


1-1-1998

Growth in Disability Benefits: Explanations and Policy Implications

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Rupp, Kalman, and David C. Stapleton, eds. 1998. Growth in Disability Benefits: Explanations and Policy Implications. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. <https://doi.org/10.17848/9780880995665>

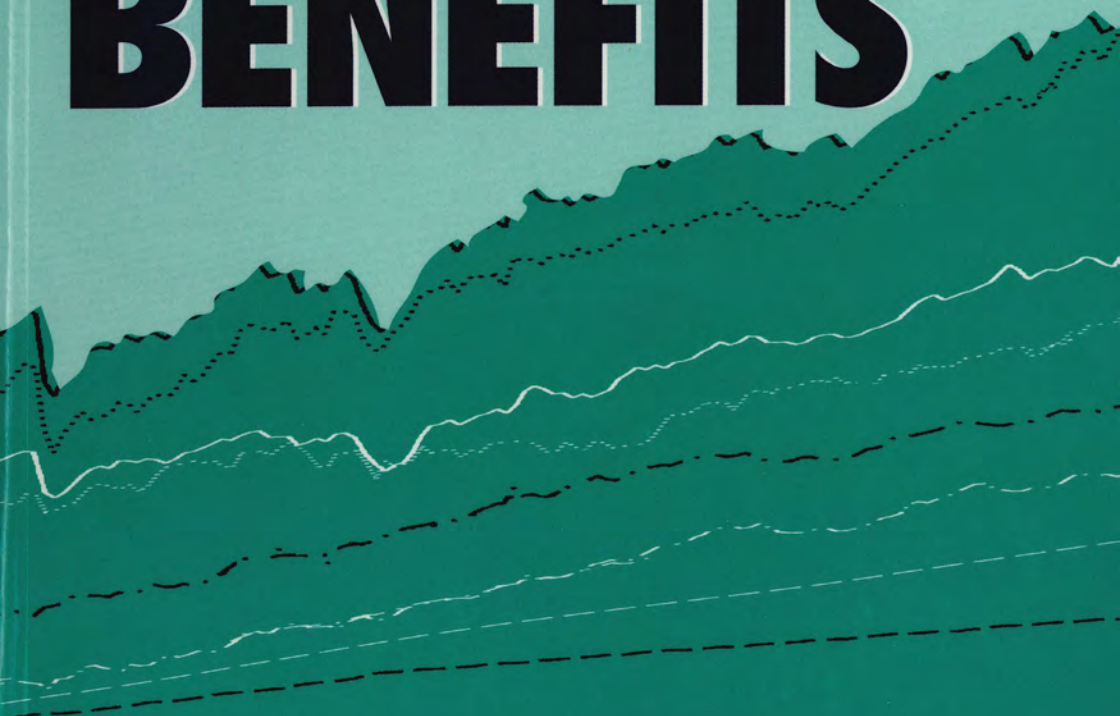


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Growth in

DISABILITY BENEFITS



*Explanations and
Policy Implications*

Kalman Rupp *and* **David C. Stapleton**
Editors

Growth in Disability Benefits

Explanations and Policy Implications

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1998

W.E. Upjohn Institute for Employment Research
Kalamazoo, Michigan

Library of Congress Cataloging-in-Publication Data

Growth in disability benefits : explanations and policy implications /
[edited by] Kalman Rupp and David C. Stapleton.

p. cm.

Papers based on the conference in Washington, D.C. entitled :
The Social Security Administration's Disability Programs :
Explanations of Recent Growth and Implications for Disability Policy
on July 20-21, 1995.

Includes bibliographical references and index.

ISBN 0-88099-188-7 (cloth : alk. paper). — ISBN 0-88099-187-9
(pbk. : alk. paper)

1. Insurance, Disability—United States—Congresses.

2. Handicapped—Employment—United States—Congresses. I. Rupp,
Kalman. II. Stapleton, David C.

HD7105.25.U6G76 1998

368.38'2—dc21

98-24695

CIP

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W. E. Upjohn Institute for Employment Research
300 S. Westnedge Avenue
Kalamazoo, Michigan 49007-4686

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Cover design by J. R. Underhill

Index prepared by Leoni Z. McVey.

Printed in the United States of America.

To the memory of Mindy Upp

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Preface

The research projects reported in this book were initiated because of the painful realization in 1992 that there was an enormous vacuum of solid empirical knowledge about the reasons for the unexpected explosion in the size of the Social Security Administration's (SSA's) disability programs—an explosion that led the Trustees to project near-term insolvency for the Disability Insurance (DI) Trust Fund in the absence of corrective action. The policy response to that crisis included the short-term fix of reallocating Old Age and Survivors Insurance (OASI) Trust Fund contributions to the DI Fund, as well as the initiation of a set of studies that are reflected in this volume.

The bulk of the original work forming the basis of this book was carried out between 1992 and 1995, culminating in a conference in 1995. Some of the papers were slightly updated subsequent to the 1995 conference, but most of the empirical work and the discussion of policy issues reflect the authors' understanding of the subject matter as of 1995. Some do not completely reflect post-1995 developments, not due to ignorance on the part of the authors, but simply as a result of not having had a good-quality crystal ball at the time of the substantive completion of the various contributions! Some of the papers include discussions of policy changes being actively considered in 1995 that have since been made and are currently being implemented.

Much changed between 1992 and the 1995 conference, and much more has changed since then. In particular, 1992 reflected a situation that we suspected all along was near the peak of unusually strong growth in the size of both the DI and Supplemental Security Income (SSI) disability program rolls, as a result of the previous recession and a host of other, primarily programmatic, developments. Good economic times followed, with a period of sustained growth, accompanied by both low inflation and low unemployment, lasting through the time that this book is going to press, in early 1998. There were other, more complex, programmatic and policy changes affecting the growth of SSA's disability program rolls, many of them taking effect after the 1995 conference. Many of these changes were in some sense policy responses to the previous explosion in the disability rolls, just as our research effort has been. They also, however, reflected continued and broader societal and political concerns with the appropriate balance between a safety net for the truly needy, personal responsibility, and the financial interests of taxpayers.

A series of legislative developments culminated in the passage of the Personal Responsibility and Work Opportunity Act of 1996. This act and separate 1996 legislation focusing on drug addicts and alcoholics have several impor-

tant provisions directly affecting important segments of SSA's disability program target populations, including children and noncitizens. This legislation also has potentially sweeping indirect effects on the disability programs as a result of the replacement of the sixty-year-old Aid to Families with Dependent Children (AFDC) program with block grants for Temporary Assistance for Needy Families (TANF). Many of the contributors to this volume, including the co-editors, are deeply involved in major policy evaluation efforts directly focusing on such post-1995 developments.

Early on in this effort we often joked about the possibility that policy research may be a lagging, rather than a leading, indicator of major program developments. Empirical trends since 1992 seem to confirm that the research program reflected in this volume is a lagging indicator of program change, just as a previous flurry of empirical research on disability caseload growth that began in 1975 followed a rapid caseload expansion in preceding years. In 1992 and 1993 we often argued that, given this perhaps inherently lagging nature of policy evaluation, one of the key potential uses of quick-turnaround research studies—lagging as they may be—might be to help prevent policymakers from overreacting to cyclical factors or other developments that might produce one-time shocks with either temporary or permanent effects on program caseloads. But we also hoped that such research would demonstrate timely, empirically solid results and eventually result in a more proactive role of policy evaluation in the arsenal of policymakers. One focal area of the research appears to have been particularly timely given subsequent policy developments: the interactions of SSA's disability programs with other social safety net programs, such as AFDC/TANF, Medicaid, and General Assistance. The subsequent passage of the historic welfare reform legislation makes our findings in this area more significant—although there is much yet to learn.

The collaboration between the co-editors of this volume goes back to the early stages of this research effort. One of us (Rupp) was assigned in 1992 at the Office of the Assistant Secretary of Planning and Evaluation (ASPE) of the Department of Health and Human Services to design the research program reflected in this volume. ASPE and SSA collaborated in the planning and funding of these studies, and Rupp was assigned to work with SSA officials and staff in creating this research effort. Many high-level DHHS and SSA officials were highly supportive of this effort at this critical early stage and in subsequent stages of the expansion of our project. Richard Eisinger, Christy Schmidt-Bayne, Wendell Primus, Gil Fisher, Larry Thompson, and David Ellwood were especially supportive. Much of the research reflected in this volume was carried out through task-order contracts between ASPE and Lewin-VHI (now The Lewin Group); Rupp was the ASPE Project Officer and Staple-

ton was the Lewin Project Director for all of these contracts. In these capacities we have established a productive working relationship focusing on creating analytic designs that are truly responsive to major policy concerns and are implemented in a technically sound manner. Our frequent and substantive interactions produced numerous ideas that shaped the overall research program in fundamental ways.

We also had the privilege of collaborating with several colleagues who played substantial roles in designing and implementing these studies and in providing support in the dissemination of the results. Peggy Trout (now Fisher) and Mindy Upp were SSA's co-project officers on the various Lewin contracts. Peggy was extremely useful and efficient in representing SSA and in coordinating the work of SSA staff involved in providing input to study design, administrative data, and analytic feedback.

We have dedicated this volume to the memory of Mindy Upp, who worked with us from the early stages of this research effort through the conference and the subsequent dissemination of the research results in the policy community, virtually up until her death at the end of 1996. Mindy played an enormous role in advocating the importance of this research within both SSA and the broader policy community. In particular, we are heavily indebted to Mindy's ideas, enthusiasm, and advocacy of using a case-study approach to complement the quantitative analysis, and in initiating and planning a separate section on policy and programmatic perspectives on program growth at the 1995 conference. It was Mindy's idea to include "The View from the Trenches" (the phrase itself is vintage Mindy), the representation of local practitioners with hands-on field experience in addition to the usual "suspects"—high-ranking officials and prominent policy experts—on panels of this kind. Mindy also had the primary responsibility for writing the subsequent SSA report to Congress, and she displayed enormous enthusiasm and skill in advocating the use of empirical results in this important document that reflected the relevant findings from these studies.

On a more personal note, Mindy was the one member of our core team who struggled with serious disabilities throughout our work together. Her courage in facing severe health problems, and eventually the very real possibility of death, has been an inspiration to all of us who have had the privilege to know her. The combination of her commitment to the civil rights of people with disabilities and her no-nonsense perspective on the dilemmas facing people with severe disabilities and those who care about them brought a very credible and fundamental human perspective to our research and shaped our thinking about the analytic and policy issues in subtle yet important ways. We hope that our association with Mindy made us more responsible human beings and researchers. Up to the final days of her life, Mindy took great pride in her

work; we hope that our collaboration with her contributed to her sense of positive accomplishment and perhaps may have eased the substantial pain she must have experienced throughout this period.

Steven Sandell has provided support in his various capacities as friend, wise colleague, and DHHS and SSA official. We are especially thankful to Steve for encouraging the early dissemination of research results through a January 1995 conference session of the Society of Government Economists (SGE), and the subsequent publication of a summary article by the co-editors of this volume in the *Social Security Bulletin*. Pete Wheeler, the Associate Commissioner of the Office of Research, Evaluation and Statistics at SSA, has been very supportive of the early dissemination of the research results through the *Social Security Bulletin* and also contributed to this volume.

Among the many colleagues who played major roles in this effort, we would like to highlight the contribution of a few who were helpful in strategic ways. Alan Shafer and Charlie Scott played the key role of assembling the SSA administrative records databases that formed the basis of analysis of applications and awards (Shafer) and duration on the disability rolls (Scott). Rick Foster, currently Chief Actuary of the Health Care Financing Administration, but at the time the Deputy Chief Actuary of SSA, provided substantial support and encouragement as a reviewer of several key design documents and as a reviewer of early output from our research—including his role of helpful discussant (with Pamela Loprest of the Urban Institute) of several papers presented at the January 1995 SGE meeting. Lewin's Gina Livermore played a significant role in conducting all of the work performed under the contracts to Lewin and also helped significantly in the preparation of this volume. Among our many colleagues who contributed to the design of the studies reflected in this volume, we would like to express our special thanks to Burt Barnow of Lewin and The Johns Hopkins University and John Bound of the University of Michigan. Finally, but not least important, we would like to express our thanks to those who made it possible to publish this volume as an Upjohn Institute book. Allan Hunt has been a vigorous and enthusiastic supporter of publishing this volume, and the editors are indebted to both him and two anonymous reviewers for numerous ideas. We are also indebted to Judy Gentry, our manuscript editor, for efficient expert assistance in the publication process, and for making this volume more readable in ways that are very real, but may be apparent only to those few who have seen both the draft we submitted to the Institute and this final product.

The views and opinions expressed in this volume do not necessarily represent the official positions of the Social Security Administration, The Lewin

Group, or any of the organizations that any of the authors, including the co-editors, are currently affiliated with, or any they have been affiliated with at any time in the past.

February 5, 1998

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1 Introduction

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This book is about the growth in income entitlement benefits for disability in the United States provided under two federal programs administered by the Social Security Administration (SSA): the Social Security Disability Insurance (DI) program under Title II of the Social Security Act, and the Supplemental Security Income (SSI) program (Title XVI). Both programs use the same definition of disability, but other eligibility criteria differ. DI is a social insurance program with disabled worker eligibility conditioned on sufficient employment in jobs covered by Social Security. SSI is means-tested, requiring beneficiaries to satisfy income and asset criteria. DI beneficiaries whose incomes, including DI benefits, are below the SSI benefit level may concurrently receive SSI payments to make up the difference, and many low-income DI applicants receive SSI benefits during the five-month postemployment DI waiting period. DI benefits are converted to Old Age and Survivors Insurance (OASI) benefits at age 65. SSI disability recipients may continue to receive benefits past age 65, although SSI benefits are also available to the nondisabled elderly meeting the income and asset tests. Children with qualifying disabilities are eligible for SSI payments in their own right subject to income and asset eligibility requirements.

SSA's disability programs have evolved into major pillars of the social safety net in the United States. While the basic design of DI has not changed since the program was created in 1956, changes in the definition of the target population, program administration, eligibility criteria, work incentives, and eligibility reviews have expanded the program. The SSI disability program replaced federal-state Aid to the Permanently and Totally Disabled and Aid to the Blind programs in

1974, and since then has expanded at a faster pace than DI. In 1995, 4.2 million DI disabled worker beneficiaries and their dependents received \$40.9 billion in benefits, and 4.9 million disabled SSI beneficiaries received \$19.5 billion in federal payments.¹ The combined value of benefits from the programs in 1995, \$60 billion, is more than 2.5 times as large as combined federal and state spending on AFDC benefits in the same year. The importance of both DI and SSI has increased enormously during recent years as the real value of medical benefits that most recipients are entitled to—Medicare (for DI recipients after a two-year waiting period) and Medicaid (for SSI recipients)—increased tremendously. In 1995, Medicare paid \$12.5 billion in benefits for DI beneficiaries, and Medicaid paid about \$40 billion in benefits for SSI-disability recipients.²

Much has changed in the broader environment of SSA's disability programs as well. The passage of the Americans with Disabilities Act of 1990, and more recently, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, are major federal laws affecting people with disabilities. Changes in family structure, population health trends, economic restructuring, and increases in female labor force participation all affect the nature and growth of SSA's disability programs.

A substantial amount of recent research and policy discussion has focused on various aspects of the disability programs and their interaction with the broader environment of our economy and society. A recently published Upjohn Institute volume, *Disability, Work and Cash Benefits*, is a compendium of studies by leading experts in disability, income security, labor economics, and rehabilitation (Mashaw et al. 1996) and represents the range of program design and institutional issues raised by the programs. Other recent work focuses on narrower, but fairly important aspects of program design, such as work incentives and vocational rehabilitation, as represented by a series of papers published in the August 1996 issue of the *Journal of Vocational Rehabilitation* (Prero 1996). SSA's Disability Evaluation Study is a major ongoing data collection effort designed to develop a better understanding of SSA's eligibility screening processes and the potential to improve this critically important aspect of the program.

This book focuses on the factors affecting the *growth* of the disability programs—both understanding the causes of growth and their pol-

icy implications. Changes in program design and in the environment of SSA's disability programs are both very important in explaining and understanding program growth. The patterns and causes of program growth point to critically important aspects of program design and the changing role of SSA's disability programs in the social safety net.

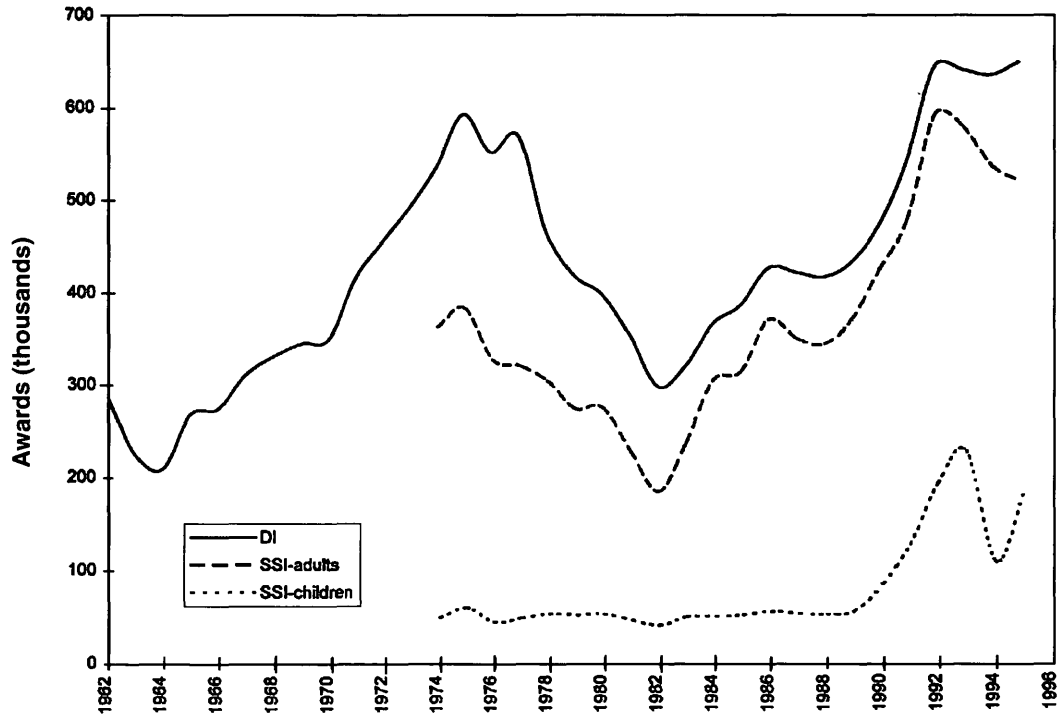
In the next section we discuss the motivation and objectives of this book in somewhat more detail. We then provide an overall conceptual framework underlying the studies in the book, an overview of the major issues, and a brief sketch of the organization of the volume.

MOTIVATION AND OBJECTIVES

The last time the growth of income entitlements to persons with severe disabilities was subject to intense scrutiny by economists was during the mid 1970s, following acceleration in the growth of DI awards (Exhibit 1.1) and deterioration in the balance of the DI Trust Fund. Researchers concluded that the 1975 recession was the primary cause of that situation and that the anticipated recovery would turn the trends around (Lando 1974; Hambor 1975; Thompson and Van de Water 1975). The DI program was viewed by many as a potential tool of countercyclical macroeconomic policy—an automatic stabilizer that, like many other government programs, came to the aid of those most hurt by a recession while stimulating much needed demand for goods and services. An important policy implication was that Trust Fund balances needed to be built up when the economy was strong in order to compensate for higher benefit payments during recessions.

Once again, a major upsurge in income entitlements to persons with severe disabilities has resulted in intense scrutiny of the DI program; this time the scrutiny extends to SSI, which was in its infancy at the federal level during the earlier period. This upsurge also coincided with a major recession, in 1991, but analysts were skeptical that it was the primary cause, despite the earlier findings. The “double-dip” recession of 1980–1982 was not accompanied by acceleration in program growth, and there are competing explanations of the recent growth—most notably changes in the program itself, the aging of the baby boomers, and declines in the value of and access to benefits from state

Exhibit 1.1 DI and SSI Disability Awards



SOURCE: Social Security Bulletin, 1996 Annual Statistical Supplement.

and local programs. Other changes in the economy and society, such as the decline in manufacturing jobs, growth in female labor force participation, growth in health care costs, changes in the structure of families, immigration, and changes in the prevalence of disabling health conditions, represent another layer of factors that could have a bearing on recent program growth.

Again, policymaker scrutiny of the programs has generated a substantial research effort. While some policymakers argued that growth would subside of its own accord once the economy turned around, and others saw no end to the rapid growth without a significant change in program policy, many believed that research on the causes of program growth was needed to inform the policy debate. Some of us thought the research was not only overdue, but perhaps a little too late; the research during the mid 1970s was initiated at the peak of growth and therefore was a lagging indicator rather than a proactive agent of change. Perhaps, again, “the damage was already done,” in part because of the lack of serious research attention to this topic during intervening years. Growth now appears to be subsiding, and it may be that, once again, the attention of policymakers will turn to other hot topics of the day.

Stanford Ross (Chapter 11) provides an intriguing perspective on the initiation of this research from the point of view of a public member of the Board of Trustees for OASDI. As Ross explains, in April of 1992 the Trustees were obligated to report to Congress, warning that reserves were projected to fall below 20 percent of annual disbursements. This was the first time that this official “alarm bell,” enacted in 1983 as Section 709 of the Social Security Act, was set off.

In response to the Section 709 mandate and recognizing the importance of developing a better understanding of the factors affecting caseload growth, the U.S. Department of Health and Human Services and SSA prepared a report (DHHS 1992) summarizing existing knowledge about the growth of the DI program and providing a comprehensive list of various demographic, economic, and programmatic factors that were hypothesized to affect caseload growth. This “709 Report” called for additional research to assess the causal role of various factors, and to quantify their effects.

A short-term fix to the impending insolvency was proposed in 1992: reallocation of a small portion of OASI Trust Fund contributions to the DI Fund. As Ross describes (Chapter 11), the Public Trustees refused

to accept the proposal unless a research agenda was pledged by the *Ex-officio* Trustees. The Public Trustees argued that the short-term palliative of a reallocation should not take place without providing the Congress and the public with information that would permit a more fundamental look at the program and could lead to appropriate reforms. Around this time, Congress mandated an examination of the reasons for the rise in the number of applications and awards and for the decreased rates of benefit terminations. SSA was to report the findings from this examination to Congress by October 1995.

In response, SSA and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of DHHS initiated a series of projects. Two of the papers in this volume are summaries of research conducted by staff at Lewin-VHI, Inc., under contract to SSA and ASPE. Three other research papers were written by academics under subcontract to Lewin-VHI, and two were written by SSA staff. The papers focus on adult program participation, but some papers also address participation of children with disabilities in SSI.

Concerned that lessons learned from the current round of research would be neglected by the policy community, SSA and ASPE sponsored a two-day conference in Washington, D.C. entitled *The Social Security Administration's Disability Programs: Explanations of Recent Growth and Implications for Disability Policy* on July 20–21, 1995. The purpose of the conference was to present and discuss findings of the research on caseload growth. The conference also featured panel discussions by regional and state program administrators on their first-hand experience, adding a human dimension to the numbers, and by well-known experts in the field of disability policy on the policy implications of the research findings and potential future directions for the federal programs. This volume is based on the research findings, administrator observations, and policy discussions featured at the July 1996 conference.

In the decade and a half between the two periods of rapid program growth there has been a marked shift in attitudes toward entitlement programs—from the benign Great Society view that such programs assist the less fortunate in our society, especially during economic hard times, toward alarm over growth in program participation and spending. Many fear that such programs are undermining the nation's economic strength. The Personal Responsibility and Work Opportunity

Act of 1996 reflects concerns about both the economic effects of previous welfare legislation and the effects on the moral fabric of our society.

Cash assistance for persons with severe disabilities has long enjoyed fundamental political support because the intended recipients were viewed as “deserving.” Early recommendations for a radical restructuring of welfare programs from entitlement to temporary support based on individual responsibility and the objective of encouraging work called for exemptions for those with severe disabilities (see, for instance, Ellwood 1988). The political backlash following the tightening of eligibility for the federal disability programs initiated during the early Reagan years confirmed the notion that disability programs were “different” from other cash assistance programs because they provided support for a group that should not be expected to work.

Much of the recent growth in program participation, however, has been among beneficiaries who might be seen as “not deserving.” There is increasing concern about the ability of the program to identify those who truly “cannot work” in the face of strong economic incentives and procedural barriers working in the opposite direction. The critics argue that the federal programs create a class of long-term beneficiaries who could and would work were it not for the increasingly strong economic incentives to get and stay on the rolls. The especially rapid growth of young beneficiaries and of beneficiaries with certain mental disorders—especially addiction disorders and affective disorders—are cited as prime examples. The now defunct Aid to Families with Dependent Children (AFDC) program is usually held up as the prime example of a program dominated by the long-term dependence of a subset of beneficiaries, but average duration on the disability program rolls is longer (Rupp and Scott 1995).

Critics have called for policies restricting entry to, and encouraging exit from, the disability rolls. Congress has responded, initially by mandating time-limited benefits for persons whose drug addiction and alcoholism (DA&A) contributed to their disability, and subsequently by requiring the removal of DA&A cases from the rolls and denial of disability benefits to future applicants for whom DA&A is judged to be material to the determination of disability. The Personal Responsibility and Work Opportunity Act of 1996 also tightened eligibility for dis-

abled children, ended SSI eligibility for aliens, and increased the resources devoted to Continuing Disability Reviews (CDRs).

The extent to which changes in the nature of the disability programs contributed to accelerated growth has been a major challenge for the research reported in this volume. The policy discussions, in turn, reflect a range of views on the nature of the disability programs, and on the extent to which work options are feasible tools for containing undesired program growth and dependence.

The provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that are directed at benefits for poor families with children have opened a new source of potential growth in the disability programs. It is possible that replacement of the AFDC program by block grants to the states for Temporary Assistance for Needy Families (TANF) will become a new source of growth in the disability programs, as disabled individuals no longer eligible for AFDC, some with access to more restrictive TANF programs, seek new sources of support, assisted by state governments that have increased financial incentives to shift welfare spending to the federal government.

CONCEPTUAL FRAMEWORK

Caseload growth is affected by both economic and noneconomic factors. Demographic and epidemiological factors, as well as the criteria for determining disability status and their implementation are, at least in a proximate sense, noneconomic factors that might affect caseload growth, often substantially. Other factors, such as the value of potential cash benefits relative to wages, the value of complementary or substitute program benefits, and business conditions are clearly in the domain of economics. The economic perspective emphasizes the role of opportunity costs—individuals making choices comparing various alternatives—and is particularly useful in understanding how economic and noneconomic forces interact in shaping decisions such as applying for and being awarded disability benefits, as well as decisions concerning leaving the disability rolls.

From the economic perspective, program participation is an outcome of the interaction of the “demand” for program benefits by individuals and the “supply” of program benefits by the government. On the demand side, the number of applications (representing the demand for awards) in part depends on

- the relative benefits of working and not working;
- the availability of substitute forms of public assistance, such as General Assistance (GA), TANF, or AFDC;
- complementary benefits provided to those receiving disability benefits—especially health insurance benefits (Medicare for DI and Medicaid for SSI beneficiaries); and
- various features of the DI and SSI programs—the costs of applying for benefits, the probability of receiving an award, and how long benefits are expected to continue.

The supply side is influenced by legislative factors, as well as administrative procedures, judicial rulings, and the resources available for making award decisions.

Once persons with disabilities begin receiving DI and/or SSI benefits, their continued “demand” for benefits is influenced by

- the duration of these benefits—over time, a beneficiary’s potential earnings decline as their human capital depreciates due to separation from the labor force;
- programmatic disincentives to work—with limited exceptions, DI beneficiaries who engage in “substantial gainful activity” (i.e., earn over \$500 per month) subsequent to a nine-month trial work period lose all their disability benefits, while, apart from certain disregards, SSI beneficiaries lose a dollar of benefits for every two dollars of earnings;
- changes in their health and disability status; and
- changes in the labor market.

The “supply” of disability benefits for those on the rolls is affected by

- the number of CDRs—i.e., determining if the beneficiary’s medical condition has improved (with benefit termination for those with sufficient improvement). The number of CDRs conducted

depends both on the availability of administrative resources and the political will to conduct these often unpopular reviews;

- changes in rules concerning the effects of work on program eligibility and benefits, especially for the SSI program; and
- the availability of vocational rehabilitation services and incentives and requirements to use them.

While as a first cut the factors affecting initial awards and length of stay can be seen as sequential, changes at the “back end” of the process have potential feedback effects as well. For example, anticipated reconsideration and administrative law judge (ALJ) decisions may affect initial eligibility determination decisions by the state Disability Determination Services, as well as applicant decisions to ask for the reconsideration of unfavorable decisions and to exercise appeal rights. The perceived strictness of the disability determination process might affect applications, too. Perceptions about SSA’s termination and suspension policies might affect work activities, and therefore continued eligibility, among beneficiaries.

Although the economic perspective focuses on choices made by disabled individuals, other parties often have a significant interest in this choice and may actively try to influence it. An important example is state and local governments, which have an interest in shifting the costs of welfare and health expenditures to the federal government. Other interested parties include family members, employers, health care providers, and private insurers.

All of these factors are addressed to some degree in the studies and commentaries presented at the conference and contained in this volume. Below, we describe the major issues and the overall contribution of the papers in this book to addressing those issues.

OVERVIEW OF MAJOR ISSUES

Growth in disability applications, awards, and program caseloads is affected by a host of complex factors. In this section we provide an overview of the major factors and how the contributions in this volume

fit into the literature on these factors. The factors are grouped as follows:

- population characteristics,
- labor market factors,
- other programs and policies, and
- features of SSA's disability programs and related supply factors.

We conclude the section with an overview of major themes from the discussion of policy implications.

Population Characteristics

The role of demographics, particularly the aging of the baby boom generation, has long been understood as important in shaping program growth, and actuarial projections explicitly consider the role of these variables. What this volume adds is a systematic accounting of the effects of demographics on applications and awards (Stapleton et al., Chapter 2), and on duration (Rupp and Scott, Chapter 4) over various periods of interest, when considered in the context of a broader range of factors. The effects of population aging on applications and awards on the one hand, and on expected duration on the other hand, are opposite. Rupp and Scott demonstrate that the net result of the contrasting effects of the aging of the baby boom generation on caseloads—as measured by expected benefit years—is positive, but smaller than could be expected based on the effects on awards alone, due to the moderating influence of reduced expected duration associated with increased age at entry.

While changes in the size and age-gender composition of the population provide the simplest explanation of changes in DI and SSI applications and awards, they do not translate directly into changes in the target populations for the two disability programs; program eligibility requirements—the presence of qualifying disabilities and economic eligibility—form essential intervening links. The disability criteria are identical for DI and SSI, while economic eligibility is tied to disability-insured status—satisfaction of past work requirements—for DI and to a means test for SSI. All three of these criteria are influenced by factors

external to the DI and SSI programs, as well as by legislative, administrative, and judicial variables.

Three target populations can be visualized as being determined by various combinations of disability-insured status, meeting the SSI means test, and having a qualifying disability. Persons with qualifying disabilities who are disability-insured but do not meet the means test are eligible for DI only, those who are disability-insured and meet the SSI means test qualify for both programs (concurrent eligibility), and those who meet the SSI means test but are not disability-insured are eligible for SSI only.

Unfortunately, available data do not permit the observation of time series for these three target populations; in fact, there are no cross-sectional data available on a reasonable proxy of the population satisfying the disability criteria in any year. SSA's Disability Evaluation Study is expected to provide detailed cross-sectional information on the most important variables affecting the disability determination process, but it will be some time before results are available from this effort.

Some information on the prevalence of self-reported disabilities is available from various surveys, such as the National Health Interview Survey (NHIS), the Survey of Income and Program Participation (SIPP), and the Health and Retirement Study (HRS). While some of the surveys (such as the HRS) incorporate a panel design, and others (NHIS) incorporate repeated cross sections over several years, the validity of longitudinal comparisons are seriously hampered by a variety of difficulties. Measurement of the prevalence of mental disorders raises complex methodological issues, and the reliable estimation of the prevalence of a number of physical and nonphysical conditions related to important impairments in general surveys is hampered by the small number of disabled respondents to each survey. Finally, the measurement of some impairments, most notably HIV-related conditions, has evolved through time, as these conditions became increasingly important sources of disability applications and awards, thereby making precise measurement of time trends difficult or impossible.

Better data are available for the measurement of trends in the DI insured population, although when it comes to survey data, reliable individual-level indicators are often not available. The measurement of trends in the SSI financial eligibility variables is more problematic, primarily because of the absence of good longitudinal data on assets.

Ongoing work at the Office of Research, Evaluation, and Statistics of SSA is expected to produce substantial advances in data availability, primarily through the creation of SIPP data files matched to SSA administrative records (Lahiri, Vaughan, and Wixon 1995).

Due to these data limitations, the studies incorporated in this volume relied on a patchwork of data pieces for examining the evidence concerning the effect of trends in SSA's target populations on disability applications, awards, and duration. Even with limited and imperfect data, some interesting analyses were feasible. Stapleton et al. (Chapter 2) incorporates quantitative analyses of the role of factors such as changes in the size of the DI-insured population, the poverty rate, the percentage of children living in single-family homes, and AIDS/HIV incidence rate. Rupp and Scott (Chapter 4) demonstrate the profound effect of demographic trends and impairments in affecting duration, as well as the interaction of demographics, DI-insured status, and SSI financial eligibility in affecting awards, and duration. They also calculate the net effects on expected benefit years. Daly (Chapter 5) provides important insights into the dynamics of SSI and DI eligibility by providing longitudinal information on the changing characteristics of awardees during the five years prior to benefit receipt, based on information from the Panel Survey of Income Dynamics.

Labor Market Factors

One of the key issues that motivated the initiation of the research studies presented in this book was the urgent need to clarify the role of the business cycle in affecting disability applications and awards during the early 1990s. Some hoped that much of the unexpected upsurge in disability applications was the result of the recession, and therefore temporary in nature. Others were concerned that the upsurge was primarily the result of other factors responsible for more permanent and lasting shifts in the nature of SSA's disability programs. The authors of the "709 Report" recognized that several factors probably made important contributions. For many analysts, the real question about the business cycles and other factors was not whether they had an effect, but how much. The answer to these questions had major implications both from a short-term budgetary perspective, especially as it relates to the allocation and management of funds for program administration, and

from the point of view of the assessment of the long-run financial health and viability of the disability programs.

While there have been numerous previous econometric studies estimating the effects of the business cycle on DI applications, awards, and caseloads, previous studies have suffered from various specification problems or low statistical power, or both. The aggregate time-series approach used in most previous studies has difficulty disentangling the effects of program changes, business cycles, and other factors, while the cross-sectional approach used in some studies had to rely on cross-state or county variation in labor market measures that is confounded with cross-state/county variation in many unmeasurable factors.

An important methodological contribution of the research effort reflected in this book is the use of state-level pooled cross-section/time-series methods to address the seemingly intractable problem of business cycle effects. This approach, presented in detail by Stapleton et al. in Chapter 2, controls for permanent differences among the states endemic to cross-sectional analyses of state data and eliminates the confounding effect of national changes endemic to time-series studies. As a result, the findings are much stronger and more credible than those obtained previously. Because of the importance of this contribution, we compare the findings presented in Chapter 2 to those from the previous literature here (Exhibit 1.2).

The new results provide strong evidence to support the conclusions from those previous studies that found significant business cycle effects. The new estimates are, however, somewhat sensitive to the data, specification, and time period chosen for the analysis, as discussed in Chapter 2.

The importance of business cycles and economic restructuring is further supported by the qualitative evidence presented in Chapters 6 (Muller and Wheeler) and Chapter 8 (Livermore, Stapleton, and Zeuschner), and by the first-hand observations of Massanari and of Hemingson (Chapter 10). An important conclusion from the five case studies conducted by Lewin researchers (Chapter 8) is that the regression estimates of the impact of the recession are probably conservative, because the models failed to capture important subtleties of the business cycle that, according to interviewees, significantly influence applications and awards.

Exhibit 1.2 Estimates of the Effect of a 1 Percentage Point Rise in the Unemployment Rate on Disability Program Growth for Adults

Study	Data type	Period	Estimated effect of a 1 percentage point increase in unemployment
Applications			
Hambor 1975	Quarterly, national	1964–71	7% for DI
Lando 1974	Quarterly, national	1962–73	2–4% for DI
Lando, Coate, and Kraus 1979	Quarterly, national	1964–78	2–7% for DI
Halpern 1989	Quarterly, national	1964–78	Negligible for DI
Muller 1982	Annual, individual, cross-section	1972	Negligible for DI
Levy and Krute 1983	Annual, individual, cross-section	1978	Negligible for DI
Hambor 1992	Annual, national	1970–91	Negligible for DI
Stapleton et al., Chapter 2	Annual, pooled cross-section/time-series	1988–92	4% for DI-only, 4% for DI-concurrent, 2% for SSI
Initial Determinations			
Stapleton et al., Chapter 2	Annual, pooled cross-section/time-series (SSI-only includes children)	1980–93	DI-only: 2% in year of change 3% after one year 5% after two years Concurrent: 2% in year of change 4% after one year 5% after two years SSI-only: 0% in year of change 1% after one year 3% after two years

Exhibit 1.2 (continued)

Awards			
Hambor 1975	Quarterly, national	1964–71	2–4% for DI
Lando 1974	Annual, state-level cross-section	1975	5–6% for DI
Muller 1982	Annual, individual, cross-section	1972	Negligible for DI
Levy and Krute 1983	Annual, individual, cross-section	1978	Negligible for DI
Hambor 1992	Annual, national	1970–91	Negligible
Stapleton et al., Chapter 2	Annual, pooled, state-level cross-section disaggregated by age, gender, and impairment	1988–92	4% for DI, 1% for SSI
Initial Allowance Rate			
Stapleton et al., Chapter 2	Annual, pooled cross-section/time-series (SSI-only includes children)	1980–93	DI-only: 0 points in year of change –1 point after one year –1 point after two years Concurrent: 0 points in year of change –1 point after one year –2 points after two years SSI-only: 0 points in year of change –1 point after one year –2 points after two years
Beneficiaries			
Thompson and Van de Water 1975	Quarterly, national	1963–74	1% for DI
Cromwell, Hurdle, and Wedig 1986	Quarterly, pooled, state-level cross-section	1975–83	Negligible for SSI Medicaid enrollees

Other Programs and Policies

An important focus of this book is how interactions with other cash and in-kind programs affect the growth of SSA's disability programs. Economic theory suggests that the availability of benefits through other programs and their relative value should affect the decision to apply for disability benefits. This is an important topic, particularly in light of substantial secular changes in the relative value of public benefits such as general assistance—the generic term for welfare programs funded entirely by state and local governments, TANF (and the previous AFDC program it replaced), Medicaid, and Medicare.

Other programs can be classified as either “substitutes” or “complements” for DI and/or SSI, in the economic sense of these terms. Substitute programs are those for which an expansion in the value of benefits reduces applications and awards for the SSA programs; benefit expansion for complementary programs increases applications and awards. GA and TANF/AFDC benefits are substitutes for SSI; they result in a dollar-for-dollar reduction of SSI benefits. Decreases in the relative value or availability of GA or TANF/AFDC benefits are expected to increase SSI applications and awards—the extent depending on the prevalence of severe disabilities among GA or TANF/AFDC beneficiaries. Medicaid and Medicare are clearly complements of SSI and DI, respectively because the later programs are gateways for those with disabilities to the former. Increases in the value of Medicaid and Medicare benefits increase the relative attractiveness of SSA's disability programs, and hence the demand for their benefits. Expansion of Medicaid to persons with disabilities who are not sufficiently poor to qualify for SSI or some form of universal health insurance coverage would reduce or eliminate the complementarity between medical insurance and the disability programs.

This book includes econometric analyses of the effects of GA program cuts and the relative value of AFDC benefits, Medicaid benefits, and SSI state supplements on applications and awards using pooled state data (Stapleton et al., Chapter 2), an econometric analysis of the impact of health care costs and Medicaid on SSI participation based on Current Population Survey data for 1987 to 1992 (Yelowitz, Chapter 4), and an in-depth analysis of the impact of the termination of Michigan's GA program on SSI application and award growth (Bound, Kos-

soudji, and Ricart-Moes, Chapter 7). The pioneering quantitative analyses in these studies are supplemented by valuable qualitative information gained through SSA's field manager survey (Muller and Wheeler, Chapter 6), case studies conducted in five states (Livermore, Stapleton, and Zeuschner, Chapter 8), research conducted by the General Accounting Office (Bordelon's comments on Chapters 6–8), and the experiences of administrators (Chapter 10, Massanari, Hemingson, Jones)—including Charles Jones, who was the director of the Michigan Disability Determination Service when Michigan's GA program ended.

Overall, both the quantitative and qualitative evidence supports the notion that such program interactions are extremely important in understanding the growth of the SSA disability caseload. In some areas, most notably with respect to the effects of the GA program cuts, the quantitative estimates show a consistent pattern of strong effects. Point estimates of the effects of changes in Medicaid and AFDC benefits are much more tentative, and the studies point to a wide range of complex data and methodological problems to be explored in subsequent work.

The recent passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 increases the importance of this line of work for the timely understanding and, potentially, the anticipation of the impact of welfare program changes on the disability programs. Some provisions of the legislation directly restrict eligibility for SSA disability benefits (among children and immigrants), and related legislation limits the access of persons with drug addiction and alcoholism to disability benefits. These changes alone will reduce the number of beneficiaries, although the extent of their impact will depend on how many of the individuals affected are able to obtain benefits anyway (e.g., by becoming citizens in the case of immigrants, and by qualifying under a different impairment category for others.)

Other provisions of the Act, however, will almost certainly contribute to DI and SSI program growth—potentially more than offsetting the reductions caused by the provisions concerning the SSA disability programs. The replacement of the federal match of state AFDC funding by federal block grants to states for TANF greatly, and immediately, increases the financial incentives of the states for cost-shifting. The new emphasis on temporary assistance, the expectation that TANF

recipients will become self-supporting or seek other sources of assistance, eligibility restrictions, time limits, work requirements, benefit reductions, and other conditions states may impose will increase the incentives to apply for SSI and/or DI among those beneficiaries with disabilities. Because states are charged with the responsibility for designing their own TANF programs, substantial state-to-state variations are likely in these effects. Moreover, the full effects of the changes may not be realized for several years, due to the time needed to redesign state systems, the likely trial and error character of reform, the inherently dynamic nature of some policy tools (e.g., time limits), and lags in behavioral responses.

The studies included in this volume suggest that the empirical study of the effect of changes in non-SSA components of the social safety net on SSA caseloads, albeit difficult, is not impossible. Moreover, the one area where this research probably made the most headway toward solid empirical estimates, the effect of the elimination or reduction in GA programs, is probably the most instructive for the study of the indirect effects of the welfare reform legislation, because the incentives related to GA cuts in many respects are analogous to the incentives that apply to TANF. Given the large magnitude of the estimated GA cut-back effects, the GA experience points to the potential for large TANF effects, especially in states embarking on radical restrictions of TANF eligibility and substantial reductions in benefit levels. Although the incidence of severe disabilities is presumably much lower among TANF recipients than among GA recipients, the number of TANF recipients is much larger.

Features of SSA's Disability Programs and Related Supply Factors

Features of SSA's disability programs such as the real value of benefits, legislative and administrative actions affecting eligibility determination, work incentive provisions, CDRs, and SSA outreach activities might substantially affect applications, awards, and duration on the rolls. Other supply factors, such as judicial rulings on appealed cases, also play a role. Research on the effects of these factors is, unfortunately, extremely difficult to perform: first, because there is only limited variation in the data; second, because most changes that do occur tend to affect the whole program, so there are no natural comparison

groups; and/or third, because it is extremely difficult to disentangle the effect of programmatic factors from potential confounding factors.

Supply factors can affect applications, awards, and duration on the rolls. This volume contains contributions in each of these areas. The most salient overall econometric evidence of the importance of the contribution of supply factors to recent growth is the fact that the demand factors in the application and award models estimated by Stapleton et al. (Chapter 2) account for proportionately more application growth than award growth, but total award growth was proportionately greater than application growth; i.e., the demand factors predict an allowance rate decline, but in fact allowance rates increased. The proportionately smaller effect of demand factors on awards implies that, in a broad sense, SSA's disability determination process screens out marginally qualified applicants. The only plausible explanation for the increase in allowance rates despite the decline implied by demand factors is an upward shift in supply. The fact that the largest increases in application and award growth occurred in impairment categories that would most likely be affected by some of the administrative changes that occurred over the period—mental and musculoskeletal impairments—reinforces this interpretation.

A crucial piece of previous research highlighting the importance of supply factors was a study by Parsons (1991) estimating the effect of denial rates on subsequent applications. Stapleton et al. (Chapter 2) confirm the importance of the perceived “tightness” of eligibility determination, albeit on a lesser scale than was indicated by Parsons' work.

The importance of supply factors in affecting applications and awards is further highlighted by the results of SSA's field manager survey reported by Muller and Wheeler (Chapter 6), case studies in five states (Livermore, Stapleton, and Zeuschner, Chapter 8), and the observations of administrators (Chapter 10, Massanari, Hemingson, Jones). Field office managers display a high degree of awareness of supply factors, such as court cases, congressional mandates, outreach activities, and changes in medical standards. Changes that appear to have had an impact include the 1985 changes to the mental impairment listings, increased emphasis on source evidence, increased consideration of pain and other symptoms, SSI outreach, the decline in CDRs, court decisions (especially *Sullivan v. Zebley*, for child SSI applicants), and

changes in the adjudicative climate. The relative importance of these factors is unknown.

Several supply factors are relevant primarily through their actual or potential effects on duration on the rolls. The potential of policies designed to reduce duration on the rolls is highlighted by the analysis of Rupp and Scott (Chapter 4), who show that expected lifetime duration on the rolls is extremely long for both DI and SSI, and is increasing as a result of the decline in the average age at first award for both programs. The results are particularly striking for SSI, where the means test provides a potentially important supply constraint; although a high proportion of SSI disability awardees leave the rolls as a result of the means test, many of them return, and overall total duration among working-age SSI awardees before age 65 is roughly comparable for SSI and DI.

Work incentives and vocational rehabilitation on the one hand, and CDRs on the other hand, represent two generic approaches to reducing duration. The first of these approaches are voluntary mechanisms, while the latter, as well as time-limited benefits briefly experimented with in the context of DAA cases, represents the mandatory removal of cases no longer deemed to qualify. Policymakers and analysts find that the experience with both strategies has been disappointing to date. While CDRs were successful in removing many people from the disability rolls during the Reagan years, many returned; a substantial political backlash, followed by a reversal of CDR policies, was the result. Whether the recent allocation of more resources for CDRs will result in substantial and marked reduction in the disability rolls remains to be seen. The evidence to date suggests that the liberalization of work incentives under SSA's disability programs during the 1980s, if anything, increased duration on the rolls. Vocational rehabilitation has affected only a small fraction of beneficiaries to date.

Rupp and Scott (Chapter 4) provide part of the explanation for the failure of past policies to reduce duration. The DI and SSI data reveal that a substantial share of both DI and SSI awardees face very high mortality risk. Data from other sources (e.g., the recently completed Project NetWork baseline survey of both disability beneficiaries who volunteer for vocational rehabilitation and those who do not) suggest that disability beneficiaries, as a group, face enormous health problems that limit the ability to work and daily functioning. Many respondents

reported substantial bed-days during the previous year, and close to half scored depressed on the CES-D depression screener (Rupp, Wood, and Bell 1996). Thus, it appears, that the tightness of SSA's disability determination screen limits the potential for back-end interventions. Other explanations for the poor performance of past policies include the fact that program incentives to demonstrate inability to work at the front end of the process are extremely strong, and that the health and human capital of beneficiaries are likely to deteriorate as they continue on the rolls.

As Daly (Chapter 5) shows, SSI recipients tend to have an extremely weak attachment to the labor market to start with, a factor also reducing the potential for back-end labor market interventions. The contribution by Craig Thornton (in Chapter 12) based on the results of the Transitional Employment Training Demonstration shows some success with vocational rehabilitation strategies, but on a very limited scale. While the net impact results from the Project NetWork experiments are not available yet, the degree of participation has been modest (Rupp, Wood, and Bell 1996).

Policy Implications

The policy discussions cover a broad range of issues, but a number of clear themes emerge. These themes for the most part reflect recognition of the importance of economic factors in determining program participation and concern over growth in program participation—especially among young adults. All of these themes first appear in the contribution of SSA's Gil Fisher and Mindy Upp (Chapter 9), the first chapter in Part III.

There is a clear consensus among the diverse authors that the disability programs do not distinguish between those who are able to work and those who are not (as required by the Social Security Act), but rather between those who are expected to work and those who are not. Some point out that the "can/cannot work" dichotomy of the programs is fundamentally in conflict with the growing acceptance of the idea that people with disabilities can work and should be afforded the opportunity to work, as embodied in the Americans with Disabilities Act (see Chapter 11, S. Ross, J. Ross, Weaver). Several authors discuss a "continuum" of ability to work and the need to "make work pay" for

people with disabilities (Chapter 11, Batavia, Goldman, J. Ross, Weaver). In recognition of this continuum, some recommend consideration of policies such as partial disability categories, subsidies for work (e.g., the Disabled Workers' Tax Credit), and improved access to health insurance for disabled workers (Chapter 11, J. Ross; Chapter 12, Daniels and West, Burkhauser).

A number of authors address the temporal dimension of disability (Chapter 11, Batavia, Goldman, J. Ross, Weaver; Burkhauser, Chapter 13). The DI program was originally established as an "early retirement" program, primarily for older workers whose physical disabilities forced them to leave the labor force prematurely and permanently. Although this scenario applies to some beneficiaries today, many who have entered beneficiary status more recently have been younger adults who are expected to remain beneficiaries for many years. These authors express great concern about growth in long-term dependency. Some conclude that many have been enticed into a lifetime of dependency and poverty by the program's promise of income security—a promise that is increasingly difficult to keep as program growth strains federal resources and taxpayers begin to question whether some beneficiaries are deserving of support (Chapter 11, Batavia, Weaver; Burkhauser, Chapter 13).

Many young beneficiaries have chronic health conditions that, with proper treatment, may be controlled sufficiently to allow them to work. The most frequently cited examples of such conditions are affective and anxiety disorders. Two authors propose time-limited benefits for selected groups of beneficiaries to address this problem (Chapter 11, Batavia, Weaver), but another author argues that specific time limits would lead to untimely, harmful terminations for many and suggests, instead, more rigorous enforcement of current review policies, which would hold harmless those who have not recovered (Chapter 11, Goldman).

Substantial discussion focuses on employment strategies. Several authors call for more emphasis on front-end interventions, shortly after the onset of the disability, instead of on back-end interventions that are used only after an individual has had to demonstrate inability to work in order to obtain program benefits (Chapter 11, J. Ross, Weaver; Chapter 12, Daniels and West, Burkhauser; Burkhauser, Chapter 13). One author suggests following the prevention and early-intervention

approaches of private disability insurers and disability management service providers (Chapter 12, Owens). Another suggests expansion of the role of the private sector in the provision of rehabilitation services (Chapter 11, J. Ross). Others emphasize the importance of customer choice in the purchase of rehabilitation and other services (Chapter 12, Daniels and West). The need for ongoing employment support for those with chronic conditions and strategies to improve employment outcomes for those with childhood disabilities are also discussed (Chapter 11, Goldman; Chapter 12, Thornton).

The abundance of sentiment for fundamental changes in federal disability policy is striking. Yet, while many of the authors express support for such changes, they also urge caution in moving ahead. The need for incremental change, even if radical, is most clearly expressed by Stan Ross (in Chapter 11), who points to the vulnerability of the population that the programs serve, the difficulties that large administrative agencies have in implementing change, and the resources needed to effect change as reasons to pursue a cautious, bipartisan approach. The international experience with disability programs is also a cautionary tale (Chapter 12, Burkhauser). Any changes must be considered in the broader context of conflicting political pressures to reduce budgets, devolve programs to states, expect personal responsibility and enforce civil rights.

ORGANIZATION OF THE VOLUME

The book is organized into three parts. Part I contains empirical analyses of the national experience. The analyses in these chapters are primarily, though not exclusively, based on quantitative studies. Chapter 2, the longest in the book, and the richest in empirical detail, summarizes the results of the econometric analyses of application and award growth that have been conducted by the Lewin team. Chapter 3, by Aaron Yelowitz, provides an econometric analysis of the impact of health care costs and Medicaid on SSI. In Chapter 4, Kalman Rupp and Charles Scott analyze trends in duration in SSA's disability programs based on the rich administrative data sources that have been created to track monthly payments in the DI and SSI programs over the years. In

Chapter 5, Mary Daly looks at the experience of SSI and DI recipients during the five years prior to program participation, using data from the Panel Study of Income Dynamics.

Part II of the book provides a closer, more qualitative, look at state and local experiences. Chapter 6, by L. Scott Muller and Peter Wheeler, provides an in-depth analysis of the perceptions of SSA field office managers based on a detailed survey. Chapter 7, by John Bound, Sherrie Kossoudji, and Gema Ricart-Moes, is a detailed case study of the effects of the elimination of general assistance in Michigan on SSI, utilizing both qualitative and quantitative information—including data obtained from a match of Michigan GA records to SSA records. Finally, Chapter 8, by Gina Livermore, David Stapleton, and Andrea Zeuschner, summarizes the results of case studies in five states conducted by the Lewin research team.

Part III of the book provides perspectives on program growth and policy by various actors in the disability community. In Chapter 9, Gilbert Fisher and Melinda Upp provide a perspective from the central office of SSA. This is followed by Chapter 10, presenting the perspectives of regional and state SSA and Disability Determination Services officials—Larry Massanari, Celeste Hemingson, and Charles Jones. In Chapter 11, five opinion leaders in the national disability policy analysis community—Stanford Ross, Andrew Batavia, Howard Goldman, Jane Ross, and Carolyn Weaver—discuss the implications of the research findings for disability policy. Four additional papers by policy experts—Susan Daniels and Jane West, Richard Burkhauser, Patricia Owens, and Craig Thornton—focus on employment policies in Chapter 12. Richard Burkhauser's summation and reflections on the past and future of the disability programs concludes the volume.

Notes

1. The SSI beneficiary number does not include 0.2 million disabled beneficiaries who received state supplement payments only, and the expenditure figure does not include \$0.2 billion in state supplements. (*Social Security Bulletin, 1996 Annual Statistical Supplement.*)
2. The Medicaid figure is an estimate because exact figures for Medicaid enrollees who are SSI-disability recipients are not reported. SSI-disability recipients are included in a larger class of "disabled" Medicaid enrollees, for whom Medicaid paid \$49.4 billion in benefits in 1995. The \$40 billion estimate assumes that the

share of this spending that is for SSI-disability recipients equals the ratio of SSI-disability recipients (4.9 million) to disabled Medicaid enrollees (5.9 million). (*Social Security Bulletin, 1996 Annual Statistical Supplement.*)

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Part I

Empirical Analyses of the National Experience

2 Empirical Analyses of DI and SSI Application and Award Growth

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From 1988 to 1992, the number of adults applying for and receiving benefits from the Social Security Administration's two disability programs greatly exceeded expectations. There were 330,000 more Social Security Disability Insurance (DI) applications in 1992 than in 1988, an average annual growth rate of 8.9 percent. Supplemental Security Income (SSI) applications increased by 430,000 over the same period, an annual growth rate of 10.5 percent. Awards grew even faster: an average of 10 percent per year for DI and 12 percent for SSI. One important feature of application and award growth during this period is that it was much higher in two major impairment categories—mental and musculoskeletal impairments—than in others.

In this chapter, we summarize findings from two related studies that analyze the determinants of the substantial growth experienced during the 1988 to 1992 period. We also summarize findings from a third study that examines program growth over the longer period from 1980 to 1993.¹

We analyze the issue of growth in the disability programs from an economic perspective. As discussed in Chapter 1, this perspective emphasizes the importance of individual choices in determining individual behaviors, such as applying for disability benefits. An individual's decision to apply for benefits will be influenced by a variety of factors, including the costs and benefits of working versus leaving the labor force to apply for disability benefits, the availability of potential sources of nonlabor income, the availability of health insurance and

noncash benefits, and the costs associated with the application process. The analysis presented here, while not directly modeling the individual's decision to apply for benefits, examines factors hypothesized to affect that decision process and therefore affect application and award growth experienced by the federal disability programs.

The major economic factors hypothesized to have an impact on growth in disability applications and awards that we examine in this analysis include

- *Business Cycles*: During times of economic downturn, persons with disabling health conditions may lose, or find it especially difficult to find, employment. Income from other sources may also decline. Disability benefits may become more attractive as an alternative source of income.
- *Economic Restructuring*: Changes in the types of jobs available in the economy, such as a reduction in the number of manufacturing jobs and an increase in service occupations, may affect disability applications if those who lose their jobs are unable to adapt to the market changes and to impairments that may qualify them for disability benefits.
- *State and Local Program Interactions*: State and local cash and noncash support programs offer an alternative source of income for some individuals who might otherwise qualify for disability benefits. As these programs face budget reductions or political pressure to reduce their caseloads, program administrators and beneficiaries may seek other sources of support more actively, including federal disability benefits.
- *“Supply” Changes*: In addition to demand factors, the “supply” of disability benefits will also impact program growth. The supply of benefits will be affected by changes in the eligibility criteria, changes in the implementation of the criteria, outreach efforts by SSA, and changes in the political and adjudicative environment surrounding the disability programs.

In addition to the economic factors described above, we also examine health and demographic factors that may affect disability applications and awards. Population growth and aging, the increase in female labor force participation, and changes in the prevalence of disabling

health conditions, such as AIDS/HIV, may have substantial impacts on disability application and award growth.

The analysis conducted uses a methodology that has not been previously applied to the analysis of disability program participation: “pooled” cross-section time-series analysis of state-level data. Past analyses have used either national time-series or cross-section data alone. The time-series analyses have been plagued by the difficulty of separating the effects of major program changes from the effects of other factors. The pooled methodology allows us to control for such changes to the extent that they affect all states equally, resulting in more definitive estimates for the effects of factors that vary by state. Analyses that rely on a single cross section are problematic because the effects of unmeasured determinants of program participation that vary across states (e.g., the prevalence of chronic health conditions and impairments) are confounded with the effects of measured determinants. The pooled methodology allows us to control for unmeasured determinants that vary across states, but not over time, in a very simple way.

The possibility remains that the estimated effects of state variables included in our models are confounded with the effects of supply factors that vary across states and the effects of unmeasured state variables that vary across states and over time. Nonetheless, we believe that the estimates obtained using the pooled methodology provide a much more accurate picture of the importance of the state-level factors included in the models than has been obtained previously. Further, national growth not accounted for by the state-level variables in the model is a more accurate reflection of the impact of program changes than national growth alone.

The remainder of the chapter is organized as follows: In the next section, we describe the application and award data used in the analysis and discuss the trends in disability application and award growth that occurred over the 1980 to 1994 period. This is followed by a description of the methodology employed to analyze the aggregate application and award data and define the independent variables used in the analysis. In the next four sections, we discuss the individual factors hypothesized to affect disability application and award growth. In each of these sections, we provide a description of the factor, discuss reasons why it is believed to have an impact on disability program growth, and sum-

marize the findings for the specific factor. Subsequent sections are devoted to population changes, to business cycles and economic restructuring, to other income support programs, and to supply factors.

APPLICATION AND AWARD GROWTH

In this paper we focus on application and award growth from 1980 to 1993, with a more detailed analysis of the period from 1988 to 1992. For the full period we analyzed the number of initial (medical) determinations and allowances made by state Disability Determination Services, and for the 1988–1992 period we examined applications filed and final awards. We describe significant features of these data below.²

The 1980-94 Period

The Initial Determination Data

Initial determinations are the sum of initial allowances and denials made by state Disability Determination Services (DDS) for medical reasons. We use initial determinations and initial allowances when analyzing the full period because state-level application and final award data are not available in the early part of this period. Initial determinations are lower than applications because denials for nonmedical reasons made before the initial medical determination are not counted. Initial allowances are lower than final allowances because the latter include allowances made on appeal.

One important feature of the initial determination data used for this report is that they are broken down into three program groups: those made on claims filed for DI benefits only (DI-only), those made on claims filed for both DI and SSI (concurrent), and those made on claims filed for SSI only (SSI-only). There are several reasons for analyzing these three groups, rather than analyzing total DI and total SSI initial determinations independently. First, the analysis of the three groups explicitly recognizes the overlap between the two programs. Second, concurrent initial determinations have grown at a substantially faster rate than either DI-only or SSI-only initial determinations. Third, applicants in the three groups are from three distinct groups with

respect to attachment to the labor force: DI-only applicants usually have had a strong attachment to the labor force with relatively high earnings; concurrent applicants have had a sufficiently strong attachment to the labor force to be covered by the DI program (“disability insured”), but relatively low earnings; and SSI-only applicants have had at most a limited attachment to the labor force. Finally, a large share of those receiving awards for both programs only receive SSI benefits until their five-month DI waiting period ends; once they receive DI benefits they no longer pass the SSI means test. Rupp and Scott (Chapter 4) estimate that 75 percent of concurrent awardees receive SSI benefits for less than twelve months.

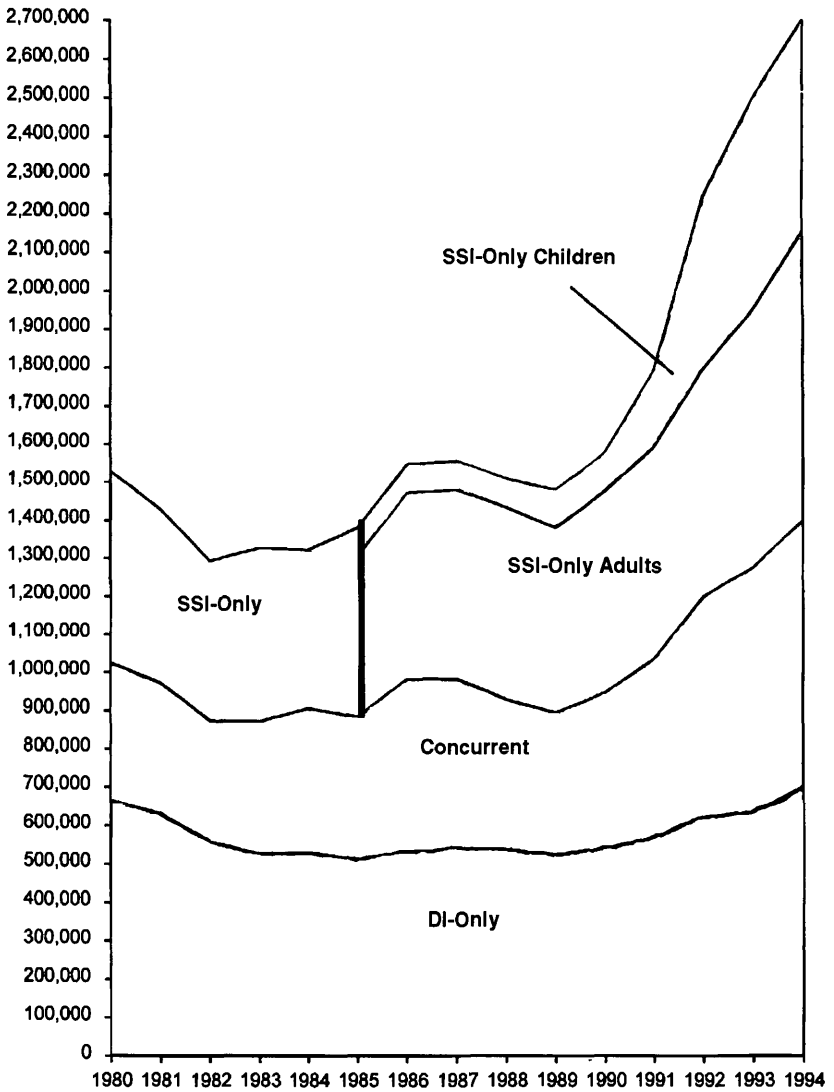
There are two important limiting features of the initial determinations data. First, they are not disaggregated by sex. As we discuss further below, data are available by sex for 1988–1992, and we found very large differences in the results for men and women. Second, SSI-only initial determinations include initial determinations for children. For analysis purposes it would be much better to separate child and adult initial determinations, but separate data were not available. We know from the national data that child growth dominates the growth in this series from 1990 on, and that the causes of this growth are primarily the 1990 Supreme Court decision in the case of *Sullivan v. Zebley* and 1991 changes in the child listings for mental disorders (GAO 1994).

Initial Determination Growth

It is useful to divide the period from 1980 to 1994 into three distinct subperiods (Exhibit 2.1). From 1980 to 1984, initial determinations declined sharply, continuing a more gradual decline that began in 1977. The decline is usually attributed to aggressive legislative and administrative efforts to reduce the size of the beneficiary population, which presumably discouraged many from applying. One notable feature of this period is that the decline occurred in the midst of a slumping economy. There was a recession in 1980, and before the economy fully recovered there was a second recession in 1981–82. If these recessions had a positive impact on initial determinations, it was masked by the response to tightening of eligibility.

The 1984 amendments to the Social Security Act reversed efforts to reduce program caseloads, and in 1985 new impairment listings that made it much less difficult to obtain benefits for mental disorders were

Exhibit 2.1 Initial Determinations for Applicants to SSA's Disability Programs, 1980-1994



SOURCE SSA, Office of Disability.

implemented. Initial determinations grew sharply from 1985 to 1986, stayed at a high level in 1987, and then declined through 1989.

Since 1989, initial determinations have grown rapidly. While growth in initial determinations for children from 1991 was greater than for adults, initial determinations for adults also grew extremely rapidly, especially in 1991 and 1992. The recession in 1990–1991 may explain some of this growth, but this is not clear from the national data because the recession of 1981–82, which was much stronger than the more recent recession, had no apparent impact.

Initial Allowance Rates

Initial allowance rates for the full period have an overall upward trend for all program groups (Exhibit 2.2). There are three notable deviations from the long-term trends: the sharp but temporary drop from 1980 to 1982, during the period of administrative tightening; the sharp increase from 1985 to 1986, after the new mental disorder listings were implemented, again followed by a decline; and a second sharp increase from 1989 to 1992, followed by a decline in 1993 and 1994.

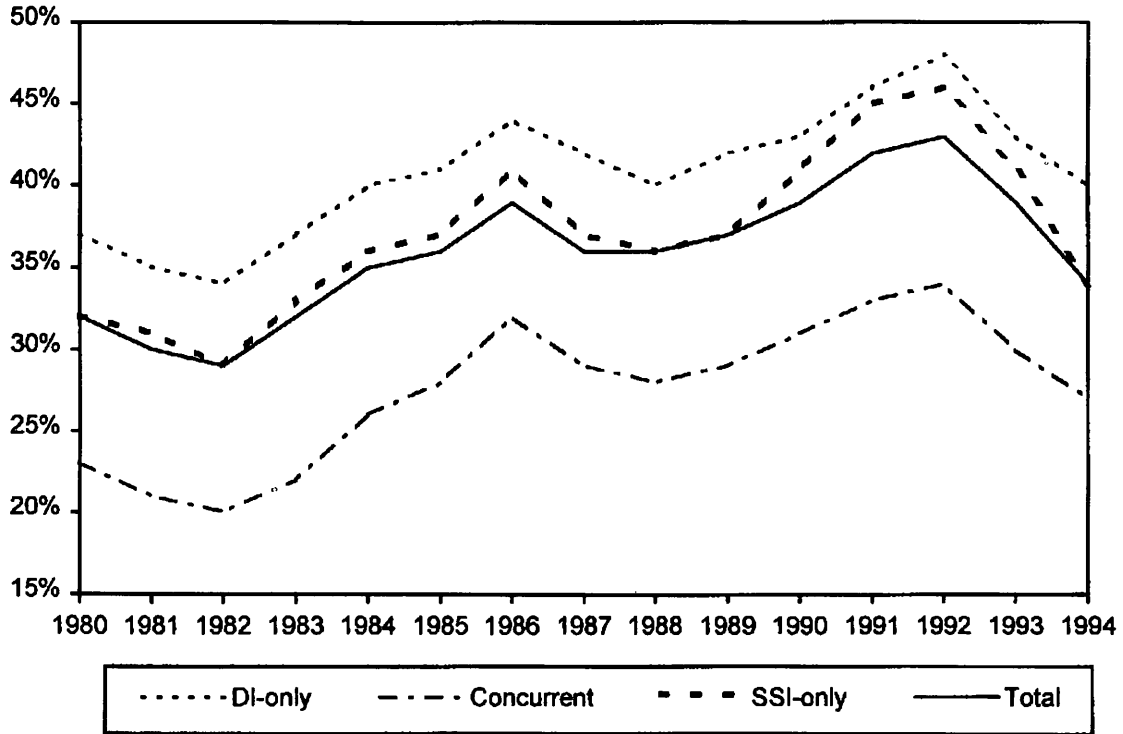
With one exception, allowance rates for the three program groups move parallel to each other throughout the period. The exception is for the SSI-only allowance rate, which grew more rapidly than the other two allowance rates from 1989 to 1991 during the dramatic increase in initial determinations for children caused by *Zebley* and the new mental impairment listings for children. As a general rule, it would seem that the dominant determinants of initial allowance rates are quite similar for all three program groups.

The 1988–1992 Period

Disability Research File Data

SSA provided state-level tabulations of applications and awards for the 1988–92 period from its new Disability Research File (DRF), a micro database on all disability applications filed from 1988 on. The tabulations for both programs include application and award tables for each year and state, cross-classified by gender, age (five age groups), and impairment. All the DRF-based estimates in this report are for those age 18–64 only, including SSI-only estimates. The classification

Exhibit 2.2 Initial Allowance Rates for Applicants to SSA's Disability Programs, 1980-1994



SOURCE: SSA, Office of Disability

of applications and awards into DI-only, concurrent, and SSI-only groups is more difficult than the classification of initial determinations and allowances because applications for the two programs are not always filed at the same time or even in the same state. For this study, the state-level DI application and award data are classified by whether the DI applicant applied for SSI, regardless of where or when (“DI-concurrent” versus “DI-only”). We did not obtain state-level SSI data disaggregated in a symmetric way (i.e., “SSI-concurrent” versus “SSI-only”). It appears likely, though, that analysis of analogously defined SSI-concurrent data would yield results similar to those reported here for DI-concurrent applications and awards. National level SSI-concurrent and SSI-only data are available. We report national trends in SSI-only applications later in this section, but omit SSI-concurrent trends because they are very similar to those in the DI-concurrent category.³

The DRF award data include allowances made at all levels, not just initial allowances. They are dated by the year the application was filed, which is often earlier than the year that the allowance was actually made. Thus, “1992 awards” means awards for applications filed in 1992.⁴ Many 1992 applications still had award decisions pending as of July, 1993, the closing date for the initial state tabulations. We subsequently analyzed updated state tabulations by gender and program, but not by age, gender, impairment, and program. Hence, we only report estimates of award models at the gender/program level, using the revised data.

