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How Are the Experiences of Individuals with Severe Mental Illness Different from Those of Other Medicaid Buy-In Participants?

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The Medicaid Buy-In program is a key component of the federal effort to make it easier for people with disabilities to work without losing health benefits. Authorized by the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act), the Buy-In program allows states to expand Medicaid coverage to workers with disabilities whose income and assets would ordinarily make them ineligible for Medicaid. To be eligible for the Buy-In program, an individual must have a disability (as defined by the Social Security Administration, SSA) and earned income, and must meet other financial eligibility requirements established by states. States have some flexibility to customize their Buy-In programs to their unique needs, resources and objectives. As of December 31, 2009, 37 states with a Medicaid Infrastructure Grant (MIG) reported covering slightly more than 150,000 individuals in the Medicaid Buy-In program.

This issue brief, the eleventh in a series on workers with disabilities, provides an in-depth profile of Buy-In participants who have severe mental illness and compares their characteristics, employment experiences, and medical expenditures with those of other participants in the program.

The onset of severe mental illness (SMI) is often accompanied by the disruption or loss of employment. That said, appropriate treatment may help individuals with SMI to continue working. Those who find employment, however, face significant barriers to obtaining the health coverage necessary to treat their mental health condition. Historically, employer-sponsored health plans have often limited or excluded coverage for many of the services people with SMI need, such as therapy or medication. In addition, some mental health conditions may be chronic, resulting in intermittent periods of disability that lead to job loss and the concomitant loss of health insurance. As a result, many individuals with SMI seek part-time positions in order to minimize stress, participate in a treatment program, or cope with the side effects of some psychiatric medications—but part-time positions seldom offer health insurance as a benefit (O'Day and Killeen 2006).

Before the Medicaid Buy-In (MBI) was established, many individuals with disabling mental health conditions who were limited in their ability to work but did not qualify for Medicaid had few options for health coverage. The MBI, however, allows participants to access comprehensive health coverage by "buying into" Medicaid, even while working part-time or earning more than is usually allowed for Medicaid eligibility. It has become an attractive program for workers with SMI: at least one in three MBI participants has a diagnosis of a major affective/mood disorder (such

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as bipolar disorder), a schizophrenic or psychotic disorder, or an anxiety or neurotic disorder (such as panic disorder).

Given the unique needs of individuals with SMI and their prevalence in the MBI, many program administrators are interested in learning more about them: Are participants with SMI demographically different from other participants? What are the relative costs of providing services for participants with SMI? Compared with other participants, do they use services differently or have different employment experiences once they are enrolled in the MBI? The answers to these questions will help not only in building a better understanding of the role played by MBI in the SMI population's return-to-work efforts, but also to design better outreach strategies and future programs for them. We have answered these questions by linking state-level data on MBI program participation to demographic and diagnosis information in SSA's 2008 Ticket Research File (TRF), Medicaid and Medicare claims data, and earnings records. (For more information on the TRF and data-related issues, see the Data and Methods box at the end of this brief.)

How Are Participants with SMI Different from Other MBI Participants?

Thirty-four percent of MBI participants had a diagnosis of SMI. More than half of these individuals were diagnosed with major affective/mood disorders (57 percent), one-third had schizophrenia disorders (32 percent), and the rest had anxiety disorders (11 percent).

Except for a few significant differences, participants with SMI were demographically similar to those without SMI (Table 1). Participants with SMI were younger than other MBI participants; a relatively larger share of SMI participants were age 31 to 50. Over half of participants with SMI were female (54 percent), compared with 46 percent for participants with other conditions.

Participants with SMI differed from other participants in the receipt of federal disability benefits. The proportion of SSDI beneficiaries in the SMI group was slightly higher (Table 1), and accordingly, a slightly higher percentage had dual coverage from Medicaid and Medicare (not shown).[1] These findings may indicate that participants with SMI were more likely to have a longer work history prior to the onset of disability, qualifying them for SSDI. In addition, a higher percentage of SMI participants had prior coverage under Medicaid before enrolling in the MBI (75 percent vs. 69 percent, not shown).[2] This difference may be due to a lower average earnings history among participants with SMI, as indicated by their average indexed monthly earnings (AIME).

Demographic characteristics and participation in public programs did not vary widely across the three subgroups of participants with SMI (those with affective disorders, anxiety disorders, or schizophrenic disorders).

