



REFORMING DISABILITY

By The Secretary's Innovation Group

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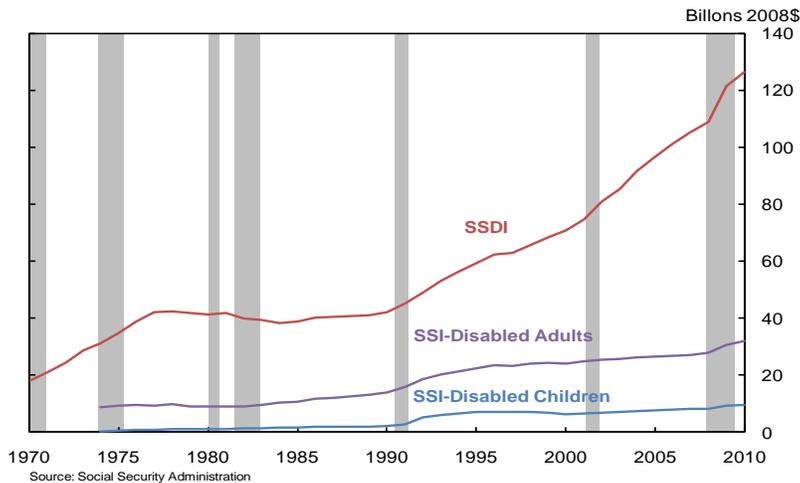
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Disability program expenditures are rising at an uncontrollable pace. Social Security Administration data indicates the inflation-adjusted cost of the disability insurance program for workers, SSDI—Social Security Disability Insurance —has exploded since 1990. The Social Security Trustees report predicts that unless policy reforms are enacted, SSDI will be *insolvent by 2016*. Insolvency just over 40 months from now demands fundamental reform, not tinkering. Meanwhile the cost of the sister program SSI - Supplemental Security Income - for disabled adults and children with disabilities, has also increased. Together, these programs are engulfing ever more numbers into lives of permanent dependency, all with no evidence there is some national health epidemic.

SSDI and SSI-Disabled Adults and Children Program Costs Over Time



The main reason that growth in disability has become unsustainable is that those who have health-related work limitations, in general, are working less and enrolling more in disability programs (lesser additional reasons are an aging population and the increase in the share of women entering the labor force covered by SSDI). As the table below shows, the proportion of people with some work limitations who are employed has been declining.



Work and Disability Receipt Among the Population Reporting Work Limitation

Year	Across Years Similar Percent reporting work limitations	Work is DOWN Employed more than 200 hours per year	Disability dependency is UP Proportion work limited adults receiving disability benefits
1981	7.3%	35.2%	32.6%
2010	7.8%	22.6%	51.4%

Source: Burkhauser and Daly using Current Population Survey data

This workplace decline has occurred in spite of the 1990 passage of the Americans with Disabilities Act, which mandates, among other things, that people with disability be provided accommodation to increase workplace access. Instead, program changes have made it easier for individuals to qualify for disability assistance at the same time states are subject to counter-productive institutional incentives for enrollment expansion, namely 100% federal entitlement financing. Together, these factors have encouraged individuals with health impairments to invest in **not** working in order to qualify for SSDI and SSI benefits.

The long-term financial burden to the taxpayers resulting from non-work among those who could otherwise join the labor force full or part-time, with or without accommodations, is not the only cost. Equally as important is the human tragedy of the wasted years of lives not lived to their fullest. Quite apart from work's economic value to society, work itself has a value to the individuals who pursue it. Work keeps individuals active, socially connected to others as part of workplace and community, better parents at home, and accessible to new opportunities of all kinds.

