

A Health-Conscious Safety Net? Health Problems and Program Use among Low-Income Adults with Disabilities

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Support options for many low-income adults with disabilities are limited to a few programs that will likely lead to a lifetime of benefit support.

Many low-income adults have a health problem or impairment that limits their ability to participate in social activities, including work. A health problem or impairment can also increase personal costs on medical expenditures and accommodations (e.g., wheelchair ramps). These combined factors represent an important potential barrier to social and economic mobility.

Policymakers have developed several federal and state programs and other supports to offset the costs and lost earnings associated with the onset of a disability. These programs share a general goal to provide income or in-kind assistance to offset the “costs” of a disability, but their target populations vary. As a result, a patchwork of programs and policies targets different segments of the population. For example, some programs provide benefits to offset the lost income of workers, including those injured on the job, while others provide benefits specifically targeted to low-income populations with severe permanent disabilities (e.g., means-tested benefits).

In recent years, policymakers and the disability community have increased momentum to create laws, policies, and programs that promote integrating people with disabilities into the mainstream, especially in work activities. One key factor in attaining these goals is expanding employment opportunities, as emphasized in the ratification of the Americans with Disabilities Act (ADA) in 1990. Unlike most income support programs that make eligibility determinations based on a person's inability to complete certain activities,

employment-focused policies, such as ADA, emphasize an individual's ability to participate in social activities.

This brief examines the employment and program participation patterns of low-income adults with disabilities, and how well the current safety net meets their needs. It compares low-income adults with and without disabilities across employment, program participation, and income status. These comparisons highlight some of the unique challenges faced by low-income adults with disabilities and motivate broader discussion of gaps in the safety net. Particularly striking are the possibly conflicting messages regarding work and program participation sent by existing programs and policies.

The findings question the current structure of the benefits and services safety net. A significant share of low-income adults report a limitation, and the employment rates of those with limitations are much lower than those of low-income adults without disabilities. Although a number of disability programs exist, support options for many low-income adults with disabilities are limited to a small set of programs that will likely lead to a lifetime of benefit support.

Methodology

The analysis uses data from the third round of the National Survey of America's Families (NSAF). The NSAF is a nationally representative survey of households that provides a wide range of economic, demographic, and program participation indicators for nonin-

stitutionalized adults in calendar year 2001. These data include detailed health, income, and program participation information that can examine the role of policies affecting low-income adults with disabilities.

The analysis builds off earlier work that used the second round of the NSAF to compare low-income adults with and without disabilities (Wittenburg and Favreault 2003). Low-income adults are defined as adults age 25 to 55 living in families with incomes below 200 percent of the federal poverty level (FPL). Adults with disabilities are defined as respondents who report a work limitation. No single definition of disability captures the complexity of disability across all programs, but people who report work limitations are generally considered an important subsample of all people with disabilities affected by disability policies. In past studies, researchers have used the work-limited population to examine various outcomes of people with disabilities, including employment and program participation (see Burkhauser, Houtenville, and Wittenburg [2003] for more details).

High Incidence of Disability among Low-Income Adults

Many low-income adults live with work limitations (table 1). Of the 30 million adults living in low-income families, 24 percent (7.3 million) report a work limitation. The incidence of work limitations is even larger among adults living below the federal poverty level; over 32 percent of these adults report work limitations.¹ By comparison, the prevalence of work limitations among adults living in families with incomes at or above 200 percent of FPL (“higher-income adults”) is 9.8 percent. These statistics illustrate that health and disability status must be considered when developing policies to serve low-income populations.

Low Employment Rates

Policymakers have generally sought to improve the economic status of all low-income adults by emphasizing employment opportunities. This message was especially emphasized in the 1996 welfare reform legislation, which instituted work requirements and time limits for Temporary Assistance for Needy Families (TANF) participants.

With the passage of the ADA in 1990, which prohibits job-related discrimination against people with disabilities and requires employers to provide reasonable accommodations, policymakers recognized the fundamental importance of work for people with disabilities. Since the ADA was passed, policymakers have developed several other policies to further promote employment opportunities for this population. For example, the New Freedom Initiative of 2001 provides funding for various services, such as assistive technologies, to improve access to employment and educational opportunities for people with disabilities (see The White House [2001] for more details).

