SUPPORTING STATEMENT FOR
ACCELERATED BENEFITS DEMONSTRATION PROJECT

OMB No. 0960-NEW

Part A

1. Circumstance of Data Collection

a. Overview

The Social Security Administration (SSA) is seeking clearance for the Accelerated Benefits Demonstration Project (AB), a long-term study which will be conducted by MDRC, Mathematica Policy Research, Inc. (MPR), and POMCO.

AB's primary goal is to enable more Social Security Disability Insurance (SSDI) beneficiaries to return to work and thereby maximize their economic self-sufficiency through employment. The AB demonstration will test whether providing early access to health benefits, care management, and expanded access to employment supports will help new SSDI beneficiaries stabilize or improve their health, regain their independence, and return to work.

Under the current rules, newly awarded SSDI beneficiaries are eligible for cash benefits five months from the date of disability onset as determined by SSA, and for Medicare coverage twenty-four months thereafter (or 29 months from the date of disability onset). The five-month waiting period is intended to provide some fiscal protections to SSA, and ensures that benefits are not paid to people with short-term disabilities who will improve during the five-month waiting period. The additional 24 month waiting period for Medicare was mandated by Congress to limit the costs of Medicare coverage, prevent cost shifting from private health insurance plans to Medicare and ensure that Medicare entitlement extended only to people with severe and long lasting disabilities (Committee on Finance 1972). Because SSA establishes the date of disability onset on a case by case basis, the actual waiting time for Medicare varies (with a maximum of up to 29 months).[1]

During the waiting period, beneficiaries' health may deteriorate because of the natural progression of the condition, lack of medical access and/or medical care (including prescription drugs), or due to physical inactivity (Riley 2006). Further, the likelihood of returning to work diminishes the longer one is away from the labor force, particularly for older populations (Thornton et al. 2005). Declines in health as well as other factors may underlie these employment outcomes.

Little is known about new beneficiaries' use of health services during the waiting period. The large health expenditures of SSDI beneficiaries in general and interviews with SSDI beneficiaries underscore the potential role of health insurance in promoting employment. Gold and Stevens (2001) found that 32 percent of disabled Medicare beneficiaries under 65 (most of whom were on SSDI) had been admitted to the hospital in the past year, and that 68 percent had

[1]For example, SSA may determine that the disability onset for a new beneficiary was one year prior to their first cash benefit, which would shorten the waiting period from 29 months to 17 months.

a condition requiring at least two physician visits and prescription medication for more than three months. Hall and Fox (2004) found that Medicaid Buy-In participants in Kansas, which is a program designed to promote employment through increased access to health insurance, listed inadequate and inconsistent medical care and access to prescriptions as two of the most insurmountable barriers to returning to work.

The AB Demonstration will test whether the provision of health benefits during the 24-month waiting period improves access to medical care and treatment, whether enhanced access prevents further deterioration, and improves participants' medical condition. It is further hypothesized that improved health outcomes will ultimately have a positive effect on the employment outcomes of new SSDI beneficiaries.

The AB demonstration will allow SSA to assess whether it can better manage the risks of cash benefits by providing earlier access to health supports for a population that is newly separated from the labor force. If successful, accelerated access to medical benefits, along with existing SSA employment supports, could allow participants to recover more quickly, re-enter the labor force, and ultimately decrease their long-term dependence on cash benefits. Because new SSDI beneficiaries might have higher propensities to return to work with additional supports relative to those who have been on the SSDI caseload for longer periods, it is possible that providing earlier access to health supports will provide enough additional incentive, along with existing SSA supports, to promote a return to work.

The AB demonstration will also provide information more generally on the effects of providing health benefits to an uninsured population. While there have been some strong suggestive links between the provision of health benefits and health outcomes, it is difficult to find situations to experimentally test whether the provision of health benefits can improve health and employment outcomes.

b. Legal Authority

Congress has, since 1980, required the Social Security Administration (SSA) to conduct demonstration projects to test the effectiveness of possible program changes that could encourage individuals to return to work and decrease their dependence on SSDI benefits. In fostering return to work, these demonstrations and the program changes they test are intended to produce savings in the Trust Funds or improve SSDI program administration.

To achieve these objectives, SSA's SSDI demonstration authority contains several key features that provide SSA with a potentially valuable tool for assessing the effectiveness of policy alternatives. One of these features is SSA's authority to waive certain SSDI and Medicare program rules. For example, when conducting demonstrations, SSA is permitted to exempt certain beneficiaries from requirements that workers with disabilities earn below a certain amount to remain eligible for SSDI benefits or that they wait 24 months to become eligible for Medicare benefits. Another key aspect of SSA's demonstration authority is the requirement that SSDI demonstration projects be of sufficient scope and conducted on a wide enough scale to ensure a thorough evaluation and results that are applicable to the SSDI program as a whole.

