The Ending of General Assistance and SSI Disability Growth in Michigan

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Applications for Supplemental Security Income (SSI) disability benefits have risen dramatically over the last several years. This growth in applications and in awards has occurred for both juveniles and adults. While the *Sullivan v. Zebley* decision has had an impact on the standards, applications, and awards for juveniles, no similar ruling or policy shift applied to adults. Even so, applications and awards have risen dramatically. In an effort to understand this rapid growth, the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services commissioned Lewin-VHI to conduct case studies of five states: California, New York, Florida, Texas, and Michigan. This paper presents our findings for Michigan.

There are a number of factors that make Michigan an interesting case study. The rate of growth of applications for SSI disability benefits in Michigan has been among the most rapid in the country. Michigan was an early pioneer in welfare restructuring, and the growth of applications coincided with the elimination of the state General Assis-
tance (GA) program in 1991. Moreover, there appears to have been quite an active outreach program in the state, with coordination among the Social Security Administration in Michigan, state agencies, and advocacy groups.

We have interviewed individuals working for the Social Security Administration, the state of Michigan, and various advocacy agencies in an attempt to learn from their interpretations of this phenomenon. We have also made simple calculations using data from the Social Security Administration and the Michigan Department of Social Services. Both our interviews and quantitative analysis present a fairly consistent picture of developments in Michigan.

In the remainder of this paper, we present data on the growth of SSI applications and awards in Michigan during the period from 1988 to 1993. We also present some background material on developments in the state of Michigan, focusing on the ending in October 1991 of Michigan’s General Assistance program. Following this background material, we review information derived from our interviews and quantitative analysis of the administrative data. We end with a short discussion of what we think we have learned from the Michigan case study.

RECENT TRENDS IN APPLICATIONS AND AWARDS FOR SSI IN MICHIGAN

In Figure 7.1 we display annual adult applications for SSI disability benefits in Michigan from 1988 to 1993. Data for men and women are presented separately. These data are drawn from the Social Security Disability Research File (DRF) and are limited to adult disability applications and awards. They do not reflect growth encouraged by the Sullivan v. Zebley decision because that applied only to children. Overall, there were approximately 246,000 applications in the six-year period, at least some of which were reapplications after a denial of an initial disability claim. While nationwide adult applications rose by 54 percent between 1989 and 1993, in Michigan they doubled, rising from 28,000 applications in 1989 to 57,000 in 1993. Patterns for women and men were very similar. Over this same period of time, the non-elderly adult population in Michigan grew by less than 2 percent. Thus, very
Figure 7.1 Total Adult SSI Disability Applications

SOURCE: Social Security Administration Disability Research File
little of the doubling of the SSI applications can be accounted for in terms of population growth.

The data also show the fraction of SSI applicants awarded benefits rising from 44 percent of 1988 applications to 51 percent of 1991 applications. Award rates fell somewhat in 1992 and even more in 1993, but much, if not all, of this drop probably reflects the fact that a substantial fraction of the 1993 cohort of applications was still pending on appeal. Data on initial determinations show the fraction of SSI applicants awarded benefits at the initial determination continued to rise through 1992. Given the fact that the fraction of denied applicants was also rising over this period of time, it seemed likely that, at least for 1992 and possibly even for 1993, award rates would eventually exceed those of preceding years. The fact that awards were rising more rapidly than applications would seem to belie any notion that what was going on was simply an increase in the number of frivolous or marginal applications.

Figures 7.2 and 7.3 document applications for those with mental impairments and those with other impairments. Applications for those with mental impairments tripled between 1989 and 1993, rising from 6,000 in 1989 to 19,000 in 1993. In contrast, applications among those with other impairments rose by roughly 75 percent. As a result, applications for those with mental impairments accounted for roughly 45 percent of the growth in total SSI applications in Michigan. Applications for those with mental impairments continue to rise after 1991, while applications for those with other kinds of impairment seem to have plateaued.

THE ENDING OF GENERAL ASSISTANCE IN MICHIGAN

Background

Between 1979 and September of 1991, Michigan funded a statewide GA program. GA was a cash-granting program for impoverished adults without dependent children. During the 1980s, the caseload varied between a high of 142,000 in 1984 and a low of 93,000 in 1989 (Michigan Department of Social Services 1991). Even though GA
Figure 7.2 Adult SSI Disability Applications for Mental Impairments

SOURCE Social Security Administration Disability Research File
Figure 7.3 Adult SSI Disability Applications for Other Impairments

SOURCE Social Security Administration Disability Research File.
technically served an able-bodied population, it is now clear that it actually served older people, the chronically ill but not classified disabled, and those who had some measure of disability. Kossoudji and Danziger (1993) found that 40 percent of the GA population was over age forty, that one-quarter had applied at some time for SSI, and that 70 percent of respondents to a sample survey reported at least one chronic illness.

