

Income Security for Workers: A Stressed Support System in Need of Innovation

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Abstract: The current mix of public and private programs to support workers after they experience disability onset provides benefits to millions of workers and former workers. Yet, despite the large and growing costs of these programs, the inflation-adjusted household incomes of workers with disabilities have been falling for over two decades, both absolutely and, especially, relative to the incomes of those without disabilities. The aging of the baby boom generation is likely to make matters worse, and the government's fiscal circumstance will make it increasingly difficult to sustain existing public programs. Current public policy initiatives might eventually improve the disability support system, 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, but have received little attention and are far from proven.

Introduction

The current patchwork of public and private protection available to workers who experience the onset of a long-term disability is both complex and expensive to administer, and less than fully effective in both returning those who can work back to work and those who cannot onto the Social Security Disability Insurance rolls. Although this mix of public and private components has served millions of workers well, many workers fall between the cracks and many others prematurely move out of the work force and onto the permanent disability transfer rolls. The household incomes of working-age people with disabilities are much lower than those of the rest of the population, and they are much more likely to live in poverty, despite massive government expenditures to support them. More ominously, the fissures in this fragmented system appear to be widening. The incomes of working-age people with disabilities are falling, the prevalence of poverty is rising, and government expenditures to support are increasing at a very rapid rate. People with disabilities themselves are increasingly frustrated with public programs that promote dependence and devalue their capabilities. Government, private insurers, and employers need to better coordinate their efforts to reverse the declining employment of working-age people with disabilities and delay the movement of workers who experience the onset of a disability onto the Social Security Disability Insurance rolls.

We first present evidence of the rising risks to the employment and economic well-being of workers and their families following the onset of a disability. We then summarize recent disability policy initiatives that have been proposed to reduce these risks and discuss why they are not likely to succeed. We conclude with a discussion of options for policy changes that would leverage private sector capabilities. Little attention has been paid to these options, and

they are far from proven. Our limited objective is to encourage further consideration of these options, and perhaps others that would serve the same policy objectives.

Stress on the Support System

Workers who experience the onset of a disability are protected by a public system that is supplemented in a variety of ways by a private system. The focus of both systems is replacement of earnings and provision of health care for those who can no longer work because of a disability. On the public side, this primarily consists of Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, and Medicaid, but also includes significant programs that serve other target populations, such as veterans, low-income parents, and workers who are unemployed.¹ On the private side, this includes private disability insurance, and workers' compensation. Much more limited funding is also available to support return to work, primarily through the federal/state vocational rehabilitation services program, private disability management services (often in conjunction with private disability insurance) and workers compensation.²

Public and private sector expenditures for the support system are very high. Goodman and Stapleton (forthcoming) estimate that the federal government spent \$226 billion – 11.3 percent of all federal outlays -- to support working-age people with disabilities in 2002, and states spent an additional \$50 billion, primarily for Medicaid. Totals for private sector expenditures are not readily available. Private disability and workers compensation insurance premiums paid by employers constitute one component of private sector costs. In 2004, employers spent approximately \$34 billion on workers' compensation premiums.³ In 2005, employers spent \$8.3 billion on long-term disability insurance.⁴ Employers also spend an unknown amount for the health care of employees with disabilities, through their health plans.

Paid sick leave and short-term disability benefits are also an important part of the support system for people with long-term disabilities.

Of course high expenditures for the disability support system partly reflect the number of working-age people with disabilities and partly the fact that our society values the lives and well-being of this population. The evidence presented here, however, demonstrates that the system is performing poorly. Many would argue that the system's inefficiency is also contributing to high costs. Specifically, the system puts a strong emphasis on providing income support and health benefits, and little emphasis on helping people increase their economic self-sufficiency and wellbeing through work (Stapleton et al., forthcoming). Goodman and Stapleton (forthcoming) estimate that, in 2002, only 1.5 percent of federal expenditures for this population were allocated to education, training and employment support programs. Policies that support and encourage work might be both improve the well-being of this population and be less expensive.

In what follows we present evidence that the risks to employment and the economic well-being of workers and their families after disability onset is increasing. Our intent is to demonstrate that this is a significant and real phenomenon, not to provide a comprehensive analysis.

