Solving the Dilemma of Work Incentives under the Social Security Disability & Supplemental Security Income Programs

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SOLVING THE DILEMMA OF WORK INCENTIVES UNDER THE SOCIAL SECURITY DISABILITY & SUPPLEMENTAL SECURITY INCOME PROGRAMS

David S. Whalen

I. INTRODUCTION

Paul Longmore, a 42 year old California native, has no use of his arms or legs because of polio and at night he must sleep with a ventilator. His disability, however, has not prevented him from working towards his goal of achieving at least partial independence. After earning a doctorate in history and completing ten years of research, he recently finished a biography on George Washington, which is expected to yield $10,000 in royalties.

A problem arose when Longmore learned that his book royalties would be considered 'unearned' income. As a Supplemental Security Income (SSI) recipient, Longmore jeopardized his continued eligibility by receiving royalties because they exceeded the program's limits on unearned income. While Longmore could manage the loss of cash assistance which the program provided, his loss of medical benefits was intolerable. In California, SSI eligibles are provided automatic qualification for California's Medicaid program, a needs based medical assistance program. Longmore receives in excess of $20,000 in essential medical assistance each year, including personal care assistance and rental of his ventilator. Without such support, he would be compelled to live in a nursing home—at greater expense to taxpayers.

Paul Longmore's story illustrates the frustration and risks that disabled persons confront when they attempt to work while remaining part of the nation's major federal programs which support the disabled—Supplemental Security Income (SSI) and Social Security Disability (SSD). Longmore, a leader in focusing attention on reform efforts, burned a copy of his book to protest these laws which block opportunity. His efforts, along with those of Rep. Steven Bartlett of Texas and other advocacy groups, have increased work opportunities for people with disabilities.

For example, under the SSI program, discussed in further detail below, recipients historically would have been denied program eligibility because of work efforts. Now they may earn far greater incomes than ever before and remain eligible for vital medical benefits and "special SSI cash payments" if needed because of the new §1619 amendments. These amendments incorporate, in part, a new formula, set forth below, which may individualize a person's earnings threshold for continued eligibility. Historically, recipients could be terminated from the SSI program based on earnings without regard to actual benefits that would be lost, including medical benefits. The new amendments correct this harshness.

Employment opportunities for disabled persons are increasing. A remarkable fact is that over the past five years, machines have become available allowing the disabled to talk, listen, teach, communicate, and translate to a far greater extent, rapidly clearing away many major workplace hurdles. Combining new sophisticated devices with enhanced educational opportunities and rehabilitation programs, as well as enlightened societal attitudes, enables far greater realization of human resources from a segment of society which has largely been untapped. The widespread availability of the personal computer, for example, and its enhancements over the past decade, has been a major reason for recent change. It has "almost single-handedly delivered the disabled from the Dark Ages." In response to such advances, the availability of work incentives will become increasingly important.

II. A FUNDAMENTAL QUESTION: HOW TO DEFINE "DISABILITY"?

Before examining the relevant disability programs, it is necessary to review the legislative evolution of the concept of disability to understand its current application. Today's definition was conceived at the inception of the Social Security Administration's first disability program in 1954. However, the first program was not designed specifically for the disabled. The intent of Congress was to bolster the needs of elderly workers who were forced into early retirement because they were no longer able to work due to total disability. Thus, the design of the program was to enable older workers to avoid work in compelling situations. Once these individuals became eligible for the program, they were
no longer expected to work. The goal of this initial program—to enable early retirement—conflicts with program policies fostering work incentives.

Because the first type of benefits was aimed at older, retiring workers, the benefits were not in the form of cash disbursements as they are today. In 1954, Congress first instituted legislation protecting retirement benefits for persons who had substantial work histories. In 1955, Congress established the disability insurance trust fund, and the disability insurance program became effective in July of 1957. In 1960, the age limitation for Social Security Disability Insurance was eliminated.

The concept of disability embodied in current law represents a politically fashioned compromise at any given time and place about the legitimacy of claims to social aid. In the early 1950s, a deep-seated legitimacy of benefits solely for disabled persons was lacking. There was opposition to creating a new program specifically for disabled persons. In order to overcome opposition, proponents of disability insurance initially presented their proposal as a modification of the retirement program in the form of a reduction in the retirement age of disabled persons.

Part of the disability definition adopted in the early 1950s rests on an individual’s inability to engage in substantial gainful activity (SGA). SGA ties the definition of disability to the individual’s ability to work and receive earnings. SGA is characterized as work activity which involves significant physical or mental activities for pay or profit, providing it is the kind of work usually done for pay or profit. In most cases, average earnings of $500 per month are considered SGA. In determining whether or not the $500 SGA figure is actually being achieved under the SSI and SSD programs, disabled workers are able to deduct certain impairment related work expenses. These expenses comprise the reasonable cost of items and services needed to work as a result of a disability.

