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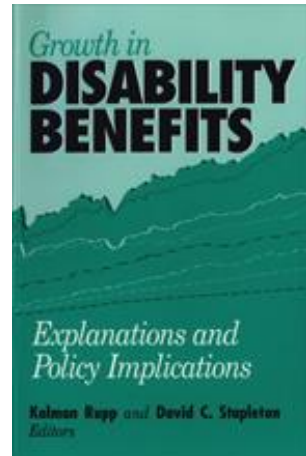
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# Lessons from Case Studies of Recent Program Growth in Five States

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# 8 Lessons from Case Studies of Recent Program Growth in Five States

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In Chapter 2 of this volume we report on our empirical analysis of growth in applications and awards, focusing especially on the period from 1988 to 1992. That analysis pooled state-level time-series data from all states to empirically estimate the impacts of specific factors. In order to further investigate the reasons for the recent growth in the disability programs, and to better understand the findings from our empirical analysis, we conducted case studies of application and award growth for Social Security Disability Insurance (DI) and for Supplemental Security Income (SSI) in five states. The states chosen for study experienced substantial application growth in either one or both disability programs and were believed to have had different experiences with regard to the factors hypothesized to have contributed to that growth. The states included in the study are California, Florida, Michigan, New York, and Texas.

We visited each state to interview staff from the following types of agencies and organizations: state Aid to Families with Dependent Children (AFDC) programs, state or local General Assistance (GA) programs, state Medicaid programs, local Social Security Administration (SSA) field offices, large county hospitals, state employment departments, public mental health agencies, state offices of immigration, and outreach programs in schools, prisons, hospitals, and homeless shelters.

In this chapter, we summarize the qualitative evidence of the impact of various factors on growth obtained during the site visits and through follow-up phone interviews. More detailed discussion of the findings is

contained in Lewin-VHI (1995a). We also present a statistical analysis of the experience of each state using the econometric models estimated from the pooled state-level data. Although the focus of the paper is on adults, some of the information collected is relevant to SSI child applications and awards.

The remainder of the paper is organized as follows: In the first section, we discuss the reasons for selecting each of the five states included in this study, and we describe the trends in applications and awards in those states over the 1988 to 1992 period. In the next section, we first present the findings from the interviews conducted during the site visits to the five states. We then present the findings from the econometric analysis of state-level disability application data from 1988 to 1992. The results of this analysis are combined with the characteristics of each of the five case study states to assess the impact of specific factors on application growth in each state. In the final section, we summarize the lessons learned from conducting the five state case studies.

## **FEATURES OF APPLICATION GROWTH IN THE CASE STUDY STATES**

All five of the case study states were large in terms of the total number of disability applications filed during the 1988 to 1992 period. Together, these states represented 35 percent of all disability applications filed in 1988, and include the four largest states in terms of total applications filed. The states were selected in part because of their size, in part because of diverse patterns in application growth, and in part because of interesting features that were identified through screening interviews with Disability Determination Service (DDS) administrators in seventeen states and from a review of the findings from a survey of field office managers conducted by SSA. We summarize some of their interesting features below.<sup>1</sup>

## California

California was the largest state in terms of DI and adult SSI disability applications in 1988, representing 12 percent of total claims filed. California is the only state of the five in which General Assistance benefits, called General Relief (GR), are mandated by the state but are completely funded and administered by counties. Several factors believed to have contributed to application and award growth nationally may have been particularly important. These include the recession (due to its relative severity in California compared to the nation), immigration, fraudulent applications, and growth in applications based on drug abuse and alcoholism (DA&A).

## Florida

Florida had the fifth largest number of DI and adult SSI disability applications in 1988, representing 4.7 percent of total claims filed. Total applications grew 69 percent between 1988 and 1992, the second highest growth rate among all states. Interestingly, however, DI-only application growth was only moderately high (ranked 14th), despite the fact that the increase in Florida's unemployment rate over the period was significantly higher than the nation's during the same time period. Factors believed to have contributed to application and award growth include the recession, immigration, and efforts by health care providers to assist clients with applications.

## Michigan

Michigan had the eighth largest number of DI and adult SSI disability applications in 1988, representing 4 percent of total claims filed. Between 1988 and 1992, Michigan experienced the second highest rate of SSI-only application growth in the nation. While SSI-only applications rose by 45 percent nationally, in Michigan they rose by 83 percent. Awards rose even more rapidly than applications. Applications based on mental impairment rose substantially faster than applications based on other conditions and accounted for over 40 percent of the growth in total SSI applications. Increases in DI-only and DI-concurrent applications were closer to the national median (ranked 22nd and 16th, respectively) despite the fact that the growth in Michigan's unem-

ployment rate was higher than the nation's during the same period. An important factor believed to have contributed to the high rate of SSI growth was the termination of the state's General Assistance program in 1991.

## **New York**

New York had the second largest number of DI and adult SSI disability applications in 1988, representing 8.6 percent of total claims filed. While DI-only application growth from 1988 to 1992 was very high (44 percent for New York vs. 27 percent for the entire country), DI-concurrent and SSI-only application growth was relatively low (34 and 25 percent for New York vs. 52 and 45 percent for the entire country). New York has a reputation for its past efforts to help low-income residents attain federal benefits, and we hypothesized that the success of past efforts was partly responsible for the comparatively slow growth in SSI applications. New York was also selected because we wanted to learn more about a New York City Board of Education project to help children in special education programs obtain SSI benefits in the wake of *Sullivan v. Zebley* and the new child listings for mental impairments.

## **Texas**

Texas had the third largest number of DI and adult SSI disability applications in 1988, representing nearly 7 percent of total claims filed. Over the 1988 to 1992 period, growth in DI-only and DI-concurrent applications was lower than average (ranking 36th for DI-only growth and 42nd for DI-concurrent growth). During this period, however, Texas experienced higher than average growth in SSI-only applications (ranked 15th). This combination of higher than average SSI-only growth and lower than average DI-only and DI-concurrent growth made Texas a potentially interesting case study. Texas experienced very small changes in the overall unemployment rate during the recession. The relatively low growth in unemployment for the state, however, masks a great variation in changes in the unemployment rate across regions within the state.

