Medicaid expenditures for the disabled under a work incentive program

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Congress enacted Section 1619 of the Social Security Act to enable the disabled receiving Supplemental Security Income (SSI) to obtain jobs and still retain Medicaid health benefits. Congress intended this work incentive to remove the fear of the severely disabled that by obtaining employment they would lose Medicaid benefits. Based on data from 11 States, our analysis found that Medicaid expenditures for Section 1619 enrollees were relatively small and only one-half the average Medicaid expenditure for the disabled. Retaining Medicaid appears to provide a significant work incentive because Medicaid expenditures represent 13 percent of Section 1619 enrollees' earnings.

Introduction

It is widely believed that some disabled persons are discouraged from working for fear of losing their Medicaid benefits (Berkowitz, 1981; Better, Fine, Simison, et al., 1979; Walls, Masson, and Werner, 1977). To counteract this, in 1980, Congress enacted Section 1619 as a temporary provision of the Social Security Act. Under this provision, some Supplemental Security Income (SSI) beneficiaries may work and continue to receive SSI and/or Medicaid benefits. This provision had been extended several times on a temporary demonstration basis and was made permanent in November 1986 under the Employment Opportunities for Disabled Americans Act, Public Law 99-643 (Rocklin and Mattson, 1987).

At the request of the House Ways and Means Committee, the Department of Health and Human Services (DHHS) prepared a report examining the impact of Section 1619 on the SSI and Medicaid programs (DHHS, 1986). This article is the result of the Health Care Financing Administration's (HCFA) study included in the report. This study examined the Medicaid use and costs of Section 1619 enrollees and compared them with the total disabled population covered by Medicaid. The study indirectly provided evidence concerning the work incentive issue by indicating the level of need for health care. Presumably, the greater the need for health care, the greater will be the incentive of continuing Medicaid coverage for the disabled worker. The Social Security Administration (SSA) prepared a study for the report to Congress that directly examined the work incentive value of Section 1619 (SSA, 1986).

Overview of Section 1619

Prior to the Section 1619 provision, disabled SSI enrollees were ineligible for both SSI benefits and Medicaid coverage if they were gainfully employed, even though their earnings did not totally offset their SSI benefit amount. Under Section 1619(a) of the Social Security Act, disabled persons covered by SSI who earn more than the $300-per-month "substantial gainful activity" (SGA) level may receive a special SSI payment and maintain Medicaid coverage. The special payments are calculated in the same manner as the SSI payments. Section 1619(b) allows the disabled person to continue receiving Medicaid coverage even though the individual's earnings exceed the amount where the SSI cash payment would be reduced to zero. Several criteria must be met for this continued coverage, such as, the person is still blind or disabled and would be inhibited from continuing employment without Medicaid coverage. The person must also demonstrate a need for Medicaid coverage either through use of medical services during the prior 12 months or expected use over the next 12 months. There is no distinction made by the Medicaid program between the Section 1619(a) and 1619(b) enrollees.

Section 1619 presents a dilemma for the SSI program. SSI has a very strict definition of disability: the inability to engage in substantial gainful activity because of a physical or mental impairment. The definition involves both medical and vocational attributes of the person. There is no recognition for partial or temporary disability. Thus, prior to Section 1619, the law did not allow persons to work and earn above the SGA level and to continue to receive SSI benefits. The dilemma then, is how to reconcile the SSI program definition of inability to work with the Section 1619 incentives to work.

From a practical viewpoint, if the structure of the SSI program discourages disabled persons from attempting to work, provisions to eliminate disincentives, such as Section 1619, may both lower expenditures and provide revenues to Federal (and perhaps State) programs. Earnings of Section 1619 enrollees are subject to income tax, providing additional State and Federal revenues. In addition, SSI cash payments are reduced to these working disabled, thereby reducing program expenditures. The Medicaid program may be positively affected because the program enrollees may use fewer Medicaid services when they work. The Section 1619 incentive also resolves the dilemma the disabled face of potentially losing their SSI and Medicaid benefits if they work.

