

Safety Net or Tangled Web? *An Overview of Programs and Services for Adults with Disabilities*

David Wittenburg
Melissa Favreault

Occasional Paper Number 68



Assessing
the New
Federalism

*An Urban Institute
Program to Assess
Changing Social Policies*

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This report is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil 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.

The authors would like to thank Amelia Gruber, Kevin McManus, and Joyce Morton for helpful research assistance on this project. Pamela Loprest, Grant Revell, Alan Weil, and Sheila Zedlewski provided extensive comments.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

About the Series

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

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Safety Net or Tangled Web?

An Overview of Programs and Services for Adults with Disabilities

For many low-income adults, a disabling health condition represents a major obstacle to daily activities. The costs of a disability can take various forms, including increased medical costs, lost wages, and diminished psychological well-being. Because these costs can be quite substantial, particularly for health care, a significant portion of these adults must turn for support to outside help, including government programs.

Policymakers have developed a range of programs and supports to address the complex needs of adults with disabilities who meet certain medical and other (e.g., income) criteria. In recent years, spending on many of these programs, particularly Medicaid and the Social Security Administration's (SSA) disability cash transfer programs, has increased substantially. Nonetheless, significant portions of low-income adults with disabilities participate in other non-disability programs, such as Temporary Assistance for Needy Families (TANF).

This paper examines the role that government safety net programs play in the lives of low-income adults with disabilities. We begin by providing background information on the prevalence of health conditions in the low-income population and the economic problems faced by adults with disabilities using data from the National Survey of America's Families (NSAF). According to our findings, an extensive overlap exists across disability and low-income issues that is relevant to general policies targeting low-income populations. Next, we summarize the programs and policies that assist low-income adults with disabilities. Our review includes information on disability-specific programs, other low-income programs that do not necessarily target disability status (e.g., TANF), and recent disability policy initiatives, such as the Americans with Disabilities Act (ADA). We use our descriptive findings and program review as a framework for discussing some challenges that low-income adults might face when accessing benefits and services from the existing safety net. We identify several issues associated with program access, including difficulties in meeting disability eligibility requirements, reduced program options for certain groups, and work disincentives. We then examine some potential policy options for addressing each of these issues, including ongoing efforts by some state and federal agencies. Finally, we conclude with a summary of our findings.

Policymakers interested in improving economic outcomes need to address the inconsistencies across these programs to improve the tangled web of services currently available to adults with disabilities. While several programs provide services targeted specifically to those with disabilities, inconsistencies across programs create



potentially conflicting messages regarding program access and work for many low-income adults. These issues can be particularly confusing for those who have less severe disabilities and/or very limited work histories.

Health Problems in Low-Income Populations

Data Description

We use data from the 1999 NSAF to examine the incidence of health conditions among low-income adults (age 25 to 55) and the problems those with health conditions face. The NSAF is a nationally representative cross-sectional survey of the noninstitutionalized, civilian population under age 65 in the nation as a whole and in 13 states.¹

While the NSAF has not been used in previous disability analyses, it contains several questions that we can use to identify people experiencing some type of functional limitation or health problem. We use this information to create the following three health and functional status indicators:

- **Work limitations:** This definition includes respondents who answered “yes” to a question about “having a physical, mental, or other health condition that limits the kind or amount of work s/he can do.”
- **Poor mental health:** We create an index using five NSAF questions to rate a person’s level of anxiety, depression, loss of emotional control, and psychological well-being.² Respondents with an index value in the lowest decile are classified as having poor mental health.
- **Fair or poor health:** This definition includes respondents who reported “fair” or “poor” general health in response to the following question: “In general, how would you say your health is?” The five possible responses include excellent, very good, good, fair, and poor.

Of these indicators, the presence of a work limitation is the most commonly used definition in the literature to examine outcomes of adults with disabilities. The major advantage of this definition is that it combines information regarding a person’s impairment with a social activity (work).³ The other two definitions are generally not used to identify disability status because they do not include information on the interaction of an impairment with a social activity. Nonetheless, they provide information on individuals who are having general mental and health difficulties.

We define a person as low-income if his or her total family income amounts to less than 200 percent of the federal poverty level, though we also examine the characteristics of adults living below the federal poverty level. In general, these cutoffs approximately correspond with the eligibility threshold for many government assistance programs described in the next section.

Findings

Reported health difficulties are highly concentrated in the low-income population, particularly among adults whose family incomes are below the poverty threshold (table 1). Of the 28.9 million low-income adults in the U.S., 23 percent report a work limitation, 25 percent report fair/poor health status, and 15 percent report poor mental health. The prevalence of these problems is even higher among those with income below the poverty level; over 30 percent of adults report work limitations and/or fair or poor health, and 23 percent report poor mental health. Each condition is about twice as prevalent in the low-income population as in the total adult population.

Compared with all low-income adults, adults in each of our three health categories are more likely to report a difficulty meeting food, housing (e.g., rent or utility), or telephone needs (table 2). People who report poor mental health reported the most difficulties in meeting these needs, with approximately half reporting a difficulty in paying their mortgage, rent, and/or utility bill. Our findings are consistent across income ranges, though, not surprisingly, those living below the poverty level reported the most difficulties in meeting these needs.

We find that low-income adults with disabilities are less likely to be employed than other low-income adults (figure 1), consistent with findings from other studies (DeLeire 2000; Maag and Wittenburg 2003; Burkhauser and Wittenburg 1996; Burkhauser and Daly 1996). Both men and women without disabilities are more than twice as likely to be working as those with a disability, generally consistent with findings using other data sources (Maag and Wittenburg 2003). Consequently, many of these adults will likely need to find another form of cash support.

These findings illustrate the important role that health conditions and disability status can play within the low-income population, a role that has broader implica-

Table 1. Prevalence of Health Conditions among Adults (age 25 to 55), by Income Level

	All adults	Low-income adults		
		Total low-income	Near-poor	Poor
Population (weighted—millions)	120.8	28.9	18.3	10.6
Percent with a work limitation ^a	12.2	22.7	18.0	30.8
Percent reporting fair or poor health	11.6	25.1	20.8	32.6
Percent reporting poor mental health ^b	8.1	15.2	11.3	22.8

Source: Authors' calculations from the 1999 National Survey of America's Families.

Notes: Low-income adults are those with incomes less than 200% of the federal poverty level (FPL). Near-poor adults are those with incomes between 100% and 199% of FPL. Poor adults are those with incomes less than 100% of FPL.

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

b. The NSAF includes a mental health rating adapted from a five-item scale (MHI-5) used in the Medical Outcomes Study (Stewart, Hays, and Ware 1988). The definition of poor mental health delineates the bottom 10 percent of the MOS distribution, as used by Loprest and Zedlewski (2001).

Table 2. Prevalence of Reported Difficulties in Meeting Food, Housing, and Telephone Needs among Low-Income Families, by Health Condition (percent)

	Food ^a	Mortgage, rent, and/or utility ^b	Telephone ^c
All low-income families			
Total	21.3	27.1	23.5
Among those with a work limitation	31.8	37.9	29.5
Among those reporting fair or poor health	35.5	36.9	31.3
Among those reporting poor mental health ^d	47.2	55.9	45.9
All near-poor families			
Total	20.3	26.4	21.7
Among those with a work limitation	30.9	37.7	27.1
Among those reporting fair or poor health	35.5	35.4	29.5
Among those reporting poor mental health	47.4	56.6	43.5
All poor families			
Total	29.3	31.9	34.5
Among those with a work limitation	35.8	38.8	39.2
Among those reporting fair or poor health	35.3	43.6	39.2
Among those reporting poor mental health	46.1	53.3	55.0

Source: Authors' calculations from the 1999 National Survey of America's Families.