## **EXPLANATIONS FOR DISABILITY APPLICATION GROWTH IN THE CASE STUDY STATES**

In this section, we first synthesize information obtained during interviews with representatives from a variety of state and local organizations in each of the five case study states. After discussing the qualitative information collected in these interviews, we present the results from a quantitative analysis of application growth in each state.

### **Findings from the Site Visit Interviews**

We organize the discussion of the qualitative information obtained through interviews by the primary nondemographic factors believed to have contributed to disability application growth from 1988 to 1992. These include the 1990–91 recession, state program changes and outreach efforts, changes in SSA eligibility requirements, and other minor factors, including immigration and changes in the prevalence of specific health conditions.

#### *The Recession*

The recession of 1990–1991 was characterized by a recovery that was much slower than other post-war recoveries. This was particularly evident in the labor market (Council of Economic Advisors 1993). This recession affected states differently, due to variations in the length, severity (Table 8.1), and nature of the recession across states.

In California, the impact of the recession was apparently a significant force behind recent DI application growth, and perhaps SSI application growth as well. The recession in the state was more severe, on average, than in the rest of the nation (California experienced a 3.8 percentage point increase in unemployment, compared to a 1.9 percentage point increase nationally). Southern California was hardest hit, where job loss was concentrated in the defense and construction industries. Interviewees in California indicated that job loss was concentrated among older, more experienced workers, and among workers in low-skill jobs. The job loss experienced by older workers was often permanent in nature, which may have contributed to DI application growth. Interviewees also reported that efforts by employers to assist laid-off employees in obtaining DI benefits increased during this period. The

**Table 8.1 Unemployment Rates by State, 1988 to 1992 (%)**

State	1988	1989	1990	1991	1992	Change 1988-1992
California	5.3	5.1	5.6	7.5	9.1	+ 3.8
Florida	5.0	5.6	6.0	7.3	8.2	+ 3.2
Michigan	7.6	7.1	7.5	9.2	8.8	+ 1.2
New York	4.2	5.1	5.2	7.2	8.5	+ 4.3
Texas	7.3	6.7	6.2	6.6	7.5	+ 0.2
All states	5.5	5.3	5.5	6.7	7.4	+ 1.9

SOURCE: Bureau of Labor Statistics (1994).

recession may have contributed significantly to SSI application growth from immigrants, as immigrants experienced particularly high rates of unemployment, but were often not disability-insured.

Florida's recession of the late 1980s and early 1990s also apparently had a significant impact on application and award growth, particularly in the DI-concurrent application category. The recession in Florida was more severe, on average, than in the rest of the nation (Florida's unemployment rate rose by 3.2 percentage points). Furthermore, while the nation's employment losses were largely concentrated in manufacturing, Florida's losses were concentrated in construction. A significant loss of low-wage jobs may partially explain the high rate of DI-concurrent application growth, and only moderate DI-only application growth in Florida since 1988.

The recession may have also been an important factor behind DI application growth during the 1988 to 1992 period in Michigan even though the increase in the unemployment rate for the period (1.2 percentage points) was less than the national average. The recession's early start in Michigan during the mid 1980s, and the auto industry's failure to recover, may account for some of the increase in DI-concurrent applications, as the income and resources of these DI recipients were reduced to SSI eligibility standards. One impact of the recession was that it led to strained state and local budgets and increased demand for public assistance. Reductions in state welfare programs due to the budgetary crisis had a clear impact on SSI application and award growth (discussed below).

The severe recession in New York was characterized by large layoffs in major firms, many of which were expected to be permanent as manufacturing companies accelerated the downsizing and restructuring of their operations. There was strong consensus among interviewees that the severity and nature of job losses during the recession contributed substantially to growth in DI applications, especially among workers with long-established jobs who were permanently laid off. Because many such workers would qualify only for DI, this may explain the rapid growth in DI-only applications. The state's Office of Disability Determination and SSA field offices worked with employers and private disability insurers to facilitate the application process for employees.

The recession that affected the nation in 1990 and 1991 had relatively little impact on unemployment in Texas, but this is because Texas was experiencing a recovery from a severe recession that affected the state in 1985 and 1986. This may explain why Texas experienced lower than average growth in DI-only and DI-concurrent applications during the 1988 to 1992 period, both because overall unemployment did not increase by much and because individuals who might have been affected in the later period may have already applied for benefits during the earlier recession. As in California, we found anecdotal evidence that high unemployment among immigrant populations contributed to growth in SSI applications from immigrants.

#### *State and Local Shifting and Outreach Efforts*

In each of the five states, we found evidence of changes in policies or procedures that may have had the intended or unintended effect of shifting individuals from state and/or locally funded assistance programs to the federally funded SSI program. The nature, intensity, and apparent success of such policies is related to the financial incentives involved. Below, we discuss some of these policies and incentives and their potential impact on primarily SSI growth in the five case study states. We first discuss policy changes related to Aid to Families with Dependent Children (AFDC) and GA programs. We then discuss policy changes associated with state Medicaid programs.

*AFDC and General Assistance.* In general, we found that efforts to shift welfare recipients onto SSI were focused on GA recipients; we found only very limited efforts targeted at recipients of AFDC. There



are several reasons for this, financial incentives for state and local governments being foremost among them.

State and local savings from shifting AFDC recipients onto SSI are fairly modest. The federal government already pays at least 50 percent of AFDC benefits in every state, so the savings to the state and/or locality are at most 50 percent of the reduction in benefits. Some states also pay SSI supplements, so these must be deducted from any AFDC savings that would be realized. In contrast, the savings from shifting a GA recipient onto SSI can be very large, for two reasons. First, states and/or localities pay for GA benefits in their entirety. Second, and often more important, states and localities usually pay for most of the health care provided to GA recipients, with no direct support from the federal government. Shifting a GA recipient to SSI in almost all cases means that the federal government will thereafter pay for at least half of the individual's health care through Medicaid. AFDC recipients are already Medicaid-eligible, so no such savings accrue when an AFDC recipient is shifted to SSI.