In the long term, the number of disabled persons covered by SSI may be reduced as Section 1619 enrollees gain work experience and move to higher

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paying jobs and jobs providing some health insurance benefits. It remains to be seen whether these long-term benefits will be achieved, given the marginal employability of many of these disabled persons. However, even without achieving the long-term benefits, the reduction in SSI payments, increased tax revenues, and the psychological benefit to the disabled who are able to achieve employment should be considered.

Section 1619 program enrollees

According to SSA program data for August 1985 (SSA, 1986) there were 816 Section 1619(a) and 7,954 Section 1619(b) enrollees. Approximately 80 percent of the enrollees were under 40 years of age, 70 percent white, and 58 percent male. These demographic characteristics greatly differ from the disabled SSI population, who are older (only 40 percent under 40 years of age), comprise slightly fewer white people (60 percent), and fewer males (40 percent).

The disabling condition of 64 percent of the Section 1619(a) and 49 percent of the 1619(b) enrollees fell under the medical code designation of mental disorder (mental retardation, psychosis, or neurosis). This compares with 48 percent for the disabled SSI enrollees. More than one-half of the Section 1619 enrollees work in private businesses or companies and approximately one-fourth work in sheltered workshops. More than one-half are employed in clerical, sales, or service occupations. In August 1985, the Section 1619 enrollees had an average income of $655 per month, with the Section 1619(a) enrollees earning $475 per month, while the Section 1619(b) enrollees earned an average of $674 per month.

Approximately 10 percent of the Section 1619 enrollees are in Medicaid-certified nursing facilities. These institutionalized Section 1619 enrollees would be covered by Medicaid even if Section 1619 did not exist.

Data sources

The primary source of data for our analysis of Medicaid use and costs of Section 1619 enrollees was a four-State Medicaid data base, developed by the Office of Research at HCFA, called Tape-to-Tape. This data base is unique because it provides person-level data on the Medicaid program that have been largely unavailable. The second source of data was aggregate recipient utilization and expenditure data from seven States. The two sources of Medicaid data used for the analysis come from a total of 11 States that contained approximately one-half (49.8 percent) of the Section 1619 SSI recipients in the SSA records for May 1982. The two data sources are described next in more detail.

Tape-to-Tape data

The Tape-to-Tape data used are for calendar year 1982 for Georgia and California, Federal fiscal year 1982 for New York, and calendar year 1981 for Tennessee. The Tape-to-Tape data base was created by extracting data from the Medicaid Management Information System (MMIS) in each State and creating uniform person-level files.

Persons making up the Section 1619 population were identified in each State by using a May 1982 SSI enrollment file. Other estimates of the Section 1619 population indicate that the May 1982 file was incomplete, identifying only 59 percent of the population. Using social security numbers, the May 1982 file was matched to Medicaid enrollment records on the Tape-to-Tape data base. Because match rates were high, Medicaid records were found for most of the persons identified in the SSI file. As a result, the Medicaid data file used in this study contains about one-half of the total Section 1619 population in the four Tape-to-Tape States. Because the SSI file appears to be a representative sample of the total Section 1619 population, Medicaid utilization and expenditure rates obtained from the sample should be accurate.

State agency survey data

To supplement Tape-to-Tape data, Federal fiscal year 1984 data were collected from Medicaid agencies in States having high proportions of Section 1619 recipients. These States provide a broader range of more timely data. The seven surveyed States are: Florida, Louisiana, Maryland, Nebraska, Pennsylvania, Texas, and Washington. Because the data from these States are limited in scope and in uniformity, they were used to supplement the more detailed analysis provided by the Tape-to-Tape data.

Participating States were provided with information from SSI program files to identify the Section 1619 SSI recipients in their State enrollment and claims files. The States summarized Federal fiscal year 1984 Medicaid recipient, utilization, and expenditure data on the Section 1619 population on data collection forms provided to them. The States provided the comparison data for the disabled population from the HCFA-2082 form that States submit to HCFA with aggregate counts of recipients, utilization, and expenditures by health service category.

