ELSEVIER

Disability and Health Journal 6 (2013) 95–99

Disability and Health Journal

www.disabilityandhealthjnl.com

Research Paper

Return to work: A critical aspect of care coordination for younger dual eligibles

Jae Kennedy, Ph.D.[a,*], Gilbert Gimm, Ph.D.[b], and Elizabeth Blodgett, M.H.P.A.[c]

[a]Department of Health Policy and Administration, Washington State University, Spokane, WA 99210-1495, USA
[b]Department of Health Administration and Policy, George Mason University, Fairfax, VA 22030-4444, USA
[c]Department of Health Policy and Management, University of North Carolina, Chapel Hill, NC 27599-7411, USA

Abstract

Background: Annual health care costs for dual eligibles now top $300 billion. Many dual eligibles are under age 65 and their needs differ significantly from retired elderly dual eligibles. For younger dual eligibles, successful return to work is an important objective for coordinated care.

Objectives: To assess relative rates of dual eligibility by age group and program enrollment (SSDI or OASI), and to identify the prevalence among these subgroups of factors associated with return to work.

Methods: Population estimates and logistic regression analysis of the 2010 Medicare Current Beneficiary Survey (MCBS).

Results: Although they make up only 16% of the total Medicare beneficiary population, disabled workers under age 65 constitute 42% of all dual eligibles. SSDI beneficiaries under age 45 have 20 times greater odds of receiving Medicaid benefits compared to retirees (AOR = 19.8, 95% CI = 16.2–24.2). The youngest dual eligible adults are more likely to work, have fewer chronic conditions, and report better health status than other dual eligibles. However, they are more likely to report problems with obtaining health care and be dissatisfied with the quality of the care they receive.

Conclusions: Dual eligible workers with disabilities are an important target population for coordinated services because of their high lifetime program costs – many will receive SSDI, SSI, Medicare, and Medicaid benefits for decades. Return to work and continued employment are important policy objectives for younger dual eligibles and should provide the greatest return in terms of reduced dependence on federal disability programs.

Keywords: Medicaid; Medicare; SSDI; Disabled workers; Return to work; Coordinated care

The Medicare and Medicaid programs combined spend over $300 billion annually for the 9.2 million adults who are enrolled in both programs. Slowing the growth of these costs is a priority for the Federal Coordinated Health Care Office (FCHCO) and the Center for Medicare and Medicaid Innovation (CMMI). At present, most cost-containment efforts are focused on avoiding hospitalizations and nursing home admissions among older dual eligibles. However, 42% of dual eligible beneficiaries are "working age" (i.e., under age 65) and therefore eligible for Medicare as Social Security Disability Insurance (SSDI) beneficiaries. This group has received relatively little research or policy attention.[1] In this paper, we show how the needs of low-income disabled workers can be quite different from those of retired elderly dual eligibles.

Dual eligibles receive Medicaid coverage when they meet state categorical and income eligibility criteria. Although Medicaid is considered to be a "second payer" when there is an overlap in service coverage with Medicare, many essential disability support services, like personal assistance, are only covered through Medicaid. Most young dual eligibles also receive Supplemental Security Income in addition to SSDI benefit payments. Because they are enrolled in at least three public programs, younger dual eligibles represent a significant cost to the Social Security Administration (SSA) and to states.[2]

Average annual Medicare and Medicaid costs incurred by younger dual eligibles ($19,000) are slightly lower than those incurred by older dual eligibles ($19,700), but younger dual eligibles account for decades more of enrollment, resulting in higher lifetime costs. Their financial assistance

Funding for this study was provided by the National Institute on Disability and Rehabilitation Research (Grant H133G070055, Jae Kennedy, PI) and the WA Life Sciences Discovery Fund (Grant LSDF 08-02, John Roll, PI). These agencies had no further role in study design, in the collection, analysis and interpretation of data, or in the writing of the report.

* Corresponding author. Tel.: +1 509 368 6971; fax: +1 509 358 7984.
E-mail address: jjkennedy@wsu.edu (J. Kennedy).