There are two other reasons that shifting efforts focus on GA recipients. First, a greater proportion of GA recipients may be likely to qualify for SSI than of AFDC recipients. According to data from the 1984 Survey of Income and Program Participation, 24 percent of persons receiving cash welfare assistance other than AFDC or SSI had a substantial disability compared to 17 percent of persons receiving AFDC (Mathematica Policy Research 1990). Second, in many ways, local governments are in a better position than state governments to implement shifting efforts effectively, and their share of the combined state and local financial responsibility for GA benefits is usually much higher than their corresponding share for AFDC. Local government familiarity with and proximity to local agencies and organizations—the local welfare department, hospitals and other health care providers, local advocacy organizations—gives them a distinct advantage over states in implementing shifting efforts. In some states, including California, Texas, and Florida, local governments are responsible for 100 percent of GA cash benefits, while the state is responsible for all AFDC payments not paid by the federal government.

Termination of Michigan's General Assistance program was the most dramatic change affecting SSI application and award growth in Michigan. GA served a substantial number of persons before its termi-

nation. As of September 1991, the last month of GA existence, 118,632 individuals were on the GA rolls, but only a fraction were enrolled in two successor programs: 11.5 percent in State Family Assistance (SFA) and 1.3 percent in State Disability Assistance (SDA). Those qualifying for SDA are required to file for SSI, a practice which was not enforced while the GA program was in operation. SDA caseloads are approximately 10,000 per month. About three to four thousand of these individuals transfer to SSI each year, representing about 13 percent of SSI awards in Michigan in 1992.

Since 1988, aggressive outreach efforts in Michigan, coordinated between SSA, state and local agencies, and advocacy groups, have been an important factor behind increases in applications and awards. The outreach efforts have been effective in targeting specific population groups and in identifying potentially eligible individuals. Special attention has been paid to children, low birth weight babies, and former GA recipients. The state of Michigan conducted its own outreach efforts through meetings with schools, probate court, nearly all social service agencies, and others who could make referrals. At the state level, a series of computerized cross-matches were conducted to see if former GA recipients had applied for, or already were on, other social service programs. At least two mass mailings of information followed these cross-matches resulting in an inflow of disability applications to SSA field offices. Of the various organizations engaged in outreach activities, health care providers have been particularly aggressive in referring individuals to the DSS offices.

In New York, the costs of health and welfare expenditures that are not paid for by the federal government are shared equally by the state and its counties. This cost-sharing arrangement creates a strong incentive for the two levels of government to cooperate in shifting welfare beneficiaries onto SSI. The cost-sharing mechanism has been in place, however, since the 1960s, and many of the state shifting mechanisms were also in place before 1988. This may partly explain New York's lower than average SSI application growth since 1988. Shifting efforts aimed at AFDC and, especially, Home Relief (HR) recipients (HR is New York's GA program), have been in place for some time. An example is the Disabled Client Advocacy Program (DCAP) implemented in 1986, which identifies and assists disabled AFDC and HR recipients in

the application process for SSI. Such efforts were intensified more recently.

The incentive to shift HR recipients in New York is particularly strong because their health care is paid for by a “state-only” (state and county financed) Medicaid program. Shifting HR recipients to SSI results in especially large gains to state and county governments because the federal government assumes responsibility for half of an HR recipient’s health care costs under Medicaid when the recipient obtains an SSI award. Medical cost savings in the typical case are substantially greater than cash benefit savings.

In addition to the outreach and SSI application assistance provided to AFDC and HR recipients, New York state and local agencies have implemented collaborative outreach efforts that target institutionalized adults prior to discharge, as part of an effort to keep discharged individuals from becoming HR recipients. Both the Department of Mental Health and the Department of Parole initiated statewide outreach activities to their target populations, individuals with severe mental illness and prisoners about to be released, in 1986. Individuals in these target populations are more likely to apply for SSI than DI. The impact of these efforts on application growth may have been strongest prior to 1988, contributing to the relatively low SSI application and award growth after 1988. We also learned of local outreach efforts to specific hospitals that began in the early 1990s. Another important group that was identified by interviewees as a target of SSI outreach initiatives is homeless persons. Such initiatives were implemented by specific SSA field offices that target homeless shelters in their service areas; the SSA field office we visited implemented such an initiative in 1985. These initiatives were very aggressive in finding potential SSI applicants and assisting them in the application process.

One particularly notable outreach effort in New York City, albeit for children with disabilities, illustrates how the impact of outreach efforts on applications and awards may diminish over time. An intensive effort was initiated in 1992 to identify children potentially eligible for SSI, with an apparently substantial impact on child applications and awards. This is a joint effort by the New York City Board of Education, the state’s Office of Disability Determination, and SSA. Since its inception in August 1992, the program has accounted for approximately 200 awards per month. During the first few months of operation, approxi-

mately 90 percent of cases were approved. At that time, the project referred only the most severely disabled children in the school system (those with IQs less than 59 or in need of physical assistance). The project's target population has expanded, however, and now that children with a wide variety of impairments (including less severe mental retardation, emotional impairments, conduct disorder, and some physical impairments) are regularly referred through the project, the allowance rate has decreased significantly. This example illustrates what has probably occurred with many of the shifting efforts initiated during the 1988 to 1992 period. New efforts can result in large immediate increases in disability applications and awards as those most likely to qualify are targeted first. Subsequently, however, the flow of referrals and the allowance rate are likely to diminish.

In California, efforts to shift individuals onto SSI focused on General Relief (GR; California's general assistance program) applicants and beneficiaries. As in New York, Los Angeles County has an "SSI Advocacy Program" in place that provides SSI application assistance to GR beneficiaries, and, in some cases, assistance at the SSI hearings level. Los Angeles County's effort to shift GR recipients onto SSI is probably among the most aggressive in the state, due to the relative severity of the recession in the county as well as the relative size of their GR population (which accounts for 52 percent of all GR recipients in the state). The county's efforts began in 1982 and were significantly increased in 1985, 1988, and 1992.

