8/5/98

DIANA FORTUNA, DOMESTIC POLICY COUNCIL

BOX 4

DISABILITY FILES

ACCOMPLISHMENTS- DISAB.
ADAPT
ADAPT/CASA
ADAPT/HOUSING
ADA BACKLASH
ADA- CURB CUTS
ADA PSY. DISABILITIES
ADA 5TH ANNIVERSARY
ADA 6TH ANNIVERSARY
ADA TRANSPORTATION
ADULT EMPLOYMENT I
ADULT EMPLOYMENT II
AIDS + MGD. CARE
ANCOR SPEECH
APPOINTEES
APPOINTEES 3/96
APPOINTEES/ERSKINE
ARMY RESEARCH INSTITUTE FOR BEHAVIORAL & SOCIAL SCIENCES
BILL FLYNN
BLIND/COPY RIGHT
BUDGET CUTS/ ADA EVENT
BUNNING/KENNEDY
BUREAU OF LABOR STATS MEASURING EU RATE OF PEOPLE W/DISABLITIIES
CAP EXPANSION
CASA TESTIMONT- GINGRICH
CHILDREN/ POLLY ARANGO
CHILDREN W/DISABILITIES CONF. CALL
CHILDREN'S BINDERS
CIA INTERN

DIANA FORTUNA, DOMESTIC POLICY COUNCIL

DISABILITY FILES

ACCOMPLISHMENTS- DISAB.
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CIA INTERN

MEMO TO: PAUL DIAMOND
DIANA FORTUNA

FROM JEREMY BEN-AMI
SUBJECT IMPROVED EMPLOYEE SERVICES FOR PEOPLE W/ DISABILITIES
DATE APRIL 26

Attached are interesting ideas concerning privatization efforts of training and employee programs for people with disabilities from Pat Kemp, RCH Technical Institute.

Mr. Kemp will be in D.C. in a couple weeks and I'd like us to meet with him. Please call me (65584) with your thoughts.

JB - Maybe I am being territorial, but I'm surprised this would go straight to me & Paul.
- Diana

Fax Transmittal

Sender

RCH Technical Institute

20150 - 45th Ave. N.E.

Seattle, WA 98155

From: Pat Kemp

Phone: (206) 368-3316

Fax: (206) 368-3339

Receiver

Company: White House

Contact: Jerome Ben Ami

Phone:

Fax: (202) 456-7028

Transmission

Date: 4-24-95

Pages: 1-2 (Including This One)

Comments:

If there is any problem with this transmission please call 362-2273. Thank you.
Revised 1/4/95

RCH Technical Institute

Patrick R. Kemp
Executive Director

20150 - 45th Ave NE Seattle WA 98155

(206) 368-3316 FAX - 368-3339 TDD - 368-3346

DIMOND

Time limits: depression ~~[illegible]~~ - usually s-r
but wait 2yrs MC

Don't return to wk bec medical care - uninsurable

Cash + med link a problem — bundled → lazy

Not yes/no anymore

$6,000 → $30,000 to make work pay (unless St f g wt)

Are work incentives - no one understands them - all statutory
(2 for 1 tradeoff?)

Rcd Book

Restruct rel w/ rehab servs providers
- PWD wants choices, we want outcomes but pay for services
SSA reimburses state VR
- fall, can send them to private if VR rejects - new reg
$61m - 2.3b fed w/20% state match
SSA only reimburses if a success
Most severe are SSI, SSDI - some states love us, most don't

VR: 20% SSDI/SSI, 80% not

State DDS ~~[illegible]~~ meets w/VR - 10% referred to VR
Not mand ~10% of them are accepted by VR

Either Educ or Labor or Ec Security or VR

Want private mkt - can't do demo - reg/l
Ticket - value to provider of % svgs if wk - cld gen to level of salary ~~[illegible]~~
1 tkt to start - maybe apply for 2nd ticket

Testimony Before The
Subcommittee On Postsecondary Education, Training, And Lifelong Learning
Of The Committee On Economic And Educational Opportunities
U.S. House Of Representatives

On

How Training And Employment Services For Individuals With DisABILITIES Can Be Improved Through Greater Consumer Choice, Better Services Through Competition Among Providers, A Focus On Performance Measures, And Coordination Of Vocational Services Within An Integrated Statewide System Of Job Training And Employment Services

By

Pat Kemp

Executive Director

RCH Technical Institute

March 29, 1995

Washington D.C.

1/2 states supplement SSI $450/mo – Calif another $450
State incentives to convert welfare to SSI – 25% AFDC w/d qualify
Wkrs Comp – offset dollar for dollar; state-operated employer financed – NE (500/mo)
To State agency w/d to contact doc, unable to act SGA by virtue of impairment – DC etc.
60–90 days
Backlog 1/2 m appeals – 50% to appeals now – 85% chance you'll ultimately win

* CR re Morrissey hearings 5/9

CDRs reqd 3-5-7 yrs DI
SSI – no CDR req'd till latest legis.
800/yr for 6 yrs to get current
last yr: 165,000

*Chris/Jen: brief/Paul & MA who are disabled

Dimond/Daniels/Strahan/West 5/4/95

retirement/survivors/disab – 1950
↳ fewer quarters needed

'84: 2.5 m ~20
'91: 3
9?: 4 ~40

>45: high disab age
Baby boomers – dd double again

SSI – same disab definition
– gen'l revenue – orig'ly for hope not covered SSDI – elderly indigent

Now – ¼m – 90% disabled } New apps
10%
poor, many kids

Current rolls: 60% disabled

-old + poor or disabled + poor
↳ now mostly immigrants others & they're dying off

Both: 25 b
58 b: DI + SSI +60 MD + one for them

3 million/yr apply – 50% accepted ultimately
30% 1st time

46%↑** people applying are ≤40 – DI so low, so SSI – live longer
Ave age DI – 53 till '90 – early ret.

35% DI also SSI

More F eligible – wk history

30% die w/in 5 yrs

leave – >65
Die
Disab fixed
other

Chairman McKeon and members of the Subcommittee. Thank you for the opportunity to testify on my experiences with private sector systemic models of rehabilitation for persons with severe disABILITIES. I am Pat Kemp, the Executive Director of RCH Technical Institute in Washington State. Our vision: to provide the opportunity for economic independence through education that leads to employment for persons with severe disABILITIES. RCH starts with jobs and ends with jobs.

RCH Technical Institute is a private non-profit postsecondary training and employment center for persons with severe disABILITIES. Our 14 years of experience has demonstrated a **90% placement record of high expectancy employment outcomes for over 1200 individuals.** Our program participants are people with a broad range of disABILITIES including sensory, motion, psychological, and mild cognitive challenges. RCH offers programs in computer programming, electronics, business, computer aided design, customer service, and computer networking. **RCH focuses on jobs.** If a program doesn't lead to employment we find another one that does.

RCH is an employer driven system. The partnership between RCH and over 250 businesses ensures training is relevant and that participants are ready to enter the work force. For instance, 50% of a class that graduated two weeks ago is now employed. An IBM study states that each successful rehabilitation saves the taxpayers approximately $500,000 over the twenty five year working life of the individual. Based on this figure RCH's work to date will save the taxpayers in excess of 600 Million dollars.

Our demonstrated success is based on three major program components:

1. **Strong industry / private sector investment and participation.** Over 250 businesses participate in curriculum development, student mentoring, internship and apprenticeship programs, and classroom instruction. Industry needs drive our programs. Additional private sector investments are provided by in-kind contributions and direct funding. The business community donates in excess of 150 labor hours per student performing these tasks. Having bought into our program though participation, these same businesses hire our graduates.

2. **Private / public sector partnerships.** Over a decade of on-site seamless service with Washington State Employment Security providing placement support to program participants. On-site support from the Division of Vocational Rehabilitation. We are currently teaming with DVR on plans for an innovative service delivery demonstration model to be implemented in July of 1995.

3. **Systemic model of integrated service delivery.** Over ten years experience providing services in a model that today would be called a "One Stop Job Center". The concept of seamless employment services integrating comprehensive supportive services, program and training services, and placement services. Team counseling concepts that result in individualized participant planning and program implementation.

Let us first be clear that persons with severe disABILITIES have special needs and including this community in generic job training programs is problematic. We must preserve the integrity of the Rehabilitation Act. While there are many ways to implement this funding strategy, the key to successful employment of persons with severe disABILITIES is to maintain dedicated program funding.

Based on our experience, we are proponents of allowing greater privatization of vocational rehabilitation services for persons with severe disABILITIES. Greater privatization is a compassionate and efficient solution that will lead to:

1. More choice of services for people with severe disABILITIES
2. Better quality of services through competition
3. Increased capacity through private sector investment and match of federal funding
4. Development of national performance standards that will enhance optimal allocation of present and future scarce federal funds.

How can we achieve greater privatization? Allow the private sector the opportunity to compete on a level playing field by:

1. **Ensure participant choice** of rehabilitation options during all phases of the process. An individual with disABILITY may select any cost effective vendor (private or public) on the approved list maintained at a one stop center. This will ensure that the laws of supply and demand (free market system) determine market share for vendors.
2. Give the **private sector direct access to a percentage of Title I funds.** Allow the private sector to participate by raising private sector match dollars to increase the overall systems capacity. The resulting competition will foster greater choice and system effectiveness.
3. Create **national performance standards that are applied equally to both the private and public sectors.** Future decision makers will have a comparative basis for decisions on allocations to public and private sectors. In addition, performance standards will ensure quality service delivery and can provide a basis to ensure effective service for the most severely disABLED. It is also our belief that any national standards must include mandates for service to SSI/SSDI recipients capable of returning to work. Legislation should mandate uniform reporting guides and formats to ensure consistent national data.
4. Legislation should **require State Plans to specify how the private sector will be involved** in the rehabilitation process. States must demonstrate their proposed plans for private sector participation.