SSDI - -

- **Provides insurance** against lost earnings to working Americans due to a disability.
- Funded by a **payroll tax of 1.8% of annual covered earnings** split evenly between employer and employee.
- **8.5 million adult** recipients and **1.8 million children**.
- Average single's benefit \$1100/mo. and family with children \$1700/mo.
- Benefit system is **federally funded** and managed.
- **States run the disability determination service (DDS)** by contract with the federal government under federal eligibility rules.
- Applicants must be **unable to engage in substantial gainful activity** by reason of a medically determinable ongoing physical or mental impairment, anywhere in the national economy.

SSI - -

- **Means-tested benefit** for the disabled and blind adults and children, or for 65 or older, with limited income and assets.
- Funded **through US general revenues**, not SSA trust fund.
- **7.1 million disabled recipients**, both adults and children (with aged, the total is 8.2 million) in September 2012.
- **Maximum benefit** is \$698/mo. for an individual and \$1,048 for a couple in calendar year 2012.
- Benefit system is **federally funded** and managed, the same as with SSDI.
- Uses the **same DDS arrangement** as SSDI.
- Definition of **adult disability is the same** as used for SSDI. Children have different criteria based on functional limitations compared to their peers.



Work occupies time in constructive activities that form the concrete part of the day. Work's absence causes a decline in physical and mental health; individuals are usually less employable over time and more likely to experience isolation and depression. Finally, those who gain acceptance to SSDI or SSI rarely exit from the program and return to the labor force. This, combined with the low level of cash benefits, condemn most of these recipients to straitened family financial circumstances over their lifetimes.

The proper objective of adult disability policy should be to keep individuals working or as active as possible at all points along the disability spectrum. Two recent reforms of long-standing government programs—TANF in the U.S. and Workplace Disability in the Netherlands, in different ways show how policy changes can dramatically increase work and reduce dependency.

The Federal Disability Determination Process (common to both SSDI and SSI) is in need of restructuring.

Both SSDI and SSI use the same medical eligibility process and thresholds. The growth in the disability benefit rolls has been affected more by federal eligibility policy and process than it has by any deteriorating health of the general population. As evidence, similar percentages of the working age population reported a work limitation in 1980 and again in 2010 (see table above). Therefore, we look to program rules and their implementation that have directly, and indirectly, expanded the number who are classified as having a disability.

Disability determinations are increasingly being awarded based on medical conditions whose effect on work is difficult to determine objectively, most especially mental illness and muscular-skeletal conditions such as back pain. Based on data from the Social Security Administration, thirty-five years ago only one-fifth of new beneficiaries were classified as having a mental illness or musculoskeletal condition, now over half are. One study has concluded that 23% of those granted disability benefits depends on whether they are evaluated by an easy or hard gatekeeper, rather than on their underlying condition.

Another factor in relaxed eligibility standards is the increasing use of vocational criteria. Taking vocational characteristics into account means SSDI/SSI evaluators consider an applicant's age, education level, and history of physical labor, not just their health limitations, when making decisions about program eligibility. The increased use of vocational characteristics in the disability determination process represents an expansion of the SSDI/SSI entry criteria. As a result, the majority of initial SSDI decisions are now based on these vocational criteria rather than on the



severity of an applicant's health condition alone, twice the proportion as in 1990.

Claimants can appeal negative decisions to an administrative law judge (ALJ) who is permitted to take into consideration new evidence provided by the claimant. Appeals are becoming the norm, rather than the exception, more than doubling in a decade from 300,000 to in excess of 700,000 per year. These appealed decisions do not necessarily represent an improvement in the accuracy of the initial determinations. In three quarters of appeals, claimants are represented by lawyers and other advocates at the hearing, while taxpayers (by proxy through SSA or otherwise) are not allowed such representation. ALJ caseload pressure may favor quick decisions in favor of claimants, with claimants often bringing additional alternative information to the appeal hearing not presented at the initial stage. Fully 60% of appeals result in the overturn of the earlier negative decision.

The Inherent Problems with SSDI as currently federally structured.

SSDI is financed by a flat-rate payroll tax, unlike UI and workers' compensation, which are employer experience rated. Employers do not face any additional costs beyond the flat tax for moving their workers into the SSDI program, nor do employees; therefore, there are no built-in checks on application filings.