In addition, the legislation authorizes SSA to use SSDI Trust Fund and Old-Age and Survivors Insurance Trust Fund monies to pay for the demonstrations and requires SSA to

periodically report to Congress on its demonstration activities, providing, when appropriate, recommendations for legislative or administrative changes.

Section 234 of the Social Security Act directs the Commissioner of SSA to carry out studies and demonstration projects to determine the relative advantages and disadvantages of:

- Various alternative methods of treating work activity of individuals receiving SSDI, including such methods as a reduction in benefits based on earnings designed to encourage these beneficiaries to return to work;
- Altering other limitations and conditions, such as lengthening the trial work period, or altering the 24-month waiting period for Medicare; and
- Implementing a sliding scale benefit offset.

The Act requires that these demonstration projects be designed to show that savings will accrue to the Trust Funds, or will otherwise promote or facilitate the administration of the SSDI program. *Section 234* also provides that these projects must be conducted in a manner that will allow SSA to evaluate the appropriateness of implementing such a program on a national scale. The AB Demonstration and planned evaluation meet these legislative and congressional mandates.

2. Use of Information

AB will target new SSDI beneficiaries who are aged 55 and younger, have at least 18 months remaining before becoming eligible to receive Medicare benefits, and who are uninsured. SSA will use administrative data to identify this population. MPR will screen the sample to determine insurance status.

Beneficiaries who are deemed eligible for the demonstration will be randomly assigned to one of two treatment groups or to a control group:

- ***AB-Basic*** will provide immediate access to health benefits for new beneficiaries.
- ***AB-Plus*** will provide the same access to health benefits as AB-Basic, but also will provide: (1) a care manager to help participants make appropriate health care choices and follow-through on recommendations of health care providers (including medication adherence), (2) an employment specialist to help them connect to employment services and supports in their local area, and (3) a benefits counselor to help them understand how their work decisions affect receipt of SSDI and other benefits.
- The ***control group*** will retain their regular SSDI benefits**.**

Testing two versions of the intervention will maximize SSA's chances to learn from the demonstration. Accelerated access to health benefits by itself (AB-Basic) might prove to be extremely effective if many beneficiaries who currently lack any insurance need more access to health related services to return to work. The care management, as well as employment and benefits counseling, added in AB-Plus might lead to much greater effects if beneficiaries face additional barriers to using health care and returning to work.

The AB demonstration involves the design and provision of a health benefits package, as well as program design and implementation, data collection and evaluation activities.

The AB health benefits package is intended to meet the health care needs of uninsured SSDI beneficiaries and facilitate health improvement and return to work. The AB health benefit will cover costs for health care services for up to 24-months, the period during which participants are waiting for Medicare benefits. At the end of that time, regular Medicare benefits will replace the health benefits offered by AB if participants remain eligible for SSDI. Accordingly, AB health benefits will aid the transition to Medicare by not departing radically from the kinds of health care coverage participants will receive in the near future. The core package of health services and cost sharing arrangements will include the components necessary to provide basic health care coverage (i.e. an expansive network that covers preventative care, hospital visits, prescription drugs, hearing, vision, and dental services). The core package also includes promising types of specialized therapy, along with rehabilitation supports (i.e. durable medical equipment). Evidenced-based practices have shown these rehabilitation supports to be efficacious in promoting employment. The advantages of the specialized therapies are carefully being weighed against the potential costs of these services. In addition, the implications of cost-sharing arrangements on participants are being reviewed to minimize barriers to health care that the financial burden on participants may cause. The design is expected to be finalized by Spring 2007.

The AB program intervention, AB Plus, moves beyond the traditional disease or care-management-only model to a new multi-component approach that attempts to address both medical and behavioral components of disability as well as the more immediate practical supports participants may need to return to work. The proposed intervention will provide the following:

- AB Plus members will receive more traditional medically based care management supports to help ensure that their medical impairments/symptoms impeding return to work are identified and stabilized.

- Participants with medical conditions that are determined stable will receive a behavioral intervention designed to incrementally change daily routines in ways that will reduce disability associated with various health conditions and increase the likelihood of return to work.

- These activities will be augmented by services to help beneficiaries address the more practical issues involved in becoming reemployed (e.g., guidance on career planning, job search, work accommodations, and benefits counseling to address the perceived financial disincentives to return to work).

AB-Plus will be implemented telephonically from a centralized location and will be provided to only AB-Plus participants during the 24-month waiting period.

The evaluation design includes a study of the implementation of the intervention, a study of the impacts of the interventions on health, health care usage, employment and continued SSDI benefit receipt, and analysis of the benefits and costs of the intervention.

MDRC along with MPR, POMCO, and a group of expert consultants will design the health benefits package and program intervention; MDRC and MPR will collaborate on research and analysis; MPR will develop and conduct the survey data collection efforts; and POMCO will administer the health benefits package to the demonstration participants and will contact beneficiaries who are randomized into the AB-Basic and AB-Plus treatment groups to inform them about their health plan. The health benefits package and program intervention will be presented for IRB review early next year.