In conclusion, we are here today because you have a historic opportunity to change the inefficient way rehabilitation has been administered in this country. Federal dollars are eaten up in large bureaucratic systems, the end result being less services for those trying to enter and re-enter the work force. The private sector wants to participate in the process of getting people with disABILITIES into the work force and off of the government subsidies that cost taxpayers in excess of 200 billion dollars.

Finally, the most compassionate solution is the one that gets the most Americans with disABILITIES into livable wage jobs and off of the self esteem destroying subsidies. The compassionate solution is a systemic model that facilitates the transition from subsidy to the work force, provides maximum participant choice, provides maximum capacity for limited federal funds, and is based on healthy competition which leads to the best possible service.

We support and are very interested in your efforts to improve efficiency, reduce waste, and provide effective rehabilitation services to people with disABILITIES. If we can provide additional information to support your efforts please contact Pat Kemp at RCH Technical Institute (206) 368-3316. I respectfully request that this testimony and transcripts from any questions be entered into the hearing record.

Thank You.

Patrick R. Kemp
Executive Director
RCH Technical Institute

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

22-Mar-1995 10:58am

TO: Carol H. Rasco
TO: Jeremy D. Benami

FROM: Diana M. Fortuna
Domestic Policy Council

SUBJECT: SSA draft plan on disability

Susan Daniels just briefed me on a confidential plan she has been working on for six months that is intended to encourage SSA's disabled beneficiaries on SSI and SSDI to work. She is planning to seek Chater's approval of the plan in the next few weeks, and so has been shopping the plan around -- supposedly quietly -- to different players to get a sense of what the reaction would be.

The plan is fairly bold. It is intended to be budget neutral, but they are still playing with the numbers. It has four "pillars":

1. Earned income tax credit: This is intended to assist low-wage disabled wrokers. Susan is aware that it may be difficult to persuade people to add the disabled to what is strongly identified as a benefit for families, but asserts that something reasonably significant could be done here for very little money. Also she points out that the last EITC expansion included some benefit for individuals for the first time. I know Jeremy says we would have some wariness on such a proposal.

2. Extended medical benefits for those on SSI: SSI beneficiaries who go back to wrok would keep their Medicaid coverage indefinitely. They would contribute to the cost of Medicaid on a sliding scale starting at 200% of poverty. Susan argues this is not as expensive as it sounds because the vast majority of SSI beneficiaries never leave the program and therefore are on Medicaid indefinitely anyway.

3. "Ticket" for rehab services: This proposal is similar to the one in the Middle Class Bill of Rights that would give a person a ticket or voucher for services. The person could use it whereever he or she wanted, at a public or private rehab agency. Part of the goal here is to create a "market" for rehab services. The rehab agency would only be paid if the person got a job, and then they would get some percentage of the savings in SSI payments. They would get this amount every year the person continued to work, on the theory that would make the rehab agency take a continuing interest in clients rather than placing people and

forgetting about them. Susan argues that, since only 1/2 of 1% of SSI and SSDI beneficiaries ever leave the rolls to return to work, we can't do any worse than we already are. A variant on this would allow a rehab agency to get some percentage of any longer-term savings up front if they needed to invest in assistive technology or some other one-time cost for the person.

4. Create a new SSI program for 18-25 year olds: To handle the difficult transition from the kids program to the adult, the plan would make 18-25 year olds eligible for a special means-tested cash stipend that they could use for living expenses and training, with the proviso that if they weren't working within 5 years they could apply for the regular adult SSI program.

This 18-25 year old program has two other interesting and controversial features: First, it would deem more family income as available to 18-25 year olds. Currently, a lot of non-poor kids suddenly become eligible at age 18 because their family's income is no longer relevant to the eligibility determination. Susan likened this plan to Pell grants, which regards young adults as not yet emancipated financially. Second, these young adults would be eligible for a one-time voucher worth about $700 that would entitle them to an independent assessment of their best prospects for employment. The agency that takes this voucher would be prohibited from taking the "ticket" for this person. This agency would help them select a rehab or training provider and explain benefits like EITC and extended medical benefits.

Obviously this plan is pretty risky and bold. It does however fit with a lot of the themes of the Administration, in terms of empowering individuals, encouraging work, avoiding a "big government" approach, and incentivizing the private sector. There are a lot of risks in terms of paying out funds in unusual ways: Medicaid for working people, ongoing incentive payments to private rehab agencies who successfully placed disabled individuals. Another consideration is how it relates to the welfare reform debate.

One question I immediately had was why Susan is developing this in isolation from the disability policy review process. Susan says she is prepared to run it through our process if she gets Chater's OK on it. On the other hand, it is wise to keep it quiet for now. That raises another issue: as she is talking to more people, the likelihood that this will leak out gets greater. Folks like Judy Heumann and Liz Savage now know about it, and I know they have some serious reservations about parts of it, and about whether Susan is adequately concerned about protecting the people with disabilities.

Any reaction? How would you like to proceed?

3/13/95

80 4m / 25b
94 8m / 57b

Four Pillars – brief Comm

make work pay

1. EITC · work effort – esp young, low wage
   ~~Bunkhouses~~ – camel's nose – indivs
   On IM rolls – $160m cost not net
2. Extended MA elig – ads getting MA indefinitely
   add 1m/yr
   DI – 2 yr wait; then MC for 3 yrs (@ $230/mo
   Chem can purchase $300/mo
   → HCFA proposal – 3 yr indefinitely
   ~~After~~ After ½ 2 yrs, accel MC, if wkg
   > 9 mos, lose DI
   (unless medically recover, lose all)

30% DI are also SSI
Keep MA up to state threshold 90–135 range
→ SSI: Keep MA indefinitely ~~@~~ 200% pov
pay some %; event. 2010
(Very unfavorable
MC reform – work ext – fit in protection
if wkg we pay
3. Rehab – ask at ag to serve — > 9 mos. – full cost
Monroe Berkowitz prog bonus

New reg: private providers if state fails to serve > 4 mos
→ Consumer gets ticket; when wk, provider draws $ for svcs

What happens to VR - still exists
only SSI benes (serve less disabled
State VR only serve 1% applicants
only 2% VR - is SSA
Gov decides
Varies a lot by state
Defense; Avoid rolls
Cheaper to serve less disabled

Δ rel. bene, SSA, rehab network.

Would they have gotten off anyway? They don't
<½% go back to work
To whom you give ticket - too expensive
to screen out ½%
Not worth cost of screening out

4. Bundle 18-25 yr olds
1 m kids
polit hardest
→ Reg SSI starts @25 (30?)
Childh prog end @18
18-25 spec class
Elig: trg stipend - means tested ~ close to current
Middle-y ~ ~$100/mo.
Expect fams to help - yda fell - not yet emancipated
Flexible cash

5 yr time limit
If not wkg, but progress, extend
If not, apply for reg

Continue to deem fam y

Blp of 18 yr old on rolls

Stipend - no other cash

→ Voucher - $700 - services - indep assessment (one time over 5yrs.)
can go to indep agy
Whoever takes this can't take tkt
Best projects for E
Helps select provider
Explain EITC, extd bens)
(SSA not rehab bus, but incentivizes)

Ticket - pd out yrly - indefinitely
high recidivism
Forever? - → assistive techn one time cost
Accid reimb tkt - get 60% svgs upfront
Save nada - after EITC + %

↳ not just legal →
also educ, eqt

→ Expand P+A - alumni w/ Het gets P+A
for mission

→ Accomm TF - grant 18-25
enormous upfront costs - assist techn
capped grant - private contractors
won't mac get served
or revolving loan - worth admin hassle?
- don't have

= ?

cost savings greater if take off ass personality type

CR → reaction - pre charter

→ Who else?

Title XIX or XX - State level - VR not main provider
private lt disab info. / who comp.

MARCH 1, 1995

NOTE TO: NATIONAL DISABILITY POLICY REVIEW PANEL
EMPLOYMENT OF WORKING AGE ADULTS WORK GROUP:

David Levine, CEA
Lynn Margherio, DPC
Diana Fortuna, DPC
Elisabeth Cohen, DPC
Judy Heumann, ED/OSERS
Howard Moses, ED/OSERS
Connie Garner ED/OSERS
Paul Miller, EEOC
Andy Imparato, EEOC
Ruth Katz, HHS
Bob Williams, HHS
Susan Hill, HCFA
Josephine Nieves, DOL
Bill Burrell, DOL
Jeff Levi, ONAP
Michael Grant, OPM
Marilyn Thornton, OPM
Rick Douglas, PCEPD
Mary Kaye Rubin, PCEPD
Dennis Duffy, VA

FROM: Susan M. Daniels, Ph.D. S.D.
Associate Commissioner for Disability/SSA
Chair, Employment of Working Age Adults Work Group

This is a reminder for our next meeting, scheduled for Wednesday, March 8, 1995, 1:00 - 2:30 p.m., HHH Building, Room 640H.

Attached, please find our agenda. I have invited Professor Emeritus, Monroe Berkowitz, from Rutgers University Bureau of Economic Research to address our group.

Also attached is a two page summary of a paper that Professor Berkowitz presented at a recent NASI (National Academy of Social Insurance) meeting. Many of his ideas are timely for us to consider as we continue reviewing and analyzing Federal disability policy.

ACTION ITEMS:

- Though we did not discuss this at the last meeting, I would like to have recommendations from your principal representatives, who have been unable to join us, as to what they would like to see reflected in our final product to the Domestic Policy Council. These recommendations, of course, will be based on our draft paper describing barriers to employment for people with disabilities. Please come prepared to share these recommendations with us.

- Follow-up on Labor reaction to EITC (Andy Imparato)
  Follow-up on response to advocates, 2/13 mtg (Delores Watkins)
  Please be prepared to give us the scoop.

If you have any questions, please contact April Waugh of my staff at (410) 965-8046. See you next week!

NATIONAL DISABILITY POLICY REVIEW
Work Group on Employment of Working Age Adults

Meeting -- Wednesday, March, 8, 1995
1:00 p.m. - 2:30 p.m.

