TESTIMONY OF

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ON BEHALF OF HIMSELF AND

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BALANCING PUBLIC POLICIES THAT FACILITATE WORK AND THOSE THAT ENSURE A FAIR AND DECENT LEVEL OF INCOME SUPPORT DURING PERIODS OF WORK INCAPACITY

BACKGROUND

Good morning. My name is Allen Jensen, director of the Work Incentives Project, Center for Health Services Research and Policy, The George Washington University. Thank you for the opportunity to present testimony today regarding our Nation's disability, health and employment-related programs. These include the Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI),[1] Medicaid (including the Medicaid Buy-In Program), Section 1619 of the Social Security Act, Medicare, Ticket to Work, vocational rehabilitation, workforce investment, and our civil rights laws, including the Americans with Disabilities Act.

Over the past 40 years at the state and national level in a variety of positions, I have been involved in program and policy development related to social security income assistance,

[1] Title II of the Social Security Act establishes the SSDI program. SSDI is a program of federal disability insurance benefits for workers who have contributed to the Social Security Trust Funds and became disabled or blind before retirement age. Disabled widows and widowers of insured workers are eligible for disability benefits. In addition, dependent children of fully insured workers (often referred to as the primary beneficiary) also are eligible for disability benefits upon the retirement, disability, or death of the primary beneficiary. Section 202 (d) of the Social Security Act also establishes the Childhood Disability Benefits program, which authorizes disability insurance payments to surviving adult children of retired, deceased, or workers with disabilities who are eligible to receive Social Security benefits, if the child has a permanent disability originating before age 22. Hereinafter in this testimony, the term "SSDI" refers to all programs that provide benefit payments made to individuals on the basis of disability under Title II of the Social Security Act and the Childhood Disability Benefits program shall be referred to as Disabled Adult Children Program and the beneficiaries of such program shall be referred to as DACs.

social services, employment and health care policy. Currently I am involved in university-based research for federal agencies and private foundations and utilizing the findings of that research to provide technical assistance to state officials, and state disability advocacy coalitions.

For the past decade, I have conducted much of my research in partnership with Robert "Bobby" Silverstein, Director of the Center for the Study and Advancement of Disability Policy and principal in the law firm of Powers, Pyles, Sutter, & Verville, PC. Our work involves trying to determine how to provide the proper balance between policies that facilitate work and those that ensure a fair and decent level of income support during periods of work incapacity.[2]

To place our research in context, a brief summary of participation in the income support and health care programs may be helpful. In December 2004, 9.8 million adults ages 18 – 64 received benefits from the Social Security Administration (SSA) on the basis of disability. There were 2.9 million who received only SSI; 5.8 million who received only SSDI and 1.2 million who received both SSDI and SSI. Over 330,000 SSI beneficiaries have earnings in any month and over 75,000 of those are in a non-payment status (i.e., they did not receive cash payments under SSI)) because of their earnings and the use of the SSI/Medicaid work incentives. Appendix A includes a table that illustrates this information and also the range of options states have in determining Medicaid eligibility for SSI and SSDI beneficiaries.

An option provided to states first in the Balanced Budget Act of 1997 and also in the Ticket to Work and Work Incentives Improvement Act of 1999 was the authority to develop and implement Medicaid Buy-In programs which are intended to reduce work disincentives by allowing persons with disabilities to work and remain eligible for Medicaid. The primary participants are persons receiving SSDI. Over the past ten years, 38 states have developed and implemented Medicaid Buy-In programs and over 75,000 individuals are currently participating.

Five years after the Federal Medicaid Buy-In program was first authorized, my colleague Bobby Silverstein and I, along with Donna Folkemer of the National Conference of State Legislatures (NCSL), conducted the first case studies of state Medicaid Buy-In programs. This research project, which was supported by the Department of Health and Human Services, developed a framework for state decision making and fiscal impact development. That study and ongoing analysis since then of the state Medicaid Buy-In programs serve as the bases for the provision of the technical assistance I continue to provide to many states in developing Medicaid Buy-In programs.

I am currently providing assistance to Montana, Florida, Arkansas and with the District of Columbia utilizing the experience and evaluations of the early implementation states, like Iowa, to help inform policy and administrative procedures in those and other states.

[2] For a select list of articles, papers and policy briefs prepared by Allen Jensen and Robert Silverstein, see Appendix D.

Current information on the characteristics of state Medicaid Buy-In programs can be found at www.medicaidbuyin.org.

PREMISES FOR POLICY RESEARCH

Our research regarding our nation's disability, health, and employment-related programs has been based on several premises.

1. Facilitate Achievement of the Goals of Disability Policy Stated in the ADA

Policy initiatives focusing on meeting the needs of persons with disabilities should be assessed in terms of whether they facilitate achievement of the goals of disability policy articulated in the Americans with Disabilities Act—

- Equal opportunity (including individualization, reasonable services and supports, and integration into the community),
- Full participation (including self-determination and informed choice),
- Independent living, and
- Economic self-sufficiency.

2. Recognize Interrelationships among SSI, SSDI, Medicaid and Medicare and Other Programs Impacting Work and Barriers to Employment

It is not helpful to focus on a particular policy initiative as a silo in isolation from other programs; rather we must recognize the interrelationships among programs. The SSI and SSDI programs do not operate in isolation from each other, Medicaid and Medicare, or from other federal and state programs. For example, a work disincentive under the SSDI program, such as the so-called "cash cliff," where a beneficiary loses eligibility if he or she earns more than a specified amount, has a dramatic adverse impact on the success of other programs designed to increase work and earnings--such as the Medicaid Buy-In program, the Ticket to Work program and the vocational rehabilitation program.

Under the Medicaid Buy-In program, adults with disabilities may work and be eligible for Medicaid i.e., they can continue to be eligible for Medicaid even when their earnings exceed the Substantial Gainful Activity test for eligibility for SSDI. The program is an essential component of efforts to remove barriers to employment by persons with significant disabilities. However, the Medicaid Buy-In program does not protect SSDI beneficiaries from losing their cash benefits and surveys in many states indicate that fear of total loss of SSDI is a remaining employment barrier. The Medicaid Buy-In program is essential but without other needed policy changes and program initiatives is not sufficient to remove the major remaining barriers to employment.