The SGA test is only part of the disability requirement. Additionally, the definition requires the showing of medical evidence. For individuals with severe disabilities in thirteen different categories, medical evidence alone establishes a presumption that such individuals are unable to engage in SGA without further inquiry.

On the other hand, claimants with less severe disabilities fall under a modification to the disability definition adopted in 1978. The Social Security Act requires that such persons must “not only [be] unable to do his previous work but [must be unable], considering his age, education, and work experience, [to] engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.” These guidelines incorporate “grid regulations” which are intended to function as a means of objectifying the SGA portion of the disability assessment. They are based on a matrix of four factors including physical ability, age, education, and work experience, and are intended to eliminate the need for vocational experts to conduct eligibility assessments.

### III. BACKGROUND

Before discussing significant new opportunities for disabled individuals to work, it is essential to outline the structure of the SSI and SSD programs as well as their collateral medical assistance provisions, Medicaid and Medicare. More importantly, readers should be aware that work opportunities differ greatly depending upon which program the eligible person qualifies for and that the underlying purposes of both programs differ significantly as well. Section 1619 is only one of many laws enabling work opportunities.

The term “disability” has been used broadly so far. It is worthwhile to note that the variety and types of disabilities vary significantly between SSI and SSD. Under the SSI program, 53 percent of the male recipients have mental illness and 10 percent have circulatory system disorders; 43 percent of the female recipients have mental disorders, 10 percent have circulatory problems, and 10 percent have musculoskeletal disorders. On the other hand under SSD, 18 percent of the male recipients have mental disorders, 23 percent have circulatory problems, and 15 percent have musculoskeletal disorders. Female SSD recipients have the lowest percentage of mental disorders at 17 percent, while 15 percent have circulatory problems and 20 percent have musculoskeletal disorders.

### (A) SUPPLEMENTAL SECURITY INCOME (SSI)

SSI functions as a safety net for indigent, aged, blind, and “disabled” persons. A person with a disability under SSI need never have worked to become eligible for payments. The program became effective in 1974, after the repeal of a 1950 state public assistance program for needy, aged, blind, and disabled persons. The new program created federal control and increased opportunities for eligibility.

SSI benefits include cash payments designed to assure a basic standard of living at a minimum federal benefit level. States may build upon the Federal income base with a state supplement so that the total amount of benefits varies by state. The benefits level in 1989, for an individual living alone, was $4,416 per year, or $368 per month. The federal poverty income guideline level for 1989, by comparison, was $5,980 or $498 per month. The federal benefit level in 1990 is $386 per month.

There are important criteria for meeting initial and continued SSI eligibility. Unlike current SSI eligibles, applicants with earnings in excess of the SGA level are ineligible. Both applicants’ and current SSI recipients’ unearned income still must not exceed a set amount. The limit on unearned income is made without regard to the severity of disability, as illustrated by the case of Paul Longmore.

Furthermore, countable resources, which generally ex-
include the cost of a principal place of residence, for both applicants and recipients, cannot exceed $2,000. Under the Plan for Achieving Self-Support (PASS), money set aside in a special income/resource shelter is excluded from countable resources. This shelter is used by disabled SSI eligibles to collect funds in order to pay for items and services to enable such persons to work. Within certain limitations, the cost of an automobile is also excluded. Lastly, SSI recipients must continue to have the disability which initially led to eligibility.

(B) SOCIAL SECURITY DISABILITY (SSD)

The Social Security Disability program is part of the Old-Age, Survivor’s, and Disability Insurance program (OASDI), commonly referred to as “Social Security.” The SSD component operates as a program of basic, mandatory government disability insurance to which workers and employers contribute. It provides protection to persons with substantial work histories. Additionally, workers’ dependents are covered.

Actual benefits afforded SSI and SSD eligibles are far greater than the program’s monthly cash payments alone. Significant medical benefits are contingent on continued eligibility. SSI eligibles in some states may receive automatic Medicaid coverage, while SSD eligibles may, after a two year waiting period, receive Medicare coverage. Benefits under Medicaid and Medicare differ and the scope is changing, not only in light of legislative changes but through recent judicial decisions as well.

(C) MEDICAID

Medicaid, established under Title XIX of the Social Security Act, is an assistance program designed to pay medical expenses for “categorically needy” individuals. All states participate in Medicaid except Arizona. Participating states must cover eligible individuals for the following required services: (1) hospitalization; (2) out-patient hospital services; (3) physician services; (4) lab tests (including x-rays); (5) nursing homes; and (6) home health care (including nursing and home care services). States may provide additional services.