Hubert H. Humphrey Building, Room 640H
200 Independence Avenue, S.W.

Welcome and Introductions
Susan M. Daniels, Ph.D., Convener

Follow-up Items
- o Organized Labor response to the EITC (Andy Imparato)
- o Response to Advocates from 2/13 mtg (Delores Watkins)

Federal Response
Marie P. Strahan and Jane West
- o Current Federal Programs Chart
- o Goals of Current Federal Programs and Eligibility
- o Draft Outline for Analysis Section

A Discussion of Improving The Return to Work of Social Security Disability Beneficiaries
Monroe Berkowitz, Professor Emeritus
Rutgers University, Bureau of Economic Research

Questions & Answers

Next Steps

Adjourn

Thank you for your attendance

National Academy of Social Insurance

December 9, 1994

Improving The Return To Work Of Social Security Disability Beneficiaries

Monroe Berkowitz

After noting that our interest is in a beneficiary rehabilitation or return to work program rather than a rehabilitation program for persons who are not receiving benefits, we begin with a look at the market for rehabilitation services recognizing that a free market for such services has not had much of a chance to exist. The purpose of sketching what an ideal market would look like is to expose the multiplicity of decisions that must be made in the absence of a market.

These decisions involving such items as the selection of candidates and the specification of the services to be offered, the questions of who should offer services and when and by whom they should be offered are explored in the next section.

We then briefly examine the current system used in the Social Security Disability Insurance program to return beneficiaries to work. The record is not a good one with only 1/2 of 1% of those coming on the rolls each year exiting via the rehabilitation route. Some of the current schemes designed to improve the process are briefly examined. These include schemes that seek to change fundamental aspects of the DI program and those that work within current constraints and propose to use vouchers.

We concentrate on one program that is a variant of a voucher program. Beneficiaries are given tickets that may be deposited with a wide range of private or public sector service providers. Nothing is paid these providers up front. No beneficiary is obliged to deposit a ticket and service providers are not obliged to accept any particular ticket.

Once deposited, the ticket becomes a contract between SSA and the provider. If the person leaves the rolls and goes to work, SSA agrees to pay the provider some percentage of the benefits that would have been paid to the person. The payments would be made yearly and only after the person leaves and stays off the rolls.

The evidence is clear that beneficiaries move off and on the rolls and the provider has an incentive to monitor the case during the entire period of eligibility for benefits, normally up until the person dies or reaches the age of 65.

The proposed scheme is applicable to the SSI program with some modifications. No feasible way is found to apply the scheme to applicants or to persons who are in the pre-application stage.

Conclusions

This paper is based on the premise that the current system in place designed to return disabled beneficiaries to work desperately needs fixing.

We assume that SSA has its hands full trying to make the disability determination process work in an equitable and efficient manner and that it has neither the expertise nor the financing to engage in the rehabilitation of its beneficiaries.

At the same time, we assume that the return to work of persons on the rolls is a responsibility of SSA.

Another important assumption is that there is no one formula, modality, or type of rehabilitation service that is obviously superior to another when it comes to returning beneficiaries to work.

Problems of what service to be used, when it should be used, who should be provide the service are best left to the market. In this proposal, we provide the beneficiary with a ticket that can be used to obtain services from a wide variety of providers. We leave it to the interaction of the beneficiaries and the providers to come up with a set of services and the conditions under which these services will be administered. In the absence of a market, we propose a system that retains some of the advantages of a market.

Payments to providers are based on results. If the beneficiary does not return to work, no payments are due. The risk is borne entirely by the provider whose incentive to get into this business is based on the generosity of the amounts received if the beneficiary returns.

The experience of the DI program is that persons move off and on the rolls. The system of compensation proposed here, where providers are paid on a yearly basis only so long as the person is off the rolls, guarantees continued interest and monitoring.

SSA has nothing to lose from this system in the sense that they can never pay providers more than a fraction of the savings accruing to the trust fund, and then only after they have the evidence that the savings have been realized.

For the system to work, providers have to be attracted to it and be willing to finance back to work programs on this contingency basis. Congress has to be convinced that providers should be paid amounts that have no necessary relationship to the cost of services provided.

All preliminary evidence is that providers will come once the legislation is in place. Our urgent recommendation is that legislation authorizing such a scheme be enacted. It can do no harm. It will be a real world concrete demonstration of what works and what doesn't work in the field of rehabilitation and it just may improve our 1/2 of one percent return to work record.

Adult Employment

EXECUTIVE OFFICE OF THE PRESIDENT

22-Mar-1995 12:11pm

TO: Diana M. Fortuna

FROM: Jeremy D. Benami
Domestic Policy Council

CC: Carol H. Rasco

SUBJECT: RE: SSA draft plan on disability

My reactions are:

(a) extremely positive substantively. Susan had shared some of these ideas with me many months ago and I like them, with the EITC caveat

(b) I completely share your question on why this is not part of the disability policy review. It is EXACTLY what the policy review is about - a fundamental rethinking of the nature of our programs and policies. Rather than being secretive, what is wrong with an open discussion of the proposals. WHAT THE HECK is her work group doing if not addressing these very questions. WHAT is the transition group doing if not addressing these questions????

Let's discuss!

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

22-Mar-1995 04:39pm

TO: Diana M. Fortuna

FROM: Carol H. Rasco
Economic and Domestic Policy

CC: Jeremy D. Benami

SUBJECT: RE: SSA draft plan on disability

My sentiments are that this is exactly what the policy review was designed to do....put ideas on the table...I personally resent Susan's method on this...I don't understand why anyone within a working policy review has to get permission of their director to put ideas on the table. I think the warning to her should be that this belongs in the policy review and then perhaps a caution to others in the review that all ideas should be able to be put forth and discussed in the context of the review without starting campaigns for and against. It is dangerous that Judy H. has heard about this outside the policy review context.

FEDERAL EMPLOYMENT PROGRAMS SERVING PEOPLE WITH DISABILITIES - The Fleet

(in thousands of dollars)

DRAFT

List of Programs		1994 Actual	1995 Appropriation	President's 1996 Request	#'s served in 1994	Employment Outcome
DEPARTMENT of LABOR						
Job Training Partnership Act-- Grants to State					people with disabilities	
Adults	total	988,021	1,054,813	1,054,813	25,000(10%)	not
Youth	total	658,682	548,682	288,979	37,000(15%)	available
Summer Youth	total	876,674	867,070	871,540	96,000(15%)	
Job Training Partnership Act-- Pilots & Demonstrations Account		4,172	4,172	4,172?	6,800	"
U.S. Employment Service					468,136	"
Veterans Employment Programs						
Unemployment Compensation	*We do not collect data on disability. Assumption is that if you're disabled, you do not work.					
Disabled Veterans Programs						
Special Certificates (sub-minimum wage)	In Fiscal 1993, DOL issued approximately 8,000 certificates to employers (sheltered workshops) for 175,000 workers with disabilities.					
DEPARTMENT OF EDUCATION						
Carl D. Perkins Vocational & Applied Technology Education Act		1,183,423	1,178,088	1,178,000		
Vocational Rehabilitation State Grants		1,974,145	2,054,145	2,118,834 (includes eligible and not served and waiting lists)	1,193,448	202,949
Supported Employment Services for Individuals with Severe Disabilities		34,536	36,536	38,152	26,000	7,450
Projects with Industry		22,071	22,071	22,071 (severe)	17,644 13,647	11,232 8,632
Special Demonstration Projects (Including Supported Employment Demonstrations)		31,676	34,158	23,942		

All supported employment and SSA placements are reflected in the Title I Vocational Rehabilitation program statistice. The majority of PWI cases are also included in the Title I counts.

FEDERAL EMPLOYMENT PROGRAMS SERVING PEOPLE WITH DISABILITIES
(in thousands of dollars)

DRAFT

List of Programs	1994 Actual	1995 Appropriation	President's 1996 Request	#'s served in 1994	Employment Outcome
SOCIAL SECURITY ADMINISTRATION					
SSA Vocational Rehabilitation Reimbursement Program	63,500,000	77,100,000	79,400,000	referred 172,000	10,297

*Of those persons referred SSA has no information on how many people received services from State VR.

SSA Work Incentive Provisions
Plans for Achieving Self Support
Impairment Related Work Expenses
1619 A and B

DEPARTMENT of HEALTH and HUMAN SERVICES			
Social Security Disability Insurance-- Total Costs (Outlays)	37,984,130	41,561,129	45,631,558
Supplemental Security Income Program-- Total Costs (Gross Budget Authority)	30,707,902	30,965,101	28,432,555
Medicare -- Total (Outlays)	40,601,162	41,462,758	67,583,000
Medicaid -- Total (Budget Authority)	89,077,413	89,240,775	82,142,072

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION			
total	230,000		18,859 charges (20% of EEOC's charges are brought under the ADA

OFFICE OF PERSONNEL MANAGEMENT

FEDERAL EMPLOYMENT PROGRAMS SERVING PEOPLE WITH DISABILITIES
(in thousands of dollars)

DRAFT

List of Programs	1994 Actual	1995 Appropriation	President's 1996 Request	#'s served in 1994	Employment Outcome
INDEPENDENT AGENCIES					
Architectural & Transportation Barriers Compliance Board	3,348	3,350	3,656		
Committee for the Purchase from People who are Blind or Severely Disabled	1,689	1,682	1,800		
National Council on Disability	1,690	1,793	1,830		
President's Committee on Employment for People with Disabilities					
Small Business Administration - Handicapped Assistance Loan Program					
The Corporation for National and Community Services	367,200	575,000	817,476		
TOTALS:					