3. Consider Fiscal Impact of Removing Employment Barriers

In assessing policy options/alternatives, cost implications should be considered. In terms of disability, health care, and employment-related programs, policy-related research

should strive to include policy recommendations that enhance the potential for net long-term savings over the working life of persons with a significant disabilities by enabling them to increase their work effort and earnings.

4. Reflect Insight from Persons with Disabilities and other Stakeholders

As articulated earlier in our testimony, a key goal of disability policy is the policy of full participation—people with disabilities must be involved in decisions affecting their lives, including the policymaking process. Thus, lessons learned from researching existing programs must reflect insight derived from stakeholders, particularly persons with disabilities.

OVERVIEW OF PRESENTATION

Today, we would like to share with you the major lessons we have learned in the course of conducting our research.

- First, we will share key **realities** that provide a foundation for many of our conclusions and recommendations. These realities include the fact that:

    - SSI and SSDI are programs of last resort.
    - There is significant overlap of beneficiaries receiving cash benefits under the SSI and SSDI programs.
    - The ability to work over time varies considerably for individual beneficiaries.
    - Most beneficiaries are unable to sustain significant work although a significant minority can, if provided security and supports.
    - Tangible and intangible factors make it impossible to identify which individual beneficiaries will be able to sustain work.

- Second we will identify three overarching **themes** that provide a framework for guiding policy development in this area. These themes are:

    - **Security--**beneficiaries are more likely to risk working with the assurance that benefits will resume if work efforts fail or successes are intermittent because of one's disability.
    - **Simplicity—**beneficiaries are more likely to risk working if and when they have sufficient information to make informed choices about the impact of their decision on the availability of cash and health benefits.
    - **Sustainability**—SSA and state-level infrastructures have the capacity to provide assistance and guidance to beneficiaries regarding decisions to risk working through the provision of adequate and accurate information and services.

- Third, we will identify key **policies** that we believe will facilitate increased work and earnings for those beneficiaries capable of doing so. The key policies include:

Security and Simplicity:

- **Continued attachment** to programs in non-benefit status as long as the disability continues.
- **Gradual reduction in benefits** as earnings increase instead of cash cliff.
- Allow for increased **savings.**
- **Comparability** between the SSI and SSDI work incentives.

Sustainability:

- **Capacity of SSA** to administer work incentives and provide timely and accurate adjustment of benefits.
- **State and local systems change initiatives** that support infrastructure development, work incentive counseling, and services.

I would like to point out to the Committee that my colleague Bobby Silverstein and I have developed a comprehensive proposal to address the SSDI cash cliff and other policy barriers in SSI, Medicaid and Medicare. The proposal can be found in a paper entitled, "*Gradual Reduction Choice Option and Related Policy Proposals*" (December 2005). In addition, we prepared an accompanying memorandum entitled, "*A Framework for Preparing Cost Estimates for SSDI $1 for $2 Gradual Reduction Demonstration Proposals*." (December 2005). The documents can be found in the SSI and SSDI section of the web site www.disabilitypolicycenter.org. A summary explanation of the specific components of our proposal is found in Appendix B of this testimony.

KEY REALITIES

We have identified six realities/assumptions that provide a foundation for our policy conclusions and recommendations on how to provide the proper balance between policies that facilitate work and those that ensure a fair and decent level of income support during periods of work incapacity:

- SSDI and SSI programs are programs of last resort.
- There is an increased overlap between populations served by SSI and SSDI programs.
- There are significant variations in work and earnings for individual beneficiary's overtime.
- Most beneficiaries are unable to sustain significant work effort and earnings.
- A significant minority of beneficiaries will choose to increase work effort under certain circumstances.
- The presence of tangible and intangible factors makes it impossible for policymakers to identify ahead of time which beneficiaries will choose work.

1. SSI AND SSDI are programs of last resort.

We reviewed the Report of the Disability Policy Panel of the National Academy of Social Insurance entitled *Balancing Security and Opportunity: The Challenges of Disability Income* Policy. (1996). We agree with a series of overarching conclusions reached by the Panel of Experts that:

- The SSDI and SSI beneficiary populations include those with the most significant disabilities impacting work;
- SSI and SSDI are programs of last resort;
- The strict and frugal design of the SSI and SSDI programs makes remaining at work preferable to benefits for those able to work;
- SSDI benefits are modest in relationship to workers prior earnings; and
- Benefits offer an essential form of economic security for persons with disabilities with limited capacity to earn.

Overall, less than 55 percent of those who apply for disability benefits under the Social Security Act were allowed in FY 2002. Further proof of the strictness of the definition of disability is the fact that among denied applicants, 58 percent were not working and over two-thirds of those not working said they had been out of work for three years and over three-fourths said they were unable to work because of poor health.[3]

2. There is an increased overlap between populations served by SSI AND SSDI programs.

The increasing role of the SSDI program in providing assistance to younger disabled workers and disabled adult children, in addition to assisting older near-retirement disabled workers has blurred the differences between the SSDI and SSI programs.

Approximately 30 percent of SSI beneficiaries between the ages of 18-65 (1.2 million) are also eligible for SSDI benefits. Some of these beneficiaries are concurrently eligible because of SSI state supplementation. More specifically, even though their SSDI benefit is in excess of the federal SSI benefit standard plus the $20 disregard, in states with SSI supplementation they still receive an SSI payment. In addition, nearly two-thirds of the Section 1619(b) SSI/Medicaid work incentive program participants are concurrent SSI/SSDI beneficiaries.[4]

3. There is a significant variation in work and earnings for individual beneficiaries over time.

The ability to work, work effort, and level of earnings varies significantly from month to month and year to year for many individual SSI and SSDI beneficiaries.

[3] Committee on Ways and Means, U.S. House of Representatives, *OVERVIEW OF ENTITLEMENT PROGRAMS, THE 2004 GREEN BOOK* at 1-28.
[4] Social Security Administration. *Annual Statistical Supplement*, 2004, Table 7 D 1.

