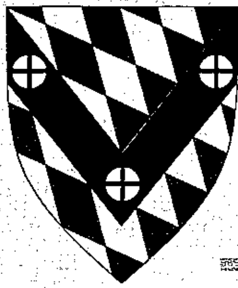


ECONOMIC DIRECTIONS

CENTER FOR ECONOMIC AND POLICY EDUCATION, SAINT VINCENT COLLEGE, LATROBE, PENNSYLVANIA VOLUME 7 NUMBER 2 APRIL 1997

WELFARE REFORM FOR THE DISABLED

(The following is a lecture delivered by Dr. Kajal Lahiri, Professor and Chair of Economics at State University of New York at Albany, at Saint Vincent College, Latrobe, Pennsylvania, on February 12, 1997 as the 36th lecturer in the Center for Economic and Policy Education's Alex G. McKenna Economic Education Series.)

Programs to help persons with disabilities are some of the most common and durable social policies in modern societies. In the U.S., there are 19 different federal agencies that administer 130 programs targeting people with disabilities. Of the 130 programs, 69 are exclusively for people with disabilities with a total cost over $60 billion in 1994. These programs deal with monetary compensation, medical care, rehabilitation services, special education, and other social and personal supports, as well as attempts to break down architectural and transportation barriers and to eliminate discrimination. The Yale law professor Jerry Marshaw characterizes the myriad of disability programs as a "patchwork quilt" that responds to multiple needs and multiple goals, which may also fail to fit together in a fashion that provides a warm and secure covering for those whom disability policy seeks to protect or empower.

Of all these, the Social Security disability insurance (DI) and the Supplemental Security Income (SSI) programs are the two most well-known income support programs. In 1994, there were nearly 7.2 million disabled recipients under the age 65. The disability benefits under the two programs grew from $26 billion in 1985 to $57 billion in 1994. Moreover, in 1993 the cost of providing Medicare and Medicaid beneficiaries was about $55 billion, bringing the federal cost of cash benefits and health coverage for the disabled to over $100 billion. The average Medicaid cost for a disabled SSI recipient can range anywhere from $7,000 to $24,000 per year, depending on the na-

ture of the medical condition.

There are many reasons for this growth. Eligibility changes have occurred as a result of actions taken by Congress and the courts. For example, Congress mandated changes in the evaluation of mental impairments and of drug addicts and alcoholics (DA&A). The Supreme court ruling under *Sullivan v. Zebley* has liberalized the concept of children's disability. For the impaired, incentives to apply for benefits have probably been affected by changes in institutional, economic, and demographic factors. Institutional factors include trends in State or State/Federal programs serving the impaired, specifically, general assistance, workers' compensation, unemployment compensation, Medicaid, and Aid to Families with Dependent Children (AFDC). The growth and composition in immigration over the last 15 years is another factor.

The most recent welfare reform (The Personal Responsibility and Work Opportunity Reconciliation Act of 1996) has far-reaching implications in a number of ways.

ECONOMIC DIRECTIONS

A Publication of Saint Vincent College
Alex G. McKenna Economic Education Series

CO-EDITORS
Andrew R. Herr, Ph.D
Assistant Professor of Economics

Gary M. Quinlivan, Ph.D
Professor of Economics

PROGRAM MANAGER
Christine M. Bender, M.P.A.

ASSISTANT EDITORS
Ronald J. Baker II, C'97
Gregory S. Thome, C'97

STAFF
Elizabeth M. Appel, C'99
Faye L. Carpenter, C'98
Andrew D. Fox, C'97
Adam D. Gasper, C'97
Matthew A. Halloran, C'97
Ken R. Hemminger, C'98
Aaron B. Hinde, C'97
Elizabeth M. Kaczmarski, C'99
Jaime M. Kochis, C'98
Amy Leonardo, C'97
Anthony R. Marciano, C'2000
Robert C. McBride, C'99
Siddhartha Namasivayam, C'99
Nicholas M. Racculia, C'2000
Steve D. Thimons, C'97
Anthony S. Zito, C'98