Adult Employment 1.0G
Michele Adler, HHS
ASPE also

Figure 3
Definition of Disability
For Cash Benefits

Program	**Purpose of Definition**	**Definition**
		Cash Benefits
Disability Insurance (OASDI)	Entitlement to benefits to partially replace past earnings.	INABILITY TO WORK. Inability to engage in SGA by reason of a medically determinable physical or mental impairment that is expected to last 12 months or result in death. The impairment must be of such severity that the individual cannot, after taking account of his age, education and work experience, do his previous work or any other work that exists in the national economy.
Private long-term disability insurance	Contractual entitlement to benefits to partially replace past earnings.	OWN OCCUPATION/ANY OCCUPATION. Often, for first 2 years, inability to do own occupation. Then inability to do any suitable occupation.
Private short-term disability insurance	Contractual entitlement to benefits to temporarily replace earnings.	OWN JOB. Inability to perform own job.
U.S. Civil Service disability	Federal employees' entitlement to disability pension.	OCCUPATIONAL. Because of disease or injury, unable to render useful and efficient service in the employee's current position or in a vacant position in the same agency at the same pay level for which the individual is qualified for reassignment.
Railroad retirement disability annuity	Railroad workers' entitlement to monthly annuity based on disability.	TOTAL AND PERMANENT DISABILITY (same as OASDI). OCCUPATIONAL disability (for workers with 20 years' service and current connection with RR job) is inability to perform the workers' regular railroad job.
Veterans' Compensation	Veterans' entitlement to compensation for disability caused during military service -- ranging from 10 to 100% disability.	A rating board of the Department of Veterans' Affairs looks into a black box to determine each individual's disability rating. We have found no expert at the DVA who can explain the main idea underlying what constitutes any particular rating.
Veterans' Pensions	Veterans' entitlement to means-tested pensions, for those with specified wartime service.	TOTAL DISABILITY. Injury or disease sustained outside of military service rendering the veteran totally impaired, based on veteran's ability to function at work or at home.
Supplemental Security Income (adults)	Entitlement to means-tested cash assistance.	INABILITY TO WORK. (same as disability insurance -- OASDI)
Supplemental Security Income (children)	Entitlement to means-tested cash assistance.	Comparable to INABILITY TO WORK. (same as disability insurance -- OASDI) Modified with individualized functional assessment based on age-appropriate functioning.

Figure 4
Definitions of Disability
for Civil Rights and Service Delivery

Program (law)	Purpose of Definition	Definition
Civil Rights Protection		
Americans with Disabilities Act	To determine who is protected by the non-discrimination and public accommodation provisions of ADA.	BROAD. Individual with a physical or mental impairment that substantially limits one or more major life activity; a record of such an impairment; or being regarded as having such an impairment.
Eligibility for Services		
Vocational Rehabilitation (Federal/State program)	To determine who is eligible to receive VR services.	SERVICE NEED. Individual with a physical or mental disability that is a significant impediment to employment, and requires VR services to prepare for, enter, engage in or retain gainful employment. SERVICE DELIVERY. If accepted for services, individualized written rehabilitation plan (IWRP) lists goals and individual services to be provided.
VR - Private employment based disability insurance	To determine who might be offered employer-financed VR services (which are not part of contractual employee benefit agreement).	COST/BENEFIT. Employer- or insurer-financed VR services are at the discretion of the employer/insurer and are provided based on cost recovery potential of the employee to return to work. SERVICE DELIVERY. At the discretion of the employer/insurer, subject to agreement of the worker.
Medicaid -- institutional care	Eligibility for Medicaid-financed institutional care, or community-based alternative	ADL LIMITATION. Needs assistance with Activities of Daily Living (ADLs) or medical assessment of need for institutional care. Depends on the State plan.
Clinton Health Care Reform Plan	Eligibility for home and community based care under the proposal.	ADL LIMITATION. Requires assistance to perform three of five ADLs: eating, bathing, dressing, toileting and transferring; or sever cognitive or mental impairment, or severely disabled child under 6 years of age.
Special Education -- Part B	Eligibility of children age 3-21 for special education services.	TYPES OF DISABILITIES. Categories include mental retardation, hearing, speech or vision impairment, serious emotional disturbance, orthopedic or other health impairment, deaf-blind, multi-handicapped, or severe learning disability. SERVICE DELIVERY. Individualized education plan (IEP) describes services the school system is obligated to provide the student.

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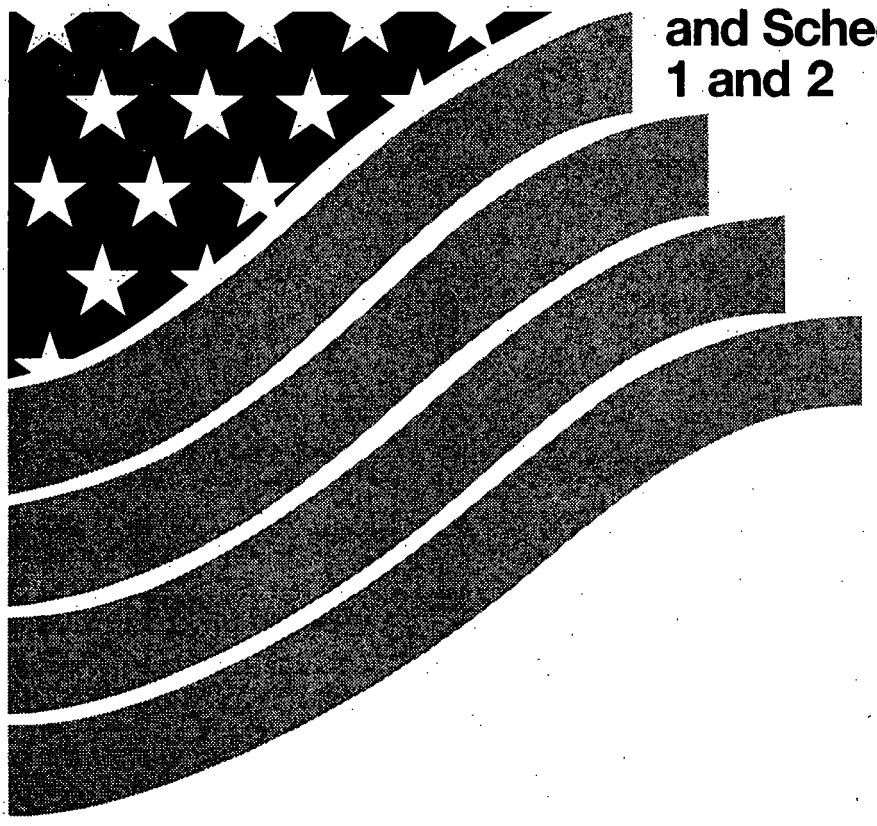
Instructions for Form 1994 1040A

and Schedules 1 and 2



Check your social security numbers (SSNs)!

Incorrect or missing SSNs for you, your spouse, or dependents may delay your refund. See page 8 for details on how to get an SSN.

Can you take the earned income credit for 1994?

If a child didn't live with you, you earned less than $9,000, and you or your spouse were at least age 25, you may be able to take this credit. If a child lived with you and you earned less than $25,296, you may be able to take a larger credit. See the instructions for line 28c on page 44.

Would you like to get your refund within 21 days?

If you would, have your return filed electronically as millions of others do. See **Electronic filing** on page 5.

Note: *This booklet does not contain any tax forms.*

Department of the Treasury
Internal Revenue Service

What's inside?

Cat. No. 12088U

Adult Employment Work Group

Post-it® Fax Note 7671	Date 2/1/95	# of pages ▶ 9
To Diana Fortuna	From Marie Strahan	
Co./Dept.	Co.	
Phone #	Phone #	
Fax # 202-456-7028	Fax # 410-965 6503	

Disability Expenditures

Monroe Berkowitz
Carolyn Greene

Benefit payments under Social Security Disability Insurance (SSDI), perhaps our largest single government disability program, have exhibited trends that are not satisfactorily explained by changes in economic or demographic conditions. The number of monthly beneficiaries and the amount of the awards under SSDI increased dramatically from its inception in 1957, peaked in fiscal year 1975, and now shows signs of increasing again.

One aspect of disability expenditures that stands out is that *so much* is being expended in this area. Disability is an expensive phenomena — a fact that is not always appreciated when we look at one program or one area in isolation. What unites these expenditures for the more than 75 programs? What allows us to group these sums together?

In work done under an NIDRR financed project entitled, "Enhanced Understanding of the Economics of Disability," we have examined total disability expenditures for the population 18-64 years of age from 1970 to 1986. We define disability expenditures as those sums that would be eliminated if, by some magic, disabilities were to disappear from the face of America. There is neither a universal definition of disability expenditures nor an agreement on how they should be calculated. Neither are these disability expenditure data represented in one place; what follows are necessarily estimates.

We recognize that our estimates of total disability expenditures are conservative due to missing and unavailable information. Most notable is the lack of complete coverage of data about expenditures made by private organizations (either through services or actual payments to disabled people), housing and transportation expenditures and out-of-pocket expenses paid by disabled people themselves. However, our estimates have been generated regularly using an estimation methodology that has remained consistent in each year.

Total Disability Expenditures — 1986

We estimate the value of disability expenditures in 1986 was over $169.4 billion (See Chart 1). This amount is made up of three types of expenditures. The first type is *transfer payment* expenditures, which totalled over $86.5 billion in 1986. Transfer payments are the actual funds that are allocated each year to people, because of disabilities. We have divided the transfers into four categories, which emphasize the major reasons why monies are transferred to disabled people. This division is only one of the many possible ways that transfer payment programs could be grouped.

