

Wisconsin Pathways to Independence Projects

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## **Wisconsin SSDI Employment Pilot**

### **Wisconsin Year 3 Report**

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**March 14, 2008**

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## EXECUTIVE SUMMARY

The Wisconsin SSDI Employment Pilot continued to use a de-centralized approach to employment service provision and support for treatment participants as they move toward use of the offset. The pilot reflects the past Social Security Administration (SSA) funded “State Partnership Initiative” as well as reflects the manner in which publicly funded services in Wisconsin are administered.

The year concluding with the end of March 2008 provided Pilot “Central Office” staff in Madison, Wisconsin and contracted staff in twenty community agencies across the state with a number of challenges that should be of interest in the design, implementation and management of the Benefit Offset National Demonstration (BOND). Pilot elements related to wage reporting and collection of earnings estimates, calculation and issuance of correct benefit checks, and timeliness of individual participant problem resolution consumed a great deal of staff time in the provider agencies, in the pilot’s central office and at SSA Central Office.

Resolution of these process challenges will be critical to successful implementation and ongoing management of BOND, to say nothing of reliable measurement of the offset’s real impact.

Section 6 of this report contains information about participant outcomes, including findings about employment rates, earnings, and attitudinal change. In most cases, findings are presented comparing the control group, the treatment group, and those in the treatment group who are known to have used the offset. Findings are preliminary because of the limited length of post enrollment data available for all participants and the small number of offset users. With those caveats, here are several important findings:

- Most of the gains in employment rates and earnings appear prior to entry to the pilot.
- Not unexpectedly, the employment and earnings gains of those in the known offset users group are much greater than those for either the control group or the treatment group as a whole. The differences between the control group and those in the treatment group are modest, and when to the advantage of the treatment group, appear to be a result of the minority who are known offset users.
- The offset appears to support continued, though modest, increases in earnings after pilot entry.
- There is preliminary evidence that the offset is strongly associated with increases in average earnings for those with high educational attainment (4 yr. degree or beyond). Most of this effect occurs after entry to the pilot.
- Both at entry and one year later, majorities of participants, including offset users, report high levels of concern that working will have negative consequences on their ability to maintain or regain attachment to SSDI benefits or to associated public health care programs. Changes are at the margins.
- High levels of subjective self-efficacy or increases in the level of self-efficacy appear related to improved outcomes, perhaps mitigating concerns about disincentives in SSA policies and other barriers.

## **SECTION 1: INTRODUCTION AND OVERVIEW OF STATE PILOT DESIGN**

### **1.1 Background and Introduction of Pilot**

The Pathways to Independence projects, administered by the Wisconsin Department of Health and Family Services (DHFS), have worked closely with the Social Security Administration (SSA) to identify employment barriers and test promising practice alternatives for disability program beneficiaries and recipients since 1998. Wisconsin, along with Connecticut, Utah and Vermont, is currently working with SSA on the *Social Security Disability Insurance (SSDI) Benefit Offset Pilot Demonstration Project*, hereafter referred to as “the pilot”.

Currently, SSDI beneficiaries that work face losing all cash benefits should earnings exceed an annually adjusted threshold (also known as the “cash cliff”). The purpose of the state pilots is to identify key process features of an offset of \$1 to benefits in relation to every \$2 in earnings beyond the Substantial Gainful Activity (SGA) threshold and to then inform SSA of the lessons learned, best practices and key elements of such a program as it designs and implements a national offset demonstration. The states also hope to learn whether beneficiaries will increase their employment and earnings if given the opportunity to have their cash benefit reduced gradually as earnings increase beyond SGA threshold. Participants were randomly assigned into treatment and control groups via an online enrollment system. Participants in both groups have access to the same system of employment supports including benefits counseling, the primary difference being the access treatment group members have to the cash benefit offset of \$1 for every \$2 earned above SGA. This approach serves to acknowledge that observed changes in employment behavior will not be a result of differences in service provision differences resulting from study group assignment.

### **1.2 Overview of State Pilot Design**

Wisconsin’s pilot design is based on a de-centralized approach to enrollment and management, one that closely models typical patterns of practical and sustainable employment and social service delivery in the United States. The project office in Madison, Wisconsin operates as the central administrative unit for the project. Twenty provider agencies serve as the direct contact points for participants. The provider agencies are contracted to collect data directly from participants, provide and coordinate services, and participate in other pilot activities as requested by central office staff.

## **SECTION 2: RESULTS OF OUTREACH AND RECRUITMENT EFFORTS**

### **2.1 Targeted Pool of Beneficiaries**

Wisconsin designed the pilot under the premise that it was better to cast the net widely in targeting potential participants for the pilot. Initially, the contracted provider agencies targeted SSDI Beneficiaries who were already accessing services at their agency and who were likely to meet the eligibility criteria set established by SSA. When this method fell short of the expected number of referrals, the pilot was then marketed to an expanded pool of beneficiaries receiving services through Wisconsin’s Medicaid managed long-term care program (FamilyCare), enrolled in the Medicaid Buy- In, and/or accessing services through the state Vocational Rehabilitation program.

## **2.2 Partnerships with State & Local Service Systems**

In conducting outreach and recruitment for the pilot it was essential to actively collaborate with various state and local entities. Wisconsin's central office staff started working with established provider agencies as they could serve as the main contact point for all pilot participants. Information was also provided to the Division of Vocational Rehabilitation (DVR), FamilyCare and other Medicaid funded long-term care programs, the Disability Program Navigators, SSA Field Offices, and County Human Service Agencies.

## **2.3 Recruitment Methods**

Wisconsin's outreach effort was conducted using several techniques including site-initiated meetings and contact with potential participants, posters and brochures designed for the general public, and a targeted mass mailing. The mailing was sent statewide to approximately 10,000 individuals receiving services through DVR, Medicaid funded long-term care programs and those enrolled in the Medicaid Buy-In program in Wisconsin.

Initially, the provider agencies in Wisconsin conducted local outreach by providing pilot information to individuals they were already working with, holding informational sessions, distributing posters and brochures to logical partners, and partnering with agencies in their service area. Additionally, central office staff conducted informational sessions for administrators and staff of statewide programs including Vocational Rehabilitation, Medicaid Waiver programs, Disability Program Navigators and others.

Although outreach materials were provided to the provider agencies, all DVR offices in the state, all SSA field offices, county-based human service agencies and others, this method of outreach and recruitment didn't prove sufficiently effective or efficient. The pace of enrollment in Wisconsin increased dramatically after the larger mailings were sent directly to individuals. However, it is important to note that the mass mailing included not only an informative letter about the pilot, but also a brochure and list of all provider agencies statewide where beneficiaries could enroll and receive access to benefits counseling and employment services. Many eventual participants reported that they were already aware of the pilot due to an existing connection with a Benefits Specialist and receipt of the letter simply confirmed that the pilot was available. The letters resulted in a high number of phone calls to both the provider agencies and central office. Many voicemail messages were received at the central office location and although they were followed up on immediately, these contacts generally resulted in several additional phone calls back and forth to adequately answer all questions.

The ramp-up and roll-out of Medicare Part D was also concurrent with the SSDI Benefit Offset Pilot enrollment period. Provider agencies reported that pilot outreach was initially difficult because many people had questions about Medicare Part D and/or stated that they couldn't consider enrolling because they were confused and concerned about Medicare Part D.

## **2.4 Response and Uptake Rates**

Given that the community provider agencies conducted all intake and enrollment activities, central office staff did not actively track response and uptake rates. Specifically, information was not gathered from those individuals who expressed interest in participating but then opted not to enroll. In August 2006, provider agencies reported

that approximately 30-50% of the calls they received were appropriate referrals by individuals interested in and eligible to enroll in the pilot.

## **2.5 Relationship Between Offset and Ticket Program**

In Wisconsin there was no requirement that participants assign their Ticket in order to benefit from the pilot provisions. No tracking has occurred to determine how many participants have assigned their Tickets to existing Employment Networks (ENs).

## **SECTION 3: IMPLEMENTATION OF THE CASH BENEFIT OFFSET**

### **3.1 State Level Administration and Technical Assistance**

The SSDI Benefit Offset Pilot in Wisconsin is administered through the Department of Health and Family Services (DHFS), operating as the “central administrative unit” for the pilot in Wisconsin.

DHFS has arranged for evaluation of the pilot through a contract with the University of Wisconsin-Stout Vocational Rehabilitation Institute (SVRI). Pilot staff conduct oversight of all activities including a) providing technical assistance to the twenty provider agencies that work directly with participants on operational issues that include participant issue tracking and utilization of SSA work incentives and offset payment problems, etc, b) all research activities, c) keeping key stakeholders informed of pilot activities, d) working directly with the local SSA Area Work Incentive Coordinator to assist with participant benefit issues and information and, e) ensuring compliance with all security measures required when working with sensitive information.

### **3.2 Statewide Coverage and Local Service Delivery through Provider Agencies**

Through the earlier SSA-funded State Partnership Initiative (SPI) project, Wisconsin developed the capacity to provide benefits counseling and other employment supports via a strong statewide network of provider agencies. It was logical to engage this network of service providers again for the pilot in order to connect with their consumer population. Further, working with community-based organizations, particularly those having experience with SSA projects, facilitates participant access to necessary supports and services locally.

Most public programs in Wisconsin are administered at the regional or county level and eventually through private sources such as Independent Living Centers, non-profit employment agencies and others. This has created a substantial, effective and efficient infrastructure for services and supports to people with disabilities. This feature extends to benefits counseling, with most practitioners employed at community agencies and on a fee-for-service basis. This facet of the services landscape has encouraged readily available benefits counseling services with a lower participant to Benefit Specialist ratio.

### **3.3 Benefits Counseling Services**

All pilot provider agencies in Wisconsin are required to have on staff or contract with a trained Benefits Specialist to provide all benefits counseling services needed by participants. Although the majority of provider agencies have retained trained Benefits Specialists, attrition has occurred at several provider agencies, in some cases more than once in the past two years. In order to ensure participant access to ongoing benefits counseling services, central office staff works closely with the provider agencies and

helps arrange interim benefits counseling until the site is again capable of providing quality benefits counseling services.

Wisconsin's system of benefits counseling is funded with both federal and state level resources. Given the nature of the pilot, a strong cadre of highly trained Benefits Specialists is critical in providing participants with timely, accurate information. Work Incentive Planning and Assistance (WIPA) services alone, as they are currently funded and provided, are insufficient to meet the needs of active participants. Integration of employment support programs for participants can be accomplished however it requires considerable time, energy and resource to achieve.

All of the pilot benefits specialists have been trained centrally through the Wisconsin Disability Benefits Network (WDBN), using a standardized, comprehensive curriculum. Although the majority of provider agencies have retained their trained Benefits Specialists from project inception through the present period, attrition has occurred at several provider agencies, in some cases involving multiple staff at the same site. In order to ensure participant access to benefits counseling services, central office staff work closely with the provider agencies and help arrange "interim" benefits counseling until the site is again capable of providing its own benefits counseling services. Wisconsin has Work Incentive Benefits Counseling (WIBC) contracts, funded by the Medicaid Infrastructure Grant (MIG), in place with each of the twenty agencies ensuring free access to this vital element of the pilot.

### **3.4 Other Employment-Related Services and Supports**

In addition to benefits counseling, employment-related services and supports have been available to all participants. The provider agencies are required to assist participants who need employment supports in getting those services. Not all provider agencies have the capacity to provide such services themselves but can help participants connect with other agencies that can assist them in achieving their employment goals. The Wisconsin pilot does not require participants to work with the DVR and/or assign their Ticket in order to participate. Examples of employment-related services include job development and placement, vocational evaluation, job coaching and other on-the-job supports, and transportation.

### **3.5 Staff Workload Issues**

The workload issues that need to be taken into consideration in a pilot such as this extend beyond the context of central office staff time. Given that Wisconsin is using a de-centralized model, the time applied to the pilot from other sources must be considered as well. The numbers indicated in this section provide an under-representation of actual hours applied to pilot activities given that information on service coordination and provision beyond the scope of the MIG-funded benefits counseling was not considered.

A very rough estimate of the staff time dedicated to the pilot on an annual basis is as follows:

Central Office Staff	9,568 hours
Provider Agency Reporting	6,000 hours
Provider Agency Benefits Counseling (MIG-funded only)	750 hours

Operational central office staff is available to answer provider agency staff and participant questions by phone or email daily. Considerable time is spent responding to

issues with participant payments, identifying participants who are or should be in benefit offset status, working with the local SSA Area Work Incentive Coordinator (AWIC) and SSA Baltimore pilot staff to rectify the issues, and communicating this information back to participants and their benefits specialists.

### **3.6 Wage Reporting**

Direct participant interaction in Wisconsin primarily occurs through the twenty provider agencies. The Wisconsin central office actively communicates with the provider agencies via email, newsletters, conference calls, face to face quarterly meetings, and site visits.

The provider agencies are required to have a minimum of monthly contact with participants and are required to gather and electronically submit specific information for evaluation purposes, especially concerning changes in employment and job characteristics. Such contact also allows 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 are needed whenever a treatment group participant has a change in earnings of +/- \$1,000.00 annually, when Trial Work Period months are used, or when earnings reach the Substantial Gainful Activity threshold. The provider agency completes the earnings estimate forms with the participant and then submits them to the project office in Madison, which in turn, on a quarterly basis, forwards the information to the Social Security Administration Central Office.

Central office staff has found reporting wage changes on a quarterly basis to be challenging for participants. Frequently there is 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 are sent to participants inconsistently. Additionally, notices are written with conflicting information that participants and central office staff alike find confusing. Occasionally, notices are not sent at all and payments are stopped or changed, leading to greater confusion. Overpayments and incorrect payments occur with enough frequency that makes it difficult for participants to budget effectively.

### **3.7 Offset Impact on Other Benefits**

Operational staff was informed anecdotally through the provider agencies that there were individuals that had tried working prior the pilot, had previously experienced adverse implications to their benefits, and were hesitant to agree to pilot participation. Others beneficiaries had heard that work and earnings were potentially problematic were similarly reluctant to accept whatever risks the pilot seemed to hold.

Although most participants receive health care through Medicare, the Wisconsin Medicaid Buy-In program provides an option for wrap-around coverage to those participants holding jobs. While, at least at enrollment into the Pilot, Buy-In participation is substantially higher than for the background population, there is concern that ongoing Buy-in participation may become suppressed for those who actually use the offset provision or had SSDI payments restored because of inclusion in the treatment group. This is because the Wisconsin Medicaid Buy-In uses a premium formula that is very sensitive to the amount paid in SSDI.

For those not working, Wisconsin offers access to the Buy-In via the Health and Employment Counseling (HEC) program, for up to one year of eligibility as employment services and supports are being acquired. Currently, thirty-six pilot participants are enrolled in the state's Buy-In using the HEC option.

Having increased earnings that are not offset with regard to other entitlements is problematic, but manageable, with the help of benefits counseling. However, slow or incorrect application of the offset on SSDI benefits has led to unforeseen complications even when benefits advisement has been provided. For example, a participant's combination of increased earnings and SSDI check that was not adjusted for the offset required her to pay a premium for the State Children's Health Insurance Program. Though the premium was minimal (less than \$50/month) she may not recover it.

Other participants had trouble with increases in their rental payment for housing because the offset was not applied correctly.

### **3.8 Impact of Offset on Family Member Benefits**

No significant problems affecting other family members have been noted. One daughter of a participant did have her auxiliary payment stopped when the offset was first applied. This was resolved with a call to the Social Security Administration Central Office in Baltimore.

### **3.9 Impact of Seventy-Two Month EPE on Behavior**

Several participants have reached the end of their seventy-second (72<sup>nd</sup>) month Extended Period of Eligibility (EPE) in Wisconsin, a point at which the offset is no longer applied. All individuals reaching this point in the pilot have planned to reduce earnings to less than Substantial Gainful Activity, or use work incentives such as Impairment Related Work Expenses (IRWE) or Subsidy, to maintain their full SSDI payment amount. Thus far, these participants have been working part-time with earning levels being insufficient to live on alone.

Example 1: In one case, a participant knew she was coming to the end of her 72 month EPE and wanted to be sure her IRWE was approved at the local SSA Field Office. The pilot site Benefits Specialist worked closely with the participant and the local Field Office the month prior to the 72<sup>nd</sup> month. With this assistance she was able to continue working at her current rate and use an IRWE to maintain her full SSDI payment amount.

Example 2: A second participant never received notice that he had reached his 72<sup>nd</sup> month and had continued to work as though the cash benefit offset would continue. It is likely that he earned over SGA and now faces the loss of benefits, which was never his intent. He is not able to work full-time and cannot live on his earnings alone.

Example 3: A third participant will reach his 72<sup>nd</sup> month in August 2008. In order to continue working at his job, which he has stated he likes very much, he needs to maintain his current schedule. At this point, he is not earning much above SGA and is unsure as to whether he will be able to live on his limited earned income once the pilot ends. At this point he is considering whether he will need to quit his job (reduced hours are not an option) or try to live on very limited earned income.

### **3.10 Use of Other Work Incentives in Conjunction with the Benefit Offset**

A number of participants in Wisconsin have requested countable wage reductions based on IRWE and Subsidies that permit employment. These participants sent letters requesting application of the IRWE/Subsidy provisions with receipts and/or proof of the expense or subsidy, to the state central office and this was submitted to Social Security Administration in Baltimore for approval or denial. Some participants had these expenses approved by their local SSA Field Office prior to entry into the pilot; yet, there was still a long delay for the approval to come from the SSA Central Office. For the most part, approval of IRWE and Subsidy took at least four months, sometimes longer. Wisconsin central office staff also sent monthly reminders to the Baltimore SSA staff requesting a status report on the IRWE/Subsidy determination. In one case, the approval of the IRWE took seven months before a notice was sent to the participant. Once approved, the IRWE/Subsidy was applied correctly to the offset and the participant did receive the full benefit of the work incentive. One IRWE request submitted in 2006 still has not been processed.

## **SECTION 4: EMPLOYMENT SERVICES USED BY PARTICIPANTS**

### **4.1 Vocational Rehabilitation Participation and Types of Services Provided**

The provider agencies are required to assist participants who need employment services and supports in accessing them. Not all provider agencies have the capacity to provide these elements but can help participants connect with other agencies that can assist them in reaching their employment goal. Participants have indicated a strong need for access to employment related services. The Wisconsin pilot does not require participants to work with VR and/or assign their Ticket in order to participate.

