

Balancing Security and Opportunity:

*The Challenge
of Disability
Income Policy*

Summary & Overview
Report of the Disability Policy Panel

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

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and

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Editors

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Washington, D.C.

1996

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INSURANCE

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In accordance with procedures of the Academy, study panel reports are reviewed by a committee of the Board for completeness, accuracy, clarity and objectivity. The findings and recommendations in this report are those of the Disability Policy Panel.

The project received financial support from The Pew Charitable Trusts, The Robert Wood Johnson Foundation and corporate members of the Health Insurance Association of America that offer long-term disability insurance.

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Preface

Disability policy covers a broad and diverse set of objectives, serves a highly heterogeneous population, and often is politically controversial. It is no surprise, therefore, that America's programs for persons with disabilities are multiple, complex, and in a constant state of flux.

In this context the Disability Policy Panel's first job was simply to understand the structure and dynamics of existing programs, the size and attributes of the population with disabilities, the history that has brought us to today's juncture in disability income policy, and the rapid changes in the broader social and economic environment that influence opportunities and constraints faced by workers with disabilities in contemporary society. The Panel's interim report presented our review of this broader environment after our first year of work. That report, *The Environment of Disability Income Policy: Programs, People, History and Context*, is being reissued as a companion to the final report. Only after gaining this common understanding of the environment could the Panel begin to propose, evaluate and, finally, recommend changes that might prove to be useful, responsible and realistic.

Responding to the challenge of the task that was put before it, this has been an extremely hard-working Panel. Its diverse group of experts has met a total of 31 days between March 1993 and January 1996. Subcommittees of the Panel have held additional meetings and have engaged in countless conference

calls. We have commissioned several special studies, convened focus groups with beneficiaries and participated in a number of public fora for the discussion of disability policy issues. Our work on issues in childhood disability, led by our Committee on Childhood Disability, is contained in a companion report, *Restructuring the SSI Disability Program for Children and Adolescents*.

Our Panel has been assisted by the cooperation of various components of the Social Security Administration, the Department of Health and Human Services, the Department of the Treasury, the General Accounting Office, the Rehabilitation Services Administration and the National Institute on Disability and Rehabilitation Research, among others. This sustained effort has been structured, facilitated and informed by the extraordinary work of a talented staff at the National Academy of Social Insurance under the superb direction of Virginia Reno.

United in the view that disability policy's overarching purpose is the integration of persons with disabilities into the social, economic and political life of the nation, Panel members have not always all agreed completely on which policies, or mixes of policies, best promote that purpose. Nevertheless, this report represents a strong consensus among a Panel of scholars, administrators, analysts, practitioners and advocates who began with very different initial perspectives, but who have now

had the common experience of studying and reasoning together over many months.

Because of the breadth of the Panel's expertise and the care and deliberation that has gone into its work, I feel confident that this report will serve two purposes. First, it provides a framework for understanding the nature of work disability and for drawing meaningful distinctions to clarify the purpose of various interventions — such as health care, rehabilitation, training and accommodations — that might prevent or remedy work disability, and the purposes of cash benefits to alleviate its economic consequences for workers and their families when earnings have been lost. Second, the report

recommends reforms that should improve work outcomes for persons with disabilities while maintaining basic income security for those who cannot work. In the final analysis, the success of American disability income policy will be judged by the balance it maintains between these two goals.

It has been a great pleasure for me to serve as chair of this remarkable and dedicated group.

Jerry L. Mashaw, Chair
Disability Policy Panel
Sterling Professor of Law
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Executive Summary

In response to a request from the Chairman of the Committee on Ways and Means of the U.S. House of Representatives and the Chairman of its Subcommittee on Social Security, the National Academy of Social Insurance in March 1993 convened a Disability Policy Panel of national experts to conduct a comprehensive review of the nation's Social Security disability benefit programs. The Academy secured funding for the Panel's work from The Pew Charitable Trusts, The Robert Wood Johnson Foundation and corporate members of the Health Insurance Association of America that offer long-term disability insurance.

The Panel was charged with determining whether the design of the programs strongly encouraged Americans with disabilities to emphasize their impairments as a means to securing and maintaining disability benefits; what changes could be made to encourage persons with disabilities to use their residual work capacity; and how rehabilitation could be incorporated into the benefit programs without greatly expanding costs or weakening the right to benefits for those who cannot work.

The Panel's findings and recommendations derive from its fundamental belief that the primary goal of national disability policy should be the integration of people with disabilities into American society.

The Nature and Scope of Work Disability

The Panel drew clear distinctions between *impairments*, such as heart disease, spinal cord injury, major depression or hearing loss, and *work disability*. Work disability occurs when an impairment reduces functional capacity and, in conjunction with the person's other abilities, the demands of work and the broader environment, makes the person unable to perform the tasks of work.

Disability policies can improve work outcomes by addressing any of the factors that together produce work disability. Potential remedies include: health care to prevent or ameliorate the disabling consequences of an impairment or chronic health condition; vocational rehabilitation, education and training to develop new work skills; job accommodations to change the tasks of work; and environmental changes to reduce other barriers to employment. These potential remedies typically are organized and financed locally, by employers, insurers, and local and state governments.

Income support ameliorates one of the consequences of work disability, loss of income from earnings. Earnings replacement benefits may be paid while remedies are tried or when they are not successful. Social Security disability insurance (DI) and Supplemental Security Income (SSI) are parts of a broader system of earnings replacement benefits for work

disability that are financed largely by employers either through insurance they purchase or through self-insurance. These include workers' compensation for workers injured on the job, private short-term sickness and disability benefits, and private long-term disability benefits.

In 1994, DI spending for disabled workers and their families was \$37.7 billion. Federally-administered SSI payments for blind or disabled working-age adults were \$14.7 billion. Workers' compensation spending in 1993 included \$23.5 billion for disability benefits, \$2.0 billion for survivor benefits and \$17.4 billion for medical care. Private short-term sickness and disability benefits totalled \$14.6 billion in 1992; an additional \$4.0 billion was paid through state mandatory temporary disability insurance. Private long-term disability insurance benefits were \$3.1 billion in 1992.

Those who receive Social Security or SSI disability benefits are a subset of a much larger population who have any sort of impairment or work disability. Many in that larger population do work. About half the 30 million working-age persons with various kinds of functional limitations are employed. Further, about half the 34 million working-age adults who experience a spell of mental illness over the course of a year are employed. Indeed, about one-third of the 16.8 million persons with work disabilities are in the labor force, that is, either working or looking for work.

A smaller group, about 7.1 million working-age adults, were receiving Social Security or SSI benefits based on disability at the end of 1994. They include 4.0 million receiving DI disabled-worker benefits, nearly 0.8 million who receive Social Security as disabled widows or disabled adult children of insured workers who have died, retired or themselves become disabled, and nearly 2.4 million who receive only SSI benefits. The beneficiary population includes those with the most significant work disabilities.

The Relationships Between Disability Benefits and Work Incentives

The Panel reviewed the purposes of DI and SSI in light of its charge to determine whether disability benefit programs strongly encourage Americans with disabilities to emphasize their impairments as a means to secure benefits. It also reviewed the adequacy of the benefits, eligibility criteria and work incentive provisions.

The Panel's basic finding is that the Social Security and SSI disability benefit programs do not pose strong incentives for Americans with disabilities to seek benefits in lieu of working. Rather, the strict and frugal design of these programs makes remaining at work preferable to benefits for those who are able to work.

The purpose of DI is to protect workers against severe financial hardship when their ability to earn a living is interrupted by disabling illness or injury. As in any insurance program, applicants for benefits must show that the insured event has occurred before benefits are paid. DI uses a very strict test of work disability — inability to engage in any substantial gainful activity because of a medically determinable impairment expected to last 12 months or result in death. DI benefits are modest in relation to the worker's prior earnings. At most earnings levels, benefits amount to less than one-half of prior earnings. The average monthly benefit for disabled workers was \$682 in December 1995.

The purpose of the needs-based SSI program is to provide a basic minimum income below which no American should have to live if he or she is elderly or has a severe work disability. The SSI federal benefit rate is modest — \$470 per month for an individual in 1996 — and amounts to about 70 percent of the poverty threshold. The program uses the same strict test of disability used in the DI program.

Focus group discussions with DI and SSI beneficiaries revealed that they had left their jobs with great reluctance. They typically had remained on the job after the onset of their conditions and turned to disability benefits as a last resort when they could no

longer function at work. Many were older workers. By the time they received benefits they had experienced the loss of their health, their livelihood and their hopes for ending their work lives with a comfortable retirement.

The strict and frugal design of the DI and SSI benefit programs is evident in cross-national comparisons. Compared with disability pension systems of other industrialized countries, U.S. public spending is relatively low. Social Security and SSI disability benefits combined amounted to 0.7 percent of gross domestic product in 1991. This is less than half the share spent on disability pensions by the United Kingdom (1.9 percent), or Germany (2.0 percent), a country that is often held up as a model for emphasizing work by requiring rehabilitation before pensions and that provides quotas, tax penalties and subsidies to encourage employers to hire persons with disabilities. Sweden, a mature welfare state that promotes public employment as a last resort for workers with disabilities, spends 3.3 percent of gross domestic product for long-term disability benefits. Other industrialized countries generally have universal systems of short-term disability benefits, while the United States does not, although many employers offer some type of short-term disability benefits. If public and private short-term benefits were included, the disparity in national spending for disability benefits would undoubtedly be larger.

Financing Rehabilitation for Social Security Beneficiaries Needs a Radical New Approach

The Panel proposes a radical new approach to paying for vocational rehabilitation and return-to-work services for Social Security disability beneficiaries. The plan would enlist private sector providers in helping beneficiaries return to work without greatly expanding costs or weakening the right to benefits for those who cannot work.

The Panel's return to work proposal builds on the principles of consumer choice and empowerment, encouraging competition and innovation among

service providers, rewarding service providers for their results rather than for the cost of their inputs, and encouraging providers to have a continuing interest in their clients' long-term success in remaining employed.

Under the Panel's plan, disability beneficiaries would receive a return to work ticket, akin to a voucher, that they could use to shop among providers of rehabilitation or return-to-work services in either the public or private sector. Once a beneficiary deposits the ticket with a provider, the Social Security Administration would have an obligation to pay the provider after the beneficiary returned to work and left the benefit rolls. Providers whose clients successfully returned to work would, each year, receive in payment a fraction of the benefit savings that accrued to the Social Security trust funds because the former beneficiary is at work and not receiving benefits.

The Panel's plan differs from the traditional approach of relying on state vocational rehabilitation agencies to serve Social Security beneficiaries. It would expand the range of service providers who can be paid to assist beneficiaries to include both the private sector and public agencies, including vocational rehabilitation, mental health and developmental disability agencies.

A New Disabled Worker Tax Credit Is Designed to Encourage Work

As a way to encourage persons with disabilities to emphasize their residual work capacity, the Panel recommends a disabled worker tax credit (DWTC). The DWTC would provide a refundable federal income tax credit to workers with disabilities that rises as their work effort rises. It would gradually phase out at income levels above the poverty threshold. The credit would be paid to persons not because they are unable to work, but because they work, albeit at low wages, despite their impairments. As such, it rewards work for low earners with disabilities without increasing reliance on Social Security or SSI disability benefits that are designed primarily for persons who are unable to work.

The Panel recognizes that disability is a continuum and that Social Security and SSI beneficiaries are those who have the most significant work disabilities. A DWTC would encourage work for persons who have some residual capacity to do so. Eligibility could be based on disability findings by the Social Security Administration and state vocational rehabilitation agencies. Those eligible for the DWTC would include: DI and SSI disability beneficiaries; certain applicants denied DI or SSI benefits; and persons certified by vocational rehabilitation agencies to have impairments that are significant impediments to employment.

The DWTC is designed to encourage work among low-income persons with impairments by:

- Encouraging older workers to remain at work even though their hours of work or wage rates decline due to progressive impairments. By subsidizing low wages, it encourages older workers to delay the point at which they turn to cash benefits.
- Easing the transition from school to work for young people with developmental disabilities whose earnings capacity is doubly limited by their youth and their impairments. By subsidizing their earnings, it encourages work even part-time or at low pay that over the long run can improve young workers' human capital through on-the-job experience.
- Easing the transition off the DI and SSI benefit rolls for beneficiaries who return to work. It would compensate for part of the loss of benefits that occurs when beneficiaries work.

The Panel believes that the DWTC is superior to other approaches that seek to encourage work by expanding eligibility for DI or SSI benefits. Proposals to pay partial disability benefits or to use a less strict test of work disability for Social Security would significantly increase benefit costs. A separate wage subsidy through the DWTC is a more targeted way

to support and encourage low-income persons to work despite their impairments.

