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Subcommittee on Social Security
On Securing the Future of Social Security Disability Insurance Program

A Proposal for Fundamental Change in Social Security Disability Insurance

Richard V. Burkhauser

Professor, Cornell University

Adjunct Scholar, American Enterprise Institute

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THE STATE OF THE PROGRAM

The Social Security Disability Insurance (SSDI) program is growing at an unsustainable pace. Over the past 40 years the number of disabled worker beneficiaries has increased nearly six-fold, rising from 1.5 million in 1970 to 8.2 million in 2010. This rapid growth in the rolls has put increasing pressure on program finances. Since 1970 real SSDI expenditures have risen from $18 to $128 billion (in 2010 dollars). Based on current growth, the SSDI program is projected to be insolvent by 2016 (Social Security Administration, 2012).

The rapid rise in caseloads and costs are made more worrisome when put in the context of the broader goals of the SSDI program—to protect the economic well-being of people with disabilities. Since the passage of the Americans with Disabilities Act of 1990 (ADA), the employment of those with disabilities has declined considerably and their household income has remained flat. Increasingly, people with disabilities are substituting SSDI benefits for labor market earnings, making them net withdrawers rather than net contributors to the tax base during their working age. This outcome challenges the finances of the SSDI program and is at odds with the view of disability codified in the ADA that people with disabilities are able and willing to participate in the labor market.

WHY HAVE SSDI CASELOADS RISEN?

Possible explanations for SSDI program growth can be broadly classified into two groups: (1) those that are exogenous to the program—the aging of the population, changes in the underlying severity of disability, and the entry of women into the labor force; and (2) those that are endogenous to the program—the cyclicality of application rates, the growth in SSDI benefits

relative to wage earnings, and specific changes in rules and their interpretation and implementation over time. The weight of the evidence suggests that the vast majority of SSDI program growth is related to endogenous program changes.

Factors Exogenous to the Program

Changes in the age distribution

The most obvious potential driver of SSDI growth is the aging of the population. Since SSDI benefits are conditioned on having a disability, and disability generally rises with age, the aging of the baby boomers will on net push up the SSDI rolls. A simple way to gauge the impact of this change is to fix SSDI recipiency rates by age group in some period and let growth in the rolls evolve based on changes in the age structure of the population. Autor & Duggan (2006, 2010) do this and find that between 1984 and 2003, changes in age structure accounted for about 6 percent of the increase in SSDI receipt among the non-elderly population over the period. Mary Daly and my updates (Burkhauser & Daly 2012) of their calculations (1984 to 2010) show a slightly larger, but still relatively small impact of changes in the age structure on the SSDI growth.

Changes in health and work disability

Another potential driver is health. To qualify for SSDI benefits, individuals must have a medically determinable ailment expected to last for at least 12 months or result in death. If the health of the insured population has declined over time this would influence program enrollment and growth. Surveys asking about activity and work limitations point to a relatively stable pattern in these measures over the last two decades. Although work and activity limitations rise with age, there is little evidence that the prevalence within an age-group of such limitations has increased over time.

Entry of women into the workforce.

Changes in the labor force participation of women also have influenced program growth. Since SSDI is an insurance program, eligibility for benefits requires a fixed number of quarters of covered employment. The substantial increase in the labor force participation of women has increased both their SSDI coverage and their receipt of disability benefits. It is straightforward to compute the magnitude of this change on the total growth in SSDI rolls. Autor & Duggan (2006, 2010) make these computations and conclude that the increased number of women in the paid labor force can explain less than one-sixth of the rise in SSDI caseloads since the mid-1980s. Our updates of these calculations through 2010 (Burkhauser & Daly 2012) confirm these findings.

Combining the estimated contributions of population aging, changes in health, and the entry of women into paid work, we conclude that at most one-quarter of the increase in SSDI caseloads over the last three decades can be explained by these factors, with the remaining 75 percent driven by factors endogenous to the program.

Factors Endogenous to the Program

Changes in SSDI rules and their implementation.