### **4.2 Supported Employment Participation**

Central office staff does not have a way to consistently identify and track participant usage of supported employment services.

### **4.3 Ticket to Work Participation**

Ticket to Work usage by participants has not been tracked. Central office staff has been contacted about problems with Ticket payments, so it can be assumed that some participants have assigned their Ticket to existing Employment Networks (ENs). In all cases the participant reported their earnings to their EN, the EN submitted the paperwork for payment but payment was denied. A staff person at the Office of Central Operations (OCO) was designated as the liaison to help with these cases. All payments were denied due to an error on the part of OCO not releasing the cases for payment and the SSA liaison was able to rectify the situation quickly.

## **SECTION 5: UTILIZATION OF THE CASH BENEFIT OFFSET**

### **5.1 Status of Treatment Group at Intake: # or Proportion in TWP or EPE**

Wisconsin central office does not have reliable information regarding the status of treatment group members during the intake period beyond whether participants met the eligibility criteria. At the time, it was assumed that SSA would be tracking TWP and EPE usage throughout the pilot. The provider agencies were not required to track or provide central office staff with this information at intake. Basic information was gathered by

provider agency staff via the Benefits Planning Query (BPQY); however the accuracy of this information varied considerably.

The provider agencies reported that a fairly significant number of individuals were ineligible for the pilot because their TWP ended more than 72 months prior, or were within the 24 month Expedited Reinstatement period. Not only had these individuals shown an interest to work, but could be better prepared to plan for an exit from SSDI payments, given the extra incentive and time the offset could provide them. Some provider agencies reported that enrollment in the pilot may have doubled if this particular eligibility criteria element did not exist.

## **5.2 Status of Treatment Group over Time**

Wisconsin operations staff tracks treatment group information for participants earning more than the TWP amount and SGA and are monitored closely. In December 2007, the provider agencies were asked to document TWP and cessation information for all treatment and control group participants. To date, this information has not been received from all provider agencies and has yet to be compiled. Once ready, the information will be used to cross-reference the operational database at central office, will be provided to research staff, and will be provided to pilot staff at SSA in Baltimore.

## **5.3 Work Participation Rate of Treatment Group Members**

Of the 265 participants in the Treatment group, 164 worked in 2007, or approximately 60%. Please refer to Sections 6.1, 6.2, 6.3 and 6.4 for the research information on earnings and employment for all participants.

## **5.4 Utilization of the Offset**

Currently, thirty-three participants in Wisconsin either are or should be receiving offset payments. Eight additional participants were receiving offset payments, but they are no longer earning above SGA and the offset payments have stopped. For those utilizing the offset payment, there is a continual fluctuation between overpayment and underpayment. Participants are required to supply considerable information and complete paperwork as a requirement of being in the pilot. Even in cases with vigilant wage reporting, the payments are inaccurate and result in incorrect payments. Much frustration from participants has been expressed about this. It is very difficult for an individual to have any reliable budgeting of their income when benefit payments are withheld without notice. As 2007 earnings information is gathered, Wisconsin central office staff are finding more participants who should have been in offset status in 2007 but their earnings estimates did not correctly identify this.

## **SECTION 6: IMPACTS ASSOCIATED WITH THE WISCONSIN SSDI EMPLOYMENT PILOT- PARTICIPANT OUTCOMES, PERCEPTIONS, AND EXPERIENCES**

The Social Security Administration (SSA) required that each of the Benefit Offset Pilots perform or arrange for an evaluation of their activities and results. An independent evaluation is being performed by staff from the University of Wisconsin-Stout Vocational Rehabilitation Institute. The descriptions and interpretations offered in this section are those of the external evaluators alone.<sup>1</sup>

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<sup>1</sup> Section Six is authored by Barry S. Delin, Ellie C. Hartman, and Christopher W. Sell; University of Wisconsin – Stout Vocational Rehabilitation Institute

SSA identified several areas it expected the evaluations to concentrate on including:

- Differences in employment outcomes between participants assigned to the treatment and control groups
- Whether the pilot had effective methods for communicating information to participants and maintaining their involvement over time
- Whether the pilot had effective methods for recruiting participants and obtaining their consent
- Whether the pilot effectively provided participants with pilot specific employment supports
- Whether the pilot and its services proved more effective with certain categories of participants than others

While Section 6 provides some information about all of these areas, it concentrates on providing information about differences in employment outcomes.<sup>2</sup> We present trends for employment rates and earnings, leaving other types of employment outcomes for future reports. When possible, we present data that includes some period before enrollment in the Wisconsin SSDI Employment Pilot (SSDI-EP), as there is always the possibility that decisions to enroll reflect changes in employment status at or immediately before enrollment.

In Section 6 we describe employment data trends. We do not attempt to estimate the impact of the benefit offset on employment and earnings trends. Such analyses will be deferred to the final evaluation report. There are several reasons for the delay. One important reason is that we do not have the minimum required amount of post enrollment data for all participants.<sup>3</sup>

An additional difficulty arises from the fact that those in the treatment group cannot use the offset provision until they have completed their Trial Work Periods and the three month “grace periods” that follow. Consequently, one cannot directly assess the Offset’s impact on employment outcomes unless one can compare outcomes for both treatment group and control group members who have completed their Trial Work Periods (TWPs) over some meaningful length of time after TWP completion. The SSDI-EP did not attempt to deliberately recruit participants who had either started or completed their TWP. Moreover, at present, our information about participants’ TWP completion is far from comprehensive and largely restricted to the subset of treatment group members who have been identified as having used the offset.<sup>4</sup>

Generally, employment outcome data is reported (and most survey data) for three groups: treatment, control, and for those members of the treatment group who we know

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<sup>2</sup> Material identifying outcomes of interest to SSA is derived from Section C of SSA-RFP-05-1003, “Scope of Work.”

<sup>3</sup> The evaluation plan requires having eight calendar quarters of data following the calendar quarter of enrollment.

<sup>4</sup> SSDI-EP operations staff is currently gathering TWP completion data through the provider agencies. This information will be shared with the evaluators. Additionally, the evaluators hope to obtain TWP data from SSA once the SSDI-EP has an approved security plan.

have used the offset provision at least one month.<sup>5</sup> This final group is quite small relative to both the treatment and control group. However, looking at this group can provide us insight into both the degree their outcomes are better than members of either of the study groups taken as a whole. Additionally, examining this offset users group may suggest reasons why they have better outcomes than other treatment group members that can be scrutinized in the final evaluation report. Unfortunately, any hypotheses cannot be directly tested until there is data that identifies all participants who have completed their TWP and the month when those TWP were completed.

Employment outcome data is presented relative to a participant's calendar quarter of enrollment. For example, a participant who enrolled in August 2005 would have an entry quarter (Q0) corresponding to the third calendar quarter of 2005. A participant who entered the SSDI-EP in October 2006 would have a Q0 in the fourth quarter of 2006. All monetary values are deflated using the Consumer Price Index for All Urban Consumers (CPI-U). We have set August 2005 as the 100 value.<sup>6</sup>

### **6.1 Participant Employment Rates from Unemployment Insurance Records**

The SSDI-EP evaluation utilizes Wisconsin Unemployment Insurance (UI) records as its primary source of information about participant employment and earnings. These data are available on a calendar quarter basis (in theory) for all who are employed by employers required to report to the system. These are administrative records that are maintained in a consistent and reliable fashion over time.

However, as suggested above, not all employment is required to be reported to the UI system. The most important exclusions likely to impact aggregated employment rates and earnings are self-employment and work for entities located outside Wisconsin. Additionally, the system provides no information about the proportion of any calendar quarter an individual is employed.<sup>7</sup> Thus the UI employment rates and, for that matter, earnings statistics using UI data are best understood as useful indicators of employment rates and earnings. Despite the inherent limitations, these data are particularly useful for comparing groups and identifying trends.

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<sup>5</sup> We think the number of known offset users is a close approximation to the actual number. Offset users should all be identified in the yearly reconciliation activities that SSA requires the Pilots to undertake. Moreover, as of the time of writing, there is not one known case of offset usage that did not involve an implementation issue such as delay in payment, incorrect payment, or substantial over payment. Benefits specialists at the provider agencies and occasionally participants inform SSDI-EP central operations of these issues. SSDI-EP central office staff is then involved in efforts to resolve these issues with the SSA Office of Central Operations (OCO).

<sup>6</sup> If we had used the official 1982-84=100 standard the monetary values reported, while accurate, would have seemed unaccountably low. One consequence of using August 2005 = 100 is that the SGA level in all deflated analyses is normalized at \$830 per month. The TWP use level is normalized at \$590 per month.

<sup>7</sup> 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.

We present time trends of two different durations. The first looks at data from four quarters prior to the enrollment quarter through the third quarter following the enrollment quarter.<sup>8</sup> These data include all participants who ever enrolled in the Pilot and did not withdraw or die before the end of their third quarter of participation after their entry number. The total number of available cases is 485, 265 from treatment and 220 from control. The number of known offset users from the treatment group is forty.

Additionally, we describe trends for the longer period of Q-4 through Q6. Though doing this has the clear advantage of allowing one to examine almost twice the period of post-enrollment experience, the price at this time is that the numbers available for analysis are far less. The current number of participants with at least six quarters of post-enrollment UI data is 191, 101 from treatment and ninety-one from control. The number of known Offset users from the treatment group is reduced to seventeen.

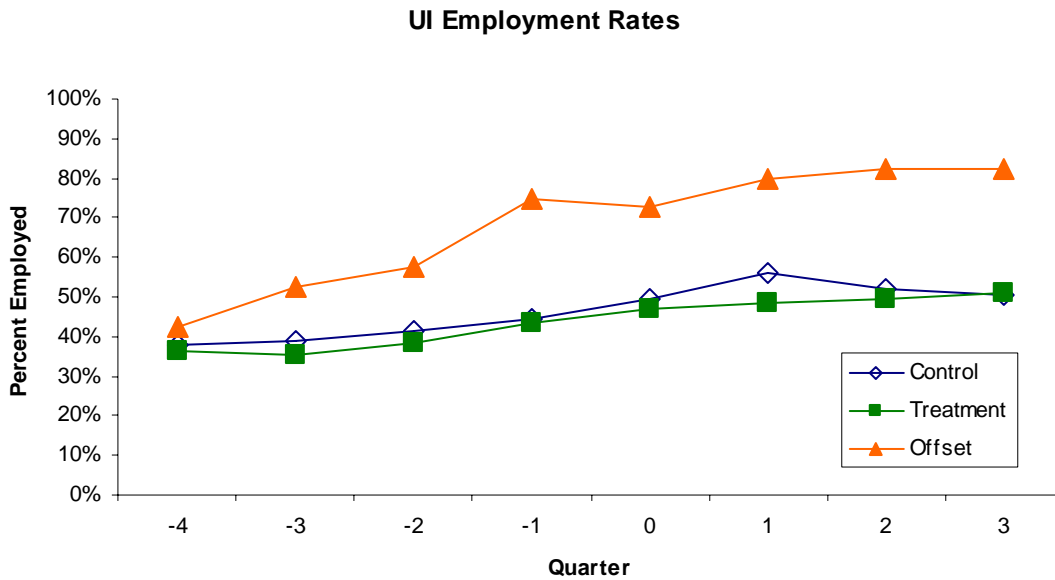
The trends exhibited in charts 1 and 2 are quite similar. Employment rates for both the treatment and control groups track closely (see table 1 for the actual values). In marked contrast, though the employment rates values for the offset users groups at Q-4 are comparable to those in both the whole treatment group and the control groups, the rates at the end of the two analysis periods are over 30% higher than for either the overall treatment or control groups.

Even prior to study entry, the UI employment rates for the offset user groups begin to become much higher than those for either study group. For example, among participants with three quarters of post-enrollment experience (i.e. the data that includes all SSDI-EP participants) the growth in the employment rates for both the treatment and control groups are slightly above 10%. By contrast the employment rate for those in the offset users group increases by another 30%. The same basic pattern is observable in the smaller groups with six months of post enrollment data.

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<sup>8</sup> The decision to describe trends starting at Q-4 is intended to set a balance between including a significant period of pre-treatment history and excluding employment and earnings from before a participant became a SSDI beneficiary. We will look at this choice again if and when we receive requested SSA data.

**Chart 1: UI Employment Rates Q-4 through Q3 for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**



Source: Wisconsin Unemployment Insurance Records  
 Note: Total N=485, T=265, C=220, O=40

**Chart 2: UI Employment Rates Q-4 through Q6 for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**



Source: Wisconsin Unemployment Insurance Records  
 Note: Total N=192, T=101, C=91, O=17

Following enrollment, the offset users groups' UI employment rates continue to increase both absolutely and relative to the rates for both the treatment and control groups. In both the three and six quarter post enrollment data, the offset users employment rates increase about another 10% to values of 83% and 89% respectively. The post-enrollment changes in the rates for the treatment group are 2% for the three post enrollment quarters group and 4% for the six post enrollment quarters group. The comparable values for the control group are 1% and -9% respectively.

**Table 1: UI Employment Rates, Treatment, Control and Offset Users, Groups with Data to Post-Enrollment Quarters Three and Six**

Quarter	T -4 to 3 Group	C -4 to 3 Group	O -4 to 3 Group	T -4 to 6 Group	C -4 to 6 Group	O -4 to 6 Group
-4	36.6%	37.7%	42.5%	45.5%	42.9%	47.1%
-3	35.5%	39.1%	52.5%	41.6%	44.0%	52.9%
-2	38.5%	41.4%	57.5%	45.5%	47.3%	52.9%
-1	43.4%	44.5%	75.0%	54.5%	51.6%	76.5%
0	46.8%	49.5%	72.5%	49.5%	57.1%	76.5%
1	48.7%	55.9%	80.0%	57.4%	59.3%	88.2%
2	49.4%	52.3%	82.5%	56.4%	54.9%	88.2%
3	50.9%	50.5%	82.5%	53.5%	48.4%	88.2%
4	NA	NA	NA	52.5%	56.0%	88.2%
5	NA	NA	NA	54.5%	56.0%	82.4%
6	NA	NA	NA	55.4%	50.5%	88.2%

Source: Wisconsin Unemployment Insurance Records

Note: For the Q-4 to Q3 Group, the total N=485, T=265, C=220, O=40

Note: For the Q4-4 to Q6 Group, the total N=192, T=101, C=91, O=17

Consequently, the data in table 1 exhibit an unexpected result. The UI employment rates for the control group can be characterized as being as high or even a little higher than those for the treatment group. What makes this finding unexpected is that the treatment group rates include the UI employment reported for the offset users, who make up about 15% of the treatment group. In considering this, it must be recalled that the employment rates for the offset user group were only marginally higher at Q-4 than the rates for the treatment group as a whole. Yet by the enrollment quarter (Q0) the rates for the offset users group were about 25% higher. The relative gain of the offset group compared to the treatment group as a whole during the Pilot was much more modest in the post-enrollment period.

This suggests that the most powerful motivators of better outcomes among the offset users were operating before entry to the SSDI-EP. It would seem likely that the offset users were more likely than other treatment group members to have started or completed their TWP before enrollment. We will return to this possibility when we examine UI earnings data. This also suggests a second, unresolved issue. Given random assignment, there should have been about the same proportions of participant who had started or completed their TWPs prior to enrollment in both the treatment and control groups. At present, we have no way of identifying the proportion of those in the treatment group who have not yet become offset users or who may not become so during the life of the SSDI-EP. Similarly, we cannot identify the proportion of those in the control group who (given random assignment) would have been in position to become

offset users in either the three or six quarter post enrollment periods had they been assigned to the treatment group.

Finally, the findings presented here for the offset users employment rates and their relationship to those for the larger treatment group should be treated with considerable caution. First, the numbers in the known offset users groups are small. Thus a small change in the number with UI employment can make a large change in the employment rate. Second, the participants in the offset users group are by definition successful cases, having both completed their TWPs. and having earned over the SGA level for at least one month following that event and the subsequent three month grace period. Nonetheless, these participants appear to be different in some important way(s) from others, whether from the treatment and control group. We will continue to explore this theme in the next material, that examining UI earnings trends.

## **6.2 Participant Earnings from Unemployment Insurance Records**

The earnings data in this portion of Section 6 are also from Wisconsin Unemployment Insurance records. These data have the same benefits and limitations as the employment data. Once again we have chosen to look at two time periods. The first covers the period of Q-4 through Q3. It captures the UI records of all SSDI-EP participants who remained in the pilot through their third post enrollment quarter. The second period, reports earnings trends through the sixth post enrollment quarter. This series presents data for approximately 40% of the participants.

As the UI earnings trends for the two time series are, as with the comparable employment rate series, quite similar, we will concentrate on the longer time series. In doing this we are consciously placing more value on having a preliminary look at a longer period of experience during the pilot than on presenting complete data for a significantly shorter period.

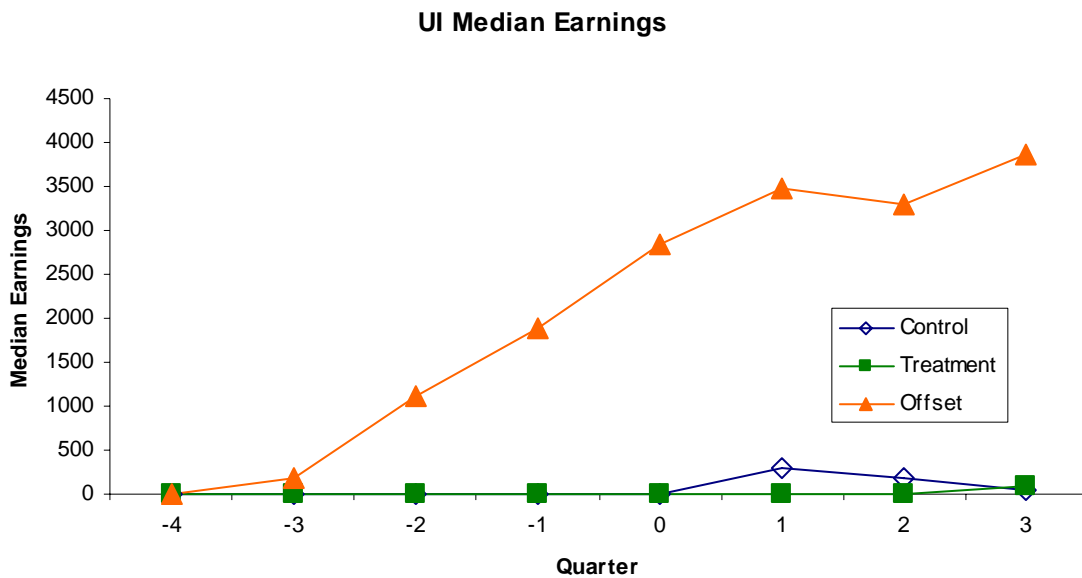
Additionally, we concentrate on presenting trends using measures of central tendency rather than focusing on distributions. Statistics such as means (averages) and medians (the values of cases at the 50<sup>th</sup> percentile) speak directly to the issue of typical effect or outcome of any policy change or program. The measures have different advantages. When numbers are small and there is any concern that distributions are not symmetrical, looking at the median has great value because outliers will not distort the median. Unfortunately, as with these data, when more than half the cases in some time periods have a value of zero, the median will be zero. By contrast, means, though subject to distorting perceptions of the typical case if there are even a small proportion of extreme values, will always have a non-zero value if the minimum value is zero and there are any positive values. This allows looking at percentage changes across any time period of interest. Readers are also advised to remember that the medians and means for earnings described in this report are very sensitive to employment rates. When employment rates are low, both measures will be far lower than the typical earnings of those participants who actually have UI employment.