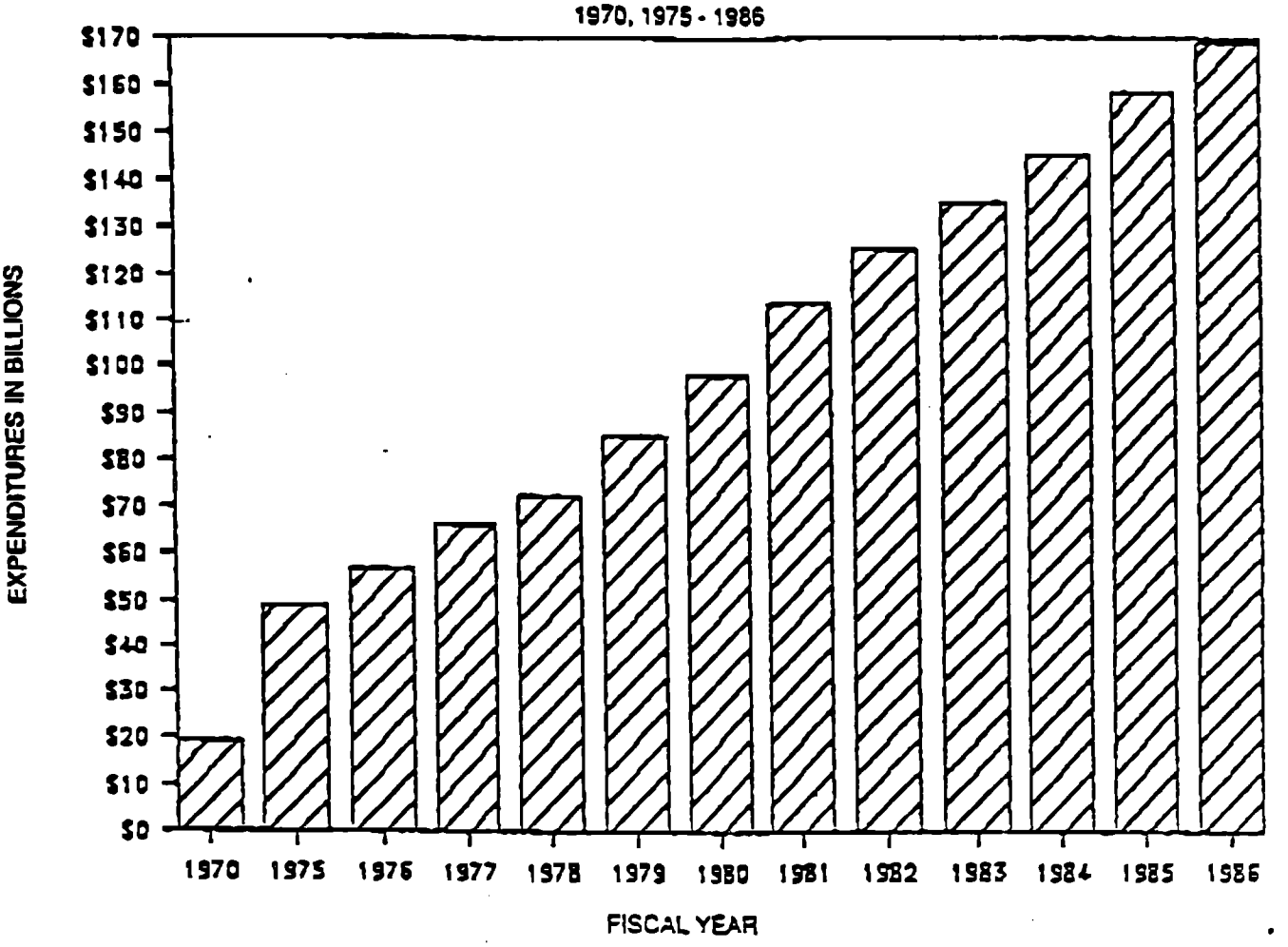
Programs that pay money for a disability because their participants are insured against that contingency occurring fall under two categories: *social insurance programs*, such as Social Security Disability Insurance, under which there is compulsory coverage of the working population; and *individual and employer provided insurance*, which an individual buys or an employer provides to employees. A third category is the *indemnity programs*, in which disabled people receive funds if they are involved in accidents where some other person is at fault. The programs under *income support*, the fourth category, pay disabled people who can demonstrate that they are without sufficient resources. An example of this category is Supplemental Security Income (SSI) for disabled and blind recipients. Table 1 displays the four categories of transfer payments and the programs within each category.

The second type of expenditures for disabled people are medical care expenditures, which amounted to over $79.3 billion in 1986. Medical care differs from transfer payments in at least two aspects. First, medical care expenditures involve using real resources, such as a hospital bed or a prescription drug. Transfers, however, are only movements of funds from one segment of the population to another. The other difference is that even if a disabled person becomes well enough to return to work and consequently transfer payments are stopped, medical

CHART 1

DISABILITY EXPENDITURES

1970, 1975 - 1986



care expenditures could still continue in order to maintain the ability to work. Despite the differences between medical care and transfer payments, the four categories used to describe transfers (social insurance, individual and employer provided insurance, indemnity, and income support) are also used to classify medical care expenditures. The breakdown of medical care expenditures into specific programs can be seen on Table 2.

Direct service expenditures are the smallest of the disability expenditures. Of the $169.4 billion expended for disabled persons in 1986, only a little over $3.5 billion was spent on direct services. The nature of the programs included under direct services leads to difficulty in separating the programs into the four categories used for medical care and transfer payments. Therefore, direct service expenditures are classified in the following five functional categories:

The first half of the 1970's was the period of the most vigorous growth in disability expenditures.

rehabilitative services, veterans' services, services offered to persons with specific impairments, general federal programs,

and employment assistance programs. Table 3 shows the direct service expenditures for 1986.

Trends in Total Disability Expenditures

Our goal now is to place the seemingly large disability expenditures estimate in perspective. Heightened interest, awareness and concern about these expenditures stem not so much from the absolute amount of money involved, but from the sharp increase in these amounts over the years. These concerns persist, although the rate of increase (growth rate) in these sums has slowed considerably. We will examine the movement of the disability expenditures growth rate in three stages.

Fiscal Years 1970-1975

The first half of the 1970's was a period of new governmental programs and social experimentation. From 1970 to 1975, social welfare expenditures (the expenditures for income maintenance, health, education, housing, veterans' programs, and other welfare services) increased by 14.75 percent each year, rising from $145.9 billion to $290.1 billion. Spending on social programs was increasing at a faster rate than the economy was growing. During this period, the *Gross National Product* (GNP) was increasing at a rate of 9.5 percent per year. The growth rates of disability expenditures, social welfare expenditures and GNP are shown in Chart 2.

As fast as social welfare spending was increasing, disability expenditures were increasing at a faster rate. Indeed, the first half of the 1970's was the period of the most vigorous growth in disability expenditures. Between 1970 and 1975, disability expenditures increased by a total of 152 percent, or 20 percent annually, from $19.3 billion to $48.7 billion. In 1970, disability expenditures amounted to 13 percent of social welfare expenditures. By 1975, however, they had increased to 17 percent, reflecting the expanding awareness of and willingness to help

Table 1

Transfer Payment Expenditures - 1986

	Amount in Thousands
Social Insurance	
OASDHI:	
Disability	$20,124,114
Survivors	1,839,055
Retirement	511,324
	22,474,493
Individual and Employer-Provided Insurance	
Whole Life	540,000
Health / Long-term Disability	2,085,583
Accidental Death and Dismemberment	391,160
Federal Life	88,274
Federal Civil Service	1,665,960
Railroad Retirement	358,974
Armed Forces Retirement	970,726
Other Federal Retirement	1,479,870
State and Local Retirement	1,386,844
Private Pensions	1,872,120
	10,839,511
Indemnity	
Workers' Compensation:	—
Federal:	
FECA	845,160
Longshoremen and Harborworkers	49,486
Black Lung Benefits	768,887
State Workers' Compensation	10,706,440
Veterans' Compensation	5,727,276
Automotive Bodily Injury	9,330,867
Miscellaneous Bodily Injury	17,558,964
	44,987,080
Income Support	
Veterans' Pension	1,096,406
Supplemental Security Income	5,394,009
AFDC	1,751,776
Food Stamps	775,723
	9,017,914
Total Transfer Payment Expenditures	87,318,998

Table 2

Medical Care Expenditures - 1986

	Amount in Thousands
Social Insurance	
Medicare	
Hospital Insurance	$5,143,044
Supplementary Medical Insurance	3,685,365
	8,828,409
Individual and Employer-Provided Insurance	
Department of Defense	
Military Medical Facilities	50,698
CHAMPUS	57,056
CHAMPUS - Handicapped	—
Private Health Insurance	
Blue Cross/Blue Shield	15,536,504
Insurance Companies	29,178,943
Independent Plans	1,327,234
	46,150,435
Indemnity	
Veterans' Medical Care	
Community Nursing	121,341
Veterans' Nursing	147,029
Veterans' State Nursing	10,723
Veterans' State Hospital	877
Hospital Based Home Care	16,616
Veterans' Hospitalization	2,004,509
Veterans' Outpatient	1,304,681
Veterans'-Prescription Drugs	126,222
Workers' Compensation	
FECA	196,420
Other Federal Employees	77,819
State Workers' Compensation	4,237,947
Black Lung Benefits	27,801
	8,271,985
Income Support	
Medicaid	15,587,952
Medical Vocational Rehabilitation	349,277
St. Elizabeth's Hospital	127,170
	16,064,399
Total Medical Care Expenditures	79,315,228

disabled people (See Chart 3). The rising impact of disability expenditures can also be seen when disability expenditures as a percentage of GNP is examined. Although the transfer payment component of disability expenditures does not figure into the measurement of GNP, we expect a growing economy would tolerate increases in disability expenditures easier than a shrinking one. Chart 4 shows the percentage of GNP that disability expenditures represents.

Adjusting the data to reflect the rising price levels experienced during this period affects the dollar amount of the expenditures, but not the comparative trends. The yearly growth in *real* GNP and *real* social welfare expenditures remained positive at 3 percent and 7 percent, respectively. *Real* disability expenditures, however, continue to show the most growth, 13 percent annually. The large growth in real disability expenditures implies that, despite the effects of price increases, more and more assistance was being given to disabled people (See Chart 4).

