Executive Summary

The Accelerated Benefits Demonstration and Evaluation Project

Impacts on Health and Employment at Twelve Months

Charles Michalopoulos
David Wittenburg
Dina A. R. Israel
Jennifer Schore
Anne Warren
Aparajita Zutshi
Stephen Freedman
Lisa Schwartz

February 2011

The Accelerated Benefits Demonstration is being funded by the Social Security Administration under a competitive award, Contract No. SS00-06-60075. The project officers are Chris Silanskis and Robert Weathers.

The findings and conclusions presented herein do not necessarily represent the official position or policies of the Social Security Administration.

Dissemination of MDRC publications is supported by the following funders that help finance MDRC's public policy outreach and expanding efforts to communicate the results and implications of our work to policymakers, practitioners, and others: The Ambrose Monell Foundation, The Annie E. Casey Foundation, Carnegie Corporation of New York, The Kresge Foundation, Sandler Foundation, and The Starr Foundation.

In addition, earnings from the MDRC Endowment help sustain our dissemination efforts. Contributors to the MDRC Endowment include Alcoa Foundation, The Ambrose Monell Foundation, Anheuser-Busch Foundation, Bristol-Myers Squibb Foundation, Charles Stewart Mott Foundation, Ford Foundation, The George Gund Foundation, The Grable Foundation, The Lizabeth and Frank Newman Charitable Foundation, The New York Times Company Foundation, Jan Nicholson, Paul H. O'Neill Charitable Foundation, John S. Reed, Sandler Foundation, and The Stupski Family Fund, as well as other individual contributors.

The findings and conclusions in this report do not necessarily represent the official positions or policies of the funders.

For information about MDRC and copies of our publications, see our Web site: www.mdrc.org.

Overview

In 2006, the Social Security Administration funded the Accelerated Benefits (AB) Demonstration to test whether early access to health care and related services would improve outcomes for new Social Security Disability Insurance (SSDI) beneficiaries. Under current law, most beneficiaries are not eligible for Medicare for a period of 24 months after they are entitled to receive cash benefits. Many SSDI beneficiaries in this "waiting period" have serious health care needs, and health insurance may provide the medical care needed to stabilize their health conditions.

AB included about 2,000 new SSDI beneficiaries without insurance. Individuals were randomly assigned to one of three research groups: (1) the AB group, which had access to health care benefits designed for the project; (2) the AB Plus group, which had access to the same health care benefits as well as voluntary services delivered by telephone to help them navigate the health care system and return to work; and (3) a control group, which could not receive AB health care benefits or AB Plus services but could obtain health insurance on their own.

Key Findings

- **Participants made extensive use of program services.** Almost all members of the AB and AB Plus groups used AB health benefits during the first year, most commonly for doctor visits, diagnostic testing, and prescription medications. Program group members averaged $19,265 in AB health benefit claims during the year. In addition, about two-thirds of the AB Plus group participated in key telephonic services.

- **AB health care benefits increased health care use and reduced reported unmet medical needs.** In addition, members of the AB and AB Plus groups reported spending less of their own money on health care. There were few differences in these outcomes between the AB and AB Plus groups, suggesting that AB's health care benefits were responsible for these improvements.

- **AB Plus services encouraged people to look for work but did not increase employment levels in the first year.** Members of the AB Plus group were more likely to use vocational rehabilitation and other job preparation services and were more likely to look for work than either the AB group or the control group. Despite this promising intermediate result, the three groups had similar employment rates in the first year.

These results are promising, but they reflect short-term impacts partway through the intervention. It will be important to continue to track outcomes to assess whether long-term employment gains and reduced need for health care result in future savings for the federal government. Despite these limitations, AB provides perhaps the most rigorous information to date suggesting that health care benefits can improve the health of a medically needy group.

Preface

When Medicare was extended to Social Security Disability Insurance (SSDI) beneficiaries in 1972, an important gap in health care coverage was introduced: beneficiaries were not eligible for Medicare until two years after they were entitled to receive SSDI cash benefits. Introduced to keep spending low by targeting health care benefits to those with long-term disabilities, this "waiting period" now leaves many individuals without health insurance during an especially vulnerable time, soon after they have suffered an event that has left them too disabled to work.

