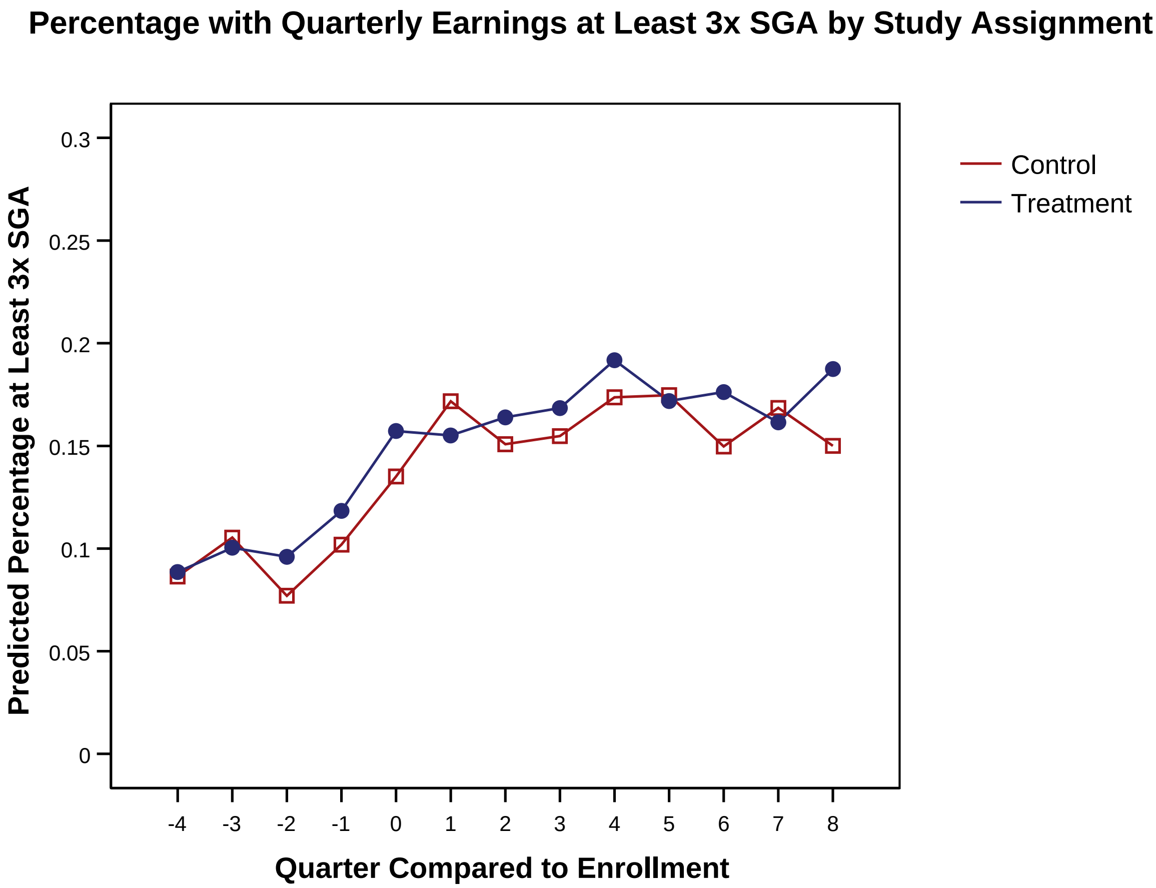


Again, study assignment was not significant in the repeated measures MANOVA for study assignment three times SGA model (see table VI.16). The covariates in this model were age, gender, and pre-enrollment mean earnings, with pre-enrollment mean earnings again accounting for the majority of the model's variance. During most quarters the three times SGA rate was higher for treatment than for control, but this difference appears small and is not present in every quarter (see figure VI. 27).

Table VI.16: Repeated Measures MANOVA – Assign – 3x SGA

		With-In Subject (Wilks' Lambda)		Between Subject	
		Sig	ES	Sig	ES
Assign	*Quarter	0.870	0.015	0.575	0.001
Age	*Quarter	0.364	0.028	0.021	0.011
Gender	*Quarter	0.024	0.050	0.041	0.009
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.083	< 0.001	0.316
Sample Size = 468 Treatment = 262; Control = 206 ES = Effect Size = Partial Eta Squared					

Figure VI.27: Predicted 3x SGA Rate, by Quarter, by Study Assignment for the Repeated Measures MANOVA for Study Assignment Model



Percentage with Quarterly Earnings at Least 3x SGA by Study Assignment

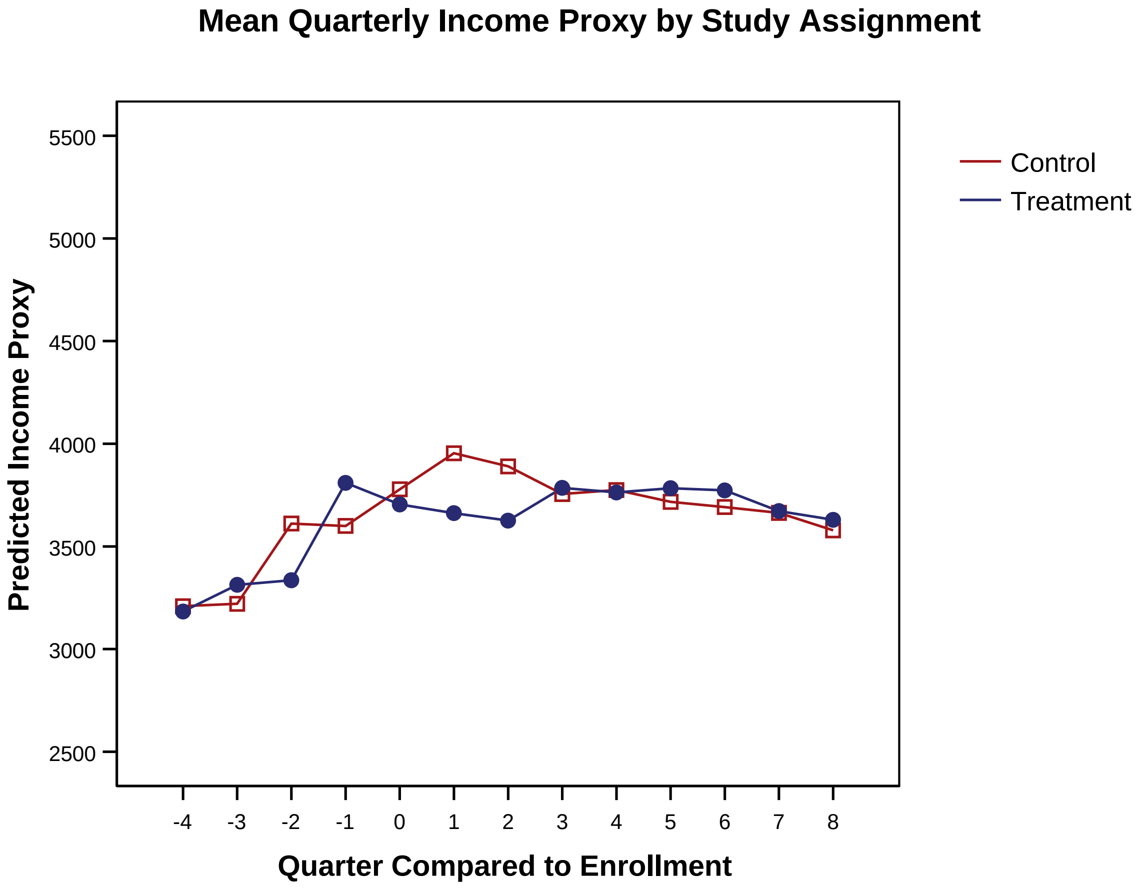
Finally, assignment to one of the study groups produced no significant differences in the predicted trends for the income proxy (see table VI.17). The control group had higher predicted income proxy means during the early post-enrollment quarters. During the later post-enrollment quarters, the treatment group had higher predicted income proxy means (see figure VI.28). The covariates for this model were age, employment post SSDI eligibility, education, PIA, and pre-enrollment mean earnings, with pre-enrollment mean earnings again accounting for the majority of the between subject (44%) and with-in (12%) subject variance. PIA also accounts for a large portion of the between (44%) subject variance.[321]

Table VI.17: Repeated Measures MANOVA – Assign – Income Proxy

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Assign	*Quarter	0.308	0.030	0.730	< 0.001
Age	*Quarter	0.324	0.030	0.015	0.013
Employment Post SSDI Eligibility	*Quarter	0.768	0.017	0.006	0.017
Education	*Quarter	0.155	0.036	0.018	0.012
PIA	*Quarter	0.116	0.039	< 0.001	0.414
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.124	< 0.001	0.441

Sample Size = 467 Treatment = 262; Control = 205
ES = Effect Size = Partial Eta Squared

Figure VI.28: Predicted Income Proxy, by Quarter, by Study Assignment for the Repeated Measures MANOVA for Study Assignment Model



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[321] This result should be treated with great caution, as the PIA is highly correlated with the SSDI payment. The SSDI payment is generally a much higher proportion of the income proxy than UI earnings. SSDI payments constitute all of the income proxy for participants who have no UI earnings in a given quarter.

2. Combined Model

Although the benefit offset may serve as a work incentive, it could not do so in isolation. For example, as part of the pilot, provider agencies were required to provide all participants with access to benefits counseling. Further, Wisconsin has a Medicaid Buy-In program that was developed as a work incentive. Almost all of the participants would have been qualified to use the program, provided they were either employed or could show they had a definite plan for becoming employed within the next six months. Finally, attitudes and perceptions can influence an individual's work behavior. For example, an individual's fear of losing income or health care benefits from public programs may reduce the probability that an individual works or attempts to increase her earnings. Similarly, an individual's level of self-efficacy might affect work behavior. For example, a person having a high level of self-efficacy may be more likely to engage in work or increase work effort even if doing so means he will need to overcome sizeable obstacles.

Previous descriptive investigation and running simpler MANOVA models[322] helped us build a combined MANOVA model that included study assignment, receipt of benefits counseling during the pilot, Medicaid Buy-in participation during the pilot and participant attitudes in two domains, 1) fears about the loss of SSDI or public health care benefits and 2) self-efficacy. Our purpose was to examine the impact these factors had on participant outcomes as well as any differential impact reflecting random assignment. We realize this emphasis is somewhat different than what SSA proposed. We think understanding what happens in both these contexts can inform better policy choices and program design, both generally and for those efforts in which Pathways and its stakeholders have been involved.

For the benefits counseling variable we chose to use a measure of the amount (dosage) of benefits counseling. The measure aggregated data that the provider agencies submitted on a monthly basis documenting how many hours of a benefits counselor's time were devoted to each participant. Based on a descriptive analysis, we identified four benefits counseling dosage categories (zero hours, greater than zero, but less than four hours, four hours to eight hours, and more than eight hours), choosing our categories both to insure useful numbers and to capture (at about four hours) a dosage that seems to make a difference in effectiveness.

Medicaid Buy-in participation was defined as participation in the program anytime from the enrollment quarter to the eighth quarter following enrollment.[323] Just over half (51%) of SSDI-EP participants were enrolled in the Buy-in for at least some portion of the Q0-Q8 period. Nearly three quarters of these individuals were in the program when they enrolled in the offset pilot. A slightly higher percentage of those in the treatment group (53%) had some period of Buy-in eligibility during the Q0-Q8 period than those in the control group.

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[322] See Delin et al., 2009. p.2.

[323] This is different from how the Medicaid Buy-in subgroup for the SSA subgroup analyses, when the Buy-in subgroup was defined as participating in the Buy-in during Q-1.

To examine whether participant fears of losing public disability related benefits had an impact on our outcome variables, we constructed an index from the six survey items that elicited perceptions about the loss or reduction of Social Security, Medicare, and Medicaid benefits.[324] Category boundaries were then defined relative to the theoretical midpoint. A change index was computed by subtracting the baseline fear index score from the score from the year one follow-up survey. Results from descriptive analyses suggested that the change score was a better candidate for inclusion in the combined model.

Self-efficacy refers to individuals' perceptions of their own capacity to act in ways likely to result in achieving their goals. Though external conditions, including the actions of other individuals, can often have an impact on goal attainment, those with higher levels of self-efficacy can be expected to more fully achieve what they want. This would appear to be especially important for those with serious disabilities who often face both significant external and personal challenges. Thus, we added a number of items to the participant surveys to measure some aspects of the efficacy construct. The individual responses to these items were used to calculate the index values used in the following analyses.[325] Though findings are shown only for categories grouping self-efficacy scores from the baseline survey, it is also possible to calculate change scores as was done with the fear of benefits loss index.

As an initial step we present the p-values for both between subject and within subject effects for the combined model. Table VI.18 provides this information for all four of the combined models. Study assignment, by itself, was again non-significant in all the models. There were differences, however, found for the other four independent variables. The between subjects difference was statistically significant for benefits counseling hours in all four of the models: i.e., those for earnings, employment, achieving SGA earnings, and the income proxy. Further, the between subject effect size for benefits counseling was the largest in all four models, but only accounted for 3% to 3.5% of the between subject variance. The Medicaid Buy-in participation between

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[324] The "fear index" is an average of the six items. Possible values range from one to five, with the higher values indicating greater fear of losing benefits. Items include

- Working for pay will affect my ability to keep my Social Security Cash benefits
- If I work for pay, it will be hard to earn enough money to make up for lost Social Security benefits
- I worry that I may lose my eligibility for my Social Security Benefits if I work for pay
- I worry that working for pay will trigger a review of my eligibility for my Social Security benefits
- If I work for pay, it will be difficult to re-qualify for Social Security disability benefits in the future
- I worry that I will not be eligible for Medicare or Medicaid if I'm working

[325] The "self-efficacy index" is an average of the six items. Possible values range from one to five, with the higher values indicating greater self-efficacy. Items include

- If something looks too complicated I will not even bother to try it
- I avoid trying to learn new things when they look too difficult
- When I make plans, I am certain I can make them work
- When unexpected problems occur, I don't handle them very well
- I do not seem capable of dealing with most problems that come up in my life
- I feel insecure about my ability to do things

subjects difference just missed statistical significance for the SGA outcome model with a p-value of 0.052 and 1.2% of the between subject variance accounted for. The baseline level of self-efficacy between subjects neared statistical significance only for the income proxy model with 1.5% of the variance accounted for. The change in fear index with-in subject difference was statistically significant for the employment model with 5.7% of the with-in subject variance accounted for.[326]

Table VI.18 also includes information about whether the interaction between assignment and one of the other independent variables in the combined models was significant.[327] None of these interactions were of consequence for estimating the UI employment rate. However, the interaction between assignment and changes in the fear index proved to have a significant impact on within subject variation for the mean UI earnings and mean income proxy variables. In addition, the interaction between assignment and the self-efficacy index had near significant impacts on earnings and the three times SGA variable.

Table VI.18: Repeated Measures MANOVA – Combined Models including Assignment – Benefits Counseling Hours, Medicaid Buy-In Participation (Q0 – Q8), Change in Level of Fear Benefit Loss Index (Year 1 – Baseline), Self-Efficacy Index at Enrollment

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Earnings					
Assignment	*Quarter	0.963	0.015	0.532	0.001
Benefits Counseling Hours	*Quarter	0.382	0.039	0.009	0.035
Medicaid Buy-In	*Quarter	0.702	0.028	0.643	0.001
Change in Fear Index	*Quarter	0.312	0.041	0.933	< 0.001
Baseline Self-Efficacy Index	*Quarter	0.922	0.023	0.101	0.014
Assignment * Benefits Counseling Hours	*Quarter	0.679	0.033	0.703	0.004
Assignment * Medicaid Buy-In	*Quarter	0.679	0.029	0.416	0.002
Assignment * Change in Fear Index	*Quarter	0.007	0.067	0.195	0.010
Assignment * Baseline Self-Efficacy Index	*Quarter	0.215	0.045	0.087	0.015
Employment					
Assignment	*Quarter	0.754	0.026	0.724	< 0.001
Benefits Counseling Hours	*Quarter	0.382	0.039	0.011	0.034
Medicaid Buy-In	*Quarter	0.602	0.032	0.824	< 0.001

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[326] In general, the effect sizes for within subject differences were larger than the effect sizes for between subject differences.

[327] The model can produce interactions for every combination of independent variable. Thus in the case of the combined models summarized in table VI.15 there were actually twenty possible interaction terms for each outcome. We decided to restrict the analysis to the interactions between study assignment and one other independent variable because of our interest in understanding whether and, ideally, by how much each of these independent variables motivates outcome differences (or in this case the lack thereof) between those in the treatment and control groups.

Change in Fear Index	*Quarter	0.042	0.057	0.270	0.008
Baseline Self-Efficacy Index	*Quarter	0.623	0.033	0.851	0.001
Assignment * Benefits Counseling Hours	*Quarter	0.714	0.032	0.459	0.008
Assignment * Medicaid Buy-In	*Quarter	0.444	0.037	0.484	0.002
Assignment * Change in Fear Index	*Quarter	0.181	0.046	0.548	0.004
Assignment * Baseline Self-Efficacy Index	*Quarter	0.746	0.030	0.335	0.007
SGA					
Assignment	*Quarter	0.991	0.011	0.477	0.002
Benefits Counseling Hours	*Quarter	0.528	0.036	0.017	0.031
Medicaid Buy-In	*Quarter	0.541	0.034	0.052	0.012
Change in Fear Index	*Quarter	0.711	0.031	0.608	0.003
Baseline Self-Efficacy Index	*Quarter	0.150	0.048	0.201	0.010
Assignment * Benefits Counseling Hours	*Quarter	0.760	0.031	0.536	0.007
Assignment * Medicaid Buy-In	*Quarter	0.103	0.056	0.601	0.001
Assignment * Change in Fear Index	*Quarter	0.191	0.046	0.659	0.003
Assignment * Baseline Self-Efficacy Index	*Quarter	0.379	0.039	0.080	0.015
Income					
Assignment	*Quarter	0.946	0.017	0.601	0.001
Benefits Counseling Hours	*Quarter	0.527	0.036	0.004	0.040
Medicaid Buy-In	*Quarter	0.857	0.022	0.722	< 0.001
Change in Fear Index	*Quarter	0.537	0.035	0.742	0.002
Baseline Self-Efficacy Index	*Quarter	0.367	0.040	0.087	0.015
Assignment * Benefits Counseling Hours	*Quarter	0.601	0.034	0.638	0.005
Assignment * Medicaid Buy-In	*Quarter	0.794	0.025	0.167	0.006
Assignment * Change in Fear Index	*Quarter	0.011	0.066	0.582	0.003
Assignment * Baseline Self-Efficacy Index	*Quarter	0.229	0.044	0.495	0.004

Sample Size Earnings and Income = 344: Treatment = 189; Control = 155; 0 Hours of BC = 60; 0.1 to 3.9 Hours of BC = 97; 4 to 8 Hours of BC = 66; Over 8 Hours of BC = 121; Medicaid Buy-In = 180; No Medicaid Buy-In = 164; Decrease in Fear = 77; No Change in Fear = 194; Increase in Fear = 73; Low Self-Efficacy = 35; Medium Self-Efficacy = 126; High Self-Efficacy = 183
Sample Size Employment and SGA = 345: Treatment = 189; Control = 156; 0 Hours of BC = 60; 0.1 to 3.9 Hours of BC = 97; 4 to 8 Hours of BC = 66; Over 8 Hours of BC = 122; Medicaid Buy-In = 180; No Medicaid Buy-In = 165; Decrease in Fear = 78; No Change in Fear = 194; Increase in Fear = 73; Low Self-Efficacy = 35; Medium Self-Efficacy = 127; High Self-Efficacy = 183

ES = Effect Size = Partial Eta Squared

The covariates that were included in the combined models are reported in table VI.19. Included covariates were those having p-values of 0.1 or less for either between subject or within subject effects. Age and pre-enrollment mean earnings were covariates in all four models. The between subject pre-enrollment earnings differences accounting for 53.4% of the variance in the earnings model, 19.7% of the variance in the employment model, 30.2% of the variance in the SGA model, and 44.9% of the variance in the income proxy model. These results were consistent with those seen with the MANOVA models where study assignment is the only independent variable. Age and the other covariates account for less than 10% of the variance in each of the models. Other covariates include PIA in the earnings and income proxy models, employment post SSDI eligibility and benefits counseling prior to enrollment in the employment and income proxy models, TWP completion pre-enrollment in the employment model, and gender in the SGA model.

Table VI.19: Covariates for Repeated Measures MANOVA – Combined Models

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Earnings					
Age	*Quarter	0.052	0.064	0.006	0.024
PIA	*Quarter	0.006	0.084	0.015	0.018
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.215	< 0.001	0.534
Employment					
Age	*Quarter	0.089	0.058	0.175	0.006
Employment Post SSDI Eligibility	*Quarter	0.046	0.065	< 0.001	0.080
TWP Completion Pre-Enrollment	*Quarter	0.087	0.059	0.015	0.018
Pre-Enrollment Mean Earnings	*Quarter	0.036	0.068	< 0.001	0.197
Benefits Counseling Prior to Enrollment	*Quarter	0.714	0.032	0.072	0.010
SGA					
Age	*Quarter	0.072	0.060	0.008	0.022
Gender	*Quarter	0.068	0.061	0.185	0.005
Pre-Enrollment Mean Earnings	*Quarter	0.039	0.066	< 0.001	0.302
Income					
Age	*Quarter	0.330	0.042	0.040	0.013
Employment Post SSDI Eligibility	*Quarter	0.910	0.019	0.098	0.009
PIA	*Quarter	0.064	0.062	< 0.001	0.433
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.179	< 0.001	0.449
Benefits Counseling Prior to Enrollment	*Quarter	0.601	0.034	0.074	0.010

ES = Effect Size = Partial Eta Squared

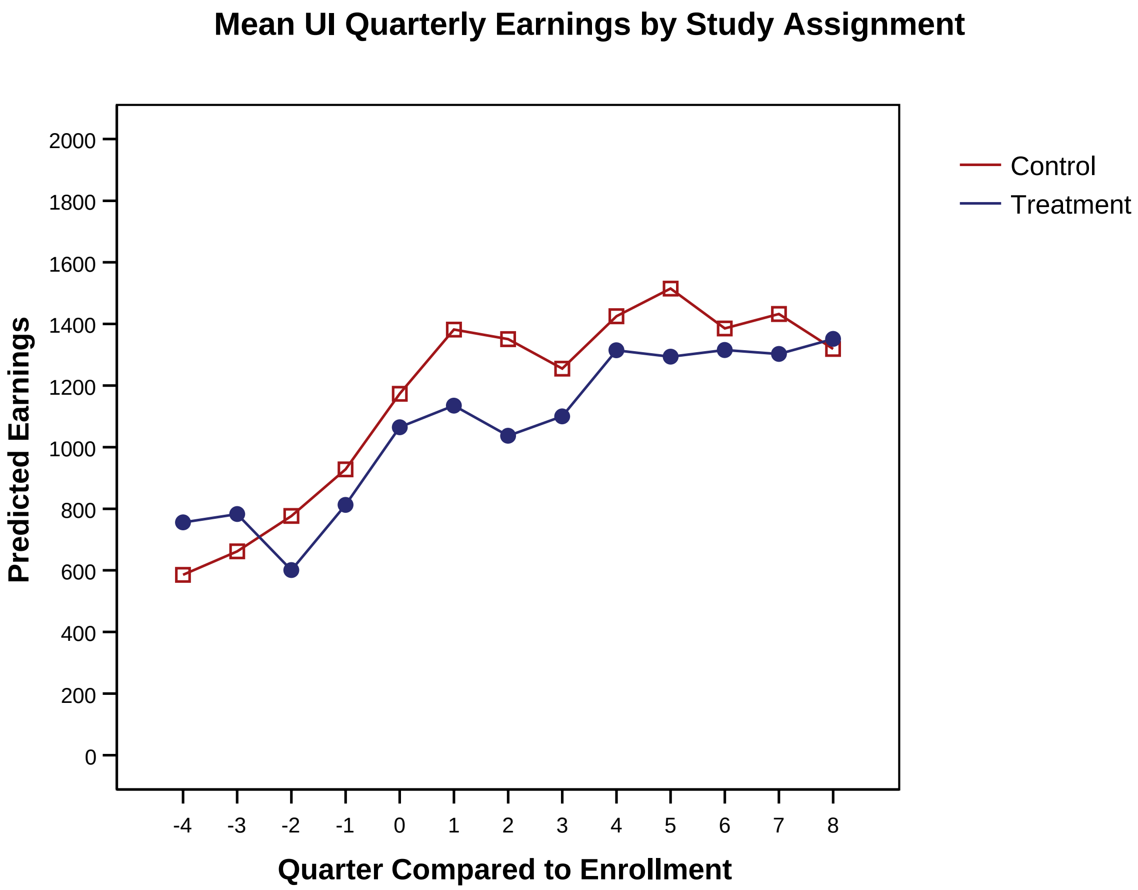
To better understand the influence of the independent variables, that is, benefits counseling hours, Medicaid Buy-in participation, change in the fear of benefits loss index, and the baseline self-efficacy index, graphs of the MANOVA predicted quarterly employment outcomes are shown below. Readers are reminded that the graphs depict the predicted mean values for each category displayed over the Q-4 through Q8 period.

Graphs are provided for the differences within each of the independent variables, first across all participants and then separately for control and treatment groups. Separate treatment and control graphs are generally provided only provided if the independent variable was significant ($p < 0.05$) or neared significance ($p < 0.10$) for the between or within subject differences whether by itself or as an interaction with assignment

a. Earnings

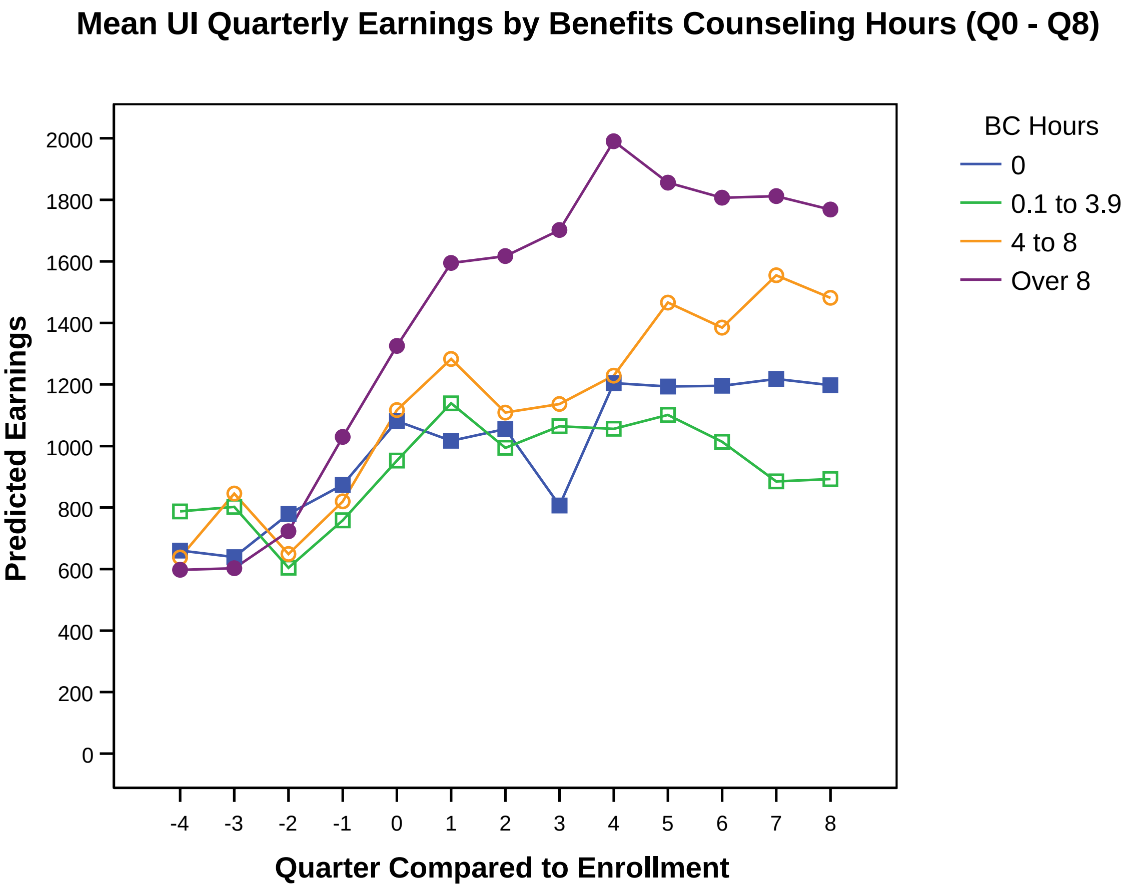
Although not identical to the assignment alone model, the predicted mean UI earnings for the combined repeated measures MANOVA model are similar (see figure VI.29). Again the control group has higher predicted mean UI earnings than the treatment group for most quarters, but the differences lessen over the final quarters of the post-enrollment period. By Q8 the predicted value for the treatment group slightly exceeds that for the control group.

Figure VI.29: Predicted Mean UI Earnings, by Quarter, by Study Assignment for the Repeated Measures MANOVA Combined Model



As stated previously, there were statistically significant differences between the predicted mean earnings of participants based on their inclusion in one of four benefits counseling dosage categories. Predicted differences become apparent by the enrollment quarter and increase through the eighth quarter (see figure VI.30). Participants with over eight hours of reported benefits counseling provided during Q0 through Q8 had the highest predicted mean earnings, followed by participants with four to eight hours of benefits counseling. There was overlap in the predicted mean earnings of those who received 0.1 to 3.9 hours of benefits counseling and those who received no benefits counseling over a period bounded by Q-4 and Q4. Starting with Q4, participants who received no hours of benefits counseling during the pilot maintained higher predicted mean earnings than those who received between 0.1 to 3.9 hours of service. During the Q4-Q8 period, the predicted mean earnings of those who received 0.1 to 3.9 hours of benefits counseling were actually decreasing. Overall, increased hours of benefits counseling was related to higher earnings, at least for those individuals who received at least four hours of benefits counseling during the pilot. For those with less than four hours of benefits counseling during the pilot, the benefits counseling provided did not appear to be enough to trigger increased earnings. In point of fact, it is not absolutely clear whether benefits counseling boosted earnings or whether people with higher earnings sought more benefits counseling. It is very likely that the effects were bidirectional.

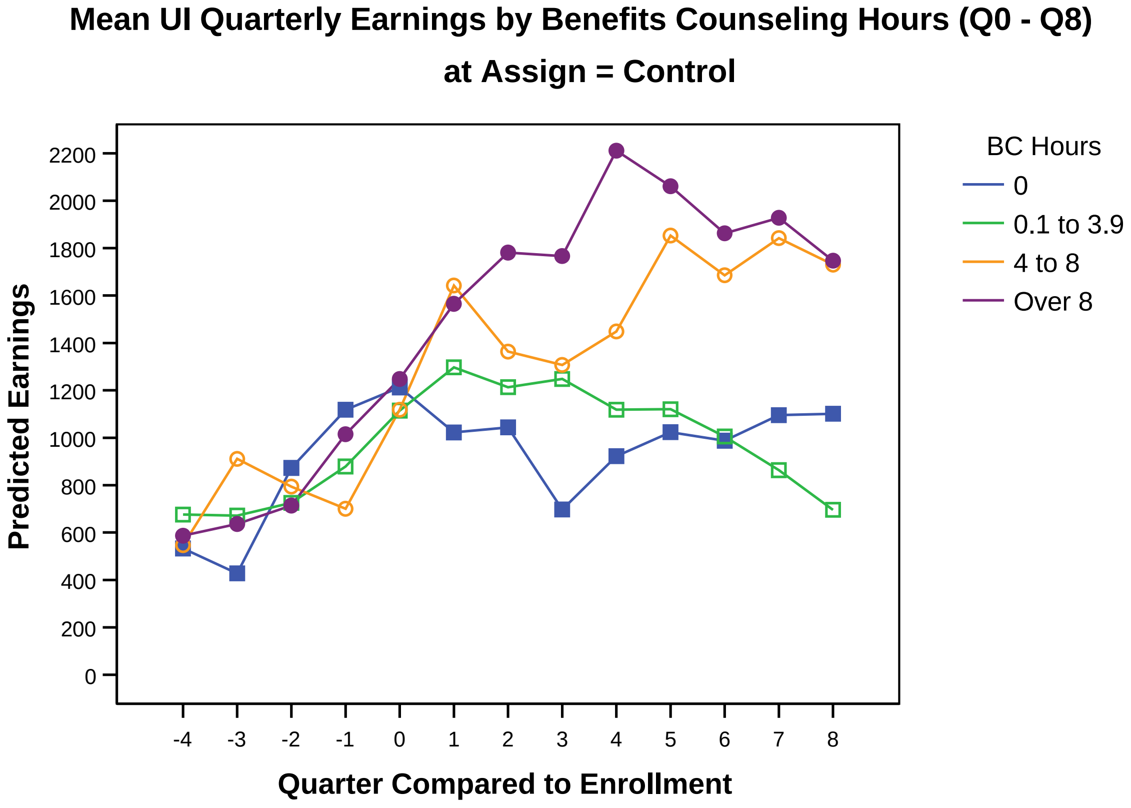
Figure VI.30: Predicted Mean UI Quarterly Earnings by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model



Although the interaction between benefits counseling hours and study assignment was not statistically significant in the combined model, the predicted quarterly earnings estimates for the treatment and control groups did vary somewhat. In turn, this variation produced somewhat different trends for how dosage categories impacted earnings for each study assignment group. Figure VI.31 displays the earnings by benefits counseling dosage categories for the control group alone. For these pilot participants, it is most unlikely likely that the effect of benefits counseling have been "corrupted" by the SSDI rule changes. This is not to say that other SSDI program rules, such as the cash cliff and periodic medical CDRs, do not powerfully influence control group members' behavior, but to point out that the conditions for control participants were relatively "normal" and may better reflect those experienced by other SSDI beneficiaries with similarly high employment outcomes.

The estimates for the control group, as shown in figure VI.31, are very similar to the estimates for all participants in figure VI.30. From quarters two through five the pattern of mean predicted UI earnings is as expected, with more benefits counseling associated with higher earnings. From quarters six through eight there is a decreasing trend in the predicted earnings of both those who received over eight hours of benefits counseling and those who received 0.1 to 3.9 hours, though those in the higher dosage group still have much higher mean earnings. The same downward trend does not occur for those who received four to eight hours of benefits counseling and those who received zero hours of benefits counseling services. By quarter eight those who had over eight hours of benefits counseling had about the same (just slightly higher) predicted mean earnings as those who received four to eight hours of benefits counseling, and those who had 0.1 to 3.9 hours of benefits counseling actually had lower predicted mean earnings than those who received zero hours of benefits counseling.

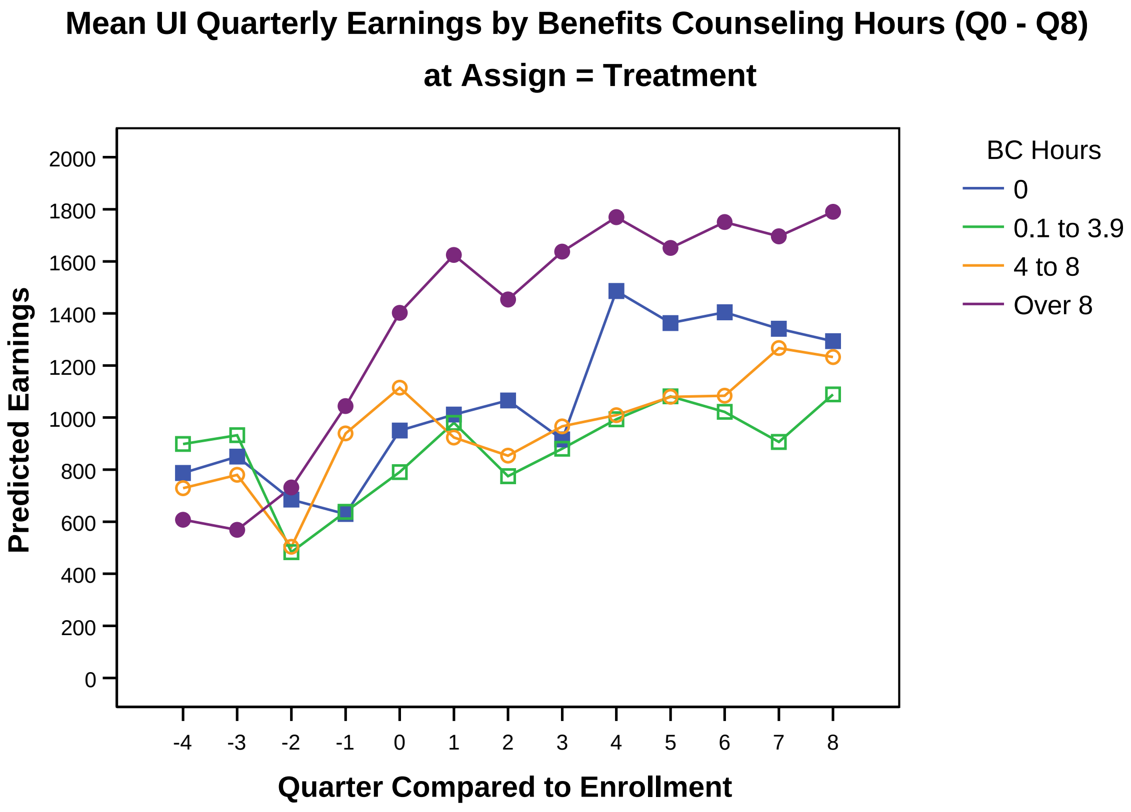
Figure VI.31: Mean UI Quarterly Earnings by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model, Control Group Only



Because the interaction between received benefits counseling hours and assignment was not significant in the combined earnings model for all participants, one might expect the predicted mean earnings to follow the same pattern for both the control and treatment groups. While this was the case for the control group, it was not so for the treatment group. Within treatment, those in the group with more than eight hours of service continued to have higher earnings than those in the four to eight hours group over the final quarters of the Q0-Q8 period. In fact, the relative position of those getting more than eight hours improved considerably (see figure VI.32). This pattern is in marked contrast to the trends observed over the same period for the same categories in control group.

Further, a much different pattern of mean earnings was observed for those in treatment getting no post-enrollment benefits counseling services compared to those in control getting no hours of service. From Q4 to Q8, treatment group members who received zero service hours had higher mean UI earnings than those in either the 0.1 to 3.9 hour or four to eight hour categories, though the mean earnings of the zero hours group still displayed average earnings that were substantially lower than those participants who received over eight hours of benefits counseling. We do not know the causes of these patterns with any certainty, especially why those in the intermediate service categories fared so poorly as the end of the study period approached. Still, we think it possible that there were additional demands for benefits counseling services related to OCO's administration of the offset and associated processes such as work CDRs. Such treatment group members would have necessarily had some period(s) of relatively high earnings, either to complete a TWP or to utilize the benefit offset.

Figure VI.32: Mean UI Quarterly Earnings by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model, Treatment Group Only



For the whole pilot sample, the difference in the mean predicted earnings trends based on participation in Wisconsin's Medicaid Buy-In during the Q0 to Q8 period was not statistically significant. Figure VI.33 shows that those who did not participate in the Buy-in had slightly higher mean predicted earnings, especially from quarter four onward, but there was substantial overlap between trend lines prior to quarter four. Trends for both the treatment and control groups were almost identical. As noted earlier, we have decided not to include graphs of estimated means for the study assignment groups when there is nothing distinctive to report.