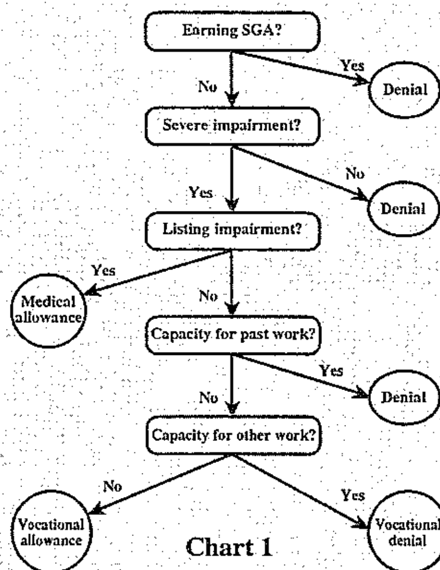


Chart 1

The bill eliminates the open-ended federal entitlement program of AFDC and creates a block grant for states to provide time-limited cash assistance to needy families. The welfare legislation also makes important changes to Child Care, the Food Stamp, and SSI programs for children and legal immigrants. As part of another reform of the SSI, the Social Security Independence and Program Improvements Act of 1994 has mandated a number of actions to strengthen controls over benefit payments to addicts.

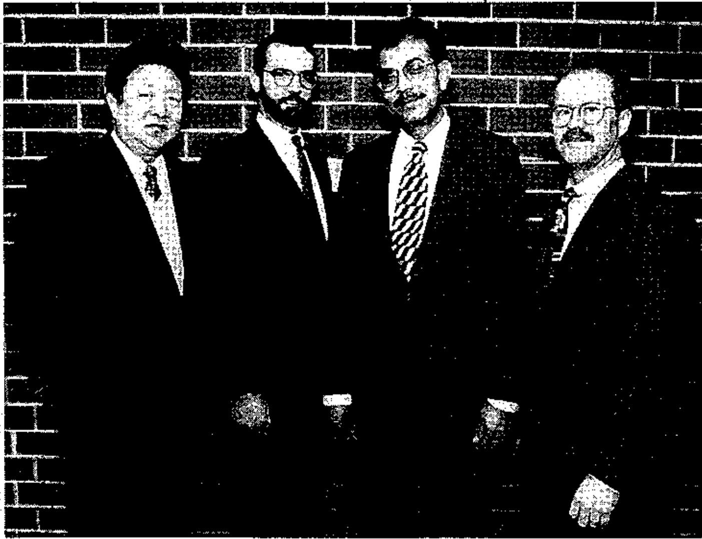
A portion of disability growth may be attributable to fraud and abuse in the past decade. A lack of empirical evidence makes it difficult to estimate the extent of the problem. Nevertheless, news reports have provided accounts of foreign-born SSI applicants coached by middlemen or translators to feign mental illness and children coached by parents to fake mental illness by misbehaving or doing poorly in schools to qualify for SSI benefits. Regardless of the actual extent of such abuse, reports like these can significantly erode public confidence in the program's integrity.

One problem of administering disability programs is that it is difficult to define "disability." The famous TV commentator Andy Rooney once complained in a newspaper column that he finds quite a few people using the disabled parking spaces even though they are not in wheelchairs or do not look obviously disabled. He received numerous letters from newspaper readers who explained how their disabling conditions do not require wheelchairs or why they do not look disabled. Rooney quickly realized his misconception about disability and readily apologized. In what follows, I will briefly explain the two federal disability programs and the definition of disability they use. Then I will discuss the context in which reforms for the immigrants, children and addicts took place.

