Medi-Cal Policy Institute

The California Working Disabled Program:

Lessons Learned, Looking Ahead

Prepared by The Lewin Group

April 2003

Report

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Acknowledgments

The authors thank Advisory Group members for their guidance in framing this study. Group members include Sharon Bishop, Senate Republican Fiscal Office; Maura Donovan, Department of Health Services (DHS); Richard Figueroa, Office of Governor Gray Davis; Allen Jensen, George Washington University Center for Health Services and Research and Policy; Bryon MacDonald, World Institute on Disability; Sherry Novick, California Children and Families Association (and of former Assemblymember Dion Aroner's staff); Vicki Partington, DHS; Marlene Ratner, DHS; Stan Rosenstein, DHS; Seren Taylor, Assembly Republican Fiscal Committee; and Doreen Wong, DHS.

The authors are especially grateful to Allen Jensen, Jim Klein, Bryon MacDonald, Sherry Novick, Vicki Partington, and Marlene Ratner for lending their expertise to the development and conduct of this study and for providing valuable feedback on drafts. The authors also thank the county eligibility workers for their candor and insight; and CWD enrollees who responded to this study's survey, especially those who shared their personal experiences with the CWD Program.

 ISBN 1-932064-33-8

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Executive Summary

The California Working Disabled Medi-Cal Buy-In Program (CWD) was implemented in April 2000 to enable disabled individuals to participate in the workforce without the threat of losing their Medi-Cal coverage. Although a relatively new program, policymakers and advocates have already begun considering programmatic and policy changes that would build on the existing program, expand eligibility, and broaden access to certain services. This study was initiated to better understand the factors affecting enrollment in CWD and to estimate the enrollment and cost impacts of select programmatic changes.

The California Working Disabled program currently covers individuals with net countable family incomes up to 250 percent of the federal poverty level (FPL) and assets up to $2,000 for an individual ($3,000 for a couple). Net countable income is derived by exempting all disability-related income and disregarding the first $65 of earned income, impairment-related work expenses, and approximately half of the disabled person's earned income. Thus, some working disabled people can have overall income well above 500 percent of FPL and still be eligible for the program. Relative to income eligibility requirements for other Medi-Cal aid categories, the income threshold for CWD is quite high; the CWD assets threshold is the same as that used in many other aid categories.

Enrollment in CWD totaled 652 as of June 2002, far below original enrollment estimates and the number of individuals estimated to be eligible. Prior to implementation, the California Department of Health Services (DHS) estimated that 7,000 to 14,000 individuals would enroll by the end of the second year of the program. Thus, enrollment in the CWD Program has reached only about ten percent of its estimated level. The modest enrollment experience to date made it important to assess the program in order to identify whether program design changes are needed to allow larger numbers of disabled individuals in California to work while maintaining health care coverage through Medi-Cal.

The goal of this study was to gain a better understanding of the factors affecting enrollment in CWD and to estimate the enrollment and cost impacts of select programmatic changes. To further study these issues, two sets of analyses were conducted. The first was a qualitative review of stakeholders' experience with the program. The experiences of CWD enrollees, those eligible

but not enrolled, and county eligibility workers were gathered to lend insight into the factors contributing to the program's current enrollment trend as well as to solicit suggestions for program improvement. This qualitative research included an enrollee survey, and in some cases follow-up interviews; a teleconference with a group eligible but not enrolled (nonenrollees); and telephone interviews with county eligibility workers. The second was a set of quantitative analyses of Census Bureau and DHS data to model program eligibility alternatives that might allow more disabled workers in California to access Medi-Cal coverage. The enrollment and cost implications of these alternatives were also explored.

CWD Enrollee, Nonenrollee, and Eligibility Worker Feedback

Several themes emerged from the qualitative research components that suggest ways of boosting enrollment in or improving the attractiveness of the current CWD Program. These themes include:

- increasing program outreach to potential enrollees;
- improving eligibility worker knowledge of the program;
- improving program attractiveness; and
- addressing barriers to employment for disabled people.

Program Outreach

Enrollees, nonenrollees, and eligibility workers agreed that there is a lack of public awareness about the program. Little program outreach has been conducted by state or county agencies or by other community-based organizations, resulting in a significant lack of awareness and understanding of the program. The outreach that has occurred has had a minimal effect.[1] There has been little public or private coordination to make program information available at agencies providing services to the CWD Program's target population or to increase the awareness of employees at those agencies. The enrollment trends experienced by the CWD Program—specifically, monthly growth of less than one percent and creating little "new" enrollment (63 percent of enrollees were already in some other Medi-Cal aid category)—demonstrates the effects of lack of outreach and awareness. Many enrollees responding to this study's survey indicated that they did not hear of the program until an eligibility worker advised them of it when they were already applying for or were having their eligibility redetermined for Medi-Cal.

Study participants agreed that an increased outreach effort would broaden program awareness among potentially eligible Californians. Suggestions for outreach activities included launching an effort similar to the BabyCal outreach campaign, using radio and television public service announcements, placing advertisements in highly visible locations, and coordinating with community-based organizations providing services to similar populations.

Eligibility Workers' Knowledge

Enrollees, nonenrollees, and eligibility workers alike raised the lack of eligibility worker awareness as a barrier to program enrollment. Eligibility workers often did not know that the program existed and in some cases advised potential applicants that there was no such program.

In other cases, individuals were enrolled in the program only after speaking with several different eligibility workers before finding one who was aware of the program. Other eligibility workers were sometimes misinformed about the income or asset eligibility requirements.

Eligibility workers' lack of knowledge about CWD may be explained by the minimal training they receive[2] and the relative infrequency of CWD cases. To determine eligibility, eligibility workers must complete appropriate CWD forms and calculate budgets manually, based on the program's eligibility rules regarding work and income. These rules are different from rules for other Medi-Cal programs. For the most part, eligibility worker training for CWD consisted of receiving revised program manuals with accompanying memoranda explaining the new program.

The question regarding usefulness of increased training opportunities for eligibility workers received mixed responses. Enrollees, who rely heavily on eligibility workers for program information, as well as some workers, thought increased training for eligibility workers would improve their knowledge of the program and its requirements. On the other hand, some eligibility workers thought training would be minimally effective because CWD cases arise infrequently, making it unlikely they would have the opportunity to exercise the newly gained information. Respondents also cited limited eligibility worker time and limited administrative resources as barriers to the effectiveness of eligibility worker training. Eligibility workers face large and growing caseloads, and may find it difficult to understand the nuances of the dozens of Medi-Cal aid categories. In this rather hectic environment, county eligibility workers may have little enthusiasm for CWD training sessions.

Program Attractiveness

Asset Limits

Many study participants thought that the asset limit was too low. Several participants commented that they purposely limited certain assets once enrolled because Medi-Cal "doesn't let them have anything." Still unknown is the degree to which otherwise eligible individuals choose not to enroll in the program because they want to retain their assets—in particular, those who have never been enrolled in Medi-Cal and who receive Social Security Disability Income (SSDI), a program for which there is no asset limit and whose beneficiaries largely comprise the target population for CWD. However, many participants did not have to dispose of assets to qualify for CWD, which can be explained in part by their enrollment in other Medi-Cal aid programs prior to enrolling in CWD.

Increasing the asset limit would result in making more individuals eligible for the CWD Program, but it would not guarantee their enrollment. Eligible individuals who have thus far opted not to enroll because of the asset limit will have to assess whether any changes in the asset level are sufficient to influence their enrollment decision. Understanding the factors related to asset limits that discourage eligible individuals from enrolling will facilitate policymakers' decision making with respect to whether and what type of asset limit changes are warranted, and will effectively yield increased program enrollment.

Employment Uncertainty

Finding and maintaining employment can be difficult for individuals with disabilities. Finding employment suited to or flexible enough to accommodate the health or personal care needs of

individuals with disabilities is challenging. Some employers might be wary of hiring disabled workers due to concerns about company liability as well as worker productivity and dependability. Once individuals with disabilities have secured employment, they then face the challenge of maintaining their jobs. Without employment, eligibility for CWD is also lost.[3] Individuals who lose eligibility for CWD can retain their Medi-Cal coverage but are reassigned to the Aged, Blind, and Disabled–Medically Needy (Medically Needy) aid category, which provides full Medi-Cal coverage but requires enrollees to pay a share of their medical costs (i.e., share-of-cost) if their net countable income exceeds the limit for eligibility. Several survey respondents noted the irony in charging a working individual with disabilities a monthly premium that is often lower than the monthly share of cost charged to disabled individuals who are not working.

Several enrollees identified assistance finding employment as a needed program improvement. While employment assistance fits within the state's goals of creating work incentives and improving workplace participation of Californians with disabilities, specific employment assistance activities would most likely be beyond the purview of the Department of Health Services. A coordinated effort between DHS and agencies whose functions are more directly related to employment, could improve the effectiveness of state activities to create work incentives and provide employment assistance.

Affordability

Enrollees stated that the premium requirement for CWD was more affordable than the share of cost they would otherwise pay for Medically Needy Medi-Cal or their premium payments for private coverage. Most enrollees pay the minimum $20 premium. However, CWD premiums can be as high as $250 per month for individuals with relatively high net countable incomes. For those individuals who are required to pay considerably higher premiums, and for individuals with infrequent health care needs, paying the monthly premium may be burdensome or seem unreasonable if they are not receiving health services in the month. They may instead choose to enroll in the Medically Needy Medi-Cal program, where they are only responsible for their share of cost in months when they have received a service.

CWD premiums are already based on a sliding income scale, but at higher incomes, they are far more than the average premium other workers across the country pay for coverage through their employer. In 2001, the average employee contribution toward health coverage was $38 per month for single coverage.[4] Adjusting premiums at higher income levels may ease the burden of some eligible individuals who are not enrolled because they are unable to afford the relatively high monthly premium.

Enrollment and Cost Impacts of Potential CWD Program Changes

In the modeling component of this study, three alternatives to expanding eligibility based on the changes proposed in AB 925, as introduced, were explored to determine whether increasing income and asset level standards for CWD would result in increased enrollment. The three options explored were:

1. raising the income limit to 450 percent of FPL;

2. eliminating asset level restrictions; and

3. raising the income limit to 450 percent of FPL and eliminating restrictions on assets (combination of the first two options).

All three alternatives were initially considered ways to increase the pool of CWD eligibles and therefore ways to increase enrollment in CWD. However, expanding income and asset eligibility under the CWD Program, while resulting in a significant increase in the number of *potentially eligible* individuals, is not projected to significantly boost enrollment. It is estimated that without other program changes, only 189 additional enrollees would enter the program. This figure applies the current enrollment rate[5] (0.17 percent) to the estimated 141,000 uninsured working disabled who would become eligible under the most generous alternatives explored. The estimated net annual program cost of these expansions is approximately $893,400.

Conclusion

This modeling, along with the qualitative data of this study, suggests that a significant increase in enrollment is unlikely if eligibility expansions are implemented without other programmatic changes such as expanding program outreach and improving community and eligibility worker awareness of the CWD Program. The expansions modeled for this study are collectively projected to yield only 189 new enrollees. The qualitative data suggest that program enrollment would increase with expanded outreach and improved eligibility worker and public awareness, even without other program expansions. For those who weigh the pros and cons of enrolling and choose not to enroll in CWD, increased outreach or eligibility worker training may not be enough to influence their decision to enroll. For individuals who face issues like the "SSDI cash cliff" (in which they risk losing eligibility of SSDI benefits as a result of increased earnings) or who are infrequent users of health care services, other program changes might be necessary to influence their enrollment decisions.

I. Introduction

Policy Context

National Policy

Across the country, there is a movement to enable individuals with disabilities to fully participate in their communities, including participating in the workforce. In February 2001, the President announced the New Freedom Initiative, a federal-government-wide commitment to improve federal programs serving individuals with disabilities.[6] This initiative includes an ongoing commitment to reduce a barrier to employment faced by individuals with disabilities—the threat of losing their health care coverage—by encouraging states to implement Medicaid Buy-In programs for disabled workers.

Even before the New Freedom Initiative, states have had the authority to provide Medicaid coverage to working individuals with disabilities who would otherwise be ineligible due to their incomes or resource levels. The Balanced Budget Act of 1997 (BBA) established the Medicaid Buy-In Program in which individuals who met the Social Security definition of disability,[7] and whose income was less than 250 percent of the federal poverty level (FPL) using Supplemental Security Income (SSI) standards, and who met the SSI resource standards[8] could buy into Medicaid by paying a monthly premium. Premiums can be based on income, and Medicaid Buy-In programs must offer the same comprehensive coverage as other categorical Medicaid coverage groups.

In 2000, the Ticket to Work and Work Incentives Improvement Act (TWWIIA) expanded states' authority to provide Medicaid to workers with disabilities between the ages of 16 and 64 who would be eligible for SSI if not for their incomes or resources. This eligibility group is called the Basic Coverage Group. TWWIIA also established a new coverage group, the Medical Improvement Group, which covers working individuals with a disability who no longer meet the SSI definition of disability. States can establish Medicaid income and resource eligibility standards using the authority in 1902(r)(2) of the Social Security Act, which permits states to use more liberal income and resource rules than are used in SSI, and establish their own cost-sharing standards. Ensuring access to health care coverage for workers with disabilities was just one

component of the broader TWWIIA legislation, which also included provisions to expand access to worker training and job placement assistance programs and benefits planning.

One goal of Medicaid Buy-In programs is to create incentives for individuals with disabilities to participate in the workforce. They can now work and earn income without losing their Medicaid coverage. Access to health care coverage is a critical component of enabling workforce participation; however, the decision to work is influenced by several factors apart from health care coverage.

A threshold issue is whether individuals with disabilities can find employment, which TWWIIA addresses through provisions relating to work supports. Another consideration is the kind of health-related supports needed once in the workplace. Some individuals with disabilities need assistance with activities of daily living such as toileting, taking medications, transferring in and out of wheelchairs, etc. Some individuals require the use of personal assistant services in the workplace, but paying for these services can be onerous. Some state Medicaid programs cover personal assistant services but are often only covered in the home or are subject to other restrictions. Individuals who wish to work and need workplace personal care but cannot afford the out-of-pocket costs if the services are not covered by their health plan, may be forced to either limit or forgo workforce participation altogether.

Other work disincentives also exist. Many individuals with disabilities who work face the "Social Security Disability Income (SSDI) cash cliff." Individuals receiving SSDI can already work, but must limit earnings to the federal substantial gainful activity (SGA) level of $780 per month (in 2002), or risk forfeiting their SSDI payment. While eligibility rules for Medicaid Buy-In programs allow individuals to earn above this amount, individuals might limit how much they work or earn to stay within SSDI limits and ensure their continued access to SSDI.

California's Policy Context

The state of California implemented the California Working Disabled (CWD) Program under BBA authority in April 2000. Working individuals with disabilities and with net countable family incomes below 250 percent of FPL and assets less than $2,000 for an individual ($3,000 for a couple) can enroll in CWD. The CWD Program uses the SSI rules for income, including earned income disregards,[9] and spousal deeming rules apply.[10] Enrollees are required to pay premiums ranging from $20 to $250 for individuals or from $30 to $375 for couples, based on their income. All of the applicant's disability-related income is exempt, and impairment-related work expenses, and some earned income, are deducted from income calculations. To determine whether an individual's assets fall within CWD limits, employer or individual retirement accounts and certain property are exempt.

CWD enrollees are required to provide proof of employment, such as pay stubs, but "work" is otherwise undefined. Individuals are required to report changes in their employment or other eligibility status. Individuals who lose their employment due to "good cause" can retain their CWD coverage for two months. Good cause includes hospitalization, inability to work as a result of the individual's disability, or other reasons beyond the control of the enrollee.

Enrollees in need of personal assistant services can obtain those services, if they qualify, through the In-Home Supportive Services Program (IHSS) administered by the Department of Social

Services. Individuals receiving IHSS are automatically eligible for Medi-Cal. The In-Home Supportive Services Programs has two component programs. The Personal Care Services Program (PCSP), through which most personal assistant services are provided, is paid for by Medi-Cal. The Residual In-Home Services Program covers those who are not eligible for PCSP, including those who receive advance pay,[11] those whose provider is a spouse or parent, or those in protective supervision. Both IHSS programs provide a maximum of 283 hours of personal attendant services each month, based on a needs assessment. Personal attendant services (PAS) through IHSS were restricted to the home and were not provided in the workplace. In December 2002, DHS submitted a state plan amendment requesting federal approval to cover PCSP in the workplace effective January 1, 2003. Under the new option, Medi-Cal would pay for workplace PAS, but the total number of authorized PAS hours would not change. This will ensure that the program does not incur PAS expenditures beyond what was already budgeted.

A 1999 fiscal analysis of CWD conducted by DHS estimated that between 6,835 and 13,811 individuals would be enrolled for CWD by the end of the second year.[12] This estimate was based on enrollment of eligible individuals who might already be enrolled in other Medi-Cal programs serving disabled individuals and from the experiences of other states that were working to boost enrollment in Medicaid work incentive programs. The fiscal analysis also assumed that, at least in the first year of implementation, that only current Medi-Cal enrollees with a share of cost would enroll in CWD. CWD enrollment thus far has fallen far short of original DHS estimates. As of June 2002, only 652 were enrolled in the program. More than half of enrollees (63 percent) were previously enrolled in other Medi-Cal categories, consistent with DHS's original assumptions.

On February 23, 2001, California Assemblymember Dion Aroner introduced AB 925, The Workforce Inclusion Act, which would have implemented and broadened employment supports for workers with disabilities and would have amended the CWD Program. As introduced, The Workforce Inclusion Act would have made the following changes to CWD:

- raised the earned income eligibility limit to 450 percent of FPL;
- authorized up to 18 months of coverage for enrollees who lose employment due to circumstances beyond their control;
- authorized the provision of personal assistant services in places of employment, education, and vocational training services;
- authorized individuals receiving advance pay to purchase personal assistant services to enroll in the Personal Care Services Program;
- established "designated independence accounts" for paying for employment- related products and services;
- raised the resource and income eligibility standards to the limits for a spouse in the community when the other spouse is in a nursing facility; and
- transferred the authority for CWD from the BBA to TWWIIA.

Only after significantly amending AB 925 in response to the state's deep budget deficit did the state legislature pass the legislation. The remaining provision most directly affecting CWD was the authorization of state-funded personal assistant services allowable in the work place. Other employment support activities were retained; however, other provisions related to changes in CWD eligibility standards were struck. Governor Gray Davis signed AB 925 into law on September 29, 2002.