According to the General Accountability Office (GAO), of working SSDI beneficiaries with earnings above the Substantial Gainful Activity (SGA), which currently is at $900 for disabled beneficiaries, in a given year, nearly one-half experience an eventual reduction in earnings in subsequent years. For example, of beneficiaries in 1985 who earned between 75 and 100 percent of the annualized SGA level, 47 percent had no earnings by 1989 while earnings of another 26 percent had fallen to between 1 and 74 percent of the annualized SGA level.[5]

According to SSA staff, nearly one-half of SSI beneficiaries receiving wages in one year stop working in the subsequent year. More specifically, 51 percent of blind or disabled adults had no wages in a year following a year of reported wages and 35 percent had maximum variation of more than 50 percent.[6] They also report that during a 15 year period only half of those employed in one year had earnings in each of the succeeding three years.[7]

This reality is important because it lays the foundation for the policy objective described at the end of our testimony to provide continued attachment to the SSDI and SSI programs when earnings reduce benefits to zero (as long as the impairment continues) in order to reduce risk and uncertainty which are major barriers to work.

4. Most beneficiaries are unable to sustain significant work effort and earnings.

Most persons receiving SSI, SSDI or concurrent beneficiaries (i.e., beneficiaries receiving both SSI and SSDI benefits) are unable to sustain work above SGA for a significant period of time.

According to SSA staff in a 2003/2004 report, utilizing SIPP data matched to SSA administrative records, only 22 percent of SSDI beneficiaries worked at some time during 1999.[8] According to a 2002 GAO report, from 1985-1997 on average, only about 7.4 percent of SSDI beneficiaries who worked (comprising about 1% of the total SSDI caseload) had annual earnings between 75 and 100 percent of the annualized SGA level. In 1995, about 58 percent of SSDI beneficiaries who worked earned no more than 50 percent of the annualized SGA level.[9]

Using data from SSA relating to work experience of SSI recipients, (*SSI Disabled Recipients Who Work*, 2004 (July 2005)), only 4.8 percent of SSI recipients (all ages)

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[5] U.S. Government Accountability Office. *SSA Disability-SGA Levels Appear to Affect the Work Behavior of Relatively Few Beneficiaries, But More Data Needed*, GAO-02-224 (January 2002) at 2, 15, 16.
[6] Balkus, Richard, and Wilschke, Susan. *Annual Wage Trends for Supplemental Security Income* Social Security Recipients in Social Security Bulletin, Vol. 65, No. 2, 2003-2004 at 51-52.
[7] Id. at 51-53.
[8] Martin, Teran and Davies, Paul S. "*Changes in the Demographic and Economic Characteristics of SSI and DI Beneficiaries Between 1984 and 1999"* in *Annual Wage Trends for Supplemental Security Income Recipients, Social Security Bulletin*, Volume 65, No. 2, 2003/2004 at 9.
[9] U.S. Government Accountability Office. *SGA Levels Appear to Affect the Work Behavior of Relatively Few Beneficiaries, But More Data Needed*, GAO-02-224 (January 2002) at 9.

worked in 1983, 6.4 percent in 1999, and 5.6 percent in December 2004. In December 2004, the percent of SSI recipients that worked was 7.8 percent. Of the SSI recipients (all ages) that worked, 59.3 percent earned less than $400 per month and 86 percent earned less than $1,000 per month.

Survey data from several Medicaid Buy-In programs is consistent with the GAO and SSA findings. For example, in Iowa, the Buy-In participants not working or that didn't want to work more (61% of participants) were asked to evaluate a number of statements and choose those that fit as to "agree"or "strongly agree," 63.2 percent reported that their health has gotten worse for reasons unrelated to working and 30.6 percent reported that working has caused their health to get worse.[10] In Minnesota, 48 percent (physical health problems) and 30 percent (mental health problems) reported that health issues prevented them from working some time during the past year.[11]

We believe this reality provides insight into the possible impact of a policy change. Policymakers should be wary of making any change to current law that imposes a work mandate on all beneficiaries when in fact most beneficiaries are unable to sustain work above SGA for a significant period of time. The current purpose of SSDI as a partial wage replacement program is appropriate and the current structure (Trial Work Period (TWP), Extended Period of Eligibility (EPE), cash cliff, and expedited reinstatement) meets the needs of most beneficiaries.

It is also important that our public policy encourage beneficiaries to work, reflect high expectations regarding the potential for work, and provide necessary services and supports, and protections. As we have stated in our introductory remarks, we should strive for a balance between the policies that facilitate work and those that ensure a fair and decent level of income support during periods of work incapacity.

5. A significant minority of beneficiaries will choose to increase work effort under certain circumstances.

A significant minority of SSI and SSDI beneficiaries will choose to work above SGA for a sustained period of time (over a beneficiary's lifetime) if public programs provide: appropriate information to make informed choices; sufficient incentives that are simple to understand; and provide for security when exacerbations of one's condition occur; necessary long-term services and supports; and protections.

Using data from SSA, (*SSI Disabled Recipients Who Work*, 2004 (July 2005)), of the limited number and percentage of SSI recipients that work (5.6% of all SSI recipients and

[10] Iowa: *Medicaid for Employed People with Disabilities: A Client Profile and Program Evaluation. Iowa Department of Human Services* (March 11, 2005), Figure 6-10, at 47.
[11] Minnesota: *How MA-EPD Does the Job-Survey of Minnesotans Enrolled in the Medical Assistance for Employed Persons with Disabilities Program*. Minnesota Department of Human Services (August 2004), page 78 and questions A41 and A42. The full report is at http://www.dhs.state.mn.us/main/group/disabilities/documents/pub/dhs_id_029455.pdf. Utah: *Self Reported Experiences of Individuals with Disabilities Involved in the Utah Medicaid Work Incentives Program*.

7.8% of SSI recipients aged 18-64), there are significant numbers and percentages of persons on SSI with earnings and resulting reduced levels of benefits. For example, of all SSI recipients that worked, 40.7% earned more than $400 per month and 14% earned more than $1,000 per month.

Using the same data from SSA (*SSI Disabled Recipients Who Work*, 2004 (July 2005)), there has been a gradual but significant increase in the use of the Section 1619 work incentives by SSI beneficiaries since its inception in 1981 when it was a temporary program. (The program was permanently authorized as an entitlement, effective July 1, 1987.) In December 1988, 35,545 beneficiaries utilized the Section 1619 work incentives. By 1993, there had been an increase to 55,327 and by 2004 the number had increased to 90,796. In short, during the 15 year period between 1988 and 2004, the program experienced nearly a 150% increase in participation.