Applications and awards in the DRF data are classified on the basis of the primary impairment listed in the administrative record for the highest level at which the application was considered. For the state-level analysis we used only four impairment groups in order to insure adequate numbers of cases in individual state/program/age/sex cells, but we report national trends in six categories: mental illness, mental retardation, musculoskeletal, circulatory, respiratory, and a combined category of all other impairments that includes neoplasms, nervous and sensory impairments, diseases of the endocrine system, genito-urinary conditions, diseases of the skin, blood, and digestive tract, infectious diseases, and a small number of unclassified cases. The categories used for the state-level analysis are: mental disorders (mental illness and mental retardation); musculoskeletal; infectious diseases and unclassified cases; and a residual category that we call “internal organ” disor-

ders, in which circulatory impairments, respiratory impairments, and neoplasms are the dominant disorders.

Application Growth

Application growth for the 1988 to 1992 period was very rapid (Exhibit 2.3), essentially following the pattern of initial determination growth examined previously; changes in application growth rates occur somewhat earlier than changes in initial determination growth rates because of the processing time between the filing of an application and the initial determination.

While the distribution of applications by impairment changed only moderately from 1988 to 1992, these changes reflect much larger variation in rates of application growth across categories (Exhibit 2.3). Within each program category, the fastest growing application categories are mental illness, mental retardation, and musculoskeletal, while the slowest growing categories are circulatory and respiratory illnesses.

There is also substantial variation in growth rates across subcategories of mental and musculoskeletal impairments (Exhibit 2.4). For mental disorders, growth in the addiction and affective disorder subcategories was much more rapid than in other subcategories for all program groups; SSI-only applications in the addiction disorder category increased by 200 percent over the period. Growth in the anxiety disorders subcategory was also high. Growth in the schizophrenia subcategory was remarkably low—almost no change at all for the three categories combined. In the musculoskeletal category, growth in the back disorders subcategory, which accounts for over half of all applications in the category, was much higher than in all other subcategories.

Allowance Rates

As with initial allowance rates, final allowance rates increased substantially over this period (Exhibit 2.5). The increase is observed in all impairment group categories and for all program groups; patterns of change across program groups and impairments are much less evident than application patterns. Across program groups, the change ranges from 5.9 percentage points for SSI-only to 4.6 percentage points for DI-concurrent. The increase in the allowance rate is greatest in the mental illness and circulatory impairment categories for all three pro-

Exhibit 2.3 Application Growth by Impairment, 1988 to 1992

Impairment	DI-only			DI-concurrent			SSI-only		
	1988	1992	% change	1988	1992	% change	1988	1992	% change
Number (000s)	421.2	536.8	27	400.4	609.5	52	393.8	636.0	62
Mental illness	10%	12%	45	18%	20%	69	20%	23%	79
Mental retardation	1%	2%	59	3%	9%	86	9%	9%	58
Musculoskeletal	27%	30%	41	21%	22%	63	13%	15%	80
Circulatory	17%	13%	2	12%	10%	17	10%	8%	30
Respiratory	5%	4%	5	4%	4%	25	4%	4%	44
All other	40%	39%	26	42%	40%	50	44%	41%	57

SOURCE: SSA, Disability Research File, and Lewin-VHI calculations.

NOTE: DI-only and DI-concurrent applications sum to total DI applications, but SSI-only and DI-concurrent applications do not sum to total SSI applications. All data are for adults age 18–64. See the text for further discussion.

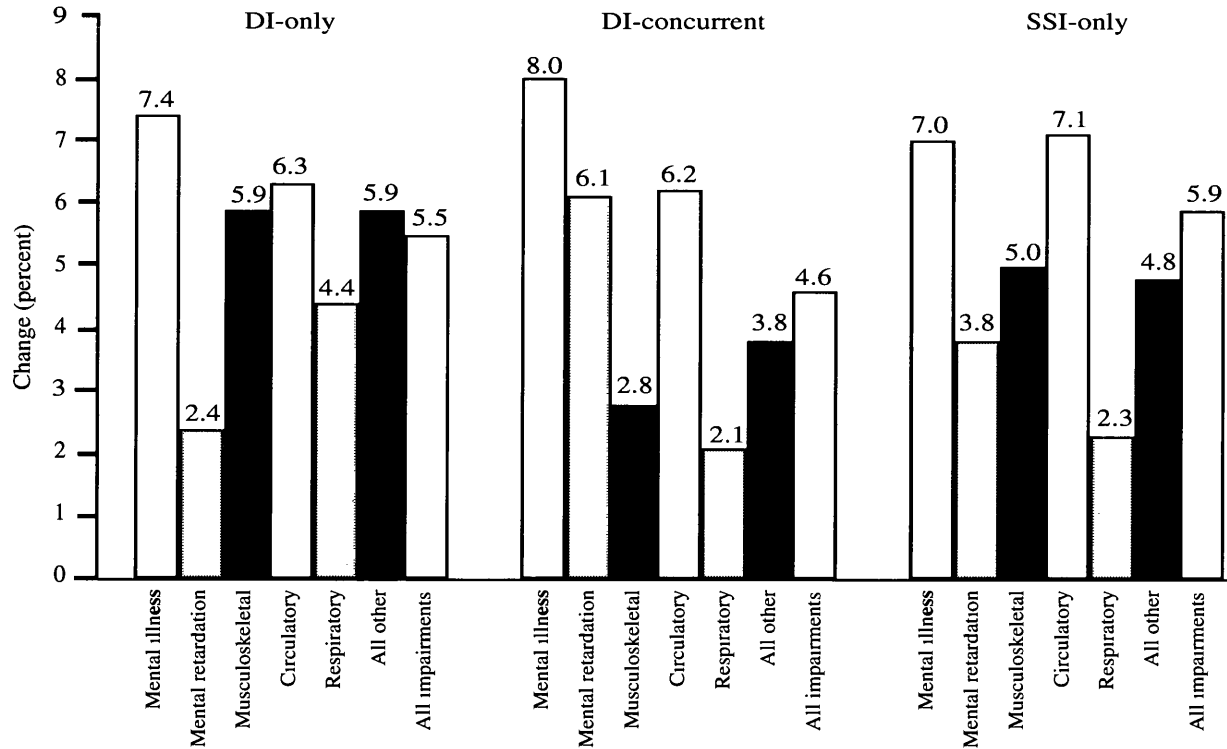
Exhibit 2.4 Application Growth in the Mental Impairment and Musculoskeletal Categories, by Specific Impairment, 1988–1992

Impairment	DI-only			DI-concurrent			SSI-only		
	1988	1992	% change	1988	1992	% change	1988	1992	% change
All mental			46			72			73
Organic	15%	13%	25	8%	8%	57	6%	6%	66
Schizophrenia	16%	11%	1	22%	12%	−4	20%	12%	4
Affective	37%	44%	72	27%	32%	105	20%	25%	112
Anxiety	10%	11%	48	7%	7%	83	6%	6%	83
Addiction	5%	6%	75	12%	18%	151	11%	18%	200
Mental retardation	10%	11%	59	16%	17%	86	30%	28%	58
Other mental	7%	4%	14	8%	6%	29	7%	5%	31
Musculoskeletal			41			63			80
Back	58%	61%	47	57%	61%	76	46%	53%	105
Other	42%	39%	32	43%	39%	47	54%	47%	59

SOURCE: SSA, Disability Research File, and Lewin-VHI calculations.

NOTE: DI-only and DI-concurrent applications sum to total DI applications, but SSI-only and DI-concurrent applications do not sum to total SSI applications. All data are for adults age 18–64. See the text for further discussion.

Exhibit 2.5 Change in Final Allowance Rates by Impairment, 1988 to 1991



SOURCE: SSA, Disability Research File, and Lewin-VHI calculations. All data are for adults age 18–64.

gram groups. For other impairment groups, the change varies considerably across program groups.

While allowance rate increases were greatest in the mental illness category in general, increases varied substantially across subcategories (Exhibit 2.6). The largest increases by far were for addiction disorders—approximately 20 percentage points in each of the three program groups. The next highest increases were for anxiety disorders—approximately 10 percentage points in each program group.

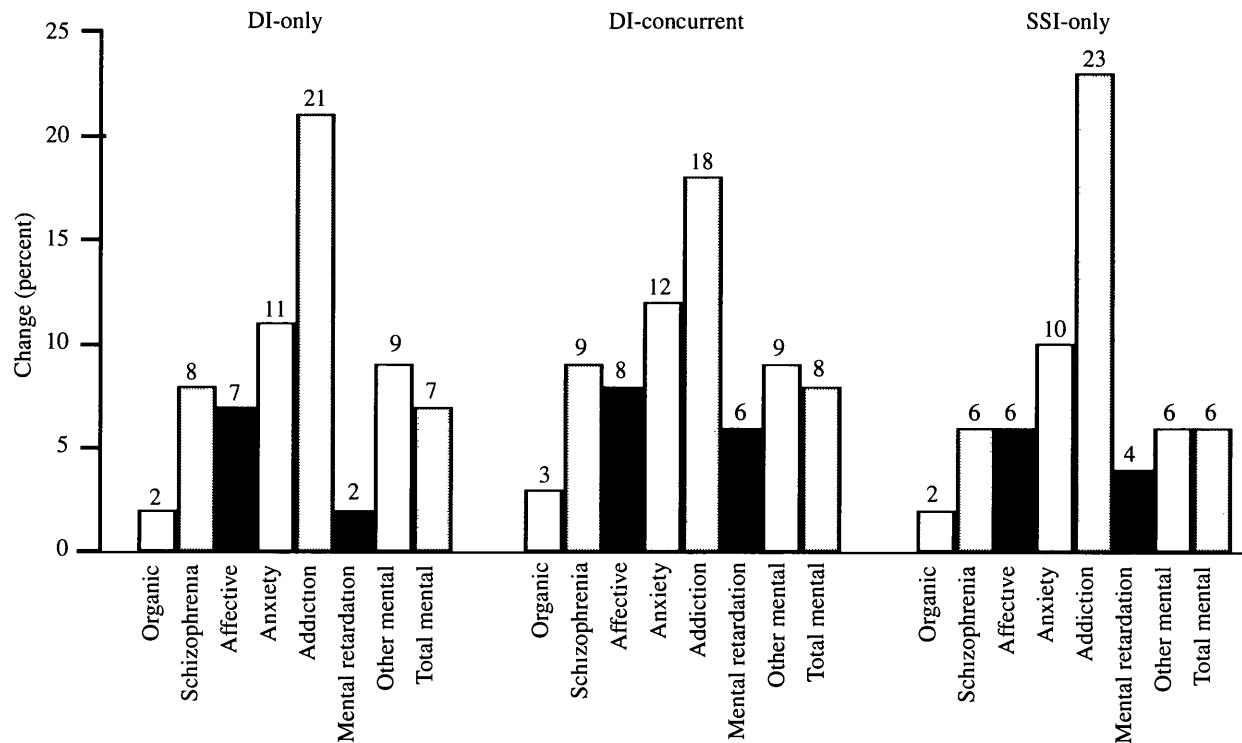
METHODOLOGY

The findings reported on here are primarily based on two sets of econometric models that were estimated with the state-level data described in the previous section. The first set uses 1980–1993 initial determination and allowance data, and the second set uses the 1988–1992 application and award data. The econometric methodology used is essentially the same for both sets. We describe this methodology below, discuss the main explanatory variables used in the analysis, and describe simulations conducted with the estimated models in order to interpret the findings. A more technical description of the econometric methodology appears in the appendix to this chapter, along with selected regression and simulation results.

The findings reported here also draw on several other activities we conducted in order to better design, interpret, and validate the econometric analysis. These include

- a national-level actuarial analysis of the impact of growth and changes in the age/sex distribution of the disability insured population on DI application and award growth
- a substantial review of relevant literature
- interviews with a series of government and academic experts on disability
- interviews with 17 state Disability Determination Service administrators

Exhibit 2.6 Change in Allowance Rate by Mental Disorder, 1988 to 1991



SOURCE: SSA, Disability Research File, and Lewin-VHI calculations. All data are for adults age 18–64.

- case studies of application and award growth in California, Florida, New York, Texas, and Michigan

The findings of the case studies are reported more fully in Chapter 8.

Econometric Model

For the 1980–1993 analysis we estimated a single initial determination and allowance rate equation for each of three program groups: DI-only, concurrent, and SSI-only.⁵ The dependent variable in each equation is the logarithm of either initial determinations per capita or the initial allowance rate (initial allowances divided by initial determinations). In assessing the findings from this analysis, it is important to keep in mind that children are included in the SSI-only category.

For the 1988–1992 analysis we estimated forty application equations for each program (DI and SSI). The dependent variable in each equation is the logarithm of either an application or incidence rate for a specific age/sex/impairment group (five age categories, two sex categories, and four impairment categories). For DI, we also estimated separate DI-only and DI-concurrent equations. For the award analysis, we estimated male and female equations for each program group.

It is important to keep in mind differences in the dependent variable data when comparing the findings from the analyses of the two periods. Three critical differences are 1) the 1980–1993 data for SSI-only include children, while the SSI data for 1988–1992 do not; 2) the dynamics of the series are different in a systematic way because of the processing lag between the date of application filing and the date the initial determinations are made; and 3) awards for the 1988–1992 analysis include allowances made at all levels, whereas those for the 1980–1993 analysis refer to initial allowances only.

Explanatory Variables

Explanatory variables that appear in the final models include

- the expected application rate, based on 1990 national application rates by age group and the age-distribution of the state's population in the current year—to capture the effect of the aging of the population
- the unemployment rate—to represent the business cycle

- the labor force participation rate—to capture the negative, cyclical effect of discouraged workers leaving the labor force during recessions. For DI, this variable may also capture the long-term positive effect of growth in the share of women who are disability-insured
- the share of employment in manufacturing—to capture the effect of economic restructuring
- GA program cuts—to proxy for the effects of state and local shifting efforts (especially for SSI)
- the poverty rate—to capture changes in poverty that are not picked up by other variables in the model
- the mean AFDC payment for a two-person household relative to mean earnings—to capture the value of AFDC benefits
- the mean SSI payment, including state supplement payments, relative to mean earnings—to capture the value of SSI benefits
- AIDS/HIV incidence—to account for the effects of the AIDS epidemic on the incidence and prevalence of disability
- the number of immigrants granted legal alien status under the Immigration Reform and Control Act (IRCA)—unlike most other immigrants, those granted legal alien status under IRCA were immediately eligible to apply for SSI
- the percentage of children living in single-family homes—to proxy for the effects of the number of households headed by single parents on applications and awards (particularly for SSI)
- a dummy variable for each year—to control for national factors

There are two important general differences between the explanatory variable specifications used for the two sets of analyses. First, for the 1988–1992 analysis, which was conducted first, we related current-year changes in explanatory variables to current-year changes in application and incidence rates. For the 1980–1993 analysis we also examined the impact of prior year (“lagged”) changes in the explanatory variables on current-year initial determinations and allowance rates and found substantial lagged impacts for two variables: the unemployment rate and the labor force participation rate. Second, the expected

application rate was used only in the 1980–1993 analysis in order to capture effects of changes in the age distribution of the population. In the 1988–1992 analysis these effects were captured through disaggregation of the analysis by age (as well as sex and impairment).

Other differences in the explanatory variables for the two sets of analyses are due to data availability and statistical significance. We found that several explanatory variables that were significant for the longer period were not significant in the 1988–1992 analysis, apparently because the variability of these variables was low during the shorter period.

Simulations

In order to interpret the findings from the econometric analyses, we used the estimated models to conduct a number of counterfactual simulations. For the 1980–1993 analysis, we simulated the impact of all explanatory variables in the model on initial determinations and allowance rates holding all “national factors” (the factors represented by the year variables) constant at their 1989 levels. Comparisons of the simulated and actual series show how much of the historical variation in these series is accounted for by the state-level variables and how much is left unaccounted for—due to national factors as well as to state-level factors that were not fully captured in the analysis. For initial determinations, we also compare the simulated and actual series to expected initial determinations; i.e., to the estimate of the number of applications expected based on national application rates by program and age for 1990 and the current year population in the state by age.

For the 1988–1992 analysis, we simulated the impact of the 1988–1992 change in each individual explanatory variable on application and award growth, holding all other variables constant at their 1988 levels. This was supplemented with the findings from the national-level actuarial analysis of the disability-insured population to get estimates of the marginal impact of the growth in the share of the working-age population (especially women) that is disability-insured.

POPULATION CHANGES

Population growth

Changes in the size and age/gender composition of the population provide the simplest and most direct explanation of changes in the number of DI and SSI applications and awards. The size of the working-age “SSA area” population grew steadily from 1975 to 1992 and is expected to continue growing steadily in the near future. The baby boom generation, born between 1946 and 1964, was still entering the working-age population in 1975. As it did, the average age of the working-age population declined, but this decline was eventually reversed as the generation aged. Both the growth in the size of the working-age population and the aging of the baby boom generation have contributed substantially to recent growth in applications and awards for SSA’s disability programs.

The SSA area population between the ages of 15 and 64 grew at an average annual rate of 1.1 percent from 1975 to 1992, but the growth in recent years has been much slower than in earlier years. From 1975 to 1980 the average annual growth rate was 1.5 percent, while it was only 0.6 percent from 1988 to 1992. During the later period, however, changes in the age distribution of the working-age population substantially offset the effect of slowing population growth.

The expected initial determination variables used in the 1980–1993 analysis are intended to capture the combined effects of growth and aging of the population on initial determinations. The contribution of these variables to the acceleration in application and award growth experienced from 1988 on can be seen by comparing their annual growth for the latter period to their annual growth in the 1980–1988 period. For all three program groups, this variable grows at a faster annual rate from 1988 to 1993 than from 1980 to 1988. For DI-only, the annual rate of growth increases from 0.8 percent to 1.3 percent; for concurrent, the increase is from 1.3 to 1.4 percent; and for SSI-only, the increase is from 0.6 to 1.2 percent. The very small increase for the concurrent category is apparently explained by the fact that a relatively large share of applicants in the concurrent category are young. Thus, these factors help explain the acceleration in growth in the DI-only and

SSI-only categories, but not in the concurrent category. It should also be noted that the acceleration in the growth rates of these variables themselves occurred before 1988, and thus does not coincide with the acceleration of applications that began in 1989.

Target populations

The number of DI and SSI applications and awards should be influenced by changes in the size of the population eligible for either or both programs, i.e., each program's target population. The most important eligibility factors are the presence of qualifying disabilities and economic eligibility. The disability criteria are identical for the two programs, while economic eligibility is tied to disability-insured status for DI and to a means test for SSI. For simplicity of discussion, those satisfying the SSI means test will be called "poor" below, although the official poverty population is an imperfect proxy for SSI eligibility. Our focus here is on exogenous changes in the size of the relevant target populations given program rules; we defer the discussion of supply factors affecting the size and composition of the eligible population until later.

The three program groups can be visualized as being determined by various combinations of the target populations defined by disability-insured status, meeting the SSI means test, and having a qualifying disability. To be eligible for DI, a person has to satisfy the insured status and disability requirements. SSI eligibility requires meeting the means test and the disability requirement. Persons with qualifying disabilities who are disability-insured but not poor are eligible for DI only, those who are poor qualify for both programs (concurrent eligibility), and those who are poor but not disability insured are eligible for SSI only.

Existing data do not permit observation of trends in the three main target populations directly, and indeed not even cross-sectional data are available on a reasonable proxy of the population satisfying the disability criteria in the general population. Therefore we must rely on an item-by-item examination of evidence on trends in these three target populations.

Based on estimates from SSA's actuaries, the share of the population that is disability-insured grew at an average annual rate of 1.2 percent from 1975 to 1992. The rate of growth was much higher for women

(2.6 percent) than for men (0.2 percent), reflecting growth of female labor force participation rates. The narrowing of gender differences also suggests that this source of growth is approaching exhaustion.

We performed an actuarial analysis of the contribution of growth and changes in the age and gender distribution of the disability insured population on DI applications from 1988 to 1992 and found an average annual contribution of 2.1 percentage points. This is almost 0.8 percentage points greater than the estimated impact of population growth and aging alone, with almost all of the added contribution due to changes in the disability-insured status of women. Results for awards were almost identical. It is important to note that the growth in the proportion of the disability-insured population suggests an increase in the share of SSI eligibles concurrently qualifying for DI, thereby depressing the growth of the SSI-only group, particularly for women.

Change in the age and gender composition of the disability-insured population will also have an impact on application growth in specific impairment categories. The large increase in the proportion of the population in their thirties and forties suggests a corresponding increase in disability applications based on impairments most likely to occur in middle age, and less growth for impairments that typically occur either earlier or later in life. Our actuarial analysis of DI application growth from 1988 to 1992 found that growth due to change in the disability-insured population was greatest in the musculoskeletal impairment category, and smallest for the internal organ category. These findings are a result of the fact that applications based on musculoskeletal impairment (most commonly back strains and injuries) represent a larger share of applications among younger and middle-aged applicants than among older applicants. Applications in internal organ categories (heart disease, respiratory disease, cancer, etc.) are a larger share of applications from older persons, which partially accounts for the relatively slow growth rate in the internal organ category.

From 1979 to 1992 the poverty rate for the working-age population grew at an average annual rate of 1.6 percent. Growth was highest for persons age 18 to 24 and in the subperiods 1979–1983 and 1988–1992, both periods of slow economic growth or even decline; in the latter period, the average annual growth rate of the pretransfer poverty rate was 3.5 percent. If we assume that increases in the poverty rate directly translate into increases in SSI applications on top of the effects of pop-

ulation growth and aging, these factors together account for 4.7 percentage points of the average annual growth in SSI applications over this period, or about 45 percent of the average annual growth of 10.5 percent.

We included the poverty rate as an explanatory variable in our SSI regressions, but found in general that it did not have a statistically significant effect on applications and awards; marginally significant, positive coefficients were obtained in analysis of initial determination data for the 1980–1987 subperiod alone. The weak findings might be attributable to substantial measurement errors in state-level poverty rate estimates. Another explanation is that important determinants of the poverty rate, especially unemployment and the age distribution of the population, are included separately in all of the analyses, so only variation in the poverty rate that is not explained by other explanatory variables is being used to identify the impact of poverty.

One of the other determinants of poverty is the growth in the number of female-headed households. We included the percent of children living with only one parent to capture this factor. More generally, this variable serves as a proxy for changes in family structure that could have an impact on applications, especially declines in marriage rates that have left many individuals with limited family sources of financial, in-kind, and emotional support. In the 1988–1992 analysis this variable was very significant for the SSI and DI-concurrent equations for both men and women. We found that this variable accounts for about 5 percent of annual SSI application growth during the period. Effects were somewhat larger for women than for men, were larger for younger age groups than for older age groups, and were concentrated in the mental disorders category. We also found strong evidence of a positive impact on initial determinations in the SSI-only and concurrent categories.⁶

These findings suggest that declines in the availability of financial, in-kind, and emotional support from spouses are making a substantial contribution to growth in applications and awards. They also help explain the rapid growth in the mental impairment category. A negative association between severe mental illness and marriage has been documented in the mental health literature; empirical evidence shows that individuals who are mentally ill are less likely to marry than others, and are more likely to get divorced if they do marry (see Bartel and Taubman 1986). Thus, the prevalence of mental illness is relatively

high in the population that is “on the margin” of marriage, so declines in marriage may result in more applications from this group. It could also be that expanded availability of disability benefits for those with a mental illness has contributed to the decline in marriage rates, by offering an alternative source of support to some who would otherwise be married.

The data available to study the prevalence of disabling health conditions is limited, especially for analyzing trends. Long-term trends in the prevalence of disabling conditions may be influencing long-term growth in applications and awards (in some cases negatively), but with one exception (AIDS/HIV) we did not find convincing evidence of health trends explaining the recent acceleration of application and award growth. The incidence of AIDS/HIV grew at an annual rate of 9.3 percent from 1988 to 1992. Our regression estimates for 1988–1992 along with counts of the number of applications in the AIDS/HIV impairment category suggest that AIDS/HIV accounts for between 0.6 and 0.9 percentage points of both DI and SSI application growth over this period.

SSI applications from legal aliens and those living in the United States under the color of law grew much more rapidly than those from citizens from 1988 to 1992—at an average annual rate of 17.4 percent versus 9.8 percent for citizens—although the share of all applications that are from this group is still small (6.8 percent in 1992). We previously have hypothesized that the Immigration Reform and Control Act of 1986 (IRCA) explained the relatively rapid growth among applications from this population. National time-series of IRCA legalizations show a striking resemblance to national time-series for SSI applications from legal aliens (Lewin-VHI 1994). Because IRCA legalizations are concentrated in a relatively few states, we expected that any impact of IRCA legalizations would be clearly distinguished in the application and award analysis for 1988–1992. In fact, however, the findings were very weak. To verify the econometric findings, we asked SSA to tabulate the number of annual SSI awards to IRCA immigrants in a 10 percent sample of all SSI applications for the period from 1989 (the first year of IRCA legalizations) to 1993. The number identified as IRCA immigrants turned out to be very small—peaking at an estimated 3,200 of the 88,500 applications from all legal aliens in 1993.⁷ Thus, the rapid growth in legal alien applications over this period appears to be primar-

ily due to the same factors that are behind growth in applications from citizens. While applications from legal aliens grew at a somewhat faster rate than those from citizens, evidence from the case studies suggests that this is because the recession had a larger impact on legal aliens than on citizens.

Thus, IRCA is apparently not responsible for the relatively rapid growth of applications from noncitizens. In the analysis of the 1980–1993 data we examined whether growth in the number of legalized immigrants who have satisfied the three-year waiting period could explain this phenomenon, but again found no significant results. Evidence from the case studies (Chapter 9) suggests that the recession had a much larger impact on the immigrant population than on citizens, but we have not tested this hypothesis empirically. It is also known that middleman fraud has played a role in helping immigrants in some areas obtain awards, but the extent of the fraud is not known.⁸

An important feature of our findings concerning population factors is that they explain why growth in concurrent applications and awards has been greater than growth in applications and awards for either program alone, and especially why concurrent application and award growth has greatly exceeded that in the DI-only category. Female and young DI applicants are more likely to meet the SSI means test than older male DI applicants, and growth in the disability insured population has been greatest for women and for young to middle-age groups. The effects of poverty and changes in family structure have roughly equal impacts on concurrent and SSI-only applications and awards, but at most small impacts on DI-only applications and awards. Finally, the effect of AIDS/HIV on concurrent applications and awards has been substantially greater than its effects on those in either the DI-only or SSI-only categories.

BUSINESS CYCLES AND ECONOMIC RESTRUCTURING

Regression Estimates of Business Cycle Effects

There have been numerous previous econometric studies estimating the effect of the business cycle on DI applications, awards, and case-

loads. Most of the previous studies used aggregate time-series methods, although some work has been conducted using state- or individual-level cross-sectional estimates (see Exhibit 1.2 in Chapter 1, pp. 15–16). The point estimates vary across individual studies, but no study finds substantial effects in a direction opposite from the predictions of economic theory. Previous studies have suffered from various specification problems, low statistical power, or both.

One of the key results from our work using annual pooled cross-section/time-series data for states relates to our estimates of business cycle effects. Our ability to control for permanent differences among the states and to eliminate the confounding effect of national changes endemic to time-series studies makes the results obtained from our analysis methodologically much stronger and more credible. Strong results were found in both the 1980–1993 analysis of initial determinations and the 1988–1992 analysis of applications (see Exhibit 1.2 in Chapter 1). In general we found stronger effects for DI than for SSI and for initial determinations and applications than for initial allowances and final awards. The estimated effects on allowance rates are negative.

In the 1980–1993 analysis of initial determinations we found that the impact of a change in unemployment begins in the year of the change, but is greatest two years after the change. Such “lagged” effects are presumably greater for initial determinations than for applications because of the substantial lag between filing and the initial determination, but nonetheless could be very significant. We did not examine lagged effects in the 1988–1992 application analysis, and this may explain the somewhat stronger findings in the 1980–1993 analysis.

We were also able to extend our DI initial determination analysis back to 1976, and found remarkably stable unemployment effects for DI in each of three subperiods: 1976–1979, 1980–1987, and 1988–1993 (see the appendix to this chapter). We also found that unemployment effects for SSI-only initial determinations were essentially as large as for DI-only and concurrent initial determinations in the 1980–1987 period, whereas we found no unemployment effect for SSI-only initial determinations in the 1988–1993 period. The difference may be related to the fact that the SSI-only data include children, and growth in this category during the latter period is dominated by growth for children.

In the initial determination analysis we also found evidence of a “discouraged worker” effect—holding the unemployment rate constant, a decline in labor force participation as individuals give up their search for work during a recession is associated with a significant increase in initial determinations.

Simulated Business Cycle Effects

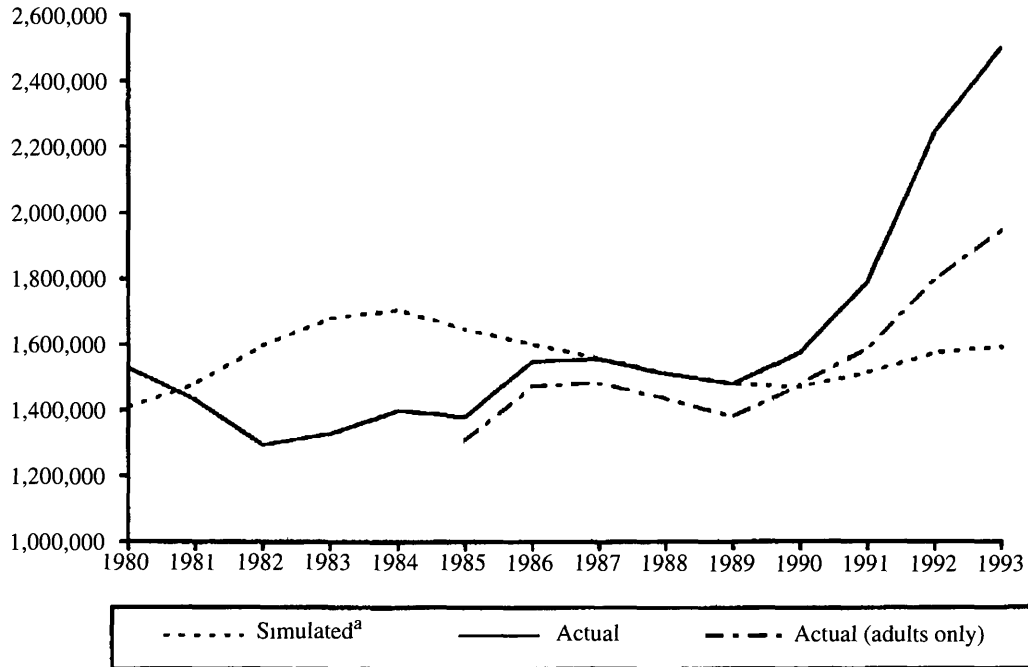
One especially notable finding in the simulations for the 1980–1993 period is that the short recession of 1980 combined with the more severe recession of 1981–1982 had a large impact on initial determinations during that period, even though initial determinations declined (Exhibit 2.7).⁹

Tightening of eligibility standards during that period (see p. 63, *The Supply of Benefits*) evidently discouraged applications sufficiently to more than offset the impact of the recession. According to the simulations, the effect of the 1981–1982 recession was much larger than the substantial simulated effect for the 1990–1991 recession.

Based on simulations using the 1988–1992 model estimates, changes in the unemployment rate over this period account for substantial fractions of the total growth in applications, especially for DI. Changes in unemployment account for 1.7 percentage points of the 8.9 percentage point annual growth in total DI applications, a 19 percent share. For SSI, changes in the unemployment rate account for 1.1 percentage points of the 10.5 percentage point annual growth rate, a 10 percent share.

Changes in the unemployment rate account for much more of the growth in DI and SSI applications for men than for women from 1988 to 1992. For example, the unemployment rate accounts for 2.2 percentage points of the 7.9 percentage point annual increase in total DI applications by men, a 28 percent share, but only 0.9 percentage points of the 10.5 percentage point annual increase in total DI applications by women, a 9 percent share. One reason changes in the unemployment rate account for a greater share of the total growth in DI applications by men is because the models do not take into account changes in the disability-insured population. It is likely that this omission results in an underestimate of the effect of the unemployment rate on DI applications by women.

Exhibit 2.7 Actual and Simulated Initial Determinations for DI and SSI, 1980-1993



SOURCE: Lewin-VHI analysis of SSA data on initial disability determinations.

^aThe simulated series is based on regression results reported in Exhibit IV.A 1, and shows the path initial determinations would have followed had they been affected solely by state-level factors. The actual and simulated series are normalized to equal one another in 1989.

In award simulations for 1988–1992, the unemployment rate accounts for 1.0 percentage points of the 10.0 percent annual growth of DI awards and 0.7 percentage points of the 12.0 percent annual growth of SSI awards, respectively; i.e., it accounts for 10 percent of DI award growth and 6 percent of SSI growth. These findings, and the findings from the 1980–1993 analysis of initial allowances, indicate that the marginal applicant who is induced to apply by a recession is less likely to obtain an award than the average applicant. Put another way, the recessions have a *negative* effect on allowance rates. This finding is especially important in view of the large *increases* in allowance rates that were observed during and shortly after the 1990–1991 recession. We return to this point later.

The findings from the five case studies add credibility to the econometric findings about business cycles, suggesting, if anything, that they are conservative. It is clear from the case studies that subtleties of business cycles not captured by the unemployment rate are relevant to a recession's impact—the industrial distribution of job losses, the perceived permanence of layoffs, and key characteristics of workers who lose their jobs (age, sex, prior earnings, skills, etc.). In effect, the unemployment rate is a crude proxy for the business cycle. As is well known by statisticians, estimated effects that rely on proxy variables tend to understate the effect of the factor they are meant to capture.

We know relatively little about the mechanisms through which business cycles have an impact on program growth. We cannot determine, for instance, the extent to which our results reflect the effects of state and local fiscal responses to recessions as opposed to job losses and pay reductions among workers with serious disabilities or spouses of persons with serious disabilities. The weaker findings for SSI-only applications and awards suggest, however, that much of the effect is due to job losses. Findings from the case studies support that interpretation as well, but they also provide evidence of a significant role for state and local fiscal responses to revenue losses, a subject we will return to later.

The dynamic aspects of business cycle impacts are also poorly understood. The considerable lagged effects found in the initial determination analysis suggest that many individuals who are induced to apply by a recession only do so after an extensive search for other sources of support.

Economic Restructuring

Many have hypothesized that economic restructuring—the replacement of high-paying manufacturing jobs with relatively low-paying service sector jobs—has had an impact on application and award growth. The short-term effect of economic restructuring is thought to be positive, because disabled workers who lose their manufacturing jobs may choose to apply for disability benefits rather than find new work in the service sector. The long-term effect may be negative, however, because service sector workers are less susceptible to disabling injuries and illnesses (see Loprest, Rupp, and Sandell 1995). The long-term effect may vary by impairment group; for instance, some have suggested that it is negative for physical impairments but positive for mental impairments.

We have previously speculated that the large business cycle effects found in the 1988–1992 application analysis may partly reflect the short-term, positive impact of economic restructuring (Lewin-VHI 1995b). In the 1980–1993 initial determination analysis we tried to capture this effect using the percent of employment in manufacturing as an additional explanatory variable. We did find the expected negative effect for the DI-only category, but it was small and not replicated for other program categories. We also developed two indices of job-related injuries and illnesses to capture the longer-term impact of economic restructuring, but found no significant results. While it may be that measurement and other specification errors account for the insignificant findings, it would appear that business cycle effects overwhelm the effects of economic restructuring in the periods we have examined.

OTHER SUPPORT PROGRAMS

The Potential for Program Interactions

Just as economic theory suggests that the relative value of disability cash benefits to potential earnings affects the decision to apply, it is reasonable to expect that the availability and relative value of benefits through other programs should also affect the decision to apply. This is

an important topic, particularly in light of substantial secular changes in the relative value of public benefits such as General Assistance (GA—the generic term for welfare programs funded entirely by state and local governments), Aid to Families with Dependent Children (AFDC—a state/federal program that primarily provides support for low-income single-parent households), Medicaid, and Medicare.

Other programs can be classified as either “substitutes” or “complements” for DI and/or SSI, in the economic sense of these terms. Substitute programs are those for which an expansion in the value of benefits reduces applications and awards for the SSA programs; benefit expansion for complementary programs increases applications and awards. GA and AFDC are examples of substitute programs for SSI; individuals who receive SSI benefits are not eligible for GA or AFDC. Tightening of eligibility rules and reductions in benefits for GA or AFDC are expected to increase SSI participation. State supplements to SSI are clear complements to SSI; reductions in state supplements are expected to reduce SSI participation.

Medicaid and Medicare are also complements of SSI and DI, respectively; most SSI recipients are automatically eligible for Medicaid, while DI beneficiaries receive Medicare coverage after a two-year waiting period. Increases in the cash value of Medicaid and Medicare benefits increase the relative attractiveness of the disability programs, and hence the demand for their benefits. Changes in eligibility rules for other programs can change the degree to which they are substitutes or complements for the SSA disability programs. For example, expansion of Medicaid to individuals who are not sufficiently poor to qualify for SSI, or the introduction of universal health insurance coverage, would reduce or eliminate the complementarity between medical insurance and income support programs.

General Assistance and Aid to Families with Dependent Children

In our state-level analysis for the 1988 to 1992 period we found strong evidence of effects of cuts in state and local GA programs on both applications and awards. GA cuts in seven states and the District of Columbia had highly significant, positive effects on SSI applications and awards for both men and women, and for concurrent applications and awards among men. Estimated effects on applications and awards

were nearly identical, and the elasticities were often large, particularly for younger men, and especially for applications and awards in the mental disorders category. We later found similar results for initial determinations in both the 1980–1987 and 1988–1993 periods. For the 1980–1987 period we also found evidence that reductions in AFDC benefits increase SSI-only initial determinations, but these findings were not replicated in the 1988–1993 analysis. The lack of findings for the later period may simply reflect a lack of large changes in AFDC benefits, the dominance of growth in initial determinations for children, and/or the confounding effects of *Zebley* and the new mental disorder listings for children.

These findings are the only direct econometric evidence we are aware of demonstrating that changes in other income and in-kind transfer programs have an impact on SSI applications and awards, but the lack of evidence may simply reflect the difficulty of measuring such effects. The lack of evidence may also reflect a widely prevailing view that anyone who is eligible for SSI as well as either AFDC or GA would already have applied for SSI because SSI benefits are greater. As several welfare administrators and other welfare experts have told us, however, this reasoning neglects the fact that the SSI application and appeals process is prohibitively difficult for many who can much more readily qualify for GA or AFDC—especially those with mental disorders.

A primary objective of the case studies was to learn more about the impact of changes in state and local welfare programs on SSI applications and awards. As described in detail in Chapter 8 of this volume, we found that cuts in GA benefits during the 1988–1992 period represent only a fraction of state and local efforts to shift welfare recipients—primarily GA recipients—onto SSI. It appears that the econometric models may substantially understate the impact of the combination of GA cuts and other state and local shifting efforts. The reason for this is methodologically the same as the reason that our business cycle estimates may understate the magnitude of business cycle effects: the GA cuts variable used for the analysis is a crude proxy for general state and local efforts; its estimated coefficient probably understates the impacts of these changes because it fails to capture the effects of shifting efforts that don't involve cuts in GA benefits.

While the findings from the case studies and econometric analysis provide much less support for the impact of AFDC benefit changes on SSI, the AFDC findings for 1980–1987 along with the long-term decline in the value of AFDC benefits relative to SSI benefits (from 1975 to 1992 the level of median AFDC benefits for a family of four declined by 37 percent relative to the value of federal SSI benefits for couples), and evidence that a substantial share of AFDC mothers have disabilities (see Adler 1993), suggest that AFDC program changes have contributed to long-term SSI application and award growth. Proposed future reforms to both AFDC and GA programs could have a substantial positive impact on SSI caseloads.

As stated above, the econometric analysis for the 1988–1992 period shows that GA cuts had an especially strong impact on applications and awards in the mental impairment category. Evidence from our interviews of DDS administrators and the case studies supports this finding and suggests that, in general, state and local shifting efforts over this period can help explain the exceptionally rapid application and award growth in the mental impairment categories. Several people we interviewed argued that the success of state and local shifting efforts would not have been possible were it not for the changes in eligibility requirements for mental disorders.

State SSI Supplements

Many states supplement federal SSI benefits with a state payment. We expect increases in total benefits (state plus federal) relative to earnings to increase applications. In the 1980–1993 analysis of initial determinations, we used the sum of the federal payment and state supplements to individuals living independently divided by earnings per worker in the state as an explanatory variable in the SSI-only and concurrent initial determination equations.

The findings were quite strong. We estimate that the elasticity of SSI-only initial determinations with respect to the sum of the state and federal benefit is 0.8. This estimate is very significant statistically and is robust to the subperiod used.¹⁰ For concurrent initial determinations the point estimate of the elasticity is smaller (0.4) and is less robust to the choice of subperiod, but is still significant.¹¹

Medicaid

We also attempted to estimate the impact of the rising value of Medicaid benefits on SSI applications and awards, but were not successful in identifying an impact. It seems likely, however, that the absence of a positive finding reflects the difficulty of measuring the value of the benefits. Welfare administrators and other experts generally attest to the importance of Medicaid benefits to SSI applicants, and recent research on the related topics of “continuation of coverage” mandates (Gruber and Madrian 1993), and the effects of Medicaid on AFDC caseloads (Moffit and Wolfe 1992; Congressional Budget Office 1993; Yelowitz 1994) confirm the importance of medical benefits to labor force and program participation decisions. In addition, as discussed further in Chapter 9, the growing burden of health care costs for indigent patients on state and local governments and health care providers is an important factor behind state and local shifting efforts.

Medicaid reform or general health care reform could have a significant impact on SSI caseloads. Medicaid block grants, which would result in federal payments to states that are not tied directly to Medicaid enrollment, would significantly reduce the incentives to shift state and local welfare recipients onto SSI. Cutbacks in Medicaid benefits could also have a negative effect. Making Medicaid benefits available to disabled persons independently of SSI, or otherwise increasing their access to health insurance, would also be likely to reduce SSI caseload growth.

THE SUPPLY OF BENEFITS

Features of SSA’s disability programs such as the real value of benefits, legislative and administrative actions affecting eligibility determination, work incentive provisions, and SSA outreach activities might substantially affect applications and awards. Other supply factors, such as court decisions on appealed cases, also play a role. Research on the effects of these factors is extremely difficult to perform for three reasons: there is only limited variation in the data; most changes that do occur tend to affect the whole program, precluding natural comparison

groups; and it is extremely difficult to disentangle the effect of programmatic factors from potential confounding factors.

In this section we first briefly discuss the contributions of our work to existing literature on the impact of increases in the value of benefits and on exogenous shifts in denial rates. We then turn to a more in-depth discussion of supply changes that occurred from 1980 to 1993 and evidence from our simulations concerning their collective impact.

The Value of Benefits

Previous econometric work has addressed some programmatic factors. Most important, there is a considerable body of econometric work since the pioneering work of Parsons (1980) and Leonard (1984) focusing on the effect of wage replacement rates on labor force and disability program participation. This body of econometric work has been plagued by serious identification problems, and has produced a wide range of estimates. An alternative quasi-experimental approach using rejected applicants as a comparison group (Bound 1989) raised fundamental questions about the validity of these estimates, but relies on somewhat questionable assumptions as well.

With one exception, we did not analyze the impact of changes in the value of benefits because benefits only change at the federal level, i.e., the value of federal benefits is a national factor that does not vary at the state level. The exception is the estimated positive effect on SSI initial determinations of the sum of federal and state SSI benefits relative to earnings, discussed in the previous section. The effect estimated is identified only through variation in the value of the state benefit and variation in earnings. Hence, caution should be exercised in using it to infer the effect of a change in the federal benefit on initial determinations.

Denial Rates

Economic theory suggests that the expected probability of award and future benefit streams should affect applications, and therefore changed eligibility rules and their enforcement might be important in determining the number of applicants. Two pioneering studies on this issue used state-level analysis for the 1970s that is similar methodolog-

ically to our own analysis for later years. These studies focused on the impact of changes in initial denial rates on DI applications and labor force participation, taking advantage of what appears to have been exogenous changes in state denial rates from 1978 to 1979. Parsons (1991) estimated that a 10 percent administrative increase in denial rates reduces applications by 4.5 percent. One limitation of Parson's work is that he did not control for changes in unemployment or demographics at the state level during this period. Gruber and Kubik (1995) use data from the same period to estimate the impact of denial rate changes on labor force participation of individuals with chronic health conditions. They did control for demographic change and the unemployment rate, and also found significant effects. We were able to replicate Parsons' findings exactly, and to test the robustness of his results in models in which we also controlled for demographic and business cycle effects. We found that taking these factors into account reduces the estimated effect of denial rate increases by 50 percent, but the estimated effects were still very significant. We also assessed the validity of Parsons' assumption that reductions in the denial rate from 1977 to 1978 reflected state DDS tightening of eligibility standards; if reductions in denial rates were due to other factors, then it is not clear that potential applicants and advocates would regard them to be indicators of changes in eligibility standards. We found that lagged denial rates had only very weak, insignificant coefficients in DI initial determination models estimated for later years, which is consistent with Parsons' assumption about the reasons for denial rate changes from 1977 to 1978.

Our econometric analysis of state data did not provide other direct evidence of program supply effects, by design. Despite this, it is possible to make some inferences concerning the effects of supply changes indirectly. In the remainder of this section we develop such inferences about supply changes that have occurred since 1980.

Analysis of Supply Changes, 1980-89

Description of the Changes

The 1980 and 1981 Amendments to the Social Security Act reduced DI benefits for some workers, introduced new work incentive provisions for DI and SSI, and required SSA to tighten adjudications.¹² In

some ways these changes codified or extended earlier administrative changes aimed at slowing the growth of the programs. The amendments set the stage for substantial administrative tightening of the eligibility standards for claims filed in the next two years, as well as for aggressive efforts to remove persons who did not meet the tightened interpretation of the eligibility standards from the rolls through continuing disability reviews (CDRs). This was followed by widespread criticism of the loss of eligibility for many, particularly those with mental impairments who were disproportionately affected by the changes. This criticism eventually resulted in a moratorium on CDRs in 1984 and the 1984 amendments to the Act.

The 1984 amendments called for new mental impairment criteria that reduced the weight given to diagnostic or medical factors and put a greater weight on functional factors, such as the degree to which the applicant is limited with respect to activities of daily living, social relations, concentration, persistence and pace, and ability to function in work or work-like settings. In 1985, SSA published revised listings of mental impairments for adults in order to comply with the amendments.

The 1984 amendments also required that “source evidence”—evidence provided by an applicant’s own physician or other health care provider (e.g., psychologist)—be considered first, prior to the results of an SSA consultative examination. This had the effect of substantially increasing the weight given to source evidence. The amendments also required that due consideration be given to pain and other symptoms. Pain had previously been an important factor in many decisions, but concerns raised by litigation, advocates, and even SSA led Congress to codify and reaffirm SSA’s existing policy. Litigation over specific guidelines for the consideration of pain continued after 1984. SSA has now promulgated detailed regulations spelling out how symptoms are to be evaluated. The new regulations also have special significance for mental illnesses because consideration of mental symptoms, such as anxiety and depression, is important in many cases.

Another change required by the 1984 amendments is often mentioned along with changes in the treatment of source evidence and pain and other symptoms: a change in the treatment of multiple nonsevere impairments. Prior to the amendments, applicants were automatically denied awards in the initial determination if all impairments were

judged to be nonsevere, even if there were several; unlike in cases of impairments that are severe, but do not meet or exceed the listings, assessments of the effects of multiple “not severe” impairments were not individualized. The change in the law stopped these automatic denials. A final change brought about by the 1984 amendments was the establishment of a medical improvement standard. Benefits could no longer be terminated without substantial evidence of medical improvement in the beneficiary’s condition.

The legislative and administrative changes that surrounded the 1984 amendments were in part instigated by, and accompanied by, court decisions that required SSA to be less restrictive in making eligibility determinations. In *Mental Health Association of Minnesota v. Schweiker*, a 1982 class action suit on behalf of persons with severe mental illness in SSA’s Chicago region whose benefits had been denied or terminated because of alleged administrative changes in the evaluation of mental impairments, the plaintiffs charged that the Chicago region DDS offices were not applying the decision-making process called for in the regulations. Claimants with mental impairments who did not meet the listings were presumed to be able to engage in unskilled work. The judge ruled in favor of the plaintiffs, declaring SSA’s policy to be “arbitrary, capricious, irrational, and an abuse of discretion” (National Academy of Social Insurance 1994). A similar suit was brought by the City of New York against SSA in 1983, ending in a decision favoring the plaintiff and declaring that such a policy was illegal.

The Effects of the Supply Changes

The 15.4 percent decline in total initial determinations that occurred from 1980 to 1982 is usually attributed to the supply tightening that occurred during this period. That is, potential applicants were discouraged from applying by reductions in benefits and the tightening of eligibility. The 10.7 percent increase in initial determinations from 1984 to 1986 is attributed to the changes surrounding the 1984 amendments, while the 4.9 percent decline in initial determinations from 1987 to 1989 is attributed to the ending of their initial impact; i.e., the “pool” of potential applicants who were affected by the changes was presumably depleted.

The initial determination simulations provide strong evidence that the effects of the supply changes on application growth during this

period were even greater than the large swings in initial determination growth indicate because the state-level factors in our models had large, countervailing effects on initial determination growth (Exhibit 2.7). In particular, if it were not for the short recession of 1980 and the more substantial recession of 1981–1982, the swings in initial determination growth would have been even larger. The simulations imply that total initial determinations would have dropped by 28.8 percent from 1980 to 1982, instead of the actual 15.4 percent drop, if the unemployment rate and other explanatory variables in the model had remained at their 1980 values. Analogously, the increase in initial determinations from 1984 to 1986 would have been 16.8 percent instead of 10.7 percent. Further, the 4.9 percent decline from 1987 to 1989 that is usually attributed to the ending of the initial impact of the changes surrounding the 1984 amendments is entirely explained by the recovery from the recession; had there been no recovery, the model predicts that initial determinations would have grown by 0.1 percent.

While the initial determination simulations show that the effects of this period's supply changes on initial determinations were much greater than previously thought, the initial allowance rate simulations show that the impacts of the supply changes on allowances, given applications, were not as large as swings in the actual allowance rate suggest. The simulations show that changes in other variables during this period, especially the unemployment rate, contributed to the decline in allowance rates from 1980 to 1982 and also contributed to their growth from 1984 to 1986. For instance, the DI-only simulations imply that the initial allowance rate would have fallen by 2.3 percentage points from 1980 to 1982 had the state-level explanatory variables remained constant over this period, rather than by the actual decline of 3.7 percentage points; the same rate would have increased by 1.5 percentage points from 1984 to 1986 instead of by the actual increase of 4.1 percentage points. Very similar results were found for the other program categories.

To summarize, the findings from our analysis of this period indicate that the impacts of historical supply changes on initial determination and allowance growth were even greater than previously thought. Further, the “indirect” effects of the supply changes on initial allowances (i.e., through effects on the number of initial determinations) are much more important relative to “direct” effects (i.e., through effects on the

share of initial determinations that result in initial allowances) than the actual initial determination and allowance rate series suggest.

Analysis of Supply Changes, 1989–93

Description of the Changes

Several additional policy changes in the DI and SSI programs occurred during the 1989–1993 period that may have affected the supply of disability benefits. As discussed previously, the 1984 amendments required that source evidence be considered first in the disability determination process. In 1991, further regulations regarding source evidence were adopted as a result of court challenges to SSA's treatment of source evidence. These regulations stipulated that deference must be given to source evidence because of the value of long-standing relationships between the patient and the health professional, and more weight must be given to source evidence the longer the relationship between the health professional and patient, or if the professional is a specialist in the relevant area. Further, if the source evidence is not accepted, the examiner must explain why.

In 1989 SSA initiated a congressionally mandated SSI outreach program. Since 1989, more intensive efforts at outreach have been pursued at the local, regional, state, and national levels. More than twenty-five cooperative agreements have been awarded for SSI outreach demonstration projects, some of which target persons with mental illness and homeless persons (Committee on Ways and Means 1994).

Another supply change during the 1989 to 1993 period is the marked decrease in the frequency of CDRs. Agency downsizing during the 1980s combined with the increased claims workload in the early 1990s resulted in a reduced allocation of resources to conduct CDRs. The proportion of DI beneficiaries leaving the rolls because of medical recovery dropped to an all time low of less than 0.5 percent in 1993.

There were very significant SSI supply shifts for children during this period, related to the 1990 Supreme Court decision in the case of *Sullivan v. Zebley* and the adoption of new mental disorder listings for children in 1991. Even though these supply changes pertain to child applications only, it has been suggested that the large impact of the decision on DDS and SSA determinations for children spilled over to decisions about adults. Because the most significant impacts of these

changes were on allowances to children with mental disorders, it would not be surprising if spillover effects for adult applications were primarily in the mental disorder category.

Finally, changes in the adjudicative climate during the 1989 to 1993 period likely contributed to application and award growth. "Adjudicative climate" refers to the attitudes of state and federal government adjudicators. The outcome in a marginal case may hinge on the attitude of a state disability determination service adjudicator or an administrative law judge toward the applicant, which may in turn be influenced by recent legislation, political and economic conditions, efforts by advocacy groups, an SSA commissioner's views, SSA's budgetary outlook, court decisions, and changes in SSA regulations and policies. Some have also argued that adjudicators faced with heavy workloads during times of rapid application growth are likely to give questionably eligible applicants the benefit of the doubt rather than spend additional time seeking additional evidence.

While changes in the adjudicative climate cannot be measured directly, there is agreement among those familiar with the determination process that they do occur and play a substantial role. Many experts we interviewed believed that there was a significant shift in the adjudicative climate in favor of making awards during the 1989 to 1993 period (see Lewin-VHI 1995a).

In addition to changes that occurred after 1989, the many changes that were implemented prior to 1989 may have had a residual impact on growth. As noted in the discussion of the initial determination simulations for 1980–1989, the decline in initial determinations from 1987 to 1989 may have been due to the economic recovery rather than the end of the impact of changes surrounding the 1984 amendments. The changes created a group of "newly eligibles" who would not have previously satisfied the disability criteria, including some who had lost benefits in the preceding years. Many newly eligible individuals probably applied for benefits right away, but many others may not have applied for benefits because they were either employed, received income from some other source, or were not aware of their eligibility. Toward the end of the decade, and continuing into the next decade, the reasons why some newly eligibles did not apply earlier began to erode: the economy deteriorated; many state and local income support programs were cut; outreach efforts by SSA, state and local governments,

and private organizations disseminated information about the new rules to potentially eligible persons; and state and local governments, advocates, and lawyers learned how to identify potentially eligible individuals and help them obtain a favorable decision.

Effects of the Supply Changes

Evidence from Initial Determination and Allowance Simulations. The simulations of initial determinations for the period from 1989 to 1993 show that much of the growth in initial determinations over this period is accounted for by unemployment and other state-level explanatory variables in the econometric model, but that much remains unaccounted for. For SSI-only, a large share of the unaccounted for growth is clearly due to *Zebley* and the change in the mental impairment listings for children. Even for DI, however, the growth not accounted for by the models is large. From 1989 to 1993 DI initial determinations increased by 21.6 percent, an increase that is 15.7 percentage points greater than predicted by the econometric models.

The growth in DI initial determinations not accounted for by the models' explanatory variables represents an implicit upper bound on the effects of supply changes on initial determinations. As discussed above, we think that growth not accounted for is partly due to impacts of some other factors (the growth in the share of women who are disability-insured, the business cycle, and state and local shifting efforts especially) that are not fully captured in our models. Hence, the unaccounted for growth in initial determinations may substantially overstate the impact of supply changes. Nonetheless, it is likely that state-level factors cannot account for all of the residual growth.

The initial allowance rate simulations for 1989–1993 provide stronger indirect evidence on the importance of supply changes. The simulations for DI show that the simulated series increased at a rate only somewhat lower than the increase in the actual series in 1989 and 1990, but from 1990 to 1992 the two series moved in opposite directions—the actual rate for DI increased by 5.4 percentage points, while the simulated rate decreased by 0.9 percentage points. It seems likely that better measures of state-level factors in the model would increase, rather than reduce, the divergence in the actual and simulated series because, in general, we have found that such factors have a proportionately smaller impact on allowances than on initial determinations.

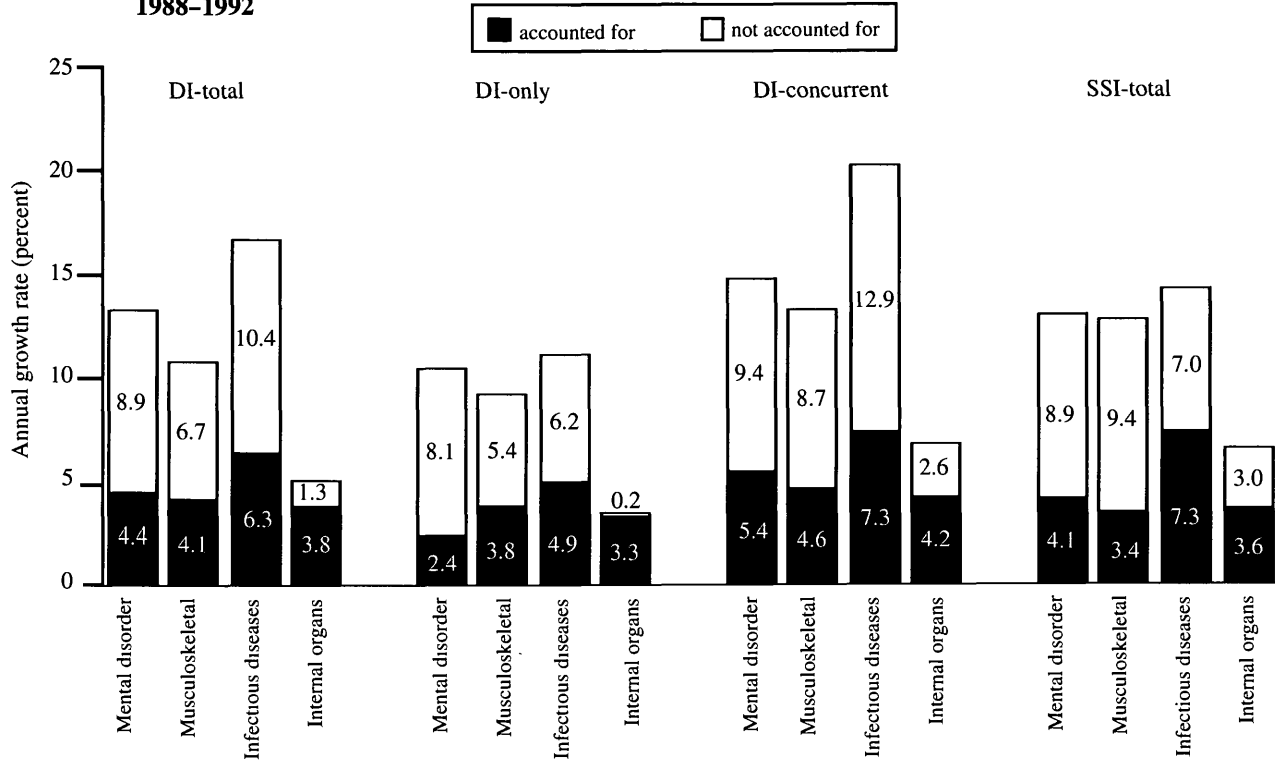
Hence, it is very difficult to explain these divergent paths by factors other than supply factors.

The initial allowance rate for DI fell by 5 percentage points from 1992 to 1993, while the simulated rate fell by only 1 percentage point. While it could be that the simulated series understates the negative impact of the recession on the allowance rate, we would also expect to find a decline in allowance rates after the initial impact of an expansion in supply is realized—just as observed in 1986–1987 following the initial impact of expansions surrounding the 1984 amendments. It is also possible that some administrative tightening occurred in 1993 in response to concerns over rapid program growth, but we are aware of no explicit effort of this sort.

Evidence from Application and Award Simulations. The application and award simulations for 1988–1992 provide some additional indirect evidence on supply changes during this period. The analysis of applications, for instance, accounts for more than three quarters of DI-only male application growth between 1988 to 1992, leaving only limited room for the net effect of either supply factors or other omitted factors on this group.¹³ The models did less well in accounting for SSI application growth, female application growth, growth in applications from those under age 50, and growth in applications in the mental and musculoskeletal disorder categories.

The fact that almost all of the application growth in the internal organs category is accounted for by factors in the model (Exhibit 2.8), while the other diagnostic groups show substantial unaccounted for growth, is consistent with the hypothesis that regulatory changes such as increasing the weight given to pain and other symptoms, increasing reliance on source evidence, and broadening the standards for those with mental impairments resulted in substantial application growth during this period. One important caution in interpreting the analysis of growth not accounted for by impairment is that relatively rapid application growth in some categories may simply reflect switching of impairment classifications toward categories in which it has become easier to obtain an award rather than applications that would not have been filed in the absence of supply changes. Thus, for instance, exceptionally high unaccounted-for growth in the mental disorder category

Exhibit 2.8 Annual Application Growth Rate Accounted for and Not Accounted for by Program and Impairment, 1988–1992



SOURCE: Lewin-VHI actuarial and regression analyses using the SSA's DRF. All data are for adults age 18–64.

may significantly overstate the effects of supply expansions on total applications.

As mentioned previously, state and local efforts to shift the burden of welfare spending onto the federal government are a significant source of the exceptionally high growth in the mental impairment category, and we suspect that a significant share of the category growth that is not accounted for by other variables is also due to these efforts. The effects of state and local efforts on application and award growth are, to some degree, inextricable from the effects of supply changes, however. As mentioned previously, many we have talked to argue that successful state and local shifting efforts were in part made possible by eligibility changes for mental impairments.

The econometric models also account for much less award growth than application growth. In fact, although final allowance rates increased over the 1988–1992 period, the models predict that they should have declined, just as with our findings for initial allowance rates. As in the analysis of initial allowance rates, it is difficult to conceive of an explanation other than a supply expansion for the growth in the final allowance rate. The econometric analysis shows that the effects on awards of most of the factors analyzed were proportionately no larger than their effects on applications, with some (especially the unemployment rate) being proportionately smaller. AIDS/HIV may be an exception, but this would only apply to the infectious disease category.

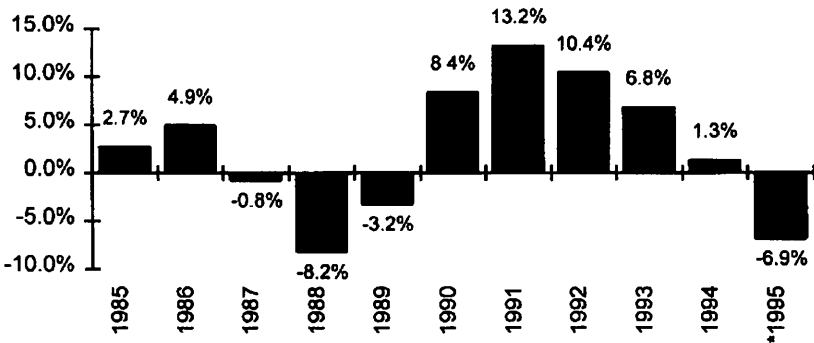
CONCLUSION

A 1992 report from the Department of Health and Human Services, known as the *709 Report*, found that the causes of DI program growth are many and complex.¹⁴ The evidence we have examined confirms this conclusion, but also points to three major causes of the acceleration of application and award growth that began in 1989: the recession of 1990–1991; new and intensified efforts by states and localities to shift the burden of welfare spending onto the federal government; and expansion in the “supply” of benefits. The relative importance of each factor varies by program and is different for applications and awards.

The recession is apparently more important for DI than SSI, while shifting efforts and supply factors are more important for SSI than DI, and supply factors are substantially more important for awards than for applications. A fourth factor that clearly contributed to the acceleration of growth, but to a lesser degree, is the AIDS/HIV epidemic.

The findings imply that the steady economic growth experienced by the economy since 1992 is very good news for policymakers worried about rapid program growth, especially for DI. This is confirmed by the most recent data available on DI application growth (Exhibit 2.9): after the growth rate reached a peak of 13.2 percent in 1991, it dropped to 1.3 percent in 1994 and was a negative 6.9 percent through the first seven months of 1995. These rates compare to expected growth of 2.1 percent based on changes in the size and age/gender composition of the disability insured population alone. We would not be surprised if the rate of growth continued to fall because application rates are still well above their 1988 level. The bad news is that DI caseloads will continue to grow in coming years because many of the large number of persons awarded benefits during the recent period are expected to remain on the roles for years to come (see Rupp and Scott, Chapter 4).

Exhibit 2.9 Annual Growth Rate of DI Applications, 1985–1994



SOURCE. SSA Office of Disability and Lewin-VHI calculations.

*The growth rate for 1995 is based on applications in the first seven months of 1995, compared to the same seven months of 1994.

The findings add to mounting evidence that economic incentives play a critical role in determining whether individuals with disabilities participate in the labor force or seek, and perhaps obtain, disability benefits. For many people with disabilities, it is not simply a matter of whether they can or cannot work because of their disabilities; rather it is a matter of whether the rewards to working are sufficient to make work more attractive than leaving the labor force and applying for disability benefits. While it must be recognized that this statement is not true for a large number of individuals with disabilities who have virtually no employment prospects even in a strong economy, the estimated magnitude of the impact of recessions on DI applications indicates that the statement is true for a large number.

Notes

1. The findings summarized here are compiled from three project reports: Lewin-VHI (1995a, 1995b, and 1995c).
2. See Rupp and Stapleton (1995) and Lewin-VHI (1995a) for discussion of earlier years.
3. The SSI-only category in the national data excludes SSI applications from individuals who were eligible for social security benefits in any category, including those eligible as DI workers.
4. There are advantages and disadvantages to analyzing awards by “application cohort.” The primary advantage is that it allows us to examine the allowance rate (awards per application filed) for each application cohort within age/gender/program groups. Aggregate statistics typically compare applications filed in each year with awards made in that year. The lag between the filing of an application and a final decision may span one or more years. During periods of rapid application growth, allowance rates calculated from aggregate data may be greatly distorted. The primary disadvantage of using awards data for application cohorts is that events that occur between the time an application is filed and the time of the final decision cannot be modeled with aggregate data because the length of this period varies greatly across individuals in each application cohort.
5. For initial determinations, the definition of concurrent is based on the status of claims at the time the determination is made.
6. This variable is not included in the initial determination regressions reported in the appendix to this chapter because we did not have data for the full 1980–1993 period. It was, however, included in models estimated using the subperiod for which it is available. See Lewin-VHI (1995c).
7. We are grateful to Charles Scott of the Office of Supplemental Security Income for providing this information.

8. See U.S. General Accounting Office (1995). A total of 6,500 cases have been identified in the states of California and Washington, combined.
9. The decline in initial determinations may have, in part, been a result of improvements in SSA's administrative computer system which were implemented in 1981. As a result of these improvements, it was frequently unnecessary to process a formal application in cases where a person was found to lack insured status. While this certainly had a large impact on the formal applications filed, it is unclear as to its impact on initial determinations.
10. The *t*-statistic for the estimate is 7.7. The estimate using the 1980–1987 subperiod is 0.73, and the estimate using the 1988–1993 subperiod is 0.84.
11. The *t*-statistic is 4.3 using the full period. The estimate using the 1980–1987 subperiod is 0.8, while that using the 1988–1993 subperiod is 0.3.
12. See the National Academy of Social Insurance (1994) for a detailed description.
13. Note that this upper bound refers to *net* effects of unmeasured factors. It is entirely conceivable that even if the net residual is small, there is room for potentially larger effects that work in opposite directions.
14. The report was mandated by Congress under Section 709 of the Social Security Act. Its full title is *The Social Security Disability Insurance Program: An Analysis*.

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Appendix to Chapter 2

As discussed in the text, we estimated a series of pooled cross-section time-series models of applications and awards for the 1988–1992 period and of initial determinations and initial allowance rates for the 1980–1993 period, using annual data for states. In the first section of this appendix we provide a technical description of the methodology. Selected regression results appear in the next section, followed by results of simulations using the 1988–1992 estimates.

SPECIFICATION OF POOLED CROSS-SECTION TIME-SERIES MODELS

For the 1988–1992 analysis, state application data were disaggregated and analyzed by program, sex, age, and impairment: three program groups (DI-only, DI-concurrent, and total SSI), the usual two sex categories, five age groups (under 30; 30 to 39; 40 to 49; 50 to 59; and 60 to 64), and four impairment categories (mental illness and mental retardation; musculoskeletal; infectious diseases, including AIDS/HIV, and impairments not otherwise classified;¹ and internal organ disorders—including cardiovascular, neoplasms, and other internal disorders, as well as impairments caused by accidents. Thus, we estimated a total of 120 (3x2x5x4) application equations; each equation refers to applications in a specific program/sex/age/impairment group.

The 1988–1992 award analysis was performed at a higher level of aggregation—by program and sex only (six equations). While we initially obtained award data at the more disaggregated level, the 1992 award data were very incomplete because many decisions were still pending. We subsequently obtained updated data, but only at the higher level of aggregation.

The 1980–1993 initial determination and initial allowance rate analysis was performed at a still higher level of aggregation—by program only (DI-only, concurrent, and SSI-only).

The models used in all of the analysis have the same structure. In each case the dependent variable is the (natural) logarithm of one of the following: an application rate (applications per thousand population); an incidence rate (awards per thousand population); an initial determination rate (initial determinations per thousand population); or an initial allowance rate (initial allowances per initial determination). In the application analysis the population in the denominator is for the relevant age/sex group; in the award analysis it is for those age 18 to 64 of the relevant sex; and in the initial determination analysis it is for all those age 18 to 64.

The dependent variable in each application equation is the logarithm of an application rate. For the higher level of aggregation, the rate is male or female applications for the program per one thousand adult males or females, respectively. For the lower level of aggregation, it is an impairment-specific “application rate” for the age/gender group—the number of applications in the relevant program category per thousand persons from the age/gender group in one of the four impairment categories. The dependent variable in the corresponding award equation is the corresponding impairment-specific “incidence rate”—the number of awards in the impairment category per thousand persons in the age/gender group.

Each equation estimated had the following general form:

$$\ln(A_{st}) = \beta_s + \beta_1 X_{1st} + \beta_2 X_{2st} + \dots + \beta_k X_{kst} + \alpha_1 V1_t + \dots + \alpha_7 VT_t + E_{st}$$

where

A_{st} is an application, incidence, initial determination, or initial allowance rate, as specified above, in state s and year t .

β_s is the intercept for state s (i.e., the equation intercept varies across states). The intercepts are sometimes referred to as fixed “state effects” because they capture the effects of all factors that vary across states but not over time.

$X_{1st}, X_{2st}, \dots, X_{kst}$ are the explanatory variables. For the 1980–1993 analysis these include both current and prior year values of selected variables.

$\beta_1 \dots \beta_k$ are the coefficients of the X variables, to be estimated.

$V1_t \dots VT_t$ are dummy variables for each year of data except the first (base) year. $V1$ equals 0 for the first year and 1 for all subsequent years, $V2$ equals 0 for the first and second year and 1 for all subsequent years, etc. VT equals 1 in the last year (T) only.

$\alpha_{89} \dots \alpha_{92}$ are the coefficients of the year dummies. These are sometimes called “year” or “time” effects because each coefficient captures the effects of changes in all national factors in the corresponding year that have the same impact on the dependent variable in all states.

E_{st} is the error term for state s and year t

As described in the text, the analysis relates within-state *changes* in the dependent variable to *changes* in the explanatory variables. This is not immediately evident in the above specification, but is in fact correct because of the

presence of a different intercept for each state. Since these control for all cross-state differences that are fixed over time, they in effect control for all of the base-year values of the explanatory variables as well as the base-year value of the dependent variable. Hence, the coefficients of the explanatory variables are determined by how the dependent variables change over time in relationship to how the explanatory variables change over time.