Caseload fluctuations line up with changes in Social Security Administration (SSA) policies that made it easier or harder to gain entry to the SSDI rolls. In the late 1970s and early 1980s relative caseloads fell, first because program gatekeepers were urged to more strictly interpret existing rules and then because Congress, in 1980, required SSA to reevaluate all current recipients to see if they still met the medical standards. This rule change, which was rigorously enforced by SSA at the start of the new Reagan administration, resulted in a drop in the SSDI rolls despite a major recession. By 1983 the widespread reevaluation of those already on SSDI

was halted as the courts and then Congress restricted the SSA's power to reevaluate beneficiaries. Furthermore, in 1984, responding to a backlash against restrictive cuts imposed in the Social Security Disability Amendments of 1980, policymakers expanded the ways in which a person could medically qualify for the SSDI program. The 1984 legislation moved away from a strict medical listing determination of eligibility to one that also considered an applicant's overall medical condition and ability to work. These changes meant that applicants could qualify for SSDI based on having multiple conditions, even when no single condition would meet the SSDI eligibility threshold. In addition, the legislation allowed for symptoms of mental illness and pain to be counted when assessing SSDI eligibility, regardless of whether the person had a verifiable medical diagnosis.

The expansion of eligibility to more difficult-to-measure impairments that do not precisely meet the medical listings means that SSA has increasingly been tasked with making more subjective decisions about the impact that presenting impairments might have on an applicant's work ability. For applicants who do not meet or exceed the medical listings, program administrators consider a set of vocational criteria. While these criteria have not changed over the history of the SSDI program, their use by program gatekeepers to determine benefit eligibility has risen dramatically since 1991. Currently, they are used to justify the majority of new awards, especially among those with the more difficult-to-determine conditions of mental illness and musculoskeletal conditions—the primary condition of more than 50 percent of all newly enrolled beneficiaries. (See Burkhauser & Daly, 2011 for fuller discussion.)

Effects on behavior and implications for work capacity

The effect of this growing share of marginal applicants is a substantial variation in the flow of applicants onto the rolls. This variation comes both from fluctuations in applicant inflow and

variations in decision making among SSDI gatekeepers. For example, Maestas, Mullen, & Strand (2011) using SSA administrative records find that at the initial Disability Determination Stage (DDS) of decision making, 23 percent of new applicants in 2005 were marginal cases whose admittance into the program was determined by the luck of drawing an easier rather than a stricter DDS gatekeeper. Importantly, when they compare the subsequent work histories of those who entered the program in this way with a matched set of applicants who drew a stricter DDS gatekeeper, they find the latter group's employment was on average 20 percentage points higher. This difference is even greater for those with less severe medical conditions. This research suggests that increasingly applicants admitted to the SSDI rolls on these looser criteria have greater work capacity than assumed for those receiving SSDI benefits.

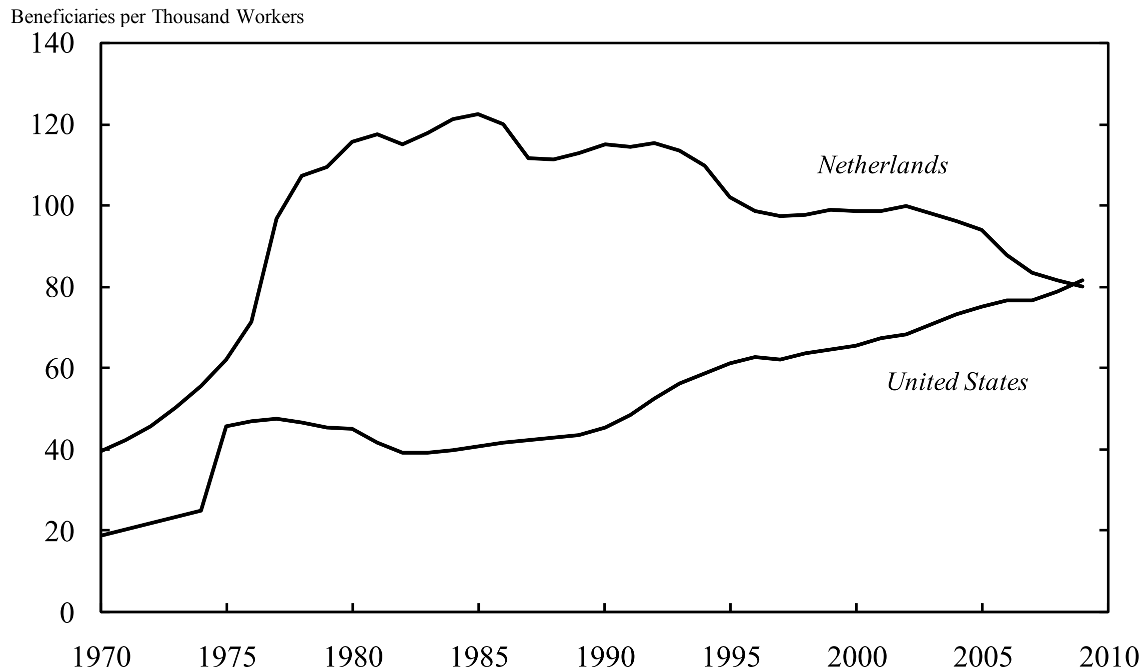
The differences in allowances are important especially when one considers how application rates fluctuate with economic conditions. Plots of the SSDI application rate and the national unemployment rate show that, with the exception of the double-dip recession in the 1980s, application rates are highly correlated with the business cycle—rising during recessions and falling during periods of economic growth. Most research on the consequence of business cycles on applications rates finds that economic conditions play a substantial role in SSDI applications and awards patterns over time. (See Burkhauser & Daly 2012)