Notes: Low-income families are those with incomes less than 200% of the federal poverty level (FPL). Near-poor families are those with incomes between 100% and 199% of FPL. Poor families are those with incomes less than 100% of FPL.

a. Respondents were asked whether they had cut or skipped meals over the past twelve months because of lack of money.

b. Respondents were asked whether they had been unable to pay their mortgage, rent, and/or utility bills in the past twelve months.

c. Respondents were asked whether they had been without phone service during the past twelve months.

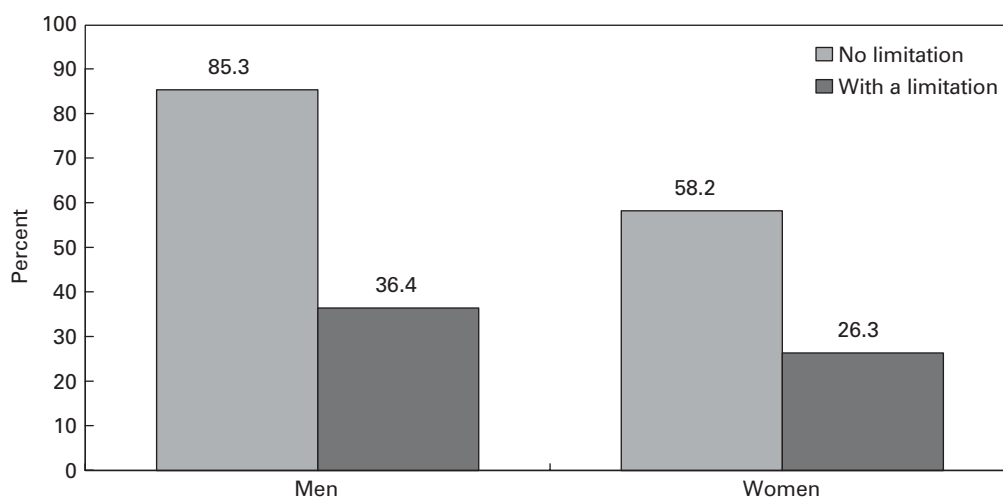
d. The NSAF includes a mental health rating adapted from a five-item scale (MHI-5) used in the Medical Outcomes Study (Stewart et al. 1988). The definition of poor mental health delineates the bottom 10 percent of the MOS distribution, as used by Loprest and Zedlewski (2001).

tions for researchers and policymakers interested in improving outcomes for low-income families. Specifically, it is important that policymakers consider the high prevalence of disabilities when formulating general policies aimed at the low-income population. Before proceeding, it is important to understand the current set of policies and programs that serve low-income adults with disabilities.

Overview of the Safety Net

Various public and private programs offer a range of services and supports to low-income adults with disabilities, including cash benefits, health coverage, rehabilitation assistance, and other specialized services (such as supported employment support). We include some programs that target benefits more generally to low-income populations (e.g., TANF). We also briefly highlight programs that target disability status

Figure 1. Employment Rates, by Gender and Disability



Source: Authors' calculations from the 1999 National Survey of America's Families.

independent of financial circumstances because some people with low incomes might qualify for these programs under certain circumstances (such as injury on the job).

In table 3, we provide summaries of the programs that a low-income adult with a disability might access for either temporary or permanent support. This table provides a brief description of the major programs described below, including a description of the target population, the cost, the number of participants, and the funding source (local, state, federal, and/or private).

Disability Cash Transfer Programs

A major component of the safety net for many low-income adults with disabilities is cash transfer programs. For some low-income adults with disabilities, these programs represent the only source of income for their household.

The Supplemental Security Income (SSI) program, administered by the SSA, is the largest means-tested transfer program targeted to low-income adults with disabilities.⁴ Adults with limited incomes and assets can qualify for SSI if they meet SSA's strict disability criteria, which require that an individual must have a medically determined disability expected to last at least 12 months or result in death and be unable to engage in substantial gainful activity (SGA). Essentially, low-income adults interested in receiving benefits must prove they have a permanent disability that impairs their ability to do any type of work.

The SSI application process is quite lengthy. To apply for benefits, an applicant must provide SSA with detailed information on his or her income, assets, and impairment. While SSA can quickly determine if the applicant meets the income and asset criteria, the assessment of disability status is far more complex and time-intensive.

(text continues on p. 9)



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Table 3. Major Public Programs and Policies Serving Low-Income Nonelderly Adults with Disabilities

Program/Policy	Description	Target population	Costs	Number of participants	Funding source
Disability cash transfer programs					
Supplemental Security Income (SSI)	Means-tested program (with both income and asset screens) to provide monthly cash income to people under 65 who are blind or disabled. ^a	Blind and people with disabilities of any age with limited income and assets	Federal blind and disabled (all): \$25.0 billion (2001) (SSA 2002); state blind and disabled: \$3.0 billion (SSA 2002)	Federal blind and disabled: 3.8 million people age 18-64 (Dec. 2001) (SSA 2002)	Federal (general revenues), states fund supplement
Social Security Disability Insurance (DI)	Program to insure workers and their dependents against loss of income due to disability. Payments are based on individuals' lifetime average earnings covered by Social Security. Spousal and children's benefits are subject to a family maximum.	Adults with disabilities with sufficient DI-covered earnings history and their dependents (spouse, children)	\$59.6 billion (2001); benefits, excluding administrative costs) (SSA 2002)	5.3 million workers, 1.5 million children, 0.2 million spouses (2001) (SSA 2002)	Federal (payroll taxes)
Workers' Compensation (WC)	Cash payments, rehabilitation services, and medical benefits provided by employers to workers who suffer work-related injuries or diseases and to their survivors (in case of fatality). Optional in Texas only.	People who suffer work-related injuries and diseases or their survivors	Cash: \$25.9 billion; Medical: \$20.0 billion (2000) (SSA 2002)	No national beneficiary estimate (see Mont et al. 2001); 126.6 million covered workers (SSA 2002)	Employer premiums (some self-insure)
Veterans Administration programs	Programs including disability compensation payments and veterans' pensions that provide payments to people age 65 or older or less than 65 and disabled who served in the military. Means-tested if disability is not service-connected.	Veterans of military service that are over 65 or disabled	Service-connected, age < 60: \$8.3 billion (start FY 2001); non-service-connected, < age 60: \$0.8 billion (start 2001) (US VA 2001)	Service-connected, age < 65: 1.3 million persons; non service-connected, age < 65: 0.1 million (1999) (US VA 2001)	Federal
Other cash transfer programs					
Temporary Assistance for Needy Families (TANF)	Program that provides time-limited cash benefits to needy families with children.	Low-income families with children	Total spending \$24.0 billion (total cash payments \$11.5 billion, other spending \$12.5 billion) (FY 2000) (HHS 2002c)	5.5 million total recipients (end of 2001-average monthly) (HHS 2002c)	Federal block grants, state
General Assistance	Temporary assistance program that varies by state and is generally targeted to low-income individuals, often targeting disabled, elderly, and children.	Varies by state, low-income households	No national estimates; for estimates for some states, see Gallagher et al. (1998)	0.7 million recipients (1996 monthly average) (SSA 2000)	States