The experience under the Medicaid Buy-In programs may also shed some light on the increased interest by SSDI beneficiaries (the primary participants in the Buy-In programs) in working when certain barriers to work (e.g., concern about loss of health care) are addressed. There has been a gradual but significant increase in enrollment in Medicaid Buy-In programs since their inception. In a survey of Vermont Medicaid Buy-In participants, 80% indicated that the Medicaid Buy-in program was very important in enabling them to keep working.[12] In Kansas, 61% of survey respondents indicated that their level of independence has increased since enrolling and 59% said their financial status has improved since enrolling.[13] In Minnesota, 72% of participants said that they would not be able to work without the Medicaid Buy-In program. 92% of participants in the Medicaid Buy-In program reported that working improved their quality of life.[14]

In Iowa, a recent survey of Medicaid Buy-In participants found that 40 percent of the participants indicated that they would like to increase the amount they are working over the next 12 months.[15] In Wisconsin, one-third of the participants reported that they wanted to work more hours.[16]

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[12] Vermont: Survey of Enrollees in the Medicaid for Working People with Disabilities Program, Prepared for the State of Vermont Department of Aging and Disabililties, October 2003 at 11. Full report available at http://www.dad.state.vt.us/dvr/vocrehab/vwii/s5_reports.htm#mbirpts

[13] Kansas: *Satisfaction Survey of Medicaid Buy-In Participants*, Reported in Policy Brief # Six, November 2004, University of Kansas Medicaid Infrastructure Change Evaluation Project at 1. http://www.workinghealthy.org/WHpolicybrierno6.pdf.

[14] Minnesota: *How MA-EPD Does the Job-Survey of Minnesotans Enrolled in the Medical Assistance for Employed Persons with Disabilities Program*. Minnesota Department of Human Services (August 2004), at 82, Question A54 at 2. The full report is at http://www.dhs.state.mn.us/main/group/disabilities/documents/pub/dhs_id_029455.pdf.

[15] Iowa: *Medicaid for Employed People with Disabilities: A Client Profile and Program Evaluation. Iowa Department of Human Services* (March 11, 2005), Figure 6-10, at 45. The full report is available at http://www.dhs.state.ia.us/dhs2005/dhs_homepage/docs/MEPD-04_report-master.pdf.

[16] Wisconsin: Medicaid Purchase Plan Evaluation Annual Report, December 2003. Submitted to the Wisconsin Department of Health and Family Services by APS Healthcare, Inc. The full report is available at *http://dhfs.wisconsin.gov/WIpathways/pdf/MAPPAnnualReport2003.pdf*.

States' Medicaid Buy-In programs have enabled a significant number of SSDI beneficiaries to work and have Medicaid without having to spend down their income under Medically Needy eligibility criteria. The rate of participation in the Medicaid Buy-In programs by SSDI disabled workers, disabled adult children and disabled widows(ers) is estimated to be as high as ten percent in Minnesota, a state with few restrictions (e.g., no unearned income limits or high cost shares).[17]

It is not possible to know the precise percent of beneficiaries that would choose to sustain work above SGA for a significant period of time. However, we can use experiences under existing programs, including SSI and Section 1619, to obtain estimates.[18] And current experience indicates that the numbers are sufficient to warrant an effort to encourage work.

This reality is important because it lays the foundation for the option of continuing eligibility when earnings exceed SGA and the concept of continued attachment as a form of ongoing support for beneficiaries who work.

6. Tangible and intangible factors make it impossible to identify in advance particular beneficiaries who will be able to sustain work.

Because of a variety of factors, including tangible and intangible variables impacting the heterogeneous population of beneficiaries, it is difficult, if not impossible, for policymakers and program administrators to determine/predict which particular beneficiaries (based on predetermined criteria) will be able to work above SGA for a sustained period.

Set out below are a series of **tangible variables** impacting work activities of the heterogeneous population of SSDI beneficiaries:

1. The impact of type and severity of disability, age, time of onset of disability (i.e., birth, during teens, after years of employment).
2. The impact of level of skills, education, experience and work previously performed,
3. The state in which the individual resides.[19]

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[17] See e.g., Jensen, Allen; Silverstein, Robert; Folkemer, Donna; Shaw, Tara. *Policy Frameworks for Designing Medicaid Buy-In Programs and Related State Work Incentive* Initiatives, Table 8. Prepared for the U.S. Department of Health and Human Services. The full report is located at http://www.aspe.hhs.gov/daltcp/projects.htm#GWU5.

[18] For a comprehensive analysis of how SSI and Section 1619 data and Medicaid Buy-In data should be used to project the numbers of SSDI beneficiaries that may increase their earnings if a SSDI $1 for $2 policy were to be adopted, see Jensen and Silverstein "*A Framework for Preparing Cost Estimates for SSDI $1 for $2 Gradual Reduction Demonstration Proposals."* (December 14, 2005).See www.disabilitypolicycenter.org.

[19] A review of SSA and SSI Work Incentives File and Revised Management Information Counts System (REMICS) data indicates significant variation among the states in the number of SSI beneficiaries who work and the level of earnings. See Table in Appendix 2. In addition, the recent report by Mathematica "Explaining Enrollment Trends and Participation Characteristics of the Medicaid Buy-In Program, 2002-

4. The strength of the state and local economy and job market.
5. The level of need for and availability of ongoing acute health care and long-term health-related and employment-related services and supports (including transportation and housing) to sustain their jobs.

Set out below are a series of **intangible variables** impacting work activities by the heterogeneous population of SSDI beneficiaries:

- **Information**–What level of confidence and trust does the individual have that he/she understands the consequences of options related to the impact of working?

- **Economics** –Does the individual believe he/she will be better off economically if he/she works, increases work effort, or changes the nature of his/her employment?

- **Independence** – What level of importance does the individual place on being financially independent through earnings and ability to accumulate resources from working?

- **Values** – What personal value does the individual place on working?

- **Personal Self-Confidence and Self-Perception** –What level of self-confidence does the individual have related to his/her ability to work in general as well as ability to work at the job available and to sustain a work effort?

- **Coping with Stress**— What ability does the individual have to cope with physical and mental stress?