Although it is intended to reduce costs, the waiting period might increase costs in the long run. If lack of health insurance discourages new beneficiaries from seeking care, their health might deteriorate, worsening the condition that landed them on the rolls. Individuals who could have been helped off the roles with the right care in the short term would then receive SSDI benefits for many years, possibly adding billions of dollars to the costs of Social Security programs.

Although it seems intuitive that the cost of health care would discourage the uninsured from receiving care and that the lack of care would result in worsened health, there is little rigorous evidence to support that intuition. Instead, past research has relied on comparisons of people with insurance and those without insurance, and the differences in health care and health outcomes between these groups might be due to other, unobserved characteristics of the two groups. For that reason, a well-cited review of the evidence written by Helen Levy and David Meltzer concluded that many studies that claim to show the effects of health insurance on health are not convincing.

The Accelerated Benefits Demonstration provides the most rigorous evidence to date on the link between health care benefits, health care use, and health outcomes for a high-needs group of health care users. Conceived and funded by the Social Security Administration, the study included about 2,000 new SSDI beneficiaries without insurance, half of whom were randomly chosen to receive a comprehensive set of health care benefits. A subset of this group also was eligible for services to help them navigate the health care system and return to work.

Results from the project not only will inform SSA's attempts to help SSDI beneficiaries return to work but also will provide crucial information to help understand the likely effects of recently passed health care reform, since individuals who would have remained uninsured during the waiting period now will be required to obtain health insurance — many of them, through state Medicaid programs or state health exchanges.

Gordon L. Berlin
President

Acknowledgments

The Accelerated Benefits (AB) Demonstration was a large and complex project, and this report resulted from the collaboration of many people and organizations.

A number of experts in the field contributed advice and insights in designing AB health benefits and AB Plus services. These include John F. Burton, Walt Francis, Larry Fricks, Jay Himmelstein, John Kemp, Joseph Newhouse, Mary Beth Senkewicz, and Michael Sullivan. Professors Himmelstein and Newhouse also commented on an early draft of this final report, while Professor Sullivan met regularly with the research team to monitor the delivery of services for the Progressive Goal Attainment Program (PGAP). A few experts played central roles in designing AB Plus services, reviewing evaluation plans, and providing technical assistance to staff throughout the demonstration. Finally, Robert Solow, Larry Katz, Jan Blustein, and Sylvia Smuller reviewed some of the results contained in this report.

A smaller group played a more ongoing role in both designing AB Plus services and modifying them to the needs of the project. These include Gregory Simon and Michael Von Korff at Group Health Cooperative and Richard Luecking of TransCen, Inc. We are also grateful to Heather Adams of the University Centre for Research on Pain and Disability — co-founder of PGAP along with Dr. Sullivan — and to Tamra Ellis, of the University Centre for Rehabilitation and Health, who adapted the program to fit the demonstration.

The evaluation would not be possible without the program managers and staff at POMCO, American Health Holdings (formerly CareGuide), and TransCen, Inc., who rose to the challenge of developing and running a new program and participating in a complex research project. POMCO's Vanessa Flynn worked with MDRC to design the AB health plan; among her staff, Roberta Adydan, Tracey Koskowski, Jennifer Sarro, Jaimee Smith, and Sandy Valerio managed the implementation of the plan. The team of coaches, nurses, and employment and benefits counselors were invaluable in bringing the AB Plus program model to life: The coaches included Sandy Bennett, Susan Bravard, Vanessa Cochran, Mary Hays, Kathy Hausmann, Annette Karnak, Martha Melloy, and Christa Watson; the nurses included Teresa Stimpson, Sandy Thornton, and Deborah Wantland; the employment and benefits counselors included Andrea Cetera Jines, Susan Klein, Janice Johnson, Rebecca Smith, and Dale Verstegen. Amy Dwyre, James Kenney, Beth Matthies, and Noel Wyatt worked tirelessly with MDRC to supervise AB Plus operations. We appreciate everyone's willingness to participate in various activities related to the study, including interviews with MDRC staff during the process study.

In addition to these program staff, Todd McCarthy and Jaimee Smith from POMCO graciously assisted in the research and in the program's implementation by providing AB health

claims each month. Sara Hooper and James Kenney from American Health Holdings aided the timely collection of data from the program's management information system.