The evaluation will be able to draw from three main sources of information – baseline and follow-up surveys, SSA administrative records, and the demonstration's Management Information System. The baseline and follow-up surveys will contain detailed information on the characteristics, activities and outcomes of the treatment and control group, while the MIS system will provide information on service usage by treatment group participants.

We will also collect qualitative data through site visits later in the evaluation to assess the implementation of all the demonstration activities, especially to monitor the fidelity to the intervention design.

The AB evaluation will address the following research questions using an experimental design.

1. ***Operation.*** What are the important issues and challenges in helping beneficiaries enroll in the health benefit and use appropriate health care and employment services? How does this vary across local areas and for different types of beneficiaries?

2. ***Structure.*** What are the characteristics of the context in which beneficiaries are seeking medical and employment services?

3. ***Participation.*** Who agrees to participate in the study? Of those participants who are randomized into the treatment groups, who utilizes health benefit, and what services do they get? How long do treatment group members agree to work with care managers? How does service use by the treatment groups differ from that utilized by the control group? How does participation differ for different subgroups?

4. ***Impacts.*** How does AB affect health, work limitations, employment and earnings, and dependence on SSA disability programs? Do these impacts differ across subgroups of the population of beneficiaries? What is the added effect of AB Plus care management over and above the AB Basic health benefit offer?

5. ***Benefits and Costs.*** How does AB affect income and payroll tax receipts, benefit outlays, and the status of the SSA trust funds? From the perspectives of beneficiaries, the government, SSA trust funds, and society, do the benefits of the intervention exceed its costs? Does AB Basic generate enough use of health care services to provide eventual savings to SSA? Are the extra costs of AB Plus offset by the extra benefits that it generates?

The first component of our evaluation will be an implementation analysis to address the questions related to operation, structure, and participation. Our proposed implementation analysis also includes site visits to the health plan administrator and several key stakeholders at local sites, including medical providers and SSA Employment Networks (**NOTE:** Please note that we will not be speaking to more than 9 health plan administrators/stakeholders, so burden is not provided for this aspect of the study). The implementation analysis will also rely on our management information system (MIS) data on healthcare service utilization, and the six-month follow-up survey will provide important information about beneficiaries' early service usage patterns and satisfaction with the health benefit.

The second component will be an impact analysis. We plan to estimate the impacts of AB-Basic and AB-Plus by comparing outcomes of treatment group participants to those in the control group. The analysis will be based on three sets of outcomes data: a follow-up survey conducted 15 months after individuals enter the study, various administrative records for up to 36 months following random assignment, and MIS data on use of health care services by those assigned to the AB-Basic and AB-Plus groups.

The final component will be a benefit cost analysis. This analysis will combine impact estimates with cost data collected through the implementation analysis to address the ultimate question of the relative benefits and costs of the AB interventions for participants, SSA, other government agencies, and society.

MPR is responsible for primary data collection. The data will be analyzed by MPR staff in collaboration with researchers from MDRC. Through the MIS, MPR will share relevant data elements from the baseline survey with POMCO so that they contact and track participants. These data elements will include basic identifying information on the respondent, such as demographic characteristics and contact information, and program information (some of which may come from SSA administrative records).

The current Information Collection Request (ICR) includes the baseline survey data collection, and six-month follow-up survey. We describe these data collection efforts in detail below. A separate ICR will be submitted for the fifteen-month follow-up survey. As a result, we discuss the 15-month follow-up survey only briefly in this document.

a. Baseline Survey

The purpose for obtaining baseline data in the AB demonstration will be to screen for insurance status, to describe the characteristics of study participants at the time of random

assignment, and to identify subgroups that may be analyzed separately. The sample size for the baseline survey is 2,000—800 each in the control and AB-Plus groups and 400 in the AB-Basic group. The baseline survey will be administered as a computer-assisted telephone interview (CATI). Data collection is scheduled to begin in the summer of 2007.

All beneficiaries who are identified in the SSA administrative records as having more than 18 months before their Medicare eligibility starts will be sent an advance letter (see Appendix A) which will provide information about the demonstration, notify them that they will be contacted, and encourage them to participate. A set of frequently asked questions (FAQs) will accompany the advance letter (Appendix B). These contacts will be made on an ongoing, rather than a one-time basis to accommodate the enrollment pattern of SSDI beneficiaries.

SSA administrative records include detailed program participation, benefit amounts, and address information that will be important in identifying and locating beneficiaries who meet the eligibility requirements for the demonstration. However, these records are not sufficient to identify eligible beneficiaries for the demonstration or to address SSA's evaluation questions.

