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Bridging Silos, Part I: Linkages among the DI, SSI, Medicare, and Medicaid Programs

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OVERVIEW — *This paper, the first of two on the general topic of public disability and health benefits, centers on the fundamentals of the Disability Insurance and Supplemental Security Income programs and their relationships with Medicare and Medicaid. In addition to looking at the programs' definitions, distinctions, and overlaps, it reviews the effects on them of the Ticket to Work and Work Incentives Improvement Act of 1999 and, to a lesser extent, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. ("Bridging Silos, Part II" lays out some key issues confronting the Social Security Disability Insurance, Supplemental Security Income, Medicare, and Medicaid programs. It also discusses major initiatives to address those issues, in light of growing administrative, fiscal, and other problems.)*

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Bridging Silos, Part I: Linkages among the DI, SSI, Medicare, and Medicaid Programs

This country's shift in social policy from giving "income support" to providing "employment assistance" to certain of its citizens brings into focus the linkages among four landmark benefit programs. The four entitlement programs are Medicare and Medicaid—health benefit programs that became public law in the mid-1960s—and Disability Insurance (DI) and Supplemental Security Income (SSI)—income maintenance programs for persons with disabilities that were enacted, respectively, in 1956 and 1972. All four are titles of the Social Security Act.

While the linkages among the four programs have evolved over the past several decades, the shift toward providing work incentives planning and assistance is mainly the result of a law enacted in 1999. Known as the "Ticket Act" or TWWIA, the Ticket to Work and Work Incentives Improvement Act of 1999 expanded and enhanced work incentives and employment support options for DI and SSI beneficiaries. These beneficiaries, in receiving income payments based on disability, also qualify for Medicare, Medicaid, or both, so changes in one program affect the administration of the others. Earlier, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) had replaced the Aid for Families with Dependent Children (AFDC) program, under which recipients automatically qualified for Medicaid, and made changes to children's eligibility for SSI. PRWORA established a welfare-to-work block grant program, Temporary Assistance to Needy Families (TANF).

Medicare provides health benefits to persons 65 years of age and over as well as to younger persons deemed disabled, while Medicaid serves low-income individuals and families, many of whom are aged and some of whom are disabled. DI and SSI are income support programs for persons recognized as disabled or blind. Persons with disabilities move from DI to Old Age and Survivors Insurance (OASI) payments¹ when they reach full retirement age, as defined by the OASI program, but remain eligible for SSI if they have limited income and resources. (OASI's definition of "full retirement age" depends upon the birth dates of beneficiaries. It is 65 years of age for persons born in 1937 or earlier. For people born in 1938 and after, it ranges from 65 and 2 months to 67.)

Medicare and DI are social insurance programs to which beneficiaries have contributed through payroll taxes, while Medicaid and SSI are social welfare programs that are based on need and are funded from general revenues. Regardless of these distinctions, all four provide a safety

net for those they serve. With benefits for persons with disabilities a dominant thread in all the programs, the considerable overlap in the programs' populations results in some individuals' qualifying for benefits under two, three, or even all of them.

The mesh of this safety net is very complicated, however, and is made more so by the TWWIA law. For the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS), the Social Security Administration (SSA), and state Medicaid offices and social service agencies, administering the programs has become increasingly complex, at times challenging public employees once viewed as check-writers to take on entirely different roles, such as outreach, enrollment assistance, and even case management activities. As the population ages, incurring increasing chronic illness and disability, program administrators—already overwhelmed at times—are likely to have greater responsibilities and to face growing burdens, exacerbated by shortfalls in the payroll tax or general revenue dollars that fund the programs.