Disability Determination

Under the disability determination procedure, the existence of an impairment alone does not qualify an applicant to receive benefits; eligibility requires that the impairment be severe enough to prevent significant work. Thus, to be disabled, the applicant must be judged unable to do *any* jobs which exist in reasonable numbers in the economy. The evaluation is based on the applicant's impairment and, in certain cases, takes into account the applicant's age, education, and work experience. Disability determination serves a gatekeeping function for both the DI and SSI programs, distinguishing allowances from denials. It is unlike typical eligibility criteria for public programs. Such criteria often relate to self-evident or easily measurable traits, such as advanced age, single parent status, or having income below a statutory limit. By contrast, disability determination is a complex evaluative process that is not widely understood. Yet, with the total number of applicants for the two programs now exceeding two million per year, its budgetary and income distributional effects are undeniable. Disability determination involves a sequence of five steps, shown schematically in chart 1.

The first step of Social Security Administration's (SSA) process is an earnings screen. At this step applicants are denied if they engage in activities which are both *substantial* and *gainful*. Activi-



GREETINGS -- Welcoming Dr. Kajal Lahiri (third from left) to Saint Vincent were, from left, Professor Mo Wenchaun, visiting professor from Shandong University in Jinan, P. R. China; Dr. Anthony E. Davies, C'87, Assistant Professor of Economics, West Virginia Wesleyan College; and Dr. Gary M. Quinlivan, Executive Director, Center for Economic and Policy Education.

STUDENT WELCOME -- Matthew A. Halloran, a senior economics major from Pittsburgh, Pennsylvania (left) and Robert C. McBride, a sophomore economics major from South Africa (right) were among those who welcomed Dr. Lahiri to Saint Vincent.

ties are defined as substantial if they involve significant physical or mental activities. They are considered gainful if done for pay or profit. Applicants earning more than the substantial gainful activity (SGA) amount are denied. The current maximum SGA amount is $500 per month. The residual group is not allowed at this step; rather, they are evaluated further under step two.

The second step is a medical screen. An applicant is denied at step two if his or her impairment (or combination of impairments) is not *severe*. An impairment is considered nonsevere if it does not exceed a conceptual threshold—if it does not significantly limit the physical or mental abilities to accomplish basic work-related activities. Basic work activities include: physical functions (such as walking, standing, or lifting); sensory capacities (such as seeing, hearing, or speaking); and routine mental functions (such as understanding simple instructions, responding to supervision, or adapting to changes in the work environment). Applicants are also denied at step two if their impairments do not meet the *duration test*, that is, if (1) the impairment is not expected to result in death, and (2) the impairment has neither lasted 12 months nor is expected to last 12 months.

The third step is to decide allowances based solely on medical criteria. Under step three, the medical evidence obtained on an applicant's impairment is assessed using codified clinical criteria relating to both the nature and severity of the impairment. These codified criteria, currently including over 100 impairments, are referred to as the Listing of Impairments.

The listings are detailed medical standards that lend objectivity and timeliness to the determination process. If an applicant has an impairment not included in the listings, but considered medically equivalent to a listed impairment, with evidence indicating the impairment is equal in severity to a listed impairment (or more severe), the impairment is said to "equal the listings" and the applicant is allowed. Applicants with impairments meeting these criteria are allowed immediately; remaining applicants are evaluated further in step four.

The fourth step is based on the question: Can severely impaired applicants work in past jobs? Under step four, an applicant's residual functional capacity to meet the requirements of the main jobs held in the past is considered. Applicants judged able to perform past work are denied; the remaining applicants, including those with no recent work, are evaluated further in step five.

Step four involves two determinations. The first is an analysis of an applicant's residual functional capacity; this analysis is used in steps four and five. The evaluation of residual functional capacity acknowledges the presence of a severe impairment and determines to what extent the applicant can perform basic work-related activities despite the impairment. This analysis takes into account, for example, whether the applicant can walk, lift objects, follow instructions, and tolerate environmental conditions encountered in the workplace. The basic work-related functions considered here are the same ones considered in step two, but they are evaluated differently in the two steps. In step two, the *presence* of such limitations would be taken as evidence of a severe limitation, but in step four the *extent* of such limitations is measured to compare the applicant's *residual capacity* with the demands of past jobs.