Figure VI.33: Predicted Mean UI Quarterly Earnings by Medicaid Buy-In Participation (Q0 – Q8), Repeated Measures MANOVA Combined Model

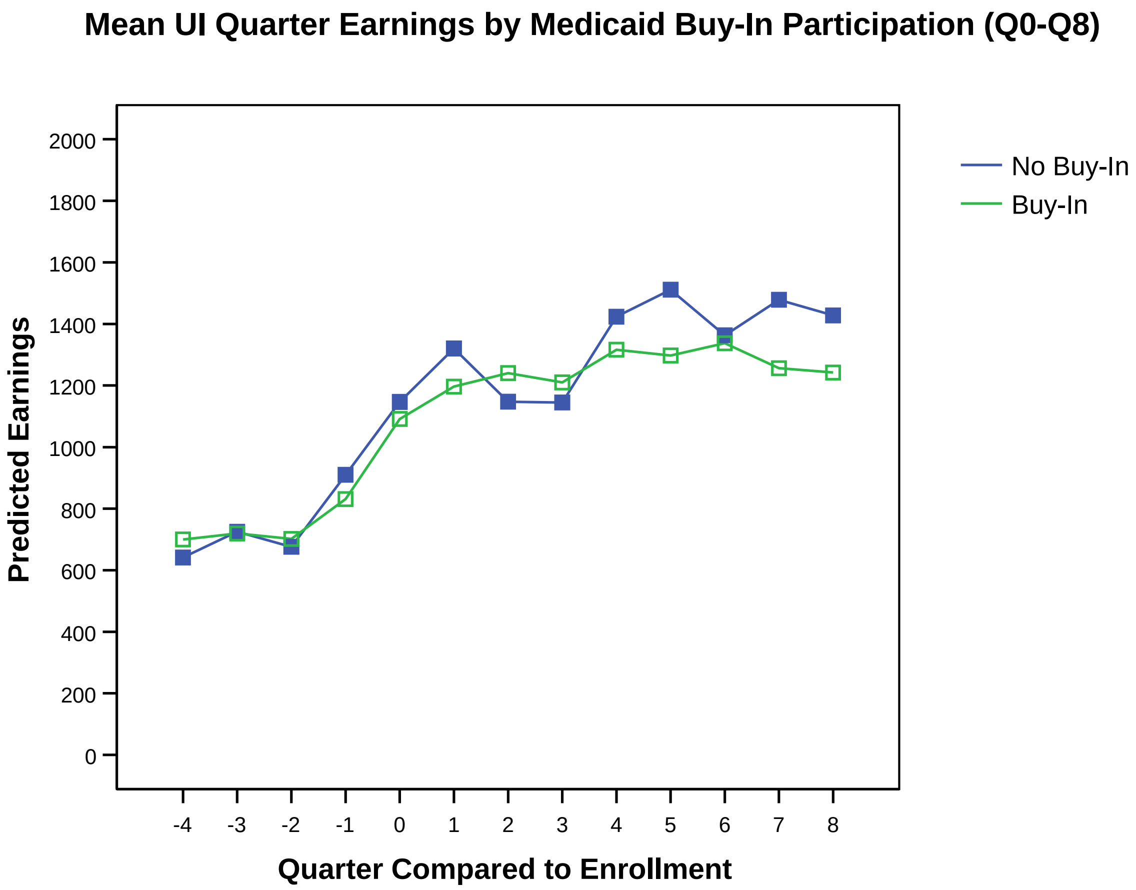
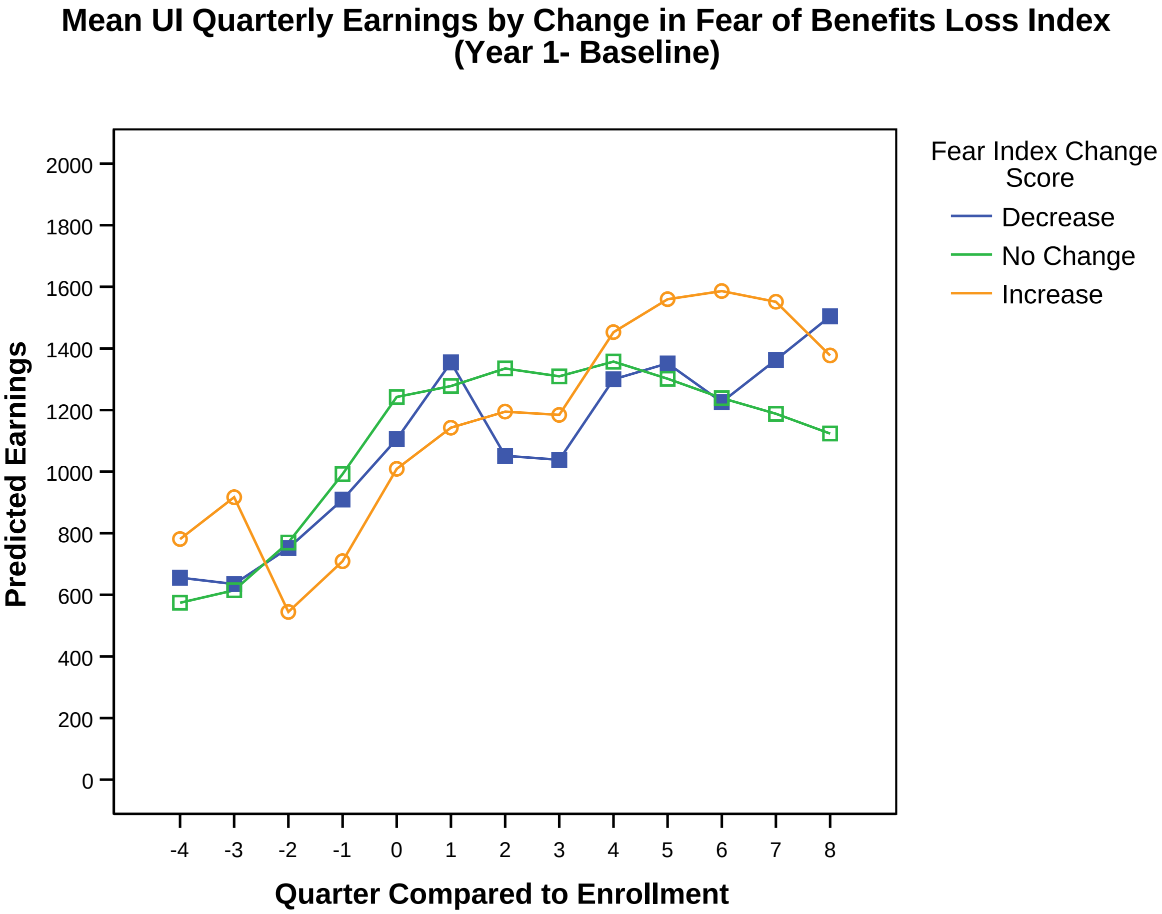


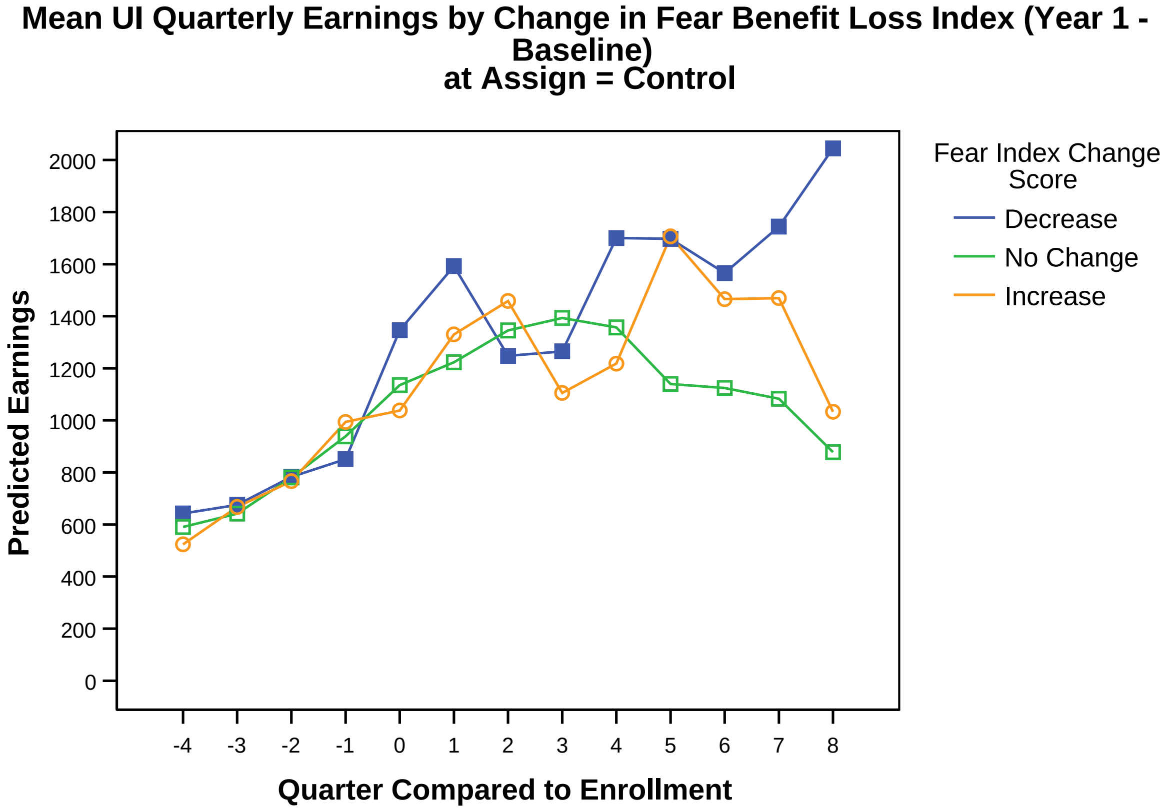
Figure VI.34 displays earnings trends for the full participant group based on changes in the level of fear of losing benefits between entering the pilot and a year thereafter. The within subject interaction between changes in the fear index and study assignment was statistically significant in the combined earnings model, though the fear change variable by itself was not significant. These differences are somewhat unexpected because one would expect decreases in fear to be associated with higher earnings and/or earnings growth. Instead, the pattern is complex. Those with increased fears over time seem to have the highest predicted mean earnings during most of the post-enrollment quarters. Those with decreased fear, however, did exhibit higher predicted mean earnings in quarter eight, which does seem to be the result of a trend for increased earnings over a several quarter period. Yet, except for quarter eight, those in the increased fear group also display better earning performance, though at a decreasing pace over time. Meanwhile, following quarter one, there is a decreasing trend in mean predicted earnings for those with no meaningful change in their fear levels. We think the unexpected patterns observed in figure VI.34 are most likely the result of "summing" the quite different trends exhibited by those in the treatment and control groups.

Figure VI.34: Predicted Mean UI Quarterly Earnings by Change in Fear Index, Repeated Measures MANOVA Combined Model



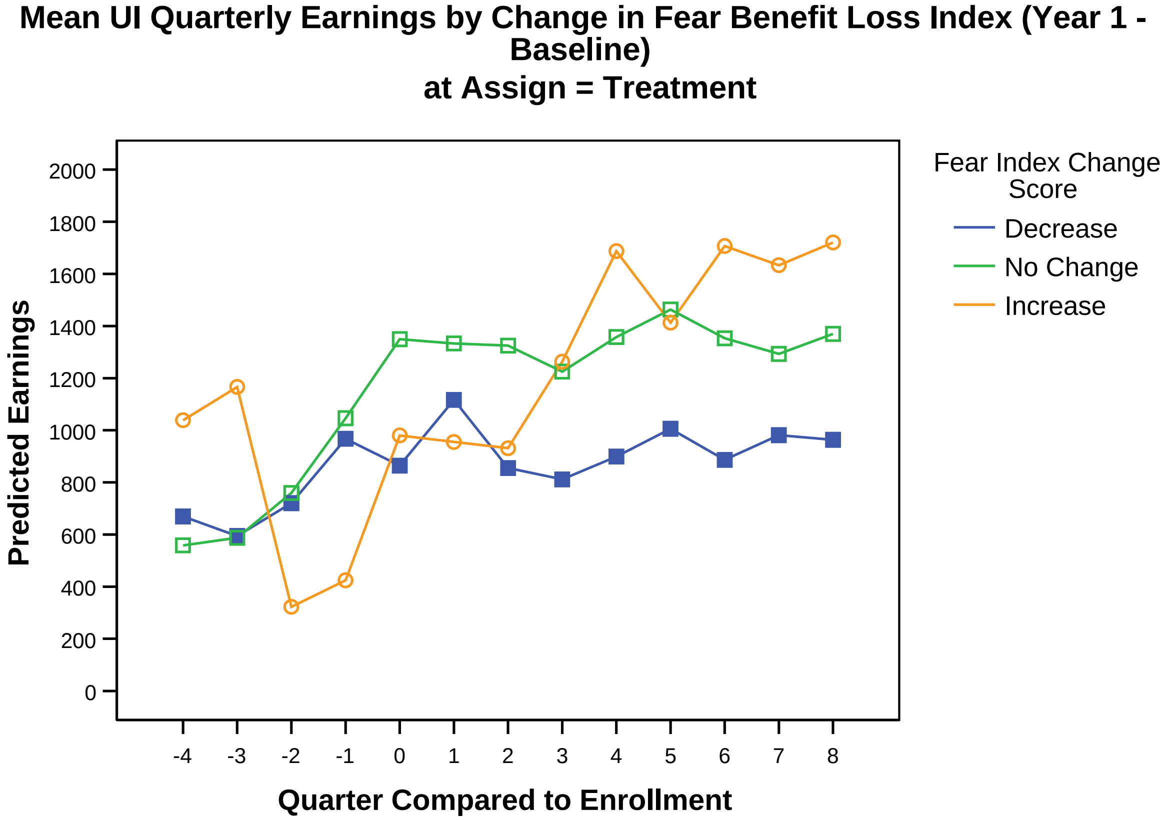
Indeed, the within subject interaction between study assignment and the change in fear index reported in table VI.18 was highly significant (p = 0.007). In other words, the change in earnings for participants with different levels of change in the fear index (increase, decrease, or no meaningful change) differed for treatment and control participants. Figure VI.35 displays these earnings differences for the control group participants only. For those participants who reported a decrease in fear, average earnings continue to increase from Q-4 to Q8. In contrast, those who reported no change in fear had increased earnings up through Q3, but their earnings decreased from Q4 through Q8. Those with an increase in fear showed a pattern similar to those with no change in fear but their earnings were much more variable. They had higher mean earnings during the post-enrollment quarters, but by Q8 their earnings were just barely greater than those who reported no change.

Figure VI.35: Mean UI Quarterly Earnings by Change in Fear Index, Repeated Measures MANOVA Combined Model, Control Group Only



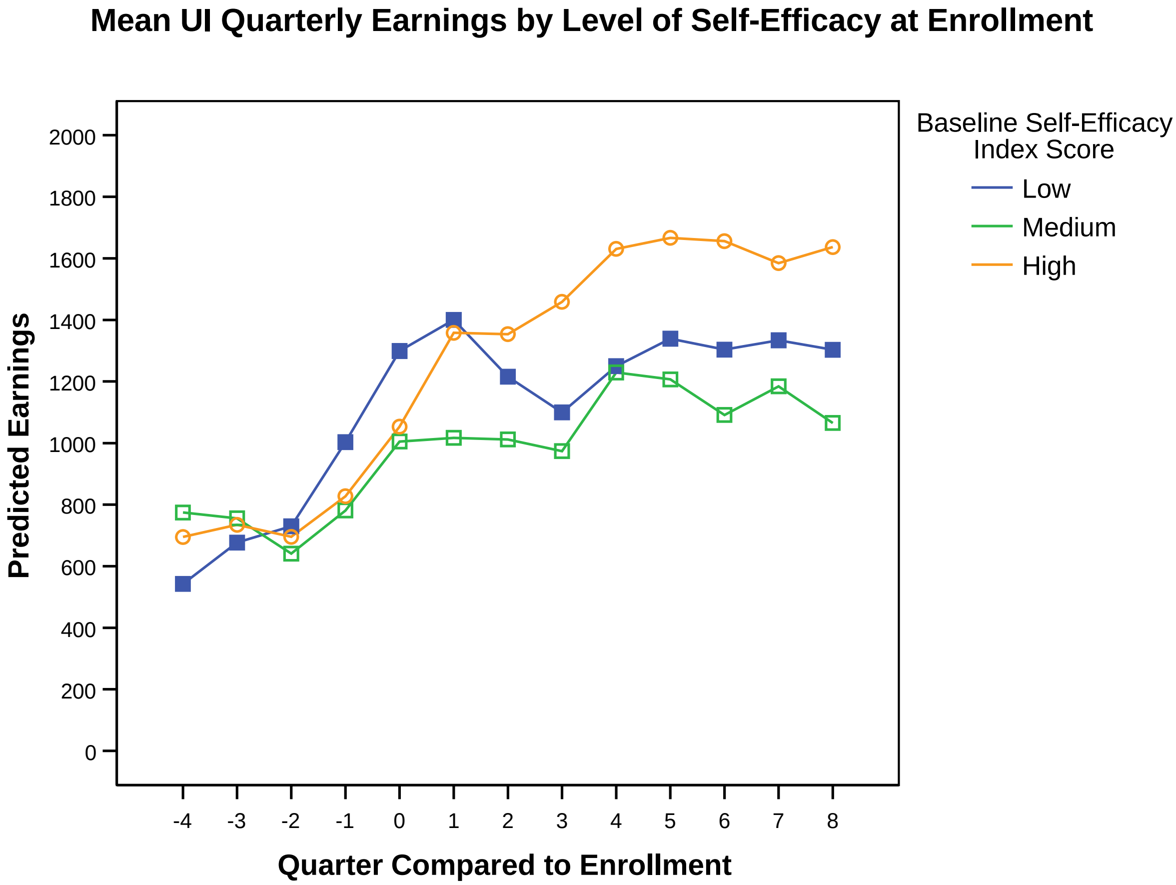
Almost the opposite pattern can be observed for the treatment group participants (see figure VI.36). Treatment group participants with an increase in fear between (roughly) enrollment and the end of their first year in the pilot had increased earnings during the post-enrollment quarters, so that by Q8 they were earning on average more than those with either no change or a decrease in their level of fear about the continuation of SSDI, Medicare and/or Medicaid benefits. In contrast, during the majority of the post-enrollment quarters, treatment group members with a decrease in fear had the lowest average earnings. Treatment group participants with no change in fear had earnings that averaged between those with increased fear and those with decreased fear from Q3 to Q8.

Figure VI.36: Mean UI Quarterly Earnings by Change in Fear Index, Repeated Measures MANOVA Combined Model, Treatment Group Only



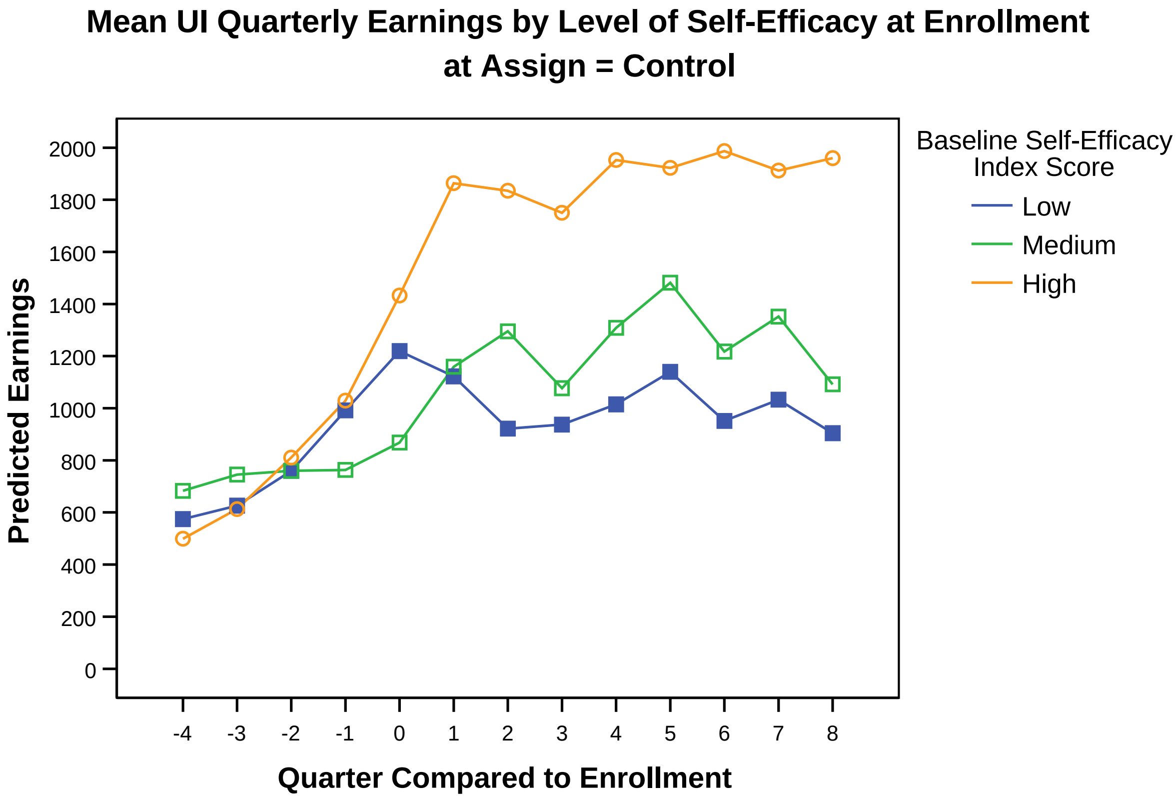
Similar to the findings for the fear index change score, self-efficacy was not significant by itself in the combined model, but it did near significance in a between subject interaction with study assignment. Figure VI.37 is provided first to demonstrate the predicted mean UI earnings for all participants by their baseline levels of self-efficacy. As expected, during most of the post-enrollment quarters (Q2 to Q8), the predicted mean earnings of those we assessed to have high levels of self-efficacy at pilot enrollment were higher than the mean earnings of those with low scores on the self-efficacy index scores. Unexpectedly those with a medium level of self-efficacy had the lowest predicted earnings, even lower than those included in the low self-efficacy group.

Figure VI.37: Mean UI Quarterly Earnings by Baseline Self-Efficacy Index, Repeated Measures MANOVA Combined Model



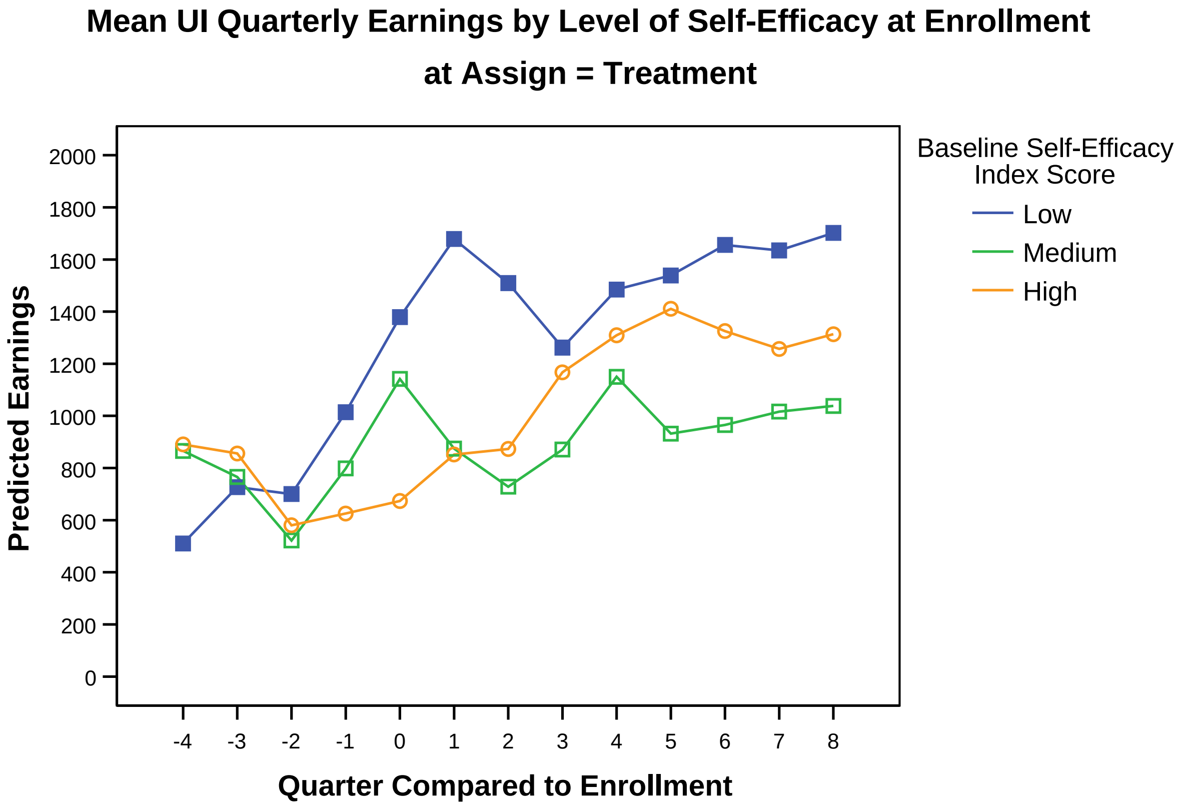
As already noted, the between subjects interaction between study assignment and baseline self-efficacy neared significance (p = 0.087). Similar to the change in fear differences, the expected patterns were observed for the control group participants, but a very different set of patterns were observed for treatment group members. The difference in mean earnings by self-efficacy for control group participants is shown in figure VI.38. During the post-enrollment quarters, control participants who reported high self-efficacy had the highest predicted average earnings, followed by participants with medium self-efficacy, and participants with low self-efficacy had the lowest predicted average earnings.

Figure VI.38: Mean UI Quarterly Earnings by Baseline Self-Efficacy Index, Repeated Measures MANOVA Combined Model, Control Group Only



In contrast, treatment group participants show a counterintuitive pattern in figure VI.39. During the post-enrollment quarters, treatment group participants with high self-efficacy still had higher average earnings than those with medium self-efficacy, but treatment group participants with low self-efficacy had higher average earnings than those with either high or medium self-efficacy. This absence of an ordinal relationship across the three self-efficacy groups is puzzling and thus worthy of future investigation.

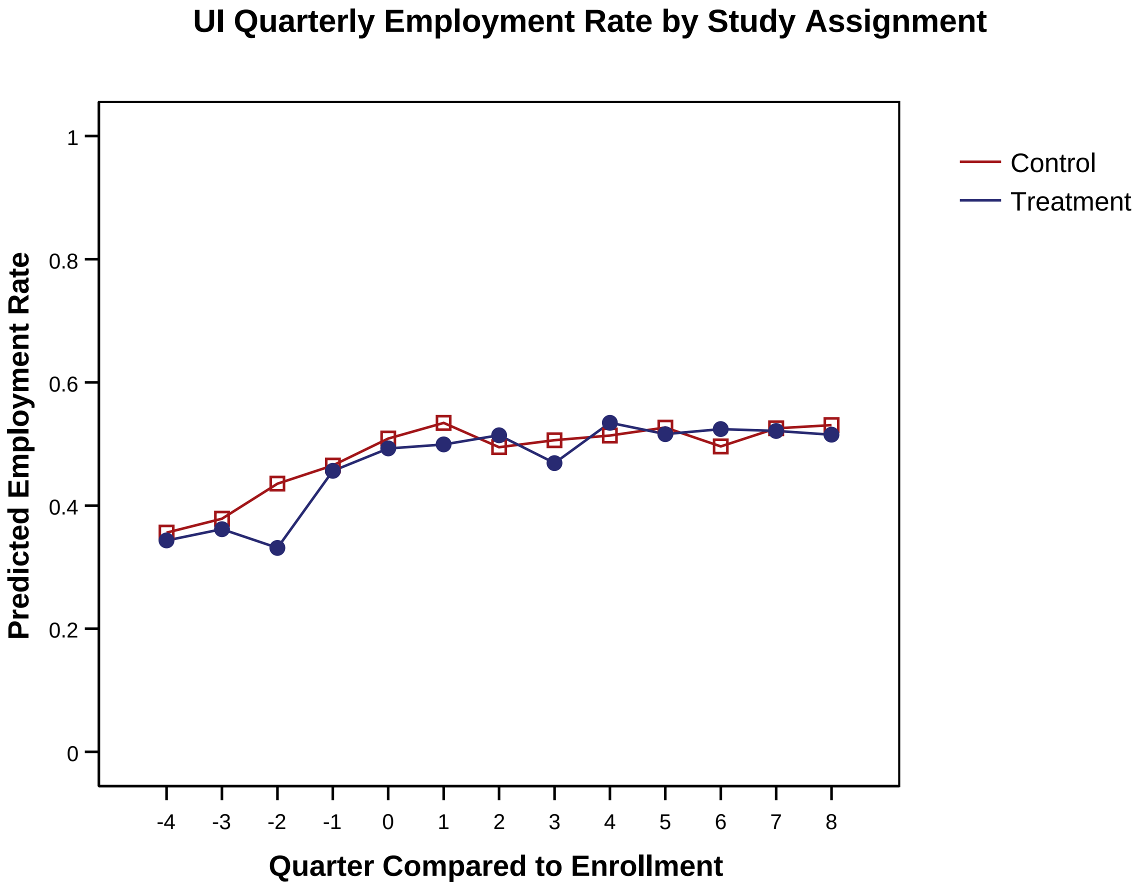
Figure VI.39: Mean UI Quarterly Earnings by Baseline Self-Efficacy Index, Repeated Measures MANOVA Combined Model, Treatment Group Only



b. Employment Rates

The predicted employment rates from the combined MANOVA model are very similar to the descriptive results and those predicted by the regression analysis and the repeated measures MANOVA for study assignment alone (see figure VI.40). There is very little difference between the predicted employment rates for treatment and control participants. In fact, there is even more overlap in the employment rates than was predicted by the other models.

Figure VI.40: Predicted UI Employment Rate, by Quarter, by Study Assignment for the Repeated Measures MANOVA Combined Model

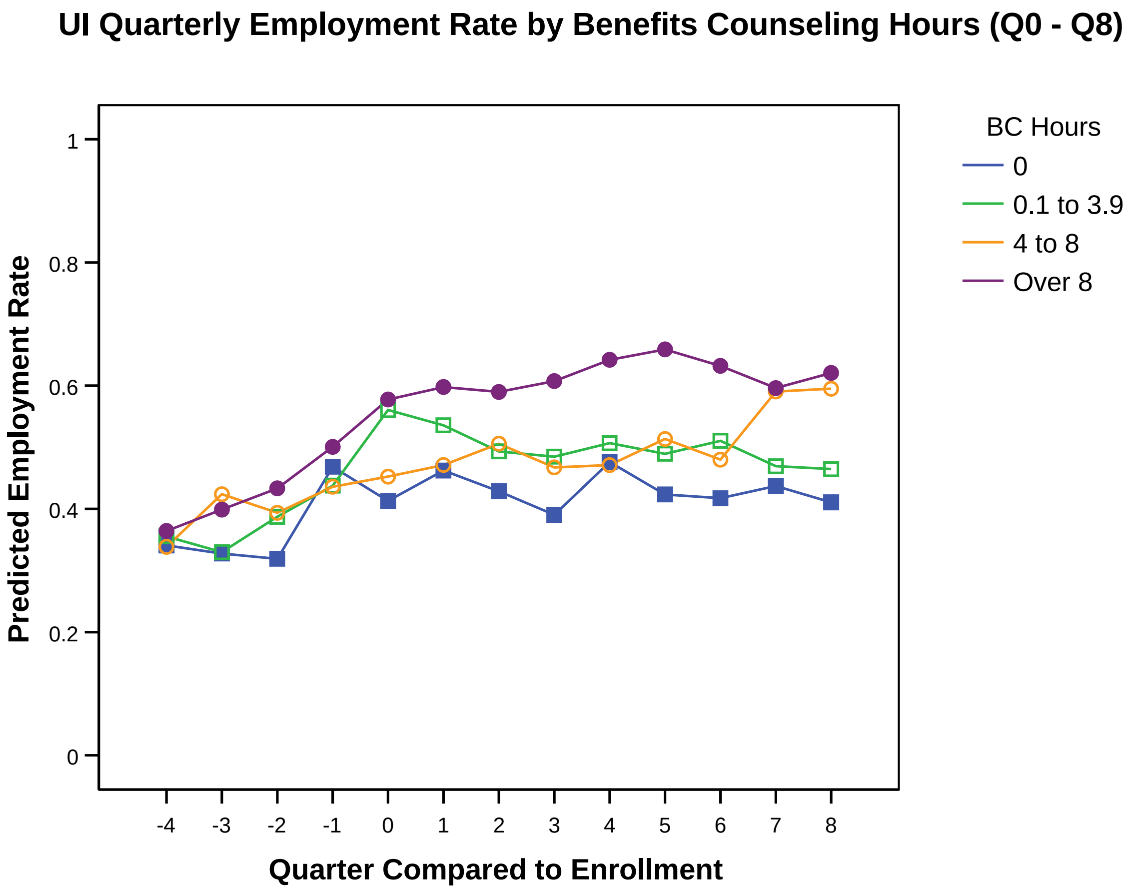


As with mean earnings, predicted employment rates varied considerably depending on the amount of benefits counseling services provided in the Q0-Q8 period. Differences in the between subject effects associated with inclusion in one of the four dosage categories proved statistically significant (see table VI.18). During the post-enrollment quarters, those with over eight hours of benefits counseling had higher predicted employment rates than those with 0.1 to 3.9 hours of benefits counseling; who, in turn. had higher predicted employment rates than those with zero hours of benefits counseling (see figure VI.41).

The participant group receiving four to eight hours of benefits counseling services had less consistent employment rates relative to participants included in the other dosage groups. The predicted employment rates for the four to eight hour group at Q0 were somewhat lower than those for other participants who would get benefits counseling after enrollment, but then increased throughout the post-enrollment period and ended relative to the other dosage based groups as one might expect: lower than those who received over eight hours but higher than those who received less than four hours. Indeed, during the enrollment quarter and first quarter following enrollment those getting four to eight hours of benefits counseling during the pilot had predicted employment rates just slightly higher than those who received no benefits counseling during the pilot and lower employment rates than those who received between 0.1 to 3.9

hours of service. During quarters two through six, the employment rates of those with four to eight hours of benefits counseling overlapped with those receiving 0.1 to 3.9 hours of benefits counseling. By quarters seven and eight, those with four to eight hours of benefits counseling had predicted employment rates just below those who had over eight hours of benefits counseling. Their predicted employment rates far exceeded those of the groups that had received lesser amounts of service.

Figure VI.41: UI Quarterly Employment Rate by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model



There were moderate differences between the study assignment groups in the predicted impact of different dosage levels of benefits counseling services on employment rates. Control participants displayed trends similar to the predicted employment rates for the full participant sample (see figure VI.42), whereas for treatment group participants, the differences across dosage categories were less pronounced (see figure VI.43). For control participants, as with the full participant group, the model predicted the highest employment rates for those who received over eight hours of benefits counseling, followed by substantial overlap in the predicted employment rates for those in the two categories receiving lesser amounts of benefits counseling. The lowest employment rates were associated with being in the group with no reported hours of benefits counseling.

For treatment participants, there was much overlap in predicted employment rates with clear differences across the four dosage groups indiscernible until the fifth quarter following enrollment. Thereafter, those in the two groups that received four or more hours of benefits counseling had overlapping predicted employment rates, though these rates were clearly higher than those for the groups getting less than four hours of service. Nonetheless, despite these characterizations of data trends, it is also accurate to say that, when considering the entirety of the Q0-Q8 period, treatment group members in the highest dosage category (more than eight hours) posted the highest employment rates.

Figure VI.42: UI Quarterly Employment Rate by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model, Control Group Only

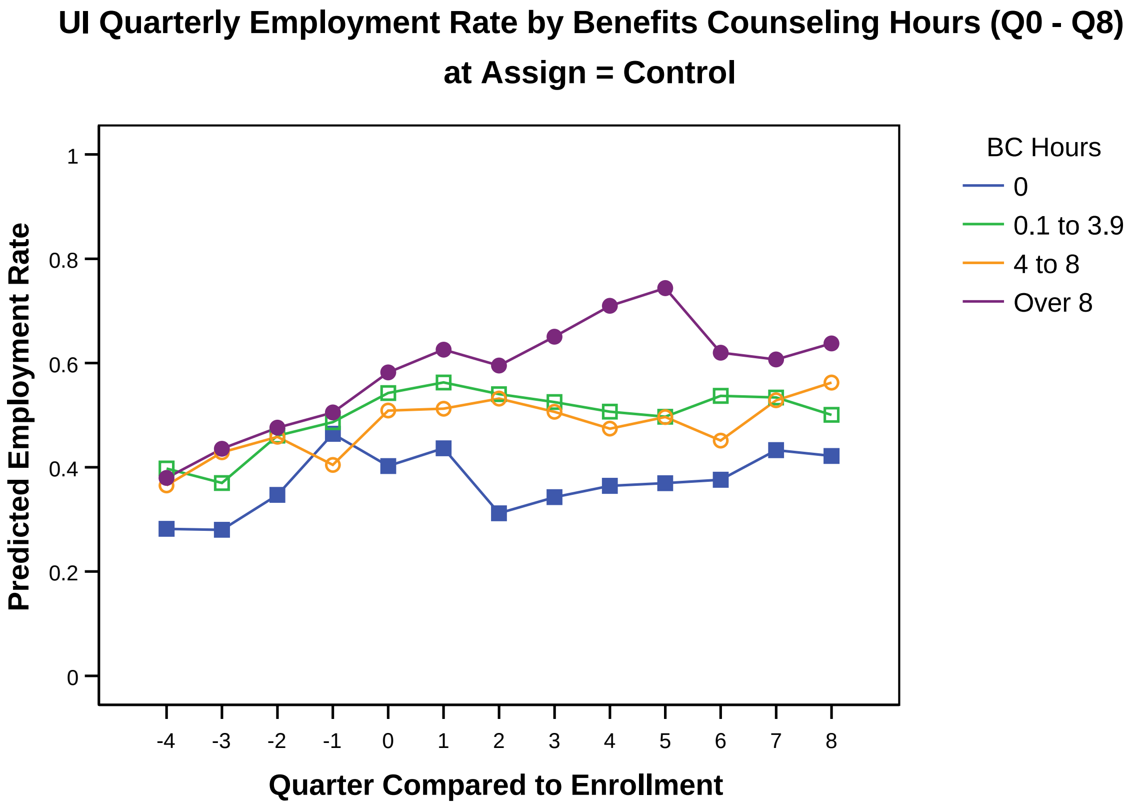
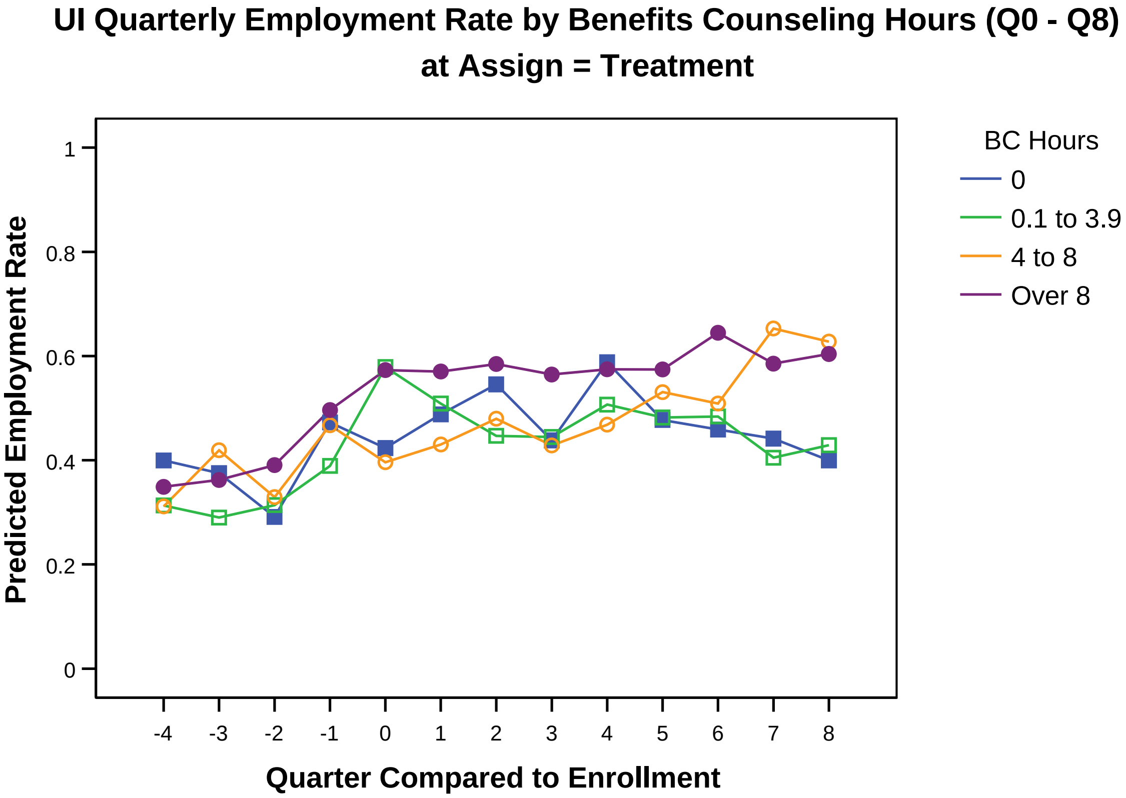
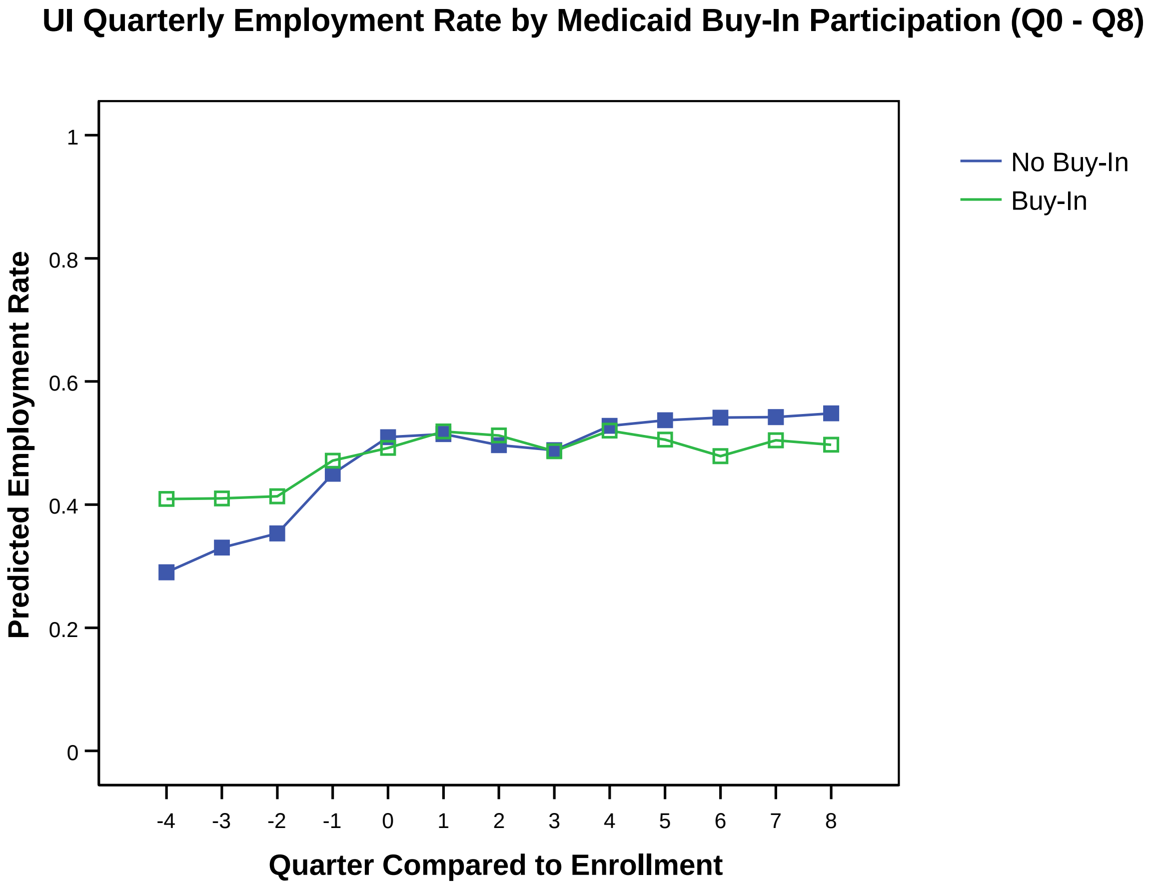


Figure VI.43: UI Quarterly Employment Rate by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model, Treatment Group Only



As with earnings, the employment rates of those who participated in Wisconsin's Medicaid Buy-in for at least some part of the Q0-Q8 period and those who did not were not statistically significant. Again, there was considerable overlap in the trend of predicted employment rates (see figure VI.44). During the pre-enrollment quarters, those who participated in the Buy-in had slightly higher predicted employment rates, whereas in the later quarters following enrollment, those who did not participate in the Buy-in had slightly higher predicted employment rates. Nonetheless, the trend differences must be characterized as minor. Lastly, as we observed no consequential differences between the trends for those in treatment and control relative to each other or the full participant group, we did not include separate graphs for those results.