Method of analysis

The methodological approach was to present total expenditure data and then to analyze differences in expenditures per enrollee by comparing Section 1619 patterns with those of the Medicaid disabled population. Because many of the Section 1619 enrollees receiving long-term care services would be covered by Medicaid regardless of Section 1619, total expenditures excluding long-term care services were also examined.

The data are further examined by type of service. Four summary classes of services are used: inpatient hospital care (acute hospitals, but not psychiatric and chronic hospitals); long-term care (psychiatric hospitals, chronic hospitals, skilled nursing facilities,

and intermediate care facilities); ambulatory visits (physician visits, outpatient department visits, emergency room visits, and other practitioner visits); and other services (for example, home health visits, dental visits, drugs, laboratory and X-ray services, and durable equipment).

In examining expenditure rates for the individual health services, we broke down expenditure per enrollee into its utilization and expenditure components to determine which component contributed to higher or lower costs for the Section 1619 populations. We examined whether the differences in expenditure per enrollee can be explained by differences in the proportion of enrollees receiving the service (user rate), the level of use per service user (e.g., number of visits per user), or the cost per unit of service (e.g., cost per visit). The relationship between these rates is shown here.

$$\frac{\text{Expenditures}}{\text{Enrollee}} = \frac{\text{User}}{\text{Enrollee}} \times \frac{\text{Service units}}{\text{User}} \times \frac{\text{Expenditures}}{\text{Service units}}$$

Enrollees are persons who applied for Medicaid coverage and were enrolled in the program. They may or may not have used Medicaid-covered services during a given period of time. Recipients are Medicaid enrollees who received at least one Medicaid service during a given period of time. Users are Medicaid recipients who received at least one specific type of service during a given period of time. Specific types of services, for example, are hospital, physician, and outpatient department services.

The analysis for the survey States followed the analytical plan used for the Tape-to-Tape analysis, where possible. Because of limitations in the data provided by the States, the number of enrollees was unknown. Therefore, total recipients of any health service was used as a proxy for enrollees. Expenditure rates were analyzed as "per recipient" rather than "per enrollee."

Findings: Tape-to-Tape States

Population characteristics

The Section 1619 enrollees in the Tape-to-Tape States accounted for 0.17 percent of the disabled in the States. (The number of enrollees shown in Table 1 was doubled to compute this percentage, because only one-half of the Section 1619 enrollees were identified in these States.) Section 1619(a) enrollees represented nearly 12 percent of the total Section 1619 enrollees in the States (derived from Table 1). This was higher than the nationwide figure of 5 percent for 1982, based on SSI administrative records. The number of Section 1619(a) enrollees in each State was too small to support reliable results, therefore, most of the following analysis focuses on the overall Section 1619 population.

Table 1

Medicaid enrollment, by disability group: Tape-to-Tape States, calendar year 1982

	Tape-to-Tape States				
Disability group	Total	California	Georgia	New York[1]	Tennessee[2]
Disabled	960,997	458,875	97,821	312,799	91,502
Total Section 1619	822	429	69	279	45
1619(a)	96	65	4	24	3
1619(b)	726	364	65	255	42

[1]Data shown are for Federal fiscal year 1982.
[2]Data shown are for calendar year 1981.

NOTES: Data are based on number of persons ever enrolled during the year. Excludes enrollees in health maintenance organizations. Tape-to-Tape States are California, Georgia, New York, and Tennessee. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Analysis of expenditures

As shown in Table 2, the total expenditures for Section 1619 enrollees identified in the Tape-to-Tape

Table 2

Total Medicaid expenditures for Section 1619 enrollees and disabled enrollees, by Tape-to-Tape States: Calendar year 1982