DEFINITIONS OF DISABILITY

SSA has a narrow definition of medical disability. For adults, the agency defines the term (for both the DI and SSI programs) as “the inability to engage in any substantial gainful activity because of medically determinable physical or mental impairment(s).” The condition either “can be expected to result in death” or has to have lasted or be expected “to last for a continuous period of not less than 12 months.”² For children and youth under 18 years of age, SSA has the following definition:

- (1) An individual under the age of 18 shall be considered to be disabled under SSI if that child has a medically determinable physical or mental disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve months, and (2) no individual under the age of 18 who engages in substantial gainful activity may be considered disabled.³

In contrast, the Americans with Disabilities Act of 1990 (ADA) has a broad definition: “with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.”⁴ The Census Bureau, on the other hand, uses the following:

A person is considered to have a disability if he or she has difficulty performing certain functions (seeing, hearing, talking, walking, climbing stairs, and lifting and carrying), or has difficulty performing activities of daily living, or has difficulty with certain social roles (doing school work for children; working at a job and around the house for adults). A person who is unable to perform one or more activities, or who uses an assistive device to get around, or who needs assistance from another person to perform basic activities is considered to have a severe disability.⁵

SSA has a narrow definition of medical disability.

Although the SSA definition is used or assumed in this paper (and in Part II, “Initiatives to Improve the Interlinked DI, SSI, Medicare, and Medicaid Programs”), some of the cited research and data are based on the ADA, Census Bureau, or other definitions. When they are based on other definitions, it is noted. The varying definitions make tracking and understanding information on the DI and SSI programs difficult at times, particularly for consumers seeking to qualify for them.

PROGRAM DESCRIPTIONS AND CONNECTIONS

The late Sen. Daniel Patrick Moynihan (D-NY) called the Social Security system’s combination of OASI, DI, and SSI benefits “the single most important domestic program in the federal government.”⁶ Putting aside OASI payments for retirees and their survivors, DI and SSI alone accounted for \$64.2 billion and \$33.8 billion, respectively, in benefit outlays in 2002. Almost 14 million recipients—nearly 7 million in each program—received the benefits in that year.⁷ (See Table 1 for a snapshot of 2002 and projected 2003 outlays and recipients and Table 2 for the average monthly benefit in those years for the DI and SSI programs.)

TABLE 1
DI and SSI Outlays and Recipients in 2002 and 2003

Program	Annual Outlays in Millions		Annual Recipients in Thousands	
	2002 Actual	2003 Estimated	2002 Actual	2003 Estimated
DI Benefits	\$64,202	\$73,444	6,983	7,363
SSI Benefits	\$33,857	\$35,885	6,735	6,863

Source: Social Security Administration, “The Fiscal Year 2004 Budget Press Release”; accessed June 14, 2003, at <http://www.ssa.gov/budget/print2004.html>, 6-10.

TABLE 2
Average Monthly Benefit by Recipient for DI and SSI

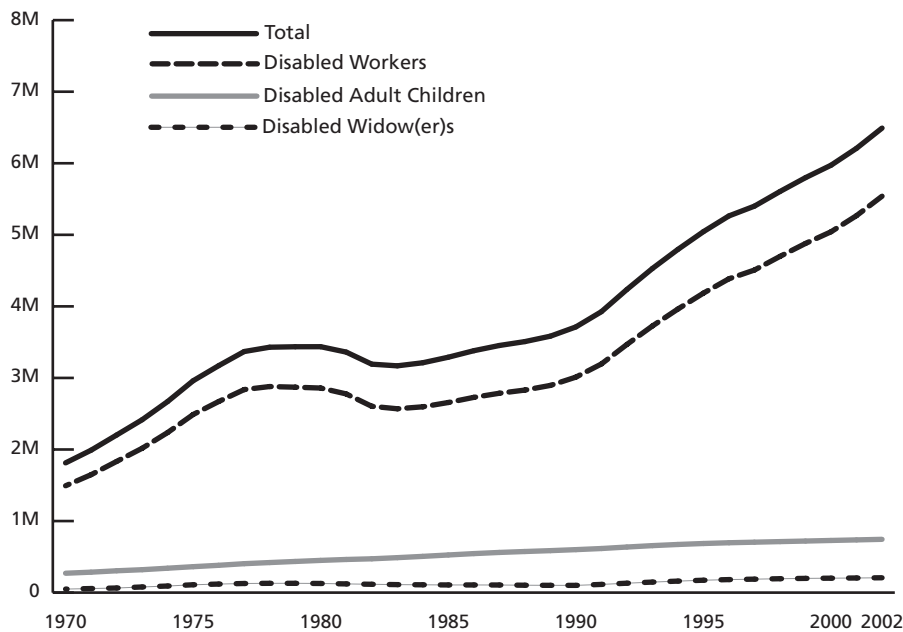
Program/Recipient	2002 Actual	2003 Estimated
DI/Disabled Worker	\$809	\$831
SSI/Blind and Disabled	\$425	\$433
SSI/Average for All Recipients	\$398	\$407