On January 10, 2003, Governor Davis released his proposed state budget for 2003–2004. To address California's $35 billion deficit, the proposed budget includes cuts across programs, including Medicaid. The governor's budget proposes to cut eligibility for the Medi-Cal Aged and Disabled (A&D) Program from 133 percent of FPL to 100 percent of FPL.[13] The 26,000 individuals who would lose eligibility for the A&D Program could enroll in either the Medically Needy Program or CWD (if they meet CWD work and premium requirements). The governor's proposal also included a new job training, placement, and recruitment initiative that would help 5,000 disabled individuals find employment and would increase awareness of available programs.[14]

Disabilities in California

Social Security Programs

Two major programs administered by the Social Security Administration provide cash benefits to eligible individuals with disabilities. The Social Security Disability Income (SSDI) program makes benefit payments to individuals with disabilities, and certain family members, who have worked a sufficient number of years and paid social security taxes. If the individual is still working, he or she may not perform substantial gainful activity or earn more than $780 per month (in 2002). SSDI is not means-tested. Individuals receiving SSDI for 24 months are also eligible for Medicare. The Social Security Administration reported that in December 2000, just over 437,000 disabled California workers received SSDI payments.[15] The average SSDI benefit paid in California in December 2000 was $799.[16]

The Supplemental Security Income (SSI) program is means-tested and makes payments to aged, blind, and disabled individuals with low or no income. California supplements SSI payments with state supplemental payments (SSP) and provides automatic Medi-Cal coverage to all SSI/SSP recipients without requiring them to complete a separate application. The California Department of Social Services reports that in November 2002, 1.1 million people received SSI/SSP payments; 742,939 of these people were disabled.[17] The average monthly SSI/SSP payment for disabled recipients in September 2002 was $576.[18]

Medi-Cal Coverage of Individuals with Disabilities

Medi-Cal automatically covers SSI/SSP recipients and those receiving IHSS, as well as individuals with disabilities, through several other aid categories. As stated earlier, the Medi-Cal Aged and Disabled Program covers people with countable monthly income less than 133 percent of FPL and with resources valued at less than $2,000 for individuals. This includes individuals 65 years or older, individuals with disabilities who would qualify for SSI but for their income, and people who receive SSDI or other Social Security disability benefits.

Others may be covered under the Aged, Blind, and Disabled Medically Needy (Medically Needy) program. The Medically Needy Program covers individuals ages 65 or older or individuals determined to be disabled under federal rules. Depending on the individual's income, he or she may be required to pay a monthly share of cost to keep this coverage. Individuals who have a share of cost are required to pay medical expenses until their income is reduced to the family maintenance need level, after which Medi-Cal provides full coverage. The family maintenance need level is an amount set by the state that represents the minimum amount a medically needy individual requires to meet his or her basic needs for food, clothing, and shelter. Family maintenance need levels range from $600 per month for an individual to $1,100 per month for a family of four. Share of cost amounts vary and can be as high as or higher than several hundred dollars because there is no upper income eligibility limit for the Medically Needy Program. The Pickle Program also covers individuals with disabilities. The Pickle Program covers individuals who would continue to be eligible for SSI/SSP benefits if the cost-of-living adjustments made to their SSDI benefit were not counted as income.

Some disabled individuals working at SGA (i.e., those earning $780 per month) can retain their Medi-Cal coverage through section 1619(a) and 1619(b) provisions. Under 1619(a), individuals who are disabled continue to receive SSI payments and therefore Medicaid, even though their earned income is at SGA, if the individual continues to meet other SSI eligibility criteria. Under 1619(b), individuals with earned income at SGA can also qualify for continued Medicaid without receiving SSI benefits if they need Medi-Cal to continue working and if they meet other SSI eligibility requirements. Individuals can keep Medi-Cal coverage until their earnings reach the "1619(b) threshold," currently $25,701. As of December 2001, some 4,186 individuals participated in 1619(a) and 6,778 participated in 1619(b).[19]

Medi-Cal coverage programs for individuals with disabilities are summarized in Table 1.

California's Disabled Population

Critical to understanding the experience of the CWD Program is examining the population that the program was designed to serve. The Survey of Income and Program Participation (SIPP) was used to project the number of disabled Californians by family income level, health coverage status, and workforce participation. Tables 2, 3, and 4 summarize these estimates for disabled Californians in the 18 to 64 age range.

Table 2 presents the distribution of California's estimated three million disabled adults by gross family income and health coverage status. Nearly half (48 percent) of the disabled adults have private insurance and 25 percent are covered by Medi-Cal. Among those covered by Medi-Cal, 76 percent are only covered by Medi-Cal, with the remainder having dual Medi-Cal/Medicare coverage. Nearly 600,000 disabled adults, or 20 percent of California's disabled adult population, are uninsured.

Table 3 recategorizes the same disabled population through a simulation of Medi-Cal's *net countable* income criteria for the CWD Program. The net countable income calculation disregards all disability income, such as SSI and SSDI, the first $65 of a disabled person's earnings, and half of the disabled person's remaining earnings. The net countable standard nearly doubles the number of disabled Californians who are eligible for CWD based on income

Table 1. Comparison of Medi-Cal Disability Aid Categories

	California Working Disabled Program	Medi-Cal Aged and Disabled Program	Aged, Blind, and Disabled Medically Needy Medi-Cal
Aid Codes	6G	6H, Full Scope 6U, Restricted	64, No Share of Cost (SOC); 67, SOC
Financial Eligibility	Net countable family income is less than 250% of FPL	Countable monthly income is less than 133% FPL	No upper income limit
Net Countable Income Determination	• SSI Income deduction rules apply* • All disability-related income is exempt • Impairment Related Work Expenses (IRWE) deducted from earned income	• SSI Income deduction rules apply* • Impairment Related Work Expenses (IRWE) and health insurance premiums paid are deducted from earned income* • Individuals in board and care facilities can deduct $315 fro personal care services	• SSI Income deduction rules apply* • Exempt income includes: social services and public assistance, foster care, public housing assistance, etc, • Health insurance premiums paid are deducted from earned income
Asset and Resource Limits	• $2,000 for individuals, $3,000 for couples • Retirement accounts (IRA, KEOGH, and 401K plans) do not count.	$2,000 for individuals, $3,000 for couples	$2,000 for individuals, $3,000 for couples
Cost Sharing	• Monthly premiums ranging from $20-$250 for individuals and from $30-$375 for couples	None	• If countable family income is less than or equal to the Family Maintenance Need Level (MNL), then no SOC • If countable family income is greater than MNL, then SOC

* (unearned income - $20) +[(earned income -$65)/2] = net countable income

Table 2. Number of Disabled Adults (Age 18–64) by Gross Family Income and Health Care Coverage Status

	Gross Family Income as a Percent of FPL			
	< 250%	**250–450%**	**>450%**	**Total**
Medi-Cal & Medicare	135,566	29,510	18,801	183,877
Medi-Cal Only	380,413	94,328	98,345	573,086
Medicare Only	82,330	57,936	52,269	192,535
Private	332,706	287,051	818,752	1,438,509
Uninsured	363,123	99,221	134,641	596,985
Total	1,294,137	568,047	1,122,807	2,984,992
Total Medi-Cal	515,979	123,839	117,145	756,963

(without regard to their current health coverage status). Under the gross income standard (Table 2), 43 percent of all disabled Californians (1.3 million) reside in families with incomes below 250 percent of FPL. Under the net countable income standard, 80 percent of disabled Californians (2.4 million) are below 250 percent of FPL. Using the CWD net countable income rules brings more than one million disabled people into the less than 250 percent of FPL income category who would otherwise be categorized as having incomes greater than 250 percent of FPL income if a *gross* family income calculation was used. Based on income alone, these individuals would be eligible for CWD.

Table 4 presents the degree to which disabled adults have a workforce presence. The top half of Table 4 presents the number of disabled adults who are working at least on a part-time basis by net countable family income and health coverage status; the bottom half indicates the percentage of disabled adults who are in the workforce in each cohort, dividing the figures in the top half of Table 4 by the corresponding values in Table 3. Nearly half (48 percent) of California's disabled adults are in the workforce, a population of nearly 1.5 million people. While 72 percent (one million) of privately insured disabled adults and 44 percent (263,000) of uninsured disabled adults are working, only 18 percent (133,000) of Medi-Cal-covered disabled adults are in the workforce.

Table 4 also shows that slightly more than one million working disabled Californians have net countable family incomes below 250 percent of FPL, making them eligible for enrollment in CWD based on only income. Most of these people (64 percent) are already covered through private health insurance, 12 percent are already covered by Medi-Cal, and 22 percent are uninsured. A large uninsured working disabled population of approximately 220,000 Californians exists, all appearing to be eligible for CWD by virtue of the net countable income standard.

The Experiences of Other States

To understand how California's Medicaid Buy-In program is performing, it is useful to examine the experiences of other states that have chosen to exercise this option. As of December 19, 2002, 26 states have implemented Medicaid Buy-In programs.[20] These states are Alaska, Arkansas, California, Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, Wisconsin, and Wyoming. There is a wide variation in how states determine income and asset eligibility.

The U.S. Department of Health and Human Services recently published case studies of nine state Medicaid Buy-In programs.[21] The studies compare the program design and implementation experiences of Alaska, Connecticut, Iowa, Maine, Minnesota, Nebraska, Oregon, Vermont, and Wisconsin. In early 2002, total program enrollment in these states was 13,000 enrollees. Of these states, four (Alaska, Connecticut, Iowa, and Minnesota) have exceeded projected enrollment, while one state (Nebraska) fell short of their estimated enrollment. Table 5 compares California's Medicaid Buy-In Programs with those underway in Connecticut, Maine, and Oregon.

Table 3. Number of Disabled Adults (Age 18–64) by Net Countable Family Income and Health Care Coverage Status

	CWD Net Countable Income as a Percent of FPL			
	<250%	**250-450%**	**>450%**	**Total**
Medi-Cal & Medicare	179,130	-	4,747	183,877
Medi-Cal Only	538,133	34,953	-	573,086
Medicare Only	188,700	3,835	-	192,535
Private	959,996	294,060	184,453	1,438,509
Uninsured	522,595	56,825	17,565	596,985
Total	2,388,554	389,673	206,765	2,984,992
Total Medi-Cal	717,263	34,953	4,747	756,963

Table 4. Number and Percent of Disabled Adults (Age 18–64) Working at Least on a Part-Time Basis by Net Countable Family Income and Health Coverage Status

	Net Countable Income as a Percent of FPL			
	< 250%	**250-450%**	**>450%**	**Total**
Number of Working Disabled Californians				
Medi-Cal & Medicare	6,233	-	-	6,233
Medi-Cal Only	113,722	13,103	-	126,824
Medicare Only	18,476	-	-	18,476
Private	642,298	235,508	153,505	1,031,310
Uninsured	221,408	31,275	10,141	262,824
Total	1,002,135	279,885	163,645	1,445,666
Total Medi-Cal	119,954	13,103	-	133,057
Disabled Californians in the Workforce as a Percent of All Disabled Adults				
Medi-Cal & Medicare	3%	-	-	3%
Medi-Cal Only	21%	37%	-	22%
Medicare Only	10%	-	-	10%
Private	67%	80%	83%	72%
Uninsured	42%	55%	58%	44%
Total	42%	72%	79%	48%
Total Medi-Cal	17%	37%	-	18%

It is difficult to make an apples-to-apples comparison of the enrollment experience of working disabled programs across states. The key difficulty is that states' baseline Medicaid programs have a myriad of different aid categories in which disabled people are enrolled, with the eligibility rules governing each aid category varying widely both across states and often within a state as well. Unraveling these complexities would be a significant undertaking and is beyond the scope of this study.[22] However, previous research indicates that existing state Medicaid programs already serving individuals with disabilities strongly affect enrollment levels in Medicaid Buy-In

programs for the working disabled. States with relatively generous Medicaid eligibility standards prior to implementing a Buy-In program have lower enrollment in their Buy-In programs, largely because the individuals who could potentially enroll in the Buy-In programs are already enrolled in Medicaid through an existing aid category.[23]

Table 5. Overview of Select State Medicaid Buy-In Programs

	California	Oregon	Connecticut	Maine
Implementation	April 2000	February 1999	October 2000	August 1999
Income Eligibility	• Countable family income to 250% of FPL • Disregarded income includes: applicant's disability-related income, earned income deductions, IRWE*	• Net individual income to 250% of FPL • Disregarded income includes: all unearned income, IRWE*, EIE†	• Gross income less than $75,000 per year	• Countable unearned family income to 100% of FPL and • Countable unearned and earned family income to 250% of FPL
Asset Level	• $2,000 for individuals, $3,000 for couples • Disregarded assets: a home, clothing, one car, retirement accounts, items necessary for employment	• $12,000 • Disregarded assets: retirement accounts, MSA‡, "approved accounts" (to enhance independence and employability)	• $10,000 for individuals, $15,000 for couples • Disregarded assets: retirement accounts, MSA, "employability accounts"	• $8,000 for individuals, $12,000 for couples
Disability	• Meet the SSA definition of disability	• Meet the SSA definition of disability	• Meet SSA definition of disability	• Meet SSA definition of disability
Cost-Sharing Level	• Monthly premiums from $20–$250 for individuals and from $30–$375 for couples	• Share of costs equaling unearned income above the state's SSI standard ($533 in 2001) • Sliding scale premium, if income is greater than 200% of FPL	• If net family income is greater than 200% of FPL, premium is 10% of the income in excess of 200% of FPL • If net family income is between 250% and 450% of FPL, premium is no greater than 7.5% of net family income	• None if countable family income is less than 150% of FPL, or if individual is currently paying their Medicare premium • $10 premium if countable family income is between 150% and 200% of FPL, $20 if income is 200%–250% FPL
Coverage of Personal Assistant Services	Covered within and outside of the home	Covered within and outside of the home	Not covered	Covered
Lapsed Employment Provisions	Continued coverage for up to 2 months for good cause	None	Continued coverage up to one year from loss of employment	6-month grace period for premium payment
Projected Enrollment	6,835—13,811 by the end of the second year	Not available. SSDI and SSI recipients were given priority	1,208 (timeframe not specified)	200 in the first year
Enrollment	652 (as of June 2002)	511 (as of Sept. 2001)	1,600 (as of Oct. 2001)	633 (as of Dec. 2001)

Source: U.S. DHHS, Medicaid Buy-In Programs: Case Studies of Early Implementer States
* IRWE: impairment related work expense
† EIE: employment and independence expenses such as car payments, noncovered medical expenses, interpreters
‡ MSA: medical savings account

Understanding California's Experience

The goal of this study was to examine the implementation of the CWD Program and to explore the factors affecting enrollment in the program. The study was designed to incorporate the perspectives of program stakeholders including: (1) those enrolled in CWD (through an enrollee survey); (2) those eligible but not enrolled in the program (discussions through teleconferences); and (3) county eligibility workers who play a critical role in educating and enrolling eligible individuals (with interviews). The study also used quantitative analysis to examine enrollment trends since the program's inception as well as to model various programmatic changes to the program to determine if they might increase access to the program for a substantial number of working disabled individuals.

This study also sheds light on the extent to which the CWD Program has enabled individuals to enter the workforce or increase their workforce participation. This study provides some insight into the issues and challenges affecting individuals' ability to find and maintain employment, the need for personal assistant services, and work disincentives and incentives.

When the enrollee survey was fielded, Medi-Cal covered personal assistant services (PAS) only in the home, but DHS was developing an option to provide PAS outside the home. The inability to pay for workplace PAS out of pocket could prevent some individuals from working. The study also attempted to gain an understanding of the impact of providing PAS in the workplace, including whether it would enable greater workforce participation.

To date, the impact of the program on private and employer-sponsored coverage is negligible. A large percentage of CWD enrollees have come from other Medi-Cal aid categories. It is unknown to what extent program expansion would result in the emergence and enrollment of individuals who previously were covered through an employer. It was also unknown to what degree any crowd-out of private coverage would occur (i.e., individuals leaving private or employer-sponsored plans to move into less expensive CWD coverage). An analysis of survey respondents' health coverage before and after enrolling in CWD provides some limited insight into whether enrollees are dropping private coverage in favor of CWD. The potential fiscal implications of a crowd-out effect have been cited as a concern with both the initial development of the CWD Program and subsequent expansions.

Data and Methods

This study used four methods to analyze the effects of the CWD Program and to understand whether the program's modest enrollment was symptomatic of a lack of demand or need for the program and the expansions as proposed in AB 925, or if other factors were influencing enrollment.

Modeling

The cost and enrollment impacts of CWD Program expansions modeled after those originally proposed in AB 925 were estimated using data from the Census Bureau's Survey of Income and Program Participation (SIPP)[24] and data supplied by DHS.

Specifically, the cost and enrollment impacts of the three policy change options described below were modeled.

1. raising the income threshold to 450 percent of FPL; or

2. eliminating the asset test for people in the CWD Program; or

3. raising the income threshold to 450 percent of FPL and eliminating the asset test (options 1 and 2 combined).

Enrollee Survey

A total of 620 enrollees were surveyed by mail regarding their health coverage, workforce participation, and satisfaction with the CWD Program.[25] The survey was administered in conjunction with the DHS Medi-Cal Eligibility Branch to ensure that the confidentiality of enrollees was protected. Respondents were given the opportunity to share more detailed information regarding their experience with CWD by volunteering their names and phone numbers for a follow-up telephone interview. To encourage enrollees to return completed surveys and to thank respondents for their participation, a 15-minute phone card was included in all survey packets free of charge, regardless of whether they completed the survey. The survey instrument is included in Appendix A.

A total of 162 responses[26] were received, producing an overall 26 percent response rate. One-third (53) of the respondents requested a follow-up interview. Multiple attempts were made to reach respondents who agreed to a follow-up call and 32 were successfully reached. During the follow-up calls, interviewees were asked to expand on their survey responses and were encouraged to share their enrollment experience and ideas for improving the program. The supplemental information obtained through follow-up interviews and select enrollee profiles are included in this paper to illustrate the real-life challenges in obtaining health coverage and in participating in the workforce experienced by some working individuals with disabilities, and the impact of CWD on their lives. This report refers to those who returned completed surveys as *respondents* and the respondents who participated in follow-up interviews as *interviewees*.

Nonenrollee Teleconference

One of the study's objectives was to capture and describe a range of perspectives on the California Working Disabled Program, including those of individuals eligible for the program but not enrolled. The goal in speaking with these individuals was to better understand their reasons for not enrolling and to identify some potential improvements to the program. Unlike enrollees, there is no discrete roster of this nonenrolled population, creating significant challenges to obtaining their input. To capture this important but all-too-often absent perspective, two strategies were pursued. The initial effort to reach nonenrollees involved conducting a teleconference during which participants discussed the CWD Program, including enrollment barriers and disincentives. The second strategy was to identify nonenrollees and conduct one-on-one interviews. The participation in both activities was minimal.

County Eligibility Worker Interviews

County Medi-Cal eligibility workers were interviewed in 11 counties representing varying levels of CWD enrollment and overall population. These counties included Contra Costa, Fresno, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Initial contact with counties was made with either program office staff or the designated county coordinator for CWD.[27] Each of the counties agreed to participate. Each participant was asked to answer questions on the following issues: outreach, eligibility worker training, eligibility determinations, challenges, and suggestions for improvement.