Health programs

Medicaid	Entitlement program that provides medical assistance primarily to low-income and otherwise needy individuals, including people with disabilities. Eligibility may be linked to SSI or TANF. Under the Balanced Budget Act of 1997, states may allow people with disabilities with incomes \leq 250% of FPL to buy in if not otherwise eligible.	People with disabilities (also low-income children and pregnant women, adults in families with dependent children, and the elderly)	\$194.7 billion vendor payments; approx. \$68.3 billion on behalf of people with disabilities (FY 2000) (HHS 2002a)	38.2 million people under age 65 (FY 2002) (HHS 2002a); approximately 7.9 million with blindness or disabilities (Wiener 2003)	Federal-state (general revenues, matching state funds)
Medicare	Public health insurance program for individuals with disabilities (also serves people 65 and older). Provides both hospital coverage (Part A) and supplementary medical insurance (Part B).	Current/former DI beneficiaries (also people age 65 and older)	\$17.4 billion in outlays for disabled (2001) (HHS 2002a)	5.6 million with disabilities (July 2001) (HHS 2002b); 6.0 million (calendar year 2002) (HHS Trustees 2003)	Federal (payroll tax plus Part B premiums)
Rehabilitation, education, and training programs					
State vocational rehabilitation	Program intended to help people with physical and mental impairments to work by providing services including medical and therapeutic services, counseling, education, training, and job placement assistance.	Adults with physical or mental impairments who are able to benefit from VR services	\$2.5 billion (federal 2001 appropriation for state grants) (US Education 2003b); \$3.3 billion (FY 1999) (US Education 2003a)	1.2 million persons (FY 1999) (US Education 2003a)	Federal-state (match requirement is 21.3%)
State Workforce Development systems	Program mandated by the Workforce Investment Act of 1998 that requires states to integrate job training, adult education and literacy, and VR programs into a one-stop delivery system.	All adults, youth who meet state-determined criteria	Unavailable	Unavailable	Federal-state match
Impairment-specific programs					
Mental Retardation/Developmental Disability	Partnership programs to assist those with developmental disabilities in reaching their full potential through increased independence, productivity, and integration. Services include prevention, diagnosis, early intervention, therapy, education, training, employment, community living, and leisure opportunities.	People with severe, chronic disabilities attributable to mental and/or physical impairment that manifest before age 22 and are likely to continue indefinitely	\$29.3 billion (2000) (Braddock et al. 2002)	Residential: 433,799; family support: 385,414 (families); supported employment: 108,004; supported living/personal assistance: 98,300 (all 2000 estimates from Braddock et al. 2002)	Federal-state-local-private (primarily Medicaid)
State mental health systems	A relatively independent set of mental health service systems for people who suffer from certain mental disorders. Medical professionals, human service agencies, and/or schools refer people into the mental health system.	Individuals with disabilities who meet specific state medical criteria. ^{a,b}	\$10 billion (1997) (Bazelon Center 2001)	3.5 million received "some service" (Bazelon Center 2001)	Federal-state-local-private (primarily Medicaid)

(Continued)

Table 3. Major Public Programs and Policies Serving Low-Income Nonelderly Adults with Disabilities (*Continued*)

Program/Policy	Description	Target population	Costs	Number of participants	Funding source
Other programs					
Food Stamps	Program that subsidizes food purchases through coupons that can be used like cash at the grocery store.	Low-income households	\$18.3 billion (2002) (USDA 2003b)	19.1 million total (2002) (USDA 2003); approx. 1.9 million nonelderly adults with disabilities and 0.2 million children with disabilities (Cunyngham 2002)	Federal-state
Public Housing	Provides rental housing subsidies to reduce housing costs and improve housing quality for low-income households.	Low-income families, the elderly, and people with disabilities	\$8.0 billion (FY 2002) (US HUD 2002)	Approx 1.2 million households, 2.6 million people (2002) (US HUD 2002)	Local-federal-state
Housing Choice Voucher Program (Section 8)	Provides rental housing subsidies.	Low-income families, the elderly, and people with disabilities	\$18.5 billion (FY 2002) (US HUD 2002)	3.3 million units (2002) (US HUD 2002)	Federal

Sources: Bazelon Center (2001); Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (Trustees HI) (2003); Braddock et al. (2002); Cunyngham (2002); Kaiser Family Foundation (2001); Livermore, Nowak, and Wittenburg (2001); Mont et al. (2001); Office of Management and Budget (OMB) (2001); Social Security Administration (2000, 2002); U.S. Department of Agriculture (USDA) (2001); U.S. Department of Education (US Education) (2003a, 2003b); U.S. Department of Health and Human Services (2002a, 2002b, 2002c); U.S. Department of Housing and Urban Development (US HUD) (2002); U.S. Department of Labor (2001); U.S. Department of Veterans Affairs (USVA) (2001); and U.S. House of Representatives, Committee on Ways and Means (2000).

a. SSI also provides benefits to those age 65 and older with limited incomes, and children under age 18 who meet specific disability and income requirements.

b. In general, these criteria are specified in the Diagnostics Statistical Manual-4R

SSA collects detailed documentation of the applicant's impairments, including physician records and other forms, that the state Disability Determination Service (DDS) then reviews. The DDS then makes a decision regarding the severity of the applicant's impairment and the ability of the applicant to complete *any* work in the national economy based on the applicant's medical information and other characteristics (such as age or education). Because of the complexity of this assessment, initial DDS determinations average approximately 120 days. While the majority of initial SSI applications are rejected, most reapply for benefits using SSA's appeals process.⁵ SSA has a multilayered appeals process, which includes a re-examination by other DDS officials not involved in the claim, a review by an administrative law judge (ALJ), and finally appeals to the courts. The entire application process can last anywhere from several months to several years. After an award is made at any level, benefits are paid retroactively from the date of disability determination.

Despite the long application process, low-income adults have a strong incentive to apply for SSI because benefit levels are higher than most other means-tested programs, there are no work requirements, and perhaps most importantly, most SSI recipients are eligible for Medicaid. In 2003, the maximum federal SSI payment for a single person was \$552 per month (approximately 75% 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 per month. Medicaid, which is discussed in more detail below, further enhances the value of these benefits by covering important medical expenses. For example, for a person with average monthly medical expenditures of \$1,000 (the approximate average for Medicaid participants classified as "disabled"), the total monthly value of the SSI and Medicaid benefit is over \$1,500.

While a small fraction of SSI recipients (about 7 percent of those age 18 to 64) works part-time while receiving benefits, relatively few ever leave the rolls completely for work. In general, SSI recipients lose 50 cents of benefits for each dollar of earnings after certain disregards and face the prospect of losing all benefits (SSI and Medicaid) if earnings exceed a certain threshold.⁶ Not surprisingly, because of the potential loss of cash benefits and health coverage, the severe impairment characteristics of recipients, and the long application process, less than 1 percent each year ever leave the rolls because of excess income (Rupp and Scott 1998). For young adults, participation in SSI could likely mean lifelong participation in a cash benefit program.⁷

In recent years, the number of low-income adults with disabilities enrolling in SSI has increased significantly, making SSI the largest means-tested cash transfer program in the United States.⁸ The combined expenditures for federal and state SSI payments in 2001 (\$31.7 billion) were larger than other programs that target low-income populations, including TANF (\$11.5 billion in assistance payments) and food stamps (\$18 billion) (see table 3 for more details). In 2001, approximately 3.8 million people age 18 to 64 received blind or disability SSI benefits.

Low-income adults with work histories, particularly those who might have been injured on the job, have significantly more options to obtain cash or health benefits than those who have never worked. The general goal of programs with work history



eligibility requirements is to replace a portion of the lost wages of a worker with a disability. Because these programs generally base benefit amounts on past work history, they tend to be more generous than strictly means-tested programs.

