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**DISABILITY RISK AND INCOME SECURITY FOR WORKERS:
A STRESSED SUPPORT SYSTEM IN NEED OF INNOVATION**

EXECUTIVE SUMMARY

David C. Stapleton, Richard V. Burkhauser, and Peiyun She Cornell University
Robert R. Weathers, II, Mathematica Policy Research, Inc.

- Over the last two decades the inflation-adjusted household incomes of working-age people with disabilities have been falling, both absolutely and, especially, relative to incomes of those without disabilities. The proximate cause of this decline is a long-term exodus of workers with disabilities from employment. Income from other sources only partially replaces lost earnings.
- Workers who experience disability onset receive support from a public/private system that serves many well, but that system is under stress and in need of innovation. We find that only 60 percent of disability-related earnings reductions experienced by older workers after disability onset are eventually replaced by income from all other sources, on average.
- The number of older workers experiencing disability onset is accelerating because of the aging of the baby boom generation. That fact, combined with the government's fiscal circumstances and the magnitude of federal expenditures to support working-age people with disabilities (over 11 percent of federal outlays in 2002) is likely to precipitate a crisis for the public programs and those they serve within the next two decades.
- In line with the 1990 Americans with Disabilities Act, federal and state governments have launched significant initiatives aimed at increasing the employment and self-sufficiency of people with disabilities (e.g., Ticket to Work and the Medicaid Buy-in), and others are being planned. These initiatives might eventually improve the disability support system and reduce expenditure growth, but they are not likely to ward off the adverse consequences of the pending crisis.
- Policy changes that leverage existing private sector practices and capabilities might achieve greater success in a timely manner. To be successful, such changes would use the private sector's ability to: innovate quickly in response to changing incentives and technological developments; change the workplace in ways that will reduce/delay the onset of disability; and quickly help workers return to work after disability onset, before they become disconnected from their employers.

Comments to: David Stapleton
dcs28@cornell.edu
Cornell University Institute for Policy Research
1342 22nd St., NW
Washington, DC 20037-3010
Voice: (202) 223-7670, x101
Fax: (866) 371-1633

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POLICY BRIEF

The Support System for Workers Who Experience Disability Onset

Workers who experience the onset of a disability are protected by a mix of public and private programs. The primary objectives of this “system” are replacement of earnings and provision of health care for those who can no longer work because of a disability. On the public side, this system consists primarily of Social Security Disability Insurance (SSDI), Medicare, and Medicaid, but also includes programs that serve other target populations, such as veterans, low-income parents, and unemployed workers. On the private side, the system includes private disability insurance and workers compensation. Limited funding is also available to support return to work, primarily the federal/state vocational rehabilitation services program, private disability management services (often in conjunction with private disability insurance) and workers compensation.¹

Public and private expenditures to support working-age people with disabilities are very high: \$226 billion in federal spending and \$50 billion in state spending in 2002; \$34 billion on workers’ compensation premiums in 2004; \$8.3 billion on long-term disability insurance in 2005; and unknown additional private costs for losses in productivity and health care.²

Support System Failure

Despite the large and growing costs of this support system, the household incomes of working-age adults who say they have work limitations have been declining for some time, both absolutely and, especially, relative to the household incomes of working-age adults that do not report work limitations. Between 1986 to 2004, years that are at roughly comparable points in the business cycle, the median household income of those with a work limitation declined relative to the median for those without a work limitation by 14.7 percent, reflecting an 11.3 percent inflation-adjusted increase for those without work limitations and a 5.0 percent *decline* for those with work limitations.³

The proximate cause of the divergence in median household incomes is the long-term exodus of those with disabilities from the labor force and into public programs. One measure of the employment rate for those with work limitations fell by 23.5 percent from 1986 to 2004, while the corresponding measure for those without such limitations increased by 1.9 percent.⁴ The exodus from employment has been accompanied by a rise in the proportion of the working-age population relying on SSDI for at least part of their income. Very high rates of SSDI participation in the late 1970s led to significant tightening of eligibility in the early 1980s. By 2002, however, participation rates were substantially higher than in 1980, especially for those in younger age groups. For instance, from 1980 to 2002 the percentage of workers ages 25 to 39 who were on the SSDI rolls increased by 46 percent increase.⁵ The SSDI participation rate for all ages combined increased by 31 percent over the same period.