Step four also requires a determination as to the requirements of past jobs. The jobs considered are those held in the 15 years prior to application, if they were held long enough for the applicant to learn the requisite skills. For example, if two applicants have the same severe arthritic impairment involving the lower extremities, an applicant who had held a desk job is the one more likely to be denied at this step, on grounds that he or she can continue to perform sedentary work; by contrast, an applicant who held a physically-demanding job will probably be evaluated further in the fifth and final step.

The fifth step seeks to answer the question: Can severely impaired applicants do any work? Under step five, the applicant's *residual functional capacity* is considered in conjunction with *vocational factors*, to determine whether the

applicant can work in jobs other than those he or she has held. The analysis of the applicant's residual capacity from step four indicates whether the applicant is able to perform sedentary, light, medium, heavy, or very heavy work. Under step five, the applicant's age, education, and work experience (if any) are used to determine whether the applicant can work in employment consistent with his or her residual capacity. This determination is based on a table called the vocational grid. To illustrate the use of the grid, suppose an applicant's impairment will permit only sedentary work. If the applicant is of advanced age, low educational attainment (six years or less), and has worked only in arduous unskilled jobs, then the applicant will be judged disabled using the vocational grid. Because this step represents the final step of the determination process, all applicants are either allowed or denied.

The sequential process provides an operational definition of disability that can be applied and replicated with uniformity throughout the nation. Over the years, SSA has aggressively and successfully defended the sequential process, which has, in principle, been endorsed by Congress and the courts.

Children

The rationale for including children in SSI is different from that for adults. Cash assistance for poor adults who are disabled is justified because they lack the capacity to support themselves through their own savings. That is also true for all poor disabled children. In addition, their disabilities impose extra cost to their families, and if they do not have appropriate developmental supports when they are young, they are at high risk of relying on public support when they become adults.

Before 1989, the growth in child beneficiaries had been relatively low. Over the last five years, the number of children receiving SSI benefits has tripled, from almost 300,000 to almost 900,000 today. If this rate of growth continues, 1.86 million children will be receiving SSI benefits by the year 2000.

Eligibility changes have affected both growth and composition of the childhood SSI cases. In December 1990, SSA revised its medical standards for assessing mental impairments in children, adding separate listing for such impairments as attention deficit hyperactivity disorder, autism, and other pervasive developmental, personality, and mood disorders. Two months later, it also added the new individualized functional assessment (IFA) process required by SSI statutory standards as interpreted by the Supreme Court, substantially expanding eligibility for children who did not meet SSA's strict

"However, in addition to financial support, promoting employment should be one of the most important goals of any disability program."

medical criteria. As a result, the number of children qualifying on the basis of the revised medical standards for mental impairments tripled, from 1,900 a month before the change to 6,000 in 1994. In addition, the new functional assessment process has added about 219,000 children to the rolls through September 1994, accounting for one-third of all awards since it went into effect in 1991.

Children with mental impairments figure prominently in this growth. Increases in awards to children with mental impairments—based on the medical standards and the new assessment criteria—account for three-fourths of the overall increase in awards since the eligibility changes went into effect. In 1994, children with mental impairments received over 70 percent of all awards, including over 85 percent of awards based on the new functional assessment criteria.

Under the new welfare law, Congress eliminated the individualized functional assessment and also maladaptive behavior, certain learning disabilities, and rheumatoid arthritis as separate domains in disability determination. It is predicted that at least 135,000 children will lose their benefits.

Immigrants

Between 1982 and 1993, the number of legal immigrants receiving SSI increased an average of 16.5 percent a year. During this time period, the portion of immigrant recipients grew from about three percent of all SSI recipients to over 11 percent. In 1993, an estimated 683,000 legal immigrants received SSI benefits at a cost of about $3.3 billion. Slightly more than 60 percent of these immigrants received aged benefits and the remainder received disabled benefits.