The Disability Insurance (DI) program, which is also administered by the SSA and employs the same disability definition as SSI, is the largest of these programs. In addition to the disability requirements mentioned above for SSI, DI applicants must meet certain work history and earnings conditions that vary based on age. SSA automatically determines whether an individual is applying for DI, SSI, or both based on his or her work history. Because DI benefits are based on past earnings, they are generally higher than SSI. Unlike SSI, however, DI beneficiaries must wait five months before receiving benefits, and DI beneficiaries are only eligible for health coverage benefits through Medicare (rather than Medicaid) after a two-year waiting period. DI beneficiaries also face the prospect of losing their DI and Medicare benefits if their earnings exceed a certain threshold.⁹

While DI is not targeted directly toward low-income adults, a large number of low-income adults with limited work histories receive DI benefits based on the large overlap of DI with SSI. Approximately 30 percent of disabled adult SSI recipients (who only include low-income adults with disabilities) also receive DI benefits. In general, these recipients must have limited work histories (to qualify for a limited DI amount) and limited resources (to qualify for SSI) to qualify for both programs.¹⁰ SSA calculates the benefit amount in these cases by replacing one dollar of SSI benefits for every dollar of DI benefits.¹¹

Low-income adults who experience the onset of a disability *on the job* have additional program options for cash and health benefits through Workers' Compensation (WC) and Veterans Administration (VA) programs.¹² WC, an insurance program funded by employers, is the largest program that specifically targets people who are injured on the job in the private sector. Unlike the programs mentioned above, WC payments are also available for partial disabilities (either temporary or permanent). In general, WC aims to replace lost wages and pay for other medical expenses resulting from the onset of a disability on the job. WC benefit levels vary by state, but temporary or permanent total disability benefits are commonly set at two-thirds of weekly earnings up to some maximum, and payments are generally discontinued upon returning to work. The VA covers honorably discharged individuals in the military under a set of programs generally similar in theme to WC. Benefits include cash payments, rehabilitation support, health support, and other employment-related support. The VA uses a disability rating (a percentage between 0 and 100) to make eligibility determinations for benefits. Unlike WC, however, VA also provides disability compensation for those injured outside of the service.

Because relatively few data sources include detailed information on the characteristics of participants in WC or VA disability programs (particularly at the national level), it is difficult to assess how they overlap with the low-income population. We presume that the participation rates of low-income adults in these programs are likely lower than those of other adults because low-income adults generally have lower rates of labor market attachment in the private sector (in the case of WC). However, a key area for future research is to better understand the target populations served in these

programs, particularly WC, which distributed approximately \$45.9 billion dollars in cash and health benefits in 2000 (SSA 2002).

Other Cash Transfer Programs

While not targeted to adults with disabilities, the TANF program provides benefits to a large number of low-income adults with disabilities who live in families with children. Zedlewski and Alderson (2001) found that 17 percent of TANF recipients from the NSAF reported a work limitation and 28 percent were in poor mental health (using the same definition as used in our analysis).

The funding sources, application process, and work incentives under TANF are very different from most disability cash transfer programs, particularly SSI and DI. TANF is a block grant program that provides cash assistance for eligible families who meet certain requirements. States have flexibility to determine the eligibility requirements and benefit levels, though benefits are subject to federal time limits and work requirements.¹³ Families with limited resources can qualify for TANF by filing an application form at local welfare offices. Eligible families can start receiving benefits immediately after submitting their applications. TANF recipients will continue to receive benefits as long as they are within their time limits and satisfy their state work requirements. States have some flexibility in exempting certain families from these requirements, though they could face financial penalties if their case-loads do not meet certain federal guidelines for work requirements and time limits.

Shorter-term cash benefit options exist for low-income adults in states with temporary General Assistance (GA) programs, though these programs vary by state, are smaller in scope compared with the programs above, and have been dwindling in number in recent years (Gallagher et al. 1999). GA payments are generally discontinued after a person qualifies for another program or becomes employed. In many states, the primary goal of GA programs is to provide temporary benefits to those in the process of applying for SSA disability benefits (i.e., SSI and/or DI).¹⁴ Consequently, GA programs tend to serve more as a temporary source of benefits than as a continuing source of support.

Health Programs

Because the medical costs of disability can be substantial, the availability of health coverage is critical to low-income adults with disabilities. Coverage has become particularly important in recent years given the escalating medical costs for many health conditions.

By far the largest program that provides health care coverage to low-income adults with disabilities is Medicaid. The federal government pays a share of Medicaid medical assistance expenditures, between 50 and 83 percent depending on a formula based on a state's per capita income. State programs have several options for setting coverage, creating payment methodologies, setting payment rates, and imposing nominal deductibles, coinsurance, or copayments on Medicaid enrollees that receive services.

Federal law mandates the coverage of some “categorically eligible” groups, including adults with disabilities, that meet state specified income levels. The state eligibility rules for adults with disabilities are similar to those under the SSI program, though states have several options for providing coverage to other low-income adults with disabilities that are “categorically related” to the SSI population. In most states, SSI recipients are automatically eligible for Medicaid under Section 1634.¹⁵ In the remaining non-1634 states, referred to as Option 209(b), SSI recipients must satisfy state Medicaid needs tests, which are generally stricter than the SSI means test. Low-income adults with disabilities who do not participate in SSI can qualify under certain optional rules that give states some flexibility in providing Medicaid coverage to low-income adults whose disability might not be severe enough to meet SSI’s strict disability definition and/or whose income and assets are just above state Medicaid eligibility cutoffs. Optional groups can include individuals receiving state SSI supplement payments, individuals in institutionalized care, individuals in home and community-based services, workers with disabilities who live in families with incomes below 250 percent of the poverty level, certain Medicare participants, some former SSA disability recipients, and “medically needy” individuals.¹⁶

Medicaid covers a broad range of important services for low-income adults with disabilities (Wiener 2003). Mandatory services include inpatient and outpatient hospital services; physician, midwife, and certified nurse practitioner services; laboratory and x-ray services; nursing home and home health care; family planning; and rural health clinics and qualified health centers. In addition, states can use waivers to cover a wide range of additional services, including prescription drugs, clinic services, prosthetic devices, hearing aids, dental care, intermediate care facilities for the mentally retarded (ICF/MRs), and a wide range of nonmedical home and community-based services. In 1998 (the most recent year of data), 57 percent of total Medicaid expenditures for people with disabilities was for acute services (e.g., physician services, prescription drugs) and 43 percent was for long-term care services (e.g., home care, nursing facilities, and ICFs).

Because people with disabilities tend to require more intensive services, the average Medicaid cost for an enrollee classified as disabled tends to be higher than other adult Medicaid enrollees under the age of 65. According to Wiener (2003), there were 7.9 million enrollees with disabilities in 2002, representing 17 percent of all Medicaid participants. The average payment for enrollees with disabilities was \$11,770, significantly larger than the \$1,999 per person average for adults without disabilities.

Coverage generally continues as long as a person meets the eligibility criteria for a Medicaid eligibility group. For example, SSI recipients can continue to receive coverage as long as their income remains below a certain threshold that accounts for the SSI benefit amount and average Medicaid spending thresholds established under Section 1619. Alternatively, other groups that do not receive SSI, such as medically needy Medicaid eligibles or former DI beneficiaries who are currently low-income workers, remain eligible as long as their income or earnings stay below established guidelines.

In recent years, there has been a major movement to expand coverage by providing buy-in options for adults with disabilities whose income or resources would otherwise make them ineligible for Medicaid. The general target population for these buy-in programs is low-income working adults with disabilities, especially former SSI and DI recipients.¹⁷ The buy-ins are intended to expand Medicaid eligibility for certain groups and influence the employment decisions of those who would work if they could obtain health care coverage. The parameters of these buy-in programs vary substantially across states, in large part because states have different Medicaid eligibility requirements and benefit plans (Jensen et al. 2002).¹⁸

As noted above, some low-income adult DI beneficiaries are eligible for Medicare coverage after a two-year waiting period.¹⁹ Medicare beneficiaries receive a range of coverage and benefit options for hospital visits, doctor visits, and other benefits somewhat similar to Medicaid.²⁰ In some cases, Medicare beneficiaries have more choice in choosing services compared with Medicaid (e.g., choice of doctor), though, unlike Medicaid, Medicare does not include coverage for prescription drug benefits. In general, Medicare coverage will continue as long as the beneficiary remains eligible for DI. Some low-income adults, such as those who receive SSI and DI concurrently, can qualify for both Medicaid and Medicare. Concurrent beneficiaries are eligible to receive services covered under both programs, which is important because Medicaid can cover the costs of certain Medicare premiums and cost-shares.

Rehabilitation, Education, and Training Programs

Rehabilitation, education, and training opportunities could enhance the employment prospects of some low-income adults with disabilities. These activities could help offset some barriers to work that may arise from an impairment, limited educational attainment, limited work history, or a combination of all these factors.

