



Upjohn Institute Press

Policy Implications of Recent Growth in Beneficiaries with Mental Illness

Howard H. Goldman
University of Maryland



Chapter 11-policy (pp. 337-341) in:
The Economics of the Great Depression
Mark Wheeler, ed.
Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, 1998
DOI: 10.17848/9780880995665.ch11-policy

Copyright ©1998. W.E. Upjohn Institute for Employment Research. All rights reserved.

Policy Implications of Recent Growth in Beneficiaries with Mental Illness

Howard H. Goldman
University of Maryland

I have taken as my task to comment on the analysis of the recent growth in the social security disability rolls, especially with respect to applications and awards due to mental impairments. I will review four questions: Is the analysis correct? Are the increases in applications and awards for mental impairments appropriate? Is this the correct set of questions from a policy perspective? Given a redefinition of the problem, what is the appropriate remedy?

1. Is the analysis by the Lewin-VHI team (Stapleton et al., Chapter 2) correct? Is there anything to add or modify in their analysis? Generally, the analysis seems both correct and consistent with the perspective of street-level bureaucrats and policymakers. The vast majority of the increase in awards is due to the tremendous increase in applications. Applications have increased in response to several factors, the most powerful of which appear to be economic in nature, particularly downturns in the economy for Social Security Disability Insurance (DI) applicants and limitations in General Assistance welfare transfers. The latter is an especially important factor for applicants for Supplemental Security Income (SSI) with a mental impairment as the basis for the application for disability benefits.

The analysis further speculates that the increases have something to do with changes in the mental impairment standards for disability introduced in 1985. It seems likely that the changes in regulations affected both applications and awards, as much by creating a change in the “adjudicative climate” as by the content and wording of the standards themselves. Although the new mental

impairment regulations addressed a number of barriers to (appropriate) awards, they also signaled a policy change at the Social Security Administration (SSA), encouraging and facilitating application and clarifying previous (inappropriate) restrictions. In addition, the new standards reinforced the importance of data on work-related functioning in combination with signs and symptoms of mental disorders (rather than signs and symptoms alone). It is worth noting, however, that the previous standards *also* had functional criteria (similar in form and content to the newer standards), but they most often were ignored in the assessment of claims.

In addition, although there is little to suggest that rates of mental disorders are increasing, there have been efforts in recent years to increase the recognition of mental disorders, especially in primary health care settings. This is particularly true for the most prevalent of the serious mental disorders, the affective disorders, applications and awards for which have increased most dramatically. The same has occurred for substance use disorders, newly uncloseted by SSA policy, permitting substance abuse claims as a direct basis for award.

2. Are the increases in applications and awards appropriate? That is, do they represent good policy or bad? To the extent that these increases represent a correction of prior (misguided) policy, the increases in applications and awards are to have been expected and should be viewed as an improvement. Generally speaking, that accurately reflects my view. If these trends represent an over-correction, admitting individuals to the disability program inappropriately, that certainly is a problem. I believe some of the stories of occasional misrepresentation, fraud, and abuse by applicants, but I believe that these cases are exceptions rather than the rule. Furthermore, I have reason to believe that such misbehavior occurs with claims involving other body systems, as well. As for problems with discrepancies in decisions between various levels of review and appeal, I believe that these represent problems with policy implementation rather than with the policies themselves—and that there are administrative remedies that should be pursued before revising the standards.

If the issue of the appropriateness of these trends actually addresses the question of whether these impairments (e.g., affective disorders) warrant such rates of applications and awards for disability benefits, an affirmative answer can be found in the epidemiology of mental disorders. Studies of the prevalence of depression indicate that approximately 16 million Americans each year meet the criteria for a depressive disorder, 2 million of whom are considered to have severe depression (National Advisory Mental Health Council 1993). Furthermore, depressive disorders are among the most disabling of common chronic conditions. Work-related disability is reported more commonly for depression than for arthritis or obstructive lung disease and is nearly as disabling as acute coronary artery disease. The work-related disability persists, as well, for longer than for the other conditions, even when it is symptomatically improved by treatment (Wells et al. 1989; Hays et al. 1995).