In Texas, we interviewed staff from the General Assistance program in Harris County (Houston area). No important policy changes in the Harris County GA program were identified. Texas does not, however, have a statewide GA program, and our findings for Harris County may not be generalizable to GA programs operated in other counties. In the state AFDC program, the implementation of an integrated eligibility screening process for AFDC clients may have had an impact on SSI applications. This process involves screening and assistance with application for other welfare programs for which the client may be eligible. In 1989, SSI was added to the screen. Although explicit shifting was not the intended goal, the increased coordination among welfare agencies may have contributed to growth in SSI applications.

As in Texas, Florida does not have a statewide GA program. Findings from our interviews with staff of the GA program in Dade County

indicate that this program actively referred recipients to SSI prior to 1988, and that changes in GA policies during the 1988 to 1992 period had little or no effect on SSI applications. As in Texas, Florida has a welfare eligibility screening system, which was implemented in 1992. The Florida system involved the training of AFDC caseworkers in SSI eligibility requirements. Though implemented late in the period of this study, the greater awareness of SSI eligibility combined with streamlining of the application process for welfare benefits may have contributed to SSI application growth in Florida.

SSA field office interviewees in Florida also indicated that SSI outreach activities in their state are among the most aggressive, sophisticated, and targeted outreach efforts in the nation and have probably had a significant impact on application and award growth in Florida since 1988. While the outreach activities of SSA field offices in the state have probably not increased significantly in intensity or aggressiveness since 1988, their continued efforts to identify and establish relationships with potential sources of referrals may have led to outreach efforts that generate higher numbers of referrals, as well as higher allowance rates.

*Medicaid Programs.* Rising health care costs, continued deinstitutionalization of persons with mental disorders, and changes in the benefits of state Medicaid programs may have affected applications to SSI. Some states, responding to budgetary pressures, have expanded Medicaid coverage to services that were previously fully financed by state or local governments. Recent studies of state responses to the growth in Medicaid spending in nine states over the 1988 to 1992 period noted that six of these states (including Michigan, New York, and Texas) expanded coverage of mental health and mental retardation services under Medicaid in order to shift more of the cost of this care to the federal government (Coughlin et al. 1994).<sup>2</sup> Such changes in Medicaid coverage might induce providers and advocacy organizations to assist potentially eligible individuals to apply for SSI in order to obtain Medicaid coverage.

These incentives may have been further enhanced by changes in SSA policies that occurred in 1991. The changes increased the weight placed on "source evidence" (evidence from a claimant's own health care provider) in disability award decisions, giving a claimant's provider greater influence over the outcome of a claim. This may have

intensified provider efforts to help patients obtain benefits, but we have not found any evidence on this point.

In Texas, the passage of legislation in 1985 requiring counties to take fiscal responsibility for their medically indigent population increased incentives for county-financed public hospitals to identify these individuals and help them to obtain Medicaid coverage. The Harris County Hospital District, one of the largest county public hospital systems in Texas, recently implemented a computerized screening program that identifies clients who are potentially eligible for Medicaid through any of a variety of programs, including SSI. In addition, Texas expanded its Medicaid coverage of outpatient mental health services in 1990–1991. This expansion increased incentives for community mental health care providers to ensure that their patients apply for Medicaid-associated programs for which they are potentially eligible. This is likely to have contributed to the above average growth in SSI applications based on mental impairment that Texas experienced during this period.

Several outreach efforts initiated in Texas during the 1988 to 1992 time period apparently stemmed from the desire to enroll clients in SSI so they would then have the health insurance coverage of Medicaid. For example, in addition to its screening activities, the Harris County Hospital District operates an SSA-sponsored outreach program to hospitals, clinics, and homeless shelters in the Houston area. Individuals potentially eligible for DI or SSI are assisted with the filing of an application. A similar program was implemented in 1994 by the Mental Health and Mental Retardation Authority of Harris County. Outreach was also conducted by representatives from the SSA field office in Houston to patients of an area AIDS clinic.

In Florida, several interviewees indicated that efforts by health care providers have been particularly important in explaining DI and SSI application growth, and that these efforts were driven, in large part, by the potential to increase Medicaid enrollment and decrease the costs of charity care to providers. Since 1988, many large county hospitals have been working with SSA field office staff to identify individuals potentially eligible for SSI. In addition, some hospitals have begun to hire contractors to recoup the funds lost in providing care for the uninsured. In exchange for assisting uninsured patients in applying for all benefits to which they may be entitled, hospitals pay these contractors a per-

centage of the recouped funds. Finally, in 1992, providers of community-based services for persons with developmental disabilities were permitted to bill Medicaid directly for their services. Prior to 1992, service providers contracted with and were reimbursed by the Department of Developmental Services, who in turn billed Medicaid. This change in Medicaid reimbursement policy creates a strong incentive for providers to ensure that their clients are covered by Medicaid, and may explain some of Florida's exceptionally large DI-concurrent and SSI application growth in the mental retardation impairment category.

### *Changes in Program Eligibility Requirements*

Several revisions to the criteria SSA uses to evaluate disability implemented in the mid 1980s and early 1990s may have had a significant impact on application growth. One of the most important changes was the revision of the criteria for determining disability based on mental impairment. These changes, implemented in 1985, increased the weight given to the functional ability of an applicant in determining eligibility relative to diagnostic criteria (see Chapter 2).

Other than state DDS administrators, interviewees had limited to no knowledge of changes in eligibility requirements except the changes for children brought about by *Sullivan v. Zebley*. We did not, however, interview individuals who might be the most knowledgeable about the changes in the disability eligibility criteria, such as advocates or disability attorneys.

In California and Florida, most interviewees indicated that changes in eligibility requirements did not have a significant impact on application and award growth for adults. In Michigan, however, interviewees indicated that an increase in applications based on mental impairment followed the 1985 changes in the mental impairment listings. The impact of these changes may have been delayed as awareness of the changes, and the perception that these changes eased the strictness of eligibility criteria, spread among professionals and potential applicants. Growth in claims based on mental impairment is closely associated with growth in drug addiction and alcoholism (DA&A) claims. It is believed that this was partly due to the increased training and clarification of the rules on how to evaluate DA&A claims. Individuals interviewed in New York also believed that heightened awareness of DA&A

eligibility criteria may have contributed to application growth in that impairment category in New York.