Medicaid is funded at the federal, state, and county level. The New York State legislature budgeted over $10 billion for the New York Medicaid program for fiscal year 1989. While the State plans to spend $3.35 billion, the federal government and New York counties will pick up the balance. State legislators are concerned with the rising cost of Medicaid, since more than half of the property tax revenues in some New York counties are being allocated to social services, with a large part of the spending being attributed to increases in Medicaid. On the federal level, New York State, with 6 percent of the U.S. population, received 20 percent of the nation’s federal Medicaid spending.

In addition to categorically needy individuals, states have the option of providing coverage to the “medically needy.” For these individuals, there are income and resource tests that must be met. These tests vary from state to state. In fiscal year 1986, 3.2 million individuals with disabilities received Medicaid. Combined federal and state expenditures totalled $14.9 billion.

Underscoring the importance of SSI eligibility is that SSI recipients automatically qualify for Medicaid in New York State. Medicaid coverage is a substantial and necessary benefit for disabled recipients. The average annual per capita estimated Medicaid expenditure for a New York SSI recipient is $7,851 in 1990, while the annualized SSI amount in 1990 is $6,696. Thus, termination of SSI has ramifications beyond the immediate loss of SSI benefits.

(D) MEDICARE

Medicare, with an annual budget of over $88 billion dollars, is the primary health insurance for over 30 million Americans. The program is mainly comprised of persons over age 65 who qualify on the basis of Old Age Survivors and Disability Health Insurance (OASDI). In mid 1987, disabled SSD beneficiaries constituted 10 percent of the Medicare population, numbering more than 3 million. Individuals who qualify for SSD benefits, on the basis of their parents’ benefits, are also eligible for Medicare. SSD eligibles must wait 24 months after receiving a disability benefit in order to receive Medicare. Other persons not covered by OASDI may pay a monthly premium and become eligible.

There are two parts to the Medicare program. The first part, Medicare Part A, comprises hospital insurance (HI). The scope of benefits for eligibles includes skilled nursing facility coverage, Home Health Care, and Hospice Care. The 1990 monthly premium is $175.00 for persons who are able to buy-in. SSD eligibles do not have to pay the premium. There are a number of other instances where Part A participants are required to pay. An important benefit to disabled individuals under the Home Health Care coverage is that eligibles are provided with an unlimited number of home health care visits by skilled nurses and home health aides, without having to pay a deductible or coinsurance rate.

A common misconception exists that persons with chronic illnesses are not entitled to Home Health Care Coverage. In Duggan v. Bowen, the United States District Court in Washington, D.C., confronted the scope of home health care coverage for Medicare recipients. Under Part A, home health care services are provided by home health agencies (HHAs) which enter into agreements with the Secretary of Health and Human Services to provide health care to persons eligible for Medicare. HHAs provide Part A services in patients’ homes rather than in an institutional setting for two principal reasons — first, home services are more humane, and secondly, they are more economical. Home health services include: part-time or inter-
mittent nursing care provided by or under the supervision of a registered nurse, physical, occupational or speech therapy; medical social services under the direction of a physician; and part-time or intermittent services of a home health aide. Under the Medicare Act, a beneficiary must meet certain conditions to receive home health care coverage. The patient must need skilled care while "confined to his home."

The issue in Duggan was whether or not the Department of Health and Human Services' interpretation of the provision pertaining to "part-time or intermittent care," was arbitrary and capricious. The Department interpreted the provision as not covering home health aide services if such services required more than four days a week. The court held that the four-day rule directly contravened the plain meaning of the statute. According to the court, services may be available in the home seven days a week and still be considered part-time or intermittent under the statute.

The second part of Medicare is Part B, Supplementary Medical Insurance (SMI). It is a voluntary program whereby eligible beneficiaries who pay a monthly premium ($28.60 in 1990) are entitled to reimbursement for some physicians' services and ancillary medical expenses, including durable medical equipment. Under Part B, Medicare recipients are required to pay an annual $75 deductible and a 20 percent coinsurance rate. Medicare recipients are also required to pay the additional fee beyond the 20 percent coinsurance rate when doctors charge above Medicare's "allowable charge" for the service rendered.