In addition, applications to SSDI (as well as SSI) have only two outcomes-either rejected as not disabled; or accepted as totally disabled. But in reality, most applicants fall between these two extremes and the federal system provides no middle ground - for example, by reducing SSDI payments for temporary or partial disability; or making payments contingent upon participation in appropriate vocational rehabilitation; or incorporating a periodic *de novo* review of the disabling condition. Nor under the federal program is there a case manager, public or private, who is assigned to help improve vocational prospects before or after a determination is made. Many such changes could lower costs and improve life circumstances of those deemed eligible - yet none of these are options present in the current federal program.

The Inherent Problems with SSI as currently federally structured

The working age applicant population for the SSI-disabled adults program, unlike SSDI, is more likely to have intermittent or no work history and in many ways are like other low income families served by TANF. For a family enrolled in TANF, adding an SSI adult or child to their case on average more than doubles the income received by the family, a sizeable incentive for pursuing enrollment.



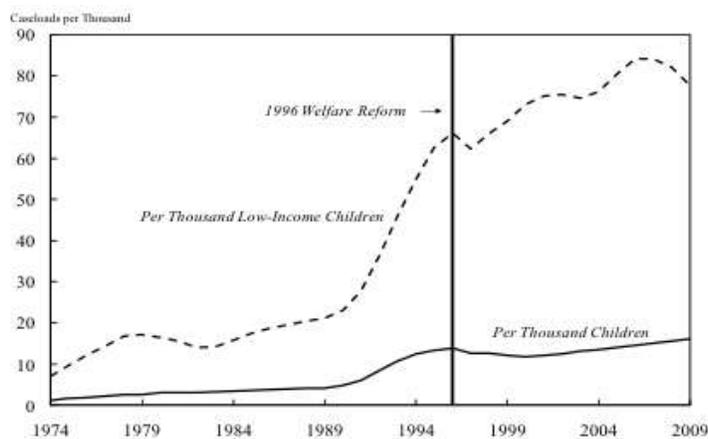
In addition, states have incentives to encourage as many TANF recipients as possible to apply for either the SSI-disabled adults or disabled children's programs. Unlike TANF, SSI is fully federally funded and so benefit costs can be shifted away from TANF. Many states now pay for advocacy organizations to recruit applicants and facilitate enrollment into SSI, with appeals supported by publicly funded lawyers. Partly as a result, transitions from TANF into SSI have increased two and a half times for adults (37% for children) as compared to the period before welfare reform.

SSI-Disabled Children

The primary purpose of providing disability benefits has always been to provide income in the event a worker is unable to perform his or her employment duties. But the rationale for providing them to the non-disabled parent or parents of children with disabilities has been less clear. Increasingly, the SSI-disabled children's program has effectively become an income supplement to non-working families often receiving TANF or other welfare benefits. Because SSI-disabled children's program benefits are larger than TANF benefits and have no work requirements, single mothers have a financial interest in applying.

SSI-disabled children's caseloads per 1,000 children and especially per 1,000 low-income children have grown dramatically (see chart) not because of a growing health epidemic among poor children but dramatic changes in disability program policies.

Rise in Poor Children on SSI



Source: Burkhauser from SSA and US Census



The number of child on SSI ballooned after the Supreme Court Zebly decision in 1990, in which children could be deemed eligible if determined they exhibited limiting abilities to engage in age-appropriate behavior, such as attending school. After reports that some parents were coaching their children to act inappropriately so as to retain SSI benefits, Congress tightened the rules as part of 1996 welfare reforms. But after a brief dip (see chart above), allowances shifted toward other medical conditions that were also difficult to determine objectively, including mental conditions such as child hyperactivity. Applications based on these more subjective mental conditions have increased from only 5% in 1983 to more than 50% of all SSI child cases today.