In Texas, interviewees at the SSA field office in Houston believed that the changes in the mental impairment listings had caused denial rates to decline considerably and thus affected awards. They also indicated that there has been a shift in the adjudicative climate, in that field office staff now provide more information to applicants regarding how to become eligible for the programs, rather than just taking information from the claimant, as was the case in the past.

### *Other Factors*

*Immigration.* With the exception of Michigan, all of the case study states have relatively large immigrant populations. New immigrants are not eligible to apply for DI until, like others, they have satisfied the work requirements for disability-insured status. During the period under study, legal immigrants, however, could apply for SSI after three years of legal residency in the United States; the waiting period has since been increased to five years. In 1987, the Immigration Reform and Control Act (IRCA) allowed certain classes of undocumented immigrants to become legal immigrants. Immigrants legalized under IRCA were not required to wait three years to apply for SSI. Prior to conducting the case studies, we had thought that IRCA immigrants may have contributed to SSI growth in the states with large immigrant populations, as IRCA created a larger pool of immigrants eligible to apply for SSI. Only a few individuals interviewed, however, commented on the extent to which applications from immigrants may have contributed to growth. Empirical evidence, described later, also indicates that IRCA legalizations had little impact on application growth (see also Chapter 2).

Interviewees in California indicated that applications from immigrants may have experienced above average growth since 1988 for several reasons. First, anecdotal evidence provided by SSA field offices indicates that, in general, immigrant groups tend to be relatively well organized and aggressive in their pursuit of SSI benefits. Second, California has recently experienced a surge in fraudulent applications, which has predominantly involved immigrant groups (see GAO 1995). Finally, the recession led to high unemployment in the immigrant population.



In Florida, interviewees indicated that immigration probably did not have a large impact on application and award growth since 1988. Any impact that did occur was probably concentrated in certain areas of the state and among certain types of immigrants (i.e., entrants and refugees as opposed to legal immigrants).

In Texas, individuals from the Houston field office and state DDS office believed that applications from immigrants had increased in recent years. This may have been, in part, due to high unemployment among the immigrant population in Texas during the 1988–1992 period. In addition, interviewees at the field office in Houston commented on an increase in suspected fraudulent applications filed by Vietnamese immigrants.

*Specific Impairments.* A few interviewees in some states commented on the extent to which applications based on particular impairments had increased.

In New York, the very high concentration of HIV/AIDS cases in the service area of the Manhattan SSA field office accounted for rapid application growth in this area. This growth, and the high allowance rates for these applications, resulted in overall allowance rates that were temporarily very high—as high as 80 percent in 1992 for SSI. The disparity between awards at this field office and other field offices caused the DDS to review all HIV/AIDS case determinations, resulting in a significant reduction in this field office’s allowance rate in 1994.

Individuals at the Houston field office also indicated that applications from individuals with HIV/AIDS, especially women, were increasingly prevalent. They attributed this growth to recent outreach efforts to patients of an area AIDS clinic.

Interviewees in California indicated that the recent national surge in DA&A applications was concentrated in California. We found several factors in addition to high prevalence rates that may have contributed to DA&A application growth in the state, including cuts in state funding to counties for mental health and substance abuse services, the impact of “word of mouth” in prisons, and the effectiveness of outreach efforts targeted to the homeless.

## Findings from an Econometric Analysis of State Data

As part of a related study, a regression model of application growth from 1988 to 1992 was estimated using state-level data on disability applications disaggregated by age, impairment, program (DI-only, DI-concurrent, and SSI) and gender (see Chapter 2). The specific factors analyzed in the model of application growth include the (log) unemployment rate, GA program cuts (per capita reductions in the number of GA recipients), HIV/AIDS incidence (new cases per capita), per capita new legalizations under the Immigration Reform and Control Act, and the (log) percent of children living in single-parent families. The last variable, children in single-parent families, is used as a proxy for changes in family structure, including declines in marriage rates. Reductions in financial support from spouses is thought to have contributed to disability application growth. Marriage rate data by state is not available, so the number of children in one-parent families is used as a proxy.<sup>3</sup>

The amount of application growth accounted for by each factor for each state is reported in Table 8.2. The first factor, population growth and aging, was relatively more important in Florida, California, and Texas than in Michigan or New York. Population growth and aging accounted for as much as 2 percentage points of annual growth in the first three states.

Unemployment accounted for a substantial amount of DI-only and DI-concurrent application growth in California, Florida, and New York, especially for males. In these states, unemployment accounted for between 50 and 70 percent of annual DI-only and DI-concurrent application growth for males.

Michigan was the only state of the five studied that experienced reductions in its General Assistance program caseload. The results from the econometric analysis indicate that this had a substantial impact on growth in Michigan's SSI applications. Annual SSI application growth accounted for by GA cuts in Michigan is estimated to be 6.4 percentage points for males and 4.3 percentage points for females. This represents 40 percent and 27 percent of annual SSI application growth for males and females, respectively. There was also a substantial impact on DI applications from men in the DI-concurrent category. A separate analysis of application growth by impairment (not shown)

**Table 8.2 Annual Growth in Applications Accounted for by Factors in the Regression Analysis, by Program and Gender, 1988 to 1992**

	DI-only		DI-concurrent		SSI-total	
	Men	Women	Men	Women	Men	Women
<b>Predicted annual growth accounted for by<sup>a</sup></b>						
Population growth and aging						
California	1.9	1.9	2.1	1.9	1.9	1.8
Florida	2.3	2.1	2.4	2.2	2.3	2.1
Michigan	0.9	0.9	0.7	0.8	0.5	0.7
New York	0.4	0.2	0.5	0.3	0.3	0.2
Texas	1.7	1.7	1.9	1.8	1.7	1.6
Unemployment						
California	4.2	2.0	4.4	1.1	3.1	1.1
Florida	3.5	1.9	4.2	1.0	3.1	1.2
Michigan	1.0	0.5	1.1	0.2	1.0	0.2
New York	5.3	2.7	5.3	1.1	3.8	1.4
Texas	0.2	0.1	0.2	0.1	0.1	0.1
GA program cuts						
California			0.0		0.0	0.0
Florida			0.0		0.0	0.0
Michigan			3.5		6.4	4.3