The proposed baseline survey, included in Appendix C, will address the limitations of the administrative data as follows:

- ***Section A: Case Management and Respondent Selection***. In this section, we will verify that we have reached the correct sample member, determine whether a proxy or assistant is needed, determine language of administration, and whether an interpreter is needed.

- ***Section B: Health Insurance Coverage and Consent.*** This section will screen sample members to identify those who are eligible to participate in the AB demonstration based on their health insurance status. Sample members with private, public, or military health insurance coverage will complete Section B and then be thanked for their time.

- ***Section C: Health and Functional Status***. In this section, sample members will be asked about their overall health status, functional health status, activity limitations, as well as mood/mental health.

- ***Section D: Use of Medical Services***. In this section, we will ask about the sample member's health care usage, such as the type of medical professionals they have visited, the frequency of visits, and follow through after visits with recommended services or prescription medications. A few questions designed to assess the respondents' level of fatigue and need for a break are included at the beginning of this section.

- ***Section E: Employment History and Supports.*** This section obtains information about current and previous employment, such as the type and frequency of work, and earnings from employment. We also ask questions to understand the perception and attitudes toward work and whether employment supports have been accessed.

- ***Section F: Household Composition and Income.*** This section asks about the number of household members, total household income, and living arrangements.

- ***Section G: Background.*** This section obtains information on marital status and education level.

- ***Section H: Contact Information and Study Group Assignment***. In this section we verify the sample member's contact information and attempt to collect contact information for up to two persons who would know how to reach the sample member in the future to facilitate follow-up.

Sections A and B will be asked of all new SSDI beneficiaries that we pool from SSA administrative records. Only those sample members who do **not** have health insurance will be eligible for the demonstration and will complete the remaining sections of the questionnaire. Those who meet the eligibility criteria for the demonstration will be offered a $25 incentive at this point in the interview. Verbal consent to participate in the demonstration will be solicited from eligible respondents in this section.

Random assignment occurs at the close of Section H. We will inform treatment group members of their assignment to AB-Basic or AB-Plus, give them the opportunity to ask questions about the health benefit, and notify them that they will need to sign and return an Understanding of Benefits form before they can begin utilizing the AB benefits and services.

Following random assignment, we will mail notification letters to all sample members in both the treatment and control study groups. The package mailed to AB-Basic and AB-Plus sample members will also include health benefit enrollment materials describing the health benefits program they have been assigned to, contact information for POMCO, the health benefit administrator, and an Understanding of Benefits form. (see Appendix D). The purpose of the form is gain acknowledgement from the sample member that the health benefits program has been adequately explained and they understand the benefits being offered. Services will not be offered to sample members who do not return the form.

b. Six-month Follow-up Survey: Early Use and Satisfaction

To gather timely information about the design and implementation of the intervention, and to assess differences in service usage patterns among treatment and control groups, we will conduct a follow-up survey after six months of participation. The Early Use Survey will be fielded with treatment and control group members who enroll during the first six months of the intake period. We expect to include the universe of beneficiaries who enroll during the first six months and are limiting this survey to early enrollees because our project team will need timely information on any problems so that they can make any necessary modifications to the AB health plan. We also anticipate that the responses of this population should be fairly representative of all participants. The advance notice letter for the Early Use Survey is included in Appendix F. The proposed Early Use Survey itself, attached as Appendix E, will include the following topic modules:

- ***Section A: Case Management and Respondent Selection***. In this section, we will verify that we have reached the correct sample member, determine whether a proxy or assistant is needed, determine language of administration, and whether an interpreter is needed.

- ***Section B: Use of Medical Services***. This section gathers information about usual care providers, and the use of specialists and mental health professionals. We obtain satisfaction ratings for the doctor seen most frequently during the previous three months. This section also collects information about changes in medical providers once the sample member began receiving the AB health benefit, use of out-of-network providers, and for those sample members identified in the MIS data as having no service usage in the prior three months, the reasons for lack of service utilization.

- ***Section C: Unmet Medical Needs.*** In this section, we find out if sample members have foregone or postponed receipt of medical services and, if so, the reasons why. We also assess reasons for noncompliance with prescription medication regimens.

- ***Section D: Health Insurance Coverage.*** Changes in health insurance coverage and reasons for foregoing additional coverage if eligible are measured in this section.

- ***Section E: Satisfaction with AB Services.*** This section assesses sample members' knowledge of what is included in the AB health plan, their use of various components of the AB health benefit, and their satisfaction with the components they've utilized. This section includes questions about use and satisfaction with the care management and employment support services that are specific to the AB-Plus treatment group.

- ***Section F: Contact Information.*** In this section we verify the sample member's contact information and attempt to collect contact information for up to two persons who would know how to reach the sample member in the future to facilitate follow-up.

c. Fifteen Month Follow-up Survey (NOTE: The clearance package for this survey will be submitted as a separate ICR. We are including a brief description of this part of the survey for informational purposes only).