The largest program geared to specifically helping adults with disabilities return to work is Vocational Rehabilitation (VR). VR is a nationwide federal-state program that provides medical, therapeutic, counseling, education, training, work-related placement assistance, and other services, generally arranged through agreements with local vendors. The federal funding for VR comes from the Rehabilitation Services Administration (RSA) Title I grants. The state-federal VR program is funded approximately 78 percent by the federal government, with a minimum 22 percent supplied by each state (Hayward and Schmidt-Davis 2003). State VR agencies have some flexibility in the types of services that they provide to different populations in using the federal grant, though all VR applicants who receive services must meet certain guidelines.

In general, to be eligible for VR services, a person must have a work-limiting disability and show that he or she could become employable after receiving services.²¹ For each applicant, state VR agencies develop a written plan to assess an individual's potential ability for employment. State VR agencies can deny benefits if they can show that an applicant cannot benefit from the services. In many cases, states VR agencies have long waiting lists for services. The likelihood of being accepted for these services varies based on age, sex, race, education level, disability



type and significance, and other characteristics (Research Triangle Institute 1996). Availability of services may also be limited to the number of providers in the area that can handle the diverse needs of people with disabilities.

Those who become eligible for services work with a VR counselor to select a vocational goal and develop a service plan to achieve that goal. To support this planning process, participants may undergo further assessments (e.g., vocational evaluation). Participants then clarify their service needs in an Individualized Plan for Employment (IPE). In 1999, 232,000 (out of approximately 1.2 million) people who received VR services were “successfully rehabilitated,” and the total program costs were approximately \$2 billion (U.S. Department of Education 2003a).²² The majority of people who receive VR services generally have some workforce experience and many have at least a high school diploma (Research Triangle Institute 1996). For example, 90 percent of VR participants have worked in one or more jobs and two-thirds have a recent work history (work within the past two years). Approximately half of VR participants are receiving support from another income support program, including SSI, DI, GA, WC, PDI, and TANF. Despite these connections, VR participants compose only a small portion of recipients in these other programs.

Low-income adults with disabilities who do not immediately contact the VR system might gain access to rehabilitation, employment, and education services through other programs. A major source of support, particularly for TANF recipients, is the State Workforce Development Systems, organized under the Workforce Investment Act of 1998 (WIA). TANF recipients often use placement, training, and education services through these systems to support their employment activities. The type of service provided often varies depending on the philosophy the state uses for employment services (e.g., “work-first” versus training and education). Another potential source of support is the Projects with Industry (PWI) program, which creates training opportunities for adults with disabilities by promoting partnerships among business, industry, labor, and rehabilitation agencies. In many cases, the WIA and PWI programs coordinate service delivery for adults with disabilities through state VR agencies.

In recent years, disability advocates have sought to expand opportunities for rehabilitation and training services, particularly for those in SSA disability programs. The largest of these efforts is the newly enacted Ticket to Work program, which is designed to promote work by providing SSI and DI recipients with a “ticket” to purchase rehabilitation from state VR agencies and other service providers. The goal of this program is to expand opportunities for rehabilitation services to SSA disability recipients. Several states are currently rolling out the Ticket program and all states will implement the program over the next couple of years.

Impairment-Specific Programs

Some low-income adults with specific impairments, such as mental retardation, can also qualify for support from specialized systems geared to helping individuals with severe health conditions. These specialized supports generally include services such as institutional care, supported employment/rehabilitation services, and social

support. Most states have separate agencies or subagencies that monitor these programs, and much of the funding support for these programs comes directly from Medicaid. People typically enter these systems after a referral by a family member or a diagnosis by a physician. Because services from these programs are often tied to Medicaid, adults interested in these services must satisfy their state's Medicaid eligibility requirements to qualify for benefits.

The two largest systems are the Mental Retardation/Developmental Disability (MR/DD) system and the mental health system. In most states, MR/DD agencies provide those with MR/DD with residential and social support, as well as several other services including after-school programs, family support, and employment (Braddock et al. 2002). These supports cost \$29.3 billion in 2000. The broad range of supports that this system offers reflects the heterogeneity of the target population and its needs. Braddock et al. (2002) estimate that 75 percent of all people with MR/DD live with a family caregiver or spouse, and 15 percent live independently. The remaining 10 percent (433,800 people) receive services in a residential setting. Costs for residential services (including supported living and personal assistance) make up around 94 percent of the total costs, with an additional 6 percent directed to family support and supported employment.

The mental health system is generally less centralized and provides services to a relatively broader population with a range of mental impairments. Those who qualify receive services from state mental health agencies oriented toward treatment and amelioration of symptoms. Approximately 3.5 million people received some sort of service from these programs in 1997, and expenditures were approximately \$10 billion (The Bazelon Center 2001).

Other Programs Not Tied to Disability

Low-income adults with disabilities can also qualify for other means-tested transfer programs, such as food stamps and housing subsidies, which are available to all low-income families. Because low-income adults are likely to have relatively high medical and other expenses, as illustrated in table 2, the need for these programs is high. Unfortunately, detailed statistics are not available on the number of low-income adults with disabilities who participate in these programs, though many could presumably satisfy the basic income eligibility requirements.

Disability Policy

The daily activities of low-income adults with disabilities are also influenced by policies directed at diminishing the barriers to equality for adults with disabilities, such as the Americans with Disabilities Act (ADA). The ADA prohibits job-related discrimination against people with disabilities and requires that employers provide reasonable accommodations.²³ In essence, the ADA provides civil rights protections to people with disabilities, guaranteeing access to a wide array of activities.

Other recent policies have further promoted the goal of independence embodied under the ADA. The landmark 1996 Supreme Court decision in *Olmstead v. L.C.*



required states to comply with the ADA by making community-based services available to those individuals with mental disabilities who, in agreement with a state treatment professional, wish to be placed in a community setting, as long as community placement could be reasonably accommodated. The recently enacted New Freedom Initiative of 2001 furthered these efforts by providing funding assistance for the swift implementation of *Olmstead*. The New Freedom Initiative also provided funding for other services, such as assistive technologies, that are designed to remove barriers to community living and to promote employment.

Disability Program and Policy Challenges

An important question is whether this complex mix of programs and policies best serves the needs of low-income adults with disabilities. While the overlap is significant, many programs have unique eligibility requirements, work incentives, and benefit durations. In some cases, policies and programs provide conflicting messages that could create a gap in the safety net of programs for adults with disabilities. Further, the approach in serving adults with disabilities has been evolving over the past several years in different ways across programs, possibly influencing access to certain types of benefits. This approach will likely continue to evolve as both state and federal budgets become stretched.

Eligibility Requirements

All the disability-related programs mentioned above include some type of health or functional limitation eligibility criteria, though specific requirements vary considerably across programs. In general, disability eligibility requirements are directly related to program goals. For example, the SSA disability program definition combines the presence of a severe impairment with an inability to work to identify those “deserving” of permanent disability cash benefits. Alternatively, the VR program combines the definition of a severe impairment with a notion that a person has some residual capacity to return to work and, hence, would benefit from VR services.

The disability requirements for many programs, particularly SSA disability programs, are very strict and significantly limit program eligibility for many people with less severe disabilities. For example, a person whose health condition only partially limits work activities will not necessarily qualify for SSI because s/he can perform some work according to SSA’s eligibility standards. Similarly, this person may not necessarily qualify for other supports, such as rehabilitation from VR, unless s/he can demonstrate a disability that satisfies the state VR eligibility requirements. Consequently, if this person needs cash support, s/he might wait (or continue) to apply for benefits until her/his condition worsens to the point that it meets eligibility standards. Alternatively, if this person has a child, s/he could choose to apply for TANF rather than first applying for SSI.