The numbers of legal immigrants in the SSI aged program and the SSI disabled program have increased dramatically. In 1982, six percent of all SSI aged recipients were immigrants; by 1993, 28 percent were immigrants. Immigrants constitute a much smaller percentage of SSI disabled recipients—about six percent in 1993, having increased from less than two percent in 1982. If the historical growth rate in the number of legal immigrants on SSI continues, this number could reach nearly two million by the year 2000.

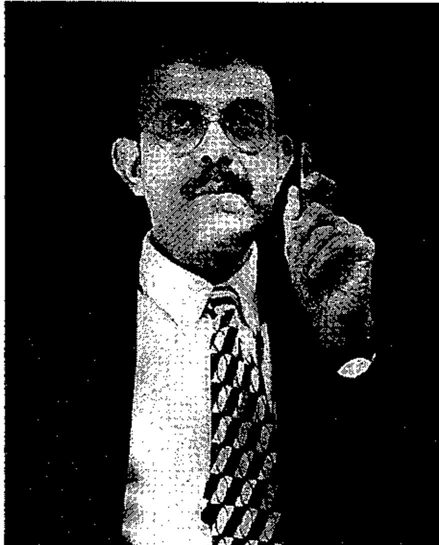
Several factors may help explain the growth of immigrants on SSI, but no studies have yet established whether, and

About the Series

The Alex G. McKenna Economic Education Series is presented by the Center for Economic and Policy Education at Saint Vincent College. These periodic lectures are open to the general public and their purpose is to explore the role of free markets in solving many of the social problems confronting the United States and the world today. Dr. Gary M. Quinlivan, professor of economics at Saint Vincent, directs the series.

The Alex G. McKenna Economic Education Series is made possible by grants from the PNC Bank Charitable Trust Committee, the Curran Foundation, Massey Charitable Trust and the Philip M. McKenna Foundation, Inc. of Latrobe, Pennsylvania.

to what extent, these actually account for the growth. First, the number of immigrants admitted annually for legal residence in the United States has gradually increased in the last decade. For example, 880,000 were admitted in 1993, compared with 570,000 in 1985. In addition, the legalization of nearly three million former illegal immigrants under the Immigration Reform and Control Act of 1986 may have expanded the population of immigrants eligible for SSI.



Second, the large increase in the percent of SSI aged recipients who are immigrants may be due in part to the admission for permanent residence of elderly immigrants who join family members already residing in the United States. Before 1994, the "deeming" provisions of the SSI program held that in determining eligibility for SSI, a portion of the sponsor's income was deemed to be available to the immigrant for three years. Administrative data indicate that about 25 percent of lawful permanent residents receiving SSI applied for benefits within a year of the expiration of their three year sponsorship periods. Some of these may have been elderly immigrants who, not having resided in the United States long enough, did not qualify for Social Security retirement benefits. The deeming period for SSI was temporarily extended from three to five years starting in January 1994 through September 1996. Under the new welfare law, legal immigrants will lose their disability as well as Medicaid provisions unless they have 40 qualifying quarters of work.