Chart 3 describes median quarterly earnings for participants with three post enrollment quarters of data. Chart 4 describes median quarterly earnings for those with six quarters of post enrollment data. Both charts exhibit similar trends for members of the control, treatment, and the offset users groups. Even in those quarters where control and treatment group employment rates are above 50%, median earnings are modest.

The highest medians reported are less than \$600 for treatment, less than \$500 for control. All of these maxima are reached in quarters following SSDI-EP entry.

The data series for the offset users group describe a far different pattern. Positive values for median quarterly earnings appear in both charts 3 and 4 by Q-3. In both charts, the gain in median quarterly earnings between Q-4 and Q0 is pronounced: more than \$2800 in chart 3, approaching \$3200 in chart 4. Thereafter, the pace of increase slows: though more noticeably in the longer data series. Among the offset users with three quarters post enrollment experience, the gain after Q0 was about \$1000 per quarter at Q3. For the smaller group with six post enrollment quarters, the median was about \$500 higher in Q6 than it had been in Q0. Thus the observed pattern closely resembles that observed for offset users' UI employment rates. Gains in employment outcomes are concentrated in the period before entering the SSDI-EP, though they continue after entry at a slower rate.

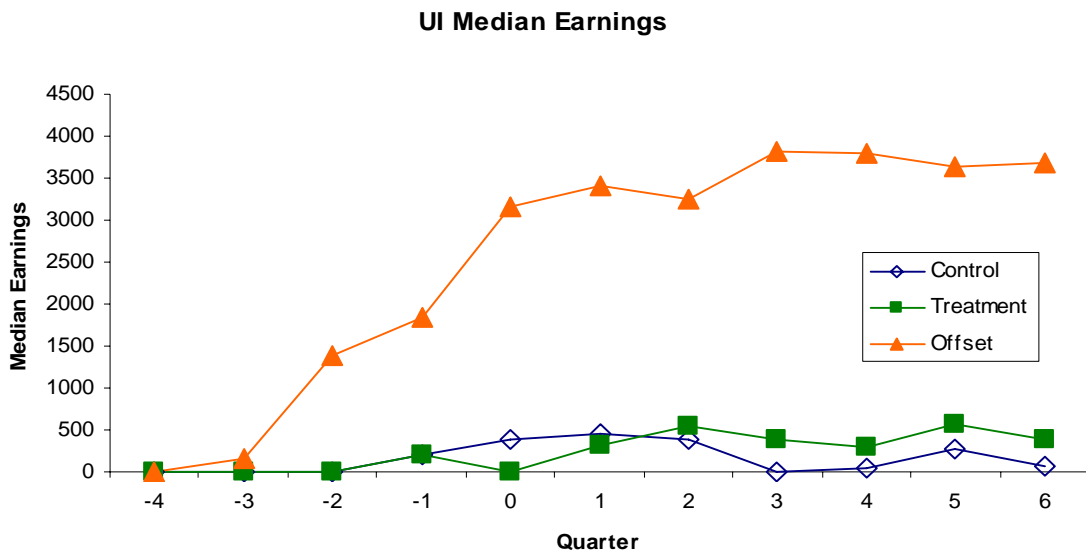
**Chart 3: UI Median Quarterly Earnings in Constant Dollars, Q-4 through Q3, for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**



Source: Wisconsin Unemployment Insurance Records

Note: Total N=485, T=265, C=220, O=40

**Chart 4: UI Median Quarterly Earnings in Constant Dollars, Q-4 through Q6, for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**



Source: Wisconsin Unemployment Insurance Records  
 Note: Total N=192, T=101, C=91, O=17

The data series describing mean quarterly UI earnings look very similar to those for median earnings. As a result, we have included only the chart for participants with UI data for six quarters beyond their enrollment quarter. However, table 2 includes data from the shorter time series.

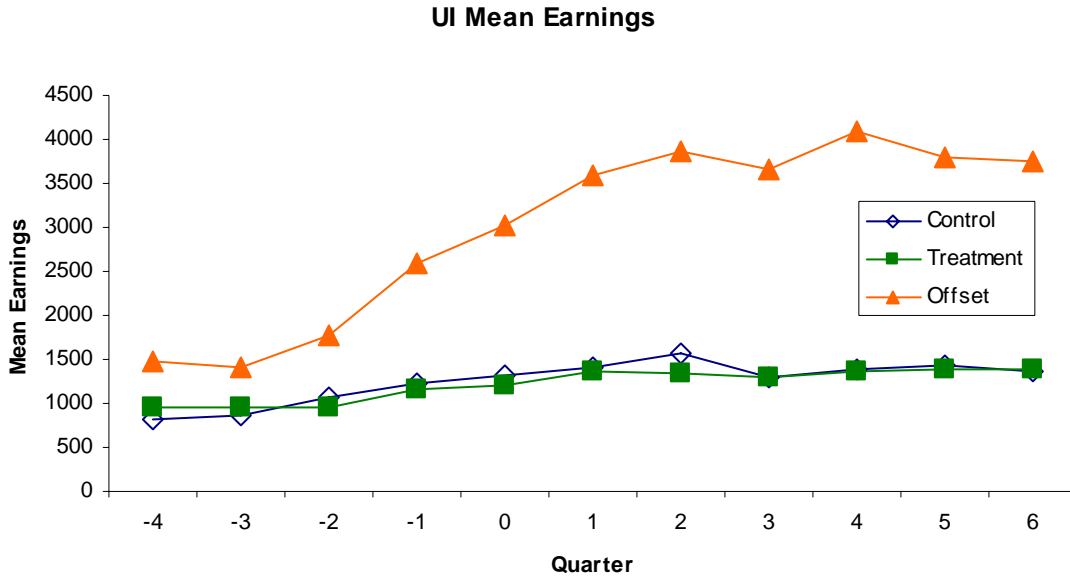
The series of mean quarterly earnings for the control and treatment groups displayed in Chart 5 show, as expected, positive values in all quarters. The values for both groups track fairly closely through the entire eleven quarter period. Mean quarterly earnings increase 59% (from \$825 to \$1308) over the Q-4 through Q0 period. The comparable value for the treatment group is a 26% increase (from \$954 to \$1206). This finding implies that the control group contains some subset of participants who made rapid gains in employment outcomes in the period prior to SSDI-EP entry. While this is a logical consequence of adequately conducted random assignment, it is still reassuring.

Following enrollment, the mean quarterly earnings for the control group increased barely 3% (\$45 per quarter in absolute terms) between Q0 and Q6. By contrast, the rise in quarterly mean earnings for the treatment group (which includes the offset users) was over 15% (\$186). This result is consistent with the offset provision having some real effect.

Though to some degree expected “by definition,” both chart 5 and table 2 document the notable increase of mean quarterly earnings for the offset users group. Even at Q-4, this sub-group exhibited substantially higher mean earnings than either the control or treatment group. For both the three post-enrollment and the six post-enrollment quarter analyses, by the ends of both data periods the offset users group posted mean quarterly earnings well over \$2000 higher than either the control group or the full treatment group.

Among members of the offset users group with six post enrollment quarters the increase in the Q-4 to Q0 period was 106% (\$1559). The increase in the Q0 to Q6 period was 24% (\$711). This result is also consistent with the offset provision having a positive effect.

**Chart 5: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q6 for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**



Source: Wisconsin Unemployment Insurance Records  
 Note: Total N=192, T=101, C=91, O=17

**Table 2: UI Mean Quarterly Earnings in Constant Dollars, Treatment, Control and Offset Users, Groups with Data to Post-Enrollment Quarters Three and Six**

Quarter	T -4 to 3 Group	C -4 to 3 Group	O -4 to 3 Group	T -4 to 6 Group	C -4 to 6 Group	O -4 to 6 Group
-4	796	643	1017	954	825	1471
-3	781	725	1119	948	867	1407
-2	731	753	1663	945	1071	1781
-1	896	895	2230	1153	1222	2587
0	1046	1071	2765	1206	1308	3030
1	1090	1301	3374	1369	1408	3589
2	1081	1354	3385	1334	1558	3863
3	1220	1320	3819	1292	1303	3666
4	NA	NA	NA	1371	1388	4099
5	NA	NA	NA	1375	1430	3785
6	NA	NA	NA	1392	1533	3741

Source: Wisconsin Unemployment Insurance Records  
 Note: For the Q-4 to Q3 Group, the total N=485, T=265, C=220, O=40  
 Note: For the Q4-4 to Q6 Group, the total N=192, T=101, C=91, O=17

Nevertheless, these results are in many respects quite discouraging. First, it was hoped that the service package available to all SSDI-EP participants, especially benefits counseling, would result in some gain in employment outcomes for those assigned to the control group. The data, at least prior to modeling, gives little support to that prospect. There is also the fact that progress in employment and earnings for the treatment group has been extremely modest, especially once the contribution of the offset users is removed. If a substantial proportion of the treatment group had begun to use trial work period months following entry to the SSDI-EP, shouldn't both employment and earnings rates be rising more briskly? For example, offset users make up 17% of the treatment group with at least six post-enrollment quarters of UI data. Thus as the UI employment rate for offset users in this sample was 88.2% in Q6, the UI employment rate for the rest of the treatment group was approximately 48.7% at Q6.<sup>9</sup> This is actually slightly lower than the UI employment rate for the control group (50.5%) at the same time point.

There is also the fact that employment and earnings outcomes for those in the offset users group have tended to grow quite slowly following study entry. Though it would be splendid if their earnings continued to rise at a rapid pace, once SGA ceases to be a factor constraining earnings other limiting factors might come to the fore. For example, the disabling condition itself or a worsening of its symptoms might constrain outcomes. So, for example, could a wide variety of factors such as the lack of appropriate education or experience, the lack of needed supports (such as transportation or personal assistance), or a souring economy. Thus, these findings appear less disturbing. There appears to be some basis for a tentative conclusion that the offset has allowed those participants with strong employment outcomes at SSDI-EP entry to maintain and to some degree extend those gains.

Though we do not have data to directly identify either initiation or completion of the TWP or whether someone (other than a known offset user) following the TWP has monthly earnings exceeding the SGA level, we can use UI earnings to impute whether someone has quarterly earnings that equal or exceed three times SGA or the TWP threshold amounts.<sup>10</sup> In 2005 the SGA level was \$830 per month. The amount of earnings needed to expend a month of the TWP was \$590. Consequently, the three month equivalents in August 2005 constant dollars are \$2490 for SGA and \$1770 for TWP.

Chart 6 exhibits the proportions of those in the control, treatment, and known offset users groups (with six post enrollment quarters of UI data) having UI earnings at or above the three times SGA equivalency level at each time point. The trends that would be observed in a chart for participants with only three quarters of post enrollment data or for the data series for UI earnings of three times the TWP equivalency level are extremely similar. Thus we have chosen not to display them.

The trends portrayed in Chart 6 are also highly reminiscent of those seen in the other charts depicting UI employment and earnings data. Quite modest proportions of both control and treatment group members have quarterly earnings above the three times SGA equivalent. In both groups there is some increase over time. For the control group

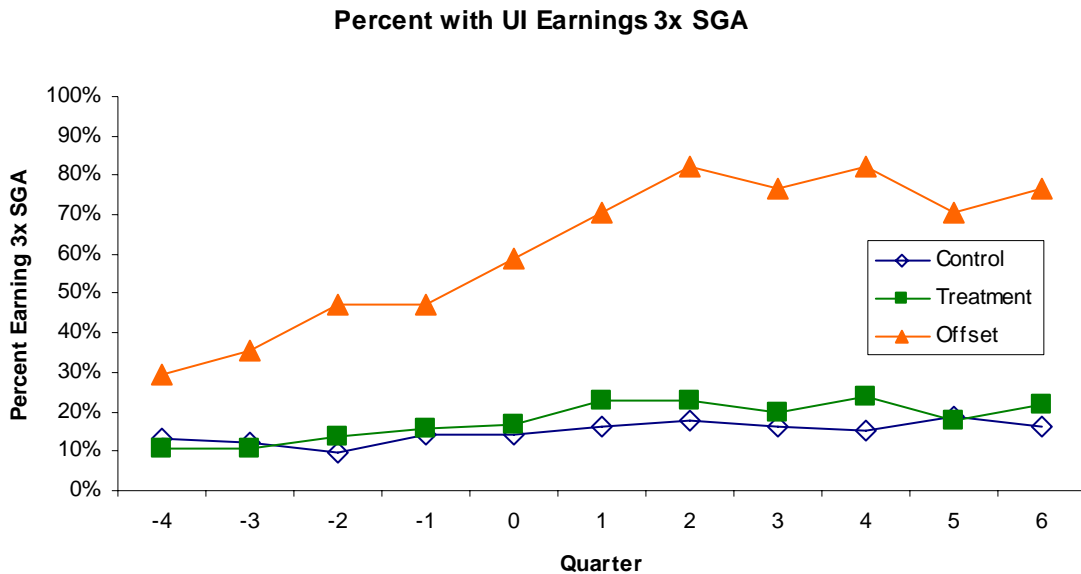
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<sup>9</sup> The rate for the overall treatment group (i.e. including the offset users) was 55.4% for Q6.

<sup>10</sup> Having quarterly earnings at or above these levels only insures that the participant had at least month in the calendar quarter with earnings at or above, respectively, the SGA or TWP levels.

the increase appears to be concentrated in the quarters immediately before and following SSDI-EP entry. For the treatment group, the overall increase is somewhat larger and appears to continue after study entry, though this is almost certainly reflects the fact that the offset users group is included in the larger treatment group.

**Chart 6: Percentage with Quarterly UI Earnings Equivalent to Three Times the SGA Level in Constant Dollars, Q-4 through Q6 for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**



Source: Wisconsin Unemployment Insurance Records  
 Note: Total N=192, T=101, C=91, O=17

Not surprisingly, the offset group has a large proportion of its members with earnings above the three times SGA equivalency level following study entry. By the first post-enrollment quarter, 77% of offset users are above the three times SGA equivalency level; the percentage remains or exceeds that level out to the end Q6. However, as with other indicators of employment and earnings outcomes, much of the gain is achieved in the quarters prior to SSDI-EP entry. As can be seen in Table 3, the proportion of those in the offset group with earnings at or above the three times SGA equivalency level increases twenty-nine percentage points between Q-4 and Q0. The gain from Q0 to Q6 is not quite eighteen percentage points.

The data in table 3 also allows insight into an important issue. Was there a subgroup within the control group that was making progress equivalent to that portion of the treatment group that eventually became identified offset users? To the extent that the proportions with either “3X SGA” or “3X TWP threshold” earnings are comparable across the Q-4 through Q0 period the answer would be a qualified yes.

**Table 3: Percentage with Quarterly UI Earnings Equivalent to Three Times the SGA Level and Three Times TWP Threshold Level in Constant Dollars, Treatment, Control and Offset Users, Groups with Data to Post-Enrollment Quarter Six**

Quarter	Equal or > 3X SGA			Equal or > 3X TWP		
	T	C	O	T	C	O
-4	10.9%	13.2%	29.4%	23.8%	24.2%	35.3%
-3	10.9%	12.1%	35.3%	21.8%	23.1%	35.3%
-2	13.9%	9.9%	47.1%	23.8%	24.2%	47.1%
-1	15.8%	14.3%	47.1%	26.7%	28.6%	52.9%
0	16.8%	14.3%	58.8%	30.7%	31.9%	64.7%
1	22.8%	16.5%	70.6%	30.7%	33.0%	76.5%
2	22.8%	17.6%	82.4%	31.7%	28.6%	82.4%
3	19.8%	16.5%	76.5%	32.7%	25.3%	76.5%
4	23.8%	15.4%	82.4%	31.7%	28.6%	88.2%
5	17.8%	18.7%	70.6%	30.8%	29.7%	76.5%
6	21.8%	16.5%	76.5%	33.7%	30.8%	82.4%

Source: Wisconsin Unemployment Insurance Records

Note: Total N=192, T=101, C=91, O=17

At Q-4, the control group exhibits slightly higher proportions of members who meet the SGA (13.2%) and TWP (24.2%) three month equivalency levels than the treatment group (10.9% and 23.8%, respectively). Between Q-4 and the entry quarter, the control group has only about a 1% increase in the percentage meeting the SGA equivalency standard. By contrast the gain in the treatment group is almost 6%. However, the trends in the TWP equivalency data for the two study groups are more similar. The gain in the proportion above the “3X TWP” level grows about eight percentage points to 31.9%. The equivalent values for the treatment group is a gain of almost seven percentage points to a Q0 value of 30.7%. As completing the TWP depends on earning above the TWP level, not SGA, for nine months, we think the proportions of participants above the TWP equivalency level in the pre-enrollment period is, in the absence of information about TWP start and end dates, a better indicator of the proportion poised to exploit the offset had it been available to them.