The subjective nature of disability eligibility requirements in several programs also likely limits the ability of some low-income adults to access some disability-

related programs. For example, a person must assess whether a specific condition, such as paralysis, completely limits an ability to work. Because disability is dynamic, this assessment will likely depend on the severity of an impairment as well as other factors, such as age, education, and occupation. For example, a pianist who loses an arm is likely more limited in his/her activities than, say, a singer with the same impairment. Alternatively, a younger person who experiences disability onset will likely have more opportunity for rehabilitation and training to accommodate an impairment than an older person who experiences the onset of a similar condition.

Program administrators also struggle with the subjective nature of disability in making eligibility determinations. For example, while the eligibility requirements for SSA disability programs are the same across all states, state allowance rates (i.e., the number of awards per application) for SSI and DI vary significantly. While there are several potential explanations for these differences (e.g., state population differences), one major factor is the difficulty in making disability determinations at different SSA offices (The Lewin Group 2001). This subjectivity contributes to disagreement during the appeals at the initial and appellate levels and to inconsistency across jurisdictions.

Even if a potential applicant is confident that his/her disability will satisfy program eligibility requirements, applying for benefits can be a major obstacle to accessing benefits. For example, the application process for SSA disability programs, which often takes over three months and includes medical testing, could deter many potential applicants. Others, particularly those with mental illness, might not apply because of the stigma attached with revealing a disability.

For many other shorter-term cash and rehabilitation assistance programs, access to important services could be further restricted by a limited employment history. For example, access to short-term cash benefits, such as WC, is only available to those who are injured on the job. Similarly, access to VR services is limited to those who can achieve an employment outcome, which, according to a Research Triangle Institute (1996) study, is generally limited to those with at least some recent work experience.

Access to Short-Term Benefit Programs/Program Coordination

Access to shorter-term cash benefits through state welfare programs has also become more limited in recent years as former state welfare participants are moving from state programs to federal SSA disability programs. For example, Bound, Kossoundji, and Ricarto-Moes (1998) found significant spikes in SSI participation following cutbacks in the Michigan GA program as administrators directly referred caseload members to SSA offices. Similarly, Stapleton et al. (2002) showed that approximately half of new young (age 18 to 40) female SSI applicants from 1990 through 1996 were former recipients from the Aid to Families with Dependent Children (AFDC) program (the program superseded by TANF in 1996).²⁴ This increase in SSI applications was partly related to state administrators' incentives to save state dollars by moving welfare recipients from state rolls onto federal disability programs. Presumably, the incentive to move welfare recipients from state rolls to SSI has



increased since the implementation of state block grants under TANF (regardless of the number of recipients).²⁵ Currently, several state TANF offices have protocols to refer applicants who report a disability directly to SSA offices. Similarly, TANF recipients with disabilities have a strong financial incentive to apply for SSI, particularly those who live in states with low TANF benefits. While the difference between TANF and SSI benefits in some states is as low as \$20, the difference in other states, such as Alabama, is over \$400 (Stapleton et al. 2002).

During this same period, SSA disability programs, particularly SSI, have grown substantially. From 1989 to 2000, the number of adult SSI recipients grew by about two-thirds (from 2.2 million to 3.6 million). Earlier research indicates that much of the growth was a result of eligibility expansions, the recession in the early nineties, local SSA outreach efforts, and other factors related to state and local welfare programs (described above), but the relative importance of each of these factors is not known (Stapleton et al. 1995, 1999). Disproportionate shares of new SSI entrants are younger (under the age of 40) and have a mental impairment, suggesting that many young adults with disabilities will likely spend several years on the rolls (Rupp and Scott 1998).

Access to specialized services has also been changing, in part because of expanding costs and changing Medicaid-covered services. For example, while there has been a movement toward more MR/DD settings with smaller group sizes, the waiting lists for these services has grown significantly in recent years (Braddock et al. 2002). In the mental health system, there were significant cutbacks in state psychiatric hospitals; more hospitals were closed in the early 1990s than in the 1970s and 1980s combined (The Bazelon Center 2001). These cutbacks could have important consequences for many low-income adults who cannot access important services and often do not receive adequate specialized care.

Access to state programs, particularly Medicaid, could be further squeezed by projected state budget deficits. The Kaiser Family Foundation (2001) estimates that state revenue declines will create state budget shortfalls at \$69 billion nationally for FY2004. Many states are looking directly to Medicaid spending to stem the crisis. For example, nearly all states have tried to limit prescription drug spending, 37 states have cut or frozen provider payments, and 25 states are reducing benefits or limiting eligibility. Because Medicaid expenditures tend to be very high for those with disabilities, these changes could have negative effects on the quality of care received by many low-income adults with disabilities.

Unfortunately, the different evolutionary processes of state and federal programs have created a rather disjointed set of services and benefits for many low-income adults with disabilities. Programs such as SSI, TANF, and GA were started at different times with different goals and have evolved with different objectives over time. Hence, administrators and policymakers often view changes in programs in isolation, rather than in the context of the entire safety net. The movement of GA and TANF recipients to permanent SSA cash benefit programs is an interesting example of the lack of coordinated disability policy. While this movement increased the income of individual recipients, as well as saved state monies in GA and TANF payments, it occurred largely without input from federal legislators, who are now

dealing with burgeoning SSA disability caseloads. Further, while this transition might have improved the short-term income prospects of some people, it is unclear if this transition is always the best long-term economic outcome for all recipients, particularly those who might have some future employment potential.

Work Incentives

A related concern to the disjointed benefit and service environment is the mixed message these policies send to adults with disabilities regarding the importance of work. Many disability advocates view the ADA as both an important legal and symbolic change in policy that promotes employment and independence among adults with disabilities. At the same time, eligibility for SSA disability programs requires a person to prove an inability to work to obtain benefits.

This mixed message is likely the result of an evolution of different policy objectives over several years. Policymakers originally developed several disability-related programs, including SSI, based on the justification that adults with disabilities were among the “deserving poor” who needed cash support.²⁶ However, public attitudes toward people with disabilities have changed substantially since the passage of the ADA and now focus on integrating people with disabilities into the mainstream and on promoting employment as an important objective of disability policy. Policymakers have even emphasized the importance of breaking down barriers to employment for SSI and DI participants through such initiatives as the Ticket to Work program, even though these participants have proven at one time that they cannot work.

However, a major concern for policymakers interested in promoting employment among adults with disabilities is the steady decline in employment rates in this population over the past 10 years, a period that coincided with a major expansion in SSA disability programs.²⁷ Burkhauser, Houtenville, and Wittenburg (forthcoming) found significant declines in employment rates from 1990 through 1999 across several different disability conceptualizations (including the work limitation definition used above).²⁸ Further, Burkhauser, Daly, Houtenville, and Nigras (2001) showed adults with disabilities were the only major demographic group that did not experience an increase in employment or income during this period. Even recent efforts to expand rehabilitation opportunities through the Ticket program for those already on the SSI and DI rolls will likely have a very limited effect. The Ticket program will not likely offset the large current work disincentives embedded in both SSI and DI, which include high implicit marginal tax rates on benefits for earnings (approximately 50% in the SSI program) and the potential loss of health insurance if earnings exceeds a certain threshold (see Rupp and Bell 2002 for more details).

Summary

While an extensive safety net of programs provides an array of benefits to the general population with disabilities, the options for many low-income adults with disabilities, particularly those with less severe disabilities or limited work histories,



are generally limited. Those eligible for SSA disability programs must choose between following a “permanent disability path,” which includes a long application for SSA disability cash benefits, or a “work path,” which means finding a job that includes covering basic expenses and health care (Burkhauser and Daly 1996). Because health and other expenses might be quite large for many low-income adults, the permanent disability path is very enticing. For some, particularly those with children, a shorter-term “welfare path” might be available through TANF or GA. But in many states, TANF and GA participants with disabilities are forced to apply for SSI, which puts them back on the permanent disability path. Further, these state welfare programs have been significantly reduced in recent years.

A major gap in available services is the lack of temporary options for benefits and other supports. Without these options, many low-income adults with disabilities are forced into making decisions between permanent benefit programs and employment. Recent program and employment trends suggest that more adults with disabilities, particularly younger adults, are choosing to participate in SSA disability programs.