Source: Social Security Administration, “The Fiscal Year 2004 Budget Press Release”; accessed June 14, 2003, at <http://www.ssa.gov/budget/print2004.html>, 8, 10.

Over the past 10 years, the participation of working-age people in the two programs has increased by 61 percent, “even as changes in medicine, technology, society, and the nature of work have increased the potential for some people with disabilities to return to, or remain in, the labor force”⁸ and TWWIIA has encouraged them to do so. By 2015, the number of DI beneficiaries is expected to increase by 37 percent and that of SSI recipients is projected to grow by 15 percent.⁹ (See Figure 1 for a chart of the growth in Social Security beneficiaries with disabilities from 1970 to 2002.) Significantly, “people with mental illness are both the largest and fastest growing group of people with disabilities receiving DI and SSI payments,” accounting for approximately \$25 billion in disability payments.¹⁰

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FIGURE 1
All Social Security Disabled Beneficiaries
in Current Payment System, 1970–2002



Sources: Social Security Administration, Annual Statistical Supplement to the Social Security Bulletin, Table 5.A17 for 1970–1999 data; Social Security Disabled Beneficiaries 100 percent file for 2000 data; Disabled Beneficiaries and Dependents Master Beneficiary Record file beginning with 2001 data.

Disability Insurance

DI is designed to restore income that is lost when wage-earners can no longer work to support themselves and their dependents. Authorized as Title II of the Social Security Act in 1956, DI originally applied to workers age 50 and over who became disabled. It was extended to the dependents

of these workers in 1958 and to workers under 50 in 1960. The program covers workers up to full retirement age, when they qualify for OASI retirement benefits. Whether for DI or OASI, coverage of disabled or blind beneficiaries and their dependents is a result of the workers' having paid Social Security payroll taxes during their working lives.

In addition to the stipulation that a worker must have paid Social Security payroll taxes for a sufficient number of years (some of them recent) to qualify for coverage, the program has the following criteria:

- The worker must meet SSA's definition of medically disabled, as indicated above.
- Coverage applies to the worker, the worker's widow or widower, and the worker's disabled adult child (age 18 or over, unmarried, and with a disability that began before the age of 22).
- To receive benefits, the recipient must "not be working or working but not performing substantial gainful activity."¹¹

For DI, as well as for SSI, SSA reviews applications and sends them to applicants' home states for consideration by a Disability Determination Services office. A clinician and a disability examiner consider medical evidence, contact providers, and examine applicants' ability to do work-related activities. They also may require a "consultative examination" by a physician or medical facility and ask for references to attest to various aspects of the application. If a negative decision is handed down, applicants have the right to appeal.¹²

Funds for the program are administered through the Disability Insurance Trust Fund, which is responsible for translating the fund's payroll taxes into some measure of security for working people and certain of their dependents. According to the 2003 OASDI Trustees Report, DI Trust Fund assets totaled \$160.5 billion at the end of calendar year 2002. The trustees projected that the DI Fund will "have sufficient funds to pay full benefits on time" until 2028.¹³ Actual DI outlays in 2002 were \$66.4 billion.¹⁴

Supplemental Security Income

SSI is designed to provide cash assistance payments to people who are aged, blind, and disabled (including children under age 18) with limited income and resources. (The resource limitation for a single individual is \$2,000 and for an individual and spouse, \$3,000.) It was enacted to replace and modernize a patchwork of state-administered income maintenance programs for many aged and disabled people. Authorized as Title XVI of the Social Security Act in 1972 and implemented in 1974, SSI uses the same definition of disability as DI for adults. In addition to requiring that a beneficiary be medically disabled or blind, with a physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months, the program has the following criteria:

- The applicant must meet certain income and resource limits (that is, “means tests”).
- The applicant must either be a U.S. citizen or meet certain requirements for noncitizens.
- The applicant must be a resident of the 50 United States, District of Columbia, or Northern Mariana Islands.
- The applicant must file for other benefits for which he or she is eligible.
- Unless the applicant is blind, he or she must either not be working or working but not performing substantial gainful activity. Once the applicant becomes a beneficiary, the substantial gainful activity requirement no longer applies and the recipient’s eligibility continues until he or she medically recovers or no longer meets one of the requirements that is unrelated to disability (such as being a U.S. resident).¹⁵

The federal government finances SSI through general tax revenues. Most state governments supplement the federal payments; some of them have agreements with SSA to combine their payments with those of the federal government, so that a beneficiary receives a single monthly check, while other states manage their own programs.¹⁶ Federal SSI outlays were \$33.9 billion in 2002, including cash payments, vocational rehabilitation, research, and reimbursement for administrative costs.¹⁷

The DI-Medicare Linkage

There is a direct link between the social insurance payments that persons with disabilities receive from the DI program and the health benefits that they get from Medicare. While Medicare is generally associated in the public mind with coverage for persons 65 years of age and older, it also covers certain younger persons who have disabilities. When people under full retirement age who have paid payroll taxes for DI and Medicare incur disabilities that prevent them from engaging in substantial gainful activity (or are persons who meet the criteria for dependents of such workers), they qualify for DI payments after 5 months and Medicare benefits after another 24 months. DI, then, is a prerequisite for Medicare for individuals with disabilities.

There are some exceptions, however. Persons with end-stage renal disease (ESRD) who are on dialysis can get Medicare benefits in the third month after treatment starts, while those who receive kidney transplants qualify the month in which they are hospitalized for transplantation. As a result of legislation enacted in 2000, persons with Lou Gehrig’s disease receive Medicare coverage at the same time that they get DI benefits.¹⁸

The linkage between DI and Medicare dates to legislation enacted in 1972, when recipients of DI or Railroad Retirement cash benefits and those with ESRD became entitled. Of the 40 million people enrolled in Medicare Part A (hospital insurance) in 2001, 6 million had disability determinations. Of

The linkage between DI and Medicare dates to legislation enacted in 1972.

the 38 million also enrolled in Medicare Part B (supplementary medical insurance) in that year, 5 million had disability status.¹⁹

The SSI-Medicaid Linkage

The tie between the income support payments that persons with disabilities receive from the SSI program and the health benefits that they get from Medicaid is not uniform nationwide, because of differences in the way states handle eligibility for the program. Jointly funded by the federal and state governments—but administered by the states—Medicaid may or may not be available to low-income persons with disabilities who meet the SSA definition of disability. However, in 32 states and the District of Columbia, people who are eligible for SSI benefits are also automatically eligible for Medicaid. There, the SSI application also serves as a Medicaid application. Seven states and the Northern Mariana Islands apply the same rules to both SSI and Medicaid but require a separate application. Eleven states have both their own SSI eligibility rules and applications. (see Appendix)

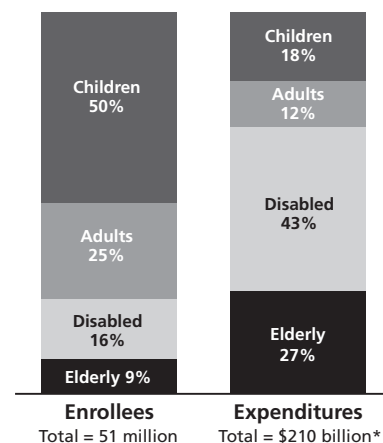
Of the 51 million persons enrolled in Medicaid in 2002, 16 percent or approximately 8.2 million were categorized as persons with disabilities. The 16 percent accounted for 43 percent (\$90.3 billion) of Medicaid expenditures of \$210 billion in that year. (See Figure 2.)