### 6.3 Participant Earnings from UI Records: Selected Subgroups

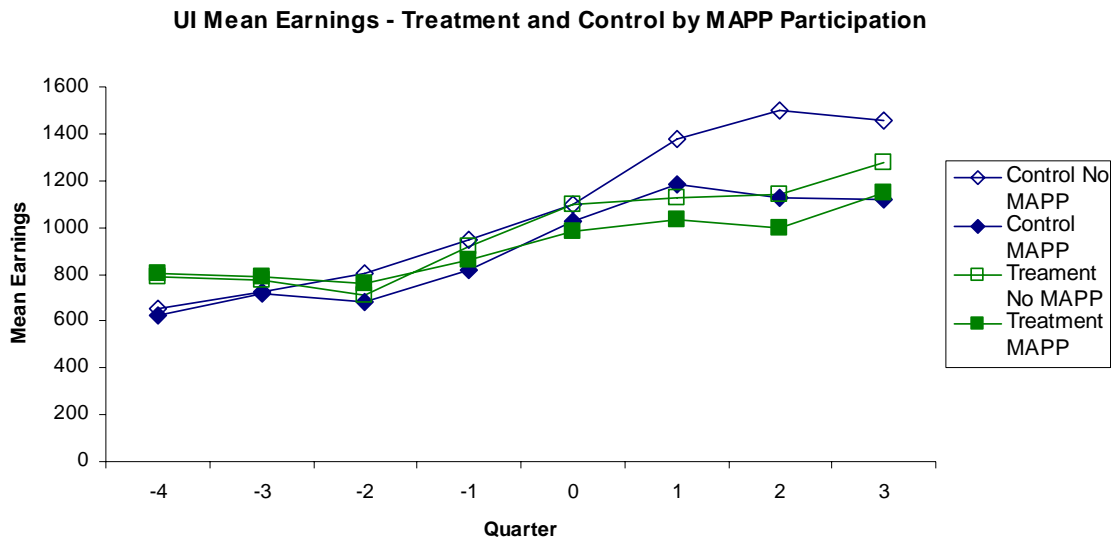
We now examine UI earnings trends for several sub-groups of SSDI-EP participants. Because using these subgroups will further divide the control and treatment groups and the offset users into smaller groupings, we restrict our analyses to the Q-4 through Q3 period. Additionally, we will restrict analyses to mean earnings, as we feel that displaying median values of \$0 makes trends harder to discern than having the mean values skewed by outlier cases. We also limit the number of trend lines in any chart to no more than four to facilitate comprehension.

The first of the subgroup analyses compares those participating in Wisconsin’s Medicaid Buy-in with those who do not. This program is called the Medical Assistance Purchase Plan or MAPP. MAPP was created in part to allow working SSDI beneficiaries without other Medicaid eligibility (such as concurrent SSI participation) to enter the program and to maintain eligibility with more generous earnings and asset limits, even after leaving the SSDI program. As MAPP is designed as a work incentive, the program

could work to reinforce the incentive effects of a SSDI benefit offset.<sup>11</sup> 40% of the control group and 43% of the treatment group were in MAPP during the calendar quarter they entered SSDI-EP.

Chart 7 displays mean quarterly earnings for both control and treatment group members based on MAPP status. We utilize a narrower data range than usual (\$0 to \$1600) to make it easier to look at the data for these four subgroups. All of the subgroups show a similar, generally slow increase in mean quarterly earnings. However, within both the control and treatment groups those not enrolled in MAPP had more earnings growth than those in MAPP. This effect was more pronounced for the control group than the treatment group. Those in the control group without MAPP made gains of \$797 per quarter over the Q-4 to Q3 period compared to \$494 for those enrolled in MAPP. In the treatment group, non-MAPP users gained \$488 compared to \$338 for those in MAPP. Consequently, this evidence is not consistent with a hypothesis that MAPP is a significant work incentive, whether in conjunction with the offset or in its absence.

**Chart 7: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q3 for Treatment and Control Groups, Based on MAPP Participation Status in the Enrollment Quarter**



Source: Wisconsin UI Records and Wisconsin Medicaid Records

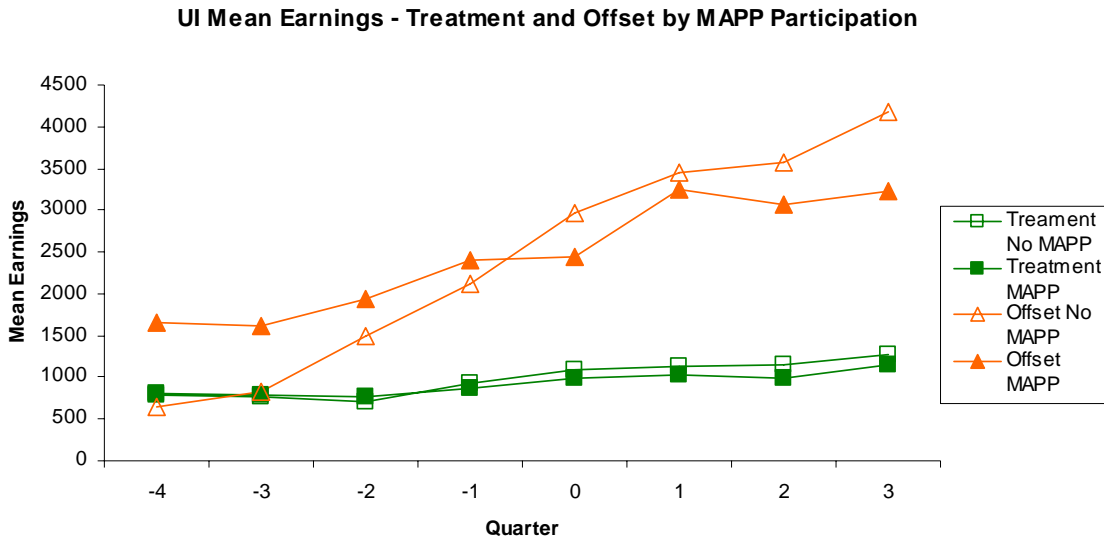
Note: C w MAPP = 87, C w/o MAPP = 133, T w MAPP = 113 and t w/o MAPP = 152

Chart 8 displays data for the treatment group and offset users using the customary \$0 to \$4500 range. This view of the data shows that MAPP participation does not lead to higher mean earnings for offset users after SSDI-EP entry. By Q3, mean quarterly earnings for non-MAPP participants in the offset users group are \$933 higher than for those in MAPP (\$4269 versus \$3236). However during the pre-enrollment period, Q-4 through Q-1, mean earnings for (future) offset users in MAPP is significantly higher for

<sup>11</sup> According to MAPP program rules, all consumers must be employed or in a limited term program preparing for employment. However employment need not require monetary compensation and thus employment that meets MAPP rules may frequently not be captured in UI records.

those not in MAPP suggesting that MAPP may have served as a genuine work incentive for these individuals. Again, this is a very tentative conclusion given the small numbers in these offset users subgroups.

**Chart 8: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q3 for the Treatment Group and Known Offset Users, Based on MAPP Participation Status in the Enrollment Quarter**



Source: Wisconsin UI Records and Wisconsin Medicaid Records

Note: T w MAPP = 113, T w/o MAPP = 152, O w MAPP = 15, O w/o MAPP = 25

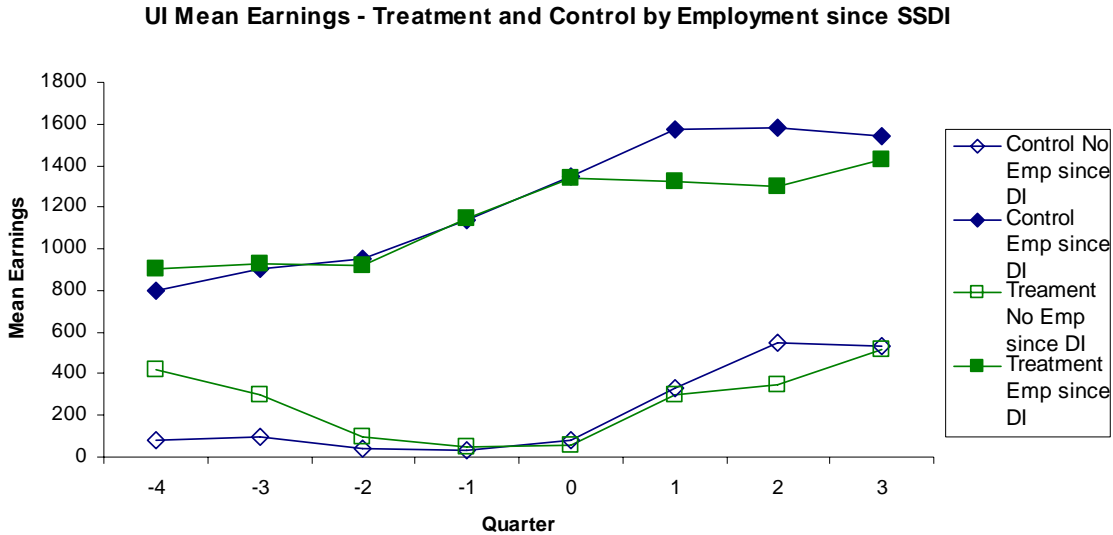
Many have observed that one of the best predictors of future employment outcomes for both persons with disabilities and the general population is having continuing labor force attachment. Most SSDI-EP participants (77% for the treatment group and 78% for the control group) reported at enrollment that they were either currently employed or had worked at some other time since becoming a SSDI beneficiary. Chart 9 exhibits the Q-4 to Q3 trends in UI mean quarterly earnings for subgroups in both the treatment and control groups based on self-reported employment before SSDI-EP enrollment. Again, because of the relatively low quarterly earnings of most participants we have used a more restricted data range than for most analyses.

The data confirm that participants with reported employment since becoming SSDI beneficiaries earn substantially more than those who did not report employment. This effect is strong across both study groups. As logically necessary, only the subgroups with employment experience exhibit earnings growth prior to enrollment.<sup>12</sup> Following enrollment earnings trends are broadly similar for all groups, but those without reported post SSDI employment experienced somewhat faster earnings growth. Still, the experienced subgroups maintained most of the absolute advantage they had at Q0. For example, during the enrollment quarter, those in the treatment group who reported post-

<sup>12</sup> Yet both subgroups without post-SSDI employment experience have positive earnings in the pre-enrollment quarters. Poor recall may be one factor contributing to this, though at Q-4 a few individuals may have just entered beneficiary status. Of course, given that all of the Benefit Offset Pilots required getting SSDI benefits based on the beneficiary's own earnings, all participants can be presumed to have work history prior to becoming beneficiaries.

SSDI employment experience had mean quarterly earnings \$1290 above those in treatment who had not. At Q3, this had closed somewhat to a \$912 advantage.

**Chart 9: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q3 for Treatment and Control Groups, Based on Employment between Entry to the SSDI Program and Entry to the SSDI-EP**



Source: Wisconsin UI Records and SSDI-EP Research Encounter Data

Note: C w post-SSDI Employment = 172, C w/o post-SSDI Employment = 48, T w. post-SSDI Employment = 204 and t w/o MAPP = 61

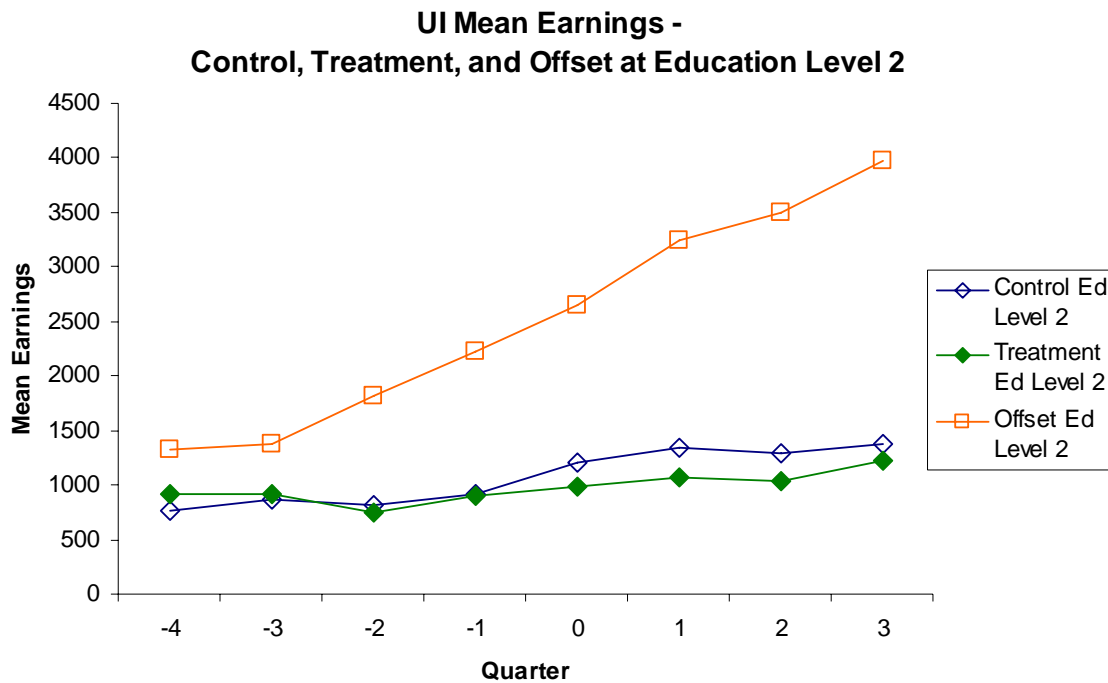
As only two participants in the offset users group did not report having employment at some point after becoming a SSDI beneficiary and entering the SSDI-EP, we do not exhibit data for this group. Still, we note that the post-enrollment increase in mean earnings for these individuals was extremely steep and led to an earnings level by Q3 well above that for other offset users.

The final subgroups examined in this part of Section 6 are based on educational attainment at the time of SSDI-EP enrollment. Educational attainment is a key indicator of human capital development and is strongly associated with higher earnings. The subgroups are defined by three ranges of educational attainment. “Level 1” includes participants who either have a high school diploma, a GED, or some lesser level of attainment. We define “level 2” as having some post secondary education, but not having completed a baccalaureate degree. Those with a baccalaureate or additional educational attainment beyond that are placed into the “level 3” category. 33% of participants are found in “level 1,” 45% in “level 2,” and 22% in “level 3.” The proportions of control and treatment group members and even offset users in each educational attainment category are similar.

The shape of the earnings trends for the control group, treatment group, and the offset users group are very similar across all of the educational attainment categories. Thus, we will limit our direct comparison of trends across the control, treatment, and offset users groups to the largest of the three attainment categories, “level 2.” These

trends can be observed in chart 10. The basic trend will be familiar. There is little difference between control and treatment. The offset users show strong upward movement in their quarterly mean earnings. Nonetheless, something different is going on. For once, the pace of the earnings increase appears to be a bit faster after the enrollment quarter than before it. This suggests the possibility that differences in education level may have an effect on the ability to exploit the offset to achieve further economic gains.

**Chart 10: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q3 for the Control and Treatment Groups and Known Offset Users, by Having Post-Secondary Education without a Baccalaureate Degree in the Enrollment Quarter**



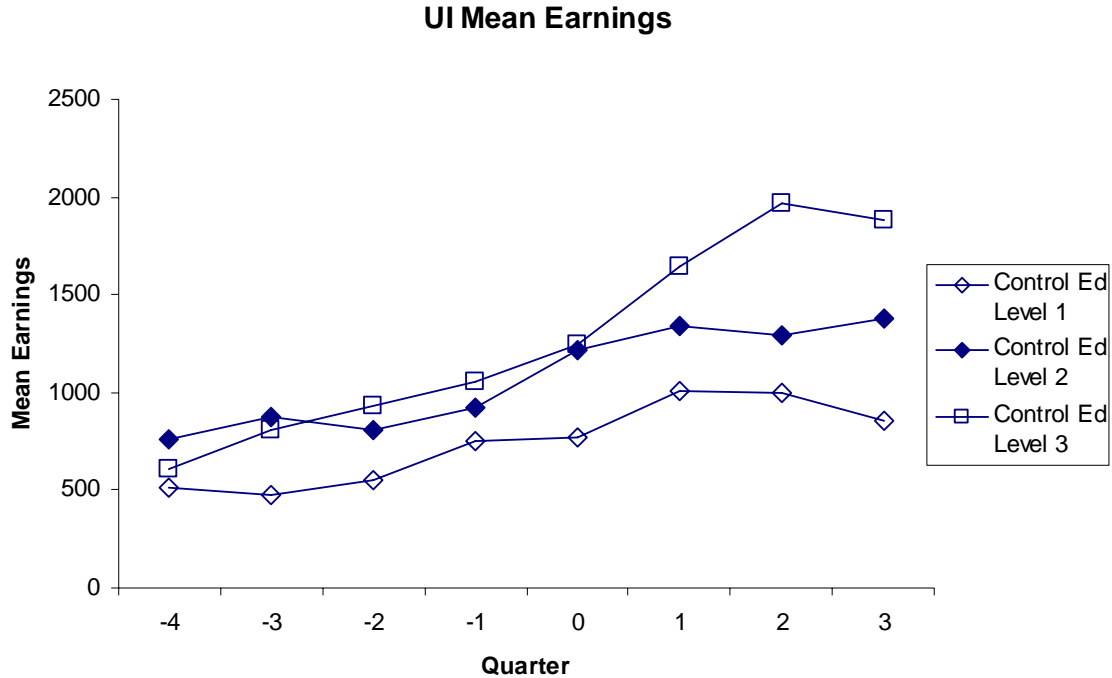
Source: Wisconsin UI Records and SSDI-EP Research Encounter Data  
 Note: C in Level 2 = 94, T in Level 2 = 122, O in Level 2 = 19

As the control group is “uncontaminated” with any offset users, we will start by looking at the relationships between educational attainment and UI earnings within the study groups by looking at the data for this group. Chart 11 exhibits trend lines describing the earnings trends for the three educational attainment subgroups. Because the control group has relatively low earnings across the entire data period, we have changed the scale to make it easier to see differences among the educational attainment subgroups. Table 4 exhibits mean earnings for Q-4, Q0 and Q3 for each subgroup for the comparison group, as well as for the treatment and offset users groups. Table 4 also contains information about the amounts and percentages of change in mean earnings observed between and across these quarters for all nine educational attainment subgroups.

The trends displayed in chart 11 are consistent with the expected relationship between education and earnings. The better educated the subgroup, the better the

outcome by Q3. The overall gain (see table 4) for those in the “level 3” category is \$1273, compared to \$613 for “level 2” and \$341 for “level 1.” Moreover this relationship is present across both the quarters prior to SSDI-EP enrollment and thereafter. It is also important to note that, as mean earnings are sensitive to variations in the employment rate, UI employment trends and even the quarterly values are fairly similar across the educational attainment subgroups within the control group.