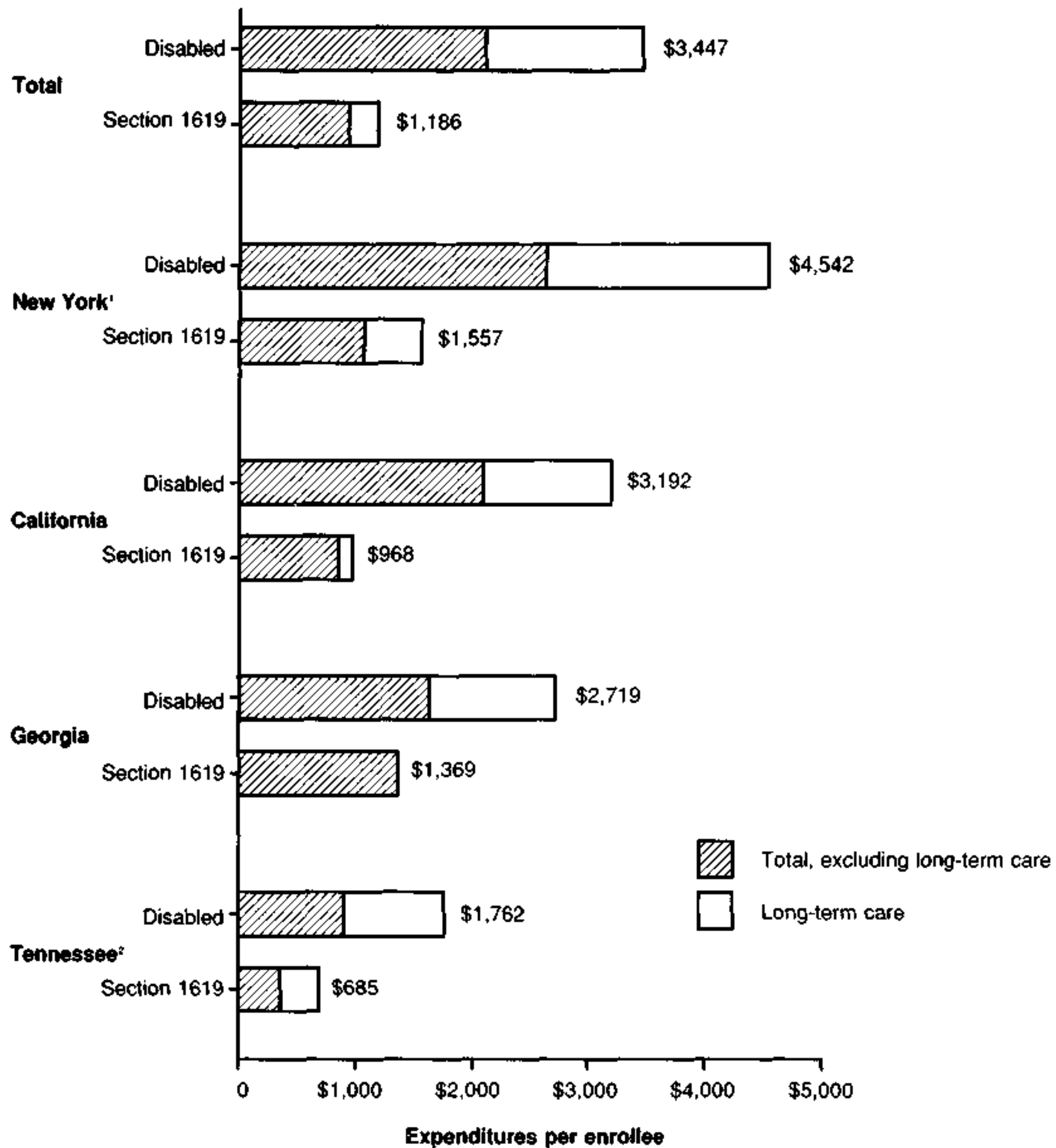
	Section 1619		All disabled	
Tape-to-Tape States	Total in thousands	Total in thousands excluding long-term care	Total in thousands	Total in thousands excluding long-term care
Total	$861	$689	$2,815,364	$1,724,536
California	380	338	1,307,809	856,463
Georgia	87	87	243,197	145,423
New York[1]	365	249	1,120,872	649,467
Tennessee[2]	29	15	143,486	73,183

[1]Data shown are for Federal fiscal year 1982.
[2]Data shown are for calendar year 1981.

NOTES: Data are based on person-years of enrollment, excluding enrollees in health maintenance organizations. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Figure 1
Total Medicaid expenditures per enrollee for Section 1619 and total disabled enrollees: Tape-to-Tape States, 1982



[1] Federal fiscal year 1982.