II. Characteristics of Existing CWD Enrollees

To understand whom the CWD Program has impacted thus far, enrollment and claims data from DHS were analyzed. This section describes enrollment in CWD, including:

- enrollment trends;
- demographic mix of enrollees;
- distribution of enrollees by California county;
- claims costs; and
- movement into and out of the program.

Enrollment History

Enrollment into the CWD Program began in early 2000 and has climbed, albeit rather slowly, at a rate of approximately 20 net additional enrollees per month. The quarterly progression of enrollment is shown in Table 6. Currently, about 650 people are enrolled in CWD, representing less than one percent of the program's target population of uninsured working disabled people with net countable income below 250 percent of FPL. These numbers are far below initial enrollment estimates developed by DHS before the program was implemented. DHS projected that between 6,835 and 13,811 individuals would enroll in CWD by the end of the program's second year. The DHS estimate was based on historical participation in SSI/SSP, SSDI, and Medi-Cal, but did not account for individuals who were not already receiving these benefits and would become eligible for Medi-Cal.

Most enrollees in CWD have very low incomes. About 70 percent of the enrollees are paying the minimum monthly premium of $20, reflecting income well below 100 percent of FPL. Thus, the program is enrolling few people toward the upper end of the 250 percent FPL income cut-off. In fact, given their income level enrollees below 100 percent of FPL might qualify for several other Medi-Cal programs. These other programs, however, do not provide the same work incentives as the CWD Program, (e.g., the ability to earn more or to keep individual retirement accounts).

Table 6. CWD Enrollment History

Month	Enrollees
April 2000	12
July 2000	54
October 2000	197
January 2001	290
April 2001	376
July 2001	450
October 2001	519
January 2002	575
April 2002	605
June 2002	652

Source: DHS Web site, www.dlts.ca.gov/mcss.

Demographic Mix

The age and gender distribution of CWD enrollees is presented in Table 7. All enrollees are at least 21 years old, and the majority are older workers. About two-thirds of the enrollees are older than 45, and ten percent are 65 or older. The program's enrollees are evenly distributed—males, 52 percent and females, 48 percent—with females outnumbering males in the 46 and older age cohorts and males outnumbering females in the 21 to 45 age cohort. It is notable that under AB 925 as introduced, people aged 65 or older would be ineligible for CWD because the program's authority would have been changed from the BBA to TWWIIA. While presumably the net effect of implementing changes proposed in the legislation would enable more individuals to enroll in the program, the 63 people aged 65 or older currently enrolled in the program would be forced to find alternative sources of coverage.

Table 7. Age and Gender Mix of Working Disabled Enrollees (April 2002)

Age Cohort	Female	Male	Total	% by Age
21–45 years	79	127	206	34.0%
46–64 years	177	159	336	55.5%
65 years or older	34	29	63	10.4%
Total	290	315	605	
Percentage by Gender	47.9%	52.1%		

Source: DHS Web site, www.dhs.ca.gov/mcss.

As shown in Table 8, most CWD enrollees are white (78 percent). Hispanics (12 percent) and Blacks (6 percent) are the largest minority subgroups.

Table 8. Ethnicity Mix of Working Disabled Enrollees (April 2002)

Ethnicity Group	Number of CWD Enrollees	Percentage
White	472	78.0%
Hispanic	70	11.6%
Black	36	6.0%
Filipino	7	1.2%
Alaskan/Am. Indian	4	0.7%
Chinese	3	0.5%
Vietnamese	3	0.5%
Asian/Pacific	2	0.3%
Korean	2	0.3%
Hawaiian	1	0.2%
Laotian	1	0.2%
Unknown	4	0.7%
Total	605	100.0%

Source: DHS Web site, www.dhs.ca.gov/mcss.

The CWD enrollment distribution by county as of June 2002 is shown in Table 9. No county had more than 100 CWD enrollees—San Diego had the state's largest enrollment with 79 enrollees. Ten counties' share of the statewide CWD enrollment was more than two percentage points above its share of statewide overall disabled Medi-Cal enrollment; these counties are Contra Costa, Humboldt, Napa, Orange, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, and Ventura. Five counties' share of the statewide CWD enrollment was more than two percentage points below its share of statewide overall disabled Medi-Cal enrollment; these counties are Fresno, Kern, Los Angeles, Sacramento, and San Bernardino. While individuals in Los Angeles County comprise 30 percent of all Medi-Cal disabled enrollees, only nine percent of CWD enrollees reside in Los Angeles County.

Table 9. Distribution of Medi-Cal Disabled and CWD Enrollees by County

County	People Disabled Enrolled in Medi-Cal	County's % of Total State Disabled Medi-Cal Enrollees	CWD Enrollees	County's % of CWD State Total
Alameda	38,463	4.4%	23	3.5%
Alpine	35	0.0%	-	0.0%
Amador	570	0.1%	-	0.0%
Butte	9,627	1.1%	5	0.8%
Calaveras	970	0.1%	-	0.0%
Colusa	464	0.1%	-	0.0%
Contra Costa	18,685	2.1%	28	**4.3%**
Del Norte	1,762	0.2%	-	0.0%
El Dorado	2,628	0.3%	3	0.5%
Fresno	31,269	3.6%	5	**0.8%**
Glenn	853	0.1%	6	0.9%
Humboldt	6,508	0.7%	16	**2.5%**
Imperial	5,529	0.6%	-	0.0%
Inyo	425	0.0%	2	0.3%
Kern	24,667	2.8%	-	**0.0%**
Kings	3,418	0.4%	-	0.0%
Lake	3,781	0.4%	5	0.8%
Lassen	990	0.1%	-	0.0%
Los Angeles	263,808	30.0%	57	**8.7%**
Madera	3,538	0.4%	-	0.0%
Marin	3,345	0.4%	13	2.0%
Mariposa	394	0.0%	1	0.2%
Mendocino	3,822	0.4%	4	0.6%
Merced	7,877	0.9%	-	0.0%
Modoc	349	0.0%	-	0.0%
Mono	100	0.0%	-	0.0%
Monterey	7,115	0.8%	-	0.0%
Napa	1,936	0.2%	27	**4.1%**
Nevada	1,738	0.2%	1	0.2%
Orange	40,258	4.6%	52	**8.0%**

(Table continues)

Table 9. Distribution of Medi-Cal Disabled and CWD Enrollees by County (continued)

County	People Disabled Enrolled in Medi-Cal	County's % of Total State Disabled Medi-Cal Enrollees	CWD Enrollees	County's % of CWD State Total
Placer	4,139	0.5%	6	0.9%
Plumas	654	0.1%	0	0.0%
Riverside	36,976	4.2%	31	4.8%
Sacramento	48,177	5.5%	5	**0.8%**
San Benito	592	0.1%	3	0.5%
San Bernardino	50,230	5.7%	2	**0.3%**
San Diego	61,201	7.0%	79	**12.1%**
San Francisco	29,693	3.4%	20	3.1%
San Joaquin	22,572	2.6%	17	2.6%
San Luis Obispo	5,538	0.6%	30	**4.6%**
San Mateo	8,457	1.0%	42	**6.4%**
Santa Barbara	8,661	1.0%	37	**5.7%**
Santa Clara	25,974	2.9%	12	1.8%
Santa Cruz	5,011	0.6%	32	**4.9%**
Shasta	8,774	1.0%	17	2.6%
Sierra	85	0.0%	0	0.0%
Siskiyou	2,232	0.3%	3	0.5%
Solano	8,781	1.0%	1	0.2%
Sonoma	9,840	1.1%	15	2.3%
Stanislaus	17,033	1.9%	12	1.8%
Sutter	2,587	0.3%	0	0.0%
Tehama	2,573	0.3%	2	0.3%
Trinity	628	0.1%	0	0.0%
Tulare	14,068	1.6%	0	0.0%
Tuolumne	1,637	0.2%	6	0.9%
Ventura	11,974	1.4%	32	**4.9%**
Yolo	4,161	0.5%	0	0.0%
Yuba	3,366	0.4%	0	0.0%
Total	880,538	100.0%	652	100.0%

Source: DHS Web site, dhs.ca.gov/mcss.
Note: Bolded figures represent counties where share of statewide 6G enrollment is 2 or more percentage points above or below the county's share of statewide disabled enrollment.

CWD Claims Cost Overview

Claims cost data were analyzed to better understand expenditures related to the CWD Program. Table 10 presents the monthly progression of claims expenses incurred by the CWD enrollees. Across the 12-month period of November 2001 through October 2002, almost $3.3 million in claims were paid on behalf of CWD enrollees. CWD enrollee claims are averaging approximately $500 per enrollee per month, or $6,000 per enrollee year.

Table 10. Overview of Monthly Claims Costs

Month of Claim Payment	Sum of Claims Paid During Month	Enrollment Two Months Prior	Average Cost per Enrollee
July 2001	$26,468	410	$65
August 2001	$161,226	428	$377
September 2001	$195,127	450	$434
October 2001	$209,507	478	$438
November 2001	$188,674	508	$371
December 2001	$277,113	519	$534
January 2002	$219,873	543	$405
February 2002	$231,442	558	$415
March 2002	$230,674	575	$401
April 2002	$288,358	585	$493
May 2002	$237,406	595	$399
June 2002	$259,019	605	$428
July 2002	$308,627	615	$502
August 2002	$294,074	625	$471
September 2002	$400,845	632	$634
October 2002	$347,117	652	$532
Most Recent 12 Mos.	$3,283,223	NA	$468

Source: Data file produced by DHS.

Note: Enrollment from two months prior to the month of payment is used to adjust for the gap between date of service and date of payment.

Table 11 presents the distribution of CWD-paid claims by provider type across the time period July 2001 through October 2002. Pharmacy expenses comprised the majority of claims payments (74 percent) and represent approximately $350 in costs per enrollee per month. The relatively large share of claims paid to pharmacies in this aid code is attributable, at least in part, to the fact that a sizable proportion of CWD enrollees (80 percent) are dually eligible for Medicare and Medi-Cal. Medi-Cal is a secondary payer to Medicare for most services, but is the primary payer for pharmacy because prescription drugs are not covered by Medicare. The fact that more than 40 percent of CWD enrollees responding to this study's survey reported having a mental disorder (see Table 18) is also likely to contribute to the high rate of pharmacy expenditures because mental disorders are frequently treated and managed through a regimen of prescription drugs.

Table 11. Distribution of CWD Claims Costs by Provider Type (Claims Paid from July 2001–October 2002)

Provider Type	Amount Paid	Percentage
Ambulance	$5,342	0.1%
Dialysis	$43,835	1.1%
Durable Medical Equipment	$57,836	1.5%
Home Health	$175,937	4.5%
Hospital	$369,826	9.5%
Lab	$7,578	0.2%
Nursing Home	$67,867	1.8%
Physician/Health Center/Practitioner	$250,846	6.5%
Pharmacy	$2,871,870	74.1%
Other/Unknown	$24,615	0.6%
Total	$3,875,551	100.0%

Source: Data file produced by DHS.

Table 12 presents the distribution of CWD claims costs by each individual enrollee. Approximately 42 percent of the CWD enrollees incurred less than $1,000 in Medi-Cal claims during the period June 2001 to October 2002. Those people generating more than $10,000 in Medi-Cal claims comprised 10.8 percent of the enrollees, but more than half (54.1 percent) of all CWD claims costs. Note that most of these people were not enrolled in CWD throughout the entire 17-month time period analyzed.

A detailed analysis of individual CWD enrollees' claims cost progressions on a month-by-month basis was also performed. In any given month, approximately 75 to 80 percent of the CWD enrollees incurred at least one claim. Of the 457 enrollees with claims in April of 2002, 64 percent had claims paid on their behalf in *every* month during the six-month period April 2002 to Sept 2002. Thus, a large group of CWD enrollees are very consistent users of Medi-Cal covered services. This is explained to a large degree by the extensive use of pharmacy benefit among the CWD enrollees, given that people using the pharmacy benefit often generate a steady stream of monthly claims.

It is noteworthy that a sizable (though smaller) group of low-users and nonusers within CWD seems willing to pay the monthly premium "just for coverage's sake." As shown in Table 12, 112 CWD enrollees had not generated $100 in claims costs, although all of these people are paying at least a $20 monthly premium. This group of enrollees may consist of individuals who also have some other source of coverage and only use CWD as wrap-around coverage or individuals who are disabled but have infrequent health care needs. These individuals may have faced the question of whether the benefit of having the "peace of mind" of CWD coverage outweighs the cost of required premiums. For those with higher incomes, their cost-benefit determination of enrolling in CWD must take into account their higher premiums.

Movement into and out of CWD

Table 12 indicates that 915 people were enrolled in CWD at some point between June 2001 and October 2002. Given that current CWD enrollment is approximately 650 people, 265 people have disenrolled from the program. Approximately four percent of CWD enrollees leave the program in a given month—a figure that closely matches typical Medicaid disenrollment rates for the Temporary Assistance for Needy Families (TANF) population. The CWD Program's disenrollment rate is therefore not uncommon in a Medi-Cal environment—particularly in an aid category where monthly premiums are required.

Table 12. CWD Claims Cost Distribution by Enrollee (June 2001–October 2002)

Individual Claims Costs	# CWD Enrollees, This Corridor	Percentage of Enrollees	Total Claims Costs, This Corridor	Percentage of Claims
< $100	112	12.2%	$4,524	0.1%
$100–499	159	17.4%	$42,087	1.1%
$500–999	113	12.3%	$80,642	2.1%
$1,000–4,999	319	34.9%	$845,926	21.8%
$5,000–9,999	113	12.3%	$806,256	20.8%
$10,000–24,999	86	9.4%	$1,331,532	34.4%
$25,000–99,999	10	1.1%	$385,469	9.9%
> $100,000	3	0.3%	$379,115	9.8%
Total	**915**	**100.0%**	**$3,875,551**	**100.0%**

Source: Data file produced by DHS.

Using DHS data, an analysis of the source of entry and exit for those people enrolling or disenrolling from CWD was conducted. Table 13 presents the results of three two-month snapshots of the flow of people moving into and out of CWD. During the time periods assessed (May through June 2000, August through September 2001, and May through June 2002), 132 people enrolled in the CWD Program. Of these new enrollees, 83 (63 percent) were already enrolled in Medi-Cal immediately prior to switching to CWD. Thus, the California Working Disabled program was creating a new source of coverage for only 37 percent of enrollees, with the others simply switching aid categories within Medi-Cal. Most of those switching into CWD left a Medically Needy aid category.

Those disenrolling from the California Working Disabled Program during the time period analyzed exhibited a similar pattern—staying in Medi-Cal but switching aid categories. Of the 54 disenrollees, 37 (69 percent) switched to another Medi-Cal aid category, and 17 (31 percent) left the Medi-Cal program altogether. Most of those switching aid categories went into a Medically Needy aid category. It was beyond the scope of this study to research the reasons causing people to disenroll from CWD; however, several reasons are plausible and warrant further investigation. Some individuals may have been involuntarily disenrolled because they failed to pay their premiums or experienced other changes in their eligibility such as no longer being employed or having income in excess of CWD limits. Others may have chosen to disenroll because they did

not want to pay monthly premiums and preferred paying a share of cost in the Medically Needy Medi-Cal Program, or because they chose not to work. Some individuals may have access to health coverage through an employer and dropped their CWD coverage although they are still eligible for coverage.

Table 13. Snapshots of Movement into and out of the CWD Program

Month-to-Month Movement of 6G Enrollees	Number of People			
	May–June 2000	Aug–Sept. 2001	May–June 2002	Total, All 3 Time Periods
6G in both months	378	363	615	1,356
Those moving into 6G	43	52	37	132
Not enrolled in Medi-Cal in Prior Month	19	15	15	49
Medically Needy Aged in Prior Month	3	4	2	9
Medically Needy-Disabled in Prior Month	15	28	14	57
Public Assistance-Aged in Prior Month	0	0	0	0
Public Assistance-Disabled in Prior Month	5	5	5	15
Other Aid Categories in Prior Month	1	0	1	2
Those exiting 6G	14	23	17	54
Not Enrolled In Medi-Cal in Subsequent Month	6	7	4	17
Medically Needy-Aged in Subsequent Month	0	2	3	5
Medically Needy-Disabled in Subsequent Month	6	12	6	24
Public Assistance-Aged in Subsequent Month	1	0	1	2
Public Assistance-Disabled in Subsequent Month	0	1	3	4
Other Aid Categories in Subsequent Month	1	1	0	2
Disenrollment rate	3.6%	6.0%	2.7%	3.8%
Percentage of disenrollees switching aid codes	57.1%	69.6%	76.5%	68.5%
Percentage of disenrollees leaving Medi-Cal	42.9%	30.4%	23.5%	31.5%
Percentage of new 6G enrollees not previously in Medi-Cal	44.2%	28.8%	40.5%	37.1%
Percentage of new 6G enrollees already in Medi-Cal	55.8%	71.2%	59.5%	62.9%

Source: Data file produced by DHS.

III. Modeling of Alternative Policy Options

Data from SIPP and DHS were analyzed to quantify the enrollment and cost effects of expanding eligibility for CWD. Specifically, three options for expanding CWD eligibility were considered:

1. raising the income eligibility to 450 percent of FPL;
2. eliminating the asset test; and
3. raising the income eligibility to 450 percent of FPL and eliminating the asset test (options 1 and 2 combined).

Raising Income Eligibility to 450 Percent of FPL

The number of uninsured working disabled Californians in the income threshold of 250 to 450 percent of FPL, as extrapolated from the SIPP, is summarized in Table 14, which also indicates the degree to which these people's monetary assets exceed current Medi-Cal eligibility thresholds of $2,000 for an individual and $3,000 for a couple. Raising the income threshold for the California Working Disabled Program would clearly create a new pool of *potentially* eligible individuals—this subgroup would include 5,885 people (counting only uninsured people and excluding those with private coverage and those already enrolled in Medi-Cal), based on the SIPP responses.

Table 14. Uninsured Working Disabled Californians by Level of Monetary Assets

FPL Cohort Based on Net Countable Income Simulation	Monetary Assets Below CWD Threshold	Monetary Assets Above CWD Threshold
< 250% of FPL	141,461	79,947
251–450% of FPL	5,885	25,390
> 450% of FPL	0	10,140

Source: Programming of SIPP data.
Note: Monetary assets include checking/savings accounts, stocks, bonds, and retirement accounts.

The rate at which uninsured people are joining the CWD Program is extremely modest. While there are an estimated 141,461 uninsured working disabled Californians under 250 percent of FPL (based on a net countable income simulation in the SIPP data) with assets below the current CWD eligibility threshold, only 652 people had enrolled as of June 2002. Moreover, 63 percent of the CWD enrollees simply switched Medi-Cal aid codes—they were not uninsured. It is estimated that only 241 people have joined CWD from outside the Medi-Cal program. This represents a take-up rate of 0.17 percent among the program's target population of uninsured workers with disabilities and net countable income less than 250 percent of FPL.