This survey is expected to be a mixed in-person (CAPI) and telephone interview (CATI) that collects information on key outcomes that cannot be measured from other sources. The interviews will include questions about beneficiaries' health, medical expenditures, program participation, and employment outcomes. This information will be essential for the participation, impact and benefit-cost analyses that will assess the overall effect of the AB intervention on demonstration participants.

The follow-up survey will be conducted 15 months following initial enrollment in AB with 1,600 respondents, an estimated 80 percent response rate**.** The survey is the only source of information about overall health care use (as opposed to use of AB services or use of Medicare and Medicaid) as well as the only source of information that applies equally to each of the three research groups. The most general questions on health care use will concern visits to health care providers, use of prescription drugs, and out-of-pocket expenses. AB is expected to increase use of health care in general, but might decrease out-of-pocket expenses. We plan to pattern questions on health care use primarily after questions from the NBS, although some questions will be adapted from other national surveys (e.g., out-of-pocket expenses from MEPS and inability to afford needed health care from NHIS). When appropriate, questions that were used

on the AB baseline or six month follow-up survey will also be asked on the 15 month follow-up to ensure consistent measurement.

To measure whether provider practice has improved, we will ask the beneficiaries about their satisfaction with how well providers kept in touch with each other, difficulty with conflicting information, the quality of explanations they received from specialists, explanations of possible side effects, explanations of treatments, how quickly they received test results, and the explanations of test results. We will also ask to assess the degree to which they felt they had a choice in treatment decisions. These measures were used successfully by MPR in their evaluation of care coordination for the Medicare population to see if care management resulted in better provider practice for the treatment group relative to the control group.

d. Site Visits

The site visits, and the associated process analysis will be conducted in two rounds. The first round, which will take place six to nine months after the AB intervention begins, will describe how the intervention is being implemented. We will then conduct an implementation analysis to determine the extent to which actual implementation deviates from the original design. By conducting this analysis during the early phases of the intervention, we will be able to remedy any significant deviations as well as implement solutions to any unforeseen challenges. The second round, which will take place two years after the AB demonstration begins, will continue to document the actual implementation of the intervention.

The process analysis will include discussions with several key stakeholders who deliver services to participants. It will address questions about the reasons for any variations in implementation and the effects of those variations. It will also inform and sharpen the benefit-cost analysis. To capture the complexity of the interventions and the service environments, we will use several data sources, listed below. We will also capture different perspectives on the intervention, including those of central office managers and front-line staff, SSA field office staff, medical providers, and other appropriate organizations. We may gather some information from employers about the perceived needs of the beneficiaries, but will balance confidentiality needs in doing so by first obtaining consent from participants to do so, and then only talking with employers who are aware of the beneficiary's disability. Only by understanding all these perspectives on the intervention can we fully assess its success and its effects.

- ***Ongoing Monitoring of Fidelity***. A specialized staff person will be devoted from the start of implementation to monitoring and maintaining the fidelity to the design of the intervention. The staff person has experience in care management and MDRC's telephonic care management random assignment evaluation in Rhode Island. Her ongoing reviews will include weekly calls with care managers to review and respond to issues with cases and adherence to the program design.
- ***Interviews and Observations During Site Visits.*** Our first round will include a visit to the POMCO call center to interview managers and staff about how the two interventions have been put in place, what problems the front-line staff and managers have encountered, and the official—and unofficial—ways that problems have been handled. During this visit, we plan to observe care manager interactions with

beneficiaries in order to gain more insight into the actual operation of the intervention.

- ***Document Reviews.*** By examining documentation — including memos, operations manuals, and other literature used internally to instruct and inform the staff of organizations involved in the demonstration — we will create an initial map of how the key staff and participants interact. These workflow diagrams and interaction maps will be updated after the first and second rounds of the implementation analysis.

- ***Telephone Interviews.*** We will use telephone interviews with the central office in the first round to supplement and confirm information gained on our site visit; we will also call selected SSA staff, medical providers, and other appropriate organizations to help us document the various contexts in which AB is being implemented. We will use phone interviews in a similar manner in the second round, though the interviews with the central office will be more extensive so we can describe in detail changes in implementation strategy or tactics made since the early implementation round.

3. Use of Improved Information Technology

Since the surveys in this study will be conducted via telephone, they are not part of the Agency's Government Paperwork Elimination Act plan. However, some electronic media will be used. For example, Computer-assisted interviewing will be used to collect data for the AB surveys. It is expected that the baseline and six month follow-up survey we be administered via the telephone; the 15-month follow-up survey will involve both CATI and CAPI. The questionnaires used in both applications will have the same core content and will differ only in the contact protocol. Both applications will incorporate standard checkpoints to assess each respondent's level of fatigue, and to provide the respondent with an opportunity to take a break, if necessary.