In September 1991, there were still 118,632 people receiving grants, although the enrollment had gone down since spring 1991 because of the termination threat. The decline in enrollment stemmed principally from a drop-off in applications to GA rather than from recipients leaving the rolls. Eligibility criteria were simply based on income and assets. Most cases represented adult individuals, but some families with dependent children—families in which both parents were unemployed or earning below the GA maximum income but who did not meet Aid to Families with Dependent Children (AFDC-UP) employment history qualifications—were eligible for GA and represented a little more than 10 percent of the caseload (Kossoudji and Danziger 1993).

The state of Michigan, along with other states, faced severe fiscal problems in the early 1990s. While the revenue the state received from both the federal government and from state sales tax were declining, the costs of incarcerations, health care, foster care, and public assistance were all rising. A new, conservative republican governor, John Engler, was elected to office in November 1990 after running a campaign in which he promised to both lower taxes and balance the budget.

Although spending in other social programs was cut, Engler singled out General Assistance for virtual elimination. Engler first proposed this action in his fiscal year 1992 budget submitted to the Michigan legislature in January 1991. In May, Engler announced publicly that the GA program would be eliminated on June 1. Actual elimination of the program was held up in court, but finally went into effect October 1, 1991. At the same time two supplemental programs, Emergency Needs and GA-Medical were cut. GA-Medical coverage provided primary ambulatory care everywhere except Wayne County, which had its own managed care program. Emergency Needs (which was later reinstated with reduced funding) provided for one-time application for
funds to pay heating bills (for example), when the situation was an emergency and not part of an ongoing problem (Kossoudji and Danziger 1993).

After GA was terminated, two much smaller programs were created for special populations: State Family Assistance (SFA) for families with children, and State Disability Assistance (SDA) for those deemed disabled, aged, or residents of substance abuse treatment facilities. The monthly grants are comparable to former GA stipends. SDA is easier to get on than SSI (processing of applications is quicker and work limitations are expected to last 90 days, not the year required for SSI); however, unlike GA, health is central to the determination of eligibility for SDA. Moreover, those qualifying for SDA are required to apply for SSI as well. The state makes an effort to recover back payments from SSA if an individual is determined eligible for SSI.

In March of 1991, GA served 122,500 cases. Eleven and one-half percent of those were in families that would automatically qualify for SFA, while 1.3 percent were identified as disabled persons and would automatically qualify for SDA (Kossoudji and Danziger 1993). Those not automatically eligible for SDA could apply, but SDA continued to serve a much smaller population than did GA. State records indicate that within the first five months after GA was eliminated, only one-fifth of former GA recipients had applied for SDA benefits. Of those who processed applications, one-quarter were approved. In May 1992, a total of 8,898 individuals were on SDA. The average monthly caseload on SDA has been about 10,000 since then, with 3,000 to 4,000 thousand annual transfers to SSI. They represent between 10 and 15 percent of SSI disability awards in Michigan.

The State Medical Program (SMP) replaced GA-Medical everywhere except Wayne County, which continued its own managed care medical program. However, SMP did not go into effect until December 1, 1991, two months after GA was terminated. Furthermore, at that time only those who had been converted to SDA and SFA were enrolled in the new medical program. Others who met SDA/SFA income and asset requirements became eligible for and could apply for SMP. SMP is less comprehensive in coverage than Medicaid. It does not cover inpatient services and requires small co-payments for services and prescriptions (Kossoudji and Danziger 1993).
Implications

Most of the people we interviewed identified the ending of GA as the single most important impetus behind the growth in SSI applications. Even before Engler announced the ending of GA, many used the program as a transition or backup. Others on GA who were potentially eligible for SSI did not, however, apply. The paradox is that SSI benefits were substantially more generous than GA benefits. For example, in 1990 an individual on GA would receive $266 per month in cash. On SSI, the same individual would have received $431. From the point of view of the state of Michigan, the person on GA would have cost $266 while the same person on SSI would have cost the state only $45. Thus, both the GA recipient and the state of Michigan had considerable incentives to shift from GA to SSI.

Various explanations were offered for why more of those in GA had not applied for SSI benefits. Bureaucratic inertia was offered as one explanation for why program administration did not do a better job encouraging individuals to apply for SSI. Health status was not a requirement for eligibility for General Assistance. As a result, those potentially eligible were not identified. What might make this situation seem more reasonable is the fact that probably only a small minority of GA beneficiaries could pass the stringent medical screening required before receiving SSI benefits, and that this fraction would have been smaller in 1979, when GA was started, before the change in the mental health listings.

Another reason why people may not have applied is the more bureaucratic process and more numerous personal contacts associated with the SSI program. Applications required considerable effort and energy, and prospects for allowance were still uncertain. GA had a simpler application and redetermination process, if for no other reason than because health was not a criterion for enrollment. Once GA was eliminated, however, people who were poor and in ill health basically had no other option besides SSI. Many of those on GA suffered mental impairments and/or had drug abuse or alcohol problems. These individuals may have been particularly reluctant to apply for SSI benefits. It was suggested to us that such individuals might find it less stressful to just get by on the low GA benefits than to be frequently reviewed, as would have been the case had they been on SSI. The simpler alternative
may have been particularly attractive to the mentally ill who are paranoic or socially isolated. GA helped them live marginally but relatively hassle free.