The first evidence is that household incomes of working-age adults (aged 21 to 64) who say they have work-limitations have been declining for a long time, both absolutely and, especially, relative to the household incomes of working-age adults that do not report work-limitations (Figure 1).⁵ To avoid confounding the differential effects of business cycles on household incomes for these two groups, it is necessary to consider comparable points in the business cycle. The most recent data are for 2004, the third year of a recovery, and 1986 and 1995 are roughly comparable. From 1986 to 1995, the median household income of those

without a work limitation *increased* by 3.1 percent (after adjustment for inflation), while the median household income of those with a work limitation *declined* by 5.8 percent. From 1995 to 2004, those without a work limitation experienced an additional increase of 7.9 percent, while those with a work limitation experienced an increase of only 0.1 percent. Over the full period, the median income of those without work limitations increased by 11.3 percent, versus a decline of 5.0 percent for those with work limitations – a relative decline of 16.3 percent.⁶

The income evidence suggests that the current disability system has not maintained the household incomes of people with disabilities, let alone allow their incomes to grow on a par with those of other households. Instead, it appears that those who do not have work limitations are enjoying the fruits of economic growth, while those who have work limitations are falling further and further behind.

The proximate cause of the divergence between the household incomes of working-age adults with and without disabilities is the long-term exodus of those with disabilities from the labor force and into public programs, coupled with the fact that income from all other sources, including benefits, only partially replaces lost earnings. The decline in one measure of the employment rate for those with disabilities is depicted in Figure 2.⁷ The rate for men fell from 40 percent in 1986 to 28 percent in 2004. In the same period the rate for women fell by much less, from 28 percent to 26 percent. These declines need to be assessed in the context of divergent long-term trends in the employment rates for men and women without work limitations – a very gradual decline for men and substantial growth for women. The relative employment rates for men and women with work limitations (the rate for those with work limitations relative to the rate for those without work limitations) controls for these trends. The declines in the relative rates for men and women with work limitations are much more similar to one another, and both

are large: from 43 percent in 1986 to 31 percent in 2004 for men, and from 42 percent to 34 percent for women.⁸

The exodus from employment has been accompanied by a rise in the proportion of the working-age population that is relying on SSDI for at least part of their income, as illustrated in Figure 3. Very high rates of SSDI participation led to substantial tightening of eligibility in the early 1980s. By 2002, however, the participation rates in every age group were higher than in 1980, with the exception of the oldest age group. Most of the increases occurred after 1990. The rise in participation among the younger age groups is particularly notable. Because few people exit the SSDI rolls for reasons other than attainment of the normal retirement age or death, most of these young beneficiaries will be relying on SSDI for decades. Autor and Duggan (2006) extensively analyze the reasons for SSDI program growth, and point to the fiscal crisis that is unfolding for this program.

SSDI and Social Security retirement (SSR) benefits (for those age 62 or older) partially replace the earnings of those who qualify, but only partially, and not all workers who experience disability-related earnings losses qualify for these public benefits. Our own analysis of married worker respondents in the longitudinal Health and Retirement Study (HRS) who experienced the onset of a work limitation lasting at least two years after their first interview (Table 1) and before age 59, found that 66 percent received at least one of these benefits six years after onset, including 25 percent who received SSDI.⁹ The percent receiving SSR is high (41 percent) because almost all workers in the sample were age 51 or older when they experienced disability onset.¹⁰ All the workers in the sample who received SSR six years after onset received early retirement benefits, because workers who experienced onset at age 59 or older were excluded from the sample. Hence, they necessarily received early retirement benefits, which are lower

than they would have received had they waited until age 65 to claim them. In the single sample, 84 percent received a Social Security benefit, including 32 percent under SSDI and 52 percent under SSR.

Mean income from Social Security (including SSDI, SSR, and SSI supplements for low income SSDI beneficiaries) replaced only 26 percent of the mean earnings decline for the married workers and 34 percent for the single workers. These figures are based on the full samples, including those who did not receive any of these benefits. If we consider only those who received benefits, however, the share of earnings replaced is not much different: approximately one third for both married and single workers. Although mean benefits for those who receive benefits are necessarily larger than for all workers in the two groups (i.e., including those with no benefits), mean earnings declines are also much larger.¹¹

Increases in other sources of income, primarily private pensions (often available at age 59) and disability insurance, fill a substantial share of the gap between the decline in earnings and the increase in income from SSDI, SSI and SSR, but the gap remaining is large. As of the sixth year after onset, increases in income from all of the worker's own sources replaced 55 percent of the mean earnings decline for married workers and 57 percent for single workers.¹² For the average married worker, increases in spousal earnings do not help compensate for the earnings decline; instead, they too decline, by a large amount: about 45 percent of the worker's average earnings decline. In some instances, onset of disability for one spouse might cause the decline in earnings of the other spouse (e.g., if the spouse spends significant time caring for the worker or must take on many household activities that were formerly the responsibility of the worker). In other instances the decline might be due to unrelated factors.¹³ For married workers,

an estimated 56 percent of the decline in all household earnings is replaced by increased income from all other sources.