- **Risk-taking** – What level of risk is the individual willing to incur related to his/her ability to sustain a work effort and potential loss or reduction of entitlement benefits if he/she works?

- **Expectations and Encouragement by Agencies, Providers and Employers-** What level of expectations and encouragement to work in competitive, integrated settings is provided to the individual by agencies, service providers, and employers?

- **Family support**— What is the level of encouragement and support provided to the individual by his/her family?

- **Informal Network of Support for Working** – What is the level of encouragement and support provided to the individual by friends, and acquaintances?

2003" (January 14, 2005) indicates wide variation in participant earnings among the states with Medicaid Buy-In programs.

This reality is critical because it suggests that a "one size fits all" policy approach that attempts to determine in advance which beneficiaries (already determined to be unable to work) should be forced to work is inappropriate. To the contrary, these realities support a policy based on choice by individual beneficiaries.

OVERARCHING THEMES PROVIDING A FRAMEWORK FOR SPECIFIC POLICY RECOMMENDATIONS

We have identified three overarching themes that we believe provide a framework for guiding the development of policy that strives for a balance between policies that facilitate work and those that ensure a fair and decent level of income support during periods of work incapacity. These themes are security, simplicity, and sustainability.

- **SECURITY.** In light of the realities described above, the decision by a beneficiary to risk working must be rational—work must pay. It is essential that the beneficiary has the security of knowing that benefits will resume if work efforts fail or successes are intermittent because of one's disability.

- **SIMPLICITY.** Disability and health care programs are complex. In the face of complexity, taking the safe course of action (i.e., not risking work) is often the wisest. We must strive to simplify our programs through policy changes and/or through the provision of assistance to help navigate the system.

- **SUSTAINABILITY.** Our infrastructures at the federal and state levels must have the capacity to support work incentive initiatives.

POLICY RECOMMENDATIONS BY NATIONAL COUNCIL ON DISABILITY AND DISABILITY ADVOCACY ORGANIZATIONS

Before we discuss our policies recommendations in more detail, we would like to recognize that the National Council on Disability and groups representing the disability community have made a number of important policy recommendations for improving the implementation of the disability benefit, health care, and employment-related programs. We support the policy objectives of many of these recommendations, including those described in summary form in Appendix C.

SPECIFIC POLICY RECOMMENDATIONS

SECURITY AND SIMPLICITY

Consistent with the themes of security and simplicity, we would like to focus on four key policies:

- Continued attachment to programs in non-benefit status as long as the disability continues;
- Gradual reduction in benefits as earnings increase instead of cash cliff;

- Reward work while allowing some savings; and
- Provide greater comparability of the SSI and SSDI work incentives.

Continued Attachment to Supports

In designing and implementing the SSI and SSDI programs, it is important to recognize the reality that they are programs of last resort. A program of last resort means that before applying for benefits, the person with a medical condition that gradually worsens over time kept trying to work but those numerous work attempts were not successful. For those with a sudden injury, many go back to school using rehabilitation funds and gain a new skill. However, the uncertainty related to the disabling condition and needed connection to ongoing support means that time limited work incentives do not fit the reality of what many beneficiaries need to attempt and sustain work.

The uncertainty of many mental or physical disabilities linked to reoccurring health conditions means that the continued availability, when needed, of income assistance and health and support services is an essential part of a employment support disability policy. That is what we call "continued attachment." Current law provides for a degree of "continued attachment" to the SSI and Medicaid programs; but it is income limited and assets limited. Current SSDI and Medicare law provides for a degree of "continued attachment" to SSDI and Medicare after a person starts work; but it is time limited.

We recommend that the SSI, SSDI and Medicaid programs include the policy of continued attachment as long as the individual's disability continues. This continued attachment would be without time limits or income limits. During those periods when beneficiaries have higher incomes, they would receive gradually reduced benefits (see below) or no benefits at all (zero benefit status). [**For recommendations regarding asset limits, see page 14 of the testimony.]**

Gradual Reduction

Since the SSI program began in 1974, there has been a policy allowing for gradual reduction in benefits as earnings increase. The reduction in benefits begins after what is called the "initial earned income disregard" of $85 month for a persons receiving only SSI. The earned income disregard has not been changed since 1974 when the SSI benefit was $150 per month compared to the current $623 per month SSI standard. In 1980, the SSI and Medicaid programs changed temporarily to provide for a continuation of SSI and Medicaid benefits when the beneficiaries earnings exceeded the Substantial Gainful Activity (SGA) test for disability. Medicaid continues up to an earnings level equivalent to the amount of income and the value of the Medicaid they would receive if they were not working. SSI recipients can return to cash benefits if they can no longer work. These are known as the Section 1619 work incentives. The Section 1619 program was made permanent, effective in 1987.

In contrast, the SSDI program is an all or nothing program. A significant work disincentive for SSDI beneficiaries is the so-called "cash cliff" where a beneficiary who

earns more than Substantial Gainful Activity (SGA) (currently $900 per month for disabled beneficiaries) becomes ineligible for benefits, after a trial work period, and an extended period of eligibility if he or she earns more than SGA. The cash cliff is the most significant work disincentive in the program.

The cash cliff not only impacts eligibility for the SSDI program, but it also impacts the outcomes/results of other federal programs designed to increase work and earnings, such as the Ticket to Work program, the Vocational Rehabilitation Program, and the Medicaid Buy-In programs. Some beneficiaries (with complex impairments that adversely impact their ability to work over time) make rational decisions to keep their earnings below SGA to retain eligibility.

Elimination of the cash cliff is a key policy objective. *On the merits, most policymakers agree that something must be done. Previous efforts have failed because of cost estimates by the actuaries.* ***Those efforts proposed to start the gradual reduction at the SGA level. This policy would be consistent with the principal of "do no harm" i.e., current beneficiaries would not be harmed because under current policy they would be ineligible for benefits if they earned more than SGA. If policymakers, however conclude that the alternative of starting the gradual reduction at SGA is too costly, then we recommend that Congress consider the Gradual Reduction Choice Option which is fully described and explained in Appendix B of our testimony and can be found on the internet at www.disabilitypolicycenter.org.***

In a nutshell, consistent with the "do no harm" principle, under the gradual reduction choice proposal, a beneficiary would be provided the choice whether to continue to be subject to current policy or choose a second option under which the gradual reduction would begin at one-half of SGA and in exchange for starting the reduction in benefits at this level, the individual would be entitled to continued attachment to the program as long as his or her disability continued. Our gradual reduction choice option proposal also includes incremental changes to the work incentive provisions under the SSI, Medicaid and Medicare programs.