[2] Calendar year 1981.

NOTE: Section 1619 is a provision of the Employment Opportunities for the Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicaid Tape-to-Tape project.

States was $861,000. Total expenditures excluding long-term care came to $689,000 for the four States. The expenditures displayed in Table 2 are probably about one-half the actual Medicaid expenditures for the Section 1619 enrollees in the four States, because only one-half of these enrollees were identified in the Tape-to-Tape data files.

The expenditures for the disabled population totaled $2.8 billion for the four States, and $1.7 billion excluding long-term care. These data indicate that less than 80 cents out of every $1,000 spent on Medicaid services (excluding long-term care) for the disabled was for Section 1619 enrollees. (Because only one-half the Section 1619 enrollees were identified in the Tape-to-Tape States, Section 1619 expenditures presented in Table 2 were doubled to compute this ratio.)

As displayed in Figure 1, the average total expenditure per enrollee was considerably higher for the disabled than for the Section 1619 enrollees, $3,447 in comparison to $1,186. The disabled had more than twice the Section 1619 rate for total expenditures per enrollee after excluding long-term care costs, $2,105 versus $944 (Table 3 and Figure 1). Although the total expenditures per enrollee were consistently at least twice as high for the total disabled as for Section 1619 enrollees in the four States, note that the expenditure rates ranged greatly between the States—from $1,577 in New York to $685 in Tennessee for the Section 1619 enrollees. Such variation is typical of Medicaid expenditure rates because the States have widely varying programs (eligibility criteria, service coverage, and reimbursement methods) and the cost of medical care varies greatly by State (Sawyer, et al., 1983).

Type of health service

In every service category, the disabled had higher costs per enrollee than the Section 1619 enrollees, as the data in Table 3 indicate. The magnitude of these differences for each service is displayed as the ratio of expenditure per disabled enrollee to expenditure per Section 1619 enrollee. Excluding long-term care, the highest ratio across the four States combined was for inpatient hospital services. The hospital expenditure rate for the disabled averaged more than 3 times the rate for Section 1619 enrollees. The category "other services," which includes laboratory services, home health, prescription drugs, and X-rays, was next in size. The disabled averaged 1.7 times the expenditure rate of Section 1619 enrollees for these other services. The difference between the two groups was lowest for ambulatory visits, for which the disabled enrollees averaged 1.4 times the expenditure rate for Section 1619 enrollees.

We next examine why expenditure per enrollee was higher for the disabled population than for Section 1619 enrollees. We analyze which factors—utilization or expenditure per unit of service, or both—explain the higher average expenditures for the disabled and the relative importance of these factors.

The expenditure per enrollee for inpatient hospital services of the disabled, $1,215, was much higher than that of Section 1619 enrollees, $379 (Table 4). This can be largely attributed to higher proportions of the disabled receiving hospital services (22 percent) as compared with the Section 1619 enrollees (10 percent). The other two rates displayed—days of care per user and expenditure per day—were higher for the disabled population, although the difference between the disabled and Section 1619 enrollees for expenditure per day was relatively small.

Ambulatory services consist of several different types of services. Three of these are examined in detail because the disabled had higher expenditure per enrollee rates than the Section 1619 enrollees for these services, and because these services represented 49 percent of overall ambulatory expenditures of the disabled. The other individual ambulatory services are too small in terms of expenditures to warrant separate analysis. The services examined are visits to physicians and outpatient departments, and use of prescribed drugs.

As shown in Table 4, for all three services the disabled had higher expenditures per enrollee than Section 1619 enrollees. The major factor explaining the higher expenditure for the disabled for physician visits compared with the Section 1619 enrollees was the greater number of such visits per user. Of lesser importance was the proportion of enrollees who were users. Expenditure per physician visit was lower for the disabled than for the Section 1619 enrollees. Outpatient visits per user and expenditure per

Table 3

Medicaid expenditures per enrollee for type of service, by disability group: Total Tape-to-Tape States, calendar year 1982[1]

Disability group	Total	Total excluding long-term care	Inpatient hospital	Long-term care	Ambulatory visits	Other services
Section 1619	$1,186	$944	$379	$242	$237	$329
Disabled	3,447	2,105	1,215	1,341	320	570
(Ratio)	(2.9)	(2.2)	(3.2)	(5.5)	(1.4)	(1.7)

[1] New York is Federal fiscal year 1982; Tennessee is calendar year 1981.