Telephones equipped with amplifiers will be available for use as needed to accommodate sample members who are hearing impaired. In addition, TTY and Relay technologies will also be used to facilitate participation in the telephone survey. A TTY is a special device that lets people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate, by allowing them to type messages back and forth to one another instead of talking and listening. A TTY is required at both ends of the conversation in order to communicate. The Telecommunications Relay Service (TRS) will be used for sample members who are deaf, hard of hearing, or speech-impaired but who do not have a TTY. With TRS, a special operator types whatever the interviewer says so that the person being called can read the interviewer's words on his or her telephone display. He or she will type back a response, which the TRS operator will read aloud for the interviewer to hear over the phone. These methods, TTY and TRS, both increase survey administration times, but enable us to conduct interviews with sample members who, without the help of these technologies, would not be able to participate.

4. Efforts to Identify Duplication

The nature of the information being collected and the manner in which it is collected preclude duplication. There is no other collection instrument used by SSA that collects data similar to that collected here.

5. Involvement of Small Entities

This collection does not impact small businesses or other small entities.

6. Consequences if Information Is Not Collected or Collected Less Frequently

Each of the data collections efforts is a one-time collection, and is necessary to conducting a credible evaluation. The baseline survey is needed to identify and select sample members into the three study groups, and obtain important covariates for subsequent analyses. The six-month early use survey will inform our cost estimates for implementing the intervention by capturing early indicators of service use, and will provide feedback directly from beneficiaries about their satisfaction with AB services. The impact analysis cannot be conducted without the fifteen month follow-up survey.

There are no technical or legal obstacles that prevent burden reduction.

7. Special Circumstances

There are no special circumstances that would cause this information collection to be conducted in a manner inconsistent with 5 CFR 1320.5.

8. Adherence to Guidelines in 5 CFR 1320.5(d)(2) and Consultation Outside the Agency

The advance 60-day Federal Register Notice was published on January 8, 2007, at 72 FR 834, and no public comments were received. The 30-day Federal Register Notice published on May 3, 2007, at 72 FR 24651. We will forward any public comments we receive in response to this Notice to OMB.

To obtain the views of additional persons outside the agency, the study team brought together a group of health researchers, insurance experts, physicians, and members of the disability advocacy community, including people who are themselves disabled. The AB expert panel includes people with experience across the public and private sectors, from academia, and medical practice. Their biographical sketches are included in Appendix G. The expert panel's contributions included the following:

- Guidance about the target population based on an assessment of who is most likely to benefit from AB.
- Recommendations on the content, scope and structure of the health and rehabilitation services that should be included in the benefit package, including how to best tailor the package of services given the likely characteristics of the target population and the project goals of improved health and return to work.
- Recommendations about the most important policy and research questions that this intervention can answer and the potential implications for the structure and costs of the SSDI and the health care systems.

- Feedback on the projected costs of the health service package in relation to the budget assumptions.
- Recommendations about the various details of how the plan should be structured including how best to address co-insurance, service limitations, out of pocket expenses, and transition to Medicare.
- Assessment of the proposed approach to centralized telephonic care management and guidance about other local service needs.

The expert panel members who provided input on these issues include the following:

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We developed the baseline and follow-up surveys by first reviewing other surveys, including the National Beneficiary Survey (NBS), the National Health Interview Survey (NHIS) and the associated disability follow-back survey (NHIS-D), the Medical Expenditures Panel Survey (MEPS) as well as the Current Population Survey (CPS) to identify questions that have been used successfully to capture information about program usage, health insurance usage, access to and utilization of health care, use of employment and other rehabilitative and supportive services, employment history, job search activities, employment and income, as well as information about household composition, functional status, general well-being, and demographics. In designing the surveys, we collaborated with colleagues working on other SSA demonstration projects, notably the Youth Transition Demonstration (YTD) and the California HIV/AI demonstration to ensure that there are common data elements across projects. We then developed new questions for outcomes of interest for which reliable questions did not already exist. Each survey will be pretested with no more than nine respondents.

9. Remuneration of Respondents

Beneficiaries will be offered $25 for each survey they complete.[2] Payments will be mailed to those respondents who are interviewed by telephone and payments will be made at the time of the interview for surveys completed in person for the 15-month follow-up survey. No payments will be made to site visit participants.

Since the majority of sample members will not be working, we believe that offering an incentive is appropriate as an expression of appreciation of their time and effort. Also, because we intend to interview sample members at approximately 15 months following enrollment in the demonstration, offering them an incentive may help to reduce attrition.

10. Assurance of Confidentiality

The secure handling of confidential data is important to the study team and its staff due to ethical and legal obligations. Ensuring the secure handling of confidential data is accomplished via several mechanisms, including obtaining suitability determinations for designated staff; training staff to recognize and handle sensitive data; protecting computer systems from access by staff without favorable suitability determinations; limiting access to secure data on a "need to know" basis and only for staff with favorable suitability determinations; and creating data extract files from which identifying information has been removed.