Lack of Access to Health Care Limits Employment Options

While neither DI nor SSI cash benefits pose strong incentives for Americans to seek these benefits in lieu of working, constraints on access to health care and related services can.

Many people with chronic health conditions or disabilities are at risk of very high health care costs. They often cannot gain coverage in the private insurance market, and even when they do have private coverage, it often does not cover the range of services and long-term supports that they need.

Current gaps in health care coverage for people with disabilities limit their labor market options in several ways. First, employers, despite the non-discrimination features of the Americans with Disabilities Act of 1990, may be reluctant to hire persons who are at risk of high health care costs if they would be covered under the employer's plan. Second, if persons with disabilities cannot obtain private insurance, work may not be an economically feasible option. Fear of losing Medicaid or Medicare coverage is often cited as a reason why some persons with disabilities work less than they would if secure health care coverage were available. Third, gaps in health care coverage can result in unnecessary losses in employment when uninsured people fail to get the care they need in order to treat, cure or ameliorate the disabling consequences of their conditions.

The Panel's interim report, *The Environment of Disability Income Policy: Programs, People, History and Context*, first issued in March 1994, emphasized that comprehensive health care coverage would be a major step forward for Americans with disabilities. Today universal health care is a more elusive goal than it appeared to be when those interim findings were issued. The Panel has three specific proposals that derive from its charge to improve incentives to return to work for persons who may now rely on cash benefit programs for support.

Improved Medicare Buy-In. The Panel recommends an improved Medicare buy-in for DI beneficiaries who return to work despite the continuation of their impairments.

Medicare coverage begins for DI beneficiaries 24 months after they enter the Social Security benefit rolls. If they return to work and leave the benefit rolls despite the continuation of their impairments, Medicare coverage continues for about four years. Then former DI beneficiaries have the option to purchase continued Medicare coverage. The coverage is expensive to purchase, the eligibility rules are extremely complex and few beneficiaries seem to know about it. By scaling Medicare premiums to the former beneficiary's earnings, the Panel's improved Medicare buy-in is more affordable, predictable and understandable for DI beneficiaries when they are contemplating a work attempt.

Medicaid Coverage. The Panel endorses the efforts of states to create affordable buy-ins to their Medicaid programs for persons with disabilities.

In most states, continued Medicaid coverage is available to former SSI recipients under the Section 1619 provisions of the Social Security Act. The provisions extend Medicaid to persons whose SSI benefits are totally offset because of their earnings, but who continue to have a disabling impairment. The Panel recommends that states, in revising their Medicaid programs, allocate both acute care coverage and on-going support services in ways that promote work and independence while maintaining coverage for vulnerable populations who rely on SSI benefits.

Personal Assistance Tax Credit. The Panel recommends a personal assistance tax credit to compensate working people with disabilities for part of the cost of personal assistance services they need in order to work.

Some persons with significant physical impairments require personal assistance services in order to live independently and, with those services, are able to work in the competitive labor market. Personal

assistance services, however, can be very costly. They are financed by public programs in some states, but generally only for low-income persons. As such, those who need personal assistance face a dilemma when they go to work. If they work successfully, their income may disqualify them from receiving publicly-financed services, yet they may not earn enough to pay for the services on their own. The Panel is recommending a nonrefundable tax credit under the federal income tax to compensate working people for part of the cost of personal assistance services they need and pay for in order to work.

Existing Work Incentives Need to Be Implemented Effectively

The Panel believes that the most important way to improve work incentives in the Social Security and SSI disability benefit programs is to implement them effectively. Such improvements would involve service providers who assist beneficiaries and the Social Security Administration.

After in-depth analysis of existing work incentive provisions and extensive field research on how they are being implemented, the Panel concluded that:

- Work incentive provisions are inherently complex. Efforts to simplify them by redesigning them are not promising. Therefore, beneficiaries need assistance to understand and comply with the provisions when they work.
- Some kinds of assistance can be offered by service providers who assist beneficiaries to return to work — such as those who accept the return-to-work tickets the Panel is recommending. Service providers need to recognize that part of their job is to understand the program rules and help their clients comply with them.
- Some tasks necessary to make work incentives work can only be performed by the Social Security Administration. They include prompt action on earnings reports from beneficiaries so that benefits can be adjusted as beneficiaries' circumstances change. Delays cause beneficiaries to be charged with overpayments or to be underpaid.

Both undermine a smooth transition to work. Actions to implement work incentives now have low priority. If return to work is to be a priority, Social Security Administration personnel and systems support for these functions are essential.

The Panel is proposing particular changes to make Social Security and SSI disability benefit provisions more “work friendly.” They include: updating and indexing the level of earnings that is considered to be substantial gainful activity for the purpose of determining initial and continuing eligibility for benefits; and an unlimited extended period of eligibility to provide a safety net for former DI beneficiaries to return to the rolls if their work attempt fails. In addition, the Panel majority recommends: revising the deduction of impairment-related work expenses to strengthen the financial gain from working for SSI recipients who incur significant impairment-related expenses, such as job coaches or supported employment services; changing the treatment of scholarship income for SSI recipients to enable college students to remain eligible for Medicaid and publicly-financed personal assistance services in states that use SSI Section 1619 eligibility criteria for those services; and a Social Security/SSI transition proposal, that would allow resource-eligible DI beneficiaries who work to qualify for Medicaid or other support services in those states that use SSI Section 1619 eligibility criteria for those services.

Understanding Recent Program Growth

After a period of stability in the last half of the 1980s, the DI and SSI programs grew rapidly in the early 1990s. The rapid rate of growth in new benefit awards appears to have been a temporary phenomenon tied to the economic recession of 1990-91. The DI incidence rate (new benefit awards as a percent of the eligible population) declined and flattened out after 1992. The benefit rolls continue to grow, however, because fewer people are leaving than are entering. Death and shifting to retirement benefits at age 65 are the main reasons why people leave the DI rolls. The proportion who medically recover or return to work has always been small, but is at an all-time low.

Trends in the broader environment have contributed to the growth in the rolls. They include:

- The eligible population is larger. The working-age population is growing and the baby boom is entering the 35-to-50 age range where the risk of work disability rises. In addition, more women have enough work experience to be insured for benefits. Consequently, when they become severely disabled, they qualify for DI benefits.
- The eligible population is younger. While the baby boom makes a bulge in the disability rolls in the 35-to-50 age range, the birth dearth during the Great Depression 60 years ago means relatively fewer disability beneficiaries are entering their 60s. Consequently, fewer people are leaving the DI rolls because of retirement. Although the DI population is younger, their death rate remains high. The proportion who have life-threatening conditions has not declined.
- The economic recession of 1990-91 caused a rapid, but temporary, increase in benefit applications and awards. When jobs are scarce and firms are downsizing, workers with disabilities who lose their jobs, particularly at older ages, have few prospects for regaining employment or shifting to new careers.
- Cutbacks in state general assistance programs and active referral of former recipients to the SSI program contributed to growth in applications. While most did not meet the strict test of disability, some did.
- Increased recognition and diagnosis of disabling conditions may be a factor. Depression, a common form of disabling mental illness, has increasingly been recognized and diagnosed following a public information campaign by the National Institute of Mental Health to improve its diagnosis and treatment.
- Structural changes in the labor market affect the kinds of impairments that result in work disability.

ity. The value placed on intellect, advanced education and adaptability mean fewer employment prospects for people with the double disadvantages of impairments combined with limited education and skills. Further, individuals whose social and adaptive functioning is impaired by mental disorders are particularly disadvantaged in a highly competitive job market.

Explicit changes in Social Security policy also contributed to growth in applications and awards. New medical and functional criteria to decide claims based on mental impairments were required by Congress in 1984 after retrenchment policies adopted in the early 1980s were challenged in the courts and lost public support. In addition, outreach to enroll eligible persons in the SSI program became a priority in 1989 when Congress earmarked funds for those efforts.

What Should Be Done

Many causes of the recent growth in the benefit programs lie in the broader environment. Some were temporary, such as the economic recession. Nonetheless, the Panel recommends specific policies to promote work for those who can, as well as administrative actions to ensure the continued integrity of the benefit determination process.

The Panel's Policy Proposals Promote Work.

All of the Panel's recommendations are designed to promote work and reduce reliance on cash benefit programs, both by facilitating return to work for beneficiaries and by offering alternative supports to low-income workers with impairments who do not receive benefits.

Adequate Administrative Resources Are Essential. Based on its review of the last 25 years of DI policy, the Panel concludes that attempts to administer a complex and expensive benefit program without adequate administrative resources ill serves both beneficiaries and the public fisc. In relation to the importance and size of the DI program, investment in administrative resources is very small, at 2.7 percent of DI program outgo in 1994.

Administrative resources including technology must be set at a level that ensures stable, effective management of the disability programs. Resources must be adequate to provide: (1) fair, accurate and prompt decisions on disability claims, (2) individualized service to beneficiaries that is contemplated under the law, including accurate information and prompt action to implement benefit adjustments when beneficiaries work, and (3) timely and predictable review of the continuing disability of those on the rolls.

Medical and Vocational Criteria Should Be Kept Up-to-Date.

The Panel believes that renewed emphasis should be placed on periodic updates of the medical and vocational criteria for assessing work disability. Updates are needed to ensure that past experience, new research and state-of-the-art knowledge are systematically incorporated into the programs' assessment of work disability. Categories of impairments that account for a significant portion of the disability rolls, or where rapid growth has prompted concern, are good candidates for expert review. They include the criteria for evaluating mental impairments and for assessing the role of pain in the disability determination.

Overview

In the summer of 1991, the Chairman of the Committee on Ways and Means of the U.S. House of Representatives and the Chairman of its Subcommittee on Social Security asked the National Academy of Social Insurance to undertake a comprehensive review of the Social Security disability benefit programs. In particular, the Academy was asked to explore the following questions:

- Is it correct that Americans with disabilities now confront strong incentives to emphasize their impairments as a means to securing and maintaining disability benefits?
- Can an emphasis on rehabilitation and work be incorporated into the program without greatly expanding costs or weakening the right to benefits for those who cannot work?
- Are there changes that would encourage beneficiaries to use their residual work capacity rather than emphasize their incapacity?
- How might we increase protection for the large numbers of claimants who are denied benefits but who still do not find employment?

The Academy was also encouraged to review other relevant issues and to take into account experience in

1. The report of the Committee was not voted on by the full Panel and does not necessarily reflect the views of all Panel members.

the private sector and in foreign disability income systems.

To fulfill the request, the Academy secured private funding for the study from The Pew Charitable Trusts, The Robert Wood Johnson Foundation and corporate members of the Health Insurance Association of America that offer long-term disability insurance. In March 1993, the Academy convened a Disability Policy Panel drawn from the nation's leading experts to conduct the review. The Panel issued its interim report in March 1994. That report, *The Environment of Disability Income Policy: Programs, People, History and Context*, is being reissued as a companion to the final report. Because of the congressional timetable for considering legislative changes in the Supplemental Security Income (SSI) childhood disability program, the Committee on Childhood Disability of the Panel issued a report, *Restructuring the SSI Disability Program for Children and Adolescents*, in May 1995 which is also being reissued.¹ This overview of the Panel's full report presents the Panel's perspective on disability income policy and work, it responds directly to the questions posed to the Academy, and it highlights the Panel's findings and recommendations.

THE PANEL'S PERSPECTIVE ON DISABILITY POLICY

The Panel believes that the primary purpose of national disability policy should be the integration

of people with disabilities into American society. To that end, we endorse the disability policy goals set forth in the Americans with Disabilities Act of 1990 (ADA): equality of opportunity, full participation, independent living, and economic self-sufficiency. In pursuing these goals, disability policy should provide resources to promote functioning and work for people with disabilities as well as income support for those who cannot work or whose ability to work is very limited. For some individuals with disabilities there is a need for both income and other support to enable them to return to or enter the work force.

In assessing the current state of disability policy and in proposing reforms affecting income and work, the Panel has been guided by the following findings:

First, work in the marketplace is the principal source of income and social stability in all modern societies. While income security programs are essential for those who are severely limited in their ability to work, disability policy should strive wherever possible to maintain and integrate people with disabilities into mainstream employment.

Second, "disability" is not just a characteristic of individuals. Instead, it results from the interaction between individuals who have physical or mental impairments with resulting loss of function and the broader environment; and it is a limitation in performing a social role, such as work.² *Work disability* involves the interaction among four elements:

- a person's *chronic health condition or impairment*;

2. A.M. Pope and A.R. Tarlov (eds.), *Disability in America: Toward a National Agenda for Prevention* (Washington, DC: National Academy Press, 1991).

3. U.S. Bureau of the Census, *American with Disabilities: 1991-1992, Data from the Survey of Income and Program Participation P70-33* (Washington, DC: U.S. Government Printing Office, December 1993).