**IV. WORK INCENTIVES**

Work incentives that are available to SSD and SSI program eligibles have been underutilized. Thus, a leading legal services attorney can assert:

The best kept secret among advocates, disability benefit recipients and, yes, even among the Social Security Administration personnel has to be the availability of work incentives under SSA's disability programs... An example of an underutilized incentive is the Plan for Achieving Self Support (PASS). The PASS "has been in place since 1974. Unfortunately, the PASS has virtually been ignored as a means to shelter and exclude income and resources of the SSI applicant and recipient." The PASS functions as an income or resource exclusion that allows a disabled person to set aside income or resources for college tuition, vocational training, starting costs for a business, work-related equipment, and other necessities needed to achieve employment. A significant aspect of the PASS is that it may enable an SSD eligible to establish concurrent SSD and SSI eligibility. This, in turn, enables the eligible to set aside SSD benefits through a PASS shelter while receiving SSI benefit payments. The accumulated SSD benefits may then be used to purchase equipment necessary to enter into employment.

The success of work incentives has been limited because policymakers assumed that a disabled person would make a transition to total independence after a trial work period. The trial work period was intended to function as a transition period during which an individual could test his ability to work without losing immediate support. However, the ability to meet large annual medical expenses accompanying severe, chronic disabilities will rarely be developed during a transition period. Moreover, SSA proposals aimed at correcting this harshness are difficult for recipients to understand and for SSA claims representatives to apply. The result of many current modifications under the SSD program has been, in effect, to extend the trial work period from 9 to 45 months.

(A) THE EFFECTS OF EARNINGS AND WORK ON SSD AND MEDICARE

Presently, under SSD, the major work incentives for disabled persons are: the use of impairment related work expenses, the Plan for Achieving Self-Support, the trial work period, the "grace period," the extended period of eligibility, and the extended period of Medicare Coverage (forty-eight months).

Once an SSD eligible earns above the SGA level, he is not automatically terminated. An eligible is provided a nine month trial work period where full benefits are maintained. After nine total months in which earnings exceeding $200 are accumulated, the trial work period is exhausted. Earnings in excess of SGA after the trial work period generally result in the individual no longer being considered "disabled" for the purposes of continued eligibility. A person receives a benefit for the month in which termination occurred plus an additional two month "grace period."

The extended period of eligibility is a consecutive 36 month term following the trial work period. If during months 3 through 36 the disabled worker's earnings for a particular month are less than the SGA level, the person is entitled to a full benefit payment for that month. Earnings greater than the SGA level result in the monthly benefit payment being reduced to zero. If earnings continue to be less than SGA between months 3 through 36, a person can automatically resume receiving regular SSD payments. SSD eligibles are not allowed an earnings-benefit offset similar to the SSI program.

During the trial work period and extended period of eligibility (forty-five months), the individual is provided with extended Medicare coverage. A major disincentive remains because eligibles who want to work face a "Catch 22" situation: if they do work, they lose their health insurance after forty-eight months. A newly enacted amendment to the SSD program, however, will help alleviate this barrier. The amendment addresses the current dilemma poten-
tial SSD workers now face by allowing SSD eligibles to buy-in to Medicare after the forty-eight month period. For SSD eligibles who are earning less than 200 percent of the poverty level, Medicaid would be required to pay their Part A premiums. But, states could require that individuals earning between 200 and 150 percent of the poverty level pay a portion of their premiums. Persons earning over 200 percent of the poverty level are required to pay their full premiums. The coverage is limited to Medicare Part A premiums, and individuals would be subject to a resource test that is twice the SSI level.

(B) THE EFFECTS OF EARNINGS AND WORK ON SSI AND MEDICAID UNDER §1619

As a result of the Employment Opportunities for Disabled Americans Act of 1987, the trial work period and extended period of eligibility for disabled and working SSI eligibles were eliminated. The Act made §1619 permanent, and eligibles no longer have benefits terminated on the basis of the SGA rule. The §1619 incentives have two essential components. First, §1619(a) provides Special Cash Benefits if the individual's earnings equal or exceed the SGA level (now $500) but are below a breakeven point. §1619(a) eligibles are automatically reinstated to regular SSI payments when earnings drop below SGA. However, §1619(a) eligibles must meet the prior month requirement, as well as all other SSI nondisability criteria. These disabled workers are automatically eligible for Medicaid coverage, so that the disincentive created from a loss of corresponding medical benefits is removed. Payment amounts are calculated the same way regular benefit amounts are determined.

The second component of the §1619 work incentives is the extension of Medicaid eligibility to disabled and working individuals who could not work but for the extension of Medicaid coverage (§1619(b)). These individuals' earnings are high enough to reduce their monthly SSI payments to zero. Such eligibles receive "Special SSI Eligibility Status" for the purposes of receiving Medicaid provided they meet a "Threshold Test." This test, under §1619(b), compares gross income with either a threshold amount or an individualized threshold.

The charted threshold amount in 1990 for New York State is $20,199. Gross earnings less than or equal to the threshold amount allow continued eligibility. If gross earnings exceed the threshold amount, an individualized threshold is used which takes into account even higher earnings for continued eligibility.