The quick rise in disability expenditures has had a major impact on per capita measures as well. Between 1970 and 1975, the U.S. population aged 18-64 maintained a slow average rate of growth, 1.9 percent per year. The large increases in disability expenditures experienced during this period, however, caused disability expenditures per capita to increase from $167 per person in 1970 to $386 per person by 1975. This corresponds to an increase of 131 percent cumulatively.

Disability expenditures are made both in the private and the public sectors. In 1970, of the $19.2 billion spent on disabled people, $12.8 billion, or 67 percent, was provided by the public sector. These public sector expenditures include the social insurance programs, all federal insurance policy and retirement plan claims, all *income support* programs, all veterans' programs, workers' compensation (included because these payments are man-

Table 3

Direct Service Expenditures - 1986

	Amount in Thousands
Rehabilitative Services	
Rehab Services - Basic Support	$1,430,818
Rehab Services - Special Projects	51,311
Rehab Services - Innovation and Expansion	18,779
Voc. Rehab for SSDI Beneficiaries	4,252
Voc. Rehab for SSI Beneficiaries	600
Voc. Education - Basic State Grants	148,793
	1,654,553
Veterans	
Blind Veterans Rehab Centers	8,783
Voc. Rehab for Disabled Veterans	103,980
Specially Adapted Housing	14,498
Direct Loans for Disabled Vets. Housing	119
Autos and Adaptive Equipment	15,785
Veterans' Prosthetic Appliances	104,917
Rehabilitative Research Prosthetics	15,375
Dependent's Educational Assistance	59,879
Veterans' Domiciliary Care	72,765
Veterans' State Domiciliary Care	9,983
U.S. Soldiers Homes	16,587
	422,671
Services Offered to Persons with Specific Impairments	
Developmental Disabilities - Basic Support	65,076
Developmental Disabilities - Spec. Project	2,680
Gallaudet College	40,248
National Technical Inst. for the Deaf	30,624
Handicapped Media Services	12,051
Books for the Blind & Phys. Handicapped	32,309
Mental Health - Hosp. Improvement Grant	—
	182,988
General Federal Programs	
Social Services (Title XX)	355,042
	355,042
Employment Assistance Programs	
Federal Employment for the Handicapped	209
Federal Employment Services	30,325
Federal Job Training Programs	127,045
	157,579
Total Direct Service Expenditures	2,772,833

dated by state law and are administered by state regulations) and all direct services. The remaining $6.4 billion (33 percent) was provided by private sources, such as automotive and miscellaneous bodily injury claims and all private medical and life insurance plans. Despite the large increase of disability expenditures, themselves, the public and private components remained relatively stable. In 1975, public sector expenditures were 65 percent and private expenditures 35 percent of the disability total. Chart 5 displays private and public sector disability expenditures.

Fiscal Years 1976-1979

The second half of the 1970's showed a slowing down of the rate of increase in disability expenditures, despite some substantial year-to-year fluctuations. During the period between 1975 and 1976, the growth of disability expenditures underwent a sharp transition. The 20 percent average yearly growth experienced in 1975 fell to 17 percent in 1976. The 17 percent rate of increase was maintained in 1977; however, in 1978 the growth rate plunged to 9 percent, the lowest rate so far. In 3 years, the growth rate had fallen to less than half of that experienced from 1970 to 1975.

This pattern was repeated in real disability expenditures as well. Between 1975 and 1976, growth in real expenditures fell to 11 percent. The fiscal year 1978 brought with it another plunge to a record low of 1 percent growth. The rate of increase recovered somewhat in 1979, but the 5 percent growth experienced did not balance out the rapid drop of the preceeding year.

The erratic growth in disability expenditures during this period, was not matched in total social welfare expenditures. The growth in social welfare expenditures fell slightly to 9 percent between 1976 and 1977, and remained at 9 percent until 1979. Similarly, GNP growth was stable. Between 1976 and 1979, GNP growth re-

There is neither a universal definition of disability expenditures nor an agreement on how they should be calculated.

mained in the range between 11 and 13 percent.

Despite the fluctuations, the importance of disability expenditures relative to social welfare expenditures climbed even higher. In 1976, disability expenditures were 17 percent of social welfare expenditures. By 1979 this ratio had increased to 20 percent. Disability expenditures per capita also rose steadily from the 1976 amount of $444. In 1979, disability expenditures per capita had grown by 7 percent each year to $625.

The public and private percentages of total disability expenditures started this period at the same levels as in the 1970 to 1975 period, 65 percent and 35 percent, respectively. By the end of 1979, little had changed. Public disability expenditures had fallen to 63 percent, or $53.8 billion. This was paralleled by the increase in the private sector to 37 percent of the total, or $31 billion.

Fiscal Years 1980-1986

The 1980's have been a period of contraction in government spending, and disability expenditures have not escaped the downward pressure. In fiscal years 1980 and 1981, the growth in disability expenditures was at its highest level during the period: 16 percent. From 1982 onward, however, the rate of growth never exceeded 10 percent. By 1986, these expenditures were growing at their slowest rate to date, 7 percent.

The lower disability expenditures growth corresponds to the growth in social welfare expenditures. The 1980 to 1986 period showed an average rate of increase of 10.3 percent. The nation's economy was also growing at the comparatively same rate. GNP increased by an average of 8 percent a year from 1980 to 1986. Although disability expenditures were growing slightly faster than social welfare expenditures and GNP, the effect was very slight. This is evidenced by the fact that between 1980 and 1986 disability expenditures remained within 20 and 22 percent of social welfare expenditures. The average was 21 percent, only 2 percent higher than in the last period examined.

The patterns of decline set by *nominal* measures repeated themselves in *real* disability expenditures. The 1980's saw a minute drop in the average rate of real growth to 5 percent per year. This paralleled the small 3 and 4 percent yearly growth experienced in real GNP and real social welfare expenditures. The rate of increase in disability expenditures per capita also fell from 10 to 9 percent per year. Consequently, from 1980 to 1986, disability expenditures per capita rose from $712 to $1,136.

The most dramatic change to be noted in this period is the rearrangement of the public sector and the private sector proportions of disability expenditures. In 1980, public sector expenditures amounted to $60.6 billion, or 62 percent of the total. By 1986, the $91.6 billion public sector sum had fallen to only being 54 percent of total disability expenditures. Simultaneously, private sector expenditures were becoming a more important part of the disability total. Between 1980 and 1986, private sector expenditures went from $37.9 billion, or 38 percent of the total disability expenditures, to $77.8 billion, or 46 percent.

What Can We Learn From Our Look at Disability Expenditures?

Cash benefits, medical care payments or services costs are made to, or for, people who have experienced long-term effects from physical or mental impairments because of injury or disease. For the most part, these are people who are limited or unable to engage in their usual activities because of some mental or physical condition. We have tried to exclude the costs of short-term illnesses and have included

Terms

Transfer Payments — Cash payments to persons, such as Social Security payments. Differs from wages, since recipient need not provide any service at the time payment is made.

Disability Insurance — Provides payment to persons unable to work due to a mental or physical impairment.

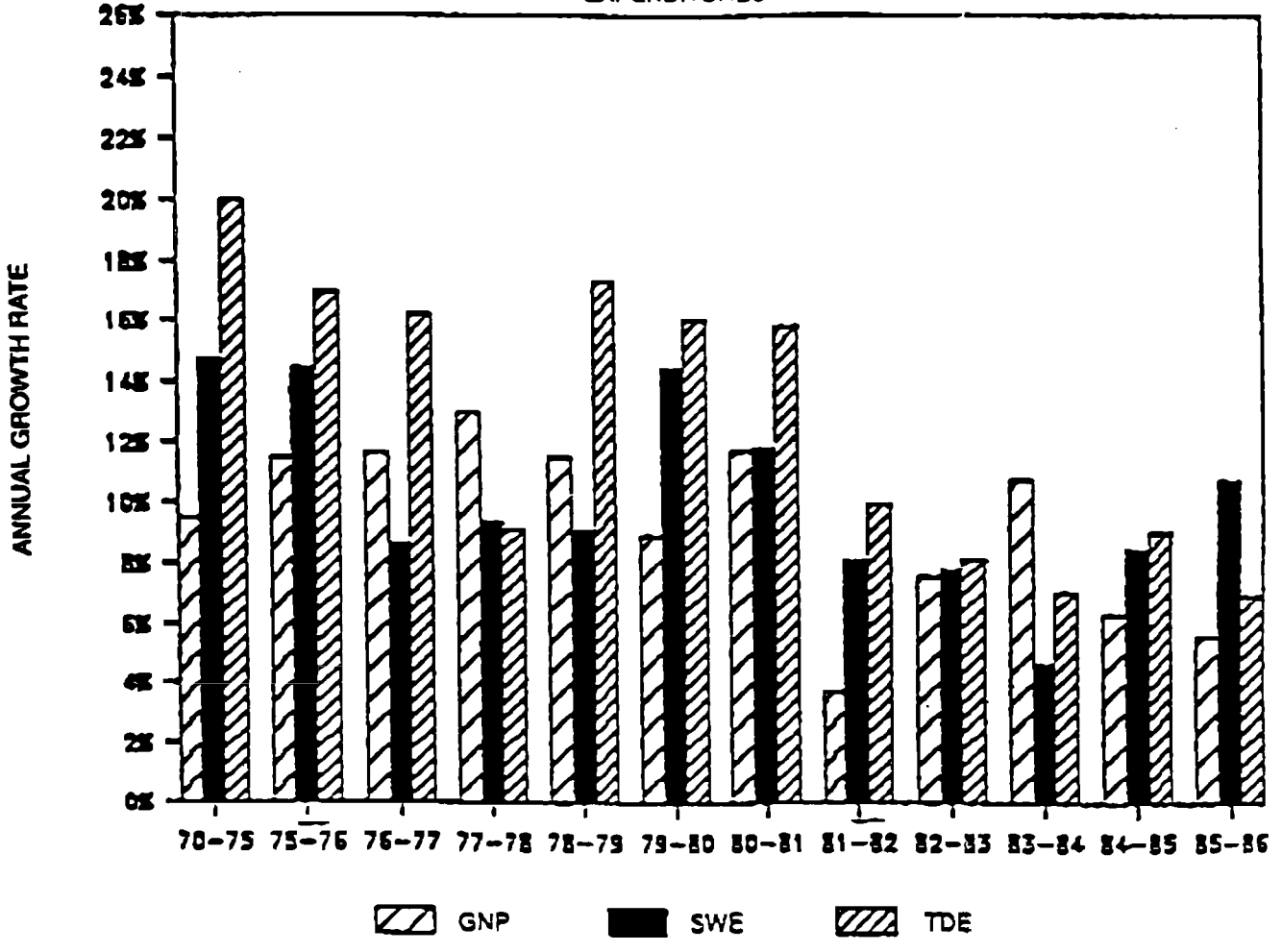
Indemnity Programs — Programs designed to compensate persons for harm caused by another party.