4. National Institute of Mental Health, Diagnostic Interview Schedule, Epidemiological Catchment Area Project.

5. U.S. Bureau of the Census, Current Population Survey, March 1994.

6. Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin* (Washington, DC: U.S. Government Printing Office, August 1995), table 3.C6.1, p. 160.

- the *tasks* that constitute work he or she can reasonably be expected to do;
- his or her offsetting *abilities* or compounding limitations in performing those tasks; and
- the physical, social, and economic *environment* in which he or she is expected to live and work.

Disability policies may seek to improve work outcomes for persons with disabilities by addressing any or all of the factors that together produce work disability.

Third, the population of persons with any sort of impairment is large and diverse. Physical and mental impairments are widespread in the population, they are a natural part of the life process, and people with impairments have extremely varied abilities, capacities, needs and limitations. Many people with impairments and/or functional limitations do work. About half of the nearly 30 million working-age persons who have various kinds of functional limitations are employed.³ Further, about half of the 34 million working-age adults who experience a spell of mental illness over the course of a year are employed.⁴ Indeed, one-third of the 16.8 million persons with work disabilities are in the work force, that is, either employed or seeking work.⁵ Obviously, a wide range exists in the severity of disabling conditions within the population. Further, there is wide variation in the effects of the same condition on different individuals in different circumstances.

A smaller group, about 7.1 million working-age adults, were receiving Social Security or SSI benefits based on disability at the end of 1994.⁶ The beneficiary population includes those with the most significant work disabilities. They include 4.0 million who receive Social Security disabled-worker benefits, nearly 2.4 million who receive only SSI and nearly 0.8 million who receive Social Security as disabled widows or disabled adult children of insured workers who have died, retired or themselves become disabled.

Fourth, disability policy, broadly construed, should match the diversity of the population with remedies that are appropriate for different subsets of the population. Social Security and SSI typically are programs of last resort for persons with significant work disabilities. Many of the most promising remedies for increasing employment among persons with disabilities lie beyond the Social Security disability insurance (DI) and SSI benefit programs. These remedies include: access to health care and related services including wellness and prevention programs; access to appropriate rehabilitation; civil rights protections and employer accommodations; wage subsidies for low-income workers with disabilities; early intervention services, family support, special education and transition-to-work planning for children and adolescents with disabilities; and general education and training for the whole population.

Fifth, social insurance and social assistance remain critical elements of disability policy. The income security goals of Social Security and SSI are thoroughly consistent with the ADA goals the Panel has endorsed. The benefits they provide offer an essential form of economic self-sufficiency for people who have lost their capacity to earn. Virtually all industrialized countries have some type of social insurance system for this purpose and most provide social assistance for those who do not achieve a basic minimum income from either work or social insurance benefits. The challenge is to design,

administer and coordinate support for people with disabilities in ways that protect those unable to work, while both minimizing the disincentives to work inherent in any income security system and avoiding unrealistic expectations about the capacities of people to return to work without other supports.

Social Security and SSI are parts of a broader system of earnings replacement benefits for work disability that are financed largely by employers either through private insurance they purchase or through self-insurance. These include workers' compensation (WC) for workers injured on the job, short-term sickness and disability benefits, and private long-term disability benefits. In 1994, DI spending for disabled-worker benefits was \$37.7 billion.⁷ SSI payments for blind or disabled working-age adults were \$14.7 billion.⁸ Private short-term sickness and disability benefits amounted to \$14.6 billion in 1992; an additional \$4.0 billion was paid through state mandatory disability programs.⁹ Workers' compensation spending in 1993 included \$23.5 billion for disability benefits, \$2.0 billion for survivor benefits and \$17.5 billion for medical care.¹⁰ Private long-term disability insurance benefits were \$3.1 billion in 1992.¹¹

Employer costs for disability can be substantial. One study of the full cost of disability for employers in selected firms estimated costs to be about 8 percent of payroll when all costs are considered, including: direct costs such as DI contributions and other disability benefits; hidden costs associated with lost productivity and the expense of replacement workers; and disability management activities that include claims management, return-to-work programs, wellness and employee assistance plans, on-site clinics and safety programs.¹²

Sixth, it is clear that in addition to the federal role, private and non-profit sectors as well as state and local governments have crucial roles in designing and funding services to help persons with disabilities integrate themselves into society. For example, improving access to health care for working-age adults and children — whether or not they have disabilities — is a challenge that involves all levels of

7. Ibid., table 4.A6, p. 179. This figure includes \$4.0 billion for benefits for dependent children and spouses of disabled-worker beneficiaries.

8. Social Security Administration, Office of Research and Statistics. This figure includes \$13.0 billion in federal SSI benefits and \$1.7 billion in federally-administered state supplementation benefits.

9. Social Security Administration, op. cit., footnote 6, table 3.A4, p. 153. Benefits for public sector employees are included in the totals for state mandatory disability insurance. They are not included in the total for private short-term sickness and disability benefits.

10. J. Schmulowitz, "Workers' Compensation: Coverage, Benefits, and Costs, 1992-93," *Social Security Bulletin*, Summer 1995, table 1, p. 52.

11. Social Security Administration, op. cit., footnote 6, table 3.A4, p. 153.

12. M. Berkowitz, et al., *Full Costs of Disability Final Report*, September 1991, unpublished report for UNUM Corporation, Portland, ME.

government and the private sector including employers and insurers. Employers typically are the source of financing for short-term sickness benefits that may provide the best avenues for early intervention to prevent long-term disability. Rehabilitation is sometimes financed by workers' compensation systems or by employers or insurers who offer long-term disability insurance. Federal/state vocational rehabilitation agencies provide rehabilitation services to some Social Security beneficiaries, but largely serve persons unconnected to federal disability income programs. Education and training is largely the purview of local and state government, state-financed community colleges and universities. And, training in the use of new technology that usually occurs on the job is financed in large part by employers. Hence, recommendations for improving disability income policies must build on the existing roles of multiple nonfederal sectors.

Disability policy is of the utmost importance to the welfare of the community as a whole. We need the fullest possible participation of all persons in the civic, economic and social life of the country. Particularly in times of constrained resources we need to assure that the supports provided to persons with disabilities are consistent both with the nation's current ability to pay and with wise investment in its long-term social and economic well-being.

In our review of foreign experience, we find that by cross-national standards, U.S. spending on public disability benefits is relatively low. Spending on federal Social Security and SSI disability benefits combined amounted to about 0.7 percent of gross domestic product (GDP) in 1991. This is less than half the share (1.9 percent) spent by the United Kingdom, a country that also has fairly strict disability benefit systems. It is also less than half of the share spent by Germany (2.0 percent of GDP), a country that emphasizes rehabilitation before pensions and provides quotas, tax penalties and

13. L.J.M. Aarts and P.R. de Jong, "European Experiences with Disability Policy," *Disability, Work and Cash Benefits*, J.L. Mashaw, et al., (eds.) (Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, forthcoming).

subsidies to encourage employers to hire persons with disabilities. Sweden, a mature welfare state that emphasizes public employment as a last resort, spends more than four times as much (3.3 percent of GDP) on long-term disability benefits.¹³

The Panel concludes that new disability policy initiatives must strive for a balance between policies that facilitate work and those that ensure a fair and decent level of income support during periods of work incapacity. That balance currently must be found in a policy environment where new public spending is sharply constrained. The Panel's response to the four questions posed to the Academy are presented in the following sections.

INCENTIVES TO CLAIM BENEFITS IN LIEU OF WORKING

Question 1: Is it correct that Americans with disabilities now confront strong incentives to emphasize their impairments as a means of securing and maintaining disability benefits?

Any income support system presents some level of work disincentive. The challenge is to design benefit policies that cost-effectively target reasonably adequate support to those who are unable to work, while minimizing work disincentives. Our findings in response to this question are in three parts, beginning with an evaluation of the basic purposes and designs of the Social Security and SSI disability benefit programs. Our second finding relates to gaps in health care coverage that limit work choices for persons with disabilities. Our last set of findings present our analysis of the reasons for the recent growth in the Social Security and SSI disability benefit programs and what should be done about it.

The Panel's basic finding is that the Social Security and SSI disability benefit programs do not pose strong incentives for Americans with disabilities to seek benefits in lieu of working. Rather, the strict and frugal design of these programs makes remaining at work preferable to benefits for those who are able to work.

Social Security Disability Insurance

The purpose of DI is to protect workers and their families against the severe financial hardship that would otherwise occur when workers sustain severe illnesses or disabling conditions that interrupt their capacity to work. DI is part of the nation's Social Security — or old-age, survivors and disability insurance — system.

DI shares with every other insurance system the requirement that applicants for benefits must show that the insured event has occurred before benefits are paid. In the case of DI, the insured event is long-term work incapacity. Although DI is sometimes criticized for making people “prove their disability,” a requirement that work disability be shown is unavoidable and is thoroughly consistent with the fundamental purpose of insurance — which is to cushion the financial loss when the insured event occurs. Any insurance system also builds in safeguards to discourage unwarranted claims and to protect the insurance system against paying them. In this regard, Social Security disability insurance includes a number of provisions that, taken together, make remaining at work preferable to claiming benefits for those who have the capacity to do so. As such, the following features could be characterized either as incentives to remain at work or as deterrents to leaving work to claim disability benefits.

First, only those who have a record of fairly steady and recent work are insured for DI benefits.¹⁴ Second, the medical and vocational test of disability for DI benefits is very stringent. Under the law,

benefits are paid only if one has a medically determinable impairment of such severity that given one's age, education and work experience, one cannot perform substantial gainful activity in any job that exists in significant numbers in the national economy, regardless of whether or not the claimant would be hired for such a job. Benefits are payable only if that impairment is expected to last at least 12 months or result in prior death.

Third, there is a five-month waiting period after the onset of disability before DI benefits are paid. And, health care coverage through Medicare begins only after an additional 24-month waiting period after benefits begin. Both of these waiting periods provide incentives for persons to remain at work, if possible.

Finally, the level of DI benefits is modest in relation to a worker's prior earnings from work. The average monthly benefit for disabled-worker beneficiaries was \$682 in December 1995.¹⁵ In December 1994, those receiving as much as \$1,000 a month accounted for 14 percent of beneficiaries, while 30 percent received less than \$500 a month.¹⁶ Hence, remaining at one's job is more financially rewarding than receiving benefits. DI benefits replace a worker's prior earnings under a sliding scale that provides higher levels of earnings replacement for low earners than for higher earners. This recognizes that low earners have a smaller margin for reducing their consumption. It also recognizes that higher earners have better prospects for having private insurance or pensions to supplement Social Security benefits. DI also pays supplemental benefits to dependent children or spouses of disabled-worker beneficiaries.

For workers whose earnings are average or above, DI replacement rates range from 43 percent for a person earning \$25,000 per year to about 26 percent for a person earning \$60,000 (table 1). At lower earnings levels, when benefits amount to as much as half of prior earnings, they provide a level of living that is below the poverty threshold, which is estimated to be \$661 a month for a working-age person living alone in 1995.¹⁷

14. To qualify for disabled-worker benefits, an individual must have worked in employment subject to Social Security contributions for about one-fourth of the time elapsing after age 21 and up to the year of disability. In addition, he or she must have recent covered work — equivalent to five of the preceding 10 years (or, if between ages 24 and 31, half the time since age 21, or if under age 24, half of the preceding three years).

15. Social Security Administration, *op. cit.*, footnote 6, table 5.E2, p. 233, updated by data from the Office of Research and Statistics.

16. *Ibid.*, table 5.E1, p. 233.

17. See chapter 2.

Table 1. Illustrative Social Security Disabled Worker Benefits, 1995

Prior annual earnings	Monthly benefit	
	Amount	Replacement rate (percent)
\$10,000	\$507	61
15,000	636	51
20,000	766	46
25,000	896	43
30,000	1,026	41
40,000	1,170	35
60,000	1,332	26

Source: Chapter 2, table 2-1.

The replacement rates for DI are considerably less than what would be needed to match the worker's standard of living while working. Studies generally find that replacement rates of between 70 and 80 percent are needed to match the worker's prior level of living. These studies take account of the difference in tax treatment of various sources of income and the absence of work-related expenses. The studies that have been done, however, generally presume that the Social Security beneficiary is a relatively healthy retiree.¹⁸ These studies do not take account of the additional costs of disabled workers, which include the need to support themselves without earnings during a five-month waiting period, and other disability-related expenses, including health care during the first 29 months after the onset of disability.

In brief, disability insurance from Social Security helps to avert financial disaster when workers sustain periods of long-term work incapacity. But the

18. B.A. Palmer, "Retirement Income Replacement Ratios: An Update," *Benefits Quarterly*, Second Quarter, 1994, pp. 59-75.