**Chart 11: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q3 for the Control Group, by Educational Attainment Level in the Enrollment Quarter**

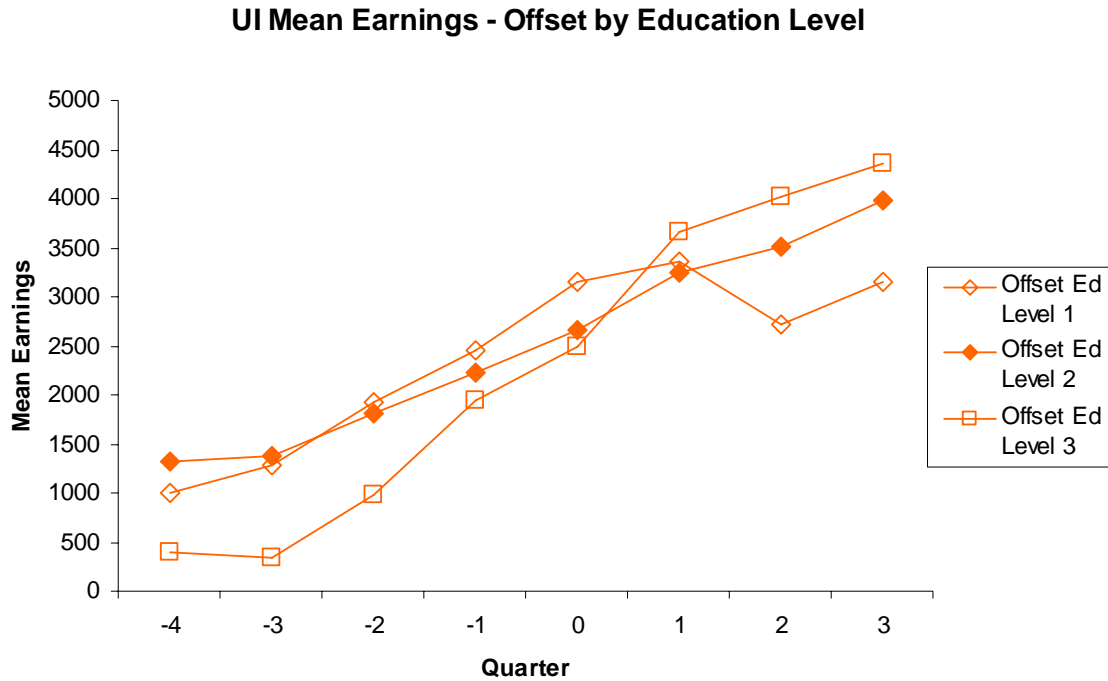


Source: Wisconsin UI Records and SSDI-EP Research Encounter Data  
 Note: C in Level 1 = 74, c in Level 2 = 92, T in Level 3 = 52

Findings for the known offset users are displayed in chart 12 and table 4. Given that the educational attainment subgroups are very small, it is unknowable whether the observed patterns would continue to appear in data representing larger groups of offset users. Still, the findings are quite unusual and may suggest that the impact of the offset provision may increase with educational attainment.

Looking at pre-enrollment trends in median earnings in chart 12, it is apparent that the usual relationship between earnings and educational attainment has been reversed. In most of the quarters through enrollment, those with the least educational attainment (level 1) have the highest mean earnings. In all of these quarters, those with the most educational attainment (level 3) trail behind the other two subgroups. These findings reflect employment levels. For example, during Q-4 the “level 1” subgroup had mean earnings of \$991 per month (see table 4). Their UI employment rate that quarter was 42%. By contrast the “level 3” subgroup had mean earnings of \$405 for Q-4, but this reflected a UI employment rate of only 11%.

**Chart 12: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q3 for Known Offset Users, by Educational Attainment Level in the Enrollment Quarter**



Source: Wisconsin UI Records and SSDI-EP Research Encounter Data  
 Note: O in Level 1 = 12, O in Level 2 = 19, O in Level 3 = 9

By the enrollment quarter those with the lowest level of educational attainment still had higher median earnings than those with the greatest attainment (\$3146 compared to \$2491). Again, this reflected substantial disparity in employment rates: 83% for “level 1” and 55% for “level 3.” However, once employment rates became comparable, median earnings reflected expected returns for human capital development. For Q3, “level 1” offset users posted a 75% employment rate. A 78% rate was reported for the “level 3” subgroup. There is still substantial divergence in mean quarterly earnings, but now the advantage is the direction of those with higher educational attainment. The Q3 mean for the “level 3” offset user’s subgroup increases to \$4366, while the value for the “level 1” subgroup is \$3150, essentially the same as for Q0.

As can be seen in table 4, those with “level 2” attainment also posted gains in mean earnings in the post-enrollment period. Both groups composed of those with at least some post-secondary education increased their mean earnings as much or almost as much in the post-enrollment period as the “level 1” subgroup. It is true that some of this gain reflected continued increases in employment rates, though for the most highly educated group the gain is much more modest than for the pre-enrollment period. Between Q-4 and Q0, the “level 3” subgroup increased its employment rate by 44%, thereafter by another 23%. Thus, while employment rate increases remain a significant driver of earnings increase, it is also clear that a substantial portion of the increased mean earnings for those in the offset user group with the most educational attainment

came from higher earnings for those who worked. At this juncture, we have not assessed the relative effects of changes in wage rates or work effort.

**Table 4: UI Median Earnings in Constant Dollars, Selected Quarters, by Control and Treatment Groups and Offset Users, by Level of Educational Attainment, All Participants with Three Quarters of UI Data after the Enrollment Quarter**

	Q-4	Q0	Q3	Change Q-4 to Q0	Change Q0 to Q3	Change Q-4 to Q3
<b>Control</b>						
Level 1	\$514	\$772	\$855	\$258 (50%)	\$83 (11%)	\$341 (66%)
Level 2	\$763	\$1212	\$1376	\$449 (59%)	\$164 (14%)	\$613 (80%)
Level 3	\$609	\$1241	\$1882	\$632 (104%)	\$641 (105%)	\$1273 (209%)
<b>Treatment</b>						
Level 1	\$771	\$1081	\$1202	\$310 (40%)	\$121 (11%)	\$431 (61%)
Level 2	\$909	\$985	\$1223	\$76 (8%)	\$238 (24%)	\$314 (35%)
Level 3	\$586	\$1127	\$1242	\$541 (92%)	\$115 (10%)	\$656 (112%)
<b>Offset</b>						
Level 1	\$991	\$3146	\$3150	\$2155 (217%)	\$4 (0%)	\$2159 (218%)
Level 2	\$1324	\$2653	\$3982	\$1329 (100%)	\$1329 (50%)	\$2658 (201%)
Level 3	\$405	\$2491	\$4366	\$2086 (515%)	\$1825 (\$75%)	\$3961 (978%)

Source: Wisconsin UI Records and SSDI-EP Research Encounter Data

Note: Level 1 = High School Diploma or less, Level 2 = Some Post-Secondary but no Baccalaureate, 3= Baccalaureate or beyond

#### 6.4 Participant Self-Employment Rates

Information about participants' self-employment is gathered by provider agency staff at enrollment and on a monthly basis thereafter. Though expected monthly earnings for the business are reported on research forms when the self-employment is originally reported, there is no ongoing tracking of earnings. As noted above, UI sourced data does not capture self-employment.

As table 5 documents, self-employment rates for both the treatment and control group are typically below 5%.<sup>13</sup> Though there is some indication of growing difference between the two study groups, the small numbers involved suggest care in identifying any trend. Also, note that the self-employment rates for those in the treatment group who have used the offset are lower and essentially inconsequential.

<sup>13</sup> A participant is classified as "self-employed" in any calendar quarter if that status is indicated on any of the monthly update forms submitted for the calendar quarter. For the enrollment quarter, this also includes the enrollment form.

**Table 5: Participant Self-Employment Rates, Enrollment Quarter through Third Quarter of Participation, for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**

	Q0	Q1	Q2	Q3
Treatment	4.9%	5.3%	5.3%	6.0%
Control	4.1%	4.5%	4.1%	3.6%
Offset	0.0%	0.0%	0.0%	2.5%

Source: SSDI-EP Research Encounter Data

Note: N for Treatment = 265, N for Control = 220, N for Known Offset Users = 40.

Table 6 exhibits data for those participants with at least six quarters of post enrollment data. The patterns observed are similar to those described for the larger group with three quarters of post enrollment data.

**Table 6: Participant Self-Employment Rates, Enrollment Quarter through Third Quarter of Participation, Selected Quarters, for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**

	Q0	Q2	Q4	Q6
Treatment	5.9%	5.9%	6.9%	6.9%
Control	5.5%	4.4%	4.4%	4.4%
Offset	0.0%	0.0%	0.0%	0.0%

Source: SSDI-EP Research Encounter Data

Note: N for Treatment = 101, N for Control = 91, N for Known Offset Users = 17.

## 6.5 Participant Perceptions about Their Pilot Experiences

In this part of Section 6 we present survey data that focuses on participants' experiences in the SSDI-EP. All of these data are taken from the first follow-up survey, administered approximately one year after each participant's enrollment date. These data are based on the 388 surveys returned for those participants who had also completed a baseline survey. Responses are presented as percentages. The actual number of participants providing usable answers varies from item to item; typically about 3% of respondents either did not answer a particular item or gave multiple answers.

Though the SSDI-EP intended treatment and control group members to have similar experiences of the project in many respects, there were always going to be differences based on random assignment. Only those in the treatment group had the ability to use the offset provision, an elongated Extended Period of Eligibility (EPE), certain Continuing Disability Review protections, and additional reporting requirements involving updating earnings estimates and, for those using the offset, reconciling those estimates with actual earnings. To use the offset and to meet related obligations, it would be useful for treatment group members to know they had been assigned to the treatment group. Additionally, a successful informed consent process would mean that those in the control group would also understand that they were not in the treatment group and thus, should they earn above SGA, would not have access to the offset.

The findings presented in Table 7 show that a very small percentage of participants had a clearly mistaken idea about their study group assignment. However 35% of the control group respondents and 40% of treatment group respondents offered that they did not know their assignment one year into their SSDI-EP participation. Though about a

third smaller a portion of offset users reported not knowing their assignment, this seems unaccountably large given the offset had been applied to their SSDI benefit check.<sup>14</sup>

**Table 7: Distributions of Participant Perceptions of Study Group Assignment, by Percentages, from SSDI-EP Year One Follow-Up Survey, for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**

	<b>Responded “Assigned to Treatment”</b>	<b>Responded “Assigned to Control”</b>	<b>Didn’t Know</b>
Control	2.4%	62.7%	34.9%
Treatment	56.5%	3.9%	39.6%
Offset	69.4%	2.8%	27.8%

Source: SSDI-EP Year One Follow-Up Survey

Note: Maximum Number for Treatment = 212, Control = 176, Offset Users = 36.

Table 8 displays responses for a series of survey items aimed at looking at different aspects of participant experience. We are interested in examining differences in response distributions between control and treatment group members. In particular, larger levels of dissatisfaction among those in the control group may ultimately lead to either withdrawal or non-cooperation, which at some threshold compromises the benefits of random assignment. We are also interested in looking for differences between offset users and other treatment group members that may provide suggestions as to whether differences in project experience within the treatment group might explain the large observed differences in employment outcomes.

The first item in Table 8 seeks to capture participant perceptions as to whether the SSDI-EP had been well explained. Both groups tend to agree that the SSDI-EP was well explained, though the proportion reporting they “strongly agree” is noticeably higher for the treatment group (57%) than for the control group (42%). There appears to be no meaningful difference between the distribution for the treatment and offset users groups.

The next two items concern participant perceptions about their needs for benefits counseling or other vocational services to successfully benefit from their SSDI-EP participation. The responses from the control and treatment groups were generally similar, with treatment group members being a little more likely to identify a need for such services. The quite similar response distributions for the benefits counseling item have over 60% of both groups saying that they “agree” or “strongly agree” that they needed benefits counseling to succeed. There was somewhat greater difference between the groups in their perceptions of their need for vocational services. While about 59% of treatment group respondents agreed they needed vocational services, only 48% of control group respondents answered similarly.

Additionally, the distributions for the overall treatment group and the offset users were generally similar; any differences may simply reflect the low number of offset users. Still offset users were far less likely to “strongly agree” that they needed vocational services (19%) than the treatment group (39%). Perhaps this is a reflection of the fact

<sup>14</sup> It is possible that some of these participants completed their follow-up survey before using the offset.

that about three in four offset users had UI reported employment in the calendar quarter they entered the SSDI-EP.

**Table 8: Distributions of Participant Perceptions of Pilot Experiences, by Percentages, from SSDI-EP Year One Follow-Up Survey, for Treatment and Control Groups and Treatment Group Members with at least One Month of Known Offset Usage**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>
<b>Staff explained the Pilot in ways I could understand</b>					
Control	5.8%	8.8%	7.0%	36.8%	41.5%
Treatment	6.3%	5.8%	5.3%	25.2%	57.3%
Offset	8.6%	0.0%	2.9%	28.6%	60.0%
<b>To use the Pilot I needed benefits counseling</b>					
Control	14.1%	9.4%	14.1%	27.1%	35.3%
Treatment	10.6%	9.7%	12.1%	24.6%	43.0%
Offset	11.1%	16.7%	13.9%	19.4%	38.9%
<b>To use the Pilot I needed vocational services</b>					
Control	23.2%	8.3%	20.2%	20.2%	28.0%
Treatment	13.1%	6.3%	21.8%	19.9%	38.8%
Offset	13.9%	2.8%	38.9%	25.0%	19.4%
<b>Central office staff talk to me regularly about my job related activities</b>					
Control	21.8%	15.9%	11.2%	21.2%	30.0%
Treatment	17.9%	13.5%	10.6%	18.4%	39.6%
Offset	13.9%	8.3%	8.3%	16.7%	52.8%

Source: SSDI-EP Year One Follow-Up Survey

Note: Maximum Number for Treatment = 212, Control = 176, Offset Users = 36.

The final item in table 8 provides information about whether participants think that SSDI-EP provider agency staff members regularly contact them. Again, though the distributions are fairly similar, treatment group members are about 10% more likely than

control group members to report that they “agree” or “strongly agree” that there has been regular contact about the pilot. There is a far greater difference between the offset users and the treatment group as a whole. For example, 53% of offset users answered “strongly agree” compared to 40% for the treatment group. This may reflect greater frequency or intensity of contact related to offset reporting and troubleshooting.

Nonetheless, based on participant focus groups, we have found that the issue of contacts between the provider agencies and participants is complex. For example, at some agencies, participants felt comfortable in initiating contact and, in individual cases, preferred that. Focus group participants also identified significant variation across provider agencies as to whether the agencies complied with SSDI-EP policy to initiate contact on at least a monthly basis.

Table 9 provides information about a survey item that only treatment group members were asked: whether the respondent had problems with their SSDI benefit check. Respondents were allowed to identify multiple issues. Thus, table 9 displays the distribution of responses instead of participants.

**Table 9: Perceptions of Problems with SSDI Benefit Checks, by Percentage, from SSDI-EP Year One Follow-Up Survey, for Treatment Group and Treatment Group Members with at least One Month of Known Offset Usage**

	No changes to SSDI check needed	Changes made accurately and/or on time	Changes not made accurately	Changes not made in time manner	Check took longer to restart than expected	Other problems
<b>Treatment</b>	50.5%	26.2%	5.3%	4.9%	3.4%	9.7%
<b>Offset User</b>	25.6%	17.9%	17.9%	23.1%	5.1%	10.3%

Source: SSDI-EP Year One Follow-Up Survey

Note: Percentages reflect distribution of responses

The first two columns represent good outcomes in the sense that they indicate no problems. It is apparent that the proportion of responses indicating a lack of problems is substantially higher (77%) for the treatment group as a whole than for the offset users group (44%). Nonetheless, given reports of problems from both SSDI-EP central and provider agency based staff of the virtually universal problems faced in getting offset users checks adjusted in either an accurate or a timely manner, we were surprised that only 56% of responses represented problems. We also didn’t expect that 26% of the responses from offset users would indicate that there had been no need to adjust their checks, a seemingly counterintuitive result. When offset users reported problems, most involved delays in getting checks or in getting accurate payments. The reported percentages for accuracy issues are over three times that for the treatment group as a whole. The incidence of what were seen as serious delays is nearly five times as high.

## 6.6 Perceptions about Policy Barriers to Employment

The SSDI-EP evaluation utilizes participant surveys at multiple time points: at project entry and at approximately the first and second anniversaries of entry. On all of these surveys, we ask participants a set of items intended to elicit how strongly each

participant believes certain conditions affect their capability to work or to achieve higher earnings. About half of these items focus on beliefs about Social Security disability programs and associated health care programs. Given that the purpose of the benefit offset and of the support services the benefit offset pilots offer is to either remove or substantially reduce the barriers to working or increasing earnings associated with the SSDI program, it is important to learn whether and, if so, in what directions participants' perceptions of the likely impact of such barriers change.

We use the data in tables 10 through 15 in two ways. First, we are interested in how perceptions within each group, control, treatment, and known offset users, changes over time. Among such changes, those for the treatment group and offset users hold the greatest interest, as the offset is intended to ameliorate fears that work will prompt adverse consequences. Nonetheless, change within in the control group is also of interest. In particular, benefits counseling may provide those in the control group information and reassurance that could by itself lead to increased employment outcomes. We are also interested in looking at across group trends. While this includes comparisons between the two study groups, it also includes comparisons between the treatment group and the subset of offset users as to whether actual experience with the offset makes a (hopefully positive) difference.

The data in tables 10-15 are from the 388 participants who completed both the baseline and first annual follow-up survey. This includes 176 from the control group and 212 from the treatment group. The responses for thirty-six participants in the offset users group are also included in the data for the treatment group. The offset users represent about the same proportion (17%) of the total treatment group as those in either length of UI data based analyses. Missing responses are never more than 2% for any of the items presented for either the Control or Treatment group. On the other hand, "not sure" responses are not uncommon, approaching 15% in a few cases.