The net result of these income changes for married workers is that their mean household incomes decline by 23 percent from two years before disability onset to six years after. The decline in median household income is much larger, 35 percent. The difference between the reduction in the mean and the reduction in the median reflects the fact that income changes after onset vary substantially across households; the means reflect the incomes of the relatively small number of workers who are fortunate enough to continue to work after onset, or who receive very high increases in other income sources, whereas the medians do not. Mean household income for single workers declines by 27 percent, and the median declines by 45 percent. Relative declines in after-tax household income would be lower, because earnings are taxed at a higher rate than other forms of income.¹⁴

The HRS findings reported above apply to older workers only, but it seems likely that younger workers would, on average, experience comparable or larger relative income declines after disability onset. SSDI and SSI medical eligibility criteria make it more difficult for younger workers than older workers to qualify, and younger workers would not be eligible for SSR or private pension benefits for many years. There are offsetting factors, however. Compared to older workers, younger workers who enter SSDI might, on average, have a larger share of their earnings losses replaced, because of lower pre-SSDI earnings, the progressive nature of SSDI benefits, and the availability of dependent benefits for their children. In addition, younger workers with children are likely to be eligible for Transitional Assistance for Needy Families and Medicaid if they are sufficiently poor. Further, if they have any earnings, they can obtain the

Earned Income Tax Credit for low-income families, which is much more generous for parents than for non-parents.

For many workers, and especially younger workers, the decline in household income after disability onset likely understates the effect of disability on household income, because in the absence of disability the worker's earnings would have grown.

Given the evidence from the HRS, it is not surprising that the decline in employment and earnings of working-age people with disabilities has translated into a decline in household income. Earnings losses are only partially replaced by all other sources of household income, including all public and private benefits for which they might be eligible. It should also be noted that the decline in living standards might well be greater than the income decline would imply, because of the direct effects of disability onset household expenses (e.g., for health care, special equipment, home or vehicle modifications, personal assistance, and special transportation) and the extent to which the worker contributes to productive household activities.¹⁵

Growth in reliance on both transfer payments and public funding for health care has also meant high growth in expenditures for public programs. Federal expenditures to support working-age people with disabilities increased from 6.1 percent of federal outlays in 1986 to 11.3 percent in 2002 (Goodman and Stapleton, forthcoming). The 2002 figure represents 2.2 percent of gross domestic product (GDP), up from 1.4 percent in 1986.

In summary, the disability support system is clearly under stress. Fewer and fewer working-age people with disabilities are relying on their own earnings for support, more and more are relying on transfer payments, but growing payments have not been sufficient to make up for lost wages, and expenditures on at least the public support programs, which account for a

very substantial share of all federal expenditures, are rising at a rate that is much faster than the growth of all federal outlays and the growth of GDP.

Predicted Increases in Stress on the Support System

Three factors will almost certainly put additional stress on the current system over the next twenty years, and beyond. The first is the aging of the baby boom generation. As evidenced in Figure 4, 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. In 1990, the oldest were age 44. By 2000, the oldest were age 54. By 2010, the oldest will reach age 64, and even the youngest will be age 46. By 2020, all will be age 56 or older. As is apparent from the figure, the population in this age group will not decline by much after the last of the baby boom cohort reaches age 65. Even though domestic fertility rates declined starting in the 1960s, immigration and declines in mortality mean that subsequent worker cohorts will be nearly as large as the baby boom cohort when they reach age 50.