The models were estimated by weighted least squares, with weights equal to the size of the state's population in the relevant age/gender category. This method yields efficient estimates if the variances of the regression disturbances are inversely proportional to the size of the group population in the state and the disturbances are independent across states and over time. Weighted estimates also provide better predictions of the national level of applications and awards relative to unweighted estimates. The reason for this is that they improve the fit for large states relative to small states, and growth in large states determines a large share of national growth.²

We also looked for evidence of serial correlation in the disturbances. In the 1988–92 analysis we assessed the importance of serial and correlation and other dynamic specification issues by comparing the results obtained from weighted least squares using the full five years of data to results obtained using just the first (1988) and last (1992) year of data alone. The main findings were very robust in this comparison. The individual state intercepts wash out any autocorrelation in the “two-year” estimates, which are the basis of the findings reported here. In the 1980–93 analysis it was essential to use all years' observations in order to examine dynamic aspects of initial determinations and allowance rates. Hence, we specified a first-order autoregressive model for each state's weighted disturbance, with a common autocorrelation coefficient for all states. The estimated coefficient was always between zero and one and usually was significant. We also found some evidence of spatial correlation in pairs of adjacent states, but the evidence was erratic and did not warrant the substantial effort required to correct for it. Ignoring spatial correlation does not bias parameter estimates but can result in estimated standard errors that are biased toward zero. The models were estimated using the Statistical Analysis System (SAS); the REG procedure was used for the 1988–92 analysis and the MODEL procedure was used for the 1980–93 analysis. Standard errors for the 1980–93 models were corrected for any cross-state heteroskedasticity in the weighted disturbances, but this was not done for the 1988–92 analysis.

REGRESSION RESULTS

Selected application and award regression results for the 1988–1992 period are reported in Exhibit 2A.1. These results were estimated using application

and award data disaggregated by program and sex only; the voluminous application results by program, sex, age, and impairment are reported in the appendix to Lewin-VHI (1995b). Selected results from the 1980–1993 analysis of initial determinations and allowance rates appear in Exhibits 2A.2 and 2A.3.

SIMULATION RESULTS FOR 1988–1992

We report simulation results based on the 1988–1992 application and award models in Exhibit 2A.4. These show the percentage points of average annual growth in applications or awards during the period that are accounted for by each variable included in the final regression models, by program and sex. The application results were obtained by aggregating results simulated by program, sex, age, and impairment to the level of program and sex. Note that they do not correspond to the aggregate regression results reported in Exhibit 2A.1, but those regressions yield results that are very similar. Application simulations by age and by impairment are reported in the appendix to Lewin-VHI (1995b). The award simulations are based on the award regressions reported in Exhibit 2A.1.

Appendix Notes

1. AIDS/HIV cases first were included in the “other” impairment category before being recategorized in the infectious disease category.
2. To test for heteroscedasticity, we estimated White standard errors and found that they were not significantly different from the standard errors estimated by weighted least squares.

Exhibit 2A.1 Selected Regression Estimates for Application and Award Regressions, 1988–1992

Dependent variable: logarithm of per capita application or incidence ratio in gender/program category

Variable	Applications						Awards					
	DI-only		DI-concurrent		SSI-total		DI-only		DI-concurrent		SSI-total	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Unemployment rate ¹	0.266	0.128	0.323	0.074	0.209	0.050	0.181	0.056	0.189	0.015	0.113	0.065
	(7.3)	(4.1)	(7.7)	(1.6)	(5.9)	(1.3)	(4.6)	(1.4)	(3.9)	(0.3)	(2.7)	(1.3)
GA program cuts ²			0.073		0.122	0.086			0.082		0.099	0.085
			(3.4)		(6.7)	(4.4)			(3.3)		(4.7)	(3.3)
AIDS/HIV incidence ³	0.037		0.107		0.078		-0.006		0.029		-0.091	
	(1.0)		(2.5)		(2.2)		(-0.2)		(0.6)		(-2.2)	
IRCA legalizations ⁴					0.016	0.003					-0.068	-0.076
					(1.3)	(0.2)					(-4.7)	(-4.3)
% of children in single parent families ⁵	-0.010	0.087	0.285	0.408	0.280	0.418	-0.142	-0.084	0.086	0.144	0.129	0.063
	(-0.1)	(0.8)	(1.9)	(2.4)	(2.2)	(3.1)	(-1.0)	(-0.6)	(0.5)	(0.7)	(0.9)	(0.4)
Time effect for 1992 vs. 1988 ⁶	0.056	0.235	0.190	0.388	0.207	0.287	0.165	0.346	0.311	0.474	0.426	0.403
	(2.2)	(14.8)	(6.4)	(16.7)	(8.0)	(14.8)	(6.1)	(16.6)	(9.0)	(16.0)	(14.1)	(15.6)

NOTE: Coefficients of variables specified in logarithms are elasticities by definition. Except for the time effect, all other coefficients have been converted to elasticities "at the mean" by multiplying the coefficient itself by the mean of the variable. Elasticities in bold type have the expected sign and an absolute *t*-statistic of at least 2.0. Elasticities in normal type have absolute *t*-statistics of less than 2.0. Italicized elasticities have the sign opposite that expected and absolute *t*-statistics of at least 2.0. A separate intercept for each state was also included in each model (not reported)

¹The variable used is the log of the state's unemployment rate.

²The GA variable is zero for every state in 1988; in 1992 it is the number of cuts in GA beneficiaries per capita between 1991 and 1992 in seven states and the District of Columbia and zero in all other states.

³The AIDS/HIV variable is the logarithm of the incidence rate

⁴The IRCA legalizations variable is zero in 1988 and is the number of legalizations per capita in 1992.

⁵The percentage of children in single parent families is in logarithms.

⁶This coefficient is an estimate of the percentage increase in the dependent variable from 1988 to 1992 that is not accounted for by the explanatory variables.

Exhibit 2A.2 Regression Estimates for Initial Determination Models, 1980–1993

Dependent variable: the log of initial determinations per capita

Explanatory variables	DI-only			Concurrent			SSI-only		
	1980–1993	1980–1987	1988–1993	1980–1993	1980–1987	1988–1993	1980–1993	1980–1987	1988–1993
Expected application rate ^{a,b}	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Unemployment rate ^{b,c}									
Current	0.086* (4.06)	0.056* (1.97)	0.099* (4.05)	0.088* (2.91)	0.083 (1.90)	0.085* (2.90)	-0.022 (-0.72)	0.045 (1.04)	-0.060 (-1.74)
-1	0.099* (4.57)	0.066* (2.36)	0.125* (4.23)	0.123* (3.88)	0.078 (1.72)	0.132* (4.20)	0.091* (2.97)	0.124* (2.99)	0.001 (0.04)
-2	0.097* (4.83)	0.117* (4.40)	0.027 (1.06)	0.050 (1.63)	-0.062 (-1.41)	0.042 (1.36)	0.073* (2.42)	0.085* (1.99)	-0.006 (-0.16)
Sum	0.282* (10.5)	0.239* (7.6)	0.251* (6.9)	0.261* (6.6)	0.099 (1.7)	0.259* (6.9)	0.142* (3.0)	0.254* (4.0)	-0.065 (-1.5)
Labor force participation ^{a,b}									
Current	-0.634* (-3.34)	-0.608* (-2.60)	-0.616* (-2.57)	0.065 (0.25)	-0.147 (-0.42)	-0.015 (-0.06)	0.201 (0.77)	-0.427 (-1.21)	0.032 (0.11)
-1	-0.046 (-0.27)	0.414* (1.97)	-0.465* (-2.12)	-0.479* (-2.03)	-0.773* (-2.50)	-0.602* (-2.48)	-0.427 (-1.78)	0.052 (0.17)	-1.196* (-3.87)
-2	-0.181 (-1.14)	-0.149 (-0.74)	0.061 (0.28)	-0.256 (-1.14)	-0.621* (-2.10)	-0.371 (-1.53)	-0.820* (-3.56)	-0.628* (-2.11)	-1.153* (-3.82)
-3	-0.040 (-0.25)	0.007 (0.03)	-0.378 (-1.70)	0.118 (0.52)	-0.055 (-0.18)	-0.362 (-1.45)	-0.223 (-0.97)	-0.117 (-0.39)	-0.632* (-1.99)

Sum		-0.901* (-2.8)	-0.336 (-0.8)	-1.398* (-3.5)	-0.552 (-1.2)	-1.596* (-2.8)	-1.350* (-2.8)	-1.269* (-2.3)	-1.120 (-1.7)	-2.949* (-4.9)
Manufacturing employment ^{a,b}		-0.072 (-1.45)	-0.180* (-2.46)	-0.072 (-0.66)						
AIDS/HIV ^b		-0.008 (-1.18)	-0.011 (-0.43)	0.004 (0.58)	-0.018 (-1.79)	-0.003 (-0.10)	-0.019* (-1.98)	-0.032* (-3.04)	-0.022 (-0.64)	0.018 (1.57)
Poverty ^{a,b}				0.037 (1.34)	0.091* (2.37)	0.007 (0.26)	0.045 (1.79)	0.065 (1.76)	0.018 (0.56)	
GA changes				0.002 (0.60)	-0.003 (-0.87)	0.004* (2.13)	0.005 (1.79)	0.009* (2.20)	0.005* (2.18)	
AFDC ^a				-0.010 (-0.20)	-0.003 (-0.05)	-0.008 (-0.09)	-0.226* (-3.84)	-0.303* (-4.90)	0.091 (0.90)	
SSI supplements ^a				0.382* (4.34)	0.758* (6.11)	0.284 (1.90)	0.801* (7.67)	0.734* (5.82)	0.840* (4.39)	
Autoregressive parameter		0.534* (14.34)	0.344* (5.81)	0.172* (2.26)	0.515* (14.99)	0.278* (4.64)	0.368* (4.92)	0.727* (22.95)	0.503* (9.14)	0.338* (4.46)
Weighted state intercept		-6.469	-6.454	-6.746	-2.494	2.180	-3.681	0.147	-1.636	4.709
Time effects	1981	-0.083* (-7.01)	-0.071* (-5.60)		-0.117* (-6.40)	-0.119* (-5.49)		-0.120* (-6.75)	-0.140* (-6.87)	
	1982	-0.187* (-15.25)	-0.187* (-14.26)		-0.160* (-9.04)	-0.158* (-7.67)		-0.169* (-9.49)	-0.190* (-9.74)	
	1983	-0.095* (-8.75)	-0.091* (-8.14)		0.044* (2.81)	0.063* (3.36)		0.030 (1.91)	0.016 (0.89)	
	1984	-0.001 (-0.05)	-0.011 (-0.82)		0.080* (4.76)	0.115* (5.45)		0.051* (3.02)	0.064* (3.19)	

(continued)

Exhibit 2A.2 (continued)

Explanatory variables	DI-only			Concurrent			SSI-only		
	1980-1993	1980-1987	1988-1993	1980-1993	1980-1987	1988-1993	1980-1993	1980-1987	1988-1993
1985	-0.015 (-1.40)	-0.028* (-2.45)		0.032* (2.12)	0.035* (1.99)		0.055* (3.73)	0.062* (3.78)	
1986	0.070* (6.73)	0.067* (6.16)		0.219* (15.20)	0.204* (12.53)		0.157* (10.92)	0.160* (9.95)	
1987	0.028* (2.94)	0.019 (1.84)		0.016 (1.15)	0.036* (2.23)		0.057* (4.15)	0.057* (3.58)	
1988	0.011 (1.17)			-0.082* (-6.05)			0.052* (3.81)		
1989	-0.005 (-0.49)		-0.008 (-0.89)	-0.035* (-2.60)		-0.032* (-2.93)	0.032* (2.42)		0.035* (2.81)
1990	0.032* (3.40)		0.026* (3.06)	0.091* (6.80)		0.096* (9.22)	0.093* (7.10)		0.102* (8.58)
1991	0.014 (1.42)		0.009 (0.98)	0.091* (6.74)		0.098* (9.17)	0.161* (12.14)		0.187* (14.94)
1992	0.038* (4.10)		0.035* (4.24)	0.175* (12.13)		0.171* (13.69)	0.281* (19.38)		0.328* (21.72)
1993	0.003 (0.26)		0.004 (0.38)	0.106* (6.27)		0.107* (7.87)	0.169* (10.00)		0.146* (9.01)

SOURCE Lewin-VHI analysis of SSA data on initial disability determinations, using data for all 50 states and the District of Columbia. SSI-only estimates include children.

^aVariable is in logarithms

^bVariable is age-adjusted.

*Significant at the 0.05 level.

Exhibit 2A.3 Regression Estimates for Allowance Rate Models, 1980–1993

Dependent variable: the log of initial allowance rates

Explanatory variables	DI-only			Concurrent			SSI-only		
	1980–1993	1980–1987	1988–1993	1980–1993	1980–1987	1988–1993	1980–1993	1980–1987	1988–1993
Unemployment rate ^{a,b}									
Current	0.032 (1.42)	-0.002 (-0.07)	0.003 (0.13)	-0.027 (-0.77)	-0.209* (-3.74)	-0.051 (-1.34)	0.000 (0.00)	-0.105* (-2.39)	-0.037 (-1.27)
-1	-0.104* (-4.54)	-0.058 (-1.63)	-0.099* (-3.53)	-0.188* (-5.28)	-0.130* (-2.40)	-0.208* (-4.94)	-0.158* (-5.66)	-0.130* (-2.89)	-0.148* (-4.77)
-2	-0.115* (-5.41)	-0.102* (-3.25)	-0.058* (-2.29)	-0.113* (-3.23)	-0.132* (-2.54)	-0.045 (-1.15)	-0.136* (-4.83)	-0.132* (-3.07)	-0.097* (-3.16)
Sum	-0.187* (-6.5)	-0.162* (-4.4)	-0.154* (-4.2)	-0.328* (-6.5)	-0.471* (-6.1)	-0.304* (-6.1)	-0.294* (-6.9)	-0.367* (-6.2)	-0.282* (-6.9)
Labor force participation ^{a,b}									
Current	0.383* (1.96)	0.726* (2.52)	0.863* (3.44)	-0.358 (-1.13)	-0.335 (-0.75)	0.477 (1.33)	-0.238 (-0.94)	0.071 (0.21)	-0.112 (-0.42)
-1	0.047 (0.27)	-0.034 (-0.13)	0.783* (3.45)	-0.040 (-0.14)	-0.381 (-1.04)	1.066* (2.94)	-0.131 (-0.58)	-0.143 (-0.51)	0.485 (1.74)
-2	-0.404* (-2.40)	0.308 (1.33)	-0.844* (-3.72)	-0.498 (-1.82)	0.175 (0.49)	-1.114* (-3.11)	-0.034 (-0.16)	0.605* (2.22)	-0.345 (-1.25)
-3	0.116 (0.68)	0.620* (2.69)	-0.104 (-0.44)	0.220 (0.80)	0.780* (2.25)	0.254 (0.69)	0.584* (2.71)	0.772* (2.91)	1.128* (3.77)

(continued)

Exhibit 2A.3 (continued)

Explanatory variables	DI-only			Concurrent			SSI-only		
	1980-1993	1980-1987	1988-1993	1980-1998	1980-1987	1988-1993	1980-1993	1980-1987	1988-1993
Sum	0.142 (0.4)	1.620* (3.6)	0.698 (1.4)	-0.676 (-1.2)	0.239 (0.3)	0.683 (0.8)	0.181 (0.4)	1.305* (2.4)	1.156* (2.1)
Manufacturing employment ^{a,b}	-0.074 (-1.47)	0.036 (0.54)	0.152 (1.32)						
AIDS/HIV ^a	0.011 (1.56)	0.001 (0.04)	-0.010 (-1.46)	0.051* (3.98)	0.124* (2.76)	-0.006 (-0.56)	0.042* (3.82)	0.064* (2.02)	-0.008 (-0.90)
Poverty ^{a,b}				0.018 (0.57)	0.065 (1.47)	-0.005 (-0.13)	-0.014 (-0.57)	0.051 (1.37)	-0.017 (-0.64)
GA changes				0.001 (0.22)	-0.012 (-1.85)	0.004* (2.08)	0.002 (0.77)	-0.010* (-2.13)	0.006* (2.83)
AFDC ^a				0.052 (0.71)	0.053 (0.66)	-0.163 (-1.17)	0.166* (2.84)	0.121* (2.06)	0.028 (0.31)
SSI supplements ^b				-0.127 (-1.12)	0.187 (1.23)	0.280 (1.08)	-0.139 (-1.50)	0.022 (0.20)	0.411* (2.18)
Autoregressive parameter	0.547* (15.45)	0.283* (4.81)	0.461* (6.36)	0.620* (17.76)	0.455* (7.95)	0.563* (8.31)	0.685* (20.34)	0.293* (4.86)	0.529* (7.73)
Weighted state intercept	-1.001	-0.924	-0.870	-2.406	1.554	0.140	-0.745	0.750	4.476
Time effects									
1981	-0.052* (-4.29)	-0.083* (-5.29)		-0.056* (-2.60)	-0.100* (-3.84)		-0.025 (-1.45)	-0.057* (-2.65)	
1982	-0.017 (-1.30)	-0.013 (-0.83)		-0.053* (-2.49)	-0.037 (-1.49)		-0.007 (-0.41)	0.004 (0.18)	

1983	0.120*	0.120*	0.218*	0.220*	0.168*	0.168*
	(10.62)	(8.82)	(11.64)	(9.83)	(11.35)	(9.25)
1984	0.110*	0.096*	0.193*	0.160*	0.136*	0.111*
	(8.96)	(6.25)	(9.59)	(6.40)	(8.62)	(5.51)
1985	0.007	0.020	0.011	0.017	-0.022	-0.018
	(0.67)	(1.45)	(0.62)	(0.85)	(-1.59)	(-1.03)
1986	0.021	0.025	0.098*	0.090*	0.064*	0.060*
	(1.92)	(1.93)	(5.70)	(4.69)	(4.66)	(3.67)
1987	-0.057*	-0.063*	-0.131*	-0.150*	-0.115*	-0.126*
	(-5.67)	(-5.30)	(-7.79)	(-7.86)	(-8.75)	(-8.34)
1988	-0.041*		-0.062*		-0.071*	
	(-4.06)		(-3.77)		(-5.48)	
1989	0.002	0.010	0.004	0.003	-0.009	-0.001
	(0.25)	(1.19)	(0.26)	(0.22)	(-0.68)	(-0.10)
1990	0.009	0.022*	0.037*	0.044*	0.077*	0.087*
	(0.87)	(2.61)	(2.31)	(3.34)	(6.15)	(8.05)
1991	0.079*	0.102*	0.061*	0.068*	0.093*	0.091*
	(7.79)	(11.04)	(3.78)	(4.97)	(7.38)	(8.60)
1992	0.059*	0.071*	0.088*	0.094*	0.064*	0.070*
	(5.93)	(9.02)	(5.00)	(5.24)	(4.65)	(5.11)
1993	-0.088*	-0.075*	-0.158*	-0.105*	-0.126*	-0.071*
	(-7.17)	(-6.95)	(-7.58)	(-5.85)	(-7.48)	(-5.03)

SOURCE Lewin-VHI analysis of SSA data on initial disability determinations, using data for all 50 states and the District of Columbia. SSI-only estimates include children

^aVariable is in logarithms.

^bVariable is age-adjusted

*Significant at the 0.05 level.

Exhibit 2A.4 Decomposition of the Growth in Applications and Awards, 1988–1992

	Change in annual applications or awards, 1988–92		Predicted annual growth rate accounted for by								
	Level	Average annual growth rate (%)	Predicted annual growth rate (%)	Population growth and aging (%)	Unemployment rate (%)	GA program cuts (%)	AIDS/HIV (%)	IRCA legalizations (%)	Children in single-parent families (%)	Interaction (%)	Share of growth accounted for (%)
Applications											
DI-total	329,369	8.9	4.1	1.3	1.7	0.1	0.5		0.3	0.2	46
Men	182,649	7.9	5.0	1.3	2.2	0.1	0.9		0.2	0.3	63
Women	146,720	10.5	2.6	1.3	0.9				0.4	0.1	25
SSI-total	434,274	10.5	4.3	1.2	1.1	0.6	0.4	0.2	0.6	0.2	41
Men	227,938	10.7	5.4	1.2	1.6	0.7	0.9	0.2	0.5	0.3	50
Women	206,336	10.3	3.0	1.1	0.6	0.4		0.2	0.6	0.1	30
Awards											
DI-total	197,569	10.0	2.3	1.0	1.0	0.1	0.1		0.0	0.1	23
Men	110,971	8.8	2.8	1.1	1.4	0.1	0.1		-0.1	0.1	31
Women	86,598	12.1	1.3	1.0	0.3				0.0	0.0	11
SSI-total	234,393	12.0	0.9	1.1	0.7	0.6	-0.5	-1.0	0.2	-0.1	7
Men	115,059	12.2	0.7	1.1	0.9	0.6	-1.0	-1.0	0.2	-0.1	6
Women	109,334	11.8	1.1	1.0	0.5	0.5		-1.0	0.1	-0.1	9

SOURCE Simulations based on regression analysis of state data for 1988 and 1992

Comments on Chapter 2

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The econometric findings reported by Stapleton et al. (Chapter 2) demonstrate a strong relationship between state unemployment rates and the growth in applications for Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) programs. The analysis is more sophisticated than previous research demonstrating this relationship, principally because the researchers were able to incorporate effects due to changes in the demographic structure and in how national program rules were implemented in different states (Hambor 1975; Levitan and Taggart 1977; and Lando, Coate, and Kraus 1979).

Given the strength of these findings and the consistency of these results with those of other researchers, policymakers concerned with DI and SSI would do well to evaluate the forces in the economy that give rise to increases in applications during periods of economic uncertainty. In this commentary, I will outline some of the long-term trends that may account for the short-term problems in disability compensation programs. In suggesting a focus on long-term changes, my hypothesis is that persons with disabilities, like minorities and others facing difficulties in the labor market, have experienced a disproportionate amount of the shift in the kind and nature of employment. Cyclical downturns may exacerbate some of these changes, or they may legitimate applications for benefits that would not be approved during good times.

Table 1 lists a few of the changes in the labor market that have occurred during the last two decades or so. As men, especially older men, have exited the labor force, women have entered the labor force in record numbers, a trend especially pronounced among younger women. These changes are associated with the shift from a manufacturing to a service economy, with men disproportionately represented in the former and women in the latter (Yelin 1992). At the same time, the nature of work has changed. Smaller proportions of the labor force

Table 1 Long-Cycle Complements to Short-Cycle Phenomena

-
- Declining employment rates of men, especially older men
 - Rising employment rates of women, especially younger women
 - Declining employment in manufacturing
 - Rising employment in services
 - Increase in part-time employment
 - Increase in contingent employment, including self-employment temporary, leased, and contract workers
 - Declining percentage with employer-provided health insurance and pensions
-

are in full-time, full-year jobs. Greater proportions are self-employed. In addition, greater proportions are not actually hired by the firms for whom they do the work. Instead, they may work on a contract basis or may be employed by a temporary firm. Increasing numbers are employed permanently by a contractor who then “leases” the workers to the firm for whom the work is done (Osterman 1988). Finally, smaller proportions of the labor force report receiving health insurance or pension coverage from their employer (U.S. Bureau of the Census 1993; Yelin 1992).

Employment data do not cover all these phenomena, but the data that are available are consistent with the notion that persons with disabilities experience these trends disproportionately. Table 2 compares overall rates of labor force participation for 1970–1972 and 1990–1992. Among all men, labor force participation rates declined slightly, by 2.6 percent. Among all men age 55 to 64, labor force participation declined more steeply, by 16.0 percent overall. Among all men with disabilities, labor force participation rates declined by more than 15 percent, almost ten times the decline experienced by men without disabilities. Similarly, among men age 55 to 64 with disabilities, labor force participation rates declined by more than twice as much as among men these ages without disabilities. In contrast, among women, those with disabilities shared in the growth in employment among all women. Indeed, young women with disabilities experienced larger relative growth than those without disabilities.

Table 2 Change in Rate of Employment of Persons with and without Disabilities, 1970–1972 vs. 1990–1992

	With disabilities (%)	Without disabilities (%)	All (%)
All men	-15.3	-1.6	-2.6
Men, 55–64	-29.3	-13.7	-16.0
All women	41.5	40.8	39.8
Women, 18–44	49.6	45.5	44.8
All persons	1.1	11.1	13.7

SOURCE: Adapted from Yelin and Katz (1994, Table 1)

Aggregating across a small net decrease in labor force participation rates among all men and a large net increase among all women, overall labor force participation rates increased by 13.7 percent during the period covered. However, the net gain among persons with disabilities was small, while among those without disabilities, it was ten times as large.

Labor force trends among persons with disabilities would appear to be tied to the contraction of manufacturing and the expansion of services (Table 3). In 1970, persons with disabilities held 9 percent of manufacturing jobs. This proportion declined in the ensuing period, so that by 1987 their share of manufacturing jobs fell to 8.3 percent. Meanwhile, the share of jobs in services held by persons with disabilities increased, albeit not in a linear fashion, from 9.8 percent to 11.6 percent, almost 20 percent in relative terms.

The foregoing data are broadly consistent with the notion that persons with disabilities are prone to a last-hired, first-fired phenomenon, displaced in declining industries and at higher rates than men without disabilities, but hired in expanding ones and at similar rates to women without disabilities.

In addition, persons with disabilities would appear to experience short-term trends in employment disproportionately. Table 4 shows labor force participation rates for persons with and without disabilities for the period 1981–1983, a recession; 1983–1990, an expansionary era; and 1990–1992, the most recent recession. In the two recessions, persons with disabilities experienced much larger declines in employ-

Table 3 Share of Employment among Persons with Disabilities, by Sector and Year

	1970 (%)	1982 (%)	1987 (%)
Manufacturing	9.0	8.9	8.3
Services	9.8	9.1	11.6

SOURCE. Author's analysis of *National Health Interview Survey*.

Table 4 Cyclical Trends in Employment of Persons with and without Disabilities (%)

Years	With disabilities	Without disabilities
1981–83	–4.5	–1.0
1983–90	14.0	8.8
1990–92	–4.1	–0.8

SOURCE. Author's analysis of *Annual March Supplement to Current Population Survey*

ment than those without disabilities. In contrast, they experienced a larger relative increase in employment when overall employment rates were growing.

The long-term phenomenon of displacement of persons with disabilities—particularly men—from industries shedding workers and the short-term downturns combine to generate a large pool of applicants for disability compensation programs. In addition, other changes in the nature of work, including the loss of security, the erosion of benefits, and stagnant wages exacerbate these pressures, as does the aging of the population and the growing prominence of conditions that begin earlier in life, including mental impairments and HIV-related illness.

Stapleton and colleagues have improved the confidence with which we can state that economic downturns increase the number of applicants. However, the long-term trends in employment play an important role in creating the pressure that emerges in recessions. Thus, although we confidently can predict that some of the pressure on disability compensation programs will relent with the end of a recession we also can predict that until the employment patterns of persons with disabilities match those of persons without, the pressure will return with the next recession.

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Comments on Chapter 2

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There is an old saying that goes something like the following: “the more things change the more they stay the same.” Perhaps nowhere is this more true in the public policy arena than for income support programs for the disabled. Despite significant changes in assistive technology and in the legal status of persons with disabilities, many of the issues raised in Chapter 2 were addressed in a various forums during the 1970s. How do economic factors influence the demand and supply of income support for the disabled? How can enhanced work incentives in disability benefit programs be implemented without making the programs more attractive to the millions of nonrecipients with significant health problems? Can rehabilitation services be effective in enabling disabled persons to participate more fully in the workplace? How consistent is the administration of the programs across different levels of adjudication, among states, and across different types of medical impairments?

My comments refer to the analysis of initial determinations and allowance rates for the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) programs over the 1976–1993 period. Unlike most studies, this chapter analyses state-level data over the period rather than national data or microdata. The authors argue that this allows them to isolate state-specific effects from the impact of national trends or changes in law. Moreover, the authors analyze the effects for several subperiods in order to examine the stability of their estimates. As they had hypothesized, initial determinations and allowances for disability benefits are strongly correlated with changes in the unemployment rate—i.e., higher unemployment rates lead to increased applications and to more allowances. These findings are similar to those of studies conducted in the 1970s.

NOTE: These comments represent the views of the author and do not reflect any official position of the Congressional Budget Office.

My comments focus on the adequacy of the economic modeling and on some programmatic factors that I think are critical which the authors have either ignored or have treated inadequately. While the authors have done a commendable job in employing state-level data in their modeling, I think they have relied too heavily on their state and time variables to capture the effects of changing program parameters.

The authors address the issues of applying for disability benefits from an economic perspective that individuals with severe health impairments will choose to apply for benefits when the expected returns are high compared with the rewards of market employment. Because this is most relevant for persons applying for DI, my comments will focus on this group of applicants. In their analysis, returns from work are modeled indirectly through unemployment rates, labor force participation rates, and manufacturing's share of total employment. There are no social security-specific variables because the program is not assumed to vary by state. Any differences among states are supposed to be captured within the state dummy variables, and any social security changes would be controlled for through the time variables.

The implications of this specification are that higher unemployment rates increase job search costs, increase worker uncertainty about job stability, and may lead to slower wage growth. Similarly, declining manufacturing employment is assumed to be associated with an increased scarcity of "good" jobs. *Ceteris paribus*, a worsening of any of these conditions would be expected to tilt the scales toward increased applications for DI.

The potential returns from applying for public benefits depend on the level of benefits (both cash and in-kind), the rate at which benefits will change over time, and the expense of applying for the benefits. But an overriding concern is likely to be the probability of actually being allowed to receive the benefits and to retain the benefits over the remainder of the person's working life. Given the relatively stringent eligibility standards for DI, the potential applicant must also weigh the loss of earnings capacity that might occur while the applicant is out of work waiting for a final disability determination. Only a minority of unsuccessful applicants are able to find market employment after they have been denied DI benefits.

The authors use time variables to proxy programmatic changes, but interpreting the variables' coefficients is not straight-forward. The variables may be picking up the impact of macroeconomic or fiscal policy effects not captured by the other instruments in the regression equations. Moreover, even within the arena of social security policy, the coefficients may be influenced by a number of changing program parameters—sometimes operating in opposing directions. During the period, there were significant legislative changes affecting the generosity of benefits and major changes in administrative factors as well. The 1977 and 1980 social security amendments resulted in reduced benefits for a significant portion of the applicant pool, particularly younger adults with families. The phasing-out of student benefits in the Omnibus Budget Reconciliation Act of 1981 also lessened family benefits for applicants with older children. In addition, the administrative climate over the 1977–1982 period was one of much greater scrutiny of applications and allowances, with applications declining by more than 17 percent and initial allowance rates falling from 47 percent in 1977 to 29 percent by 1982. The fact that applications continued to decline amidst the worst recession in the postwar experience is very likely an indication that potential applicants recognized that it was much more difficult to be found disabled by the Social Security Administration than it had been in the previous decade.

As if these programmatic factors weren't enough, several other aspects of program administration also played a role. First, an increasing number of denied applicants are appealing their denials to obtain a hearing with an Administrative Law Judge (ALJ). Moreover, the ALJs are reversing a larger and larger share of the determinations that they review, with the reversal rate climbing from around 60 percent in 1987 to 75 percent in 1992. The result is that more than one-half of the growth in awards from 1986–1992 came from reversals by ALJs. Because the authors' analysis for the 1980–1993 period focuses on initial determinations, this large and critical contributor to program growth is ignored.

Although the quality control data of the Social Security Administration (SSA) have indicated little change in the accuracy of decisions made by state Disability Determination Services (DDSs), there are reasons to suspect that the DDSs may not be as thorough as they were in the early 1980s, thereby leading to higher reversal rates upon appeal.

Despite a 60 percent increase in the number of decisions made by DDSs over the 1986–1993 period, DDS staffing levels were virtually unchanged leading to decisions per staff year rising from 149 in 1986 to 247 in 1993. Such a large increase in productivity over a relatively short period is remarkable, and it would be surprising—at least to certain observers—if none of this gain was in fact attributable to a less comprehensive review of applications by the DDSs.

Another and possibly related pattern is the increasing use of vocational factors in disability determinations. In 1983, only 17.7 percent of awards at the initial determination level depended on vocational factors; the comparable figure for 1991 was 31.7 percent. This trend might be expected to increase the frequency with which the determinations are questioned, because decisions based on vocational considerations rather than solely medical evaluations tend to be more subjective.

Federal court decisions and the SSA's responses to them can also change the calculus facing the potential applicant. Since 1986, SSA has had a policy of acquiescing to circuit court decisions for all cases in that particular circuit. Consequently, instead of having a unified federal policy concerning disability determinations, the standards vary from state to state and from one judicial circuit to another. This raises questions about the interpretation of the coefficients of the state dummy variables as indicators of state-specific effects rather than of programmatic differences.

Despite these limitations, the authors' analysis is encouraging to researchers in the area. Given the aging of the baby-boom population into the stages of life with higher disability rates, it is important to understand better the factors that influence growth in public disability programs. This study and many others like it are necessary if we are to have enough information to adapt our nation's support system for the disabled in an ever-changing society.

Comments on Chapter 2

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The point of departure for the analysis reported in Chapter 2 is that there has been substantial growth in applications and awards under both the Supplemental Security Income (SSI) and Social Security Disability Insurance (DI) disability programs over the period 1988–1992. The chapter represents an effort to look behind the overall trends in program growth and to identify some basic forces that might be contributing to the impressive rates of growth in awards. The authors proceed by gathering evidence from a variety of sources. They make use of econometric analysis, interviews with experts, and documentary materials on program changes. This is a very appealing approach to developing a complete view of the evolution of two complex programs.

In the comments below, I will attempt to accomplish three things. First, I will highlight several key observations made by the authors about the nature of growth during the period. Second, I will review their list of key forces that may be most important for understanding the exceptionally high growth in SSI and DI awards in the mental illness category. Finally, I will comment in some detail on three forces that may offer the most promising explanations and discuss what I found to be most persuasive in the authors' work and where more analysis may be needed.

BASICS

In assessing the growth in disability awards under SSI and SSDI, the authors decompose growth by two variables: 1) program status—DI-only, SSI-only, and DI/SSI concurrently; and 2) impairment class—i.e., disease class. When the data are stratified by these two factors, a number of important observations immediately emerge that serve to

focus the rest of their work. The first observation is that even though changes in both application and allowance rates occurred during the 1988 to 1992 period, it was the rise in application rates that made the largest contribution to the growth in awards for all three program classes (83 percent for DI-only, 91.8 percent for DI/SSI, and 91.2 percent for SSI-only). The second observation is that the growth in both applications and allowance rates for the mental illness class were well above the overall rates of growth for all impairments. For example, for the SSI-only program class, the growth in applications was 86 percent for mental illness, compared to 66.9 percent for all conditions. The third observation is that the growth in the application rate for the mental illness class was above that for all other conditions, thereby driving up the growth in awards for this impairment group above that for all impairments.

EXPLANATIONS

Five basic explanations are offered in Chapter 2. Table 1 associates each type of explanation according to which component of the award rate it is most likely to affect. The likely impact of changes in the Social Security Administration criteria are clear and were relevant primarily to mental illness, so I will not address that factor in any detail here. State outreach activities have also been well documented and discussed by the authors, so that I will not deal with that policy change.

Cost Shifting

This factor involves economic choices that differ from those typically discussed in the context of disability policy. The choices made in cost shifting behavior are generally not initially made by program beneficiaries or potential beneficiaries. Issues related to cost shifting are among the most important discussed by the authors. They present some very suggestive econometric evidence showing that decisions about the structure of state income support programs made by state governments may have large impacts on federal disability programs and the federal budget. The primary policy analyzed by the authors is the impact of

Table 1 Explanations of Observed Trends

Explanations	Applications	Allowance
SSA criteria		√
State outreach	√	
Cost shifting	√	
Recession	√	
Demographics/need	√	

cuts in state General Assistance (GA) programs. They show that the impact on growth in awards for the mental illness category is especially large and significant.

It is important to note that there is more to the cost shifting story than GA cuts. A question implied by the line of research pursued by the authors is: What has changed for states to make cost shifting more attractive in the late 1980s and early 1990s? Part of the explanation offered by the authors relates to fiscal pressure on state budgets due to 1) the economic slowdown of the early 1990s, and 2) limits placed on growth and taxation at the state level. Also growth in nonhealth and human service segments of state budgets, such as prisons, may have caused states to more aggressively pursue other ways to pay for income support and medical assistance for indigent people.

A second explanation is important in explaining the growth of awards for mental disability. During the late 1980s a number of states were decentralizing their public mental health systems. Decentralization was usually accompanied by altered financial incentives for local government. Among the most important changes was abandoning deficit funding of local mental health programs. The result is strong incentives to enroll people in programs where federal dollars can be captured, since localities can keep the state dollars offset by the federal monies. This is an area where more probing would undoubtedly be valuable.

Recession

The authors advance two explanations about how the recession generates the observed pattern of awards by impairment class. The first

argues that the recession hits “marginal” workers hardest. The second posits that the recession causes mental illness. The evidence on the first is reasonably strong. There is also other evidence suggesting that the marginal worker effect is not a transitory phenomenon. Recent papers by Cutler and Katz (1991) and Levy and Murname (1992) show that throughout the 1980s demand for labor shifted away from low-skill, low-education workers. The severely mentally ill disproportionately fall into this group.

The second explanation offered, that recessions cause mental illness, is not very persuasive. If one examines rates of major mental disorders in the 1980-1983 and the 1990-1991 periods, one is struck by the stability in prevalence rates. Moreover, if one examines the research on mental health and work where there exists some opportunity to sequence events, the impact of mental health on work is far stronger than the effect of work on mental illness.

The last point builds on the impact of mental illness on social outcomes such as work. Virtually all the research in this area suggests that mental disorders lead to elevated rates of divorce, early marriage and child-bearing in women, and lower levels of household income. This accords well with the observations that 1) SSI mental illness awardees are more female than the overall SSI population; and 2) females in the mental illness impairment group tend to be older than other SSI females.

CONCLUSIONS

The authors have carefully examined available evidence and used good sense and solid statistical analysis to study SSI award growth by impairment class. They have offered some important empirical clues about what matters most. A particularly unsettling finding relates to cost shifting behavior. The result suggests that state welfare reforms may lead to shifting of responsibility to federal programs and new pressures on the federal budget. I believe they are pointing to key factors that need immediate analysis in order to understand the consequences of our newest political currents as they become policy.

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3 The Impact of Health Care Costs and Medicaid on SSI Participation

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From 1984 to 1993, the disabled Supplemental Security Income (SSI) population grew at an annual average rate of about 9.2 percent (U.S. House of Representatives 1994). This chapter asks whether the availability of public health insurance through the Medicaid program contributed to the caseload growth. I specifically examine the effect of increasing Medicaid's value on SSI participation. I focus my analysis largely on the working-age population by examining the SSI participation behavior of adults between the ages of 18 and 64 using the Current Population Survey (CPS) data spanning the years 1987 to 1992.

Unlike the dramatic Medicaid program reforms for pregnant women and children who might otherwise be eligible for Aid to Families with Dependent Children (AFDC), and for the elderly who might otherwise be eligible for SSI, the extensions of Medicaid for the disabled during the 1980s were relatively minor.¹ Although I cannot use the type of legislative variation that has been used in other research to assess the importance of Medicaid for other populations, I will assess the impor-

NOTE: Work on this chapter was supported by the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services and the Social Security Administration. It solely reflects the opinions and interpretations of the author. This chapter summarizes preliminary findings from a larger study, "Why Did the SSI-Disabled Program Grow So Much? Disentangling the Effect of Medicaid." I am grateful for the helpful comments and encouragement from Janet Currie, Wei-Yin Hu, James Poterba, David Stapleton, Duncan Thomas, and Barbara Wolfe. Kimberly Dietrich kindly provided some of the state-level data used in the analysis. Gloria Chiang and Sheri Zwirlein provided excellent research assistance. Any errors are the sole responsibility of the author. Correspondence may be sent to me at Department of Economics, University of California, Los Angeles, 405 Hilgard Avenue, Los Angeles, California 90095-1477. Telephone: (310)825-5665. Fax: (310)825-9528. E-mail: yelowitz@prometheus.sscnet.ucla.edu.

tance of health insurance for the disabled using variation in Medicaid expenditure across states.

The primary estimation technique (instrumental variables) leads to the conclusion that the rising value of Medicaid contributed greatly to the increase in the SSI rolls in the late 1980s and early 1990s. The instrumental variable estimates suggest that around one-quarter of the increase can be explained by this. In addition, the effects of Medicaid are much more important for the white population than the African-American population. The remainder of the paper is organized as follows. The next section provides some background on SSI and Medicaid and reviews the economic importance of Medicaid for other populations, followed by presentation of some theoretical considerations. Next, a descriptive analysis of the CPS data is presented. The regression results follow, and a final section explores policy implications.

INSTITUTIONAL BACKGROUND

Background on the SSI Adult Disabled and Medicaid Program

SSI was introduced in 1974, replacing state-run programs for the needy aged, blind, and disabled. In 1993, \$23.5 billion was spent on SSI cash benefits for these groups. While the number of elderly and blind SSI participants remained stable, the number of disabled SSI participants increased from 2.9 million recipients in 1988 to 4.0 million recipients in 1992.

In addition to having limited income and assets, an adult between the ages of 18 and 64 must be disabled to qualify for SSI. For purposes of eligibility, disabled individuals are those "unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months." While this definition may appear to be quite objective, eligibility standards, especially for mental impairments, have changed due to legislative, regulatory, and judicial action (U.S. General Accounting Office 1995).

Besides receiving a monthly cash supplement, Medicaid provides the disabled adult with a second valuable benefit from SSI participation. Each state's Medicaid program offers its own package of covered medical services within broad federal guidelines. Federal law requires states to offer eight mandatory services and allows them to offer thirty-one optional services.² Although only 15 percent of all Medicaid beneficiaries are disabled, they account for a much larger share of Medicaid costs. The average spending on disabled beneficiaries amounted to \$7,717 per beneficiary in fiscal year 1993.³ In contrast, average spending on nondisabled recipients was \$2,233.

For disabled adults, there is little opportunity to receive public health insurance except by participating in SSI. A notable exception to this is section 1619 of the SSI law, which is intended to remove some of the work disincentives for the disabled. Section 1619(a) of the law provides continuation of cash benefits on the basis of disability even if earnings are at or above the "substantial gainful activity" level as long there is not a medical improvement in the disabling condition. Under section 1619(b), disabled individuals can continue to be eligible for Medicaid even if their earnings take them past the SSI breakeven point. These provisions turn out to be quite minor, however. In September 1992, just 48,000 of the 2.6 million disabled adults between the ages of 18 and 64 participated in either the 1619(a) or 1619(b) program (U.S. House of Representatives 1993).

Prior Studies of Medicaid and Welfare Participation

While the Medicaid program was introduced thirty years ago, and the program costs have been soaring, only recently has the program garnered much academic interest. The key obstacle in assessing Medicaid's impact on outcomes such as welfare participation has been that eligibility for Medicaid and cash benefits had been highly correlated. The reason that most of the recent academic interest on Medicaid has focused on its interaction with AFDC and not SSI is due to the belief that the behavioral elasticities of the blind, elderly, and disabled are extremely small.

Several studies have examined the impact of Medicaid on AFDC participation and work effort. While some of the earlier studies found that Medicaid had a surprisingly small effect on the AFDC and labor

market decisions of female-headed households, more recent work has found larger effects.

Blank (1989) exploits the fact that the average Medicaid expenditure differs tremendously across states.⁴ She used data on 475 female-headed households from the 1980 National Medical Care Utilization and Expenditure Study (NMCUES). She finds that health problems significantly increased AFDC participation, but that program rules—such as the presence of the Medically Needy (MN) program or the value of Medicaid insurance coverage—had insignificant effects on AFDC usage. The effects on the MN program are not necessarily surprising because eight of the thirty MN states in her sample had a protected income level below the maximum AFDC payment level. More surprising was the robustness of the finding that the mean state-specific Medicaid insurance value did not affect AFDC participation.

Moffitt and Wolfe (1992) construct an individual-specific valuation of health insurance to surmount Medicaid's collinearity with AFDC eligibility and benefits levels. They note that a Medicaid variable that is constructed from a state-specific average may not proxy for the valuation of the Medicaid program by any particular family. They link 545 female-headed households from the 1984 Survey of Income and Program Participation to the 1980 NMCUES for health information to construct a "heterogeneity" index for Medicaid's value based on different health characteristics of the woman and her family. This index yields enormous variation in Medicaid: the total actuarial values range from \$2.18 to \$2,740 per individual, which is then combined across family members to get a family-specific value. Using this approach, they find sizable effects of Medicaid on labor market outcomes: if all workers were covered by private health insurance, AFDC participation would fall by 7.3 percentage points and the employment rate would rise by 16.0 percentage points.

Yelowitz (1995) examines expansions in Medicaid eligibility targeted toward young children between 1988 and 1991. These expansions linked Medicaid eligibility to the federal poverty line rather than a state's AFDC income eligibility limit, thus offering an incentive to leave welfare. He finds that these reforms significantly decreased AFDC participation and increased labor force participation. Among female-headed households, the effects were largest for divorced and separated women, and negligible for never-married women. Yelowitz

(1996b) examines recent changes in the Medicaid program on the SSI participation of the elderly. By using the implementation of a buy-in program for Medicare in the 1980s (which offered a substitute for the cost-sharing provisions of Medicaid), he finds that Medicaid has a bigger impact on exits from SSI for the elderly than the expansions targeted towards children had on exits from AFDC for female heads.

THEORETICAL CONSIDERATIONS

This section briefly explores how Medicaid may influence the SSI participation decision. The disabled individual maximizes a utility function, $U(C, L)$, which is a function of consumption goods (C) and leisure (L). The price of consumption goods (P_C) is normalized to \$1 per unit, while the price of leisure is simply the wage rate (W). He is given a time endowment (T) which he can allocate between work and leisure. He may also receive nonlabor income (N), for instance from the earnings of his spouse. Therefore his full budget constraint is defined as

$$(1) \quad P_C C + WL = WT + N.$$

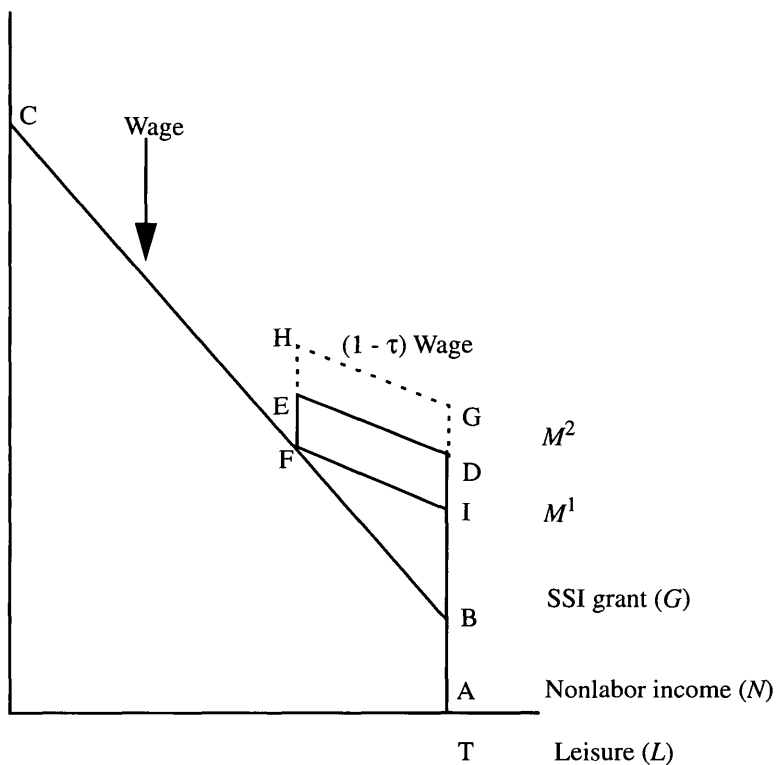
In Figure 3.1, this is represented as the segment ABC. Given this budget constraint, the consumer maximizes his utility.

By introducing the SSI system into the model, the government essentially changes the budget constraint. The program offers a grant (G), which was \$669 per month for a married couple in 1994, and reduces this grant for earning income in the labor market. This reduction, known as the “benefit reduction rate” (τ), is 50 percent of earned income. Therefore the net wage falls to $(1 - \tau)W$ along the initial part of the budget constraint.

The final institutional feature to consider is incorporating Medicaid. Broadly speaking, Medicaid is received when the individual is on SSI and is lost in its entirety after leaving SSI. This discrete drop in benefits is known as the “Medicaid notch”—the design of the program creates a portion of the budget constraint where we would predict that no utility-maximizing person would choose. Consider an individual who lives in

Figure 3.1 Incorporating SSI and Medicaid into the Budget Constraint

Consumption goods (C)



a state where Medicaid is valued at some small amount, M^1 —this can be thought of as the dollars the family would have to spend on medical expenses in the absence of insurance. His budget constraint now is represented by ADEFC in Figure 3.1. Consider a second individual who lives in a different state that has the same SSI grant but a more generous Medicaid program, so that $M^2 > M^1$. In this state, the budget constraint is represented by AGHFC.⁵

Given these different budget constraints, we can predict that the more valuable the Medicaid package, the higher the SSI participation rate. This arises for two reasons. First, increasing the value of Medicaid makes SSI more attractive to those who are ineligible based on their earnings. In this case, some people in this group may reduce their earnings in order to qualify. Second, increasing the value of Medicaid may encourage individuals who were previously eligible but not participating to join the program. In this case, the net benefit may not initially outweigh the stigma cost of participating, but it could after the value of Medicaid increases.

DESCRIPTIVE ANALYSIS

I use the 1988–1993 March Annual Demographic File, which provides retrospective information on family income, health insurance coverage, and program participation from 1987 to 1992 on the noninstitutionalized population. I choose to begin the analysis using the March 1988 CPS onward because several additional questions on health insurance coverage were added that make these later surveys less comparable to earlier ones.⁶ I end the analysis with the March 1993 CPS because the last data on Medicaid average expenditure (the key independent variable) is for fiscal year 1992.⁷

Table 3.1 shows sequential selection criteria and the number of observations eliminated from each screen for each CPS year. I use about one-third of the roughly 900,000 observations contained in the 1988–1993 CPS years. The nine most important exclusions were being over the age of 64, being under the age of 18, living in Arizona, having imputed information on SSI or Medicaid receipt, having an imputed spouse number, being a woman under the age of 45, being a race other

Table 3.1 Sample Selection Criteria, Current Population Survey: March Annual Demographic File

	1988	1989	1990	1991	1992	1993
Initial number of observations	155,980	144,687	158,079	158,477	155,796	155,197
Over 64	18,610	17,740	18,902	19,043	18,954	19,074
Under 18	43,032	39,482	43,281	43,762	42,700	42,901
Lived in Arizona	1,091	1,045	1,078	1,057	993	974
Imputed disability status	287	280	367	291	274	414
Imputed SSI receipt	463	447	427	469	333	354
Imputed SSI value	74	78	86	91	103	96
Imputed Medicaid	1,188	1,067	1,208	1,378	1,429	1,504
Imputed veteran status	495	418	503	524	508	471
Imputed age	280	190	199	142	212	187
Imputed marital status	1,007	900	432	360	272	311
Imputed spouse number	1,212	1,606	2,309	2,223	969	902
Imputed sex	172	166	157	160	140	159
Imputed education	443	328	284	231	302	201
Imputed race	41	38	53	36	33	34
Women under age 45	31,077	28,520	31,789	31,693	31,323	30,611
AFDC participants	276	223	266	266	297	305
Not African American or white	1,952	1,820	2,148	2,290	2,381	2,624
Imputed wage/salary income	548	505	561	514	461	434
Imputed worker's comp income	112	93	106	141	114	95
Imputed veterans benefit	84	78	86	79	69	64
Imputed disability income	95	79	97	81	105	105
Female head with child present	1,164	1,045	1,222	1,234	1,244	1,254
Male head with child present	804	745	885	852	928	959
Related children in family	1,232	1,058	1,249	1,298	1,247	1,262
Final number of observations	50,241	46,736	50,384	50,262	50,405	49,902

than African American or white, living in a single-parent household, and having more related children than own children in a family.⁸ The CPS is, perhaps, more useful than other household data sets because only a small fraction of the adult population participates in SSI-disabled.

Table 3.2 presents some summary statistics for the variables used in the analysis for the entire population, SSI recipients and SSI nonrecipients. Among the entire group, SSI participation is 1.15 percent over the time period, while Medicaid participation is nearly double that number, 2.24 percent. Even with the exclusions of single-parent households above, it is still possible that some families have access to Medicaid from alternative sources rather than through the SSI disabled program. Part of the gap between the two participation rates could result from the existence of the Medically Needy program or the General Assistance program. Among SSI recipients, more than 90 percent also receive Medicaid. There are at least two reasons why Medicaid participation may not be complete for SSI recipients. First, survey respondents might only report that they received Medicaid if they actually went to the hospital. Second, because a number of states require a second application for Medicaid, the respondent may not apply for benefits until they become sick. This table also shows that Medicare participation averages 28.2 percent for SSI recipients and 2.2 percent for nonrecipients. Since an SSI recipient is much more likely to participate in the disability insurance (DI) program than the average member of the population, a prolonged spell can result in Medicare coverage. A nonrecipient can also qualify for DI and thereby qualify for Medicare.

The next five variables in Table 3.2 represent state-level policy variables for the Medicaid and SSI program.⁹ The average Medicaid expenditure for disabled SSI recipients is more than \$2,000 higher than for elderly SSI recipients and more than \$2,400 higher than for blind SSI recipients. The real Medicaid expenditure also exceeds the maximum annual SSI grant (which includes state supplements) by more than \$800. There appear to be small differences in the average levels across SSI recipients and nonrecipients: nonrecipients appear to live in states with a higher Medicaid expenditure and substantially higher SSI grant. On the surface, these differences in average expenditure on Medicaid and average SSI benefits would suggest that higher benefits reduce participation. There are a variety of other factors, such as atti-

Table 3.2 Summary Statistics, 1987–1992

Variable name	Entire sample	Nonrecipients	SSI recipients
SSI participation	0.0115	0.0000	1.0000
Medicaid participation	0.0224	0.0121	0.9074
Medicare participation	0.0247	0.0217	0.2817
Average annual Medicaid benefit for disabled (1990 \$)	\$7,948 (3,662)	\$7,952 (3,665)	\$7,605 (3,361)
Average annual Medicaid benefit for blind (1990 \$)	\$5,529 (5,177)	\$5,525 (5,168)	\$5,890 (5,887)
Average annual Medicaid benefit for elderly (1990 \$)	\$5,936 (3,747)	\$5,935 (3,744)	\$6,015 (3,994)
Annual SSI benefit (1990 \$)	\$7,131 (2,130)	\$7,146 (2,130)	\$5,884 (1,747)
Section 209(b) state	0.2491	0.2490	0.2650
Respondent's age	42.20 (13.14)	42.13 (13.13)	47.91 (13.09)
African American	0.0763	0.0746	0.2231
Resides in central city	0.2122	0.2098	0.3268
Education < 9	0.0640	0.0608	0.3412
9 ≤ Education < 12	0.1013	0.0993	0.2275
Education = 12	0.3779	0.3792	0.2712
Currently married	0.6640	0.6690	0.2316
Number of own children under age 6	0.1932 (0.5249)	0.1950 (0.5270)	0.0357 (0.2406)
Number of own children aged 6 to 17	0.4222 (0.8296)	0.4256 (0.8318)	0.1244 (0.5209)
Male	0.7520	0.7543	0.5503
Veteran	0.2088	0.2104	0.0708
Private coverage	0.7601	0.7681	0.0794

NOTES: Author's tabulations of the March 1988–1993 Current Population Survey Annual Demographic File. Standard deviation in parentheses. Total number of observations is 297,930, of which 3,414 are SSI recipients.

tudes toward welfare participation, that also vary across states and are correlated with benefit levels.

Finally, Table 3.2 presents several demographic characteristics that are included in the regression analysis. On average, SSI recipients are older and less educated. They are also more likely to be single, have fewer children, and be female. Finally, there are large differences in the take-up (and presumably availability) of private insurance coverage. While less than one-tenth of SSI recipients had coverage, more than three-quarters of the nonrecipient sample had private coverage.

Table 3.3 illustrates trends in SSI participation from 1987 to 1992 for the entire sample and for several demographic groups. For the entire sample, the SSI participation rate increased steadily, from 0.98 percent in 1987 to 1.27 percent in 1992. Perhaps the most striking feature of this table is that the level of participation for the African-American population is more than three times as high as for the white population. The trend in participation, however, shows no consistent pattern—the participation rate falls from 3.07 percent in 1987 to 2.81 percent in 1989, and rises to 3.33 percent in 1992. The trend for whites is more clear: the SSI participation rate increased by more than one-third between 1987 and 1992, from 0.81 percent to 1.09 percent, despite varying economic conditions. The different trend foreshadow the different empirical findings for whites and African Americans in the regression analysis below.¹⁰ Finally the table shows that SSI participation rate for adult women was more than 1 percentage point higher than the rate for men, though both groups show a similar increased trend in participation.

It is important to note that program participation in the CPS, as with many other household surveys, appears to be underreported. The national SSI participation rate in the adult population was 1.75 percent in 1992, compared to 1.27 percent in the CPS (U.S. House of Representatives 1993). While participation rates also appear to be consistently under-reported in most states, the discrepancies vary. The participation rate is underreported by 0.07 percentage points in Florida, by between 0.32 to 0.48 percentage points in Illinois, New York, and Texas, and by 0.95 percentage points in California. If the stigma of reporting program participation to a survey taker varies across states, then the patterns we see across states would be likely to emerge.

Table 3.3 Trends in SSI and Medicaid Participation over Time (%)

	Entire sample	African American	White	Men, 18–64	Men, 45–64	Women, 45–64
SSI						
1987	0.985 (0.044)	3.078 (0.280)	0.813 (0.041)	0.727 (0.043)	0.992 (0.091)	1.768 (0.118)
1988	1.067 (0.047)	3.846 (0.327)	0.845 (0.044)	0.777 (0.046)	1.080 (0.099)	1.958 (0.129)
1989	1.073 (0.045)	2.812 (0.265)	0.928 (0.044)	0.776 (0.045)	1.114 (0.096)	1.988 (0.125)
1990	1.155 (0.047)	3.559 (0.300)	0.959 (0.045)	0.813 (0.046)	0.956 (0.089)	2.201 (0.131)
1991	1.319 (0.050)	3.511 (0.293)	1.133 (0.049)	0.992 (0.050)	1.346 (0.105)	2.310 (0.134)
1992	1.268 (0.050)	3.346 (0.288)	1.093 (0.048)	0.942 (0.050)	1.178 (0.098)	2.225 (0.131)
Medicaid						
1987	1.966 (0.061)	5.972 (0.384)	1.638 (0.058)	1.706 (0.066)	1.907 (0.126)	2.756 (0.146)
1988	1.919 (0.063)	6.015 (0.404)	1.592 (0.060)	1.608 (0.067)	1.946 (0.133)	2.872 (0.155)
1989	2.070 (0.063)	5.830 (0.376)	1.756 (0.060)	1.715 (0.066)	2.220 (0.135)	3.160 (0.157)
1990	2.397 (0.068)	6.881 (0.411)	2.031 (0.065)	2.065 (0.073)	2.314 (0.138)	3.411 (0.163)
1991	2.495 (0.069)	6.234 (0.385)	2.179 (0.067)	2.177 (0.074)	2.288 (0.137)	3.461 (0.163)
1992	2.601 (0.071)	6.177 (0.386)	2.299 (0.069)	2.253 (0.076)	2.349 (0.137)	3.622 (0.166)

NOTE: Results from the March 1988–1993 Current Population Survey. Standard errors in parentheses.

Table 3.4 illustrates trends in the average real SSI benefit level and real Medicaid expenditure from 1987 to 1992.¹¹ The average benefit level is computed from the CPS, based on the respondent's state of residence, time period, and marital status. Clearly, two different trends emerge here. Real SSI cash benefits remain largely unchanged. This may not be too surprising since the federal benefit level is indexed for inflation. Medicaid expenditure increased by more than \$3,000 in real terms over this period. This pattern in Medicaid expenditure is similar to the pattern in overall SSI participation rates, and is at least suggestive that a link between the two trends may exist.

Table 3.4 Trends in SSI Benefits and Medicaid Expenditures

	Annual SSI benefit	Average Medicaid expenditure
1987	7,211	6,700
1988	7,074	6,482
1989	7,163	7,771
1990	7,090	8,308
1991	7,112	8,607
1992	7,133	9,730

NOTES: Results from the March 1988–1993 Current Population Survey. All values are in 1990 dollars. Medicaid expenditures is deflated by the medical CPI.

REGRESSION RESULTS

Ordinary Least Squares (OLS) Estimates Using Average Medicaid Expenditure of Disabled

For ease of interpretation, I present results from a linear probability model. The coefficients from the models below therefore may be interpreted as percentage point changes. The basic estimating equation is denoted by

$$(2) \quad \text{SSI_PART}_i = \beta_0 + \beta_1 \text{MEDICAID_BEN}_{jt} + \beta_2 \text{SSI_BEN}_{jt} \\ + \beta_3 X_i + \sum_j \delta_j S_j + \sum_t \delta_t T_t + \varepsilon_i.$$

The subscript i refers to individuals, j to states, and t to time periods. The outcome, SSI participation (SSI_PART) is a binary variable equal to 1 if the respondent participated in the program in the previous year. Two key policy variables that are expected to increase SSI participation are the average real Medicaid expenditure (MEDICAID_BEN) and the average real SSI benefit (SSI_BEN).¹² The vector X contains several individual-level variables that may also influence SSI participation, including the respondent's age and its square, race, residence in a central city, education, marital status, number of children present, gender, and veteran status.¹³ In addition, I amend this basic specification to allow for nationally uniform, time-varying shocks to SSI participation through the inclusion of five time dummies, as well as time-invariant, state-specific shocks to SSI participation through the inclusion of forty-nine state dummies. The coefficients β_0 , β_1 , β_2 , β_3 , δ_j , and δ_t are to be estimated, and ϵ_i is an error term.

By including state-fixed effects (S_j) and time-fixed effects (T_t), the regression framework accounts for some of the other factors that may lead to an increase in SSI participation. I am able to control for the effects of the business cycle (at the national level) with the time dummies. Since other studies have demonstrated that this influences disability insurance applications, it may be reasonable to expect it to influence SSI participation. If changing economic conditions are correlated with Medicaid expenditure, the results will be biased by not accounting for this omitted variable.

Three other explanations for SSI growth, which essentially vary over time, are also controlled for. First, SSI spell lengths may have increased in duration because the Social Security Administration was performing fewer disability reviews. Second, some medical breakthroughs may have allowed disabled people to live longer than they otherwise would have (U.S. General Accounting Office 1995). Third, there has been growth over time in outreach efforts for SSI.

Several unmodeled or unobservable variables that differ across states could bias the results. As shown earlier, the SSI reporting behavior in the CPS data varies by state. If admitting program participation represents permanent differences in attitudes that vary by state, including state-fixed effects will account for this. In addition, the availability of Medicaid coverage varies across states, and this could affect SSI participation. For instance, a poor adult may be able to receive health

insurance coverage through the Medically Needy program or the General Assistance program. It is possible that these variables are correlated with Medicaid expenditure and affect SSI participation. For instance, more liberal states may have these optional programs, which would tend to discourage SSI participation, and have more generous Medicaid services, which would increase average Medicaid expenditure. This type of modeled difference across states would likely lead to the conclusion that increased Medicaid expenditure reduces SSI participation. To the extent that the MN and GA program remain fixed over the time period, this heterogeneity would be accounted for with state-fixed effects. It is plausible that the programs may have changed over time, however. Several states, including Michigan, eliminated their GA program in the early 1990s. If this program change is correlated with Medicaid expenditure, then even the model that includes state- and time-fixed effects will be biased. To account for these possibilities, I include four additional variables that vary over time at the state level: 1) the Medically Needy protected income level for one person, 2) measures of the state unemployment rate, 3) labor force participation, and 4) a measure of cuts in a state's General Assistance program.¹⁴

The results in the first column of Table 3.5 show that the OLS estimate of β_1 is statistically insignificant and economically unimportant. The point estimate suggests that increasing Medicaid by \$1,000 leads to an increase in SSI participation of 0.005 percentage points. Since Table 3.4 illustrates that average Medicaid expenditure for the entire sample rose in real terms from \$6,700 in 1987 to \$9,730 in 1992, this coefficient estimate implies that increased Medicaid expenditure raised the probability of SSI participation by 0.015 percentage points. Since SSI participation for the whole sample increased from 0.98 to 1.27 percent (or 0.290 percentage points), the OLS estimate implies that rising health care costs can explain less than six percent (0.015 divided by 0.290) of the rise in SSI participation.

On the other hand, this model shows that increasing the SSI benefit increases SSI participation, though it is only marginally significant. Raising the benefit by \$1,000 results in an increase in SSI participation of 0.053 percentage points. While this estimate could be an explanation for the rise in participation, Table 3.4 shows little change in cash benefits over time. The CPS estimates indicate that from 1987 to 1992, SSI benefits fell slightly in real terms from \$7,211 to \$7,133. While the

Table 3.5 Linear Probability Model from Full Current Population Survey Sample on SSI Participation

	(1) Ordinary least squares	(2) Instrumental variables
Medicaid benefit/10 ⁶	0.0510 (0.0950)	0.2453 (0.1536)
SSI benefit/10 ⁶	0.5397 (0.3201)	0.5284 (0.3201)
Section 209(b) state	0.0035 (0.0038)	0.0038 (0.0038)
Per capita GA cut	-0.0002 (0.0001)	-0.0002 (0.0001)
Unemployment rate/10 ⁵	0.2737 (0.2321)	0.1761 (0.2372)
Labor force participation/10 ⁶	-0.0035 (0.0012)	-0.0030 (0.0012)
Annual Medically Needy income limit/10 ⁶	-0.0626 (0.6884)	0.0159 (0.6396)
Respondent's age	0.0016 (0.0001)	0.0016 (0.0001)
Age ² /100	-0.0012 (0.0001)	-0.0012 (0.0001)
African American	0.0164 (0.0007)	0.0164 (0.0007)
Resides in central city	0.0017 (0.0005)	0.0018 (0.0005)
Education < 9	0.0520 (0.0008)	0.0520 (0.0008)
9 ≤ Education < 12	0.0176 (0.0006)	0.0176 (0.0006)
Education = 12	0.0032 (0.0004)	0.0032 (0.0004)
Currently married	-0.0300 (0.0010)	-0.0299 (0.0010)
Number of own children under age 6	0.0042 (0.0004)	0.0042 (0.0004)
Number of own children aged 6 to 17	0.0001 (0.0002)	0.0001 (0.0002)

Table 3.5 (continued)

	(1)	(2)
	Ordinary least squares	Instrumental variables
Male	-0.0039 (0.0005)	-0.0039 (0.0005)
Veteran	-0.0048 (0.0005)	-0.0048 (0.0005)
Observations	297,930	297,930
Adjusted R^2	0.0363	0.0363

NOTES. Results from the March 1988–1993 Current Population Survey. Standard errors in parentheses. All models also include state-fixed effects (49), time-fixed effects (5), and a constant term. Instruments in column 2 are average Medicaid expenditures for the blind and elderly.

cash benefits increase the probability of participation, they cannot explain the growth in participation. The table also shows the effect of a third policy variable, whether the respondent lived in a Section 209(b) state. Since very few states changed status from Section 209(b) to Section 1634 during the period, the effect of 209(b) status is essentially subsumed in the state-fixed effect. The estimate in this column is not significantly different from zero and economically small.

The labor market variables enter the model with the expected signs: increases in the unemployment rate raise SSI participation (though it is imprecisely estimated), while increasing labor force participation lowers SSI participation. Not surprisingly, the MN variable is imprecisely estimated: after controlling for state-fixed effects, there is little independent variation in the income limit. Contrary to expectations, the parameterization of the GA cut variable is “wrong-signed” and marginally significant. While larger GA cuts (indicating a larger positive value) should presumably increase SSI participation (and therefore enter into the model with a positive sign), instead the sign is negative.

Education and family structure appear to play important roles in SSI participation. Relative to those with a college degree, individuals with less than nine years of education are 5.2 percentage points more likely to participate in SSI, while those with less than twelve years are 1.8 percentage points more likely to participate. In addition, those who only completed high school are significantly more likely to participate

in the SSI disabled program than those who entered college, but the economic impact is not as dramatic as for the other educational groups. Being married lowers SSI participation by 3 percentage points, while having an additional young child increases the probability of participation. The positive effect of young children may indicate a “spillover” effect on SSI participation resulting from the Supreme Court’s *Sullivan v. Zebley* decision. It is well known that the number of children on SSI skyrocketed during this time frame, and once a household enrolled one member on SSI, its propensity to enroll other members may increase.

The signs of the other demographic and location-specific characteristics enter into SSI participation largely as expected. SSI participation increases with age, but at a decreasing rate. Since many physical disabilities may not occur until later ages, this finding makes sense. Relative to whites, being African American raises the probability of SSI participation by 1.64 percentage points. This is consistent with the continually higher levels of participation in Table 3.3. Living in a central city raises SSI participation. This may occur for two reasons. First, those in central cities may have more access to welfare and social security offices or health care facilities, which lowers the transaction costs of SSI participation and raises the value of Medicaid, respectively. Second, if living in a central city means that individuals have better information about the programs, they would be more likely to participate. Finally, being male or being a veteran significantly lowers SSI participation.

Instrumental Variables (IV) Estimates Using Average Medicaid Expenditure of Elderly and Blind as Instruments

The prior estimates using variation in disabled expenditure may be biased if changes in the underlying health of the SSI population affected both Medicaid’s value and SSI participation. If the eligibility criteria for disability becomes less strict, for example, so that people who were previously found to be ineligible are now deemed eligible for SSI, then the former estimates of β_1 would be too small. In the Supreme Court’s *Sullivan v. Zebley* decision, such a reevaluation occurred for children, and this may have had spillovers into the adult population.¹⁵ In addition, if states attempted to shift their GA and MN beneficiaries onto the SSI rolls, and if these groups happened to be

healthier, the OLS results would be biased. In this case, the marginal disabled SSI recipient will likely incur less health care expenditure than the average recipient, so that average expenditure falls while SSI participation increases. This would lead to a spurious negative correlation (which in turn biases the coefficient downward).¹⁶

To correct for this simultaneity bias, I instrument for average Medicaid expenditure of the disabled in each state-year cell with the corresponding average expenditure of the elderly and of the blind. These variables reflect different aspects of the state's Medicaid program that influence its value, such as variation in health care prices, access to care, and scope of services. Since the criteria to qualify as a blind or elderly recipient is more objective, these instruments are unlikely to be correlated with changing definitions of disability.¹⁷

At this point, it is important to discuss the validity of the instrumental variables. Expenditure for neither the blind nor elderly fully captures the breadth of a state's Medicaid program—the blind tend to be healthy, and the differences in elderly expenditure may reflect differences in nursing home access. This does not invalidate the estimation technique, however. Two conditions must hold: the instruments must be correlated with the endogenous regressor and uncorrelated with the error term. While the expenditure on the elderly and blind is not perfectly correlated with expenditure on the disabled, they are extremely powerful instruments—the first stage *F*-statistic (predicting Medicaid expenditure for the disabled) is over 10,000. In any case, if the instruments were weak predictors, the instrumental variable estimates would be biased toward the OLS estimates so I would be unlikely to find any effect of Medicaid.