Despite the increase in SSDI participation, median incomes for those with work limitations fell. SSDI benefits and other income sources fall far short of replacing earnings declines after disability onset. Our own analysis of workers who experience long-term disability onset during their fifties indicates that only 25 to 30 percent continue to work six years later, and that their average household income from all sources is about 25 percent lower than what it was prior to disability onset. On average, income from all other sources, including SSDI, private disability benefits, workers compensation indemnity payments, and both public and private retirement benefits replaces less than 60 percent of the decline in the worker’s earnings. Only those with the most severe disabilities receive public support. Less than one third of the

workers studied received SSDI benefits by the end of six years; many others relied on lower early Social Security retirement benefits.⁶

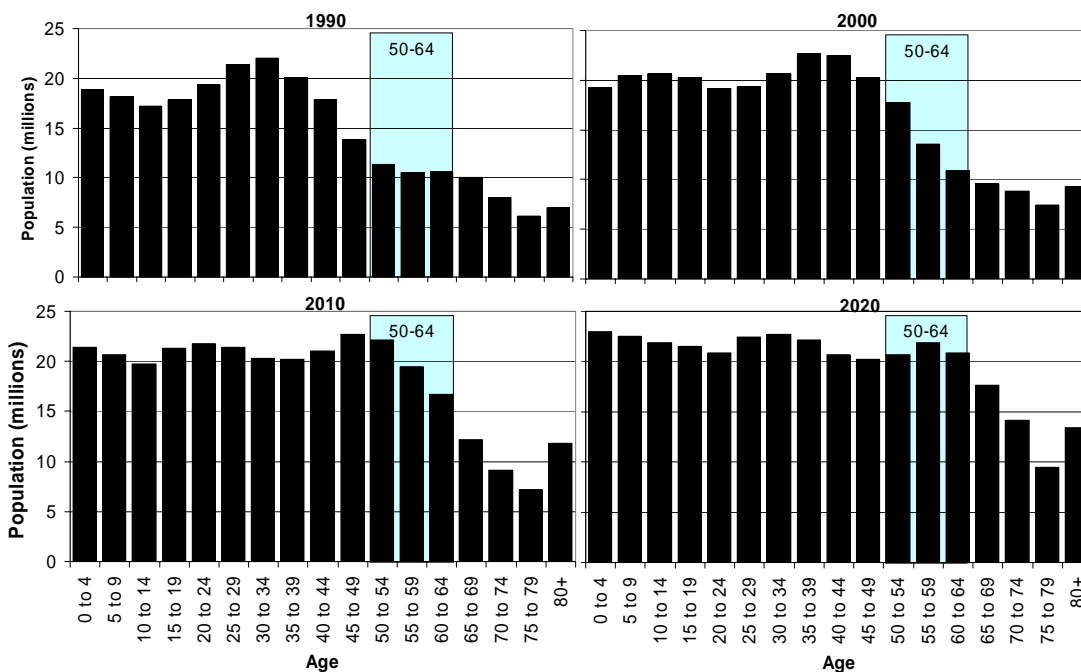
High growth in reliance on transfer payments and public funding for health care has also meant high growth in public expenditures. Federal expenditures to support working-age people with disabilities increased from 6.1 percent of all federal outlays in 1986, to 11.3 percent in 2002.⁷

Growing Stress on the Support System

Three inter-related factors will put significant additional stress on the current system over the next twenty years, and beyond. The first is the aging of the “baby boomers.” This large birth cohort, born between 1946 and 1964, is now entering the working-age group in which the incidence of disability onset is highest, ages 50 to 64 (Figure 1). The population in this age group will not decline substantially after the last of the baby boomers reach age 65, because of immigration and declines in mortality.