According to the Kaiser Commission on Medicaid and the Uninsured, people who have disabilities are more likely to be enrolled in the Medicaid program and less likely to have private health insurance than those in the general population. Moreover, the overwhelming majority of such enrollees—four-fifths of them in 1998—qualify because they are SSI recipients. Also in 1998, “Medicaid covered 78 percent of poor children under age 5 with disabilities and 70 percent of children ages 5 through 17 with disabilities.” The program also provided coverage to significant numbers of children with disabilities who were “near poor.”²⁰

The “Dual-Eligible” Medicare-Medicaid Linkage

Approximately 7 million persons are covered under both Medicare and Medicaid. Representing 17 percent of all Medicare recipients and 19 percent of all Medicaid beneficiaries, this population accounted for about \$50 billion (24 percent) of total Medicare spending and \$63 billion (35 percent) of overall Medicaid spending in 1999.²¹ There are two types of dual-eligible enrollees: (a) those who receive full Medicaid and (b) those who get supplemental Medicaid. The 5.8 million full-Medicaid duals are both categorically and financially eligible for both Medicare and Medicaid and receive full benefits from both programs, although there is coordination of benefits, which can result in their being bounced back and forth between the two programs. In the coordination of benefits, Medicare is supposed to be the primary payer when there are duplicate benefits and Medicaid the gap-filler when Medicare falls short. The supplemental-Medicaid duals get help

FIGURE 2
Medicaid Enrollees and Expenditures, 2002



*Expenditures on services based on historical state share data.

Estimates based on Centers for Medicare and Medicaid Services and March 2003 Congressional Budget Office data.

Source: Kaiser Commission on Medicaid and the Uninsured.

with the Medicare Part A deductible and coinsurance and the Medicare Part B premium and copayments. (For a profile and discussion of dual eligibles, see NHPF's September 30, 2003, issue brief, "Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?"²²)

There are four ways in which the supplemental-Medicaid duals can obtain assistance with Medicare cost-sharing:

■ The "qualified Medicare beneficiary" (QMB) program requires states to pay the Medicare Part A coinsurance and Part B premiums and deductibles for qualified individuals. "The QMB program helps beneficiaries with incomes equal to or below 100 percent of the federal poverty level and limited financial resources." Under the program, beneficiaries receive premiums, deductibles, coinsurance, some skilled-nursing expenses, and coinsurance.²³

■ The specified low-income Medicare beneficiary (SLMB) program "helps beneficiaries with incomes at least 100 percent but not more than 120 percent of the federal poverty level and limited financial resources." Under the program, recipients' Medicare Part B premium is paid.²⁴

■ The "qualifying individual" (QI) program helps persons with incomes of between 120 percent and 135 percent of the federal poverty level and limited financial resources. It is funded by a block grant and available on a first-come, first-serve basis.²⁵ Under the program, recipients' Medicare Part B premium is paid.²⁶

■ The "qualified disabled and working individual" (QDWI) program "helps working individuals with disabilities whose incomes do not exceed 200 percent of the federal poverty level, who have limited financial resources, and are not otherwise eligible for medical assistance." Under the program, recipients are covered under Medicare Part A.²⁷

EFFECTS OF TWWIIA

Section 1619 Options Prior to TWWIIA

Prior to enactment of the Ticket to Work and Work Incentives Improvement Act of 1999, SSI beneficiaries interested in pursuing work while retaining Medicaid eligibility had the option to use Section 1619 of the Social Security Act. The section, enacted in 1987, authorized work incentives for SSI recipients while permitting them to keep Medicaid.

Section 1619(a) allows eligible SSI recipients to receive reduced cash payments if their earnings exceed the substantial gainful activity level but are below a break-even point and to remain eligible for Medicaid. Because SSI beneficiaries who are blind are not subject to the substantial gainful activity provision, Section 1619(a) does not apply to them. Section 1619(b) permits eligible individuals whose cash payments have stopped due to earned income to remain under SSI for purposes of Medicaid eligibility.