It should be noted that while there are about 650,000 privately covered working disabled Californians in this income cohort, it seems unlikely that these people would drop their private coverage in favor of Medi-Cal coverage—particularly in an aid code where a monthly enrollee premium is required. Medi-Cal offers certain benefits such as prescription drugs and durable medical equipment beyond coverage levels of most private coverage, creating some incentive to drop private coverage in favor of Medi-Cal. However, there is no evidence to date that such "crowd-out" of private coverage has occurred to a significant extent in CWD, and therefore no reason to expect that it will occur. Thus, the take-up rate calculation is based only on the uninsured population.

Table 15 estimates net enrollment and cost impacts of raising the CWD income eligibility threshold to 450 percent of FPL without other changes being made to the program or the implementation of new outreach efforts. This modeling does not account for movement into CWD from other forms of coverage including Medi-Cal or private coverage. It is assumed that new enrollees will largely be people who are dually eligible for Medicare, as is the case with existing CWD enrollees. While 5,885 uninsured working disabled people would seemingly become eligible for the CWD Program, a take-up rate of 0.17 percent would result in a Medi-Cal net enrollment gain of only 10 people. Based on an estimate that these individuals' claims costs would average $6,000 per year, which closely approximates the current enrollees' per capita claims costs, the annual claims cost estimate for raising the income threshold to 450 percent is $60,000. However, the monthly premiums for people above 250 percent of FPL would be at least $250 under the CWD Program's current sliding scale. The net result of applying these premium payments against the claims costs is overall program costs of $3,000 per new enrollee per year, or $30,000 for the projected 10 new enrollees.

Note that these program costs will increase substantially if the current take-up rate of 0.17 percent is exceeded. For example, a take-up rate of one percent, which is still quite modest in the context of most Medi-Cal coverage groups, would lead to 59 new people and net costs of $177,000 per year.

Increasing the income threshold creates more large-scale financial risk to Medi-Cal, as much larger numbers of people could enroll. However, the current take-up rate would need to increase a *hundredfold* for the net enrollment impact to reach even 1,000 people.

Table 15. Estimated Cost of Expanding CWD Eligibility to 450% of FPL

		Derivation Comments
Current Take-Up Rate		
Uninsured working disabled Californians, 101–250% of FPL with assets below Medi-Cal threshold	141,461	Derived from SIPP
Current CWD enrollees from outside Medi-Cal	241	652 people x 0.37 (63% of existing CWD enrollees convert from another Medi-Cal aid category)
Take-up rate among income-eligible people	1.17%	241 / 141, 461
Enrollment Estimate		
Uninsured working disabled Californians, 251–450% of FPL with assets below Medi-Cal threshold	5,885	Derived from SIPP
Cost Estimate		
Estimated average annual medical costs per person	$6,000	Approximates average level of existing CWD enrollees' claims
Estimated annual premiums paid per new enrollee	$3,000	Multiplies program's current maximum premium ($250) by 12
Estimated additional annual program costs	$30,000	10 people x ($6,000 - $3,000)

Note: The estimated costs of those people enrolling in CWD from another Medi-Cal aid category are assumed to be negligible, although people leaving a share of cost aid code will likely pay a different amount under the CWD premium structure.

Eliminating the Asset Test

Another option for promoting enrollment into CWD would be to remove the asset test for this subgroup. As shown earlier in Table 14, SIPP estimates that approximately 80,000 uninsured, working disabled Californians are not currently eligible for CWD due to their assets—those with incomes below 250 percent of FPL and assets above current Medi-Cal thresholds.

Table 16 develops enrollment and cost estimates for the CWD Program associated with elimination of the asset test. Applying the previously derived current take-up rate of 0.17 percent to the population of uninsured working disabled people with assets above current program qualifying thresholds yields a net Medi-Cal enrollment increase of 136 people. Using an annual cost per person estimate of $6,000, overall annual net additional medical costs of $816,000 are projected if the CWD asset test were completely eliminated. An assumed average monthly CWD premium for these enrollees ($50) results in offsetting premium payments of $81,600 across the 136 enrollees. Net annual program costs would therefore be $734,400. Again, to illustrate the impact of higher take-up rates, new enrollment and annual medical costs were calculated at a take-up rate of one percent. At this take-up rate, the net enrollment increase would total 799 new people, with net program costs totaling $4.3 million.

Table 16. Estimated Cost of Eliminating Asset Test for CWD Population

		Derivation Comments
Current Take-Up Rate		
Take-up rate among people who are both income-eligible and asset-eligible	0.17%	Derived in previous table
Enrollment Estimate		
Uninsured working disabled Californians, below 25% of FPL (net countable) with assets above current Medi-Cal threshold	79,947	Derived from SIPP
Additional CWD Enrollees below 250% (who aren't already on Medi-Cal)	136	Applies current take-up rate (0.0017) to target population (79,947)
Cost Estimate		
Estimated average annual medical costs per person	$6,000	Approximate average level of existing CWD enrollees' claims
Estimated annual premiums paid per new enrollee	$600	Multiplies assumed monthly premium ($50) by 12
Estimated additional annual medical costs	$734,400	136 people x ($6,000 - $600)

Note that another policy option, in lieu of complete elimination of the asset test, would be to increase the allowed asset threshold. Several states have chosen to allow asset levels above California's current levels. Given that elimination of the asset test is projected to have a modest impact, raising the threshold from, for example, $3,000 to $10,000 will have a minimal impact on program enrollment. The SIPP data indicates that nearly half (44.9 percent) of California's 50,783 uninsured working disabled people who are ineligible due to excess assets have assets in the $3,000 to $10,000 corridor. Thus, a policy option of increasing CWD's allowed asset threshold to $10,000 could create roughly half the enrollment and cost impact of completely eliminating the CWD asset test. The exact estimate of this policy change would be an enrollment increase of 61 people at an annual medical cost of $366,000 and a net program cost (after subtracting premium payments) of $329,400.

Another option for modifying the asset test is allowing enrolled individuals to accumulate assets beyond the limits established for determining eligibility. Under this option a state could retain its current asset eligibility standards, but establish new, higher standards for asset accumulation subsequent to enrolling in the Medicaid Buy-In program, or decide not to implement an upper asset limit at all. This option would permit enrolled people to save to the maximum extent possible once enrolled. Some states are implementing "independence" or other approved accounts in which enrolled people can save for goods or services to enhance their independence, without those accounts applying to the asset limit. For example, Vermont permits people enrolled in its Medicaid Buy-In program to keep liquid assets accumulated on or after January 1, 2000, in a separate account without being counted toward the asset limit.[28] Modeling these options was not conducted in this study; however, the cost and enrollment impacts of such changes warrant further investigation.

Raising Income Eligibility to 450 Percent of FPL and Eliminating the Asset Test

The two policy components described earlier are additive in that the additional enrollees from raising the income threshold (without changing the asset test) are an entirely separate group from those who would join if the income threshold were kept at 250 percent of FPL but the asset test were eliminated. However, these two changes in combination would also create a third source of potential enrollment—making working disabled people eligible for CWD who have assets above current CWD thresholds and with net countable incomes between 250 percent and 450 percent of FPL. The size of this target population is 25,390 uninsured people as derived by SIPP (see Table 14). Applying the current CWD take-up rate of 0.17 percent to this subgroup would result in 43 additional enrollees.

Table 17 summarizes the results of the three expansion options explored in this paper and shows the resulting enrollment and cost impacts of making both changes to the CWD eligibility rules. The combined estimate is a net increase in Medi-Cal enrollment of 189 people at an annual medical cost of $1.1 million and a net program cost (after subtracting enrollee premium payments) of $893,400. While these are not the only policy options for broadening the pool of potential enrollees, these closely match the options explored in the original language of AB 925.

Table 17. Summary of Explored Expansion Options: Projected Enrollment and Cost Impacts

Expansion Option	Projected Net Enrollment Impact	Estimated Net Annual Program Cost	Derivation Comments
1. Expand income eligibility to 450% of FPL (without changing CWD asset test)	10	$30,000	Derived from SIPP (5,885) and observed take-up rate (0.0017) among current CWD eligible people
2. Eliminate asset test for the current CWD population (without expanding eligibility)	136	$734,400	Derived from SIPP (79,947) and observed take-up rate (0.0017) among current CWD eligible people
3. Eliminate asset test for people from 250–450% of FPL	43	$129,000	Derived from SIPP (25,390) and observed take-up rate (0.0017) among current CWD eligible people
Total impact of options 1, 2, and 3 (raise income threshold to 450% of FPL and eliminate asset test)	189	$893,400	Sum of estimated annual costs for each new enrollee group ($30,000 + $734,400 + $129,000)

Other Policy Changes to Medi-Cal

While this report was being prepared, Governor Davis released his 2003-2004 state budget proposal, in which he tries to close the state's $35 billion budget shortfall. One proposal would decrease eligibility for the Medi-Cal Aged and Disabled Program from its current level of 133 percent of FPL to 100 percent of FPL, which is projected to save the state $127.6 million.[29] Another effect of this proposal might be to increase CWD enrollment if those losing Aged and Disabled Medi-Cal eligibility both work and are willing to pay CWD premiums (which for this population would range from $50 to $75 per month).[30] Individuals affected by this proposal also could retain Medi-Cal through a Medically Needy aid category, but would be responsible for paying a monthly share of cost, which would most likely be greater than the amount of a monthly premium. Thus, individuals could choose to enroll in the program that they believe will provide the greatest benefit relative to the cost and risks of enrolling. This will be further discussed later in this report.

IV. Enrollee Survey

Information gathered from CWD enrollees is critical to understanding CWD's overall performance. The CWD enrollee survey was designed to answer specific questions about respondents' experiences with various aspects of the program, given an individual's unique circumstances. Survey respondents addressed issues such as:

- types of disabilities;
- workforce participation while enrolled in CWD;
- access to health care coverage prior to and after joining CWD;
- factors that influenced the decision to enroll in CWD;
- sources of CWD information; and
- overall satisfaction with the program.

In addition to the information gathered from the survey, several respondents agreed to participate in follow-up interviews and to share their stories, which are included in this chapter of the report.

Characteristics of Respondents

Survey respondents were demographically well matched with the overall CWD population. Both the survey respondents and the broader CWD enrollee population were made up of about 80 percent whites. Females were somewhat over-represented in the survey, comprising 60 percent of the respondents as compared to 48 percent of the overall CWD enrollees.

Respondents were asked to describe their disabilities, which were then categorized according to Social Security disability classifications. More than 40 percent of respondents reported having mental disorders,[31] the most common disability category among respondents, followed by neurological and musculoskeletal disabilities. Table 18 provides a more detailed distribution of reported disabilities. Twenty-seven respondents had more than a single impairment, the majority of whom reported "mental disorders" as one of their impairments. Data from the Social Security

Administration show that the most common diagnosis among disabled workers in December 2000 was mental disorders (27.4 percent), followed by musculoskeletal diseases (23.2 percent) and circulatory system diseases (10.7 percent).[32] Thus, individuals with mental disorders were slightly overrepresented among CWD survey respondents.

Table 18. Distribution of Disabilities among Survey Respondents

Disabling Condition(s)*	Number of Respondents	Percentage †
Mental disorders	61	41%
Neurological	28	19%
Musculoskeletal	25	17%
Immune system	24	16%
Endocrine	10	7%
Cardiovascular	7	5%
Digestive	6	4%
Genito-urinary	5	3%
Respiratory	5	3%
Blind	3	2%
Multiple body systems	3	2%
Neoplastic diseases	3	2%
Special senses & speech	1	1%
Hemic & lymphatic	0	0%
Skin	0	0%
Unclear	5	3%

* Survey respondents self-reported their impairments and were grouped in accordance with the SSA-defined "Listing of Impairments–Adult."
† Percentages add up to greater than 100% due to some respondents reporting multiple conditions.

Workforce Participation

Hours of Work

Table 19 describes the weekly work hours of respondents. The majority of respondents (71 percent) worked 20 hours or less per week. Of that 71 percent, 60 percent worked between 10 and 20 hours a week. During follow-up phone interviews, interviewees were asked what factors influenced the number of hours they currently work. Health conditions prevented more than half of interviewees from being able to work more hours; and for nearly one third of interviewees, the number of work hours was limited by the amount of work available or the temporary or seasonal nature of the job. Six individuals interviewed limited their work hours to keep their income within program limits.

Table 19. Number of Work Hours per Week

Weekly Hours	Current Number of Work Hours		Hours of Work If No Income Limit	
	Respondents	*Percentage*	*Respondents*	*Percentage*
None	10	6%	14	9%
1–10 hours	46	28%	27	17%
10–20 hours	69	43%	57	36%
20–30 hours	20	12%	30	19%
30–40 hours	17	10%	32	20%

Six percent of respondents were not working, which would make them ineligible for CWD. During follow-up phone calls, some interviewees reported a recent lay-off or an inability to work at the current time due to a health condition, although technically they remain employed. Under Medi-Cal policy, eligibility is redetermined every 12 months, but enrollees are required to report changes in eligibility status even if they occur before the redetermination. Individuals who are enrolled in CWD but are not working have probably not reported the change in their eligibility status. For others, the number of hours worked per week fluctuated, depending both on their health status and the amount of work available through their employer. During particularly slow periods, there may be little or no work for the enrollee even though he or she is still employed.

> *"Having Medi-Cal is like having peace of mind. For me it's worth it to pay the premium to know that Medi-Cal will pay for what Medicare does not."*
> —CWD Enrollee

Follow-up interviewees suggested that the program implement special provisions to address temporary lapses in work that are beyond the enrollee's control. Several interviewees noted the irony of a program charging a monthly premium to a working individual with disabilities that is lower than the monthly share of cost charged disabled individuals who are not working. Many thought that individuals who are laid off from jobs or who are unable to work during temporary flare-ups of their condition should retain CWD coverage for a longer period of time than is currently allowed. Most were unaware of the CWD policy providing two months of continuing coverage when loss of employment is due to good cause. Several survey respondents also commented that finding employment in the first place could be difficult and believed that helping disabled individuals find jobs would improve the program.

Table 20 shows that respondents generally indicated that they would work more hours each week if there were no income eligibility limit for the program. Eighty-four respondents would work 20 or fewer hours, and 62 respondents would work more than 20 hours each week if they did not have to limit their earnings. Fourteen people would not work at all. Some of the latter work just to keep their CWD coverage because they do not have access to other coverage or because their share of cost in another Medi-Cal aid category is higher than they can afford.

Slightly over one-third of respondents indicated that knowing they would be eligible for CWD did influence their decision to go to work. For most respondents, however, enrolling in CWD did not change how much they worked. About twice as many individuals (17) work more hours than

work fewer hours (8) as a result of enrolling in the CWD Program. It is possible that those who work fewer hours do so in order stay within the income eligibility limits for CWD. Some individuals indicated that over time, they have been promoted at work and that those promotions were accompanied by an increase in their wage or salary. However, they have had to either forgo the raise or decrease their work hours to stay within CWD earnings limits. Others who also receive SSDI payments may limit their work hours to stay within the SGA limit (currently $780 per month). Individuals working at or above the SGA lose eligibility for SSDI benefits, which could significantly reduce their total monthly income if their earned income is insufficient to make up for the lost SSDI payment.

Size of Employer

As shown in Table 20, most respondents worked for employers with less than 100 employees. Seventy-five percent of respondents worked for employers with less than 25 employees. Some follow-up interviewees stated that because they needed to be working to be eligible for CWD, they asked a friend or church to "employ" them by paying them for services rendered, even if they were just to be paid for a few hours of work each week. Thus, some of the individuals who indicated that they work by themselves are not technically self-employed. Rather, they might be describing a work environment in which their work tasks are completed without the presence of other employees.

Table 20. Size of Respondent's Employer

Number of Employees	Number	Percentages
Just myself	41	26%
2–5 people	29	19%
5–24 people	45	29%
25–99 people	21	14%
100+ people	19	12%

Other individuals sought new employment expressly for the purpose of attaining eligibility for CWD. Two interviewees started their own businesses, turning hobbies into work. Both work from their homes. One began her business in order to qualify for CWD, while the other, who was already enrolled, began her business to retain her CWD eligibility after she was laid off.

Health Insurance Coverage

Table 21 presents the health insurance coverage of survey respondents prior to joining CWD, as well as any additional coverage they had as CWD enrollees. Fourteen percent of respondents were uninsured prior to having CWD coverage. Similar numbers of respondents had only Medi-Cal (33) or only Medicare (29) prior to enrolling in CWD, and 48 respondents (30 percent) had both types of coverage. Sixteen percent of respondents had private coverage, paid for either out of pocket or by a family member; or they were covered through their employer before enrolling in CWD. Additional information provided by respondents who purchased private coverage

suggests that some of those respondents were actually referring to Medicare coverage for which they pay monthly premiums. Of the 16 respondents with private coverage, nine had health coverage through their employer.

Table 21. Health Insurance Coverage of Respondents

	Prior to CWD Coverage		With CWD Coverage	
	Respondents	*Percentage*	*Respondents*	*Percentage*
Medi-Cal only	33	20%	24	15%
Dually eligible	48	30%	123	76%
Private coverage	26	16%	15	9%
Uninsured	23	14%	0	0
Medicare, non-dual	29	18%	0	0
County	3	2%	0	0

Enrollees were asked about what other health coverage they had in addition to CWD at the time of the survey. Respondents with Medicare coverage totaled 123 (46 more than those who had Medicare prior to enrolling in CWD). CWD was the only source of health care coverage for 15 percent of respondents. Among the nine percent who have private coverage in addition to CWD, just four respondents (three percent) had health coverage through their employer in addition to being enrolled in CWD. The overall rate of private coverage decreased slightly from 16 percent to nine percent once respondents gained CWD coverage

As shown in Table 22, a majority of respondents (76 percent) did not have access to employer-sponsored coverage, in most cases because their employer did not offer it at all or because they were ineligible as part-time or temporary employees. Some respondents were not eligible for employer-sponsored coverage because they were not currently working. Fewer than five percent of respondents were also enrolled in insurance coverage provided by their employers; a similar number had access to employer-sponsored coverage, but chose not to enroll.