After GA was terminated, there were both federal and state outreach efforts targeted at former GA recipients who might have been eligible for SSI. The Chicago Regional Office of the Social Security Administration initiated one such campaign, sending letters to this population in December 1993. Returned letters were routed to the field offices. The individuals we talked to did not seem to think this effort had been terribly effective. The letter gave minimal information about the SSI program. For example, it did not clearly mention that one must be disabled. The result was an increase in claims from people who wanted to get SSI but, by their own admission, were not disabled. Rather, they were unable to work due to the lack of job opportunities and inadequacy of their skills.

State-level efforts are thought to have been more effective. A series of computerized cross matches was conducted to see if the former GA recipients had applied for or already were on other social security programs. At least two mass mailings followed these cross matches. The mail included information about other available sources of disability funding as well as a preset initial appointment time at the local Michigan Department of Social Services (MDSS) office. Field office staff we talked to thought these efforts had been somewhat effective.

OUTREACH AND ADVOCACY

Outreach

Whether we talked to social security field office staff, individuals from MDSS, or representatives of the advocacy community, there seemed to be general agreement that outreach efforts coordinated among the Social Security Administration, state agencies and advocacy groups had a strong impact on applications and awards for SSI and Social Security Disability Insurance (DI).

Recent outreach efforts by field offices have expanded significantly for two main reasons. First, over the past several years, SSA has issued
a series of mandates for field offices to conduct outreach to specific population groups which, among others, include low-birth-weight babies, children, and the homeless. Second, the Zebley decision led to a mandate from SSA that requires all field offices to increase the accessibility of their staff to community residents.

The MDSS has conducted its own outreach efforts through meetings with schools, probate court, nearly all social service agencies, and others who could make referrals. They provided an in-depth description of disability and instructions on how to file. In addition, MDSS hired temporary workers to screen files for possible leads for social security. The individuals we talked to thought that these efforts had resulted in a substantial increase in applications for SSI.

Two state-specific outreach initiatives—the Michigan Inter-agency Task Force on Disability and the Client Services Task Force—are thought to have had a significant impact on rates of applications. Each task force includes representatives from a variety of state agencies, including the Departments of Health, Social Services, Labor, Education, and Mental Health, with additional representatives on the Client Services Task Force from Legal Aid, and senate and congressional offices. These task forces focus on outreach through education and increasing awareness of the SSI and DI program changes. The outreach initiatives have been especially active since 1988 and target mostly potential SSI beneficiaries (the clientele of most groups represented on the task forces).

The education of workers in agencies participating in SSI outreach has had a major impact. There have been internal departmental alerts in SSA, and teachers and health care professionals have been trained to help identify possible cases. We were told that there is now close cooperation with local agencies and liaisons with shelters and community health agencies. Better understanding of the process of applying for disability benefits and increased awareness of programs available for different populations have enabled the social service personnel to do a better job of informing and referring potential SSI applicants to the MDSS office. Hospitals and social workers as well as all the human services agencies, both local public and private, have been very assertive in getting people to apply. Those we talked to felt that outreach works best when one goes to providers; direct appeals have not proven to be as effective.
In addition, many health care providers have, over the last few years, become more in touch with MDSS and helped people apply for SSI. Health care providers have an incentive for trying to get individuals onto SSI. Since those on SSI also have Medicaid, getting clients onto SSI implies that the health care providers will end up reimbursed for the services they provide. The Medicaid coverage is more extensive than SMP (for example) and also pays more under the DRG prevailing rate cap. MDSS has its own staff in the major hospitals collecting necessary medical information on the clients. This facilitates their helping people to apply.

Substance abuse clinics and providers also represent significant referring agents. They refer a lot of people under rehabilitation to the MDSS office. Coupled with the GA cut, the state initiated outreach efforts targeted to alcoholics who were on GA and rehabilitation. For example, Harbor Light in Detroit was very active in searching for and finding drug addition and alcoholism (DA&A) people and helped them apply for SSI. Legislation dating from 1972 as well as more recent legislation mandates rehabilitation, monitoring, and facilitation of treatment. In Michigan, the Drug Abuse and Alcohol Referral and Monitoring Agency (DARMA) refers clients to the proper rehabilitation agencies. However, there is an insufficient number of resources available to which to refer these individuals can be referred. Since DARMA started in 1989 there has been an extensive outreach effort. A great deal of time has been spent in talking to different advocacy groups and social services providers, giving them accurate information, organizing workshops and implementing panel discussions. In addition, DARMA monitors compliance and reports to MDSS. They have mental health therapists and substance abuse therapists as well as rehabilitation counselors working with them. They organize transportation and have contact with different agencies, like homeless shelters, to facilitate the process for the clientele. They assist in finding resources, cooperate with the rehabilitation council, and monitor progress.