Despite these policies, employment rates of low-income adults with work limitations are significantly lower than those of other low-income adults (table 2). Low-income adults with work limitations are about half as likely to have worked during the past year as those without work limitations (39 versus 76 percent). The differential across those with and without limitations living in families with incomes below the poverty level is even larger (28 versus 64 percent), suggesting that employment opportunities are especially scarce for many of the lowest income adults with disabilities.²

These findings are generally consistent with those from earlier studies and illustrate low-income adults with disabilities are having difficulty in the workplace (Wittenburg and Favreault 2003). In part, the lower relative employment rates likely represent the

TABLE 1. Prevalence of Work Limitations among Adults, by Income Level

	Low-Income Adults		Higher-Income Adults
	Income below 200% of FPL	Income below 100% of FPL	
Population (weighted—millions)	30.0	11.7	96.2
Percent with a work limitation ^a	24.2	32.4	9.8

Source: Author’s calculations.

Notes: Adults are age 25–55. Low-income adults are those with family incomes below 200% of the federal poverty level (FPL). Higher-income adults are those with family incomes at or above 200% of FPL.

a. Respondents who said they had a physical, mental, or other health condition that limits the kind or amount of work they can do.

TABLE 2. *Employment and Program Participation Rates for Low-Income Adults, by Work Limitation and Income Status*

	Income below 200% of FPL		Income below 100% of FPL	
	With work limitations	Without work limitations	With work limitations	Without work limitations
Employment (%)				
Employed in the previous year	39.3	76.2	28.3	63.5
Any cash transfer program^a (%)	51.5	13.4	52.2	15.8
Any SSA disability program	34.3	1.8	36.5	3.6
Supplemental Security Income (SSI)	19.8	1.1	23.2	2.3
Disability Insurance (DI)	19.9	0.9	19.1	1.5
Any other disability-related cash program	9.1	1.6	5.0	0.9
Workers Compensation (WC)	5.4	0.7	3.4	0.4
Veterans Benefits (VB)	2.0	0.5	1.1	0.4
Private Disability Insurance (PDI)	1.9	0.4	0.6	0.1
Any non-disability cash transfer program	14.2	10.4	15.6	12.1
Temporary Assistance for Needy Families (TANF)	8.5	4.3	10.7	7.4
General Assistance (GA)	5.9	1.5	7.2	2.6
Unemployment Insurance (UI)	3.6	6.1	2.3	4.4
Any noncash transfer^b (%)	59.1	22.5	67.9	34.6
Medicaid	37.6	12.3	45.9	19.6
Medicare	20.0	1.1	20.4	2.0
Housing Assistance (receives assistance with rent or lives in public housing)	16.1	7.5	22.2	12.1
Food Stamps	28.0	11.9	37.1	20.9
Population (weighted—millions)	7.3	22.7	3.8	7.9

Source: Author's calculations.

Notes: Adults are age 25–55. Low-income adults are those with family incomes below 200% of the federal poverty level (FPL). Some cells may not sum exactly because respondents participate in multiple transfer programs.

a. Includes respondents who reported cash benefits from SSI, DI, WC, VB, PDI, TANF, GA, or UI.

b. Includes respondents who reported in-kind assistance from Medicare, Medicaid, Food Stamps, or Housing Assistance.

added costs of a disability that affect a person's ability to work, including diminished productivity, lost work time, and higher medical expenses. However, previous studies also note that employment rates among higher-income populations with work limitations are much higher, suggesting other factors beyond health (such as educational attainment) might influence labor market outcomes.

High Rates of Disability and Non-Disability Program Participation

Because of a generally weak attachment to the labor market, many low-income adults with disabilities must turn to government programs for cash or other in-kind support (e.g., health care). Some adults turn to programs specifically for people with disabilities, while others turn to programs for the general low-income population.

The Supplemental Security Income (SSI) and Disability Insurance (DI) pro-

grams, administered by the Social Security Administration (SSA), are the two largest cash transfer programs targeted to the general population with severe disabilities. SSI targets low-income adults with disabilities who meet certain income and asset criteria, and DI is a social insurance program designed to replace the lost wages of adults with disabilities.³ Both programs use the same strict disability eligibility determination process, which requires applicants to show a permanent inability to work to qualify for benefits. Over one-third of low-income adults with work limitations participate in SSI and/or DI (see table 2). Similar patterns exist among adults with work limitations living below the poverty level, though reported income receipt from SSI is higher among this population.