New York			0.0		0.0	0.0
Texas			0.0		0.0	0.0
<b>AIDS/HIV</b>						
California	0.2		0.9		0.4	
Florida	0.4		1.6		1.0	
Michigan	0.4		1.3		0.8	
New York	0.4		0.5		0.3	
Texas	0.2		0.5		0.3	
<b>IRCA legalizations</b>						
California					0.9 <sup>b</sup>	1.2 <sup>b</sup>
Florida					0.1	0.2
Michigan					0.0	0.0
New York					0.1	0.1
Texas					0.1	0.3
<b>Children in one-parent families</b>						
California	-0.1	0.2	0.7	0.9	0.7	0.8
Florida	-0.1	0.2	0.5	0.7	0.5	0.7
Michigan	0.0	0.3	0.9	1.2	0.9	1.1

(continued)

Table 8.2 (continued)

	DI-only		DI-concurrent		SSI-total	
	Men	Women	Men	Women	Men	Women
New York	0.0	0.0	-0.1	-0.1	-0.1	-0.1
Texas	-0.1	0.2	0.5	0.6	0.5	0.6
<b>Share of growth accounted for by regression model<sup>c</sup> (%)</b>						
California	84.0	47.8	66.3	32.2	62.5	49.3
Florida	98.5	43.1	58.7	21.7	48.0	28.0
Michigan	61.5	23.2	64.9	17.4	65.4	42.9
New York	68.9	26.9	81.3	18.2	53.3	26.0
Texas	64.5	25.6	48.5	22.9	34.6	26.9
<b>Annual growth rate (%)</b>						
California	7.8	9.0	13.6	12.6	12.6	10.9
Florida	6.7	10.2	16.7	18.9	16.1	15.9
Michigan	3.9	7.8	12.8	13.2	16.1	15.7
New York	9.0	10.8	8.0	7.5	8.6	6.5
Texas	3.1	7.8	6.6	11.2	8.5	10.0

SOURCE Lewin-VHI (1995a).

<sup>a</sup>Growth due to specific factors expressed as percentage points. The results are based on application regressions estimated by age/impairment/gender/program subgroups. Not all variables were included in each model.

<sup>b</sup>Large growth accounted for by IRCA legalizations in California is the product of a very large growth in the variable and statistically insignificant coefficients.

<sup>c</sup>Total growth accounted for includes a small interaction among the factors above.

indicates that the elimination of Michigan's GA program accounted for 49 percent of all Michigan SSI application growth in the mental impairment category (Lewin-VHI 1995a).

New cases of HIV/AIDS accounted for the most application growth in Florida and Michigan for male DI-concurrent applications (the variable was not included in the regressions for females). Annual growth accounted for by HIV/AIDS was generally higher for DI-concurrent applications than for DI-only or SSI applications in all five states.

Growth in the number of IRCA legalizations accounted for the most SSI application growth in California, about 1 percentage point for both males and females. The coefficient for the IRCA variable, however, is statistically insignificant in the application regression. As discussed in Chapter 2, estimates of SSI applications from IRCA immigrants calculated by SSA also indicate that this group had a very small impact on SSI application growth.

The final variable, children in single-parent families, accounted for a small amount of the DI-concurrent and SSI application growth in all states except New York. This variable accounted for somewhat more growth in Michigan and California than in the other case study states.

## SUMMARY AND CONCLUSIONS

The five case studies provide some important lessons concerning both the factors that contributed to the tremendous growth experienced from 1988 to 1992 and the determinants of application and award growth in general. These lessons confirm or enrich many of the findings from our related research on caseload growth (see Chapter 2).

**Lesson 1:** The acceleration of growth in applications and awards during the period from 1988 to 1992, above longer-term trends, was primarily due to three factors:

- the recession
- states and localities shifting the burden of welfare spending onto the federal government
- expansion in the "supply" of benefits

The relative importance of each factor varies by program and is different for applications and awards.

There was a broad consensus among interviewees that the recession played an important role in high DI application and award growth in California, Florida, Michigan, and New York, and that the relatively mild downturn in Texas explains relatively low growth in that state. This consensus is strongly supported by the econometric evidence.

State and local policy and program changes had the effect of shifting many recipients of state and local welfare benefits onto SSI and, to a lesser extent, DI during this period. The apparent impact of the termination of Michigan's GA program and accompanying outreach efforts provides the strongest example, but aggressive efforts were found in other states as well. While in some states these efforts predated the period under consideration, many were initiated during the period and others were intensified. This factor can be viewed as an extension of the first because new and intensified shifting efforts were, to a significant degree, responses to recession-induced budgetary shortfalls.

Supply changes refer to regulatory and policy changes, SSA outreach activities, court decisions, and the adjudicative climate. The evidence on this factor comes primarily from the regression analysis and the interviews with experts, conducted for related studies. The regression analysis shows that much growth remains unaccounted for after taking into account the recession, GA cuts, and some other factors. While some of the residual growth is likely due to limitations on our ability to fully capture the impact of the recession, shifting, and other factors in the regression analysis, patterns of residual growth across impairment groups and across applications and awards are consistent with the hypothesis that a substantial fraction of the residual growth is due to supply changes. Anecdotal findings from the case studies are consistent with this conclusion.

The recession was a more important factor for DI growth than for SSI growth, while shifting of welfare beneficiaries and supply changes were more important for SSI. Supply changes were clearly much more important for awards than for applications. It is difficult to explain why allowance rates increased over this period in any other way; evidence from the regression analyses indicate that the other important factors had a *negative* impact on the allowance rate, if any.

We have also found evidence that AIDS/HIV and changes in family structure contributed to the acceleration of application and award growth during this period, but their effects appear to have been small by comparison to the effects of the three factors cited above. Long-term growth in applications and awards is due to factors that we did not examine in the case studies—principally growth and aging of the population and, for DI, growth in the share of women who are disability-insured (see Chapter 2).

**Lesson 2:** Regression estimates of the impact of the recession and of cuts in GA programs may significantly understate the full impact of the recession and efforts to shift the burden of welfare spending onto the federal government.