Reward Work While Allowing Some Savings

Significant increases in earnings by SSI beneficiaries can be further encouraged by allowing for a greater accumulation of resources. The $2,000 limit for an individual and $3,000 limit for a couple that is currently allowed under SSI and Medicaid has not be increased since 1988. At state option, most state Medicaid Buy-in programs allow for an accumulation of resources that is higher than the SSI standard. The policy in Medicaid Buy-in programs allowing for increased savings is intended to enable and reward persons with significant disabilities to increase their levels of independence and economic self-sufficiency. We believe that similar rewards should be authorized for working SSI beneficiaries (See Appendices B & C).

We recommend that the resource limit be increased and indexed. The limit has not been updated since 1988. If this recommendation is deemed not feasible because of

costs considerations, at a minimum, states should be provided the option to provide for a higher resources test for SSI beneficiaries with earnings.

Comparability

As explained earlier in our testimony, there is a significant overlap in the population of beneficiaries receiving benefits under both the SSI and SSDI programs. In fact, these concurrent beneficiaries now constitute nearly one-third of the adult disabled beneficiaries under SSI. Consistent with this reality, the Committee should consider alternative strategies that make the work incentive provisions in these two programs more compatible. **In our Gradual Reduction Choice proposal, we recommend that the earned income disregard be set at one-half of SGA for both programs (recall that under the SSI program the current disregard is $85).** It is important to note that consistent with the principle of "do no harm" only those SSDI beneficiaries who choose the gradual reduction choice option would be subject to this disregard; all other SSDI beneficiaries would still be able to work up to the SGA level, without being subjected to this disregard and a gradual reduction in benefits.

SUSTAINABILITY

Under sustainability, we would like to focus our testimony on the following two policies:

- Capacity of SSA to administer work incentives and provide timely and accurate adjustment of benefits; and
- Support state and local systems change initiatives that enhance infrastructure development, work incentive counseling, and services.

SSA Capacity

Implementation of enhanced work incentive policies will require a significant commitment of resources by Congress to SSA. SSA must have the administrative capacity and procedures to process earnings information from beneficiaries accurately and on a timely basis to prevent overpayments and other confusion that can negate work incentive policies.

Systems Change and Infrastructure Development

As explained above, we have concluded that changes in policy such as removing the cash cliff and providing for continued attachment are necessary to enhance employment outcomes for SSI and SSDI beneficiaries. However, we also have concluded that these changes are in no way sufficient to generate better employment outcomes. A key component in any work incentive initiative must include comprehensive work incentives planning and assistance (also known as benefits counseling). Beneficiaries have told us that they often distrust SSA and need someone who they can trust to help them navigate the system and respond when they face personal barriers and institutional roadblocks. They need ongoing assistance to utilize work incentives. We have also learned from the

experience of implementing the current SSI and Medicaid Buy-In program work incentives that there must be a concerted effort to train eligibility workers and service staff in order to increase the likelihood that beneficiaries will be willing to risk work and utilize the work incentives available to them.

In addition, it is critical that states receive ongoing support to continue to improve their infrastructures and break down artificial barriers among state agencies. We recommend that SSA, CMS and other federal agencies **jointly** support comprehensive state work incentive initiatives. Authorized use should include:

- Improved implementation of the Section 1619 and SSI programs to expand the numbers and percentages of SSI beneficiaries who work and to increase earnings levels;
- Benefits counseling (work facilitation);
- Expanded funding and support for personal assistance services, including services provided in the workplace;
- Improved implementation of Medicaid buy-in programs; and
- Expansion and improvement of state work incentive initiatives, including efforts to develop comprehensive seamless systems of services and supports.

SUMMARY REMARKS

Based on decades of research, we would like to reiterate to the Committee one piece of advice—please be cognizant of the maxim "do no harm." It is critical that you and your staff understand the consequences and unintended consequences of alternative proposals in your attempt to provide the proper balance between policies that facilitate work and those that ensure a fair and decent level of income support during periods of work incapacity.

APPENDIX A

Supplemental Security Income (SSI) &
Social Security Disability Insurance (SSDI) Beneficiaries &
Medicare and Medicaid

	18 – 64 years old December 2004	*Medicare& Medicaid Eligibility & Options*
SSI only	**2,850,815**	**Medicaid** **State Options** - **Automatic** - **SSI Criteria state administered** - **State criteria (209 (b)** **Medicaid waivers**
Concurrent SSI & SSDI	**1,116,293**	**Medicare** **(2 yr wait)** **Medicaid** **(See state options**
SSDI only **Disabled worker, Disabled adult children & Disabled widows & widowers**	**5,756,093**	**Medicare (2 yr wait)** **Medicaid** **State Options** - **Poverty Level option** - **Standard of need option** - **Medically Needy option** - **Medicaid Buy-In** **Medicaid waivers**
Subtotal Ages 18 – 64	**9,773,201**	
SSI only – payment status **SSI only – nonpayment status (not included in SSI –only or concurrent)**	**(17,394)** **(89,350) (December 2006)**	**Medicaid: Section 1619 (a)** **Medicaid: Section 1619(b)**
	Other Ages December 2004	
SSI Disabled Children	**993,127**	**Medicaid** **(See state options for SSI)**
SSI on basis of disability over age 65	**749,000**	**Medicare (if also OASDI)** **Medicaid** **(See state options for SSI**
Total All Ages	**11,515,328**	
Adults with Disabilities: **SSI suspension status, SSDI or neither**	**67,980** **December 2006**	**Medicaid Buy-In**

APPENDIX B

COMPONENTS OF THE GRADUAL REDUCTION CHOICE APPROACH. AND RELATED POLICY PROPOSALS

EXCERPTED FROM

GRADUAL REDUCTION CHOICE OPTION AND RELATED POLICY PROPOSALS (DECEMBER 2005)

www.disabilitypolicycenter.org

1. Retain Current Initial Eligibility Standards.

The criteria for the initial determination of eligibility (including i.e., the definition of disability) under the SSDI and SSI programs will not be changed.