Figure VI.44: Predicted UI Quarterly Employment Rates by Medicaid Buy-In Participation (Q0 – Q8), Repeated Measures MANOVA Combined Model



For the combined repeated measures MANOVA employment model, there was a within subject statistically significant difference between participants based who exhibited different patterns of change in their level of fear of losing SSDI and related health care benefits (p = 0.042). In other words, the employment rate changes across time were significantly different between the groups of participants exhibiting increases, decreases, and no changes in their fear levels between those reported at, respectively, study entry and the first annual follow-up survey. The predicted employment rates presented in figure VI.45 followed a similar pattern to those predicted for mean earnings. Unlike the earnings model, there was not a significant interaction between changes in fear levels and study assignment for the employment model. [328]

During post-enrollment quarters two through seven, a persistent and counter-intuitive pattern can be observed. Those in the group having increased fear scores had higher predicted employment rates than those groups were the fear levels decreased or remained essentially unchanged. The trend lines for these two groups were very similar and frequently overlapped over most of the post-enrollment period. At quarter eight, the relationships between the three groups more closely fit expectations, though it is not yet clear whether this is simply an anomalous data point. The group with a decrease in fear

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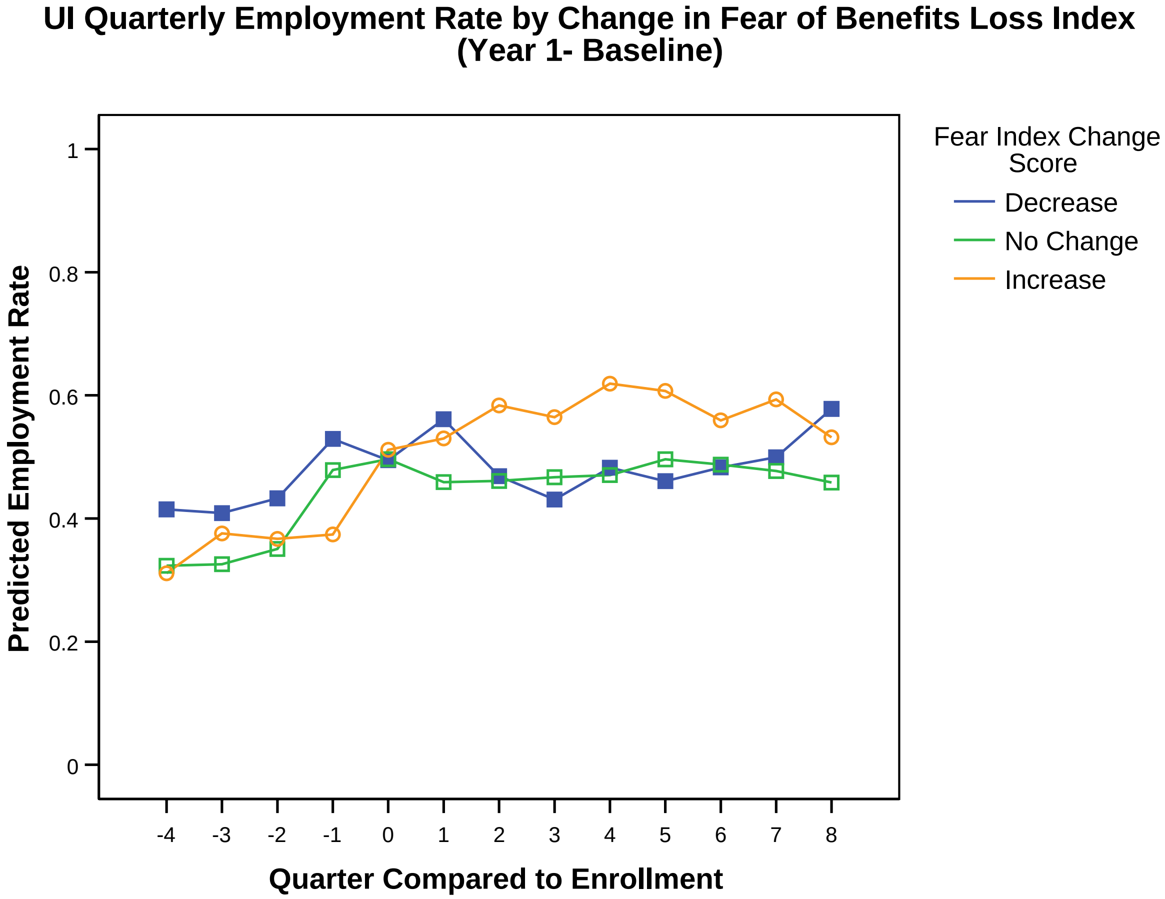
[328] Because the difference patterns are largely similar to the overall graph (figure VI.45), separate control and treatment graphs of these differences in employment rates are not provided.

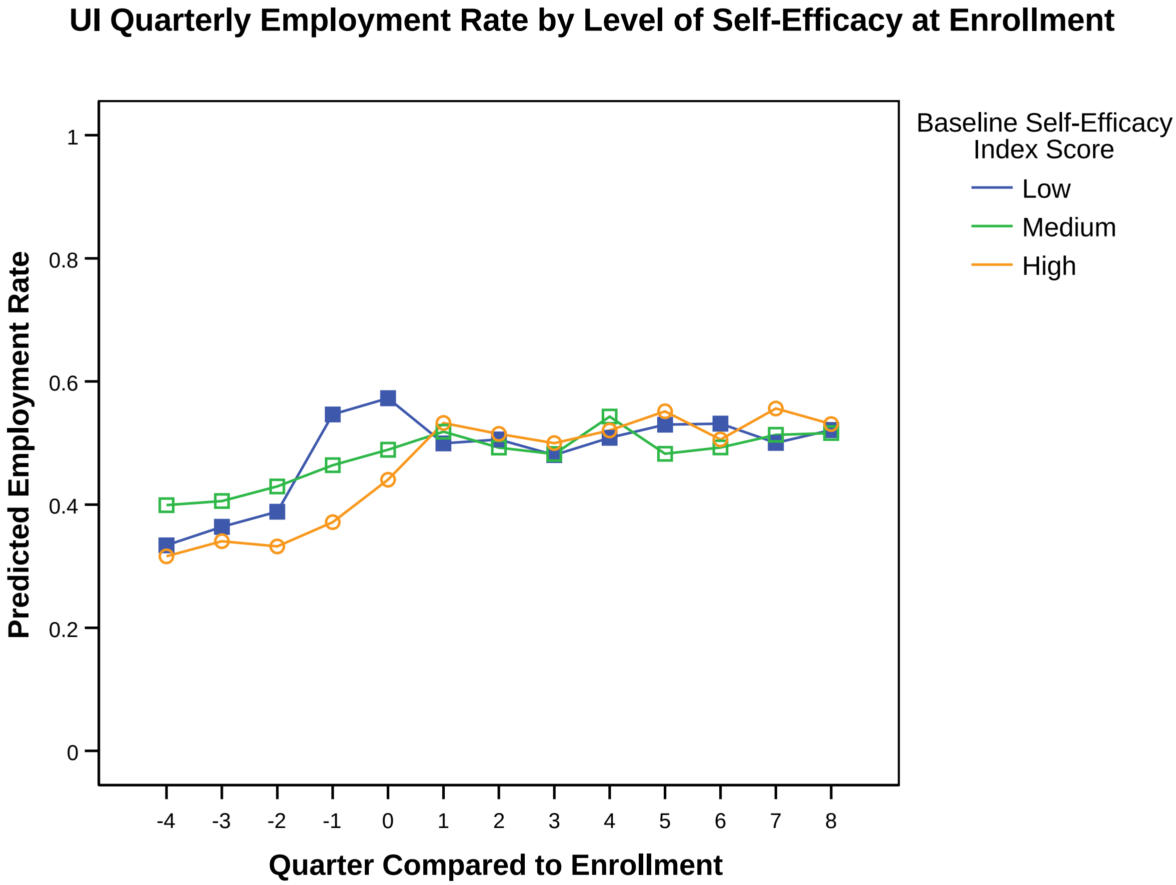
has a higher predicted employment rate than those in the group exhibiting increased fear. Still, those with an increase in fear had a higher predicted employment rate than those with no change in fear.

Figure VI.45: Predicted UI Quarterly Employment Rate by Change in Fear Index, Repeated Measures MANOVA Combined Model



There were no statistical differences in employment rates for those with varying levels of self-efficacy. Further (and consistent with the lack of statistical differences), there was much overlap in the predicted employment rate trends for those with low, medium, and high self-efficacy as measured at study entry. The similarity of trends is particularly apparent during post-enrollment quarters (see figure VI.46).

Figure VI.46: Predicted UI Quarterly Employment Rate by Level of Self-Efficacy at Enrollment, Repeated Measures MANOVA Combined Model



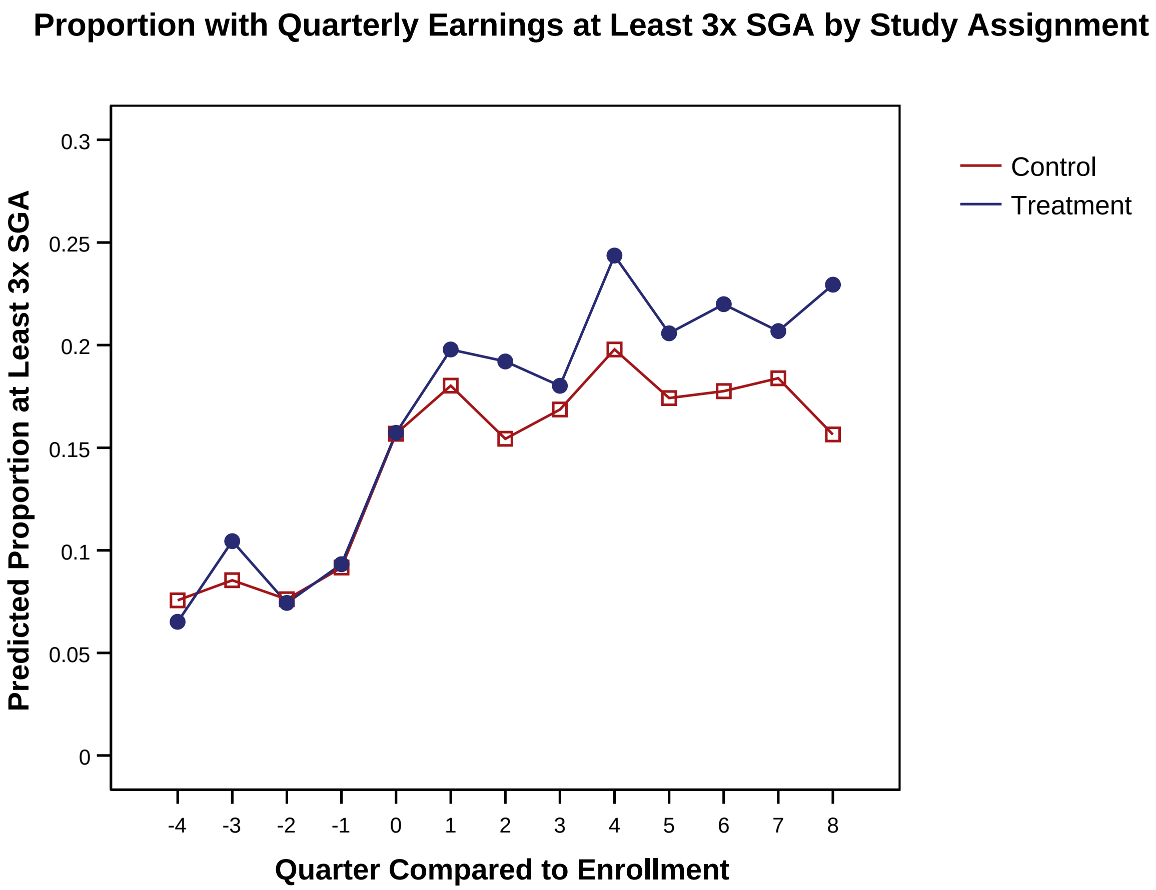
c. SGA Proxy

We observed no statistically significant differences between treatment and control participants in the likelihood that individuals in these respective groups achieved quarterly earnings that equaled or exceeded three times SGA (i.e., our proxy indicator for having monthly SGA earnings). This result, using repeated measures MANOVA, is consistent with what was observed in the descriptive data and the SSA prescribed regression models.

Still, the model's predicted SGA proxy rates were visually different during the post-enrollment quarters as shown in figure VI.47. During the pre-enrollment quarters and the enrollment quarter there was very little difference between the three times SGA rates when comparing treatment and control participants. By quarter one and all the subsequent post-enrollment quarters, treatment group participants had consistently higher predicted three times SGA rates than did control group participants.

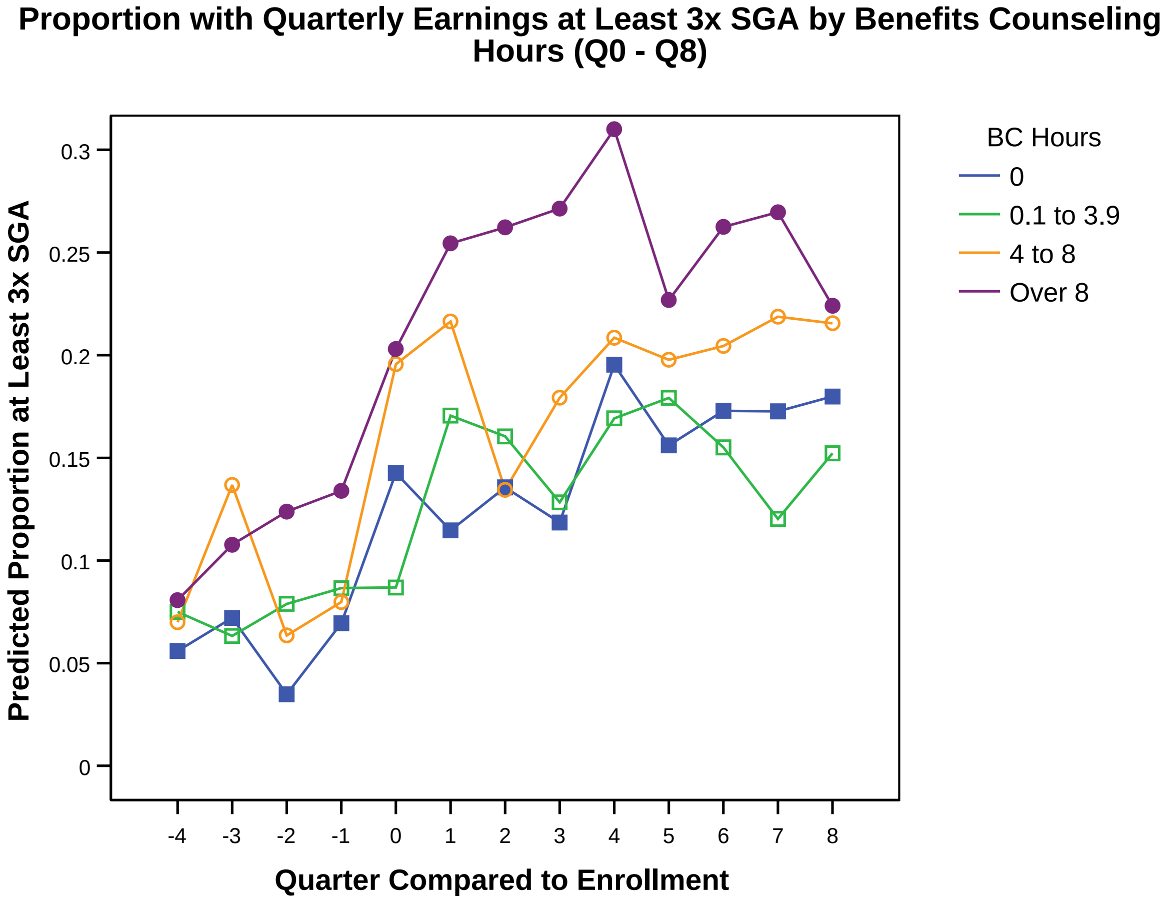
These results raise the question that the non-significant result may be a result of limited sample size. Consistent with this possibility is the fact (presented later in this chapter) that there was a significant difference between the TWP completion rates for those in treatment and control. However, other factors, most notably Medicaid Buy-in participation, which was found to substantially reduce the probability of SGA earnings, may have motivated the non-significant result presented here.

Figure VI.47: Predicted 3x SGA Rate, by Quarter, by Study Assignment for the Repeated Measures MANOVA for Study Assignment



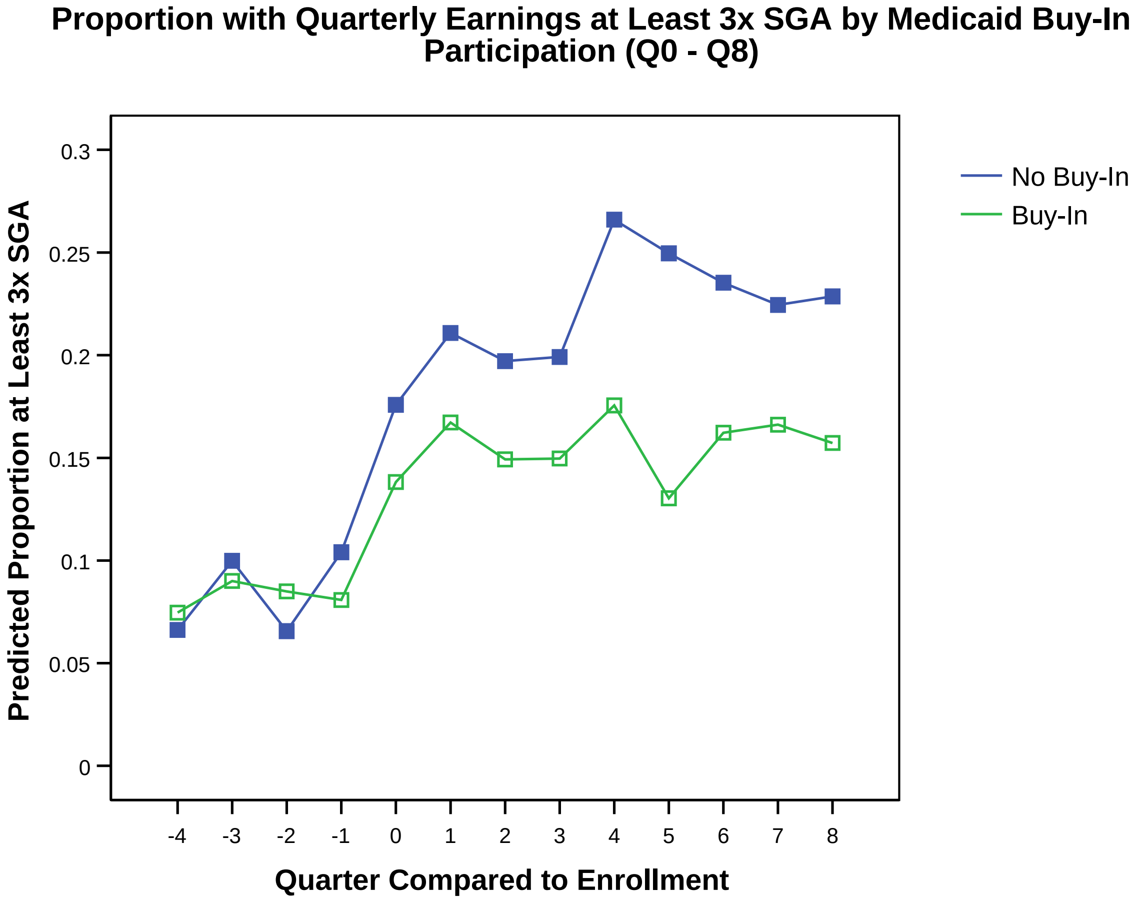
The overall pattern of MANOVA estimated impacts for the dosage of benefits counseling on the probability of having SGA earnings proved quite similar to that observed on quarterly mean earnings. Figure VI.48 displays the estimated proportions of all participants with SGA equivalent earnings for the four dosage groups. The differences observed across these groups are statistically significant with a p-value of 0.017 for between subject differences. With the exception of the group receiving between 0.1 and to 3.9 hours, the expected ordinal relationships were in place. In particular, those getting greater amounts of benefits counseling services had clearly better outcomes in the later quarters of the study period, though there appears to have been be a trend toward reduced differences between those receiving four to eight hours of service and those receiving more than eight hours. As estimated trends for the treatment and control group closely approximated those for the all participant group, the corresponding graphs are not displayed.

Figure VI.48: Predicted 3x SGA Rate by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model



The between subjects difference in Medicaid Buy-in participation almost reached statistical significance (p = 0.052). Though the trend lines shown in figure VI.49 are generally similar to those estimated for the mean income variable, the scale of divergence between estimates for those using the Buy-in and those not using the Buy-in were some greater. It is important to recall that anyone with quarterly earnings of at least $2,490 would be well above the value of mean earnings achieved in any quarter. It is also critical to remember that, above a certain income threshold, premiums for Wisconsin’s Medicaid Buy-in program increase with earnings. Thus, it isn’t surprising that estimates for the SGA proxy are more sensitive to Buy-in participation than those for the earnings variable.

Figure VI.49: Predicted 3x UI 3X SGA Rate by Medicaid Buy-In Participation (Q0 – Q8), Repeated Measures MANOVA Combined Model



Figures VI.50 and VI.51 show results for both the control and treatment groups. Though, for both groups, those not utilizing the Buy-in are more likely to have SGA equivalent earnings, the trends are otherwise quite different. The scale of differences, especially in the later quarters, is much greater for those assigned to the control group. By contrast, in the treatment group the performance gap between Buy-in users and non-users is smaller across the post-enrollment period and the disadvantage associated with Buy-in participation largely disappears toward the conclusion of the study period.

We do not have a clear understanding about why the negative relationship between Buy-in utilization and SGA earnings was relatively benign within the treatment group, especially given the treatment group's greater rate of TWP completion over Q0-Q8. Those completing TWP months would have a combination of relatively high earnings (approaching, equaling, or exceeding SGA) and their full SSDI benefit amounts. Above a certain threshold for adjusted income, such individuals would face Buy-in premiums that would "tax" the unearned portion of their incomes (i.e., the SSDI benefit) at 100%. It is conceivable that, in some cases, the application of the benefit offset might lower the SSDI benefit amount enough to provide protection against needing to pay very large premiums, but we have no information that would allow us to estimate the size or even the reality of this effect. It is also conceivable that a subset of those in the treatment group valued the offset enough to risk higher premiums.

Figure VI.50: UI Quarterly 3x SGA by Medicaid Buy-In Participation (Q0 – Q8), Repeated Measures MANOVA Combined Model, Control Group Only

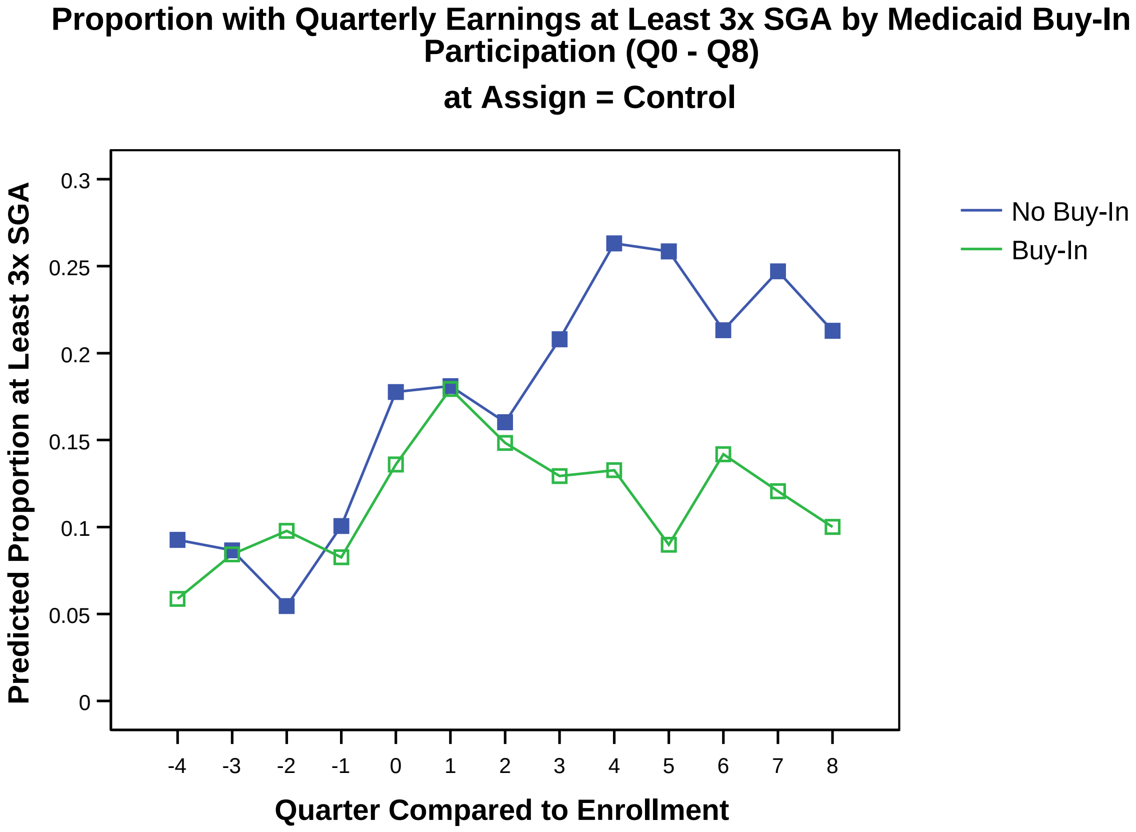
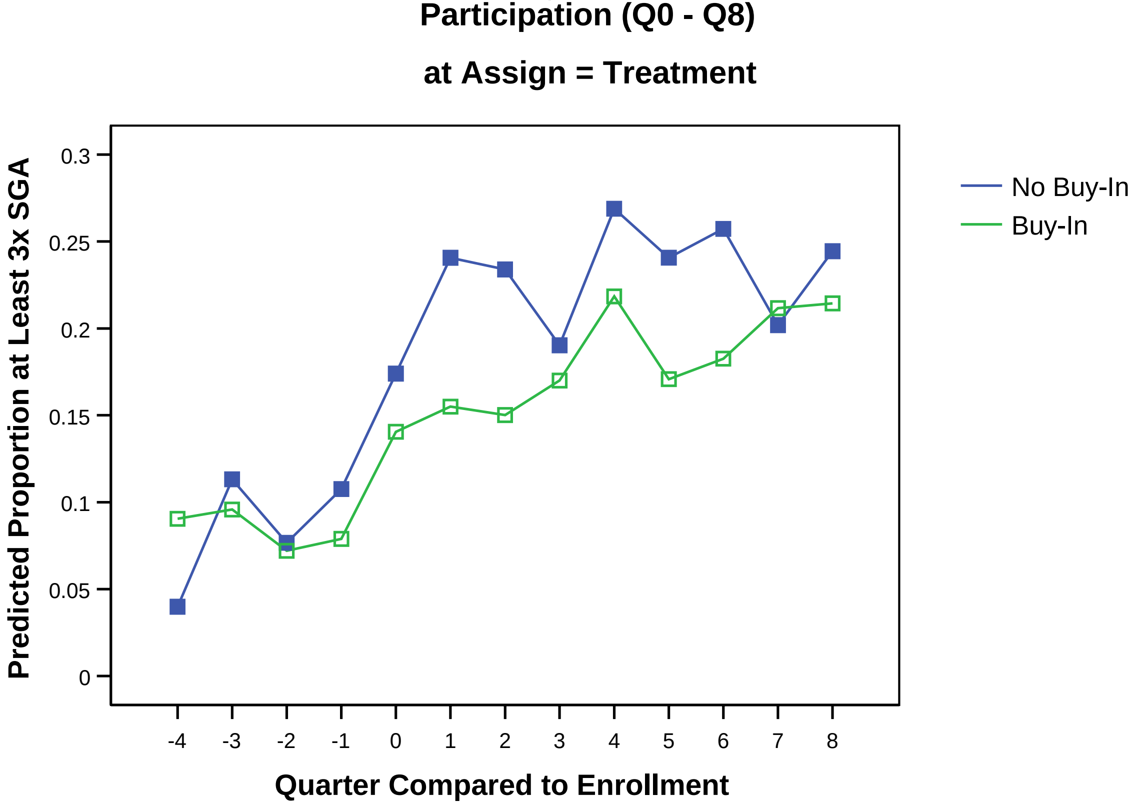


Figure VI.51: UI Quarterly 3x SGA by Medicaid Buy-In Participation (Q0 – Q8), Repeated Measures MANOVA Combined Model, Treatment Group Only

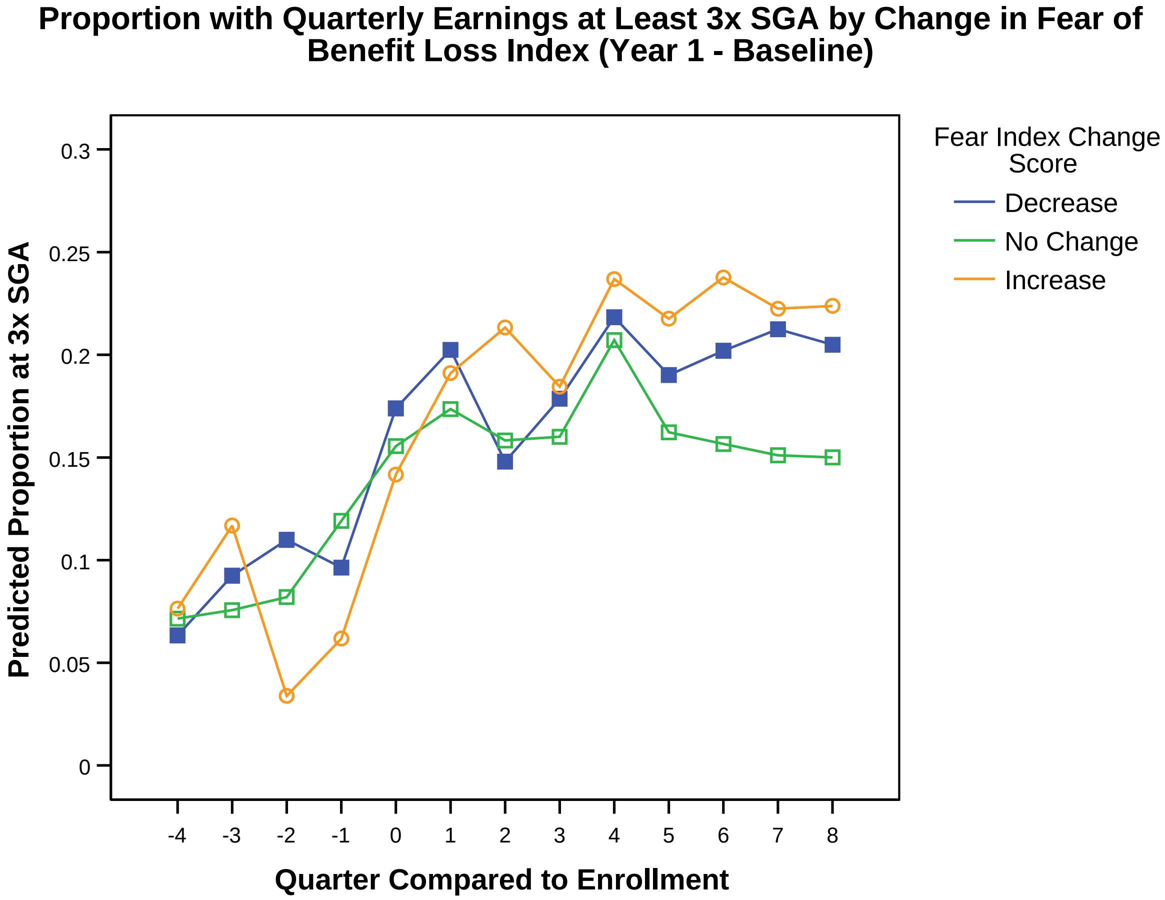


When we used MANOVA to estimate quarterly earnings, we found that the interaction between study assignment and change in the level of fear about losing benefits was statistically significant. Though the SGA proxy represents a type of earnings outcome, the change in fear variable no longer has a statistically significant effect, either in interaction with assignment or by itself. Thus, we have chosen to display the results for only the full participant group.

Despite the non-significant results, there appears to be a clear pattern in the differences in the three times SGA rates reflecting different levels of changes in fear levels between study entry and completion of the first annual follow-up survey. These results are shown in figure VI.53. From post-enrollment quarter three to quarter eight, those with an increase in fear from baseline to year one had the highest predicted three times SGA rate. This is again unexpected because one would assume poorer employment outcomes for those with increased fear. Those with a decrease in fear did have higher predicted rates of achieving SGA equivalent earnings than did those with no change in fear, which might be expected, but again these rates are lower than those with an increase in fear.

However these patterns are largely an artifact of combing treatment and control group results. Results for the treatment group alone tended to be similar to those depicted in figure VI. 52, though with somewhat larger differences between the trend for those with increased fear levels and the trends for those with either lower or unchanged fear levels. By contrast, the pattern for control participants was quite similar to that seen for mean earnings, where those with decreased fear, as expected, were more likely to have better outcome trends.

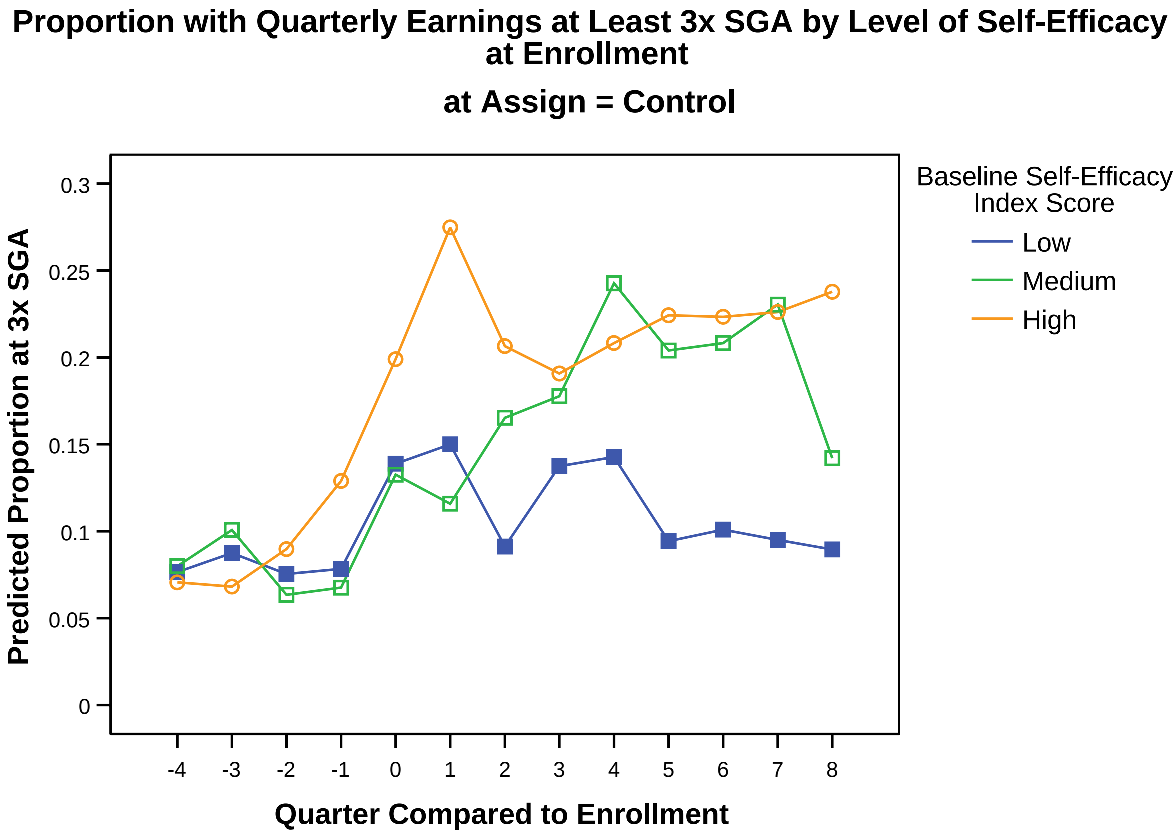
Figure VI.52: Predicted UI 3X SGA Rate by Change in Fear Index, Repeated Measures MANOVA Combined Model



Figures VI.53 and VI.54 display SGA attainment trends associated with three different levels of self-efficacy as measured at study entry. The first of these two graphs show estimates for control group members, the second for treatment group members. The patterns displayed are quite different, though, in turn, they are also very similar to those observed for the impact of the interaction between study assignment and self-efficacy on quarterly earnings.