As we found in the case studies, the nature of job losses during the recession varied from state to state, and this variation apparently had an impact on applications: job losses among older, more experienced workers in California were believed to have had an impact on DI-only applications; job losses in construction were thought to have affected DI-concurrent growth in Florida and California; and low-wage job losses and high unemployment among immigrants were thought to have contributed to SSI growth in California, Florida, and Texas. The unemployment rate variable used in the regression fails to capture these subtleties of the business cycle that are important for application and awards. If the regression models were able to capture these more subtle changes in labor market conditions, they would almost certainly account for even more of the application and award growth during this period.

An analogous conclusion applies to the GA variable. The variable used in the regression analysis is an imperfect measure of state and local efforts to shift the burden of welfare spending onto the federal government. In the case studies, we found substantial new or intensified shifting efforts in California, Florida, New York, and Texas, many unrelated to GA programs in those states, or occurring in GA programs that were not cut during the 1988 to 1992 period.



**Lesson 3: Significant departures from long-term trends in application and award growth are generally self-limiting.**

When we began this work, applications and awards were still growing very rapidly, and there were fears that they would continue to grow unless something changed. The major factors that we have identified as contributing to the acceleration of growth over this period—the recession, state and local shifting of welfare recipients onto SSI, and the expansion of the supply of benefit—were, however, one-time changes that temporarily increased application and award growth. Continued *increases* in unemployment, *increases* in efforts to shift the burden of welfare spending onto the federal government, and *expansion* of the supply of benefits would be necessary to sustain the rapid growth of this period. Instead, increases in unemployment are rarely sustained for long periods and are usually followed by declines during economic recoveries, opportunities to shift the burden of welfare spending onto the federal government diminish as the remaining pool of disabled welfare recipients shrinks, and the effects of supply expansions also diminish as the number of nonrecipients in newly eligible groups gets smaller. While the impact of changes in specific factors on application and award growth may be self-limiting, the consequences of such growth for caseload and program expenditure growth may be experienced for some time into the future (see Rupp and Scott, Chapter 4).

**Lesson 4: The burden of health care spending on state and local governments is a significant factor behind efforts to shift GA recipients and other indigent users of health care services onto SSI.**

The burden of health care costs for indigent users of health care falls largely on state and local governments. Once such an individual receives an SSI award, the federal government pays for 50 to 80 percent of his or her health care, via Medicaid. Savings to state and local governments from this change are often significantly greater than the reductions in cash payments. Reductions in direct state and local funding for indigent health care and for mental health services and simultaneous expansion of Medicaid mental health benefits may have substantially increased the intensity of provider outreach efforts in some states during this period, and outreach efforts undertaken by pub-

lic hospitals and other health care providers appear to be among the most effective.

**Lesson 5:** Recent welfare and health reforms are likely to have a substantial impact on SSI applications and awards.

When we began examining growth in SSA's disability programs, we frequently encountered skepticism with the suggestion that reductions in general assistance and AFDC benefits would have an impact on SSI applications and, especially, awards. Since SSI benefits are more generous than GA or AFDC benefits, why wouldn't anyone likely to be eligible for SSI apply? The answer to this question was provided by many we interviewed. In brief, the intellectual and emotional investments required to successfully apply for SSI are a sufficient obstacle that many who are eligible will not apply when other sources of support, although lower, are more readily available. Thus, cuts in other support, or provision of intellectual and emotional support for application, can induce the filing of SSI claims. This explanation is most apparent for individuals with severe mental disorders.

Many proposals to impose significant new limitations on AFDC benefits are currently under consideration by most states, and some states have already implemented major reforms. While disabilities are less prevalent among AFDC recipients than among GA recipients, a significant number of AFDC recipients—adults and children—have disabilities. Unless these recipients are exempt from work requirements, time limits, and other criteria, they can be expected to apply for SSI benefits. Furthermore, as a result of federal financing for AFDC being converted to block grants to the states, the financial incentives for states to shift AFDC recipients onto SSI have substantially increased, and, again, we should expect increased shifting to occur.

## Notes

1. Throughout this chapter, we describe growth in adult applications and awards in three program groups: DI-only, DI-concurrent (low-income DI applicants who also file for SSI within six months of their DI filing), and SSI (blind and disabled categories only). In some instances, we examine growth in SSI applications from individuals who are not eligible for any type of social security benefit (SSI-only), but in general, SSI applications because of technical reasons that are related to differences in the time and place of filing for the two programs, and because SSI-

- only applications exclude SSI applicants who are eligible for social security benefits other than DI disabled worker benefits.
2. Little or no shifting of mental health services was indicated for California and Florida in this study. While California did not expand Medicaid mental health services, the state did reduce funding to counties for mental health and substance abuse treatment services.
  3. Elasticities obtained from an econometric analysis where data are disaggregated by program and gender only are reported in the appendix to Chapter 2. Estimates from a more disaggregated analysis (report in Lewin-VHI 1995b) and data for each of the five case study states were used to obtain the results reported here.

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# Comments on Chapters 6, 7, and 8

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As a discussant, I have focused on one of the explanations for SSI application growth discussed by Muller and Wheeler (Chapter 6); Bound, Kossoudji, and Ricart-Moes (Chapter 7); and Livermore, Stapleton, and Zeuschner (Chapter 8): state outreach activities that shift individuals with disabilities from state-funded assistance to the federally funded SSI program. I compare their findings with those of the U.S. General Accounting Office (GAO) and elaborate on GAO's results. I conclude with some implications for public policy.

## **STATE OUTREACH EFFORTS SHIFT INDIVIDUALS TO SSI**

Early in 1995, GAO profiled eight state-funded disability advocacy projects through telephone interviews with state welfare administrators. Similar to findings reported by Livermore, Stapleton, and Zeuschner in Chapter 8, GAO found aggressive state outreach efforts that shifted individuals from state-funded assistance to Supplemental Security Income (SSI). GAO's findings also provide evidence to support the perceptions of financial burden shifting from state and local governments to the federal government reported in Muller and Wheeler (Chapter 6).