The lack of employer-sponsored health coverage is not surprising given that most respondents work less than 20 hours per week. Part-time workers are typically not eligible for employer-sponsored health coverage. One recent survey found that only two out of five part-time workers are eligible for health plans offered by their employers to full-time workers.[33] Part-time workers and self-employed workers are more likely to be uninsured than full-time workers. The same survey showed that 26 percent of part-time and 35 percent of self-employed workers were uninsured, in comparison to 21 percent of full-time workers. Moreover, most survey respondents work at small businesses with less than 25 employees. The smaller the business enterprise, the greater the likelihood that health coverage is not offered to the workers. A California HealthCare Foundation–funded survey of California employers found that 89 percent of employers with 25 to 50 employees offered coverage to full-time employees. This percentage drops to 82 percent for firms with 10 to 24 employees and to 64 percent for firms with two to nine employees.[34]

Table 22. CWD Enrollees with Access to Employer-Sponsored Coverage

Access to Employer-Sponsored Coverage	Respondents	Percentage
Not currently working	18	12%
Employer does not offer health insurance	63	40%
Not eligible for insurance through work	56	36%
Enrolled	6	4%
Choose not to enroll	6	4%
Not sure	7	4%

The Decision to Enroll

Respondents were asked to rate the importance of selected factors in their decision to enroll in CWD. Responses to this rating question were then categorized by respondents' coverage prior to enrolling in CWD, as shown in Table 23. Most respondents in all coverage groups ranked each factor as "somewhat" to "very" important in their decision to enroll. This trend suggests that there is no single most influential component of the program, but that the decision to enroll in this program is based on a confluence of factors.

Among respondents who had either private coverage or some other form of Medi-Cal coverage prior to enrolling in CWD, more than 80 percent indicated that lower monthly costs were very important in their decision to enroll. Seventy-two percent of dually eligible and 75 percent of uninsured individuals responded the same way. Among individuals who previously were insured privately, 92 percent said that the ability to work and keep their Medi-Cal coverage was very important in their decision. The most important factor in uninsured individuals' decision to enroll in CWD was that they had no other available coverage.

Sources of Information That Led Enrollees to CWD

Table 24 summarizes the respondents' sources of information about the CWD Program. County eligibility workers were most often the key source of information; nearly 60 percent of all respondents heard about CWD from an eligibility worker. Overall, community-based organizations (CBOs), such as those providing community benefits counseling or planning services, were the second most common source, with 20 percent of respondents identifying community-based organizations as their source for information. The least common source of information among all previous coverage groups was employers.

While eligibility workers were the primary source of information about the program for all respondents, respondents also got information from eligibility workers. Some follow-up interviewees indicated that eligibility workers did not actively provide information on CWD or suggest the program until the enrollee requested information. Interviewees also stated that when

Table 23. Importance of Select Factors in Enrollment Decision by Prior Coverage Group

Prior Coverage	Factor	Level of Importance				
		Not at All	Not Very	Not Sure	Somewhat	Very
Medi-Cal Only	Ability to work and keep Medi-Cal	9%	3%	3%	13%	72%
	Services covered	3%	0	10%	13%	73%
	Quality of care available	7%	4%	18%	14%	57%
	No other coverage available	4%	0	33%	13%	50%
	Did not have to spend down	11%	0	7%	11%	70%
	Lower monthly costs	3%	0	10%	7%	80%
	Lower cost per doctor visit	3%	0	10%	14%	72%
Dually Eligible	Ability to work and keep Medi-Cal	2%	0	7%	9%	83%
	Services covered	0	2%	5%	14%	80%
	Quality of care available	2%	10%	10%	17%	62%
	No other coverage available	15%	0	25%	5%	55%
	Did not have to spend down	17%	2%	14%	14%	52%
	Lower monthly costs	5%	5%	7%	12%	72%
	Lower cost per doctor visit	17%	2%	5%	5%	71%
Private Coverage	Ability to work and keep Medi-Cal	0	0	4%	4%	92%
	Services covered	4%	0	13%	8%	75%
	Quality of care available	9%	0	14%	27%	50%
	No other coverage available	14%	0	14%	5%	68%
	Did not have to spend down	25%	0	4%	13%	58%
	Lower monthly costs	9%	0	0	4%	87%
	Lower cost per doctor visit	13%	0	0	13%	74%
Uninsured	Ability to work and keep Medi-Cal	21%	0	0	5%	74%
	Services covered	12%	0	6%	6%	76%
	Quality of care available	13%	7%	7%	7%	67%
	No other coverage available	5%	0	5%	5%	84%
	Did not have to spend down	25%	0	6%	6%	63%
	Lower monthly costs	25%	0	0	0	75%
	Lower cost per doctor visit	29%	0	0	7%	64%
Medicare, Non-Dual	Ability to work and keep Medi-Cal	3%	0	0	14%	83%
	Services covered	0	0	0	11%	89%
	Quality of care available	14%	0	18%	11%	54%
	No other coverage available	15%	4%	23%	8%	50%
	Did not have to spend down	18%	0	7%	0	75%
	Lower monthly costs	15%	0	0	8%	77%
	Lower cost per doctor visit	16%	4%	12%	4%	64%

Table 24. Source of CWD Information by Previous Insurance Coverage

Prior Coverage	Friend or Relative	Ad*	CBO†	Provider	Eligibility Worker	Work	State or County Entity‡
Medi-Cal only	3	0	3	0	23	1	3
Dually eligible	2	3	9	1	34	1	3
Private coverage	0	1	7	4	12	0	1
Uninsured**	1	0	5	1	13	0	1
Medicare, non-dual	7	0	6	0	14	0	3
Total	13	4	30	6	96	2	11
Percentage	8%	2%	19%	4%	59%	1%	7%

* Advertisement.
† Community-based organization.
‡ An entity other than Medi-Cal such as Vocational Rehabilitation.

asked, a few workers immediately recognized the program, but many did not. Interviewees often had to make multiple attempts to obtain information about CWD, speaking with one eligibility worker after another until finding one who knew enough about the program to begin the eligibility determination process. This observation by survey interviewees was consistent with those of the county eligibility workers.

Several respondents had little or no understanding of the program even once they were enrolled; some indicated that they were "switched" into the program by an eligibility worker who did not provide any other information about the program. Respondents experienced difficulty obtaining various types of needed information, including:

- program benefits, such as covered services and coverage limitations;
- eligibility requirements;
- enrollee responsibilities; and
- differences between CWD and other Medi-Cal coverage categories.

Asset Limits

The current CWD asset and resource limit is $2,000 for individuals and $3,000 for couples. Assets are defined as income, savings or checking accounts, investments, or property. As shown in Table 25, most respondents did not have to eliminate or limit their assets in order to enroll in CWD. Income and savings or checking accounts were more often eliminated or limited than were investments or property. The fewest number of respondents indicated that property was the asset they had to eliminate or limit.

Table 25. Respondents Eliminating Assets in Order to Enroll in Medi-Cal

	Yes	No
Income	18%	82%
Savings/Checking Accounts	19%	81%
Investments	5%	95%
Property	2%	98%

Of the follow-up interviewees who did not reduce assets, most (19 respondents) did not even have assets prior to enrolling in the program. Some interviewees were enrolled in Medi-Cal (through another aid category) prior to enrolling in CWD and therefore their assets were already within the permissible limits. For others, whatever assets they had were spent to cover their health care costs before they applied for CWD enrollment.

Personal Assistant Services

The enrollee survey included questions regarding the use of personal assistant services (PAS) and whether providing PAS in the workplace would enable greater workforce participation. Most survey respondents did not use personal assistant services (PAS), but of the 20 individuals who did, six also used PAS at work. Follow-up interviewees who did not use PAS stated that they did not require PAS at the time. Some interviewees could not afford an assistant and some were unaware of programs that provided assistance with PAS.

For those respondents using PAS, services were most often either obtained through the In-Home Supportive Services (IHSS) program or paid for out of pocket. Individuals paid from $12 to $225 per week out of pocket for PAS. The next most common sources of payment for PAS were family members or friends. Most respondents who use PAS would not increase their workforce participation if they could use PAS at work.

Enrollee Satisfaction

Areas of Satisfaction

Table 26 summarizes respondents' overall levels of satisfaction with the CWD Program. Respondents are highly satisfied with CWD, regardless of what their coverage status was prior to joining the program. No one who was previously uninsured or who had either Medi-Cal or Medicare coverage was "not satisfied at all." Sixty-one percent of individuals who were privately covered prior to enrolling in CWD were "very satisfied" with the program. Those previously covered privately also had the highest rate (four percent) of being "not satisfied at all."

Satisfaction with the CWD Program was similar for both men and women, with 68 percent of both men and women being "very satisfied" with the program. Seven percent of women and 11 percent of men were "somewhat unsatisfied" or "not satisfied at all" (data not shown).

Table 26. Enrollee Satisfaction Level by Type of Coverage Prior to CWD

Prior Coverage	Not Satisfied at All	Somewhat Unsatisfied	Not Sure	Somewhat Satisfied	Very Satisfied
Medi-Cal only	0%	6%	15%	21%	58%
Dually eligible	2%	0%	5%	18%	75%
Private coverage	4%	0%	9%	26%	61%
Uninsured	0%	5%	5%	11%	79%
Medicare, non-dual	0%	7%	7%	18%	68%
All respondents	1%	3%	8%	19%	68%

Respondents who use personal assistant services also reported a high level of satisfaction with the program. More than three quarters of respondents who use personal assistant services either at home or at work were "somewhat" or "very satisfied" with the program, and no one within this subgroup expressed dissatisfaction with the program (data not shown).

Follow-up interviewees were asked about their satisfaction with specific aspects of CWD. Interviewees were most satisfied with the reasonableness of premium payments, followed by the quality of care received.

Eligibility workers won praise from some respondents. One interviewee stated that once he was able to identify an eligibility worker aware of the program, that worker was very helpful in processing his application. Others noted that they would not have found out about the program if their worker had not provided them with program information.

Areas of Dissatisfaction

Respondents are highly satisfied with the program overall; however, in follow-up interviews they did identify some areas that had caused them difficulty. Interviewees were most dissatisfied with their ability to obtain needed information and the enrollment process. Almost one-half expressed dissatisfaction with their ability to get needed information and nearly one-third were dissatisfied with the enrollment process (data not shown). Many interviewees and respondents indicated that they experienced difficulty reaching their eligibility worker when they had questions, and that their phone calls or other correspondence often went unreturned or unanswered.

Respondents also expressed concern with the benefits covered. Respondents want expanded access to pharmaceuticals and were frustrated with the monthly limit on the number of prescriptions they can fill without submitting a treatment authorization request (TAR), especially when those drugs are often part of ongoing treatment regimens. Other respondents took issue with the Medi-Cal drug formulary, stating that all drugs should be available to all Medi-Cal enrollees, especially those with disabilities. Expanding the type and amount of covered services was also identified as a needed improvement to the program. In particular, several respondents cited a need for more dental and vision coverage.

Survey respondents experienced difficulty finding a provider who accepts Medi-Cal. In many cases, respondents were not able to find conveniently located providers, and some travel up to

two hours to the nearest provider accepting Medi-Cal. Several respondents demonstrated their awareness of provider reimbursement rates in Medicaid by stating that they believed low provider reimbursements made accepting Medi-Cal unappealing to providers, leading to their own difficulty in finding providers.

Many respondents were also frustrated with the premium payment system in which DHS is to supply enrollees with premium payment envelopes, stating that they were not receiving the envelopes in a timely manner.[35] As a result, some respondents forgot to pay premiums at all or premium payments were late. These individuals were concerned that they would lose their coverage if their premium payments were late and stated that they rely on the envelopes to serve as a reminder to send payment.

> *"Without this program, costs would be so high it would be impossible for me to live because my medicine costs alone are $1,000 a month. I thank God every day for this program."*
>
> —CWD Enrollee

Most of the issues cited above by survey respondents as areas in which they experienced some dissatisfaction warrant clarification. The issues raised by respondents and interviewees—specifically, concerns with limitations in certain benefits, difficulty finding providers that accept Medi-Cal, and dissatisfaction with the enrollment process—are not unique to the CWD Program. Rather, these concerns are consistent with those that have been raised over time by enrollees, policymakers, and advocates about the Medi-Cal program in general. It is beyond the scope of this study to examine these issues further. However, the repeated identification of these areas of concern warrants further study and investigation.

Stories from Enrollees

Several of those interviewed in follow-up to the enrollee survey shared experiences illustrative of the real-life choices and challenges working individuals with disabilities confront. Several of the respondents' situations are described below. These stories demonstrate the benefits and ironies of the policies governing CWD, including those that create work disincentives rather than incentives. These stories demonstrate that CWD enrollees are diverse in many ways, including in their demographic characteristics, level of need for health care services, need for assistance at home or at work, and the work-related issues they face. The value enrollees place on CWD emerges in their stories, as do their frustrations in obtaining needed information and the challenges they face in navigating multiple public benefit programs and private insurance. Enrollees must carefully weigh their options for benefits and often are placed in the tenuous position of having to choose one program over another. Enrollee names have been changed to protect their confidentially, but their circumstances have not been altered.

Michael

Age:	33 yrs. old
Employment:	Managerial, 35 hours/week
Disabling Condition(s):	Quadriplegic

"If it wasn't for the California Working Disabled Program, I would not be able to work. Increas[ing] the income limits [would improve the program]. I just got a promotion where I was offered more than $42,000 per year. I took the promotion, but I asked not to be paid more than $41,500."

Michael became a quadriplegic after suffering a spinal cord injury and uses a wheelchair and help from a personal assistant. He was lucky because his family could help either by providing personal assistant services themselves or by paying for services. After completing college Michael began working and did not apply for Medi-Cal or other benefits. When he was informed that his personal assistant, a family member, could no longer continue helping him, Michael realized that he needed help finding and paying for his personal care services, which would cost him about $1,700 per month. His employment-based health insurance covered most of his medical expenses but did not pay for personal assistant services.

In June 2000, Michael applied for CWD so that he could access the In-Home Supportive Services program, which would help him with his personal care needs. When he first inquired about CWD, Michael was told that the program did not exist, but he persisted and was eventually approved for coverage two months later. Since then he has been enrolled in CWD, accessing IHSS services through Medi-Cal and using his employer-sponsored coverage for other medical services.

Michael is very happy with CWD and is grateful for the personal assistant services he receives through IHSS. However, he cites the program's income limits as a major restriction. Michael currently earns about $41,500 annually, which, after all permissible exemptions and reductions, puts him at the upper limit of eligibility. Over the last couple of years, he has been offered several significant pay raises and promotions. While he can accept the promotions, taking on additional work responsibilities, including a managerial role, he has had to decline raises in order to keep his eligibility for CWD. He reports having to turn down one position that would have paid him approximately $60,000 annually.

Robert

Age:	49 years old
Employment:	Consultant, 1–10 hours/week
Disabling Condition(s):	Liver cancer

"Not a lot of people know about this program. In business, the filtering of information is primary, and in this program, a lot of information is not being disseminated."

Before getting liver cancer, Robert was employed as a corporate executive, earning about $275,000 annually. Now, he is too sick to work full time, but feels lucky enough to get paid for doing some consulting work for his church, a job that is flexible enough to accommodate his health condition. After struggling with a $1,200 monthly share of cost for Medically Needy Medi-Cal and speaking with four different eligibility workers and one supervisor, he enrolled in CWD. Before Robert enrolled in Medi-Cal, he exhausted his COBRA coverage with his former employer and spent his savings and retirement funds to pay for his health care. He states that he has always worked and because he never needed to apply for benefits before, he did not know what programs were available. Robert states that the share of cost he was paying before enrolling in CWD was too high, and even

though his SSDI income was relatively high, he was only left with $600 every month. He spoke with several eligibility workers about lowering his share of cost, but no one had any options for him. Finally, he spoke with one worker who only vaguely knew about CWD, but was able to get the application process started.

Robert is awaiting transplant surgery and he plans to go back to work full time once he is fully recovered. Until that time, he plans to go back to work gradually to ensure that his income stays within SSDI and CWD eligibility limits.

Robert is highly satisfied with the CWD Program although he did not find information as readily as he would have liked, and he had to submit his paperwork a second time after his original submission was lost. He states that there needs to be standardization in the information that is being shared by eligibility workers, referring to his experience speaking with three different eligibility workers and a supervisor before speaking to a person who was aware of the program. Robert suggests that people "who have not been in the system," or individuals who have never collected state benefits, do not know about the program. Robert says, "I cannot be the only one who has worked his entire life and had a catastrophic illness that made him unable to work [in his existing job]."

Mary

Age:	47 years old
Employment:	Self-employed, 10–20 hours/week
Disabling Condition(s):	Paraplegia, spinal cord injury

"I was a social worker for 18–20 years and could advocate for myself."

"Provisions to cover a person if they become unemployed due to layoffs or business cutbacks [would make the program better]. Something like four to six months of coverage after the layoff…"

Before being laid off, Mary was eligible for her employer's health insurance plan, but she says she would have had to pay a $500 monthly premium, more than 60 percent of her monthly $800 salary. Instead, she enrolled in CWD and is very pleased with her coverage. Mary was recently laid off from her part-time job, but was told that her company would rehire her in December 2002. Mary was very concerned about retaining her CWD coverage, knowing that she had to be working to stay eligible. She did not want to accept other employment because she knew that in December, she would be working again for her former employer. In order to keep her CWD coverage, Mary applied for and obtained a business license, and turned a hobby into a business.

Mary has experienced some difficulty finding providers. She is very pleased with her primary care provider, but reports that finding specialists and dentists who accept Medi-Cal coverage has been difficult. She currently drives an hour and a half each way to see her specialist.

Mary initially learned of CWD through independent Internet research and by reading the Social Security Handbook. She contacted the Department of Social Services for additional information, and they referred her to Medi-Cal. When she called Medi-Cal, she was referred back to the Department of Social Services. When Mary first applied one and a half years ago, she was told that she was ineligible because she earned too much.

Jane

Age:	50 years old
Employment:	10 hours/week
Disabling Condition(s):	Borderline bipolar

"I don't know what I would have done without this program. I live in my own condo and I had run up some $60,000 worth of debt because no one can live…in our times on $620 a month. That's [the maintenance need level] Medi-Cal was using when I first became disabled.…I went back to work before the 250% program because I wanted to improve myself, but I still only got $620 a month. Everything else went to Medi-Cal."

Jane has been enrolled in Medi-Cal for over 20 years, paying a monthly share of cost over $600. When the CWD Program was implemented, her eligibility worker told her about it and helped her enroll. Now Jane pays a monthly premium of $20. She is grateful for her Medi-Cal, and says, "Now I pay $20 and everything Medicare doesn't pay is covered, including my expensive meds!" However, not all her medications are covered and she still pays $62 out of pocket for some prescriptions. For three prescriptions that Medi-Cal did not cover, Jane's doctor filed treatment authorization requests (TAR), which were approved. Jane could ask her doctor to file a TAR for the other drugs that she currently pays for, but states that filing TARs is "a hassle" and that she feels badly asking her doctor to do this. Jane says that because her doctor does not get paid very much, she will only ask for TARs for the most expensive medications. Jane says, "Medi-Cal should make all drugs available if they are the best on the market."