In upcoming years, policymakers will have to make some tough choices in providing benefits and services to low-income adults with disabilities. Access to certain specialized services might be heavily influenced by current state budget deficits. Before making cuts to these programs, however, policymakers should be aware of the potential changes these actions could have on this population, particularly if certain program cuts lead to unintended expense increases in other areas. For example, a cut in prescription drug benefits could have the unintended consequence of increased hospital visits if people are not receiving the appropriate treatments.

Policy Options

In recent years, researchers and policymakers have struggled to develop options for improving the safety net and promoting employment opportunities for adults with disabilities. A major issue in developing these options is balancing access to disability programs with the ideal of promoting independence. For example, some researchers are concerned that improving work incentives in the DI program could induce more people who are currently working to apply for DI. Hence, caution must be used in balancing these objectives.

Several options are currently being explored to improve program access or promote employment opportunities. These options include improving the disability determination process, implementing temporary support programs, and supporting employment of adults with disabilities through early intervention activities.

Disability Determinations

SSA is currently attempting to address some inadequacies in the disability determination process by updating the medical criteria they use to make eligibility decisions. Specifically, they are examining possible changes to the qualifying conditions

used in making the disability determinations (which are officially referred to as the *Medical Listings*).

Despite these changes, Robertson (2002) found that progress has been slow and much more work needs to be completed in this area. For example, Robertson notes that while it is important to update these medical criteria to improve the disability determination process, SSA has not updated important vocational criteria that are relevant to the disability determination process. Consequently, some of the methods used in this process are outdated.

A recent volume sponsored by the Institute of Medicine (Wunderlich et al. 2002) suggests a more comprehensive approach in revising SSA disability determination process, though its recommendations could also apply to other programs with a disability determination process. The two major concerns noted throughout the book are the inconsistency of disability determinations and the lack of research resources at SSA to better understand the disability determination process. The authors recommend that SSA develop a more systematic approach to incorporating economic, social, and physical environmental factors in the disability determination process. To develop these approaches, however, SSA would first have to invest in research to better understand the dynamics of disability.²⁹ SSA could then establish specific criteria for evaluating different approaches before implementing a revised disability determination process.

Temporary Disability Programs

To address the lack of temporary cash options for adults with disabilities, some have proposed creating temporary disability programs. Ross (1998) suggests a disability program that runs on two tracks. The first track would be for those who are least likely to return to work, and the second would be for those with some remaining capacity to function in the workplace. Participants in the first track would receive the same types of benefits as current SSA disability recipients, while participants in the second track would receive time-limited benefits. Similarly, Burkhauser (1998) proposes providing benefits to a subpopulation of DI beneficiaries on a time-limited basis. During this temporary period, beneficiaries could access the necessary services, such as training and VR, to enable them to return to work.

It is important to note, however, that a key goal for any proposed temporary disability program would be to develop a set of disability criteria for temporary benefits. These criteria would have to be flexible enough to distinguish between those who need permanent benefits and those who need shorter-term benefits.

Employment Supports

To promote better access to employment opportunities, policymakers have proposed several different types of early intervention efforts that aim to accommodate the effects of a particular impairment before it worsens and provide necessary services to adults with disabilities before they turn to SSA disability programs. SSA is

currently attempting to develop various pilot demonstrations that will provide early intervention services, including rehabilitation and temporary cash support, to SSA disability applicants (Berkowitz 2002). These demonstrations plan to test whether early intervention strategies can help keep some applicants in the workforce. Several state Medicaid programs are also attempting to provide health and rehabilitation supports that will help workers with disabilities remain in the workforce. As noted above, one of the most important supports is the optional provision of Medicaid after a person leaves a benefit program and the potential to buy in to Medicaid coverage for workers whose incomes are above state income eligibility thresholds. These supports address the concern over the potential loss of health coverage cited as an important barrier to employment by many adults with disabilities (Jensen et al. 2002).

Another option to promote employment is to increase the relative value of work by augmenting the salaries of people with disabilities through the use of tax credits. For example, Burkhauser, Glenn and Wittenburg (1997) suggest implementing a Disabled Workers Tax Credit (DWTC) to supplement the incomes of low-income adults with disabilities. Similar to the earned income tax credit, a DWTC would supplement the earnings of low-income workers through the tax code and hence improve the return on earnings. One possible target group could be SSA disability applicants, such as those in the early intervention studies, who could presumably use the benefit to increase the value of staying in the labor market relative to receiving permanent disability program benefits.

Finally, because low-income adults with disabilities often need a complex set of services to keep active in the labor force, states have also been modifying their approaches to providing services and setting up contracts with difference programs. For example, since the passage of welfare reform in 1996, it has become increasingly apparent that welfare-to-work programs need to increase the range of services provided and broaden the outcome measures used in contracts with service providers to reach a harder-to-serve population (Kramer et al. 2002). It is now common for welfare agencies to incorporate nonemployment as well as employment criteria—such as completed assessments or provision of case management services—into payment schedules, reflecting the reality that employment providers may have to provide extensive pre-employment and supportive services. The lessons from these programs could also be important in improving service delivery in other programs, including the new Ticket program.

Summary

While it is unlikely that policymakers could develop a single comprehensive system to serve all people with disabilities using a simple set of objective criteria, important policy options exist. As these policies unfold, state and federal officials will need to work more closely in developing policies across various programs to serve low-income adults with disabilities. These options must also take into account the complex dynamics of disability. As noted by Jensen et al. (2002, 1), “The design of a comprehensive, person-centered system requires breaking down policy ‘silos’ and

designing a system that recognizes the interplay between cash assistance programs (such as SSI and SSDI), health entitlement programs (particularly Medicaid), and other programs.” A more coordinated effort would protect against a change in one program having unintended consequences on another.

Conclusion

Our descriptive analysis from the National Survey of America’s Families illustrates the importance of understanding the health and functional limitation status of adults in designing policies to serve the low-income population. We find that low-income adults are more likely than other adults to report a health condition. We also show that those with a health condition face more difficulties in meeting daily needs than other low-income adults. Because of these issues, disability-related programs, particularly SSI, are becoming a much larger part of the safety net for all low-income adults.

Unfortunately, the safety net supporting many low-income adults with disabilities is more like a tangled web of conflicting goals and gaps in needed services. The opportunities for temporary cash, training, and rehabilitation support are generally very limited for many adults with disabilities, particularly those who have limited work histories or experienced disability onset outside of work. In general, the primary option for these adults is SSI, which will likely lead to a lifetime of program support. This outcome might be undesirable for some low-income adults, particularly those who have some work capacity that could be enhanced with further temporary training or rehabilitation.

The lack of economic progress by adults with disabilities relative to other demographic groups and the large amount of public dollars spent on these programs (over \$100 billion on disability cash transfer programs) suggest that policymakers should examine this safety net more closely. However, these gaps can only be effectively addressed if both researchers and policymakers take a more comprehensive view of each program within the safety net and develop a more coordinated policy in serving the complex needs of adults with disabilities. While no simple solution would address all of the gaps in the safety net, important options exist to serve this economically vulnerable—and growing—population.