DARMA works very closely with the Disability Determination Services and has provided them with a good deal of information. In the opinion of the director, Ms. Rojas-Dedenback, DARMA has created a willingness by the MDSS to provide information about the available options to DA&A persons. The whole community has become more aware and has started to contact more people about applying for dis-
ability. Previously, there was a lack of awareness; people thought that GA was all there was for them, and it was not until they received better information that DA&A people have started to come forward. Primary referral sources for DARMA are the agencies they work with, i.e., service providers, homeless shelters, advocacy groups, women’s shelters, and treatment providers. The availability of benefits to those who are addicted has been spreading by word of mouth and has dramatically increased the number of claims being filed.

As evidence of the effectiveness of the outreach efforts to the DA&A population, field office representatives mentioned changes in the general knowledgeability of the population potentially eligible for SSI. Others also thought that there had been a change in attitudes, most importantly a change in attitudes among potential applicants regarding the acceptability of identifying oneself as a substance abuser. While five years ago individuals would rarely identify themselves as substance abusers, currently it is not uncommon for individuals to enter an SSA office announcing that they were participating in some specific drug rehabilitation program and that they thought that doing so qualified them for SSI payments. DA&A people “hang together,” and SSI is discussed. Field office staff also mentioned that, largely as a result of the changes that had occurred in the applicant pool, the staff had become much more aware of the interrelation between substance abuse and mental health problems.

The general perception among the people we talked to was that the increased awareness of SSI could be attributed to a combination of various outreach efforts and word of mouth. Specifically, the growth of the shelter population, a group targeted for these outreach efforts, contributed to the rise in SSI applications. Many shelters in Michigan are now actively helping residents apply for disability benefits, including providing vans to help residents get to local MDSS offices, providing staff time to help individuals fill out paperwork, or having outside agencies come in to help. For example, in Detroit, at the request of a shelter, the Detroit Urban League will come out with SSI applications and help residents fill out forms.

Outreach efforts underway with the homeless shelter population illustrate the way in which outreach efforts may have interacted with the ending of GA to spur SSI application growth. The shelter population in Michigan grew substantially after the ending of GA because the
termination affected the population most at risk for homelessness. The state poured in funds for new shelters and additional beds, instigating a growth of shelters. In the Detroit area, emergency shelter providers think that over 75 percent of their adult clientele were former GA recipients (Park, Danziger, and Parrot 1994). Thus, the ending of GA indirectly increased the size of the population targeted for outreach efforts. Moreover, the state’s increased investment in sheltering the homeless has added an extra incentive for getting those in the shelters onto SSI.

Advocacy

In recent years, advocacy groups that assist people in different levels of the application procedure and ensure that cases get through the bureaucracy have grown rapidly. Opinions differ as to what accounts for this growth. Some of the individuals we talked to thought the growth represented a response to a perceived need on the part of SSI and DI applicants. Others emphasized the fact that advocacy has become financially profitable. Various groups have begun to compete with each other for customers and funding. The advocacy and non-attorney groups can also increase their potential income by applying for federal and state funds (allocated for outreach effort, for example), and they can apply for grants from different foundations like the Mott Foundation and Robert J. Wood Foundation. Attorneys advertise on TV, in newspapers, and the yellow pages to handle disability claims. The fact that attorneys consider DI/SSI disability cases as almost always winnable is evidenced by their willingness to accept these cases on a contingency basis. The fraction of SSI and DI applications that have some form of representation has increased greatly in recent years and continues to do so.

The Medicaid Assistance-SSI advocacy program (MA-SSI) was started in the late 1970s and was funded at a higher rate starting in late 1982. It was instituted to serve two populations, the primary population being the GA and Medicaid recipients (single adults who DDS determined to be disabled). The other group that the MA-SSI advocacy program has under contract to service are clients from the Community Mental Health Agencies and the Department of Mental Health (people who were moved out of state hospitals).
The MA-SSI advocacy program helps clients get through the application process. The program had a 89 percent reversal rate on denials, once they got to the federal level. This kind of success rate was partially a result of the fact that the advocacy program only sent people to apply whom they felt were probably eligible and whom they were willing to back up by being present as paralegals.

**QUANTITATIVE EVIDENCE ON THE IMPORTANCE OF GA**

While those we talked to emphasized both outreach and the ending of GA as important, the kind of qualitative information we derived from our interviews can never resolve questions regarding the relative importance of these two forces. Moreover, opinions varied somewhat as to the relative importance of the ending of GA.

There is a variety of quantitative information available that can shed some light on the potential impact of the ending of GA on SSI applications. Much of this information comes from the Michigan Department of Social Services administrative data on GA recipients collected by Sandra Danziger and Sherrie Kossoudji at the University of Michigan as part of a project evaluating the impact of the ending of GA. This data base includes information on three populations of GA recipients: those on GA in September 1990, in March 1991, and in September 1991.