The charted threshold is calculated by adding a "base amount" representing the annual gross earnings figure which would reduce an individual's combined state and federal SSI benefit to zero, including the recipient's estimated state annual average per capita Medicaid expenditure. The base amount consists of a Federal breakeven point annualized — $10,284 in 1990 — plus two times the State supplementary payment level (e.g., $2,064 for New York recipients in 1990). Thus, the base amount is $12,348 for New York eligibles. The effect of the charted threshold is to prohibit an individual from retaining eligibility if he has sufficient gross earnings to replace SSI cash benefits, publicly-funded personal care benefits, and an estimated per capita Medicaid expenditure.

The individualized threshold enables a determination to be made based on whether the recipient has sufficient earnings to replace all benefits actually provided through SSI eligibility. In some instances, individuals may have a higher per capita Medicaid expenditure, PASS, or work expense. The individualized threshold includes the following: the base amount plus the sum of the actual expenditures for Medicaid services received or expected for a designated 12-month period, impairment-related work expenses, expenditures under an approved plan for achieving self-support and publicly-funded personal attendant care. As long as other SSI criteria are met, recipients could earn in excess of the $20,199 charted threshold amount. Because the new law takes into account all benefits which would actually be lost if SSI eligibility were cut, the effect of either calculation is to permit far greater earnings than ever before for SSI recipients.

Other Special SSI Eligibility Status criteria include the following: the individual must (1) be under age 65, (2) continue to have the disabling impairment which enabled initial receipt of SSI, (3) continue to meet all SSI nondisability requirements, and (4) meet the "Medicaid Use Test" and "Prerequisite Month Requirement." §1619(b) recipients are reinstated automatically to either §1619(a) status or regular SSI status depending on earnings level.

For example, if X, a disabled New York SSI eligible lived alone with no other income, and his gross income equaled $30,000 dollars a year in 1990, the individualized threshold would apply. Since X had $20,000 in medical expenses and all other SSI criteria were met, X would maintain program eligibility because his individualized threshold of $32,348 (combining the $12,348 base amount plus the actual medical expenses of $20,000) would exceed gross income. Under the SSI program, the government must balance the need to limit basic assistance to the needy disabled with the need to allow program recipients to reach America's economic mainstream. Although §1619 participants will be able to earn higher incomes, income level should effect eligibility. By defining disability with a strict SGA earnings limitation, SSA was assured that persons with incomes higher than SGA would not remain on SSI when they could provide for themselves. This policy, however, did not consider the individual's actual loss of benefits and instead compelled individuals who sought to work to remain dependent on SSI and a subsistence based income. Even though the passage of the Employment Opportunities for Disabled Americans Act of 1987 eliminated the SGA rule, the remaining SSI criteria continue to dissuade people who want to work. For example, if a participant wants to work and save towards the down-payment on a
home, a child's college education, or an Individual Retirement Account, they would become ineligible for §1619 after exceeding the $2,000 limit on SSI's countable resources. Participants are forced to spend their earnings in order to stay below the SSI limit. In effect, financial dependence on the program is fostered because individuals cannot build equity.

People on §1619 "may face a bleak future" because they rely on Medicaid for their medical care. Reagan era policies have shifted the financial burden from the federal government to state and local governments. State and local governments are either unable or unwilling to meet this new financial burden. [In all states, and particularly in recent years, the scope of services covered is a source of continuing controversy. Few states are generous and all are becoming increasingly willing to cut back ... to impose cost-sharing requirements on recipients, and to utilize a variety of restrictive administrative techniques.] Another serious shortcoming of Medicaid is the limited reimbursement available in most states and the resulting reluctance of many providers to accept Medicaid patients. Similar concerns rest with Medicare eligibles as well.

Lastly, §1619 status also triggers an annual "continuing disability review", historically, a vulnerable point for eligibles. In the early 1980s, wholesale terminations of SSD eligibles resulted from continuing disability reviews. The Reagan Administration attempted to cut costs via a "crack down on ineligibility." Citing a General Accounting Office (GAO) report claiming that 20 percent of the SSD beneficiaries were actually ineligible, the Administration's goal was to create $2 billion in savings. Governors in nine states, including New York, halted the terminations on their own initiative, charging that the new federal guidelines unfairly denied benefits to eligible recipients.

One factor which helped the Administration track down ineligible beneficiaries was the change set forth in §901 of the Social Security Disability Amendments of 1980, which required, beginning in January of 1982, continuing eligibility reviews at least once every three years for persons not considered "totally disabled." The Department of Health and Human Services, however, moved up the date of implementation and accelerated the rate of reviews beyond the schedule in the 1980 Amendments.