In sum, SSDI growth has primarily been driven by factors other than an aging workforce, health declines, and the increasing SSDI coverage of women. Loosening of program rules in the 1980s has made it more difficult for gatekeepers to judge eligibility and increased the likelihood that applicants facing rising replacement rates or declining economic opportunities will apply for SSDI benefits. A growing number of individuals being allowed onto the rolls could work in some capacity and would do so if they were not judged eligible for benefits.

THE CASE FOR FUNDAMENTAL CHANGE

Evidence that growth in U.S. disability rolls has been primarily driven by policy and associated behavioral responses among gatekeepers and workers with disabilities are consistent with those found for the Netherlands during a period when it was known as the "sick country of Europe." (Aarts, Burkhauser & de Jong, 1998). Following many failed attempts to modify the system from within, in 2001, the Netherlands decided to fundamentally restructure the system. As can be seen in Figure 1 below, the results have been notable; the share of the Dutch work force receiving disability benefits has declined significantly and has done so without raising the rolls in other transfer programs at the same time that the share of the United States work force receiving disability benefits has grown. (Burkhauser & Daly, 2011).

Figure 1. Comparison of U.S. and Dutch disability beneficiaries per 1,000 workers



Source: Burkhauser and Daly (2011)

The Dutch reforms focused on reducing inflows onto long-term disability benefits by making employers more directly bear program costs. 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. Research shows that the 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 disability cash benefits. Importantly, the research shows that the reduction in inflows owes to the fact that workers with disabilities are more regularly returning to work (de Jong, 2008; van Sonsbeek, 2010).

In the spirit of the Dutch reforms, recent proposals by Autor & Duggan (2010) and Burkhauser & Daly (2011) call for prioritizing supported work over cash benefits for people with disabilities. Like the Dutch, both proposals focus on slowing the movement of workers with impairments onto the SSDI rolls, rather than attempting to reduce the current beneficiary population via the stick of greater enforcement (tried in the 1980s) or the carrot of changing the incentives for current beneficiaries to return to work (impetus for Ticket to Work). Such fundamental reforms would end the archaic and counterintuitive policy currently in place that provides access to work-focused support only after SSDI applicants have gone through an extended process of demonstrating that they are unable to work.

Autor & Duggan (2010) propose a new mandate on all firms to provide the first two years of "short-term" disability insurance. This would increase the willingness of employers to provide

additional accommodation and rehabilitation by more directly linking the cost of disability payment to firms. It would also create growth in the private insurance market and greater case management of workers following the onset of a work limiting impairment and hence greater return to work. However, it could result in substantial added costs to the system.

Alternatively, Mary Daly and I (Burkhauser & Daly 2011) argue that like the Dutch, the United States should impose some form of experience rating on firms paying into the SSDI system. Raising the SSDI payroll tax of firms whose workers enroll in the system at above-average rates and lowering the SSDI payroll taxes on firms whose workers enroll at below-average rates via experience rating would more directly link the costs to the firm of one of its workers moving onto the SSDI program. Employers who bore the costs for both options would be more incentivized to make the investments in accommodation and rehabilitation that could prolong the employment tenure of a worker with a disability. This is currently the system used to fund state workers' compensation benefits, and the best practices from these state programs could be considered for SSDI as well. Alternatively, employers who provide short-term private disability insurance for employees and whose private insurance agents cooperate with SSDI gatekeepers in managing their cases could be granted a reduction in SSDI tax rates, while firms that did not offer such private insurance could be charged higher SSDI tax rates. Either of these reforms would bend the cost curve of projected SSDI program expenditures by reducing incentives for employers and employees to overuse the system.

Although the details differ, the messages of the Autor & Duggan and Burkhauser & Daly proposals are the same: The current SSDI program built on the assumption that disability and employment are mutually exclusive states is both archaic and fiscally unsustainable.

Fundamental reform is needed to restore solvency to the U.S. disability insurance system and to support continued employment and greater self-sufficiency among workers with disabilities.

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