The MDSS data on these three populations were matched to data from the Social Security Administration’s Disability Research File data. To maintain confidentiality, the information on the merged file was restricted to basic information on applications and awards for SSI, together with variables indicating which of the three GA populations the applicant belonged to. These merged data allow us to calculate the number of SSI applications per month made by individuals from each of the three GA populations.

The merged data show that of the 112,800 individuals receiving GA benefits as of September 1990, 43,700 (or close to 40 percent) had applied for SSI by the end of 1993. GA beneficiaries accounted for 46 percent of total applications in 1991.
This 46 percent could exaggerate the impact of the ending of GA on SSI applications. Many former GA recipients who applied for SSI benefits might have done so even if GA hadn’t been eliminated. At the same time, we cannot measure the impact of the termination on people who were not enrolled in GA but who, after 1991, might have applied to GA rather than SSI. One way to gain insight on the causal impact of ending GA on SSI applications is to look at data on monthly applications. There are quite distinct seasonal patterns in the monthly data with, for example, applications falling during December. For this reason, we deseasonalized the application data. The deseasonalized monthly applications are presented in Figure 7.4. They reveal a limited upward trend through 1990. There is a small spike in January 1991 after Engler took office, a much larger spike in May, when Engler announced the ending of GA, and an even more dramatic spike in October 1991, when GA actually ended. Post-1991 applications, while more variable than those before the transition, never fall close to their pre-1991 levels. While many factors contribute to these changes, GA termination is almost certainly responsible for the transitional spikes.

Patterns are even more distinct when we focus on applications from the populations on GA. Figure 7.5 shows such data for the population on GA in September 1990. This figure makes clear that there had always been a flow of individuals between GA and SSI. Not surprisingly, many appear to have used GA as a transitional or backup program, applying for SSI benefits either before or immediately after beginning to receive GA benefits. At the same time, this graph also indicates that the GA population responded both to the announcement that GA was ending and to the actual termination of benefits with an immediate heightened interest in SSI. The September 1990 GA recipient population continued to apply for SSI benefits at higher levels well past 1991. In 1990, they accounted for roughly 10 to 20 percent of monthly SSI applications. Even after being responsible for large numbers of applications through 1992, these same people still represented an average 20 percent of applications in 1993. The loss of the GA option, deteriorating health (perhaps associated with the loss of GA), and community outreach all stimulated the increased interest in SSI.

We wondered whether the increase in applications for the GA population might have come primarily from the more marginally impaired. One might imagine that before the ending of GA such individuals
Figure 7.4 Adult SSI Disabled Applications, Deseasonalized Series

SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data
Figure 7.5 Adult SSI Disabled Applications, Sept. 1990 GA Population—Deseasonalized Series


SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data
would not have bothered applying for SSI since the chance of succeeding was low. We checked to see if the application peaks seem to have represented a more marginally impaired population by examining award rates by month of application. In fact, award rates for those applying in May, September, and October of 1991 were no lower than were award rates in the preceding months. What we did find is that a somewhat disproportionate share of applications in May, September, and October of 1991 represented first-time applicants.

Figures 7.6 and 7.7 reproduce Figure 7.5 but distinguish between those with and without mental impairments. These figures highlight the nature of these GA recipients' health impairments, contribute to the verification of expert opinion about the reluctance to apply for SSI for those with mental impairments, and reflect the intensified outreach efforts to the DA&A population. Mental impairment applications for September 1990 GA recipients virtually soar after January 1991, particularly for men. Applications for other impairments exhibit the now familiar three spikes but then retreat to lower levels. In September 1990, when the population was measured, 29 percent of women's and 33 percent of men's SSI applications were associated with mental impairment. Exactly two years later, and one year after GA termination, mental impairment represented 36 percent of GA women's and 47 percent of GA men's applications.

We have also used the data we have to obtain crude estimates of the effect that the ending of GA had on applications for SSI. We use a number of different approaches to do this. Our first approach uses the overall number of applications for SSI benefits to project what applications would have been like had they followed the pre-1991 trend. To do this we regressed the log of applications on monthly dummies and a linear spline with kinks at January 1989 and January 1990. We then used these estimates to project applications for 1991 (Table 7.1). We attribute the gap between the actual and projected number of applicants to the ending of GA. The implicit assumption behind these calculations is the notion that, were it not for the ending of GA, applications would have continued increasing at the same rate they had been during 1990. These estimates suggest that the ending of GA can account for about two-thirds of the total increase in the number of applications between 1990 and 1991.
Figure 7.6 Adult SSI Disabled Applications for Mental Impairments, Sept. 1990 GA Population—Deseasonalized Series

SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data.
Figure 7.7  Adult SSI Disabled Applications for Other Impairments, Sept. 1990 GA Population—Deseasonalized Series


SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data
Table 7.1 Estimates of the Short-Run Effect of Ending GA on SSI Applications in Michigan

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<td>1836</td>
<td>6591</td>
<td>2081</td>
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<td>3391</td>
<td>1313</td>
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<td>(53%)</td>
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<td>(63%)</td>
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<tr>
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<td>(26%)</td>
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SOURCE: Social Security Administration Disability Research File matched to the Michigan Department of Social Services Data.