TABLE 1. CHARACTERISTICS OF MBI PARTICIPANTS, BY PRIMARY DISABLING CONDITION: SMI VS. OTHER PARTICIPANTS, N(%)

	SMI 66,777 (34%)	Other Disabling Condition 127,539 (66%)
Age		
Under 30	8,930 (13%)	16,726 (13%)
31-50	41,310 (62%)	60,623 (48%)
Over 51	16,537 (25%)	50,190 (39%)
Female	36,134 (54%)	59,089 (46%)
SSDI Beneficiaries	59,329 (89%)	108,776 (85%)
Highest Average Indexed Monthly Earnings among SSDI Beneficiaries*	$1,291	$1,398

Source: MBI Finder Files; SSA's Ticket Research File (TRF 08)

Note: The study population includes MBI participants with at least one month of enrollment between 1997 and 2008 and who have a known primary diagnosis in the TRF.

*As an indicator of earnings history, for those participants who received SSDI benefits, we looked at their average indexed monthly earnings (AIME). AIME is based on the beneficiary's highest 35 years of earnings, indexed for inflation, and is used to calculate the monthly SSDI benefit amount. Highest AIME is determined for each individual then averaged in the group with and without SMI, respectively.

[1]Medicare is available to all SSDI beneficiaries after they receive benefits for at least 24 months.

[2]The analysis of prior Medicaid coverage includes only those first-time enrollees in 2004 who had at least one month of Medicaid coverage in 2003, because of data constraints.

Do Participants with SMI Use Care Differently from Other MBI Participants?

MBI participants with SMI used fewer or less expensive services than other MBI participants (Table 2), confirming findings from Schimmel et al. (2007). Average monthly Medicaid expenditures of participants with SMI totaled only three-quarters of expenditures among other MBI participants ($946 vs. $1,266). Among dual-eligible participants (those with both Medicaid and Medicare) who had Medicare as their first payer, average monthly Medicare expenditures were also lower for the SMI group ($531 vs. $706). Expenditures differed widely between the three SMI diagnosis subgroups: participants with schizophrenia had the highest average monthly Medicaid expenditures ($1,095), followed by participants with affective disorders ($893) and those with anxiety disorders ($732).

SMI and other MBI participants differed in the services they used (not shown). Participants with SMI were slightly more likely to use any Medicaid or Medicare services. They were also more likely to use Medicaid prescription drug benefits but less likely to use community long-term care benefits. They were also less likely to use Medicare Part B durable equipment.

How Have the Employment Experiences of Participants with SMI Differed from the Experiences of Other MBI Participants?

Compared with other participants, a greater percentage of MBI participants with SMI had at least one year of positive earnings during their enrollment period (80 vs. 69 percent, Table 3). They were also slightly more likely to have at least one year of earnings above the level of Substantial Gainful Activity (SGA) while enrolled in the MBI.[3] However, among those with positive earnings, participants with SMI had lower average and median annual earnings than other MBI participants ($6,784 vs. $6,990 for average earnings; $6,069 vs. $6,113 for median earnings), confirming findings from Gimm et al. (2008).

Among the three subgroups of SMI participants, those with schizophrenia were significantly more likely to be employed. However, once employed, participants with anxiety disorders earned more than the other two subgroups.

Participants with SMI were more likely than other MBI participants to increase their earnings in the second year of enrollment (Figure 1). Of those with SMI who first enrolled in the MBI from 1997 through 2005, nearly half (46 percent) had higher earnings in the second year of enrollment compared to the year prior to enrollment; this was true for just 35 percent of other participants. The average inflation-adjusted increase itself was higher for participants with SMI: $5,549 for participants with SMI vs. $5,170 for others.

[3]SGA is the level of earnings at or above which an individual is likely no longer considered eligible for SSA disability benefits. In 2010, SGA for an individual with a disability other than blindness was $940 per month, or $11,280 a year. SGA for a blind individual was $1,570 per month, or $18,840 per year.