We will take several steps to assure sample members that the information they provide will be treated confidentially and used for research purposes only. Sample members will be told that they will not be identified individually (by name) in any reports or in any communications to the Social Security Administration. When disclosure of personally identifying information is necessary, for example when we need to provide such information to POMCO so that they may contact beneficiaries to enroll them in the AB health benefit, we will obtain consent to do so from the sample members. The assurances and limits of confidentiality will be made clear in all advance materials sent to recruit potential participants and restated at the beginning of each

[2]Most sample members will complete two surveys—one baseline and one 15-month followup survey. Some sample members will complete up to three surveys—baseline, early use and 15-month follow-up surveys.

interview session. The Privacy Act and Paperwork Reduction statements appear on the advance letter.

A detailed informed consent process will be employed to enroll potential sample members in the demonstration. Once eligibility is established, interviewers will read a detailed consent agreement to the sample member. The consent will specify the risks and benefits of participating in the demonstration, the probability of selection to the treatment or control groups, the use of SSA records, and the sharing of contact information with POMCO. Frequent, scripted opportunities for sample members to ask questions and obtain clarification about any aspect of the study and their involvement in it are incorporated into the consent agreement. Sample members will be sent a written version of the consent agreement, for their records. To be enrolled, sample members (or their proxies) will have to acknowledge that they fully understand the project.

Subcontractors, consultants, and vendors will be required to establish confidential information safeguards that meet prime contract security requirements. The project director or task leader will take action to ensure that any confidential information provided to or generated by a subcontractor, consultant, or vendor is properly disposed of at the completion of the agreement between the parties.

11. Questions of a Sensitive Nature

The purpose of the study is to test whether providing early access to health benefits, care management, and expanded access to employment supports will help new SSDI beneficiaries regain their independence and return to work. As a result, obtaining information about potentially sensitive topics, such as the health status and medical condition of sample members is central to the intervention. The surveys will not collect data that can be obtained directly from other sources (for example, information about receipt of disability benefits is best obtained directly from SSA administrative records).

The survey will include questions about the following topics that can potentially be considered sensitive:

- Health insurance coverage
- Health status, including disability information
- Assistance needed with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) (for example, help or supervision needed with bathing, dressing, eating, using the toilet).
- Doctor's visits and hospital stays

Many of the questions were adapted without modification from other national surveys of similar populations, such as NBS, NHIS, The Youth Transition Demonstration (YTD), and the Current Population Survey (CPS).

Because of the sensitivity of the information collected in this study, we will make every effort to store the data securely.

12. Estimates of Annualized Hour Burden

Table 1 shows the expected number of participants in the baseline and early use surveys, the number of interviews, hours per response, and the total response burden associated with each of these data collection efforts.

TABLE 1

RESPONSE BURDEN

	2007		2008		
	Baseline Survey		Baseline Survey		Early Use Survey
	Screener	Interviews	Screener	Interviews	Interviews
No. Respondents	9,669	540	26,143	1,460	480
Responses per Respondent	1	1	1	1	1
Minutes per Respondent	10	40	10	10	30
Total Respondent Burden (Hours)	1,612	360	4,357	243	240
Total Burden (Screener + Interview)	1,972		4,600		240

The total estimated annual burden is 6,812 hours. The total burden is reflected as burden hours, and no separate cost burden has been calculated.

13. Estimates of Annualized Capital Burden

There is no known cost burden to the respondents.

14. Estimates of Annualized Cost to the Government

The estimated cost for designing, administering, and analyzing the survey data is $1,694,000. On a year-by-year basis, these expenses are estimated to be:

Year	Cost
2006	$333,000
2007	$794,000
2008	$567,000

15. Changes in Burden

This is a new information collection which will increase the public reporting burden by 6,812 hours.

16. Publication, Analysis Plan, and Timeline

a. Process and Implementation Analysis Plan

The AB process and implementation analysis will document recruitment strategies and operations. We will develop measures that summarize services received by the control group and the two treatment groups, allowing us to estimate the difference between those groups in terms of the types and intensity of services. We will carefully document how participants are recruited to assess how findings might be generalized to other settings and groups. We will examine characteristics of the local environment such as existing agencies, organizations, and the services they offer, as well as document the existing relationships between WIPAs, the SSA field offices, medical providers, and the vocational rehabilitation, workforce, and behavioral health agencies. Finally, we will examine how the intervention interacted with existing SSA work incentives, such as the trial work period, extended period of eligibility, Ticket To Work, and the host of other incentives available for SSDI beneficiaries wishing to return to work.

b. Impact Analysis

The impact analysis will focus primarily on the health and employment outcomes for beneficiaries, both overall and for meaningful subgroups. Our analytical approach combines the power of a random assignment design with statistical modeling.