We also wish to acknowledge the contributions of Mathematica's team of interviewers, locators, survey operations supervisors, and monitors who collected the high-quality data on which this report is based. Amy Raduzycki oversaw this team at the Survey Operations Center. Barbara Kolln oversaw the IT work on this project. We thank her and her team of programmers. The survey research team included Julita Milliner-Waddell, Rebecca Weiner, and Stacie Feldman. We thank them for their important contributions to this study.

At MDRC, the report benefited greatly from the hard work of many programmers and research staff. Natasha Piatnitskaia processed the AB health claims, Social Security Administration administrative data, and 12-month survey data. Sonya Williams processed data from the AB Plus management information system and also contributed to the 12-month survey processing effort. Reanin McRoberts helped monitor the implementation of the AB health plan and created many exhibits using the AB health claims. Alla Chaplygina transmitted, collected, and logged administrative and survey data files.

Many MDRC staff members also contributed to the project. David Butler directed all aspects of the project. Peter Baird helped design AB Plus and directed the AB Plus team during implementation. Rachel Pardoe helped monitor the implementation of AB Plus services, created many exhibits using AB Plus participation data, and coordinated the production of all AB publications. John Lewison provided invaluable guidance on the design and administration of the health plan and ensured that all demonstration staff were screened and cleared by the Social Security Administration. Jesús Amadeo oversaw all financial, legal, and data security matters. Lorraine Karlen, Mahendra Budhram, Lina Litvin, Anne Fenton, and Amor Aquino administered AB health plan payments. Joel Gordon and Angelica Manigbas advised the project about data security. Marjorie Singer and her team reviewed challenging legal questions. Karen Paget and the MDRC Institutional Review Board ensured the protection of human subjects. This report received comments from several MDRC reviewers from outside the team, including Gordon Berlin, Dan Bloom, and Sue Kim. John Hutchins and Robert Weber edited the report, and it was prepared for publication by David Sobel and Stephanie Cowell.

Finally, we extend our deep appreciation to the participants in the AB research sample, without whom this work would not have been possible.

The Authors

Executive Summary

Many Social Security Disability Insurance (SSDI) beneficiaries have serious health care needs, but, under current law, most are not eligible for federally funded health care benefits through Medicare for a period of 24 months after they are entitled to receive cash benefits. During this "waiting period," most beneficiaries have poor health and limited functioning, but many lack health insurance. In 1999, Congress provided the Social Security Administration (SSA) the authority to examine the effect of changing the waiting period. The result was the Accelerated Benefits (AB) Demonstration, a five-year study of whether a short-term investment in health care and related services for newly entitled SSDI beneficiaries leads to improved health, increased employment, and reduced reliance on SSDI benefits. MDRC led the design and evaluation of AB in collaboration with Mathematica Policy Research, Inc. This final report from the project describes all activities to date, including a summary of impacts one year following recruitment into the study. In addition to helping SSA design policies to help SSDI beneficiaries, results from AB have broader policy implications as the first random assignment study of the efficacy of providing health care benefits to a high-needs population.

Two versions of AB were tested. Both provided health care benefits to new SSDI beneficiaries who did not have health insurance during the Medicare waiting period. The second version of AB — called "AB Plus" — added three voluntary services delivered by telephone to help individuals navigate the health care system and to help them return to work.

New SSDI beneficiaries without health insurance who consented to be part of the study were assigned at random to one of the three research groups: (1) the AB group, which had access to the program's health care benefits; (2) the AB Plus group, which had access to the health care benefits and could use the other services delivered by telephone; or (3) a control group, which could not receive AB health care benefits or AB Plus services but could obtain health insurance on their own. Random assignment ensures that any differences among the three groups when participants entered the study were due to chance and that any systematic differences that later emerged were most likely due to the program services being studied.

Recruitment and Characteristics of Sample Members

The study targeted uninsured new SSDI beneficiaries, since they were most likely to benefit from AB's health care benefits. Sample members also had to meet the following criteria: (1) have at least 18 months until they were eligible for Medicare, so they would receive AB services soon after the onset of their disability; (2) be between 18 and 54 years old, so there was a reasonable expectation of returning to work; and (3) live in one the 53 metropolitan statistical areas with the most new SSDI beneficiaries. There was a strong interest in participating in

services among beneficiaries who met these criteria: of the 12 percent of new SSDI beneficiaries who were without health insurance, over 99 percent completed a baseline interview and enrolled in the demonstration. From October 2007 through January 2009, 2,005 individuals meeting these criteria consented to be in the study and were randomly assigned. Subsequently, seven individuals were later determined by SSA to have been ineligible for the SSDI program and therefore ineligible for the study, and an eighth person was removed because it was later determined that she was insured at the time of randomization and therefore ineligible for the study. The study sample thus consists of 1,997 individuals assigned to the control group (986 individuals), the AB group (400 individuals), or the AB Plus group (611 individuals).