Drug Addicts and Alcoholics

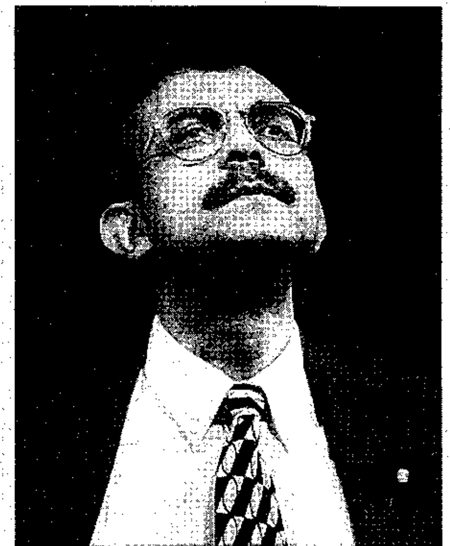
Under a special SSI program commonly referred to as the DA&A (drug addicts and alcoholics) program, certain recipients can receive SSI benefits only if two conditions are met. Specifically, they must (1) undergo and comply with treatment, when available, and (2) have a third party or representative payee manage their monthly benefit payments. There have been past problems with the representative payee system. The DA&A program is restricted to those addicts whose addiction is material to the determination of their disability; that is, if it were not for their addiction, they would not qualify for benefits.

> *"... alarming growth and allegations of program abuse prompted the Congress to eliminate DA&A completely"*

About 101,000 DA&A recipients on the SSI rolls in 1994 received an estimated $382 million in annual federal SSI benefits. The SSI caseload grew nearly 700 percent for the DA&A program from only about 13,000 cases in 1988. This alarming growth and allegations of program abuse prompted the Congress to eliminate DA&A completely. The cases will be reevaluated in terms of the usual determination process, and all addict recipients will be mandated to go through drug rehabilitation programs.

Solutions

As we have discussed, the 104th Congress has taken a number of extraordinary measures to curb the excessive growth in disability caseload. However, in addition to financial support, promoting employment should be one of the most important goals of any disability program. People with disabilities constitute an underutilized workforce and a potential resource to the U.S. economy. Surveys have shown that 18 to 40 percent of such people have jobs—far below the 73 percent of people without impairments. Since 1972, Congress has instituted a number of back-to-work and other vocational rehabilitation initiatives. Despite these statutory provisions, as well as medical and technological changes that have afforded greater potential for some beneficiaries to work, not more than 1 out of every 500 disability beneficiaries have left rolls by returning to work. Thus for a real reform of our disability programs, we have to ask: What changes could be made to these programs to encourage individuals with disability to use their residual work capacity? and How can rehabilitation be incorporated into the benefit programs without greatly expanding costs or weakening the right to benefits for those who can not work? We should, of course, learn from the 1991 General Assistance termination episode in Michigan where almost one of every two disability beneficiaries were not realistic candidates for return to work because of their severity of impairments or because they were expected to live only a few more years. The strict and frugal design of the disability programs in the U.S. does not seem to pose strong incentives for Americans to seek benefits in lieu of working. Thus, placing a time limit on disability benefits may not generate sufficient savings. Nevertheless, a flexible way to encourage persons with disabilities to emphasize their residual work capacity may be to provide them with a



refundable federal income tax credit that rises as their work effort rises. Also, disability beneficiaries could be given a work ticket, akin to a voucher, that they can use to shop among providers of rehabilitation services in either the public or private sector. The provider can then be reimbursed for its services based on deposited tickets after the beneficiary has returned to work and left the benefit rolls. Economists are currently examining some of these proposals. ▲