19. U.S. Senate, *Social Security Amendments of 1972, Report of the Committee on Finance, U.S. Senate to Accompany H.R. 1*, S. Rpt. No. 92-1230 (Washington, DC: U.S. Government Printing Office, September 26, 1972), p. 384.

benefits are designed to make remaining at work a more rational and economically rewarding choice for those who are able to do so.

Supplemental Security Income

The purpose of the needs-based SSI program is different from that of Social Security disability insurance. SSI is intended to provide a basic minimum income below which no American should have to live if he or she is elderly or has a severe work disability. Although SSI, unlike DI, does not require prior covered employment that is the hallmark of social insurance, it has a number of features that make work preferable to claiming benefits for those who have the capacity to work.

SSI provisions that discourage benefit claims among those who have the capacity to work include: very modest benefits; a strict test of means that takes account of other income and financial resources; and a strict test of disability that is essentially the same as that for DI.

The SSI federal benefit rate (\$470 a month for an individual in 1996) is modest, amounting to about 70 percent of the official poverty threshold for an individual under age 65. When SSI was originally being developed, Congress intended that it would keep elderly and severely disabled individuals out of poverty.¹⁹ Financing fell short of that goal. While some states supplement federal SSI benefits, the federal benefit rate remains well below the poverty threshold.

The SSI means test reduces SSI benefits dollar for dollar for all other countable income. To build in incentives to work, a portion of the recipient's earnings from work is excluded from countable income. The SSI resource test renders an individual ineligible for benefits if he or she has financial resources in excess of \$2,000.

Finally, the SSI program uses the same strict test of medical and vocational work disability used in the DI program. For individuals to choose SSI over work at reasonably remunerative employment would often mean choosing a level of living below the

poverty threshold. Thus, the SSI benefits, themselves, are not a powerful incentive for individuals to emphasize their impairments rather than their capacities to work if they are able to earn a living wage.

Notwithstanding these basic findings, the Panel believes that there are reasonable concerns about potential work disincentives that need to be addressed. The first involves gaps in health care coverage that limit employment options for persons with disabilities. The second involves concerns about recent growth in federal disability benefit programs.

LACK OF ACCESS TO HEALTH CARE LIMITS EMPLOYMENT OPTIONS

While the Panel believes that neither DI nor SSI, in and of themselves, pose strong incentives for Americans to seek these benefits in lieu of working, constraints on access to health care and related services can.

Health care is important to all Americans. It is particularly important to people with chronic health conditions or disabilities because many are at risk of very high health care costs. They often cannot gain coverage in the private insurance market, and even when they do have private coverage, it often does not cover the range of services and long-term supports that they may need in order to live independently.

The current structure and gaps in health care coverage for people with disabilities can limit their labor market options in several ways. First, on the demand side of the labor market, employers, despite the ADA, may be reluctant to hire persons who are at risk of high health care costs if they would be covered under the employer's plan. Second, on the supply side of the labor market, if persons with disabilities cannot obtain private insurance, work may not be an economically feasible option. Fear of losing Medicaid or Medicare coverage is often cited as a reason why some persons with disabilities work

less than they would if secure health care coverage were available. Finally, gaps in health care coverage can result in unnecessary losses in employment when uninsured people fail to get the care they need in order to treat, cure or ameliorate the disabling consequences of their conditions.

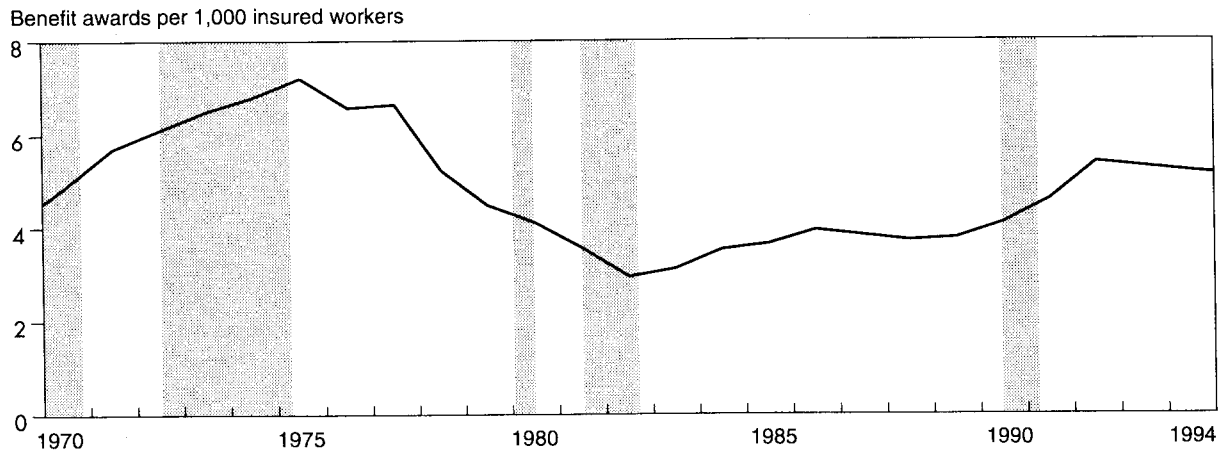
The Panel's interim report emphasized that comprehensive health care reform would be a major step forward for persons with disabilities. The Panel recognizes that today, universal health care is a more elusive goal than it appeared to be when we issued our interim findings in March 1994. The Panel has two specific recommendations for incremental reforms in Medicare and personal assistance services: an improved Medicare buy-in for former recipients of DI who return to work; and a tax credit for personal assistance services to compensate working people for part of the cost of the services they need in order to work. The Panel also endorses the efforts of states to create affordable buy-ins to their Medicaid programs for working people with disabilities.

The Panel recognizes these are piecemeal solutions to a much broader problem. Our proposals are limited in both scope and cost and derive from the Panel's charge to improve incentives to return to work for persons who may now rely on cash benefit programs for support. The broader challenge — to control the growth in health care costs and expand access to needed health care — is beyond our charge.

UNDERSTANDING RECENT GROWTH IN THE ROLLS

While the Panel believes that the designs of DI and SSI tend to discourage benefit claims, we recognize there is concern about the recent growth in the size and cost of the Social Security and SSI disability programs. Both the growth in benefit awards and the decline in benefit terminations have more complex causes than the potential work disincentive effects of cash benefits. While some of these causes lie in the broader economic and policy environment, others are amenable to policy prescriptions in the DI and SSI benefit programs.

Figure 1. DI Incidence Rates, 1970-94 (shaded areas are economic recessions)



Abbreviation: DI = Social Security disability insurance.
Source: Social Security Administration, Office of the Actuary.

Our analysis reviewed the causes of recent growth in the DI program in terms of the eligible population, the fluctuations in benefit awards, and the decline in benefit terminations. The review focuses largely on the DI program, drawing on research by others and data available from the Social Security Administration (SSA). Research and data on trends in the SSI program for working-age adults are more limited.

Growth in the Eligible Population

The number of persons who enter the benefit programs is influenced by the size of the eligible population. Those eligible for DI disabled-worker benefits are persons under age 65 who have enough covered work experience to be insured. The eligible population has grown for two reasons. First, the underlying working-age population has grown. Second, more women have enough paid employment to be insured for benefits. Consequently, they qualify for DI benefits when they become severely disabled. Had they remained housewives as many of their mothers were, their disabilities would not be recognized in federal benefit programs. Between 1988 and 1994 the insured population grew by 10 percent — 3 percent for men and 14 percent for women. This continues a longer term trend: between 1980 and 1994, the insured population

grew by 27 percent, 15 percent for men and 45 percent for women.

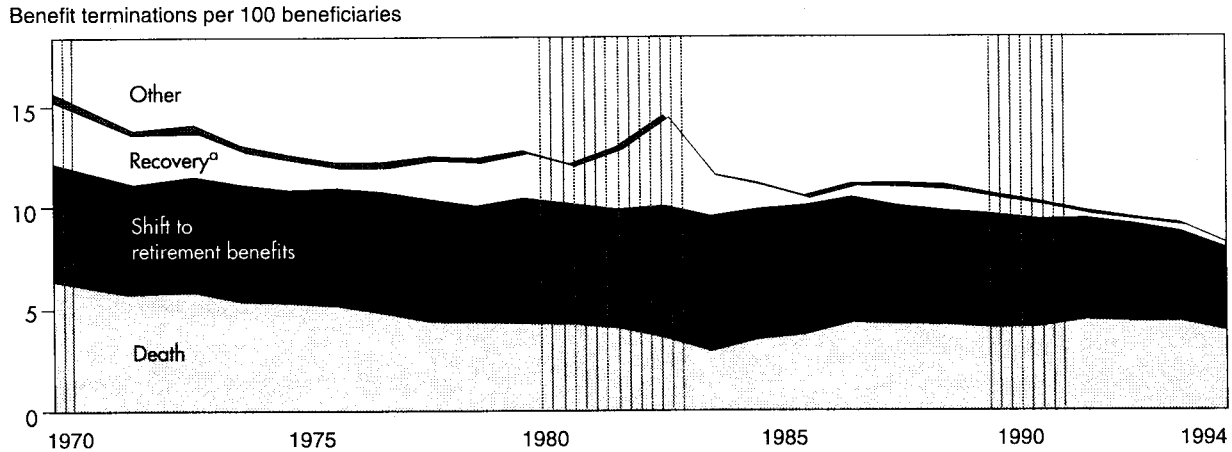
Growth in DI Benefit Awards in 1989-92

The DI incidence rate (new awards as a percent of the insured population) grew rapidly between 1989 and 1992. It then dropped in 1993 and again in 1994. While the incidence rate remains higher today than in the 1980s, it is lower than it was in the mid-1970s (figure 1).

Some of the factors that contribute to fluctuations in new benefit awards have been quantified in research studies. Others that are likely to contribute are more difficult to quantify.

First, the economic recession of 1990-91 clearly contributed to the number of benefit applications and awards, as did economic recessions during the 1970s. Economic recessions increase the likelihood that workers with serious physical or mental impairments will lose their jobs and apply for and qualify for disability benefits. This has occurred with the Social Security program, in private disability insurance and in foreign disability systems. When jobs are plentiful and employers are actively seeking qualified employees, they are much more inclined to

Figure 2. DI Termination Rates, by Cause 1970-94 (lined areas are economic recessions)



a. Includes terminations because of return to work or a finding that the beneficiary no longer has a disabling impairment.

Abbreviation: DI = Social Security disability insurance.

Sources: Social Security Administration, Office of the Actuary; and U.S. Department of Health and Human Services, *The Social Security Disability Insurance Program: An Analysis*, requested by the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds (Washington, DC: U.S. Department of Health and Human Services, December 1992), chart 2, p. 7.

accommodate workers who have impairments. When jobs are scarce and firms are downsizing, workers with disabilities who lose their jobs, particularly at older ages, have fewer prospects for regaining employment or shifting to new careers.

The early 1980s were an exception to the trend of increasing disability incidence rates during economic downturns. Retrenchment policies adopted then sought to reduce the size and cost of disability benefit programs by applying increasingly restrictive interpretations of the disability eligibility criteria both for new applicants and in the review of the continuing disability of persons on the rolls (figure 2). Disability incidence rates reached an all-time low and benefit terminations based on a finding of “no longer disabled” reached an all-time high.

20. U.S. House of Representatives, Committee on Ways and Means, *Overview of Entitlement Programs (1994 Green Book)*, WMCP: 103-27 (Washington, DC: U.S. Government Printing Office, July 1994), pp. 254-257.

21. L.S. Muller and P.M. Wheeler, “Disability Program Growth: Results From Social Security’s Survey of Field Office Managers,” unpublished paper presented at a conference sponsored by the Social Security Administration (SSA) and the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (DHHS/ASPE), Washington, DC, July 20-21, 1995.

Public support for the retrenchment eroded when its consequences became known. The policies were challenged in the courts, some states ultimately refused to implement them, and the administration placed a moratorium on benefit termination and on denial of certain categories of benefit claims until new policies were developed. Congress in 1984 enacted legislation to preclude the kinds of policies that had been adopted, challenged and halted in the early 1980s.

Second, mandated outreach activities to enroll eligible persons in the SSI program contribute to growth. During the 1980s Congress mandated a number of SSI outreach activities.²⁰ Beginning with earmarked appropriations in 1989, SSI outreach became a priority for SSA. These outreach activities were cited by SSA field office managers as a source of growth in disability applications.²¹ Some who applied for SSI were found to have enough covered work experience to qualify for DI benefits concurrently with SSI. Outreach activities contributed to growth in the early- and mid-1970s as well, with a nationwide effort to enroll eligible persons in the new SSI program that was enacted in 1972 and implemented in 1974.