At random assignment, the participating sample members had diverse impairment characteristics, were in very poor health, and reported high rates of unmet medical needs. They had a range of impairments, including mental disorders (22 percent) and diseases of the musculoskeletal system (19 percent), nervous system (17 percent), or circulatory system (12 percent); and neoplasm (usually cancer; 8 percent). Reflecting their disability status, nearly all participants were limited in performing such activities as preparing meals, taking medications, and using the telephone. In addition, nearly three in ten reported very serious limitations that prevented them from performing basic daily activities, such as getting in or out of a bed or chair, using the toilet, or eating. Although a majority of sample members reported being uninsured for more than six months, most had seen or talked with a doctor in the preceding six months. In terms of demographic characteristics, sample members were 47 years old, on average, at the time of random assignment, and nearly 80 percent of them possessed at least a high school diploma or its equivalent.

The AB Health Plan

AB and AB Plus group members could use the AB health plan from the day of random assignment until they became entitled for Medicare. In addition to covering basic health care needs, such as hospitalizations and physician visits, the AB health plan covered some rehabilitation supports and treatment for mental health problems and chemical dependency. The plan gave program group members access to a network that included 450,000 providers nationwide, and it required modest copayments when network providers were used. Compared with Medicare, the AB health plan had lower copayments, provided greater reimbursement to health care providers, and paid for some durable equipment rehabilitation therapies not covered by Medicare. At the same time, individuals were limited to $100,000 in health care until they became eligible for Medicare.

Almost all program group members used the AB health benefit during the year after random assignment — most commonly for doctor visits, diagnostic testing, and prescription medications. Program group members averaged $19,265 in paid AB health benefit claims during

the first year, but less healthy individuals used more: those with a primary diagnosis of neoplasm (cancer) used $39,698, on average. As is typical with health insurance, a minority of members accounted for a large share of the costs: 12.3 percent had payments of more than $50,000, accounting for 53 percent of costs, and about 4 percent reached the benefit limit of $100,000.

AB Plus Services

AB Plus included three voluntary services delivered by telephone, the first two of which were designed to help participants return to work:

- **A behavioral motivation program called the "Progressive Goal Attainment Program" (PGAP).** PGAP is a 10-module program designed to incrementally increase participants' activity levels and change daily routines to be consistent with holding employment (for example, waking up at a regular time). PGAP also tries to reduce participants' perceptions of disability and to help them better manage pain and discomfort. The staff who administered PGAP — all of whom had social work backgrounds — also coordinated AB Plus services and acted as participants' primary point of contact during the demonstration.

- **Employment and public assistance benefits counseling.** Employment counselors helped participants develop and achieve employment goals. For example, they helped participants prepare résumés, identify work or training opportunities, and make use of local services. AB Plus benefits counselors identified participants' benefits concerns and provided information on how work would affect their SSDI status and other benefits. Benefits counselors also helped participants make the transition to Medicare, helped those who had hit the plan's $100,000 cap find ways to pay for health care, and helped financially strapped individuals receive assistance paying bills.

- **Medical case management.** Nurses helped participants address short-term health problems that might be barriers to using the two employment-related services above. One nurse handled individuals who had mental health needs, developing simple care plans, reviewing medications, and occasionally making referrals to mental health providers. Other nurses handling physical health problems helped participants navigate the health plan, particularly following a hospital stay. PGAP coaches also provided some basic disease-specific education as part of medical case management.

During the year after random assignment, 84.9 percent of the AB Plus group completed an intake, during which AB Plus services were explained and the participant was assessed for health care needs and the ability to participate in PGAP. In addition, 73.8 percent had at least one additional session with AB Plus staff following intake. About one-third participated in each of the employment-related services. Participants averaged 8.7 contacts with AB Plus staff, lasting a total of 4.2 hours. However, there was substantial variation in the degree to which people used different services. While about one-third used PGAP, for example, only about one-sixth of that group completed all ten modules, and half completed at least four. The one-third of the AB Plus group who used employment and benefits counseling averaged six telephone sessions, for a total of 2.5 hours.