2. Maximize Comparability Between SSI and SSDI.

There is the need to maximize comparability between the SSI and SSDI work incentive provisions as a means to encourage and enable beneficiaries to work or increase their work effort and update the SSI work incentives but at the same time maintain SSI as a federal minimum income assistance program and maintain SSDI as a wage replacement program for the insured worker and his/her family. Both programs should embody policies that facilitate, not impede achieving the overarching national goals of disability policy. Increasing comparability has the potential of increasing utilization of work incentives and level of earnings by reducing confusion because of current differences between SSDI and SSI work incentives.

3. Provide SSDI Beneficiaries with an Informed Choice (which entails tradeoffs) Between Current SSDI Policy (cash cliff) and an Alternative (providing gradual reduction in benefits).

Choice and Tradeoffs for SSDI Beneficiaries. Provide choice for the individual SSDI beneficiary to determine whether he or she wants to utilize current policy (TWP, EPE, the "cash cliff," and expedited reinstatement) or utilize the gradual reduction choice option (which includes, among other things, a gradual reduction in benefits after an initial earned income disregard of one-half of SGA and no time limit on continued attachment to the SSDI program when benefits are reduced to zero). In other words, the choice will entail a tradeoff. On the one hand, in utilizing current policy the beneficiary can choose limited risk and limited reward i.e., limited earnings below SGA and no reduction in benefits up to the SGA level followed by a cash cliff. On the other hand, the beneficiary can choose the gradual reduction choice option which entails short-term risk (i.e., a gradual reduction in benefits at earnings less than SGA) to obtain increased disposable income (i.e., continued eligibility for cash benefits above SGA) and long-term security (i.e., no time limit on continued attachment to the SSDI program as benefits are reduced to zero).

Choice Times. A beneficiary's earnings would be subject to treatment under the current policy (i.e., "the default") until he/she affirmatively chooses the gradual reduction choice option. This initial decision can be made at any time after the individual obtains sufficient information and work experience to make an informed choice. This initial decision to utilize the gradual reduction choice option would continue until an "open season" during which the beneficiary would have the option to return to current policy. The open season would be available on an annual basis for a duration comparable to that currently available to Medicare beneficiaries related to enrollment in Part B. Thus, the individual would be permitted to exercise the option to move back and forth between options but only during an annual open season.

Informed choice. As explained above, when an individual initially becomes eligible for SSDI cash benefits, the "default" is current policy. The individual must affirmatively choose the gradual reduction choice option. An individual will explicitly make a choice between the SSDI cash cliff option or the gradual reduction in benefits option i.e., the individual will sign-off on the option chosen. The choice must be informed, i.e., the administrative infrastructures must ensure that the beneficiary has a sufficient level of confidence and trusts the information provided and the beneficiary must understand the consequences of his or her decision, including the nature and extent of the risk.

4. Earned Income Disregards and Gradual Reduction in Benefits

Uniform Initial Earned Income Disregard for SSI and SSDI. There would be one initial earned income disregard before there is a reduction in SSDI benefits and SSI benefits that would apply to SSI-only beneficiaries, SSDI-only beneficiaries and concurrent SSI/SSDI beneficiaries. The initial earned income disregard would be one-half of SGA as it applies to disabled beneficiaries and one-half of the special SGA as applied to blind beneficiaries. The reduction in benefits would occur as soon as the individual has earnings in excess of the initial earned income disregard and impairment-related and blind work expenses. The higher SSI initial earned income disregard would apply to all SSI beneficiaries with earnings, not just concurrent SSI/SSDI beneficiaries.

$1 for $2 Reduction in Benefits. The gradual reduction in SSDI and SSI benefits after the initial earned income disregards would be $1 reduction in benefits for $2 of earnings.

Order of Reduction for Concurrent Beneficiaries. For concurrent SSI/SSDI beneficiaries, Federal SSI cash benefits would be reduced first, SSI state supplement benefits second, the individual's SSDI benefits next, and OASDI auxiliary benefits would be the last to be reduced. The current $20 disregard of any income (earned or unearned) would still apply in determining SSI benefits.

Individual's SSDI Benefit Level is Beginning Point for Reduction Based on Earnings. The individual's SSDI benefit amount would be used as the unearned income level at which SSDI benefits are reduced based on earnings as a means to recognize SSDI as an individualized wage replacement program and the insured worker's previous contributions to the Trust Fund. In other words, the reduction based on earnings would apply against the SSDI benefits the individual is eligible to receive.

Impairment-Related Work Expenses (IRWE) Disregard. Provide that an SSDI beneficiary who chooses the SSDI gradual reduction option can apply for an individualized determination of impairment-related work expenses in determining earnings not to be counted in reducing SSDI benefits as is now provided for SSI beneficiaries with earnings. There would be one IRWE disregard allowed for concurrent SSI/SSDI beneficiaries.

Blind Work Expenses (BWE). Provide that an SSDI beneficiary who is eligible on the basis of blindness and chooses the gradual reduction option can apply for an individualized determination of BWEs in determining earnings not to be counted in reducing SSDI benefits as is now provided for SSI beneficiaries who are blind with earnings. There would be one BWE disregard allowed for concurrent SSI/SSDI beneficiaries.

Student Earned Income Exclusion. Provide that an SSDI beneficiary who chooses the SSDI gradual reduction choice option and who is under age 22 and regularly attending school will have earnings excluded from income at a higher rate than the initial earned income disregard as is now provided for SSI student beneficiaries with earnings. There would be only one exclusion for those who are concurrent beneficiaries.

Asset Accumulation. Expand the purpose of a Plan for Achieving Self Support (PASS) to include not only employment goals but also asset accumulation (savings) for SSI beneficiaries related to housing and independent living.

5. **Provide for Continued Attachment to the SSDI, SSI, and Medicaid Programs as Work Incentives. Medicare for Working SSDI Beneficiaries with Reduced Benefits.**

Continued Attachment to SSDI under the Gradual Reduction Choice Option. Those SSDI beneficiaries who chose the SSDI gradual reduction choice option would continue to be considered SSDI beneficiaries in a non-payment status when their earnings make them no longer eligible for cash benefits. They will be able to return to SSDI cash payments if they have a reduction in their earnings as is now the case in the SSI program.