Income Support Programs — These are the "safety net" programs designed to maintain individuals at some minimal standard of living.

Gross National Product — The dollar value of all of the output of the economy produced during a given year.

Nominal Dollars — Current dollar amounts. Real dollars. Current dollar amounts adjusted for changes in the price level (inflation).

CHART 2
ANNUAL GROWTH IN
GNP, SOCIAL WELFARE & DISABILITY
EXPENDITURES



only people aged 18-64 where we have been able to make these age distinctions.

It is not only that we consider these expenditures to be large, it is that they are made for a variety of reasons in a huge assortment of programs. Like other industrialized countries of the world, we have not adopted a single uniform approach to disability. We have separate programs for veterans, civil servants, work injured people, employed people and their dependents, and those people who can prove they are sufficiently poor to qualify for benefits. Disability programs exist for many reasons, including providing incentives to optimal safety behavior.

Like other industralized countries of the world, we have not adopted a single uniform approach to disability.

In deciding what to pay to whom, we look not only at the results of an injury or a disease, but why it came about and to whom it happened. The person hit by a car driven by an insured motorist is treated differently than the person who falls off the roof of his own home, even if both are similarly impaired. This differentiation is not necessarily bad. Most countries treat work injuries differently

We have separate programs for veterans, civil servants, work injured people, employed people and their dependents, and those people who can prove they are sufficiently poor to quality for benefits.

than nonwork injuries. New Zealand and Holland are the two exceptions, and Holland is moving back to possibly making such distinctions once again.

We have tried to indicate something of the overall trends in disability expenditures since 1970. These are puzzling trends and we have no satisfactory theory to explain them. We are sure of one thing: *These fluctuations in disability expenditures are not matched by corresponding fluctuations in injuries or diseases.* These changes then must be accounted for by demographic changes, changes in social and economic conditions, changes in the public perception of disability, and the way that the benefits laws are administered. Our look at disability expenditures emphasizes an old lesson that cannot be repeated too often. *Disability is a socioeconomic phenomenon, not a medical one.*

Although we accept the fact that in the real world there will be these many different programs which we have here put together, this does not mean that we have necessarily arrived at the best allocation of resources in this field. We are struck with how little we seem to spend comparatively on direct services such as rehabilitation. We would argue that part of the problem is that the methods we are using to evaluate rehabilitation programs have been deficient.

CHART 3

DISABILITY EXPENDITURES AS A PERCENT OF

SOCIAL WELFARE EXPENDITURES

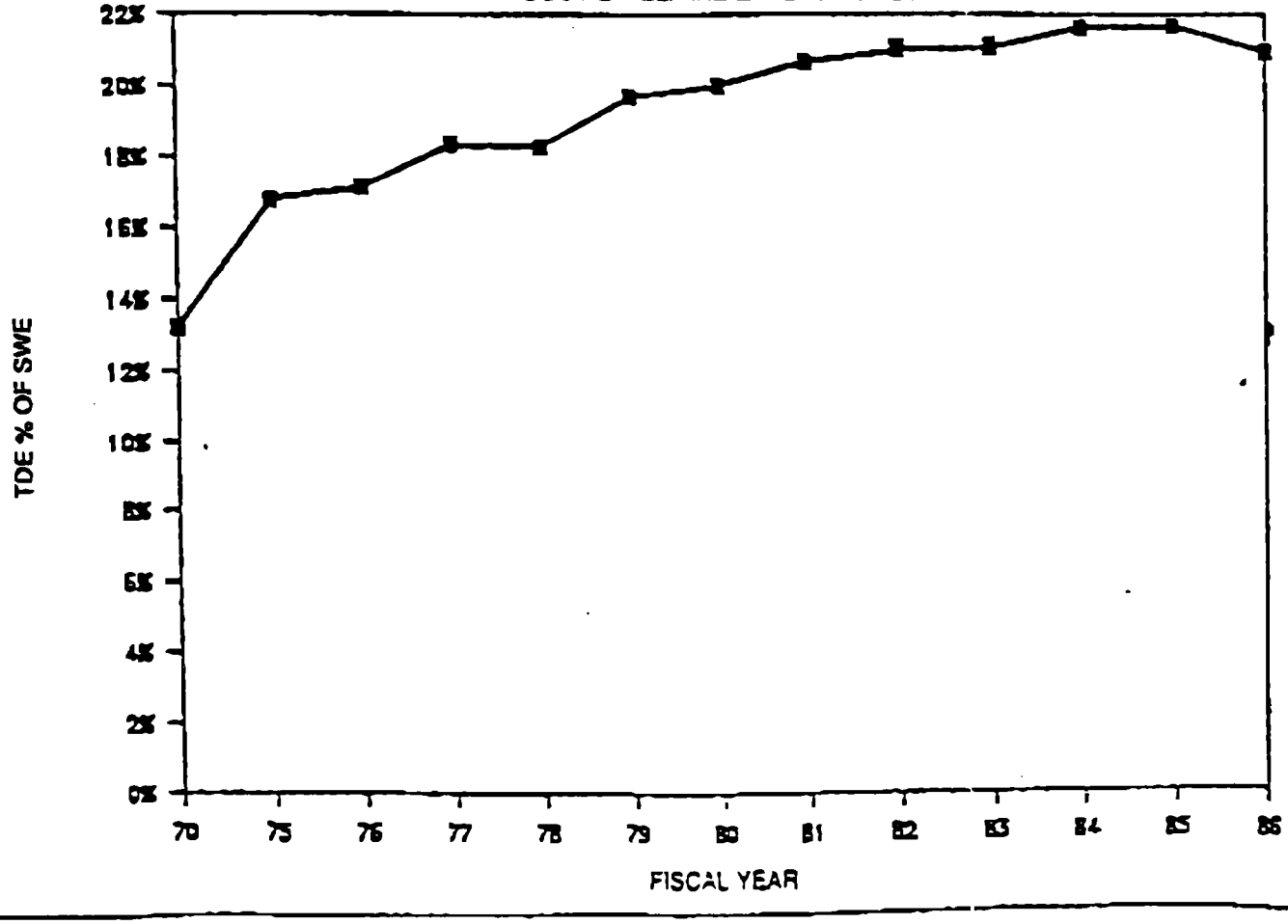
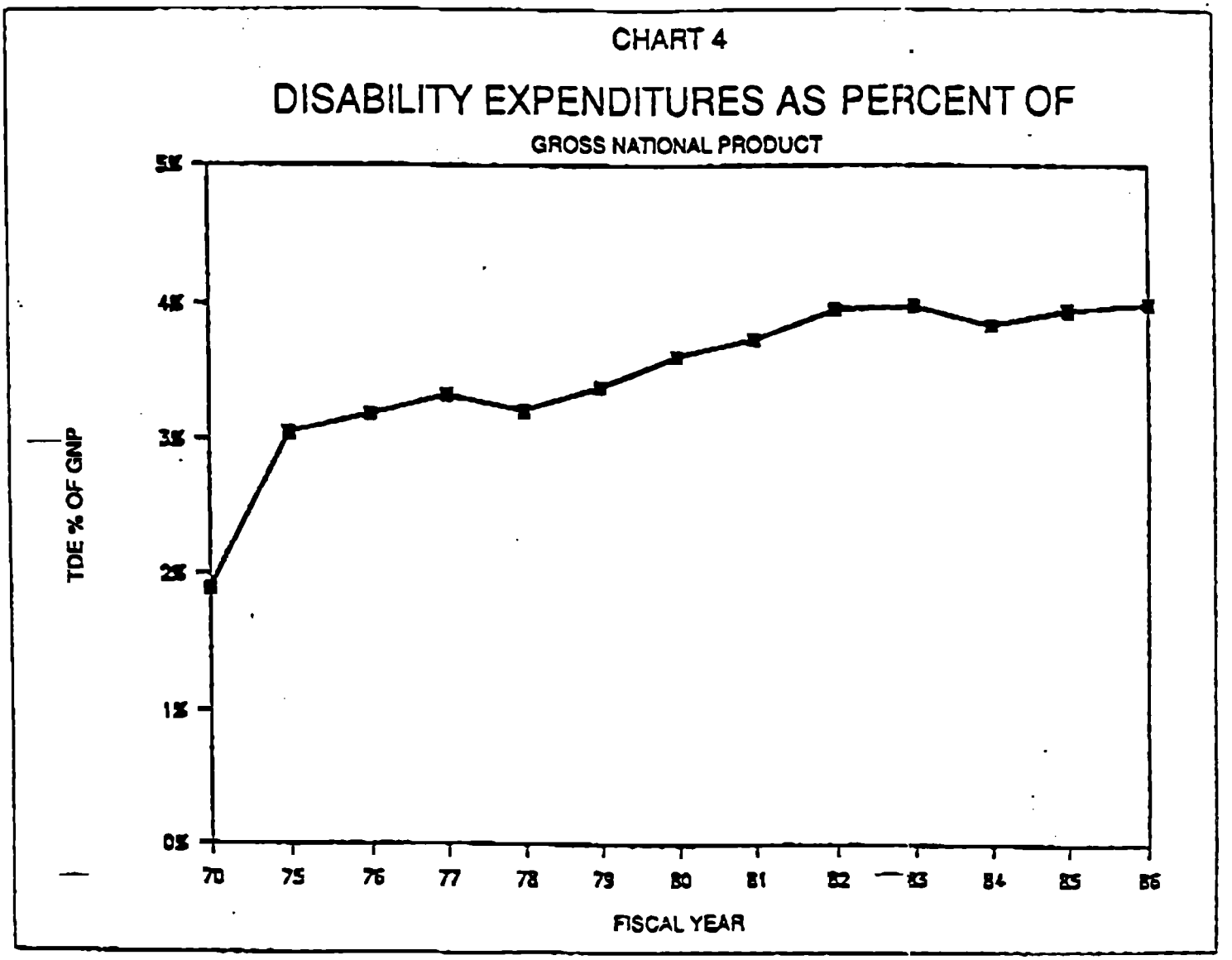