In testimony before the Congress, GAO reported that state efforts to enroll state welfare recipients in SSI were one of several factors that contributed to a tremendous growth in the number of disability recipients between 1985 and 1994 (GAO 1995a). GAO estimated that at least one-half of all states funded disability advocacy programs. These programs proactively assisted state welfare recipients with disabilities in negotiating the SSI application and appeals process. In so doing, the states hoped to accomplish three ends (Hardin 1992):

- Increase recipients' income and often improve their access to medical care
- Enhance savings to the state government
- Bring more federal dollars into the state economy

GAO found that state disability advocacy projects primarily served General Assistance recipients. As noted by Livermore, Stapleton, and Zeuschner (Chapter 8), state and local governments paying 100 percent of General Assistance benefits had a financial incentive to transfer their qualifying General Assistance recipients with disabilities to a fully federally funded program such as SSI.

Moreover, states avoided costs by moving individuals from state-funded medical assistance programs to Medicaid, which is partially federally funded. (In most cases, individuals qualifying for SSI are eligible for Medicaid benefits.) Although some state disability advocacy projects served Aid to Families with Dependent Children (AFDC) clients and foster care children, those caseloads generally were considerably smaller than their General Assistance caseloads.

## MODELS OF DISABILITY ADVOCACY SERVICES

GAO found that states generally used one of the following three models to deliver disability advocacy services.

- **State contracts for advocacy services.** Some states contracted with private-sector firms for disability advocacy services. For example, the state of Maryland contracted for the management of its Disability Entitlement Advocacy Program with Health Management Associates, Inc., for about \$3 million annually. This amount covered the contractor's management fee and reimbursement of basic costs, including legal services. Similarly, the Massachusetts Public Welfare Department contracted with ten community groups that helped public assistance recipients applying for SSI. The state also contracted with a legal services program to represent SSI applicants during reconsideration and hearings. Massachusetts sent about 5,000 letters a year informing General Assistance recipients who had been denied SSI benefits

about the state's legal services.

- **State advocacy units staffed by state employees.** Some state advocacy programs were staffed by state employees. For instance, the state of Washington employed specialists—called SSI facilitators—to help with the SSI application process. Facilitators identified potential SSI candidates; assisted candidates with the application process; and helped the client file for reconsideration of the initial eligibility denial, administrative hearing, and appeals through the courts. With the assistance of facilitators, 80 percent of the cases filed were approved, 60 percent at the initial level, reportedly due to thorough client screening and case development, as well as attentiveness to timely filing of paperwork.

As another example, Oregon state employees—called SSI liaisons—were trained in the SSI application process by the local Disability Determination Service (DDS). The liaisons tracked the status of a case through an online hook-up to the DDS and provided needed information to help the DDS in its decision-making process. They also represented clients at hearings.

- **Combination of state employees with contracted legal services.** Finally, Pennsylvania illustrates a third model that combined contracting with the use of state employees. Pennsylvania's Disability Advocacy Program had 139 advocates who were state employees in sixty-seven county offices. For legal services, the state contracted with the Pennsylvania Legal Services Center to support half the cases at the hearings level. The balance of the cases were supported by private attorneys.

## **DISABILITY ADVOCACY: FINANCIALLY BENEFICIAL TO STATES**

As Livermore, Stapleton, and Zeuschner note, strong financial incentives exist for state and local governments to shift general assistance recipients to SSI. State officials with whom GAO talked found disability advocacy to be extremely cost-effective. The state could usually more than make up for its advocacy expenses, which were often

less than the recouped General Assistance payments made by the state during the waiting period for SSI benefit approval,<sup>1</sup> while avoiding the costs associated with General Assistance and medical assistance.

In fact, GAO found that, together, five states reported using disability advocacy programs to generate gross savings of about \$90 million in a given year by helping enroll in SSI nearly 26,000 individuals receiving state benefits (GAO 1995a). Most of these reported gains came from one state. In fiscal year 1994, Pennsylvania reported net savings of \$55 million by helping more than 15,000 public assistance recipients enroll in SSI instead of state General Assistance.

## **IMPLICATIONS OF OUTREACH FOR PUBLIC POLICY**

Outreach is a legitimate activity for states to inform their citizens of their entitlement to SSI and its eligibility requirements. Consequences may result, however, that may have a potentially negative effect on the states' disability advocacy project.

1. Given the difficulty of predicting work capacity on the basis of medical impairment, to what extent do outreach efforts direct individuals who may have some capacity to work to a system that emphasizes work incapacity?

The literature shows that work capacity is a function of many factors and that accurately predicting work incapacity for most people with a physical or mental impairment is difficult (U.S. Department of Health and Human Services 1988). Given the difficulty of accurately predicting work capacity, beneficiaries may have a greater capacity to work than was previously believed. Therefore, to what extent do outreach efforts contribute to labeling someone as work disabled who in fact has the potential to work, inadvertently encouraging work incapacity?

2. Outreach is a front-end activity of the disability program that seems to receive much more attention than back-end activities that help individuals leave the rolls by returning to work. Can we afford to continue to overemphasize front-end activities to the detriment of activities that enhance independence through employment?

State outreach efforts emphasize the front end of the process—increasing awareness of the disability program, identifying eligibles, and supporting the disability determination process—while, at the back end of the process, less than 1 percent of beneficiaries with disabilities leave the rolls to go to work.

Moreover, vocational rehabilitation (VR) plays a limited role in disability programs, with state VR agencies successfully rehabilitating only about 1 out of every 1,000 beneficiaries, on average, each year (GAO 1995b). Compare these dismal outcomes at the back end of the process to the success of the extensive outreach efforts at the front end that is documented in these papers. And then ask yourself whether we can afford NOT to pay attention to a) setting up an early expectation for maximizing work potential through various types of employment and rehabilitation services, and b) early intervention before contact is lost with the employer to maintain skills, prevent job loss, and enhance capacity.

Enduring solutions to these public policy issues will take time and resources to craft, but steps should be taken immediately to improve the direction of federal disability.

### Note

1. The Social Security Administration requires that an interim assistance agreement must be in effect with the state if SSA is to repay the state for the amount of General Assistance it gave the individual during the waiting period for approval of SSI benefits. This is referred to as an “interim assistance agreement.”

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