Figure 1: The Age Distribution of the Population, 1990, 2000, 2010 and 2020

Source: Bureau of the Census: <http://www.census.gov/ipc/www/idbpyr.html>. Accessed October 1, 2006



The second factor is the growing cost of health care. Some of this growth is attributed to the aging baby boomers, but the more powerful forces behind this growth appear to be advances in health care combined with a financing system that encourage patients and providers to give little weight to costs when making treatment decisions. Health care costs have risen steadily as a share of gross domestic product (GDP) with almost no interruption for 40 years, from just six percent in 1965, to 17 percent in 2004.⁸ The latest official projection is that health care costs will reach 20 percent of GDP in about ten years.

The third factor is projections of rapid growth in federal outlays relative to federal revenues that threaten taxpayer support for the public programs (Figure 2). Expenditures for Medicare, Medicaid and Social Security alone are projected to rise from 8 percent of GDP in 2010 to 12 percent in 2020 – a 50 percent increase in just 10 years. Federal borrowing would have to exceed federal revenue by 2070 in

order to sustain current law programs and revenues. Thus, there is enormous fiscal pressure on lawmakers to reduce the growth rate in federal expenditures.

Public System Reforms

The weaknesses of the public support system for workers with disabilities have long been recognized, and significant efforts have been undertaken to strengthen it. In line with the 1990 Americans with Disabilities Act, reform efforts have targeted opportunities to help people with disabilities become more self-sufficient, by addressing the work disincentives that are built into the existing programs and by encouraging program integration and coordination across multiple agencies and multiple levels of government. Administrators and lawmakers have shown a growing interest in such reforms, partly in response to the demands of advocates, and partly because of pressing fiscal concerns.⁹

But current reforms are unlikely to offset the downward trends in the income and employment of working-age people with disabilities or the near-term financial strains that the aging of the baby boom generation will put on the current disability system. Reform efforts are in their infancy and have not yet demonstrated success. Notably, the Ticket to Work and Medicaid Buy-in programs, both intended to encourage work and reduce dependence on public income support, have yet to demonstrate significant success in achieving those objectives.¹⁰ A series of SSA demonstrations authorized by the 1999 Ticket to Work and Work Incentives Improvement Act and intended to test interventions that would increase self-sufficiency of income support recipients or potential recipients, are several years from bearing fruit.

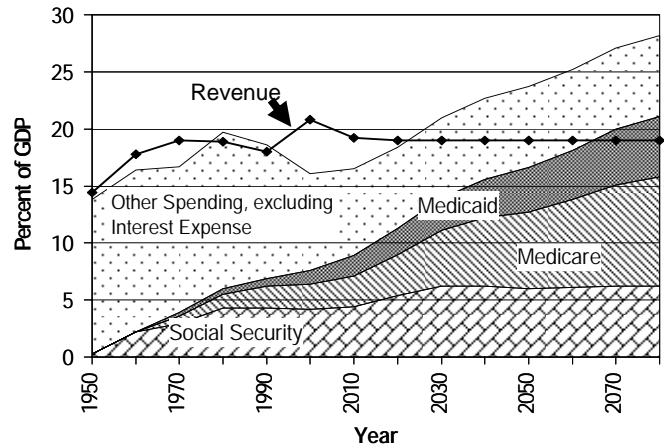
Prospects for Private Sector Innovation

More fundamental reforms that encourage the private sector to respond to the growing crisis in the disability system should be considered. Private disability insurers, disability management vendors, and private employers themselves are at the vanguard of efforts to reduce their overall disability costs. In general, private actors have several advantages relative to public actors in reducing overall costs including: the ability to innovate quickly in response to changing incentives and technological developments; the ability to change the workplace in ways that will reduce/delay the onset of disability; and the ability to identify employees in the early stages of disability onset, and help them return to work before they become disconnected from their employer.