Responses indicating agreement with the survey items are associated with strong concerns or fears about the incompatibility of working and maintaining attachment to SSDI benefits. Responses indicating disagreement are consistent with lower levels of concern or fear of negative consequences.

Before examining the individual tables, a brief summary of the trends generally exhibited across the six tables may be useful. The overriding trend is stability, with either marginal or insignificant changes observed either within or between groups over the year between the baseline and the follow-up survey.<sup>15</sup> For whatever reasons, attitudes about the dangers that work activity have for maintaining access to public income support or health care benefits seems to be deeply entrenched. The response distributions for most combinations of question and participant group, whether at baseline or after one year, have more than 50% of responses in the "agree" or "strongly agree" categories, indicating substantial concern about the compatibility of work and maintaining access to public benefits.

It is important to remember that SSDI-EP participants as a group are far more likely to participate in the workforce than the general population of those in SSA disability programs. An examination of table one will show that the lowest UI employment rate

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<sup>15</sup> These characterizations are based on examining aggregate responses to the survey items. We have not yet examined the extent and direction of individual level changes in perceptions.

reported for any SSDI-EP study group in any quarter from enrollment forward was 47%. More than half of SSDI-EP participants have had, to some degree, the opportunity to “reality test” the impact of SSDI program features and those of associated federal health care programs on their ability to pursue employment goals.<sup>16</sup>

Within this broad pattern, it appears that control group members, whether despite or because of benefits counseling, tend to become a little more concerned about the tensions between engaging in work activity and continuing to receive SSDI or maintain access to those benefits. The offset users tend to become a little less concerned and/or less likely to answer “not sure” to an item, though as always the reader is cautioned that these findings rest on a small number of cases. On the surface, the treatment group shows the most stability in their perceptions, though this stability is only modestly greater than for either the control group or offset users. Additionally, this stability is likely to be an artifact of the inclusion of the responses for the offset users in the treatment group. It is quite likely that treatment group members who haven’t utilized the offset more closely resemble control group members.

Table 10 presents responses about the implications of work for keeping cash benefits. In point of fact, SSDI program rules allow beneficiaries to work and maintain full benefits as long as their earnings remain below SGA. The offset is aimed at ameliorating the 100% loss of cash benefits that occur once earnings reach the SGA level after the TWP has been expended. Assuming treatment group members understood the purpose of the offset (and believed that SSA could dependably implement the offset), it is reasonable to expect reduction in their concerns. In the case of the offset users, assuming accurate and timely application of the offset to their SSDI payment, they should have been able to perceive that they were no longer subject to the “cash cliff.” Of course, other than the offset users, less than 20% of participants have earned the quarterly equivalent of SGA during any calendar quarter of their SSDI-EP participation (table 3).

The data in table 10 suggests minor reductions in the concerns of both the treatment group and offset users. In the case of the treatment group there is a 7% decline in the “strongly agree” category with a lesser increase in the proportion that disagree with the item. While there is a similar reduction in “strongly agree” responses for the offset users, the responses in the “agree” category actually increase a bit more. The largest change is in the nearly 6% reduction in those who respond “not sure.”

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<sup>16</sup> What these provisions were depended, of course, on assignment to either the control or treatment group. For those in the control group the “reality testing” was in the context of current law and SSDI program rules, though with the benefit of better access to putatively useful services. The treatment group’s “reality testing” was done in the context of the Offset Pilots’ modifications to existing SSDI program rules.

**Table 10: Responses to Survey Item: in Percentages, Baseline and First Annual Follow-Up Surveys, “Working for pay will affect my ability to keep my Social Security cash benefits.”**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Sure
T <sub>0</sub>	7.7%	5.8%	14.9%	17.3%	42.8%	11.5%
C <sub>0</sub>	4.5%	4.5%	13.1%	17.0%	56.3%	4.5%
O <sub>0</sub>	11.1%	5.5%	8.3%	13.8%	52.8%	8.3%

T <sub>1</sub>	7.1%	11.0%	15.8%	17.7%	35.9%	12.4%
C <sub>1</sub>	7.5%	4.0%	11.0%	11.0%	58.4%	8.1%
O <sub>1</sub>	11.1%	5.5%	13.8%	22.2%	44.4%	2.8%

Source: SSDI-EP Participant Surveys

The intent of the item reported in table 11 is similar to that in table 10. The main difference is the item's emphasis on the scale of potential income loss from work. Again, this concern should only apply to earnings above SGA. One would anticipate high levels of concern among control group members as they received no protection from the 100% marginal tax rate applied to the SSDI check when earnings are at or above SGA. At baseline, control group members have essentially the same proportion of “strongly agree” (39%) responses as the treatment group. This increases over the first year of participation to 56%.

The treatment group exhibits stability on this item. However, those who have actually used the offset show movement in two dimensions. The proportion of these participants who answered either “disagree” or strongly disagrees” increases 14% to 28%. The percentage of “not sure” answers decreases from 8% to 0%. Though this, in terms of the treatment theory, is a desirable result, it still must be remembered that over half of the responses at both time points indicated concern that it would be difficult to earn enough to make up for lost benefits.

**Table 11: Responses to Survey Item: in Percentages, Baseline and First Annual Follow-Up Surveys, “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
T <sub>0</sub>	9.1%	8.2%	14.9%	17.9%	38.5%	11.5%
C <sub>0</sub>	9.1%	10.8%	15.9%	16.5%	38.6%	9.1%
O <sub>0</sub>	8.3%	5.6%	13.9%	19.4%	44.4%	8.3%

T <sub>1</sub>	9.1%	11.0%	14.4%	14.8%	41.6%	9.1%
C <sub>1</sub>	10.3%	2.9%	8.6%	14.9%	56.3%	6.9%
O <sub>1</sub>	5.6%	22.2%	16.7%	19.4%	36.1%	0.0%

Source: SSDI-EP Participant Surveys

The preceding two tables report participant perceptions about the relationship between working for pay and keeping SSDI cash benefits or compensating for reductions in SSDI benefits. The next three tables display information about participant perceptions concerning whether working for pay threatens continued eligibility for SSDI.

Table 12 shows that all three groups express significant levels of concern that employment threatens their eligibility. To the extent there is any discernable pattern, there was a little increase in concern in the control group and a bit of reduction in concern among the treatment group. The distribution for the offset users group is puzzling. Unlike the treatment group as a whole, they appear to become a bit more concerned that working for pay will negatively affect their SSDI eligibility. The proportion of answers in the “agree” and “strongly agree” increases 4% with no change in the proportion of “not sure” responses. Though this shift may be a result of chance given the small number of offset users, it is also true that these participants represent empirical proof that working for pay, even above SGA, does not necessarily lead to loss of eligibility.

**Table 12: Responses to Survey Item: in Percentages, Baseline and First Annual Follow-Up Surveys, “I worry that I may lose eligibility for my Social Security benefits if I work for pay.”**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Sure
T <sub>0</sub>	10.1%	7.2%	13.9%	15.4%	46.2%	7.2%
C <sub>0</sub>	7.4%	9.7%	13.6%	18.8%	48.3%	2.3%
O <sub>0</sub>	16.7%	8.3%	8.3%	16.7%	47.2%	2.8%
T <sub>1</sub>	12.0%	11.1%	14.4%	18.8%	38.9%	4.8%
C <sub>1</sub>	13.2%	4.0%	9.8%	12.1%	56.3%	4.6%
O <sub>1</sub>	13.9%	8.3%	8.3%	25.0%	41.7%	2.8%

Source: SSDI-EP Participant Surveys

Those assigned to the treatment group receive protections from work induced continuing eligibility reviews. Thus, we expected that concerns that working for pay will trigger an eligibility review would be much reduced among the treatment group a year into their participation. This expectation would apply even more strongly to those who used the offset; that is, offset users would have direct evidence that work, even at SGA, would not induce eligibility reviews. As the data in table 13 shows, this expectation was wrong. Not only are the response distributions strongly tilted toward answers indicating concern during both time periods, the level of concern actually increases. In particular, the proportion of offset users who “strongly disagree” that work would trigger a review declined from 17% at baseline to 6% at their first anniversary. Finally, control group members also became a bit more convinced that work would trigger an eligibility review after a year’s participation in the SSDI-EP

**Table 13: Responses to Survey Item: in Percentages, Baseline and First Annual Follow-Up Surveys, “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
T <sub>0</sub>	14.4%	10.6%	20.2%	13.0%	35.1%	6.7%
C <sub>0</sub>	12.0%	9.7%	15.4%	20.6%	37.1%	5.1%
O <sub>0</sub>	16.7%	8.3%	25.0%	13.9%	33.3%	2.8%
T <sub>1</sub>	13.9%	12.5%	11.1%	17.8%	37.0%	7.7%
C <sub>1</sub>	11.5%	4.0%	12.6%	15.5%	48.3%	8.0%
O <sub>1</sub>	5.6%	19.4%	22.2%	16.7%	33.3%	2.8%

Source: SSDI-EP Participant Surveys

Table 14 reports information about how participants view the relationship between work and the ability to qualify again for SSDI benefits if they need them in the future. Unfortunately, in retrospect we see that the context for this question is not entirely clear. Does it apply to a return to cash benefit status during the Extended Period of Eligibility or to a return to SSDI eligibility after cessation? Nonetheless, despite this ambiguity, the item speaks to perceptions about how difficult it is to return to some previous status if a prolonged return to work effort is not successful.

The results displayed in table 14 suggest that the high level of participant concern displayed by the control and treatment groups at SSDI-EP entry are not in the least assuaged by a year of participation in the pilot. By contrast, the data for the offset users suggest some reduction in concern. First the “not sure” responses decline by more than half. At the same time there is a substantial increase (from 3% to 11%) in the proportion who “strongly disagree” with the proposition that work will pay will make re-qualification difficult. Nonetheless, this change must be understood in the context of 53% of offset users still answering that they “agree” or “strongly agree” that work negatively affects their ability to reestablish some aspect of attachment to the SSDI program.

**Table 14: Responses to Survey Item: in Percentages, Baseline and First Annual Follow-Up Surveys, “If I work for pay, it will be difficult to requalify for Social Security disability benefits in the future.”**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Sure
T <sub>0</sub>	8.7%	13.0%	15.9%	15.5%	32.9%	14.0%
C <sub>0</sub>	11.9%	13.6%	10.8%	13.1%	38.1%	12.5%
O <sub>0</sub>	2.8%	13.9%	19.4%	22.2%	27.8%	13.9%
T <sub>1</sub>	13.0%	12.6%	13.5%	14.0%	35.7%	11.1%
C <sub>1</sub>	9.7%	10.3%	9.1%	12.6%	44.8%	13.2%
O <sub>1</sub>	11.1%	8.3%	22.2%	16.7%	36.1%	5.5%

Source: SSDI-EP Participant Surveys

Note: 388 survey pairs. 212 from T (36 from Offset Users); 176 from C

The data exhibited in table 15 provides information about participant’s level of concern about maintaining eligibility to health care programs where that eligibility is based on SSDI participation or meeting the Social Security disability standard.<sup>17</sup>

Once again, the basic story remains the high level of concern across all of the groups that work threatens benefits. A year of SSDI-EP participation does nothing to lessen this concern among either the control or treatment groups. If anything, the concern is slightly exacerbated. By contrast, there is some evidence of reduced concern among offset users. For example, the proportion of “strongly agree” responses for the offset users group declines 11%. Nonetheless, it would be a mistake to overstate this trend. Half of this group still respond that they “agree” or “strongly” agree that they worry that work might negatively impact their access to Medicare or Medicaid.

**Table 15: Responses to Survey Item: in Percentages, Baseline and First Annual Follow-Up Surveys, “I worry I will not be eligible for Medicare or Medicaid if I’m working.”**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Sure
T <sub>0</sub>	13.9%	6.7%	10.6%	18.3%	44.7%	5.8%
C <sub>0</sub>	8.0%	11.4%	11.4%	13.1%	49.1%	6.9%
O <sub>0</sub>	13.9%	11.1%	16.7%	16.7%	38.9%	2.8%
T <sub>1</sub>	14.8%	9.6%	13.4%	14.8%	44.1%	3.3%
C <sub>1</sub>	11.5%	8.6%	9.2%	10.9%	54.0%	5.7%
O <sub>1</sub>	16.7%	11.1%	19.4%	22.2%	27.8%	2.8%

Source: SSDI-EP Participant Surveys

Finally, we want to reiterate the point that perceptions of how well SSA is able to apply its procedures, whether current program rules or offset modifications are likely to influence participants’ answers to the survey questions for which we presented results in tables 10-15. We did not think to ask this type of question on our surveys. However, the data we presented in table 9 indicate a high frequency of problems in implementing SSA policies. The reported problem rate for the offset users group was 56%, for the treatment group as a whole 23%. Discussions with operational staff suggest, at least for the offset users, is substantially underestimated. Additionally, both participant focus groups and discussions with staff provide anecdotal data of problems affecting control group members. Given how dependent beneficiaries can be on the income support (and access to health care) SSDI provides, these problems, even if infrequent, can have very serious impacts on the affected beneficiaries. It is easy to imagine how problems with SSDI check amounts, eligibility reviews, etc. could powerfully affect the perceptions of affected individuals and those of other beneficiaries who hear about those experiences.

### 6.7 Participant Self-Efficacy and Perceptions of Employment Opportunities

Subjective self-efficacy, in the broadest sense, refers to an individual’s beliefs in that individual’s abilities to act in ways that increase the probability of reaching chosen goals. Majorities of surveyed participants, including treatment group members and known offset

<sup>17</sup> In the case of a Medicaid Buy-in, meeting this standard does not require having earnings less than SGA.

users, indicate continuing concern about whether Social Security program rules (including those associated with the offset) allow them to work or increase earnings without reducing their economic welfare or making it difficult to maintain or regain access to SSDI. An individual's level of self-efficacy may predict who will try something new despite barriers and concerns. Within both the baseline survey and the year one follow-up survey, participants agreed or disagreed to statements about themselves that provided information about their level of self-efficacy. We looked at individual responses to four self-efficacy items we thought most directly related to work effort. Our goal was to determine if responses to these items were related to changes in earnings, including earnings sufficient to result in offset use. These four items were:

- 1) If something looks too complicated I will not even bother to try it.
- 2) I avoid trying to learn new things when they look too difficult.
- 3) When unexpected problems occur, I don't handle them very well.
- 4) I do not seem capable of dealing with most problems that come up in my life.

Participants responded to each item on a five point Likert-type scale ranging from strongly disagree (1) to strongly agree (5). Respondents also had the option of marking "not sure." Disagreement with any item was indicative of high self-efficacy, whereas agreement 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.

We hypothesized that those who tended to agree with these four items (low self-efficacy) would be less likely to have high earnings and thus, when available, to utilize the offset. We also hypothesized that individuals who changed their responses from baseline to year one from disagreement to agreement (decrease in self-efficacy) would also be less likely to have high earnings and, if in the treatment group, to utilize the offset. Finally, we also wanted to examine the possibility that improving one's employment outcomes may increase one's self-efficacy. We were especially interested in comparing the offset users to the rest of the participants, whether from the control or the treatment group, because of the offset users much higher earnings average earnings.

To examine these hypotheses, the answers to these four items were summed, resulting in one baseline and one year one score that ranged from four to twenty.<sup>18</sup> Lower scores were associated with higher self-efficacy, whereas higher scores were associated with lower self-efficacy. In addition, a change score was calculated by subtracting the year one score by the baseline score. Therefore, a negative change score indicated increased self-efficacy and a positive change score indicated decreased self-efficacy. A zero indicated no change in self-efficacy.

The number of individuals who responded to all four baseline items was 440, with 203 control participants and 237 treatment participants (including thirty-four known offset users). The number of individuals who responded to all four follow-up survey items was 374, with 169 control participants and 205 treatment participants (with thirty-two offset users). The number of individuals who responded to both all four items for both surveys,

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<sup>18</sup> If a respondent marked "not sure" for an item, it was coded as a neutral response and given a value of "3." This was done to facilitate calculation of a consistent overall index score.

thus making a change score possible, was 366, with 168 control participants and 198 treatment participants (including thirty offset users).

Overall, participant responses indicated high levels of subjective self-efficacy with scores averaging about nine on both the baseline and follow-up surveys. Table 16 provides the mean self-efficacy baseline, year one follow-up, and change scores both across all participants (total) and within experimental group, control, treatment, and offset. There is very little difference in the self-efficacy scores of control and treatment group members. Both responded with a mean summary score of nine to the four self-efficacy items during baseline, and both increased this disagreement (increased self-efficacy) by about two tenths of a point on the year one survey. Treatment members who participated in the offset responded with some differences. They averaged slightly more agreement (slightly lower self-efficacy) to these items during baseline (although this mean responding was still well within the high self-efficacy range) and with slightly higher self-efficacy during the year one survey. Thus, their agreement to the four items decreased (meaning increased self-efficacy) by a larger amount, over one and a half points, from baseline to year one.

**Table 16: Self-Efficacy Scores, Baseline Survey, Year One Follow-Up Survey, and Change Scores, By Treatment, Control and Offset Users Groups**

	Self Efficacy Baseline		Self Efficacy Year 1		Self Efficacy Change Score	
	Mean	StDev	Mean	StDev	Mean	StDev
Control	9.03	4.10	8.82	3.76	-0.20	4.03
Treatment	9.03	3.89	8.94	7.77	-0.23	3.80
Offset	9.26	3.59	8.34	2.84	-1.57	4.25
<b>Total</b>	<b>9.05</b>	<b>3.95</b>	<b>8.85</b>	<b>3.69</b>	<b>-0.32</b>	<b>3.94</b>

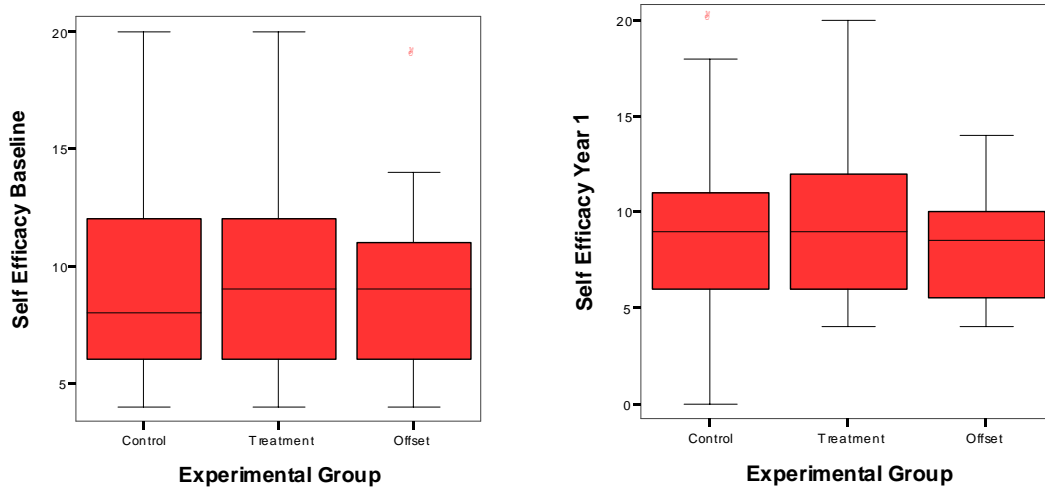
Source: SSDI-EP Participant Surveys

Note: Baseline: 440 responses. 237 from T (34 from Offset Users); 203 from C  
 Follow-up: 374 responses: 205 from T (32 from Offset Users); 169 from C  
 Change: 366 survey pairs. 198 from T (30 from Offset Users); 168 from C

Table 16 also includes standard deviations. The standard deviations averaged just below four points, much larger than any differences observed in the above paragraph. Therefore, the distributions were compared visually via box plots and an ANOVA was conducted to determine whether there are any significant differences between the offset group and the rest of the participants. We still examine the control and treatment groups separately, but in the ANOVA the treatment group now excludes known offset users.