Under its present structure, it is unclear how the current SSI cash transfer system helps child recipients prepare for a productive independent adult life and vocation after their eligibility ends at age 18. Inside the current federally managed system, most children are simply recommended through caseworkers to apply for SSI-disabled adults benefits once they age-out of the children's program. As a result, the vast majority of these children simply move into a permanent system of adult SSI dependency without experiencing the challenges and rewards of employment and independence.

The Secretary's Innovation Group Recommendation

The Federal government does not have the capability, capacity or management incentive to help the disabled improve their employment prospects, or otherwise maximize their human potential. Unlike the pro-work incentives inherent in welfare as reformed through TANF, the work discouraging incentives embedded in the federal SSDI/SSI system has led to excessive enrollment for benefits in lieu of work.

In this respect, states are far better equipped to manage the true costs of disability. States **opting to transfer** either or both of the federal programs **would place new applicants and recipients** into their new state-managed SSI and SSDI systems. Under this plan, beneficiaries already enrolled in SSI/SSDI would remain in the federal system for the sake of simplicity.

SSI

A state-run SSI program would have many of the characteristics of TANF, with its principal objective to maximize work and economic independence, and with accrued savings reverting to the state for expanded supplementary services. This new state disability program will operate under similar incentives along with broad authority to



manage new disability applications, enrollment and case management so long as it meets the general federal disability purpose.

Federal funding for the state-managed SSI system would be annually appropriated using a formula which provides the same amount of federal funds which would otherwise have been received under the old federal program. States that reduce their caseloads below estimated SSI expenditures under the old program would share in the savings 50/50 with the federal government. States that exceeded their estimated expenditures would likewise share these additional costs 50/50.

SSDI

Under this reform, the SSDI program would be integrated into the existing state-managed workers' compensation program, effective for those newly enrolled. This is an appropriate fit because the state workers' compensation program harnesses the private sector in rehabilitation interventions and incentivizes employers through experience rating. The new state system would be funded as now through payroll taxes or as states choose. If, as anticipated, the state-run system is less costly than the current federal program, these savings would accrue to the states.

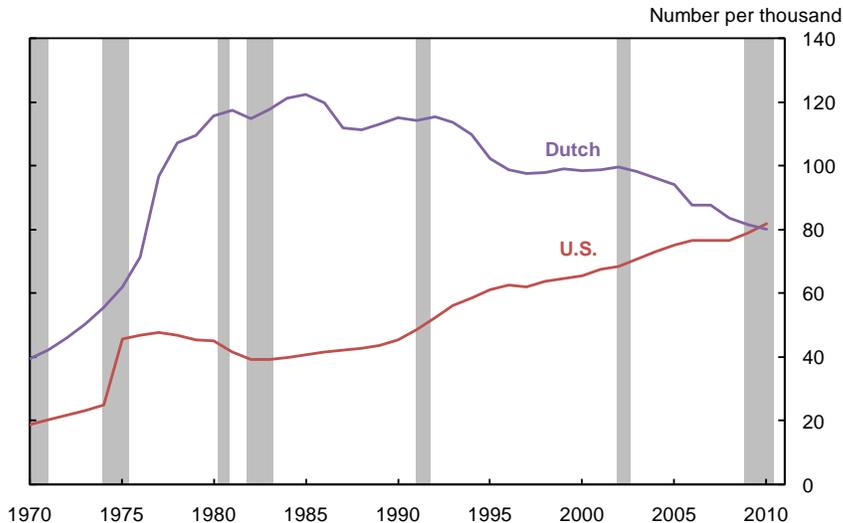
What could states do with new authority over disability programs?

Dutch example

Once known as the "sick country of Europe" for its runaway disability rolls, the Netherlands decided to fundamentally restructure its disability system. As can be seen in the chart below, the results have been impressive. The number of disability beneficiaries per 1,000 workers has declined significantly and without raising the rolls in other transfer programs, while the US has had opposite results.