NOTES: Data are based on person-years of enrollment, excluding enrollees in health maintenance organizations. Tape-to-Tape States are California, Georgia, New York, and Tennessee. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 4

Medicaid use and expenditure rates, by type of service and disability group: Total Tape-to-Tape States, calendar year 1982[1]

Type of service and disability group	Expenditure per enrollee	User rate	Units of service per user	Expenditure per unit of service
Inpatient hospital				
Section 1619	$379	0.10	[2]11.9	[2]$318
Disabled	1,215	0.22	[2]15.9	[2]358
Physician visits				
Section 1619	78	0.46	8.0	22
Disabled	107	0.51	11.6	18
Outpatient department visits				
Section 1619	66	0.26	6.3	38
Disabled	109	0.29	8.3	46
Prescription drugs				
Section 1619	100	0.58	14.1	12
Disabled	206	0.73	24.9	11

[1] New York is Federal fiscal year 1982; Tennessee is calendar year 1981.
[2] Unit of service is hospital day.

NOTES: Data are based on person-years of enrollment, excluding enrollees in health maintenance organizations. Tape-to-Tape States are California, Georgia, New York, and Tennessee. Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 5

Summary of factors contributing to differences in Medicaid expenditure per enrollee for disabled and Section 1619 enrollees, by type of service: Total Tape-to-Tape States, calendar year 1982[1]

		Factors		
Type of service	Expenditure per enrollee	User rate	Units of service per user	Expenditure per unit of service
Total	H	H	DNA	DNA
Inpatient hospital[2]	H	H	H	+
Physician visits	H	+	H	—
Outpatient department visits	H	+	H	H
Prescription drugs	H	H	H	—

[1] New York is Federal fiscal year 1982; Tennessee is calendar year 1981.
[2] Unit of service is hospital day.

NOTES:
H = Disabled 15 or more percent higher than Section 1619.
+ = Disabled 0-15 percent higher than Section 1619.
- = Disabled 0-15 percent lower than Section 1619.
DNA = Data not applicable.
Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986. Tape-to-Tape States are California, Georgia, New York, and Tennessee.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

outpatient visit were the major factors in the higher outpatient department expenditure per enrollee for the disabled. The higher expenditures for prescription drugs for the disabled is largely attributable to the higher proportion of enrollees using services and prescriptions per user.

In summary, the expenditure rate for the disabled was consistently higher than the rate for Section 1619 enrollees, regardless of service (Table 5). The number of service units per user was an important factor in explaining this difference for all types of service. A higher user rate was a major factor only for inpatient hospital services and prescription drugs. Expenditure per unit of service was a major factor only for outpatient department visits.

Findings: Survey States

The findings from the survey States show similar patterns to those of the Tape-to-Tape States, despite the need to use different per capita measurements (per enrollee in Tape-to-Tape versus per recipient in the survey). These patterns are briefly described here.

Section 1619 recipients are a very small proportion of all Medicaid disabled recipients (Table 6). They

Table 6

Number of Medicaid recipients, by disability group and survey State: Federal fiscal year 1984

	Disability group	
Survey State	Section 1619	Disabled
Total	951	479,994
Florida	196	99,784
Louisiana	160	63,861
Maryland	90	35,584
Nebraska	23	9,117
Pennsylvania	214	123,760
Texas	128	106,979
Washington	140	40,909

NOTE: Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 7

Total Medicaid expenditures for Section 1619 recipients and disabled recipients, by survey State: Federal fiscal year 1984

	Section 1619		Disabled	
Survey State	Total in thousands	Total in thousands excluding long-term care	Total in thousands	Total in thousands excluding long-term care
Total	$3,803	$856	$2,018,918	$829,930
Florida	223	155	279,167	151,573
Louisiana	1,542	77	289,162	121,618
Maryland	115	115	102,380	77,528
Nebraska	96	51	48,403	18,950
Pennsylvania	932	213	605,304	186,417
Texas	420	94	500,047	192,247
Washington	476	151	194,455	81,597