3. Are these the correct questions to ask from a policy perspective? Is there a problem with the disability program with respect to mental disorders? We have become concerned because of the rate of growth in applications and awards without knowing what level to expect. We do not know what is the “right” rate for mental disability in the population, and we will not know until we conduct a careful study, such as that proposed by SSA in their Disability Examination Study. That investigation should begin to give us an estimate of what the appropriate demand for benefits due to mental (and other) impairments *ought* to be, using several criteria (signs, symptoms, physical exam and laboratory findings, lay reports, and functional assessments). Our current alarm about rate increases is this year’s reaction (in the context of fiscal concerns) to the same data praised last year as a correction of long-standing barriers to access for claimants with mental impairments and substance use disorders.

The Lewin-VHI analysis (Stapleton et al., Chapter 2) does not tell us precisely what to expect in the future. It does hint at a possible major problem with the SSI program in the wake of welfare reform: given the experience with limited welfare reform and the reactive cost shift of individuals with mental impairments from

the general relief rolls to the SSI program, we should be prepared (and not be surprised) when applications and awards continue to rise (or increase at a faster rate).

Applications and awards, however, are not the only potential problem. Although I can offer an explanation for the appropriateness of such increases, I am concerned about the duration of disability status for many individuals with mental disorders. This is especially true for the affective and anxiety disorders, which are very amenable to treatment. If SSA does not do more to encourage appropriate treatment and rehabilitation, then the large numbers of individuals entering the front door of the disability program will not be matched by a steady exit from the back door. This is how I would characterize the real problem associated with the mental disorders and the SSI and DI programs.

4. What are some potential remedies to a reformulation of the problem? What might be done to reduce the duration of receipt of disability benefits? Unlike some of my colleagues, I do not favor a "time-limited benefit" to solve this problem. Current policy supports the selective review of cases through the Continuing Disability Review (CDR) process. Although it has been misused in the past and is not very well implemented at present, the CDR process represents a rational policy. One could reexamine the issue of medical improvement and burden of proof. I prefer to retain the current policy rather than experiment with a new policy that threatens individuals who continue to be disabled with termination of benefits, subject to the (incredibly slow) process of reapplication at the end of a "time-limited" benefit period. If SSA cannot effectively implement a current policy requiring periodic case-by-case review, why should we introduce another new approach with what may prove to be at least as burdensome an administrative requirement? Some argue that people on a time limit will not reapply in great numbers. I believe that current beneficiaries *already* believe they have a time limit and are afraid they will lose their benefits with any "false move" (such as even using a work incentive program to return to work). A time-limited benefit might actually stimulate applications and increase awards by adjudicators who may decide to just make an allowance,

“since it is only for a short time, anyway.”

If the goal is to change expectations about the disability program, let SSA make clear its *current* policy regarding the duration of benefits. There is no current policy suggesting that benefits should be expected for life. The *de facto* policy may be one of limited exits from the rolls, but this is not because of stated policy. It is a problem of policy implementation and should be addressed administratively, not by wholesale change in *de jure* policy for which there is no better expectation of improved implementation of the essential case-by-case review.

Perhaps the most important potential change in policy would be to directly address the need for state-of-the-art treatment for beneficiaries. I am certain that this problem is not unique to individuals who are functionally limited because of mental impairments. There are special barriers to treatment of mental illness, including stigma, lack of available treatment resources, and lack of individual financing for such care. The need to encourage treatment and rehabilitation, however, is a universal recommendation for improving SSA's disability program.

References

- Hays R., K. Wells, C. Sherbourne, W. Rogers, and K. Spritzer. 1995. “Functioning and Well-being Outcomes of Patients with Depression Compared with Chronic General Medical Illnesses.” *Archives of General Psychiatry* 52: 11–19.
- National Advisory Mental Health Council. 1993. “Health Care Reform for Americans with Severe Mental Illnesses.” *American Journal of Psychiatry* 150: 1447–1465.
- Wells K., A. Stewart, R. Hays, A. Burnam, W. Rogers, M. Daniels, S. Berry, S. Greenfield, and J. Ware. 1989. “The Functioning and Well-being of Depressed Patients: Results from the Medical Outcomes Study.” *Journal of the American Medical Association* 262: 914–919.