The second factor is the growing cost of health care. Some of this growth can be attributed to the aging of the baby boom generation, but the more powerful forces behind this growth appear to be advances in health care combined with a health care financing system that encourages inefficient use of health care resources and fails to control growth in their use. Health care costs have risen steadily as a share of GDP with almost no interruption for 40 years, from just six percent in 1965 to 17 percent in 2004. The latest official projection is that they will reach 20 percent of GDP in about ten years.¹⁶

Growth in health care expenditures puts pressure on the system in two ways. First, tightening of employer coverage in response to higher health care costs and growing out-of-pocket expenditures for workers increases the incentive for workers with disabilities, who are

relatively high users of health care, to exit employment and enter public programs, including Medicare and Medicaid -- especially if they have inadequate private coverage or none at all. Second, the growing cost of government health care programs makes it more likely that program eligibility and coverage will be tightened as a way to contain costs.

Projections of rapid growth in federal outlays relative to federal revenues threaten taxpayer support for the public programs. The aging of the baby boom generation and rapid growth in health care are two of the most important factors driving growth in federal outlays (including outlays for the entitlement programs), as a share of GDP. Once the leading edge of the baby boom generation reaches the normal age of retirement, in about 2010, growth in federal expenditures for Social Security, Medicare, and Medicaid will accelerate. The most recent long-range projections from the Congressional Budget Office appear in Figure 5. Expenditures for these three programs are projected to rise from about 8 percent of GDP in 2010 to about 12 percent in 2020 – a 50 percent increase in just 10 years.

Under current law, federal revenue (including payroll tax contributions to the Social Security and Medicare trust funds) is projected to remain stable at about 18 percent of GDP. The projections indicate that, in the absence of large reductions in the growth of outlays or large increases in taxes, the federal government will need to increase its borrowing substantially from 2024 forward. By 2070, borrowing would have to exceed federal revenue to sustain current law programs and taxes. Thus, there is enormous fiscal pressure on lawmakers to reduce the growth rate in federal expenditures. As that growth is driven by the growth rate in expenditures for the entitlement programs, including the programs that are the most important components of the public support system for workers who experience disability onset, it seems very likely that those programs will be scaled back in some significant way.

Efforts to Improve the Public Support System

Policymakers, program administrators, and advocates have long recognized the weaknesses of the public support system for workers with disabilities, and significant efforts have been undertaken to strengthen it. Two characteristics of the public programs are the focus of many of the reform efforts. First, they discourage workers with disabilities from achievement of greater self-sufficiency through work, because the major programs provide support only if the worker's earnings are very low.¹⁷ Most notably, in 2006, eligibility for SSDI and, eventually, Medicare, required that the individual be capable of earning no more than \$860 per month – an amount that is just over the federal poverty threshold for a family of one, and somewhat less than can be earned working 40 hours per week at the federal minimum wage.¹⁸

The second characteristic targeted for reforms is that the support system is highly fragmented and poorly coordinated. This is especially problematic for low-income people with disabilities, who might need to rely on public support for personal assistance services, housing, transportation, food, etc. Obtaining and managing services can be a significant drain on the individual's time, financial, cognitive and emotional resources – resources that might otherwise be devoted to self-sufficiency. Behind the poor integration is highly fragmented responsibility for financing and service delivery. Multiple federal agencies have significant responsibilities for specific support programs, and Congressional responsibility for agency oversight resides in diverse House and Senate committees. These fragmented responsibilities are mirrored by fragmentation at the state and local level. In addition, funding and/or administrative responsibilities for most programs are shared across multiple levels of government. As a result, programs are poorly coordinated, there are many opportunities for agencies to defer responsibilities to other agencies or levels of government rather than take responsibility

themselves, and many political and administrative resources are spent on cost-shifting issues, especially between state and federal governments.¹⁹

Opportunities exist to both improve the lives of people with disabilities and slow the growth in public spending on their support. Taking advantage of those opportunities requires reforms that help people with disabilities become more self-sufficient, by addressing both the disincentive and fragmentation issues. The disability rights movement has been pushing for such reforms, most notably through the 1990 Americans with Disabilities Act and the 1999 Ticket to Work and Work Incentives Improvement Act. 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 (see, for example, Social Security Advisory Board, 2006b).