NOTE: Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

Table 8

Medicaid expenditures per recipient for type of service, by disability group: Total survey States, Fiscal year 1984

Disability group	Total	Total excluding long-term care	Inpatient hospital	Long-term care	Ambulatory visits	Other services
Section 1619	$3,999	$900	$387	$3,098	$201	$311
Disabled	4,206	1,729	889	2,477	373	466
(Ratio)	(1.05)	(1.92)	(2.30)	(0.80)	(1.86)	(1.50)

NOTES: Section 1619 is a provision of the Employment Opportunities for Disabled Americans Act, Public Law 99-643, November 1986. The seven survey States are Florida, Louisiana, Maryland, Nebraska, Pennsylvania, Texas, and Washington.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Medicaid Tape-to-Tape project.

make up only 0.2 percent of the disabled recipients in the survey States.

Section 1619 Medicaid expenditures are about $1 of every $1,000 spent on the disabled, excluding long-term care expenditures. The total expenditure, excluding long-term care was $856,000 for Section 1619 recipients and $829.9 million for the disabled (Table 7).

Total expenditures per capita, excluding long-term care, were nearly twice as high for the disabled as for the Section 1619 recipients (Table 8). The expenditure for the disabled per recipient (excluding long-term care) was $1,729 compared with $900 for the Section 1619 recipients.

The ratio of expenditures per recipient was greatest for inpatient hospital care (Table 8). The inpatient hospital expenditure rate for the disabled was 2.3 times that for Section 1619 recipients, $889 as compared with $387. Next in relative size was ambulatory visits, with the disabled having 1.86 times the expenditure rate of that for Section 1619 recipients, $373 versus $201. The disabled had a 1.5 times higher expenditure rate than Section 1619 recipients for other services, $466 as compared with $311.

Conclusion

The higher utilization and expenditure levels of the disabled population compared with the Section 1619 enrollees can be partly attributed to differences in demographic composition. Section 1619 enrollees are mostly young adults, younger overall than the general Medicaid disabled population, and they have a larger proportion of males than the general disabled population (Department of Health and Human Services, 1986). Both of these characteristics are associated with lower Medicaid utilization and expenditures (O'Brien et al., 1985). In addition, the fact that they are able to work makes it likely that their health status is better than those disabled persons unable to obtain work. It is also possible that working has a retarding effect on the use of health services.

This study provides indirect evidence that Section 1619 is a work incentive by contrasting health care costs to earnings. Section 1619 enrollees in the Tape-to-Tape States had average annual total Medicaid expenditures of $1,186 ($944 excluding long-term care), and, based on SSI administrative data, average annual earnings of $8,988 for 1982. These health care costs are a substantial part of this income, representing 13 percent of earnings (11 percent excluding long-term care) and excludes attendant care needed by some disabled. These data substantiate the SSA (1986) finding that only 2.8 percent of Section 1619 enrollees are able to earn a high enough income to obtain coverage equivalent to Medicaid. Because most Section 1619 enrollees do not receive employer health benefits (Social Security Administration, 1986),

the working disabled would have the full burden of these health care costs or need to obtain expensive nongroup health insurance without Section 1619's Medicaid coverage. It seems, then, that Section 1619 does act as a work incentive because it provides a significant benefit to the disabled who attempt to work.

In conclusion, Section 1619 provides benefits both to the disabled and to the Federal and State governments. As a work incentive, it provides the opportunity for the disabled to attempt to work with the safeguard of having their health care coverage maintained. The disabled benefit personally from the program by engaging in gainful activity in their communities. Government agencies benefit from Section 1619 in terms of reduced SSI cash payments, increased revenues through income taxes on enrollees' earnings, and the eventual reduction of the number of disabled enrollees as a few of them move into jobs with higher pay and health benefits. In evaluating the work incentive program established by Section 1619, these benefits must be weighed against the financial cost of the program.

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