A second major factor, combined with accelerated reviews, was that SSA introduced a stricter eligibility standard. During the 1970s, decreasing numbers of beneficiaries left the benefit rolls with no corresponding overall decline in the health of the nation's workforce. SSA's policy setting forth standards for review were consequently questioned. The number of continuing disability investigations increased sharply, and the strain placed on the Social Security Administration was enormous. From March 1981 to March 1984, 470,000 SSD eligibles were terminated, with 160,000 persons later being reinstated upon appeal, and 120,000 appeals pending as of March 1984. The policy from 1969 to 1975 was to continue benefits on a medical basis if the person's condition had not improved since initial determination of medical eligibility. In June 1976, SSA issued orders to apply a stricter "current disability" standard. The then new standard allowed termination when a recipient could not produce substantial evidence of continuing disability, whether or not there was evidence of actual medical improvement. SSA was criticized because the medical criteria in the newer standards, particularly in mental impairment cases, "focused too heavily on the severity of the medical condition without making an adequate evaluation of the beneficiary's ability to work, with the result that benefits were terminated for many people who cannot function in the work environment."

Congress reacted to the wholesale terminations with strong bipartisan support in opposition. Representative Fortney Stark co-sponsored a bill that would place a moratorium on continuing disability investigations (CDIs) of the mentally disabled until reforms were passed. Congress instituted a temporary moratorium on mental improvement reviews and a stricter standard requiring the government to establish evidence that individuals' conditions "have not medically improved to the point of ability to perform SGA." The Congressional Budget Office (CBO) estimated that the cost of the crack down to SSA was an additional $1.4 billion dollars for 1984 through 1990 (SSA's estimated cost was $1 billion higher than CBO's).

V. A LEGISLATIVE HISTORY OF §1619

In 1978, the House passed a bill that would have increased the SGA level, making it harder to lose SSI through increased earnings. The bill would have raised the SGA amount by the Federal SSI "breakeven point" and doubled the allowable money spent on work expenses and attendant care.

The legislation would have individualized SGA and changed the definition of disability for the SSI but not SSD. The 95th Congress adjourned before the Senate could take action.

In October 1979, the House passed a bill which was also intended to remedy the harshness of the SGA limitation by setting a higher minimum SGA level, but at the SSI "breakeven point" only. The bill did not include a provision to double the allowable money spent on work expenses and attendant care. The Social Security Administration, however, opposed changing the definition. Testifying before the Senate Finance Committee, the Commissioner of the Social Security Administration warned that program costs were projected to rise from $15 billion to $30 billion within 10 years, unless measures were taken to curb spending. The Senate Committee felt it necessary to move with great care in addressing those disincentives to avoid making unintended and undesirable changes in fundamental scope and purpose of the program. The Senate rejected changing the SGA level.
The House and Senate reached a compromise. Instead of mandating an increase in SGA level, the bill established the §1619 provisions as a temporary three-year demonstration project. §1619 leaves SGA and the definition of disability unchanged. However, working disabled eligibles under §1619, receiving earnings in excess of SGA, were afforded either "special eligibility status" or "special cash payments" if their earnings fell below the "breakeven point" but remained above SGA. The bill was signed into law in June of 1980.

In August 1983, the Subcommittee on Public Assistance and Unemployment Compensation, of the House Committee on Ways and Means, heard testimony at a hearing on a bill that would make permanent the work incentive provisions of §1619. At the hearing, SSA's Deputy Commissioner for Programs and Policy voiced opposition to the bill, citing the need to control escalation of the program's costs. However, the Deputy Commissioner's opposition was criticized by members of Congress for not considering the program's effectiveness. Before eliminating the program, members of Congress urged further study.

Before the Subcommittee's hearing, advocates for the disabled had informed Congress that SSI field personnel lacked training and knowledge of the demonstration project and its incentives. They asserted that the temporary nature of the project created a weak incentive for SSA to provide extensive training to its personnel and properly inform recipients of their §1619 benefits. The advocates further maintained that disabled individuals were less likely to engage in a temporary program and risk a cutoff of vital medical and cash benefits if the demonstration project was not extended. At the end of the three-year project in 1983, there was an administrative extension by the Department of Health and Human Services. In 1984, Congress enacted an extension of §1619 until June of 1987. The new law directed SSA and the Health Care Financing Administration to undertake further study of the effectiveness of §1619.

In 1984, Representative Steve Bartlett (R. Tex.) sought permanent authorization for §1619, but Congress took no action on the bill. In 1985, Bartlett, introducing another bill, once again sought permanent authorization of §1619. Testifying at a Congressional Hearing on the bill, SSA asserted that until more facts were available and a better understanding of how best to encourage the disabled to work was developed, no further action should be taken, noting that §1619 was already authorized through June 1987.