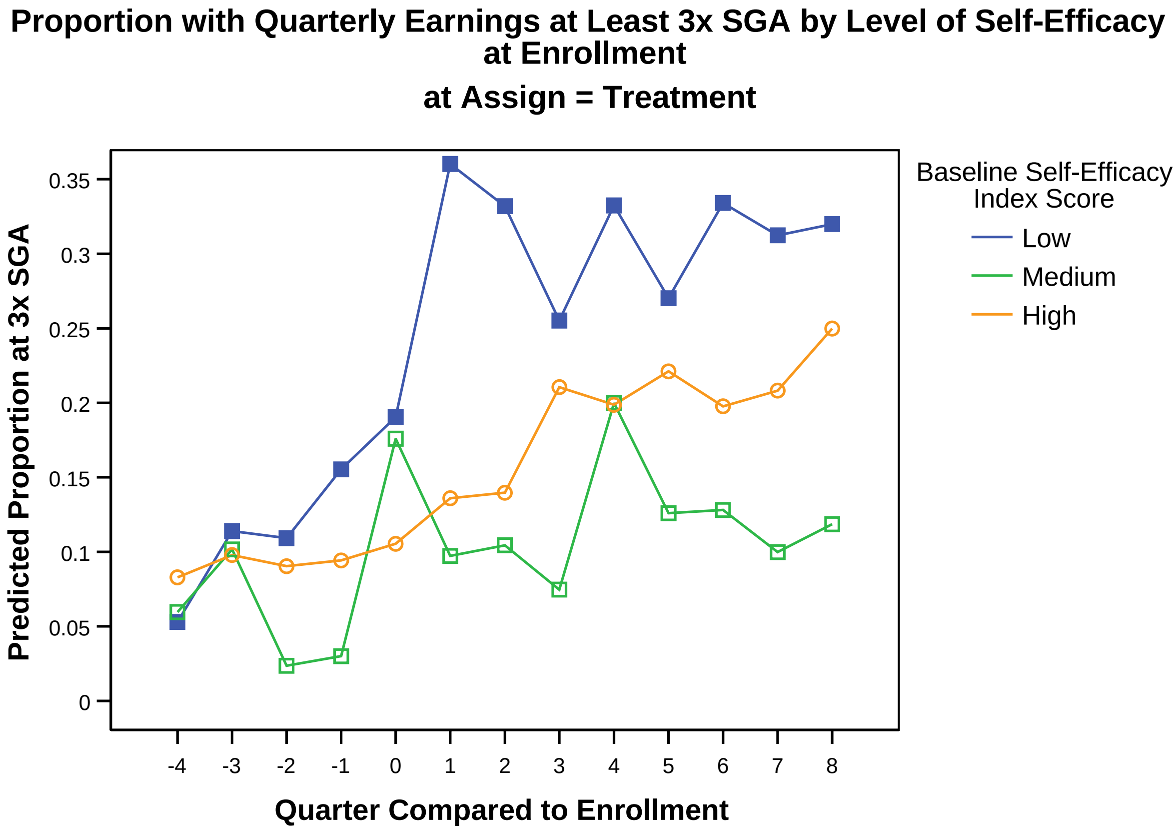
The combined MANOVA results indicated a near significant difference in the between subject impact of self-efficacy on achieving SGA equivalent quarterly earnings, reflecting the interaction between study group assignment and self-efficacy (p = 0.080). Examination of figure VI.53 confirms the presence of the expected ordinal and positive relationship between the independent variable, self-efficacy, and the outcome. However, there appears to be relatively modest difference between having medium and high efficacy over much of the post-enrollment period.

Figure VI.53: UI Quarterly 3x SGA by Baseline Self-Efficacy Index, Repeated Measures MANOVA Combined Model



By contrast, the trends within the treatment group confound expectations. Those with low self-efficacy are much more likely to have SGA equivalent earnings than those at higher efficacy levels. Additionally, there is no ordinal hierarchy. Those in treatment with higher self-efficacy levels at enrollment, have higher rates of SGA equivalent earnings than those with medium self-efficacy. The relative advantage of the high self-efficacy group over the medium group increases over the later post-enrollment quarters and the proportions of SGA earners starts to approach the results estimated for the low efficacy group.

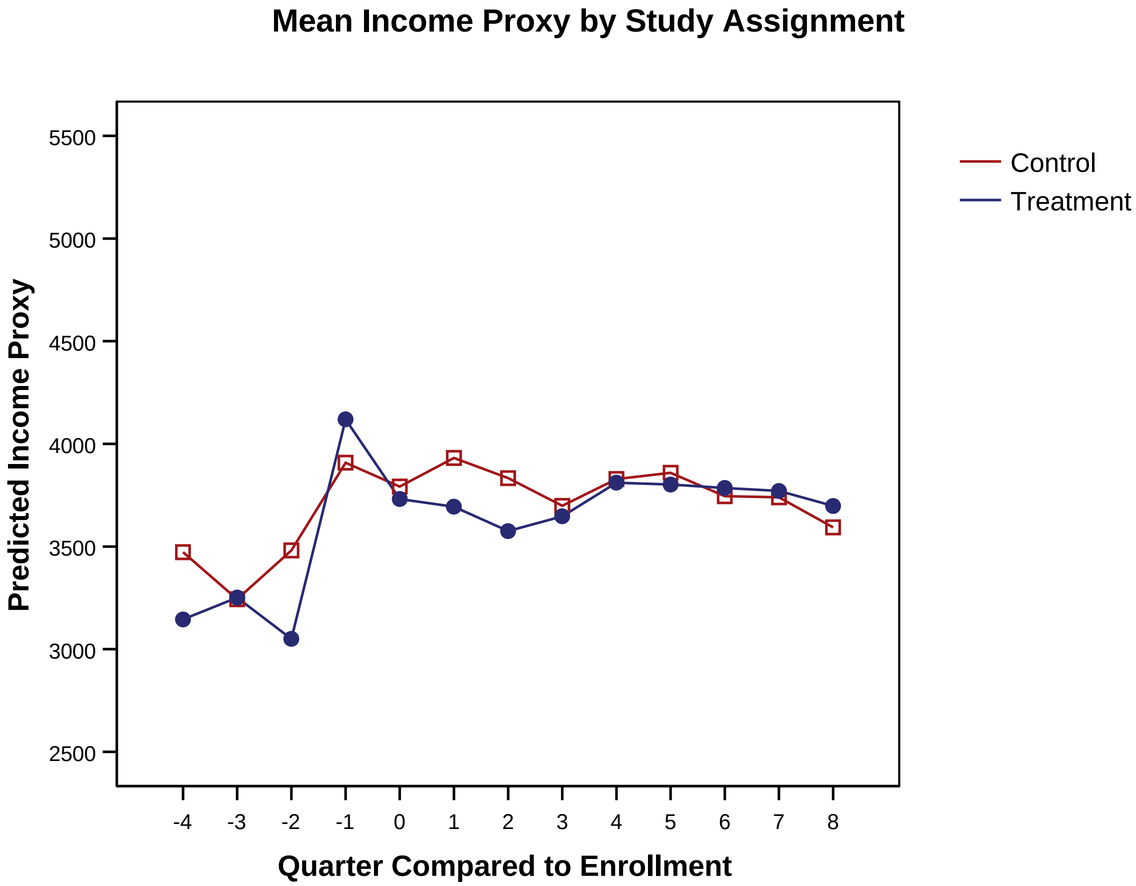
Figure VI.54: UI Quarterly 3x SGA by Baseline Self-Efficacy Index, Repeated Measures MANOVA Combined Model, Treatment Group Only



d. Income Proxy

Again, much like the previous models and the descriptive data for this outcome, there were no significant differences between the predicted income trends for treatment and control participants. Still, as with the previous models and descriptive data, the repeated measures MANOVA combined model also predicts that by the later post-enrollment quarters, treatment group members have higher mean incomes than control group members as indicated by the proxy measure (see figure VI. 55). Offset use was meant to increase income for those assigned to treatment, but only in the specific circumstance of having earnings above SGA following the completion of the TWP. It is possible that offset use may be a contributing factor to the observed pattern. However, it is not improbable that late quarter differences between treatment and control are an artifact of a decrease in predicted income proxy values for control participants, as there was no observable increase in the income proxy for treatment participants during the post-enrollment quarters (relative to Q0).

Figure VI.55: Predicted Mean Income Proxy, by Quarter, by Study Assignment for the Repeated Measures MANOVA Combined Model

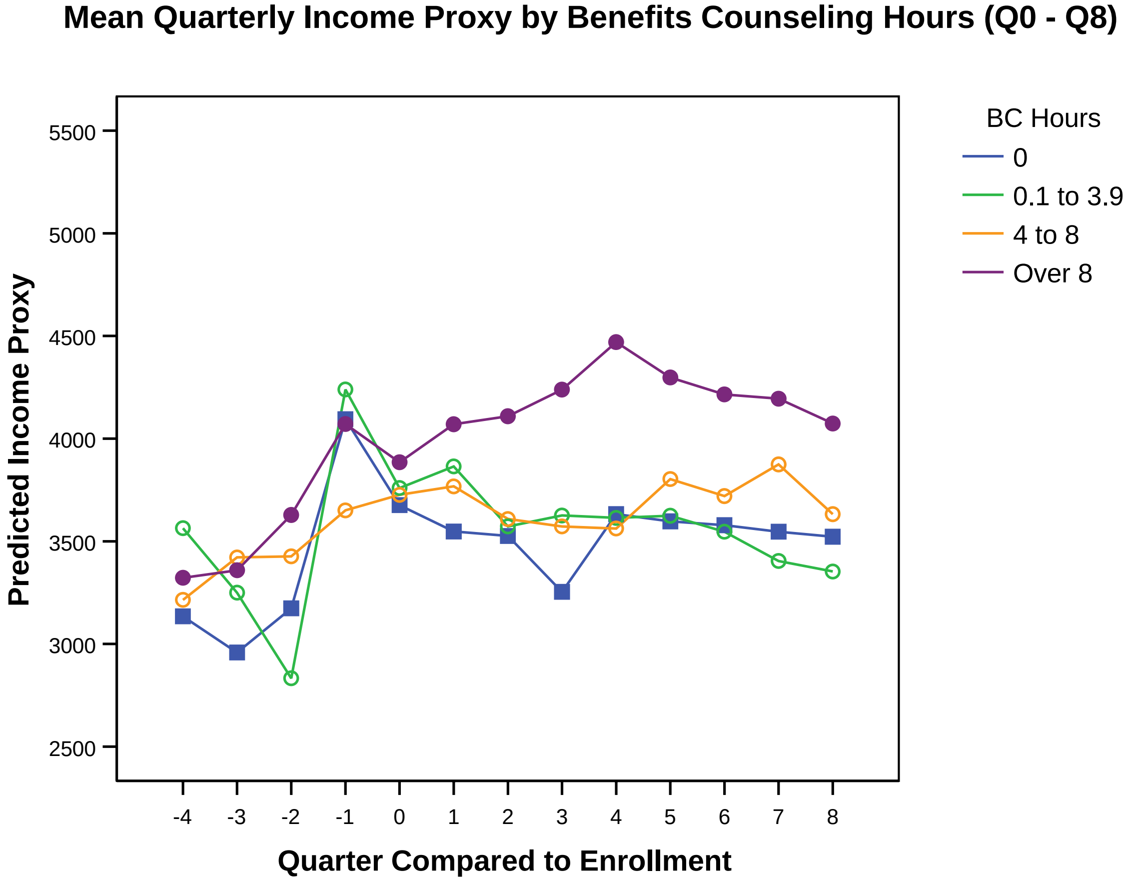


As for the three other combined MANOVA models, hours of benefits counseling services motivated statistically significant between subject differences in quarterly income trends. The pattern of differences was similar to those found for predicted quarterly mean earnings and the proportions of those with quarterly earnings at least three times SGA. Figure VI.56 shows quarterly estimates for the full participant group. As the trend data for control and treatment group members closely reflected those for the full participant group, those graphs are not displayed.

In general, the pattern shown in figure VI.56 was consistent with the expectation that more hours of benefits counseling service would be associated with higher income. For example, the highest predicted values for the income proxy during the post-enrollment period were always those for the group receiving over eight hours of benefits counseling. Further, from post-enrollment quarter five to quarter eight, the second highest predicted values for the income proxy were found for those with four to eight hours of benefits counseling.

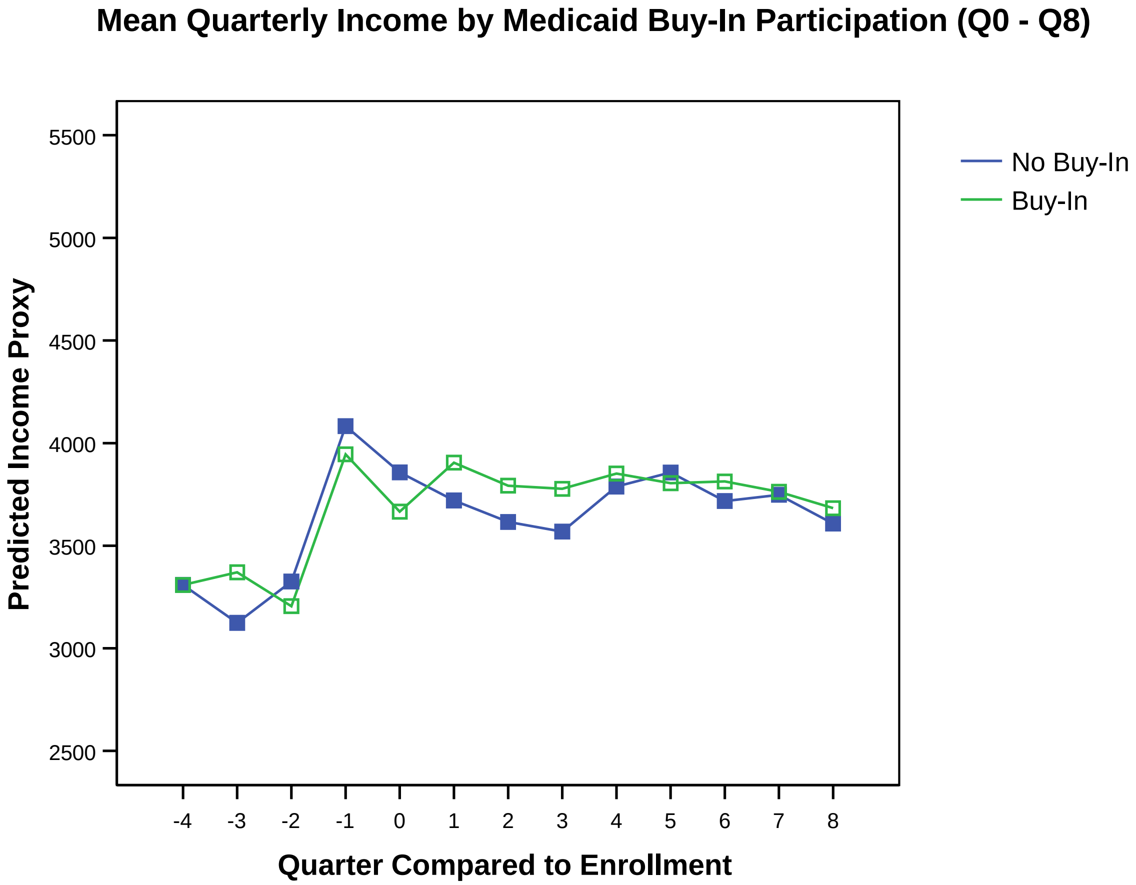
One seeming inconsistency is that those with zero hours of benefits counseling had a higher predicted average income than those with 0.1 to 3.9 hours of benefits counseling from Q6 to Q8. This may be less of an anomaly than it first appears. In the descriptive earnings data, increases in the dosage of benefits counseling did not have a linear impact. Four hours of service appeared to be a "takeoff" point and even four hours of service is quite a small amount over a two year period.

Figure VI.56: Predicted Mean Income Proxy by Benefits Counseling Hours (Q0 – Q8), Repeated Measures MANOVA Combined Model



No significant differences in income trends were observed based on utilization of the Wisconsin Medicaid Buy-in during the Q0-Q8 period. This pattern of results closely approximated those observed for the MANOVA employment and earnings models (though the absolute values for the income proxy estimates were much larger than those generated for earnings alone). The trend lines (see figure VI.57) overlapped to a considerable extent and to the extent they diverged, differences seemed to reflect those observed in the descriptive data for employment rates and mean earnings. Nonetheless, in contrast to results from the MANOVA earnings and, especially, the SGA attainment models, the predicted income proxy did tend to be slightly higher for Buy-in participants during the post-enrollment period. This result is consistent with that observed in the relevant SSA subgroup regression models; that is, while Buy-in utilization seems associated with somewhat less favorable earnings outcomes (especially achieving earnings over SGA), those who use the Buy-in appear to keep a higher proportion of any incremental growth in their earnings.

Figure VI.57: Predicted Mean Income Proxy by Medicaid Buy-In Participation (Q0 – Q8, Repeated Measures MANOVA Combined Model

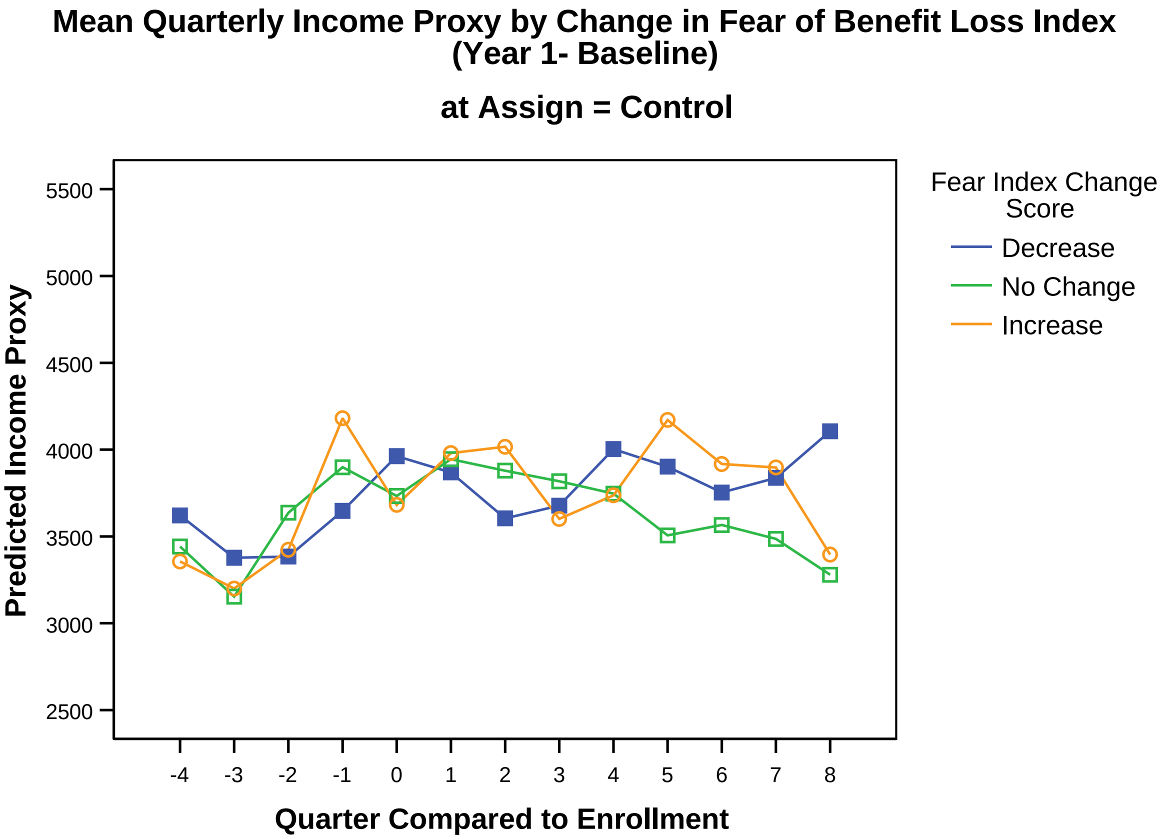


There proved to be a statistically significant relationship between changes in the level of fear of benefits loss and the income proxy. Specifically, the significant relationship was in the within subject effects of the interaction between study assignment and changes in the fear level. The resultant pattern of income estimates and trend lines resembled those produced by the combined MANOVA model for quarterly earnings.

During the second year of the pilot (following completion of the year one follow-up survey), the control group members who had a decrease in their fear levels relative to that measured at pilot entry ultimately had the highest predicted mean values for the income proxy at Q8 (see figure VI.58). The predicted income proxy, for those with a decrease in fear, increased from quarter five to quarter eight, whereas the income proxy for those with an increase or no change in fear decreased during this same period.

This is an expected result, but it is uncertain whether this is an anomaly or indicative of a genuine trend. Indeed, over most of the “year two” period those with increased fear levels maintained a higher mean on the income proxy measure than those with decreased fears. In any case, there was no ordinal relationship among the three “change in fear level” groups. In the second year of the post-enrollment period, those we categorized as having no meaningful change in their fear level had average incomes far behind those for the groups with either increased or decreased fears of benefit loss.

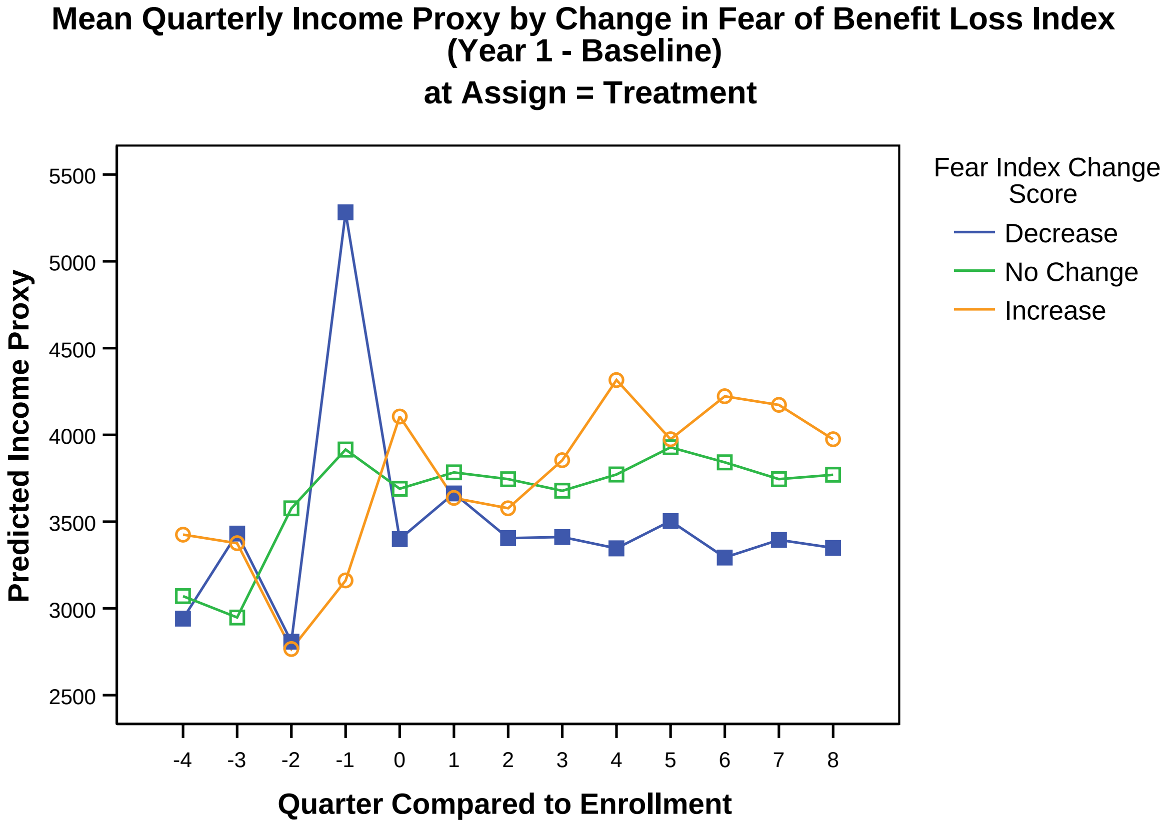
Figure VI.58: Predicted Mean Income Proxy by Change in Fear of Benefit Loss Index (Year 1 – Baseline), Repeated Measures MANOVA Combined Model, Control Group Only



If the control group had results that were not entirely consistent with expectations, the treatment groups' predicted values diverged even more from the expected pattern. The data trends can be viewed in figure VI.59. Consistent trends become apparent from Q3 onward. Though the results can now be characterized as ordinal, the hierarchy expresses a negative association between fear reduction and mean values for the income proxy.

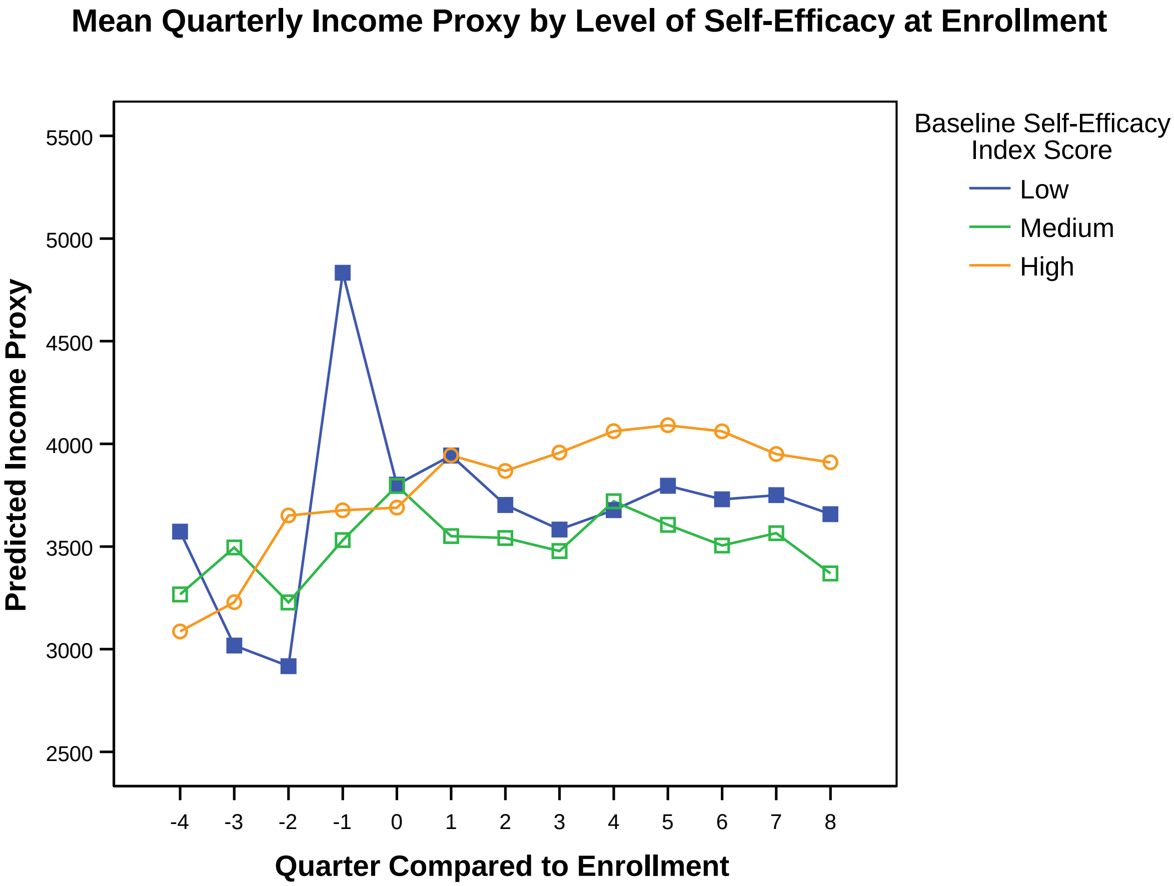
This result, at least in isolation, is highly inconsistent with the intervention theory that has been put forth by many who contend that an SSDI benefit offset will be an effective work incentive. The availability of an offset is expected to calm fears about the loss of income and of program eligibility should a beneficiary's work activity continue to result in above SGA earnings after completion of the trial work period.

Figure VI.59: Predicted Mean Income Proxy by Change in Fear of Benefit Loss Index (Year 1 – Baseline), Repeated Measures MANOVA Combined Model, Treatment Group Only



Between subject differences for the income proxy reflecting differences in the “baseline” level of self-efficacy neared statistical significance (p=0.087). This relationship had not proved significant in the MANOVA models for any of the other employment related outcomes (though those for assignment and self-efficacy interaction sometimes did). Looking at the predicted trends for mean income proxies in figure VI.60, it appears this significant difference is due to the higher predicted income proxies for participants with a high self-efficacy index score at enrollment. This trend is most evident in post-enrollment quarters two through eight. Participants with low and medium self-efficacy had lower predicted mean income proxies, though contrary to expectations those with low self-efficacy having slightly higher predicted mean income proxies than those with medium self-efficacy. This difference pattern is very similar to the predicted mean earnings differences for participants based on their baseline survey self-efficacy index scores.

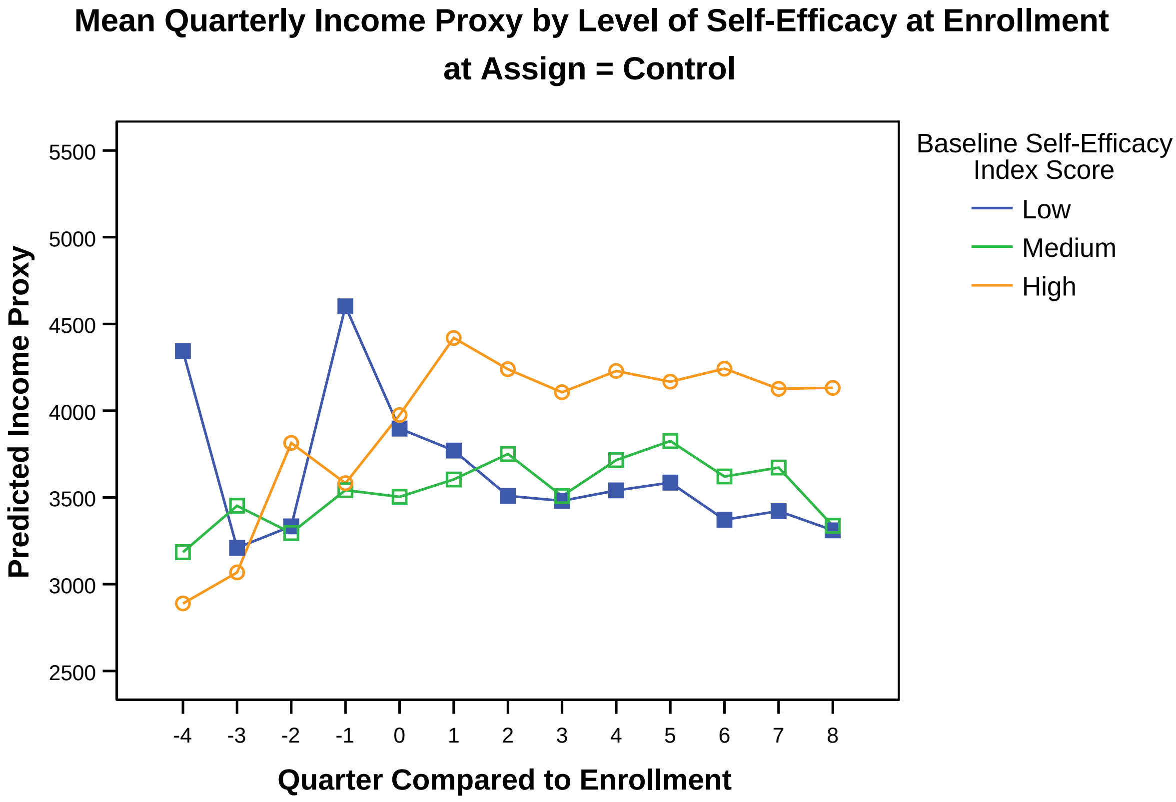
Figure VI.60: Predicted Mean Income Proxy by Baseline Level of Self-Efficacy, Repeated Measures MANOVA Combined Model



Although the interaction between study assignment and baseline self-efficacy index scores was not statistically significant, the observable difference patterns across the baseline self-efficacy index varied for treatment and control participants. This pattern for control participants is shown in figure VI.61. This pattern is very similar to the predicted mean earnings for control participants with low, medium, and high self-efficacy and is a pattern one might expect. Those with high self-efficacy had the highest predicted mean income proxy. After Q0, the differences in mean income between this group and the other two were striking.

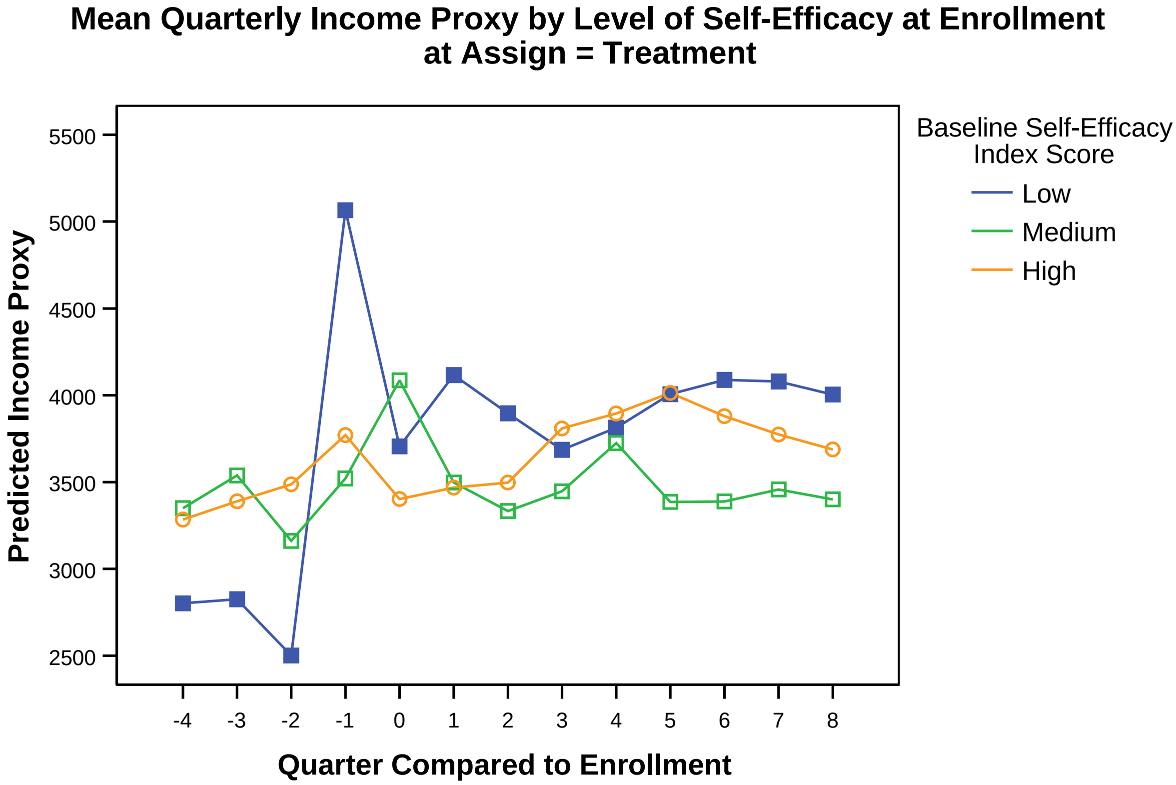
Those in medium self-efficacy group had the next highest group of estimated income proxy values in the Q0-Q8 period. While those with low self-efficacy had, as expected, the lowest predicted mean income proxy, in most quarters the absolute differences between them and those with medium efficacy scores were comparatively modest.

Figure VI.61: Predicted Mean Income Proxy by Baseline Level of Self-Efficacy, Repeated Measures MANOVA Combined Model, Control Group Only



Again, much like for the earnings model, the MANOVA model results for the treatment group do not portray a consistently positive relationship between self-efficacy and the relevant outcome. The results for the income proxy are displayed in figure VI.62. In fact, after Q4, results directly contradict any expectation that there would be a consistently positive relationship between the baseline self-efficacy level and the income proxy. While treatment participants with a high baseline self-efficacy index score did have higher predicted mean income proxies compared to those with a medium self-efficacy, treatment participants with a low baseline self-efficacy index score had mean predicted income proxies that were similar and, in more time periods than not, above those predicted for treatment participants with high self-efficacy. These differences were not as large as those observed in predicted mean earnings. This is because the SSDI benefit component of the income proxy is relatively stable for most participants and, for a majority, a larger component of the proxy than earnings.

Figure VI.62: Predicted Mean Income Proxy by Baseline Level of Self-Efficacy, Repeated Measures MANOVA Combined Model, Treatment Group Only



3. Quarters in which Benefits Counseling was Received

As a result of performing exploratory descriptive analyses, we determined that dosage was the most important variable for determining the impact of post-enrollment benefits counseling services. Consequently, we decided to include benefits counseling hours in the combined MANOVA model. Meanwhile, we also determined that receiving benefits counseling over multiple time periods was associated with improved employment outcomes. To measure this continuity or persistence of service, we recoded monthly encounter data into the same quarterly structure as used for the employment related outcome variables. Though in our models the persistence variable is an integer with values ranging from zero to nine, in any given quarter the variable is dichotomous in the sense that it captures whether or not any benefits counseling services were delivered. Many participants received all of their post entry benefits counseling in three or fewer calendar quarter, most frequently concentrated in the months following their enrollment into the pilot.

Because the categories capturing benefits counseling hours was included in the combined model, the variable quarters of received benefits counseling could not also be included in the model.[329] The two variables are highly correlated ($r = 0.845$, $p < 0.05$), so one would likely cancel the effect of the other out in the combined model. Therefore, this section looks at the impact of the number of post-enrollment quarters with benefits

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[329] Like all independent variables entered into a MANOVA model, the “persistence” variable had to be transformed into a categorical structure.

counseling (persistence") on our four employment related outcome variables using a repeated measures MANOVA analysis. Covariates having a p-value < 0.10 are included in the models, but there are no additional independent variables.

Table VI.20 presents significance levels and effect sizes for the benefits counseling "persistence" variable. The number of quarters in which services were received had a statistically significant impact on the estimates of between subject effects for all four employment variables. Additionally, within subject effects appear significant for the probability of employment and nearly so for earnings. The covariates for each model are identified in table VI.21.

Table VI.20: Repeated Measures MANOVA – By Number of Quarters in which Benefits Counseling was Received (Q0 – Q8)

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Earnings	*Quarter	0.082	0.037	0.006	0.022
Employment	*Quarter	0.028	0.042	0.015	0.018
SGA Proxy	*Quarter	0.549	0.024	< 0.001	0.048
Income	*Quarter	0.215	0.032	0.001	0.029
Sample Size Earnings and Income = 467 0 Quarters = 98; 1 to 3 = 227; 4 to 9 = 142 Sample Size Employment and SGA = 468 0 Quarters = 98; 1 to 3 = 227; 4 to 9 = 143 ES = Effect Size = Partial Eta Squared					

Table VI.21: Covariates for Repeated Measures MANOVA – By Number of Quarters in which Benefits Counseling was Received (Q0 – Q8)

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Earnings					
Age	*Quarter	0.082	0.042	0.005	0.017
Gender	*Quarter	0.081	0.042	0.170	0.004
Employment Post SSDI Eligibility	*Quarter	0.056	0.045	0.076	0.007
Education	*Quarter	0.813	0.017	0.082	0.007
PIA	*Quarter	0.127	0.038	0.012	0.014
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.186	< 0.001	0.491
Employment					
Age	*Quarter	0.063	0.044	0.010	0.015
Gender	*Quarter	0.033	0.048	0.868	< 0.001
Employment Post SSDI Eligibility	*Quarter	0.004	0.062	< 0.001	0.210
TWP Completion Pre-Enrollment	*Quarter	0.169	0.036	0.004	0.018
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.092	< 0.001	0.210
Benefits Counseling Prior to Enrollment	*Quarter	0.195	0.035	0.045	0.009
SSA Race	*Quarter	0.818	0.017	0.093	0.006

SGA					
Age	*Quarter	0.422	0.027	0.033	0.010
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.093	< 0.001	0.301
Benefits Counseling Prior to Enrollment	*Quarter	0.501	0.025	0.034	0.010
Income					
Age	*Quarter	0.371	0.028	0.019	0.012
Employment Post SSDI Eligibility	*Quarter	0.161	0.036	0.008	0.015
Education	*Quarter	0.748	0.019	0.020	0.012
PIA	*Quarter	0.129	0.038	< 0.001	0.426
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.135	< 0.001	0.435
Benefits Counseling Prior to Enrollment	*Quarter	0.156	0.037	0.033	0.010
ES = Effect Size = Partial Eta Squared					

Figure VI.63 displays a clearly positive relationship between receiving benefits counseling over relatively many time periods. What is most notable is that the earnings trend for participants receiving some benefits counseling in at least four quarters is far more positive than for the other two categories. Estimated quarterly earnings grow from $1,167 for Q0 to $1,633 for Q8; an increase of $466 or 40%.[330] Though the trends for those in the low continuity group and those who received no service were more similar to each other than to those getting services in four or more time periods, those getting services in one to three quarters still exhibited slight better performance compared to those receiving no benefits counseling whatsoever. Quarterly earnings increased about $130 (13%). Quarterly earnings for those getting no services declined about $80 (7%) in this model.