Estimated Effects of AB and AB Plus

Estimated short-term effects of AB health benefits and AB Plus services are shown in Table ES.1 and are summarized below. Results are based primarily on a survey administered about 12 months after random assignment.

- **AB health care benefits increased health care use and reduced unmet needs.** Although most control group members had a regular source of health care, both AB and AB Plus groups were about 13 percentage points more likely to have a regular source of care and to have made three or more doctor visits. In addition, program group members were substantially less likely to report delaying or not getting needed care. Both program groups also had lower out-of-pocket expenditures on health care costs, although AB led to greater reductions than AB Plus. These effects should be interpreted in light of the fact that about 40 percent of control group members obtained health insurance during the year (not shown in the table).

- **AB health care benefits improved health outcomes.** Increased use of health care and AB Plus medical case management were intended in part to improve health and functioning. The second panel of Table ES.1 shows that higher proportions of the AB and AB Plus groups than of the control group reported that their health was good or better than good. Results presented in the report confirm a range of positive effects on health from AB's health care benefits.

- **AB Plus services encouraged people to look for work but did not increase employment levels in the first year.** Members of the AB Plus group were more likely to use vocational rehabilitation and other job preparation services and were more likely to look for work than either the AB group or the control group. This was not true for the AB group. Despite this promising

The Accelerated Benefits Demonstration

Table ES.1

Summary of Estimated Effects Across Domains During the First Year of Follow-Up

Outcome	AB Plus Group	AB Group	Control Group	AB Plus-Control Difference (Impact)	AB Plus-Control P-Value	AB-Control Difference (Impact)	AB-Control P-Value	AB Plus-AB Difference (Impact)	AB Plus-AB P-Value
Direct outcomes									
Had a regular source of care (%)	89.2	90.7	77.7	11.5 ***	0.000	13.0 ***	0.000	-1.5	0.552
Had 3 or more visits	83.0	82.1	69.9	13.1 ***	0.000	12.2 ***	0.000	0.9	0.774
Had any unmet medical needs (%)	52.5	50.2	70.1	-17.7 ***	0.000	-20.0 ***	0.000	2.3	0.504
Total out-of-pocket medical expenditures (%)									
Less than $1,000	47.5	56.8	35.4	12.1 ***	0.000	21.4 ***	0.000	-9.3 **	0.012
$1,000 to less than $5,000	39.2	28.8	37.6	1.6	0.585	-8.9 **	0.015	10.5 ***	0.004
$5,000 or more	13.3	14.4	26.9	-13.7 ***	0.000	-12.5 ***	0.000	-1.2	0.687
Number of doctor visits	22.7	22.4	17.2	5.5 ***	0.000	5.2 ***	0.003	0.3	0.862
Mediating outcomes									
Good, very good, or excellent self-reported health (%)	28.0	31.7	21.3	6.6 ***	0.007	10.4 ***	0.001	-3.8	0.209
Received employment or vocational rehabilitation services (%)	9.0	3.6	4.9	4.1 ***	0.005	-1.3	0.468	5.4 ***	0.003
Ever looked for work (%)	15.5	10.5	12.5	3.0	0.142	-2.0	0.433	5.0 **	0.046
Ultimate outcome									
Ever employed (%)	10.5	10.7	9.3	1.2	0.507	1.4	0.522	-0.2	0.921
Sample size (total = 1,360)	548	274	538						

(continued)

Table ES.1 (continued)

Outcome	AB Plus Group	AB Group	Control Group	AB Plus-Control Difference (Impact)	AB Plus-Control P-Value	AB-Control Difference (Impact)	AB-Control P-Value	AB Plus-AB Difference (Impact)	AB Plus-AB P-Value
Died since random assignment[a] (%)	5.2	5.2	3.5	1.8	0.109	1.7	0.203	0.0	0.973
Sample size (total = 1,531)	611	305	615						

SOURCES: Calculations from responses to the Accelerated Benefits 12-month follow-up survey and Social Security Administration administrative data.

NOTE: Estimates were regression-adjusted using ordinary least squares, controlling for pre-random assignment characteristics of sample members. For each comparison, a two-tailed t-test was applied to differences between outcomes for research groups. Statistical significance levels are indicated as: * = 10 percent; ** = 5 percent; and *** = 1 percent. Sample sizes may vary because of missing data.