TWWIIA Provisions

TWWIIA offered comprehensive work incentives programs for both DI and SSI beneficiaries. The law seeks to address the “perverse incentives” faced by DI and SSI recipients who would like to work or who would like to test their capacity to be employed but fear that, in doing so, they will lose their income support and health benefits. The law does the following:

- Establishes certain employment supports for persons with disabilities who receive DI and SSI benefits, including employment counseling and placement services, “tickets” for gaining access to certain services necessary in obtaining and retaining employment, and critical benefits counseling through SSA-funded benefits planning and assistance outreach organizations.
- Expands Medicare for certain categories of working persons with disabilities.
- Gives states the option of providing Medicaid buy-ins to individuals between the ages of 16 and 64 who would qualify for SSI benefits except for having higher income or resource levels and individuals who were once eligible but have been determined to have medically improved to such a degree that they no longer meet the disability test.

Employment Supports — The law authorized SSA to establish the Ticket to Work and Self-Sufficiency Program (generally known as Ticket to Work), consisting of employment services, vocational services, and other services to help DI and SSI beneficiaries become employed. Employment networks—private organizations or government agencies, including state vocational rehabilitation agencies—are responsible for providing the services to beneficiaries who opt to participate by getting tickets from SSA.

The program is quite comprehensive and affects not only SSA and CMS but also the Department of Labor. Under regulations promulgated in December 2001, the program is being phased in over a three-year period.²⁸ The first phase includes 13 states. The second has 20 states and the District of Columbia. The third has the remaining 17 of the 50 states as well as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands.²⁹ In states in which the program has not yet been implemented, potential participants are referred to state vocational rehabilitation agencies. While taking part in the program, participants cannot be subjected to continuing medical review of their medical condition due to work activity. Tickets are viable for five years.

DI recipients have at least nine years in which to test their ability to work. During the first year, they have full cash payments, followed by a 36-month extended eligibility period and then by a five-year period in which they can receive cash payments again without reapplying. For SSI recipients, the qualifying disability continues until recipients medically recover, even if they work. They, too, have flexibility in receiving payments again without submitting a new application.³⁰

TWWIIA offered comprehensive work incentives programs for both DI and SSI beneficiaries.

The law also authorized SSA to set up benefits planning, assistance, and outreach projects by awarding cooperative agreements to various kinds of community organizations to provide services different from those provided by employment networks under the Ticket to Work and Self-Sufficiency Program. Services, provided by benefit specialists, include outreach to potential participants in work incentives programs, liaison with public and private agencies that serve SSA beneficiaries with disabilities, and provision of work incentives planning and assistance to beneficiaries.

Expanded Medicare and Medicaid Coverage — Effective October 1, 2000, most DI beneficiaries who work can have extended Medicare Part A insurance (premium-free) for a minimum of 8½ years. Effective January 1, 2001, if DI or SSI recipients' disability payments end due to work earnings, they can include Medicare in their request for benefits reinstatement (having to leave work due to a medical condition) without filing a new application. Temporary benefits—cash payments and Medicare and/or Medicaid—may be available for six months while a case is being reviewed. If SSI recipients' earnings are so high that they do not qualify for cash payments, they may still be eligible for Medicaid.³¹

Optional State Medicaid Buy-Ins — Recognizing that the most frequently noted barrier to employment for persons with disabilities is the loss of health care coverage because of earnings and resources accrued from earnings, Congress included in the Balanced Budget Act of 1997 (BBA) the first Medicaid buy-in state plan option authority. This authority gave states the option of extending Medicaid coverage to working individuals with disabilities who would continue to be eligible for Medicaid coverage except for earnings in excess of 250 percent of the federal poverty level.