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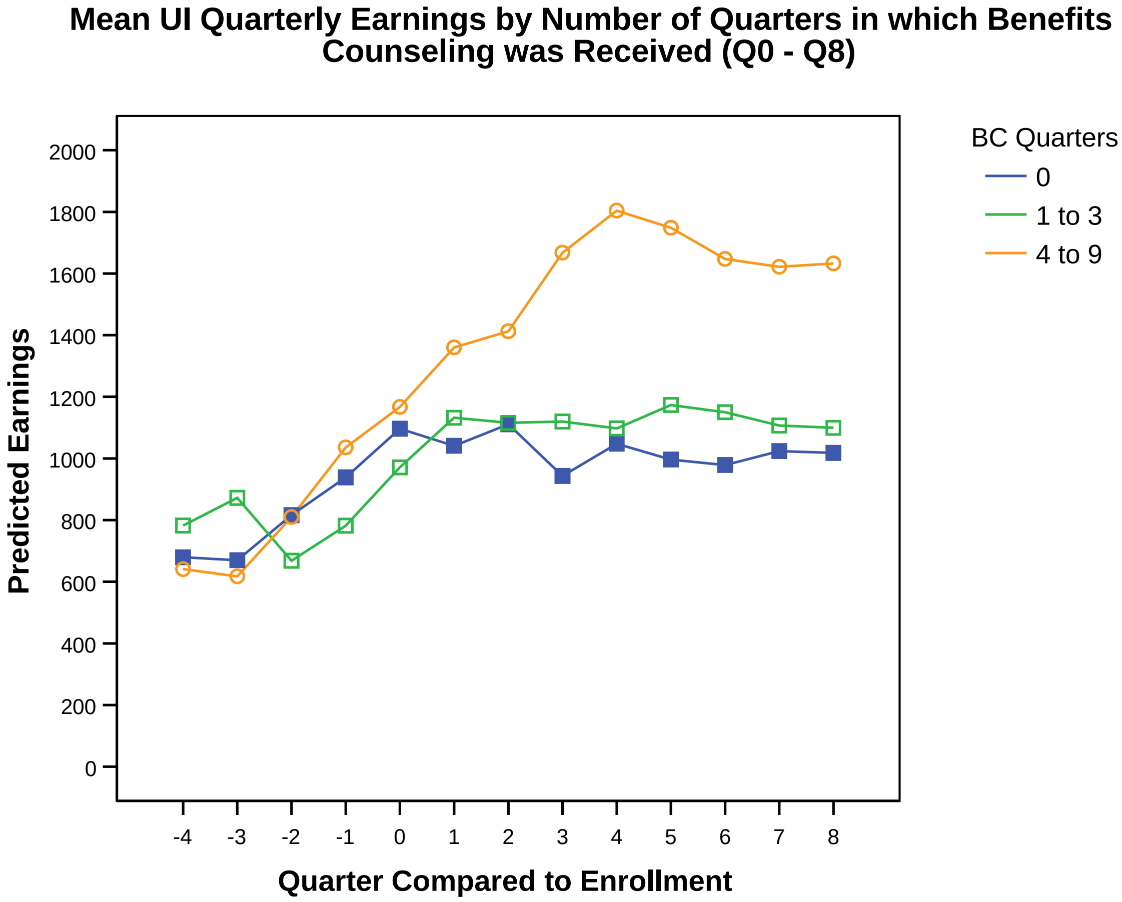
[330] Though the peak value was reached relatively early in Q5. Earnings then declined almost 7% relative to that maximum.

Figure VI.63: Mean UI Quarterly Earnings by the Number of Quarters in which Benefits Counseling was Received



Employment rate trends (see figure VI.64) present a similar pattern across the three groups, though differences across the groups appear less pronounced. This time, the participant group that received benefits counseling services in one to three calendar quarters exhibited a trend roughly midway between the high continuity group and those getting no service. Still, the middle group saw its employment rate decrease by 2.6% points over the Q0-Q8 period. By contrast, those who received benefits counseling services in at least four quarters saw their employment rate increase by almost 11%. The Q8 value for this group reached 60.0%, almost fourteen percentage points above the Q8 employment rate for those getting services in one to three quarters. As usual, those participants who did not get benefits counseling services suffered reverses. Their Q8 estimated employment rate of 37.9% was nearly seven percentage points lower than it was in Q0.

Figure VI.64: UI Quarterly Employment Rate by the Number of Quarters in which Benefits Counseling was Received

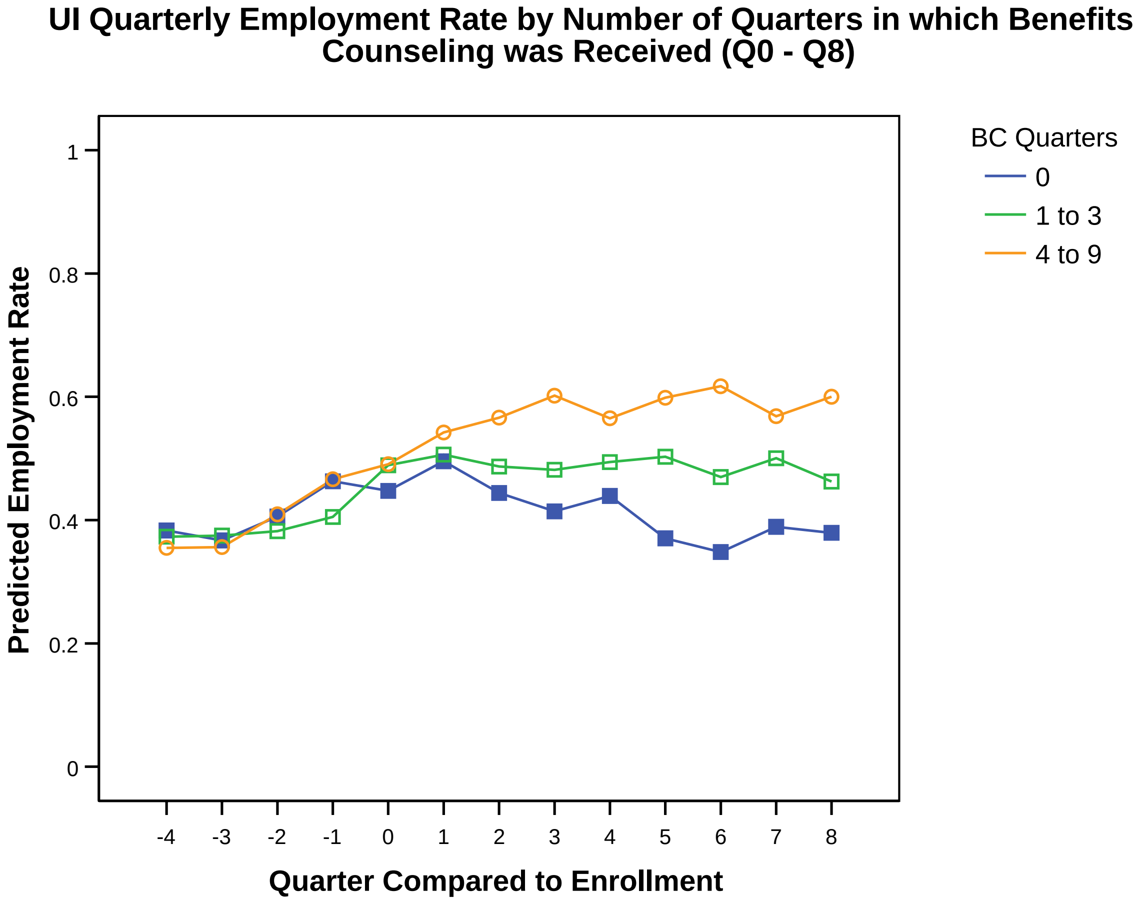
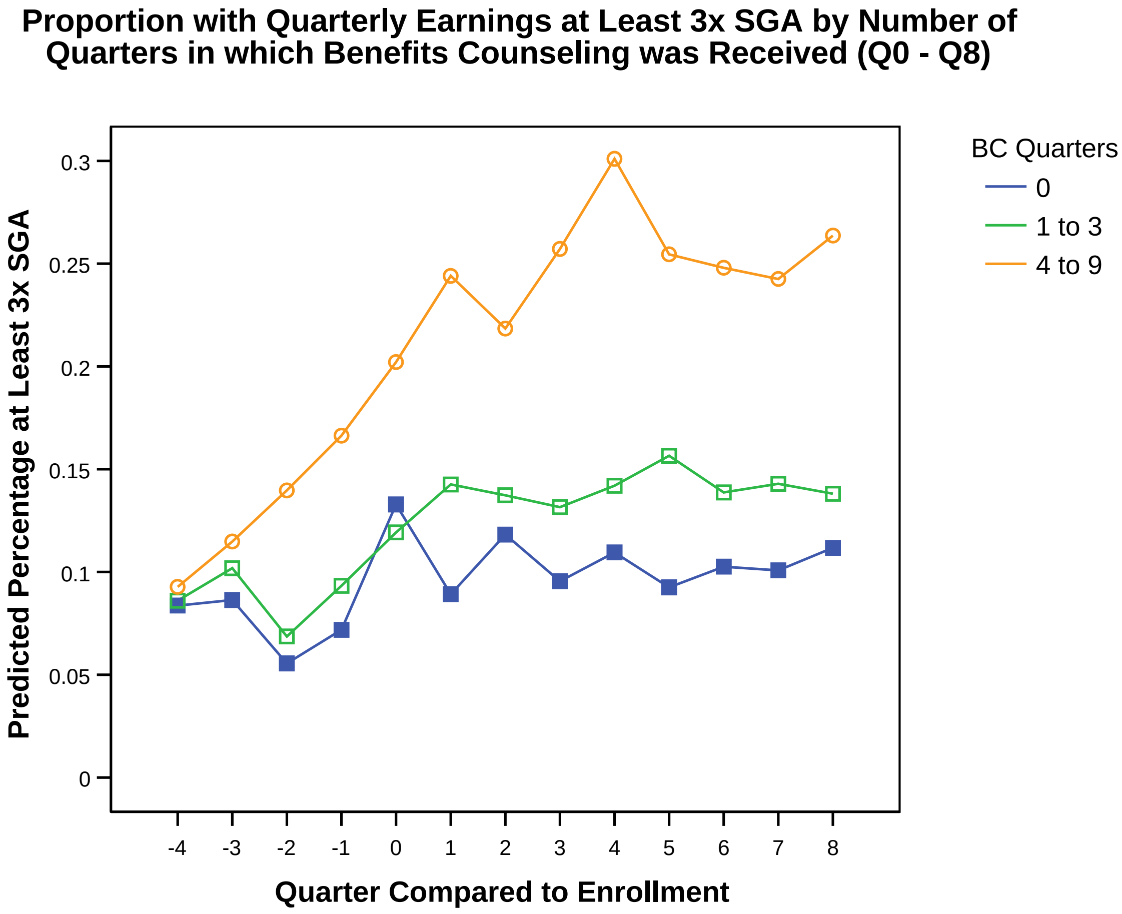


Figure VI.65 displays how the proportion with earnings at least three times SGA varied across the study period. The pattern of results is generally similar to those observed in the earnings data shown in figure VI.63. Between Q0 and Q8 the proportion of imputed SGA earners in the group with benefits counseling in at least four quarters increased six percentage points compared to two percentage points in the group getting services in one to three quarters and a decline of two percentage points in the group not getting benefits counseling services in any quarter from enrollment forward.

There is a second trend that can be inferred from figure VI.65. We have already noted that employment outcomes generally begin to increase well prior to entering the offset pilot. Certainly that trend is present. However, looking at these subgroups, the trend appears to be reinforced for those getting benefits counseling on a relatively persistent basis. At Q-4, the proportion of those who would get service in at least four quarters with quarterly earnings that implied meeting the SGA standard was 9.3%, less than one percent higher than that for the other two groups. By Q8, the proportion was 26.4%, nearly double the 13.8% for the participants who received services in no more than three calendar quarters. It may be that those with persistent benefits counseling are more likely to complete Trial Work Periods or to use their offset. Nonetheless, even a finding that the association between receiving benefits counseling services on a relatively persistent basis and the SGA earnings proxy variable was stronger in the treatment group would not mean the relationship is causal. Benefits counselors working with high earners in the treatment group have reported increased demands on their time, either to expedite work reviews for those completing TWP or to deal with check and overpayment problems for those actually using the offset.[331]

Figure VI.65: Proportions with UI Quarterly Earnings at least 3X SGA by Number of Quarters in which Benefits Counseling was Received



Gains in the income proxy took place, for the most part, prior to enrollment (see figure VI.66). The groups who would receive no benefits counseling after pilot entry or only one to three hours experienced decreases in the groups' mean values for the income proxy measure over the post-enrollment period. By contrast, the group getting services on a more persistent basis continued to report increased mean income relative to Q0, though the growth rate was modest compared to the period before Q0 and there was some decline in the mean value of the earnings proxy after Q3.

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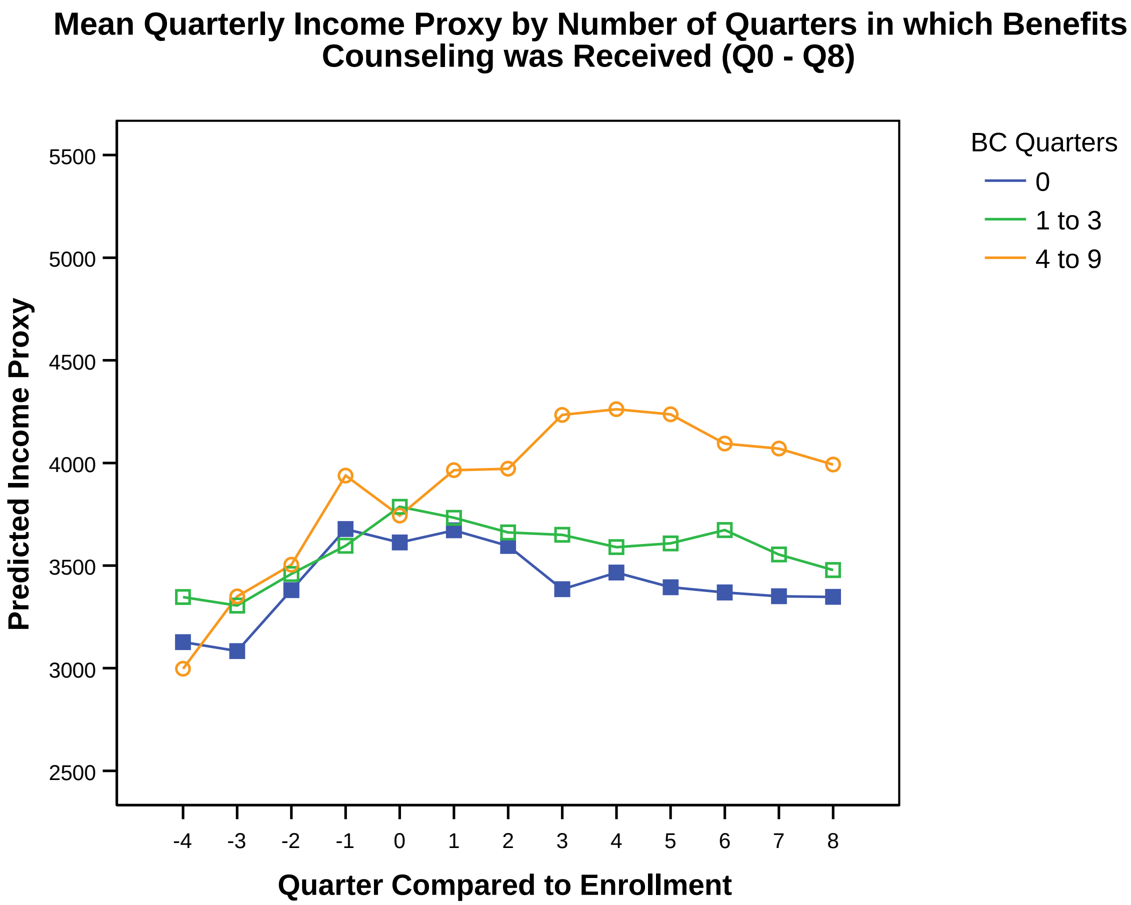
[331] SSA performs work reviews for all beneficiaries completing TWP. However for those in the offset pilot treatment groups, these reviews were done by the SSA Office of Central Operations in Baltimore, MD. Staff at both the central SSDI-EP office and at the provider agencies said this added significant delays. This was collaborated by remarks offered by several participants in focus groups held in fall 2008.

Figure VI.66: Predicted Mean Income Proxy by Number of Quarters in which Benefits Counseling was Received



4. TWP completers and offset subgroups

The offset could not be utilized unless an individual assigned to treatment first completed the nine month TWP. Therefore, there is merit in comparing the employment outcomes of only those in the treatment group who completed their TWP to completers from the control group. Such a comparison would better allow us to answer the question: Does having the opportunity to utilize the offset increase an individual's employment outcomes? To answer that question three repeated measures MANOVA analyses were conducted with study assignment (treatment, control) as the independent variable and mean UI earnings, the employment rate, and quarterly earnings three times SGA as the dependent variables. The same covariates that were used in the combined model were included in these models if their p-values were below 0.10. Most importantly, the covariate, TWP completion prior to enrollment, was included in each model. This is important because it supports examination of the differences between treatment and control TWP completers by controlling for whether participants had completed a TWP prior to the pilot (including the post-enrollment portion of the enrollment quarter).

TWP completers were defined as those who had finished a TWP by Q8. Over half of this category had completed the TWP prior to enrollment, occasionally several years before. Consequently, for the purpose of these analyses, "Q0" was defined differently than it was for all analyses previously described. If an individual completed his/her TWP prior to enrollment or during his/her enrollment quarter, then Q0 remained the enrollment quarter. If, however, the individual completed his/her TWP after his/her enrollment quarter, then Q0 for these analyses was the quarter during which this individual completed his/her TWP. The sample sizes for the analyses by type of Q0 are reported in table VI.22.

Table VI.22 Sample Size for TWP Completers Subgroup Analyses

		Sample Size	Percent of Sample
Treatment	Enrollment as Q0	62	53.4
	Enrollment and TWP Completion as Q0[332]	7	6.0
	TWP Completion as Q0	47	40.5
	Total	116	100.0
Control	Enrollment as Q0	54	56.3
	Enrollment and TWP Completion as Q0	14	14.6
	TWP Completion as Q0	28	29.2
	Total	96	100.0

The results of the repeated measures MANOVA for the TWP completer subgroup analyses are given in table VI.23. Statistically significant study assignment employment outcome differences were only found within subjects for the earnings variable ($p = 0.013$). This difference is illustrated in figure VI.67. Both groups display predicted trends that decline relative to their starting point, but there is a steeper decrease in mean quarterly UI earnings predicted for the control participants. This pattern of a steeper decrease in employment outcomes was also observed in those predicted by the employment rate (figure VI.68) and SGA attainment rate (figure VI.69) models, but these steeper declines for the control group were not statistically significant.

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[332] Despite the differentiation in the table between a) enrollment and TWP completion as Q0 and b) TWP completion as Q0, both groups were included in the covariate as not completing TWP by Q-1. In contrast, the enrollment as Q0 group was included in this covariate as having completed TWP by Q-1.

Table VI.23: Repeated Measures MANOVA – TWP Completer Subgroup Analyses

	With-In Subject (Wilks' Lambda)			Between Subject	
		Sig	ES	Sig	ES
Earnings					
Assignment	*Quarter	0.013	0.076	0.105	0.013
Age	*Quarter	0.049	0.060	0.004	0.039
TWP Completion Pre-Enrollment	*Quarter	0.130	0.047	< 0.001	0.172
Pre-Enrollment Mean Earnings	*Quarter	< 0.001	0.142	< 0.001	0.309
Employment					
Assignment	*Quarter	0.216	0.040	0.861	< 0.001
Age	*Quarter	0.766	0.016	0.004	0.040
Employment Post SSDI Eligibility	*Quarter	0.075	0.055	0.007	0.035
TWP Completion Pre-Enrollment	*Quarter	0.373	0.032	0.001	0.053
Pre-Enrollment Mean Earnings	*Quarter	0.459	0.028	< 0.001	0.127
Race	*Quarter	0.013	0.077	0.870	< 0.001
SGA					
Assignment	*Quarter	0.955	0.008	0.802	< 0.001
Age	*Quarter	0.029	0.067	0.018	0.027
TWP Completion Pre-Enrollment	*Quarter	0.355	0.032	< 0.001	0.097
Pre-Enrollment Mean Earnings	*Quarter	0.477	0.027	< 0.001	0.118
ES = Effect Size = Partial Eta Squared					

Figure VI.67: Mean UI Quarterly Earnings by Study Assignment, Repeated Measures MANOVA TWP Completer Model

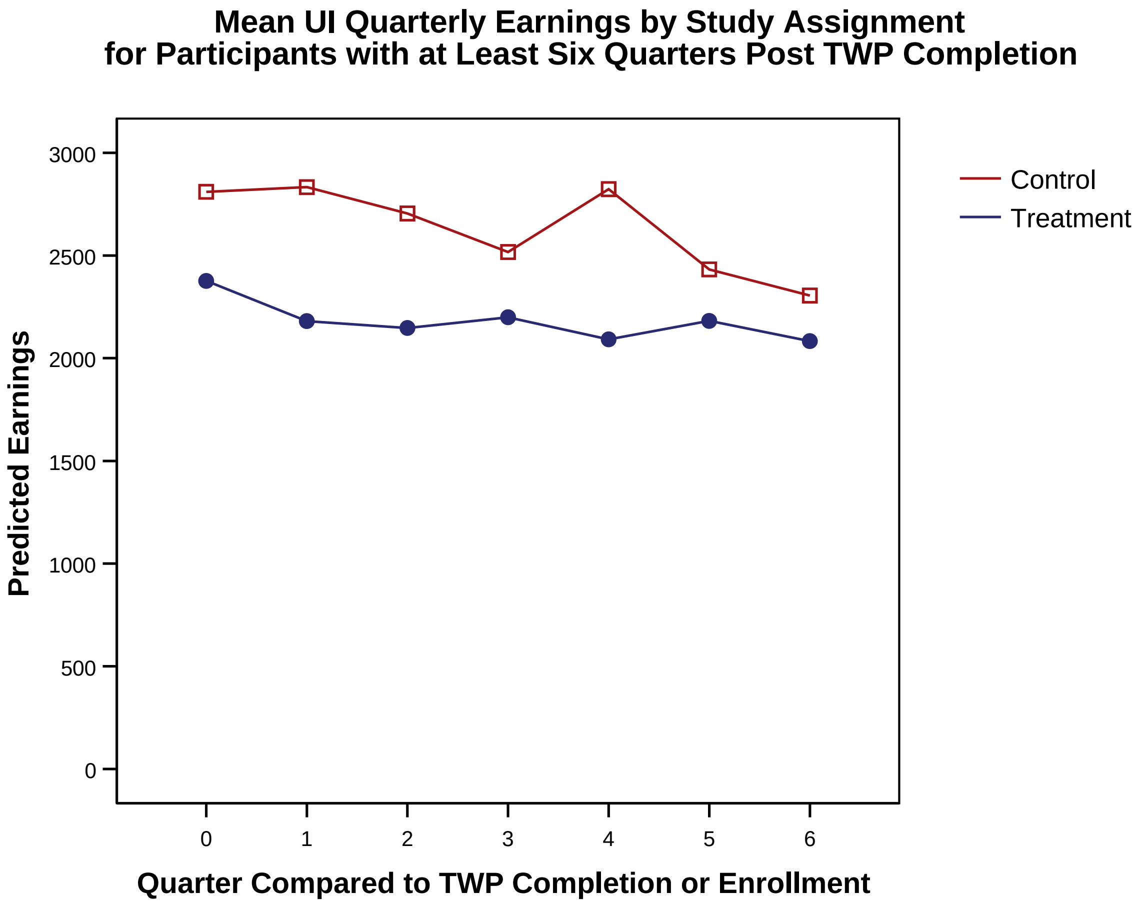


Figure VI.68: UI Quarterly Employment Rate by Study Assignment, Repeated Measures MANOVA TWP Completer Model

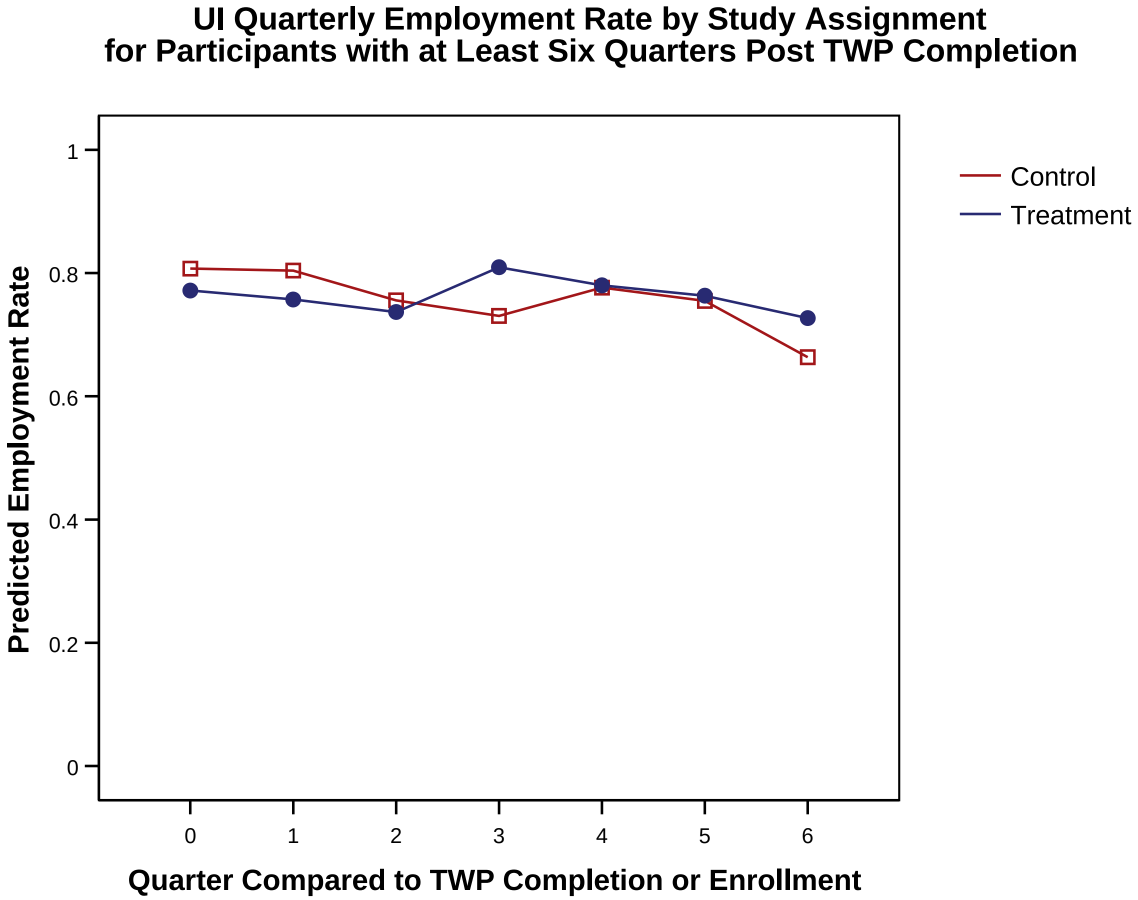
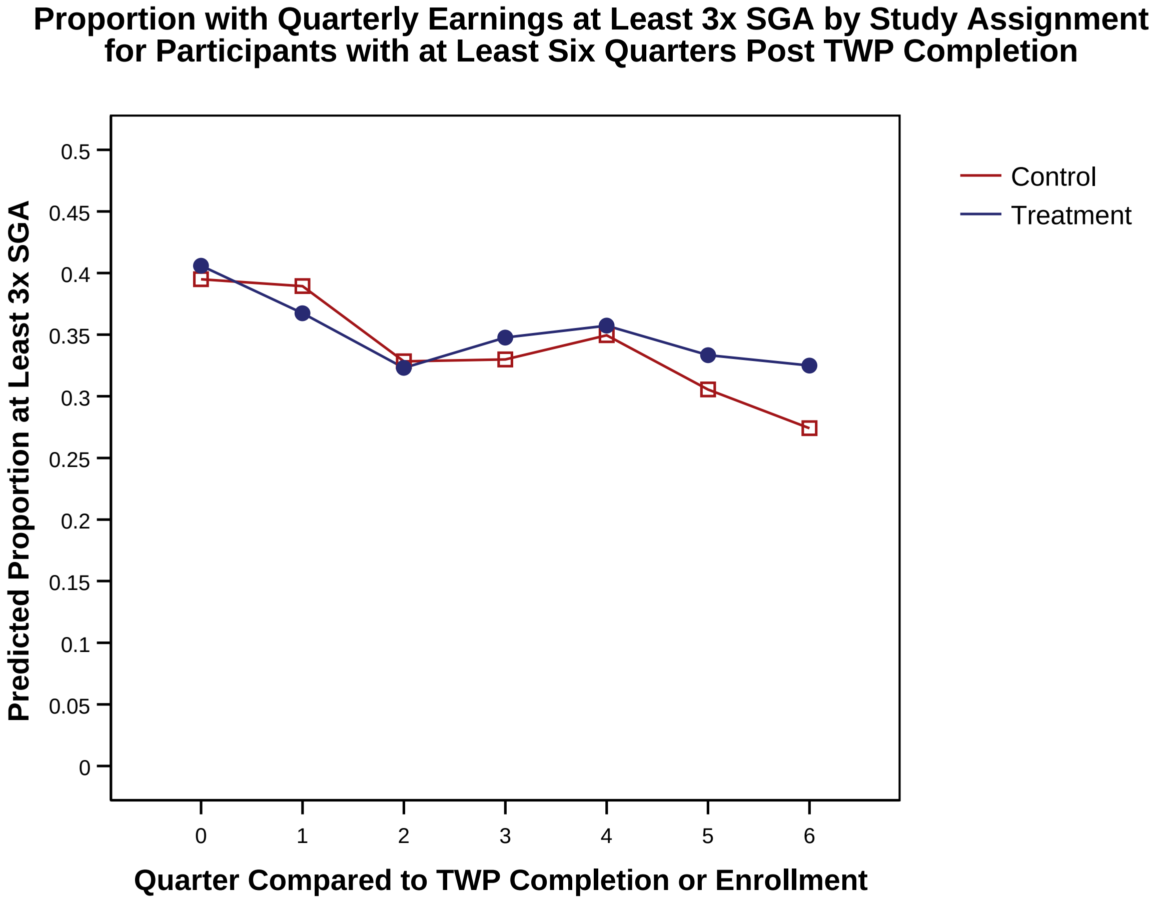


Figure VI.69: UI Quarterly 3x SGA by Study Assignment, Repeated Measures MANOVA TWP Completer Model

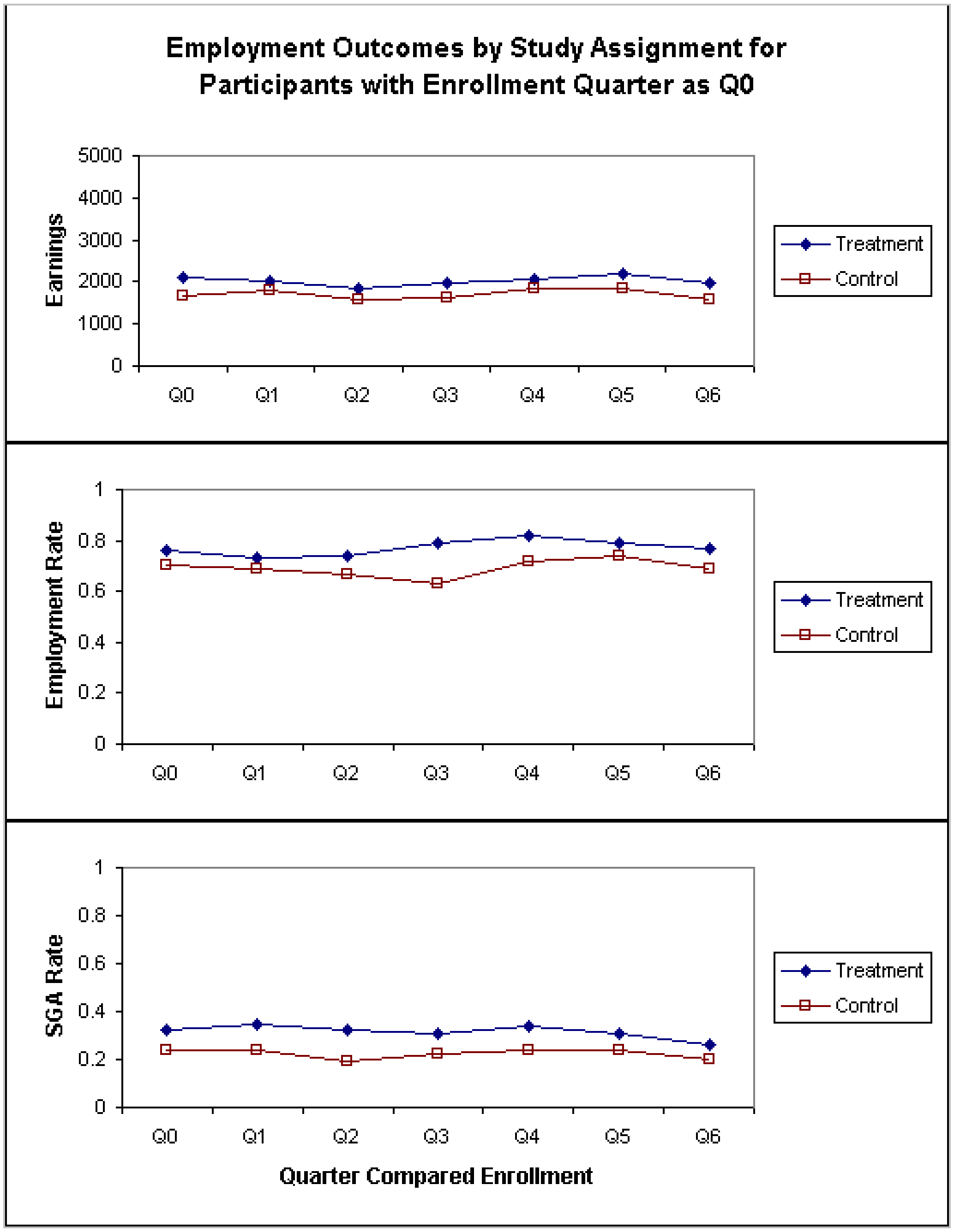


The declines in employment outcomes for the TWP completers are striking considering that most of our previous analyses show increases in employment outcomes. Even when decreases were predicted, relative to the enrollment quarter, their magnitudes were small compared to those observed in the TWP completer data. One possible explanation for the greater decreases experienced following TWP completion is that employment outcomes generally peak in the final months of most individuals' TWP. After the last TWP month, individuals must decide whether they want to earn over SGA and either utilize the offset and risk poor offset administration (if a treatment participant) or lose their monthly SSDI payment (if a control participant). Some individuals may also fear that if they work over SGA the may lose their eligibility for SSDI or Medicare – if not immediately, then after a future medical CDR. Other individuals may not be able to continue to earn at the rate they did during their TWP, whether due to a worsening of their disabling condition or some other adverse circumstance. A quick descriptive comparison of employment outcomes between participants who completed their TWP prior to enrollment to participants who completed their TWP following enrollment supports the notion that, as a group, those completing a TWP most often reach their peak earnings level at or near the end of their TWPs.

For those individuals who completed their TWP prior to enrollment, there is a very slight decline in earnings and in the proportion with SGA equivalent earnings, though there is no change in the employment rates (see figure VI.70). Through Q0 to

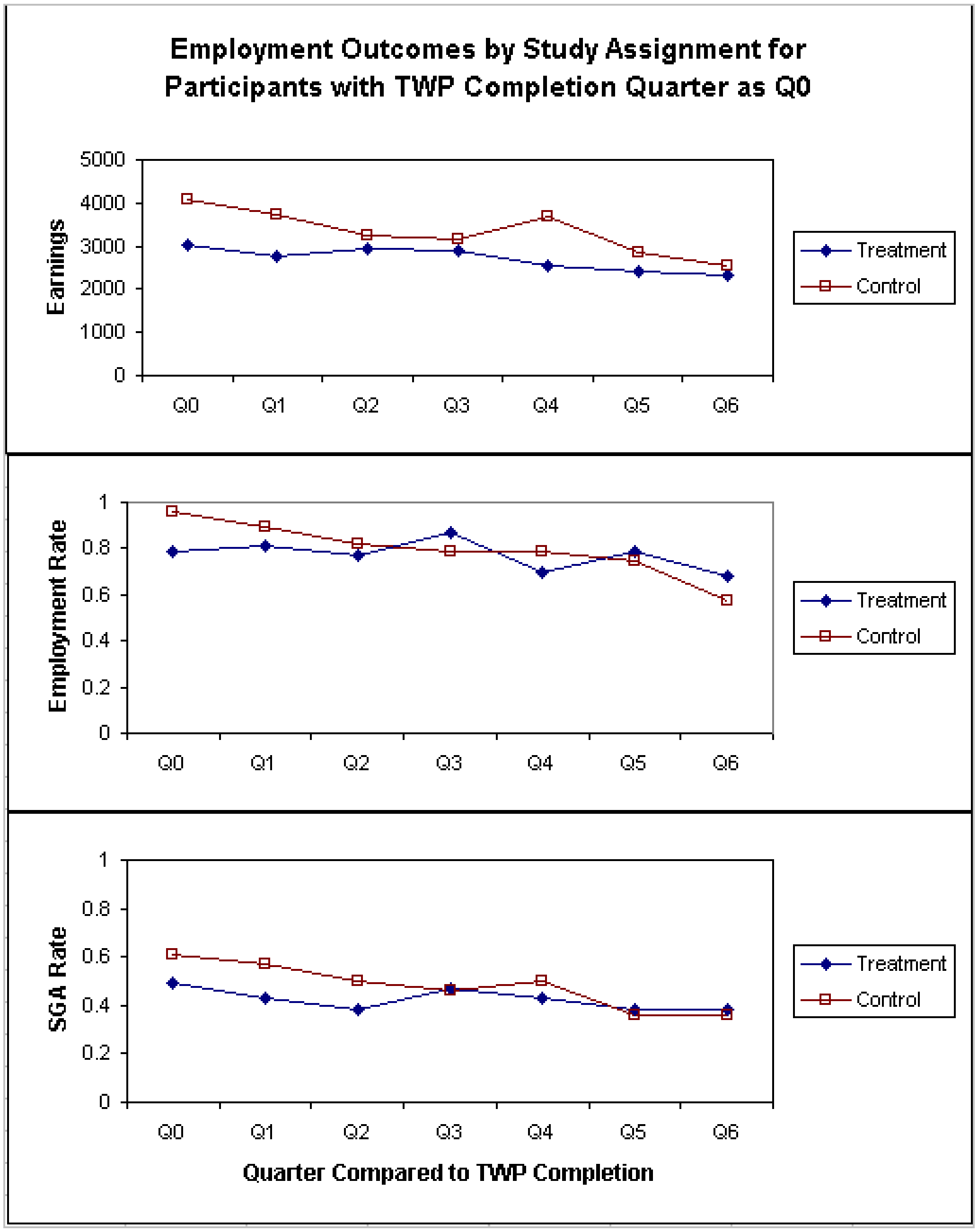
Q6, treatment group participants who completed their TWP prior to enrollment have slightly higher employment outcomes than do control group participants. This steady pattern is highlighted by comparing Q0 outcomes to Q6 outcomes. Treatment group participants had mean quarterly earnings of $2,093 in Q0 and $1,979 in Q6, whereas the mean earnings of control participants were $1,665 in Q0 and $1,592 in Q6. The employment rates for treatment group participants were 76% in Q0 and 77% in Q6 and for control participants 70% in Q0 and 69% in Q6. Finally, 32% of treatment group participants had quarterly earnings of at least three times the SGA amount compared to 26% in Q6. The percentage for control participants was 24% in Q0 and 20% in Q6.