[a]This measure is based on Social Security Administration administrative data and includes survey respondents (N = 1,360) and nonrespondents (N = 171). It shows only deaths that occurred within the one-year follow-up period.

intermediate result, the three groups had similar employment rates in the first year. Since looking for work is the first step toward returning to work, impacts on employment might emerge after the evaluation has ended. In addition, since the study period coincided with one of the deepest recessions in recent U.S. history, impacts on employment might emerge as the economy grows stronger.

- **Death rates were somewhat higher for program group members than control group members.** One note of caution is that, compared with the control group, more sample members in the AB and AB Plus groups died. In particular, 5.2 percent of the AB and AB Plus groups died within a year of random assignment, compared with 3.5 percent of the control group, although the study's sample size is too small for this difference to be statistically significant. Neither the demonstration's logic model nor prior evidence suggest that AB would increase death rates, and further analyses did not find an association between specific AB or AB Plus services and death. For these reasons, the research team concludes that the important difference in death rates between the AB and AB Plus groups and the control group is unlikely to represent a true effect of the AB interventions.

- **SSA's short-term investments might produce long-term savings, but it is too early to estimate these potential effects.** The AB health plan is projected to cost $31,370 per program group member, and AB Plus services are projected to be over $3,000 per AB Plus member. While the impacts described above are not substantial enough to cover these costs in the short term, they have the potential to generate cost savings in the future. Improved health and reduced unmet medical needs might result in savings for the Medicare and Medicaid programs once individuals leave the 24-month waiting period. Short-term improvements in health and increases in work preparation and job search might result in increases in long-term employment that reduce the cost of SSDI benefits. It is too early to know whether or how much will be saved through these avenues, but outcomes for study participants should continue to be followed so that those effects can be estimated.

Summary and Policy Implications

The results described above are promising. Health benefits not only substantially increased health care use but improved health, providing the most rigorous information to date on the link between health benefits and health. Employment-focused services delivered by tele-

phone increased the number of people preparing for work or looking for work by a substantial degree, given the low rates of employment among SSDI beneficiaries.

Nevertheless, some caution is in order because the results cover only the first year of the intervention, even though individuals were eligible for services for about 21 months, on average. This final report is being published before the program has ended in order to coincide with the end of the contracted evaluation led by MDRC and Mathematica. It will be important to use administrative records and follow the sample members beyond the demonstration period to determine whether there are long-term effects on employment that lead to reductions in SSDI benefits and whether increased health care use and improved health during the demonstration period result in reduced Medicare use later on. Such long-term effects could help recoup the costs of the program. In addition, administrative data should be used to track the death rates of sample members, to confirm that AB did not increase mortality.

It is also important to remember that AB Plus services were delivered by telephone. This was done because the research sample in any one location was too small to support the delivery of services at each location. Other interventions, including tests of care management and PGAP, have found stronger effects for other target populations when they were delivered in person, and it is possible that in-person delivery would have led to larger effects.

Finally, it is not clear how these results relate to what will happen under health care reform or if Congress votes to end the Medicare waiting period. It is likely that the effects of Medicare or Medicaid eligibility on health care use for the AB target population would be smaller than under AB, since those programs cover fewer services and often provide more limited access to health care. In addition, Medicare and Medicaid typically reimburse providers less than AB did, so costs might be lower than under AB, although neither Medicare nor Medicaid has a cap on benefit payments, as AB did. At the same time, the costs under AB likely understate the true costs of providing health care benefits to new SSDI beneficiaries, since the costs ignore the possibility that some individuals would drop private insurance if they could receive public insurance during the waiting period. Finally, it is important to remember that AB systematically excluded some key groups of SSDI beneficiaries. In particular, individuals receiving both SSDI and Supplemental Security Income were excluded, since most are insured through Medicaid, and limiting the study to individuals who had at least 18 months remaining in the Medicare waiting period left out those who take longer to be approved to receive SSDI benefits. Results presented in this report at best reflect what might happen to the group that was targeted for the study.

Despite these limitations, AB provides perhaps the most rigorous information to date suggesting that health care benefits can improve the health of a medically needy group. Longer-term follow-up would be needed to understand whether these effects last or translate into later effects on employment, SSDI benefits, and health care.