By instrumenting, the coefficient estimate in the second column of Table 3.5 increases dramatically, consistent with changing the budget constraint in Figure 3.1. Increasing Medicaid expenditure by \$1,000 is now associated with an increase in the probability of SSI participation by 0.024 percentage points. Again, taking the rise in Medicaid expenditure from Table 3.4, this estimate implies that rising health care costs from 1987 to 1992 raised the probability of participation by 0.070 percentage points. Since the total increase in SSI participation was 0.290 percentage points, the point estimate indicates that rising health care costs can explain around one-quarter of the rise in SSI participation. The point estimates on the other explanatory variables remain largely

unchanged, both in significance and in magnitude. By comparing the coefficient estimates on Medicaid expenditure and SSI benefit levels, a \$1,000 increase in SSI leads to a similar rise in participation as a \$2,170 increase in Medicaid expenditure.

Recall that Table 3.3 showed dramatic differences in SSI participation rates across racial lines. This may suggest that rising health care costs have different effects on the African-American and white populations. The two columns in Table 3.6 divide the sample into whites and African Americans, respectively. Again, I instrument for average disabled Medicaid expenditure with average blind and average elderly Medicaid expenditure in each state-time cell.

The Medicaid coefficient estimates for the white population are slightly larger than the IV estimates from the second column of Table 3.5. The effect of Medicaid expenditure increases slightly, and the coefficient is more precisely estimated than in the full sample. Cash benefits appear to play a less important role in SSI participation than for the full sample. In contrast, Medicaid appears to play little role in the SSI participation decision of African Americans, though the coefficient is imprecisely estimated. While the policy variables explain little of the SSI participation decision for African Americans, the demographic variables on education, family structure, gender, and veteran status are all significant predictors of participation.

CONCLUSIONS AND EXTENSIONS

This chapter finds that rising health insurance costs are an important reason for participation in the SSI-disabled program. By using a large, nationally representative household data set, I find that around one-quarter of the rise in SSI participation may be due to increases in the value of Medicaid. The effects appear to be concentrated in the white population, not the African-American population.

I show that ordinary least squares estimates of Medicaid effect produce badly biased estimates, since the health status of the disabled population was changing. The estimates using instrumental variables produce much stronger positive effects of Medicaid on SSI participation. Is it reasonable to assume that the health status of the disabled

Table 3.6 Differences in Medicaid's Impact Based on Race

	(1) White	(2) African American
Medicaid benefit/10 ⁶	0.2828 (0.1421)	0.2118 (1.6752)
SSI benefit/10 ⁶	0.3014 (0.3043)	1.4481 (2.3016)
Section 209(b) state	0.0041 (0.0035)	0.0432 (0.1305)
Per capita GA cut	-0.0001 (0.0001)	-0.0007 (0.0007)
Unemployment rate/10 ⁵	0.1695 (0.2256)	3.0078 (16.5125)
Labor force participation/10 ⁶	-0.0014 (0.0012)	-0.0241 (0.0093)
Annual Medically Needy income limit/10 ⁶	0.5453 (0.6200)	-5.6620 (3.4722)
Respondent's age	0.0016 (0.0001)	-0.0003 (0.0006)
Age ² /100	-0.0014 (0.0001)	0.0017 (0.0007)
Resides in central city	0.0014 (0.0005)	0.0037 (0.0027)
Education < 9	0.0475 (0.0008)	0.0944 (0.0048)
9 ≤ Education < 12	0.0159 (0.0006)	0.0323 (0.0035)
Education = 12	0.0030 (0.0004)	0.0095 (0.0027)
Currently married	-0.0265 (0.0010)	-0.0546 (0.0067)
Number of own children under age 6	0.0032 (0.0003)	0.0132 (0.0026)
Number of own children aged 6 to 17	0.0000 (0.0002)	0.0022 (0.0015)
Male	-0.0024 (0.0005)	-0.0248 (0.0035)

Table 3.6 (continued)

	(1) White	(2) African American
Veteran	-0.0043 (0.0005)	-0.0073 (0.0032)
Observations	275,187	22,743
Adjusted R ²	0.0303	0.0591

NOTES: Results from the March 1988–1993 Current Population Survey. Standard errors in parentheses. In addition to the coefficients shown, all models also include state-fixed effects (49), time-fixed effects (5), and a constant term. Instruments in columns 1 and 2 are average Medicaid expenditures for the blind and elderly.

changed so dramatically while the health status of elderly and blind did not? Knowing the answer to this question is vital for assessing the validity of the instruments. It is difficult to believe that the health status of the blind changed dramatically from 1987 to 1992, and the instrumental variables results do not change markedly by only using the Medicaid expenditure for the blind as an instrument. On the other hand, it is possible the health status of the elderly on SSI may have changed because the Qualified Medicaid Beneficiary (QMB) program in the 1980s and 1990s offered an incentive for the elderly to leave SSI and still retain Medicaid. Around 1.4 million elderly were enrolled in this program in December 1992; however it is not known whether the health status of former SSI recipients who left and enrolled in the QMB program was better or worse than the average SSI recipient.

Are the estimated effects too large? At this point, it is important to remember about the recent empirical findings on other Medicaid populations. In other work, Yelowitz (1995, 1996b) finds significant effects on AFDC participation for female household heads and on SSI participation for elderly households. In those studies, the policy experiment was somewhat different from this study, however. The policy changes for young children and for the elderly offered Medicaid benefits without necessarily applying for AFDC or SSI, which therefore offered incentives to leave those welfare programs. In a closer comparison to this study, Moffitt and Wolfe (1992) attempt to value Medicaid and find strong effects on AFDC participation for female-headed households. It is plausible to think that health insurance plays a more important role in the economic decision making of disabled adults than either female

household heads or elderly households. Therefore, the stronger results here appear reasonable.

The findings have several policy implications for program design. Since Medicaid is an important determinant of SSI participation, offering health insurance without the need to participate in SSI may reduce total costs. This could occur because disabled adults may then forego the cash benefits from SSI—which amounts to more than \$20 billion annually. On the other hand, some disabled adults who were not previously participating in SSI, because the program may be stigmatizing, may decide to participate in a Medicaid-only program, which could increase costs. In theory, this could occur through the Medically Needy program. The program typically has lower income limits than SSI and fewer covered services under Medicaid than for categorically needy recipients. Thus, Medically Needy may not offer enough of an incentive for the disabled to leave. Therefore modifications of existing SSI program rules concerning Medicaid may have an impact on total costs.

Notes

1. See Yelowitz (1995, 1996b) for explanations of the Medicaid reforms for children and the elderly, respectively.
2. Required coverage includes inpatient and outpatient hospital services, rural health clinic services, federally qualified health center services, laboratory and x-ray services, nursing facility services for individuals under age 21, family planning services, physicians' services, home health services for any individual entitled to nursing facility care, nurse-midwife services, and services of certified nurse practitioners.
3. These expenditure numbers include spending on intermediate care facilities and skilled nursing homes. I believe that it is important to include these numbers because access to these facilities is indeed part of Medicaid's value. While it is certainly true that only a small portion of the population will be institutionalized, it is also true that a small portion will use any particular Medicaid service. Therefore excluding this expenditure seems ad hoc.
4. Winkler (1991) takes a similar approach.
5. It is not necessarily clear that an increase in Medicaid spending per beneficiary translates into an increase in the value to individuals, however. For example, as real payments to doctors or other service providers increase, the individual getting the same service at higher cost may not have greater value. It is much more difficult to obtain a family- or individual-level valuation, although other studies, such as Moffitt and Wolfe (1992) have tried.

6. These questions specifically dealt with the health insurance status of children in the household. Survey respondents were effectively asked twice about the health insurance coverage of children in the household.
7. Furthermore, I restrict my attention to adults who would be unlikely to collect Medicaid from a program other than SSI. Thus, I exclude single-parent households with children under age 18 (who may be eligible for Medicaid under the Aid to Families with Dependent Children, or AFDC, program). I also eliminate women between 18 and 44 from my sample. For this group, the primary health insurance expense would be due to pregnancy, and other reforms in the Medicaid program from 1984 onward could bias the results for SSI participation. To accurately examine the impact of Medicaid for these groups, not only would the expansions need to be parameterized, but the joint AFDC, SSI, and labor force participation decisions would have to be modeled, which is beyond the scope of the current paper. See Currie and Gruber (1994) for an analysis of these Medicaid pregnancy expansions.
8. I follow Winkler (1991) in excluding Arizona from the analysis. Arizona had a Medicaid demonstration project for part of the time period I examine, and data on average Medicaid expenditure are not available.
9. All of these variables were obtained from various editions of U.S. House of Representatives (1993).
10. Although the difference for African Americans is striking, it is not all that surprising for a means-tested program.
11. These are deflated using the CPI-U for the SSI benefit level and the medical services CPI for Medicaid.
12. I include a third state-specific variable, whether or not the respondent lived in a section 209(b) state. Several states changed status between section 209(b) and section 1634 between 1987 and 1992, but in models with state-fixed effects, this effect is never reliably estimated. I would expect the coefficient to be negative—living in a state with extra application procedures for Medicaid increases transaction costs and thus lowers SSI participation.
13. I include many of the same demographic variables that Winkler (1991) includes in her AFDC participation equation using the CPS. In addition, I tried restricting the sample to adults aged 22 to 64 since some rules which govern the SSI eligibility for a child who reaches the ages of 18 to 21 have changed over time. The results on the Medicaid and SSI variables are similar to the coefficients reported here.
14. These variables are carefully explained in Stapleton et al. (Chapter 2). It is possible that the inclusion of the labor market and General Assistance variables reflect outcomes of the same utility maximization process that lead to SSI participation, since these are constructed from participation rates rather than changes in the budget constraint. However, it is more likely that they are instead driven by changes in the business cycle, so that they are not endogenous, at least at the person-level.
15. The Supreme Court ruled that disability standards for children may not be narrower than those applied for adults. As a result, eligibility criteria for children are based on a child's developmental delay and limitations on the child's ability to engage in age-appropriate activities of daily living. This has increased the number

of children classified as disabled. Prior to 1990, the same disability criteria that applied to adults were also applied to children.

16. This argument suggests growth in SSI-disabled expenditure should be slower than other groups who use similar Medicaid services, for whom the health mix was not changing. My calculations show average expenditure on the disabled grew 41 percent in real terms from 1987 to 1993. The growth rates for the blind and elderly were much greater, 77 and 144 percent, respectively.
17. An aged person age 65 and over with limited income and resources can qualify under the aged SSI program, while blind individuals are defined as those with 20/200 vision or less with the use of a correcting lens in their better eye, or those with tunnel vision of 20 degrees or less.

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Comments on Chapter 3

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I like the paper by Aaron Yelowitz (Chapter 3) and believe its general finding that Medicaid is a significant factor in explaining the recent growth in numbers of adult Supplemental Security Income (SSI) recipients. We know that Medicaid has been growing—from 22.9 million recipients (\$48.7 billion expenditures) in 1988 to 35.1 million recipients (\$107.9 billion expenditures) in 1994. Medical expenditures have increased tremendously over the period studied, and an existing body of literature on other population groups finds similar results: that publicly provided health insurance is an important determinant of individual choices concerning both age of retirement and applications for Aid to Families with Dependent Children.

The theoretical framework is one established in the literature and makes sense as applied here. It is a choice-based, utility-maximization model in which the provision of Medicaid (an either/or or a 0/1 choice, the so-called Medicaid notch) is incorporated into an individual's *choice*, selecting the option that maximizes well-being. Well-being is proxied by potential income (including the value of benefits in-kind) in each of the two options, SSI with Medicaid versus working. Health is not fully incorporated into the model; Yelowitz discusses the need to incorporate health into his model, but at the moment, well-being under the work option depends only on earnings for each individual. Health limitations are not incorporated, and although Yelowitz mentions this omission, he never discusses how it might influence the model. For consistency, he needs to incorporate the probability of being offered private insurance and a value for it if it is offered by an employer.

One further comment on the model is that most states have a spend-down provision that allows certain persons to obtain Medicaid without being on SSI, and many states offer medical care coverage through another program, General Assistance (GA). Hence, a number of persons are potentially eligible for Medicaid or GA, and the probability of

eligibility and the speed by which they could be found eligible are also factors to be considered. These factors are not incorporated into the model.

In regard to the data and empirical work, most of the exclusions seem reasonable, except perhaps for those eliminated because they have imputed information—but this is a problem that plagues all of us doing empirical research. In this case such exclusion seems quite minor and pertains to a very small proportion of the observations.

There are a few puzzles in the data.

1. The author reports Medicaid expenditures for disabled persons that are too high according to official figures in *Health United States, 1995*. In these official statistics, average spending in 1993 was \$7,706, compared to Yelowitz's reported value of \$9,226. The author states that his figure includes nursing home expenditures (see note 3 in Chapter 3), but so do the official statistics as reported in Table 139 in *Health United States, 1995*, which are based on Health Care Financing Administration data. A similar issue arises with the data used for Medicaid in the study. Why these differences?
2. It would be meaningful to see a comparison of the insurance coverage in a matched sample according to education, age, and marital status. I do not think that a comparison to the total U.S. population is very informative.

Many of the results seem plausible. A few raise questions about the reasonableness of the estimation. Perhaps the most puzzling involves the dummy variable included as an indicator of 209(b) states, which are more stringent with regard to Medicaid eligibility: not all persons eligible for SSI are eligible for Medicaid. This leads to an expected negative sign on the variable for a 209(b) state, yet the result is positive, though not significant. The other puzzle is why the number of children should be positive when there are no dependent benefits associated with SSI and, hence, no additional benefit to families with children. The author's explanation of a link to the *Zebley* case seems inadequate (unlikely) as an explanation.

Yelowitz appropriately raises the issue of endogeneity of the value of Medicaid. His argument is that if the benefits become more gener-

ous, an increased number of marginal persons (i.e., those who tend to be healthier and use less medical care) will be attracted to SSI and Medicaid. This means that as more people join the ranks of those on these programs, the expected benefit, at least as measured in this study, will fall. This fall will not reflect *decreases* in program generosity, but rather *increased* generosity. Because of this potential problem, instrumental variables are used in the next set of estimates. But the choice of instruments is not compelling, in the following ways.

Expenditures on the blind and the elderly are used as instruments. According to the statistical test reported, they work well. Yet at least on an intuitive basis, neither of these groups seems able to fully measure the breadth of a state's Medicaid program. Blind persons tend to be healthy, so their medical expenditures will not reflect the scope of a state's Medicaid program. And differences in expenditures of the aged across states are likely to reflect differences in nursing home access rather than in breadth of acute and chronic coverage. Preferable instruments would seem to be expenditures by disease category. This would require background information on the basis for a disability determination, which is not available in Current Population Survey data. One suggestion, drawing on an alternative data set, is to identify groups by expected expenditures—grouping, for example, into the following four categories: low cost, low technology, high technology, and experimental and related groups. This also suggests that using SIPP data may be preferable, although the time span would be shorter.

Finally, other factors that may or may not be fully taken into account may help explain the growth in SSI and Medicaid enrollment among adults.

- Reduced coverage of private insurance over this same time period, resulting in more co-payments and less coverage for other family members. This could explain some of the growth in SSI and Medicaid spending.
- Poor health, which reduces potential wages. This is also part of the utility-maximization framework and should be incorporated into the model.
- The increase in the number of AIDS cases. Many of these people are covered by SSI and Medicaid; \$55 million was spent on AIDS in 1989, \$280 million in 1992 and \$500 million in 1994. The

number of persons covered for AIDS differs substantially across states.

- There may also have been significant changes in the treatment and diagnosis of many illnesses over this period, which would also influence expenditures over time.
- Some drug addicts and alcoholics have become recipients of SSI and Medicaid during this period, and 75 percent of these persons are in two states—California and Illinois. If their use of medical care differs significantly from that of traditional recipients, the means of these states would be influenced by these persons in ways that would not represent *true* differences in the expected value of Medicaid across the states.

This type of research could be improved through the use of data sets, such as the Survey of Income and Program Participation, with more information on health conditions, as well as through the use of a new data set—the supplement to the National Health Interview Survey, which oversamples and resamples persons with disabilities. Use of such data may allow some additional work on how to create better groupings by diagnosis to predict the value of Medicaid, in particular to test whether those requiring greater expenditures are more likely to apply.

Given the available data, this author has done a good job of exploring the role of Medicaid in explaining the recent growth of SSI. The chapter provides evidence to convince us that Medicaid is an important factor in accounting for that growth.

4 Determinants of Duration on the Disability Rolls and Program Trends

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Discussions of factors causing the increases in social security disability caseloads usually feature rises in the number of awards. Changes in the number of new awardees, however, do not directly translate into caseloads; duration is the essential link. Those who stay on the rolls for a long time contribute disproportionately to caseloads, and therefore to program cost. A better understanding of factors affecting duration on the disability rolls should contribute to improvements in our ability to project future caseloads, to assess the effects of policy alternatives on caseloads, and to identify promising interventions designed to contain caseload growth. Duration on the rolls can be seen both as a function of factors affecting selection into the Supplemental Security Income (SSI) and Social Security Disability Insurance (DI) programs and as the result of factors directly affecting program exits and reentry. Selection into the SSI and DI disability programs is affected by the disability and economic criteria of eligibility. SSI and DI share the disability selection criteria. The severity of disability criteria exerts two contrasting effects on duration: the relatively high mortality risk reduces expected duration, while low recovery associated with severely disabling conditions increases it.

SSI and DI differ in terms of economic eligibility. DI requires that the person meet an insured status based on recent work activity. It is important that, while the DI-insured status is a precondition of entry, it does not affect exits from the rolls. In contrast, SSI is means-tested, and therefore financial eligibility factors (changes in income and assets) form a potential source of exits and reentry. Some people qualify for both SSI and DI benefits. Over the years, the disability and eco-

nomic eligibility criteria of DI and SSI interact with largely exogenous demographic and economic factors to influence duration.

Programmatic variables also directly affect duration by influencing exits and reentry. Such variables include work incentive provisions, continuing disability reviews, vocational rehabilitation, and various rules concerning suspensions, terminations and return to the rolls. Some of these variables directly affect program eligibility (e.g., Continuous Disability Reviews [CDRs]), while others are expected to affect duration on the rolls through altering behavior (e.g., vocational rehabilitation). All of these variables affect the generosity of the benefits and therefore may have indirect effects through altering application behavior.

The purpose of this paper is to provide an overview of the factors affecting duration on the DI and SSI disability rolls based on previous studies and original research by the authors, and to analyze implications for caseload growth, projections, and policies. Several previous studies analyzed duration on the SSI and DI rolls on the basis of micro data from the Social Security Administration's administrative records systems. Most described the experiences of a single annual cohort of awardees using a fixed (e.g., two- or four-year) follow-up window (e.g., Treitel 1979; Bye, Riley, and Lubitz 1987; Scott 1989; Bye et al. 1991). Hennessey and Dykacz (1992, 1993) compared two annual cohorts on the basis of a four-year follow-up window. With the single exception of Scott (1989) focusing on SSI disability stays, the above studies analyzed duration on the DI rolls among DI awardees, some of whom may have had concurrent unobserved SSI disability benefit receipt experience. Two studies (Hennessey and Dykacz 1989; Rupp and Scott 1995) utilized a much longer follow-up observation period (nine years and ten years, respectively), and used statistical methods to adjust for the lack of complete data on the completion of first DI spells (right censoring) and on first spell and total duration (including multiple spells) data for the SSI disability program. These are the only two previous studies that presented mean duration statistics that are adjusted for censoring bias. Hennessey and Dykacz (1989) based their estimates on the experience of a single (1972) annual cohort of DI awardees, while Rupp and Scott (1995) utilized a data file containing multiple annual cohorts of SSI disability awardees and based their estimates of mean duration on the experience of persons first awarded pay-

ments during 1974–1982. They also conducted comparisons of duration patterns in DI, SSI, and Aid to Families with Dependent Children. Other relevant previous studies looked at terminations (Schmullowitz 1973), analyzed the postrecovery experience of DI beneficiaries (Dykacz and Hennessey 1989), and compared the health and earnings of DI beneficiaries with the experience of rejected disability applicants (Bound 1989). Treitel (1979) analyzed the outcomes of appeals by initial DI denials and presented six-year follow-up data on death rates among rejected applicants. Only one previous study focused on the implications of trends in the composition of disability awardees on duration (Chirikos and Rupp 1992; Chirikos 1993). The study was based on aggregate data on awardees and a secondary analysis of micro data on duration, but was limited to DI.

AWARDEE CHARACTERISTICS AND DURATION

In this section we describe the effects of key awardee characteristic variables on duration and analyze the effect of the changing mix of awardees along these dimensions on trends in expected duration on the DI and SSI disability rolls. We will focus on the effects of age, gender, and diagnosis.

- Age is expected to affect duration because of its negative effect on the length of exposure to potential program participation, the positive relationship between age and mortality risk, and the negative relationship between age and the probability of return to work. The first two factors suggest a negative relationship between age at award and duration, while the third one is expected to affect duration in the opposite direction.
- Gender may affect duration because of the lower mortality risk of females in the general population, although this may be clouded by selectivity in the award process. Also, work-related suspensions may be affected by gender differences, since men and women differ in work histories and work-related incomes.

- Diagnosis fundamentally affects mortality risk, as well as the nature and severity of functional limitations and work disabilities affecting the opportunity costs of return to work.

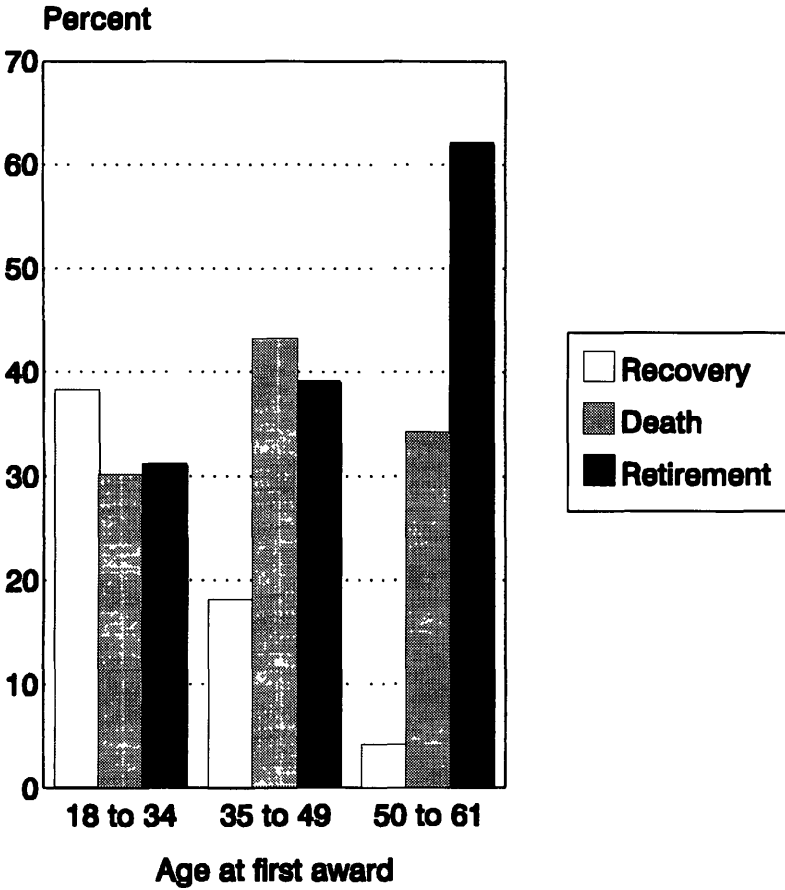
We will analyze duration on the DI and SSI disability rolls separately due to the current lack of comprehensive event history data for both programs within a unified framework. In the first half of this section we will focus on DI awardees, some of whom received SSI benefits for many years, while others, particularly those applying for both programs, received them for a short period of time. According to our previous estimates (Rupp and Scott 1995), approximately 75 percent of awardees applying for both DI and SSI benefits complete their first SSI payment eligibility spell for reasons of excess income, presumably largely as a result of the start of DI payments. We can infer that the bulk of the disability payment experience of these concurrent awardees consists of duration on the DI rolls. Since concurrent awardees are implicitly reflected in the DI duration data, and because of the predominance of early SSI exits for this group, the second half of this section focuses on nonconcurrent SSI awardees, i.e., persons initially eligible for SSI but not DI payments.

Duration on DI: Characteristics and Trends

There are three principal reasons for the suspension or termination of DI benefits: medical or work-related recovery, death, and retirement (conversion to the old-age component of social security at age 65). Overall, more than half of first DI disability spells end with retirement, more than a third are terminated due to death, and only 11 percent recover. Gender differences are dominated by the lower mortality risk of females. There is a strong negative relationship between age and the probability of recovery (Chart 4.1).

As age at award increases the probability of death increases, but the numbers also indicate that the competing outcome of conversion to the retirement program overtakes as the main reason for termination at the older age groups. Diagnostic differences are also marked, particularly among younger awardees. We note that changes in program rules, to be discussed later in more detail, play an important role in a beneficiary's recovery. In particular, changed work incentives, such as the introduction of the extended period of eligibility, changes in the number of

Chart 4.1 Reason for First DI Exit



CDRs, and the introduction of the medical improvement standards might have substantially altered the probability of recovery during the last two decades.

The net effect of age on expected duration is negative (Table 4.1). While overall expected length of first spells varies substantially by diagnosis—ranging from the low of 3.4 years for neoplasms to the high of 15.6 years for mental disorders, age differences are also important, especially for mental illness and nervous system disorders, where the expected duration of first spells is around 25 years in the youngest age group.

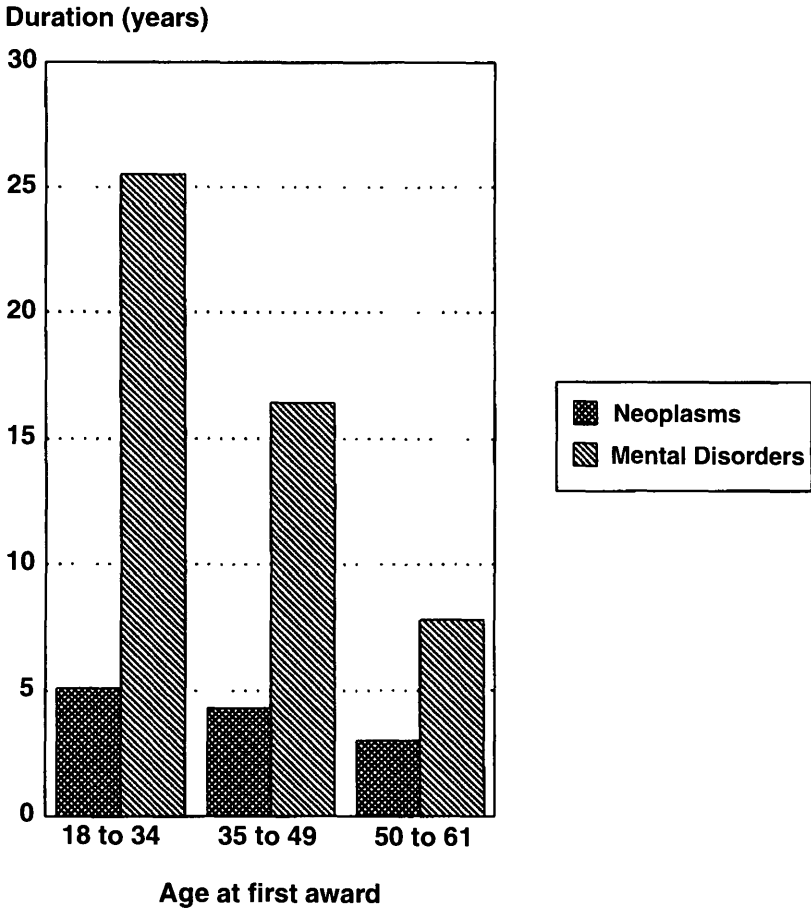
As expected, diagnostic differences are strongest in the youngest group and least pronounced among 50- to 61-year-olds (Chart 4.2). The lengths of stay shown in Table 4.1 represent the first uninterrupted

Table 4.1 Estimated Average Length of First DI Spells by Age and Diagnosis, 1972 Awardees (in years)

Diagnosis	Age group			All ages
	18–34	35–49	50–61	
Infective	7.4	8.8	6.7	7.6
Neoplasms	5.1	4.3	3.0	3.4
Endocrine	11.1	11.7	6.9	8.3
Mental disorders	25.5	16.4	7.8	15.6
Nervous system	23.4	16.2	7.4	12.5
Circulatory	16.7	11.6	6.4	7.5
Respiratory	15.9	12.4	6.3	7.3
Digestive	9.0	8.9	5.8	7.0
Geritourinary	9.5	9.6	5.4	7.5
Musculoskeletal	15.4	14.7	7.6	10.0
Congenital abnormalities	21.8	15.0	6.9	13.5
Accidents	11.8	11.2	7.4	9.9
Other	24.2	14.5	7.2	12.0
All diagnoses	18.4	12.5	6.5	9.3

SOURCE Hennessey and Dykacz (1989, pp. 10, 12).

Chart 4.2 Average Length of First DI Spells



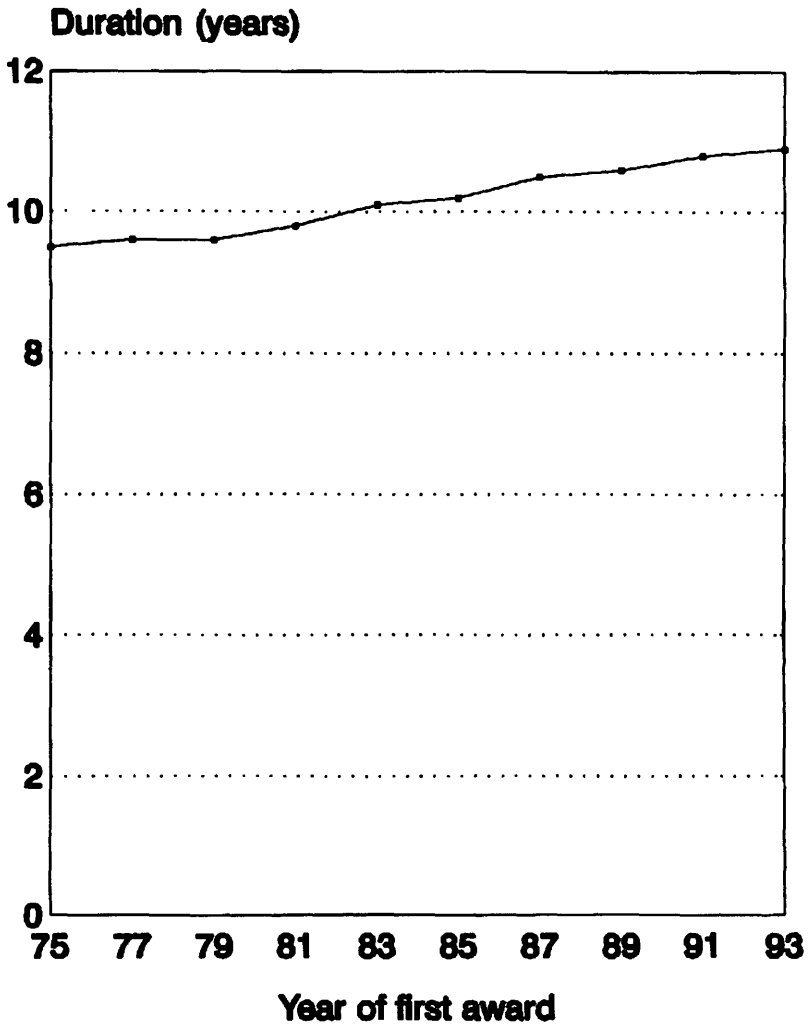
stay on the DI rolls. We do not currently have good data on expected total duration on the DI disability rolls that would account for multiple spells. Accounting for multiple spells is potentially important, because some beneficiaries who leave the rolls may subsequently return. Based on data by Dykacz and Hennessey (1989), the authors estimated that accounting for multiple spells may result in an increase in mean duration of as little as a 0.4 years, from the 9.3 years average presented in Table 4.1 to 9.7 years in the aggregate (Rupp and Scott 1995).

Given the obvious importance of age and diagnosis in affecting duration, it is natural to ask whether changes in the mix of awardees along these characteristics through time resulted in marked changes in the expected duration of successive cohorts of DI awardees. The proportion of younger awardees (aged 34 years or less) has increased from 13.5 percent in 1975 to 19.3 percent in 1993. The data also show some marked shifts in the mix of awardees by diagnosis. The proportion of awardees with a primary diagnosis of mental disorders has increased from 11.5 percent in 1975 to 26.1 percent in 1993, while the proportion of awardees in the circulatory disorders category decreased from about 30 percent in 1975 to 14 percent in 1993.

By combining information on the changing mix of awardees by age with disaggregated data on spell length for subgroups identified by age, it is possible to simulate mean spell length over time. Our estimates reflect the effect of changes in the age mix of new awardees on the expected mean length of first spells. Changes in the age mix of awardees produce a slow upward trend in expected duration from about 9 years in 1960 to about 11 years in 1992; most of the estimated increase occurred since the early 1980s (Chart 4.3).

We did some additional work to see if the addition of diagnostic detail would change the results of the simulation substantially. We tested this hypothesis by conducting an alternative simulation using information on mean duration of first spells by age and diagnosis and data on the joint distribution of awardees by age and diagnosis for 1975 and 1993. The results of the two simulations were virtually identical, suggesting that using age-specific information for the simulation produces robust results with respect to diagnosis. This is an important finding with respect to projection methodology highlighting the primary importance of the age distribution of new awardees for expected duration. We also compared our results with those of Chirikos (1993),

Chart 4.3 Simulated Average Length of First DI Spells



who used a different methodology but arrived at results consistent with ours. This provides further evidence concerning the paramount importance of the age mix of new awardees.

Changes in the age mix of new awardees reflect a variety of forces, including changes in demographics (e.g., aging of the baby boom generation), epidemiological trends in the incidence of various disabling conditions with various age distributions of onset, and changes in the Social Security Administration (SSA) regulations (e.g., mental impairment regulations). Thus the results reflected in Chart 4.3 cannot simply be attributed to demographics alone. In order to better understand the role of demographics in explaining our results, we conducted an analysis of the effect of changes in the age mix of the DI-insured population on duration. Changes in the age mix of the DI-insured population between 1975 and 1993 reflects largely, though not exclusively, the aging of the baby boom generation and therefore are indicative of demographic shifts in the U.S. population. In order to estimate the effect of changes in the age mix of the DI-insured population, we analyzed the effect of year-to-year changes in the age mix of the DI-insured population on duration, assuming unchanged incidence rates between successive years and using the age-specific duration estimates used in the previous analysis that produced Chart 4.3. In our simulation we updated the incidence rate assumptions annually.

Actuarial data show that the proportion of younger (18 to 34 years old) DI-insured workers peaked during the early 1980s, while the proportion of older insured workers declined until fairly recently. Much of the overall decline in the average age of DI-insured workers between 1975 and 1993 is attributable to an increase in the proportion of middle-aged (35 to 49 years old) DI-insured workers at the expense of older (50 to 61 years old) DI-insured workers.

Our analysis shows that a substantial portion of the increase in the mean duration of first DI spells we attributed to changes in the age mix of DI awardees can be explained by demographics, but other factors contributed almost as much. We estimate that about half (0.8 years) of the 1975–1993 increase in expected duration (1.4 years) is attributable to changes in the mix of the DI-insured population. The rest (0.6 years) is attributable to other factors contributing to the lowering of the age at entry among new awardees. For example, if the incidence of awards for conditions with a relatively early onset (e.g., mental retardation and

psychiatric conditions) disproportionately increases, average age at award may decline, even if no demographic factors are at play.

The data also suggest that the trend of increasing duration of new awardees has magnified the implied effects of the rapid rise in the number of new awards during the last decade on eventual caseloads. While the number of DI awards (aged 62 or less) has increased from about 250,000 in 1982 to about 580,000 in 1993, expected duration also increased by about 1 year (about 10 percent). Together, the influx of awardees and the increase in stay length substantially affect caseloads. This effect can be seen by multiplying the two factors (first two columns in Table 4.2). Expected benefit years rose from 2.5 million for the 1982 entry cohort to about 6.3 million for the 1993 cohort. The 1982–1993 increase in benefit years was primarily the result of increased awards; the increase in expected duration had a relatively small contribution to the overall change. However, if we take a longer view by looking at changes between 1975 and 1992, the previous and most recent peak in DI awards, duration becomes the key factor; an increase in expected duration from 9.5 to 11 years is a major contributor to the increase in simulated benefit years.

Finally, we note that our simulations reflect only the effect of changes in the mix of awardees (by age, and probably diagnosis as well) and do not capture changes affecting mean duration either for selected subgroups or across the board. For example, changes in work incentives, such as the introduction of the extended period of eligibility, might have increased mean duration, particularly for younger groups of awardees. In this case, due to such cohort effects, mean expected duration may have increased during recent decades more than our simulations seem to suggest.

Duration on the SSI Disability Rolls

In this section we focus on duration on the SSI disability rolls among nonconcurrent awardees prior to reaching their 65th birthday. In contrast to the discussion of DI, our analysis here also covers children, who form an important, rapidly increasing, and controversial part of the SSI disability program. We will, however, present some information for working-age SSI awardees separately that will be of use in comparisons with DI. The main difference between the DI and SSI dis-

Table 4.2 Simulated Expected Mean Length of First DI Spells and Expected Total Benefit Years by Annual Cohort of Awardees

Year	Total awardees under 62	Simulated mean length	Simulated benefit years
1960	158,497	8.9	1,405,721
1965	219,236	8.8	1,939,064
1970	288,813	9.4	2,708,524
1975	494,662	9.5	4,720,422
1976	455,037	9.5	4,341,190
1977	471,708	9.6	4,526,983
1978	388,888	9.6	3,747,513
1979	349,781	9.6	3,363,795
1980	335,901	9.7	3,258,407
1981	302,231	9.8	2,952,807
1982	254,921	9.8	2,500,992
1983	267,851	10.1	2,709,214
1984	313,259	10.2	3,194,568
1985	364,325	10.2	3,700,105
1986	370,500	10.6	3,922,681
1987	366,865	10.5	3,838,548
1988	373,483	10.4	3,878,463
1989	372,024	10.6	3,925,845
1990	423,777	10.8	4,558,993
1991	468,238	10.8	5,071,412
1992	583,507	11.0	6,394,946
1993	580,038	10.9	6,306,206

ability programs affecting duration is the fact that DI is conditioned on prior work history, while SSI is means-tested. SSI recipients might lose payment eligibility as a result of changes in their family income or assets. It is to be noted, however, that DI beneficiaries are more at a risk of losing payment eligibility for work-related reasons, even after the liberalization of work incentive provisions during the 1980s. The differences in program design between the two programs need to be considered in comparing the SSI results, to be presented below, with the analysis of DI duration.

Overall, the SSI means test is the most important reason for first suspensions during the first ten post-award years (Table 4.3). Death and reaching age 65 are clearly much less important reasons for first exits than in DI, even accounting for the fact that the eventual first suspension of many of the approximately one-quarter of awardees who did not exit during the first ten post-award years will be one of these two categories. The data show marked differences in the reason for first exits by age, diagnosis, and to a lesser extent by gender, generally in directions consistent with the DI findings.

The SSI stays of the 1974–1982 cohorts (Table 4.4) were corrected for the right-censoring of observations (Rupp and Scott 1995). Projections were made not only for first spells but also for total years expected on the rolls. Not surprisingly, the data show that the mean duration of first spells is substantially lower for working-age SSI awardees when compared to DI awardees. Moreover, subgroup differences are less marked in SSI, particularly by age group. These program differences appear to be driven by the effect of the SSI means test on the dynamics of first spells. Early suspensions due to the failure to continue to qualify for the means test affects SSI awardees largely independently of age and diagnosis.

When multiple stays are accounted for (Chart 4.4), the overall picture dramatically changes, however. Overall, the mean SSI stay almost doubles from 6.9 years for first stays to 13.2 years for all spells for nonconcurrent adults and children combined. This brings the mean SSI stay to a level clearly higher than the mean DI duration, even accounting for the lack of precise data on DI total duration. The difference between the two programs appears largely attributable to the inclusion of children in the SSI disability program, although the data do not allow for a precise comparison. We note that the DI first spell and SSI

Table 4.3 Reason of Completion of First SSI Disability Spell during First 10 Post-award Years for Persons First Awarded SSI Disability Benefits during 1974–1982, Nonconcurrent Adults and Children

Age, diagnosis, and gender	All persons	Total (%)	Reason for first suspension (%)						
			No exit during 10 post- award years	Excess income	Death	Public instit.	Excess resources	Reached age 65	Other
Total	22,747	100	23.3	32.7	11.7	4.1	2.9	12.9	12.5
Age									
0 to 17 years	3,922	100	35.9	34.9	6.7	3.4	3.5	0.0	15.5
18 to 34 years	5,566	100	33.2	33.7	6.3	8.6	3.0	0.0	15.3
35 to 49 years	3,911	100	32.9	28.5	16.1	4.8	3.0	0.0	14.7
50 to 61 years	7,411	100	10.1	36.3	17.5	1.6	2.8	22.0	9.6
62 years and over	1,937	100	0.0	20.4	6.0	0.6	1.2	66.8	5.0
Diagnosis									
Missing	5,663	100	26.6	29.8	11.7	3.6	2.8	15.7	9.9
Infectious and parasitic	199	100	17.6	33.7	16.1	1.5	4.0	12.6	14.6
Neoplasms	936	100	3.5	28.5	53.4	0.6	0.5	4.4	9.0
Endocrine	738	100	16.9	32.7	18.2	0.5	2.0	17.3	12.3

Psychiatric	2,793	100	25.4	26.6	6.5	14.4	3.1	8.0	16.0
Mental retardation	3,606	100	40.2	31.1	3.5	5.7	3.9	2.6	13.0
Central nervous system	2,047	100	23.5	42.5	6.7	1.3	3.8	7.6	14.6
Circulatory	2,295	100	11.3	34.4	15.3	0.6	1.8	25.4	11.1
Respiratory	678	100	12.4	32.3	17.7	1.0	2.4	22.4	11.8
Digestive	288	100	10.1	28.1	34.0	1.7	0.7	11.5	13.9
Genitourinary	164	100	12.2	36.6	22.0	1.2	1.8	12.2	14.0
Musculoskeletal	1,743	100	14.1	39.4	6.7	0.8	3.0	23.9	12.0
Congenital	416	100	27.4	42.5	8.9	1.7	4.3	2.4	12.7
Injury	577	100	19.2	35.9	9.4	3.1	1.6	12.5	18.4
Other	604	100	14.9	36.8	12.6	2.6	3.6	14.4	15.1
Gender									
Female	13,226	100	23.2	31.9	11.3	2.8	3.1	15.9	11.7
Male	9,521	100	23.3	33.8	12.3	5.9	2.6	8.6	13.5

SOURCE: Authors' longitudinal study file of 22,747 persons first awarded SSI benefits during 1974–1982

Table 4.4 Estimated Mean Duration of First SSI Disability Spells and Total Preretirement-Age Duration on the SSI Disability Rolls by Age and Diagnosis, Nonconcurrent Adults and Children (years)

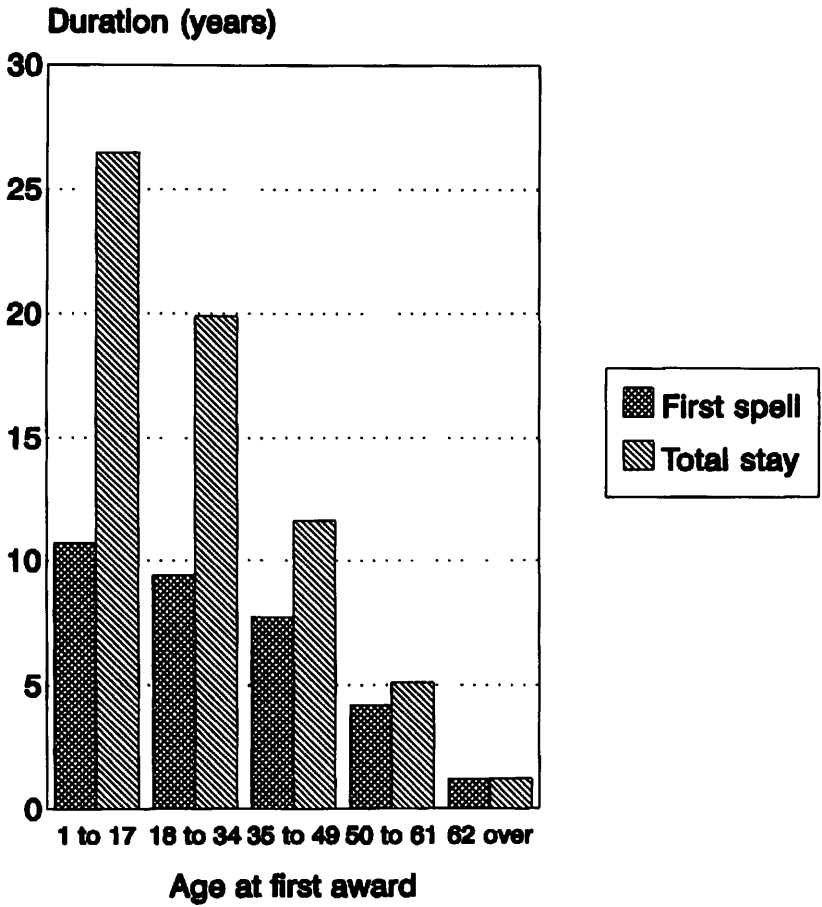
Diagnosis	0 to 17 years	18 to 34 years	35 to 49 years	50 to 61 years	62 years and over	All ages
First spell						
Infectious and parasitic	10.1	9.8	6.8	3.8	1.0	6.0
Neoplasms	3.4	2.6	2.0	1.5	0.8	1.8
Endocrine	4.3	6.2	9.0	4.3	1.2	5.2
Psychiatric	9.1	7.3	8.7	4.8	1.2	6.9
Mental retardation	11.9	12.2	9.5	5.8	1.3	11.3
Central nervous system	8.6	8.2	7.4	4.3	1.3	7.2
Circulatory	4.9	8.9	6.4	3.9	1.1	4.1
Respiratory	6.6	5.3	8.0	4.0	1.2	4.4
Digestive	7.1	4.2	5.0	2.8	1.2	3.6
Genitourinary	3.6	4.5	5.9	3.9	1.0	4.2
Musculoskeletal	5.8	7.0	7.4	4.4	1.3	4.7
Congenital	8.7	8.0	8.8	4.8	1.1	8.1
Injury	7.4	7.6	6.8	4.0	1.3	5.8
Other	8.9	6.8	5.3	3.4	1.0	5.0
Missing	13.1	10.4	8.8	4.6	1.3	7.8
All diagnoses	10.7	9.4	7.7	4.2	1.2	6.9

Total disability stays

Infectious and parasitic	32.3	17.2	8.3	4.9	1.2	9.6
Neoplasms	11.2	6.8	2.8	1.7	0.8	3.2
Endocrine	25.3	14.2	12.1	5.5	1.2	8.2
Psychiatric	25.8	19.6	13.5	6.0	1.2	14.4
Mental retardation	28.1	23.3	14.8	7.2	1.3	23.3
Central nervous system	26.1	18.8	11.9	5.3	1.3	17.0
Circulatory	17.3	13.7	10.1	4.8	1.1	5.6
Respiratory	26.0	11.3	11.1	4.8	1.2	6.6
Digestive	17.9	14.8	7.2	3.3	1.3	5.7
Genitourinary	15.6	12.9	9.6	5.1	1.1	9.4
Musculoskeletal	23.7	15.7	11.8	5.4	1.3	7.2
Congenital	27.0	20.0	13.3	6.9	1.3	22.1
Injury	23.6	16.1	10.8	5.0	1.3	11.2
Other	25.8	14.9	9.5	4.3	1.0	10.2
Missing	26.7	20.4	12.4	5.4	1.3	13.3
All diagnoses	26.5	19.9	11.6	5.1	1.2	13.2

SOURCE Authors' estimates based on longitudinal study file of 22,747 persons first awarded SSI benefits during 1974-1982.

Chart 4.4 Average Length of First SSI Disability Spell and Total Pre-65 Stay: Nonconcurrents



total stay estimates by age-group among prime-age adults are fairly close. Accounting for multiple stays in SSI highlights the age, and to a lesser extent, diagnostic differences in duration.

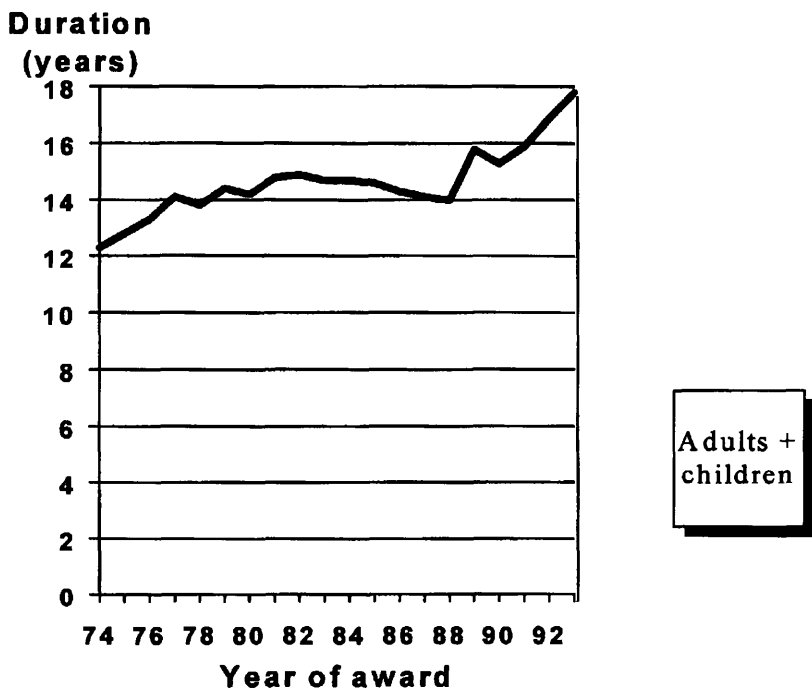
With duration patterns already described, we need to see how the demographic and diagnostic mix has changed over time. The most dramatic trend is the increasing proportion of children from 12.7 percent of new awardees in 1974 to 40.9 percent in 1993. Changes in the diagnostic mix of new awardees are also substantial, with the proportion with mental retardation and psychiatric conditions increasing dramatically, from 5 percent to 22 percent (mental retardation) and from 6.8 percent to 31.1 percent (psychiatric conditions) between 1974 and 1993. A long-term decline of the proportion of females among new nonconcurrent SSI awardees from 56.8 percent in 1974 to 47.5 percent in 1993 reflects the increase in the proportion of women in the DI-insured population during this period of time.

Armed with both durations and demographic patterns, we were able to produce simulations that reflect changes in the joint distribution of new awardee cohorts by age, gender, and diagnosis. We also conducted simulations using information on changes in the age distribution alone and on changes in the age-gender mix. These latter, cruder methods, resulted in almost identical results. This robustness suggests that factors associated with the age mix of new awardees dominate the results. This is consistent with our findings for DI in this respect.

Changes in the age distribution of new awardees between 1974 and 1993 are responsible for a substantial increase in expected duration from a mean of 12.3 years in 1974 to a mean of 17.8 years in 1993 (Chart 4.5). This is a much more dramatic increase than was observed for DI. However, when children are excluded from the analysis, the trends for DI and SSI nonconcurrent adults appear much more similar. The combined effect of changes in the number of new awardees and the mix of awardees by the demographic variables considered in our analysis can be represented by the simulated benefit years associated with each entry cohort. As previously shown for DI, this is simply the product of the number of new awards and simulated mean total duration for each annual cohort of new awards (Table 4.5).

The combined effect of the dramatic drop of new awards between 1974 and 1982 and the dramatic increase in childhood disability awards with long expected duration during subsequent years produces

**Chart 4.5 Simulated Average Length of Total Pre-65 SSI Disability Stays:
Nonconcurrents**



a dramatic pattern of changes and contrast between the early 1980s and recent years.

The analysis above is limited to the effects of awardee mix on expected duration and does not address the possibility that factors other than age, gender, and diagnosis might have also induced changes in duration on the rolls. Such other factors could include either awardee characteristics other than the three variables considered, or factors (such as programmatic variables) directly affecting duration events.

Table 4.5 Simulated Expected Total Preretirement Age Duration on the SSI Disability Rolls among Children and Nonconcurrent Adults, 1974–1993

Year	Number of awardees	Simulated mean total duration (years)		Simulated benefit-years (total)
		Total (adults + children)	Adults only	
1974	423,400	12.3	9.8	5,207,820
1975	366,900	12.8	9.9	4,696,320
1976	295,100	13.3	10.3	3,924,830
1977	266,600	14.1	10.4	3,759,060
1978	225,000	13.8	10.2	3,105,000
1979	195,000	14.4	10.3	2,808,000
1980	196,000	14.2	10.3	2,783,200
1981	158,200	14.8	10.2	2,341,360
1982	160,800	14.9	10.5	2,395,920
1983	198,700	14.7	10.7	2,920,890
1984	222,300	14.7	10.8	3,267,810
1985	261,300	14.6	11.3	3,814,980
1986	262,200	14.3	11.0	3,749,460
1987	250,100	14.1	10.7	3,526,410
1988	253,500	14.0	10.7	3,549,000
1989	327,400	15.8	10.8	5,172,920
1990	391,700	15.3	10.8	5,993,010
1991	472,900	15.9	11.0	7,519,110
1992	549,400	16.9	11.3	9,284,860
1993	525,400	17.8	11.3	9,352,120

NOTE: Number of awardees estimated from SSI 1-percent sample file. Simulations based on joint distribution of annual awardees by age, gender, and diagnosis and authors' estimates of total stay for subgroups.

PROGRAMMATIC FACTORS DIRECTLY AFFECTING DURATION

In the previous section we have demonstrated that the mix of award-ees fundamentally shapes duration on the rolls. Nevertheless, these effects are conditional on programmatic rules concerning exit and reentry events. In this section we will focus on programmatic factors directly affecting duration, including suspensions and terminations for medical- and income-related reasons, work incentive provisions, and vocational rehabilitation.

CDRs form the primary vehicle for removing persons from the DI and SSI disability rolls for medical reasons. The number of CDRs performed greatly varied over the years subject to swings in political decision making and SSA staffing constraints. During the early Reagan years, CDRs were perceived as important tools for containing the growth of the disability rolls. Following a political backlash and numerous court decisions, a moratorium was issued on CDRs during the mid 1980s, followed by the introduction of the medical improvement standards making the removal of persons from the disability rolls for medical reasons more difficult. At the 1983 peak, 436,000 DI cases were reviewed, comprising 13.5 percent of the caseload (U.S. House of Representatives 1993, p. 64). More than 40 percent (182,000) were removed from the rolls. In contrast, during 1995 only 0.1 percent of the DI caseload was reviewed, and only 15 percent of these (475 cases) were removed from the rolls. Subsequently the number of CDRs performed increased somewhat. The experience with CDRs in the SSI program also showed great variations, with a minimum level of activity during the last couple of years.

More recently, the role of CDRs as a policy tool has increased again, as exemplified by Section 212 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 concerning SSI childhood disability cases, as well as other recent initiatives. Section 201 of P.L. 103-296, the Social Security Independence and Program Improvements Act of 1994, introduced time-limited benefits for persons disabled based on a finding that drug addiction or alcoholism was a contributing factor material to the finding of disability. More recently, these provisions were replaced by stricter provisions of P.L. 104-121,

the “Contract with America Advancement Act of 1996,” providing for the outright termination of cash benefits and health coverage for all DI and SSI disability recipients who received disability benefits based on drug addiction and/or alcoholism at the time of the enactment of the law as of January 1, 1997, and prohibiting future DI and SSI disability benefit allowances (and associated Medicare and/or Medicaid eligibility) to any future disability applicant whose drug addiction and/or alcoholism would be material to the determination of disability.

CDRs clearly affect duration on the rolls and may affect subsequent applications similar to the effect of denial rates, as was demonstrated by Parsons' work (1991). In this pioneering study, based on economic theory, Parsons hypothesized that high denial rates discourage subsequent disability applications as a result of their negative effect on the expected net benefits of DI application. His empirical analysis—based on data from the late 1970s—provided results consistent with this hypothesis. CDRs may have negative effects not only on duration among those on the rolls, but also on subsequent DI applications for similar reasons.

However, past experience suggests difficulties with relying on CDRs as a primary strategy of containing caseload growth both because of the legal and political problems embedded in the approach and for substantive reasons. Many persons on the disability rolls face serious medical problems; identifying those whose medical condition sufficiently improves and is likely to improve in the future is inherently difficult. Moreover, time spent on the disability rolls results in the depreciation of work skills and is expected to result in difficulties in returning to the labor force, especially without assistance. The General Accounting Office study of DI beneficiaries terminated during 1981–84 found that more than half returned to the rolls, and of those who did not, nearly half were not working (quoted in U.S. House of Representatives 1993, p. 70).

Administrative changes related to the SSI means test are also of potential importance in affecting duration. As we discussed previously, the data presented in Table 4.5 suggest that recent changes in the handling of failure to respond to an agency request for information had a negative effect on suspensions, and hence a positive effect on length of stay. In general, procedures designed to tighten the monitoring of SSI means-test eligibility are expected to reduce duration, while loosening

of procedures and/or reduction in the amount of resources devoted to monitor SSI income or asset eligibility are expected to increase duration.

In light of the difficulties of relying on the stick-only approach of CDRs, the interest in the carrots of work incentives is understandable. Both SSI (Section 1619 program) and DI (trial work period and extended period of eligibility) have gone through substantial liberalizations. Little is currently known about the effects of these changes on duration. The cohort-based comparison of DI exit rates during the 1970s and 1980s (Hennessey and Dykacz 1993) suggests that the liberalization of DI work incentives during the early 1980s actually increased length of stay. Similarly, with the introduction of Section 1619 provisions SSI suspensions directly resulting from work activities were eliminated, and data presented in Table 4.6 suggests no secular increase in income-related suspensions either. Thus, it appears that previous reforms of work incentive provisions might have increased duration in both programs. In addition, as Hoynes and Moffitt (1996) argue, such changes in work incentive provisions may induce additional applications thereby further adding to caseload size.

Vocational rehabilitation (VR) is another positive strategy to reduce duration in the disability rolls. The number of disability beneficiaries served by the state VR system has been historically small and has decreased further since SSA's placement-oriented reimbursement of VR agencies was introduced. Moreover, little is known about the effectiveness of these interventions because of the difficulty in establishing a useful control group. The interest in vocational rehabilitation demonstrations is rooted in the perceived failure of work incentives to move sizable numbers of beneficiaries to productive employment in an efficient manner. Six-year experimental follow-up results from the Transitional Employment Training Demonstration (Decker and Thornton 1995) indicate that the employment services raised the average employment and earnings levels of the mentally retarded SSI recipients who were offered transitional employment services, and that the increases persisted relatively undiminished during the six-year period. However, the modest reduction in SSI payments offset only a fraction of the cost of transitional employment services. Moreover, only a small subset of eligible SSI recipients volunteered for the demonstration. A more recent SSA demonstration initiative, Project NetWork, targets a

Table 4.6 Reason for First Exit by 24, 48, and 120 Months after First Award, Children and Nonconcurrent SSI Awardee Cohorts (%)

Exit reason	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Total ^a	4,234	3,669	2,951	2,666	2,250	1,950	1,960	1,582	1,608	1,987
Exit status at month 120										
No exit	22.6	22.8	23.1	21.3	23.4	23.6	25.1	25.3	24.5	26.3
Excess income	31.7	30.6	32.0	33.3	32.4	34.4	33.7	33.6	35.2	34.5
Death	10.2	9.9	9.7	10.5	11.3	11.3	11.6	11.6	11.3	10.5
Public institution	3.4	4.1	3.8	4.7	4.4	4.5	4.1	3.7	4.2	4.9
Excess resources	2.4	2.6	2.3	2.4	3.1	3.3	3.8	3.7	2.9	4.0
Other	29.7	30.1	29.1	27.9	25.4	23.0	21.7	22.2	22.0	19.8
Total	100	100	100	100	100	100	100	100	100	100
<hr/>										
	1984	1985	1986	1987	1988	1989	1990	1991	1995	
Total ^a	2,223	2,613	2,622	2,501	2,535	3,274	3,917	4,729	5,494	
Exit status at month 120										
No exit	27.1									
Excess income	35.5									
Death	10.4									
Public institution	4.5									
Excess resources	2.3									
Other	20.1									
Total	100									

(continued)

Table 4.6 (continued)

Exit reason	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Total ^a	4,234	3,669	2,951	2,666	2,250	1,950	1,960	1,582	1,608	1,987
Exit status at month 48										
No exit	46.2	45.5	44.1	43.7	44.3	43.9	45.8	47.5	46.3	48.0
Excess income	23.9	24.0	24.9	25.9	25.0	26.6	25.6	25.7	27.7	26.9
Death	6.4	6.5	6.1	6.8	8.0	8.5	8.4	7.1	7.5	5.9
Public institution	2.5	3.0	3.0	3.6	3.5	3.2	3.1	2.5	3.1	3.9
Excess resources	1.6	1.5	1.5	1.0	2.2	2.3	2.8	2.5	2.0	3.2
Other	19.5	19.5	20.4	19.0	17.0	15.6	14.3	14.7	13.4	12.1
Total	100	100	100	100	100	100	100	100	100	100
	1984	1985	1986	1987	1988	1989	1990	1991	1995	
Total ^a	2,223	2,613	2,622	2,501	2,535	3,274	3,917	4,729	5,494	
Exit status at month 48										
No exit	48.2	50.7	51.5	51.9	51.7	55.0	57.2			
Excess income	27.7	25.2	24.6	24.8	26.1	22.4	23.3			
Death	7.0	5.9	7.4	8.2	7.5	7.4	6.3			
Public institution	3.3	3.7	3.1	3.3	2.5	2.4	2.3			
Excess resources	1.8	2.1	1.9	1.6	1.4	2.2	1.8			
Other	12.0	12.4	11.4	10.2	10.9	10.7	9.1			
Total	100	100	100	100	100	100	100			

Exit reason	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Total ^a	4,234	3,669	2,951	2,666	2,250	1,950	1,960	1,582	1,608	1,987
Exit status at month 24										
No exit	63.7	61.1	59.7	60.2	59.5	60.1	61.6	60.5	58.1	61.1
Excess income	16.9	18.6	19.6	19.7	20.1	20.7	19.4	20.5	23.7	21.1
Death	4.6	4.4	4.0	4.4	5.8	5.6	5.7	5.8	5.6	4.2
Public institution	1.6	2.2	2.3	2.4	2.5	2.1	2.2	1.5	2.5	2.9
Excess resources	1.0	1.1	0.9	0.6	1.4	1.4	1.4	1.6	1.4	2.4
Other	12.1	12.7	13.5	12.7	10.8	10.2	9.6	10.2	8.8	8.2
Total	100	100	100	100	100	100	100	100	100	100
	1984	1985	1986	1987	1988	1989	1990	1991	1995	
Total ^a	2,223	2,613	2,622	2,501	2,535	3,274	3,917	4,729	5,494	
Exit status at month 24										
No exit	62.3	65.0	64.2	65.4	64.7	67.8	69.2	70.5	72.1	
Excess income	22.1	19.3	19.8	19.6	20.8	17.9	18.5	17.4	16.1	
Death	4.8	4.0	4.9	5.6	5.1	4.4	4.0	4.0	3.9	
Public institution	1.8	2.6	2.2	2.2	1.5	1.7	1.6	2.0	1.9	
Excess resources	1.2	1.7	1.4	1.0	0.6	1.1	1.3	1.1	0.7	
Other	7.8	7.4	7.6	6.1	7.3	7.0	5.5	5.0	5.4	
Total	100	100	100	100	100	100	100	100	100	

^aNumber, not percent

much broader group, including all DI beneficiaries and SSI recipients in the demonstration areas and uses a case-management approach to return-to-work (Rupp, Bell, and McManus 1994). The net impact results of this large-scale experimental evaluation are not available yet, but preliminary analyses of demonstration participation suggest that—similar to the Transitional Employment and Training Demonstration—only a fraction of project eligibles volunteered for the demonstration (Rupp, Wood, and Bell 1996).

In view of the increases in the size of the caseload, policymakers continue to have an interest in these more direct methods of limiting duration on the rolls as evidenced by SSA's evolving employment strategy and the recent review of the disability program by the National Academy of Social Insurance (Mashaw et al. 1996). Whether such initiatives are going to have substantial effects on duration in the desired direction (reduction) is too early even to speculate on. Nevertheless, while much more research needs to be done on the effects of CDRs, work incentives, vocational rehabilitation, and other programmatic variables on duration, it appears safe to infer that none of these factors had a large overall effect on containing caseload growth over the last decade. If anything, the most consequential recent changes probably had effects in the opposite direction. By all likelihood the medical improvement standards, changes in the mental regulations, and the *Zebley* decision contributed to increased expected duration. Thus, the results of our simulations concerning expected length of stay in the previous section are likely to provide a conservative view of past trends in expected duration.

IMPLICATIONS FOR FUTURE DURATION AND CASELOADS

In our analysis so far we have focused on past trends in awardee characteristics and expected duration. These factors do affect the future by virtue of the fact that the potential exposure to program participation of new awardees, especially among those young at first entry, is extremely long. Thus, as we have demonstrated, and assuming no major changes in program rules, the past trend toward younger entrants

in both DI and SSI, most notably evidenced by the recent influx of a large number of children to the SSI disability rolls, is expected to put a strong upward pressure on caseloads for many years to come, unless a large number of the recent entrants are removed from the rolls through new policy initiatives. This implication of past trends for future caseloads will affect SSA's disability programs even if the past trends toward younger entrants were to be reversed in the future.

This section addresses the next logical question. What can we say about the expected duration of future cohorts of new entrants? Can we assume that the past trends toward younger entrants and increasing expected duration will continue in the future? Or perhaps we should expect the reversal of these trends and shorter duration for future entrants? What are the expected effects of such future trends in duration on caseloads?

There are a large number of potential factors that might affect the duration of future entry cohorts, from demographic and economic factors to future policy and procedural changes. The purpose of this section is not to provide crystal ball speculations about the net effect of all of these diverse forces, but rather to spell out the implications of some relatively tangible factors, notably demographic trends.

While we did not attempt to project future changes in age-specific incidence rates, we have used actuarial projections of the age distribution of the DI-insured population to assess the likely future effects of the aging of the baby boom generation on expected future mean duration.

Our analysis shows that this factor alone is likely to result in a one-year decline in expected duration of first spells between 1993 (see Table 4.2) and 2006 (Chart 4.6). While this appears as good news, the same demographic forces also seem to imply future increases in incidence rates.

The net effect may be an upward demographic pressure on caseloads during the next ten to fifteen years as suggested by the relationship between age, DI incidence rates, and duration in a cross-sectional framework (Table 4.7). The two factors (incidence and expected duration) work in the opposite direction: as age increases the incidence of disabling conditions serious enough to warrant the award of DI disability benefits increases, while expected duration decreases. The product of these two factors represents the net effect on caseloads: expected DI

Chart 4.6 Estimated Effect of Changes in Age-Mix of the DI Insured Population on Average Length of First SSDI Spells

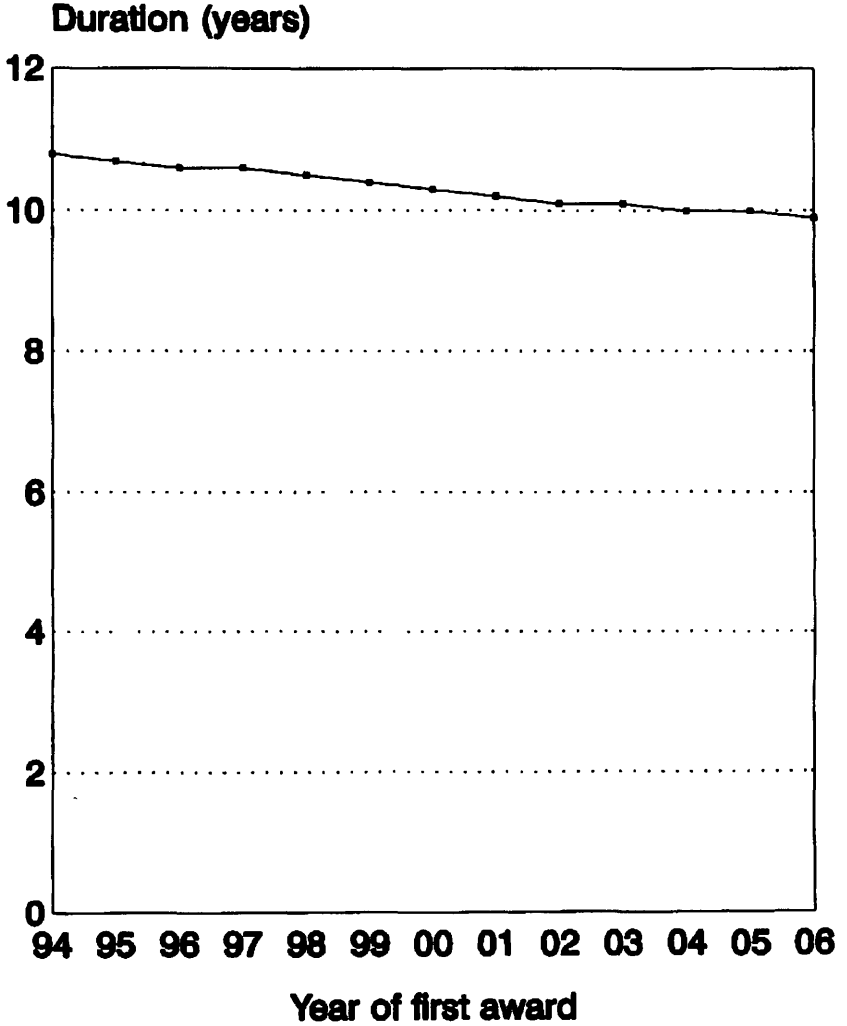


Table 4.7 DI Incidence Rates, Expected Duration, and Benefit Years per 1,000 Insured Workers

Age group	Awards per 1,000 DI-insured workers	Expected first-spell duration (years)	Expected DI benefit years per 1,000 insured workers
18–34	2.1	18.4	39.0
35–49	4.5	12.5	55.9
50–61	13.1	6.5	85.3

SOURCE Incidence rates were calculated by the authors based on data on the number of DI-insured workers (1993) provided by SSA's Office of the Actuary and the number of 1993 awards by age group. Estimated first-spell duration data by age group are based on estimated by Hennessey and Dykacz (1989)

benefit years increase as we move toward the older cohorts of new entrants, because the positive effect of age on incidence rates is stronger than the negative effect on duration.