Third, cutbacks in state general assistance programs, and active referral of former recipients of such benefits to the SSI program, contributed to recent growth in applications for SSI benefits in some jurisdictions.²² While most did not meet the strict test of disability, some did. Similar effects could be expected from state initiatives to cut back on Aid to Families with Dependent Children (AFDC) programs.²³ One study found a high rate of disability among families receiving AFDC.²⁴

Fourth, revised medical and functional criteria and new evidentiary requirements used to determine eligibility for Social Security disability benefits were required by Congress and the courts. The changes included new criteria for evaluating mental disorders that complied with a 1984 Congressional mandate that such applicants be evaluated with an emphasis on the individual's ability to engage in substantial gainful work in a competitive work place environment. These changes were prompted by widespread agreement that SSA's practices with respect to mental impairment claims had been overly restrictive in the late 1970s and early 1980s.²⁵

Fifth, increased recognition and diagnosis of disabling conditions, particularly mental disorders, may have contributed to growth in claims and awards in the early 1990s as well as to a change in the composition of the beneficiary population. In recent years, depression, a common form of disabling mental illness, has increasingly been recognized and diagnosed, perhaps due in part to a public information campaign launched by the National Institute of Mental Health designed to improve the diagnosis and treatment of depression. Further, depression often coexists with other physical or mental impairments. Therefore, improved diagnosis would increase the chances that depression is identified as a beneficiary's primary diagnosis. In the case of multiple impairments, the one identified as primary is likely to be the one that can be most promptly and cost-effectively documented by SSA.

Finally, structural changes in the labor market influence the kinds of impairments that result in work disability. The growing premium placed on intellect, advanced education and public relations skills can mean fewer employment prospects for people who have the double disadvantage of physical or mental impairments combined with limited human capital (education, skills, and aptitude).²⁶ Advances in assistive technology and public accommodations called for by the ADA may bring new opportunities for workers with physical impairments who have high aptitude and advanced education. The changing demands of work, however, may limit employment prospects for individuals whose social and adaptive functioning is impaired by mental disorders.

DI Benefit Terminations Have Declined

People leave the DI benefit rolls for one of four reasons: they die, they shift to retirement benefits at age 65, they medically recover, or they return to work despite the continuation of their impairments. While benefit termination rates (the number of persons who leave the benefit rolls per 100 beneficiaries) have been more stable than incidence rates, they too have fluctuated to some degree. They have declined since the mid-1980s (figure 2).

22. J. Bound, et al., "The Ending of General Assistance and SSI Disability Growth in Michigan: A Case Study," unpublished paper presented at a conference sponsored by SSA and DHHS/ASPE, Washington, DC, July 20-21, 1995, p. 9; and D.C. Stapleton, et al., "Lessons from Case Studies of Recent Program Growth in Five States," unpublished paper presented at a conference sponsored by SSA and DHHS/ASPE, Washington, DC, July 20-21, 1995, p. 16.

23. D.C. Stapleton, et al., op. cit., footnote 22, p. 17.

24. U.S. Department of Health and Human Services, "Disability Among Women on AFDC: An Issue Revisited," as reported in *Family Matters*, Fall 1993.

25. H. Goldman and A. Gattozzi, "Balance of Powers: Social Security and the Mentally Disabled," *Milbank Quarterly*, Number 66, 1988, pp. 531-551; and Disability Policy Panel, *The Environment of Disability Income Policy: Programs, People, History and Context*, J.L. Mashaw and V.P. Reno (eds.) (Washington, DC: National Academy of Social Insurance, 1996), see chapter 5.

26. One study found that men who were doubly disadvantaged by disabilities and limited human capital did not recover from the program cuts and economic recession of the early 1980s. It further concluded that the doubly disadvantaged were not likely to benefit from new mandates for job accommodations. R.V. Burkhauser, et al., "How People with Disabilities Fare When Public Policies Change," *Journal of Policy Analysis and Management*, Spring 1993.

Death and retirement have always accounted for the vast majority of DI benefit terminations. These termination rates are influenced by the underlying health and age distribution of the beneficiary population.

Terminations Because of Death Are Stable. The proportion of DI beneficiaries who die each year is high — between 4.5 and 5.0 percent. One study found that over one-quarter of DI beneficiaries (27 percent) died within five years of entering the rolls.²⁷ The annual probability of death for DI beneficiaries is much higher than in the general working-age population, where the probability of death ranges from about 0.1 per 100 insured workers at age 30 to about 1.2 per 100 at age 60. The death rate for DI beneficiaries has been quite stable, suggesting that the proportion of beneficiaries with life-threatening conditions has not changed.

Terminations For Retirement Are Down. The benefit termination rate due to retirement gradually declined since the mid-1980s. This is because a smaller proportion of DI beneficiaries are age 60 or older. Those ages 60 to 64 accounted for one-quarter of DI beneficiaries in 1994, down from one-third of beneficiaries in 1985. There are two reasons why a smaller proportion of DI beneficiaries are in their 60s. First, the underlying insured population is more concentrated at younger ages. The baby boom is entering the 35-to-50 age range, where they produce a bulge in both the work force and in work-based disability programs. At the same time, the cohort of workers entering their 60s in the 1990s is relatively small, because relatively few babies were born in the birth dearth of the Great Depression 60 years ago. The second reason why the DI beneficiary population is younger is that insured workers under age 50 are somewhat more likely than in the past to be receiving DI benefits. While the likelihood of receiving DI benefits rises sharply after the age of 55, the prevalence of benefit receipt has increased for those under age 50 since the mid-1980s.

27. See table 6-4.

Terminations For Recovery or Return to Work Have Declined. Finally, while the DI benefit termination rate due to medical recovery or return to work has always been modest, it is at an all-time low. This rate is influenced by the number and target-effectiveness of continuing disability reviews (CDRs) that SSA conducts and by the level of investment in efforts to assist beneficiaries return to work despite the continuation of their impairments.

What Should Be Done

The recent rapid rate of growth in new benefit awards appears to have been a temporary phenomenon, tied to the economic recession of 1990-91. The rate of new benefit awards declined and flattened out after 1992. Nonetheless the benefit rolls continue to grow because fewer people are leaving the rolls than are entering. Some reasons for this growth lie in the broader environment — such as shifts in the size and age composition of the population, or in broader social and economic trends. Nevertheless, policy and administrative changes should be pursued to promote return to work among beneficiaries and to ensure the continued integrity of the benefit determination process and the disability income support system as a whole.

The Panel's Policy Proposals Promote Work.

Most of the Panel's proposals are designed to promote work and therefore should increase the number of people who leave the benefit rolls for this reason. Those proposals, which are described in more detail later in this overview, include:

- Return-to-work tickets that beneficiaries can use to get the vocational services they need to return to work (chapter 6);
- A disabled worker tax credit which is designed to facilitate exit from the DI and SSI benefit programs, as well as to encourage individuals to work despite their impairments instead of turning to DI or SSI benefits (chapter 7);
- An affordable and understandable Medicare buy-in option for former DI beneficiaries who return

to work. To the extent that fear of losing Medicare coverage discourages beneficiaries from seeking work, a Medicare buy-in option that is understandable, predictable and affordable should eliminate this deterrent to work attempts (chapter 8).

- Enhanced implementation of existing work incentive provisions so that beneficiaries who seek to return to work can do so without unexpected consequences in their benefits (chapter 9).

Adequate Administrative Resources Are Essential.

A review of the last 25 years finds a common theme in the three periods that produced major concern about the disability programs: the two periods of rapid growth, in the mid-1970s and in the early 1990s, and the period of sharp retrenchment in the early 1980s. All three periods coincided with economic recessions, which place increased demands on disability benefit systems. In each case, new administrative demands were placed on the system without commensurate investment in administrative resources. In all three cases, the under-investment in administrative resources was followed by concerns that the program was out of control.

In the mid-1970s, SSA was called upon to implement the new SSI program and was not provided sufficient additional resources to do it. In the early 1990s, after agency staffing had been “downsized” by nearly 25 percent, SSA did not have the resources to respond to the growth in new claims that accompanied an economic recession. When backlogs grow and claims are not decided promptly, Congress responds to constituent concerns by urging the agency to speed up its disability decisions.

Pressure to speed up decisions in spite of inadequate administrative resources can contribute to growth in the rolls in a number of subtle and interrelated ways.²⁸

28. Disability Policy Panel, *op. cit.*, footnote 25, see chapter 5.

29. *Ibid.*

- New instructions may be issued to ease standards for documenting claims that are allowed.
- Personnel involved in quality review of disability decisions are likely to be reassigned to help process claims. Fewer allowed claims then are reviewed for accuracy.
- Greater reliance may be placed on third parties to assemble and submit claims for disability benefits. While SSA does not pay third parties, some have a financial interest in benefits being allowed.
- Personnel responsible for CDRs of those on the rolls are shifted to processing new claims.
- Personnel and systems supports for so-called “post-entitlement actions” that are essential to support beneficiaries’ attempts to work get low priority.

In the retrenchment period of the early 1980s, new policies were initiated to vigorously review the disability rolls and terminate benefits to anyone not found to meet a very restrictive interpretation of the eligibility criteria. This was done without adequate staffing or training in the new review procedures. The 1980 legislation that had required stepped up review of those on the rolls had estimated modest savings from this initiative, recognizing that investment in administrative resources in the early years would outweigh any early benefit savings. The reviews were vigorously launched, however, without the investment in staff and training. They were abandoned after they lost public support, were successfully challenged in the courts and some states refused to implement them.²⁹

Given this history, the Panel repeats the concern expressed in our interim report that attempts to administer a complex and expensive benefit program without adequate administrative resources ill serves both beneficiaries and the public fisc. In relation to the importance and size of the disability benefit program, investment in administrative resources is very modest, at 2.7 percent of DI program outgo in 1994. In particular:

Administrative resources including technology must be set at a level that ensures stable, effective management of the disability programs. Resources must be adequate to provide: (1) fair, accurate and prompt decisions on disability claims, (2) individualized service to beneficiaries that is contemplated under the law, including accurate information and prompt action to implement benefit adjustments when beneficiaries work, and (3) timely and predictable review of the continuing eligibility of those receiving disability benefits.

The Panel considered a proposal to further emphasize review of the continuing disability of those on the rolls by making benefit allowances time limited for beneficiaries with reasonable prospects for return to work. The basic reason for considering such an approach was a desire to set expectations of return to work at the time benefits are allowed. Several members of the Panel believe that such an approach is consistent with the goals of more fully integrating people with disabilities into the work force and would send a signal to both people with disabilities and to Social Security administrators that permanent disability-based transfers are a last resort. The majority of the Panel, however, believes that the financial and administrative problems with time-limited benefits make them unworkable.

Briefly stated, the objections to time-limited benefits include: (1) the very limited success to date in developing criteria at the time of benefit award that are good predictors of recovery or return to work, (2) the potential for the availability of “temporary” benefits to increase applications and awards, and (3) the use of extremely scarce administrative resources in redetermining large numbers of claims in which the prior determination of disability may be confirmed. Given these difficulties, the Panel recommends greater commitment to staffing and implementation of the existing CDR process combined with its proposal for return-to-work tickets. It believes these initiatives can produce outcomes similar to the positive expectations for time-limited benefits.

The effectiveness of a systematic CDR process is supported by historical trends in benefit terminations. Termination rates because of medical recovery or return to work were considerably higher during the 1970s than they are today. During much of that period, SSA used a medical improvement standard for review that is similar to the standard in place today. SSA has indicated its intention to resume continuing disability reviews and to develop procedures to cost-effectively target reviews on those with the best prospects for recovery. The Panel supports those efforts.

A more fundamental restructuring of disability benefits, built on the German or Swedish models, would make the transition onto long-term disability benefits a two-step process in which a period of provisional benefits and extensive rehabilitation and accommodation efforts preceded entry onto the long-term disability rolls. This approach was discussed briefly. It was not pursued in depth because it would require substantial new resources, in both new short-term benefits and in services, which are unlikely to become available.

Medical and Vocational Criteria Should Be Kept Up to Date.

The Panel believes that renewed emphasis should be placed on periodic updates of the medical and vocational criteria for assessing work disability. The Panel fully supports the use of medical criteria along with vocational criteria in the disability determination process. We did not review particular medical criteria, nor was that our job. Experts agree on the need for periodic reviews and updates of the criteria to ensure that past experience, new research and state-of-the-art knowledge are systematically incorporated into the programs’ assessment of work disability. Categories of impairments that account for a significant portion of the disability rolls, or where rapid growth has prompted concern, are good candidates for expert review. For example:

- *Mental impairments.* Standards have now been in place for 10 years. It is time to undertake a comprehensive, expert examination of the mental impairment listings in light of experience and

current thinking in the professional mental health community.

- *Pain*. As required by Congress in 1984, SSA convened a Commission on the Evaluation of Pain and a Committee on Pain and Disability of the Institute of Medicine, which reported in 1986 and 1987, respectively. Both recommended research to develop pain assessment instruments, which has now been completed.³⁰ SSA should convene an expert group to determine how to apply what has been learned to the Social Security disability determination process.