TABLE 2. AVERAGE MONTHLY MEDICAID AND MEDICARE EXPENDITURES AMONG MBI PARTICIPANTS, BY PRIMARY DISABLING CONDITION AND DUAL ELIGIBILITY STATUS

	All Enrollees		Dual Enrollees	
	Number	Average Monthly Medicaid Expenditures ($)	Number	Average Monthly Medicare Expenditures ($)
Severe Mental Illness	26,574	$946	24,455	$531
Affective/Mood Disorders	14,627	$893	13,301	$617
Schizophrenia Disorders	2,741	$1,095	2,467	$414
Anxiety Disorders*	9,206	$732	8,687	$479
Other Disabling Condition	51,785	$1,266	45,642	$706

Source: MBI Finder Files; MAX data file (2005)

Note: The study population includes MBI participants in 2005, the same population studied in Gimm et al. (2009). Calculations for statistical testing excluded dual enrollees who did not have Medicare expenditures during the study period. Although this analysis is based on the same population as Gimm et al., 2009, the SMI figures do not match exactly due to a revised definition of SMI categories used in this issue brief.

*Differences in expenditures for individuals with anxiety disorders compared to other individuals with SMI were significant at the five percent level; all other differences are significant at the one percent level.

TABLE 3. EARNINGS OF MBI PARTICIPANTS BY PRIMARY DISABLING CONDITION: SMI VERSUS OTHER PARTICIPANTS

	Number	Percent with at Least One Year of Positive Earnings While Enrolled in MBI	Percent with at Least One Year of Earnings Above SGA While Enrolled in MBI	Average Annual Earnings Among Positive Earners
Severe Mental Illness	66,777	80%	18%	$6,784
Affective/ Mood Disorders	38,042	78%	18%	$6,940
Schizophrenia Disorders	21,152	87%	17%	$6,241
Anxiety Disorders	7,583	76%	21%	$7,702
Other Disabling Condition	127,539	69%	16%	$6,990

Source: MBI Finder Files; the Ticket Research File (2008), Master Earnings File (2008)

Note: The study population includes MBI participants with at least one month of enrollment between 1997 and 2008 who have a known primary diagnosis in the TRF.

Among those who increased their earnings in the second year of MBI enrollment, a smaller percentage of people with SMI went on to increase their earnings by their fourth year of enrollment (67 percent vs. 74 percent). It is possible that due to their relatively higher initial increase in earnings, participants with SMI faced losing their SSDI benefits sooner, and therefore slowed any additional increases in earnings. Additional analysis is necessary to clarify whether this SSDI "cash cliff" plays a role.

Relative to other participants with SMI, a larger share of participants with schizophrenia increased their earnings from the first to second year of enrollment. But, from the second to fourth year of enrollment, a smaller share of participants with schizophrenia increased their earnings than in the other two subgroups.

Overall, thirty-eight percent of participants with SMI increased their earnings from the year before enrollment to the fourth year of enrollment by an average of $6,849, while only 29 percent of other participants increased their earnings by an average of $6,490 during the same period (not shown).

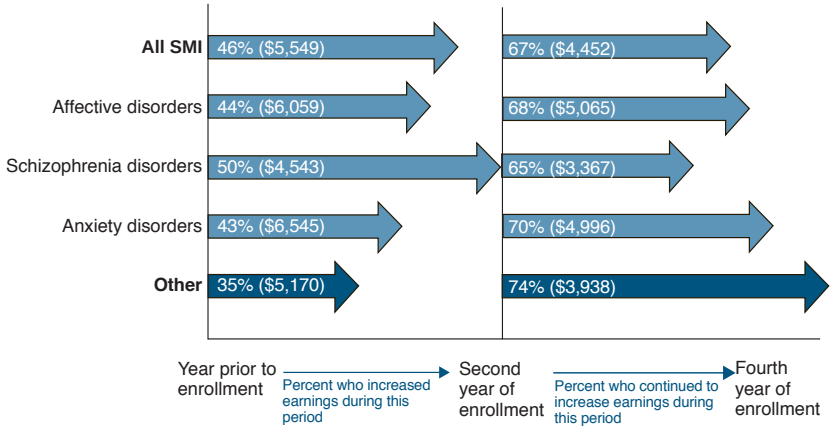
Policy Implications and Next Steps

Compared with other MBI participants, participants with SMI had lower medical expenditures and were more likely to be employed and to increase their earnings over time. These findings suggest that for relatively lower expenditures, participants with SMI have better employment outcomes than other participants, at least in the short to medium term. This raises questions for researchers and policymakers to answer going forward. Does the nature of SMI create different challenges for long-term success in employment? In other words, do relapse, the SSDI cash cliff, or other factors lead to reduced potential for earnings growth in the long run? If so, are there particular MBI program features that could be modified to benefit this population?