<sup>a</sup>Method 1: The log of monthly applications were regressed on a linear spline in time plus monthly dummies for the 1988–1990 time period. Predictions based on this regression were calculated for 1991. Method 1 estimates the impact of the ending of GA as the difference between the actual number of 1991 applications and the number predicted from the regression.

<sup>b</sup>Method 2: Using deseasonalized data for the three GA populations combined, applications were predicted for 1991 assuming that applications continued at their Oct. 1990–Dec 1990 level. Difference between actual and predicted represents estimated effect of ending GA.


An alternative approach to trying to estimate the impact of the ending of GA on 1991 applications is to estimate the number of individuals on GA who applied for SSI but would not have done so, were it not for the ending of GA. Since not all of those induced by the ending of GA to apply for SSI during 1991 will have received GA benefits, the question we are now asking is slightly different than asking about the impact of the ending of GA altogether.

To estimate the fraction of those on GA during the year prior to its termination who were induced to apply for SSI benefits, we took simple approaches meant to bound the total affects. First we assumed that applications from those who had been on GA some time during 1991 would have continued at the (deseasonalized) rate they were appearing during the last three months of 1990. Results from such calculations are shown in the third row of Table 7.1. Method 2 suggests that the ending of GA could account for roughly 50 percent of the increase in
overall applications and somewhat more of the increase for those with mental impairments.

Of course, it is possible that applications from those on GA might have risen even were it not for the ending of GA. A more conservative approach is to simply use the applications that occurred during the May, September, and October peaks to estimate the impact of GA. Figures 7.5-7.7 would clearly seem to indicate that this approach will underestimate the total impact of the ending of GA on applications. As such it represents a conservative lower bound estimate. The fourth row of Table 7.1 shows the spikes account for roughly 25 percent of the 1990-1991 growth in applications for SSI. Even these conservative estimates suggest an important role for the ending of GA.

Similar methods can be used to calculate the longer term effects of the ending of GA. Obviously, the further out our projections go, the less confidence we have. Using pre-1991 data and method 1 to project applications into 1992 and 1993 suggests that while the ending of GA continued to have an effect, it accounted for a smaller and smaller fraction of the overall growth in applications—45 percent of the growth in applications between 1990 and 1992 and 31 percent of the growth between 1990 and 1993.

Finally, cross-state variation can also shed light on the longer-term impact of GA's termination on SSI applications. Other states that recently restricted the availability of GA benefits have also experienced above-average growth in SSI applications. Estimates produced by Lewin-VHI personnel found a statistically significant association between the growth in SSI applications and the downsizing of GA. Simulations based on the Lewin model on Michigan show the ending of GA accounting for roughly 30 percent of the overall growth in SSI applications and 50 percent of the growth in applications involving mental impairments between 1988 and 1992 (Stapleton and Dietrich 1995).

The September 1990 GA population is a convenient one for analyzing GA termination's impact on SSI applications because it was measured before rumors of termination began to alter the GA population itself. It was only four months later, however, that Governor Engler set in motion the termination action. Earlier GA populations could be more informative about the stable transition to SSI over longer periods of time. We were unable to match data on earlier GA populations to the
Table 7.2 Percentage of Various General Assistance Population Subsequently on SSI by Date

<table>
<thead>
<tr>
<th>Date</th>
<th>General assistance population in September</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 1989</td>
<td>2.9</td>
</tr>
<tr>
<td>September 1990</td>
<td>5.5</td>
</tr>
<tr>
<td>September 1991</td>
<td>8.1</td>
</tr>
<tr>
<td>September 1992</td>
<td>11.5</td>
</tr>
<tr>
<td>June 1993</td>
<td>13.0</td>
</tr>
</tbody>
</table>

SOURCE: Michigan Department of Social Services Data

Disability Research File. However, the MDSS administrative data itself does indicate when individuals were enrolled in SSI. Table 7.2 presents data for populations on GA during September of each year from 1988 through 1991. The columns give the number and fraction of the original GA populations receiving SSI benefits one, two, three, and four years later. Thus, for example, 2.9 percent of those on GA in September 1988 were on SSI in September 1989. Again, we see transition rates rising over time. After two years, 5.5 percent of the September 1988 GA population was receiving SSI benefits. In contrast, after somewhat less than two years, 11.0 percent of the September 1991 GA population was on SSI.