We do not have actuarial projections for the population financially eligible for SSI. Nevertheless, the population satisfying the SSI means test is conceptually akin to the notion of the DI-insured population. While the SSI financial eligibility criteria are much more complex than the concept of the DI-insured status, a microsimulation model developed by analysts at the Social Security Administration (Wixon and Vaughan 1989; Vaughan and Wixon 1989) based on the rich income and asset information available from the SIPP provides an opportunity for some analysis. Table 4.8 provides an estimate of the size and age-distribution of the population economically eligible for SSI. The estimate, provided by Denton Vaughan to the authors, suggests that approximately 25.7 million persons aged 18–64 were financially eligible for SSI disability benefits in 1984. These estimates include (but do not identify) persons concurrently satisfying the economic eligibility criteria of both programs, as well as working-age persons eligible for SSI only. Our analysis shows that overall, the relationship between age, incidence, and expected duration of benefits is similar in the two programs. Nevertheless, there are some notable differences.

First of all, the SSI incidence rate is higher than the DI incidence rate. The comparison is affected by the exclusion of concurrents from

Table 4.8 SSI Awards per 1,000 Persons Satisfying the SSI Means Test, Expected Total Duration and Benefit Years per 1,000 Financially Eligible Persons

Age group	Number of persons financially eligible for SSI (000)	New SSI noncurrent awards per 1,000 financially eligible persons in 1984	Mean total duration on SSI disability rolls (years)	Expected SSI disability benefit-years of new awardees per 1,000 financially eligible persons
18-34	18,198	3.4	19.9	68
35-49	3,791	10.7	11.6	124
50-61	2,713	22.5	5.1	115
62-64	470	26.4	1.2	32

NOTE: The estimated number of financially eligible persons was provided to the authors by Denton Vaughan based on the 1984 SIPP using the microsimulation model developed by him and Bernard Wixon (Wixon and Vaughan 1991; Vaughan and Wixon 1991). The SIPP estimates reflect the estimated number of persons satisfying the SSI income and assets means test, irrespective of eligibility for DI. The number of SSI awards estimated from the author's 1-percent SSI study file, however, is limited to persons receiving SSI benefits only, at least during the initial year following first award. Total duration estimates reflect all SSI disability spells and are based on age-specific means

our SSI incidence rate numerator and by the fact that the SSI incidence rates reflect the 1984 experience, while the DI incidence rates reflect 1993 data. However, considering both of these factors would strengthen, rather than weaken the contrast. An important issue for future research is the reason for the higher SSI incidence rate. There are at least three competing hypotheses that might contribute to this finding. First, the average health and disability status of the financially eligible SSI population might be relatively low. Second, SSI benefits are more attractive relative to alternative sources of income for the SSI financially eligible population than the DI benefits are relative to the wages of DI-insured workers. Third, because of differences in human capital and the lack of work experience, financially eligible SSI applicants might have an easier time of qualifying under SSA's vocational criteria than might be the case with the average DI applicant. One factor that might work in the opposite direction is that a substantial por-

tion of the financially eligible SSI population may meet the means test only marginally, and therefore face only relatively low levels of expected SSI payments reducing the economic incentive to apply. When both cash and noncash benefits are considered, however, the net incentives to apply for SSI may be very strong even for financially eligible persons qualifying only for a small amount of SSI cash benefits because of the importance of Medicaid for many SSI applicants.

Table 4.8 shows that the relationship between age and expected benefit years is somewhat different for SSI when compared to DI. In particular, the increase between the two younger age groups is reversed as age increases. The implication of this finding for the projection of the future effects of demographics on caseloads is that the aging of the baby boom generation might have a smaller net effect on SSI caseloads when compared to DI. However, because of the complex relationships between age, poverty status, family structures, disabilities, and other factors affecting the size of the SSI financially eligible population and incidence rates, much more work needs to be done before firm conclusions can be reached about trends in future awards, duration, and caseloads in the SSI disability program.

CONCLUSIONS

In this chapter we assessed the relationship between age, gender, diagnosis, and duration on the DI and SSI disability rolls, and quantified the implications of past trends in awardee characteristics and future caseloads. We also looked at programmatic factors directly affecting duration, and the combined effect of incidence rates and expected duration on age-specific expected benefit years. We also made some inferences about the likely effects of the aging of the baby boom generation on expected duration and caseloads.

The data show that lifetime duration in both the DI and SSI disability programs is long; thus long duration is an important determinant of caseloads, and hence of program cost. Between 1975 and 1993 the shift toward younger entrants resulted in substantial increases in the expected duration of new awardees in both DI and SSI. These past trends in expected duration create an upward pressure on future case-

loads, especially in SSI where the recent influx of children is expected to have substantial future effects on caseloads, under the assumption that current program rules will stay in effect for persons already on the rolls in the future. An important issue for future research concerns the effects of Section 211 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 envisioning substantial tightening of SSI childhood disability eligibility provisions.

Our analysis suggests that the aging of the baby boom generation contributed to the 1975–1993 increase in the expected average duration of successive cohorts of new DI entrants, but that these trends will reverse during the 1993–2006 period as the baby boom generation ages. This will moderate, but not entirely eliminate, the likely upward pressures of the aging of the baby boom generation on future caseloads arising from rising incidence rates.

Our analysis suggests the usefulness of cohort-based studies of duration for understanding and quantifying the factors affecting future terminations and caseloads. In particular, such a perspective seems useful in disentangling the effects of awardee characteristics, the size of successive awardee cohorts, programmatic variables and other factors. Several important issues remain for future research. We need to learn much more about the interaction of the SSI and DI programs as they affect the duration of disability benefits and future caseloads, and particularly about the duration experience of concurrent awardees. Much more work needs to be done, and is feasible to do, concerning trends in SSI financial eligibility and their effect on duration and caseloads. Finally, there is a clear need for creative and rigorous work on the likely consequences of various strategies to contain the growth of the disability rolls through affecting entry and exit events.

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Comments on Chapter 4

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Kalman Rupp and Charles Scott (Chapter 4) provide an important extension to the work on award growth presented in this volume. As they correctly point out, the extent to which caseloads grow is dependent not only on the inflow of recipients to the major disability programs, but how long those recipients remain on the rolls.

The aging of the baby boom generation, report Rupp and Scott, will increase caseloads. This increase, however, is the result of two opposing effects. On the one hand, an older population will have more occurrences of disability; that is, awards should increase as baby boomers age. On the other hand, older people typically have shorter spells of receiving disability benefits. Once they reach the normal retirement age they are no longer classified as disabled, and their benefits convert to retirement benefits.

Rupp and Scott examine factors other than age that influence the duration of spells on Social Security Disability Insurance (DI) and Supplemental Security Income (SSI), such as gender and diagnosis. What is lacking, as they point out, are analyses that isolate the impact of programmatic factors. Continuing Disability Reviews (CDRs), vocational rehabilitation, the trial work period and extended period of eligibility, and the level of substantial gainful activity presumably all have an effect on the length of time someone receives benefits. The impacts of these program characteristics are not well understood.

The main reason concern has risen over growing caseloads in the DI program is the dwindling of the program's trust fund. Recently, the disability trust fund was bolstered, but this was by reallocating resources away from the retirement trust fund. The fundamental problem remains.

To understand the effects of age on total benefits paid (and thus on the trust fund), it is necessary to not only consider the effect of age on caseloads but on benefits paid. Since DI benefits are a function of past

earnings, more awards to older applicants will generally mean higher average monthly checks. As shown in Table 1 (using demographic and program data reported in Rupp's and Scott's paper), the age distribution of awards in 2005 should be much higher than in 1993, the most recent year reported in the paper. Furthermore, older awardees get significantly larger monthly checks; as shown in Table 1, the difference can be hundreds of dollars per month. Therefore, the impact of aging baby boomers on the disability trust fund will be larger than their impact on caseloads.

Table 1 Percentage of DI Awards by Age, Recipients under 62

	Under 35	35-49	50-61
1993	19.3	34.7	46.1
2005 ^a	14.2	30.6	55.2
Average monthly benefit of new award in 1993	\$521.6	\$681.6	\$809.5

SOURCE: Computed using data from the Social Security Administration.

^aProjection

5 Characteristics of SSI and DI Recipients in the Years Prior to Receiving Benefits

Evidence from the PSID

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One of the most disturbing aspects of the recent growth in the Supplemental Security Income (SSI) and Social Security Disability Insurance (DI) rolls has been the increasing number of young people—individuals in their 20s, 30s, and 40s—who have moved onto the disability benefit system. Research on transitions off of the disability rolls suggests that many of these young recipients could remain on the system for much of their adult lives (Rupp and Scott 1995). This potential change in program usage, from a bridge between work and retirement to a long-term income maintenance alternative, coupled with rising program expenditures and a growing commitment to supporting people with disabilities in the labor market, have renewed interest in the paths that individuals take to benefit receipt.

This chapter begins to characterize these paths by describing the circumstances and experiences of SSI and DI beneficiaries in the years before they receive benefits. Specifically, it examines the labor market effort, living arrangements, income sources, and economic well-being of a sample of SSI and DI recipients during the five years prior to benefit receipt. This pre-award view of disability benefit recipients is important to the development of preventative policies designed to maintain individuals in the labor market and outside of the social safety net.

NOTE: Opinions expressed in this paper do not necessarily reflect the views of the Federal Reserve Bank of San Francisco or of the Board of Governors of the Federal Reserve System.

BACKGROUND

Almost all of the research on SSI and DI recipients has focused on characteristics of current recipients and on their economic well-being and labor market behavior after benefits have been awarded. Scott (1989) described the characteristics of individuals who came onto the SSI rolls between January 1974 and December 1986. Kochhar and Scott (1995) examined the disability patterns among SSI and DI recipients and related changes in the SSI caseload to specific changes in disability requirements and outreach initiatives. Rupp and Scott (1995) estimated the length of stay on SSI by age and diagnosis. Hennessey and Muller (1994) followed a group of DI recipients to determine the factors that influence their decisions to return to work. Scott (1992) examined the work efforts of individuals on SSI both before and after receiving benefits. Each of these studies began at the point of benefit receipt and focused on the factors that contribute to changes in the size and composition of the recipient population. Whereas such studies provide valuable information about the circumstances of individuals receiving benefits, they yield little information about these recipients' pre-award characteristics.

Several pre-award scenarios are plausible. One possibility is that individuals with average income, skills, and attachment to the labor market become so severely disabled that they are prohibited from working and must rely on transfer income for their economic well-being. In this situation, SSI and DI act as public insurance and protect the recipient from economic losses associated with the onset of a disability. In alternative scenarios, the onset of disability may not be the event that precipitates applying for and receiving benefits. Instead, individuals with disabilities may be capable of work, but unable to find employment because of insufficient or mismatched skills and education or because of declining economic conditions that reduce labor market opportunities. In these cases, disability benefits represent "unemployment insurance" for people with disabilities who are unable to find jobs.¹

From the perspective of policymakers, the road that people take towards benefit receipt is important. Economic disparities that were present before the application for and receipt of benefits may not be eliminated by disability-based programs designed to offset the losses

associated with working-age disability or to provide transitional income security during periods of health-related losses in economic well-being. Moreover, the extent to which work can be used to reduce the disability benefit rolls will depend largely on the path that people take to benefit receipt. Individuals with average work histories who become unable to work either because of an acute change in their health or because of a transitory shift in economic conditions will be more easily integrated back into the labor market than either individuals with a history of long-term transfer receipt or persons with an increasingly severe long-term health condition.

Finally, while income transfers represent one option for maintaining the economic well-being of all individuals with disabilities, their effectiveness for all groups may not be equal. Examining this and similar issues requires that we look at individuals and their circumstances before they begin to receive benefits. It is this prebenefit picture that will provide the information necessary to make judgments about alternatives to moving onto the rolls.

DATA AND METHODOLOGY

Data

The empirical results in this study come from the Panel Study of Income Dynamics (PSID). The PSID data span more than two decades, from 1968 to 1991. Since 1968, the PSID has interviewed annually a sample of some 5,000 families, representing a disproportionate number of low-income individuals. At least one member of each family interviewed has been either part of the original families interviewed in 1968 or born to a member of one of these families. Partial information on individuals who ceased to be respondents prior to 1991 is included in the analysis whenever possible. The PSID currently contains data on over 42,000 persons, approximately 23,000 of whom are current respondents. This study uses the 1991 Family Individual Response-Nonresponse File, including data from 1970 to 1991. Sample weights are applied in the analyses to correct for the original oversampling of low-income households. For a more complete discussion of these data, see Hill (1992).

Methods

This study relies on longitudinal data that record information about income, benefit receipt, family composition, employment, and, to a lesser extent, health in each year for a set of individuals. Using this longitudinal information, the analysis selected a sample of individuals who began to receive benefits at some point during the data history. It then determines that information on these sample members for the previous five years is complete and organizes these individuals by the onset of their benefit receipt.

Capturing SSI and DI Awards

Unlike administrative data, the PSID does not provide a complete history of SSI and DI receipt. However, because the PSID began interviewing families in 1968, there are now 22 years of data over which benefit receipt can be traced. Since 1975, the PSID has collected information on the types of transfer benefits collected by each member of interviewed families. Respondents are asked to identify the program(s) that their benefits come from and to estimate the total amount of money transferred to each household member. Information from these questions is used to identify SSI and DI receipt for all members of the sample.

Individuals are included in the sample of SSI(DI) initial awardees when five consecutive periods of no SSI(DI) benefits are followed by one period of SSI(DI) receipt.² To further refine the sample of individuals with a beginning spell of SSI(DI), individuals living in households reporting SSI(DI) receipt during the period immediately preceding the individuals' award are excluded from the sample.

Sample Development

The sample includes all adults who experienced an observable spell of SSI or DI receipt, who were between the ages of 18 and 64 when receipt began, and who have at least five years of data recorded in the years immediately preceding the award year. Some members of the sample experienced multiple spells of benefit receipt over the periods covered. However, since the analysis is intended to capture experiences preceding the first award of benefits, subsequent spells are excluded from the analysis.

Initial SSI awards are recorded beginning in 1979; DI awards are evaluated beginning in 1984. Although the PSID contains information on SSI receipt prior to 1979 and Old Age and Survivors Disability Insurance (OASDI) receipt prior to 1984, there are insufficient data to build a complete history during these periods. In the case of SSI receipt there are no data on a respondent's pre-SSI association with one of the state-based programs for Old-Age Assistance, Aid to the Permanently and Totally Disabled, and Aid to the Blind. Since the analysis sets out to examine the pre-award circumstances of new SSI recipients, individuals receiving benefits between 1974 and 1979 are excluded from the analysis. For DI the problem is slightly different. Prior to 1984, the PSID data do not include an indicator for the type of OASDI benefit received. Thus, it is not possible to separate SSDI transfers from transfers based on age or survivorship.³

Applying these criteria, the final sample of new SSI recipients, which includes all those individuals who had five consecutive periods of no SSI receipt followed by at least one period of SSI benefits between 1979 and 1991, contains 211 individuals. The DI sample, which contains individuals who have five consecutive periods of no social security benefits followed by at least one period of DI receipt, has 199 members.^{4,5}

Measuring Disability

Self-reported disability is recorded in order to observe the time between a self-reported health event and the beginning of disability benefits. There is continued discussion in the literature about the best way to ascertain disability status from self-reported measures, but since all members of the sample have already been classified as disabled for the purpose of receiving benefits (by passing the substantial gainful activity screen), the most comprehensive set of measures is used (see Burkhauser and Daly [1996a, 1996b] for a brief summary of this debate). Four questions are combined to create the self-reported disability measure used here. The four PSID variables used are 1) disabled or in need of care, 2) lists primary activity as permanently disabled, 3) ranks health as fair or poor, 4) reports having a physical or nervous condition that limits the type or amount of work that can be performed. Any individual falling into one or more of these categories is considered to have a self-reported disability.

Measuring Employment and Presence of Other Earners

Individuals are classified as employed in the previous year if they report that they worked 52 hours or more and had positive wage earnings. Individuals are classified as living with other earners if anyone in the family unit reported both positive hours and positive earnings during the year.

Measuring Social Assistance and Social Insurance

Social assistance includes all means-tested public transfers such as AFDC, food stamps, and General Assistance. The PSID data identify two welfare programs: AFDC and food stamps. All other social assistance programs are classified as other welfare. Social insurance includes all public transfers made on the basis of employment contributions; these include workers' compensation, unemployment insurance, and social security.

Measuring Economic Well-Being

Since this analysis focuses on changes in an individual's access to resources, household economic status in the absence of government taxes and transfers (pregovernment income), and in their presence (postgovernment income), are measured.⁶ To account for differences in family size, the equivalence scale weighting factor contained in the U.S. Bureau of the Census poverty measures is applied to each individual household income.

The variables used in this analysis describe the economic and family characteristics of individuals who receive disability transfers. The variables are intended to capture the relative costs and benefits of applying for or receiving transfers. At the individual level, a person's marital status, self-identification of disability, and labor force status are reported. Although individuals apply for and receive benefits, these decisions are often made within the context of family resources. Thus, the analysis reports on the presence of other earners, other transfer income, and the level of household size-adjusted income inclusive of taxes and transfers. Finally, household composition is examined by comparing the two types of living arrangements in which a recipient has no other adult present: single-person households and single-parent households. To the extent that co-residing adults have two sources of income (either

transfer income or earnings), these single adult families may be more vulnerable to economic losses associated with disability and thus more likely to apply for benefits.

RESULTS

The analyses presented here use multiperiod data to follow the path of adult SSI(DI) recipients in the five years prior to benefit receipt. The initial award is captured by requiring individuals to have five years of no SSI or DI benefits followed by at least one year of benefits. The longitudinal sample is used to examine the labor market activity, household economic well-being, and household composition of individuals prior to the beginning of SSI and DI payments. By examining these transitions, a clearer picture of who comes onto the disability benefit rolls, and what factors put individuals at risk for receiving benefits, can emerge.

Tables 5.1 and 5.2 report the percentage of individuals who are in a particular circumstance—such as having a disability, falling below the poverty line, or living in a single-adult household—in each year prior to benefit receipt (t). Table 5.1 describes the experiences of the sample of SSI recipients. The average age at award among SSI recipients is 42.0 years. About one-third of the sample is married in each of the five years. The percentage of individuals reporting that they have a disability increases as the award year (t) draws nearer, moving from 42 percent to 63 percent.⁷ As the employment and transfer receipt percentages reveal, many of these individuals are unemployed or out of the labor force and relying on transfer income well before they receive SSI payments. Less than 30 percent were employed five years before receiving benefits, and less than one-quarter were employed three years before receiving benefits. However, more than one-half were living with other earners and more than three-quarters were living in a household receiving some type of government transfer (social assistance or social insurance).

The stability of the percentage of other earners and the percentage of households receiving transfer income helps explain the very static pattern of pre- and postgovernment income over the evaluation period. Mean pregovernment income decreases modestly from five years prior

Table 5.1 Characteristics of the Population of Adult SSI Recipients in the Years Prior to Benefit Receipt in Year *t*

Characteristics	<i>t</i> -5	<i>t</i> -4	<i>t</i> -3	<i>t</i> -2	<i>t</i> -1	<i>t</i>
Individual ^a						
Married (%)	32	34	34	32	30	29
Self-reported disability (%)	42	45	50	56	61	63
Employed (%)	28	29	24	25	24	24
Household						
Other earners (%)	60	58	56	53	56	57
Receiving social assistance(%)	32	34	34	32	30	8
Receiving any public transfer (%)	73	72	77	82	82	100
In poverty (%)	32	34	36	32	31	37
Pregovernment income (\$)	9,151	9,170	9,416	8,459	8,413	8,253
Postgovernment income (\$)	11,421	11,593	11,913	11,333	11,387	11,639
Household composition						
Mean family size	3.82	3.75	3.50	3.39	3.32	3.23
Single-person household (%)	7.5	7.9	7.7	10.5	11.0	16.5
Single person with children (%)	17.3	12.4	15.6	13.8	12.7	8.2
All others (%)	75.2	79.7	76.7	75.7	76.3	75.3
Head or partner in household (%)	64.4	64.6	64.8	65.1	66.8	69.6
Child of head or partner (%)	28.4	28.3	28.2	27.9	25.8	21.9
Other related or unrelated adult (%)	7.2	6.1	7.0	7.0	7.4	8.5

SOURCE 1991 Panel Study of Income Dynamics

NOTE Sample of individuals 18-64 years of age who began to receive SSI benefits between 1979 and 1991 (*N* = 211). Results are weighted to reflect population values.^aIndividuals' average age at award in year *t* is 42.0.

Table 5.2 Characteristics of the Population of Adult DI Recipients in the Years Prior to Benefit Receipt in Year *t*

Characteristics	<i>t</i> -5	<i>t</i> -4	<i>t</i> -3	<i>t</i> -2	<i>t</i> -1	<i>t</i>
Individual ^a						
Married (%)	50	50	49	51	49	49
Self-reported disability (%)	42	44	49	55	66	75
Employed (%)	51	49	42	39	33	18
Household						
Other earners (%)	66	58	58	59	59	59
Receiving social assistance (%)	11	9	15	10	11	4
Receiving any public transfer (%)	57	58	65	64	72	1.0
In poverty (%)	14	12	18	16	23	20
Pregovernment income (\$)	17,104	16,004	16,579	15,649	15,651	13,383
Postgovernment income (\$)	17,238	16,676	17,211	16,670	17,472	17,350
Household composition						
Mean family size	3.33	3.25	3.13	3.07	3.05	2.92
Single-person household (%)	13.3	15.6	16.5	16.4	13.6	14.5
Single person with children (%)	7.3	6.9	5.6	5.7	9.0	8.5
All others (%)	79.4	77.5	77.9	77.8	77.5	77.5
Head or partner in household (%)	77.9	79.4	79.4	80.9	80.9	83.2
Child of head or partner (%)	16.8	15.4	16.5	15.1	15.0	12.7
Other related or unrelated adult (%)	5.3	5.2	4.1	4.0	4.1	4.1

SOURCE: 1991 Panel Study of Income Dynamics

NOTE: Sample of individuals 18–64 years of age who began to receive DI benefits between 1979 and 1991 (*N* = 199). Results are weighted to reflect population values^aIndividuals' average age at award in year *t* is 44.9

to receipt ($t - 5$) to the award year (t), declining by 8 percent. After taxes and transfers have been included, this decline in household income disappears. Mean postgovernment income actually increases by 2 percent over the same period.

Although household income does not fluctuate very much over the period, the components of household income do change. The divergence in pre- and postgovernment income over the five years indicates that as the award year draws near, an increasing portion of the average recipient's household income comes from public, rather than private, sources. Finally, the static pattern of average economic well-being comes with more than 30 percent of the eventual recipients in poverty each year. Thus, the income stability observed is at a relatively low level of economic well-being.

Apart from changes in individual characteristics and household economic well-being, future awardees may experience changes in household composition that create the need for, or access to, benefits. For some individuals, disability benefits may be the mechanism by which they can live independently. The final portion of Table 5.1 describes the changes in household composition and living arrangements that occur prior to period t . As the year of benefit receipt draws closer, the number of eventual recipients living in single-person households increases. This rise is correlated with declines in both the number of single-parent families and the number of individuals living with their parents. The percentage of single-parent families falls from 17.3 percent in $t - 5$ to 8.2 percent in t . Likewise, the percentage of individuals living in their parents' homes falls from 28.4 percent in $t - 5$ to just over 20 percent in t . The growth in the number of single-person households suggests that living in a single-person household and receiving SSI benefits may go together. Overall, these results show that a majority of eventual SSI recipients are heads or partners of their own households.

In Table 5.2 the focus shifts to DI recipients. Because of the minimum quarters of coverage required of DI applicants, their prebenefit experiences are likely to include more work and higher levels of economic well-being than the SSI recipients. The average age of recipients in the first year of benefits is 44.9 years. As with SSI recipients, the prevalence of disability among the sample members increases as the award date approaches. As the prevalence of self-reported disability increases, the percentage employed decreases, moving from 51 percent

in year $t - 5$ to only 18 percent in year t . DI recipients were more likely than SSI recipients to be employed five years prior to receiving benefits; one-half of the DI recipients were employed in $t - 5$ compared to less than one-third of the SSI recipients. Moreover, there is a discernible process of transitioning out of the labor market among DI recipients. Over the five-year period the percentage of eventual DI recipients employed declined steadily, whereas among SSI recipients employment status remained relatively static.

In addition to their own work efforts, DI recipients have more household resources to draw on than did the SSI recipients in the years prior to receiving benefits. A larger fraction live with other earners, more are married, and fewer are living in single-adult households. Not surprisingly, a smaller percentage are in poverty or receiving transfers. As for SSI recipients, mean postgovernment income among future DI recipients remains stable throughout the five years preceding their DI receipt. And like SSI recipients, pregovernment and postgovernment income among future DI recipients remains stable throughout the five years preceding their DI receipt. And like SSI recipients, pregovernment and postgovernment income among future DI recipients diverge as the benefit year approaches, implying a growing reliance on public transfers for income support.

Tables 5.1 and 5.2 describe the prevalence of characteristics and circumstances in each year among the sample of eventual recipients, but do not provide information about individual transitions or patterns of behavior over the five years. The remaining analyses focus on individual patterns and transitions prior to benefit receipt. Tables 5.3 and 5.4 show the percentage of eventual recipients living in a particular circumstance by the number of years prior to receipt. Since this analysis encompasses a five-year span, an individual may be in a particular state from 0 to 5 years. These results provide some indication of the duration of circumstances among eventual recipients.

Table 5.3 reports findings for the sample of SSI recipients. The first row of Table 5.3 shows that more than one-third of the eventual recipients reported being disabled in each of the five years prior to receiving benefits. An additional one-third never report being disabled in the PSID data. The next row of Table 5.3 shows that about one-half of eventual SSI recipients did not work at any time during the five years prior to receiving benefits. The remaining 50 percent who did work

Table 5.3 Characteristics among SSI Recipients Five Years Prior to Benefit Receipt (%)

Recipient was:	(Number of years prior to receipt)					
	5	4	3	2	1	0
Reporting a disability	36.2	3.7	10.6	7.8	11.3	30.4
Employed	9.9	9.1	9.4	8.4	12.1	51.1
Living with other earners	40.3	7.7	8.0	9.9	7.2	26.9
Receiving social assistance	15.6	11.3	3.9	3.3	17.0	48.9
Receiving any public transfers	61.0	11.0	5.8	6.6	5.2	10.4
In poverty	17.7	6.3	3.9	12.2	14.6	45.2
Living alone	7.1	0.2	0.4	0.9	5.3	86.1
Living as single parent	5.1	7.0	0.9	5.4	4.4	77.1

SOURCE: 1991 Panel Study of Income Dynamics

NOTE: Sample of individuals 18–64 years of age who began to receive SSI benefits between 1979 and 1991 ($N = 211$) Results are weighted to reflect population values**Table 5.4 Characteristics among DI Recipients Five Years Prior to Benefit Receipt (%)**

Recipient was:	(Number of years prior to receipt)					
	5	4	3	2	1	0
Reporting a disability	36.8	2.2	9.4	11.5	11.7	28.4
Employed	5.7	26.1	15.3	13.8	6.0	33.1
Living with other earners	47.5	5.5	5.1	7.2	11.2	23.5
Receiving social assistance	1.0	5.1	3.9	5.1	9.6	75.3
Receiving any public transfers	42.1	10.1	15.2	4.8	11.0	17.0
In poverty	3.6	4.5	4.0	9.9	15.1	62.9
Living alone	9.9	3.6	2.2	1.6	1.8	80.9
Living as single parent	3.3	1.3	2.1	0.5	5.4	87.4

SOURCE: 1991 Panel Study of Income Dynamics.

NOTE: Sample of individuals 18–64 years of age who began to receive DI benefits between 1979 and 1991 ($N = 199$) Results are weighted to reflect population values.

over the five-year period were about equally dispersed over the distribution of years 1–5, although a slightly larger number reported one year of market work than reported two, three, four, or five years of market work. Moving down the table reveals that a large fraction (40.3 percent) of eventual recipients lived with other earners in each of the five years prior to receiving benefits. An even larger fraction (61.0 percent) received some form of government transfer in each of the five year prior to receiving SSI. Only about 10 percent of the future recipients received no government transfers prior to being awarded SSI. Although a majority of eventual recipients lived with other earners and received government transfer income prior to receiving benefits, less than one-half maintained incomes above the poverty line in each of the five years. About 20 percent were in poverty over the entire five-year period, and about 25 percent were in poverty for one or two years over this period.

These results add to the picture of SSI recipients in the years just prior to benefit receipt. This view diverges slightly from the one cast in Table 5.1. Table 5.3 indicates that work is more important and transfer receipt less important than the percentages in Table 5.1 would imply. At the same time, the results in Table 5.3 show that the incidence of poverty among eventual recipients is higher than implied by the yearly prevalence rates in Table 5.1.

In Table 5.4, the analysis is repeated for DI recipients. Like the SSI recipients, about one-third of the DI recipients reported being disabled in each of the five years prior to receiving benefits, and an additional one-third were never captured as disabled in the PSID data. Although the patterns of self-reported disability are similar among SSI and DI recipients, Table 5.4 shows that eventual DI recipients are more likely to work, less likely to receive benefits, and less likely to be in poverty than individuals who move onto SSI. Two-thirds of the eventual DI recipients (compared to one-half of SSI recipients) work at some time over the five-year period; about one-quarter work in each year up to the year prior to receiving benefits. Only 25 percent report receiving social assistance over this period, although about 80 percent received some form of public transfer. Consistent with a greater reliance on work, only one-third of the DI recipients are in poverty at any point during the five years prior to benefit receipt, compared to more than one-half of eventual SSI recipients.

Tables 5.3 and 5.4 identify the fraction of eventual recipients who are either always or never in a particular circumstance. Tables 5.5 and 5.6 shift the focus to the proportion of beneficiaries who experience transitions prior to receiving benefits. These results capture the paths of those who were not at either of the endpoints (0 or 5 years) in Tables 5.3 and 5.4.

Table 5.5 reports results for SSI recipients. The first column records the percentage of individuals experiencing a transition at some time over the entire five-year period; the second column reports the rates of transition in the year prior to benefit receipt. Events for disability, divorce or separation, loss of employment, and move to a single-person household are recorded for the individual.⁸ In addition, changes in an individual's household economic status are recorded as loss of other transfers, fall into poverty, and a change (positive or negative) in household income of more than 50 percent. Finally, increases and decreases in family size are recorded. These transitions describe the amount of movement into and out of circumstances that potentially change the need and eligibility for disability-related benefits.

Among SSI recipients the events of disability and job loss are the most common. About 30 percent of the sample of SSI recipients moved from reporting no disability to reporting a disability during the five-year preaward period. Only about 10 percent reported that the transition to disability occurred just two years prior to being awarded SSI. Loss of employment was slightly more common. Loss of employment is defined as moving from having earnings to not having earnings at some point between $t - 5$ and $t - 1$. Thirty-two percent of the sample reported such a transition. A little less than half that number, 12 percent, report a loss of employment between $t - 2$ and $t - 1$.

Based on the movements recorded in the previous tables, both the loss of employment and the transition into disability were expected. Less expected were the large number of individuals who experienced a change in one of the measures of household economic well-being. Tables 5.1 and 5.3 showed that the percentage of eventual benefit recipients living in households with other earners and receiving transfer income was relatively stable over the five-year period. But Table 5.5 reveals that the stability captured for the average is not representative of all individuals. More than one-quarter of eventual SSI recipients lose the support of other earners in their household prior to receiving

Table 5.5 Changes in Family and Economic Circumstances Prior to Benefit Receipt among Adult SSI Recipients (%)

Change	Periods <i>t - 5 to t - 1</i>	Periods <i>t - 2 to t - 1</i>
Individual		
Event of disability	29	10
Divorce or separation	3	1
Move to a single-person household	6	3
Loss of employment	32	12
Household income		
Loss of other household earners	26	4
Loss of welfare income	24	10
Loss of all transfer income	18	5
Fall into poverty	28	9
50% or larger decline in postgovernment household income	20	7
50% or larger increase in postgovernment household income	42	10
Household composition		
Decline in family size	52	17
Increase in family size	34	14

SOURCE: 1991 Panel Study of Income Dynamics.

NOTE: Sample of individuals 18–64 years of age who began to receive SSI benefits between 1979 and 1991, ($N = 211$) Results are weighted to reflect population values

Table 5.6 Changes in Family and Economic Circumstances Prior to Benefit Receipt among Adult DI Recipients (%)

Change	Periods <i>t</i> - 5 to <i>t</i> - 1	Periods <i>t</i> - 2 to <i>t</i> - 1
Individual		
Event of disability	32	14
Divorce or separation	8	1
Move to a single-person household	6	1
Loss of employment	53	17
Household income		
Loss of other household earners	22	3
Loss of welfare income	17	4
Loss of all transfer income	19	2
Fall into poverty	29	12
50% or larger decline in postgovernment household income	23	5
50% or larger increase in postgovernment household income	44	14
Household composition		
Decline in family size	38	13
Increase in family size	30	11

SOURCE 1991 Panel Study of Income Dynamics.

NOTE: Sample of individuals 18–64 years of age who began to receive DI benefits between 1979 and 1991 (*N* = 199). Results are weighted to reflect population values.

benefits. Similarly, 24 percent stop receiving social assistance for at least one year prior to receiving benefits. Fewer individuals move entirely out of the transfer population. About 18 percent lose all transfer income during the five years prior to receiving benefits.

Nearly 30 percent of the recipients transitioned from not poor to poor over the course of the period. One-fifth experienced a drop in their postgovernment household income of more than 50 percent. The frequency of these types of transitions point to a significant level of economic uncertainty during the years preceding movement onto the SSI rolls. This economic uncertainty is underscored by the finding that 42 percent of eventual SSI recipients experience a 50 percent or larger increase in their postgovernment family income during the study period. Although increases in income are much more likely given the low base from which these individuals start, these fluctuations indicate that many future recipients experience substantial changes in their household income just prior to benefit receipt. Finally, both increases and decreases in family size are common in the years prior to an SSI award. About 50 percent of the future recipients experience a decline in family size at some time during the five years before receiving benefits. A smaller number—about 34 percent—have an increase in family size.

Taken together, these results point to a frequency of events that put individuals at risk for losses associated with their disability. The fact that changes in economic and household factors are as common as changes in health suggests that for many eventual SSI beneficiaries, becoming a recipient may often be a response to economic factors that interact with health.

Moving to changes among DI recipients, Table 5.6 reports similar patterns to the ones found for SSI recipients. Loss of employment is more common than changes in disability status. Loss of other earners and loss of public transfers occurs for about one-fifth of the sample. Approximately equal numbers of DI and SSI recipients experience a fall into poverty, or a positive or negative change in postgovernment household income. A smaller number of DI recipients, compared to SSI recipients, experience declines in family size, but about the same percentage report an increase in family size.

CONCLUSIONS

This analysis has examined the characteristics of individuals in the years prior to receiving disability-related benefits. The picture that emerges is one in which changes in individual employment, household economic status, and household composition are as likely as changes in health. Moreover, for a large fraction of individuals, health status remains constant over the course of the five years prior to benefit receipt. However, since the PSID data include no measure of severity, no clear interpretation of this can be made.

Like other research, this analysis confirms that work is an important component in the lives of many future recipients. Transitions out of employment in the five years prior to benefit receipt occur for about 30 percent of the SSI recipients and for about 50 percent of the DI recipients. It is these groups who could potentially benefit—conditional on the severity of their impairment—from programs that encourage work and attempt to maintain people independently in the labor market. Despite some connection to the labor market, a large fraction of benefit recipients have been on public transfers for a number of years, particularly among SSI recipients. For these individuals, interventions designed to avoid movement onto the transfer rolls must begin long before they apply for disability transfers.

While these data do not permit more elaborate determinations of the experiences of disability benefit recipients in the years prior to their awards, the results encourage this type of analysis. Further research in this area will help complete the picture of the transition of individuals onto the disability rolls and the types of assistance and support that would best serve to reduce long-term reciprocity.

Notes

1. See Chapter 3 for an analysis of the relationship between economic conditions and the disability rolls.
2. The PSID data do not consistently permit the identification of concurrent SSI/DI recipients. To account for the possibility that SSI/DI concurrent recipients are different from SSI-only recipients, a two-year SSI receipt criterion is applied for sensitivity analysis. This two-year restriction is based on the findings of Rupp and Scott (1995), which show that approximately 75 percent of concurrent SSI/DI

recipients exit the SSI program within the first year. The results are not sensitive to this change.

3. The sample is a proxy for the first onset. In the case of SSI recipients who came into the panel after 1974, and those who were eligible for benefits under the previous programs for the aged, blind, and disabled, individuals may have had spells of benefit receipt that are not observed in the data. In the case of DI benefits, individuals may have had benefits prior to the beginning of the panel in 1968 or prior to becoming part of the panel at some later period.
4. Using the stated criteria, there are 293 SSI recipients and 258 DI recipients. However, 82 of the SSI recipients and 59 of the DI recipients are not part of the PSID original sampling frame. These "out of sample" members of the PSID do not have sampling weights and therefore cannot be used in this analysis.
5. The robustness of the results to the small sample sizes was checked by shortening the in-sample requirement from five to three years. Although the sample sizes increased by approximately 50 cases the results were not changed. Therefore, the analysis reported refers only to the five-year requirement sample.
6. The tax routing developed by the staff of the PSID is used to compute the post-government income measure.
7. Given that each member of this sample has passed the substantial gainful activity test to receive benefits, it is somewhat surprising that only two-thirds report that they have a disability at the time they are awarded benefits. This discrepancy in self-identified disability and an official disability classification may be associated with the lack of specific questions about mental impairments in the PSID data.
8. Death of a spouse is not an option for SSI recipients due to the difficulty in identifying why benefits were received (i.e., for disability or survivorship).

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Comments on Chapter 5

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Mary Daly uncovers the instability that lurks beneath the seemingly stable behavior of aggregate measures of poverty and living arrangements among people in the years prior to the receipt of disability benefits. For example, the percentage of adult Supplemental security Income (SSI) recipients living with other earners in each of the five years prior to receiving benefits remains almost constant at just under 60 percent. However, Daly shows that during those five years prior to receiving benefits, over 20 percent of recipients experienced the loss of an earner in their family.

These important results, however, can be easily misinterpreted if used to draw conclusions about the causes of Social Security Disability Insurance (DI) or SSI receipt. Take the above statistics. One should not conclude that the loss of an earner from one's household necessarily leads to a big increase in the chances of going on SSI. If the total number of future recipients in households with other earners stays constant at 60 percent, and 20 percent are losing household earners, then many future recipients, maybe as many as 20 percent, must be gaining household earners. One could equally conclude that gaining a household earner increases one's chances of receiving SSI! Of course, what could be happening are two separate types of events. Some people could lose the assistance of other earners and seek help through the SSI program, while others could be finding it harder to live on their own and so move in with others, but still end up receiving SSI.

The point is that there are a lot of transitions occurring among these people. It is unclear, however, how these factor in to the dynamics of SSI and DI reciprocity.

The fact that instability exists among future SSI recipients is not surprising. After all, in order to qualify for SSI benefits a person by definition has not had a stable work history.

The finding that there is a reasonable amount of change in the family and economic circumstances prior to the receipt of DI benefits is more interesting. Nevertheless, the impact of this finding is tempered by the fact that Daly makes no comparison with people *not* receiving benefits. How can you judge if instability is associated with DI receipt unless you know if future DI recipients experience more or fewer transitions than their nondisabled counterparts?

The work Daly has done is an important first step at examining the path to receiving disability benefits and provides a much needed description of the lives of beneficiaries prior to their becoming beneficiaries. Interesting extensions of this work would include

- comparing the rate of transitions reported in Chapter 5 to similar rates for people with similar levels of economic resources who do not end up receiving benefits
- investigating how circumstances surrounding transitions that lead to receipt of benefits differ from other transitions
- undertaking an event history analysis, or some other procedure, to determine how changes in living arrangements and economic circumstances affect the probability of beginning a spell of SSI or DI reciprocity
- decomposing the disabled into categories of people who have had more similar experiences, for example by age or type of disability.

Comments on Chapter 5

Virginia Reno

National Academy of Social Insurance

This is a very well-done paper. It is a thoughtful, clear, and concise descriptive analysis of what can be learned from the Panel Study of Income Dynamics (PSID) about Social Security Disability Insurance (DI) and Social Security Income (SSI) beneficiaries in the years prior to benefit receipt. It leaves the reader wishing to know more, yet grateful that the author did not stretch the analysis beyond what the data can show. I have two brief comments about the paper's conclusions and some more general observations about disability policy research.

The paper concludes that changes in employment and economic status are as likely as changes in health in the five years before receipt of DI or SSI disability benefits. On one level, this should not be surprising. The purpose of DI and SSI is to provide benefits to people with severe *work disabilities*, not simply those with impairments. Consequently, it is reasonable to expect changes in employment and economic status along with changes in health status prior to benefit receipt.

This finding is consistent with what we heard in focus group interviews conducted for the Academy's Disability Policy Panel (Mashaw and Reno 1996a, p. 177–193). Those interviews included beneficiaries in three broad impairment categories: musculoskeletal, mental, and "other," which included circulatory, respiratory and other body-system diseases. In all three groups the onset of *work disability* was often gradual. Despite the onset of illness or injury, people often remained at their jobs months or even years after the onset of their conditions. They typically turned to DI only after they could no longer hold down their jobs. Often they had exhausted other remedies, such as rehabilitation, and other avenues of support, such as unemployment insurance or workers' compensation. Those on SSI sometimes had relied on other assistance before they learned about and qualified for SSI. While focus groups are only anecdotal, they, like the PSID data, suggest that the

transition onto the disability benefit rolls is a gradual process. Benefit recipients tend to be older workers with chronic, progressive conditions. They do not fit a conventional image of "persons with disabilities" that might be conveyed by the popular wheelchair logo. Wheelchair users are only a small proportion of DI beneficiaries, less than 5 percent some years ago (Lando, Cutler, and Gambler 1982). It appears that the nature of the person's impairment, and its interaction with the demands of work the person can reasonably be expected to do, are more important than the suddenness of impairment onset in understanding antecedents of benefit receipt.

Daly's paper goes on to conclude that "for a majority of individuals health status remains constant over the course of the five years preceding benefit receipt," but adds a caveat that measures of severity of health conditions are lacking. I would suggest that the caveat makes the conclusion of dubious validity. Because health status is measured in such a rudimentary way, changes in health status are not fully captured. In this analysis, health status and disability status are used interchangeably. It is a binary variable made up of answers to four questions about 1) disability or need for care; 2) whether primary activity is permanently disabled; 3) whether health is fair or poor; and 4) presence of a physical or nervous condition that limits the type or amount of work that can be performed. Presence of a disability is a positive response to at least one of the above. Absence of disability is none of them. By this construct, the only change captured is a transition from having none of these conditions to having at least one during the five years that end before benefit receipt. Changes in the severity of progressive health conditions after onset are not measured, nor are onsets that occur in the year of benefit receipt. Without more refined measures of health and disability status, the conclusion that health status remains constant does not seem to be supported.

The remaining points I want to make are not about the paper, but about what the author had to work with, or more important, what she did not have to work with. The paper highlights the serious dilemma researchers face in attempting to do policy research on the DI and SSI programs without adequate data. Investment in appropriate data bases has been sorely lacking over the last fifteen years. General household surveys designed for other purposes have two serious limitations for

studying beneficiaries, problems of sample size and ambiguity in identifying the population of interest.

The PSID yielded 199 persons classified as having been newly awarded DI benefits from 1984 through 1991, an eight-year period when 3.4 million persons were awarded DI benefits (SSA 1995, p. 264). Similarly, it yielded 211 adults identified as new SSI awardees over the thirteen-year period from 1979 through 1991 when 4.1 million adults were awarded SSI benefits on the basis of disability or blindness (SSA 1995, p. 302). The very sparse observations seriously constrain what can be reliably quantified with regard to the diversity of people's experiences as they enter the disability benefit rolls.

General purpose surveys simply are not very cost-effective ways to sample disability beneficiaries, particularly new entrants. Despite concern about the size of the disability benefit rolls, entry onto the rolls remains a rare event. DI incidence rates over the period under study ranged from about 3 to 5 per 1000 insured workers (Mashaw and Reno 1996a, p. 16). If we take account of the fact that only about three-fourths of the working-age population are insured, the overall DI incidence rate is about 2 to 4 per 1,000 Americans between 18 and 65 years old. SSI incidence rates are no larger than these over the period under study. Because receipt of social security or SSI disability benefits is rare, special surveys are needed to target and screen adequate samples of individuals who are at risk of entering the disability benefit rolls.

A second data limitation for the purpose of studying the characteristics of DI and SSI beneficiaries is the lack of an exact match between administrative records and responses to household surveys. There are a number of reasons to worry about the validity of beneficiary status as reported in household surveys. First, anecdotal evidence suggests that beneficiaries often are unsure about what kind of benefits they are receiving. Distinctions among DI, SSI, workers' compensation, or other public or private benefits are not as clear to beneficiaries as they may be to policy analysts. Second, in many household surveys, one person in the household answers for everyone in the household. If we are worried about beneficiaries knowing the kinds of benefits they receive, we should be equally worried about proxy respondents knowing this information. Third, there are situations in which a working-age person may be correctly reported as the "recipient" of social secu-

rity or SSI but is not the "beneficiary" whose health, disability, and employment status are of interest. This could occur if the recipient is a representative payee for a beneficiary who is too young, too disabled, or too impaired in old age to manage his or her own affairs. The payee is, technically, a recipient in that her or his name is on the check. Some 4.2 million social security beneficiaries and 1.7 million SSI beneficiaries have representative payees (Mashaw and Reno 1996b, p. 56). The payees are very likely to be working-age adults who are not disabled. It remains a question how general household surveys distinguish benefit "receipt" from disability beneficiary status among the working-age population.

For all of these reasons, our confidence in survey findings about the relationship between disability status and receipt of social security or SSI benefits among working-age adults would be greatly enhanced by an exact match with the Social Security Administration's administrative records. This is true whether we are talking about the PSID, the Current Population Survey, the National Health Interview Survey or the new Health and Retirement Survey. Exact matches are not simple. They must comply with federal confidentiality requirements and are resource-intensive to construct well. But they are critically important for policy research on disability benefit programs and the cost is small in relation to the size of the programs for which policy evaluation is needed.

I recognize that researchers always want more and better data. But for purposes of research on the DI and SSI programs, data no better than that which existed nearly two decades ago would be a vast improvement. Between 1960 and 1978 the Social Security Administration (SSA) sponsored special surveys of the disabled population every six years. The surveys were designed to capture the segment of the working-age population at risk of entering the disability rolls, as well as beneficiaries themselves, and some surveys included denied applicants. Each survey matched the reports by individuals in households with SSA's administrative records of the respondents' work and benefit histories. The period since 1978 has been a long dry spell in data base development.

This research conference is encouraging if it indeed harkens a revival of commitment within the federal government to investment in data bases that are needed to study the social security and SSI disabil-

ity benefit programs. A promising new development is the first release of data files of the 1994-1996 Disability Survey sponsored by an inter-agency consortium led by the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services (Adler 1996). In addition, the SSA's New Beneficiary Data System provides longitudinal data that follow a cohort of new DI beneficiaries for a decade after they entered the benefit rolls (Ycas 1996). Finally, SSA's Disability Evaluation Study, which holds promise for study of the programs' eligibility criteria, continues to move through the planning, development and funding process (SSA 1996). All of these are promising new developments for disability research

Mary Daly's paper is a masterful job of gleaning from an existing data base new insights about the antecedents of entry to the DI and SSI disability rolls. If all of the new data bases under development are brought to fruition, researchers will have new opportunities over the next few years to refine our understanding of social security and SSI disability programs and the people who turn to them.

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Part II

A Closer Look at State and Local Experiences

6 The Growth in Disability Programs as Seen by SSA Field Office Managers

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There are 1,300 persons in the Social Security Administration (SSA) who have witnessed firsthand the recent dramatic growth in the Social Security Disability Insurance (DI) and SSI disability programs: the managers of local social security offices. This group provides a truly unique source of information, and we knew, if asked, they would give us straightforward, thoughtful responses. So in March 1994 we surveyed them for their perceptions as to what factors contributed to the increase in the number of persons applying for and receiving disability benefits.

The survey had both structured questions—to get the managers' thoughts on specific issues such as the impact of the local economy and the types of advisors and organized outreach efforts in their area—and open-ended questions—to enable the managers to provide any feedback they wanted. All 1,300 managers were surveyed, and 1,171 responded, for a 90 percent response rate. About 38 percent of those responding (or 446 managers) took extra time and effort to write insightful, in-depth comments to the open-ended questions.

Before getting into the findings, though, it is important to mention three caveats to the survey. First, the managers were not anonymous in the survey. It was critical that we be able to recontact them for clarification if needed. (Judging from the quoted material in this article, however, they certainly seemed to be indifferent to being identifiable.) Second, much of the information requested was subjective: the survey solicited their opinions, not quantifiable data. And third, the survey did not discriminate between factors that would affect social security (DI) versus SSI claims. (Note: A more detailed version of this paper—with

additional information about the survey, its methodology, and findings—is available from the authors.)

SURVEY FINDINGS

The field office managers identified a wide range of factors that they thought affected the recent (since 1989) growth in the number of persons applying for and receiving disability benefits: local economic conditions, increased awareness of the availability of benefits, court cases, the decision process (that is, the way SSA determines if a person is disabled), changes in medical standards, the impact of state and local governments, the value of the disability benefit package, the lack of continuing disability reviews, other financial incentives (such as a private insurance company's requiring a disability application as a condition to receive payment), and other miscellaneous factors.

Considering these factors led us to conclude that the growth in the disability programs was not simply a demand-side phenomenon (that is, the growth was not simply due to the fact that more persons were seeking benefits and/or more beneficiaries were staying on the rolls). There was a supply-side effect as well: for example, court rulings had made whole new classes of persons eligible for benefits, and outreach efforts had sought applications from persons who had heretofore not chosen to apply for benefits. Further, we found that the factors could be grouped by whether they were internal or external to the agency (Table 6.1). The distinction is important because the external factors are outside SSA's control, but the internal factors can be more easily altered or influenced by policymakers.

Local Economic Conditions

High unemployment is often thought to cause an increase in the number of persons applying for disability. The field office managers were asked the extent to which they believed that local economic conditions influenced the number of applications in their area. About a quarter of the managers said that local conditions had either no impact (9 percent) or had very little impact (14 percent); the remaining three-

Table 6.1 Factors Identified by Field Office Managers as Influencing the Growth in SSA Disability Programs

Demand effects	
External to SSA:	Internal to SSA:
Economy, unemployment	Outreach, program awareness
Changing occupational structure	Higher allowance rates
State cutbacks, burden shifting	Fewer continuing disability reviews
Advisors, attorneys, etc.	Attractiveness of benefits package
HIV/AIDS	Easier medical standards
Incentives to apply	Attorney fee policy
Aging of the population	
Change in attitudes, less stigma	
Supply effects	
External to SSA:	Internal to SSA:
Court cases	Outreach
Congressional mandates (includes outreach, medical improvement standard, etc.)	Easing medical standards (includes <i>Zebley</i> regulations, new mental listing, drug addicts and alcoholics)
	Fewer continuing disability reviews
	Workload credits

quarters of the managers were about evenly divided between those who believed that local economic conditions had a modest impact (39 percent) or a large impact (37 percent).

Managers were asked to cite some past events that had affected their particular office. Some listed event after event of specific plant closings and severe cutbacks, clearly demonstrating a sensitivity to events in their local economy and labor market. Others simply said “general economic conditions” or “layoffs in construction industry.” More than a third of the managers listed three or more events. Some said that growth during the recent recession was different from that of past recessions. Under-employment was cited as often as unemployment as

the source of the problem. Some managers, however, said their area experienced growth in the number of disability applications and awards despite a healthy or improving economy. A few of the reasons they gave for this are discussed in the section on miscellaneous factors.

Overall, the survey responses from the field office managers tended to support a link between poor local economic conditions, unemployment, and layoffs and increased applications for disability benefits. Among the comments offered were the following:

Economic conditions definitely have a major impact in the rise in disability claims. When factories have massive layoffs or close down, we receive DIB [disability insurance benefit] claims from workers with medical problems who had been working despite of their impairments.

The economy has taken a downturn. You cannot lay off thousands of people in their mid-forties and not think that they are not going to file for benefits.

Lack of retraining, lack of access to health insurance, and unavailability of alternative employment that replaces lost earnings can lead to physical and/or emotional deterioration that gradually builds until SSA is the only option left.

Increased Awareness of the Availability of Benefits

Since the late 1980s, SSA has made a concerted effort to increase public knowledge and understanding of the disability program. Did the managers think that these efforts contributed to the growth in the disability programs? Clearly they did.

The managers were asked for some details about their own efforts in this area. For example, did their office provide information about the disability program to the local media? About 80 percent said yes. (Managers who responded negatively sometimes noted that these activities were handled by their area director's office, or that their office was in a major metropolitan area so that these activities were done by the offices in the city. Some managers said that they had tried to place materials in the local media, but were unsuccessful due to lack of interest from the media—usually newspapers.) The survey listed eight public information or outreach activities that might have been done: more than half of the managers did at least three.

Nearly four out of five field offices maintained outside contacts for the purposes of providing information and advice. The contacts were usually with hospitals, advocacy groups, welfare and social service agencies, mental health clinics, doctors, employers, vocational rehabilitation providers, AIDS clinics, and penal institutions. More than half the managers said that their office had made special arrangements with these contacts for taking disability claims.

Obviously, the managers had put considerable time and effort into their public information and outreach work—which may explain why many of them were frustrated with our inquiries about outreach activities.

We were asked to do SSI outreach for many years. When we are asked to do something we do it and we do it quite successfully. Why do you now want to know why there was an increase in applications?

Question—if we’ve pushed outreach for years and awarded millions to grantee agencies [to help us reach all potential claimants], why are we now concerned that applications are on the rise?

It appears that our agency’s own initiatives are responsible. Several years ago we undertook massive outreach initiatives to spread the word and contact as many potential disability applicants as possible. We worked hard at this; we were successful; and, now we are reaping the benefits of our efforts. The increase in disability claims is not a great mystery to us in the field offices. Rather it is a logical outcome of this agency’s initiatives and goals over the past several years.

Some managers felt that SSA had gone overboard in its outreach efforts—and they said so:

I strongly believe that SSA is pushing outreach too much.

I personally believe SSA has taken outreach efforts to the extreme. In doing so I’m concerned that we have not always served the other half of those we represent—the taxpayer—properly.

In addition to SSA’s outreach and public information activities, there are many other ways that a person could have become aware of the DI and SSI disability programs. Some of the ways mentioned by the managers include referrals from state or local agencies or advocacy

groups; referrals by attorneys; the publicity generated by court cases; or word of mouth.

According to nearly 90 percent of the managers, claimants were often sent to their office by local welfare agencies. One-third said that the local legal aid society, advocacy groups for the disabled, or private social service agencies often referred claimants to them. The survey asked if any of these groups gave bad advice—that is, were they referring persons who were clearly not eligible for disability benefits? More than 20 percent of the managers could name one or more advisors who consistently did this: half of them cited local welfare agencies—those who administer the General Assistance, Aid to Families with Dependent Children (AFDC), food stamps, and Medicaid programs. One manager stated:

Most of our applicants are referred to us by the state welfare offices. . . . Many physicians believe they are "helping" their patient to continue receiving welfare benefits if they were to check 12 months or longer, not realizing that the patient is then required to file for SSA/SSI benefits. Claimants with broken leg(s), or pregnancy or some other mild ailment are unnecessarily being referred.

Nearly 60 percent of the managers said that attorneys in their area often advertised for disability claimants. Furthermore, about 90 percent of the managers could list at least one person or organization in their area who actively promoted filings for disability benefits by providing either information or assistance to persons going through the application or appeals process. Nearly 25 percent of the managers could name nine or more such advisors! In all, the managers gave over 3,500 names of persons or groups who provided advice and assistance. (Perhaps the most interesting of these were the third-party arrangements whereby a state government contracts with a private company and pays a fee for each individual who is deemed eligible for a disability benefit. For example, under one Maryland program, the private contractor is paid a fee for each welfare recipient who is placed on the SSI rolls. Other states and localities have adopted similar strategies.)

More than 80 percent of the managers said that TV, radio, or newspapers in their area usually or sometimes provided coverage of the disability programs.

The press reports on people receiving SSI because of drug or alcohol addiction have resulted in an increase in people filing alleging these disabilities.

News articles on the substance abuse cases allowance rates have had some impact.

Word of mouth was cited as a source of information by nearly 20 percent of the managers who offered comments. They said that new applicants often came to their office after talking with other applicants or because they were encouraged to apply after hearing stories about others being allowed benefits and getting large retroactive checks.

The impact of “word on the street” in connection with SSI for children and DA&A [benefits based on drug addiction and alcoholism] cannot be ignored. Individuals file because neighbors and relatives have received benefits. It is not infrequent that a parent will make an appointment for a child who has been diagnosed by the schools with “special needs,” but by the time of the appointment he/she will want to file applications for other children in the family.

Court Cases

Court decisions was the topic most frequently addressed in the field office managers’ comments: fully half of them mentioned the courts as a factor in the growth of the disability program.

Nothing creates an incentive for filing a claim like a court case which results in adding a lot of people to the rolls. Nothing creates new claims like a neighbor getting a big retro check.

And among the court cases, none has had more impact than the *Zebley* decision. In fact, the *Zebley* case (which dealt with benefits for disabled children under the SSI program) was the single factor most cited as influencing the growth in the disability rolls: 43 percent of the managers who offered comments said it was a major factor in the increase in workloads and growth in the disability program. The managers also thought that some teachers and school administrators either assisted parents to apply or actually pushed parents to apply because their school could then receive benefits (such as additional special education funding and access to medical and other tests). As one manager stated:

These [SSI disabled children's benefits] are being pushed by local schools, physicians, and most of all economically disadvantaged parents. In addition to the cash received by the family, entitlement to our disability programs opens the door to other federal government funding for agencies as well as individuals in assisting these children.

None of the managers indicated approval of SSA's *Zebley* policy; all indicated that this was an area in need of attention. Some of the managers had strong opinions.

We have observed some disability claims (mostly SSI disabled child's claims) where the medical evidence used to establish benefit entitlement has seemed to us to be so "slim" that it would make one think that almost any adolescent and pre-adolescent child going through the typical socialization experiences and "growing pains" may qualify for SSI.

Rarely do we take a claim from a disabled child who has a physical disability. Almost all of them are mental. The decisions are based on subjective "evidence" and the claimants have learned how to act and answer the questions. I do not have the figures but it appears that generally there is more than one SSI applicant or recipient in the household. It is not unusual for an applicant to file for 2 to 5 children at the same time.

Once a parent gets one child on SSI they begin the process of qualifying others in the family, 5 or more siblings getting SSI is not unusual.

The Decision Process

The application and decision process has clearly changed in recent years. Allowance rates (particularly through reversals at the Administrative Law Judge [ALJ] level) are up. Attorney involvement is up, appeals rates are up, and denied applicants refile more than they did in the past. SSA's attorney fee arrangements guarantee payment will be received—and large backlogs and slow processing time, combined with high ALJ allowance rates, guarantees large retroactive payments and large fees for representatives. The managers had the following comments about recent changes in the decision process.

Field office staff believe that there are too many levels of disability appeal and find it difficult to accept SSA's disparities of allowances at the different decisional levels: 30% at initial level, 12% at reconsideration, and 80–90% at hearings level.

We are seeing more non-attorney reps soliciting clients, even across state lines; some appear to have questionable motives, to the point of coaching prospective applicants on responses, impairments, limitations, and conduct.

We continue to get disturbing allegations that the word is out and that anyone can get disability by “faking” their way through consultative examinations. We are repeatedly getting disability applicants who have never been treated for their alleged impairment and the sole medical source for the decision is a single consultative exam.

Disability applicants have expressed a belief that there is a different set of criteria used at the hearings level. Applicants frequently ask if they can't go straight to filing a request for a hearing because they have had other applicants tell them they will be denied at the initial and reconsideration levels but will be allowed at the hearing level.

We believe the High allowance/Reversal rate by ALJs encourages both applicants and local firms to pursue disability no matter how slight the impairment might be. “The word” is out on the street—file for disability. You'll get denied but if you appeal to a judge you'll get approved. Unfortunately, the stats prove this theory . . .

. . . they will file and refile if denied. Many believe that if you keep trying, an approval will come sooner or later.

Changes in Medical Standards

More liberal standards—either because of court cases, legislation, or changes in regulations—have encouraged more individuals to apply for benefits. Comments about SSA's drug addiction and alcoholism (DA&A) policy were offered by nearly 20 percent of the field office managers who provided comments. As was the case with comments concerning the *Zebley* case and SSI childhood disability benefits, no manager indicated that SSA had made an improvement to the program with its current policy in this area.

Drug and alcohol abusers are also finding easy benefits with SSI. A couple of years ago, addicts needed a primary diagnosis relating to a mental or physical impairment before benefits could be paid. As I am writing this, I have an SSA-831 [disability determination form] in front of me showing a primary diagnosis of Cocaine Dependence, with a secondary diagnosis of Alcohol Abuse. This applicant has no physical or mental impairment alleged or diagnosed. Most addicts have responded positively to the promise of easy, free money from the government.

The most significant cause for the increase in our disability claims was because of the change in criteria for the mentally ill and DA&A cases. . . . We need a different approach to behavior controlled illnesses. . . . Our present system only encourages people to continue their destructive behavior.

In 1984 Congress mandated that SSA review and update its listings of mental impairments. This was done, and allowances for mental impairments rose considerably before leveling off. Nearly 10 percent of the managers who offered comments mentioned mental impairments.

The word is out in the legal profession that: (a) if you go to a hearing and (b) show some mental involvement of disability in addition to the physical documentation, you will win.

If a comment by an applicant or observation by an interviewer shows any indication of a mental problem, we order a psychological [exam]. This is done even though the claimant has never been previously treated for a mental problem and in all probability never will be. Thus, in numerous cases, a one time exam forms a significant piece of evidence on which an allowance is made. We base allowances on such terrible impairments as attention deficit disorder, hyperactivity, personality and mood disorders.

About 7 percent of the managers who gave comments discussed the impact that easier standards and high or disparate allowance rates were having on the program. One manager noted how his own disability determination service responded to pressure to loosen standards:

After media coverage of the low allowance rate . . . of individuals filing for disability benefits, we began to see our allowance rate increase from 24 percent to 48 percent. It is now averaging about 40 percent.

However, not all managers felt that easing the standards was an error on SSA's part. Some felt that these more liberal standards were more appropriate, particularly in light of the problems some workers have in finding jobs. One manager questioned the validity of the standards "when 80 percent of the initial claims are denied."

The Impact of State and Local Governments

Many states have tried to solve their budget problems by cutting back their social programs and shifting the financial burden to the federal government. Has this affected the DI or SSI disability programs? Of course: about 10 percent of the managers who offered comments mentioned state welfare offices and their referral policies as a factor in the growth SSA disability programs; more than 5 percent mentioned cutbacks in state welfare benefits and other programs; and about 5 percent mentioned state efforts to shift the burden from state or local programs to federal programs.

We believe another major factor is increased referrals from public and private welfare agencies. The economic crunch facing states and localities has caused them to look to SSA programs as they have never done before.

Our local welfare office employs over 250 people, our office but 21. The welfare office now has 4 disability advocates whose job it is to refer people to get them off welfare rolls and onto other programs like SSI and disability.

The Value of the Disability Benefit Package

Some managers felt that the benefit package (cash benefits as well as health coverage under Medicaid or Medicare—after a twenty-four-month waiting period) was becoming more generous than the work alternative, considering the paucity of good, high-paying jobs. Benefits—especially SSI benefits to disabled children—were considerably more generous than welfare payments. Although only 3 percent of the managers who commented mentioned the value of the benefits package, some of their comments are worth noting.

The program is turning into an income subsidy for anyone who can get it, with very large financial rewards when you include

medical assistance, cash tax free payments, and all the other related benefits. People can still earn a lot of wages or SE [self-employment income] each month plus the underground economy.

In many instances receipt of SSA and SSI benefits provide a standard of living comparable to that of those who work full time in this area.

AFDC households are enticed by the possibility of receiving monthly check of \$469.00 per child instead of the \$115/month AFDC grant, with no limit for the number of children in the household. We have an unknown number of households in our service area receiving SSI for 2, 3, and even 4 members. They tell others in the neighborhood who come in to file for their child who they say is “dumber” than the neighbor’s child who is getting SSI.

The Lack of Continuing Disability Reviews

Over the past several years, SSA has opted to conduct fewer Continuing Disability Reviews (CDRs) in order to devote more staff to processing the backlog of initial claims. In the past, CDRs were done regularly to make sure that a person continued to be eligible to receive disability benefits. About 20 percent of the managers who offered comments felt that the reduction in CDRs contributed to program growth—not because there were fewer beneficiaries being found ineligible and thus removed from the rolls, but because fewer CDRs encouraged claimants to apply—it made benefits appear to be a lifetime promise of support. All the managers who commented in this area indicated that conducting more CDRs should be a priority; none thought that this was a workload that could be sacrificed without a detrimental effect on the programs. Some of them commented as follows.

Even the fact that Social Security has failed to perform a significant number of medical CDRs in the last few years may contribute slightly in making disability-based benefits appear more attractive. Having a “permanent” source of income may increase one’s motivation to contact Social Security and apply for benefits.

We believe the permanent nature of SSA disability benefits (usually paid for the rest of an individuals life) encourages filings as a means of a lifetime income.

CDR's [continuing disability reviews] aren't being done, so the idea is becoming more wide spread that if you "get on" Social Security disability you are there forever, so it is worth the effort.

Other Financial Incentives

The survey asked the field office managers to list any sources of financial incentives offered to individuals to encourage them to apply for benefits. One-fourth of the managers listed one or more such incentive. Among those mentioned were 1) some private insurance companies require an application for disability benefits as a condition for disability or long-term sickness benefits—and some reduce disability pay if the insured fails to apply; 2) some employers or unions require a disability filing as a condition for extended sick pay; 3) some welfare or general assistance programs provide a higher payment while a disability claim is pending or require a disability application as a condition for receiving benefits or continuing benefits; 4) some state general assistance or welfare programs do not have work requirement for persons filing for disability benefits; 5) some local governments have a fund for health expenses for indigents that pays medical expenses only while a claim is pending; 6) some AFDC payments are terminated after a child reaches a certain age unless there is a disability claim pending; and 7) some states provide no access to the Medicaid program unless there is a disability application pending. Some of the managers pointed out:

We receive far more applications from persons who know they will be denied but are required by their insurance company to file. Insurance company can then get a copy of our file and not have to pay for a lot of medical reports.

We have numerous employers with sick pay plans which require participants to file for DIB [disability insurance benefits]. In many cases, there is no doubt that the claim will be denied. However, the individual must file as a requirement to continue to receive benefits. In some cases, the individual says they know they will be denied and are filing only because they must.

The State, through Welfare and the school boards, as well as some private Agencies, quickly figured out by having children file for

SSI, we would conduct needed medical tests at our cost. With a simple release form they then have access to those records.

Many of the people who file for disability are required to do so by the State or County in order to receive medical assistance. They only need medical help not disability benefits to get back on their feet. Universal medical coverage would reduce the number of applicants.

Some people file for SSI each year or so, even though they are regularly denied, because they want a visit to the doctor, and we will pay for consultative exams for those without medical evidence.

Other Miscellaneous Factors

Changes in Attitude

Field office managers stated that they've noticed a real change in the public's attitude about receiving government benefits. There is a greater acceptability—with less stigma attached. Some of the managers said that they have found that disability is now viewed as an acceptable alternative to work.

. . . there are available jobs in high enough numbers to rule out local economic conditions as the primary factor for any increase in disability claims. The fact is, however, when a potential job applicant or already employed person working for the Federal minimum wage or even \$5.00 an hour sees their monthly take-home pay vs. what their friends are getting in monthly welfare or disability benefits, there is no incentive to work . . . It is therefore our belief that IT IS THE WORK ETHIC that is missing from the population in our area, not the lack of available work.

Prior to the 1960's, there was great reluctance on the part of most citizens to ask for government assistance. The work ethic was strong and those who could work, even in spite of impairments, sought every opportunity to work as a matter of pride and self-esteem. This is not longer the case. The definition of disability has changed in the minds of the American public. Conditions that were once seen as impairments are now seen as totally disabling. Shrinking job markets and the growth of government programs are contributing factors. The stigma that was once attached to asking for public assistance is gone . . .

A subtle change in how people view disability has occurred in recent years. It is no longer viewed (or even presented by SSA) as a severe long-term condition preventing you from doing anything. It is viewed today as an income supplement to unemployable or underemployed individuals.

The Aging of the Baby Boomers

More than 7 percent of the field office managers who offered comments mentioned changing demographics and the aging of the baby boom generation as a factor in the growth of the disability rolls.

We've noticed an increase in disability claims in our area even though our economy has remained strong, and we're not in a hot bed of advocacy group activity. My spin on the increase in claims is due to: the babyboomers are getting into their 40's and 50's, which is prime DIB [disability insurance benefit] filing time.

. . . there are more people in their mid to late 40's, i.e., the age that the individual is more likely to become disabled. In other words, the "baby boomers" are getting older and their age is causing them to fall victim to the impairment related statistics.

Prisoners and Prison Newsletters

Just over 4 percent of the field office managers who offered comments mentioned a growing trend among prisoners to seek benefits—which should not be surprising: SSA has been doing outreach efforts in penal institutions for several years. Two of the managers commented as follows.

Folsom Prison in our service area turns over 100 prisoners a week who believe they are SSI eligible and who will file claims as soon as they are on the street.

The prison system underground tells inmates they are eligible for DIB [disability insurance benefits] . . . In the last 4 years we have seen a big increase of applicants recently released from prison. Parole Officers often refer claimants to file for disability.

Employer Disincentives to Hire the Disabled

Despite whether the economy is good or bad, there are certain disincentives to employers to hire the disabled: a disabled worker may cause an increase in the company's group insurance rates, or he or she

may increase workers' compensation rates for the company or file workers' compensation claims. Several field office managers mentioned these disincentives as possibly influencing the growth in the DI and SSI disability programs.

Employers, because of workmen's comp, will not hire anyone with any type of physical problems.

Many people comment that they would work, but no one will hire them because:

- 1) Insurance/workers' compensation risk
- 2) Group insurance would be cancelled
- 3) Worried about workers' comp claims
- 4) Previous medical problems (e.g., back problems)

CONCLUSIONS

According to the field office managers, much of the increase in disability applications and awards was influenced by changes in the way SSA does business. Some of these changes were internal (for example, SSA's decision to do fewer continuing disability reviews in order to process more initial claims), and some of these changes were external (for example, the *Zebley* court case).

Overall, the field office managers strongly agreed in three areas: first, attention needs to be given to SSA's current policy regarding disabled children's benefits under the SSI program; second, attention needs to be given to SSA's current policy regarding drug addicts and alcoholics; and third, reinstatement of continuing disability reviews needs to become an agency priority.

The survey responses make it difficult to ignore the potential impact SSA's own decisions have on program growth: the growth since the late 1980s cannot be solely attributed to outside influences beyond the agency's control.

7 The Ending of General Assistance and SSI Disability Growth in Michigan

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Applications for Supplemental Security Income (SSI) disability benefits have risen dramatically over the last several years. This growth in applications and in awards has occurred for both juveniles and adults. While the *Sullivan v. Zebley* decision has had an impact on the standards, applications, and awards for juveniles, no similar ruling or policy shift applied to adults. Even so, applications and awards have risen dramatically. In an effort to understand this rapid growth, the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services commissioned Lewin-VHI to conduct case studies of five states: California, New York, Florida, Texas, and Michigan. This paper presents our findings for Michigan.