SSA has been engaged in reengineering its disability claims process. One of the premises of this redesign is a new, simplified assessment of disability. Such a fundamental realignment of the medical and functional assessment criteria would appear to require many years to develop and test before it is ready to be put into regulations as a substitute for existing criteria. In the meantime, existing criteria should be updated and those associated with rapid growth in allowances should be given high priority in order to maintain public confidence in the integrity of the program. Because the reengineering effort is ongoing and incomplete, the Panel is unable to evaluate it.

Experts on SSA's medical criteria report that there is considerable variation among the criteria used for different body systems in terms of the severity of impairments that are presumed to constitute work disability. To date no systematic research has been done to evaluate the consistency of the presumptions underlying the medical criteria for different body systems. Research of this kind should have high priority. The Panel supports investment in SSA's research program for this purpose.

30. U.S. Department of Health and Human Services, *Report of the Commission on the Evaluation of Pain*, (Washington, DC: U.S. Government Printing Office, 1986); M. Osterweis, A. Kleinman, and D. Mechanic, (eds.), *Pain and Disability: Clinical, Behavioral and Public Policy Perspectives* (Washington, DC: National Academy Press, 1987); K.S. Rucker, et al., "Final Report on All Aspects of the Pain Assessment Instruments Development Project," unpublished paper, Virginia Commonwealth University, Richmond, VA, 1994.

REHABILITATION AND CASH BENEFITS POLICY

Question 2: *Can an emphasis on rehabilitation and work be incorporated into the disability benefit programs without greatly expanding costs or weakening the right to benefits for those who cannot work?*

Yes, and the Panel has a proposal to do so.

Return-to-Work Tickets

The Panel is proposing a new approach to financing vocational rehabilitation and return-to-work services for beneficiaries. The plan would promote consumer choice and enlist private sector providers in helping beneficiaries return to work, without greatly expanding costs or weakening the right to benefits for those who cannot work.

The Panel's return-to-work (RTW) proposal builds on the principles of consumer choice and empowerment, encouraging competition and innovation among service providers, rewarding service providers for their results rather than for the cost of their inputs, and encouraging providers to have a continuing interest in their clients' long-term success in remaining employed.

Under this plan, new beneficiaries would receive an RTW ticket, akin to a voucher, that they could use to shop among providers of rehabilitation or RTW services in either the public or private sector. Once a beneficiary deposits the ticket with a provider, the Social Security Administration would have an obligation to pay the provider only after the beneficiary returns to work and leaves the benefit rolls. Providers whose clients successfully return to work would, each year, receive in payment a fraction of the benefit savings that accrue to the Social Security trust funds because the former beneficiary is at work and not receiving benefits.

The Panel recognizes that disability benefits are paid to a very impaired population, only a fraction of whom have prospects for returning to work. As long as DI continues to have very strict eligibility rules, it is reasonable to expect that only a small percentage of beneficiaries will be able to return to work, even with rehabilitation services. Nonetheless, we believe this incentive-based system of financing rehabilitation and return to work services could bring a substantial increase in the very low rate at which beneficiaries leave the benefit rolls because they have successfully returned to work.

The Panel considered several illustrative plans, including one in which RTW tickets would be given to newly-awarded DI beneficiaries (other than those expected to medically recover in the near term), and providers of RTW services would be paid 50 percent of the benefits savings that would accrue over five years after a beneficiary returned to work and left the rolls. If effective in October 1996, such a plan is estimated to save a total of \$440 million through the year 2005.³¹ The SSI savings over the same 10-year period are estimated total \$235 million.³²

Paying for Rehabilitation: Distinguishing Purposes

The Panel recognizes that there are different purposes for financing rehabilitation services. One purpose is to improve the quality of life, independent living and community integration of persons who receive services. This is the purpose of publicly-financed rehabilitation provided by the federal/state vocational rehabilitation (VR) program. It is required by law to give first priority to persons with the most significant impediments to employment.

31. Social Security Administration, Office of the Actuary, memoranda, July 21, 1995, September 25, 1995 and December 15, 1995. The savings estimate is based on the assumption that new cases of beneficiaries returning to work would gradually rise to about 6,000 by the year 2003, nearly doubling the number of beneficiaries who leave the rolls to return to work under current law. (Although the number of beneficiaries who return to work as a result of the proposal rises, the savings are somewhat reduced because the trust funds would pay for RTW in some cases for which it does not now pay.)

32. Social Security Administration, Office of the Actuary, memorandum, December 1, 1995.

Success is defined in terms of placement for 60 days in settings which include unpaid homemaking or family work, sheltered employment and competitive employment.

A different rationale is used to justify paying for rehabilitation services out of funds earmarked for cash benefit programs. While services should improve the quality of life of persons served, the unique rationale for using benefit funds to pay for rehabilitation is to reduce long-run benefit expenditures. This is the rationale used by private insurers when they decide to invest in rehabilitation services. It has long been the legislative rationale for using Social Security funds to pay for rehabilitation. The Panel's RTW proposal is based on this rationale.

Cash Benefits and Rehabilitation: Distinguishing Assessments

The Panel also recognizes that an assessment of rehabilitation potential is different from an assessment of eligibility for disability insurance benefits. This is true in both private and public cash benefit programs.

In the private sector, long-term disability insurers sometimes pay for rehabilitation services for recipients of their cash benefits. But the decision to do so is made after the determination of benefit eligibility and it is based on a different set of criteria. Insured employees have a contractual entitlement to cash benefits if they meet the eligibility criteria in the insurance contract. Employees do not have a contractual entitlement to rehabilitation services.

The decision to pay for rehabilitation services is a discretionary choice for the insurer. It is based on cost-benefit considerations analyzed on a case by case basis and takes into account the insurers' future benefit liability as well as the employee's return-to-work prospects. Preferred candidates tend to be employees who are younger, have stable medical conditions, are well-educated white collar employees and who are highly motivated to return to work. Insurers often use rehabilitation professionals to screen and select candidates for rehabilitation and to develop service plans.

The Panel's proposal for linking Social Security beneficiaries with rehabilitation services also provides for an assessment of rehabilitation potential that is distinct from the determination of benefit eligibility and, as in the private sector, is made after a finding of benefit eligibility. The Panel recognizes that SSA does not have the personnel or expertise to make case by case assessments of rehabilitation potential and it is not likely to get the additional resources necessary to do so. Consequently, the Panel's proposal enlists the expertise of service providers to identify candidates for return-to-work services. Providers would be paid based on their success in assisting those beneficiaries to return to work.

Early Intervention: Getting Rehabilitation First

It is an article of faith in the rehabilitation community that early intervention after the onset of illness or injury is the best time to offer rehabilitation services. In an ideal world, rehabilitation services would be offered *first*, before an application is made for long-term disability benefits. This is done in some foreign countries that have national systems of short-term disability benefits that are coordinated with long-term disability benefits. In Germany, for example, employers pay an ill or disabled worker full salary for the first 6 weeks of absence from work, after which sickness funds pay for up to 18 months of temporary disability, during which publicly-financed rehabilitation services are provided before a determination of long-term disability is made.³³

33. L.J.M. Aarts and P.R. de Jong, *op. cit.*, footnote 13.

34. Disability Policy Panel, *op. cit.*, footnote 25, p. 47.

35. A plan for national short-term sickness and disability benefits was developed in 1974 for the Department of Health, Education and Welfare. L.J. Haber, "Sickness and Injury Cash Benefits (SICB): Recommendations for a Temporary Incapacity Program," unpublished paper prepared for the Assistant Secretary of Planning and Evaluation, Department of Health, Education and Welfare, June 1994. At that time, it was estimated to cost about 1 percent of Social Security covered wages. The Panel did not update the plan. Rough estimates indicated the cost, as a percent of Social Security covered wages, would be no less today.

36. U.S. Department of Education, Rehabilitation Services Administration. Those "successfully rehabilitated" were placed for 60 days in the chosen outcome. Beneficiary status is from Rehabilitation Services Administration data.

The Panel considered a plan for universal short-term disability benefits in the United States. The purpose of such a plan would be to fill gaps in short-term disability income protection; to promote early intervention through a case management system to link employees with rehabilitation and RTW services; and to reduce reliance on long-term disability benefits from Social Security. Many consider the lack of short-term disability benefits to be a major gap in beneficiary protection and to inhibit early intervention to prevent long-term disability. Fully 30 percent of private sector employees have no formal sick leave or short-term disability insurance. Another 26 percent have only sick leave, which typically provides wage replacement for a few days or weeks, far less than the duration needed to cover the five-month waiting period for DI.³⁴

The main drawback of such a plan is its cost. If financed equally by employees and employers, short-term disability protection has been estimated to cost roughly 1 percent of earnings that are subject to Social Security taxes (0.5 percent each for employees and employers).³⁵ Given today's very tight constraints on public budgets and lack of interest in new employer mandates, the Panel concluded such a proposal is not feasible. Further, if the United States were to expand social protection for American workers, in the Panel's view, comprehensive health care coverage should be the first priority.

If rehabilitation is to be provided *before* a determination of eligibility for DI or SSI benefits, the federal/state VR program is the main source of public financing for such services. Its availability is not limited to Social Security beneficiaries and most people it successfully serves are not beneficiaries. In FY 1992, Social Security or SSI beneficiaries accounted for about 20 percent of all those considered successfully rehabilitated. They included 15 percent of those placed in competitive employment; 70 percent of those placed in sheltered employment; and 40 percent of those placed in unpaid homemaking or family work.³⁶

Whether the state VR program has the capacity to serve a much larger number of DI and SSI applicants is an open question. If state VR agencies are willing and able to serve a larger share of applicants before cash benefit claims are decided, SSA and state agencies could promote early intervention by setting up administrative arrangements to more actively promote VR services sooner by:

- Training local Social Security staff to actively inform benefit applicants about state VR agencies in their area, what those agencies offer and where and how to apply for such services. The main impediment to this approach appears to be a limitation on SSA field office staff; and
- Locating VR counselors in or near local Social Security offices to seek out benefit applicants, as was tested with reported success in SSA's Project NetWork demonstration in Virginia and New Hampshire.³⁷

Encouraging Work Among Beneficiaries

Question 3: *Are there changes that would encourage beneficiaries to use their residual work capacity?*

Yes. The Panel recommends several initiatives to facilitate remaining at work or going to work among persons with disabilities, including a wage subsidy, better access to health care coverage and personal assistance services, and improvements in the implementation of work incentives.

A Wage Subsidy for Low-Income Workers with Disabilities

The Panel recommends a disabled worker tax credit (DWTC) that would be separate from disability benefit programs. The wage subsidy would be paid to low-income persons not be-

cause they are unable to work, but because they work despite their impairments.

As a way to encourage and subsidize work among low-income workers with disabilities, the Panel is proposing a wage subsidy that is separate from the DI and SSI programs. It is proposing a DWTC that would be paid to persons not because they are unable to work, but because they work, albeit at low wages, despite their impairments. As such, it rewards work for low earners with disabilities without increasing reliance on disability benefit programs that are designed primarily for persons who are unable to work.

The Panel recognizes that disability is a continuum and that Social Security and SSI beneficiaries are those who have the most significant work disabilities. A DWTC would encourage work for persons who have some residual capacity to do so. Eligibility could be based on disability findings by SSA and state VR agencies. In the illustrative plan developed by the Panel, those eligible for the DWTC would include: DI and SSI disability beneficiaries; certain applicants denied DI or SSI benefits;³⁸ and persons certified by VR agencies to have impairments that are significant impediments to employment. Thus the DWTC would be available to low-income workers with significant disabilities who work and do not receive DI or SSI benefits. As such it is designed to:

- Encourage older workers to remain at work even though they experience a decline in hours of work or wage rates due to progressive impairments. By subsidizing low wages, it encourages older workers to delay the point at which they turn to cash benefits.
- Ease the transition from school to work for young people with developmental disabilities whose earnings capacity is doubly limited by their youth and their impairments. By subsidizing their earnings, it encourages even part-time or low-paid work that over the long run can improve young workers' human capital through on-the-job experience.

37. Social Security Administration, Office of Disability.

38. In the Panel's illustrative proposal, the DWTC would be available to applicants denied at the last step of the Social Security determination process. They are individuals who have severe impairments and are found unable to do their past work, but are considered able to do other work.

- Ease the transition off the DI and SSI benefit rolls for those who return to work. The wage subsidy would compensate for some of the loss of benefits that occurs when beneficiaries return to work.