Other disability cash transfer options for low-income adults with work limitations are limited. Rates of income receipt from other disability cash transfer pro-

grams, including Workers Compensation (WC), Veteran's Benefits (VB), and private disability insurance (PDI), are generally low. In addition to the disability eligibility requirements, to qualify for these programs, a person must either be a veteran (for VB), been injured on the job and in covered employment (for WC), or have private insurance coverage from an employer or personal account (for PDI). Less than 10 percent of low-income adults with work limitations receive income from WC, VB, or PDI. An even smaller portion (5 percent) of adults living in poverty receives income from these programs. WC and PDI are major sources of benefits for many workers with disabilities, but many in the low-income population are likely ineligible for these programs because they have limited work experience or their disability occurred outside a work setting.

A sizeable percentage (14 percent) of low-income adults with work limitations participates in non-disability-related cash transfer programs, including TANF, General Assistance (GA), and Unemployment Insurance (UI). These programs target unemployed workers (UI) and different segments of the low-income population (TANF is available to low-income families with children, GA eligibility varies by state). Similar patterns exist for those living below the poverty level, though not surprisingly those living below the poverty level are more likely to report receipt of income from the means-tested programs of TANF and GA than the employment eligibility-based UI program.

In addition to cash transfer benefits, the majority (59 percent) of low-income adults with work limitations report receiving in-kind support for health care, housing, or food assistance. Over one-third of these adults have coverage under Medicaid and one-fifth have coverage through Medicare, which is especially important given that these programs cover potentially expensive medical costs. The average payments for "disabled" Medicaid enrollees were \$11,770 in 2002, significantly larger than the \$1,999 per person average for adults without disabilities (Wiener 2003). Because Medicaid coverage is generally linked to SSI participation and Medicare coverage to DI participation, SSI and DI participants represent a major portion of those covered under Medicaid and Medicare.⁴ A large portion of these adults also receives assistance from housing assistance and food stamps (16 and

28 percent, respectively), which is not surprising given that most can qualify for these programs based on their low income levels. Except for Medicare, which does not include any income eligibility requirements, participation rates in these programs are significantly higher among adults with work limitations living in poverty.

Comparing program participation rates of those with limitations with those of other low-income adults provides some context for the very high participation rates in the disability and non-disability programs. More than half of low-income adults with work limitations report receiving cash transfers from one of the programs mentioned above, compared with 13 percent of low-income adults without work limitations. Similar differences exist among adults living below the poverty level. Not surprising, the biggest differences in participation are across disability-related cash transfer (SSI and DI) and health programs (Medicaid and Medicare). Nonetheless, income receipt from non-disability cash transfer programs, especially TANF, is higher among adults with work limitations than among other adults (14 versus 10 percent).

People with health difficulties are much more likely to access services from government programs. Additionally, despite programs targeted to people with disabilities, significant portions of adults with work limitations participate in some other non-disability related program, such as TANF.

Financial Difficulties

In designing safety net policies, policymakers seek to ensure that low-income families are able to meet food, housing, and other essential expenses. Compared with those without work limitations, low-income adults with work limitations are more than twice as likely to report skipping a meal in the past 12 months because of a lack of money (29 versus 14 percent, as shown in table 3). These adults also report more difficulties making mortgage, rent, and utility payments (28 versus 16 percent), and a larger portion went without telephone service in the past year (19 versus 11 percent). Not surprising, reported difficulties are higher among those living below the poverty level, though similar differences exist across those with and without limitations.⁵ The higher incidence of these difficulties is likely related to the other costs faced by people with disabilities, such as higher medical expenses. Some people

People with health difficulties are much more likely to access services from government programs.

TABLE 3. Income Status and Reported Financial Difficulties among Low-Income Adults, by Work Limitation Status

	Income below 200% of FPL		Income below 100% of FPL	
	With work limitations	Without work limitations	With work limitations	Without work limitations
Family income status				
Ratio of total family income to poverty level	1.0	1.2	0.5	0.5
Financial difficulties in the past 12 months (%)				
Cut or skipped meals because of lack of money	28.7	13.9	33.0	18.2
Unable to pay mortgage, rent, or utility bills	28.1	15.5	32.4	19.2
Without telephone service	18.5	11.0	20.3	13.5

Source: Author’s calculations.

Notes: Adults are age 25–55. Low-income adults are those with family incomes below 200% of the federal poverty level (FPL).

with disabilities, especially single adults with no other sources of support, might have to pay for all out-of-pocket medical expenses on a limited income and therefore forgo other daily needs.