Figure VI.70: Employment Outcomes by Study Assignment, TWP Completers Prior to Enrollment



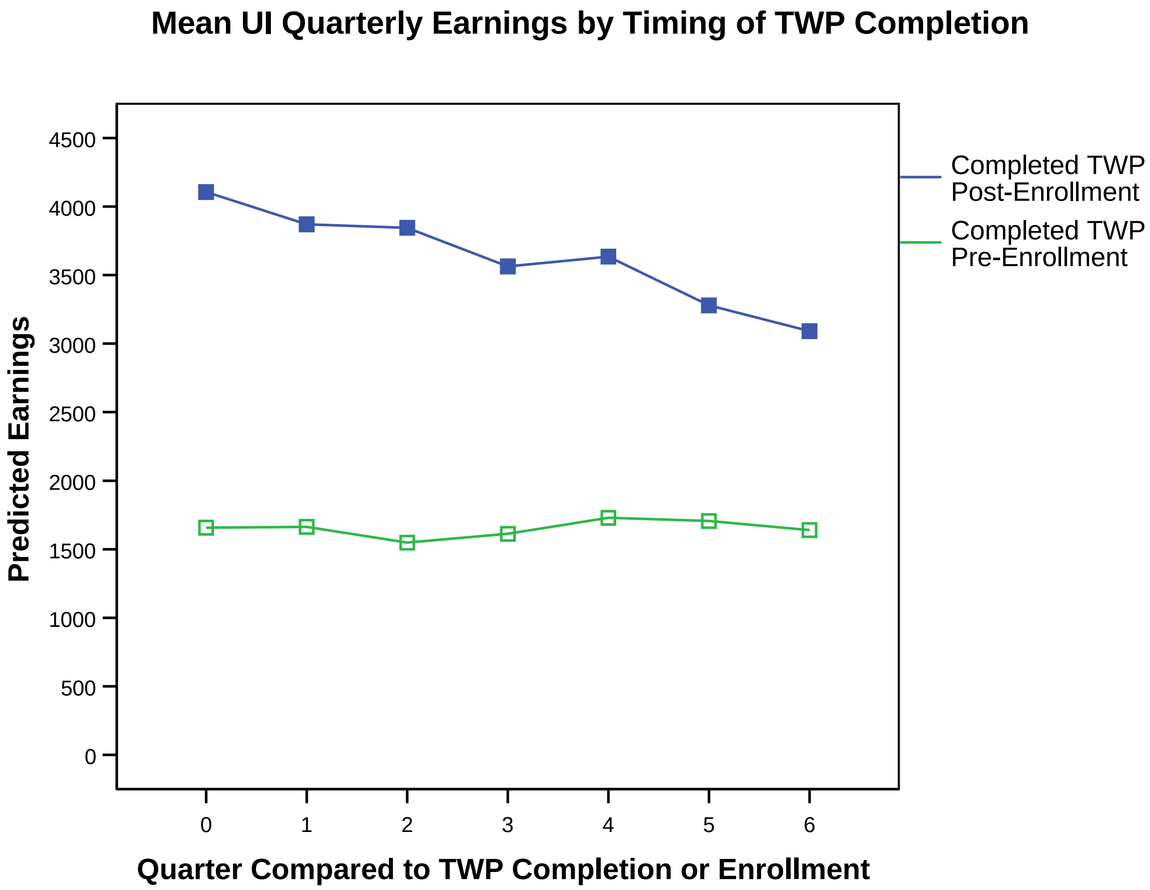
The decreases in employment outcomes are greater and visually easier to see for those participants who completed their TWP after enrolling in the pilot (see figure VI.71). These decreases are clearly larger for the control group than they are for the treatment group, the same effect that was observed during the repeated measures MANOVA subgroup analyses. During the quarter the participants finished their TWP, control group participants had higher employment outcomes than did treatment group participants. By Q6, this gap was reduced for earnings and reversed for the other outcome variables, so that the treatment group now had slightly better outcomes than the control group for employment and SGA rates. Again, these changes are highlighted by comparing Q0 and Q6 means and rates for treatment and control participants. For earnings, the treatment group went from $3,020 in Q0 to $2,326 in Q6, a 23% decline, whereas the control group went from $4,072 to $2,530, a 38% decline. For employment rate, the treatment group decreased from 79% to 68%, a 14% decline, and the control group decrease from 96% to 57%, a 41% decline. For SGA rate, the treatment group decreased from 49% to 38%, a 22% decline, and the control group decrease from 61% to 36%, also a 41% decline.

Figure VI.71: Employment Outcomes by Study Assignment, TWP Completers After to Enrollment



When comparing figure VI.70 with figure VI.71, another difference is that the Q0 employment outcomes are higher for those who completed their TWP after enrollment than those who completed their TWP prior to enrollment. This may be because the group who completed TWP prior to enrollment may have experienced decreases to their employment outcomes prior to enrollment, so they were no longer at or near the peak of their employment outcomes by the enrollment quarter. This difference is highlighted in figure VI.72, which shows the predicted earnings for participants who completed their TWP post- and pre-enrollment for the repeated measures MANOVA for the TWP completers subgroup. Although the graphs are not shown here, a very similar pattern can be found in the predicted results for the employment and SGA attainment rates.

Figure VI.72: Mean UI Quarterly Earnings by Timing of TWP Completion, Repeated Measures MANOVA TWP Completer Model



D. State Specific Analyses: Other Descriptive

Study assignment may have influenced other outcomes besides quarterly mean earnings, employment rates, the SGA attainment rates, and the average values of the income proxy variable. The SSDI-EP evaluation team looked at the influence of study assignment on other outcomes: TWP completion, the probability of offset use, the fear of benefits loss index, the self-efficacy index, and subjective health status as measured by several SF-8 scales.

1. TWP completion and offset use

SSA sent its most recent information about TWP completion to the evaluation team in August 2009. From the SSA data we calculated the proportions of treatment and control participants who completed their TWP prior to enrollment, the month of enrollment, after enrollment, or had no record of TWP completion (see table VI.24). While the majority of TWP completion dates were prior to or in December 2008, three treatment group completion dates were later, with single cases in January, February, and May 2009. Even though TWP completion occurred following December 2008, these three cases were counted as "TWP Completed Post-Enrollment."[333] There was no significant difference in completion rates between treatment and control participants who completed their TWP prior to enrollment. Slightly more control group participants (2.6%) than treatment participants (0.8%) completed their TWP in the same month they enrolled in the pilot. Again, this difference was not statistically significant. Finally, slightly more control participants (51.3%) than treatment participants (45.9%) did not complete their TWP, but again this difference is not statistically significant.

Table VI.24: Percentage of Participants with TWP Completion

	Treatment Group		**Control Group**		**Difference**			**All**
	Estimate	Std. Err	Estimate	Std. Err	Estimate	Std. Err	P-value	Estimate
TWP Completed Pre-Enrollment	26.7	2.71	27.0	2.93	-0.3	3.99	0.940	26.8
TWP Completed Month of Enrollment	0.8	0.55	2.6	1.05	-1.8	1.18	0.128	1.6
TWP Completed Post-Enrollment	26.7	2.71	19.1	2.59	7.6	3.75	0.043	23.2
TWP not Completed	45.9	3.06	51.3	3.30	-5.4	4.49	0.230	48.4

Data Source: SSA administrative records
Sample Size: 496, T=266, C=230

If a treatment group participant completed a TWP by December 31, 2008, he had the opportunity to use the offset. Of the 141 treatment group participants who completed their TWP by December 2008, fifty-five or 39% were identified by SSDI-EP operations staff as "known offset users." Among those individuals who completed their TWP, those completing it either the month of enrollment or following enrollment were more likely to

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[333] The reason these individuals are included is that they would have had to complete their TWP months by the end of December 2008, even if it took some time for SSA to confirm that fact and conduct the requisite work CDR. With this in mind, there is a statistically significant difference (p = 0.043) between treatment and control participants who completed their TWP post-enrollment, 26.7% and 19.1% respectively. Please note that excluding even one of the three treatment cases with TWP completed after December 2008 would make the difference non-significant.

use the offset. This information is displayed in table VI.25. Of those who completed their TWP prior to enrollment, twenty-one (29.6%) are known offset users compared to the thirty-four (48.6%) known offset users who completed their TWP by enrollment or the end of the active phase of the pilot.

Table VI.25: Number of Treatment TWP Completers who Used the Offset

	TWP Completed Pre-Enrollment	**TWP Completed Month of Enrollment**	**TWP Completed Post-Enrollment**
	Estimate	Estimate	Estimate
Offset Users	21 (29.6%)	2 (100%)	32 (47.1%)
Total Treatment Group	71	2	68

Data Source: SSA administrative records; Policy/Operation Reports

In order to begin understanding who, among TWP completers, made any use of the benefit offset, it is important to look at the underlying characteristics of the individuals in both these groups. Tables VI.26, VI.27, VI.28 provide a comparison of demographic, employment, and program participation characteristics of those who completed their TWP post-enrollment, those who have not completed their TWP, and known offset users. Please note that all this information is descriptive and no analyses were conducted to determine if any differences were statistically significant.

Some demographic differences (see table VI.26) emerge when comparing TWP completers and the offset users to those who did not complete their TWP. Although the split between male and females is nearly even for control group members who completed their TWP, a higher percentage of control group males (compared to females) did not complete their TWP (59%). These results were not replicated for the treatment group. A clear majority of treatment group members who completed their TWP were male (55%). In contrast, females (53%) were a slight majority amongst known offset users. Those who did not complete their TWP were generally older with a majority of individuals forty-five and older (about 63%) compared to those who were forty-four and younger. The older group was not quite as dominate a component among those who completed their TWP, ranging from 47% of completers in the treatment group to 55% completers in the control group. Non-whites, particular when assigned to the control group, appeared somewhat less likely to have completed a TWP than white participants. No clear differences can be observed for the education variable or for the various disability variables.

Table VI.26: Participant Demographics in Percentages by TWP Completion					
	TWP Completed Treatment	**TWP Completed Control**	**TWP Not Completed Treatment**	**TWP Not Completed Control**	**Offset Users**
	Estimate	Estimate	Estimate	Estimate	Estimate
Gender					
Female	45.1	50.9	44.3	40.7	52.7
Male	54.9	49.1	55.7	59.3	47.3
Age					
44 or younger	52.8	44.6	37.7	35.6	49.1
45 or older	47.2	55.4	62.3	64.4	50.9
Race					
Non-White	11.1	8.9	18.0	11.9	10.9
White	88.9	91.9	82.0	88.1	89.1
Education (WI recode)					
High School or less	34.0	27.7	30.3	39.0	29.1
More than High School, but less than 4-yr College degree	42.2	45.5	51.6	39.0	54.5
4-yr College degree or more	23.6	26.8	18.0	22.0	16.4
Primary Disability Status					
Physical	46.0	46.2	50.0	50.0	54.5
Cognitive	9.5	6.6	6.8	5.6	1.8
Affective/Mental Health	35.8	35.8	39.0	38.0	32.7
Sensory	5.8	7.5	3.4	2.8	1.8
Other	2.9	3.8	0.8	3.7	3.6
OOS category					
Most Significant (1)	34.6	51.4	43.8	38.9	21.8
Significant (2)	63.6	48.6	56.3	58.9	54.5
Not Significant (3)	1.9	0.0	0.0	2.2	1.8
Impairment					
Musculoskeletal	13.2	17.0	14.8	13.6	20.0
Neurological	16.7	8.0	13.1	12.7	18.2
Mental-Mental Retardation	9.0	3.6	1.6	2.5	3.6
Mental-Not Mental Retardation	43.1	49.1	45.1	48.3	41.8
All Others	18.1	22.3	25.4	22.9	16.4

Data Source(s): SSDI-EP Encounter Data, WI Division of Vocational Rehabilitation administrative records, SSA administrative records
Sample Sizes: 496, TWP Completed Treatment =144, TWP Completed Control =112; TWP Not Completed Treatment=122, TWP Not Completed Control=118; Offset Users =55
Primary Disability Status Sample Size:469, TWP Completed Treatment = 137, TWP Completed Control = 106; TWP Not Completed Treatment=118, TWP Not Completed Control=108; Offset Users=52
OOS Sample Size:367, TWP Completed Treatment = 107, TWP Completed Control = 74; TWP Not Completed Treatment=96, TWP Not Completed Control=90; Offset Users=43

Pre-enrollment employment differences for the TWP completion subgroups are reported in table VI.27. The findings are not surprising. TWP completers and offset users had higher pre-enrollment employment and earnings than non-completers. No less than 88.2% of TWP completers reported employment between becoming an SSDI beneficiary and project entry compared to 64.4% of those who did not complete their TWP. Likewise, around 60% of TWP completers had at least one pre-enrollment quarter (Q-4 to Q-1) with at least $1,200 in UI earnings, whereas less than 20% of those who did not complete their TWP earned as much in at least one of the four pre-enrollment quarters.

Table VI.27: Pre-Enrollment Employment Information in Percentages by TWP Completion

	TWP Completed Treatment	**TWP Completed Control**	**TWP Not Completed Treatment**	**TWP Not Completed Control**	**Offset Users**
	Estimate	Estimate	Estimate	Estimate	Estimate
Employment between SSDI Entry and Project Enrollment					
Reported Employment	88.2	92.0	63.1	64.4	89.1
Did not Report Employment	11.8	8.0	36.9	35.6	10.9
Pre-Enrollment (Q-4 to Q-1) UI Earnings					
Less than $1200 per quarter	41.7	34.8	86.9	83.1	40.0
At least one quarter of earnings at least $1200	58.3	58.3	13.1	16.9	60.0

Data Source(s): WI UI records, SSDI-EP Encounter Data, and SSA administrative records
Sample Sizes: 496, TWP Completed Treatment =144, TWP Completed Control =112; TWP Not Completed Treatment=122, TWP Not Completed Control=118; Offset Users=55

Figures VI. 73 through VI.76 display the employment outcomes for TWP completers, offset users, and TWP non-completers differentiated by study assignment. The TWP completers group for the treatment group in these graphs excludes those who are known offset users. These graphs show results for declining sample sizes, though the differences in total sample size are not large. Table VI.28 provides this information.

Table VI.28: Sample Sizes for TWP Completers, TWP Non-Completers, and Offset Users Differentiated by Study Assignment Employment Outcome Graphs

	Control		**Treatment (Excluding Known Offset Users)**		**Known Offset Users**
	TWP Completed	**TWP Not Completed**	**TWP Completed**	**TWP Not Completed**	**TWP Completed**
Q-4	118	112	122	89	55
Q-3	118	112	122	89	55
Q-2	118	112	122	89	55
Q-1	118	112	122	89	55
Q0	115	108	122	89	55
Q1	114	106	121	89	55
Q2	114	106	120	88	55
Q3	113	106	120	88	55
Q4	111	106	120	88	55
Q5	110	104	120	88	55
Q6	109	103	119	88	55
Q7	107	100	119	88	55
Q8	107	99	119	88	55

A similar pattern emerges for all four of the employment related outcomes. In general, observed trends are what would be expected given that TWP or offset use requires employment at relatively high levels.[334] TWP completers had higher employment outcomes than did TWP non-completers, with offset users having consistently the highest employment outcomes out of all five groups. While TWP completers in the control group had lower employment outcomes than offset users, they had higher employment outcomes when compared to TWP completers in treatment who had not used the offset. Additionally, control group TWP non-completers generally had better outcomes than did treatment TWP non-completers. This finding would appear to be consistent with the greater tendency of treatment group members to complete a TWP; essentially a larger proportion of those with relatively high earnings have taken action to remove themselves from the non-completers group.

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[334] Use of a TWP month requires having earnings approximately 71% of SGA. Offset use requires at least one month of SGA earnings after TWP completion and a three month grace period.

Figure VI.73: Mean UI Earnings, By Quarter, For TWP Completers, TWP Non-Completers and Offset Users Differentiated by Study Assignment

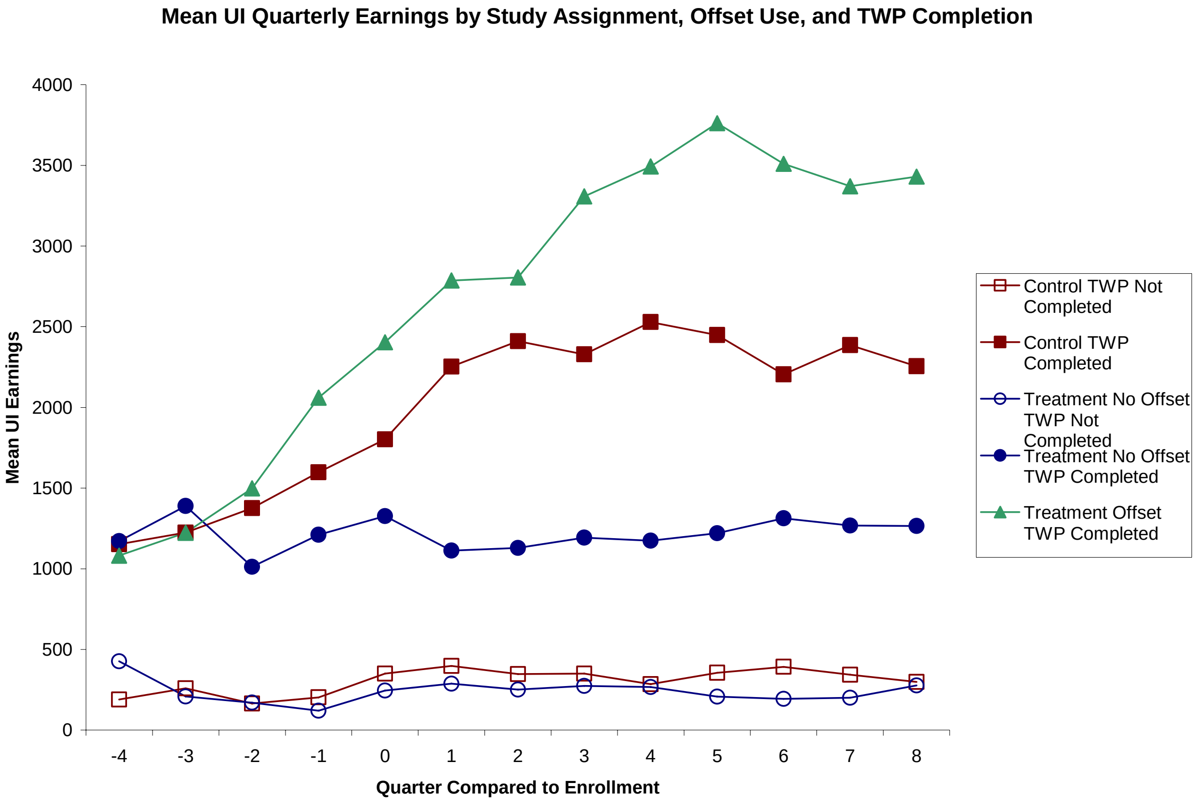

Table VI.29 gives the values for Q-4, Q0, and Q8, summarizing the trends illustrated in figure VI.73. The offset users had the biggest increases in earnings across the full study period, as well as for both the pre-enrollment and post-enrollment components of that period. The offset users group actually achieved a larger increase in mean earnings during the one year pre-enrollment period ($1,323) than it did during the two year post-enrollment period ($1,027). Indeed, there was some decline in mean earnings over the second year of participants' involvement in the pilot. The maximum was reached in Q5.

TWP completers in the control group had slightly higher earnings than the eventual offset users at Q-4, but their earnings grew at a much slower rate. There was a $649 increase during the one year pre-enrollment period and a $453 increase during the Q0-Q8 period. Again, some of the increases observed during the first year of post-enrollment were lost during the second year of post-enrollment. In contrast, the treatment TWP completers (which in these graphs excludes offset users) had slightly lower earnings than the offset group at Q-4 and had earnings that grew at a much slower pace during the one year pre-enrollment period (a $454 increase) and actually decreased by $63 during the post-enrollment period. Treatment and control group non-completers showed almost no growth in earnings during either the pre-enrollment or post-enrollment periods.

Table VI.29: Mean UI Earnings for Quarters -4, 0, and 8 for TWP Completers and TWP Non-Completers Differentiated by Study Assignment and Offset Use

		Quarter -4	Quarter 0	Quarter 8
TWP Completed	Treatment Offset	$1080.75	$2403.40	$3430.18
	Control	$1152.85	$1801.99	$2255.39
	Treatment No Offset	$1171.57	$1327.15	$1264.63
TWP Not Completed	Control	$188.65	$349.37	$298.78
	Treatment No Offset	$425.75	$245.41	$276.50

Most employment rate increases were observed during the one year pre-enrollment period (see figure 73 and table 30). Again the offset group had the largest increase, a twenty percentage points within this one year period. Control TWP completers had an increase of thirteen percentage points, whereas treatment TWP completers posted an increase of eleven percentage points. By contrast, TWP non-completers had the lowest increases: nine percentage points for the control group and four percentage points for the treatment group.

Though employment growth slowed during the Q0-Q8 period, the offset users group continued to display vigorous growth reaching an 82% employment rate (an increase of eighteen percentage points relative to Q0). All other groups had very little change in their employment rates during the Q0-Q8 period. Changes ranged from a two percentage point increase to a three point decrease.

Figure VI.73: UI Employment Rate, By Quarter, For TWP Completers, TWP Non-Completers and Offset Users Differentiated by Study Assignment

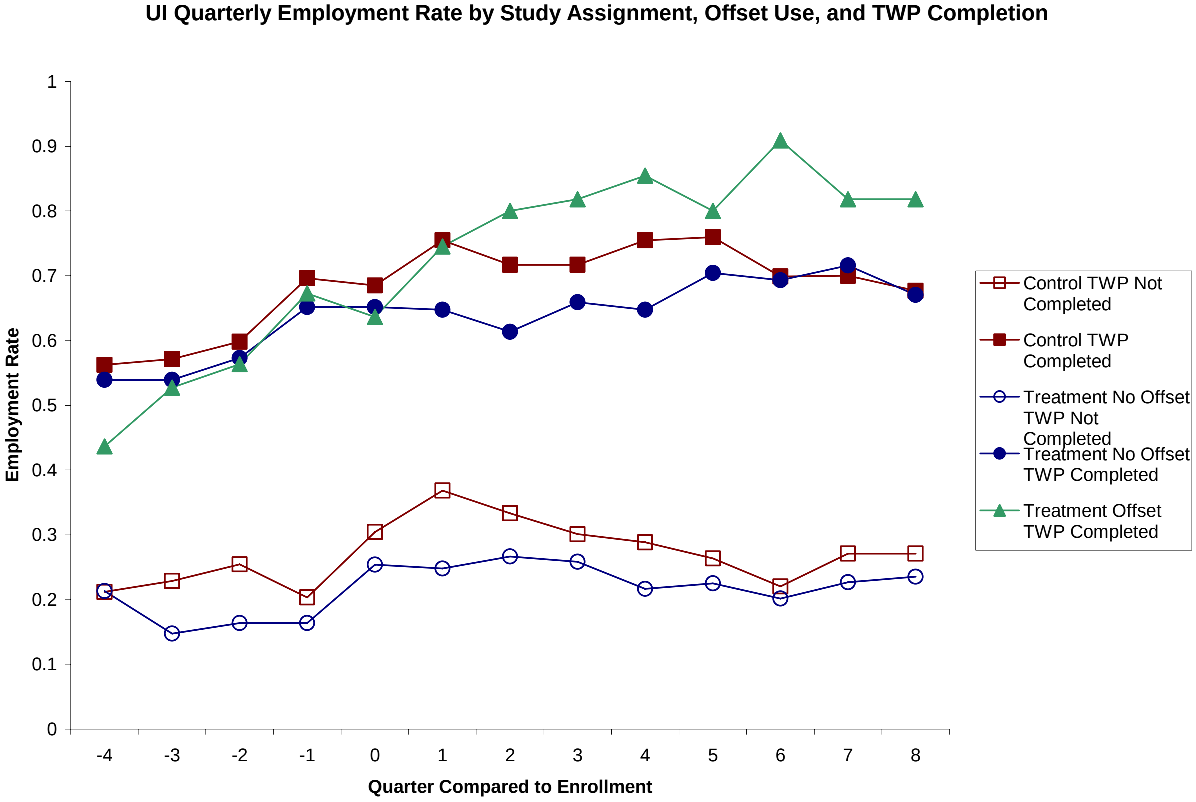

Table VI.30: UI Employment Rates for Quarters -4, 0, and 8 for TWP Completers and TWP Non-Completers Differentiated by Study Assignment and Offset Use

		Quarter -4	Quarter 0	Quarter 8
TWP Completed	Treatment Offset	44%	64%	82%
	Control	56%	69%	68%
	Treatment No Offset	54%	65%	67%
TWP Not Completed	Control	21%	30%	27%
	Treatment No Offset	21%	25%	24%

Offset users, not surprisingly, had the largest gain in the proportion that appeared to have SGA earnings during both the pre-enrollment and post-enrollment periods (see figure VI.75 and table VI.31). While, by definition, an offset user must have had at least one month of above SGA earnings after TWP completion, this does not necessarily mean that the offset user had above SGA earnings over a protracted time period. Still figure VI.75 shows that a majority of those in this group had quarterly earnings at least three times SGA from Q1 onward. The largest gain again occurred during the shorter pre-enrollment period, a thirty percentage point increase. By contrast, the SGA rate of offset users increased by half as much in twice the time over the post-enrollment period. Control group TWP completers had much more modest gains, six percentage points in the pre-enrollment period and four points in the post-enrollment period. The proportion with “SGA equivalent” earnings never rose beyond about 30%. Yet this performance was substantially better than that of all the subgroups besides the offset users.

The treatment group TWP completers who did not use the offset also had a six percentage point gain over the Q-4 through Q0 period, but then a one percentage point decline over the Q0-Q8 period. Meanwhile, neither of the two groups of TWP non-completers had more than 5% of their members earning three times SGA in any quarter. Additionally, there was no discernable upward trend.

Figure VI.75: UI 3x SGA Rate, By Quarter, For TWP Completers, TWP Non-Completers and Offset Users Differentiated by Study Assignment

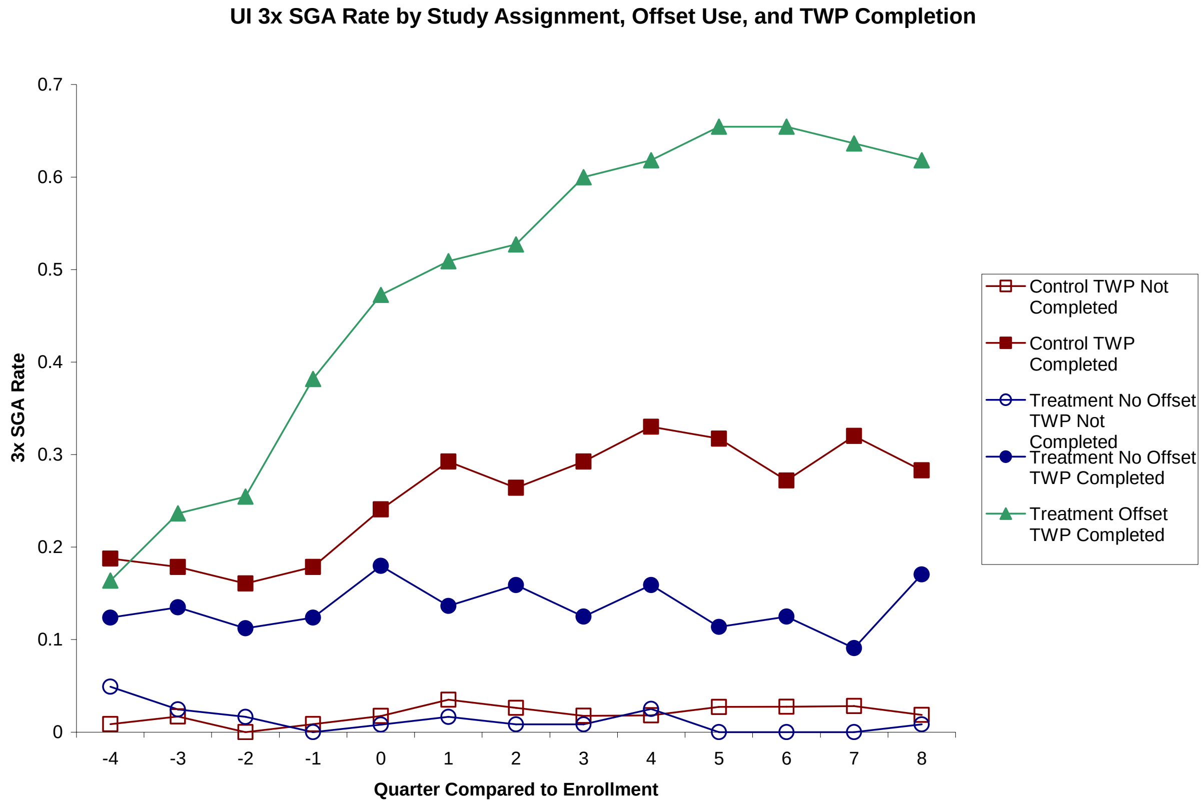

Table VI.31: UI 3x SGA for Quarters -4, 0, and 8 for TWP Completers and TWP Non-Completers Differentiated by Study Assignment and Offset Use

		Quarter -4	Quarter 0	Quarter 8
TWP Completed	Treatment Offset	0.16	0.47	0.62
	Control	0.18	0.24	0.28
	Treatment No Offset	0.12	0.18	0.17
TWP Not Completed	Control	0.01	0.02	0.02
	Treatment No Offset	0.05	0.01	0.01

The offset user group also exhibited the largest levels and increases in the quarterly means for the income proxy variable. Again the largest increases were observed during the pre-enrollment period (see figure VI.76 and table VI.32). The offset users, on average, increased their income by $1,279 during the one year pre-enrollment period and by another $670 during the two year post-enrollment period. Similar to what was seen in the earnings data, some of the increases observed during the first year after enrollment was lost during the following year.

The income growth trend for the control group TWP completers was less robust than that for the offset users. There was a smaller increase of $408 during the pre-enrollment period (starting from equivalent levels at Q-4) and an even smaller increase of $70 over Q0-Q8. The mean income for this group was over 90% of that for the offset users during Q0, but dropped to around 80% of that for offset users during Q8. In contrast, the treatment TWP completers who did not use the offset had an even smaller increase of $167 during the pre-enrollment period, and then a decrease of $249 during the post-enrollment period. Non-completers, irrespective of study assignment had group income means that barely increased over the Q-4 through Q8 period. At Q-4 their mean income had been about 75% that of the eventual offset users. By Q8, the mean had decreased to about 50% of that for the known offset users.

Figure VI.76: Mean UI Income Proxy, By Quarter, For TWP Completers, TWP Non-Completers and Offset Users Differentiated by Study Assignment

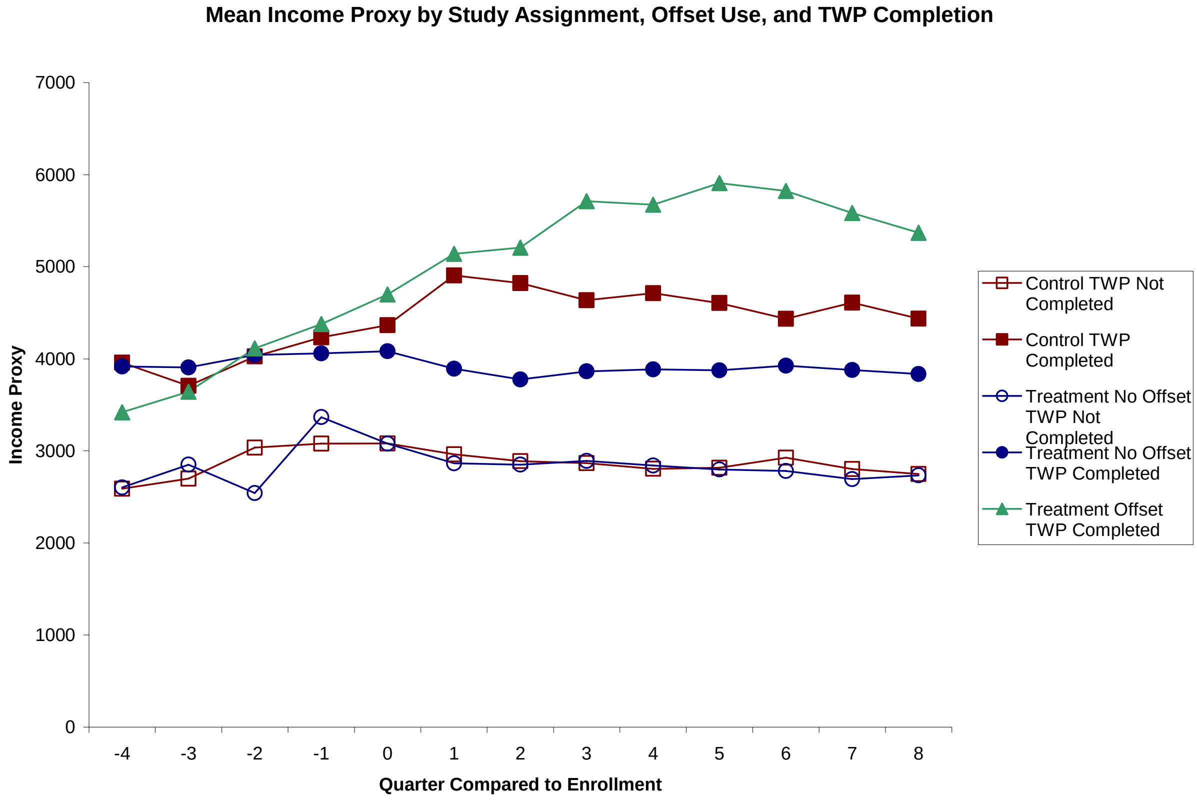

Table VI.32: Mean Income Proxy for Quarters -4, 0, and 8 for TWP Completers and TWP Non-Completers Differentiated by Study Assignment and Offset Use

		Quarter -4	Quarter 0	Quarter 8
TWP Completed	Treatment Offset	$3418.67	$4698.02	$5367.86
	Control	$3958.66	$4366.35	$4436.49
	Treatment No Offset	$3916.08	$4083.49	$3834.40
TWP Not Completed	Control	$2590.50	$3082.48	$2748.31
	Treatment No Offset	$2602.94	$3080.08	$2734.92

2. Employment Persistence

Though SSA was primarily interested in looking at the impact of being in the treatment group and having access to the offset on earnings, the probability of employment, and the probability of having earnings at or above SGA, the agency also expressed interest in knowing whether those in the treatment group tended to sustain employment over a longer period of time. The material in this section represents a preliminary and descriptive examination of this topic.

We do not directly compare the durations associated with specific positions. We have no information about the start dates of jobs that began prior to entering the SSDI-EP nor are we prepared to estimate how much longer jobs held at the end of Q8 were likely to continue. As an alternative, we look at information about the number of calendar quarters in the Q0-Q8 participation period participants have reported employment. There are two sources of information: UI administrative data and monthly encounter data collected through the provider agencies.

Table VI.33: Number of Quarters Q0-Q8 in which Employment was Reported by Study Assignment

	Treatment	Control	All
UI Employment			
0 quarters	22.6%	24.8%	23.6%
1-3 quarters	23.7%	20.9%	22.4%
4-6 quarters	13.9%	16.5%	15.0%
7-9 Quarters	39.8%	37.9%	39.0%
Mean	4.4	4.4	4.4
Median	4.0	4.0	4.0
Standard Deviation	3.6	3.6	3.6
Encounter Form Employment			
0 quarters	15.0%	20.0%	17.3%
1-3 quarters	16.6%	15.7%	16.1%
4-6 quarters	13.9%	9.2%	11.6%
7-9 Quarters	54.4%	55.2%	54.9%
Mean	5.7	5.5	5.5
Median	7.0	7.0	7.0
Standard Deviation	3.5	3.8	3.6

Data Sources: WI Unemployment Insurance records & SSDI-EP Encounter Data
Sample Sizes: 496, Treatment=266, Control=230
Notes: Pearson R between UI and Encounter employment are .655 for All, .638 for Treatment, and .673 for Control All correlations are significant at the .01 level (2-tailed)

In table VI.33 we include the percentages of participants with reported employment in four categories (0, 1-3, 4-6, and 7-9 quarters). We also provide means, medians, and standard deviations. The data suggest that there is no difference between the two study groups in their ability to sustain employment.

Nonetheless, the data in this table exhibits some interesting patterns. A greater proportion of participants appear to be persistently employed when one looks at the encounter data. This may result from the differences in the range of jobs included, especially self-employment. First reports of new businesses in the encounter system often had no earnings associated with them. There is also anecdotal evidence suggesting that participants were reluctant to report the end of self-employment.

Additionally, data distributions were strongly bi-modal. When one looks at the quarterly data, instead of the categories in the table, the larger proportions of those employed in either none of or all nine quarters becomes clear. According to the UI data, about 23.6% reported no employment in the Q0-Q9 period. The exact same percentage was employed in all nine quarters. No UI employment rate was higher than 8.5% for any intermediate total of quarters.

3. Fear of Losing SSDI and Health Benefits

This report has already examined the potential impact of changes in participants' self-reported levels of fear about losing SSDI and related health care benefits on employment related outcomes, but fear can also be viewed as an outcome. This is especially appropriate given the rationales for both the benefit offset and the provision of benefits counseling services.

The purpose of the fear of benefit loss index was to capture the relative level of fear or concern that SSDI-EP participants have about the loss of SSDI eligibility, income from SSDI, and/or access to public health care programs that are related to maintaining SSDI eligibility or equivalent disability status due to employment or an increase in earnings. It was used to assess fear levels at specific time points and to examine changes in fear levels across time. The index is the average of the sum of six items on the SSDI-EP participant survey.

The maximum score (5.0) indicates a high level of fear. Participants with this score always indicated that they “strongly agreed” that employment activity would negatively affect benefit eligibility or the level of benefits received. A minimum score (1.0) indicates a low level of fear. Participants always answered that they “strongly disagreed” with statements that employment activity would have negative consequences on their SSA and related health care benefits. A score of 3.0 on a particular item indicates neither agreement nor disagreement with the items. As it is possible that an index score of 3.0 would include answers that indicated agreement or disagreement with specific items, it is better to think of this index score as representing an intermediate level of concern or fear relative to those with higher or lower scores, rather than neutrality per se.

Approximately 65% of participants reported a high level of fear, as defined as a score averaging higher than 3.5, during baseline. Around 20% reported a medium level of fear (average scores ranging from 2.5 to 3.5), and under 15% reported low fear (average scores below 2.5). Changes in this distribution during the pilot both at one and two years following enrollment are reported in table VI.34. By the end of year one, the percentage of treatment participants who reported high fear decreased to about 57%, whereas the percentage of control participants who reported high fear increased to about 73%. The percentage of treatment participants who reported high fear in the year two survey maintained at year one level of about 57%, whereas the percentage of control participants reporting high fear decreased to the baseline level of about 67%.

Table VI.34: Percentage with Category of Fear Index by Study Group Assignment

	Baseline		**Year 1**		**Year 2**	
	Treatment	Control	Treatment	Control	Treatment	Control
Sample Size	240	212	211	179	187	146
Low Fear (Less than 2.5)	14.2	12.7	17.5	12.3	14.4	16.4
Medium Fear (2.5 to 3.5)	21.7	20.8	25.1	14.5	28.9	16.4
High Fear (More than 3.5)	64.2	66.5	57.3	73.2	56.7	67.1

Descriptively, there does appear to be a study assignment effect on the percentage of individuals with high self-reported fear, especially one year following enrollment in the study. This discrepancy appears to dissipate somewhat in the year two survey results. To see if these differences are statistically significant a t-test was conducted comparing the mean fear index of treatment and control participants at baseline, year one, and year two. At all three time points the control group mean fear index score was higher than the treatment group mean. Further, the mean fear index scores for both study groups fell into the high fear category, i.e., higher than 3.5. As suspected, the difference in the fear index between treatment and control participants was not statistically significant at baseline ($p > 0.05$), but was statistically significant one year following project enrollment with a p-value of 0.001. The treatment group mean was 3.63, whereas the control group mean fear index score was 4.02. Despite being significantly different, as indicated earlier, both these scores still fall within the high fear category. Finally, by year two, the control group's mean fear index value fell to 3.8, whereas the treatment group's mean fear score remained at 3.6. The difference between the two groups was no longer statistically significant.

Table VI.35: Beneficiaries Fear Index, By Study Assignment Group

	Treatment Group			**Control Group**			**Difference**	
	N	Estimate	Std. Err	N	Estimate	Std. Err	Estimate	P-Value
Fear Index Baseline	240	3.72	0.07	212	3.85	0.07	-0.12	0.222
Fear Index Year 1	211	3.63	0.08	179	4.02	0.08	-0.39	0.001
Fear Index Year 2	187	3.64	0.08	146	3.80	0.10	-0.16	0.195

To determine whether the changes between each combination of survey points were statistically significant within the control and treatment groups, more t-test comparisons were conducted. The results are reported in table VI.36.[335] The increase of the control group's fear index from baseline to year one neared statistical significance at $p = 0.060$, a 0.16 increase in the five point index. The subsequent 0.20 decrease from year 1 to year 2 was statistically significant ($p < 0.05$). As suspected, the difference between the control group's fear index score at baseline did not significantly differ from its mean score at year two. Therefore, the pattern observed in the descriptive data, an increase in the control group's fear at year 1 that then lessened in year two either neared or proved to be statistically significant. As for the treatment group's fear index scores, the changes from baseline to either year one to year two were not statistically significant; the same was true for the comparison between the year one to year two mean index scores.

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[335] Only those individuals who completed at least two questions on the fear index portion of the survey were included in the t-test comparing later fear indexes to previous fear indexes. Therefore, the mean fear index varied depending on who was included in the sample.

Table VI.36: Change in Beneficiaries Fear over Time							
Study Group	Baseline	Year 1	Year 2	N	Mean Change	Std. Err	P-Value
Control	3.87	4.03		166	0.16	0.09	0.060
		3.98	3.78	144	-0.20	0.08	0.016
	3.82		3.85	137	0.03	0.11	0.789
Treatment	3.76	3.65		195	-0.11	0.08	0.142
		3.66	3.64	184	-0.02	0.08	0.797
	3.75		3.62	175	-0.13	0.10	0.179

4. Self-efficacy

Subjective self-efficacy, in the broadest sense, refers to an individual's beliefs in her abilities to act in ways that increase the probability of reaching chosen goals. An individual's level of self-efficacy tends to predict the likelihood that an individual will try something new, despite barriers and concerns. Though the pilot was not explicitly designed to increase self-efficacy, it was not unreasonable to hypothesize increases related to work or, possibly, to the experience of the pilot's person-centered service delivery approach.