The exact parameters for a DWTC will determine its cost and impact. The illustrative proposal the Panel developed would provide a refundable credit to low-income persons with disabilities who work, including those who do not receive DI or SSI benefits. Under the proposal, about 3.1 million low-income working people with disabilities are estimated to receive the credit, at a total cost of about \$3 billion in 1996. The average subsidy would be about \$1,000 per year, over any subsidy the individual might receive from the existing earned income tax credit. The credit targets low-income people who work despite their impairments. It is estimated that about 1 in 3 recipients of the DWTC would be persons with tax-unit incomes below the poverty threshold, and 3 in 4 would have incomes below twice the poverty threshold.³⁹

Access to Health Care for Persons with Disabilities Who Work

Concerns about loss of health care coverage are reported to be a major impediment to leaving the disability benefit rolls.

The Panel recommends an improved Medicare buy-in for DI beneficiaries who return to work. It also recommends that states design their Medicaid programs in ways that promote work and independence while maintaining coverage for vulnerable populations who rely on SSI benefits.

39. Estimates were prepared by Richard Burkhauser and David Wittenburg of Syracuse University. Data from the 1990 Current Population Survey were used to estimate the size of the eligible population with disabilities and the impact of different credit options upon incomes. The estimate is based on 1996 earned income tax credit (EITC) parameters established by the Omnibus Budget Reconciliation Act of 1993. At the time this report was being prepared, changes in the EITC were under consideration in Congress.

40. Health Care Financing Administration, Office of the Actuary.

Medicare Buy-In. Under current law, DI beneficiaries who leave the benefits rolls because they have returned to work despite the continuation of their impairments are eligible to purchase Medicare coverage. The eligibility criteria are complex, the coverage is expensive to purchase, beneficiaries appear not to know that this option would be available if they returned to work, and very few former beneficiaries purchase Medicare coverage. The Panel is proposing a simplified Medicare buy-in with premiums charged on a sliding scale related to the former beneficiary's earnings. If former beneficiaries paid a premium equal to 7 percent of earnings in excess of \$15,000, capped by the full amount of the premium under current law, the buy-in is estimated to cost \$230 million over FY 1996-2000.⁴⁰

Medicaid. In most states, continued Medicaid coverage is available to former SSI recipients under the Section 1619 provisions of the Social Security Act. Under these provisions, Medicaid is available to persons whose SSI benefits are totally offset because of their earnings, but who continue to have a disabling impairment. Medicaid coverage continues until the former SSI recipient's earnings are sufficient to compensate for federal SSI benefits, any state supplements, the value of Medicaid, and any publicly-financed personal assistance services.

The Panel endorses the efforts of states to create affordable buy-ins to their Medicaid programs for persons with disabilities. It recommends that states, in revising their Medicaid programs, allocate both acute care coverage and on-going support services in ways that promote work and independence while maintaining coverage for vulnerable populations who rely on SSI benefits.

Personal Assistance Tax Credit

The Panel recommends a personal assistance tax credit to compensate working people for part of the cost of personal assistance services they need in order to work.

Some persons with significant physical impairments require personal assistance services in order to live independently and, with those services, are able to

work in the competitive labor market. Personal assistance services, however, can be very costly. They are financed by public programs in some states, but generally only for low-income persons. As such, those who need personal assistance services face a dilemma when they go to work. If they work successfully, their income may disqualify them from receiving publicly-financed services, yet they may not earn enough to pay for the services on their own. The Panel is recommending a tax credit to compensate working people for part of the cost of personal assistance services they need and pay for in order to work.

The credit would be available to persons who have a medically determinable impairment that is expected to last at least 12 months and who need personal assistance in order to engage in substantial gainful activity. The credit would be equal to one-half of personal assistance services expenses up to \$15,000 (for a maximum credit of \$7,500) and would phase out for persons with annual income between \$50,000 and \$70,000. The 5-year cost is estimated to total \$537 million for FY 1996-2000.⁴¹

Administering DI and SSI Work Incentives

The Panel believes that the most important enhancement needed in existing work incentives in DI and SSI is to improve the way in which they are implemented. Such improvements would involve both service providers who assist beneficiaries and SSA.

After in-depth analysis of existing work incentive provisions and extensive field research on how they are being implemented, the Panel has concluded that:

- Work incentive provisions are inherently complex. Efforts to simplify them by redesigning them are not particularly promising. Therefore, beneficiaries are likely to need assistance with understanding and complying with the work

incentives when they work. This is particularly true for SSI recipients because their benefits are subject to a monthly means test, where changes in other income or assets affect their benefit amounts.

- Some kinds of assistance could be offered by service providers who assist beneficiaries in returning to work — such as those who accept the RTW tickets the Panel is recommending, or state VR counselors, state or local mental health or developmental disabilities agencies, independent living centers, job coaches, providers of supported employment services or those who work with recipients of private disability benefits. Such service providers would, themselves, need to understand the rules and reporting requirements of the work incentive provisions and consider it part of their job to assist their clients in complying with them.
- Some tasks necessary to make work incentives work can only be performed by SSA or an entity employed by SSA. These tasks include prompt processing of earnings and other reports from beneficiaries so that benefits can be adjusted promptly as their circumstances change. If return to work is to be a priority, SSA personnel and systems support for these functions are essential.

Additional Work Incentive Proposals

The Panel is proposing several changes in DI and SSI to make them more “work friendly.”

Updating and indexing the level of earnings that is considered to be substantial gainful activity (SGA) would keep it current with economy-wide wages, as is done for other earnings-based parameters of the Social Security program. The concept of SGA is used in determining initial and continuing eligibility for disability benefits. The SGA threshold is set by regulation at earnings of more than \$500 per month. It has not been raised since 1990. The proposal would raise the SGA threshold to what it would have been if it had kept pace with growth in economy-wide wages since the beginning of the DI

41. U.S. Department of the Treasury, Office of Tax Analysis.

program — about \$720 per month in 1996 — and would adjust it to keep pace with future wage growth. The change is estimated to increase DI expenditures by \$700 million over 5 years (FY 1996-2000), and to increase SSI expenditures by \$265 million over 5 years (FY 1997-2001).⁴² It is projected to increase Medicare costs by \$70 million over 5 years (FY 1996-2000) and to increase federal Medicaid costs by \$1.2 billion over 5 years (FY 1997-2001).⁴³

An unlimited extended period of eligibility would provide a “safe period” for former DI beneficiaries who work despite their impairments to return to the rolls if their work attempt fails. It particularly targets individuals with episodic mental or physical conditions who are able to work during “good spells,” but need an earnings replacement benefit during “bad spells” of their conditions. (The extended period of eligibility under current law is 36 months.) The DI cost is estimated at \$1.0 billion over 5 years (FY 1996-2000).⁴⁴

In addition, the majority of the Panel supports the following changes.

Revising the deduction of impairment-related work expenses for SSI recipients would strengthen work incentives and the financial gain from working for SSI recipients who incur significant impairment-related expenses, such as job coaches, supported employment services, or other goods and services

needed to accommodate their impairments so they can work.⁴⁵ The SSI cost of this change is estimated to be \$26.1 million over 5 years (FY 1996-2000).⁴⁶

Changing the treatment of scholarships for SSI purposes, such that any portion not already excluded from countable income would be treated as earned, rather than unearned, income, would enable college students to remain eligible for Medicaid and publicly-financed personal assistance services in states that use SSI Section 1619 eligibility criteria for those services. The cost of this proposal is estimated to be negligible.⁴⁷

A Social Security-SSI transition proposal would enable resource-eligible Social Security disability beneficiaries who work to qualify for Medicaid or other support services in those states that use SSI Section 1619 eligibility criteria for those services.⁴⁸ This proposal is estimated to increase SSI expenditures by \$25 million per year by 2005 and to increase federal Medicaid spending by \$235 million over 5 years (FY 1997-2001).⁴⁹

Proposals Not Recommended

The Panel considered a variety of proposals that would increase employment among beneficiaries by using a less strict test of eligibility for benefits. We are not recommending them because of their cost. Further, we believe that our recommendation for a DWTC — a wage subsidy for low-income workers with disabilities — is a more target effective and equitable way to encourage work for low-income persons whose impairments limit, but do not preclude, work.

Proposals that on their face sound appealing because they would increase the “work friendliness” of disability benefit programs by expanding eligibility for benefits are discussed in chapter 4 and include:

- Paying benefits based on impairment irrespective of its impact on ability to work, as is done in the Veterans’ Compensation program, which pays veterans for impairments ranging from 10% to 100%.

42. Social Security Administration, Office of the Actuary, memoranda, January 25, 1995 and December 7, 1995.

43. Health Care Financing Administration, Office of the Actuary.

44. Social Security Administration, Office of the Actuary, memorandum, June 15, 1994.

45. The proposal would change the order in which impairment-related work expenses are deducted from earnings so that they are excluded after, not before, the exclusion of half of earned income under the SSI earned income exclusion.

46. Social Security Administration, Office of the Actuary, memorandum, June 19, 1995.

47. Social Security Administration, Office of the Actuary, memorandum, June 16, 1995.

48. SSI Modernization Project, *Final Report of the Experts* (Baltimore, MD: Social Security Administration, August 1992), p. 103.

49. Social Security Administration, Office of the Actuary, memorandum, December 7, 1995; and Health Care Financing Administration, Office of the Actuary.

The obvious appeal of such an approach is that benefits are not affected by the recipient's work effort. But, to pay benefits to working-age persons with impairments comparable to a 50% or higher rating on the scale used for Veterans' Compensation could mean paying benefits to a population roughly twice the size of the current disability beneficiary population. Furthermore, the rationale for Veterans' Compensation is based on the government's liability, as employer, to compensate veterans (or their survivors) for harm sustained or lives lost while in military service in the government's employ. That rationale does not extend to income support for all members of society.

- Paying benefits based on an occupational test of disability.

Many long-term disability insurance contracts use an occupational test — inability to perform one's own occupation — which pays benefits to those who are unable to do the kind of work they have done before. This approach could be viewed as more "work friendly" because it would allow benefits to individuals who are able to do other work. The increased cost of an occupational disability program would depend on the specifics of its design, but the increases are likely to be substantial. One proposal for using an occupational test in Social Security was estimated to increase the cost of the DI program by about \$20 billion per year (in 1994 dollars) after 10 years.

- Paying partial benefits for partial loss of earnings capacity as is done in some foreign disability systems.

The obvious appeal of such systems is that they recognize that work disability is a continuum. Some individuals sustain reduced earnings capacity, but nonetheless are able to work fewer

hours or at reduced wage rates. The benefits help to compensate for partial disability. Foreign systems that pay partial disability benefits, such as in Sweden or The Netherlands, spend several times more on disability benefits as a share of GDP than does the United States on DI and SSI benefits. Further, payments for permanent partial disability in workers' compensation systems in the United States have been found to be the most contentious and costly part of cash compensation payments.

- Providing a partial benefit offset for DI beneficiaries, as is currently provided to SSI beneficiaries, by reducing DI benefits by \$1 for each \$2 of earnings as beneficiaries return to work.

As discussed in chapter 9, the appeal of this approach is that by easing the transition off the DI benefit rolls, it could encourage more DI beneficiaries to return to work. Such a proposal, however, would also result in many more people receiving benefits. Benefit savings from more beneficiaries returning to work would be more than offset by increased benefit payments where none would now be paid. The net cost over a 5-year period is estimated to be \$5.1 billion. Furthermore, such a proposal would pay partial DI benefits to some individuals who have quite high incomes from work.

In brief, the Panel recognizes that the current DI and SSI programs employ a very strict test of work disability. Easing the strictness of the test would result in more people receiving benefits. As such it would increase the size and cost of disability benefit programs. We believe our proposal for a tax credit that is a wage subsidy for low-income workers with disabilities is a more effective and equitable way to encourage work when impairments limit, but do not preclude, work.

THE POSITION OF DENIED APPLICANTS

Question 4: *How might we improve protection for the large numbers of claimants who are denied benefits but still do not find work?*

The problem of income support for those who are denied benefits but do not find work is a particularly challenging one in the United States. The difficulty is not a shortage of models to choose from, but of the willingness to implement and pay for them.

Most other industrialized countries have much more comprehensive protections for those with partial disabilities who cannot find work. They include universal health care coverage, universal short-term sickness benefits, extended unemployment benefits, family allowances, public employment programs, subsidies for employer accommodations and more widespread general assistance for the poor.

Applicants who are denied benefits at the last step of the Social Security determination process would be eligible for the Panel's DWTC. They are individuals who have severe impairments and are found unable

to do their past work, but are considered able to do other work. If they succeed in gaining employment, they would be eligible for the DWTC.

If SGA is indexed as proposed, then some persons with very limited earning ability would no longer be denied benefits. And if states create affordable buy-ins to their Medicaid programs for working people with disabilities, as endorsed by the Panel, this could be of significant assistance to denied claimants. Further, the federal/state VR program remains available to provide publicly-financed rehabilitation services to individuals who do not receive Social Security benefits, including denied applicants. In general, however, the Panel's recommendations are directed at promoting work opportunities for existing beneficiaries or for nonbeneficiaries who are able to work some despite their impairments. The federal Social Security disability insurance program rightly targets earnings-replacement support to persons with very severe work disabilities. Broader social and economic policies for job creation, job training, employment assistance and generalized income support for those disadvantaged in the labor market remain critically important. These remedies lie beyond the scope of disability income policy.