U.S. DI/SSI and Dutch Disability Beneficiaries per 1000 Workers Ages 15-64



Sources: Dutch data from the Central Plan bureau (CPB), National Social Insurance Institute, and U.S. data from the Social Security Administration

Before the reforms, there was little relationship between the direct costs that employers bore for their workers coming onto the Dutch long-term disability program. Hence there was little incentive for employers to provide accommodation and rehabilitation to their workers who experienced the onset of a disability and little reason for their workers to comply with any such work-first initiatives. The Dutch reforms focused on reducing inflows onto long-term disability benefits by making employers more directly bear program costs, while at the same time requiring workers to cooperate with work-first efforts to keep them off the rolls as a condition of future consideration of disability enrollment.

To achieve this end, the reforms required all Dutch firms to fund the first two years of disability benefits to their workers and to pay an experience-rated disability tax based on the number of workers they subsequently moved onto the long-term Dutch disability insurance program. These reforms provided incentives for employers, who are in the best position to offer accommodation and rehabilitation, to do so in lieu of moving workers with disabilities onto cash transfers. Workers who do not cooperate with these work-first treatments are barred from receiving long-term disability benefits. These reforms led to the development of a private sector market for disability insurance and the management of impaired workers, which is credited, in part, with a significant decline in inflows to their long-term disability cash benefit program.



Following the Dutch example, states could take any number of steps to help create a thriving private/public disability insurance market which, through the right financial incentives, focuses interventions on steps to employ or re-employ applicants for disability at the early stage when such efforts are most likely to be effective.

Workers' compensation example

Under our proposed integration of SSDI into the existing state workers' compensation system, many of the features of the Dutch system could become applicable within a state-designed disability program.

Workers' compensation is a state-mandated insurance program which provides indemnity or partial wage replacement, medical and rehabilitation benefits to employees who become injured or ill as a result of their employment. These mandated programs vary across states in terms of the level of benefits, which medical conditions are compensated, and which organizations are permitted to provide insurance. The focus of workers' compensation is on preventing injuries and hastening the return to work, and it is financed almost exclusively by employers who have the incentive to manage the claim and return to work process with potential for significant cost savings. As evidence of the positive incentives at work, under state managed workers' compensation programs lost work days have declined over a period of many years.

For SSDI - -

A state designed innovative SSDI program might include any of the following features, many of which are already common in workers' compensation:

- Provide for a state disability fund which is financed by experience-rated payroll tax rather than current flat tax so as to encourage employers to reduce their costs by investing in accommodation and rehabilitation where feasible.
- Mandate minimum long-term disability coverage levels and then allow businesses to shop for best value among private disability insurance providers. Additionally, permit a state owned and funded disability plan to compete with private providers.
- Create additional alternatives to permanent disability including temporary disability; partial disability; and time limited disability periodically renewable upon health need certification.

- Allow vocational rehabilitation agencies to compete for state contracts in which compensation is determined on the basis of agency performance in return to work.
- Upon application for disability, require a fixed period of intervention with a public or private disability manager to seek alternatives to enrollment in disability. The likelihood of change or recovery is greatest at the outset of a disabling event.
- Allow businesses to self-insure for disability claims if they meet certain state standards for coverage.
- Create portable partial income-replacement accounts with tax favored contributions from employers and employees.

For SSI

A state designed program might include any number of features, some for adults and others for children:

- For children, use funds which are currently distributed in the form of cash benefits to families, to instead be allocated for services to the child such as case management aimed at improving the child's adaptation and future outcomes, particularly in preparation for his integration into the labor force or post-secondary training and education at age 18.
- For adults, invest more in work-oriented assistance and target assistance to those most likely to join the labor force (i.e. less severely disabled). Allow states to require ongoing participation in vocational rehabilitation efforts as a condition of benefits for those whose employment prospects might be improved.
- Consider state EITC incentives which would improve the income available from work for the disabled and offset some of the disability benefit amount upon taking a job.