Within the population of low-income adults with work limitations, income levels and reported financial difficulties vary across employment and program status (table 4).⁶ Employed individuals less likely live in poverty than those receiving a cash transfer (37 versus 53 percent). Interestingly, poverty rates are higher among those who received a cash transfer from SSA disability programs than among those receiving transfers from all other programs (55 versus 48 percent). Despite these poverty differences, SSA disability participants are less likely than other cash transfer program participants to report difficulty making mortgage, rent, or utility payments or going without telephone service in the past year. In part, these differences likely reflect the higher take-up rate of other in-kind assistance programs among SSA disability participants. For example, other assistance programs, such as Section 8 housing, make special provisions for SSA disability participants. Relative to employed individuals, SSA disability participants are more likely to report skipping a meal (30 versus 25 percent), but less likely to report being unable to make mortgage, rent, and/or utility payments (22 versus 30 percent). The relatively high need for housing among employed individuals suggests that those not currently on SSA disability programs might be missing other important supports.

Discussion

The low employment rates and high economic hardship rates among low-income adults with disabilities imply that current policies are not meeting the needs of this population. Compared with other low-income adults, adults with disabilities are less likely to be employed and more likely to receive income from a government program. Potentially more important, low-income adults with disabilities also report more financial difficulties related to food, housing, and other expenses than those without limitations.

Reexamining these policies is even more important given that federal disability cash transfer programs have expanded in recent years, while the employment rates of people with disabilities have fallen (Burkhauser et al. 2003). This expansion in disability programs is particularly disturbing in light of upcoming budget deficits at the state and national levels across numerous social service programs.

A major question facing policymakers is whether current programs, especially SSI and DI, best serve the complex needs of adults with disabilities. These programs provide a vital source of support for many adults with disabilities, especially those with life-threatening illnesses. But the impairment and demographic characteristics of people with disabilities are diverse. The current benefit structure for SSI and DI uses a one-size-fits-all eligibility definition to make an “all-or-nothing” decision that

TABLE 4. *Income Status and Reported Financial Difficulties among Low-Income Adults with Work Limitations, by Program Participation and Employment Status*

	Any Cash Transfer Receipt			Employed, No Cash Transfer Receipt
	Total	DI/SSI	Other cash transfer program	
Family income status				
Ratio of total family income to poverty level	1.0	1.0	1.0	1.2
Percent living in poverty ^a	52.9	55.4	47.8	37.4
Financial difficulties in the past 12 months (%)				
Cut or skipped meals because of lack of money	31.2	30.1	33.3	24.8
Unable to pay mortgage, rent, or utility bills	26.7	22.1	35.9	30.3
Without telephone service	19.9	17.6	24.5	17.9

Source: Author's calculations.

Notes: Adults are age 25–55. Low-income adults are those with family incomes below 200% of the federal poverty level. The total column includes respondents who reported cash benefits from SSI, DI, WC, VB, PDI, TANF, GA, and UI. The DI/SSI column includes respondents who reported cash benefits from SSI or DI. The other cash transfer program column includes respondents who reported cash benefits from WC, VB, PDI, TANF, GA, or UI. The employed column includes respondents who were employed during the previous year and did not report any cash transfer receipt.

a. Adults living in poverty are those with family incomes below 100% of FPL.

could lead to a lifetime of benefit receipt (Wittenburg and Loprest 2003). Once on these programs, few people ever leave, especially for employment.

Because of how the current disability benefit programs are structured, people potentially eligible for disability programs must choose between applying for permanent benefits from SSI and/or DI, which includes a long and difficult application process that can take several months or years to complete, or finding some other source of income *and* health care coverage through work or another program. Those not on SSI and DI often have difficulties making payments for certain necessities, such as housing. Because many low-income adults with disabilities have substantial health and other expenses, applying for permanent disability benefits, which often include important links to health care coverage and other supports, is very enticing. But many adults may not need permanent disability benefits, particularly those with some work capacity that could be enhanced by further temporary training, rehabilitation, or health coverage.

The focus of federal disability programs on providing permanent lifetime benefits also illustrates how social welfare policy treats low-income adults with disabilities differently from other low-income groups, especially mothers with children. While policymakers have sought to limit

caseload sizes and implement time limits in TANF and GA over the past decade, they have not focused such attention on SSI and DI, even though more people than ever are receiving lifelong SSI/DI cash transfers (Burkhauser and Stapleton 2003). Over this same period, employment rates of mothers with children increased, while rates for people with disabilities fell. Further, many people with disabilities are moving from the temporary benefit options available in state welfare programs to the lifelong options provided through SSI and DI (Stapleton et al. 2002).