Disability Policy Panel Biographies

Jerry L. Mashaw, Chair, is Sterling Professor of Law at Yale Law School and a Professor at the Institute of Social Policy Studies at Yale University. He is a leading scholar in administrative law and has written widely on social insurance and social welfare issues, including disability policy. His works related to disability policy include: *Social Security Hearings and Appeals* (1978); *Bureaucratic Justice: Managing Social Security Disability Claims* (1983); *Social Security: Beyond the Rhetoric of Crisis* (1988); and *America's Misunderstood Welfare State* (1990). He received his LL.B. from Tulane University and his Ph.D. in European governmental studies from the University of Edinburgh.

Monroe Berkowitz is Professor of Economics, Emeritus at Rutgers University and Director of Disability and Health Economics in the Bureau of Economic Research. He is also the Director of Research at Rehabilitation International. He is a leading authority on the economics of disability and rehabilitation in both public programs (Social Security disability insurance and workers' compensation), private disability insurance and public and private rehabilitation systems. Professor Berkowitz has also conducted extensive comparative analyses of foreign systems. His publications include: *Disability and the Labor Market* (1986), winner of the Book of the Year Award from the President's Committee on the Employment of People with Disabilities; and *Measuring the Efficiency of Public Programs*, (1988). He received his Ph.D. in economics from Columbia University.

Richard V. Burkhauser is a Professor of Economics and Associate Director for the Aging Studies Program at the Center for Policy Research, part of the Maxwell School of Citizenship and Public Affairs, at Syracuse University. He has published widely on social insurance issues, particularly in disability policy. He has also conducted several comparative analyses of foreign systems. His works include: *Disability and Work: The Economics of American Policy* (1982); *Public Policy Toward Disabled Workers: A Cross-National Analysis of Economic Impacts* (1984) and *Passing the Torch: The Influence of Economic Incentives on Work and Retirement* (1990). He received his Ph.D. in economics from the University of Chicago.

Gerben DeJong is Director of the National Rehabilitation Hospital Research Center in Washington, DC, and Professor in the Department of Family Medicine at Georgetown University's School of Medicine. He has written extensively on health, disability and income policy issues. He has experience in state income assistance programs and has conducted numerous studies on health and disability issues over the last 20 years. His works include: "Physical Disability and Public Policy" (in *Scientific American*, 1983); *Economics and Independent Living* (1985); and "America's Neglected Health Minority: Working Age Persons with Disabilities" (in *Milbank Quarterly*, 1989). In 1985, he received the Licht Award for Excellence in Scientific Writing from the American Congress of Rehabilitation Medicine. He received his Ph.D. in public policy studies from Brandeis University.

James Ellenberger is Assistant Director of the Department of Occupational Safety and Health for the AFL-CIO. He represents the federation on disability issues and workers' compensation. He co-chairs the Labor-Management Discussion Group on Workers' Compensation. He has written on a wide variety of subjects for various publications, including articles on disability policy, social insurance, health reform, and international labor and management issues. Mr. Ellenberger received his bachelor's degree from San Francisco State University and is a Certified Employee Benefit Specialist.

Lex Frieden is Senior Vice President of the Institute for Rehabilitation and Research and Professor of Physical Medicine and Rehabilitation at Baylor College of Medicine in Houston. He also currently serves as Vice President for North America for Rehabilitation International. From 1989-1993, he served as Chair of the Advisory Board for the National Center for Medical Rehabilitation Research at the National Institutes of Health. As Executive Director of the National Council on Disability from 1984-1988, Mr. Frieden was instrumental in developing the analyses and advocacy leading to the Americans with Disabilities Act of 1990. Working in the independent living movement for people with severe disabilities since the early 1970s, Mr. Frieden has published several books and papers on independent living. He has received two Presidential Citations for his work in the field of disability. Mr. Frieden received his M.A. in social psychology from the University of Houston.

Howard Goldman, M.D. is a Professor of Psychiatry at the Institute of Psychiatry and Human Behavior at the University of Maryland School of Medicine. He has extensive research publications on issues in public health, mental illness, and disability policy. He served on the American Psychiatric Association Work Group on the Diagnostic and Statistical Manual (DSM) IV (1988-93), the President's Task Force on Health Care Reform (1993), and the Social Security Administration's expert panel to update the mental impairment listings (1985). Among his many publications are: *Long-term Care for the Chronically Mentally Ill*

(1983); "Cycles of Institutional Reform" in *Mental Illness and Social Policy* (1984); and *Inching Forward: A Report on Progress Made in Federal Mental Health Policy in the 1980's* (1992). He received his M.D. from Harvard University and his Ph.D. in social welfare research from Brandeis University.

Arthur E. Hess is a consultant in public administration, health care, and social policy. He has led a distinguished career in public service in the Social Security Administration, where he served as the Acting Commissioner of Social Security (1973-74) and the Deputy Commissioner of Social Security beginning in 1967. Mr. Hess was also the first Director of Health Insurance (Medicare, 1965-1967). As the first Director of Disability Insurance (1954-65), he developed the administrative structure for linking federal Social Security offices with state agencies for making disability determinations. He has consulted widely and received numerous citations for distinguished service, including a President's Award for Distinguished Federal Civilian Service. Mr. Hess received his A.B. from Princeton University and his LL.B. from the University of Maryland.

Thomas C. Joe is a social policy analyst focusing on the organization and delivery of human services, social insurance programs and income maintenance. He is the founder and Director of the Center for the Study of Social Policy. Mr. Joe served on the first National Council for the Handicapped in 1982, was instrumental in developing the nation's SSI program and helped two administrations draft welfare reform plans for families in poverty. He served as Special Assistant to the Undersecretary of the Department of Health, Education and Welfare, and subsequently served as consultant to the White House Domestic Policy Council. Mr. Joe received his M.A. in political science from the University of California, Berkeley.

Mitchell P. LaPlante is Associate Adjunct Professor in the Department of Social and Behavioral Sciences, Institute for Health and Aging at the University of California, San Francisco. He is also Director of the National Disability Statistics Rehabilitation

Research and Training Center. He has written extensively on conceptual and definitional issues in disability, the demography and epidemiology of disability, and disability policy. Among his publications are: *Data on Disability from the National Health Interview Survey, 1983-85* (1988); contributor in *Disability in America: Toward A National Agenda for Prevention* (1991); "The Demographics of Disability" (in *Milbank Quarterly*, 1991); and *Disability in the United States: Prevalence and Causes, 1992* (1996). Professor LaPlante received his Ph.D. in sociology from Stanford University.

Douglas A. Martin is Special Assistant to the Chancellor at the University of California, Los Angeles, and as one of the original national pioneers of the independent living movement, co-founded the Westside Center for Independent Living in Los Angeles. His extensive knowledge of the Americans with Disabilities Act and the work incentive provisions of the Social Security disability insurance and Supplemental Security Income programs distinguish him as a leading scholar in disability studies. He is a founding member of the Society for Disability Studies and helped develop the research agenda for the National Institute on Disability and Rehabilitation Research, under the U.S. Department of Education. He was instrumental in the creation of a host of Social Security work incentive amendments including the SSI Section 1619 legislation. Mr. Martin received Ph.D. in urban studies from the University of California, Los Angeles.

David Mechanic is Director of the Institute for Health, Health Care Policy, and Aging Research and the René Dubos Professor of Behavioral Sciences at Rutgers University. He is also the Director of the NIMH Center for the Organization and Financing of Care for the Seriously Mentally Ill. As a recognized expert in mental health issues, he served as Coordinator of the Panel on Problems, Scope and Boundaries for the President's Commission on Mental Health and as vice chair of the Institute of Medicine's Committee for Pain, Disability, and Chronic Illness Behavior. Among the books he has written are: *Future Issues in Health Care: Social Policy*

and the Rationing of Medical Services (1979); *From Advocacy to Allocation: The Evolving American Health Care System* (1986); *Mental Health and Social Policy* (3rd Edition, 1989); and *Inescapable Decisions: The Imperatives of Health Reform* (1994). Professor Mechanic received his Ph.D. in sociology from Stanford University.

Patricia M. Owens is President of Integrated Disability Management at UNUM America. She is responsible for developing new linkages of disability, health and workers' compensation programs and for overseeing research on disability issues at UNUM, and she coordinates an ongoing study of the full employer-related costs of disability to identify better risk sharing and risk management solutions. She has consulted with numerous employers assisting in compliance with the Americans with Disabilities Act and improved management of psychiatric disabilities. She served as Associate Commissioner for Disability of the Social Security Administration (1982-86), and was awarded the Health and Human Services Distinguished Leadership Award and a Social Security Commissioner's Public Service Citation for management of the disability program. Ms. Owens received her M.P.A. from the University of Missouri.

James Perrin, M.D. is Associate Professor of Pediatrics at Harvard Medical School, and Director of Ambulatory Care Programs and General Pediatrics, Pediatric Service, at the Massachusetts General Hospital. He serves as chair of the Committee on Children with Disabilities of the American Academy of Pediatrics and served on the expert panel for the Social Security Administration to establish eligibility criteria for the SSI childhood disability program to comply with the Supreme Court decision in *Sullivan v. Zebley*. He also served on the congressionally mandated National Commission on Childhood Disability (1995). A recognized expert in the field of pediatrics and chronic conditions, Dr. Perrin has published widely on the issues of chronic illnesses and public policies affecting children and disability. Some of his works include: "Reinterpreting Disability: Changes in SSI for Children" (in *Pediatrics*,

1991); *Home and Community Care for Chronically Ill Children* (1993); and "Health Care Reform and the Special Needs of Children" (in *Pediatrics*, 1994). He received his M.D. from Case Western Reserve University.

Donald L. Shumway is co-director of "Self-Determination for Persons with Developmental Disabilities," the Robert Wood Johnson Foundation Project at the Institute on Disability at the University of New Hampshire. A leading advocate for people with developmental disabilities and those with mental illness, Mr. Shumway is managing a nationwide grant-giving and technical assistance program involving health care and long-term care needs in a managed care environment. Formerly, he was Director of the Division of Mental Health and Developmental Services in New Hampshire, and was appointed by the governor to assume overall responsibility for the division's statewide system of institutions and community services for persons who have mental illnesses, developmental disabilities, or are homeless. New Hampshire became the first state to completely close its institutional levels of care and develop an integrated system of community supports. Mr. Shumway received his M.S.S. from Bryn Mawr College.

Susan S. Suter is the President of the World Institute on Disability. Ms. Suter has held several leading positions in the rehabilitation field including Commissioner of the Rehabilitation Services Administration, U.S. Department of Education (1988); Director of the Illinois Department of Rehabilitation Services (1984-88); Director of the Illinois Department of Public Aid (1988-89); and Director of the Illinois Department of Children and Family Services

(1991-92). A distinguished and active expert in the disability community, she consults widely on issues involving the Americans with Disabilities Act, human resources and other employment issues. Ms. Suter received her M.A. in clinical psychology from Eastern Illinois University.

Eileen P. Sweeney is Director of Government Affairs at the Children's Defense Fund. Previously, she was a staff attorney with the National Senior Citizens Law Center, where she specialized in Social Security and SSI, and at the Legal Assistance Foundation of Chicago. She is a recognized expert in the field of administrative law, particularly the Social Security programs where she served as co-counsel on several cases. She is an effective advocate for children, the elderly, people with disabilities, and those in poverty. She also served as a member of the SSI Modernization Panel (1992), which was charged to examine the fundamental structure and purpose of the SSI program. Ms. Sweeney received her J.D. from Northwestern University.

Jerry Thomas is the President of the National Council of Disability Determination Directors. He is also the Director of Adjudicative Services for the state of Georgia. He has spent over 20 years in the state disability adjudication agency in various positions. He is a member of the Social Security Administration's Disability Redesign Advisory Council, a member of SSA's National Disability Issues Group, and has represented state disability agencies on many national panels and work-groups. He received his M.S. in political science from Florida State University. Mr. Thomas replaced Charles Jones on the Panel in July of 1994.

List of Abbreviations

ADA	Americans With Disabilities Act of 1990	RTW	return to work
AFDC	Aid to Families with Dependent Children	SGA	substantial gainful activity
CDR	continuing disability review	SSA	Social Security Administration
DI	Social Security disability insurance	SSI	Supplemental Security Income
DWTC	disabled worker tax credit	VR	vocational rehabilitation
FY	fiscal year	WC	workers' compensation
GDP	gross domestic product		