In 1984, the Social Security Disability Benefits Reform Act authorized a congressional report on §1619. After the report was completed in 1986, SSA gave strong support in making the §1619 incentives permanent. The Employment Opportunities for Disabled Americans Act of 1987 made the incentives permanent.

In January 1989, Congressman Bartlett reintroduced a bill which would have brought §1619 type incentives to SSD eligibles. Part of the bill's provisions — the Medicare Buy-in — were signed into law.

VI. CONCLUSION

A new problem confronting Congress is not that some persons are avoiding work and seeking early retirements. Since 1982, there has been a 7,639 percent increase in §1619(a) worker participation, while §1619(b) participation has increased by over 300 percent. The combined §1619 incentives have allowed approximately 55,000 severely disabled SSI eligibles to work — some for the very first time. Eligibles are, in fact, seeking work where in the past they lacked opportunity. Recent changes have created important new opportunities.

Aside from higher self-esteem and better lives for disabled SSI eligibles now able to work, millions of dollars of savings result from the reductions in benefit payments. Although the Social Security Administration (SSA) initially opposed §1619, §1619's track record has created support. Without such incentives, severely disabled persons will be kept from America's economic mainstream, even though technology and training opportunities could allow these individuals to participate more fully in American society. They would be compelled to rely on a subsistence-level welfare income, because work efforts, despite severe impairment, could disqualify entitlement to vital government benefits. §1619 is a positive step, but it is not enough.

As a result of §1619, a disparity in work incentives has arisen between SSI and SSD eligibles. A principal reason for the disparity is the uneven application of the SGA rule and the SGA termination of SSD eligibles after 45 months of work. The new SSD Medicare Buy-in provision, however, is a positive step in creating continued access to health insurance for such workers. In light of the rapid growth of the programs, current work incentives policy must be re-examined. Today, less than one half of one percent of the SSD beneficiaries ever return to work, and a greater percentage of younger workers are receiving benefits. A remaining disincentive in the SSD program is the unavailability of an earnings-benefit offset similar to the SSI program. An offset similar to the SSI program must be added. Additionally, SSD and SSI eligibles, many in their 'prime working years,' must be made aware that these important new opportunities exist.
ENDNOTES

2. Supplemental Security Income (SSI) is a means tested cash assistance program for needy blind, aged, and disabled individuals. For further discussion of SSI, see infra text accompanying notes 24-32.
6. The renowned Steven Hawking is an example of such success. He is a professor of mathematics at Cambridge University and the author of a best-selling survey of modern cosmology. He is unable to speak, paralyzed by Lou Gehrig's disease. A 12 pound computer that processes close to 2,600 words at a time has helped him to communicate more effectively. Daly, PCs Smooth Disabled Workers' Road to MIS, Computerworld, Oct. 3, 1988 at 101.
7. Id.
8. Id.
17. Prior to January 1, 1990 this figure was $300.54 Fed. Reg. 53600 (1989).
23. Id.
31. For further discussion see infra text accompanying notes 55-56.
33. In fiscal year 1987, more than 4 million people received cash benefits in excess of $20.4 billion dollars, consisting of approximately 3 million workers and 1.3 million workers' children and spouses. Supra note 24.
34. 42 U.S.C § 396 et seq. (1988).
35. NY. Social Services Law § 365-a (Consol. 1984). In New York coverage also includes private duty nursing and prescribed visits to podiatrists, optometrists, and dentists. See, Herman, Medicaid Lobbyists Hogtie Legislature, Schenectady Gazette, March 25, 1989, at 35.
36. Herman, supra note 35.
37. Id.
38. 42 C.F.R. § 301(a) (1988).
39. The 1986 allowable resource limit for an individual was $2,950 and the income limit was $4,900. 18 NYCRR parts 352, 360. Arizona, on the other hand, has a federal medical assistance program that operates as a demonstration project with waivers from certain Medicaid program requirements.
42. P.O.M.S. SI 02302.000E.
45. This category now includes individuals who no longer qualify for SSD after 48 months of working above the SGA level. See infra note 64.
47. E.g., in 1989, there was a $560 annual deductible for a hospital stay.
52. Id.
54. Sheldon, supra note 18.
55. Id. at 1074 (emphasis added).
56. For examples of PASS shelters as well as further details see generally supra note 18.
57. Id. at 1080.
SPRING 1990

Program, dependence on those with partial disabilities should the definition become
gation to work. Further, lawmakers have stressed their aversion to fostering
tors feel individuals are receiving benefits by avoiding their societal obli-
scores of new claimants. Tension is manifest when the public and legisla-
changing the scope and nature of government responsibility leading to
a costly, premature retirement from the nation's workforce, or inadvertently
cause they fear that liberalizing the definition may either undermine the