Jane expressed frustration over some administrative components of the program. She stated that it seemed like every six months she gets a new eligibility worker and that each worker advises her differently. She complained that every year, she has to submit documents that were submitted in previous years and that had not changed, such as copies of her Kaiser and Social Security cards; and that after she sends the documentation, she often is asked to resend it. Jane also complained about how long it takes to process premium payments.

Amy

Age:	30s
Employment:	Office worker, part-time
Disabling Condition(s):	HIV/AIDS

Amy has to make the difficult choice between keeping her part-time job and struggling to make ends meet or quitting her job so she can continue to collect her SSDI benefit. Amy currently receives a monthly SSDI payment of just over $900 and works part time making approximately $600 per month. She is not eligible for her employer's health benefits.

Amy was diagnosed as being HIV positive in 1998 and lost her full-time job following a hospitalization. She struggled for two years to obtain SSDI and General Assistance (GA) benefits, and during that time she was unable to work. Eventually, Amy began receiving SSDI and GA, and Medi-Cal covered her medical costs. In February 2002, Amy was able to return to work and began working 20 hours a week. Amy reported her new employment status to Medi-Cal, and as a result, she lost her Medi-Cal coverage.

Amy never received notification that her Medi-Cal coverage would be terminated. Instead, she learned of her uninsured status at the pharmacy where she was denied coverage for the prescription she was picking up. Amy was able to obtain an emergency supply of her medication

while she straightened out her coverage situation. With the help of a local community-based organization, Amy was eventually able to get on a nine-month trial program during which she would receive Medi-Cal coverage with a share of cost and an SSDI check. After the nine-month period she can keep her Medi-Cal coverage, but her SSDI payments will end. In exploring her options, Amy learned that she was also eligible for the California Working Disabled Program with a monthly premium. Amy continues to work part-time, but her employer does not offer health coverage to part-time employees.

Amy wants to keep working because she feels better when she is "doing something," but she is concerned that continuing work disadvantages her. She is looking for a full-time job, but if she is unable to find full-time work and instead remains at her current part-time job, her monthly income from earnings would stay at $600—$300 less than what she would receive in SSDI payments if she were not working. Amy is willing to pay a premium, but is unsure if she will be able to pay her monthly premium and meet her other financial obligations on just her part-time salary.

V. Nonenrollee Perspectives

A small group participated in nonenrollee teleconferences, offering insight into why individuals are not enrolling in the California Working Disabled Program. Issues that influenced their decision not to enroll in the program include:

- lack of awareness and information about CWD;
- discouragement from eligibility workers; and
- uncertainty in maintaining employment and in deciding between programs.

Their insights are consistent with the information shared by both enrollees and eligibility workers.

Reaching Nonenrollees

Identifying nonenrollee participants for this study was a significant challenge, and the two strategies used to obtain their input yielded only minimal participation. The first attempt was to conduct teleconferences with nonenrollees during which a loosely structured conversation was facilitated. Four teleconferences were scheduled. The teleconference format was chosen because it was believed to be accessible to the greatest number of people without requiring travel and could easily accommodate the schedules of working individuals. The goal for each teleconference was to have five to seven participants who would represent California's substantial regional diversity in geography, population, and access to services.

The California Work Group on Work Incentives and Health Care (CWG) was asked for its assistance in finding individuals to participate in the teleconferences.[36] A flyer explaining the purpose of and schedule for the teleconferences was distributed through the CWG network. The flyer also provided a toll-free phone number and email address to contact in order to participate. Knowing in advance that identifying the nonenrollee population would be difficult, this approach for soliciting participation was chosen after consulting with the World Institute on Disability (WID), a widely recognized nonprofit research, public policy, and advocacy organization headquartered in Oakland. The response to this effort, however, was minimal. Only six

individuals requested participation in the teleconferences. Of those participants, three individuals were employees of independent living centers.

Following the teleconference attempt, an effort was made to reach nonenrollees for one-on-one interviews. CWG members were contacted and were asked to help identify individuals who fit the target population and who would be willing to be interviewed for this study. Unfortunately, the results of this effort were also disappointing. Most CWG agency representatives expressed concern that this population would be very difficult to find and were unable to identify prospective interviewees. Agency representatives stated that when their agency interacted with individuals, those individuals were referred to and enrolled in appropriate programs, thereby removing them from the target population. Otherwise, once a referral was made, no further contact was made unless that individual returned to the agency.

Lack of Awareness and Information

All teleconference participants cited lack of awareness as the primary reason for nonenrollment in CWD. Many working individuals with disabilities do not request enrollment in CWD because they do not know that the program exists. One participant noted that during an informational workshop on programs and services for people with disabilities, most workshop attendees were unaware of the program. Participants were largely unaware of outreach activities for CWD, but noted that some independent living centers (ILC) sponsored briefings on the program. Specifically, one participant noted that one ILC hosted an informational workshop specifically about the CWD; however, only five individuals attended.

Teleconference participants also reported that it was sometimes difficult to obtain information about the program, including from social services. They remarked that sometimes potential enrollees know more about the program than social services employees. In one case, an individual specifically requested to apply for CWD, but was unable to obtain the correct contact information, and, as a result, her application was passed along various routes without action. Her application was still pending at the time of the teleconference. Another participant commented that some people experience so much frustration with "the system," including with other benefits programs, that when they eventually learn of the program, they will not attend informational workshops or apply because of their disillusionment. Teleconference participants also discussed a failure on the part of the state to provide individuals with "Ramos packages." Ramos packages are letters informing those who lose eligibility for SSI that they may still be eligible for Medi-Cal coverage. These packages also describe the process for requesting an eligibility screening.[37]

One teleconference participant suggested using a Web-based application for CWD. He thought this would facilitate a more convenient and efficient application process, noting that applicants are working and may experience difficulty getting time off during the day to apply. The participant also suggested that the system could prompt applicants for the supporting documentation they need to send to the social services office to help ensure that applicants provide all necessary information as quickly as possible. Using a Web-based application may in fact facilitate the enrollment of at least a subgroup of the CWD target population of working individuals who have Internet access in the workplace but who otherwise would have no or very limited means of accessing the Web.

Discouragement from Eligibility Workers

Teleconference participants reported that some eligibility workers who are aware of the California Working Disabled Program actively discourage individuals from enrolling. The eligibility workers advise potential enrollees that the program requires a monthly premium payment, which they perceive to be more onerous than the share of cost requirement in the Medically Needy Medi-Cal program. Because enrollees in Medically Needy aid categories are required to pay a share of cost only in the months they receive health care services, those with relatively infrequent health care needs may not incur expenditures in some months. If the same individual were enrolled in CWD, he or she would be responsible for making premium payments each month, regardless of whether or not they received health care services. Eligibility workers who discourage enrollment in CWD may believe it is in the financial interest of the enrollees to make payments only when they actually receive services. Eligibility workers confirmed that when an individual is eligible for both CWD and the Medically Needy Medi-Cal program, he or she may choose which program to enroll in.

Uncertainty

One self-employed participant said that uncertainty about future income influenced his decision not to enroll in CWD. This individual is a new small business owner who expressed a strong desire to be enrolled in a program for working individuals. However, because his business was new, he was unsure whether his income would be sufficient to pay monthly premiums. This individual opted for continued enrollment in Medically Needy Medi-Cal until he has developed enough experience with his business to feel secure about a decision to enroll in CWD. Another participant stated that some eligible individuals are wary of public benefit programs, and, in the case of CWD, may be even more so because they are unaccustomed to benefits program that required payment for enrollment.

VI. County Eligibility Worker Interviews

As demonstrated by both the enrollee survey and the nonenrollee teleconference findings, eligibility workers play a critical role in educating and enrolling eligible individuals in CWD. Eligibility workers interviewed for this project identified several issues, also raised by enrollees and nonenrollees, that contribute to CWD enrollment trends, including:

- the asset test burden;
- lack of CWD outreach and information; and
- lack of and/or insufficient eligibility worker knowledge.

County eligibility workers also suggested that the following factors contributed to the CWD enrollment trend:

- strained county resources;
- other Medi-Cal programs with very similar target populations; and
- systems issues.

The Asset Test Burden

> *"We need more incentives to work and maintain our savings so that we can remain independent. The restrictions on how much checking/savings we can have are confusing and impractical."*
> —CWD Enrollee

Eligibility workers and county staff provided mixed responses when asked whether the asset test was a barrier to enrollment in the program. Some workers did not think that the asset test was a significant barrier to enrollment and were not aware of denials of eligibility due to asset levels. A county staffer from a large county believed that the asset level did keep certain individuals from being eligible for CWD. Staff in two large counties believed that some individuals do not want to disclose asset information and therefore choose not to apply, even though they might be eligible.

Public Outreach and Information

Eligibility workers were interviewed and asked to describe outreach activities conducted to promote CWD. In general, interviewees report that the state, counties, or community-based organizations (CBOs) conduct little or no outreach for CWD. Eligibility workers reported that upon program implementation, the state issued a one-page flyer that provided basic information about the program, including eligibility, cost sharing, and asset levels; and that directed individuals to counties for more information. One county long-term care supervisor involved in CWD implementation reported that he received several hundred inquiries in response to the DHS flyer. However, most respondents misunderstood the information, thinking that the program was a new cash benefit program, rather than a new option for Medi-Cal coverage.

In the initial stages of implementation, the state directed all counties to review their roster of enrollees in share of cost Medi-Cal aid categories for their potential eligibility for the CWD Program. Enrollee cases determined to be potentially eligible for CWD were flagged, but there was no requirement to contact enrollees. In most cases, individuals who were identified as potentially eligible were not screened until they had some other reason for contacting their caseworker or until their redetermination.

Ventura County took a particularly proactive approach in reviewing share of cost enrollee cases. Once potentially eligible enrollees in share of cost Medi-Cal programs were identified, the county mailed letters informing them of their potential eligibility for a new Medi-Cal program that may have lower cost-sharing requirements. Individuals were advised to contact the county to be screened for CWD, and a county eligibility worker then followed up with those who had indicated interest in the program. Of the initial group of individuals screened in Ventura, most were enrolled in CWD. The eligibility worker estimates that since that time, about half of those initially enrolled have stayed enrolled in CWD. As a result of their proactive approach to recruitment for CWD, Ventura County has experienced some of the highest levels of CWD enrollment seen in a California county.

> *"If I had known I qualified for this program sooner, it really would have helped me. I was eligible in April 2001, but didn't know until November 2001."*
> —CWD Enrollee

Counties have not pursued outreach targeted specifically at boosting CWD enrollment. Outreach for CWD is more often a component of more general Medi-Cal outreach, such as participating in health fairs, making presentations at CBOs, and sharing information at meetings with other county agencies, such as social services agencies. One eligibility worker reported that her county chose not to actively promote this program because of the county's lack of resources. In previous years, the county had participated in weekend health fairs where general information about Medi-Cal, including CWD, was shared with the community. Health fair participation required a commitment of staff to work at the fair and the financial resources necessary to pay staff overtime. The county felt it could not promote a program that it could not effectively implement. Specifically, the county believed it lacked sufficient resources to efficiently respond to a potential influx of inquiries or applications resulting from an outreach campaign. The interviewee stated that adding more cases to the eligibility workers' already burdensome caseloads would cause difficulty.

Overwhelmingly, eligibility workers stated that the primary obstacle to more robust enrollment in CWD was the lack of program awareness by potential enrollees and by eligibility workers themselves. Eligibility workers report that few, if any, clients request enrollment in the CWD Program and that clients generally are unaware of the program or are otherwise misinformed. According to eligibility workers, many clients believe that they are not eligible for the program because they work more than a certain number of hours or by virtue of the fact that they work at all. Other potential clients believe that if they have other forms of health coverage, they are not eligible for CWD. One eligibility worker stated that clients do not understand that CWD offers full-scope Medi-Cal benefits, just like other programs for individuals with disabilities. Others are concerned about having to change doctors. Eligibility workers report that only on rare occasions has a client specifically requested screening for CWD.

Eligibility Worker Training

Training Practices

Training for the CWD Program has occurred in much the same way as training for other Medi-Cal programs—through the dissemination of written materials, first from the state to county program and policy offices and then from those county offices to county eligibility units. The State issues "All County Welfare Directors Letters" that provide basic program information and subsequent updates regarding benefits, eligibility, and cost-sharing requirements. The first "All County Welfare Directors Letters" and accompanying draft procedure manual sections were issued to counties on March 16, 2000, in advance of the program's April 1, 2000, implementation date. "All County Welfare Directors Letters" about CWD were also issued on September 27, 2000, and April 17, 2001.

The counties' written notices established whether the screening procedure for the CWD Program would be centralized or decentralized. In counties with centralized eligibility determination, program guidance set forth the procedures for referrals to appropriate staff for determinations. In a centralized eligibility determination process, all applications are initially distributed among eligibility workers. If eligibility workers receive an application for an individual who appears to qualify for CWD, they forward the application on to the specialized eligibility worker or unit to make the eligibility determination.

Where the official eligibility determination process is centralized, it is still incumbent on all workers to recognize potentially eligible clients and make referrals to the specialized worker or unit. Without the initial referral, the eligibility screening for this program will not occur. According to eligibility workers interviewed, centralized eligibility systems are used because so few CWD cases appear. County managers believe it is more effective to develop program expertise within a core group of specialized eligibility workers than it is to train all eligibility workers, as many may never encounter a CWD case.

> "…the CWD Program does not impact enough people to warrant its own training…"
> —County Medi-Cal Eligibility Worker

Counties with a decentralized eligibility determination process do not designate specialized eligibility workers. Instead, all eligibility workers make eligibility determinations for all Medi-Cal aid categories.

Eligibility workers were expected to read the new Medi-Cal manual sections and begin screening for eligibility in the program. The guidance also provides instructions for completing required forms, such as *SSI/SSP Property Test Worksheet for the 250 Percent Working Disabled Program* (MC 338C) and the *Premium Differential Worksheet in the 250 Percent Working Disabled Program* (MC 338J). The budget is calculated using the *250 Percent Income Test Worksheet for the 250 Percent Working Disabled Program* (MC 338).

As with outreach, CWD Program training is incorporated into broader Medi-Cal training sessions, rather than being offered as a separate CWD-dedicated training. In some counties, training consisted of supervisors briefing eligibility workers on new programs. In one county with centralized eligibility determination, the eligibility worker who processed the first CWD case was asked to develop a training outline for eligibility staff, including technical instructions and background information on the program.

Eligibility workers report that they primarily learned about CWD and other programs on their own. Aside from their "hands on" experience, eligibility workers received little other training. Some workers in decentralized eligibility counties reported that they have been identified as the county's "CWD expert" because they were the first worker in their county to process an application for the CWD Program. When other workers have a CWD case, they consult their county "CWD expert" for advice as needed. Eligibility workers often use the earliest cases as examples upon which decisions about new cases are based.

Training Shortcomings

Eligibility workers commented that even with the training described above, sometimes they, themselves, are unaware of the CWD Program at all and therefore do not screen for eligibility or make referrals for eligibility; or they have misconceptions about people with disabilities. Some eligibility workers do not think that many individuals with disabilities work, preventing them from informing those interested in returning to work about CWD. Some interviewees reported that workers in their counties, especially new eligibility workers, are often overwhelmed with the number of aid categories and cannot recall them all or remember how to process the appropriate application.

The perception of difficulty in completing forms and calculating budgets was identified by one eligibility worker as a reason for lack of enrollment in CWD. The additional forms that must be completed may also intimidate some eligibility workers, particularly the budget forms. In most counties, budgets are calculated manually and use rules different from other aid categories. Like nonenrollees, some eligibility workers thought that increased use of automated systems would facilitate eligibility determinations, or at least make them simpler. They believed that having a system to prompt eligibility workers about which information to provide would help ensure that enrollees are assessed for appropriate aid categories, and would be especially useful in budget calculations.

One worker shared her belief that some workers choose to overlook the program to avoid having to complete the forms. Some eligibility workers report that program regulations are too complex and the program manual too unclear, making it difficult for eligibility workers to obtain clear, easy-to-understand program information. The majority of workers stated that eligibility determinations for this program were slightly more difficult or confusing than for other

programs. Only two workers, one from a centralized and the other from a decentralized county, thought that screening for CWD eligibility processing is relatively straightforward.

Eligibility workers, who are charged with assessing applicants' eligibility across all Medi-Cal aid categories and enrolling them in the most beneficial program, are often potential enrollees' only source of program information. When eligibility workers fail to refer applications to the specialized eligibility worker (in the case of counties with centralized eligibility determinations), or do not themselves screen the applicants for CWD eligibility, potentially eligible individuals remain unaware of the program.

When asked whether additional training would be helpful, eligibility workers provided mixed responses. Some thought additional training would be useful if the trainings were ongoing, reinforcing that the program was available and how applications are processed. Other workers questioned the value of additional training, stating that the information presented at trainings is understood while at or immediately following the training, but that it is not always retained because there are few opportunities to use the newly gained information. Moreover, the time necessary to attend a training session is sometime perceived as an additional burden on the eligibility worker's time, especially in this era of increasing state deficits and decreasing administrative budgets.

Strained Resources

Eligibility workers are responsible for keeping track of all Medi-Cal aid categories and ensuring that applicants are enrolled in the most beneficial aid category. Currently, Medi-Cal comprises more than 100 aid categories.[38] However, eligibility workers report that it is difficult to keep current with program changes because changes occur so frequently. Assessing eligibility for so many programs can be time-consuming, especially since the process is manual. Some workers believe that the CWD Program is considered "just one more program to keep track of." In another county, program office staff stated that the caseload of eligibility workers is so great that they don't have time to complete the lengthy paperwork to screen for eligibility for all aid categories. Instead, eligibility workers' goal is to get clients enrolled in a program so that clients can access services as soon as possible, rather than having them wait to be screened for all eligibility categories and being enrolled in the most technically correct aid category.

Eligibility workers report that program guidance is confusing, which is particularly problematic given that shrinking administrative budgets and growing caseloads are creating pressure to process cases quickly. Eligibility workers might not take the time to read program guidance in order to enroll an individual in CWD when that person receives the same benefits by enrolling in another aid category more familiar to the eligibility workers. Eligibility workers may decide to enroll clients in the aid code for which the client is first determined eligible without further investigation of other coverage categories. New eligibility workers especially may have a harder time remembering the CWD Program simply because they are in the process of learning all aid codes and CWD is relatively uncommon and complex.

One interviewee described some eligibility workers as "apathetic" and unwilling to make the extra effort to screen for CWD eligibility. Some eligibility workers report that instead of screening for eligibility in new aid programs during redetermination, individuals are simply re- enrolled in the same program.