- ***Basic Impacts.*** The first tool for understanding the effects of the intervention is to compare average outcomes for the AB Plus, AB Basic, and control groups. This is a straightforward calculation that is generally easy to explain to policymakers and other nontechnical audiences.

- ***Conditional Outcomes.*** Some outcomes can be measured for only a subset of beneficiaries. For example, hourly wage rates can be measured only for workers. For such outcomes, the experimental framework can be preserved by analyzing distributions. For example, we could compare the proportion of people who worked and earned above a certain wage amount rather than average hourly wages among workers.

- ***More Sophisticated Methods.*** Most random assignment studies attempt to increase the precision of estimated basic impacts by adjusting for baseline characteristics. In estimating these effects, we can use a linear regression framework, or a more complex set of methods depending on the nature of the dependent variable and the type of issues being addressed, such as: logistic regressions for binary outcomes (e.g., whether or not someone works); Poisson regressions for outcomes that take on only a few values (e.g., months of employment); quantile regressions to examine the distribution of outcomes for continuous outcomes, such as benefit payment amounts, earnings, and income; and duration (hazard) models for outcomes that depend on an event, such as the conditional probability of entering employment over several periods.

The impact analysis findings will be presented in a series of reports designed for a broad audience of policymakers, program planners and managers, and researchers. For the interim and final reports, estimates of impacts for the full sample and for policy-relevant subgroups will be presented. Drawing on findings from the implementation/process analysis, we will describe differences in the target populations, project services, project implementation, and community context that may explain differences in impacts. These reports will present both a global analysis of the effectiveness of the projects and then a targeted analysis that addresses more specific questions such as which program model works best and for whom. The scope of project-specific "letter reports" will be more limited. These reports will be based on administrative data and will focus more narrowly on the presentation and interpretation of the impact estimates themselves and less on the context. Subgroup estimates will be presented and the data and analytical methodology will be fully described.

Table 2 below provides the schedule for the project.

TABLE 2

PROJECT SCHEDULE

Activity	**Beginning Date**	**End Date**
Pretest Baseline Survey	March 2007	April 2007
Baseline Survey	July 2007	October 2008
First Round of Site Visits	March 2008	May 2008

Second Round of Site Visits	October 2009	October 2009
Early Use Survey	January 2008	September 2008
Fifteen-Month Follow-Up	October 2009	January 2010
Project Assessment		December 2007
Second Year Report		December 2008
Third Year Report		December 2009
Final Report		September 2010

c. Benefit-Cost Analysis

To ensure that the benefit-cost findings are as helpful as possible to SSA, we will present the information in a way that has proven useful for communicating this type of information to the SSA Office of the Actuary and to OMB. First, we will summarize all of the information that is based directly on data collected during the demonstration period. Second, we will present the size of future effects (if any) that would be required for the interventions to generate benefits that exceed costs. We will then assess the plausibility of observing the impacts needed for the program to break even. The latter steps in this process are important because of the limited observation period during which we will be able to observe costs and benefits. While most of the costs of the program will be incurred upfront (i.e., during the observation period), the benefits are likely to accrue for years in the future. It is possible that the net value of the program during the observation period is negative, but with carry-over effects, in the future the net value may become positive. By presenting these components, the actuaries will be able to see the net value generated during the observation period, and then use the more speculative analysis of possible future benefits and costs to draw conclusions about whether the interventions will ultimately pay for themselves. This approach differs from the more common approach to presenting results that provides a single bottom-line benchmark estimate that incorporates both directly observed evidence and the best available evidence of benefits and costs that occur after the observation period. In addition to using this general presentation format, we will work with the actuaries during the demonstration to ensure that the other assumptions used in the analysis (such as the discount rate, correction for inflation, and projections about potential productivity growth) are consistent with the ones they are using to assess other potential SSA initiatives.

The analysis will address the level of certainty with which SSA and other policymakers can view the findings. The final benefit-cost numbers will be based on a range of estimates and

assumptions, each of which is inherently associated with some level of uncertainty. The starting point for the analysis of uncertainty is to conduct a series of sensitivity tests that indicate how the bottom line would be affected by changes in specific underlying estimates or valuation assumptions. In this way, we will give SSA a series of plausible estimates instead of a single, inherently imprecise, estimate. We will also analyze uncertainty by using probabilistic sensitivity analysis, which allows us to simultaneously assess the uncertainty in all values by using Monte Carlo simulation, which, in turn, will tell us how the bottom line would be affected when all underlying values move within a specified probability distribution. We prefer to use both methods because the series of specific sensitivity tests is typically easier for policy makers to understand, while the more complex method indicates the extent to which possible correlations between the values would make such sensitivity tests misleading.

17. Expiration Date for OMB Approval

We are not asking for an exemption to display the OMB expiration date.

18. Exceptions to the Certification Statement

SSA is not requesting an exception to the certification requirements at 5 CFR 1320.9 and related provisions at 5 CFR 1320.8(b)(3).