Policymakers also need to consider the large numbers of low-income adults with work limitations not participating in SSI or DI, who might nonetheless need some short-term, periodic cash, or in-kind (e.g., health or rehabilitation) support. Some adults might have disabilities that are not severe enough to qualify for benefits. Even potentially eligible adults might choose not to apply because they prefer to work, want to avoid a lengthy application process, or do not know about the benefit programs.

One gap in the safety net for low-income adults with disabilities, especially those with some residual work capacity, is the lack of temporary cash, training, health, and rehabilitation support. Although supports are available for workers who experience an onset of a disability, especially through WC and PDI, only a small percent-

age of low-income adults receive benefits from those programs. Presumably, many low-income adults lack work experience, and therefore have limited potential for receiving assistance from these other programs.

In summary, the general disconnect across programs has created a tangled web of services and supports affecting the decisions of all adults with disabilities, including those currently receiving disability benefits. Given the large incidence of health problems, policymakers must recognize how disability policy and other policies supporting low-income populations overlap. Policy improvements are particularly important for adults with disabilities who are still capable of working, with the appropriate supports. However, until policymakers develop coordinated policies that recognize the heterogeneous needs of adults with disabilities, they will likely be unable to stem the tide of declining employment rates and expanding disability program rolls.

Notes

1. Unless otherwise stated, all descriptive comparisons of estimates presented in this brief are statistically significant at the 5 percent level.
2. Similar differences exist when data are disaggregated by gender, although the disparity in employment rates across men with and without work limitations is larger than it is for women.
3. A person qualifies for DI by meeting certain work history and earnings conditions that vary based on age. DI benefits are calculated based on an applicant's previous earnings history. In some cases, a low-income applicant with some work experience could satisfy the income and asset test for SSI benefits as well as the work history tests for DI benefits, and hence qualify for both programs. DI benefits vary based on earnings history, but are generally larger than SSI benefits. In 2003, the maximum federal SSI payment for a single person was \$552 a month (approximately 75 percent of the poverty level for an individual), and many states provided a separate supplement to the federal payment, ranging from a few dollars to approximately \$150 a month. The average monthly payment for DI beneficiaries was \$815 in 2001 (SSA 2002). Additionally, unlike SSI, DI has a five-month waiting period before applicants receive benefits. For more information, see Wittenburg and Favreault (2003).
4. In most states, SSI recipients are categorically eligible for Medicaid. SSI recipients living in states without the categorical link can generally receive coverage by meeting other income eligibility requirements for Medicaid. Additionally, some people can qualify for Medicaid under optional state rules for low-income adults who meet certain disability criteria. Medicare coverage for DI beneficiaries begins after a two-year waiting period. Medicare coverage is also available to certain groups under age 65, including those who have End Stage Renal Disease.
5. Even after controlling for income level, adults with work limitations are significantly more likely to report these difficulties. The probability of a difficulty was estimated controlling for income and work limitation status. Across all estimates, the coefficient on work limitation status was significant. The magnitude of the differences is generally similar to those reported in table 3. These estimates are available upon request.
6. A small number of low-income adults are not employed and do not participate in a cash transfer program. Statistics on this subpopulation are available upon request.

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About the Author



David Wittenburg is a senior research associate at the Urban Institute. Over the past several years, he has written a number of peer-reviewed articles, book chapters, government reports, and policy briefs that examine issues related to Social Security Administration disability programs, employment of people with disabilities, welfare reform, food stamps, Unemployment Insurance, minimum wage increases, changes in the normal age of retirement, and job training.

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This series presents findings from the 1997, 1999, and 2002 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at <http://newfederalism.urban.org>.

The NSAF is part of *Assessing the New Federalism*, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Olivia A. Golden is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

The *Assessing the New Federalism* project is currently supported by The Annie E. Casey Foundation, The Robert Wood Johnson Foundation, the W. K. Kellogg Foundation, The John D. and Catherine T. MacArthur Foundation, and The Ford Foundation.

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The author thanks Kelly Rader for valuable research assistance on this project. Pamela Loprest, Alan Weil, and Sheila Zedlewski provided helpful comments.