CHART 4



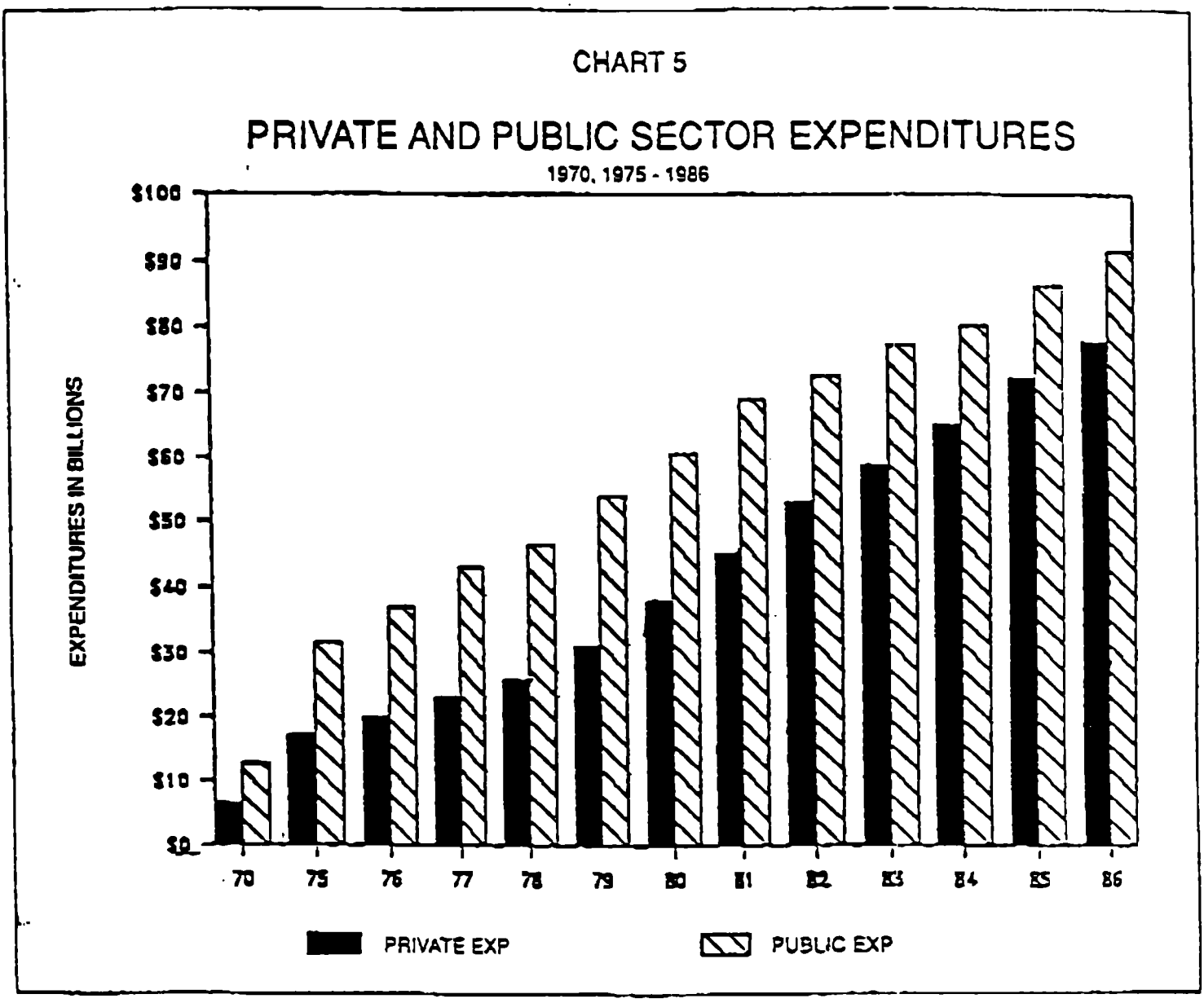
In deciding what to pay to whom, we look not only at the results of an injury or a disease, but why it came about and to whom it happened.

As with any other research endeavor, our look at disability expenditures raises as many questions as it answers. There is more work to be done here. We think that these measures could be improved. But the problems are more than inadequacies in the data. We have been working on these concepts for some time, but our measures are still crude, especially in the services area. We need a model which will better explain the trends that have been experienced and that will help us forecast what will happen in the future.

The relationships between private sector and public sector programs are not well understood. In the last several years for which we have data, the private sector programs have been growing at a more rapid rate than those in the public sector. In part, this is because of an increase in indemnity payments which arise from suits for payment for personal injury. Lawyers have long been interested in reforming the indemnity legislation, but those of us concerned with the social and economic consequences of disability have tended to ignore this area. Are increases in these indemnity programs to be encouraged, or would equity and adequacy considerations argue for a different allocation?

(Continued on page 29.)

CHART 5



Expenditures

(Continued from page 15.)

In some global sense, as Calabresi and others' have argued, society makes two kinds of decisions in this world of limited resources. The first order decision is to decide how much of our goods and services should be allocated to disabled people; the second order decision is to decide how to divide the sum which has been allocated among all qualified people. It goes without saying, that, to the true disability advocate, whatever is allocated will not be enough; but looking at aggregate disability expenditures forces us to examine whether we are making these second order allocation decisions in the best possible way.

Dr. Berkowitz is Professor of Economics, Rutgers University; Ms. Greene is Research Associate at the university.

References

1) The research project (G008300151), funded by the National Institute on Disability and Rehabilitation Research, not only examined disability expenditures, but various methods to determine the impact of the state-federal vocational rehabilitation programs. In this article we look only at the work done on disability expenditures.

2) Calabresi, Guido and Philip Bobbitt, *Tragic Choices*. Norton Publishers, New York, NY, 1978.

Work and Disability:

Creating a Return-to-Work System

David Levine

Council of Economic Advisers

March 27, 1995

A draft Eng Comment

Exploding Rolls

- Rolls of SSDI and SSI
  - 1982: xx million
  - 1992: 7.6 million

Exploding Costs

- Costs of SSDI and SSI
  - 1982: $30 billion
  - 1992: $60 billion
  - 2005: $120 billion?

No Coherent System

- 43 definitions of "disability"
- Incomprehensible bureaucracy

Workers' Compensation

- State-regulated system
- After a waiting period, replaces 2/3 lost wages
  - Designed as no-fault

Workers' Compensation

- Many workers not paid
- Rising costs
  - Small employers' #2 problem

Applying for SSDI

- Wait six months to apply
  - May fall into poverty
- Lottery-like application
  - Half of denials overturned
  - Years of appeals
  - Inconsistent gatekeepers

Applying for SSDI

- Lifetime benefit
  - Even if, like some depression, curable
- Continuing Disability Reviews
  - From Discretionary Budget
  - Politically !!

Applying for SSI

- If not enough work history for SSDI
- Supplement low SSDI

Vocational Rehabilitation

- State Vocational Rehabilitation Agency
  - Social Security offices refer some names
  - Funded by Dept. of Education

Vocational Rehabilitation

- Services include
  - physical therapy
  - equipment such as wheelchairs
  - retraining

Vocational Rehabilitation

- Law requires service to most disabled
  - Very few SSDI or SSI served
- Few positive evaluations

Health Insurance

- SSDI receive Medicare
- SSI receive Medicaid
- Both have limited access
  - Veterans have even more limited access

Work Disincentives

- Four out of five disabled want to work
- One out of 200 ever leaves SSDI for work
- SSDI defines working disabled as an oxymoron

Work Disincentives

- Even a few hours a week are likely to lose:
  - SSDI cash benefits
  - Medicare health insurance (often irreplaceable)
  - HUD-subsidized housing
  - ...

Create a Return-to-Work System

- Empower customers
  - Return-to-work services
  - Choosing health care
- Maintain work incentives
  - SSDI
  - Health insurance

Create a Return-to-Work System

- Vocational assessment
- Most would receive
  - Time-limited income support
  - Vocational rehabilitation services
- Some lifetime stipends

Vouchers for Voc Rehab

- Vouchers
  - Empower customers
  - Extends President's Middle Class Bill of Rights
- Good information system

Vouchers for Voc Rehab

- Pay for results
  - Job placement, wages and tenure
  - Savings to SSDI

Vouchers for Medical Insurance

- Empower customers
- All systems:
  - Medicare
  - Medicaid
  - VA

Phase-out SSDI

- 50 percent phase-out for earnings
  - over a threshold
  - adjusting for work expenses
- Never lose SSDI status
  - Stipend flexible after job loss

Continue Medicare and Medicaid

- Phase out as income rises
- Integrate with employer-provided insurance

Create a Return-to-Work System

- Vocational assessment
- Most would receive
  - Time-limited income support
  - Vocational rehabilitation services
- Some lifetime stipends

Next Steps

- Is Return-to-Work System a good idea?
  - Policy
  - Scoring
  - Politics
- Selling to Rasco & Rivlin