"Competing" Aid Categories

In two counties, eligibility workers thought that other Medi-Cal coverage programs (see Table 1) with eligibility overlapping CWD eligibility "competed" with the CWD Program for enrollees. Eligibility workers are directed also to assess the eligibility of CWD applicants for other aid categories such as the Medically Needy Program to determine which program is the most beneficial to the applicant. Both programs offer full-scope coverage of services, but differ in how net countable income is determined for the purposes of eligibility and enrollees' financial responsibilities. One major difference in how income is determined is that for CWD, all disability-related income is exempt. The CWD Program requires individuals to pay monthly premiums using an income-based sliding scale, while in the Medically Needy Program, individuals are responsible for a share of cost. Eligibility workers are directed to complete budgets for both programs to first determine whether the applicant is eligible for either program and to determine the cost-sharing requirement of both, if any. Applicants are advised of their eligibility and responsibilities under each program and are permitted to choose the program that they believe best meets their needs.

Some workers reported that individuals who were not familiar with premium payments preferred making share-of-cost payments, a familiar payment scheme. Another worker stated that clients have told her that they did not want to make monthly premium payments for the months in which they would not receive services. However, most enrollees stated that they prefer making monthly premium payments in lieu of share-of-cost payments because premiums were significantly less than share-of-cost payments.

One county staff person stated that the county's potential Medi-Cal enrollees are, for the most part, low-income, and although it has actively tried to enroll individuals in CWD, most clients are found eligible for A&D. California's Medi-Cal Aged and Disabled Program (A&D) was implemented on January 1, 2001, and provides no-cost Medi-Cal to individuals aged 65 or older or individuals with disabilities with incomes up to 100 percent of FPL. In some counties, clients identified as potentially eligible for CWD or who were initially enrolled in CWD were subsequently determined to be eligible for A&D.

Systems Issues

Some eligibility workers report systems issues in which county systems do not properly interface with the Medi-Cal Eligibility Data System (MEDS) with regard to the CWD Program. Counties operate, maintain, and adjust their own eligibility systems into which they enter enrollee eligibility data, including aid codes. The information from the county system is interfaced with the MEDS system, which is maintained by the state. When interface problems occur, eligibility workers can circumvent them by entering another code, such as the Medically Needy aid code. The result of this practice is an undercount of individuals who enrolled in the CWD program and an overcount of individuals who enrolled in the Medically Needy category. All counties have an assigned MEDS coordinator who assists them when issues arise related to interfacing with MEDS. One state Medi-Cal eligibility staff person noted that sometimes state staff do encounter errors in coding of enrollee eligibility. The staff person did not provide specific reasons for the errors, but stated that when such errors are found, the counties are notified and the coding issues are addressed.

VII. Lessons Learned

The CWD Program provides a valuable means of coverage to a target population of working disabled people. The program is intended to facilitate both workplace participation and health care coverage among disabled Californians with modest incomes.

At the same time, the CWD Program currently serves only 650 people, of whom only 189 were previously uninsured—a "take-up" rate that represents enrollment of less than one percent of the target population. This final section summarizes the key factors that might contribute to the program's enrollment experience thus far and impact future efforts to boost enrollment. These factors are listed below.

- The target population includes an estimated 150,000 uninsured working individuals.
- Potential enrollees lack awareness of the program.
- Eligibility workers lack knowledge, but effective training may be difficult to achieve.
- Little coordination with other agencies or organizations occurs.
- Some aspects of the program detract from its attractiveness.
- Expanding eligibility rules alone yields only small gains in enrollment.

Size of Target Population

The CWD Program's modest enrollment to date does *not* seem to be attributable to the lack of a sizable eligible target population. Approximately 900,000 disabled people are already enrolled in Medi-Cal. Many of these people might find the CWD Program desirable either in providing a means of returning to the workplace while retaining Medi-Cal coverage, or in lowering their out-of-pocket expenses by converting from a share-of-cost coverage category to a monthly premium setting.

SIPP indicates that approximately 150,000 disabled Californians are working, have no health coverage, and meet the current CWD program's income and asset eligibility criteria. This

subgroup seems to be well positioned to benefit from enrolling in CWD. The fact that so few have done so (most CWD enrollees have converted from another Medi-Cal aid category) is perhaps the most vexing aspect of the program's enrollment thus far.

Potential Enrollee Awareness

Outreach

By all accounts—from existing enrollees, county eligibility staff, and other stakeholders interviewed during the project (e.g., DHS and World Institute on Disability staff)—awareness issues have hampered CWD enrollment. The most compelling evidence of the awareness barriers comes from the difficulties many existing CWD enrollees experienced when they asked about the program, and from the extremely low number of people who have joined CWD from outside of Medi-Cal. Little outreach has been conducted to encourage enrollment. DHS attempted to promote the CWD Program by disseminating flyers to those already enrolled in Medically Needy Medi-Cal. However, the state's effort caused confusion in at least one county where some who received the flyer misunderstood the information presented, and thought that CWD was a cash benefit program rather than health insurance coverage.

A portion of the target population of uninsured disabled workers has received some outreach through the activities of the World Institute on Disability (WID), including promoting CWD in their regular newsletter, posting a CWD Question and Answer Guide on their Web site, and convening a work group focusing on work incentives and health coverage programs for people with disabilities. However, WID's efforts have not led to a substantial level of enrollment in CWD. WID itself is a strong proponent of the need for further outreach.

If the goal is to boost enrollment in the program among those currently eligible, implementing an active outreach campaign with clear information could be helpful. Study participants referred to the BabyCal outreach campaign as a model and also suggested public service announcements, bus advertisements, and flyers and posters in locations frequented by potentially eligible individuals. Outreach targeted to potentially eligible individuals, beyond those who are already enrolled in other Medi-Cal aid categories, was particularly encouraged.

Program Ramp-Up

An important factor to consider is that CWD was implemented only 30 months ago. It clearly takes time for a new coverage program to take hold, for eligibility workers to become knowledgeable about the program, and for awareness to grow among the target population. There are many other relatively new Medi-Cal aid categories with fewer than 1,000 enrollees. For example, aid codes 5T, 5Y, 6U, and 7K, which provide pregnancy-related coverage, all have fewer than 1,000 enrollees and have been in place for two or more years. Thus, it is possible that the program will soon reach an awareness threshold at which point word of mouth and eligibility worker familiarity will result in increased enrollment.

At the same time, the program's enrollment is inching upwards at an average rate of approximately 20 people per month and does not seem to be on the verge of a larger-scale influx. It is important to consider opportunities to promote the program more successfully—both in getting information out to the potential pool of applicants who are not yet enrolled anywhere in

Medi-Cal and in helping assure that eligibility workers are appropriately facilitating the enrollment of CWD-eligible people.

One means of quantifying the potential enrollment impacts of greater county-based awareness efforts is to extrapolate the enrollment experience of those counties that have achieved disproportionately high CWD enrollment levels. The ten counties with the greatest proportion of CWD enrollees—relative to their share of statewide Medi-Cal disabled enrollees—are Contra Costa, Humboldt, Napa, Orange, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, and Ventura. Those counties collectively account for 19 percent of all disabled Medi-Cal enrollees but account for 58 percent of CWD enrollees. CWD enrollment across these counties equates to 0.22 percent of their overall disabled Medi-Cal enrollment.

If this rate were achieved statewide in the current program, enrollment would triple to roughly 2,000 people. Such an increase (of about 1,300 people) would of course have cost implications. If the new enrollees' per capita costs are similar to those of existing CWD enrollees (approximately $6,000 per year), total annual medical costs associated with the 1,300 enrollees would be as high as $7.8 million, while total program costs would be $7.0 million (taking into account enrollee premiums paid). These figures apply only if all the new enrollees are new to Medi-Cal and are not switching from other aid categories. However, if only 37 percent of the additional enrollees were new to Medi-Cal, as in the current CWD Program, total annual medical costs would be much lower—$2.9 million; and total program costs would be $2.6 million, taking into account enrollee premiums. Much larger enrollment impacts are likely to accrue if successful efforts are made to broaden awareness among currently uninsured disabled workers. The challenge lies in achieving that awareness at an affordable cost, as this target population is not easy to reach.

While it is difficult to draw generalizable conclusions from conversations with eligible but nonenrolled individuals, some important themes emerge. The difficulty in finding participants for teleconferences and interviews may be indicative of the real challenge that Medi-Cal and advocates might face in conducting outreach for the CWD. Across the country, notwithstanding the significant outreach efforts underway, states have struggled to find individuals eligible for programs like Medicaid and the State Children's Health Insurance Program and continue to pursue strategies to enroll those who are eligible but not enrolled.

Eligibility Worker Knowledge of CWD

From an eligibility worker's perspective, the CWD Program is challenging in three important ways. First, it is a relatively new aid category. Second, the eligibility and income rules are different from other more common aid categories, and they are complex. Third, few cases of applicants likely to be eligible for the program have presented themselves, and few individuals are expressly requesting enrollment in CWD. Thus, the program and its rules do not immediately come to eligibility workers' minds when determining eligibility. Collectively, these factors create a significant lack of program awareness.

Eligibility worker awareness was repeatedly cited as a barrier to enrollment in the program because workers were often unaware that the program existed or misunderstood the eligibility requirements. For example, some eligibility workers erroneously advised clients that they would

not be eligible for the program due to their incomes (without first completing an eligibility determination) or that in order to qualify they would have to dispose of any retirement accounts. The lack of eligibility workers' awareness may be attributable to the fact that this program is still relatively new and that, over time, their knowledge and understanding of the program will improve. Training may also be an issue for eligibility workers, who, for the most part, receive only minimal, if any, program training.

Most enrollees responding to the survey learned about the program from an eligibility worker, and there is little active outreach for the program. These facts underscore the need for eligibility workers not only to be aware of the program but also to understand program requirements and rules. While providing training on CWD may appear to be the obvious solution to improving eligibility worker awareness, the feasibility and effectiveness of such training may be questionable. Moreover, the training itself represents another demand on eligibility workers' already constrained time. Eligibility workers have reported that the "formal" training they have received is only slightly helpful and that "on-the-job training" was more effective. Formal training curriculums could be developed to use a more "hands-on" approach. However, eligibility workers face increasing case loads and may find it increasingly difficult to take time away from processing cases to attend trainings; they are unlikely to pursue learning about the program on their own.

In addition to the increasing demands on eligibility workers' time, the complexity involved in determining CWD eligibility may hamper eligibility workers' willingness to assess eligibility under both CWD and Medically Need Medi-Cal, as they are instructed to do. Instead, eligibility workers may be inclined to determine eligibility for only the Medically Needy program, which was established prior to CWD and with which they have greater familiarity and understanding. Providing eligibility workers with a reference chart that compares enrollees' financial requirements for CWD and the Medically Needy Medi-Cal Program at various incomes might facilitate the CWD eligibility determination process. The chart could be used as a quick reference to advise applicants of their financial responsibilities under either program and to help them determine which program is most beneficial financially.

When discussing the lack of awareness of the CWD Program, an interesting dynamic emerges between eligibility workers and potential enrollees, where each believes that the onus is on the other to initiate a discussion of CWD. Eligibility workers state that potential enrollees do not know enough about the program to request an eligibility screen. However, potential enrollees and some eligibility workers report that many eligibility workers do not know about the CWD Program and therefore fail to screen applicants who might be eligible. Study participants overwhelmingly cited this common lack of awareness as the primary reason for the program's low enrollment.

Coordination with Other Organizations

The lack of coordination with CBOs or other agencies that provide services to the CWD's target population inhibits awareness. Coordinating with such agencies could help boost program enrollment. County Medi-Cal staff could meet with staff from other agencies and organizations to provide background information on CWD; in turn, agency staff could refer individuals to the CWD Program. Additionally, informational materials could be developed for dissemination or

display at various sites. Agencies and organizations that might be targeted for a coordinated outreach effort include:

- vocational rehabilitation centers;
- Social Security offices;
- departments of aging and adult services;
- County Welfare Directors Association;
- hospitals;
- independent living centers; and
- job placement agencies.

Results from the enrollee survey demonstrate that CBOs and other local agencies have already provided at least some basic information about the CWD Program to a small subset of the target population. While working with these agencies and organizations would require a modest investment of time and resources, it could prove a valuable way to reach CWD's target population. Agency employees who have frequent or ongoing contact with the target population and who have an understanding of this program can continue to refer potentially eligible individuals to the CWD Program long after any concentrated outreach campaign has ended.

Program Attractiveness

Awareness is not the only barrier to enrollment in CWD. While the program achieved extremely high satisfaction ratings from its existing enrollees, it is plausible that at least some subset of CWD-eligible individuals were aware of the program but chose not to enroll because they did not view CWD as desirable. More broadly, Medi-Cal itself is often regarded as "second-class" coverage, where care can only be accessed from a limited set of providers with long waiting periods for appointments. For some, the decision to enroll in CWD requires consideration of several factors not relevant to other Medi-Cal programs (e.g., the ability to maintain relationships with providers; implications for their monthly out-of-pocket health care costs; and eligibility for other benefit programs). Individuals considering CWD must weigh the costs of enrolling—some of which are described below—against the benefits of coverage.

Provider Relationships

Individuals with disabilities may have established relationships with providers, including specialists, which they wish to maintain. Finding providers, particularly specialists who accept Medi-Cal coverage, is a barrier to care for many Medi-Cal enrollees. Often enrollees are unable to find providers who accept Medi-Cal coverage in the areas where they live, requiring enrollees to travel significant distances to obtain services. Thus, enrolling in CWD may force individuals to find and develop new relationships with providers. Knowing that from a limited provider pool they have to find new providers that are likely to be unfamiliar with their medical history and may at best be inconveniently located could deter some individuals from enrolling in CWD.

Financial Requirements

Premium affordability is another factor that could be discouraging enrollment. Seventy percent of the existing enrollees are paying the program's minimum premium of $20. People with net countable income above $1,100 per month are required to pay a monthly premium of $100, which increases to $250 for individuals with monthly income above $2,100. It appears that very few people in these income cohorts are currently willing to pay the program's premiums. CWD premiums at these higher income levels are higher than the average premiums paid by those covered through their employer.

The SIPP data indicate that most low-income working disabled people are "asset poor" as well. While low asset levels make them eligible for CWD, those eligible also have no source of savings that can be drawn upon to help pay their monthly premiums. A rational cost-benefit decision for many working disabled people may well be to remain uninsured. If their health status worsens, odds are that they will not be able to continue working and they will become eligible for Medi-Cal through other aid codes that do not entail a monthly premium (or a share of cost).

Impact on SSDI Benefits

Another factor that might influence the decision of eligible people whether to enroll in CWD is the impact on their SSDI cash benefit. The generous income standards of CWD encourage individuals to work and earn, often beyond the permissible income standard of SSDI. However, once a person earns more than $780 per month, that individual loses eligibility for SSDI. Such an individual's earnings will often be from a low-wage, part-time job, and may not be enough to make up for the lost SSDI income. The threat of losing what can be a substantial monthly benefit, coupled with the uncertainty of finding and maintaining employment, may cause some eligible people to forgo pursuing employment and CWD coverage, choosing instead the security of a monthly SSDI benefit.

Work Requirement

The work requirement is another issue that may push eligible people to choose other aid codes or take their chances and remain uninsured. CWD coverage may be perceived as an unreliable coverage option among disabled people who are struggling to maintain an already-tenuous workforce presence. CWD enrollees who responded to this study's survey worked predominantly in part-time jobs or in jobs where availability of work may be inconsistent. Disabled workers also experience challenges to workforce participation, such as personal care needs, flare-ups of conditions that make them temporarily unable to work, and the need for certain accommodations, such as for those using wheelchairs. Those who are not yet working may experience some difficulty finding any employment at all. These individuals may opt to avoid risking their health coverage in the event that they are unable to find or maintain employment, choosing instead to enroll in another Medi-Cal aid category.

Expanding Eligibility Rules

As found in the development of AB 925 and other related legislative initiatives, many disabled people currently ineligible because of some combination of income and asset levels might benefit from the features of CWD. The modeling component of this study supports the contention that a sizable number of additional working disabled people could become eligible for CWD if the income threshold were increased and if the asset test were eliminated. However, based upon the program's low participation among those already eligible, it was also projected that very low enrollment impacts would result from these policy changes—only 189 additional enrollees if the income threshold were increased from 250 percent to 450 percent of FPL and if the asset test were completely eliminated.

Given CWD enrollment levels to date, crowd-out of private coverage has not materialized to any significant degree. Crowd-out, which is frequently cited as a concern when public health insurance programs are developed for the first time or are expanded, may especially be a concern to states that are currently facing drastic budget deficits. Findings from the enrollee survey and data analysis indicate that thus far, working individuals with disabilities have not been dropping private coverage or employer-sponsored coverage in favor of CWD—nor does this seem likely in the near future.

Only 16 percent of survey respondents had private coverage prior to enrolling in CWD, and nine percent reported having private coverage while they were enrolled in CWD. Although the number of people with private coverage dropped slightly, this change could be attributable to changes in employment or level of workforce participation. Survey data show that relatively few individuals had private coverage prior to enrolling in CWD and that once enrolled, enrollees are keeping their private coverage, leaving CWD to serve only as wrap-around coverage. The coverage history of CWD enrollees also provides some proof that crowd-out is not occurring in the CWD Program. Most CWD enrollees (63 percent) were already enrolled in a Medi-Cal aid category and not in private health insurance.

Most CWD-eligible individuals do not have access to employer-sponsored coverage. People working 30 or fewer hours per week typically do not receive employer-sponsored coverage. Among those who do have private coverage and are CWD eligible, the program's premium requirement may serve to deter them from dropping their employer's coverage in favor of CWD. CWD requires individuals to pay monthly premiums ranging from $20 to $250 for individuals and $30 to $375 for couples, depending on income. For many at the higher levels of income, premiums for CWD may be substantially more burdensome than their share of premiums for employer-sponsored coverage. In 2001, the average employee contribution toward health coverage was $38 per month for single coverage.[39] CWD premiums jump to $50 for individuals with net countable monthly income between $700 and $900 and to $75 for those with net countable income between $900 and $1,100.

Another deterrent to crowd-out is that the provider network available through Medi-Cal is often far less comprehensive than what is available through private coverage. Disabled people who have longstanding relationships with providers and who have private coverage will often find that they must sever such relationships if they switch to Medi-Cal.

VIII. Conclusion

A variety of programmatic and policy challenges confront those interested in increasing enrollment in the CWD Program. The approach contemplated early in the life of AB 925 would have increased the income and asset eligibility limits, thereby creating a significant new pool of potentially eligible individuals. However, the CWD Program's sluggish uptake rate demonstrates that granting eligibility in and of itself does not necessarily result in enrollment in the program.