There are a number of factors that make Michigan an interesting case study. The rate of growth of applications for SSI disability benefits in Michigan has been among the most rapid in the country. Michigan was an early pioneer in welfare restructuring, and the growth of applications coincided with the elimination of the state General Assis-

NOTE: Work on this chapter was supported by the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services. Data collection for the General Assistance termination project was supported by the Ford Foundation. The paper solely reflects the views of the authors and does not necessarily represent the official positions of the Department of Health and Human Services. Much of the authors' interpretations represented here are based on interviews conducted with various individuals representing different organizations in the state of Michigan. We are grateful for the considerable time these individuals devoted to answering our questions. We also appreciate the assistance provided us by Alan Shafer and his staff at the Social Security Administration.

tance (GA) program in 1991. Moreover, there appears to have been quite an active outreach program in the state, with coordination among the Social Security Administration in Michigan, state agencies, and advocacy groups.

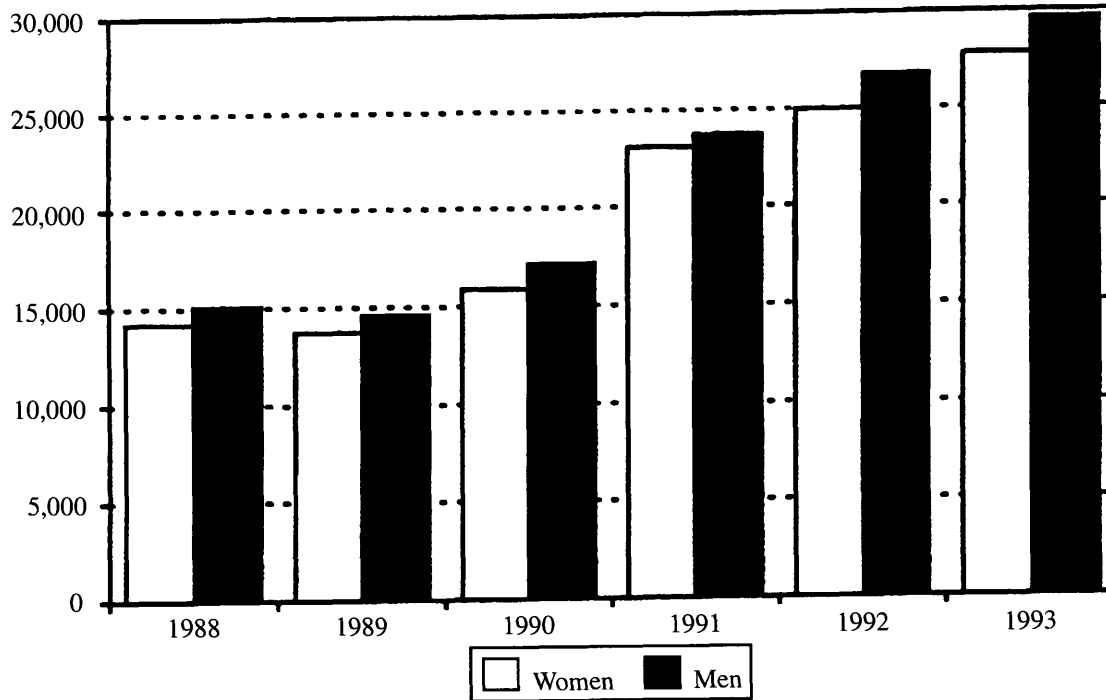
We have interviewed individuals working for the Social Security Administration, the state of Michigan, and various advocacy agencies in an attempt to learn from their interpretations of this phenomenon. We have also made simple calculations using data from the Social Security Administration and the Michigan Department of Social Services. Both our interviews and quantitative analysis present a fairly consistent picture of developments in Michigan.

In the remainder of this paper, we present data on the growth of SSI applications and awards in Michigan during the period from 1988 to 1993. We also present some background material on developments in the state of Michigan, focusing on the ending in October 1991 of Michigan's General Assistance program. Following this background material, we review information derived from our interviews and quantitative analysis of the administrative data. We end with a short discussion of what we think we have learned from the Michigan case study.

RECENT TRENDS IN APPLICATIONS AND AWARDS FOR SSI IN MICHIGAN

In Figure 7.1 we display annual adult applications for SSI disability benefits in Michigan from 1988 to 1993. Data for men and women are presented separately. These data are drawn from the Social Security Disability Research File (DRF) and are limited to adult disability applications and awards. They do not reflect growth encouraged by the *Sullivan v. Zebley* decision because that applied only to children. Overall, there were approximately 246,000 applications in the six-year period, at least some of which were reapplications after a denial of an initial disability claim. While nationwide adult applications rose by 54 percent between 1989 and 1993, in Michigan they doubled, rising from 28,000 applications in 1989 to 57,000 in 1993. Patterns for women and men were very similar. Over this same period of time, the non-elderly adult population in Michigan grew by less than 2 percent. Thus, very

Figure 7.1 Total Adult SSI Disability Applications



SOURCE: Social Security Administration Disability Research File

little of the doubling of the SSI applications can be accounted for in terms of population growth.

The data also show the fraction of SSI applicants awarded benefits rising from 44 percent of 1988 applications to 51 percent of 1991 applications. Award rates fell somewhat in 1992 and even more in 1993, but much, if not all, of this drop probably reflects the fact that a substantial fraction of the 1993 cohort of applications was still pending on appeal. Data on initial determinations show the fraction of SSI applicants awarded benefits at the initial determination continued to rise through 1992. Given the fact that the fraction of denied applicants was also rising over this period of time, it seemed likely that, at least for 1992 and possibly even for 1993, award rates would eventually exceed those of preceding years. The fact that awards were rising more rapidly than applications would seem to belie any notion that what was going on was simply an increase in the number of frivolous or marginal applications.

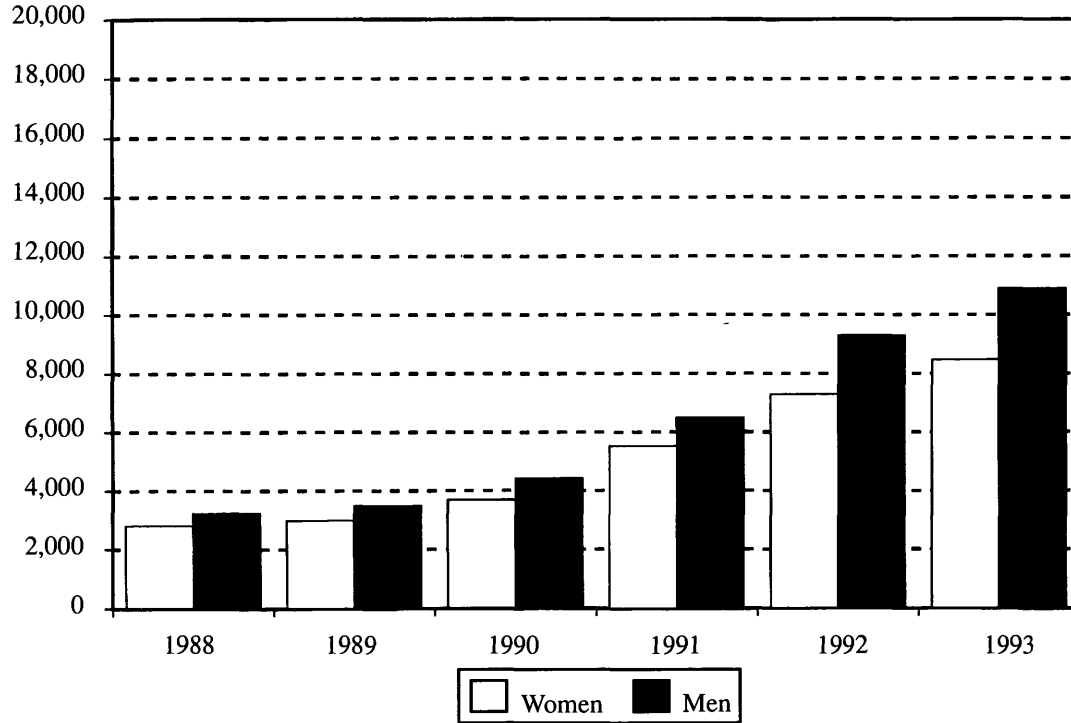
Figures 7.2 and 7.3 document applications for those with mental impairments and those with other impairments.¹ Applications for those with mental impairments tripled between 1989 and 1993, rising from 6,000 in 1989 to 19,000 in 1993. In contrast, applications among those with other impairments rose by roughly 75 percent. As a result, applications for those with mental impairments accounted for roughly 45 percent of the growth in total SSI applications in Michigan. Applications for those with mental impairments continue to rise after 1991, while applications for those with other kinds of impairment seem to have plateaued.

THE ENDING OF GENERAL ASSISTANCE IN MICHIGAN

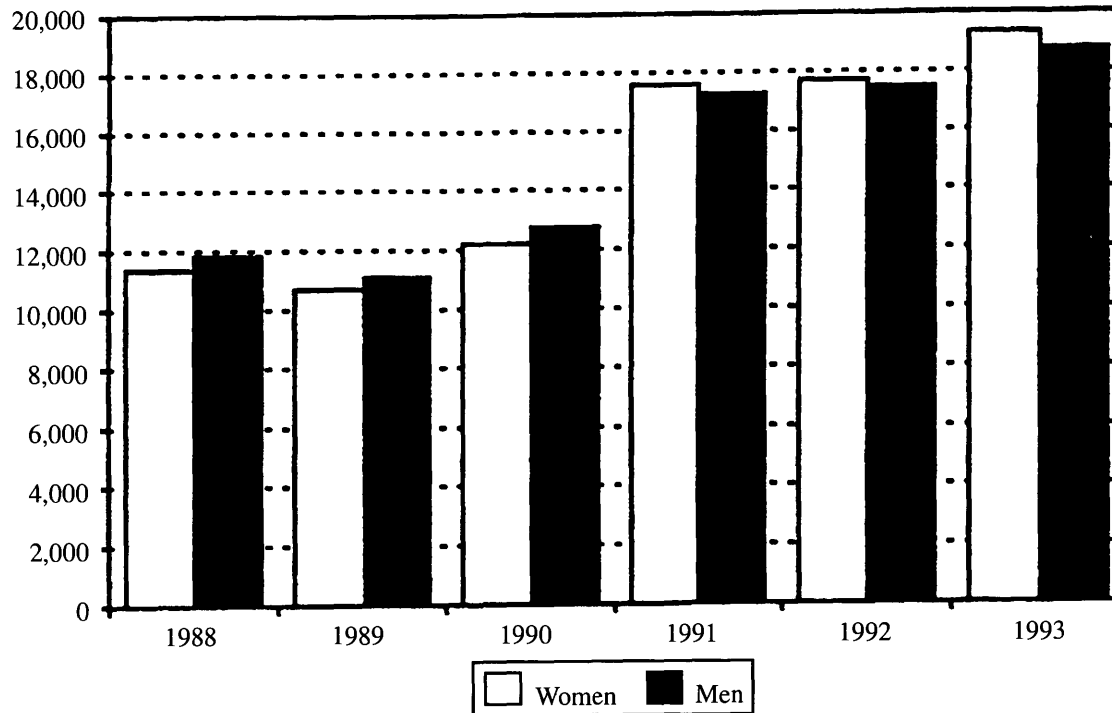
Background

Between 1979 and September of 1991, Michigan funded a statewide GA program. GA was a cash-granting program for impoverished adults without dependent children. During the 1980s, the caseload varied between a high of 142,000 in 1984 and a low of 93,000 in 1989 (Michigan Department of Social Services 1991). Even though GA

Figure 7.2 Adult SSI Disability Applications for Mental Impairments



SOURCE Social Security Administration Disability Research File

Figure 7.3 Adult SSI Disability Applications for Other Impairments

SOURCE Social Security Administration Disability Research File.

technically served an able-bodied population, it is now clear that it actually served older people, the chronically ill but not classified disabled, and those who had some measure of disability. Kossoudji and Danziger (1993) found that 40 percent of the GA population was over age forty, that one-quarter had applied at some time for SSI, and that 70 percent of respondents to a sample survey reported at least one chronic illness.

In September 1991, there were still 118,632 people receiving grants, although the enrollment had gone down since spring 1991 because of the termination threat. The decline in enrollment stemmed principally from a drop-off in applications to GA rather than from recipients leaving the rolls. Eligibility criteria were simply based on income and assets. Most cases represented adult individuals, but some families with dependent children—families in which both parents were unemployed or earning below the GA maximum income but who did not meet Aid to Families with Dependent Children (AFDC-UP) employment history qualifications—were eligible for GA and represented a little more than 10 percent of the caseload (Kossoudji and Danziger 1993).

The state of Michigan, along with other states, faced severe fiscal problems in the early 1990s. While the revenue the state received from both the federal government and from state sales tax were declining, the costs of incarcerations, health care, foster care, and public assistance were all rising. A new, conservative republican governor, John Engler, was elected to office in November 1990 after running a campaign in which he promised to both lower taxes and balance the budget.

Although spending in other social programs was cut, Engler singled out General Assistance for virtual elimination. Engler first proposed this action in his fiscal year 1992 budget submitted to the Michigan legislature in January 1991. In May, Engler announced publicly that the GA program would be eliminated on June 1. Actual elimination of the program was held up in court, but finally went into effect October 1, 1991. At the same time two supplemental programs, Emergency Needs and GA-Medical were cut. GA-Medical coverage provided primary ambulatory care everywhere except Wayne County, which had its own managed care program. Emergency Needs (which was later reinstated with reduced funding) provided for one-time application for

funds to pay heating bills (for example), when the situation was an emergency and not part of an ongoing problem (Kossoudji and Danziger 1993).

After GA was terminated, two much smaller programs were created for special populations: State Family Assistance (SFA) for families with children, and State Disability Assistance (SDA) for those deemed disabled, aged, or residents of substance abuse treatment facilities. The monthly grants are comparable to former GA stipends. SDA is easier to get on than SSI (processing of applications is quicker and work limitations are expected to last 90 days, not the year required for SSI); however, unlike GA, health is central to the determination of eligibility for SDA. Moreover, those qualifying for SDA are required to apply for SSI as well. The state makes an effort to recover back payments from SSA if an individual is determined eligible for SSI.

In March of 1991, GA served 122,500 cases. Eleven and one-half percent of those were in families that would automatically qualify for SFA, while 1.3 percent were identified as disabled persons and would automatically qualify for SDA (Kossoudji and Danziger 1993). Those not automatically eligible for SDA could apply, but SDA continued to serve a much smaller population than did GA. State records indicate that within the first five months after GA was eliminated, only one-fifth of former GA recipients had applied for SDA benefits. Of those who processed applications, one-quarter were approved. In May 1992, a total of 8,898 individuals were on SDA. The average monthly caseload on SDA has been about 10,000 since then, with 3,000 to 4,000 thousand annual transfers to SSI. They represent between 10 and 15 percent of SSI disability awards in Michigan.

The State Medical Program (SMP) replaced GA-Medical everywhere except Wayne County, which continued its own managed care medical program. However, SMP did not go into effect until December 1, 1991, two months after GA was terminated. Furthermore, at that time only those who had been converted to SDA and SFA were enrolled in the new medical program. Others who met SDA/SFA income and asset requirements became eligible for and could apply for SMP. SMP is less comprehensive in coverage than Medicaid. It does not cover inpatient services and requires small co-payments for services and prescriptions (Kossoudji and Danziger 1993).

Implications

Most of the people we interviewed identified the ending of GA as the single most important impetus behind the growth in SSI applications. Even before Engler announced the ending of GA, many used the program as a transition or backup. Others on GA who were potentially eligible for SSI did not, however, apply. The paradox is that SSI benefits were substantially more generous than GA benefits. For example, in 1990 an individual on GA would receive \$266 per month in cash. On SSI, the same individual would have received \$431. From the point of view of the state of Michigan, the person on GA would have cost \$266 while the same person on SSI would have cost the state only \$45. Thus, both the GA recipient and the state of Michigan had considerable incentives to shift from GA to SSI.

Various explanations were offered for why more of those in GA had not applied for SSI benefits. Bureaucratic inertia was offered as one explanation for why program administration did not do a better job encouraging individuals to apply for SSI. Health status was not a requirement for eligibility for General Assistance. As a result, those potentially eligible were not identified. What might make this situation seem more reasonable is the fact that probably only a small minority of GA beneficiaries could pass the stringent medical screening required before receiving SSI benefits, and that this fraction would have been smaller in 1979, when GA was started, before the change in the mental health listings.

Another reason why people may not have applied is the more bureaucratic process and more numerous personal contacts associated with the SSI program. Applications required considerable effort and energy, and prospects for allowance were still uncertain. GA had a simpler application and redetermination process, if for no other reason than because health was not a criterion for enrollment. Once GA was eliminated, however, people who were poor and in ill health basically had no other option besides SSI. Many of those on GA suffered mental impairments and/or had drug abuse or alcohol problems. These individuals may have been particularly reluctant to apply for SSI benefits. It was suggested to us that such individuals might find it less stressful to just get by on the low GA benefits than to be frequently reviewed, as would have been the case had they been on SSI. The simpler alternative

may have been particularly attractive to the mentally ill who are paranoid or socially isolated. GA helped them live marginally but relatively hassle free.

After GA was terminated, there were both federal and state outreach efforts targeted at former GA recipients who might have been eligible for SSI. The Chicago Regional Office of the Social Security Administration initiated one such campaign, sending letters to this population in December 1993. Returned letters were routed to the field offices. The individuals we talked to did not seem to think this effort had been terribly effective. The letter gave minimal information about the SSI program. For example, it did not clearly mention that one must be disabled. The result was an increase in claims from people who wanted to get SSI but, by their own admission, were not disabled. Rather, they were unable to work due to the lack of job opportunities and inadequacy of their skills.

State-level efforts are thought to have been more effective. A series of computerized cross matches was conducted to see if the former GA recipients had applied for or already were on other social security programs. At least two mass mailings followed these cross matches. The mail included information about other available sources of disability funding as well as a preset initial appointment time at the local Michigan Department of Social Services (MDSS) office. Field office staff we talked to thought these efforts had been somewhat effective.

OUTREACH AND ADVOCACY

Outreach

Whether we talked to social security field office staff, individuals from MDSS, or representatives of the advocacy community, there seemed to be general agreement that outreach efforts coordinated among the Social Security Administration, state agencies and advocacy groups had a strong impact on applications and awards for SSI and Social Security Disability Insurance (DI).

Recent outreach efforts by field offices have expanded significantly for two main reasons. First, over the past several years, SSA has issued

a series of mandates for field offices to conduct outreach to specific population groups which, among others, include low-birth-weight babies, children, and the homeless. Second, the *Zebley* decision led to a mandate from SSA that requires all field offices to increase the accessibility of their staff to community residents.

The MDSS has conducted its own outreach efforts through meetings with schools, probate court, nearly all social service agencies, and others who could make referrals. They provided an in-depth description of disability and instructions on how to file. In addition, MDSS hired temporary workers to screen files for possible leads for social security. The individuals we talked to thought that these efforts had resulted in a substantial increase in applications for SSI.

Two state-specific outreach initiatives—the Michigan Inter-agency Task Force on Disability and the Client Services Task Force—are thought to have had a significant impact on rates of applications. Each task force includes representatives from a variety of state agencies, including the Departments of Health, Social Services, Labor, Education, and Mental Health, with additional representatives on the Client Services Task Force from Legal Aid, and senate and congressional offices. These task forces focus on outreach through education and increasing awareness of the SSI and DI program changes. The outreach initiatives have been especially active since 1988 and target mostly potential SSI beneficiaries (the clientele of most groups represented on the task forces).

The education of workers in agencies participating in SSI outreach has had a major impact. There have been internal departmental alerts in SSA, and teachers and health care professionals have been trained to help identify possible cases. We were told that there is now close cooperation with local agencies and liaisons with shelters and community health agencies. Better understanding of the process of applying for disability benefits and increased awareness of programs available for different populations have enabled the social service personnel to do a better job of informing and referring potential SSI applicants to the MDSS office. Hospitals and social workers as well as all the human services agencies, both local public and private, have been very assertive in getting people to apply. Those we talked to felt that outreach works best when one goes to providers; direct appeals have not proven to be as effective.

In addition, many health care providers have, over the last few years, become more in touch with MDSS and helped people apply for SSI. Health care providers have an incentive for trying to get individuals onto SSI. Since those on SSI also have Medicaid, getting clients onto SSI implies that the health care providers will end up reimbursed for the services they provide. The Medicaid coverage is more extensive than SMP (for example) and also pays more under the DRG prevailing rate cap. MDSS has its own staff in the major hospitals collecting necessary medical information on the clients. This facilitates their helping people to apply.

Substance abuse clinics and providers also represent significant referring agents. They refer a lot of people under rehabilitation to the MDSS office. Coupled with the GA cut, the state initiated outreach efforts targeted to alcoholics who were on GA and rehabilitation. For example, Harbor Light in Detroit was very active in searching for and finding drug addition and alcoholism (DA&A) people and helped them apply for SSI. Legislation dating from 1972 as well as more recent legislation mandates rehabilitation, monitoring, and facilitation of treatment. In Michigan, the Drug Abuse and Alcohol Referral and Monitoring Agency (DARMA) refers clients to the proper rehabilitation agencies. However, there is an insufficient number of resources available to which to refer these individuals can be referred. Since DARMA started in 1989 there has been an extensive outreach effort. A great deal of time has been spent in talking to different advocacy groups and social services providers, giving them accurate information, organizing workshops and implementing panel discussions. In addition, DARMA monitors compliance and reports to MDSS. They have mental health therapists and substance abuse therapists as well as rehabilitation counselors working with them. They organize transportation and have contact with different agencies, like homeless shelters, to facilitate the process for the clientele. They assist in finding resources, cooperate with the rehabilitation council, and monitor progress.

DARMA works very closely with the Disability Determination Services and has provided them with a good deal of information. In the opinion of the director, Ms. Rojas-Dedenback, DARMA has created a willingness by the MDSS to provide information about the available options to DA&A persons. The whole community has become more aware and has started to contact more people about applying for dis-

ability. Previously, there was a lack of awareness; people thought that GA was all there was for them, and it was not until they received better information that DA&A people have started to come forward. Primary referral sources for DARMA are the agencies they work with, i.e., service providers, homeless shelters, advocacy groups, women's shelters, and treatment providers. The availability of benefits to those who are addicted has been spreading by word of mouth and has dramatically increased the number of claims being filed.

As evidence of the effectiveness of the outreach efforts to the DA&A population, field office representatives mentioned changes in the general knowledgeability of the population potentially eligible for SSI. Others also thought that there had been a change in attitudes, most importantly a change in attitudes among potential applicants regarding the acceptability of identifying oneself as a substance abuser. While five years ago individuals would rarely identify themselves as substance abusers, currently it is not uncommon for individuals to enter an SSA office announcing that they were participating in some specific drug rehabilitation program and that they thought that doing so qualified them for SSI payments. DA&A people "hang together," and SSI is discussed. Field office staff also mentioned that, largely as a result of the changes that had occurred in the applicant pool, the staff had become much more aware of the interrelation between substance abuse and mental health problems.

The general perception among the people we talked to was that the increased awareness of SSI could be attributed to a combination of various outreach efforts and word of mouth. Specifically, the growth of the shelter population, a group targeted for these outreach efforts, contributed to the rise in SSI applications. Many shelters in Michigan are now actively helping residents apply for disability benefits, including providing vans to help residents get to local MDSS offices, providing staff time to help individuals fill out paperwork, or having outside agencies come in to help. For example, in Detroit, at the request of a shelter, the Detroit Urban League will come out with SSI applications and help residents fill out forms.

Outreach efforts underway with the homeless shelter population illustrate the way in which outreach efforts may have interacted with the ending of GA to spur SSI application growth. The shelter population in Michigan grew substantially after the ending of GA because the

termination affected the population most at risk for homelessness. The state poured in funds for new shelters and additional beds, instigating a growth of shelters. In the Detroit area, emergency shelter providers think that over 75 percent of their adult clientele were former GA recipients (Park, Danziger, and Parrot 1994). Thus, the ending of GA indirectly increased the size of the population targeted for outreach efforts. Moreover, the state's increased investment in sheltering the homeless has added an extra incentive for getting those in the shelters onto SSI.

Advocacy

In recent years, advocacy groups that assist people in different levels of the application procedure and ensure that cases get through the bureaucracy have grown rapidly. Opinions differ as to what accounts for this growth. Some of the individuals we talked to thought the growth represented a response to a perceived need on the part of SSI and DI applicants. Others emphasized the fact that advocacy has become financially profitable. Various groups have begun to compete with each other for customers and funding. The advocacy and non-attorney groups can also increase their potential income by applying for federal and state funds (allocated for outreach effort, for example), and they can apply for grants from different foundations like the Mott Foundation and Robert J. Wood Foundation. Attorneys advertise on TV, in newspapers, and the yellow pages to handle disability claims. The fact that attorneys consider DI/SSI disability cases as almost always winnable is evidenced by their willingness to accept these cases on a contingency basis. The fraction of SSI and DI applications that have some form of representation has increased greatly in recent years and continues to do so.

The Medicaid Assistance-SSI advocacy program (MA-SSI) was started in the late 1970s and was funded at a higher rate starting in late 1982. It was instituted to serve two populations, the primary population being the GA and Medicaid recipients (single adults who DDS determined to be disabled). The other group that the MA-SSI advocacy program has under contract to service are clients from the Community Mental Health Agencies and the Department of Mental Health (people who were moved out of state hospitals).

The MA-SSI advocacy program helps clients get through the application process. The program had a 89 percent reversal rate on denials, once they got to the federal level. This kind of success rate was partially a result of the fact that the advocacy program only sent people to apply whom they felt were probably eligible and whom they were willing to back up by being present as paralegals.

QUANTITATIVE EVIDENCE ON THE IMPORTANCE OF GA

While those we talked to emphasized both outreach and the ending of GA as important, the kind of qualitative information we derived from our interviews can never resolve questions regarding the relative importance of these two forces. Moreover, opinions varied somewhat as to the relative importance of the ending of GA.

There is a variety of quantitative information available that can shed some light on the potential impact of the ending of GA on SSI applications. Much of this information comes from the Michigan Department of Social Services administrative data on GA recipients collected by Sandra Danziger and Sherrie Kossoudji at the University of Michigan as part of a project evaluating the impact of the ending of GA. This data base includes information on three populations of GA recipients: those on GA in September 1990, in March 1991, and in September 1991.

The MDSS data on these three populations were matched to data from the Social Security Administration's Disability Research File data. To maintain confidentiality, the information on the merged file was restricted to basic information on applications and awards for SSI, together with variables indicating which of the three GA populations the applicant belonged to. These merged data allow us to calculate the number of SSI applications per month made by individuals from each of the three GA populations.

The merged data show that of the 112,800 individuals receiving GA benefits as of September 1990, 43,700 (or close to 40 percent) had applied for SSI by the end of 1993. GA beneficiaries accounted for 46 percent of total applications in 1991.

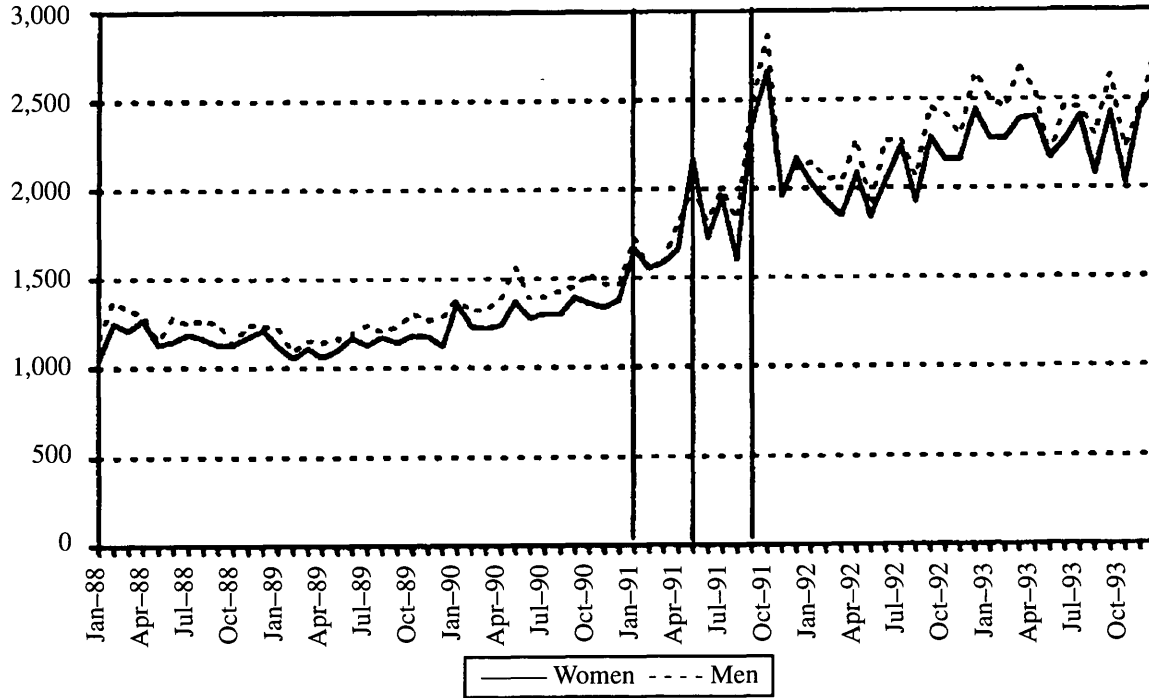
This 46 percent could exaggerate the impact of the ending of GA on SSI applications. Many former GA recipients who applied for SSI benefits might have done so even if GA hadn't been eliminated. At the same time, we cannot measure the impact of the termination on people who were not enrolled in GA but who, after 1991, might have applied to GA rather than SSI. One way to gain insight on the causal impact of ending GA on SSI applications is to look at data on monthly applications. There are quite distinct seasonal patterns in the monthly data with, for example, applications falling during December. For this reason, we deseasonalized the application data.² The deseasonalized monthly applications are presented in Figure 7.4. They reveal a limited upward trend through 1990. There is a small spike in January 1991 after Engler took office, a much larger spike in May, when Engler announced the ending of GA, and an even more dramatic spike in October 1991, when GA actually ended. Post-1991 applications, while more variable than those before the transition, never fall close to their pre-1991 levels. While many factors contribute to these changes, GA termination is almost certainly responsible for the transitional spikes.

Patterns are even more distinct when we focus on applications from the populations on GA. Figure 7.5 shows such data for the population on GA in September 1990. This figure makes clear that there had always been a flow of individuals between GA and SSI. Not surprisingly, many appear to have used GA as a transitional or backup program, applying for SSI benefits either before or immediately after beginning to receive GA benefits.³ At the same time, this graph also indicates that the GA population responded both to the announcement that GA was ending and to the actual termination of benefits with an immediate heightened interest in SSI. The September 1990 GA recipient population continued to apply for SSI benefits at higher levels well past 1991. In 1990, they accounted for roughly 10 to 20 percent of monthly SSI applications. Even after being responsible for large numbers of applications through 1992, these same people still represented an average 20 percent of applications in 1993. The loss of the GA option, deteriorating health (perhaps associated with the loss of GA), and community outreach all stimulated the increased interest in SSI.

We wondered whether the increase in applications for the GA population might have come primarily from the more marginally impaired. One might imagine that before the ending of GA such individuals

Figure 7.4 Adult SSI Disabled Applications, Deseasonalized Series

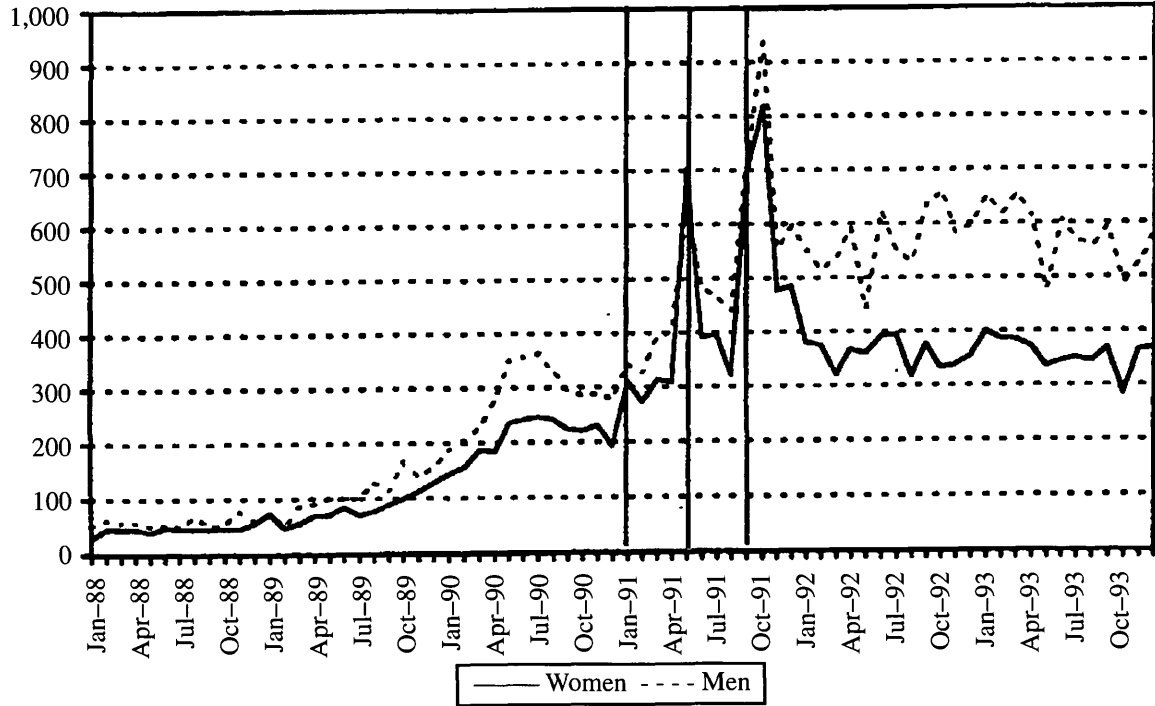
Reference lines on Jan. 1991, May 1991, and Sept. 1991



SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data

Figure 7.5 Adult SSI Disabled Applications, Sept. 1990 GA Population—Deseasonalized Series

Reference lines on Jan. 1991, May 1991, and Sept. 1991



SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data

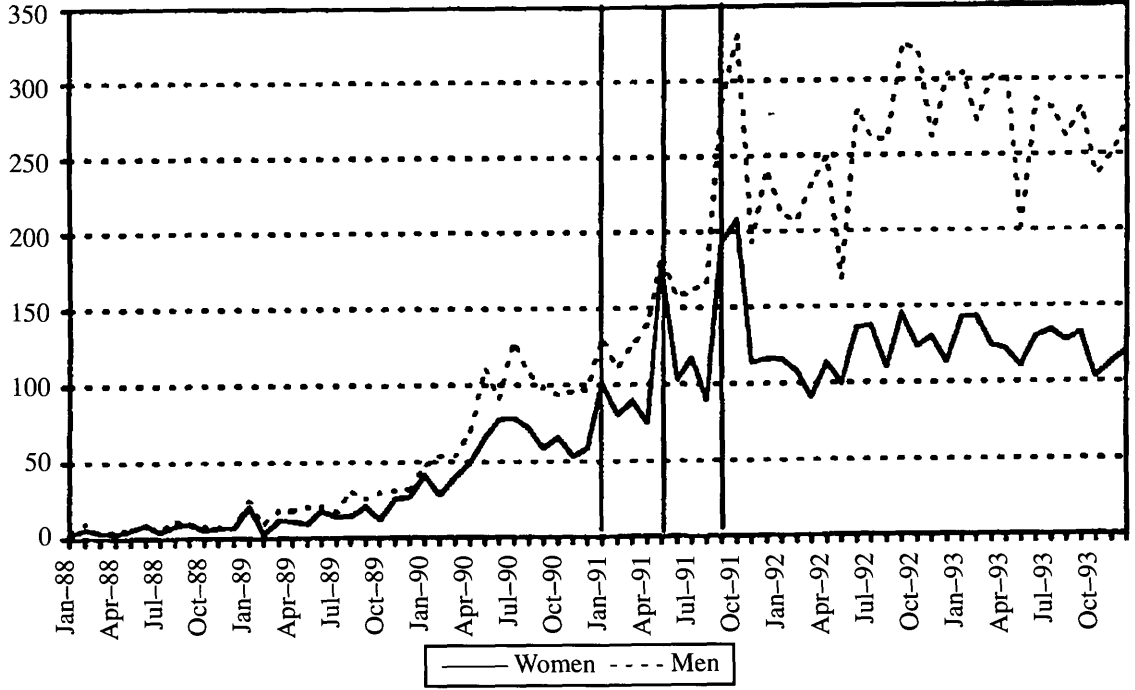
would not have bothered applying for SSI since the chance of succeeding was low. We checked to see if the application peaks seem to have represented a more marginally impaired population by examining award rates by month of application. In fact, award rates for those applying in May, September, and October of 1991 were no lower than were award rates in the preceding months. What we did find is that a somewhat disproportionate share of applications in May, September, and October of 1991 represented first-time applicants.

Figures 7.6 and 7.7 reproduce Figure 7.5 but distinguish between those with and without mental impairments. These figures highlight the nature of these GA recipients' health impairments, contribute to the verification of expert opinion about the reluctance to apply for SSI for those with mental impairments, and reflect the intensified outreach efforts to the DA&A population. Mental impairment applications for September 1990 GA recipients virtually soar after January 1991, particularly for men. Applications for other impairments exhibit the now familiar three spikes but then retreat to lower levels. In September 1990, when the population was measured, 29 percent of women's and 33 percent of men's SSI applications were associated with mental impairment. Exactly two years later, and one year after GA termination, mental impairment represented 36 percent of GA women's and 47 percent of GA men's applications.

We have also used the data we have to obtain crude estimates of the effect that the ending of GA had on applications for SSI. We use a number of different approaches to do this. Our first approach uses the overall number of applications for SSI benefits to project what applications would have been like had they followed the pre-1991 trend. To do this we regressed the log of applications on monthly dummies and a linear spline with kinks at January 1989 and January 1990. We then used these estimates to project applications for 1991 (Table 7.1). We attribute the gap between the actual and projected number of applicants to the ending of GA. The implicit assumption behind these calculations is the notion that, were it not for the ending of GA, applications would have continued increasing at the same rate they had been during 1990. These estimates suggest that the ending of GA can account for about two-thirds of the total increase in the number of applications between 1990 and 1991.

**Figure 7.6 Adult SSI Disabled Applications for Mental Impairments,
Sept. 1990 GA Population—Deseasonalized Series**

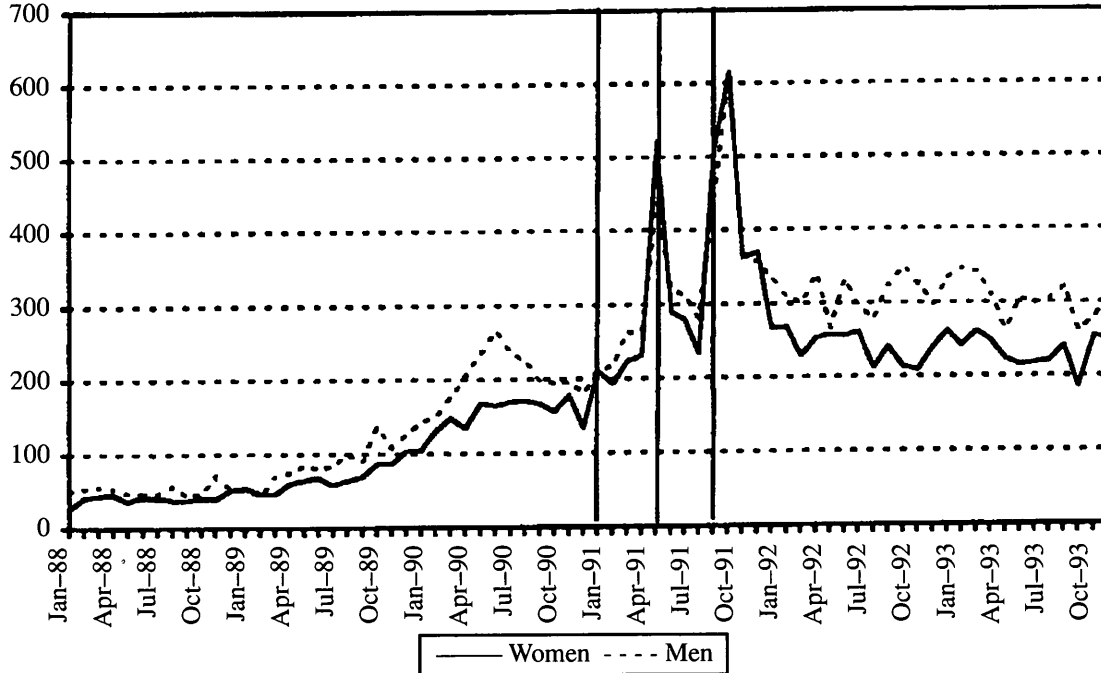
Reference lines on Jan. 1991, May 1991, and Sept. 1991



SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data.

**Figure 7.7 Adult SSI Disabled Applications for Other Impairments,
Sept. 1990 GA Population—Deseasonalized Series**

Reference lines on Jan. 1991, May 1991, and Sept. 1991



SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data

Table 7.1 Estimates of the Short-Run Effect of Ending GA on SSI Applications in Michigan

	Women		Men	
	Total	Mental	Total	Mental
Actual rise, 1990–1991	7212	1836	6591	2081
Estimated effects				
Method 1 ^a	4996 (69%)	527 (29%)	4221 (64%)	869 (42%)
Method 2 ^b	3832 (53%)	830 (45%)	3391 (51%)	1313 (63%)
Method 3 ^c	1866 (26%)	460 (25%)	1545 (23%)	496 (24%)

SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data.

^aMethod 1: The log of monthly applications were regressed on a linear spline in time plus monthly dummies for the 1988–1990 time period. Predictions based on this regression were calculated for 1991. Method 1 estimates the impact of the ending of GA as the difference between the actual number of 1991 applications and the number predicted from the regression.

^bMethod 2: Using deseasonalized data for the three GA populations combined, applications were predicted for 1991 assuming that applications continued at their Oct. 1990–Dec. 1990 level. Difference between actual and predicted represents estimated effect of ending GA.

^cMethod 3: Excess of deseasonalized applications of May 1991 over April 1991 and of Sept. and Oct. 1991 over Aug. 1991 represents estimated impact of GA.

An alternative approach to trying to estimate the impact of the ending of GA on 1991 applications is to estimate the number of individuals on GA who applied for SSI but would not have done so, were it not for the ending of GA. Since not all of those induced by the ending of GA to apply for SSI during 1991 will have received GA benefits, the question we are now asking is slightly different than asking about the impact of the ending of GA altogether.

To estimate the fraction of those on GA during the year prior to its termination who were induced to apply for SSI benefits, we took simple approaches meant to bound the total affects. First we assumed that applications from those who had been on GA some time during 1991 would have continued at the (deseasonalized) rate they were appearing during the last three months of 1990. Results from such calculations are shown in the third row of Table 7.1. Method 2 suggests that the ending of GA could account for roughly 50 percent of the increase in

overall applications and somewhat more of the increase for those with mental impairments.

Of course, it is possible that applications from those on GA might have risen even were it not for the ending of GA. A more conservative approach is to simply use the applications that occurred during the May, September, and October peaks to estimate the impact of GA. Figures 7.5–7.7 would clearly seem to indicate that this approach will underestimate the total impact of the ending of GA on applications. As such it represents a conservative lower bound estimate. The fourth row of Table 7.1 shows the spikes account for roughly 25 percent of the 1990–1991 growth in applications for SSI. Even these conservative estimates suggest an important role for the ending of GA.

Similar methods can be used to calculate the longer term effects of the ending of GA. Obviously, the further out our projections go, the less confidence we have. Using pre-1991 data and method 1 to project applications into 1992 and 1993 suggests that while the ending of GA continued to have an effect, it accounted for a smaller and smaller fraction of the overall growth in applications—45 percent of the growth in applications between 1990 and 1992 and 31 percent of the growth between 1990 and 1993.

Finally, cross-state variation can also shed light on the longer-term impact of GA's termination on SSI applications. Other states that recently restricted the availability of GA benefits have also experienced above-average growth in SSI applications. Estimates produced by Lewin-VHI personnel found a statistically significant association between the growth in SSI applications and the downsizing of GA. Simulations based on the Lewin model on Michigan show the ending of GA accounting for roughly 30 percent of the overall growth in SSI applications and 50 percent of the growth in applications involving mental impairments between 1988 and 1992 (Stapleton and Dietrich 1995).

The September 1990 GA population is a convenient one for analyzing GA termination's impact on SSI applications because it was measured before rumors of termination began to alter the GA population itself. It was only four months later, however, that Governor Engler set in motion the termination action. Earlier GA populations could be more informative about the stable transition to SSI over longer periods of time. We were unable to match data on earlier GA populations to the

Table 7.2 Percentage of Various General Assistance Population Subsequently on SSI by Date

Date	General assistance population in September			
	1988	1989	1990	1991
September 1989	2.9			
September 1990	5.5	3.4		
September 1991	8.1	6.5	2.6	
September 1992	11.5	10.3	8.0	5.8
June 1993			13.0	11.5

SOURCE: Michigan Department of Social Services Data

Disability Research File.⁴ However, the MDSS administrative data itself does indicate when individuals were enrolled in SSI. Table 7.2 presents data for populations on GA during September of each year from 1988 through 1991. The columns give the number and fraction of the original GA populations receiving SSI benefits one, two, three, and four years later. Thus, for example, 2.9 percent of those on GA in September 1988 were on SSI in September 1989. Again, we see transition rates rising over time. After two years, 5.5 percent of the September 1988 GA population was receiving SSI benefits. In contrast, after somewhat less than two years, 11.0 percent of the September 1991 GA population was on SSI.

DISCUSSION

A variety of factors in combination seem to have been responsible for the rapid rise in the number of adult SSI disability applications. The elimination of General Assistance removed one possible alternative option for potential SSI applicants. Along with this, extensive and well-coordinated outreach efforts seem to have increased awareness among both social service providers and potential applicants themselves. Finally, resources have been increasingly targeted at helping potential applicants with the application process. While we continue to

have an interest in estimating the impact of the ending of GA on SSI applications, this change did not occur in isolation. The ending of GA might have had a very different impact on SSI applications had outreach or advocacy efforts been different. Similarly, outreach efforts were certainly motivated and facilitated by the ending of GA.

Our analysis of the rapid rise in SSI applications in Michigan quite clearly implicates the elimination of GA as an important factor in spurring this rise. Other states in which similar case studies were conducted did not eliminate or drastically scale back welfare benefits. However, one can interpret the elimination of GA benefits as a dramatic attempt to cut state expenditures and to shift some welfare expenses from the state to the federal government. Results from the case studies done in California, Texas, and New York suggest that many states have responded to their fiscal problems by a similar shifting of individuals off state-funded onto federally funded programs (Stapleton et al., Chapter 2 in this volume).

Most economists modeling the decision to apply for disability benefits (or, more generally, welfare benefits) have modeled the decision as a function of the potential gains for program beneficiaries. While we have no doubt that such gains play an important role in determining the choices individuals make, our results suggest that a number of other factors are also important. For SSI applicants, what Richard Burkhauser has referred to as “gate keepers” and Michael Lipsky (1980) has referred to as “street-level bureaucrats” would seem to play a central role. When GA existed, many people were satisfied enrolling in this less lucrative but also less bureaucratically onerous program.

Notes

1. We have not included mental retardation with other mental impairments.
2. To do so we regressed the log of the number of applications on a linear time trend together with monthly dummies. The coefficients on the monthly dummies were then used to adjust the raw data. To be precise, we estimated twelve monthly dummies constraining the coefficients to average to 0. Letting β_i represent the coefficient of the i^{th} month's dummy, and letting n_{it} represent the number of SSI applications in the i^{th} month of the t^{th} year, then the adjusted number of applications is $n_{it} = n_{it} / \exp(\hat{\beta}_i)$.
3. Those enrolled in GA in September of 1990 could have entered the program at any time previously.

4. Social security numbers were not available on existing files for populations of GA beneficiaries before September 1990.

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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.¹

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).² 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.³

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
Predicted annual growth accounted for by^a						
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
AIDS/HIV						
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	
IRCA legalizations						
California					0.9 ^b	1.2 ^b
Florida					0.1	0.2
Michigan					0.0	0.0
New York					0.1	0.1
Texas					0.1	0.3
Children in one-parent families						
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
Share of growth accounted for by regression model^c (%)						
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
Annual growth rate (%)						
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).

^aGrowth 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.

^bLarge growth accounted for by IRCA legalizations in California is the product of a very large growth in the variable and statistically insignificant coefficients.

^cTotal 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 and 7

Martha R. Burt
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For someone like myself, who comes to this conference from the perspective of research on homelessness and on the severely and persistently mentally ill, these papers by Muller and Wheeler (Chapter 6) and by Bound, Kossoudji, and Ricart-Moes (Chapter 7) contain some very interesting and provocative findings. I will focus most of my comments on the latter chapter, since that was my primary assignment, and refer to the former as it augments the findings of Bound, Kossoudji, and Ricart-Moes.

A SUCCESSFUL POLICY

Both papers describe something we very rarely see documented in evaluation research—the successful administration of public policy. I strongly agree with the comments of several field managers (Chapter 6), who said, “What else did you expect?” as the consequence of greatly expanded and targeted outreach efforts to bring eligible nonparticipants onto the rolls. To that comment I might add, “What else did you expect?” as the consequence of Governor Engler’s decision to end Michigan’s General Assistance (GA) program for all but a very few individuals. Both appear to have been quite successful at achieving their goals. The latter action also appears to have had some results that its supporters denied would occur despite strong evidence to the contrary: the documented rise in the homeless sheltered population as reflected in Chapter 7, and the rise in SSI applications and awards indicating significant levels of long-term disabilities among the former GA population. It is particularly telling that the largest jump in SSI applications and awards related to the end of GA occurred among those with mental impairments. I think it likely that the same is true for the jump in the number

of sheltered homeless (and probably also the unsheltered homeless population).

Both of these chapters document the effectiveness of persistent and well-focused outreach efforts. Chapter 7 differentiates between outreach, seen as actions of local Supplemental Security Income (SSI) offices, and advocacy, seen as actions of direct service providers and state agencies. I think the two go hand-in-hand, and it is quite likely that some of the SSI outreach efforts (and also the state agency activities) involved increasing the knowledge and program savvy of direct service providers so they could prescreen potential applicants and also help them to complete their applications. Thus I do not think one can separate the effects of outreach and advocacy; I see them as two arms of the same body, both intent on drawing people into the application process and assuring that they succeed at it.

THE ROLE OF STATE INTERESTS

However, what we can see as a success story from the point of view of SSI participation we can also see as illustrating some troubling trends in state-federal relations, which have potentially negative implications for the well-being of poor and disabled people. The role of state agencies in expanding the SSI rolls is instructive. For decades, states have sought ways to shift costs from their own coffers to those of the federal government. In the past decade or so they have gotten significantly more sophisticated at this cost-shifting. In the case of SSI, Michigan had two major programs that were entirely state-funded—General Assistance (and its accompanying medical program) and state mental hospitals. By ending General Assistance, the state could eliminate the cost of supporting the entire caseload and shift the burden of support for SSI-eligibles to the federal government. By furthering the efforts of state mental hospital patients' move into the community once they have the support of SSI, the state could shift to the federal government a portion of its responsibility to provide both domiciliary and health care. The people who succeed in getting SSI are financially better off than they were on GA or as state hospital residents, but those who cannot qualify or who never apply are certainly worse off. The

fact that significant numbers of people in both the GA and mentally ill populations *cannot and do not* receive SSI, and therefore end up destitute and sometimes homeless, is usually overlooked or downplayed by state officials as they try to reduce state outlays for services and assistance to poor and disabled people.

It is important to recognize that all levels of government are divesting themselves of responsibility for some categories of disability—chief among them mental disabilities—and that this has been going on for a long time. State efforts to shift costs will only increase in the coming years; their effects should not be overlooked, or masked by lumping federal, state, and nonprofit actions together into overall categories of “outreach” and “advocacy.”

THE NEED FOR ATTENTION TO REHABILITATION

It is also possible that there has been some overextension of SSI, or at least a failure to consider or require participation in rehabilitation efforts for those who might benefit from them. The most obvious newly expanded group of SSI recipients to whom this applies is those eligible by reason of drug abuse or alcoholism. Even among the long-term street homeless with drug or alcohol addictions, research evidence now indicates that recovery is possible, along with a return to gainful employment. Both the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism have sponsored demonstrations showing significant success rates. Further, the efforts of many homeless service providers have helped at least some substance abusers recover, although formal evaluations are lacking. Rather than making the assumption of lifelong dependency for these conditions, the Social Security Administration (SSA) should be promoting efforts to help SSI recipients move toward self-sufficiency to the extent possible.¹

Let us assume that we can think of a four-part research agenda for SSI participation, including 1) who are the pool of eligibles; 2) what gets them to apply; 3) what affects awards (whether their applications are successful); and 4) what affects exits. I am suggesting that we need to pay somewhat more attention than we do at present to the last of

these. We need to look at exit rates differentially by disabling condition and try to understand what SSA actions or policies could affect exit rates.

NEED FOR MORE FLEXIBILITY

My earlier caveat, “to the extent possible,” brings me to the final point I want to make. My final comment does not really stem from either Chapter 6 or Chapter 7. However, I think it is important to use this forum to raise the issue of the stringency of SSI eligibility criteria, particularly with regard to capacity to work. We probably all recognize that our current ability to define “disability” with any precision leaves a good deal to be desired. For SSI purposes, we must deal not only with the presence of a physical or mental condition (diagnosis), but also with the extent to which the condition entails significant functional limitations (disability), and the extent to which it has lasted and can be expected to last a long time (duration). The biggest problems in determining eligibility come with identifying the level of functional limitation and the expectation for duration.

To ease the burden on determining gradations of functional limitation, the SSI eligibility criterion has been set quite high with respect to work—to be eligible for SSI, recipients must be completely unable to work. Yet the nature of some illnesses (particularly mental illnesses) that qualify a person for SSI may permit some work, in either a steady part-time capacity or episodically. The strong bent of current thinking about the severely and persistently mentally ill is that working, at whatever level is possible, is good for self-esteem, physical health, and mental health, even if it may not be enormously rewarding financially. The same is probably true for other disabilities.

But people also rely on the medical care available to them through Medicaid while they are on SSI. They often feel they cannot risk losing their SSI, even if their work activity could compensate for the income, because they would also lose health benefits. Perhaps it is time for SSA to reexamine the nature of some of the disabilities that form the biggest categories of current recipients. It could give some consideration to rule changes that would allow recipients to do whatever level of paid

work they could, while still retaining their Medicaid coverage. Some fair reduction in cash grant levels might also be worked out. This would be in everybody's interest—clients, states, SSI, and providers.

To the extent that the opportunity already exists under current regulations for significant levels of paid work while still retaining benefits, SSA should make greater efforts to assure that direct service providers and advocates know about this opportunity. From my experience with community-based providers of services to the severely mentally ill, I do not think anyone is clear about what clients can and cannot do and still retain their SSI. Participants at this conference have told me that there is considerable flexibility for paid work under current SSI rules. But ignorance of these opportunities among the people working most closely with SSI program beneficiaries seems to be widespread. Therefore it is likely that fewer recipients work than might otherwise do so.

Note

1. This point may now be moot. The ability of these programs to continue serving clients whose primary diagnosis and reason for receiving SSI is alcohol or drug abuse will be challenged severely by new provisions for SSI eligibility contained in the Personal Responsibility and Work Opportunity Act of 1996. The loss of SSI income and Medicaid eligibility for this population reduces their ability to pay for housing and to receive needed medical care, both of which helped maintain them in the housing supplied by these demonstration programs.

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,¹ 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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Part III

Perspective on Program Growth and Policy

9 Growth in Federal Disability Programs and Implications for Policy

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Social Security Administration

This is a time of immense change in the world of disability: change in how we think about disability, change in the nature of work, change in the characteristics of persons applying for disability benefits, and change in our thinking about the role of the federal government in assisting some of our most vulnerable citizens.

The subject of this conference is causes and implications of growth in the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) disability programs. This presentation argues that it is not just change in the size of the programs that is, or should be, at issue. In addition, it is change in the needs and demands of persons with disabilities and changes in the attitudes of society that must cause us to consider some of the fundamental underpinnings of the federal disability programs.

When we started this project in 1992, the Social Security Administration (SSA) was faced with the need to understand largely unanticipated growth in the DI and SSI disability programs. Our focus on the determinants of program growth was essential for many reasons, including the need to effectively plan for adequate program financing, adequate staffing to process workloads, and policy changes to meet the needs of a changing beneficiary population. The primary concern was whether the rapid increase in the application rate—and to a somewhat lesser degree, in the award rate—would continue.

Thus, the research reported on in Part II of this volume was largely driven by the policy needs of the government, especially SSA. In this chapter we review the principal findings, then discuss their relevance to policy issues.

NOTE: Ms. Upp died in 1996.

REVIEW OF THE FINDINGS

The principal findings of the research conducted by Lewin-VHI as well as by in-house staff at SSA and the Office of the Assistant Secretary for Planning and Evaluation are as follows:

- Application and award rates have peaked and now are in decline.
- Changes in the characteristics of those applying for and being awarded benefits are leading to beneficiaries spending longer times on the benefit rolls.
- The resultant decline in the termination rate may well be the most important driver of program growth for the next two decades or so.

More specific aspects of these findings are discussed below.

The Relationship between DI and SSI

This conference considers both the DI and SSI disability populations. Usually, we have considered the programs separately, believing that they serve quite different kinds of persons, one group insured for DI benefits on the basis of significant work experience and the other eligible for SSI because they do not have a significant attachment to the labor force. Increasingly, these lines are becoming blurred. Our study of growth in the DI program almost immediately became a study of growth in both the DI and SSI programs, as it became apparent that the major source of growth in the DI program was individuals applying concurrently for DI and SSI. These concurrent applicants are persons with enough work experience to become insured for DI benefits but whose economic status is so poor that their income and resources are below the means test limits for SSI. Concurrent DI and SSI applicants are now more than half of all DI applicants. Generally, the research finds that factors influencing growth in one program are the same as those that influence growth in the other, although they may differ in the degree of influence that they exert.

Applications and Awards

One fundamental question underlying the research effort was, are the increases in applications and awards short- or long-term phenomena? The answer is both.

The research reported here, as well as actual experience, indicates that applications and awards in both the DI and SSI programs have leveled off. There were fewer DI applications in 1995 than in 1994, and fewer SSI applications in 1994 than in 1993. Final awards (awards after all appeals are heard) have leveled off in both programs. Declines in awards at the initial level have somewhat offset continuing increases at the appeal/hearings level.

Short-Term Factors

One important cyclical source of growth—more so for the DI than the SSI program—was the *poor economic conditions* that prevailed in the early 1990s. In a bad job market, some who meet the programs' strict definition of disability and otherwise would have worked may apply for benefits. Lewin found that about one-fifth of the increase in DI applications and about a tenth of the increase in SSI applications from 1988 through 1992 seemed to have been influenced by increased unemployment.

Relatively short-term fluctuations in *public awareness* of the DI and SSI programs and perceptions about whether program rules are being strictly or less strictly enforced also influence program growth. It is generally believed that the programs were administered relatively strictly in the early 1980s. The administration, the courts, and the Congress all responded in the mid 1980s by making it easier to get on the rolls and harder to put beneficiaries off the rolls. These attitudes seem to have prevailed until fairly recently.

Another factor at work has been *state efforts to shift beneficiaries from state to federally financed programs*. Lewin found that cuts in state welfare programs (general assistance) in seven states and the District of Columbia contributed significantly to the increase in both SSI applications, including DI-concurrent applications.¹ The incentives for states to shift persons from their rolls to SSI so that the beneficiaries will become eligible for Medicaid would be significantly diminished by funding Medicaid through block grants to the states. However,

funding other programs, such as AFDC, as block grants would increase incentives to shift beneficiaries to programs, such as SSI, that are more directly funded by the federal government.

Longer-Term Factors

Lewin found that the *aging of the baby boomers* was contributing significantly to long-term growth in application and awards for both programs.² This source of growth can be expected to continue for at least two decades for the DI program, until the boomers approach age 65, and even longer for the SSI disability program.³

Another long-term source of growth in the number of applications for DI is the *increased work experience of women* and the accompanying increase in their likelihood of being insured for benefits. This factor has the opposite effect on the SSI program, however: as more women become insured for DI benefits, fewer apply only for SSI benefits.

New eligibility criteria for benefits on the basis of mental and pain-related impairments also appear to be a continuing source of application and award rate growth.⁴

An increase seems to be continuing in applicants' *appeals of denied applications and in award rates at the appeals level*. Appeals and award rates clearly influence each other, and high appellate award rates encourage more applications.

Finally, Lewin found that a *decline in family support* contributed to application growth in both the DI and SSI programs. Lewin used a proxy measure to capture this effect—the increase in the number of single-parent families. Again, this trend does not appear to be turning around.

Terminations

The other main driver of program growth is duration on the rolls, or termination rates. Work done by our Office of Disability and by Rupp and Scott (Chapter 4) shows that duration is up and that termination rates are down. These changes, in turn, are being driven in large part by the changing characteristics of those who are now applying for and being newly awarded benefits.

First, they are younger. More than half of persons newly awarded DI benefits are younger than 50, and almost two-thirds of those awarded

SSI benefits are younger than 50. Second, they are increasingly likely to suffer from lingering impairments, such as mental and musculoskeletal disorders. Awards to persons with mental disorders increased by 80 percent between the 1988 and 1992 DI applicant cohorts, compared with an overall increase of 48 percent in awards. The comparable increase in SSI awards was 81 percent, compared to an overall increase of 65 percent. Meanwhile, the share with heart disease and cancer declined dramatically in both programs.

These interrelated changes—in the age distribution and impairment mix of beneficiaries—mean beneficiaries are staying on the rolls longer because they are less likely to recover, and in the case of DI, they also are less likely to convert to old-age benefits. Thus, it is increasingly clear that fundamental, long-run program growth will be driven not by ever-increasing application and allowance rates, but rather by the changing characteristics of our beneficiaries. These changes in the characteristics of our beneficiaries are not news. But to some of us, at least, their importance is just beginning to be fully understood.

POLICY ISSUES

The questions raised in this section stem from concerns about the change in the characteristics of our beneficiaries, the effect of this change on program growth, and the effect of our program on the beneficiaries.

Definition of Disability

What do we define as disability? For both the DI and SSI programs, the Social Security Act defines disability as inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve months.

SSA is being challenged to rethink this definition of disability for several reasons. First, under the Americans with Disabilities Act

(ADA), as Martynas Ycas (1995, p. 55) put it in a recent paper, people are not either disabled or not disabled. Rather, they are at different points along a continuum of needing accommodation and assistance in order to work.

Second, many with impairments that meet our definition nevertheless work, while others similarly impaired do not. So do our listings really distinguish between those who can and cannot work? Or do they distinguish between those who are *expected* to work and those who are not? Many blind persons work, for example, but blind persons are automatically presumed to be disabled under our rules. While in fact some blind persons can do some kinds of work, our rules are based on a presumption that a blind person should not have to work and that there is a public responsibility to that person.

Third, the creators of the disability program had in mind, for the most part, those with acute illnesses, such as heart disease or cancer. Especially when we think of the DI program, we think of older persons with a steady attachment to the labor force who are struck down with potentially terminal disorders. But, thanks to enormous strides in medical technology, some diseases—many kinds of heart problems, for example—are survivable that used not to be. So even persons with these kinds of illnesses are living and receiving benefits longer. As we have said, the increases in our rolls are coming from those who are younger and/or those who suffer from mental disorders and back problems. Persons with these impairments are not expected to die as a result, but improvement often is either not expected or difficult to measure. So these beneficiaries are receiving benefits longer.

If we are going to revisit our definition of disability, what should be our new criteria? SSA has been exploring criteria that reflect ability to function in the workplace, but our experience so far suggests that this may be difficult to implement in a way that can be codified and administered as objective national standards and in a way that society will find acceptable.

The Federal Role

Having raised and not attempted to answer the difficult question of defining disability, we move to a second: What should be the federal role be in providing for persons with disabilities? Should we worry less

about a one-size-fits-all definition and more about different types of interventions for different types of persons?

For a long time we have grappled with the belief that our programs should 1) provide income support until recovery or death for those who cannot work and 2) encourage return to work for those who have the potential to work. As more beneficiaries are young or suffer from chronic impairments, concerns mount about the role of DI and SSI disability benefits in encouraging a lifetime dependency on public income support.

- Is this fair to the person with a disability? Is it in their best interest?
- Is this a desirable public policy outcome?
- With regard to the DI program, what is the appropriate role of a social insurance program?

Moreover, SSA is an agency with its roots in providing long-term income support for retirees. Its primary function has been to get the right check to the right person at the right time. We do not have much experience or expertise in facilitating self-sufficiency.

As we grapple with strategies to encourage employment, we have to consider a number of issues. One of the most difficult of these is how to develop standards that can be applied nationally to determine what type of intervention is best for whom. This is especially difficult when the differences among persons with a given kind of impairment are at least as great as the differences among persons with different kinds of impairments.

There is no question that many people with disabilities strongly want to work. And society expects those who can support themselves to do so. But in providing work opportunities, we must 1) not put anyone at risk of losing life-sustaining support, such as medical benefits, and 2) take account of the fact that many of our beneficiaries are poorly educated, have few work skills, and have had, at best, a fragile attachment to the workforce.

A number of options to change the federal role have been proposed. These include time-limited benefits; providing only services, but no cash; and offering partial benefits. Each of these approaches has some

advantages over our present system, but each presents some issues, as well. For example,

- What happens when the time limits are up and the person is not self-sufficient? What are the criteria for deciding whether benefits should continue? And, what is the alternative to benefits for those for whom benefits are the last resort?
- Is it fair to limit any category of persons with a disability to services only and no cash support? Being disabled costs money, not only in terms of forgone earnings, but also in terms of the need to buy ongoing support for daily life.
- What might be the criteria for partial benefits? How do we define partial? Could a change from the current definition toward some standard for partial benefits be equitably and uniformly administered?
- What is the appropriate federal role, if any, for those who meet our definition of disability but who nevertheless work and have significant impairment-related work expenses?

Subsequent chapters in this volume address these and other issues. They are immensely challenging and complex issues.

It is tempting, on the one hand, to think that all is well and to resist change in the disability programs now that application and award growth have slowed, to think that the disability programs no longer present an issue. It is equally tempting to regard growth as bad, to assume that something is wrong if the programs are increasing in size and cost. Neither is the case.

As we consider the DI and SSI disability programs, we must keep in mind what it is that is driving fundamental, long-term growth: the changes in the nature of disability and of persons being awarded benefits, and the resultant increases in duration on the rolls and declines in termination rates.

We must, of course, be certain that elements over which SSA has some influence are not driving application and award growth out of control. We must be certain that we have adequately financed the disability programs. We must make sure that we take appropriate administrative steps to ensure that only those who continue to be eligible stay on the rolls.

But most important, we must be certain that our programs continue to serve the best interests of persons with disabilities and the best interests of society.

Notes

1. Research conducted under the Lewin-VHI contract has been summarized in Chapters 2 and 8.
2. Application rates are defined as the percent of applications based, in the case of DI, on those insured for disability benefits and, in the case of SSI, on those in the population covered by the SSI program. Award rates have been variously defined; the term here is used to mean awards in any year as a percent of applications in a given year.
3. Technically, in the DI program, an applicant may be disabled before age 65, but becomes retired at age 65 or older. This is because benefits stop being paid from the DI trust fund and start being paid from the separate Old-Age and Survivors' Insurance trust fund for beneficiaries at age 65. No such distinction is made in the SSI program.
4. The same medical eligibility criteria are used for the DI and the SSI programs.

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10

The View from the Trenches

The View from SSA's Philadelphia Regional Office

Larry Massanari
Social Security Administration

Although this chapter is entitled, “The View From the Trenches,” I would challenge the premise that the authors of this chapter are really the ones working in the trenches. Whatever the case, each of us is a practitioner and is responsible for managing a portion of the disability process.

The commentaries we provide are a departure from the formal research papers that make up Chapters 2 through 8. The discussions here are more intuitive and more anecdotal, and perhaps more subjective and speculative than analytical; and I think it is safe to say that they are based less on hard objective data than on our impressions, observations, and opinions. We very much appreciate and are very much impressed by the work that is presented in the earlier chapters. The analyses have certainly added to our understanding of the causal relationships between those factors that most of us had assumed were generating the dramatic increase in our claims. By and large, the findings reflect our own experience, particularly those findings that relate to application growth.

While the results are very useful in the aggregate, we do need to be cautious in applying generalized conclusions to specific sections of the country, and even in assuming that state-level findings are applicable to every area of a particular state. We have seen widely diverse patterns of application growth, and our experience suggests that the reasons for growth vary greatly, not only among states but among counties as well.

My comments are based on observations and experience in the five-state Philadelphia region. Application growth in the mid Atlantic states for the past seven years has generally been consistent with national patterns. The overall rate of growth in this region was a few percentage points ahead of the national average in five of those seven years. We

have seen very little, if any, increase in Social Security Disability Insurance (DI)-only receipts. At the other extreme, Supplemental Security Income (SSI)-only cases have increased by a full 102 percent and concurrent claims by 73 percent over that seven-year period.

As you would expect, application growth has been uneven across our five states, ranging from a 34 percent increase in West Virginia to a 64 percent increase in Maryland. The most significant growth has been in Maryland and Virginia. Since 1988, concurrent and SSI-only claims in both of those states have increased by well over 100 percent. Our experience in the Philadelphia region so far in fiscal 1995 would suggest that the rapid growth in initial claims is not yet over. During the first eight months of this fiscal year, our claims receipts were running 13 percent higher than during the same period one year ago. That's five times greater than the national average and more than double the growth in any of the other nine regions. The sharp rise in initial determinations this year is largely the result of a 22 percent increase in the Commonwealth of Pennsylvania. That increase is being driven by significant cuts in the Commonwealth's general assistance program.

In describing the demographics of recent disability applicants, front-line employees tell me that applicants today are more likely to be younger, even younger than the baby boom cohort. They are more likely to be women, and they are more likely to allege a mental or stress-related impairment than at any time in the past. Particularly in the large metropolitan areas in the region, applications for AIDS, HIV infection and Drug Addiction and Alcoholism (DA&A)-related impairments are increasing. Employees are beginning to see the second and third generation of adults from the same household filing for SSI benefits. As a growing number of applicants come to accept SSI as a legitimate and permanent source of income—as a legitimate and permanent way of life—we fear that we may be creating a cycle of dependency that families are going to find more and more difficult to escape.

As in other parts of the country, the business cycle has clearly influenced receipt patterns in this region. The impact of the 1990–1991 recession was very apparent, particularly in highly industrialized areas of the region. However, we are beginning to wonder if longer-term structural changes in the economy have not had an equally significant impact on certain parts of this region. We also wonder whether the widening gap between low- and high-income families has had and will

continue to have a significant effect on program growth. The general economic decline in some parts of this region as well as industrial restructuring have resulted in the elimination of many jobs that in the past have been held by unskilled workers. In our region, job loss has been concentrated in heavy manufacturing, in mining, and in the construction industry. Increased automation and technology have reduced the demand for unskilled and semiskilled labor. Consequently, large numbers of people have simply removed themselves from the labor market because they don't have the education or the skills to compete.