Hence, our expectation is that the private sector will significantly intensify its current efforts to manage the growing cost of disability as the crisis unfolds. The appeal of private disability insurance to employers and employees will increase, and employers will increasingly find that disability prevention and management efforts make economic sense. Incentives for disability management companies to innovate will increase, and opportunities to take advantage of new technologies will also increase.

What reduces costs to the private sector does not necessarily reduce costs to the public sector, or even to society as a whole. On the one hand, return-to-work efforts funded by employers and private

Figure 2: Total Federal Outlays and Revenues as a Share of GDP, 1950 to 2075



Source: Data from Congressional Budget Office (2003).

disability insurers could slow entry into SSDI. On the other hand, efforts by private insurers to reduce long-term benefit costs could increase SSDI entry. Private insurers often undertake such efforts because the typical private insurance contract promises to replace a fixed percentage of the lost earnings of successful claimants (e.g., 60 percent) net of any SSDI payments. Thus, when an SSDI award is made, the private insurer's payment is reduced, dollar for dollar.

The government could potentially harness the private sector's clear advantages with respect to delivery of return-to-work services in ways that would benefit workers, employers and taxpayers. To date, very little attention has been paid to this general approach to policy reform. Interestingly, however, the restructuring of the public programs advocated by the Social Security Advisory Board (2006) calls for the development and use of capabilities that already exist in the private sector.

To be successful, any effort to leverage private sector capabilities must preserve the private sector's advantages. An approach with incentives that support prevention, early intervention, maintenance of the employee-employer connection, efficient use of technology, and innovation might be quite successful, whereas an approach that is prescriptive and bureaucratic is likely to fail. Similarly, an approach that builds on existing private sector services in an integral fashion is likely to be more successful than an approach that calls on the private sector to provide segregated services to the public sector.

It would be risky to implement an innovative public-private program without a preliminary test, but some innovative ideas are less risky and more amenable to a quick test than others. Efforts that target workers with private disability coverage might be the least risky, as well as the easiest to test, because private insurers and disability management firms already provide services to such workers and have significant relationships with their employers.

The most important point is that harnessing of private-sector capabilities might well be the best near-term option available to address the developing disability system crisis. More fundamentally, a successful public-private partnership in this arena would advance the transformation of the disability support system from one that often discourages work and encourages dependency, toward one that offers better opportunities for people with disabilities to be self-sufficient and to share in the fruits of our economy.

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ENDNOTES

- ¹ See Stapleton et al. (2006) for further description and analysis of the public system.
- ² See Goodman and Stapleton (forthcoming); National Council on Compensation Insurance, Inc. (2005); and JHA (2006), Exhibit B.
- ³ Source: The Current Population Survey, as tabulated by Cornell University's Disability and Demographic Statistics Research Rehabilitation and Training Center. www.disabilitystatistics.org, October 19, 2006. See also Burkhauser et al. (2006).
- ⁴ The employment rate reported is the percentage of those ages 21 to 64 who worked at least 52 hours in the previous calendar year, by work limitation status. Source: Current Population Survey. See www.disabilitystatistics.org, October 19, 2006. See also Burkhauser and Stapleton (2004), Stapleton, Houtenville and Burkhauser (2004), and Houtenville and Burkhauser (2006).
- ⁵ As reported by the Social Security Advisory Board (2003). The denominator for the percentage includes only those who had met SSDI's work history requirements.
- ⁶ See Stapleton et al. (2007).
- ⁷ See Goodman and Stapleton (forthcoming).
- ⁸ Based on health expenditure estimates and projections from http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp, and GDP estimates and projections from <http://www.gpoaccess.gov/eop/tables06.html>. Accessed 11/05/2006.
- ⁹ See Stapleton et al. (2006) and Social Security Advisory Board (2006).
- ¹⁰ See Thornton et al. (2006), Liu and Ireys (2006), and Goodman and Livermore (2004).