DISCUSSION

A variety of factors in combination seem to have been responsible for the rapid rise in the number of adult SSI disability applications. The elimination of General Assistance removed one possible alternative option for potential SSI applicants. Along with this, extensive and well-coordinated outreach efforts seem to have increased awareness among both social service providers and potential applicants themselves. Finally, resources have been increasingly targeted at helping potential applicants with the application process. While we continue to
have an interest in estimating the impact of the ending of GA on SSI applications, this change did not occur in isolation. The ending of GA might have had a very different impact on SSI applications had outreach or advocacy efforts been different. Similarly, outreach efforts were certainly motivated and facilitated by the ending of GA.

Our analysis of the rapid rise in SSI applications in Michigan quite clearly implicates the elimination of GA as an important factor in spurring this rise. Other states in which similar case studies were conducted did not eliminate or drastically scale back welfare benefits. However, one can interpret the elimination of GA benefits as a dramatic attempt to cut state expenditures and to shift some welfare expenses from the state to the federal government. Results from the case studies done in California, Texas, and New York suggest that many states have responded to their fiscal problems by a similar shifting of individuals off state-funded onto federally funded programs (Stapleton et al., Chapter 2 in this volume).

Most economists modeling the decision to apply for disability benefits (or, more generally, welfare benefits) have modeled the decision as a function of the potential gains for program beneficiaries. While we have no doubt that such gains play an important role in determining the choices individuals make, our results suggest that a number of other factors are also important. For SSI applicants, what Richard Burkhauser has referred to as “gate keepers” and Michael Lipsky (1980) has referred to as “street-level bureaucrats” would seem to play a central role. When GA existed, many people were satisfied enrolling in this less lucrative but also less bureaucratically onerous program.

Notes

1. We have not included mental retardation with other mental impairments.
2. To do so we regressed the log of the number of applications on a linear time trend together with monthly dummies. The coefficients on the monthly dummies were then used to adjust the raw data. To be precise, we estimated twelve monthly dummies constraining the coefficients to average to 0. Letting $\beta_i$ represent the coefficient of the $i^{th}$ month’s dummy, and letting $n_{it}$ represent the number of SSI applications in the $i^{th}$ month of the $t^{th}$ year, then the adjusted number of applications is $n_{it}' = n_{it} / \exp(\beta_i)$.
3. Those enrolled in GA in September of 1990 could have entered the program at any time previously.
4. Social security numbers were not available on existing files for populations of GA beneficiaries before September 1990.

References


Comments on Chapters 6 and 7

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For someone like myself, who comes to this conference from the perspective of research on homelessness and on the severely and persistently mentally ill, these papers by Muller and Wheeler (Chapter 6) and by Bound, Kossoudji, and Ricart-Moes (Chapter 7) contain some very interesting and provocative findings. I will focus most of my comments on the latter chapter, since that was my primary assignment, and refer to the former as it augments the findings of Bound, Kossoudji, and Ricart-Moes.

A SUCCESSFUL POLICY

Both papers describe something we very rarely see documented in evaluation research—the successful administration of public policy. I strongly agree with the comments of several field managers (Chapter 6), who said, "What else did you expect?" as the consequence of greatly expanded and targeted outreach efforts to bring eligible nonparticipants onto the rolls. To that comment I might add, "What else did you expect?" as the consequence of Governor Engler's decision to end Michigan's General Assistance (GA) program for all but a very few individuals. Both appear to have been quite successful at achieving their goals. The latter action also appears to have had some results that its supporters denied would occur despite strong evidence to the contrary: the documented rise in the homeless sheltered population as reflected in Chapter 7, and the rise in SSI applications and awards indicating significant levels of long-term disabilities among the former GA population. It is particularly telling that the largest jump in SSI applications and awards related to the end of GA occurred among those with mental impairments. I think it likely that the same is true for the jump in the number
of sheltered homeless (and probably also the unsheltered homeless population).

Both of these chapters document the effectiveness of persistent and well-focused outreach efforts. Chapter 7 differentiates between outreach, seen as actions of local Supplemental Security Income (SSI) offices, and advocacy, seen as actions of direct service providers and state agencies. I think the two go hand-in-hand, and it is quite likely that some of the SSI outreach efforts (and also the state agency activities) involved increasing the knowledge and program savvy of direct service providers so they could prescreen potential applicants and also help them to complete their applications. Thus I do not think one can separate the effects of outreach and advocacy; I see them as two arms of the same body, both intent on drawing people into the application process and assuring that they succeed at it.