Enacted two years after the BBA, TWWIA provides two additional options for states. One allows them "to cover working disabled individuals who would be eligible for Medicaid except that their earnings exceed the income limit that marks the cut-off point for mandatory coverage in their state." The other permits them to provide coverage to working individuals who were receiving Medicaid under the first option but lost it because "they are determined no longer to be disabled 'by reason of medical improvement.'" However, they still must have "a severe medically determinable impairment." These are individuals whose condition has improved due to medical coverage. Likely populations to use this coverage option are persons with severe mental illness, HIV/AIDS, and epilepsy.

The primary Medicaid buy-in target populations include the following:

- DI beneficiaries who cannot utilize Section 1619(a) and Section 1619(b) protections.
- Persons receiving SSI who have exceeded or could exceed the state-established income or resource limits under Section 1619(b).
- Individuals with disabilities who have been working but have never received, or are not currently receiving, Social Security benefits and/or are on the Medicaid rolls.

The goal of both Section 1619(a) and Section 1619(b) is to foster increasing levels of employment on the part of persons with disabilities—employment that also yields significant earnings and heightened levels of self-sufficiency.

To date, 28 states have implemented or soon will implement a Medicaid buy-in program. States have chosen to use either the BBA or the TWWIIA option in establishing eligibility categories. Twelve states (Alaska, California, Iowa, Maine, Mississippi, Nebraska, New Mexico, Oregon, South Carolina, Utah, Vermont, and Wisconsin) are using the BBA option. Sixteen states (Arkansas, Arizona,³² Connecticut, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Washington, West Virginia, and Wyoming) are using TWWIIA's. The state of Minnesota implemented its Medicaid buy-in under the BBA but converted its program to TWWIIA's option in July 2002. Of the states utilizing the TWWIIA option, seven states (Arizona, Connecticut, Indiana, Kansas, Pennsylvania, Washington, and West Virginia) have elected to implement both coverage options. Massachusetts's Medicaid buy-in is operated within the state's Section 1115 demonstration program, called "Commonwealth." An additional two states, Texas and Virginia, have a legislative directive to submit Section 1115 demonstration proposals. Four more states—Colorado, Maryland, North Dakota, and Oklahoma—have enacted legislation but have not yet begun enrollment.³³

Demonstration Project — TWWIIA also included a project, Demonstrations to Maintain Independence and Employment, under which states can receive federal matching funds to provide Medicaid coverage to persons between the ages of 16 and 65 who are "workers with a potentially severe disability" but who are not disabled for Medicaid purposes. The six-year project, which began October 1, 2000, requires states to use matching funds—provided at their regular matching rate—"to supplement, but not supplant, the level of state funds expended for workers with potentially severe disabilities at the time [the state] demonstration projects are approved."³⁴ Two states, Mississippi and Rhode Island, and the District of Columbia have received demonstration grants.

Medicaid Infrastructure Grant Program — Recognizing that states may clearly develop and articulate policies but not have the necessary administrative and systems infrastructure to translate them into services, TWWIIA included a provision to address the dearth of infrastructure aimed at supporting employment and return-to-work initiatives. The Medicaid Infrastructure Grant Program provides funds to build critical intergovernmental and public-private partnerships to address barriers to the initiatives' success. To date, CMS has awarded funds to 36 states under the program.³⁵

PRWORA'S IMPACT ON CHILDREN

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is best known for reforming the nation's welfare system by requiring

To date, 28 states have implemented or soon will implement a Medicaid buy-in program.

that recipients return to work or receive only time-limited assistance and by replacing the AFDC program with TANF, thereby cutting the automatic link between family cash assistance and Medicaid eligibility.³⁶ However, it also had a major impact on the SSI program and hence on Medicaid by changing the definition of childhood disability, delinking it from the definition of disability for adults (see "Definitions of Disability," above).

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA's regulations. SSA must (1) discontinue the individualized functional assessment for children and (2) eliminate maladaptive behavior in the domain of personal/behavior function in determining whether a child is disabled.³⁷

In addition, PWRORA required all youth under 18 who were receiving SSI benefits to undergo redetermination of their eligibility at age 18, according to the adult standard, based on ability to work.³⁸ Redeterminations for adults may occur within three months of the awarding of benefits but most often are between one and six years after eligibility is established. Reporting of life changes, such as marriage, that might affect eligibility and payment amounts also may trigger the redetermination process.