Continued Attachment to SSI and Medicaid. SSI beneficiaries who exceed the Section 1619(b) threshold for Medicaid eligibility would be able to continue their

attachment to SSI (non-payment status) and Medicaid (non-benefit status) without the current 12 month time limit.

Medicare for Working SSDI Beneficiaries with Reduced Benefits. Consistent with current policy regarding continued eligibility for Medicare, a beneficiary would continue to be eligible for Medicare as long as he or she is in SSDI payment status. To the extent the beneficiary is in nonpayment status, the current time limits and eligibility for regular Medicare and the Medicare Buy-In would apply.

6. Increase Work Incentives under Medicaid for SSI and SSDI Beneficiaries.

State's Option to Increase Section 1619(b) Earnings Limit. Each state would have the option to establish an earnings limit (for continued Medicaid eligibility for SSI beneficiaries in nonpayment status) at a level higher than the minimum Section 1619(b) threshold established each year for each state by SSA under administrative regulations. Current policy, which enables an individual to have an individualized Section 1619(b) earnings limit based on higher medical costs, would continue.

State's Option to Increase Resources Limit for Working SSI Beneficiaries. In addition, states would be authorized to establish a higher resources limit and additional resource exclusions (as work incentives) than under current law for SSI beneficiaries with earnings. Such funds from earnings would be in separate accounts as is now the case under the administration of PASS plans. Under this authority, State's may also provide for exclusions of retirement accounts and "independence" accounts. Such accounts would be disregarded for purposes of SSI eligibility.

Disabled Adult Children and Section 1619(b) Eligibility. Under current law, persons who become newly eligible or have increases in their DAC benefits under Title II are protected against loss of Medicaid eligibility if their new eligibility for benefits or increased amount of benefits makes them ineligible for SSI. However, for SSI beneficiaries who were utilizing Section 1619 their loss of SSI status makes them ineligible for the work incentives under the provisions of Section 1619(b). We are proposing that for purposes of continued eligibility for Medicaid under Section 1619(b) they would be "deemed" to be SSI beneficiaries.

APPENDIX C

SELECTED POLICY RECOMMENDATIONS BY THE NATIONAL COUNCIL ON DISABILITY AND OTHER DISABILITY ADVOCACY ORGANIZATIONS

The following recommendations have been proposed over the years by others. We support the policy objectives of these recommendations.

SSI and SSDI programs. Increase the SGA level for disabled beneficiaries (currently $900) to be consistent with the level of blind beneficiaries (currently $1,500). This change would increase the percentage of beneficiaries willing to risk work and increase their disposable income.

SSI program—Increase and index the resource limit (currently $2,000 for an individual and $3,000 for a family). This limit has not been updated since 1988. Increase and index the income disregard to at least recognize the cost of living since 1974 to approximately $250.

SSDI and Medicare— Eliminate the 24 month waiting period for eligibility for Medicare for SSDI beneficiaries. Allow permanent access to Medicare for beneficiaries who work—provide lifetime certification of health coverage for beneficiaries with lifelong conditions.

Disabled Adult Children—Ensure that past work above SGA does not remain a barrier to SSDI benefits for people who otherwise are eligible for DAC benefits.

Benefits counseling. Dramatically increase funding for the Work Incentives Planning and Assistance Grants (formerly benefit counseling). This recommendation is essential to assist beneficiaries understand work incentive policies and to navigate the system of services and supports. Without sufficient numbers of qualified counselors no work incentive policy will have broad-based, nationwide success.

Ticket to Work program. Consistent with the policy set out in the proposed regulation promulgated by SSA, modify the payment systems to provide enhanced payment for upfront costs (increase milestones and allow for payment by state vocational rehabilitation agencies for certain costs and then allow employment networks to still receive payments) Note: The Ticket to Work program will always be of limited efficacy so long as the SSDI cash cliff exists and a policy is not adopted that allows outcome payments when benefits are reduced rather go to zero.

Medicaid. Congress should block CMS from implementing revisions to Medicaid policy regarding the scope of the rehabilitation services option. CMS, through administrative action is already narrowing the scope of the rehabilitation option. The effect of these

actions is to discourage states from using best practices designed to enhance employment of beneficiaries.

APPENDIX D

Selected Publications, Papers, and Manuals By Allen Jensen and Robert Silverstein

(Selected papers, articles and policy briefs can be downloaded from www.disabilitypolicycenter.org and www.medicaidbuyin.org)

Silverstein, Robert; Jensen, Allen. Systems Change Information Bulletin #2: Opportunities for State VR Agency Participation in Statewide Systems Change (January 2007).

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Jensen, Allen; Silverstein, Robert. Systems Change Information Bulletin #4: Medicaid Infrastructure Grants and State VR Agencies (January 2007).

Jensen, Allen; Silverstein, Robert. Systems Change Information Bulletin #5: Work Incentives & Benefits Planning and Assistance & State VR Agencies (January 2007).

Jensen, Allen; Silverstein, Robert. Systems Change Information Bulletin #6: The Role of State VR Agencies in Proposing Reforms to Existing Work Disincentives in the SSI and SSDI Programs (January 2007).

Jensen, Allen; Silverstein, Robert. Gradual Reduction Choice Option and Related Policy Proposals (December 2005).

Jensen, Allen; Silverstein, Robert. A Framework for Preparing Cost Estimates for SSDI $1 for $2 Gradual Reduction Demonstration Proposals (December 2005).

Silverstein, Robert, George Julnes and Renee Nolan. What Policymakers Need and Must Demand from Research Regarding the Employment Rate of Persons with Disabilities, Behavioral Sciences and the Law (Wiley InterScience, 2005).

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Silverstein, Robert. Policy Brief: The Ticket to Work and Self-Sufficiency Program and Established Under the Ticket to Work and Work Incentives Improvement Act of 1999 (February 2000).

Silverstein, Robert, Allen Jensen. *P*olicy Brief: Improvements to the SSDI and SSI Work Incentives and Expanded Availability of Health Care Services to Workers with Disabilities Under the Ticket to Work and Work Incentives Improvement Act of 1999 (February 2000).