When comparing the offset users group to the rest of SSDI-EP participants, there is very little visual difference between the offset group and the control and treatment groups (see chart 13). The medians fall at about the same point for all three groups, although both the control group and treatment group covered a larger range of responses than did the offset group. When looking at the change score box plots (see chart 14), the median of the change score for the offset group is slightly below the median for the control and treatment groups. Again the variability is less for the offset group. In addition, no outliers fall within the upper range (increased agreement with the four items/decreased self-efficacy) for the offset group, whereas participants in both the control and treatment groups responded within this upper range. Similar to the previously reported numbers, the visual display of responses in these box plots shows some differences when comparing the offset group to the treatment and control groups, but it is still unclear if this is a significant difference.

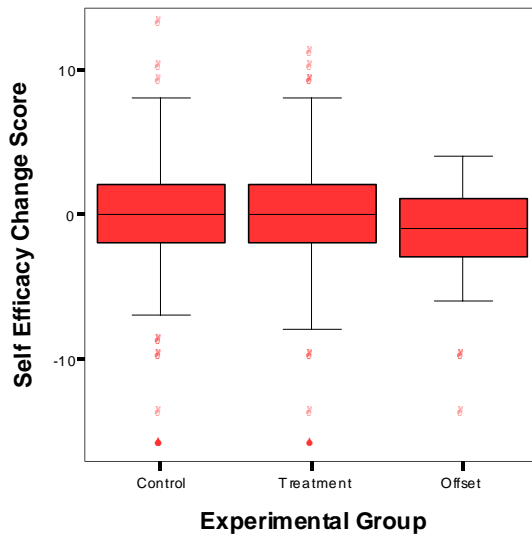
**Chart 13: Baseline and Year 1 Self-Efficacy Scores for Treatment, Control Offset Users, Groups**



Source: SSDI-EP Participant Surveys

Note: Baseline 440 responses: 237 from T (34 from Offset Users); 203 from C  
 Follow-up: 374 responses. 205 from T (32 from Offset Users); 169 from C

**Chart 14: Self-Efficacy Change Scores for Treatment, Control Offset Users, Groups**



Source: SSDI-EP Participant Surveys

Note: 366 survey pairs. 198 from T (30 from Offset Users); 168 from C

An ANOVA was conducted to determine if the offset group's responses to these four self-efficacy items was statistically different than the responses by control and treatment group members (see table 17). The offset user's responses were no different than the responses by control and treatment group members on the baseline survey and year one follow-up survey with p values equal to .72 and .39 respectively. There is, however, a statistically significant difference between offset user's change score and the change score of control and treatment participants with a p-value equal to .0478, which just

meets the .05 p-value that typically denotes statistical significance in most social or behavioral studies.

**Table 17: ANOVA Results of the Difference between Offset Users and Non-Users on Baseline, Year 1 and Change Self-Efficacy Scores**

ANOVA		Sum of Squares	df	Mean Square	F	Sig.
<b>Self Efficacy Baseline</b> <b>* Offset Use</b>	Between Groups	2.04	1	2.04	0.1281	0.7205
	Within Groups	6964.58	438	15.90		
	Total	6966.62	439			
<b>Self Efficacy Year 1</b> <b>* Offset Use</b>	Between Groups	10.36	1	10.36	0.7331	0.3924
	Within Groups	5272.93	373	14.14		
	Total	5283.30	374			
<b>Self Efficacy Change Score</b> <b>* Offset Use</b>	Between Groups	59.63	1	59.63	3.9447	0.0478
	Within Groups	5502.32	364	15.12		
	Total	5561.95	365			

Source: SSDI-EP Participant Surveys

Note: Baseline 440 responses: 34 from Offset Users; 406 from Non-Offset Users

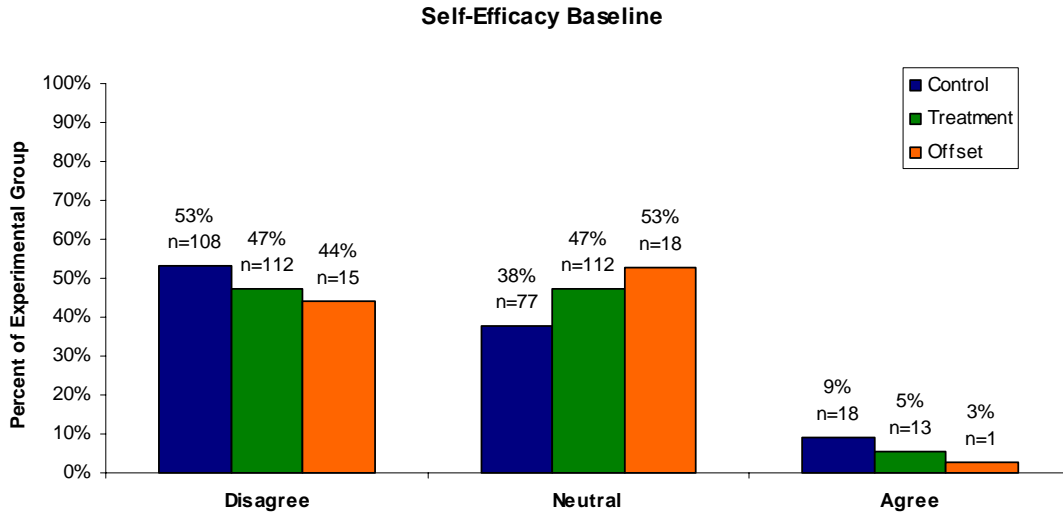
Year One 374 responses: 32 from Offset Users; 342 from Non-Offset Users

Change 366 survey pairs: 30 from Offset Users; 336 from Non-Offset Users

Because no differences were found between the baseline scores of treatment, control, and offset users, responses to these four self-efficacy items do not appear to predict offset use. However, differences were found between the change score of offset users and the change scores of treatment and control members. This result can be interpreted in two different ways. One possibility is that successful use of the offset may have increased offset users self-efficacy, as indicated by a decrease their agreement with the four items. Alternatively, following the completion of the baseline survey, offset users may have increased their self-efficacy, decreasing their agreement to the four above items, (possibly via benefits counseling or some other mechanism related to the SSDI-EP), and this increase in self-efficacy increased earnings to a degree and for a duration that resulted in offset use.

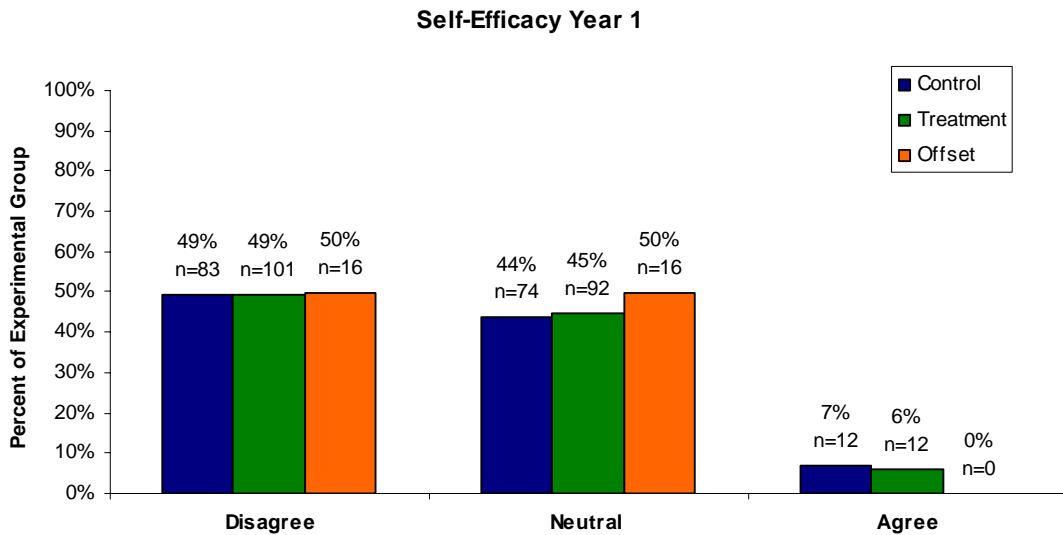
As stated above, self-efficacy may potentially influence an individual's earnings. To determine whether responses to the four above self-efficacy items were related to earnings, baseline, follow-up, and change scores were converted into three separate categories. Baseline and year one scores were grouped into a high self-efficacy category (values ranging from four to eight), a neutral category (values ranging from nine to fifteen), and a low self-efficacy category (values ranging from sixteen to twenty). Change scores were grouped into an increase in self-efficacy category (values ranging from negative sixteen to negative six), a no change category (values ranging from negative five to five), and a decrease in self-efficacy category (values ranging from six to sixteen). Both chart 15 and chart 16 demonstrate the majority of individuals in any of the three groups exhibited either high or middling self-efficacy scores. However, there were a small proportion of individuals within the control, treatment, and offset users groups who agreed had low self-efficacy scores.

**Chart 15: Baseline Self-Efficacy Responses to the Four above Items for Treatment, Control Offset Users, Groups** Source: SSDI-EP Participant Surveys



Source: SSDI-EP Participant Surveys

**Chart 16: Year 1 Self-Efficacy Responses to the Four above Items for Treatment, Control Offset Users, Groups**



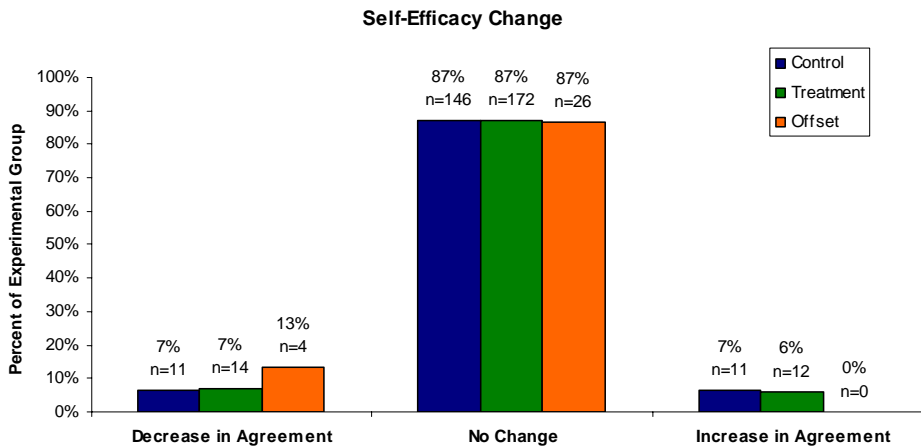
Source: SSDI-EP Participant Surveys

When looking at changes from baseline to year one (see chart 17), the vast majority of participants exhibit change scores indicating no important change in their self-efficacy scores. Indeed, the proportions in the “no-change” category is the same (87%) across the three groups. Nonetheless, some individuals from the control, treatment, and offset groups have change scores that indicated increased self-efficacy. Consistent with the above findings, the offset group had the largest percentage (13%) of individuals who exhibited changes consistent with increased self-efficacy. By contrast only 7% of those

in either the control or treatment groups exhibited change scores indicative of greater self-efficacy

Moreover, there were also some individuals in the control and treatment groups who exhibited decreased self-efficacy, but no individuals in the offset group who did. Indeed, not one individual in the offset group provided a response on any of the four items on the follow-up survey that indicated low self-efficacy (i.e., an “agree” or “strongly agree” response).

**Chart 17: Changes in Self-Efficacy Responses, from Baseline to Year 1 Follow-up, for Treatment, Control, and Offset Users Groups**

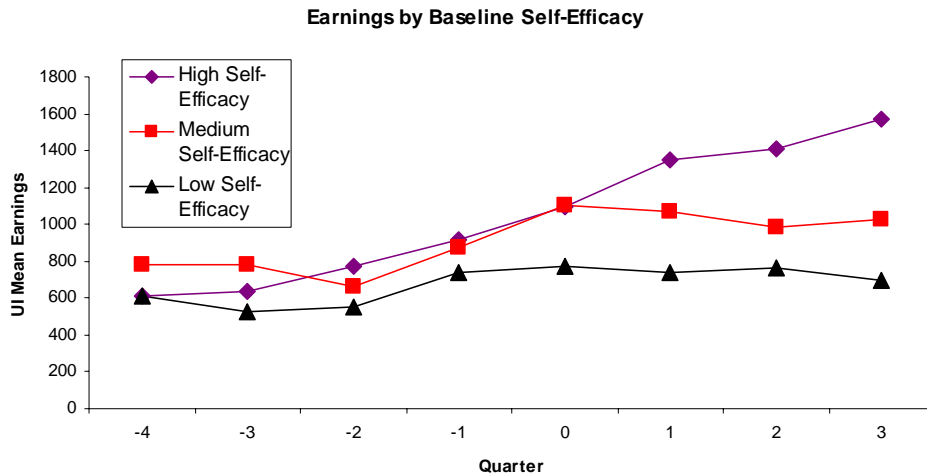


Source: SSDI-EP Participant Surveys

Descriptive results suggest that self-efficacy is related to and likely predictive of earnings during SSDI-EP participation (see chart 18). In these results we concentrate on all participants as the subgroups associated with the control, treatment, and especially the offset user, groups would be quite small.

Those participants displaying lower levels of self-efficacy consistently earned less, with little evidence of growth over time (starting at \$612 in Q-4 and ending at \$693 in Q3). Before the beginning of the SSDI-EP until the start of the pilot (from Q-4 to Q0) no differences were observed in the earnings between those with a medium level of self-efficacy and those reporting a high level of self-efficacy. Once the pilot began, those who had medium self-efficacy decreased their mean earnings slightly from \$1104 in Q0 to \$1030 in Q3. In marked contrast, those with high levels of self-efficacy increased their earnings from \$1092 in Q0 to \$1570 in Q3. Thus, having a high level of self-efficacy at the start of the pilot, predicted an increase in earnings during the pilot.

**Chart 18: UI Mean Earnings, Q-4 through Q3, by Self-Efficacy Category on the Baseline Survey**



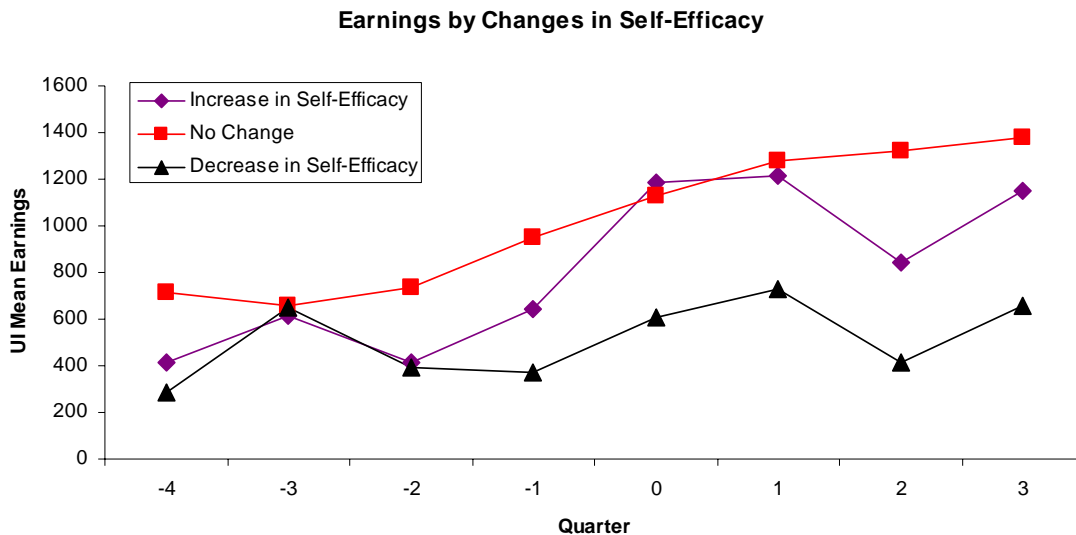
Source: Wisconsin Unemployment Insurance Records and SSDI-EP Participant Surveys  
 Note: Total N=440, High=220, Medium=189, Low=31

Chart 19 displays information comparing changes in mean earnings for participants based on the level of changes in self-efficacy between the baseline and follow-up surveys. Those individuals who did not change their self-efficacy scores (i.e. had change scores within five points of a zero value) are used as our reference point. The UI earnings for those in the “no change” group these individuals averaged \$715 during Q-4. These increased over the next seven quarters ending at an average of \$1379 during Q3. In comparison, those who had change scores indicating decreased self-efficacy demonstrated much lower earnings compared to the reference group. While average earnings slowly grew from \$286 in Q-4 to \$660 in Q3, the deficiency in quarterly earnings relative to the reference group increased from \$429 to \$719.

Individuals who increased their self-efficacy during their first year of SSDI-EP participation, though having mean earnings well below those of the reference group at SSDI-EP entry, experienced increases in earnings that brought them almost to the mean earning level of those individuals whose self-efficacy remained unchanged. Those in the increased self-efficacy group had earnings of \$414 at Q-4. These increased to \$1147 by Q3.