As a result of PRWORA, "an estimated 1.6 million SSI-linked Medicaid beneficiaries were at risk of losing their Medicaid benefits." This included 200,000 adults with disabilities based on drug or alcohol addiction, 785,000 elderly and disabled legal immigrants, and 275,000 children. While about three-fourths of the adults with addictions requalified on the basis of other disabilities, the remainder of those adults either did not respond to SSA notices or were cut off by various states. The BBA restored eligibility for most of the legal immigrants and grandfathered most of the children who were eligible for SSI (and Medicaid) prior to PWRORA's passage in 1996.³⁹

CONCLUSION

As the descriptions of DI, SSI, Medicare, and Medicaid and of their interworkings indicate, the programs are bureaucratic mazes that are difficult for public policy specialists, let alone consumers, to follow. Developed and changed over time to respond to varying social, economic, and political goals, as well as to sometimes competing federal and state objectives, the programs are increasingly confronting administrative challenges, employment support and outreach barriers, and problems in coordinating disparate Medicare and Medicaid benefits. Various initiatives are under way by SSA and DHHS to address these issues. For a discussion of both the issues and the initiatives, see "Bridging Silos, Part II: DI, SSI, Medicare, and Medicaid Issues and Initiatives."

ENDNOTES

1. Old Age and Survivors Insurance (OASI)—commonly known as “Social Security retirement”—dates to legislation passed in 1935 to provide a federally administered program to guarantee income to retired workers. In 1939, the program was extended to the dependents of retired workers and to the surviving family members of deceased workers. Disability Insurance (DI) was added in 1956. Funded by contributions from workers and employers, OASI and DI have separate trust funds.
2. Social Security Administration (SSA), *2003 Red Book, A Summary Guide to Employment Support for People with Disabilities under the Social Security Disability Insurance and Supplemental Security Income Programs*, SSA Publication No. 64-030 (Baltimore, MD: Office of Disability and Income Security Programs, Social Security Administration, January 2003), 16.
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6. Ben Wildavsky, “Entitlements: Social Insecurity,” *National Journal*, October 11, 1997, 1.
7. Social Security Administration, “The Fiscal Year 2004 Budget Press Release,” 6–10; accessed June 14, 2003, at <http://www.ssa.gov/budget/print2004.html>. Using a definition based on limitations in activity rather than ability to work, the Census Bureau estimates that there are 53 million Americans of all ages with disabilities, with two-thirds having severe disabilities.
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APPENDIX: State SSI-Medicaid Linkage Policies

(includes District of Columbia and Northern Mariana Islands)

State	Same Rules and Application	Same Rules but Different Application	Different Rules and Application
Alabama	X		
Alaska		X	
Arizona	X		
Arkansas	X		
California	X		
Colorado	X		
Connecticut			X
Delaware	X		
District of Columbia	X		
Florida	X		
Georgia	X		
Hawaii			X
Idaho		X	
Illinois			X
Indiana			X
Iowa	X		
Kansas		X	
Kentucky	X		
Louisiana	X		
Maine	X		
Maryland	X		
Massachusetts	X		
Michigan	X		
Minnesota			X
Mississippi	X		
Missouri			X
Montana	X		

continued

Appendix (cont.)

State	Same Rules and Application	Same Rules but Different Application	Different Rules and Application
Nebraska		X	
Nevada		X	
New Hampshire			X
New Jersey	X		
New Mexico	X		
New York	X		
North Carolina	X		
North Dakota			X
Ohio			X
Oklahoma			X
Oregon		X	
Pennsylvania	X		
Rhode Island	X		
South Carolina	X		
South Dakota	X		
Tennessee	X		
Texas	X		
Utah		X	
Vermont	X		
Virginia			X
Washington	X		
West Virginia	X		
Wisconsin	X		
Wyoming	X		
N. Mariana Islands		X	

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