States with an MBI authorized under the Ticket Act have the opportunity to sponsor a Medical Improvement Group through which they can offer coverage to participants whose conditions have improved beyond SSA's definition of disability. Only nine states with a Medicaid Infrastructure Grant and an MBI now offer this option, and enrollment in the group is just above 100 participants nationwide. Individuals with SMI might be an appropriate target for this coverage, given that it would allow them to stabilize their conditions and stay healthy for a long time while gradually increasing their earnings.

Services such as vocational or community rehabilitation or supported employment may have influenced the employment experiences of MBI participants with and without SMI. Due to data constraints, this analysis did not account for differences in the provision of these types of services. But understanding the role of the MBI in the context of employment-related services and work incentives is a rich area for future research. It may also be worthwhile to consider differences in employment experiences the variation from one SMI subgroup to another as a basis for developing outreach strategies or for providing customized services.

Figure 1. Percent of Participants Who Increased Their Earnings over Time and Average Increase, by Primary Disabling Condition



Source: MBI Finder Files; the Ticket Research File (2008), Master Earnings File (2008)

Note: The study population includes MBI participants who enrolled for the first time from 1997 through 2005. The enrollment year is defined as the year in which an individual first enrolled, regardless of the month.

Results from other programs that promote employment among individuals with SMI might shed light on the role of supported employment and vocational rehabilitation and offer additional insight for improvements in the MBI. SSA's Mental Health Treatment Study, for example, is testing the impact of providing health and employment services on the well-being and functioning of SSDI beneficiaries and whether enrollees with certain mental disorders respond differently to these services.[4] Lessons learned from programs like this should be synthesized and shared with policymakers and practitioners in order to provide beneficiaries with the support they need in the most effective and efficient ways possible.

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[4]The Mental Health Treatment Study is an SSA demonstration project that's designed to test the impact of increasing access to medical treatment and employment supports for SSDI beneficiaries with a primary diagnosis of schizophrenia or affective disorder. See http://www.ssa.gov/disabilityresearch/mentalhealth.htm for more information.

DATA AND METHODS

Data for this analysis came from MBI enrollment records from 35 states linked with administrative data from the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA). SSA's 2008 TRF contains longitudinal data on individuals ages 18-65 who participated in the SSI or SSDI programs at any time from 1996 to 2008. Personal characteristics such as age, race, gender, type of impairment, and SSI/SSDI participation were captured in the month prior to MBI enrollment from the Buy-In finder files and the TRF.

Because most MBI participants receive SSDI or SSI, TRF data cover three-fourths of MBI participants. Our study population of 194,316 excludes 40,281 participants who did not appear in the TRF, and an additional 23,156 who were in the TRF but did not have a known primary diagnosis. Unless otherwise noted, the study population includes MBI participants who had at least one month of enrollment in the program between 1997 and 2008.

Individuals were categorized as having SMI or another disabling condition based on the primary disabling condition reported in the TRF. It is possible that individuals in the "other disabling condition" group might have SMI as a secondary disabling condition, or vice versa. The definition of SMI we used includes three categories of diagnoses described by SSA in its listing of mental disorders: schizophrenic and other psychotic disorders, major affective disorders, and anxiety and neurotic disorders. We excluded the following from SMI: organic mental disorders, mental retardation, somatoform disorders, personality disorders, substance addiction disorders, and autistic disorder. Diagnoses were identified using codes in the TRF.

Medicaid and Medicare participation and expenditures data were drawn from CMS's Medicaid Analytic eXtract (MAX) and Medicare enrollment and claims files, which contain eligibility and enrollment data for Medicaid and Medicare, respectively. The analysis of medical expenditures is based on 2005 data from the data set constructed for Gimm et al. (2009).

Data on annual earnings were obtained from SSA's Master Earnings File. Average annual earnings were calculated for each individual, and then averaged at the group level for comparison. For analyses examining individuals' earnings growth over time, only those enrollees who participated in MBI for the first time by December 2005 were included. To account for inflation, earnings from previous years were adjusted to dollars in the final year of earnings (through 2008) using the Consumer Price Index.

Differences presented are statistically significant at $p<0.01$, unless otherwise noted. Earnings increases in Figure 1 were not tested for statistical significance.

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