Please note that the baseline survey was completed during Q0 and the first follow-up survey during Q4, yet this increase in earnings for the high change group began during Q-1. Likewise, the earnings of the group whose self-efficacy decreased remained low and unchanged throughout the course of all eight quarters. It is unknown whether the self-efficacy levels of these two groups began changing at an earlier point, whether an increase in earnings caused an increase in self-efficacy, or, conversely, whether continued low earnings caused a decrease in self-efficacy. It is also possible that some third variable might explain this relationship. Finally, it is important to remember that the absolute numbers of those with either sizable increases or decreases in self-efficacy are small. This is especially important in understanding the implications of change for the offset users, who constitute a disproportionate proportion of those with increased self-efficacy and none of those with decreased self-efficacy.

**Chart 19: UI Mean Earnings, Q-4 through Q3, by Self-Efficacy Score Change Category (from Baseline Survey to the Year 1 Follow-up Survey)**



Source: Wisconsin Unemployment Insurance Records and SSDI-EP Participant Surveys  
 Note: Total N=366, Increase=25, No Change=318, Decrease=23

### 6.8 Participant Attachment to the Pilot

The concept of participant attachment to a project or research study is subject to variable interpretation depending on the amount of activity or cooperation required of participants. Nonetheless, the obvious place to begin an analysis of attachment, particularly for a multi-year effort like the SSDI-EP, is whether participants have remained enrolled in the pilot. Of the 499 participants who validly enrolled in the SSDI-EP in 2005 and 2006, 473 remained as participants by late February 2008. Of these twenty-six withdrew, though five of these dying after enrollment. Consequently, the voluntary withdrawal rate to date has been 4%. All but one of those who withdrew voluntarily had been members of the control group. This represents a voluntary withdrawal rate of nearly 9% for the control group. Though only a few of those who withdrew have returned attrition surveys, these former participants indicated that their main reason for withdrawing was that they saw no benefit from being in the control group.<sup>19</sup>

Survey completion rates provide an indicator of the level of a more active form of participant attachment: compliance with research requirements. The baseline survey was completed as part of the enrollment process conducted by provider agency staff. Thus, the 94% completion rate is of no surprise. By contrast, the annual follow-up surveys are mailed out to participants at the approximate anniversary of their enrollment dates. Participants must take the initiative to return the surveys.

Though the return rates for the first follow-up survey (82%) and the second follow-up survey (79%) are lower than for the baseline, the response rates are more than large

<sup>19</sup> Most of these individuals left the SSDI-EP in the months immediately following enrollment. However, there has been an increase in the rate of voluntary withdrawals since the end of November 2007, with five in the last three months.

enough to support analysis. More remarkably, given expectations that those assigned to the control group have fewer reasons to remain involved with the Pilot, the return rates for those in the control group are actually marginally higher than for the treatment group (see Table 18).

**Table 18: Participant Survey Response Rates**

	Treatment Group	Control Group	All
Baseline Survey	94.4%	93.9%	94.2%
Year One Follow-Up	81.6%	83.3%	82.3%
Year Two Follow-Up	79.3%	84.8%	79.3%

Source: SSDI-EP Survey Data

Note: The Baseline and Year One Follow-up response rates are final. The response rates for the Year Two Follow-Up are based on surveys mailed by the end of November 2007. This includes surveys mailed to approximately 21% of participants.

Nonetheless, as the data in Table 19 shows, the return rates from successive mailings has tended to decline, though to date not precipitously so. Although this is perhaps not an unexpected trend in a multi-year project, we will continue to monitor this trend in the response rates for the series of year two follow-up survey mailings.

**Table 19: Participant Survey Response Rates for Year One Follow-Up Survey by Enrollment Date**

Mailing Groups	Response Rates
Group 1 (8/1/05 through 9/31/05)	85.4%
Group 2 (10/1/05 through 11/31/05)	89.2%
Group 3 (12/1/05 through 1/31/06)	79.4%
Group 4 (2/1/06 through 3/31/06)	85.2%
Group 5 (4/1/06 through 5/31/06)	78.3%
Group 6 (6/1/06 through 7/31/06)	81.8%
Group 7 (8/1/06 through 9/30/06)	81.7%
Group 8 (10/1/06 through 10/31/06)	77.2%

Source: SSDI-EP Survey Data

Note: Surveys for enrollment dates in parentheses are mailed at the same time, approximately one year after enrollment.

## 6.9 Service Provision to Participants<sup>20</sup>

The material in this section looks at the provision of services to participants. In particular, it addresses issue of consistency in the amounts of pilot related services, particularly benefits counseling, that participants assigned to different study groups received. The SSDI-EP was designed to provide all participants, irrespective of study assignment, with equal access to services. Beyond any ethical dimension to this commitment, it was aimed at insuring that the evaluation could get a reasonably clean measure of the benefit offset's impact on outcomes. While no participant, aside from access to necessary benefits counseling, was guaranteed a specific package or amount

<sup>20</sup> Material in this sub-section was extracted from Delin, Barry S., Reither, Anne. E. and Sell, Christopher W. "Challenges to Conducting Randomized Field Trials: The Experience of the Wisconsin SSDI Employment Pilot," American Evaluation Association Annual Meeting. November 2007. It has not been updated for this report.

of services, those assigned to the treatment group were not to receive additional services by virtue of their study group assignment.<sup>21</sup>

Assessing this issue presents several challenges, not all of them resolved. The most important of these is how to determine when differences in the patterns of service provision between treatment and control group members are the result of differential behavior stemming from the availability, whether immediate or in the future, of the offset and its associated Continuing Disability Review protections. If the benefit offset is an effective work incentive, it is reasonable to expect those in the treatment group to seek out or exploit opportunities for working more, having higher hourly pay rates, and/or pursuing career development. Consequently, treatment group members, on average, might be expected to seek out and then receive more benefits counseling or other employment related services even when provider agencies adhere to the requirement that all participants have equal access to services. Unlike, “discrimination” based upon service provider or funding source knowledge of participants’ study group assignments, these differences in service provision would be “legitimate” within the structure of the experiment.

While we don’t have a method to clearly distinguish between these sources of differences in service provision, we contend that there should be less difference in the patterns of service provision near the time of enrollment than later on. Our claim stems from the reality that it generally takes time to plan how one is going to take advantage of the opportunities that the offset presents. We think two additional factors add purchase to our argument. It appears only a small proportion of new enrollees completed or had come close to completing their TWP. Second, SSDI beneficiaries are known to be a highly risk adverse population.

Provider agencies report hours of service provision for every participant on a monthly basis for nine categories of services. To look at differences close to the enrollment date, we chose a period including the calendar month of enrollment and the first three calendar months following enrollment.

Table 20 contains data comparing service provision for the two study groups over participants’ initial period in the SSDI-EP. The typical participant received about the same amount of benefits counseling irrespective of their assignment to treatment or control. Standard deviations are quite similar, suggesting (but not confirming) similar patterns of within group variation. These data strongly support a conclusion that the SSDI-EP had met its commitment to provide equal access to benefits counseling services.

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<sup>21</sup> Our ability to examine this question is largely limited to services from the provider agencies.

**Table 20: Hours of Service Provision, By Treatment and Control Groups, Enrollment Month through the Third Month Following Enrollment**

	<b>Benefits Counseling</b>	<b>Any Vocationally Related Services</b>	<b>Any Services</b>
<b>TREATMENT</b>			
Mean Hrs.	3.6	5.0	8.6
Median Hrs.	1.5	0.0	4.0
Standard Deviation Hrs.	4.9	11.8	13.1
<b>CONTROL</b>			
Mean Hrs.	3.8	6.3	10.1
Median Hrs.	1.5	0.0	3.0
Standard Deviation Hrs.	5.3	25.0	25.3

Source: SSDI-EP Research Encounter Data

The data for hours of vocational service provision, as well as the total of all service hours that the provider agencies delivered are still generally consistent with a conclusion that provider agencies complied with the equal access policy. One important finding is the far greater variability in vocational (and as a result, overall) service provision for control group members.<sup>22</sup> The data in table 21 provides further insight into this result, though it does not explain it.

**Table 21: Percentage of Participants Receiving SSDI-EP Related Services from their Provider Agency, Treatment and Control Groups, Enrollment Month through the Third Month Following Enrollment**

	<b>Benefits Counseling</b>	<b>Any Vocationally Related Services</b>	<b>Any Services</b>
<b>TREATMENT</b>	60.4%	39.9%	74.3%
<b>CONTROL</b>	60.2%	33.5%	69.7%

Source: SSDI-EP Research Encounter Data

Essentially the same proportion (60%) of participants in both the treatment and control groups received benefits counseling services. By contrast, about 6% more participants in the treatment group received some form of vocationally related services from their provider agency than control group members. Though one could hypothesize that this might be a result of almost immediate gains in treatment group employment rates and earnings compared to the control group, no such trend can be seen in the UI employment and earnings data presented earlier in this section of the report.

While we cannot say for certain whether some portion of the observed differences in service provision were the result of “undeserved” preference for the treatment group, given the relatively small divergence in the proportions getting vocational services and the presence of other explanatory factors, we believe that provider agencies were complying with the “equal access” well enough to not raise serious concerns that any differences between the treatment and control groups will be chiefly due to differential

<sup>22</sup> Across the period of the enrollment through third post-enrollment month, the standard deviation for vocational services was 25.0 hours for the control group, compared to 11.8 hours for the treatment group.

access to services because of study assignment alone. Still, it will be important to see if the early pattern of substantially equal access continues over participants' full tenure in the pilot.

The annual follow-up surveys include items to elicit participant perceptions about their need for services and whether the services received through the SSDI-EP met those needs. The results described in tables 22 and 23 are from the first 312 surveys (165 from treatment, 147 from control) received from participants who completed the first annual follow-up. These respondents enrolled in the SSDI-EP before August 2006 and represent over 60% of pilot participants.

Most of these participants, irrespective of study group assignment, tend to agree that they need benefits counseling and vocational services and do so at almost the same magnitudes. However, the data in table 22 also shows that the percentages of those who "strongly agree" that they need such services is substantially higher for respondents from the treatment group. Given that the surveys were completed roughly a year after entering the SSDI-EP, these findings are consistent with the expectation that treatment group members would be in a better position to exploit available opportunities (or seek new ones) to improve their employment outcomes because of access to the benefit offset. In turn, this suggests having greater need for benefits counseling and other services.

**Table 22: Participant Responses to Service Need Items, One Year after Enrollment, by Valid Percentage<sup>23</sup>**

	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Neither Agree or Disagree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
<b>TREATMENT</b>					
Needed Benefits Counseling	46.0%	22.4%	11.8%	8.7%	11.2%
Needed Job-related Services	40.9%	18.2%	22.0%	5.0%	13.8%
<b>CONTROL</b>					
Needed Benefits Counseling	33.3%	30.5%	12.8%	9.9%	12.8%
Needed Job-related Services	25.2%	22.3%	21.6%	8.6%	21.6%

Source: SSDI-EP Research First Annual Follow-up Survey

Note: Rows may not add to 100% because of "could not code" cases

The data in table 23 speaks more directly to participant opinions about the value of the services they received (or perhaps more precisely, thought they had received) through the SSDI-EP. Respondents from the treatment group were far more likely to report that they "strongly agreed" that the benefits counseling services they received met

<sup>23</sup> The number of non-responses on the items described in tables 3 and 4 is never greater than 2. Similar non-responses numbers also apply to other survey results presented in this section.

their needs than did control group respondents (41% versus 18%). This finding suggests an important question: is the control group's lesser satisfaction with the benefits counseling services received mainly an assessment of the value of those services or is it related to their dissatisfaction with being assigned to the control group and/or the reduced opportunities that may have resulted from assignment to the control group?

The data reported in table 23 for job-related services exhibit a somewhat different pattern. The distribution of treatment and control group responses are quite similar, albeit the distribution is slightly tilted toward the "negative" in the case of the control group. Nonetheless, both groups were more likely to report neutral or negative assessments of how well vocational services met their needs than positive ones.

**Table 23: Participant Responses to Service Quality Items, One Year after Enrollment, by Valid Percentage**

	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Neither Agree or Disagree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>	<b>Did Not Receive Service</b>
<b>TREATMENT</b>						
Received Benefits Counseling that Fit Needs	40.6%	22.5%	13.1%	5.0%	8.8%	10.0%
Received Job-related Services that Fit Needs	17.4%	20.5%	19.9%	9.3%	12.4%	19.3%
<b>CONTROL</b>						
Received Benefits Counseling that Fit Needs	18.4%	29.1%	20.6%	12.1%	7.1%	11.6%
Received Job-related Services that Fit Needs	14.2%	17.0%	20.6%	8.5%	14.2%	25.5%

Source: SSDI-EP Research First Annual Follow-up Survey

Note: Rows may not add to 100% because of "could not code" cases

The results in table 23 can be further explicated by what participants told us during the spring 2007 focus groups. Participants at all the focus groups, save one, clearly identified benefits counseling services as the main service provided to them by their provider agency. By contrast, when asked to discuss what employment services and supports their agencies had provided, focus group participants usually spoke about services arranged through the Division of Vocational Rehabilitation and other sources. Though sometimes participants would mention that the provider agency had an

important role in helping them connect to a service provider or a funding source, just as often participants would talk about their own efforts or those of some third party.<sup>24</sup>

Table 23 also contains information about the percentages of participants who report not getting services. On one dimension the reported findings reinforce the patterns exhibited in the encounter data reported earlier in this section. Again, roughly the same proportion of treatment and control group members received benefits counseling, while the disparities in the proportions getting vocationally related services are of similar magnitude and low enough to be consistent with the SSDI-EP policy of equal access. Nonetheless, there are huge discrepancies between the two data sources in the percentages of participants receiving services. The encounter data suggests about 60% of participants received benefits counseling, the survey data suggests 90%. At first glance, the differences in the time periods contained in the assessment (3-4 months versus a year) would seem to be a likely explanation.

The problem with this explanation is that encounter data from the provider agencies show that few participants receive many hours of additional services from their agencies after the first months in the pilot.<sup>25</sup> Moreover, the newly reported hours, especially for benefits counseling, are more likely to be for additional than de novo services. It is more likely that participants did not distinguish between services that they received from the agency because of SSDI-EP participation and those they may have received from the agency for some other reason. Our experiences observing SPI and other projects suggest that many consumers do not make that kind of distinction. Moreover, the SSDI-EP did not require a provider agency to perform a full benefits analysis for an enrollee if one had been performed within the previous year and there had been no important changes in the enrollee's circumstances. Thus, some of the 30% difference in the two indicators of whom did not receive benefits counseling services may be due to some participants not making distinctions between services received before and after their entry into the pilot.

## **SECTION 7: IMPLICATIONS FOR BOND**

As SSA and Abt design and prepare to implement the Benefit Offset National Demonstration (BOND), there are several critical components that need to be considered.

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<sup>24</sup> It is important to note that by chance none of the 2007 focus groups were held at the agencies that, based on monthly encounter data, report comparatively high average hours of employment related services.

<sup>25</sup> This fact raises an important implementation issue. Did participants, even in the treatment group, have good access to benefits counseling services throughout the pilot? Our initial look at the data raises concerns as to whether there has been adequate access, as average monthly hours of service provision, including benefits counseling, have been quite low across the project and most providers. We think the phenomenon deserves further investigation because of the possibility that inadequate amounts of support services would seem to have the potential to affect participant outcomes. It would be unfortunate if a "no difference" result was motivated by the absence of benefits counseling and other services that the SSDI-EP's designers argued were critical for effective use of a benefit offset.

### **7.1 Partnership with State and Local Entities**

Involving the local SSA Area Work Incentive Coordinators (AWICs) will be an important item to consider in implementing BOND. Many of the participant issues occurring in the pilot needn't be addressed by Baltimore staff, but rather, they could be resolved quickly and efficiently by trained SSA staff at the local offices. Additionally, it will be important to educate the entities providing benefits counseling services via the Work Incentive Planning and Assistance (WIPA) grants, the local Medicaid agency, the local Vocational Rehabilitation administration, and others about the national demonstration in the areas where it will be taking place.

### **7.2 Provision of Benefits Counseling**

It is recommended that SSA and Abt conduct a thorough environmental scan of the BOND areas to ascertain the availability of benefits counseling services and supports for participants. Regardless of whether individual participants choose to utilize this service, it is important to have it available locally. Again, providing information and training to these individuals as well as to local SSA staff will be important.

### **7.3 Operational Issues Involved in Implementing Offset Payments**

Offset payments for participants in the Treatment group have been consistently late and/or incorrect. SSA is aware of this and understands that many of the problematic issues are connected back to the data/information flow and timing issues between individual participants and Baltimore pilot staff, as well as internal complexities at SSA. In order to accurately and efficiently implement offset payments, SSA will need to dedicate staff exclusively to work on the pilot, have a clear method for identifying both pilot and BOND participants in the SSA system, eliminate the annual estimate system currently in place for pilot participants, and involve local SSA staff in the planning and implementation phases. The SSA E-Work system could be utilized to gather employment and earnings information more accurately without the existing time delays as well incorporate a benefit offset calculator and tracking features.

### **7.4 Availability of Employment Services and Supports**

The state/federal Vocational Rehabilitation program is available in most areas of the country. There is variability between states in how the program is administered as well as the funding available to assist participants. Other employment supports may be obtained through Medicaid-waiver funded programs, Workforce Investment Act (WIA) programs and Employment Networks through the Ticket to Work program. The key is to ensure that participants are aware of these options and to link the employment services and benefits counseling supports rather than offer them as stand-alone services.

## **SECTION 8: PLANNING FOR PILOT PHASE-OUT**

Wisconsin central office staff will develop a comprehensive phase-out plan and submit it to Mark Green, SSA Project Officer, for approval. The plan will encompass elements including information gathering from key stakeholders, a timeline, and possible areas of overlap with the Benefit Offset National Demonstration (BOND). Participant data will be collected for events through December 31, 2008. Thus, provider agencies will be contacting participants for evaluation purposes through January 2009 and, in some cases where data is incomplete, for some period thereafter. Every effort will be made to ensure that the phase-out plan and activities are clear, promote transparency across service delivery systems, delineate areas of concern regarding current and future

Treatment participant issues, provide suggested solutions for the concerns presented, and prepare a smooth transition for pilot participants in both the Treatment and Control groups.