Notes

1. We only include data from the 1999 NSAF. The NSAF is available in 1999 and 1997, with each round containing approximately 44,000 nonelderly families. For more information, see Wang, Cantor, and Vaden-Kiernan (1997).
2. The NSAF includes a mental health rating adapted from a five-item scale (MHI-5) used in the Medical Outcomes Study (MOS) (Stewart et al. 1988). The definition of poor mental health delineates the bottom 10 percent of the MOS distribution, as used by Loprest and Zedlewski (2001).
3. This definition is also very similar to popular disability conceptualizations developed by Nagi (1965, 1991) and used by the World Health Organization.
4. SSI benefits are also available to the elderly and children, though eligibility requirements for these groups are different than those for adults. For more information, see Burkhauser and Wittenburg (1996).
5. In recent years, just under 40 percent of initial applicants were awarded benefits at initial disability determination stage (SSA 2002). In general, most rejected applicants reapply for benefits. In fact, approximately one-third of new awards were awarded on appeal in 1999.
6. Specific income disregards and benefits allow SSI recipients to work and retain their SSI eligibility. All recipients have a \$20 monthly income disregard for all forms of income except means-tested transfer income. Recipients also have an additional \$65 monthly disregard for any labor income. After these disregards, a working recipient loses 50 cents for every one dollar in labor earnings. All other income, including benefits from Disability Insurance (DI), offsets SSI benefits dollar for dollar. In-kind assistance, such as food stamps, is not counted as income against the individual's SSI benefit. These rules apply to the federal SSI benefit, as well as any state supplement. Under Section 1619 of the Social Security Act, SSI recipients with earnings that exceed substantial gainful activity (SGA) level (\$780 in 2002) may still be SSI- and Medicaid-eligible. The Medicaid eligibility requirements are particularly important because most SSI recipients are eligible for Medicaid.
7. Rupp and Scott (1998) estimated that the average expected duration on SSI for recipients age 18 to 34 is 19.9 years.
8. Earlier research indicates that much of the growth resulted from eligibility expansions, the recession in the early nineties, local SSA outreach efforts and other factors related to state and local welfare program changes, but the relative importance of each factor is not known (Stapleton et al. 1995, 1999).
9. In general, as long as a DI beneficiary has earnings below SGA, which was \$780 per month in 2002, he or she do not lose any cash benefits. However, if benefits exceed SGA for a certain threshold period, a DI beneficiary could lose both DI and Medicare benefits. For a detailed explanation of DI benefit marginal tax rates, see Burkhauser and Wittenburg (1996).
10. Many DI applicants also receive SSI during their five-month waiting period before receiving DI benefits. Concurrent beneficiaries are also generally eligible for health coverage from Medicaid (because of their SSI eligibility status) *and* Medicare (because of their DI eligibility status). Consequently, the value of both the cash and medical benefits for these beneficiaries is higher than that for SSI-only recipients.
11. The \$20 monthly disregard for any income in calculating SSI benefits mentioned earlier could include income from DI.
12. In addition to these programs, five states (California, Hawaii, New Jersey, New York, and Rhode Island) have Temporary Disability Insurance programs that provide cash benefits to certain workers to ensure against wage loss when they cannot work because of sickness or injury not caused by their jobs. In general, these programs are similar to WC, except they do not require that the individual experience disability onset on the job, and the duration of payments is limited. Individuals can also privately buy insurance against the potential costs of a disability regardless of the location of onset (e.g., home vs. work), though it is unlikely that low-income adults could afford such an option (or work with an employer who provides this option). For example, Private Disability Insurance (PDI) is an employer-sponsored or individually purchased benefit that usually replaces 60 percent of earnings in case of a long-term disability. Generally, PDI programs are more readily available in higher paying jobs.
13. The TANF work requirements are relatively complex. In general, states must place adult TANF recipients in work no later than their twenty-fourth month of assistance. TANF recipients who do not satisfy

- the work requirements are subject to either reduced benefits or benefit termination. States that do not meet certain participation requirements are subject to financial penalties.
14. States often receive a share of back payments due to SSI and/or DI recipients if that person participated in temporary state programs while awaiting benefit determination. At the time of first payment, most SSI and DI recipients receive back payments because their date of disability onset—the date SSA uses to determine the benefit start-up date—occurs prior to receipt of their first payment.
 15. Most Section 1634 states automatically enroll SSI recipients in the state Medicaid program, though in some of these states, SSI recipients must complete a separate application before they qualify for Medicaid.
 16. Medically needy provisions generally cover individuals who have high medical expenses and are categorically eligible (e.g., disabled), but have incomes higher than state eligibility cutoffs.
 17. The specific target populations include DI beneficiaries with earnings and other income who face the prospect of losing their health benefits through Medicare if their income exceeds a certain threshold, current SSI recipients who have or could exceed current Medicaid income limits (under Section 1619), and people with disabilities who are not receiving any types of benefits.
 18. For example, the parameters of the buy-in will vary based on the state's current SSI supplemental payment, which varies significantly across states.
 19. Medicare coverage is also available for adults under age 65 who have End Stage Renal Disease (ESRD).
 20. Medicare coverage includes three parts: Hospital Insurance (Part A), Supplemental Medical Insurance (Part B), and Medicare+Choice (Part C). Part A provides coverage for inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Part B, which is voluntary (i.e., those eligible must pay a premium to participate), provides coverage for doctor services, other medical and health services (e.g., x-ray and other therapy), and home health services. Part C provides an expanded set of options for health care delivery (e.g., coordinated care plans).
 21. SSI and DI beneficiaries are automatically eligible for VR services, which are reimbursed through a special SSA reimbursement program. In general, the SSA reimbursement program reimburses VR agencies for successful employment outcomes of SSI and DI recipients that result in a decrease in SSA benefit payments. For a detailed description of this program, see Kregel and Revell (2003).
 22. It is important to note that many of these enrollees may still be in the process of achieving an employment outcome.
 23. The ADA also prohibits state and local governments from discriminating against people with disabilities in employment practices and in excluding people with disabilities from participating in or receiving benefits of programs, services, or activities. The ADA requires that all public and private transportation services be accessible to all people, including public accommodations (such as restaurants, movie theaters, museums, malls, and the like). Finally, the ADA requires telecommunication carriers to increase availability of interstate and intrastate telecommunications relay services.
 24. In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that transformed AFDC into TANF. These changes eliminated the open-ended entitlement and replaced it with a state block grant program. While states still have flexibility to determine eligibility requirements and benefit levels under TANF, those benefits are subject to federal time limits and work requirements. The federal time limit is five years, although states can choose a shorter limit. States are permitted to exempt up to 20 percent of their caseload from this limit.
 25. An important aspect of the interactions between TANF and SSI is the sources of funding for the two programs. The federal government pays for the bulk of SSI benefits (100 percent in some states), while states pay TANF benefits. While the federal government finances a large share of TANF benefits through block grants to the states, the size of the block grant is not dependent on the number of TANF recipients. Hence, states have a significant financial incentive to encourage TANF recipients who might be eligible for SSI to apply, or, in other words, to shift the burden of their support to SSI. Under AFDC, this incentive was smaller because states retained 50 percent or less of the AFDC benefit savings. Presumably, the major expansions in eligibility for SSI children during the early nineties provided additional incentive for children in AFDC/TANF families to apply for SSI benefits.
 26. The SSI program was established following the Negative Income Tax experiments. At that time, policymakers favored providing benefits to certain “deserving” groups, rather than the entire low-income population. The work rules for the SSI program are an adaptation from these earlier Negative Income

- Tax experiments. The DI program was initially established in the early fifties as an early retirement program for older workers with disabilities. The age of eligibility for DI benefits was gradually expanded following the implementation of the program.
27. Burkhauser and Stapleton (forthcoming) summarized several potential factors that other studies have identified as possible contributors, including SSA program growth, the implementation of the ADA, rising health care costs, diminishing overall health of the population, and changes in the characteristics of the population (e.g., aging). The evidence on the effect of the ADA on employment has been mixed. Kruse and Schur (2003) find zero or positive effects, whereas Acemouglu and Angrist (2001) and DeLeire (2000) find negative effects.
 28. They used data from repeated cross-sections of the Current Population Survey (CPS), Survey of Income and Program Participation (SIPP), and National Health Interview Survey (NHIS). They found significant declines in the employment rates of men and women relative to those without disabilities. The declines for men were very large, whereas the trends for women were flat, though significantly lower than the large increases for women without disabilities over this period.
 29. Specifically, they recommend developing research to better understand the relationship between the physical and social environments and work disability and the factors that influence work disability.

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