02302.025; P.O.M.S. SI 02302.025; P.O.M.S. SI 00840.140; P.O.M.S. SI 00840.140.
82. This figure is for an individual with no other income.
83. $7,851 in 1990.
84. P.O.M.S. SI 02302.010 b.
86. The test is as follows:
1. Has Medicaid coverage been used within the past
12 months?
2. Is Medicaid expected to be used in the next 12
months?
3. Would the individual’s unexpected medical benefits
arise in the next twelve months so that the individual would
be unable to pay without Medicaid?
P.O.M.S. SI 02302.040.
87. Before an SSI recipient can become eligible for §1619, they must
establish that they were eligible to receive a regular SSI cash payment
for a prior month within the current period of eligibility. P.O.M.S. SI
02302.025; P.O.M.S. SI 02302.010 b.
88. P.O.M.S. SI 02302.010 b.
89. Inherent in the nation’s disability policies is a societal obligation
to work. Lawmakers are cautious in their efforts to define disability be-
cause they fear that liberalizing the definition may either undermine the
work ethic that drives our capitalist system, providing some workers with a
costly, premature retirement from the nation’s workforce, or inadvertently
changing the scope and nature of government responsibility leading to
scores of new claimants. Tension is manifest when the public and legisla-
tors feel individuals are receiving benefits by avoiding their societal obli-
gation to work. Further, lawmakers have stressed their aversion to fostering
dependence on those with partial disabilities should the definition become
liberalized.
90. Wing, The Impact of Reagan-Era Politics on the Federal Medicaid
91. The latest example of this paring process, in New York, is Gover-
nor Cuomo’s proposed requirement in his 1989-90 budget to require
recipients to pay part of their medical treatment. The Governor has pro-
posed a $350 million cut in Medicaid spending and a 15 percent reduc-
in in the rates paid to hospitals. Cross, Cuomo’s 1989-90 Budget


117. Id.

118. "The House-passed bill would have effectively and significantly liberalized the basic definition of disability under the SSI program by changing the definition of what constitutes SGA... [T]he result of the House bill could well be to increase dependency among less severely disabled severe enough to be considered total or near-total disabilities into liberalized the basic definition of disability under the SSI program by changing Na 3 (1987), 26 [hereinafter Summary Provisions].

Legislative History and Summary of Provisions.

Allowing them to continue receiving income maintenance benefits recognizes that some individuals determined to meet the Social Security Act necessary and important to limit eligibility under these programs to those who necessary to limit eligibility under these programs to those who


139. In support of making the section permanent the Commissioner of the Social Security Administration stated: "Senator Dole's proposal to make §1619 permanent is a desirable change. It is an opportunity for disabled persons to achieve their potential, and gives them even more incentive to work... Work incentives are not always found in public programs, and I think that this is a very positive step in that direction." Hearing before the Subcomm. on Social Security and Income Maintenance Programs, Comm. on Finance, 99 Cong., 2nd Sess. (1986) (testimony of Dorcas Hardy, Commissioner, SSA).


141. When Congress created the SSD program in 1956, for example, it estimated that by 1980 it would be paying $85 million a year to one million beneficiaries. However, in 1984 SSD transferred $17 billion to 3.8 million Americans. Lane, supra note 95.


145. The following excerpt from a congressional report states the new dilemma policy makers confront: "While Congress has found it necessary and important to limit eligibility under these programs to those who are so medically disabled that they cannot work, the Committee recognizes that some individuals determined to meet the Social Security Act definition of disability are nevertheless so motivated towards work and independence that they later manage to work in spite of their impairments... Allowing them to continue receiving income maintenance benefits would seem to undermine the fundamental Congressional decision that eligibility be limited to those that cannot work... On the other hand, terminating benefits in such circumstances can be a powerful disincentive to the work efforts which these severely disabled individuals are otherwise motivated to attempt... By definition, these programs deal with individuals who have limited resources to fall back on should their work attempts fail or prove insufficient to meet their medical and other needs." S. Rep. No. 466, 99th Cong., 2d Sess. 132, reprinted in 1986 U.S. Code Cong. & Admin. News 6087, 6088.

From December 1982 to August 1985 participation in §1619(b) rose from 5,515 to 7,954, while participation in §1619(a) rose from 287 to 817 participants. This was a during a time when reliance upon the law could have left persons without vital benefits since it was set to expire in 1987; it was also a time when SSA was deeply criticized by advocates for not informing recipients of their legal rights. Clearly, disabled program recipient want work. Dept. of HHS supra note 126.

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