All three survey instruments (the baseline survey and the year one and year two follow-up surveys), included the items that were used to measure self-efficacy levels. These items asked participants to agree or disagree with statements about themselves using a five point Likert-type scale. Responses were coded in integer values ranging from one to five. A score of five was indicative of high self-efficacy, whereas a score of one was indicative of low self-efficacy. However, as the response to any item may be idiosyncratic, the assessment of an individual's level of self-efficacy involved "pooling" information. Thus the index is an average of the responses on the relevant items.

Table VI.37 presents information about the distribution of self-efficacy scores for both study assignment groups. Results from all three survey periods, baseline, year one, and year two, indicate that the majority of both treatment and control participants had a mean self-efficacy index score greater than 3.5, indicating high self-efficacy. There was a slight decrease in the percentage of individuals who reported a low self-efficacy (score less than 2.5) during year one. This decrease continued in year two for treatment participants, but disappeared by year two for control participants.

Table VI.37: Percentage with Category of Self-Efficacy Index by Study Group Assignment						
	Baseline		**Year 1**		**Year 2**	
	Treatment	Control	Treatment	Control	Treatment	Control
Sample Size	244	210	215	178	189	148
Low Self-Efficacy (Less than 2.5)	11.1	10.0	9.3	7.9	5.8	12.8
Medium Self-Efficacy (2.5 to 3.5)	35.2	33.8	37.7	38.8	37.6	39.2
High Self-Efficacy (More than 3.5)	53.7	56.2	53.0	53.4	56.6	48.0

Again, t-tests were conducted to determine whether there were any difference in the self-efficacy index scores for treatment and control participants during the baseline, year one and year two survey periods. During baseline and year one, no statistically significant differences were observed (p > 0.05). Scores ranged from 3.59 to 3.63, all within the high self-efficacy category (more than 3.5) and within 0.03 points of each other. During year two, treatment participants reported a higher mean self-efficacy index score, 3.71, than did control participants, 3.45. This 0.26 difference (out of 5 points) was statistically significant (p = 0.007). Not only did the treatment mean index score, 3.71, remain in the high self-efficacy category, it was higher than it had been during the either of the previous two years. In contrast, the control group mean index dropped into the medium self-efficacy category at 3.45, albeit only barely.

Table VI.38: Beneficiaries Self-Efficacy, By Study Assignment Group								
	Treatment Group			**Control Group**			**Difference**	
	N	Estimate	Std. Err	N	Estimate	Std. Err	Estimate	P-Value
Self-Efficacy Index Baseline	244	3.59	0.06	210	3.62	0.06	-0.03	0.700
Self-Efficacy Index Year 1	215	3.63	0.06	178	3.63	0.06	0.01	0.949
Self-Efficacy Index Year 2	189	3.71	0.06	148	3.45	0.08	0.26	0.007

T-tests were then conducted to determine whether self-efficacy index aggregate score changes were significant (see table VI.39). There was no significant change in the control group’s self-efficacy index score from baseline to year one, but there was a significant decrease of 0.19 points from year one to year two (p = 0.002). The year two self-efficacy index score of 3.45 was also significantly (p < 0.05) less than the mean baseline score. In comparison the treatment group’s increases from baseline to year one and from year two were not statistically significant, although the combined increase from baseline to year two, an increase of 0.12 points, neared significant at a p-value of 0.072. In any case, two different patterns in changes in self-efficacy were observed in the control and treatment groups. While the control group’s self-efficacy decreased by year two, treatment group’s self-efficacy increased. As reported previously, at baseline there was no statistically significant difference between the two study groups’ self-efficacy index scores, by year two, the treatment group had a higher and statistically significant self-efficacy score.

Table VI.39: Change in Beneficiaries Self-Efficacy over Time

Study Group	Baseline	Year 1	Year 2	N	Mean Change	Std. Err	P-Value
Control	3.61	3.63		166	0.02	0.06	0.867
		3.64	3.45	145	-0.19	0.06	0.002
	3.63		3.45	139	-0.18	0.07	0.009
Treatment	3.57	3.62		199	0.05	0.06	0.333
		3.63	3.70	188	0.07	0.05	0.128
	3.58		3.70	175	0.12	0.06	0.072

5. Perceived Health Status

The SF-8™ Health Survey was incorporated into the baseline, year one, and year two participant surveys. The SF-8™ Health Survey, also known as the SF-8™ is a generic survey of an individual's health status. It is a short-form (SF) survey with eight questions. All questions were in the four week recall form, requiring participants to answer questions in reference to their perceptions about their health status or their abilities to perform certain activities or tasks over the previous four weeks. Each item among the eight utilizes norm-based scoring with a mean of fifty and a standard deviation of ten. We use one "free-standing" item in the following analyses: the general health scale for the SF-8™ or the SF8GH. From the eight item set, we calculated both the Physical Component Summary (PCS-8) and a Mental Component Summary (MCS-8) using the SF-8 standardized methodology. The general US population estimated mean in 2000 for the SF8GH was 49.44 (standard deviation (SD) = 7.45), for the PCS-8 was 49.20 (SD = 9.07), and for the MCS-8 was 49.19 (SD = 9.46).[336]

The mean SF-8™ scores for the general health item, SF8GH, the Physical Component Summary (PCS-8), and the Mental Component Summary (MCS-8) for treatment and control participants during baseline, year one, and year two are reported in table VI.40. All reported mean scores are below the relevant general population means. To give an idea how far below the mean, it is useful to compare the scores in table VI.40 to those scores one standard deviation below the standard population mean for each item. These "benchmarks" would be, respectively, 41.99 for SF8GH, 40.13 for the PCS-8, and 39.73 for the MCS-8.

For the SF8GH and the PCS-8, most of the scores at baseline and year one are within one standard deviation of the mean during baseline and year one, though as, already noted, well below the general population mean. However, most of the general health item and physical health component results from the surveys completed roughly two years after pilot enrollment fall below one standard deviation of the general population mean. For the MCS-8 (mental health component), all scores remain within one standard deviation of the mean during baseline, year one, and year two. No statistically significant differences ($p > 0.05$) were found between the mean scores of treatment and control participants on any of the measures at any of the three time points.

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[336] Information found in "A Manual for Users of the SF-8™ Health survey."

Table VI.40: Beneficiaries' SF-8 General Health, Physical Component Summary, and Mental Component Summary Scores, By Study Assignment Group

	Treatment Group			**Control Group**			**Difference**	
	N	Estimate	Std. Err	N	Estimate	Std. Err	Estimate	P-Value
SF8GH Baseline	223	44.19	0.50	210	44.33	0.53	-0.14	0.843
SF8GH Year 1	192	42.64	0.62	173	41.34	0.71	1.30	0.167
SF8GH Year 2	166	41.05	0.69	145	41.18	0.70	1.00	0.321
PCS-8 Baseline	223	41.92	0.69	210	43.43	0.72	-1.50	0.133
PCS-8 Year 1	192	41.36	0.76	173	41.27	0.88	0.09	0.936
PCS-8 Year 2	166	39.97	0.87	145	39.94	0.90	0.03	0.980
MCS-8 Baseline	223	42.52	0.77	210	42.70	0.77	-0.18	0.867
MCS-8 Year 1	192	40.56	0.92	173	40.18	0.99	0.38	0.781
MCS-8 Year 2	166	41.18	1.02	145	41.28	0.93	-0.10	0.945

Although there were no statistically significant differences between treatment and control groups on the health measures, there were significant within group changes across time. Both treatment and control participants reported a decrease in general health as measured using the SF8GH from baseline to year one. Although their reported general health did not continue to decrease in year two, it remained at year one levels and was significantly lower than they reported at baseline (see table VI.41).

Table VI.41: Change in Beneficiaries SF8GH (General Health) over Time

Study Group	Baseline	Year 1	Year 2	N	Mean Change	Std. Err	P-Value
Control	43.83	41.36		161	-2.47	0.66	< 0.001
		41.90	41.95	134	0.05	0.72	0.946
	44.03		41.82	136	-2.22	0.63	0.001
Treatment	44.02	42.66		164	-1.36	0.66	0.041
		43.00	42.57	153	-0.44	0.62	0.481
	44.50		42.94	142	-1.56	0.68	0.024

Decreases in the PCS-8 were also observed for both treatment and control group members (see table VI.42). The decrease from baseline to year one neared significance for control participants ($p = 0.056$), but was not significant for treatment participants (0.179). The decrease from year one to year two was again significant for control participants ($p = 0.035$), and also neared significance for treatment participants ($p = 0.084$). Likewise, the overall decrease in PCS-8 from baseline to year two was significant for control group members ($p < 0.001$) and neared significance for treatment group members ($p = 0.060$).

Table VI.42: Change in Beneficiaries PCS-8 (Physical Component Summary) over Time

Study Group	Baseline	Year 1	Year 2	N	Mean Change	Std. Err	P-Value
Control	42.77	41.52		161	-1.26	0.65	0.056
		41.94	40.35	134	-1.59	0.74	0.035
	43.18		40.14	136	-3.05	0.80	< 0.001
Treatment	42.00	41.17		164	-0.83	0.62	0.179
		41.51	40.23	142	-1.24	0.71	0.084
	41.57	40.33		153	-1.27	0.67	0.060

Finally, there were also decreases observed on the MCS-8 for both treatment and control participants, but only from baseline to year one and not from year one to year two (see table VI.43). The decrease from baseline to year one was statistically significant for control participants (p = 0.009) and neared significance for treatment participants (p = 0.068). As already indicated, there was not a statistically significant change in the MCS-8 scores from year one to year two for either control or treatment participants. Control participants' mean MCS-8 score for the year two surveys remained significantly lower than that for baseline (p = 0.015), but treatment participants MCS-8 year two mean score was not significantly different from that at baseline (p = 0.303).

Table VI.43: Change in Beneficiaries MCS-8 (Mental Component Summary) over Time

Study Group	Baseline	Year 1	Year 2	N	Mean Change	Std. Err	P-Value
Control	42.16	39.97		161	-2.19	0.83	0.009
		40.93	41.07	134	0.14	0.86	0.871
	43.01		40.80	136	-2.21	0.90	0.015
Treatment	41.87	40.56		164	-1.32	0.72	0.068
		40.66	40.80	153	0.14	0.82	0.860
	42.02		41.14	142	-0.87	0.85	0.303

Overall, it is reasonable to asset that participants in both assignment groups experienced a general decrease in perceived health status after entering the pilot, especially over their first year of participation. This decrease appears to be more pronounced with control group members with more instances of statistically significant decreases. Yet, there were not statistically significant differences in these measures when comparing treatment and control participants at baseline, year one, and year two. Though it is possible that some a result of some aspect of the pilot experience may have contributed to these findings, our working hypothesis would be that participants, especially those with cyclical disabling conditions, may have tended to enroll when they felt themselves to be in relatively good health.

E. Summary and Conclusions

Overall, both treatment and control participants increased their employment outcomes from enrollment through the eighth quarter following enrollment. These increases were generally not statistically significant nor were the differences between treatment and control either within or across quarters. Even though the growth rates were not statistically significant, they were large enough to suggest policy implications. Further, we suspect that with a larger sample size, the growth rates in at least some of the employment outcomes would have been statistically significant for all SSDI participants irrespective of study group assignment. Nonetheless, for UI earnings, the UI employment rate, and the proportion with UI earnings at least three times SGA the treatment group had higher growth rates than did the control group, irrespective of whether the analysis was descriptive, used quarterly regressions, or was performed using a repeated measures MANOVA technique. Thus, we will concentrate on the descriptive data as these results are reasonably similar to the predicted net impacts from the regression and MANOVA models.

The treatment group increased its mean UI quarterly earnings from $1,054 to $1,270, a 21% increase. The control group's mean earnings increased from $1,053 to $1,240, an 18% increase. However, only the treatment group posted an increase in its employment rate over the Q0 through Q8 period. It grew from 47% to 52%, an 11% increase. [337] By contrast, the control group ended the period with a marginally lower employment rate. The decline was from 49% to 48%, a 2% decrease.

Earnings growth suggests the possibility of some increase in the proportion of SSDI-EP participants who had quarterly earnings of at least three times SGA over the Q0-Q8 period. In fact, this happened. The proportion in the treatment group with "SGA equivalent" earnings increased from 16% to 19%. This represents a growth of 19% (though only three percentage points) from "base." The increase was a little less for the control group. The proportion with UI earnings at least three times SGA grew 13% to 15%, a 15% gain in percentage terms.

By contrast, decreases were observed in the income proxy measure over the Q0-Q8 period for those in both study assignment groups. The mean quarterly income for treatment participants declined from $3,750 to $3,657, a 2% decrease. Mean quarterly income for control participants decreased from $3,899 to $3,560 (9%). These are discouraging findings. Though in different ways, both the benefit offset provision and the services delivered or brokered through the pilot were intended to help participants achieve greater levels of economic sufficiency. It is difficult to celebrate increases in either mean earnings or the proportion of individuals with earnings above SGA, if those who achieved them appear, on average, to be worse off as a result.

An important finding is that the observed increases in employment related outcomes during the approximately two year period following participants' entry into the pilot were smaller than the increases observed over the year prior to entry. Despite the shorter pre-enrollment period, increases in employment outcomes were consistently higher during the pre-enrollment period compared to the post-enrollment period. For example, the Q0 to Q8 increase in mean UI earnings for treatment group members was

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[337] Changes in employment rates and, later, changes in the proportions with three times SGA earnings are shown here as percentage changes. In some other places in this report, changes in percentage points are described as the difference in percentage points. As an example while the percentage growth Q0-Q8 in the treatment group's employment rate was 11%, the growth in percentage points was 5 (i.e., 52% - 47%).

21%, which represents an average quarterly gain of 3%.[338] In comparison, in the Q-4 to Q0 period, the average rate of quarterly increase was 8%. The pre-enrollment quarterly rate of increase was thus more than twice that calculated for the Q0-Q8 period. An even larger disparity can be observed between the pre-enrollment and post-enrollment rates of quarterly earnings growth in the control group. The quarterly increase during Q-4 to Q0 averaged 15% compared to only 2% during the later period.

This considerable divergence in growth rates was also observed for other employment related outcomes. During the pre-enrollment period, the average quarterly percentage growth in the UI employment was identical for both treatment and control participants at 7%. From the enrollment quarter forward, the treatment group posted only a 1% per quarter increase in the probability that a member was employed. For the control group the rate of quarterly change was actually negative (-0.25%) over the Q0-Q8 period. For the SGA proxy outcome, the treatment group's average rate of growth per quarter was 15% during the pre-enrollment period and 2% during post-enrollment, whereas the comparable values for the control group members were lower pre-enrollment (8%) but the same (2%) post-enrollment. Finally, the quarterly percentage gains in the income proxy were in the 3% to 4% range during the pre-enrollment period, but actually decreased (0.25% to 1.13% per quarter) during the Q0-Q8 period.

All in all, these findings that the lion's share of improvements in the employment related outcomes we tracked occurred in the year leading up to pilot enrollment, probably speaks more to enrollee characteristics and pilot recruitment dynamics than the efficacy of either the offset provision or pilot services. As previously discussed, pilot participants were not representative of the general SSDI beneficiary population in either Wisconsin or the U.S. However, these results should not be dismissed on that basis, as they may provide insight into the behavioral propensities of those in the SSDI population most likely to view a benefit offset as a potentially valuable work incentive.

Another important finding is that, while overall changes in employment related outcome levels were very similar for both study assignment groups, the treatment group and control group consistently exhibited somewhat different trends within the Q0-Q8 period. Increases in the treatment group's outcomes occurred slowly and steadily. By contrast, control group increases were much quicker, especially during Q1 and Q2 (a time period where a relatively large discrepancy can be observed between the study assignment groups with control participants having higher employment outcomes). These initial increases observed for control group members were largely lost by Q8; so by the end of the analysis period there was little difference between the control and treatment groups' outcomes.

One of our goals was to determine which factors tended to promote work activity and then lead to economic gains that would be represented in outcomes such as higher earnings and income. Results from the repeated measure MANOVA analyses suggest that the level of pre-enrollment earnings (that is, the average UI earnings over the Q-4 to Q-1 period) account for the largest proportion of variance in these models. The between subject differences in pre-enrollment earnings explained twenty to fifty percent of the variance, whereas none of the other variables explained even ten percent of the

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[338] To calculate the average per quarter increase for any time period, the percentage change in the outcome was divided by N-1 quarters included in the period.

variance.[339] Even the within subject variances, though smaller, were higher for the pre-enrollment variable than for any other variable. This result isn't altogether surprising; it has long been recognized that persons attached to SSA disability programs who exhibit persistent work activity have a greater probability of continuing their work activity in the future. Still, this serves as a reminder that policy tools like a benefit offset, a Medicaid Buy-in, or providing funding and technical assistance to support access to high quality benefits counseling may encourage better employment related outcomes mainly at the margins. No policy tool is likely to constitute the proverbial "silver bullet."

Nonetheless, in the SSDI-EP's implicit intervention theory, benefits counseling is conceptualized as a useful policy tool for promoting work activity, both directly and as a factor that would reinforce the benefit offset's effects. In all the repeated measure MANOVA models that included a benefits counseling variable, whether dosage or the measure of the number of quarters service was provided ("persistence"), the benefits counseling variable was statistically significant, although the a benefits counseling variable never accounted for more than 3.5% of the between subject variance. Still the findings were consistent. When participants received more service, whether measured in service hours or getting the service in multiple time periods, employment outcomes, on average, were more likely to increase over time. Although one is tempted to attribute causality to these results, it is also possible that better employment outcomes led to a need or desire for more benefits counseling. For example, as an individual's earnings increase, she may experience additional benefits issues or be in a position to make use of previously unutilized work incentives. It is quite possible that the relationship between benefits counseling and employment outcomes is bi-directional. Hopefully, there will be future research efforts to explore the direction, and if there is bi-directionality, the relative strength of the causality of this relationship.

Some have argued that the association between benefits counseling and achieving better employment outcomes rests, in large part, on the potential of benefits counseling to reduce fears about losing public benefits. Benefits counseling should lead to fewer misconceptions about the implications of work and of increased earnings on keeping benefits. When real tradeoffs or threats are identified, benefits counselors can help identify strategies more likely to help a person achieve his goals. However, for this sample of relatively high earning SSDI beneficiaries, this "explanation" for the positive effects of benefits counseling is not supported. Despite widespread and easy access to benefits counseling during the pilot, on average, participants' fear levels were not reduced. Further, within the treatment group, increases in fear after study entry were associated with better employment outcomes. This was not true for those in the control group, as decreases in fear of benefits loss were associated with improved employment outcomes. This difference between study assignment groups in the association between fear levels and employment related outcomes could well be related to differences in the typical experiences that treatment participants and control participants had during the project. One example of these differences is the problems with offset administration, broadly construed, that we identified in chapter V. Though some of these problems mainly affected the fifty-five participants who used the offset, pilot staff reported that most members of the treatment group were negatively affected by the challenges that

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[339] The one exception is the Primary Insurance Amount variable in the income models. As SSDI payments are the largest component of the income proxy for most participants, it is likely that the influence of the PIA derives from this fact.

OCO faced in performing work reviews, conducting earnings reconciliations, and/or processing amended earnings estimates.

Additionally, though perhaps not as closely related to benefits counseling, we observed that control group members who had a higher level of self-efficacy at enrollment generally had better employment outcomes trends. Yet, the opposite was observed for the treatment group. Low self-efficacy at pilot entry was associated with higher outcomes. Though we do not understand the dynamics of how experiencing the pilot as a treatment participant or a control participant motivated these results, these divergent patterns broadly resemble those observed for the fear of benefits loss variable.

The benefit offset was not the only work incentive related policy that was analyzed in this chapter. The influence of Wisconsin's Medicaid Buy-in on employment outcomes was also examined through the repeated measures MANOVA combined model. Overall, those who did not participate in the Buy-in during the Q0 to Q8 period exhibited higher employment outcomes than did Buy-in participants. This difference was only statistically significant for the SGA proxy with larger within group differences observed amongst control participants than amongst treatment participants. Yet, in contrast, Buy-in participation was associated with better results for the income proxy variable following enrollment. Control participants who had used the Buy-in suffered less income loss than control participants who had not. Those in the treatment group who utilized the Buy-in constituted the one "subgroup" which reported increases in mean income over the Q0-Q8 period. Though the differences in earnings and the income-proxy related to Medicaid Buy-in participation were non-significant, we think they may still be of interest to policymakers in Wisconsin and elsewhere.

We found that more treatment participants completed their TWP following enrollment into the pilot than did control participants. This difference was statistically significant. This suggests the possibility that an offset feature might well provide a strong incentive for completing a TWP. The fact this occurred in a context where offset users would ultimately be returned to regular SSDI rules suggests that a benefit offset that was not time limited would be even more likely to encourage beneficiaries to start and complete a TWP.

Whereas TWP completion requires a fairly prolonged period of continued employment and relatively higher earnings, it would seem that completion suggests strong potential for maintaining or even increasing employment outcomes in the future. This potential has been quite obviously negated by the cash cliff and other SSDI program rules; indeed that is the chief motivation for testing the benefit offset feature. Unfortunately, the results of the SSDI-EP tend to confirm the destructive power of current rules, despite the availability of the offset for those in the treatment group and of benefits counseling (and often a person centered planning process) for all participants. For those who completed a TWP during the pilot, subsequent decreases in earnings were observed, irrespective of study group assignment. Still, it is important to note that the decreases were smaller for treatment participants. It is possible that the difference is attributable, at least in part, to actual offset use. Indeed, the treatment group's relative advantage in their still declining earnings trajectory remained statistically significant when the outcome trends for all TWP completers, including those who completed before enrollment were examined.

Lastly, our suggestions about the research areas in which SSA might consider sponsoring work can be found in the following chapter. Some of these research areas might well be pursued through new pilot and demonstration projects. In the material in this section of chapter VI we indicated that we would find value in research intended to elicit better knowledge about the conditions in which benefits counseling is effective and the reasons why it is so. To this we would add that areas where good research is needed also include those aimed at understanding (1) the impact of different SSDI program features on beneficiary subgroups defined by either a history of relatively high levels of post-entitlement work activity or TWP completion, (2) the interaction between decentralized state service delivery systems and the use of SSA work incentives, and, above all, (3) efforts to devise policies and work incentives that will genuinely encourage beneficiaries to move toward higher levels of self-sufficiency. We would include studies of “early intervention” programs in this third category.

SECTION FOUR: SUMMARY AND CONCLUSIONS

This report represents the work of independent evaluators, not that of the SSDI-EP's managers or operations staff. The descriptions, findings, and opinions that appear in this report are strictly our own. Nonetheless, we did not perform our work in isolation. We worked side by side with SSDI-EP managers and operations staff at the Pathways office. While we are greatly indebted to these individuals for their insights, both we and they think it is important to SSA that they have an opportunity to provide their own unmediated assessment of the pilot, just as they have given us that opportunity. The following material is their summary of what happened during the SSDI-EP, the lessons learned, and the implications for future policy. To more clearly identify the distinct origin and perspective of the operation staff's statement, it is bolded and italicized.

SSDI-EP Statement on Lessons Learned and Policy Implications

A. Lessons Learned: Considerations in Designing the Service Delivery System

The design of the Wisconsin Pilot's system of services and supports was based on lessons learned in earlier "return to work" demonstrations and projects. A number of strategies reflected in the design appear to be supported based on our operational and managerial experience during the study and as it is now concluding. Perhaps the most fundamental experience from previous work is that system change in policy and practice rarely achieves monumental proportions. That is, though change is possible, little of what is tested translates into permanent practice, and that which does, will be relatively short-lived if the implementing organizations do not fully incorporate these changes into their mission and culture.

Our intention is not to sell short the SSA commitment to testing and implementing effective return to work strategies. Rather, the input is provided to note areas of concern that SSA may wish to address as they move forward in developing and implementing the Benefit Offset National Demonstration (BOND). Specifically, employment services and supports that may be integral to BOND fall beyond SSA's primary responsibility of "getting the right check to the right person at the right time". In any event, administration of BOND's features will require highly experienced and knowledgeable partners to assist in assuring participants have access to quality employment services.

While the purpose of the State Pilots was primarily to inform the development of BOND, Wisconsin approached the design effort with this longer view. We hoped to learn what we could about the sole additional factor of a $1 reduction in cash benefits for every $2 earned beyond the earning threshold SSA established. We believed then, as we do now, that the one element of the BOND intervention likely to be a permanent element of the SSDI program post-BOND is the offset itself.

Several of the key features that appear in BOND were also built into Wisconsin's pilot design, a specific example being work incentive benefits counseling. What differs in the Wisconsin environment relative to many states is beneficiary access to this service. Many parts of the country still find availability of this service is quite limited. However the Wisconsin Pilot was conducted in an

environment rich in work incentive benefit services tradition and resources. Between substantial funding from the state's Medicaid Infrastructure Grant, certain Medicaid waivers, and the Vocational Rehabilitation program, benefits counseling is widely and routinely available and readily accessed. This feature of our project is not materially different from the common experience of all people with disabilities residing in Wisconsin. We expect this will continue through and beyond BOND. As a feature of our Pilot we made certain that every participant, regardless of group assignment, understood benefits advisement would be provided upon request.

Another feature of the Wisconsin landscape retained faithfully during the Pilot was a reliance on community-based service providers to carry out enrollment and support of local participants, including many with whom they had a prior relationship. Rather than assigning day-to-day activities to Central Office staff or staff out-stationed across the state, we contracted with local agencies reflecting how services have traditionally been delivered in Wisconsin, something not likely to change in the years ahead.

The "downside" of a decentralized approach is unevenness in application of project protocols. For example, aside from specified scripted discussions, routine contacts between "site staff" and participants likely took on a different character site-by-site. What this means to participants relative to the variables being studied, we will let the Research Team authors describe. But operational and managerial staff believe that eventual, permanent implementation of BOND treatments may also be subject to the same variability.

1. Employment support services: work incentive benefits counseling

Each of the twenty pilot sites in Wisconsin was required to have at least one trained Benefits Specialist to work with participants in both the Treatment and Control groups. A "trained" Benefits Specialist is defined as one who completed the comprehensive nine day benefits counseling training provided by the Wisconsin Disability Benefits Network (WDBN). The training includes in-depth information and instruction on federal, state-level, and other benefits programs in Wisconsin. Intensive technical assistance is available to Benefits Specialists for an additional year following the completion of the comprehensive training.

Wisconsin Benefits Specialists are strongly encouraged to attend and participate in quarterly meetings organized and facilitated by the WDBN. The quarterly forums provide an opportunity for Benefits Specialists with varying levels of experience to interact, remain updated on various programmatic and legislative changes, and troubleshoot challenging benefits scenarios together.

This level of program coordination has been important in establishing and maintaining consistency in the benefits counseling services provided to participants. Although a formal Quality Assurance (QA) process for benefits counseling was not in place during the majority of the pilot, oversight provided both by WDBN training staff as well as Pathways Operational staff seemed sufficient and ensured that participants had access to practitioners with at least adequate specialized training and experience.

Lack of a formal QA process throughout the pilot did not inherently compromise the integrity of services provided. However, consideration of a quality assurance process is underway in Wisconsin and is closely connected to broader efforts taking place nationally. Development of a QA process based on data will support and improve benefits counseling service delivery to project participants and other beneficiaries. Wisconsin frequently utilizes a de-centralized approach to program development, and as such, it is important to ensure that new practice, such as benefits counseling, subscribe to established standards and ethical practice.

2. Paying for employment support services

Work Incentive Benefits Counseling and employment service coordination were the two primary employment supports provided to participants in both Treatment and Control groups. The pilot did not use SSA funds to directly pay for service in either category. Rather, funding was leveraged through other sources. Employment service coordination, when needed, was typically provided by site staff and paid for through a variety of sources including but not limited to the Division of Vocational Rehabilitation (DVR), Medicaid Home and Community Based Waivers and the "Family Care" managed long-term care system, Independent Living Center funding or other existing resources.

Although the Work Incentive Planning and Assistance (WIPA) benefits counseling services are available in Wisconsin, pilot staff were concerned that access would be problematic in some areas of the state. The Wisconsin pilot opted to utilize an existing network of trained benefits specialists, located at twenty community agency "sites" throughout the state, to ensure that choice and access would not present as barriers. Funding for the "supplementary" benefits counseling services was provided through the state's Medicaid Infrastructure Grant (MIG). Both the SSDI pilot and the MIG are administered through the Pathways office and coordination of efforts was therefore simplified. Each pilot site also had a contract to provide work incentives benefits counseling services funded by the MIG. This ensured participants access to responsive services by benefits specialists in their immediate locale.

An issue of note was the limited nature of services purchased by DVR throughout the pilot. The Wisconsin state Vocational Rehabilitation program was actively engaged in an Order of Selection (OOS) closure from the pilot's inception to the present time. OOS is a caseload management technique employed by state VR systems to prioritize services and funding for individuals with the most significant disabilities in accordance with the Rehabilitation Act. Individuals receiving Social Security benefits are not necessarily deemed eligible for Category 1-those with the most significant disabilities. Additionally, movement on the OOS waiting list may operate differently in various geographic regions of the state based on population and other factors. Although DVR services should theoretically be available to all participants in the pilot, it is strongly suspected that this was not the case.

B. Administrative Challenges

The primary administrative challenges experienced in Wisconsin were SSA's difficulty in initiating and adjusting offset amounts in a timely manner, calculating correct cash payments, and conveying full information about changes to Pilot participants.

1. Work Continuing Disability Reviews (CDR)

Most participants entered the pilot with past work activity that had not been developed by SSA. Subsequently, there was a need to initiate work Continuing Disability Reviews (CDR) for nearly all treatment group participants across the 4 pilot states. The work CDRs took a considerable amount of time to complete and delayed offset implementation by months. This delay was caused by gaps in the staffing structure at SSA (initially one operational staff person was assigned to work on the pilot in addition to other duties) and the lack of work incentive knowledge exhibited by some staff. This caused numerous errors in Trial Work Period (TWP) and cessation determination. Over time, a second staff person began working on the pilot in addition to other duties. SSA finally received approval to establish a dedicated unit assigned to work on the pilot. However, the work is considered a "detail" assignment and union rules only allow detail assignments to last for 120 days. Staff are required to rotate through the pilot assignment approximately every four months resulting in continuous retraining and subsequent processing delays.

After the initial deluge of work CDRs, the process was repeated annually for participants who worked but had not yet used all nine TWP months or their cessation month. While some improvements were made in processing time, delays of several months still occurred before the CDR was complete and offset (when applicable) was calculated.

Wisconsin Pathways staff worked to better track where beneficiaries were in their Trial Work Period-Extended Period of Eligibility (EPE) cycle in order to be more proactive about initiating work Continuing Disability Reviews (CDRs). Wisconsin staff were then able to inform SSA Central Office in Baltimore of needed Work CDRs. More timely decisions were made by Baltimore after tracking was initiated, however, overpayments and incorrect payments continued.

2. SSA Central Office versus local administration

Delays and errors in the calculation of the offset amount continued throughout the pilot. This may have been attributed to a lag in data collection and submission at sites, the continuous staff rotation at SSA, or a combination thereof. The process that SSA has in place requires that a disability examiner do the work development (TWP and cessation decisions) and also do the manual calculation to determine how much a participant's SSDI regular payment is offset. This information is then forwarded to a Benefits Authorizer who determines how much the participant has already been paid during the year and how much was actually owed based on the offset amount. This left room for errors to occur by either person working on the case.

Initially SSA's Office of Central Operations (OCO) wanted pilot participants to work only with SSA-OCO on their cases. Early in the pilot it became apparent, that some participants were used to going to their local SSA office with questions and concerns about their SSDI payments. Treatment group participants were informed that their local office would no longer be handling the pilot cases but when letters arrived or payments were wrong, local offices still received calls and visits. Local office staff occasionally contacted SSA-OCO directly but many contacted the Area Work Incentives Coordinator (AWIC) in Wisconsin. The AWIC then worked with Wisconsin SSA staff to try to rectify the situation. The other three states had similar experiences and eventually SSA-OCO noted that local involvement was not only inevitable but was helpful to the state staff in assisting participants.

3. Continuous over and underpayments for treatment group participants

As noted earlier, direct interaction with participants primarily occurred through the twenty provider agencies. The Wisconsin Pathways central office actively communicated with provider agencies via email, newsletters, conference calls, face to face quarterly meetings, and site visits.

The provider agencies were required to have a minimum monthly contact with participants and to gather and electronically submit specific information for evaluation purposes, especially concerning changes in employment and job characteristics. Such contact also allowed staff to gather information for operational purposes including changes in employment, earnings, services and supports, etc. to facilitate service provision and, in the case of the treatment group, update the earnings estimates.

Revised earnings estimates were needed whenever a treatment group participant had a change in earnings of +/- $1,000.00 annually, when Trial Work Period months were used, or when earnings reached the Substantial Gainful Activity threshold. The provider agency completed the earnings estimate forms with the participant, then submitted them to the Pathways central office in Madison, which in turn, on a quarterly basis, forwarded the information to the Social Security Administration Central Office.

Wisconsin staff found reporting wage changes on a quarterly basis to be challenging for participants. Given the frequent staff rotation at SSA in Baltimore, some cases were not dealt with in a timely manner. Frequently there has been a significant lag in time between the point of an earnings change and the adjustment in (offset) benefit payments, while SSA notices explaining the changes or apparent discrepancy were sent to participants inconsistently. Additionally, notices were written with conflicting information that participants and central office staff alike found confusing. Occasionally, notices were not sent at all and payments were stopped or changed, leading to greater confusion. Overpayments and incorrect payments occurred with enough frequency that made it difficult for participants to budget effectively.

Through conversations with Benefits Specialists, the Pathways central office learned that overpayments caused participants a great deal of emotional stress. Most did not understand why they had an overpayment as it was not

clearly stated in the overpayment notices. The language in the notice that SSA sends beneficiaries asks them to send a check for "X" thousands of dollars. Although the information on how to appeal the decision is included in the notice, some beneficiaries do not read the whole letter or do not understand it.

Many overpayments were incurred by participants that vigilantly reported their earnings monthly, even though this was not a requirement. The use of annual earnings to determine the offset amount nearly guarantees an overpayment in any situation in which the earnings change during the year.

C. Participant enrollment

A number of mythologies regarding work persist among beneficiaries. Foremost among them is that any level of employment earnings will be a basis for cessation and eventual loss of connection to the disability entitlement program. While it is true that earnings, if high enough and consistent enough, can result in benefit loss, the many work incentive provisions that are part of SSA and Medicaid permit work while maintaining a connection to these programs, even without the $1 for $2 offset.

Myths, while powerful in influencing behavior, are subject to the overriding power of facts. This is the essence of benefits counseling-replacing disability/employment myth with factual program tools. In the Wisconsin pilot, substantial outreach via benefits counseling, posters, brochures, short public meetings, presentations at conferences and targeted mailings were strategies used to counter the messages, based in myth, that were in part inhibiting return to work.

A key lesson learned during our outreach effort is that the counter message to strongly held beliefs must be equally strong, but fundamentally simple. Attachment to benefits is critical for most beneficiaries, and that connection is based on adherence to entitlement rules that are unequivocally complicated. Outreach presentations that only add to these complexities by heaping on additionally complex incentive provisions serve no useful purpose. The message had to be simple and it needed to acknowledge the importance of managing and retaining the connection to benefits in many cases. The rules are complex, as are the "workarounds", including the offset, and trained, quality and reliable assistance in navigating these complexities should always be available.

A particularly troublesome element of the all Pilots from our operational and policy perspectives was time limited access to the offset itself. We argued vigorously with SSA to make offset available to participants for the full term of their entitlement. While 72 months from start to finish is a substantial period, it simply moved the artificial "cash cliff" out to another point in time. We believe that this had a substantial chilling effect on enrollment during the Pilots, and will serve to do so as far as participation in BOND.

D. Policy & Process Implications

A number of policy and process issues arose throughout the course of the pilot that warrant mention. Some of these issues extend beyond the borders of the pilot, but left unaddressed, may surface as concerns in BOND and other future research and demonstration projects.

1. Identification of eligible candidates

Wisconsin "enrolled" 33 people in the pilot that ultimately were not eligible for the pilot. These individuals were removed from the pilot due to having already reached the 72nd month, being eligible for SSI, or receiving SSDI on another beneficiary's record. The majority of these ineligible individuals were "enrolled" in the pilot using incorrect data from the Benefits Planning Query (BPQY). There were two specific problem areas with the BPQYs. The first problem involved beneficiaries who received SSDI on their own record as well as that of a parent (dual eligibility). Initially, Benefits Specialists did not know that a special request had to be made to look for dual eligibility because both records would not show up on one BPQY. The second problem area on the BPQYs was incomplete and incorrect data in the Trial Work Period (TWP) section. Contributing factors to this incomplete and incorrect data were the lack of work development that had been done for beneficiaries and local area staff not inputting the information in the proper places. SSA has continued to work to improve the quality of the data being generated on the BPQY, which will help in future projects.

2. Administrative case records

One of the current and future concerns for adequately assisting pilot participants involves the nature of SSA's beneficiary record system. The current record keeping system makes it difficult for SSA Field Office staff to quickly and accurately identify and assist pilot participants assigned to the treatment group. Better utilization of SSA's e-Work option in BOND will enhance the ease with which participants can be identified, tracked, and assisted with payment issues and inaccuracies.

We anticipate that some participants will have access to the cash benefit offset feature through December 2014 based on the fact that they used their last Trial Work Period (TWP) month in December 2008. If the chronic nature of under and overpayments continues for these individuals as it has with other treatment group participants, it is critical that they have access to ongoing and responsive benefits counseling services. Although this could theoretically be offered through the WIPA contracts, future funding for WIPA beyond 2010 remains an unknown at this point. This is raised as a point because it is highly unlikely that the current case file system utilized by SSA will allow field office staff to properly identify pilot participants over the next several years. This may become an issue when beneficiaries approach local field offices with questions after the state Pilots have fully ended.

3. Medicaid Buy-In programs

A widely recognized barrier to return to work are the multiple program rules attendant to disability entitlements that create a fragmented disability system in which programs work at cross purposes to each other. For example, while higher earning is allowable under Pilot rules, the cap on earnings under Medicaid remains fully in force, despite more generous caps under a Medicaid buy-in, such as Wisconsin's Medicaid Purchase Plan (MAPP).

Wisconsin's MAPP features a premium structure designed to encourage work. The premium is based not on total income-earned and unearned (e.g. SSDI cash benefit)- but on the proportion of income that comes from each source. It contemplates that as earned income rises, unearned income (i.e. SSDI cash benefit) decreases, resulting in a lower premium. The MAPP premium structure was developed in 1999 with the expectation that an SSDI cash benefit offset feature would be implemented. Unfortunately the MAPP premium does not take into account that the cash benefit does not decrease during the Trial Work Period (TWP), an SSDI program feature not suspended as part of the pilot. Before the offset would kick in, all TWP months had to be expended. This resulted in extraordinarily high premiums for participants who earned at higher rates while keeping their full cash benefit during their TWP effort. Doubtless this had a chilling effect on increased earning among those participants who also were enrolled in MAPP. Further, it portends an even more pronounced chilling effect on Wisconsin's participants randomly assigned to the treatment group of the vastly larger BOND.

E. Concluding Remarks

If the policy goal of BOND is to reduce outlays from the Trust Fund by creating the circumstances assumed necessary for increased work activity, some assurance to participants must be made that they are not simply helping the SSA cease their benefits through demonstration of the very work activity they are being encouraged to undertake.

Pilot participants in the treatment group were held harmless for the attainment of SGA level earnings, as will BOND participants assigned to the treatment. That is, such participants are assured that the performance of SGA level work itself will not result in a Continuing Disability Review. Nevertheless, many participants understand that disability adjudication involves more than a simple look at earnings. They are aware, through hard experience initially becoming entitled, that the fundamental activities of working (e.g. walking, bending, lifting, responding to supervision, etc) are scrutinized during adjudication to assess level of impairment and functional capacity, which have a direct bearing on the outcome of the adjudicative process. It is only a short leap of imagination for beneficiaries to believe that increased work activity during BOND will imply to an adjudicator that "medical improvement" has likely taken place, serving as the starting point for an evaluation process with an uncertain outcome, at best. This leap of imagination isn't necessary for Wisconsin's cadre of disability advocates and practitioners who work as claimant representatives during adjudication and the frequent progression of adverse decisions through the SSA appeal process.

A possible enhancement to BOND would be a process wherein any special conditions made available to working participants would be fully documented and updated regularly. This could provide particularly relevant, valuable and decision-changing evidence for CDR examiners.