THE ROLE OF STATE INTERESTS

However, what we can see as a success story from the point of view of SSI participation we can also see as illustrating some troubling trends in state-federal relations, which have potentially negative implications for the well-being of poor and disabled people. The role of state agencies in expanding the SSI rolls is instructive. For decades, states have sought ways to shift costs from their own coffers to those of the federal government. In the past decade or so they have gotten significantly more sophisticated at this cost-shifting. In the case of SSI, Michigan had two major programs that were entirely state-funded—General Assistance (and its accompanying medical program) and state mental hospitals. By ending General Assistance, the state could eliminate the cost of supporting the entire caseload and shift the burden of support for SSI-eligibles to the federal government. By furthering the efforts of state mental hospital patients' move into the community once they have the support of SSI, the state could shift to the federal government a portion of its responsibility to provide both domiciliary and health care. The people who succeed in getting SSI are financially better off than they were on GA or as state hospital residents, but those who cannot qualify or who never apply are certainly worse off. The
fact that significant numbers of people in both the GA and mentally ill populations cannot and do not receive SSI, and therefore end up destitute and sometimes homeless, is usually overlooked or downplayed by state officials as they try to reduce state outlays for services and assistance to poor and disabled people.

It is important to recognize that all levels of government are divesting themselves of responsibility for some categories of disability—chief among them mental disabilities—and that this has been going on for a long time. State efforts to shift costs will only increase in the coming years; their effects should not be overlooked, or masked by lumping federal, state, and nonprofit actions together into overall categories of “outreach” and “advocacy.”

THE NEED FOR ATTENTION TO REHABILITATION

It is also possible that there has been some overextension of SSI, or at least a failure to consider or require participation in rehabilitation efforts for those who might benefit from them. The most obvious newly expanded group of SSI recipients to whom this applies is those eligible by reason of drug abuse or alcoholism. Even among the long-term street homeless with drug or alcohol addictions, research evidence now indicates that recovery is possible, along with a return to gainful employment. Both the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism have sponsored demonstrations showing significant success rates. Further, the efforts of many homeless service providers have helped at least some substance abusers recover, although formal evaluations are lacking. Rather than making the assumption of lifelong dependency for these conditions, the Social Security Administration (SSA) should be promoting efforts to help SSI recipients move toward self-sufficiency to the extent possible.¹

Let us assume that we can think of a four-part research agenda for SSI participation, including 1) who are the pool of eligibles; 2) what gets them to apply; 3) what affects awards (whether their applications are successful); and 4) what affects exits. I am suggesting that we need to pay somewhat more attention than we do at present to the last of
these. We need to look at exit rates differentially by disabling condition and try to understand what SSA actions or policies could affect exit rates.

**NEED FOR MORE FLEXIBILITY**

My earlier caveat, "to the extent possible," brings me to the final point I want to make. My final comment does not really stem from either Chapter 6 or Chapter 7. However, I think it is important to use this forum to raise the issue of the stringency of SSI eligibility criteria, particularly with regard to capacity to work. We probably all recognize that our current ability to define "disability" with any precision leaves a good deal to be desired. For SSI purposes, we must deal not only with the presence of a physical or mental condition (diagnosis), but also with the extent to which the condition entails significant functional limitations (disability), and the extent to which it has lasted and can be expected to last a long time (duration). The biggest problems in determining eligibility come with identifying the level of functional limitation and the expectation for duration.

To ease the burden on determining gradations of functional limitation, the SSI eligibility criterion has been set quite high with respect to work—to be eligible for SSI, recipients must be completely unable to work. Yet the nature of some illnesses (particularly mental illnesses) that qualify a person for SSI may permit some work, in either a steady part-time capacity or episodically. The strong bent of current thinking about the severely and persistently mentally ill is that working, at whatever level is possible, is good for self-esteem, physical health, and mental health, even if it may not be enormously rewarding financially. The same is probably true for other disabilities.

But people also rely on the medical care available to them through Medicaid while they are on SSI. They often feel they cannot risk losing their SSI, even if their work activity could compensate for the income, because they would also lose health benefits. Perhaps it is time for SSA to reexamine the nature of some of the disabilities that form the biggest categories of current recipients. It could give some consideration to rule changes that would allow recipients to do whatever level of paid
work they could, while still retaining their Medicaid coverage. Some
fair reduction in cash grant levels might also be worked out. This
would be in everybody’s interest—clients, states, SSI, and providers.

To the extent that the opportunity already exists under current regu-
lations for significant levels of paid work while still retaining benefits,
SSA should make greater efforts to assure that direct service providers
and advocates know about this opportunity. From my experience with
community-based providers of services to the severely mentally ill, I
do not think anyone is clear about what clients can and cannot do and
still retain their SSI. Participants at this conference have told me that
there is considerable flexibility for paid work under current SSI rules.
But ignorance of these opportunities among the people working most
closely with SSI program beneficiaries seems to be widespread. There-
fore it is likely that fewer recipients work than might otherwise do so.

Note

1. This point may now be moot. The ability of these programs to continue serving
clients whose primary diagnosis and reason for receiving SSI is alcohol or drug
abuse will be challenged severely by new provisions for SSI eligibility contained
in the Personal Responsibility and Work Opportunity Act of 1996. The loss of SSI
income and Medicaid eligibility for this population reduces their ability to pay for
housing and to receive needed medical care, both of which helped maintain them
in the housing supplied by these demonstration programs.