Last week, a 65-year old coal miner filed a retirement application in our office in Clarksburg, West Virginia. He had made well over \$50,000 per year, he had lived a good life, and he was now ready to retire. But according to the claims representative who took his application, the man was probably functionally illiterate. He had a very difficult time understanding the most simple explanation or instruction. Similar situations are arising throughout the region. Today, with industries such as coal mining and glass manufacturing beginning to close, it is doubtful whether that same person entering the labor market today could earn more than minimum wage. These individuals might well end up poor, underemployed, perhaps being paid cash "under the table," and filing for SSI on the basis of a developmental disability. In many parts of the region, this is becoming a common applicant profile. These are people who, out of frustration, are dropping out of the labor market and are no longer seeking a job. Sadly, they have no alternative but to turn to us for financial support. These individuals, of course, are not reflected in any of our unemployment statistics.

In the Philadelphia region, cost-shifting actions by state and local governments have been, and I think will continue to be, a major contributor to increased claims receipts. All of our states require, or certainly strongly encourage, applicants to their assistance programs to also file with us. Many local welfare offices continue to refer people to social security (SSA) who are obviously not disabled. Yet, these offices still insist that SSA provide a formal denial.

Two of our states, Pennsylvania and Maryland, operate well-organized and highly effective referral programs. They are aimed at shifting disabled persons from state-funded programs to SSI. For instance, Maryland began contracting with a private company back in the late 1980s to carry out its referral function. The contractor screens, refers,

and represents applicants in an effort to get them on the federal rolls. The contractor is also paid a fee for each welfare recipient who is ultimately placed on SSI or DI rolls. The Maryland program, and a similar program in Pennsylvania, have been highly successful from our perspective in SSA, as well as from theirs. They have been successful because the states' and the contractors' employees are well trained, and they have a very solid understanding of our program. They are also plugged into SSA's service delivery network, which enhances the processing of these referrals and subsequent shift to our rolls.

Our claims workloads, as you would expect, have surged following the introduction of state welfare reform initiatives. Those initiatives have, of course, all been aimed at reducing state expenditures. Both the Commonwealth of Virginia and the District of Columbia tightened up their General Assistance (GA) programs back in 1991, driving a large number of applicants into our offices. Since that time, the District has removed over 40 percent of their eligibles from their GA rolls. Pennsylvania, in 1994, introduced major changes in its GA program affecting a significant number of chronically and transitionally needy persons. That action has had an enormous impact on new SSI applications in the State of Pennsylvania.

The state of Maryland eliminated its GA cash benefit program for disabled persons this month. Effective July 1995, they dropped 22,000 disabled persons from their cash benefit rolls. That cash benefit will now be replaced by a much more modest provision for special services. Needless to say, we expect the action by Maryland to have a sizable effect on new SSI applications in that state. As several state workers have said in Maryland, SSI is now "the only game in town," and so we are expecting large numbers of applicants to come into our offices in the coming months.

We think it is likely that Virginia also may eliminate its General Assistance program, except for emergency assistance, during their next legislative session. They nearly did so this year. Considering our experience with the reduction of state GA programs and what has happened to claims intake in our offices, I can't help but believe that the welfare reform proposals that are currently being debated in the Congress will have an enormous impact on social security offices. If limits of any kind are imposed upon Aid to Families with Dependent Children (AFDC) benefits, I think we can expect many former recipients to

begin filing for SSI. I agree with the conclusions reached by the authors of Chapters 2 and 8 with respect to the welfare reform initiatives. I think, too, that their conclusions with respect to block granting, AFDC, or Medicaid are also right on target.

Finally, just a brief comment on our SSI outreach activities in the Philadelphia region. Our local field offices, like field offices across the country, conducted very aggressive outreach programs back in the late 1980s and early 1990s. We worked in close cooperation with private agencies, community organizations, and service providers to increase program understanding, to train their employees, and to target potential eligibles. Despite a high level of commitment and an equally high level of activity, neither these internally managed initiatives nor the work of outreach grantees has, in my judgment, had an appreciable affect on application growth. While we would see sudden spurts of claims following major outreach events or outreach activities, our impression is that most of those new applicants would have eventually filed for SSI at some future stage anyway. So, at most, my suspicion is that our outreach efforts got people to file somewhat earlier than they would have otherwise. Frankly, I am inclined to believe, as are many of my staff, that the expanded involvement of advocates, the legal aid community, and even private attorneys has done more to influence program growth than our own agency-sponsored initiatives.

The View from SSA's Concord, New Hampshire, District Office

Celeste Hemingson
Social Security Administration

The Concord, New Hampshire, field office certainly experienced the same expansion that is being reported elsewhere, but in our case, the growth continued into 1995. Although the increases tapered off in 1993, we had a 17 percent increase in disability claims receipts in 1994, and so far the intake in 1995 is as least as high as in 1994. The same thing has been happening throughout New Hampshire. The 1994 phenomenon is puzzling to me. Although I could partially explain it by some changes in state welfare department policies that I will describe later, those changes would normally account for an increase in SSI claims. The biggest growth we experienced in fiscal year 1994 was actually in Title II claims.

I present only one other piece of quantifiable information in this chapter, and that is a description of a disability outreach project that I did. I think this example provides a useful illustration of outreach projects, and I'm particularly proud of this one because it was very cost effective.

In 1991, I made a deal with the director of the State Department of Special Education to deliver fliers I had printed up to the parents of severely disabled children. The flier described basic entitlement requirements and included a tear-off coupon parents could mail in if they thought their child might qualify. We gave New Hampshire's Department of Special Education 8,000 flyers, which they distributed to teachers. We received thirty-eight replies, fourteen of which resulted in allowances.

The other types of outreach activities we do in district offices are not quantifiable. They are generally aimed at advocacy groups and others with whom disabled people come into contact and they're designed to enable the disabled to access our programs more easily. Several of the

studies in this volume indicate that SSI and social security disability are difficult programs to access and that this might be why some potential beneficiaries would rather stay on General Assistance than apply for our benefits. If that's true, then perhaps our work with these groups may have broken down that barrier and paid off in additional claims.

We train workers in homeless shelters on who to refer to us; we set up telephone links for filing claims; we train veterans' service organizations such as the VFW on who to refer to us and what types of evidence we need. That's the type of outreach we do.

Outreach is always a form of publicity, but publicity, even if it's unwanted, will increase the application rate. I will describe the role of publicity in disability claims growth.

In 1968, my job was to place information about social security on nationwide radio and television networks. It was a tough sell. Public affairs directors believed that carrying information about elderly or disabled people would undermine the young image stations were eager to project. My biggest—in fact my only—success on that job was to place on a network radio feed a series of vignettes about sports figures who had obtained disability benefits. I used to think that if I could only make our program seem controversial, I could get some air time. Luckily my bosses didn't go for the idea.

They didn't have to. Ever since the controversy hit the press about our payment of benefits to drug addicts and alcoholics, we've been getting calls from people identifying themselves as drug addicts or alcoholics, asking for benefits.

Word of mouth is also an important factor that encourages applications for disability benefits. We have found that increasing the supply of awards increases the demand for awards. Many of those who apply for benefits say they're doing so because a relative or a neighbor was allowed, and they're sure they're just as disabled as he is. Many tell us they understand they'll have to apply three times before they're allowed.

I would like to turn to some changes in state and local welfare practice that have impacted us in New Hampshire. Here the changes have not been an instance of cost-shifting. I think for us cost-shifting is yet to come. In our case what happened is an indication of how Medicaid is a driver of SSI claims. Under a New Hampshire state law which went in to effect on December 1, 1993, the state was required to use the

Social Security Administration's definition of disability in determining Medicaid and Aid to the Permanently and Totally Disabled (a state program) entitlement. (New Hampshire is a 209B state, which means it makes its own determination about Medicaid entitlement). In the interest of efficiency, the state decided to use our actual disability decision instead of making a separate decision on their own. As a result, we quickly heard from applicants who told us they had to apply with us before the state would take their Medicaid application. Others said they were required to file with us within twenty days of filing for Medicaid. Although the state had always required Medicaid applicants to file for social security or SSI, there was now more follow-through in making those applications happen.

Another change we've noticed is more applicants being referred from their town welfare directors. (General Assistance in New Hampshire is paid for from town budgets and is administered by individuals elected to a post often titled "overseer of the poor.") We also see more towns requiring interim assistance agreements from applicants. We believe these increases are because town budgets are becoming increasingly stressed by the downturn in the economy.

We do notice that unemployment influences "demand for awards." We continue to see more people filing because they can't find work. Many tell us they *can* work but just can't get work. We also get more disability claims from 62-year-old workers who are also filing for retirement benefits. Our assumption is that the economy as much as disability is causing these workers to retire early.

These facts are surprising, because the unemployment rate in the Concord area is only 2.8 percent. However, this brings up a point we should all consider: most of the new jobs in New Hampshire are in retail sales and services, not jobs that pay enough to present a meaningful alternative to disability benefits. Many of the available jobs are the type that Richard Frank described (see the discussion following Chapter 2), which are limited in hours just enough so that the employer will not have to provide benefits. These are not jobs that are a meaningful alternative to disability benefits.

Another cause of disability applications is not directly related to current unemployment. It's what I categorize as economic deprivation. People contact us because they no longer have other resources to fall back on. Two signs of this are the increased inquiries we get from those

with short-term disabilities and those who are still working, but who have been advised by their doctors to stop working. These are workers who have no savings and no benefits to cover the period of time during which no social security or Supplementary Security Income (SSI) is available.

There have also been some changes in the world of work that cause people to apply for Social Security Disability Insurance (DI). This is the other side of the coin. More employers are requiring a disability claim before a company's private insurance policy will pay.

Recent trends to hire those with developmental disabilities have resulted in more and more SSI and disabled child beneficiaries becoming insured on their own. Gina Livermore and her colleagues found that growth in the Mental Retardation category was greater than for any other category in DI-only and DI-concurrent applications (Chapter 8). An advocate told me last week that she counsels disabled teens in school-to-work programs to apply for SSI in order to lock in Medicaid entitlement through the 1619 program. Once again, Medicaid drives SSI claims.

In summary, and this is particularly directed to those who don't work for social security, an article of faith for social security employees is that our programs provide a safety net. One of the things we say when we talk about retirement benefits is that you can depend on social security even when you can't depend on anything else. Our protection is portable, it's inflation-proof, and it's not vulnerable to stock market downturns. These facts also apply to the disability program, but in addition there are some other relevant facts: we're there when other income maintenance programs drop out of the picture. States, towns, and employers are relying on social security to pick up the slack when they can't do it. We are increasingly becoming the program of last resort.

The View from Michigan's Office of Disability Determination

Charles Jones

Michigan Family Independence Agency

I am going to be wearing two hats since I come from one trench as a Disability Determination Service (DDS) administrator, and I am now in another trench with respect to the disability process redesign. So I am going to be talking with you from both of those perspectives. What I want to do, though, is to describe to you a cartoon that I saw in Los Angeles earlier this year because it really put a lot of things into perspective for me that I had sort of been thinking about relative to social policy and how we tend to approach it in this country. The cartoon was a scene from Washington, D.C., and there was a well-dressed man who was walking down the street. Behind him you could see the Capitol dome and the Washington Monument in the background and in front of this man was an open manhole and there was a hand sticking out of the manhole and a voice was saying, "Help me out!" Well, as the man approached the manhole he reached into his pocket and pulled out some money and stood as far away from the hand as he possibly could and gave this hand some money. In the next scene the man was walking on past the manhole and the person was still saying, "Help me out!" When the man was past the manhole, the hand and the person were still down in the manhole. I think that is very descriptive in terms of how we tend to approach social policy in this country. We tend to think that we are helping people out of the hole, but once we do whatever it is that we do with them in whatever arena, most people are still stuck in that hole.

Yesterday, I heard a lot of very good things in terms of reasons why there is program growth, and I agreed with most of what I heard. In terms of being from the trench in DDS in Michigan, I didn't hear anything that was new. It was not surprising that when the economy gets bad, people file for disability. It was not surprising that when govern-

ments become economically strapped, they cost-shift. It was not surprising that when we change the program to make it more attractive for people to receive disability benefits, they apply in greater numbers. And it was no surprise that, as Celeste Hemingson indicated, when we advertise, there is a growth in the number of applications. What I was a little bit surprised about yesterday was that there was no discussion regarding what it is that we are going to do with all of this valuable research and all of this valuable information. Are we going to use it to anticipate future workloads? Hopefully, that would allow us to better react to them. Or, are we going to use it to prevent future work loads? Probably, the information is going to be used in both ways, but not in the context of any overall social policy.

In terms of the view from the trench, in the Michigan DDS trench we always had this picture of a giant pendulum out there and this pendulum would swing from left to right, left to right, over the years. I don't mean that necessarily to signify any political spectrum, but it does swing, and we never seemed to get that pendulum right in the middle where it would do the most good. We saw the pendulum swinging in the early 1980s with the Continuing Disability Review (CDR) debacle, where a decision was made that we need to get people off the rolls because in fact there were, and still are, people on the disability rolls who should no longer be there. But there was no discussion, there was no thought of why they got there, who they were, and more important, what we were going to do with them once we got them off the rolls. The result was a knee-jerk reaction where we kicked a lot of people off the rolls and another knee-jerk reaction when we wound up putting them back on at the hearing level. Now we just have all these people on the rolls and everybody is screaming that we've got to get them off. We also saw the *Zebley* decision, which I personally thought was a good decision, but which resulted in putting a lot of kids on the rolls. We didn't have any thought or discussion regarding that aspect of program growth and what we wanted to accomplish with these kids. What did we want them to do once they got on the rolls? Again, this knee-jerk reaction. Now we have another knee-jerk reaction that is going to swing the pendulum in the other direction, probably take a lot of kids off the rolls, or prevent them from getting on the rolls—kids who should be getting disability. And yet there is no discussion about

what's the best thing for the kids or what objectives we want for the kids.

We saw in Michigan these knee-jerk reactions with respect to cost-shifting, and I was a part of that. We were very successful and very good at what we did. We saved a lot of money for the state, we got a lot of people onto SSI, and hopefully people benefited from the money that they got and from the medical care they received. But in Michigan, we had no discussions of return-to-work, we had no discussions of whether or not we were actually helping people with disabilities meet their needs on a daily basis to help them live, and we had no discussions about what we expected in terms of educational outcomes for children. We just had a very successful cost-shifting effort. I am hopeful that we did help some people in the interim, but again all of this was done without any specific objectives for us to head toward. These knee-jerk reactions we have are temporary solutions that two or three or five years from now we spend millions of dollars trying to correct.

Now, the program growth discussion, in my opinion, has to be combined with a larger discussion in our country on a comprehensive public policy of what disability programs should achieve. We have a lot of excellent efforts that are going on right now that are looking at various aspects of the disability program or disability in general. We have the National Academy of Social Insurance Disability Panel, we have the Childhood Commission, there are a lot of congressional efforts going on, there is proposed legislation that will have even new committees and new groups looking at the area of disability, and of course we have internal efforts within Social Security Administration. I know that in the private sector, private insurers are also struggling with this issue. All of these efforts are very good, but all of them really need to be done after a national decision is made about what it is we want to achieve with disability policy. That way, all of our efforts, whether we are talking about disability redesign, whether we are talking about doing more CDRs, whether we are talking about program growth or childhood disability, will all be working toward the same end and for the same objective and hopefully for the betterment of everyone. Again, my view from the trench, if I were still in the Michigan DDS, is that the pendulum is still swinging and that five years from now we are going to be spending millions of dollars and hundreds of work-years trying to correct whatever problems we are correcting today.

Now the people in the trenches don't have time to ponder why applications have grown. In Michigan, when our caseloads were going up, we didn't have time to think about what the reasons were. The issue was how were we going to handle it, and how were we going to do it with inadequate resources? The view from the trenches was also what mess am I going to get blamed for and how am I going to clean it up, because the policymakers were, once again, overreacting. One facet of addressing program growth is to improve the process, and the other trench that I am in is intended to try to do that. The disability process redesign is not a panacea for the disability program; we need to decide where we are headed with disability. But I think there are some features in the redesign that will help in this area of program growth. One of them is our comprehensive public relations program, which is really focused not on a "come on down and file" kind of a message, but on a message that will give our customers better information and more realistic information about the process. It is also focused on providing third parties with information they need to get the information we need. We want to couple that comprehensive public relations campaign with working with and expanding the use of third parties.

Our experience in Michigan was very successful with this, and despite the fact that we doubled the number of SSI applications and the rolls increased because of a tremendous amount of advocacy and outreach, the fact of the matter is that our application growth could have been much greater had we not gone out and worked with other state departments, advocates, and others who were helping people to file. What we were able to do to was to prevent a lot of frivolous applications from being filed, because the initial reaction of the Michigan Department of Social Services to cutting off General Assistance was going to be to tell all 83,000 to go file for social security disability. So there are some benefits to having a very focused, a very tailored public relations process that would get you "good claims." When I say "good claims," I am not necessarily meaning to differentiate between good claims and bad claims, but we have a very high allowance rates on our SSI efforts in Michigan. There were a lot of reasons for that—primarily because we did go out and work with other people to focus on those applicants who were most likely to be disabled—that saved everybody time and money, and we think it was beneficial to the customers we were trying to serve.

Another thing we are trying to do with the disability redesign is to unify the process so the cases that should be allowed will be allowed as early in the process as possible. We need to restore a sense of fairness to the program and to eliminate the tremendous growth at the hearing level. One observation that I do have about yesterday was that all the discussion of growth focused on initial applications and not on recons and hearings. I think this is also a very significant issue that needs to be dealt with.

There are some other features in the disability process redesign that I hope to be able to return and discuss with you in the future, but I really do want to leave you with this thought: what is needed is a comprehensive public policy debate and decisions regarding the goals that we as a society want to achieve in assisting persons with disabilities. Until that takes place, the vast majority of people who apply for disability benefits, no matter what we do, are going to continue to remain in that hole. And I am hopeful that through a lot of discussion and making some decisions about where we want to go, the next time we approach a hole and someone is reaching out to us saying "Help me out," that when we are past that hole we leave with that person traveling beside us and not still left in the hole.

11

**Policy Responses
to Program Growth**

The Perspective of a Public Trustee

Stanford G. Ross
Arnold & Porter
Washington, D.C.

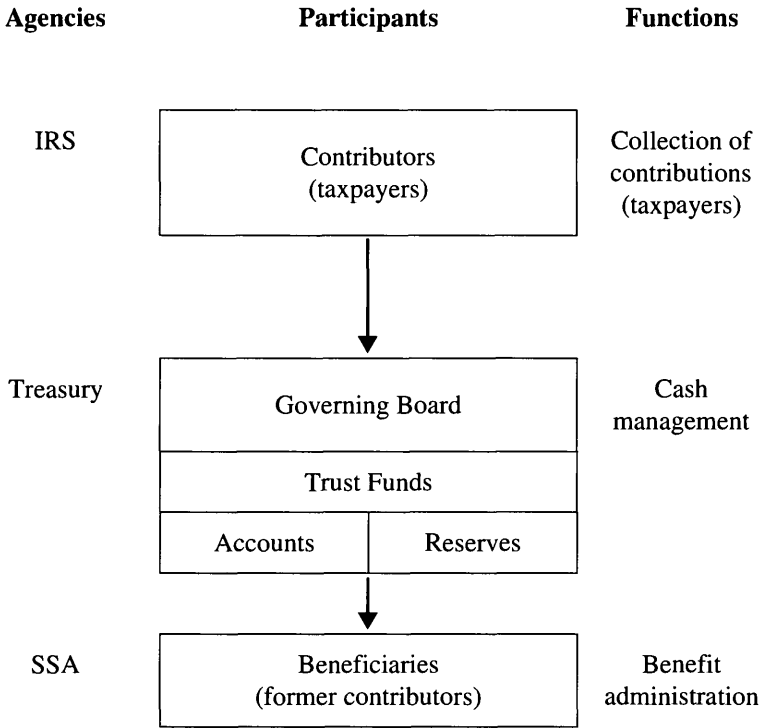
I begin by describing in a very brief fashion how the policymaking institutions are working today and, in particular, how this discussion fits into that setting. Focusing attention on institutional issues can help us to be more practical in our consideration of policy responses.

I served as a Public Trustee of the Disability Insurance Trust Fund from 1990 to 1995. As shown in Figure 11.1, the Public Trustees serve with the ex-officio Trustees (the Secretaries of the Treasury, Labor, and Health and Human Services) on the governing board of the Social Security Trust Funds and have an important oversight role in the management of the system. In that regard, I have a certain sense of responsibility for the Lewin-VHI work product that is being discussed at this conference. Also, from that vantage point, I offer some thoughts about what should be done with the important information produced by that study.

When the rapid expansion in applications and awards took place in the early 1990s, the Trustees were called upon to issue a "Section 709 letter" to the Congress in April of 1992 informing them that the reserves were projected to fall below 20 percent. This was the first time that this alarm bell was set off since this provision was enacted in 1983 in response to the concern that there should be some institutionalized early warning signals given to the Congress when trust funds were approaching insolvency.

Then, when the proposal for reallocation from the Old-Age and Survivors Insurance Trust Fund to the Disability Insurance Trust Fund was made in late 1992, my co-Public Trustee and I refused to approve unless a research agenda was pledged by the ex-officio Trustees, who were then members of the Bush administration. We felt strongly that the short-term palliative of a reallocation should not take place without providing for the Congress and the public to gain information that

Figure 11.1 Overview of U.S. Administrative Process



would permit a more fundamental look at the program and hopefully lead to some reform efforts.

In April of 1993, with new *ex-officio* Trustees from the Clinton administration, we again had the commitment to a research agenda renewed and took the position that the Section 709 letter should continue to be issued until the conditions that called for it were corrected by legislation. In other words, the Public Trustees provided continuity in seeking a solution to the problem of the impending insolvency and persisted in persuading the executive branch and the Congress to reach a position where a substantive policy discussion would take place.

Legislative action to do the reallocation took place in 1994, somewhat over two years after the Section 709 warning was issued. In fact, it was very close to the last possible legislative moment, since funds

would have been unavailable to pay benefits sometime in mid 1995 without that action. As in 1983, there was procrastination, even on a relatively noncontroversial way of acting to avert the crisis.

The combination of the 1994 reallocation and the delivery to Congress in 1995 of the study we are discussing sets the stage for the possibility of a informed debate on the Social Security Disability Insurance program and the companion Supplemental Security Income program. I saw reallocation then, and I see it today, as providing time and opportunity to address the substance of a program that is fundamentally troubled and that clearly requires serious reconsideration. At the same time, we must not lose sight of the great importance of the social security programs to the social fabric of the nation and to the many deserving people who rely upon them. The considerable achievements of the Social Security Administration (SSA) over the years in carrying out its responsibilities for administering the program must also be acknowledged. As needed changes to the program are developed, it is important that such changes be done in a careful and considered manner.

A few basic points can provide perspective in considering the policy aspects of the new study.

1. Looking across the entire spectrum of OECD countries, all advanced industrialized countries have disability insurance programs and all are more or less troubled. The United States is not an isolated case and, indeed, its problems are not as severe as in some other countries. I say this not to lower enthusiasm for undertaking the necessary review and reform, but only to indicate that we must keep a sense of perspective as we go about this task.
2. The problems of the disability program to date seem to go in cycles, or, if not in cycles, at least in fits and starts. My first hands-on experience with the program was as Commissioner of Social Security in 1978 and 1979, when I worked on the legislation that resulted in the disability reforms of 1980. That policy reconsideration and legislative activity was produced as a result of the unexpected expansion of the rolls in the mid 1970s. Then as now, a rapid expansion was followed by a plateauing of the applications and awards.

3. I believe that at least part of the reason for the fits and starts, if not cycles, relates to administration of the program. This is not the time or place to go into this subject in detail, but my conclusion on this is that administration is as critical to the results of the program as the legal provisions. Unfortunately, the institutional arrangements underlying the program are flawed and sometimes unable to accomplish what the law requires or what any reform laws are likely to require. This is not to say that all of the institutional arrangements are flawed, because indeed some work well. But when the Disability Determination Services are allowing some 30 percent of claims and administrative law judges allow 75 percent, basic issues of administration in both of these processes are suggested. In short, unless the administration of the program can be improved dramatically, no amount of informed policy debate and reform legislation will truly be effective to meet the challenges that this troubled program presents.
4. While the law is hard to change, the program in fact changes as the society changes, but its shape today is not consistent with current thinking about such programs. When enacted in 1956, the legal concepts were more a product of the 1930s than of the contemporary society that then existed, much less the one we have now. The Americans With Disability Act of 1990, which emphasizes concepts of self-help and equal opportunity, is closer to current thinking. I recognized that anachronisms were present at some level when I had hands-on responsibility in the late 1970s, but the shift in underlying premises was just beginning to take place at that time. A new paradigm is clearly present today and needs to inform the policy debate and any reform legislation. There are changes in the economy, new patterns of work, and changes in the society that must be taken account of more fully than has heretofore been the case.
5. Among the new directions that require greater consideration today are employment strategies by which applicants for disability are given more help to return to work. Similarly, more effort might be given to considering privatizing aspects of the process. It is entirely possible that private contractors might do a better job than government agencies at providing rehabilitation, training,

and assistance with employment strategies. Recent experiences in other areas such as workers' compensation, in which integrated approaches to providing medical treatment, long-term health care, rehabilitation, and return-to-work assistance, might well be instructive. The SSA programs for too long have tended to be isolated from innovative changes that are taking place in the private sector, and the use of privatization techniques might be a way to better relate aspects of these governmental programs to those private sector developments.

6. Underlying much of the current debate is the question of whether incremental changes can achieve a desired restructuring of the program or whether more fundamental or radical change is needed. I would submit that there is no reasonable alternative here but to provide for all changes to be incremental, with adequate transition periods. It may be that far-reaching, "radical", change is appropriate, but the way to achieve that goal is not through drastic, precipitous action, but by moving incrementally in a measured and orderly way. We must constantly be aware of the disruption that can be caused by sudden changes in policy for which the affected people are not adequately prepared. Also, administrative agencies such as SSA, even though well intentioned with many dedicated people, are inherently limited in their ability to implement change. Political realism suggests that problems of implementation be given careful consideration at the time legislation is enacted and that the constraints imposed by the need for effective and reasonable implementation be taken into account in any reforms. There is a tension between more radical proposals and the administrative capacity to make them feasible. While there must be a presumption that needed new policies can be effectively implemented, it also must be recognized that making changes may require that additional resources and adequate time be provided to the agencies that are called upon to discharge these responsibilities.
7. Bipartisan approaches are needed. We need to overcome the inertia of Washington lobbyists and others representing what they think benefits their constituents, which is generally for maintaining as much of the status quo as possible. In our own limited area

of responsibility, the two Public Trustees, by operating in a bipartisan, nonpolitical, professional way to stimulate research and hopefully a substantive policy debate, show the benefits of this approach.

Thus, I would urge that an open and candid discussion of alternatives is needed, and I hope we can all contribute to an atmosphere that permits that today and in the many difficult days ahead as the process towards reform continues.

Unsustainable Growth: Preserving Disability Programs for Americans with Disabilities

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The Social Security disability programs, which constitute the essential safety net for people with disabilities in our country, are growing at an unsustainable rate. If we are truly committed to meeting the needs of people with disabilities, we must make the changes necessary to ensure the long-term viability of these programs. I do not want my following remarks to be misconstrued; while I have no commitment to the status quo, I am deeply committed to developing well-designed disability programs that provide income security while encouraging independence for people with disabilities.

I approach these issues from two different, but mutually reinforcing, perspectives. First, I view them as a policymaker on Capitol Hill who is responding to several national goals: to balance the budget and to get the economy back on track, to make government run more efficiently, and to assist people with disabilities to live productively and independently. Second, I look at them as a person with a disability, who was once a recipient of the Supplemental Security Income (SSI) program,

NOTE: This chapter is based on comments delivered when the author was serving as Legislative Assistant to Senator John McCain. Several significant program changes have occurred since the time of that presentation, particularly with respect to the eligibility of legal aliens and proposals concerning treatment of children with disabilities. The chapter should therefore be read not for current program content, but for conceptual and historical insight into the programs from the perspective of a Senate aide who has a disability and significant experience with the programs. Andrew Batavia is currently associate professor at the School of Policy Management, College of Urban and Public Affairs, Florida International University. The views expressed are solely those of the author, and do not necessarily represent the positions of Senator McCain, or any organization with which Mr. Batavia is or has been affiliated.

and who has some serious concerns about the disability programs and their effect on people with disabilities.

A POLICY PERSPECTIVE

From the perspective of a policymaker, the rapid rate of growth of the disability programs in recent years is alarming. The number of Social Security Disability Insurance (DI) beneficiaries alone increased 27 percent from 1989 to 1993, as compared with a 7 percent increase in retired worker social security beneficiaries (DHHS 1994). Disability benefit payments increased 51 percent over that period. Applications, eligibility awards, and payments for the SSI program are also growing dramatically.

Altogether, the federal government is currently spending about \$70 billion each year for the social security disability programs, almost twice as much as five years ago (Board of Trustees 1995; Committee on Ways and Means 1994). If this upward trend continues, the programs soon will be subject to increasing political scrutiny and criticism. Eventually, public support for them will dissipate. Because these programs are so important, we must get them under control.

There has been a dramatic change over the past thirty years in the way our society perceives people with disabilities (see articles by Ross and by Weaver, this chapter). Previously, when an individual incurred a permanent and significant disability, the general expectation was that he or she would no longer be employable or even potentially employable. In recent years, as a result of the independent living movement, improvements in assistive technology, and enhanced environmental accessibility, there is an increased expectation that even people with very substantial disabilities can work.

This social change is best evidenced by the enactment of the Americans with Disabilities Act of 1990 (ADA), the civil rights law that represents a national consensus on the goals of our nation's disability policy and the legitimate expectations for our citizens with disabilities. Many of our disability laws that were established prior to 1990 are inconsistent with the ADA's basic premise that people with disabilities can be employable and must be given the opportunity to live full and

productive lives. It is incumbent upon policymakers to ensure that all disability policy is consistent with the premises and goals of the ADA (DeJong and Batavia 1990).

A PERSONAL DISABILITY PERSPECTIVE

From my perspective as a person with a disability, I am concerned about the “entitlement mentality” that the social security disability programs impose on their recipients, particularly on young people with disabilities. Beneficiaries, and even potential beneficiaries, are repeatedly given the message that they have a right to benefits as long as they can demonstrate an inability to work by virtue of a disability. Even those raised with a strong work ethic begin to think about how they can demonstrate their absolute inability to work. Once that mind set is internalized, it is very difficult to alter.

To avoid this counterproductive self-fulfilling prophecy, people with disabilities must be brought into the mainstream of the community as soon as possible. This is why antidiscrimination laws such as the ADA and the Individuals with Disabilities Education Act (IDEA) are so important. People with disabilities must obtain an expectation of employability before they receive and accept the societal message that they are “too disabled” ever to work.

In 1973, when my spinal cord was injured in an automobile accident at the age of 16, I was confronted with conflicting messages from the people running our nation’s disability programs. I was informed that, because of the “severity” of my disability (C2-3 quadriplegia), I would qualify for SSI and therefore be entitled to cash benefits and Medicaid for the rest of my life. However, if I demonstrated the ability to earn a small amount of money, I would be disqualified and all of these benefits would no longer be available to me. (This was before the various work incentive provisions were enacted in the 1980s.)

I made a decision that was, in a sense, irrational. I decided to take a great risk—to go to college, law school, and graduate school with the support of vocational rehabilitation, and to thereby become employable notwithstanding my disability. To most Americans, this decision may seem neither irrational nor risky. However, by doing so, I was

potentially compromising tens of thousands of dollars of life-sustaining support for the rest of my life. Moreover, I was doing so without any assurance that I would be able to earn comparable benefits through employment. The likelihood of regaining eligibility once I had demonstrated the ability to work seemed remote.

I was fortunate. I have a supportive family and friends who encouraged me to take that risk. I also had a vocational rehabilitation counselor named Joan Brown who believed in me and who provided advocacy in obtaining the educational benefits I needed. Many people with disabilities do not have such supports. As evidenced by program statistics, most make the low-risk decision to stay on the programs permanently. Given the basic structure of the system, even with its current work incentive provisions, this is *not* an irrational economic decision. Many simply do not trust the government to allow them to regain their benefits once they have lost them.

This has convinced me that we need to alter the programs' structures to create strong incentives for people with disabilities to seek gainful employment and ultimately to leave the programs. I come to this conclusion not because it will save the taxpayers money. In fact, it will probably cost somewhat more in the short run to provide the opportunity for people with disabilities to work. I support structural reform of the programs because it will improve the lives of people with disabilities by helping them to achieve their highest potentials.

THE STRUCTURAL PROBLEMS

The 104th Congress recently enacted major welfare reform. Interestingly, in a political climate in which almost all means-tested welfare programs were being considered to be block granted to the states, the disability programs have been largely exempt from the block-granting debate. There appears to be a general consensus that these programs are such an important part of the safety net that they should continue as entitlements. However, that does not mean that they should maintain their current structures and policies. The rapid growth of the disability programs ensures that we will soon be engaged in a debate over what changes should be made.

The causes of the programs' growth is an extremely complex issue and is not well understood (GAO 1994). Among the factors that appear to affect the increase in program applications are economic conditions, the policies of other social programs, state efforts encouraging people to apply, and demographics (Stapleton et al., Chapter 2). However, all of these factors interact with the policy structures of the disability programs. There is a basic conflict between the fundamental premises of these programs and the ADA. I believe that this incongruity explains much of the reason that very few beneficiaries ever leave the disability rolls.

The disability programs are based on an outdated premise equating disability with unemployment. DI was initially structured as an early retirement program, with the foundational notion that if a person had a disability, he or she was basically unemployable; and there was therefore no reason to expend substantial resources in a futile effort to get the individual ready to work. In this stage of our history, we recognize that this is simply not the case. There have been attempts over the years to modify the programs' presumption of unemployment through the various work incentive provisions. However, the programs still maintain their self-defeating historical premise. Until we address this flaw, we are not going to get beneficiaries to work.

Adults with Disabilities

The recent growth in the number of adults in the programs appears to be largely a result of economic recessions and changes in state public assistance programs (Stapleton et al., Chapter 2). In addition, the demographics of our aging population is expected to contribute significantly to future growth, as the large baby boom population becomes more disabled and chronically ill.

While such factors have important implications and represent a challenge to finite federal and state budgets, they should not be the primary focus of program policy. Such growth could be constrained through more restrictive eligibility criteria. However, to the extent that this would disqualify individuals with significant disabilities that, at least temporarily, preclude employment, it would ultimately increase their vulnerability and interfere with their employment objectives. By far, the more important policy considerations for addressing the growth

of the adult beneficiary population are appropriate vocational rehabilitation, education, and return to work.

Certainly, we should be developing better criteria and mechanisms (e.g., functional assessment measures) to determine who should be eligible (Batavia 1992). The current eligibility system is based primarily on a medical model of disability that equates impairment with the inability to work. The Listing of Impairments used by the Social Security Administration (SSA) is a poor proxy for determining functional deficits and inability to work. SSA's system of ongoing medical reviews in which beneficiaries are categorized and reviewed periodically according to expected medical improvement is also largely irrelevant. Capacity to work is not necessarily associated with medical condition or improvement in medical condition; the relationship is far more complex, with the more important variables being functional capacity and social (e.g., family) support.

Return to work is currently impeded by program policies that discourage beneficiary efforts to become rehabilitated and employed and that do not encourage maintenance of any existing relationships with former employers (Mashaw et al. 1996; Burkhauser and Haveman 1982). These policies range from the medical model definition of disability (assuming a causal relationship between an impairment and the ability to work), to a waiting period for eligibility that discourages early rehabilitation, to a benefit structure that creates an enormous disincentive to work.

As suggested above, in response to a general consensus that these disability programs impose substantial disincentives to work, several laws were enacted by Congress in the 1980s to encourage SSI and DI beneficiaries to seek gainful employment and leave the disability rolls (NARF 1988). Yet, despite this legislation and indications that many disability beneficiaries wish to work, few ever leave the programs voluntarily (Muller 1989). In December 1993, only 35,299 of the 5.98 million disabled SSI recipients participated in the Section 1619 work incentive program (DHHS 1994, Tables 7.F5 and 7.A3).

The unabated growth of the programs and the failure of the work incentive provisions to curtail such growth have demonstrated that incremental changes are not sufficient. We need substantial structural reform to ensure the long-term viability of the disability programs. In 1991, when Susan Parker was Associate Commissioner for Disability

of SSA and I was associate director of the White House Domestic Policy Council in the Bush administration, we and our staffs developed a proposal to fundamentally alter the premises of the disability programs. It would maintain the entitlement status of the programs but make them time-limited, thus creating a presumption and expectation of employability (Batavia and Parker 1995).

Our proposal would create four categories of disability:

1. A Permanent Disability Pension, which would apply to individuals with no capacity to work (e.g., people with severe brain injury)
2. A Temporary Disability Benefit, which would apply to the vast majority of beneficiaries, whose benefits would be limited to three years but would be potentially expandable for education, training, and other activities to become employable
3. An Early Retirement Benefit, which would allow people with disabilities 55 years of age and over to opt out of the job market and accept early social security retirement
4. Provision Benefits, including personal assistance services, assistive technology, and training that would be provided to Temporary Disability beneficiaries to become employable

In addition, the proposal includes several other provisions that are geared to enhance administrative efficiency and encourage beneficiaries to work. These include elimination of the current five-month waiting period for DI, expediting the paperwork, determining the appropriate course of action through increased beneficiary and physician responsibilities, using case management techniques to capitalize on the beneficiary's functional capacity and relationship with former employers, creating positive incentives to work, and establishing a contract between the SSA and the beneficiary in which both would have responsibility to ensure that the beneficiary may become employed as soon as feasible.

The overarching goal of the proposal is to alter the culture of the programs by changing the expectations of all parties. However, the proposal will only work if there is adequate funding for rehabilitation, training and provision benefits, and if positive incentives to work are

built in. Fear of losing health insurance and personal assistance services creates among the greatest disincentives to work for people with disabilities (Friedland and Evans 1996; Batavia, DeJong, and McKnew 1993; Burns, Batavia, and DeJong 1991). An array of policy options, including reform of our in-kind benefit programs, are available to reduce these disincentives (Batavia 1993, 1996).

Children with Disabilities

Much attention has been focused on the rapid growth in the number of children in the disability programs after the *Zebley* Supreme Court decision. That decision dealt with the legal standard for children's eligibility. At this time in the history of the programs, we should reexamine the policy rationale underlying that eligibility standard. With respect to adults with disabilities, a cash benefit is clearly justified as income replacement for individuals who, as a result of their disabilities, cannot work. This rationale applies to adults, at least for the period of time that they are incapable of employment. It does not apply to children with disabilities, who are not breadwinners and who therefore have not forgone income as a result of their disabilities.

Consequently, some other rationale is needed for a cash payment to children. Typically, the justification offered is that the child's disability requires the parents to work less and earn less than they otherwise would or to hire outside help to assist in addressing the child's disability-related needs. The needs of a child with a disability are often much greater than those of a nondisabled child, and the costs of meeting those needs are correspondingly higher for children with disabilities.

Because the policy rationale for a cash benefit is stronger with respect to adults than children with disabilities, further policy consideration should be given as to which children justify a cash payment. It may be that the needs of many children with disabilities can be addressed entirely through in-kind benefits, including health care, assistive technology, and personal assistance services. Alternatively, a cash benefit may be warranted in certain cases to allow one of the parents to stay home and take care of the child. Analysis may reveal that some children warrant higher payments than they are currently receiving.

Assuming that it is determined that a cash payment continues to be justified for certain children, substantial research will be needed in

assessing the appropriate eligibility criteria for identifying such children and in determining the appropriate amount of the payment.

Legal Aliens

Another issue that has received increasing attention lately is the large increase in the number of individuals from other countries who have entered the United States legally and who have become recipients of the disability programs. It has been reported to Congress that approximately 738,000 legal aliens currently receive SSI, up from 127,000 in 1982 (Rector and Lauber 1995; Matloff 1994). This constitutes a growth rate of 580 percent in just twelve years. The vast majority are elderly, and most apply for benefits within five years of entry into the United States. This disturbing trend should not be occurring under long-standing federal immigration policy, which precludes aliens who may become a "public charge" from entering our country.

There is a tendency to scapegoat noncitizens for the problems of our country. In fact, legal aliens have always played an important role in our economy and have contributed significantly to the growth of our nation. To the extent that they pay into social programs over an extensive period of time, they should be entitled to benefits, proportionate to their contribution. However, there is evidence that many are attracted to our country primarily by its generous social programs (Rector and Lauber 1995). To the extent that this is occurring, policy changes are needed. One approach might be to preclude benefits for a stated period of time (e.g., three, five, or ten years) after the individual legally enters the country.

CONCLUSIONS

There are those committed to the status quo who would argue that the policy changes being suggested here, such as time-limiting disability benefits, lack compassion. They are wrong. What lacks compassion is a system that convinces people with disabilities, and particularly children with disabilities, that they are too disabled ever to work. Our disability programs currently are fundamentally flawed. While incre-

mental reforms have improved the programs, they have not corrected the basic problems. We must fix the programs to ensure that the people who rely on them will receive the benefits that they need, but in a manner that encourages and empowers them to be more independent and productive.

Most important, for all people with disabilities, we must raise the expectations of our disability programs. As much as any other factor, including the work disincentives built into the current system, the presumption that an impairment necessarily limits the ability to work has handicapped generations of program beneficiaries. The experience of hundreds of thousands of people with disabilities who are now working, despite significant functional limitations, proves that this presumption is false. People with disabilities can become gainfully employed if we expect them to become gainfully employed, and if they expect themselves to become gainfully employed.

Adults with disabilities must be given the expectations, opportunities, and incentives to seek and obtain gainful employment. Children with disabilities must receive the education and training that they need, alongside children without disabilities to the extent possible, to offer them full opportunities throughout their lives. The programs should be reformed to ensure that every dollar spent is invested efficiently in the future of their beneficiaries. People with disabilities in our country must be encouraged to seek employment to improve their personal situations and to remove themselves from the dependency of the disability programs. Such dependency is neither in their interest nor that of our country.

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Policy Implications of Recent Growth in Beneficiaries with Mental Illness

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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.

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Rethinking the Social Security Disability Programs: Causes and Options

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The Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) programs have been experiencing substantial stress as a consequence of rapid growth in the number of program beneficiaries.¹ Several operational problems have also contributed to program stress. For example, the media have spotlighted several examples of program abuse and inadequate management action, and policy analysts have criticized the inefficiency of the disability eligibility determination process as well as the lack of attention to assisting beneficiaries in returning to gainful employment. Faced with this broad range of problems and the increased scrutiny focused on these programs, policymakers and the public seem to be open to considering program changes.

At the same time, changes have occurred in the way society views people with physical and mental impairments—changes that are leading to a rethinking of the relationship between cash benefit programs, such as DI and SSI, and the ability of people with significant impairments to engage in productive work.

These comments address some of the operational problems within the DI and SSI programs and some of the societal changes that, in combination, are resulting in a receptiveness to rethinking the purpose and design of these programs. The comments also summarize some of the proposals for change that are currently being discussed.

OPERATIONAL PROBLEMS

Both DI and SSI currently have significant backlogs of cases awaiting decisions on eligibility. In particular, waiting time for those who are appealing denials of their initial application now averages about a year.

As the Social Security Administration (SSA) has struggled to process the tremendous number of applications for benefits, it has for many years reduced the number of reviews of the disability status of people already receiving benefits. Since the same workers are responsible for initial determinations and these periodic reviews, SSA has had to prioritize workloads and has done so by limiting its reviews of continuing disability status.²

The net result of the eligibility determination backlogs and limited review of continuing eligibility is that SSA has been giving poor service to its applicants and neglecting its responsibility for maintaining program integrity.

A second operational problem involves Administrative Law Judges (ALJs), who hear the appeals of applications that have been denied. The ALJs are reversing decisions denied at the initial level in about 70 percent of the cases that they hear. This reversal rate is much higher than it has been in years past and reflects the lack of a consistent systemwide process for determining eligibility. Adverse publicity about SSI program abuse by drug addicts and alcoholics, the parents of some disabled children, prisoners, and immigrants also signals that program managers have not been sufficiently vigilant in determining eligibility for benefits or monitoring people once they begin receiving benefits.

Finally, neither the DI nor the SSI program has a good record of returning beneficiaries to work. While no one is certain what proportion of the beneficiary population can be expected to work, currently about 1 in 500 DI beneficiaries leaves the benefit rolls to return to work—a number that is generally agreed to be too low.

SOCIETAL CHANGES

Society's view of the right of people with physical and mental impairments to be accommodated in the work place has changed significantly. The public appears to believe that people with impairments ought to be assisted in a variety of ways to lead economically productive lives. More and more, we are coming to believe that categorizing people as either disabled or not disabled can't be done accurately. Rather, disabled people have a broad range of impairments with varying levels of severity. Many can be assisted to increase their involvement with the workplace through adaptive technology and medical advancements.

There is also greater appreciation that the link between medical impairments and ability to work is a weak one. Several studies suggest that medical criteria by themselves are poor predictors of work potential, and many people who meet the DI and SSI eligibility criteria currently are working.

Society in general also seems to think that people ought to work. This view suggests not only that people ought to work if they are better off financially when working than when not working, but that most people have a responsibility to work. We have seen this view come to the fore in the new welfare legislation that limits the amount of time individuals can draw benefits. Such proposals are framed in terms of numbers of years of receiving benefits, not in terms of income available to the family. This same view is now being articulated with respect to disabled people in proposals that would limit the amount of time that they can receive DI and SSI benefits.

There is also a general concern about the overall size of the government sector and whether programs such as DI and SSI are including larger numbers of people than is appropriate. In the case of the DI program, some people are also concerned that taxes used to fund DI benefits reduce the revenue that realistically can be raised for the retirement and survivors' insurance programs.

These shifts in the way decision makers and the public think about people with disabilities and about the size of the disability programs have generated a great deal of discussion about how to ensure that

everyone who can work is assisted in doing so, while still ensuring income support for those who are unable to work.

POLICY OPTIONS

The policy options currently being discussed can be described as fitting into one of three categories: incremental changes that modify specific provisions to encourage work, leaving the structure of the DI and SSI programs intact; changes that alter the current terms under which benefits are received, such as imposing time limits for certain beneficiaries, but leave the current eligibility definitions in place; and changes that fundamentally redefine program eligibility and the benefit structure.

Regardless of whether incremental or more fundamental change might occur, most participants in discussions about DI and SSI policy changes agree that two actions currently under way at SSA must go forward. The first and most ambitious of these is the disability redesign project, the goal of which is to make the disability determination process more timely, consistent, and cost-effective. This effort includes initiatives designed to reduce the time involved in making determinations to standardize the ways in which disability is evaluated at all levels of decision making, and to change the standards by which disability is evaluated toward measuring one's ability to function in the workplace. Second, there also appears to be general agreement that SSA should increase the number of reviews of continuing eligibility that it performs, so that individuals with some likelihood of medical recovery will be reviewed on a regular basis.

INCREMENTAL CHANGES

The main thrust of most incremental reforms is to increase the total income and benefits of current beneficiaries who attempt to work. One such measure would increase the amount that a beneficiary could earn while still receiving benefits. Currently, most beneficiaries become

ineligible to receive benefits when they earn more than \$500 a month for nine months.

Another proposal suggests reducing cash benefits gradually as earnings increase over time, rather than terminating benefits abruptly after a certain time at work or after a certain earnings level has been achieved, as is currently the case. (This proposal is targeted primarily at DI, since SSI already has this more gradual benefit offset.)

A third suggestion is that beneficiaries who return to work be allowed to retain their Medicare or Medicaid eligibility for much longer periods than provided in current law. The fear of losing medical coverage may be the most powerful barrier facing beneficiaries who consider attempting to work.

Others have suggested a different type of work incentive—a tax credit that functions as an earnings supplement for beneficiaries who work. A credit would be designed to ensure that an individual's combined income from earnings and the tax credit would be sufficient to encourage him or her to try to work and then to stay at work.

A final example of incremental change is a proposal to allow SSA to use private rehabilitation firms to help beneficiaries develop skills that will facilitate their return to work. Currently, almost all vocational rehabilitation financed by SSA is conducted by state agencies. Many people believe that expanding the capacity of rehabilitation services and introducing competition among providers would be more effective in returning beneficiaries to productive activity.

INCREMENTAL PLUS

Some participants in the current policy discussions are concerned that the incremental options listed above will not provide enough encouragement for current beneficiaries to attempt to work. They believe that younger beneficiaries or those with certain impairments should receive benefits only for a limited number of years, so that they will have very strong incentives to try to work. Time-limited or temporary benefits could be proposed in conjunction with several of the incremental options.

Another more substantial change to encourage more attempts to return to work would be to provide vocational rehabilitation services to people who have not yet been determined to be eligible for benefits. This approach has been suggested by those who believe that rehabilitation would be much more successful if it were provided well before the time an individual is determined to be eligible for benefits.

FUNDAMENTAL CHANGE

This category of suggested policy changes involves a fundamental reorientation of the DI and SSI programs, with a shift in focus from proving an individual's inability to work to enhancing and supporting an individual's ability to work. The programs might run on two tracks. One track would be reserved for those whose disabilities represent much more profound functional limitations than the current DI and SSI definitions. These individuals would be evaluated as the most unlikely to return to work. The second track would be for those with some remaining capacity to function in the workplace, but a level roughly the same as the current DI and SSI definition of disability. The program rules for this group would be quite different from those that exist today and would allow for long-term receipt of both benefits and earnings. The idea would be to encourage as much work as possible and allow benefits to serve as a supplement. The underlying rationale for segmenting the program in this way would be to separate the conflicting goals in the current system, providing full benefits as long as an individual couldn't work while providing significant encouragement and incentives to work.

CONCLUSION

The DI and SSI programs are being criticized because of operational failings and because they appear to undercut the beliefs that people with severe impairments ought to have more opportunity to work and that cash benefits should be viewed as a last option. Policymakers and

the public appear willing to consider changes in the DI and SSI programs to address both of these types of problems. Many ideas for operational changes are incorporated in SSA's disability redesign initiative, but its focus does not extend to assisting and encouraging beneficiaries to return to work. Proposals to encourage return to work range from changes in the amounts that individuals can earn and still retain eligibility for benefits to restructuring the programs so that some individuals receive both benefits and earnings while those who are unable to work continue to receive cash benefits.

Those who support more fundamental reforms acknowledge that they don't know what proportion of the DI and SSI populations can be expected to work. Even if there is a shift in attitude toward much greater emphasis on work, the DI and SSI definition of disability is very strict, and most people receiving benefits have severe mental and physical impairments. Supporters of these fundamental reforms point out, however, that those who apply for benefits under new program rules may be more open to the possibility of change than those who are currently receiving benefits and who may not be able to adjust to these new expectations.

Common to all of these proposals is the recognition that the characteristics of people receiving benefits are changing as are the societal norms about the programs and their beneficiaries. In order to restore wide public support, DI and SSI will need to respond to these new realities.

Notes

1. These comments were revised in September 1996 to reflect recent developments in legislative provisions and in program growth.
2. In 1996, the Contract with America Advancement Act authorized over \$4 billion in separate funding for reviews of disability status in fiscal years 1996 through 2002. In addition, the Personal Responsibility and Work Opportunity Reconciliation Act authorized an additional \$250 million total in fiscal years 1997 and 1998 for SSI reviews. These additional funds, as appropriated, will allow SSA to do more disability status reviews without shifting resources away from competing priorities.

Policy Changes to Improve Market Outcomes

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I appreciate having the opportunity to participate in this conference and discuss the very important issues surrounding the rapid growth of the social security disability programs. This conference really is a first, as far as I know, in terms of bringing a significant analytical effort to bear on this problem and trying to bridge the gap between the research and the public policy worlds. This effort is important and long overdue. I hope it turns out to be the first of other such efforts that might broaden the base of our knowledge about disability and about the ways the government can and cannot reasonably be expected to improve the lives of people with disabilities.

Having said this, I will begin with a conclusion: The research presented by David Stapleton and others confirms what we have known for a very long time—disability is not an all-or-none condition, the presence or absence of which can be readily discerned in some systematic and reliable way. Disability is a complex and changing phenomenon; it exists on a continuum; and its presence (or absence) and severity are extremely difficult to quantify or assess with precision. There is not only a problem of assessing the medical severity of individuals' physical or mental impairments, but also a problem of assessing the impact of these impairments on work ability or on labor market or other outcomes. Moreover, the severity of work disabilities for people with any particular impairment can be affected mightily by the economic incentives and constraints they face.

Superimposed on these problems are all of the problems attendant to decentralized, public decision making. Disability determinations are made by literally tens of thousands of people in various bureaucratic, political, and judicial roles—as well as medical and vocational roles—who are subject to constantly changing rules and regulations and bud-

getary and political pressures. *Findings* of disability, in other words, can be affected mightily by incentives and constraints—in this case, the ones facing decision makers (Weaver 1986).

One implication of all of this is that the federal government's largest cash benefit programs for people with disabilities, Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) can grow—and shrink—rapidly and serve populations whose compositions change dramatically, for reasons that are quite independent of underlying trends in public health or in federal legislation. While this may not be news to program administrators or to researchers, it is nevertheless cause for deep concern. The federal government makes a very large commitment of tax dollars to the social security disability programs—close to \$70 billion this year (\$100 billion including Medicare and Medicaid), nearly double the level just five years ago (U.S. Government 1995; Committee on Ways and Means 1994; Board of Trustees 1995). Ensuring that these dollars flow to the people the programs were intended to serve would seem to be the first test of their effectiveness. Social policies cannot be deemed effective, and certainly not cost-effective, simply because a lot of money has been thrown at a problem and some of it seems to have stuck in the right place.

This brings me to a question: Who are the social security disability programs intended to serve? It is easy enough to give a definitional answer—the programs are intended to serve people so severely impaired that they cannot engage in *any* substantial gainful activity *anywhere* in the national economy (it says so right in the law!). But in a world with modern technologies, therapies, and medical and vocational interventions and techniques, this defines a small segment of the working-age population with mental or physical impairments. Indeed, a fundamental tenet of the Americans with Disabilities Act (ADA) is that even people with severe disabilities can, if provided the right environment, work and make lives for themselves and their families. One need only consider the example of a person who is, say, blind or deaf—and thus categorically “disabled” under social security law regardless of educational or professional attainment—to appreciate the fact that the social security programs provide ongoing cash support to a broader population than implied by the general definition of disability.

The research findings presented at this conference bring into sharp focus the extent to which the disability programs are not what they

once were and do not serve who they once did. Gone are the days when DI, for example, served people with physical disabilities who found themselves out of work (or quitting work) late in life. Increasingly, DI serves prime-age men and women with mental illnesses of some sort, most of whom never leave the benefit rolls. Despite dramatic improvements in science and medicine, in technology and information, and in the educational opportunities of young people with disabilities, which have improved the quality of life of people with disabilities as well as the job opportunities open to them, the number of people on the disability rolls has never been higher (Weaver 1992; Koitz, Kollman, and Neisner 1994).

This has many important public policy implications, not the least of which is that the idea that DI is an “early retirement” program may die hard, but die it must. The beneficiary population is getting younger and the opportunities for rehabilitation, recovery, and return to work are getting better. Work is the key determinant of economic well-being in our society and a widely shared goal of working-aged Americans, disabled and nondisabled alike. Pursuit of this goal is undermined by the government only at great fiscal and social cost.

In the spirit of some of the welfare reform proposals now under discussion, there may be merit to reorienting the social security disability programs toward transitional aid for people whose conditions are not permanently disabling. The presumption underlying federal policy should, in the main, be that people who are disabled *can* gain the skills necessary to work; people who become disabled *will* recover and go back to work. A practical change in current policy that might help bring about such a reorientation would be to place a time limit on benefits. For example, benefits might be granted for a period of three years. Individuals could reapply for benefits, and, if found unable to work, be granted benefits for another fixed period, but the presumption would be that work would follow. (This is not inconsistent with the suggestion made by Stapleton, Coleman, and Dietrich [1995; and Chapter 2, this volume] regarding the payment of temporary benefits during economic recessions.)

More direct “work incentive” provisions, which have been added to the programs over the years, have been largely ineffective (Muller 1992; Hennessey and Muller 1994). While the reasons, no doubt, are many and varied, two stand out: first, work incentives and other poli-

cies designed to promote work have typically been superimposed on the back end of the disability process—after the individual has left the labor force or made the transition from school to unemployment and has begun drawing cash benefits; second, they have built a more and more complex system atop the central (contradictory) policy—the definition of disability—which requires that the individual be unable to work. Individuals who, in order to work, overcome the severe impairments that qualify them for benefits and take advantage of the work incentive provisions ultimately find themselves ineligible for cash benefits and without the security of Medicare coverage.

Clearly, reforms intended to improve labor market outcomes for people with disabilities must focus on the front end of the disability process, keeping people at work or on the path to work so that—to the extent possible—they never enter the system in the first place, a system described by some disabled people themselves as a “trap.” Research suggests, for example, that employees who become disabled have better labor market outcomes, in terms of duration of employment, when their employers work with them from the onset of the disability, maintaining the continuity of the employee-employer relationship throughout the period of hospitalization and rehabilitation, and accommodating the workers’ changing abilities and circumstances at the workplace (Burkhauser, Butler, and Kim 1995). The employer is critical to work recovery efforts.

The same message is echoed by rehabilitation counselors. Early intervention—ideally before the individual has ever lost his or her job—is critical to success.

More generally, reforms must address the employer side of the work equation, which is now largely ignored by policymakers. Consider the reasonable accommodation requirement in the Americans with Disabilities Act. This amounts to a mandated benefits program, the cost of which is imposed on employers. Or consider the DI tax. Employers who make accommodations and go the extra mile to hire or retain people with disabilities—thus sparing the social security system of at least a portion of the potentially large cost of supporting these people for life—must pay the same tax as all other employers. Or consider increases in minimum wage laws and other mandated benefits programs. These policies increase the cost of hiring low-skilled workers, discouraging the employment of precisely the kind of people who

dominate the SSI rolls, people with poor educations and few job skills. Enhancing the employment of these people—aptly described by Burkhauser (1992) as the “doubly disabled”—will clearly require more than work incentives and civil rights; it will require basic measures to enhance the skills these people bring to the labor market, to reduce the barriers to part-time or low-wage work, or to subsidize employer’s adjustment costs (Weaver 1991).

In the longer term, serious consideration should be given to privatizing the supply of disability insurance—not for all risks faced by all workers, but for the routine risks faced by workers who are not yet disabled. While private insurers do not, by any means, have the answers to all or even most of the problems besetting the social security disability programs, they do have the ability to respond quickly to changes in knowledge and to new circumstances and opportunities—and the incentives to do so are strong (Weaver 1986, 1992).

If private insurers were to cover the routine risks faced by the typical worker, the federal government could turn to the question of how best to target resources on, and to provide more adequately for, people with special needs: people born with severe congenital abnormalities, unemployed people who become disabled, people with terminal illnesses, people with catastrophic health expenses. DI provides the same coverage for everyone and, as a result, cannot meet the needs of any particular group particularly well. Some of the substantial resources being devoted to providing income support to prime-age men and women with substantial work histories could then be redirected to other worthy causes—including meeting the needs of children and adults with disabilities that leave them little hope of one day competing in the job market, with or without civil rights protections.

To date, Congress has managed to side-step the issue of the very rapid growth of the DI program—and obscure a very large (50 percent) increase in the DI tax rate—by a so-called “tax reallocation” between the social security retirement and disability programs (Board of Trustees 1995). Since both programs are in long-range deficit, this was a stop-gap measure at best and, in my view, not well advised. The social security disability programs cannot retain broad public support without effective control over the beneficiary rolls, and effective control is unlikely to be achieved until policymakers confront directly the financial, economic, and social causes and consequences of rapid growth.

Perhaps the next fiscal crisis will focus the attention of policymakers and provide the impetus for considering revamping two programs that provide much needed support to some and one-way tickets out of the labor market for many others.

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12

Employment Policy

Return to Work for SSI and DI Beneficiaries: Employment Policy Challenges

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Advances in medical treatments, technology, and civil rights policy have created optimism that people with disabilities will increasingly become a part of the labor force. Yet that optimism has not yielded measurable outcomes in the employment rate of people with disabilities, which has consistently ranged between 23 percent and 45 percent, depending on the definitions of “employment” and of “disability” used. In addition, the number of people entering the Supplemental Security Income (SSI) and Social Security Disability Insurance (DI) rolls has increased notably in the last decade, from 4.2 million in 1985 to 11 million in 1996. The percentage of those leaving the rolls for the purpose of returning to employment persistently remains less than 1 percent.

Puzzled by this seeming contradiction between the improvements that should lead to increases in employment for people with disabilities and the steady increase on the SSI/DI rolls, the Social Security Administration (SSA) set about to examine why the return-to-work rate (or the rate of entering the workforce for the first time) is so low for beneficiaries with disabilities. We reviewed the literature, talked to the experts, and dedicated ourselves to hearing from beneficiaries themselves about the obstacles they face when they consider returning to work. The following is a summary of what we learned.

HIGH RISK OF LOSING ACCESS TO HEALTH CARE

When people with disabilities become SSI beneficiaries, they generally become Medicaid beneficiaries as well. After two years, DI beneficiaries are eligible for Medicare. In general, loss of cash benefits may eventually lead to loss of health insurance as beneficiaries increase work earnings, even though they may not have improved medically. Between 1988 and 1992, the number of uninsured people grew by five million people in the United States. In addition, limits on employer-based health coverage for chronic conditions expanded. People with disabilities may find it difficult to access private health insurance because of preexisting condition exclusions and waiting periods imposed by carriers. Some people with disabilities need part-time employment due to limitations imposed by their disabilities. Part-time employment is rarely accompanied by health insurance benefits. Some people with disabilities need personal assistance services, which in many states are covered only by Medicaid. Thus, even if beneficiaries were to replace their public health insurance with private health insurance, they would not likely receive coverage for all the services they need.

In a survey of more than 1,200 disability leaders from every state, the President's Committee on Employment of People with Disabilities (1994) found that loss of Medicare and Medicaid was perhaps the single greatest barrier to employment. Another survey of disability program applicants found that 75 percent of DI applicants and 79 percent of SSI applicants considered continued medical coverage as key to encouraging work.

Several work incentives address this problem. DI beneficiaries can continue Medicare coverage for at least 39 months following a trial work period and purchase Medicare after that time. SSI recipients can continue receiving Medicaid coverage up to a state-determined income ceiling after their earnings become too high for them to be eligible for cash payments. For example, in 1994 the cutoff point was \$17,480 in Pennsylvania.

These work incentives do not appear to have a significant impact on the return-to-work rate of a large number of beneficiaries. Beneficiaries are generally unaware of the provisions. One survey found that 80 per-

cent of beneficiaries who returned to work were unaware of the incentives at the time they did so (Hennessey and Muller 1996). When beneficiaries are aware of the incentives provisions, they rarely understand them fully; the incentives are complex, with different provisions applying to SSI and DI. Social security claims representatives have a difficult time explaining them and are generally focused on establishing the applicant's eligibility and inability to work rather than pursuing return-to-work goals.

WORK THAT PAYS THE BILLS

Some people with disabilities have enormous disability-related expenses, such as assistive technology or personal assistance services, for which there is rarely a subsidy, tax credit, or insurance reimbursement. Some people with disabilities require extra time to accomplish daily activities, which means they may have less time and energy available for work. Others may have recurring or cyclical health problems, such as mental illness or multiple sclerosis, that require flexible work situations enabling them to meet their intermittent disability-related needs. Finding employment that is responsive to these needs and that offers a living wage can be difficult.

In addition, people with disabilities are often less educated than people without disabilities and thus tend to have lower-paying jobs. While people with disabilities who work have an average income that is higher than people with disabilities who do not work, people with disabilities earn less than people without disabilities. One analysis found the average earned income of workers with disabilities in 1995 to be \$15,556, while it was \$24,667 for workers without disabilities (Yelin 1996).

In addition to receiving cash benefits and health care, people with disabilities who have low incomes may be receiving other types of public subsidies, such as food stamps, housing assistance, and energy assistance. Returning to work may jeopardize the cash benefits, the health insurance benefits, and all addition benefits. The loss of cash, medical, and other benefits may total an irreplaceable loss to a low-skilled worker who is likely to be compensated at minimum wage.

CUSTOMER CHOICE AND PROVIDER INCENTIVES FOR RETURN TO WORK

While most recipients of disability benefits are unlikely candidates for return-to-work programs, a significant percentage are. Thirty-five percent of DI beneficiaries responding to a 1993 questionnaire indicated an interest in receiving return to work services (cited in U.S. General Accounting Office 1996). Demonstration projects conducted by SSA, such as Project Network, have enabled beneficiaries with vastly different impairments to return to work. Yet the current system yields few beneficiaries who do return to work.

The Social Security Act requires referral of disability applicants to state vocational rehabilitation (VR) agencies. On average, state Disability Determination Services offices refer about 8 percent of applicants who are awarded benefits. Less than 10 percent of those referred are accepted by the VR agencies as clients. State VR agencies successfully rehabilitate about 1 out of every 1,000 beneficiaries each year (U.S. General Accounting Office 1996).

Because of the limited capacity and resources to serve all who may benefit from VR services, many state VR agencies limit the referrals they will accept to those they consider to be the best VR candidates. SSI or DI beneficiaries are often perceived as less appealing candidates because they may be seen as more difficult to rehabilitate. Although SSA pays VR agencies for rehabilitation costs of beneficiaries successfully employed for nine months, the delay in payments and the risk accepted by the VR agency are often cited as disincentives to rehabilitate SSI/DI beneficiaries.

Customers assert that they know best which services would help them return to work. They dislike becoming involved with yet another government bureaucracy in order to access such services. Some need training that employers can best provide. Some need personal assistance services or assistance with transportation. Customers want to choose the service provider that will enable them to design their own individualized rehabilitation services to meet their unique needs.

In 1996, SSA initiated a program to allow private rehabilitation providers to be reimbursed for serving SSI/DI beneficiaries when the state VR system does not serve them. SSA hopes that private providers will

offer greater choice for beneficiaries who seek to return to work. They also invited state VR agencies to create performance partnerships. While only six agencies are participating, early results are promising.

YOUTH IN TRANSITION

The average age of SSI/DI recipients has decreased in recent years. As of 1994 about 4.2 percent of SSDI beneficiaries and 19.2 percent of SSI recipients were between the ages of 18 and 29. Today more than one million beneficiaries are younger than 22. Many who enter the rolls as children stay on the rolls through their adolescence and into adulthood. The proportion of beneficiaries with long-lasting impairments, such as mental impairments, has increased in the last decade. Thus, many recipients are coming on the rolls earlier and staying longer.

DI, and to a lesser extent SSI, was originally constructed as an early retirement program. The programs are intended to replace cash income when a wage earner needs to retire before age 65. Therefore, in the eligibility process, the focus is on the limitations of people needing to retire, not on their abilities. The programs were not designed for young people with significant impairments who nevertheless have ambitions and need to develop skills to achieve them. Too often they, and sometimes their families, may become dependent upon cash benefits that limit both their income and their potential. As the number of young people coming on the rolls increases and the length of stay increases, we must ask ourselves if a “retirement” model will best meet the needs, ambitions, and potential of so many of our nation’s youth with disabilities.

CONCLUSIONS

We believe the four key areas we have identified as obstacles to return to work for SSI/DI beneficiaries—access to health insurance (including personal assistance services), finding work that pays enough

to live on, customer choice of return-to-work services, and the unique needs of youth—must be addressed if we are to improve our employment outcomes among beneficiaries. SSA is committed to supporting all beneficiaries who want to work. However, many of the obstacles people with disabilities encounter in seeking to work are beyond the scope of cash benefit policy and programs. Our nation's employment policy must accept and support people with disabilities as part of the American workforce, not as ancillary to it. SSA is working with other federal agencies to identify policy options that will remove employment obstacles encountered by our beneficiaries. Our customers have told us clearly that our federal return-to-work efforts need improvement. We have heard them and we are moving forward with our federal partners seeking to address their concerns.

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Policies to Make Work Pay for People With Disabilities

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The onset of a disability need not, and in the majority of cases does not, mean the end of work for people with disabilities (see Burkhauser and Daly 1996a, 1996b). The premise that most people with disabilities can work contradicts the image of people with disabilities as “victims.” Dedicated disability advocates have succeeded in getting an increasing share of young people with disabilities on the Supplemental Security Income (SSI) rolls. The question is, should this continue to be the primary policy goal of our disability system?

Previous chapters in this book have documented that changes in the business cycle and in policy variables account for more of the growth in Social Security Disability Insurance (DI) and SSI applications and awards over the past decade than does a nationwide decline in health. General economic conditions and the relative ease of access to and generosity of benefits encourage some people with disabilities to apply for benefits. Aarts, Burkhauser, and de Jong (1996) offer additional evidence that this is happening internationally. They compare disability transfer populations across countries and time periods and argue that these differences cannot be explained by differences in underlying health conditions alone. In 1994 the United States had about five working-age people on disability transfers for every one hundred workers, while in the Netherlands, which has an extremely generous and easily accessible disability transfer system, there were fifteen working-age people on disability transfers per one hundred workers. Policy matters.

But this does not imply that all persons with disabilities can work. There is great diversity within the population with disabilities both with respect to the severity of their disability and the skills they bring to the workforce. Those with disabilities who also have poor work skills are doubly disadvantaged in the labor market. Nevertheless,

while severe disabilities or poor work skills limit market opportunities, the previous chapters are heartening because they suggest that changes in policy could result in more employment for people with disabilities.

To date, efforts to encourage disability transfer recipients off the rolls via extending Medicaid benefits or lowering the implicit tax on SSI benefits have not been successful. This is not surprising, given Moffitt's (1992) study of exits from AFDC and his more recent study (Hoynes and Moffitt 1996) of exits from disability transfer programs. Both papers suggest that people on government transfer rolls are not very sensitive to tax rate changes. In fact, Hoynes and Moffitt argue that making eligibility easier for those with disabilities who do work is likely to increase program participation rather than lower it, since a large share of people with disabilities who work might become eligible for benefits with a more relaxed work test. It appears doubtful that any of the back-to-work incentives now being tried will succeed.

Furthermore, Bound (1989) documents that the majority of those who go through the DI application process and are rejected do not return to work. Initially, these findings suggest that policy variables may not be important in the decision of people with disabilities to work, since few applicants to DI and SSI, rejected or successful, return to work.

But there is an alternative explanation. The timing of a work-based intervention may be as important as the intervention itself. By the time people with disabilities have gone through the long application and appeals process, in which not working is critical evidence of an "inability to perform substantial gainful activity," most of their links to the labor market have been severed. Hence, interventions to return them to work are much less likely to succeed than those applied immediately following the onset of a disability to reduce the likelihood of their leaving work.

There is evidence that early intervention helps to keep people with disabilities in the workforce. Burkhauser, Butler, and Kim (1995) find that accommodation by employers extends tenure on the job following the onset of a disability. The average worker without accommodation stayed 2.2 years with his employer after onset. The average worker who was accommodated stayed 7.5 years with his employer after onset. To put this another way, 75 percent of those who were not accommodated were gone after three years. But it was nine years

before 75 percent of workers who were accommodated left their employer.