Center Announcements

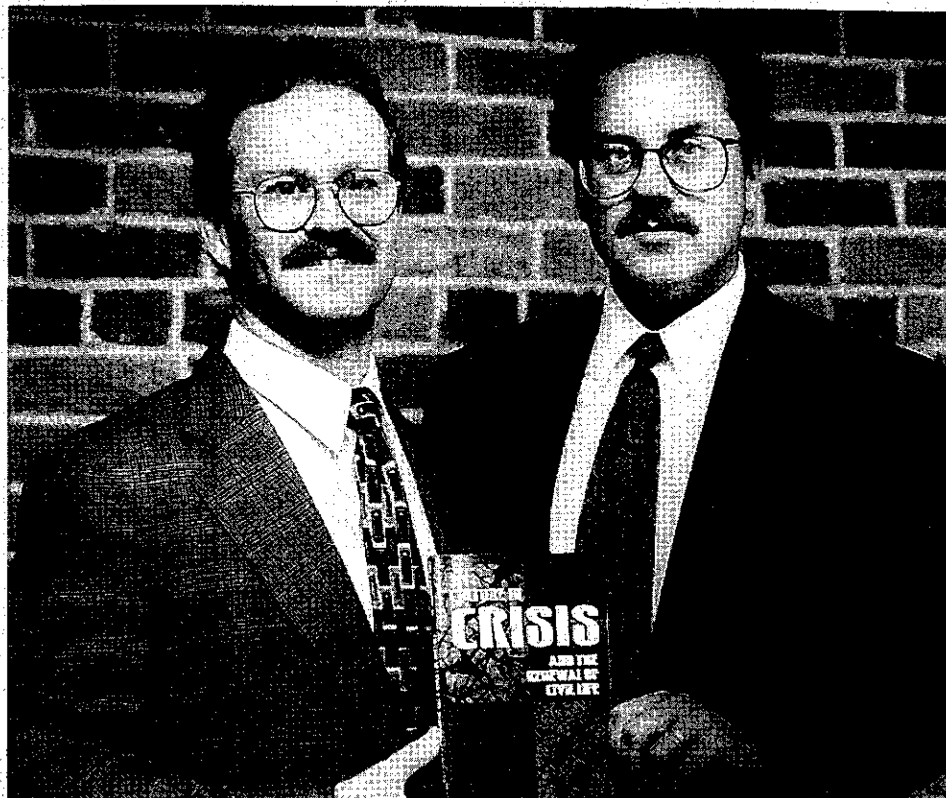
April 10-12, 1997, the Center hosted a conference that addressed the topic "The Political Order and Culture: Towards the Renewal of Civilization." Our speakers included William B. Allen, Hadley Arkes, Martha Bayles, Dinesh D'Sousa, Joyce Little, Elizabeth Fox-Genovese, Robert George, Charles Kesler, Hilton Kramer, Ralph McInerny, Claes Ryn, and Stephen Tonsor III. ▲

On May 13, the Center's Government and Political Education Series will feature a lecture by William Kristol, editor and publisher of the *Weekly Standard.* The lecture will be at the Duquesne Club in Pittsburgh. This lecture is by invitation only. ▲

On Our Mailing List?

If you would like your name to be added to the mailing list for the Alex G. McKenna Economic Education Series and the Economic Directions newsletter, please send your name and address to:

Ms. Christine M. Bender
Center for Economic and Policy Education
Saint Vincent College
300 Fraser Purchase Road
Latrobe, Pennsylvania 15650-2690



Gary M. Quinlivan and T. William Boxx's newest book, *Culture in Crisis and the Renewal of Civil Life* is now available from Rowman & Littlefield (ISBN 0-8476-8288-9). Call 1-800-462-6420 for orders. The book is an edited collection of new articles written by T. William Boxx, Linda Chavez, Midge Decter, Don E. Eberly, Heather R. Higgins, Gertrude Himmelfarb, Russell Hittinger, Glenn C. Loury, Michael Novak, Robert Royal and James Q. Wilson.

ECONOMIC DIRECTIONS

Saint Vincent College
300 Fraser Purchase Road
Latrobe, Pennsylvania 15650-2690

Non Profit Organization
U.S. Postage PAID
Latrobe, PA 15650-2690
Permit No. 110

An Equal Opportunity /
Affirmative Action Institution

Saint Vincent College subscribes to a policy of equal opportunity in accodeance with federal, state and local laws. In so doing, Saint Vincent does not discriminate against any individual on the basis of race, color, sex, religion, national origin, age, veteran status or disability in any of its programs, activities, admission or employment decisions. The Director of Personnel, Saint Vincent College, Latrobe, Pennsylvania 15650-2690 is the college officer with responsibility for overseeing the implementation of this equal opportunity policy and the affirmative action plan.

2529-10M-3/97