1936-6574/$ - see front matter
http://dx.doi.org/10.1016/j.dhjo.2013.01.003

needs place a strain on SSA's limited resources: the disability portion of the Trust Fund will likely be exhausted by 2016.[3]

To reduce dependence on federal disability programs, SSA encourages SSDI enrollees to pursue workforce re-entry. However only around 4% of SSDI beneficiaries leave the rolls due to substantial gainful activity.[4] This low rate is not necessarily a result of beneficiary preference; many SSDI beneficiaries are interested in returning to work, and around 9–15% are engaged in some form of employment.[5] Fear of losing benefit payments and health insurance coverage may represent a barrier for SSDI beneficiaries who have spent many months applying for and documenting their inability to work. While efforts to improve use of vocational rehabilitation services, such as the Ticket to Work program, have been effective at increasing return-to-work rates for program participants, participation is minimal.[6] Only around 1% of eligible beneficiaries participate in Ticket to Work, and just 2.8% of SSDI beneficiaries aged 18–64 reported using any services "to find a job or get a better job" in 2003.[7] Existing research shows that among SSI and SSDI beneficiaries, younger workers, recent awardees, non-Hispanic blacks, and people with intellectual disabilities are more likely to be employed.[8]

In 2011, the FCHCO and the CMMI awarded design phase contracts to improve care coordination for dual eligibles in 15 states. Review of the initial proposals shows that the majority (9 of 15) will include duals of all ages in their analysis, and one (Massachusetts) intends to focus specifically on younger duals with disabilities.[9] Younger dual eligibles face coordination challenges above and beyond the integration of health insurance benefits. In addition to health care services, coordinated care for younger duals may include vocational rehabilitation, personal assistance, adaptive technologies, and transportation. These services are needed to maintain independence and quality of life, and are critical to successful workforce re-entry. Successful return to work and continued employment are key elements of effective care coordination in this population, and represent an opportunity to reduce dependence on SSA's programs. The goals of this study are: 1) to assess relative rates of dual eligibility by age group and program enrollment (SSDI or OASI), and; 2) to identify the prevalence of factors associated with return to work among dual eligible subgroups.

Methods

Data and sample selection

This study uses data from the 2010 Access to Care Survey of the Medicare Current Beneficiary Survey (MCBS). The MCBS is a nationally representative panel survey administered by the Centers for Medicare & Medicaid Services.[10] The stratified random sample included 13,878 community-dwelling respondents and 883 respondents living in nursing homes or other facilities. The youngest respondents were 21, while the oldest was 104. Consistent with prior Medicare studies,[11,12] we omitted decedents and persons who were eligible for benefits due to end-stage renal disease. The final sample included 14,491 respondents.

Definition of dual eligibility

Dual eligibility is defined as a verified CMS record of one or more months of Medicaid program participation in 2010. Within the final sample, 3016 respondents were deemed dual eligible. This relatively conservative inclusion strategy omits people who self-report Medicaid coverage but do not have a corresponding administrative record verifying Medicaid participation.

Definitions of program eligibility and age

Current SSDI enrollees were divided into 3 age groups: younger (age 21–44, $n = 1250$); middle aged (age 45–54, $n = 554$); and older (age 55–64, $n = 739$) disabled workers. For Medicare beneficiaries age 65 or older, we distinguished former SSDI beneficiaries who, according to CMS records, began to receive Medicare coverage before age 65 ($n = 1054$) from regular OASI beneficiaries who became eligible for Medicare at age 65 ($n = 10{,}894$).

Other beneficiary attributes

The logistic regression analysis controlled for type of residence (community or facility), rural location (lives in metropolitan statistical area or not), gender (male or female), race (black or white), ethnicity (Hispanic or non-Hispanic), education (did or did not graduate from high school), and self-assessed health status compared to others in the same age cohort (fair or poor health). The number of chronic conditions (none, one, two, three or more) was calculated based on the following 9 disease categories: hypertension, arthritis, mental illness and/or depression, diabetes, cardiovascular disease, respiratory conditions, cancer, stroke, and neurological disorders.

Statistical analysis

All MCBS data were weighted to be generalizable to the "always enrolled" population of living Medicare beneficiaries who were continuously enrolled in the program. The survey employs a complex sample design, drawing from metropolitan statistical areas and clusters of non-metropolitan counties. This design forgoes the precision of a simple random survey in favor of a more efficient data collection process. To compensate for this design effect, SUDAAN software was used for all analyses.[13]

The SUDAAN RLOGIST procedure was used to evaluate the relationship between dual eligibility, program