If the timing of an intervention is critical to its success, then there may also be more effective strategies to reduce the disability rolls and further increase work among people with disabilities than are currently being tried. Below I suggest four such possibilities.

TAX-SUPPORTED SUBSIDIES TO KEEP EMPLOYEES WITH DISABILITIES ON THE JOB

Employers are much more likely to accommodate workers who become disabled on the job than to take on new workers with disabilities. Most employers have made some investment in their employees and have better knowledge of their work capabilities than they do of potential employees. Hence, it is not surprising that they are more willing to maintain such workers on the job after the onset of a disability than they are to hire new workers with disabilities. But it is not obvious that the stick of the Americans with Disabilities Act of 1990 mandate is the appropriate mechanism for increasing accommodation. The carrot of tax-supported subsidies to pay for employer-provided accommodations would be more effective. Moreover, it would get us out of the habit of thinking that such accommodations, which we pay for in higher prices for the products we buy, are costless just because the costs do not show up on the federal budget.

TAX SUBSIDIES FOR RELATIVELY LOW-PRODUCTIVITY WORKERS

A larger share of people with disabilities work full time in Sweden and Germany than in the United States because Sweden, through direct job creation, and Germany, through explicit quotas, directly intervene in the labor market to make sure that people with disabilities are employed. Neither of these interventions into the labor market make political sense in the United States. But there is a uniquely American

alternative to such direct market interventions: the Earned Income Tax Credit (EITC).

The EITC, which currently uses the tax system to subsidize the work of low-income families with children, could substantially increase work by people with disabilities, especially those with low productivity. In 1993, the Clinton administration, with bipartisan support, dramatically increased the size and scope of this program. In 1996, workers with two children received 40 cents in benefits for every dollar of their labor earnings up to a maximum of \$8,900. For a minimum-wage worker, for instance, this tax credit transforms a \$5.15 per hour minimum wage into a wage of \$7.21 per hour ($\$5.15 \times 1.40 = \7.21).

A variation on this program would offer a Disabled Workers' Tax Credit (DWTC) to subsidize the labor earnings of people with disabilities who live in low-income households. This would especially target the doubly disadvantaged, whose work skills yield them relatively low labor earnings in the private sector. For instance, a 40 percent tax credit on the wage earnings of those aged 18 to 25 with a disability would 1) encourage children with disabilities reaching the age of transition from school to work to choose work rather than SSI, and 2) offset, to a large degree, the effective tax rate on current SSI recipients who do work. The 1996 National Academy of Social Insurance's Disability Policy Panel recommends such a credit for a broad range of people with disabilities who have serious disabilities, whether or not they are eligible for disability transfer benefits (Mashaw and Reno 1996). (For a broader discussion of the DWTC, see Burkhauser, Glenn, and Wittenburg 1997.)

A great public policy tragedy occurred in 1993 when the Assistant Secretary for Policy Evaluation, David Ellwood, convinced the administration to push for an extension of the EITC but no one in the administration or in the disability advocacy community seized that moment to extend the credit to people with disabilities. I understand why Ellwood didn't do it. He, like most poverty policy experts, divides the population into two groups: those who are expected to work and those who are not expected to work. To him people with disabilities are not expected to work. But where were the disability advocates? Why didn't they push the message behind the Americans with Disabilities Act of 1990 to its logical conclusion and fight to extend the EITC as a means

of further integrating the doubly disadvantaged into the labor market? I believe in 1993 there would have been a bipartisan majority ready to make that logical step if only someone had pointed the way. A bipartisan majority continues to support the EITC's role as the major federal program aimed at making work pay. And I believe the passage of a DWTC is possible. But to achieve this goal, policymakers need to be convinced that most people with disabilities can work and should therefore be expected to work. And, therefore, that people with disabilities should first be targeted for work-based programs, not transfer programs. But to win over policymakers, it is first necessary that the advocates of people with disabilities believe that work is possible.

ADMINISTRATIVE PROCESS

Previous chapters have documented how the Social Security Administration's outreach efforts, together with state efforts to shift welfare costs, increased applications for SSI. This is further evidence that the marching orders federal and state policymakers give to the frontline gatekeepers of our disability system influence the work versus transfer outcomes of people with disabilities. The Carter administration in 1978 sent word to state administrators that DI and SSI rolls were rising too fast and that the eligibility process needed tightening. This moral, or immoral suasion, depending on your point of view, greatly reduced acceptance rates with no formal change in the law.

Aarts, Burkhauser, and de Jong (1996) compare work and transfer aspects in the disability programs of several western industrial countries. Those countries in which gatekeepers are given a clear signal that return-to-work is the primary goal of disability policy—e.g., Sweden and Germany—are the countries that best achieve this goal.

While the supply of disability applicants is influenced by the individual incentives they perceive, the "demand" for applicants by gatekeepers, which can be evidenced both by explicit procedures as well as by attitudes, also matters. If the gatekeepers of our disability system are signaled that successful placements into rehabilitation, training, and jobs are their measure of administrative success, it is likely we will see more such placements. But, unlike many European countries, our

rehabilitation system is almost completely separate from our benefits transfer system, and it would be much harder to achieve coordination between the two.

TIME-LIMITED BENEFITS

To be eligible for permanent SSI or DI benefits, a person must be unable to perform “substantial gainful activity” for at least one year. I propose that those who meet this criterion but still may recover or be able to return to work after one year be given only a temporary SSI or DI benefit. After one year they would be fully reevaluated for permanent benefits. During this temporary benefit period, recipients would have an opportunity to receive training and/or rehabilitation necessary to put them back to work. This proposal is much more important now that DI and SSI are shifting from bridges to early retirement toward lifelong programs for younger workers.

CONCLUSION

For the majority of people with disabilities, onset of a disability occurs after they have entered employment. Most people continue to work for some time after the onset of a disability. The timing of policies to prolong workforce participation may prove to be as important as the implementation itself. Policymakers should begin to make work pay for people with disabilities through tax subsidies to employers, disability tax credits, the use of temporary benefits as a mechanism for trying rehabilitation before permanent transfers, and as a general signal to gatekeepers that return to work is the primary goal of social policy. The enactment of these pro-work reforms is likely to reduce the disability transfer population and increase the employment of people with disabilities.

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Private Sector Disability Management Activities and the Social Security Disability Program

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Social security is a work disability construct, and work disability is a core concept for workplace disability managers as well. When a person is unable to work because of an illness or injury, an alternative income stream may be made available from public and private sources during the period of disability. Private sector disability management is an increasingly important influence over how the various disability programs interact. Studies done by insurers and academic researchers reveal that employers spend up to 1 percent of payroll on disability management. This includes a variety of programs to prevent disability or minimize disability impact, such as wellness programs, employee assistance plans, medical clinics geared toward minimizing disability, employee safety programs, claims management activities, and return-to-work programs.

Thus, workplace disability management can be defined as services and programs that involve providers, employers, and employees in promoting healthy workers and workplaces and that are believed to actually reduce the impact and cost of disability to all parties. The field is evolving in more sophisticated directions as its foundation becomes more grounded in the multifaceted and evolutionary nature of disability and recognizes the various contributors to disability. Its activities focus on both the employer or organizational level and on the individual worker.

With its development, workplace disability management is helping discover a host of contributors that affect why an individual cannot and does not work. Medical factors are among many multidimensional contributors that develop over time on a work disability continuum.

The demands of work, changes in work environment, economic conditions, family issues, and education are just a partial sample of the potential contributors or forces in each case. Given this circumstance, determining disability status under any program designed to provide income in lieu of work is as much art as science. As others have noted, this complexity can cause various levels of functional loss to be compensated, depending on definitions and decision-making approaches.

Workplace disability management often focuses on people who are unable to work because of a medical condition and, after a time, recover function. However, this field also concerns itself with worsening impairments and functional limitations that can be episodic. Accommodation or return to work for current employees in these situations, or hiring a person with this type of disability, raises a different set of issues.

Clearly, the framework for accommodation or return to work is different for a current employee (as distinguished from a job applicant). Employers have legal and moral obligations relating to the health, safety, and general welfare of employees. As a result, this is an area where we can more readily see the impact of workplace disability management and its relationship to Social Security Disability Income (DI).

The course of action for employees who become disabled is influenced by whether an illness or injury arose from work. The employer has liability in workers' compensation, and the employee recourse to litigation is more common. This can impact employment policy, both positively and negatively.

Other issues will come into play when the injury or illness is not work-related. For example, whether the employer provides health and disability benefits and whether those benefits are insured or self-insured will affect employment policy toward persons who become disabled. Employers paying for health and disability benefits in lieu of wages can be more eager to get the person back to work in order to minimize these payouts. By contrast, if insurance pays and the employer feels no direct or indirect costs that cannot be cost-benefit rationalized, the employer's motivation might be to replace the disabled person with a more productive employee or downsize and abolish the job. Benefit programs are either seen as a bridge to return a person to work or as a humane way to assist the person out of the

workplace and both techniques can improve productivity. Often it is the insurer advocating stay at work or return to work.

Disability management principles emphasize the costs of not managing disability. Potential savings sources range from the fundamental benefit of prevention to savings produced by returns to work or integration of health and disability benefits. The fact that the disability management field has recognized and advanced these principles is having an effect on employment policies. At one time, disability programs focused on assisting a qualified person to secure social security benefits to offset any private benefits. This still happens, but more often now as a last resort. The reason: disability managers have recognized that, absent a full recovery, return to work is much less likely once a person is receiving social security benefits. However, the last resort of securing social security benefits is still driven by employment policies, which do not focus on return to work. In this way, social security entitlement becomes a focal point in the increasingly complex interaction of workplace disability management and employment policy.

Social security eligibility is linked to these dynamics in another unique way. With its strict definition, often stricter than private programs, social security payment becomes a benchmark that the person truly cannot work. In effect, this relieves the insurer and employer of return-to-work responsibility and of at least part of the liability, assuming there is no recovery.

The wide expanse of the economic environment affects the employment of persons with disabilities. Employer cost-cutting caused by global competition, economic downturns, or shareholder demands are among the issues that will act upon employment policies. Social security disability experience is influenced by the range of business climate issues that affect employment policies.

Individual disability management outcomes are influenced by employee and employer motivations. The genesis, nature, and timing of the impairment will produce different outcomes, depending on where a person is in his or her work cycle. Issues such as how workers like their boss, their work environment, and whether they have worked with a disability or impairment before can all be relative to whether they seek disability payment. The employer's experience with the employee—past performance and whether that performance has been

poor because of attitude—will influence how the employer deals with an employee.

The nature of the impairment is important too. For example, comorbidity of untreated depression with other impairments can prevent a return to work. Work requirements may fit or accommodate well with some and not other disabilities.

Presuming an enlightened employer, employment policy with regard to persons with disabilities depends partly on persons wanting to work and having more incentive to work than to stay at home. It also depends on there being a job available that the person can do and wants to do. This is not meant to be uncomplimentary. Too often it makes more sense from the individual's perspective to stay home—there is too much to risk in even trying to go back to work, especially if health and cash benefits are at stake. Employers, for their part, may feel they have done their moral duty by paying social security and private benefit premiums.

Private sector disability management works regularly with all of the aforementioned incentives and disincentives. The field is having an increasingly important impact on employment policies. These activities become important considerations when addressing social security disability policy.

The Promise and Limitations of Employment Policies for Current SSI Recipients

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I would like to use a specific example to illustrate some of the promise and limitations of using employment support programs to assist current Supplemental Security Income (SSI) recipients to obtain employment and reduce their dependence on SSI. This example comes from the Social Security Administration's Transitional Employment Training Demonstration, which tested time-limited employment and training services for SSI recipients with mental retardation.

THE TRANSITIONAL EMPLOYMENT TRAINING DEMONSTRATION

The Transitional Employment Training Demonstration, which operated from 1985 to 1987, was designed to help SSI recipients with mental retardation increase their economic and social self-sufficiency.¹ Specifically, it sought to overcome a number of barriers that appeared to prevent SSI recipients with mental retardation from obtaining and holding jobs. In this way, the program attempted to help the recipients by increasing their employment, earnings, level of community integration, and total income while at the same time reducing government expenditures for SSI payments.

Intensive Employment Support Services

Transitional employment as fielded in the demonstration consisted of five core services intended to assist SSI recipients with mental retar-

dation obtain and hold competitive jobs—that is, economically productive jobs that are essentially undifferentiated from other jobs that exist in the economy. The five core services were

- Outreach to all mentally retarded SSI recipients between the ages of 18 and 40 to invite them to enter the demonstration programs
- Waivers to SSI regulations to ensure that any recipients who chose to enroll in the demonstration could maintain their eligibility for SSI benefits while they received training
- Placement in potentially permanent competitive jobs
- On-the-job training that was provided by program staff and was gradually faded out over time so as to promote independence on the job
- Post-placement support and follow-up as necessary for job retention

The other distinguishing feature of transitional employment in the demonstration was that services were time-limited. In the demonstration, the core services were to be provided within one year from the time the SSI recipient enrolled in the demonstration. However, there was an expectation that arrangements would be made during that year for any necessary job-retention services, although those services had to be funded by a source other than the demonstration.

This approach to training and employment support was based on the then-emerging literature on supported employment (Moss 1980; Rusch and Mithaug 1980; Wehman 1981; Kiernan and Stark 1986; Rusch 1986). A key feature of this approach is the customization of services inherent in using program staff to provide on-the-job training. This training enables participants to learn their jobs in the actual work environment in which they would continue to work after the training was completed. The training covers the production aspects of the job and the equally important nonproduction aspects such as travel to and from work, relations with supervisors and co-workers, and effectively managing the money earned from the job.

In general, the outreach, waivers, job placement, on-the-job training, and job retention services called for in the demonstration model were provided (Thornton, Dunstan, and Schore 1988). SSI recipients who enrolled in the program stayed for an average of 10.5 months, during

which staff provided each enrollee with an average of 114 hours of direct service (that is, staff time spent working directly with a client or on that client's behalf). It is estimated that it would cost approximately \$5,600 (in 1986 dollars) to provide these services in an ongoing program that was not part of a demonstration (this cost would be approximately \$7,400 per enrollee in 1995 dollars). There was substantial variation across individuals, with some enrollees receiving services costing less than \$500 and others costing more than \$25,000.

Active Outreach to Eligible SSI Recipients

Eligibility for the demonstration was limited to SSI recipients who 1) were between 18 and 40 years old, 2) had a diagnosis of mental retardation in their SSI files, and 3) lived in one of the thirteen communities served by the eight demonstration training organizations. The case folders of over 30,000 SSI recipients were screened to identify such recipients. Approximately 13,800 eligible recipients were identified and were sent invitation letters that described the demonstration. In addition, follow-up letters, telephone calls, and outreach to service providers in the communities were also used to recruit recipients into the demonstration. A total of 2,404 recipients expressed at least some interest in the demonstration. Intake workers in the training organizations described the available demonstration services to all interested applicants and explained that participation in the demonstration was strictly voluntary. If the applicant consented to participate and the intake worker decided that the applicant could be served, the applicant was formally enrolled in the demonstration. A total of 745 SSI recipients with mental retardation (approximately 5 percent of the eligible population) were enrolled in the demonstration: 375 of these recipients were assigned randomly to the treatment group and the remaining 370 of the recipients were assigned to the control group.

Limitations of Demonstration Enrollees

The average IQ score for the mentally retarded SSI recipients who enrolled in the demonstration was 57: approximately 84 percent had IQ scores between 40 and 70, and 6 percent had scores below 40.² In addition, 83 percent of the enrollees also had physical, social, or emotional

problems that could be expected to impair their ability to function in the labor market. Approximately a third of the persons who were enrolled had no vocational activity during the year prior to their application, and another third had only worked in sheltered workshops during that time. Only 10 percent of the enrollees had held a competitive job in the previous year.

Rigorous Evaluation Component

In order to assess the extent to which the demonstration accomplished its goals, the demonstration included a formal evaluation component designed to produce accurate estimates of the impact of the demonstration services on the key outcomes. The key feature of the evaluation was the use of an experiment that randomly assigned eligible volunteers to either a treatment group, which was offered transitional employment services, or a control group, which was precluded from receiving the demonstration services but was free to obtain any other available services. By comparing the post-randomization activities of these two groups, the evaluation estimated the impact of adding the demonstration services to the services and incentives characterizing the status quo. Data for the evaluation came mostly from the Social Security Administration's (SSA's) *Supplemental Security Record* files and from an *Intake Data Collection Form* that collected information about the characteristics of sample members at the time they enrolled. In addition, enrollees at nine of the thirteen sites were interviewed in the fall 1988 (approximately three years, on average, after they enrolled in the demonstration). This survey provides a point-in-time glimpse of the job characteristics, wages, and work hours of the sample members.

Increased Services and Earnings for Enrollees

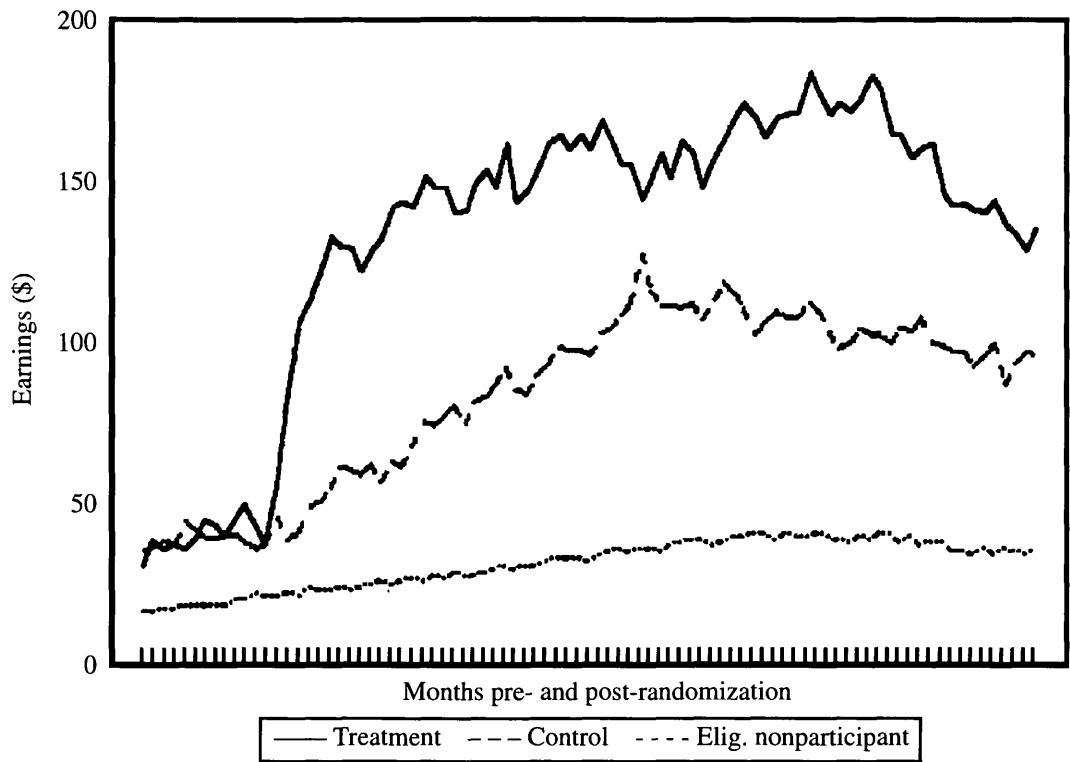
A comparison of the treatment and control groups indicates that the demonstration was successful in delivering the transitional employment services. The demonstration projects placed two-thirds of the treatment-group members on jobs during the demonstration. Half of those persons (or one-third of all treatment-group members) were successfully stabilized on a potentially permanent job, that is, they

reached a point where project staff felt that the person was capable of performing the work without the active ongoing support of the training program. This placement rate is consistent with the rate observed for other large employment programs for persons with disabilities (see, for example, Kerachsky and Thornton 1987).

The evaluation also showed that the demonstration services had a clear and persistent impact on the treatment-group members who were offered the demonstration services (Decker and Thornton 1994, 1995). The most important findings include the following points (many of which are illustrated in Figure 12.1).

- The SSI recipients who enrolled in the demonstration differed substantially from the eligible nonparticipants. Enrollees were slightly younger, had been on SSI a shorter period, and were more likely to have had recent earnings.
- Prior to enrolling in the demonstration, members in the treatment and control groups were essentially identical.
- Average employment and earnings levels for the treatment-group members rose quickly after enrollment, continued on an upward trend for about four years, and then fell slightly over the next two years.
- Average employment and earnings levels for the control-group members also increased over time, but not nearly at the levels observed for the treatment-group members.
- The impact of the services on average employment and earnings levels (which is estimated by the treatment-control difference) is statistically significant, proportionally large, and relatively persistent over the six-year follow-up period: average earnings for the treatment group were 73 percent greater than for the control-group over this period.
- Despite the proportionately large impact on earnings, the absolute change was small: average cumulative earnings rose \$4,282 for the six years (roughly \$714 per year).³
- Many of the treatment-group members held part-time jobs with relatively low wages: at the time they left the program, those treatment-group members who had jobs worked an average of

Figure 12.1 Average Monthly Earnings for Demonstration Participants and Nonparticipants



Earnings expressed in 1986 dollars.

27 hours per week and earned an average wage of \$3.95 per hour; approximately three years later, less than a quarter of the treatment group members earned more than \$300 per month, and only 43 percent earned more than the minimum wage.

- The impact on average SSI payments was statistically significant, but relatively small: over the six years, payments fell by an average of \$870 or about 5 percent.
- Participants in the demonstration generally benefited from the services, their total income rose and they increased their productive activity and integration into society at large.

IMPLICATIONS OF THE DEMONSTRATION

This demonstration by itself is an extremely small foundation for developing employment policy for all SSI recipients. Nevertheless, the demonstration findings are quite relevant for efforts to assist SSI recipients obtain and hold jobs. Their relevance stems from the fact that persons with mental retardation make up approximately 30 percent of current SSI recipients and 43 percent of the children receiving SSI (Kochhar and Scott 1995). The results are also relevant because the demonstration is one of the few rigorous evaluations of an employment program for SSI recipients. Finally, when the demonstration findings are combined with the available literature, several tentative conclusions emerge.

First, it seems likely that *the services required to move SSI recipients into employment will be relatively expensive*. In the demonstration, the services had three characteristics that tend to make for an expensive program: customization, intensity, and duration. The training services were individualized to meet the specific abilities and interests of each participant, and this included individualized placement and on-the-job training provided by program staff. Participants tended to need substantial supports, at least early in the training process. This led programs to provide intensive services: in some cases, program staff worked directly with a single client full time for several weeks to teach the client the job. Once clients learned the job, the program support

was gradually withdrawn to promote independence. However, this process might take several months. In addition, program staff worked to establish ongoing job retention services from formal or informal sources (parents, co-workers, supervisors, and friends). The need for this ongoing support meant that many participants received 12 months of demonstration services followed by less intense job-retention services.

As noted, it would cost about \$7,400 per enrollee (in 1995 dollars) to provide the Transitional Employment Training Demonstration service package. This figure is comparable to the costs estimated for similar employment support programs serving persons with mental retardation or other severe disabilities. For example, costs for a state-wide program in Illinois averaged \$5,300 per person served, and costs for a similar program in New York averaged \$7,700 per person served (both figures are expressed in 1995 dollars). While the costs for these types of programs may decline as the training methods improve, it seems likely that efforts to place, train, and maintain persons with mental retardation or similar severe disability will be much more expensive than the average costs currently incurred by state vocational rehabilitation agencies. For example, Dean and Dolan (1991) estimated that costs in the Virginia Vocational Rehabilitation program averaged approximately \$2,300 per client (when converted to 1995 dollars).

Second, it appears that *a relatively small percentage of current SSI recipients will enroll and obtain employment*. The available evidence suggests that relatively few SSI recipients work or seek employment supports. In the demonstration, 5 percent of the eligible population enrolled. Of the recipients who enrolled, two-thirds were placed on a job and one-third were successfully training on a job where there was a clear expectation of future independent work. Thus, less than 2 percent of the eligibles made the program-assisted transition to work. The Disability Policy Panel (1996) reports that for the Social Security Disability Insurance program, fewer than 2 in 21,000 beneficiaries leave the rolls because of a return to work. Finally, Scott (1992) reports that while 80 percent of working-age SSI recipients had worked prior to receiving SSI benefits, only 22 percent ever work after benefits begin.

These figures suggest that voluntary employment support programs are likely to attract a relatively small percentage of current recipients. Even if more recipients did apply, it is not clear that the system has the

capacity to provide supported employment services. Braddock et al. (1994) report that after more than a decade of rapid growth in the availability of supported employment and the inclusion of supported employment as part of every state's vocational rehabilitation program, approximately 90,000 persons are now receiving supported employment services. While this is remarkable growth for a program that existed largely as university-based prototypes in 1980, it is nevertheless quite small when compared to the 4.8 million persons currently receiving SSI disability benefits.

Third, the available evidence suggests that services like those provided in the demonstration *can increase earnings dramatically but still not reduce SSI payment substantially*. The demonstration services had a huge proportional, but nevertheless a small absolute, impact on employment and earnings. While the participants are clearly better off in terms of income and work place integration, they generally remain poor and eligible for SSI payments. SSI payments were lower for the demonstration's treatment group, but the savings averaged only \$870 per enrollee over the six years following entrance into the program. This small impact seems to reflect a combination of factors, including the work incentive provisions of the SSI program (particularly the exclusion of half of earnings from countable income and the provisions of Section 1619), the relatively low wages and work hours of many the participants who entered the labor force, and the desire of participants to keep Medicaid coverage. While the demonstration evidence does not indicate whether the wage and hours patterns reflect the full ability of the participants or decisions by the participants to limit their earnings in order to retain SSI eligibility, the available evidence suggests that the earnings increases are likely to be too small for recipients to earn their way off SSI.

Fourth, *a replication of the demonstration would generate better results, but might still not generate net benefits to the SSI program*. Three of the eight demonstration programs produced better than average impacts in the demonstration. These three programs seemed to share some specific program elements that differed from those of the other five. In particular, they tended to put more emphasis on careful job matching and seemed to stick with their clients longer when initial job placements did not work out (Decker and Thornton 1994). In addition, site-specific impact estimates indicated that one of the eight pro-

grams reduced SSI payments sufficiently to offset more than a third of the costs of the transitional employment services. These findings suggest that replication efforts might improve on the performance of the demonstration programs. At the same time, replication efforts might have worse performance. The demonstration programs were selected from the eighty training programs that submitted applications in a national competition. Efforts to implement transitional employment on a national scale might not be as selective in their choice of providers and therefore might have smaller impacts than those observed in the demonstration. This seems to have been the case in Illinois as supported employment programs expanded from small university-based prototypes to a statewide program (Tines et al. 1990).

While more study is required, the currently available evidence suggests that employment support services can play an important role in making people with disabilities better off, but a limited role in helping SSI recipients earn their way off SSI. The demonstration tested one service model with a small group of recipients with a specific disabling condition. As a result, it is a very slim reed for shaping rehabilitation policy for the 4.8 million SSI recipients (or the 4 million disabled workers receiving Old-Age and Survivors Disability Insurance benefits). Nevertheless, until the Project Network results are available, the Transitional Employment Training Demonstration remains one of the clearest pieces of evidence (Rupp, Bell, and McManus 1994). It suggests that it will be very difficult to move a large number of recipients off the rolls: few current recipients may volunteer (and motivation to work is probably a key ingredient to success), only a fraction of the volunteers may make the transition to work, and many may still not earn enough to become economically independent.⁴ Participants appear to benefit from the services, but SSI benefits are not reduced sufficiently to pay for all of the program services.

The outlook may be better if replication efforts adopt the service approach of the best-performing demonstration programs. The outlook may also be better for employment-support programs that target other subgroups of the SSI population, such as children who have been allowed on the basis of an Individual Functional Assessment. By targeting children before they have entered the labor market, programs may have success in shaping expectations and attitudes about work as well as transmitting the skills required for work. Efforts to help chil-

dren think of work and independence as their future rather than ongoing SSI receipt should help to reduce long-term SSI dependence. This point is suggested by Scott's (1992) finding that young recipients who began receiving SSI benefits before they were 18 years old were more than twice as likely to work while receiving benefits as were persons who entered the program at an older age. Similarly, the many school-to-work programs serving students with disabilities offer some promise (Wehman 1991). However, these programs are still emerging and a dominant model has yet to emerge. Furthermore, there have been no controlled studies that compare the success of participants with what they would have done in the absence of the services.

With regard to employment support programs like those fielded in the Transitional Employment Training Demonstration, at least three possible funding plans deserve consideration: 1) to provide vocational rehabilitation agencies with grants based on the number of SSI recipients served in transitional or supported employment, 2) to provide funding for ongoing job-retention services to agencies that have placed and trained SSI recipients on jobs that are likely to enable them to earn their way off SSI, or 3) to encourage SSI recipients to purchase employment support services by expanding use of two current provisions of the SSI program—Plans for Achieving Self-Support (PASS) and Impairment Related Work Expenses (IRWE). Grants to vocational rehabilitation agencies could be based on formulas like the ones used in SSA's Beneficiary Rehabilitation Program or the one suggested by Berkowitz (1996). In either case, the funding could be based on the estimated SSI savings attributable to the transitional employment services, so that funding could be kept in line with the expected reduction in SSI payments. By allowing working SSI recipients to deduct work expenses from earnings used to calculate their countable income and SSI benefit amount, the PASS and IRWE provisions essentially enable recipients to shift at least some of the costs of job supports back to the SSI program without increasing costs to SSA (Prero 1993). Such subsidies could encourage greater use of employment supports and ultimately save money for the SSI program if the supports led to greater earnings or economic self-sufficiency.

The overall assessment of transitional employment, however, should not rest solely on the perspective of the SSI program. It seems likely that transitional employment services could save money for the gov-

ernment as a whole, particularly if those services substituted for facility-based services now being provided to many people with mental retardation. In addition, the program seems likely to generate net benefits to society as a whole. From this perspective the earnings gains of participants would be balanced against the costs of the services. During the six-year observation period, the average earnings gains of participants offset approximately 75 percent of the gross cost of the services. Savings from the shift in service use seem likely to offset the remaining social costs. In addition, the SSI recipients who received the transitional employment services not only gained income, but also gained from their increased integration in the labor force. It is essential that society keep track of these nonpecuniary benefits and the overall satisfaction derived from helping individuals with severe impairments participate more completely in society, because these aspects represent a major justification for transitional employment services.

Notes

1. Prero and Thornton (1991) and Thornton, Dunstan, and Schore (1988) describe demonstration operations and the evaluation design.
2. The IQ scale used here has a mean of 100 and standard deviation of approximately 15 points. Thus, many enrollees had scores that implied cognitive functioning at a level that was at least three standard deviations below the general population mean.
3. These figures are in 1986 dollars.
4. The difference between the Transitional Employment Training Demonstration control-group members and the eligible nonparticipants suggests that the motivation implied by volunteering for an employment program is an important factor in predicting subsequent earnings and employment.

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13 Summing Up: Reflections on the Past and Future of Disability Policy

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Readers of this book old enough to remember the rapid increase in the disability rolls in the 1970s and the political response and counter-response that followed have now witnessed a complete disability policy cycle. Hence, in that sense, much of what has occurred in the first years of the 1990s is not new. Further evidence of *dejà vu* is provided by the introduction of a now out-of-print book *Disability and Work: The Economics of American Policy* Robert Haveman and I wrote in the midst of the last great disability policy crisis brought on by rising disability rolls.

Political currents during the early 1980s have challenged the role of the federal government in American society . . . No set of programs offers a better microcosm of the political, moral, and economic debates that will result from this general rethinking of the role of social policy than those comprising the United States disability system . . . Clearly, a strong moral commitment to provide some form of protection and compensation to the disabled exists in this country. However, increases in public spending on programs for the disabled and the network of regulations established in an attempt to integrate fully the handicapped into society have caused even the traditional supporters of government intervention to pause. Concern with the rising costs of disability programs has affected all recent administrations, irrespective of political party.

Any informed debate over the direction of United States disability policy must take into account the complex nature of the existing

system—its size, structure, recent growth, economic status, and labor market effects. (Burkhauser and Haveman 1982, pp. 1–2).

It is a bit daunting to revisit work written over a decade and a half ago. Having done so, I believe the general principles of disability policy analysis described there are as valid today as they were in 1982. But in some important ways I was quite wrong about how disability policy would evolve.

While Burkhauser and Haveman (1982) has a chapter on the rise of policies to provide equal access to education, employment, and mobility, we did not expect accommodation to become as dominant a theme as it is in current disability policy. We certainly did not foresee the strength of the disability movement that helped pass the Americans with Disabilities Act of 1990, nor did we advocate as strongly as I would now for the goal of full integration of people with disabilities into the labor market. I was wrong about the future course of the debate because in 1982 I believed that while it was possible that more people with disabilities could work than were currently doing so, most people with disabilities could not be integrated into the labor market.

As my discussion in Chapter 12 makes clear, I am now convinced that not only are the majority of people able to work following the onset of a disability but that they, in fact, are already doing so. Hence, public policies that focus on encouraging work following the onset of a disability are not based on daydreams or good wishes. (See Burkhauser and Daly 1996a, 1996b.)

The following four propositions based on the research I have done since Burkhauser and Haveman (1982) will reflect my perspective on past and future disability policy and set the stage for the conclusions I draw from the previous chapters.

1. *Every person reading this book will die.*

This proposition requires no additional evidence and, unfortunately, will occur even if you don't turn another page.

2. *Most of us will experience the onset of a disability before we die, and many of us will do so while we are of working age.*

Based on data from the Health and Retirement Survey, Burkhauser and Daly (1996b) show that most people with disabilities aged 51 to 61 in 1992 experienced the onset of their disability during their work life.

3. *The most effective way to observe the importance of disability on work and economic well-being is to track the labor earnings and economic well-being of people before and after onset of a disability.*

Most comparisons of those with and without disabilities use cross-sectional data. But simple comparisons of this nature can overstate the importance of disability in explaining the difference between the two groups. In Table 13.1, Burkhauser and Daly (1996b) use multiperiod data from the Panel Study of Income Dynamics (PSID) to track the work, labor earnings, and economic well-being of men and women following the onset of a disability. Our definition of disability is that the respondent reports that a physical or nervous condition limits the type of work or the amount of work he or she can do. Since this is multiyear data, the respondent must report this for two consecutive years to be counted as having a disability.

Using event history analysis and PSID waves of data for 1970 to 1989, we first find all persons between the ages of 25 to 61 who experience a disability and then look at what happens in the years prior to and after this event.¹ As can be seen in Table 13.1 the median percentage change in the labor earnings of men (women) from one year prior to onset to one year after onset is a decline of 24 percent (41 percent); the median decline two years after is 31 percent (62 percent). Clearly, onset of a disability decreases labor earnings but does not end work, and as Table 13.1 also shows, on average it is even less devastating to the economic well-being of households.

We are able to look at the household size-adjusted income of people with disabilities that comes from private sources by excluding all government taxes and transfers. This “counterfactual,” which assumes people would not change their behavior in the absence of taxes and transfers, is a crude measure of what would have happened, but it does provide an approximation of the importance of government in reducing the shock of disability.

What we find belies the notion that the onset of a disability is on average a devastating economic event. For men the median change in before-government household size-adjusted income is a drop of 10 percent. After two years the median change is a drop of 12 percent. For women the median change is positive. Once government is taken into

Table 13.1 Economic Changes Following the Onset of a Disability among Working-Age Men and Women in the United States, 1979–1989

Time point	Men				Women			
	Percent working positive hours	Median labor earnings ^a	Equivalent median 1991 dollars ^b		Percent working positive hours	Median labor earnings ^a	Equivalent median 1991 dollars ^b	
			Before government income	After government income			Before government income	After government income
Two years prior	90.4	21,215	17,347	16,224	67.3	5,063	18,247	16,842
One year prior	90.8	21,543	18,381	16,812	68.0	6,582	19,921	17,370
Year of disability event	87.2	18,760	16,434	16,160	70.0	5,995	19,827	17,923
One year after	72.3	13,220	14,567	15,739	63.6	3,277	18,446	17,859
Two years after	68.2	11,798	13,930	15,406	57.6	1,699	20,251	18,537
Median percentage change from:								
One year prior to one year after disability	na	-24.0	-9.7	-2.6	na	-41.0	1.7	5.0
One year prior to two years after	na	-31.0	-12.1	-3.7	na	-61.7	5.5	7.6

SOURCE: Burkhauser and Daly (1996b, Table 4, p. 71).

NOTE: The sample is based upon data from the 1970 to 1989 waves of the Panel Study of Income Dynamics (PSID). The sample includes household heads and spouses who report two consecutive periods of no disability followed by two consecutive periods of disability, who were between the ages of 25 and 61 at onset. A period of disability is one in which the respondent reports that a physical or nervous condition limits the type of work or the amount of work that he/she can do. Sample size for men in the first four periods is 725. It is 677 in the fifth period (two years after). Sample size for women in the first four periods is 303. It is 236 in the fifth period (two years after). The sample size is smaller for women because the PSID did not ask about spouses' disability status until 1981.

^aMedian labor earnings includes zero earnings. Earnings are in 1991 dollars.

^bBefore- and after-government incomes are adjusted for household size using the equivalence scale implied by the United States poverty lines. Income-to-needs ratios can be computed by dividing equivalent median income by the 1991 one-person poverty threshold of \$6,932.

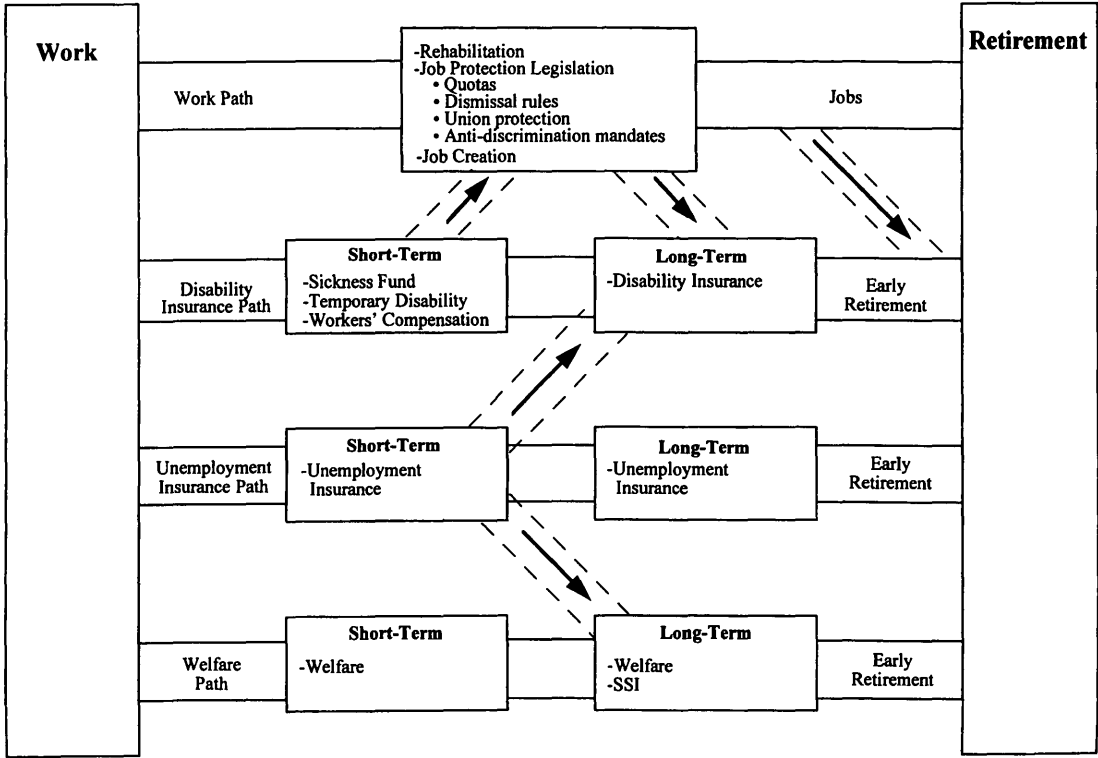
account, the news is even better. After one year the median fall for men is less than 3 percent and after two years less than 4 percent. Table 13.1 shows that our network of family and government does a reasonably good job of protecting people from dramatic drops in economic well-being following a disability. In making these assessments we do not simply look at the replacement rates of a given program to evaluate the change in economic well-being following the onset of a disability; we look instead at the change in overall household income. And we key on the transition into disability as the critical event, rather than the transition into a given program. While not perfect, on average our disability system works to prevent serious economic losses to the households of adults who experience the onset of a disability, at least in the short run. Hence, if forced to label persons with disabilities as either heroes who have coped with their disability and managed to offset its economic consequences or as victims who have been overwhelmed by their disability and suffered dramatic economic loss, the stereotype I would choose is hero.

4. *Sophisticated social insurance and welfare networks were created in western industrial countries to offset the economic effects of a disability, as well as other economic events (e.g., recessions, depressions, plant closings, etc.) that threaten unemployment and economic well-being.*

Figure 13.1 puts disability-based insurance and disability-based welfare programs in the context of overall social policy. In the next sections I will use it as a means of putting the findings of the volume into that same context. Figure 1 has its origins in Aarts, Burkhauser, and de Jong (1996), which focuses on differences in social programs across five western industrial countries—the United States, the Netherlands, Sweden, Germany, and Great Britain.

Figure 13.1 conceptualizes attempts by government policy to ameliorate job loss caused by economic or health factors in the context of a series of paths that workers may take as they move from full-time work to normal retirement. For workers who remain on the job over their work life the path to retirement is a straightforward one. It is not until they reach retirement age that they must choose between retirement and continued work. But for a significant number of workers, job separa-

Figure 13.1 Social Welfare Protection System



ration before retirement is a reality for which social welfare policy must prepare.

No single figure can show all the possible paths that workers with a disability may take over their lifetime, especially one that is intended to show how labor market and social welfare institutions influence those paths across countries. But it is possible to show in a broad way how the incentive structure built into a country's institutions affect the average person in that country. In general one can imagine four paths that workers may take following the onset of such a disability. The first, which is defined as the work path, encompasses public programs that provide or encourage rehabilitation in order to overcome the work limitations caused by a disability. But it also includes more direct government intervention into the labor market through the creation of specific government jobs for people with disabilities, subsidies to those who employ such workers, job quotas, job protection legislation—dismissal rules, etc., or general antidiscrimination legislation requiring accommodation for workers with disabilities. The intent of these policies is to maintain those with disabilities on the job and in the labor market, either through the carrot of subsidies or the stick of mandates.

The second, which is defined as the disability insurance path, encompasses traditional disability insurance-based transfer programs. They may include short-term programs that mandate employers to provide replacement of lost wages during the first few weeks of sickness or directly provide such replacement through short-term social insurance. In all European countries, they would include the provision of health care at no marginal expense to the worker. After some point, workers are then eligible to move to a long-term disability insurance program. Often acceptance into this program requires meeting both health and employment criteria. This path eventually merges with social security retirement programs.

The third, which is defined as the unemployment path, encompasses the short-term provision of unemployment benefits that to replace lost wage earnings due to cyclical economic downturns. At some point longer-term unemployment insurance is made available, often at a lower replacement rate. Finally, this also merges with the social security retirement system at older ages. As we have seen, disentangling exits from a job because of a disability and exits from a job because of economic forces is in practice a difficult and often controversial task,

especially since these exits can be influenced by the rules established by a country's social welfare system.

The final path is defined as the welfare path. These means-tested programs serve as a safety net for workers without jobs who are not eligible for disability or unemployment-based social insurance programs. Such programs can be universal, subject only to a means test and/or linked to an inability to work either because of health, poor job skills, or child-rearing responsibilities. This track can continue past retirement age for those not eligible for social security retirement benefits.

The extremely simplified social welfare system pictured in Figure 13.1 provides some important insights for evaluating the disability transfer system in any country. And it can be used to explain the important empirical facts uncovered in Stapleton et al. (Chapter 2) and Livermore, Stapleton, and Zeuschner (Chapter 8).

For persons who have a disability that begins to affect their ability to work, important decisions about work often must be made. When making those decisions in conjunction with an employer, the social institutions of the country in which those persons work may also be important influences. Such a worker is likely to look at the relative rewards of continued movement along the work path versus entry onto an alternative path. Similarly, a firm's willingness to accommodate workers may also be influenced by the social institutions it faces.

Not all workers can or will transform themselves into candidates for disability insurance benefits. But workers with a disability who are having difficulty with their current job or who are no longer working will be influenced by the relative rewards provided by the disability, unemployment, and welfare paths in their country when deciding whether to try to remain in the labor force or apply for transfer benefits. Nor do all those with disabilities have the ability to continue to work. Some people's disabilities are so severe that continued employment is impossible and a movement onto the transfer rolls is inevitable. But for some portion of the population who suffer the onset of a disability that affects their ability to work, the length of time they continue on the job depends on the social institutions that are in place as well as their specific health problems. These workers add to the supply of candidates to disability transfer programs.

Countries with low or nonexistent welfare benefits, low unemployment benefits, and little available rehabilitation and job protection are

likely to have a large supply of applicants for the disability insurance path. This supply increases as the replacement rate increases and the period of time over which benefits can be received increases. Examples of such countries are the United States and the Netherlands where increases in applications for disability benefits put tremendous pressure on disability-based programs in times of serious economic downturns. Alternatively, when the protection offered by the unemployment path is similar to that offered in the disability insurance path, as in Germany, the supply of disability applicants does not increase significantly during economic downturns.

In Sweden, where disability benefits are as generous as in the Netherlands, application pressure on disability programs is far less severe because all persons with a serious disability who seek disability transfer benefits are first required to receive rehabilitation. Following rehabilitation, it is government policy to provide jobs in the public sector if private sector jobs are unavailable. In Germany a combination of lower replacement rates and a quota system and nonactuarially reduced early retirement benefits deflect much of the pressure away from disability transfer programs.

Figure 13.1 shows how the incentive structure inherent in a country's social welfare system influences the supply of disability candidates. But it can also be used to describe the demand for such candidates. To enter any of the four paths described in Figure 13.1, it is necessary to satisfy entry requirements. In a social security retirement insurance program, entry requirements are usually straightforward. A worker must have worked in covered employment for a given time or have performed other easily verified activities (e.g., attend school, rear children) and must be a given age. Such eligibility criteria are easy to administer. This makes the task of the front-line gatekeepers routine. They simply follow relatively objective criteria with little room for individual interpretation.

Of course, the overall size of the population on the retirement rolls will change if a higher benefit is paid or the age of eligibility is lowered, but gatekeeper discretion will not enter into this change. They will simply follow new criteria. Determining eligibility for the various paths open to those who have a disability that begins to affect their work but who are below early retirement age is not as clear-cut.

Unlike age, which is relatively easy to verify, disability is a complex concept that has both health- and work-related components. One easy way to screen for benefits is to require a waiting period of around one year between the onset of the condition and eligibility, and to record how much the person is actually working. Then, either a private physician or a physician employed by the system determines the seriousness of the health condition with respect to the person's ability to work. While the first two pieces of evidence are easily measurable, the third is less so. Doctors can evaluate health conditions as they relate to a norm, but there is no unambiguous way to relate a health condition to one's ability to work. Hence, disability program gatekeepers' discretion in carrying out established criteria is much greater than it is for retirement.

Access to the work path and the disability insurance path may be closely coordinated, as in Sweden, where a centralized group of gatekeepers determines who can be rehabilitated and who goes directly onto disability transfer rolls. But these paths may also be administered in quite independent ways. In the United States, rehabilitation services are administered by an entirely different group of gatekeepers with little or no coordination between them and the gatekeepers who administer the disability transfer system.

All of these factors then enter into the way that front-line disability gatekeepers respond to changes in supply and to the voices of those at higher levels of administrative responsibility who are attempting to control the overall flow of people into the system. In periods of economic downturn, the number of workers who leave their jobs rises and applications to transfer programs increase. In countries like the United States and the Netherlands, with generous disability benefits relative to other alternatives, tremendous pressure is put on the disability system to provide income to those workers. The pressure may lead to a specific easing of the rules or simply to a change in the interpretation of the rules. In this way "demand" may shift to accommodate supply.

What Stapleton et al. (Chapter 2) have documented is that the business downturn of 1989–1991 had an important role in the upsurge in disability applications, as Figure 13.1 would predict. But they also find that entrance into the program is not inevitable. The major recession of the early 1980s also had an important effect on applications but did not result in additions to the rolls since the gatekeepers were signaled by

Congress and the administration to resist. None of these ebbs and flows in application and acceptance rates can be explained by changes in underlying health conditions in the United States.

As Figure 13.1 suggests, countries with generous and easily accessible unemployment and welfare paths are not as likely to see the impact of major business cycle shifts on applications to their disability insurance path. But in the United States our unemployment system is not particularly generous and is short term. And, unlike most European countries, we have no universal income maintenance system. General Assistance and Aid to Families with Dependent Children (AFDC) are the primary nonhealth-related sources of income for low-income people. As the eligibility criteria are tightened and the length of stay made more limited on these two programs, Figure 13.1 suggests that this will lead to increased pressure on SSI as an alternative to these two programs. Bound, Kossoudji, and Ricart-Moes (Chapter 7) suggest that this is exactly what happened in Michigan when their General Assistance program was cut. Several other chapters on the topic of application and growth (Stapleton et al., Chapter 2; Livermore, Stapleton, and Zeuschner, Chapter 8; and Bordelon's comments on Chapters 6–8) show that at the gatekeeper level there is a movement from General Assistance and to a lesser extent from AFDC onto the SSI rolls.

In addition to the supply story emphasized in Figure 13.1, there is the “cost-shifting” issue that is a generic problem of our multilevel approach to social welfare policy in the United States. An important message of this book is that there has been a systematic effort by state governments to shift their welfare costs to the federal government, which explains part of the upsurge in Supplemental Security Income (SSI) applications. (See especially Livermore, Stapleton, and Zeuschner, Chapter 8.) The welfare reforms of 1996, which require states to pay 100 percent of the marginal cost of AFDC clients will make SSI an even more inviting program for state administrators anxious to shift costs back to the federal government.

While Livermore, Stapleton, and Zeuschner have concentrated on the importance of policy changes in General Assistance and AFDC on the SSI rolls, another policy change already adopted will also affect the Social Security Disability Insurance (DI) and SSI rolls in the next decade. To reduce the financial burden of the aging baby boom population on the Old-Age and Survivors Insurance system, the normal age of

retirement is scheduled to increase from 65 to 67 in the next century. It is likely that further increases in both the early and normal retirement age will come. But Figure 13.1 shows that as we make the paths to retirement longer, the populations on DI and SSI will increase, because duration on the program will increase as will the incidence of new enrollment at older ages. This notion of the importance of duration on the size of the disability rolls is addressed by Rupp and Scott (Chapter 4) as well as by Muller and Wheeler (Chapter 6).

A final issue related to disability program growth discussed in this book is the shift in impairment trends among applicants and awardees over the last decade. Stapleton et al. (Chapter 2) document that applications and awards based on mental disorders and musculoskeletal conditions have grown much more rapidly than applications and awards based on other impairments. To paraphrase their arguments in terms of Figure 13.1, they argue that this phenomenon is much more related to changes in the actions of disability gatekeepers than in underlying changes in conditions. Changes in the eligibility criteria and the greater emphasis on functional criteria rather than on medical evidence has led to more awards, not a change in underlying health conditions.

GROWTH IN THE DISABILITY TRANSFER POPULATION: A POLICY SUCCESS OR FAILURE

While Figure 13.1 is useful in providing a fuller policy context for the rapid increase in the disability rolls documented in this book, it is less useful in determining whether this increase was a policy success or a failure.

While I am confident a consensus exists on the importance of economic and policy factors on recent disability program growth, I am much less confident consensus exists on the appropriateness of this policy outcome. This lack of consensus is best captured by the competing views of Goldman and Weaver in Chapter 11. While Goldman sees the growth in mental disorder awards as the expected consequence of a society finally reaching out to an underserved population in need, Weaver sees this as a substantial lowering of the gates with respect to

our definition of disability. Likewise, the tremendous outreach “achievements” discussed by Livermore, Stapleton, and Zeuschner (Chapter 8) and Bordelon (comments on Chapters 6–8) can either be seen as an appropriate attempt to provide deserved disability benefits to people unaware of their rights or as further evidence of a concentrated effort to shift the burden of general welfare assistance from the state to the federal government.

Ultimately, policy outcomes of the 1990s will be judged by one’s overall view of the goals of social policy, and of disability insurance and welfare programs within it. It is at this point that I must confess that as a “poverty policy expert” of the 1970s, I and many of my colleagues advocated and laid the groundwork for the system we have today.

I was among the majority of academics who supported a Negative Income Tax in the 1970s. In fact, it was then common in policy circles to whisper that the passage of Supplemental Security Income effectively gave us a Negative Income Tax (NIT) not only for all older people but, with a broad enough definition of disability, most younger people as well. Today many policy experts and most advocates for the poor see the expansion of SSI as the best practical method of insuring a universal federal government-financed minimum income floor under all Americans.

Many things have changed about me in the last twenty years: first, the length of my hair, which was the defining characteristic of my generation, is shorter and has turned from brown to grey. Second, my faith in the NIT as the basis for assisting poor people has been critically affected by the very mixed results of thirty years of war on poverty programs. I now more fully recognize the dangers to the human spirit that permanent transfers bring. I am no longer a supporter of an NIT or any other universal guaranteed transfer program that requires no *quid pro quo* of its beneficiaries. I do not believe that residency or even citizenship confers an entitlement to a minimum benefit, and I believe it is neither in the beneficiaries’ interest nor in the interest of taxpayers to provide such benefits. Third, and more to the point, I am not alone. I doubt if even in the 1970s a majority of Americans supported universal guaranteed welfare minimums. Otherwise, then why did we have to hide the universal minimum in the guise of a disability program? But today the political mood is much less supportive of federally imposed

minimums. The passage of welfare reform legislation that ended the open-ended guarantee of support payments for AFDC recipients by a Republican dominated Congress and signed by a Democratic president just before the presidential elections of 1996 is evidence of the political consequences of this mood. To the degree that SSI is seen as a mechanism for supporting those who could work, its survival is also threatened. This is the real danger that people with disabilities should recognize in their support of current DI and SSI eligibility criteria.

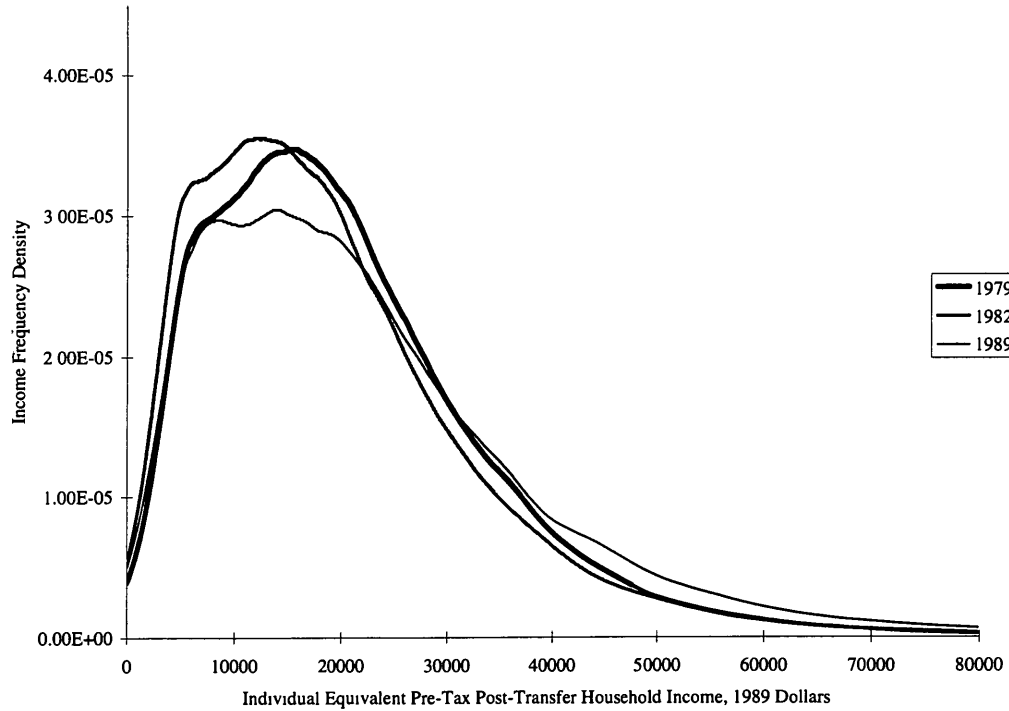
Fourth, what I believe is more in keeping with traditional American values and what a majority of Americans will support are government programs that subsidize work, not welfare, or, to borrow a phrase from a current political leader—programs that make work pay. As general transfer programs like General Assistance and AFDC are cut in an effort to shift people into the workforce, there will be increasing efforts to place these former beneficiaries on SSI as their benefits expire. Daly (Chapter 5) shows that this is already occurring, and the 1996 welfare reform legislation guarantees it will increase.

Finally, let me suggest why the defenders of our current system of transfer payments should pause. It is often said by veteran activists that while SSI is not a very generous program, at least it provides a safe haven against the uncertainty of the work path. And advocates of people with disabilities have labored tirelessly in Congress and in the courts to ensure that most people on SSI will never have to leave that program. But there is evidence that the uncertainty of the work path may in the long run be preferable to what appears to be the safety of SSI and other welfare-based transfer programs.

In a series of papers (Burkhauser et al. 1996a, 1996b; Burkhauser, Crews, and Daly 1997) look at how income distribution in the United States changed over the 1980s and early 1990s. We then look at how subpopulations within these countries fared over this period.²

Figure 13.2 shows the distribution of real pretax, posttransfer individual household size-adjusted income in the United States in 1979, 1982, and 1989. Since much of the discussion in this book has centered around the importance of business cycles, it is important to recognize that 1979 and 1989 are peak years in the business cycle of the 1980s while 1982 is the trough year in that business cycle. Hence, one can see the powerful negative effect the recession of the early 1980s had on the economic well-being of the entire population, as it shifted the entire distribution to

Figure 13.2 The Income Distribution in the United States in 1979, 1982, and 1989 (total United States population)



SOURCE: Burkhauser et al. (1996a).

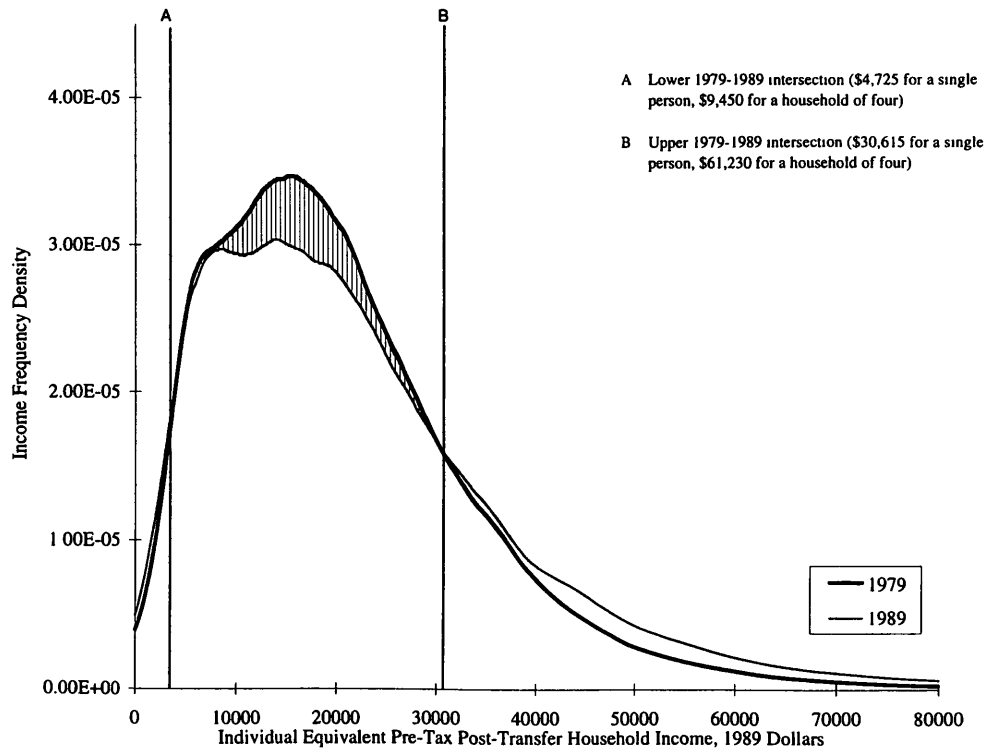
the left from 1979 to 1982. Over the next seven years, however, economic growth shifted the entire distribution back to the right.

Much of the discussion of the 1980s ignores the importance of general economic conditions on income distribution and simply compares income distributions between two arbitrary years. Figure 13.2 shows that the years chosen can greatly influence one's view of that decade. But in looking at the 1980s it is most appropriate to choose points at the same place in the business cycle. Figure 13.3, compares the two peak years—1979 and 1989.³ It confirms conventional wisdom that inequality increased and the mass of people in the middle of the distribution fell. Note the shaded area. This is the “vanishing middle class.” Some of the mass fell to the left—the mass of people at the bottom of the distribution grew. But the important news is that the vast majority—90 percent—of the mass in the middle shifted to the right. That is, the majority of the “disappearing middle class” became better off rather than worse off. Inequality grew, but it did so because people in the middle became better off at different rates.⁴

We then divided the population into three broad subsets: persons living in younger households (all persons living in a household headed by an individual aged 61 or younger, in which some household labor earnings but no social assistance benefits are reported; persons living in older households (all persons living in a household whose head was aged 62 and older); and persons living in younger social assistance households (persons living in a household whose head was aged 61 or younger in which some form of social assistance—SSI, AFDC or other welfare transfers—was received). When we do this for young working households the distribution mirrors Figure 13.3. Inequality grew, and the middle mass fell. While there was some small growth on the left, the majority of people in these households became richer. For older households the entire distribution moves to the right between 1979 and 1989. There was an unambiguous improvement in the economic well-being of older people living in households in the 1980s, in large part because of increases in social security retirement benefits and in the prevalence and generosity of employer pensions over the period.

What I want to focus on is the third subgroup—persons living in younger social assistance households. Figure 13.4 shows that the distribution of household size-adjusted income of this population shifted to the left between 1979 and 1982. That is, like other Americans, those

Figure 13.3 The Income Distribution in the United States in 1979 and 1989 (total United States population)



SOURCE: Variation of Figure 3 in Burkhauser et al (1996a)

persons in social assistance households were worse off in the business cycle trough year of 1982 than in the peak year of 1979. But unlike other Americans, seven years of economic growth was not able to return them to their previous 1979 high, let alone shift the distribution to the right of its 1979 position. While on average, persons on social welfare assistance were slightly better off in 1989 than in 1983, they were less well-off than in 1979. The overall economic well-being of those on welfare actually declined.

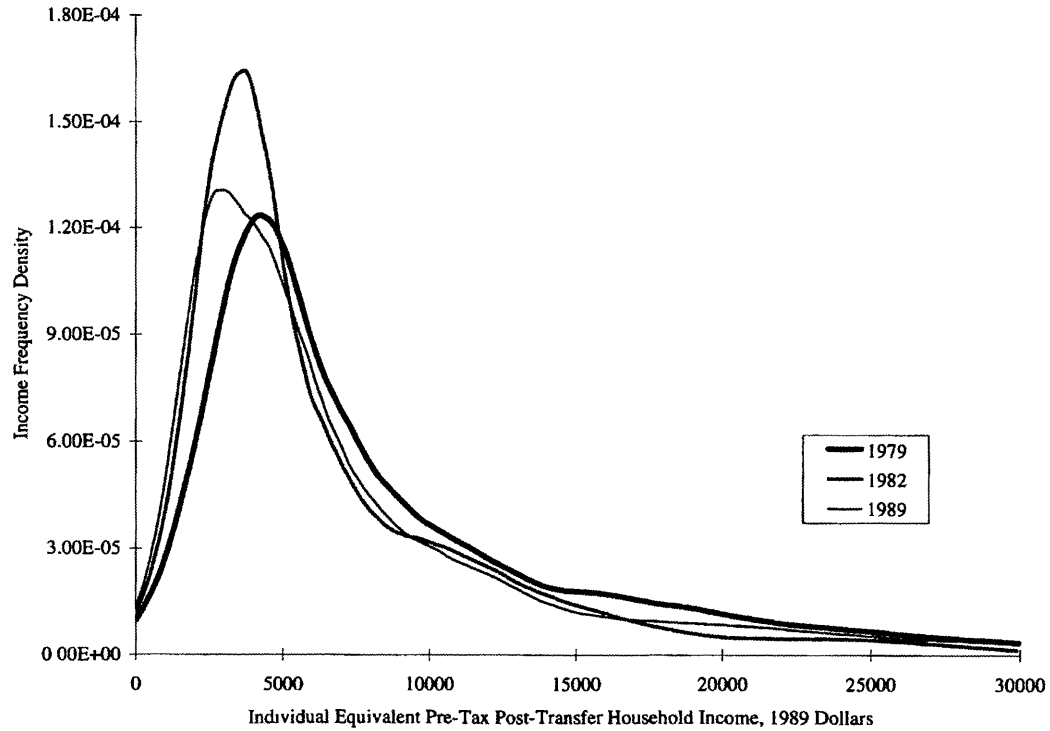
In the 1990s the bipartisan groups that are “reinventing government” and “changing welfare as we know it” show precious little support for increasing the economic well-being of nonworking welfare recipients. Thus, for young people with disabilities who are on the verge of moving toward either the work or welfare paths, the future value of a lifetime of SSI benefits is quite uncertain. Perhaps it is time for the advocates of people with disabilities to shift their efforts from the lost cause of defending and enlarging support for programs that subsidize nonwork to programs that encourage work.

In fact, the Americans with Disabilities Act of 1990, with its emphasis on accommodation and the view that the majority of people with disabilities can work, should be at the center of a set of policies that begin to shift our collective energies from nonwork to work subsidies. But this movement should recognize that with rights come responsibilities. If people with disabilities are able to work, then our public policies should be built around this expectation and not around a guaranteed lifetime of welfare transfers.

As I discussed in Chapter 12, accommodation, disabled worker tax credits, rehabilitation, and training offer real alternatives for an important segment of the population with disabilities who would otherwise be in the next wave of SSI or DI beneficiaries.

This book has established that economic and policy forces significantly affect the DI and SSI rolls. While we will always need SSI and DI for some people with disabilities, for many others this is a poor second-best alternative. It is time to stop using SSI as a back door route to universal welfare minimums. Rather, we should recognize that people with disabilities have more in common with other Americans than they have differences. Economic growth is the primary engine of growing economic well-being for most Americans, including those with disabilities. People with disabilities who have good job skills are already able

Figure 13.4 The Income Distribution in the United States in 1979, 1982, and 1989 (social assistance recipients)



SOURCE: Burkhauser et al. (1995a).

to integrate themselves into the American workforce; those with disabilities and poor work skills, the doubly disadvantaged, do need a hand up, but we should first try to improve their economic well-being through work programs before we push them onto the welfare path.

Notes

1. Burkhauser and Daly (1996b) also provide cross-sectional information on the labor force participation of people with and without disability. We find the majority of men and women aged 25 to 61 who report a disability in 1989 (using the same two-period definition of disability) worked at least 52 hours in that year and about 40 percent of men worked full-time. As was discussed in Stapleton et al (Chapter 2), the business cycle plays a role in the work lives of people with disabilities. The year 1988 was the sixth straight year of economic growth in the United States and hence reflects work outcomes near the peak of the 1980s business cycle. Using the same definition of disability and work, Burkhauser and Wittenburg (1996) look at labor force participation rates of people with disabilities between October 1990 and January 1992 using the Survey of Income and Program Participants. Labor force participation of people with disabilities is lower during this weaker economic period; yet, about one-half of men with disabilities worked.
2. The data used in these papers come from the Current Population Survey. As in Table 13.1, the unit of analysis is the person, but within a household context in which it is assumed that household income is equally shared using an equivalence scale with an elasticity of 0.5. For the United States, household income is pre-tax and post-transfer. In-kind transfers are not counted.
3. Burkhauser et al. (1996b) repeat this exercise using the trough-to-trough years 1982 and 1992. The results are similar to the peak-to-peak comparisons. Both these results are quite different from those one would find by comparing a peak year—1979—with a trough year—1992 (see, for instance, Danziger and Gottschalk 1995). Not surprisingly, comparisons of peak-to-trough years lead to a much worse outcome but one that mixes changes along a business cycle with changes across business cycles. For a fuller discussion of the sensitivity of across-year comparisons of economic well-being see Burkhauser, Crews, and Daly (1997).
4. The definition of middle class used here is basically a statistical one. It is the middle of the 1979 distribution, which is bounded by the upper and lower intersections of the 1989 distribution—the “middle mass” of the distribution. Of course, these “intersection points” do not reflect the political concept of the middle class. In 1989 dollars the lower minimum is \$4,725 for a single person (\$9,450 for a household of four), or 74.9 percent of the poverty line and the maximum of \$30,615 for a single person (\$61,230 for a household of four—48.5 times the poverty line). Burkhauser, et al. (1996a) offer an alternative lower boundary of twice the poverty line \$12,622 for a single person (\$25,244 for a household of four), which more closely matches the lower boundary of the political middle class, and

reach the same conclusion—that the overwhelming majority of the middle class became richer in the 1980s.

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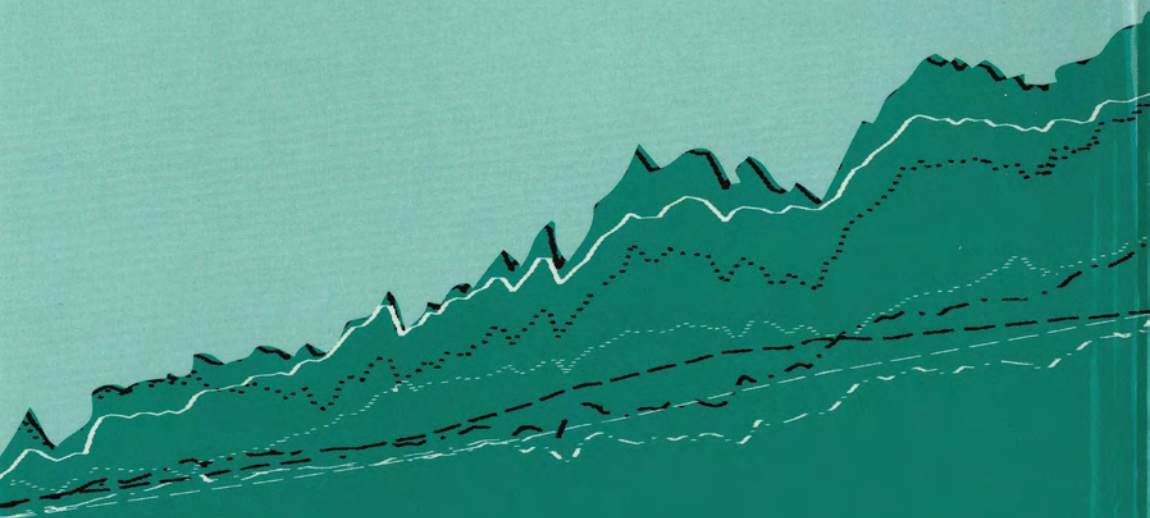
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