To maximize the benefits CWD can offer—that is, providing health insurance to working Californians with disabilities—it may be necessary to improve performance on multiple fronts. Current program experience demonstrates that merely expanding income and asset eligibility levels is unlikely to significantly boost program enrollment if those expansions are not accompanied by outreach efforts and improved eligibility worker awareness. In fact, the CWD Program might experience more significant gains in enrolling those who are already eligible under current program rules by concentrating efforts in these two areas. Specifically, activities that would increase enrollment under current CWD standards without changes to eligibility include:

- promoting awareness among the uninsured eligible population that is currently not enrolled in any Medi-Cal program;
- promoting awareness among providers, including specialists and safety net providers such as county health clinics that traditionally serve the uninsured; and
- strengthening eligibility worker awareness of and familiarity with CWD.

Focusing efforts to enroll those who are already eligible under current program rules would not only result in greater increases in enrollment than would occur through program expansions, but the increases would occur more expeditiously. Such expansions and policy changes require vetting by policymakers and program administrators; they ultimately may require legislation, which could be an arduous process. However, if programmatic expansions are to be pursued, policymakers may want to:

- identify opportunities to make the program's premium and work requirements more attractive; and

- consider broadening CWD eligibility by adjusting the program's income and/or asset criteria.

This study demonstrates that although the demand for this program is thus far modest, it has been effective in achieving its goals among those who are enrolled. Once enrolled, individuals are working and feel that their health care needs are being met. Enrollees are very satisfied with their CWD coverage. Almost all survey respondents (87 percent) were "somewhat" or "very" satisfied with CWD, compared to four percent of respondents who were "somewhat unsatisfied" or "not satisfied at all." Enrollees, who prior to enrolling in CWD likely had no or very limited prescription drug coverage, were especially thankful to have the prescription coverage available to them under CWD. Without CWD, they would have to bear the burden of paying out of pocket, juggling various other sources of prescription drugs such as samples, or having to forgo filling their prescriptions altogether. Enrollees also expressed a great deal of satisfaction with the relative affordability of premiums. The data show that many CWD enrollees were previously enrolled in another Medi-Cal aid category in which they were required to pay monthly share of costs significantly higher than their monthly CWD premiums. For these individuals, enrolling in CWD meant not only health insurance coverage and the ability to maintain employment; it also meant substantial reductions in their monthly out-of-pocket health care expenditures.

For many individuals, the ability to work is key to their overall feeling of well-being, and they want to feel that they were contributing to their communities rather than "just being in the system." Even those whose ability to work is restricted by their physical capability (or who prefer not to work) find significant enough value in maintaining their CWD coverage that they continue to work to stay enrolled. Many individuals expressed that the peace of mind that comes with having health insurance coverage far outweighed the cost of monthly CWD premiums or the other "hassles" of enrolling in Medi-Cal. Given the high level of satisfaction of current enrollees, enabling more individuals to enroll in the program, whether by exercising options to create new eligibility pools or by focusing on the already eligible population, would provide significant benefit to those individuals.

Appendix: Enrollee Survey

The Lewin Group
3130 Fairview Park Drive
Suite 800
Falls Church, VA 22042
703.269.5500/Fax 703.269.5501
www.lewin.com

August 8, 2002

Dear Sir or Madam:

What do you think about the Medi-Cal 250% Working Disabled Program?

We are asking people to tell us about their experiences in the program. This program is also called the Medi-Cal Working Disabled Program, the California Working Disabled Program, or CWD.

Your ideas are important and can help make the program better. If you would like to help, please answer the attached survey and send it back in the self-addressed stamped envelope that we provided. Please try to return your answers by **September 25, 2002** so that your opinion can count.

The Medi-Cal Policy Institute and The Lewin Group are doing this survey with the help of the World Institute on Disability (WID) to learn how to make the program better. The Medi-Cal Policy Institute is NOT a part of Medi-Cal. It is a separate group that gathers and shares information about Medi-Cal.

Answering these questions is optional. Your answers are totally confidential. You do not need to give us your name or address. Your eligibility for the Medi-Cal 250% Working Disabled Program will not change whether you fill out the survey or not. Medi-Cal helped by mailing our survey to you, but they will NOT see your answers. We were not given your name or address to mail you these questions.

Your ideas and thoughts are important to us. We thank you for answering our questions. To say thanks, we are sending you a free phone card. If you can't use the phone card, please share it with someone that can use it. Thank you for your time!

Sincerely,

Joanne Jee
Senior Associate
The Lewin Group

P.S. If you want to learn more about the Medi-Cal Policy Institute or The Lewin Group, please go to www.medi-cal.org or www.lewin.com. If you have questions about your Medi-Cal coverage, please call your case worker.

Questions 1–3 ask about your decision to enroll in the Medi-Cal 250% Working Disabled Program.

1. How long have you been enrolled in the Medi-Cal 250% Working Disabled Program?

   ☐ Less than 6 months
   ☐ 6–12 months
   ☐ 1–1½ years
   ☐ 1½–2 years
   ☐ More than 2 years

2. What kind of health insurance did you have before joining the Medi-Cal 250% Working Disabled Program? (Check all that apply.)

   ☐ Medi-Cal (I switched from another Medi-Cal coverage program into the Working Disabled Program)
   ☐ Medicare
   ☐ Insurance through work
   ☐ A health insurance plan I paid for myself, please specify _____
   ☐ A health insurance plan through a family member, please specify _____
   _____
   ☐ No health insurance
   ☐ Not sure
   ☐ Other, please specify _____

3. How important were the following in your decision to enroll in the Medi-Cal 250% Working Disabled Program.

	How important?				
	Not At All	**Not Very**	**Not Sure**	**Some-what**	**Very**
Ability to work and keep Medi-Cal	☐	☐	☐	☐	☐
Services covered	☐	☐	☐	☐	☐
Quality of care available	☐	☐	☐	☐	☐
No other coverage available	☐	☐	☐	☐	☐
You did not have to spend down (Spend down is when you have to spend your own money before Medi-Cal covers your health care bills)	☐	☐	☐	☐	☐
Lower monthly costs (premiums)	☐	☐	☐	☐	☐
Lower cost per doctor visit (copayment)	☐	☐	☐	☐	☐

Question 4 is about your experience joining the Medi-Cal 250% Working Disabled Program.

4. How did you hear about the Medi-Cal 250% Working Disabled Program? (Check all that apply.)

- ☐ Friend or relative
- ☐ Advertisement
- ☐ Community benefits counselor or planner
- ☐ A doctor, nurse or other health care professional
- ☐ *Internet*
- ☐ Medi-Cal Eligibility Worker
- ☐ Employer
- ☐ Other, please specify _____

Questions 5–12 ask about your work.

5. How many hours a week do you usually work now?

- ☐ None
- ☐ 1-10 hours
- ☐ 10-20 hours
- ☐ 20-30 hours
- ☐ 30-40 hours

6. How many hours a week would you work if you did not have to limit your income to keep your Medi-Cal 250% Working Disabled coverage?

- ☐ None
- ☐ 1-10 hours
- ☐ 10-20 hours
- ☐ 20-30 hours
- ☐ 30-40 hours

7. How many other people work where you work?

- ☐ Just myself
- ☐ 2 - 5 people
- ☐ 5 - 24 people
- ☐ 25 - 99 people
- ☐ 100 or more people

8. Are you self-employed?

- ☐ No
- ☐ Yes

9. How has enrolling in the Medi-Cal 250% Working Disabled Program changed how much you work per week? (Check only one box.)

- ☐ It has not changed how much I work
- ☐ It might change how much I work, but I am still considering my options
- ☐ I work fewer hours (please tell us how many fewer hours per week you work _____)
- ☐ I work more hours (please tell us how many more hours per week you work _____)

10. Did knowing you would be eligible for the Medi-Cal 250% Working Disabled Program affect your decision to go to work?

- ☐ No
- ☐ Yes

11. Have you gotten rid of or limited the value of any of the following so you could get and keep your Medi-Cal 250% Working Disabled coverage?

Income	☐Yes	☐No
Savings or checking accounts	☐Yes	☐No
Investments (like stocks or bonds)	☐Yes	☐No
Property (like more than 1 home or car, jewelry)	☐Yes	☐No

12. Can you get health insurance through work? (Check only one box.)

- ☐ No, I am not working right now
- ☐ No, my employer does not offer health insurance
- ☐ No, I am not eligible for insurance through work (Please explain: _____

  _____)
- ☐ Yes, I am enrolled
- ☐ Yes, but I choose not to enroll
- ☐ Not sure

Questions 13–14 ask about other health insurance coverage you may have.

13. Besides the Medi-Cal 250% Working Disabled Program, what other health insurance do you have right now? (Check all that apply.)

- ☐ None
- ☐ Medicare
- ☐ Insurance through work
- ☐ A health insurance plan I pay for myself
- ☐ A health insurance plan through a family member
- ☐ Not sure
- ☐ Other, please specify _____

14. If you have ever dropped out of the Medi-Cal 250% Working Disabled Program, what kind of health insurance did you switch into? (Check all that apply.)

- ☐ I have not dropped the Medi-Cal Working Disabled Program
- ☐ Health insurance through work
- ☐ Other Medi-Cal coverage
- ☐ Medicare
- ☐ A health insurance plan I paid for myself
- ☐ A health insurance plan paid for by a family member
- ☐ I did not have health insurance

Questions 15–18 ask about your use of personal assistant services (PAS). Personal assistant services are also called personal care or personal attendant services.

15. Where do you use a personal assistant? (Check all that apply.)

- ☐ I do not use a personal assistant
- ☐ At home
- ☐ At work
- ☐ Other, please specify _____

16. How do you pay for personal assistant services? (Check all that apply.)

- ☐ I do not use personal assistant services
- ☐ The In-Home Supportive Services (IHSS) program pays
- ☐ My private health insurance pays for it
- ☐ I pay for it myself (How much per week? $ _____)
- ☐ A family member or friend pays for it
- ☐ Other, please specify _____

17. Who pays for MOST of your personal assistant services? (Check only one box.)

- ☐ I do not use personal assistant services
- ☐ The In-Home Supportive Services (IHSS) program
- ☐ My private health insurance
- ☐ Myself
- ☐ A family member or friend
- ☐ Other, please specify _____
- ☐ Not sure

18. If you could use personal assistant services at work, would you be able or want to work more hours per week?

- ☐ I do not use a personal assistant
- ☐ Yes
- ☐ No
- ☐ Not sure

Question 19 asks about your level of satisfaction with the Medi-Cal 250% Working Disabled Program.

19. How satisfied are you with the Medi-Cal 250% Working Disabled Program in general?

- ☐ Not satisfied at all
- ☐ Somewhat unsatisfied
- ☐ Not sure
- ☐ Somewhat satisfied
- ☐ Very satisfied

What changes would make the Medi-Cal 250% Working Disabled Program better? Why?

_____

_____

Questions 20–23 are about you.

20. County of residence is: _____

21. Sex: ☐ Male ☐ Female

22. Race/ethnicity:

- ☐ African American
- ☐ Asian American/Pacific Islander
- ☐ Hispanic
- ☐ White
- ☐ Other

23. Please describe the disability(s) you have: _____

_____

_____

_____

24. Other Comments: _____

_____

_____

_____

_____

****

There are no more questions. We thank you for helping us with our survey.

We are interested in learning more about what you think of the Medi-Cal Working Disabled Program. If you would like us to call you by phone to talk about this, please give us your name, phone number with area code, and good time to reach you. Our phone call will be confidential and no one will know we spoke to you.

Please give us your phone number ONLY if you want us to call you.

Name: _____

Phone Number & Area Code: _____

A Good Time to Reach You: _____

Please return the survey in the stamped envelope provided. There is no need to put a return address on this envelope.

Notes

1. The state's CWD outreach attempts included sending an informational flyer to enrollees in the Medi-Cal Aged, Blind, and Disabled Medically Needy (Medically Needy) program who would likely be eligible for the new program; and requiring counties to flag all Medically Needy cases as potentially eligible for CWD. There was no requirement to contact enrollees.

2. In several counties, providing eligibility workers with updated program manual sections or conducting briefings on the program made up the training activities.

3. Some individuals experience temporary lapses in work due to circumstances beyond their control, such as lay-offs or temporary flare-ups of their conditions. CWD currently extends coverage for two months for individuals who lose their jobs for good cause.

4. Kaiser Family Foundation and Health Research and Educational Trusts, *2002 Employer Health Benefits Survey*, 2002.

5. The enrollment trend is based on the CWD enrollment of individuals who were not previously enrolled in another Medi-Cal aid category before enrolling in CWD.

6. Department of Health and Human Services Press Release, 5/9/02 (www.hhs.gov/news/press/2002pres/disable.html).

7. The Social Security Administration 2002 Red Book on Employment Support defines disability as the inability to engage in any substantial gainful activity (SGA) because of a medically determinable physical or mental impairment(s) that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months.

8. The SSI resource standard is $2,000 for an individual or $3,000 for a couple.

9. Income disregards include the first $65 of earnings, $20 without regard to source, and half of the remaining income.

10. In some cases, some of the income of spouses is "deemed" to the applicant and counted as the applicant's income.

11. Advance pay is payment sent directly to the beneficiary for purchasing authorized IHSS services before those services are actually provided. California Department of Developmental Services. *What about IHSS? 2001* (www.dds.cahwnet.gov/SupportSvcs/PDF/WhatAboutIHSS.pdf).

12. California Department of Health Services. *Fiscal Forecasting and Data Management Branch, Fiscal Analysis of AB 155 (Migden) As Enrolled:* September 13, 1999.

13. Governor's Budget Summary 2003-2004.

14. Sanders, Jim. *Jobs Top Davis' Script.* Sacramento Bee, January 2, 2003.

15. Social Security Administration. *Annual Statistical Report on the Social Security Disability Insurance Program, 2001* (www.ssa.gov/policy/pubs/index.html?main=/statistics/Supplement/index.html).

16. Social Security Administration. *Annual Statistical Supplement, 2001. Table 5.J8* (www.ssa.gov/statistics/Supplement/2001/).

17. California Department of Social Services. *SSI/SSP Program Monthly Report.* December 19, 2002 (www.dss.cahwnet.gov/research/res/pdf/ssissp/2002/SSINov02.pdf).

18. Ibid.

19. Social Security Administration. SSI *Annual Statistical Report, 2001 Table 30* (www.ssa.gov/statistics/ssi_annual_stat/2001/table30.html).

20. Fact sheets about state Medicaid Buy-In program are found online (www.cms.gov/twwiia/statemap.asp).

21. Department of Health and Human Services. *Medicaid Buy-In Programs: Case Studies of Early Implementer States.* Prepared by Donna Folkemer, National Conference of State Legislators; Allen Jensen, Center for Health Services Research and Policy, School of Public Health and Health Services, George Washington Medical Center; Robert Silverstein, Center for the Study and Advancement of Disability Policy; Tara Shaw, National Conference of State Legislatures. May 2002 (http://aspe.hhs.gov/daltcp/reports/EIcasest.htm).

22. CMS is currently working to develop a state-by-state comparison. Phone call with Allen Jensen of Center for Health Services Research and Policy, School of Public Health and Health Services, George Washington Medical Center on December 19, 2002.

23. Department of Health and Human Services. *Policy Frameworks for Designing Medicaid Buy-In Programs and Related State Work Incentive Initiatives.* Prepared by Allen Jensen, Center for Health Services Research and Policy, School of Public Health and Health Services, George Washington Medical Center; Robert Silverstein, Center for the Study and Advancement of Disability Policy; Donna Folkemer, National Conference of State Legislators; and Tara Shaw, National Conference of State Legislatures. May 2002 (http://aspe.hhs.gov/daltcp/reports/polframe.htm#table8).

24. SIPP data was used in lieu of Current Population Survey data because it contains more detailed disability and work data fields. The SIPP includes questions relating to the labor force, program participation, and income. The SIPP consists of a continuous series of national panels, with sample size ranging from 14,000 to 36,700 interviewed households. Each panel lasts between two-and-a-half and four years. The SIPP is administered by the U.S. Census Bureau. Modeling efforts used data obtained during Waves 11 and 12, between August 1999 and March 2000.

25. The number of survey packets prepared for mailing was based on estimated enrollment. According to Medi-Cal staff, 652 individuals were enrolled in the program as of August 2002.

26. For some survey questions, the total number of responses does not equal 162. Not all respondents answered each question and for some questions, respondents provided multiple responses. The survey analysis accounts for the variability in number of responses.

27. Counties were directed to designate a county coordinator for CWD matters. Department of Health Services, Letter No. 00-16.

28. Center for the Study and Advancement of Disability Policy and Center for Health Services Research and Policy at George Washington University. *State Work Incentive Policy Options: Medicaid Buy-In Programs and Income Assistance Demonstrations* (www.uiowa.edu/~lhpdc/work/VI_buy-in.html).

29. Governor's Budget Summary 2003-2004.

30. Data on the number of individuals who would be affected by this proposal and who could potentially become eligible for CWD was not available in a timeframe amenable to the publication of this report.

31. Reported mental disorders include anxiety disorders, clinical depression, manic-depressive disorder, bipolar disorder, schizophrenia, and post traumatic stress disorder.

32. Social Security Administration. *Annual Statistical Supplement 2001, Table 5D4.1* (www.ssa.gov/statistics/Supplement/2001/).

33. Davis, Karen, for the Commonwealth Fund. *Work in America: New Challenges for Health Care.* April 2002 (www.cmwf.org/annreprt/2001/presmess.pdf).

34. California HealthCare Foundation. *Why Don't More Small Businesses Offer Health Insurance?* March 2002 (http://www.chcf.org/topics/view.cfm?itemID=19737).

35. Enrollees were advised that DHS would mail self-addressed, postage-paid payment envelopes for monthly premium payments. However, several enrollees stated that they do not receive the envelopes and instead have to request them from their eligibility workers in

small increments. Eligibility workers confirmed that they are providing enrollees with the envelopes, and that they also were advised that DHS would supply envelopes to enrollees. Enrollees wanted to receive 12 months' worth of envelopes to minimize the number of times they have to request envelopes and minimize the chance that they would overlook a payment. Other respondents suggested that premium payments be processed more quickly. Some enrollees thought that the premium payment system would be improved if enrollees were mailed invoices at the time their premium payments were due.

36. The California Work Group on Work Incentives and Health Care (CWG) is a network of consumers, advocates, and agencies that have been active in monitoring and supporting the effort to expand and improve access to programs and services, including health care, for working individuals with disabilities. The CWG is made up of representatives from community-based organizations, independent living centers, resource centers, and other organizations that provide services or resources, or have frequent interactions with individuals with disabilities. Because these agencies have been active and because they represent the community resources trusted and used by individuals with disabilities, the CWG was approached as a link to the nonenrollee population.

37. Requirements for SB 87 ex parte eligibility determinations may supercede the "Ramos" procedure.

38. Medi-Cal Policy Institute. *The Guide to Medi-Cal Programs: A Description of Medi-Cal Programs, Aid Codes, and Eligibility Groups*. 1999.

39. Kaiser Family Foundation and Health Research and Educational Trusts, *2002 Employer Health Benefits Survey*. 2002.

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California HealthCare Foundation