While the definition of disability remains as is (e.g. disability equates to an inability to work), or without some CDR protection related to the fundamental activities of work, our belief that return to work participation during BOND will be limited. Furthermore, we remain convinced that the impact of all work incentives, including an offset to earnings by SSDI beneficiaries, will be marginalized if this issue is not examined more thoroughly.

CHAPTER VII: CONCLUSION

In general, we agree that the description and assessment of the SSDI-EP presented in the operation staff's summary is accurate. There are some, usually modest, differences in our perception of facts, of their relative importance, and of their interpretation. We already had an opportunity to present our account of events, mainly in chapters III, IV, and V (those examining recruitment, enrollment, and the administration of the offset). Though we will touch on some of this material in this chapter, we refer the reader back to that more detailed material.

The operations staff summary makes no direct reference to participants' employment outcomes. Certainly, there is discussion of implementation difficulties, especially in the administration of the offset that might influence outcome levels. Presuming that the intervention theory is substantially correct, one would expect serious implementation problems to reduce the attainment of desired outcomes.

As discussed in chapter VI, we did not find statistically significant differences between the treatment group and control group for any of the employment outcomes of greatest interest to SSA over our primary analysis period.[340] This period starts with the calendar quarter in which enrollment occurred and ends with the completion of the eighth calendar quarter thereafter (i.e., Q0-Q8). Conceptually, these outcomes include earnings, the probability of employment, or the probability of having earnings equal or above SGA. As actually measured, these were, respectively, quarterly earnings reported in Wisconsin Unemployment Insurance (UI) records, quarterly employment rates as calculated from UI records, and the percentage of those with quarterly UI earnings at least three times greater than SGA.[341] This basic result held true irrespective of the method used to analyze the data.[342] Moreover, the differences between the treatment and control groups after entering the pilot proved insignificant for every subgroup

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[340] We require that the p value is equal or less than .05 to denote statistical significance. There were analyses where the interaction between study assignment and another variable was statistically significance. These are noted in chapter VI.

[341] All monetary amounts are deflated using the CPI-U (1982-84=100) adjusted so the index value for August 2005 would equal 100.

[342] These included t-tests of descriptive data, the SSA required quarter by quarter regressions, MANOVA models where study assignment was the sole independent variable, and the MANOVA models where independent variables pertaining to benefits counseling, Medicaid Buy-in participation, fear of losing SSA benefits, and/or self-efficacy were included.

analysis we performed, with the single exception of the earnings of those who had completed a TWP. [343]

While we agree that implementation problems probably had some negative impact on participant outcomes and present some evidence to support that type of claim, it will not be possible to establish the relative impact of poor implementation to other possible factors causing the largely null results. One possibility is that the intervention is built on a substantially incorrect understanding of what factors are likely to motivate beneficiaries to increase employment outcomes. A second possibility is that the intervention theory is substantially correct, but there is something unusual or unexpected about the situation in which it is being tested that has truncated the intervention's potential effectiveness. A third possibility is that, while the intervention theory is sound and implementation quality was good, the translation of the theory into the programmatic intervention was somehow lacking. Though this phenomenon could be conceptualized as part of implementation, we chose to distinguish inadequate project design from inadequate program delivery.

We still find the SSDI-EP's basic intervention theory largely convincing. Reductions in marginal tax rates on earnings should generally motivate efforts to increase earnings, especially for those who generally have modest resources relative to their basic needs. Similarly, we think fear reduction, whether achieved through participants' observation of successful implementation of an offset feature or experiencing high quality benefits counseling, should increase treatment group participants' willingness to use the offset or to engage in the work behavior that will lead to that use. Admittedly, we find the intervention theory convincing because we are not aware of any evidence that those with severe disabilities have fundamentally different goals and respond in fundamentally different ways to the incentives and disincentives they face compared to other persons in the same society.[344]

In our discussion of participants' characteristics at enrollment, we observed that SSDI-EP participants were not representative of adult SSDI beneficiaries or even those who met SSA's eligibility requirements for inclusion. Though there were some differences in standard socio-demographic characteristics, what makes the participant sample genuinely different is its relatively high level of employment outcomes and activity in the year prior to entering the pilot. For example, at Q-1 (the calendar quarter immediately prior to the enrollment quarter) 43% of future treatment group members had UI records of employment as did 44% of those in the control group. Average quarterly earnings for both groups exceeded $880.[345] Almost 30% of those who would enroll had already completed a Trial Work Period (TWP). Their outcomes are roughly three times higher than what might be expected for adult SSDI "only" beneficiaries, suggesting far

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[343] Using the SSA approach of separate regressions for each quarter resulted in statistically significant results in isolated quarters. However, there was nothing that suggested significant differences related to study group differences over any meaningful series of quarters.

[344] We will leave aside discussion of how central "economic rationality" is to human nature, though we think that it is a significant element of human behavior in most, if not necessarily all, cultures.

[345] Q-1 is the last quarter in which there is absolutely no post-enrollment information included in the outcome measures.

higher levels of employment outcomes and motivation than might have been expected from a truly representative group of beneficiaries.[346] Further, these differences are apparent from long before participants signed up for the pilot. The sample had relatively high employment outcomes as far back as we have UI data, a full eight quarters (two years) prior to the enrollment quarter.

The SSDI-EP did not deliberately seek to recruit a participant sample with high levels of employment outcomes, but at the project's start most of those associated with the effort would surely have said that having a sample with that profile would be desirable. Recall that both SSDI-EP central office and provider agency staff members had been disappointed with SSA's decision to exclude beneficiaries who were seventy-two months or more past their TWP completion date from the pilots. The conventional wisdom was that many among this beneficiary group would have relatively continuous work histories and were fairly likely to be restraining their earnings ("parking") in the absence of a benefit offset provision. The argument was that such individuals were both better positioned and more likely to be motivated to use the offset. Irrespective of whether this conventional wisdom was true, the sample that the SSDI-EP actually enrolled included a substantial proportion of cases that looked much like this theoretical group, excepting those who had completed their TWPs had done so more recently.

Those who entered the pilot did, on average, achieve considerable gains in their employment outcomes relative to what they were at Q0. Those in the treatment group posted a three percentage point increase in their employment rate, a 21% increase in mean earnings, and a three percentage point increase in the proportion of those with earnings comparable with or exceeding the SGA level. While those in the control group had results that were a little less positive, these differences from what the treatment group achieved were not statistically significant. Nonetheless, increases in employment outcomes prior to enrollment (Q-4 through Q0) were much stronger. Using future treatment group members as examples, in approximately a year's time, rather than the roughly two years represented by the Q0-Q8 period, the proportion of those with UI employment increased ten percentage points, mean earnings 30%, and the proportion with three times SGA earnings six percentage points. Though growth started from a smaller base, the levels of employment outcomes were hardly trivial at Q-4. The treatment group's UI employment rate was 37% at the start of the full thirteen quarter analysis period, the control group's rate was 38%.

Thus, participation in the SSDI-EP resulted, for whatever reasons, in a slower rate of outcome gain than observed over the year prior to entry. Moreover, the improvement in outcome levels for the treatment group over the Q0-Q8 period was only marginally better than for those in the control group. The primary intervention, that is the benefit offset provision and its associated protection from medical CDRs, does not appear to be associated with meaningful improvement in employment and earnings relative to being in the pilot and, as a result, having the same theoretical access to benefits counseling and person centered employment services irrespective of assignment to treatment or control.

Though material presented in chapter VI supports the claim that benefits counseling, especially above a minimum dosage and when available over substantial time periods, is strongly associated with better employment outcomes, at most it can

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[346] By SSDI "only" we mean those who are not also eligible for SSI.

explain only a modest proportion of the improved outcomes observed across all participants. Indeed, in the relevant MANOVA models, hours of benefits counseling, whether alone or in interaction with the attitudinal variables, never explains even 10% of the observed variance. We think the dominant factor in observed results may well be the unusually strong behavioral orientation of SSDI-EP participants toward work. As reported in the 2008 focus groups, i.e., those restricted to treatment group members who had at least entered a TWP, it was having a good job and being able to support one's self that was highly valued. Attendees indicated they would have been just as motivated to find a good job had they been assigned to the control group and had no opportunity to use a benefit offset.

Thus, even though there were strong indications that SSDI-EP participants wanted to increase their earnings, the reduction in marginal tax rate represented by the offset seems not to have made much difference.[347] We also know that participation in the pilot did not result in reducing participant fears that increased work effort or earnings would make up for reductions in SSDI benefits, potential loss of SSDI eligibility, or potential loss of eligibility for Medicare or Medicaid. The fears of control group members increased over time; those of treatment group members remained more or less at the same levels. Given this, we think it probable that the SSDI-EP recruited a study population that was strongly motivated to work up to an individually defined comfort level which many participants were approaching by their times of enrollment. For whatever reasons, the design and/or execution of the pilot did not induce many to reset that comfort level upward. If this speculation has merit, the question is raised as to whether this result was encouraged by the sample's atypical characteristics. In particular, we believe it is important to consider the possibility that project or policy design decisions that make perfect sense in the abstract world of homo economicus, may not work for all components of a given population. In short, do an offset and/or supporting features and services that are most likely to motivate better outcomes for either the general beneficiary population or those displaying little or no post-entitlement work activity necessarily work as well for those beneficiaries who already exhibit a strong behavioral orientation for work?

We think it quite likely that they do not. With only limited support we identify two possible features of the SSDI-EP's design (and that of the other offset pilots) that may have not been the most suitable for incentivizing treatment group members to achieve significantly better employment outcomes than control group participants. There are two design decisions that may have contributed to the null results observed in Wisconsin.

Though we have largely dismissed the claim that the seventy-two month rule had significantly reduced the proportion of participants interested and ready to use an offset provision, this does not mean that we think that the time limited nature of offset use was without impact. On the basis of information from focus groups and, indirectly, from the high and persistent levels of fear about benefit loss manifested in survey responses, we think that participants assigned to the treatment group were extremely aware of the seventy-two month rule. This appraisal is further strengthened by what we heard from program staff and key informants. To paraphrase what one informant said, by limiting offset usage to a maximum of seventy-two months, SSA made the desired transition from being primarily a beneficiary to being primarily a worker illusory. Given the high

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[347] There appears to be one important exception to this assertion, those in the treatment group seem to be more likely to complete a TWP after entering the pilot than those in the control group.

stakes associated with maintaining SSDI eligibility or, at the least, maintaining a disability allowance that would permit continued eligibility for public health care programs, it is simply asking too much of most beneficiaries to pretend that there is not a medical CDR down the road. While one may promise that no harm will come from offset usage, in the absence of experience that confirms that will be the case it is more reasonable not to take undue risks. Though we do not have direct evidence to prove the point, we find it hard to believe that evident problems associated with offset administration, including the timeliness of checks, the accuracy of checks, and the heightened probability of overpayments has increased beneficiaries' confidence that the return from offset use back to regular rules will go smoothly. We don't know how widely stories about poor offset administration spread to those in the treatment group who had not used the offset, though remarks made at focus groups suggest that there was some diffusion of such information. In any case, benefits counselors and other provider agency staff knew about the problems early on. Given the ethical requirements of performing their jobs, it is reasonable to infer that benefits counselors passed on information about problems in administering the offset to treatment group members contemplating use of the option.

The second feature that may have had a constraining effect on employment outcomes affected those in both the control and treatment groups, though perhaps with additional force in the latter. Work CDRs may occur for many reasons, especially for beneficiaries who have reportable earnings. Most important for our purposes are the work related CDRs that follow the ninth TWP month for all SSDI beneficiaries. Delays are not unusual. Even if beneficiaries almost always retain eligibility, delays can result in payment problems.[348] Thus, beneficiaries with relatively high levels of employment outcomes nearing the end of their TWP may begin to reduce their work efforts as a precautionary step. Some evidence of this can be seen in figures 67, 71 and 72 in chapter VI, especially for those in the control group. Those in the treatment group faced the danger of even greater delays. Treatment group members had their work reviews performed at OCO by staff inexperienced in that procedure and subject to frequent rotation. Delays appear to have been exacerbated in the SSDI-EP, relative to the other pilots, due to the longer reporting chains associated with a highly decentralized project structure. Still the key point to be made is that the general inconveniences associated with work reviews may blunt the offset's effectiveness, particularly in a subgroup that is unusually apt to be working. We think this issue may be an important one in the context of a national demonstration or a statutory offset. The issue however is less one of whether work reviews should be conducted as it is lessening the time and the stress on a beneficiary involved in completing one.

A. (Other) Key Results and Lessons

The purpose of the following material is to review some of the key findings of the report. Readers are encouraged to read pertinent material from earlier in the report, especially the chapters about enrollment processes (IV), administration of the offset (V) and impact estimates (VI) for supporting evidence and more complete discussion of

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[348] Both participants and benefits counselors reported that such delays can have a ripple effect. Beneficiaries lack reserve funds to pay their bills when SSDI checks do not arrive on schedule. Those that have set up automatic withdrawals to meet utility and other monthly expenses often incur substantial financial penalties from both the billing entities and their financial institutions.

findings. Key process findings are identified first; then information about participant outcomes is presented. These are hardly separate domains. Process information is vital for understanding whether the pilot was well enough implemented to allow a reasonable assessment of outcomes. It may also provide useful information about why desired outcomes were or were not achieved.

Saying all this, one should be careful about generalizing outcomes from a relatively small project with a sample that appears to be quite unrepresentative of the beneficiary population who would have the opportunity to use a statutory offset. Again, the SSDI-EP was intended (along with the other pilots) to generate information that could inform design of the Benefit Offset National Demonstration (BOND). In that sense, we are willing to characterize the SSDI-EP as a success. However, the SSDI-EP was not a preliminary test of BOND.

1. Process findings

- The SSDI-EP was able to mobilize a network of partners to implement a benefit offset pilot on a statewide basis in a relatively short period. Community based organizations serving disability populations agreed to serve as loci (provider agencies) for recruiting, enrolling, and providing services (principally benefits counseling) for pilot participants. The SSDI-EP, through its within state sponsoring entity, the Pathways Projects, provided the training, technical assistance, and program monitoring capacity that allowed a highly decentralized program to operate much as planned over a three year period.

- This network, as desired, closely modeled Pathways' goal of operating the pilot in a context that would closely resemble that in Wisconsin should a statutory SSDI benefit offset become available in the not distant future. The Wisconsin context resembles that in many other states in that service provision is decentralized and is authorized and funded through multiple public agencies. However Wisconsin is distinct in important ways. For example, it has an unusually large number of work incentive benefits counselors and a well developed training and technical support system to support benefits counseling and, increasingly, other forms of employment related service provision and businesses that want to employ persons with disabilities.

- The SSDI-EP was able to use its technical assistance structure to meet unanticipated needs or to perform anticipated tasks at much higher levels of demand than originally expected. In particular, central office staff members were able to meet major challenges involved in ensuring successful completion of a large number of work reviews and responding to problems, such as delayed or inaccurate checks and resolving large overpayments. This ability was in part contingent on the project's success in identifying staffing needs and finding and retaining individuals who could successfully implement the pilot.

- Though the SSDI-EP was able to insure the delivery of benefits counseling services at most provider agencies through most of the pilot, we have concerns about the availability of benefits counseling services to all participants on an equal basis. Approximately 22% of participants received no benefits counseling services after enrolling in the pilot. These individuals were disproportionately from the control group. Differences in the delivery of benefits counseling services associated with study group assignment were most pronounced following the initial months after project enrollment. We find it difficult to know when variation reflects participants' choices or those by provider agency staff. In particular, we are concerned by the large variation in benefits counseling delivery patterns exhibited across provider agencies. Though these variations sometimes reflect the size of case loads or agencies' ability or willingness to have a fully trained benefits counselor on staff, we do not have a ready explanation for many of the differences observed, though, as will be explained, lower amounts or lack of continuation of benefits counseling service were strongly associated with poorer participant outcomes.

- We have some concerns about the quality as well as quantity of benefits counseling service delivery. Though we are aware of the strong efforts made to insure that benefits counselors were well trained and had access to good technical assistance, roughly a third of participants indicated through surveys that they had not received benefits counseling services that fit their needs. Levels of dissatisfaction were somewhat higher in the control group. Given the fairly substantial amount of participant skepticism about the value of the services received, dissatisfaction is not restricted to the relatively few provider agencies identified having persistent problems delivering benefits counseling. It is quite possible that negative assessments were related to the quantity of services received as opposed to quality in the strict sense. The average number of hours of benefits counseling a participant received over the Q0-Q8 period totaled less than eight hours; the median value was only four hours.

- Nonetheless, in both surveys and focus groups virtually all participants characterized benefits counseling as an important, even critical service. In focus groups, participants, including some from the control group, have as often stressed the need for benefits counseling as a support for dealing with issues arising out of SSA's administration of the SSDI program (not only the offset). There was consensus that neither BOND nor a statutory offset should be implemented without the ready availability of benefits counseling services.

- Both staff and participants expressed substantial concern about the ability to obtain needed employment related services, especially given Order of Selection closures at Wisconsin's VR agency. Nonetheless, on average, participants received nearly four times as many hours of employment related services as benefits counseling through their provider agencies. Yet less than half of participants received any hours of employment related services. Again, inclusion in the treatment group made it somewhat more likely to get services, though control group members who received services received, on average, substantially more hours.

- There was close to unanimity among participants, pilot staff, key informants, and to a surprising degree, at SSA itself, that the offset was poorly administered. Pilot staff offered that they were unaware of any case when the offset had been initially applied to a beneficiary's SSDI check accurately and/or in a timely manner. We were informed that In many cases overpayments or a cycle of alternating overpayments and underpayments resulted. Survey data and feedback from focus group corroborated what staff reported, though in a few cases participants reported no problems. Staff reported concerns with both OCO processes and the quality of staff, especially due to frequent staff rotations in that office. Staff reported some improvement in results after a designated unit for offset administration was created at OCO late in the pilot.

- Many of the problems in offset administration had their roots in other processes either set up specifically for the pilots or moved to OCO for the duration of the pilots. An example of the first class of problems is SSA's choice of using annual earnings estimates as a critical source of information for determining the amount of SSDI checks once a treatment group member entered offset status. It proved difficult for treatment group members, even with the aid of benefits counselors, to complete estimates accurately and to know when and how to update them. Beyond the technical difficulties of the task from the participant's perspective, two factors added to the difficulties. SSA did not establish fully standardized inter-project content or instruction for the estimates until late in the project. SSDI-EP central staff, though very responsive to revising the estimate forms and instructions as problems were identified in the field, did not carefully pre-test revisions with typical users.

- OCO processes for performing activities normally performed through SSA field offices often led to delays and frustration beyond those normally experienced by beneficiaries. In particular, already stressful and occasionally problematic activities such as retrospective reporting of earnings, associated reconciliation of SSDI payments, and work CDRs, were made more difficult because they were performed by inexperienced and at times overworked staff at OCO. In some cases delays or problems in obtaining and maintaining relevant information could directly affect offset administration narrowly construed. However, in some cases treatment group members who never used the offset faced challenges in establishing they had completed their TWP or in reporting earnings. Problems were further compounded by having additional layers of information transfer and having the benefits counselors at provider agencies excluded from being able to directly communicate with OCO. Though pilot central office staff worked hard to both anticipate and ameliorate problems, their ability to do so was limited by how OCO had structured its pilot related activities, especially prior to the creation of the dedicated unit for offset administration.

- SSA letters to those in the treatment group appear to have been written to meet the agency's legal needs or to address fears of potential litigation. Both participants and staff reported that the letters were difficult to understand, often contained inaccuracies, and tended to reinforce existing fears about the implications of work activity on maintaining attachment to SSDI and public health care programs requiring a disability allowance.

- Most provider agencies did a reasonably good job of maintaining contact with participants over as much as a three and one-half year period. Direct evidence of this is apparent in the high proportion of encounter forms returned on a timely basis, provider agencies' capacity to follow-up on evaluators' data cleaning requests, and, less directly, as evidenced by participants' survey responses and focus group feedback. Though severe problems were concentrated at a small number of agencies, there was a general tendency to remain in better contact with participants assigned to treatment than with those assigned to control.

- There is strong evidence that provider agency staff failed to follow data protocols fully, especially when applying instructions for the collection of employment related data. This resulted in some reduction in the quality of encounter data. In some cases problems reflected ambiguities in the instructions. In other cases, problems arose from some provider agency staff members' practice of describing participant jobs and how they ended as positively as possible. Finally, data quality appears to have been affected by having clerical staff unfamiliar with the details of participants' cases collect encounter data in violation of SSDI-EP policy.

- Attrition from the project was relatively modest, but voluntary withdrawals were concentrated in the control group. Less than 9% of the control group voluntarily left the pilot, mostly before the end of the Q0-Q8 period. Nonetheless, most control group members who remained in the project had levels of involvement (e.g. survey completion, responding to provider agency contacts) quite similar to those of treatment group members.

2. Impact findings

- According to SSDI operations staff, fifty-five treatment group members appear to have made some use of the offset provision through mid-year 2009. Thus, approximately 21% of the treatment group and 38% of TWP completers in that group were known offset users.

- As previously noted, there is no evidence that those in the treatment group achieved better employment related outcomes than those assigned to the control group during the primary post-entry analysis period of Q0-Q8. As documented in chapter VI, participants in both study assignment groups achieved some gains in UI employment rates (though only temporarily for the control group), average quarterly UI earnings, and the proportion of those with quarterly earnings at least three times the SGA level.

- Participants achieved larger percentage gains in employment outcomes in the year prior to entering the pilot than in the two years following entry. Moreover, even one year prior to entering the SSDI-EP, the employment rates, quarterly earnings, and proportion with quarterly earnings suggestive of exceeding SGA, were two to three times higher than those of other adult SSDI only beneficiaries.

- Although there were no significant differences between outcome trends for those in the treatment and control groups through Q8, descriptive data generally show that those in the control group had stronger outcomes relative to those in the treatment group during the early quarters of the Q0-Q8 period. In the later quarters, treatment group outcomes are better relative to control. This suggests the possibility that looking at longer time periods may show that those in the treatment group have better long term outcome trajectories. Doing this analysis would be complicated by the return of approximately half of the remaining treatment group members to regular SSDI program rules in January 2009.

- There were decreases in the mean value of the income proxy variable (quarterly earnings plus the sum of SSDI payments in that quarter) over the Q0-Q8 period. Though these declines could be characterized as modest (2.5% for treatment, 4% for control) in absolute terms, the fact they occurred while there had been increases in participants' average quarterly earnings (21% for treatment and 18% for control). This is a highly undesirable finding. A major goal of the pilot was to help participants increase their economic welfare (via offset use for those in treatment and benefits counseling for both treatment and control group members). Finally, though the trends observed for the two study assignment groups, over the Q0-Q8 period, were not significantly different, the treatment group suffered smaller income losses in dollar as well as in percentage terms. Technically speaking, the treatment group exhibited somewhat greater ability to translate earnings growth into income growth.

- Receipt of benefits counseling is strongly associated with increases in employment outcomes, especially earnings, in even relatively small dosages. In the MANOVA analyses presented in chapter VI those receiving four hours or more of service had much better outcomes than those getting less (or no) service. Earnings growth in the Q0-Q8 period for those getting four to eight hours of benefits counseling was 37%; those getting more than eight hours witnessed a 30% increase. By contrast, Q0-Q8 earnings increased 7% for those who received less than four hours of benefits counseling and declined 7% for participants who received no benefits counseling following SSDI-EP enrollment. Despite these promising findings about the value of benefits counseling, it is premature to claim that there is a causal relationship between benefits counseling and better employment outcomes.

- Nonetheless, there appears to have been significantly different patterns in how participants in the treatment group responded to benefits counseling than those in the control group. The impact of dosage appears stronger and more predictable for those in the control group. Differences in the treatment group are more muted, with those getting no benefits counseling (16%) doing quite well in comparison with those getting between four and eight hours of benefits counseling. This apparent anomaly will require additional analysis, but it is likely that the unexpected relationship between attitudinal variables and treatment group outcomes (see below) may contribute to this result.

- There is also evidence that receiving benefits counseling in multiple time periods rather than in a single time period was associated with stronger employment outcomes. In particular, participants getting benefits counseling during four or more quarters during the Q0-Q8 period had Q8 earnings at least $700 more than participants in groups that received benefits counseling in three or fewer quarters or did not receive any benefits counseling after entering the SSDI-EP.

- Those in the treatment group were significantly more likely to complete a trial work period (TWP) after entering the pilot than those in the control group (27% versus 19%). This difference is especially noteworthy given the relatively small proportions of participants (3%) in TWP when they entered the pilot. It also suggests the possibility that the offset feature provides an incentive for TWP completion, an incentive likely to be stronger if the offset were not time limited.

- All told 52% of participants completed a TWP by December 31, 2008. Those who entered the SSDI-EP with a completed TWP tended to maintain earnings at roughly the level they had at project entry. However those who completed the TWP during the project tended to reduce their earnings following completion, much as might be expected in the absence of a benefit offset. This tendency was stronger in the control group than in the treatment group.

- Nonetheless, earnings and income gains were strongly associated with completing a TWP, irrespective of study group assignment. However, gains in the treatment group were concentrated among those TWP completers who went on to make some use of the offset.

- Participation in the Wisconsin Medicaid Buy-in was associated with lower earnings and a reduction in the proportion of those earning three times SGA. The finding is statistically significant only for the SGA proxy. Wisconsin's Medicaid Buy-in premium structure treats earnings far more favorably than SSDI benefits and other unearned income. Those with relatively high earnings and a relatively high SSDI benefit check were sometimes subject to very high premiums that more than offset increases in earnings.

- Paradoxically, though Medicaid Buy-in utilization was associated with lower earnings, especially a lower probability of earnings at or above SGA, those in the Buy-in did better than those not using the Buy-in in "converting" earnings growth into income growth. In particular, treatment group members using the Buy-in actually increased their average income over the Q0-Q8 period. Nonetheless, even in this subgroup, income growth was only a fraction of earnings growth over the same period.

- Survey results showed high levels of concern that work activity would either reduce SSDI benefits or threaten eligibility for SSDI, Medicare and/or Medicaid. Over the following two years fear levels for control group members increased. Meanwhile, response distributions for treatment group members tended to remain about the same.

- MANOVA results for the impact of a fear of benefits loss index and for self-efficacy were quite different based on assignment to the treatment and control groups. To simplify some complex patterns, those in the control group who entered the pilot less fearful of losing public benefits, who became less fearful over time, or had high levels of self-efficacy exhibited better employment outcome trends. These results are consistent with expectations. However, many of the results for the treatment group were counterintuitive. Those with highest level of fear at pilot entry or who became more fearful after a year or more of participation had better outcome trajectories compared to those who either entered the project with the lowest level of fear or appear to have become less fearful over time. Yet this result was not linear. Those with moderate fear levels or little change in fear levels over time had generally poorer trajectories over the Q0-Q8 period than those with lower fear levels. These findings suggest that the interaction between participant attitudes, benefits counseling, and employment outcomes may be very complex. These findings suggest the possibility that benefits counseling may not always need to reduce fears in order to be effective in supporting better employment outcomes.

- The MANOVA results were congruent with findings from previous studies that those who work and have relatively high employment outcomes after entering a disability program are likely to continue doing so. Covariates such as UI earnings in the year prior to entering the SSDI-EP explained far more of the variance in the models (sometimes as much as half) then the statistically significant indicators of benefits counseling, fear of benefit loss, or self-efficacy. This finding tends to support claims about the likely value of "early intervention" efforts intended to help individuals with disabilities return or stay at work before applying for or becoming acclimated to programs such as SSDI.

3. Summary impact tables

We conclude our summary of impact findings by providing summary tables of participant outcomes over the Q0-Q8 period. Tables provide descriptive results and estimates from the SSA quarterly regressions, the MANOVA model using study group assignment as the sole independent variable, and the combined MANOVA model that adds benefits counseling hours, Medicaid Buy-in participation, change in the fear of benefits loss index, and the baseline self-efficacy index.

Table VII.1: Descriptive and Model Predicted UI Mean Earnings

	Quarter 0		**Quarter 8**		**Difference (Q8 –Q0)**		
	Estimate	S.E.	Estimate	S.E.	Estimate	S.E.	P-Value
Descriptive							
Treatment	1053.6	108.27	1270.4	115.95	216.9	158.64	0.172
Control	1052.9	119.30	1239.1	170.60	186.2	208.18	0.371
Treatment – Control	0.7		31.3		30.7		
SSA Regression							
Treatment	1053.6	90.35	1264.8	55.15	211.2	105.85	0.046
Control	1061.9	96.67	1236.0	71.18	174.1	120.05	0.147
Treatment – Control	-8.4		10.8		37.2		
MANOVA (Assign)							
Treatment	1022.99	82.30	1240.6	120.06	217.6	145.56	0.135
Control	1100.36	93.07	1249.5	135.77	149.1	164.61	0.365
Treatment – Control	-77.37		-8.9		68.5		
MANOVA (Combined)							
Treatment	1064.63	139.61	1351.2	208.86	286.5	251.22	0.254
Control	1173.33	150.50	1318.7	225.14	145.3	270.81	0.592
Treatment – Control	-108.7		32.5		141.2		

Table VII.2: Descriptive and Model Predicted UI Employment Rates

	Quarter 0		Quarter 8		Difference (Q8 –Q0)		
	Estimate	S.E.	Estimate	S.E.	Estimate	S.E.	P-Value
Descriptive							
Treatment	47	3	52	3	5	4.24	0.239
Control	49	3	48	3	-1	4.24	0.814
Treatment – Control	-2		4		6		
SSA Regression							
Treatment	47	2	50	2	3	2.83	0.289
Control	49	2	47	2	-2	2.83	0.480
Treatment – Control	-2		3		5		
MANOVA (Assign)							
Treatment	47	3	50	3	3	4.24	0.480
Control	50	3	47	3	-3	4.24	0.480
Treatment – Control	-3		3		6		
MANOVA (Combined)							
Treatment	49	4	52	5	3	6.40	0.639
Control	51	5	53	5	2	7.07	0.777
Treatment – Control	-2		-1		1		

Table VII.3: Descriptive and Model Predicted UI 3x SGA Percent

	Quarter 0		**Quarter 8**		**Difference (Q8 –Q0)**		
	Estimate	S.E.	Estimate	S.E.	Estimate	S.E.	P-Value
Descriptive							
Treatment	16	2	19	2	3	2.83	0.289
Control	13	2	15	2	2	2.83	0.480
Treatment – Control	3		4		1		
SSA Regression							
Treatment	16	1	19	1	3	1.41	0.034
Control	12	1	15	1	3	1.41	0.034
Treatment – Control	4		4		0		
MANOVA (Assign)							
Treatment	16	2	19	2	3	2.83	0.289
Control	14	2	15	3	1	3.61	0.782
Treatment – Control	2		4		2		
MANOVA (Combined)							
Treatment	16	3	23	4	7	5.00	0.162
Control	16	4	16	4	0	5.66	1.000
Treatment – Control	0		7		7		

Table VII.4: Descriptive and Model Predicted Income Proxy

	Quarter 0		Quarter 8		Difference (Q8 –Q0)		
	Estimate	S.E.	Estimate	S.E.	Estimate	S.E.	P-Value
Descriptive							
Treatment	3750.4	150.53	3656.9	120.54	-93.4	192.84	0.628
Control	3704.3	169.66	3559.6	155.63	-144.6	230.23	0.530
Treatment – Control	46.1		97.3		51.2		
SSA Regression							
Treatment	3750.4	69.14	3655.9	52.16	-94.5	86.61	0.275
Control	3706.2	72.34	3574.2	56.30	-132.1	91.67	0.150
Treatment – Control	44.1		81.7		37.6		
MANOVA (Assign)							
Treatment	3704.67	128.35	3629.4	110.47	-75.3	169.34	0.657
Control	3777.96	145.15	3578.4	124.93	-199.6	191.51	0.297
Treatment – Control	-73.29		51.0		124.3		
MANOVA (Combined)							
Treatment	3737.33	174.68	3697.4	191.59	-39.9	259.27	0.878
Control	3791.89	187.41	3593.1	205.55	-198.8	278.16	0.475
Treatment – Control	-54.56		104.3		158.9		

B. Implications for Public Policy

We are hesitant to provide general policy recommendations based on our evaluation. After all, SSDI-EP participants were hardly representative of the overall SSDI population. Yet hesitant is not quite the same as unwilling. We think that what we learned through examining the project has some broader applicability. Before offering our suggestions, we want to make it clear that despite the largely non-significant findings about the offset's ability to motivate better employment outcomes, we would still favor its enactment into law. To the extent that the U.S. government is serious about wanting to encourage greater self-sufficiency and a higher standard of living among those who use federal disability programs, it would be well to make work pay. That is, work activity resulting in above SGA earnings should result in higher income from the first dollar of over SGA earnings. Beyond this we have no specific position on the size of the offset. In general we would suggest an offset that results in a marginal tax rate not too much higher than that faced by other low income Americans, but understand that program cost and comparability with other programs (e.g. SSI) are legitimate considerations in establishing an offset's slope.[349]

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[349] As the SSDI is an income subsidy rather than earnings, we do not object to an offset being set at a somewhat higher rate than the marginal income tax rate that persons with similar earnings but not receiving SSDI or a similar benefit would face.

It is obvious that a legislated offset provision needs to be better administered than it was during the pilots and that SSA data systems need to be set up to automatically calculate check amounts and to expedite earnings reporting and reconciliation. Our understanding is that such efforts are occurring in the context of preparing for BOND. Nonetheless, it is unlikely that administering the offset will ever be a strictly automatic function. It would appear that SSA would have to engage in assigning and training staff at its field offices to aid offset users and to help with troubleshooting inevitable problems. We urge that BOND be used to identify the best approaches for doing this. Similarly, SSA needs to substantially improve the content of notices and letters so that they are reasonably easy to understand and less likely to induce beneficiary fears.

Annual earnings estimates have proven difficult for beneficiaries to make and revise and did not support good implementation of the offset itself during the pilots. The current system is untenable, especially should literally millions of beneficiaries have access to an offset provision. While we do not have a specific recommendation, we note that our key informants tended to favor using retrospective information to generate annual estimates for the succeeding year. More informants cited the estimation approach utilized by early OASDI retirees as a viable approach, though the system used by SSI recipients also received mention.

It was only late in the pilot's active period that we came to understand the extent that work CDRs, especially following the ninth TWP month, slowed down the process of ascertaining whether the offset could be applied. Delays in work reviews probably motivated significant delays in offset administration and thereby increased the probability of overpayments. Though having these CDRs done through OCO exacerbated delays, we have been told that serious delays occur frequently at the SSA field offices that normally process work reviews. Though we are aware that delays can result from actions taken (or more often not taken) by beneficiaries or employers, backlogs in completing work CDRs will almost certainly discourage beneficiaries from using an offset provision. Assuming that the SSDI program will continue to have a TWP, we think it critical that SSA explore ways to expedite the work review process.[350]

Though SSDI-EP participants were not a typical group of beneficiaries, their experience suggest that having ready access to high quality benefits counseling may be a necessary condition for reasonably widespread and effective use of a SSDI benefit offset. Beyond the direct and not yet fully understood positive effect of benefits counseling on employment outcomes, it appears that having the support of a benefits counselor can be important to addressing problems that come up in offset administration or in associated processes such as work reviews. We have no settled opinion as to whether the expansion of benefits counseling services should be accomplished through enlarging the SSA sponsored WIPA program or through other means. We do concur with SSDI-EP operations staff's stress on establishing both high quality training/TA for benefits counselors and having a meaningful system for quality assessment.

One concern that many SSDI-EP stakeholders raised was to make sure that when those in the treatment group return to regular rules there are adequate records for staff at SSA and above all, for adjudicators at state DDSs, of the context in which work

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[350] Several informants suggested that TWP be eliminated and that SSDI beneficiaries have access to a benefit offset as soon as they entered the program (essentially as those in SSI do).

activity, especially that resulting in SGA or greater earnings, took place. Beyond this, SSA needs to provide clear guidance to DDS adjudicators as to when and how offset users' work activity can be viewed as evidence of medical improvement. In the context of the offset pilots (and implicitly BOND), doing this is a straightforward application of SSA's commitment not to harm the beneficiaries who volunteered and were assigned to a treatment group. However, to the extent that SSA is serious in promoting use of any future statutory offset, it is important that everyone knows the rules of the game. Telling beneficiaries that a new work incentive is available and that SSA supports its use is not enough to assuage fears formed over decades.

One of our key informants raised a telling point. This individual observed that the SSDI offset as implemented during the pilots and as planned for BOND is really little more than a delay in the end of the TWP and, ultimately, the EPE. Consequently, just why should beneficiaries risk acting differently than they otherwise would? This issue of how to motivate different behavior in a program that is predicated on demonstrating inability to work is the one that SSA and Congress must ultimately address if they want to have a benefit offset that is genuinely and widely used to support a higher level of self-sufficiency and community inclusion.

C. Research Recommendations for SSA

As we believe that the basic structure of BOND is in place, we will begin by making suggestions based on our understanding of the demonstration and its associated evaluation design. We have tried to avoid making suggestions that require any major alteration to what has been planned.

First, during the offset pilots the most important implementation challenges arose at the SSA Office of Central Operations, not within the state pilots. None of the evaluators of the state pilot were in a position to directly observe what occurred in Baltimore. We implore SSA to support a vigorous process evaluation of SSA operations within the overall BOND evaluation plan.

Second, we have expressed doubt whether straightforward comparisons between treatment group and control group outcomes is the best way to understand the benefit offset's impacts. While these comparisons may be useful for some questions such as estimating take-up rates, making cost estimates, and examining TWP entry and completion dynamics, they provide a very roundabout way of assessing the offset's actual impact on the behavior of beneficiaries who are qualified to use the benefit offset. We urge SSA to also include more targeted comparisons: including, but not necessarily limited to:

- Comparisons between those in the treatment and control who have completed their TWP

- Comparisons between those in the treatment group who completed a TWP and used the offset and comparable treatment group members who did not

We realize that just as for the offset pilots the time limited nature of offset availability during BOND will constrain the ability to perform these kinds of analyses; it takes time to complete a TWP. However, unlike the pilots, whoever evaluates BOND will have the advantage of having many thousands of cases to work with.

Third, we urge SSA to pay more attention to gaining information about all BOND participants' experience in the project, not just the volunteers in the much smaller tier two samples (involving various combinations of offset and support service availability). Similarly, we urge SSA to pay more attention to the question of whether those in the treatment group, especially those using the offset, actually have income gains that are commensurate with the theoretical promise of an offset provision. From a beneficiary's perspective, increasing one's earnings is likely to represent a hollow victory if real income gains do not result.

Moving beyond BOND, we make four general recommendations for research SSA may wish to sponsor. Our first reflects the seemingly strong association between getting benefits counseling and improving employment outcomes observed during the Wisconsin pilot. We suggest that SSA consider sponsoring a study examining the effectiveness of benefits counseling both in general and for important subgroups. We urge that any study look closely at the different pathways through which benefits counseling may have an impact. We also urge that SSA cooperate with efforts to determine how to assess the quality of benefits counseling services.

Next, we wonder whether research could be framed to understand which program features or supports would be most important to various subgroups of beneficiaries, especially as defined by their relative level of work activity following either entry to SSDI or completion of a TWP. Based on what we observed during the SSDI-EP, we think it important to understand what encourages or discourages use of a work incentive or a reduction in marginal tax rates (as, for example, represented by a benefit offset) beyond its strictly economic features.

The SSDI-EP was delivered through a highly decentralized structure. Though there were narrowly practical reasons for structuring the project in this manner, the choice also reflected a belief that it was likely that beneficiaries would use a statutory benefit offset in a fragmented and decentralized system of government support programs and localized service provision. We suggest that SSA, whether in the context of new research efforts or BOND, look at the consequences of implementing an offset or other work incentives in such environments. In particularly, what can be done to more fully insure adequate supports and service provision when they are delivered through third parties?

Finally, we recommend that SSA give more attention to the issue of how to encourage a transition from a beneficiary perspective to one of a largely self-sufficient worker. We want to make it clear we are not suggesting studies with the primary intent of learning how to help or force beneficiaries off the rolls. Instead, we are thinking about programmatic efforts to allow beneficiaries to move forward to higher levels of income and self-sufficiency without feeling an overwhelming need to avoid actions that may potentially end attachment or easy reattachment to income support and particularly health care programs.

Given the current disability determination criteria and processes designing such testable initiatives will not be easy, especially when, as in the benefit offset pilots and presumably BOND, participants need to return to standard program rules. It is possible that the implementation of the 2010 Patient Protection and Affordable Care Act, by creating a de facto and substantially universal national health insurance program, may create a better opening for devising testable strategies. Another possibility is to reconsider conducting “early intervention” demonstration projects. These could involve applicants to SSA disability programs, but it may be even better to explore cooperative efforts with CMS, the Rehabilitation Services Administration, or the Department of Labor to devise demonstrations that would include individuals who have not yet applied for benefits as well as those who have.