But unless things change, significant reforms will not be implemented in time to effectively address the increasing stress created by the aging of the baby boom generation. Reform efforts are in their infancy and have not yet demonstrated significant success. Notably, the Ticket to Work and Medicaid Buy-in programs, both intended to encourage work and reduce dependence on public income support, have at most achieved very limited success in achieving those objectives to date.²⁰ SSA's considerable efforts to launch a number of demonstrations, authorized by the 1999 Ticket Act and intended to test interventions that would increase self-sufficiency of income support recipients or potential recipients (e.g., the Benefit Offset National Demonstration, the Accelerated Benefits Demonstration, Youth Transition Demonstration, the Mental Health Treatment Study, and the HIV/Auto-immune Impairments Demonstration), are several years from bearing significant fruit.

In the absence of reforms, fiscal constraints will become more problematic, and pressure for program administrators and lawmakers to slow the growth of existing programs via eligibility

and benefit cuts will intensify. Such cuts are politically very unpopular because of the hardships they impose on people with disabilities, but fiscal pressures are very likely to make such cuts irresistible.²¹

The Role of the Private Sector

In many ways, the major players in the private sector—private disability insurers, disability managers, and employers and employees themselves—are good candidates to respond to the increasing costs of disability onset. How they do so will play a significant role in determining the consequences of the increased stress on the disability support system.

Competitive market forces require disability insurers to offer plans to employers that help them reduce their liabilities related to the onset of a disability for their workers. To do otherwise would mean they are out of business. Disability insurers hire and train disability managers who use a variety of different methods to reduce the liabilities associated with the onset of disability, including identifying necessary work accommodations, health care, return to work services, and providing assistance with applications for disability transfer programs. Hence they are critical decision makers in the mix of accommodation, health care, return to work training and transfers that workers will receive following the onset of a disability.

These same market forces require employers to provide a competitive mix of wage and non-wage compensation to their workers, including protection against earnings loss because of disability. To do otherwise means that they will not be able to hire and retain their workers. Because ultimately workers are paying for their own disability insurance via lower wages or other compensation, presumably they value this protection at least as much as the other compensation they must forego to receive this protection. Hence it is in the interest of all parties in the private sector to provide any given level of protection at the least possible cost.

Private sector entities also have several advantages relative to public programs with respect to addressing the developing crisis, 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 or support return-to-work after disability onset; and the ability to identify employees in the early stages of disability onset and work with them before they become disconnected from their employer.

Only a minority of workers have private disability coverage, however. According to the latest National Compensation Survey (Bureau of Labor Statistics, 2006), only 29 percent of private sector workers had long-term disability coverage in March 2006, and 37 percent had short-term coverage. Coverage rates vary substantially by job type. Long-term coverage rates are relatively high for white collar jobs, full-time jobs, and high-wage jobs. They are relatively low for blue collar and service sector jobs, part-time jobs, non-union jobs, and low-wage jobs. Short-term coverage rates vary in a similar fashion, except that they are relatively high for unionized and blue-collar jobs.²²

Our expectation is that the private sector will significantly intensify its current efforts to manage the growing cost of disability as the crisis unfolds. Insurer efforts to market disability insurance to employers and employees will be increasingly successful as the latter observe first hand the rising incidence and high cost of disability. Employers that face rising labor costs for workers with specific skills and, especially, experience, will invest more in disability prevention, accommodations, and services that help workers return to work after disability onset. Incentives for disability management companies to innovate will increase, and opportunities to take advantage of new technologies will also increase.

The effect of expansion in private coverage on public program expenditures is hard to predict. On the one hand, increased private insurer investment in return-to-work efforts will very likely reduce or delay the entry of some workers into public programs. On the other hand, private insurers help some of their long-term claimants to obtain SSDI and (indirectly) Medicare; some such claimants might not have obtained these benefits if they did not have private coverage. The latter possibility arises primarily because the application process for SSDI is very burdensome on the applicant. The applicant must cooperate in the collection of pertinent medical information, including a medical examination if there is insufficient evidence in available medical records, and must wait an average of four months for the initial decision (Social Security Advisory Board, 2006a, Chart 62). Many applications are initially denied, but many of these are eventually allowed on appeal. In fact, almost 30 percent of all SSDI allowances are made only after the appeal of an initial denial, including over 20 percent that are allowed only after appeal to an administrative law judge (Social Security Advisory Board, 2006a, Chart 14) – a process that took an average of 14 months in 2005 (Social Security Advisory Board, 2006a, Chart 64). If the burden of the SSDI application process had a negligible effect on the number of SSDI awards, then the expected expansion in private coverage would likely reduce growth in SSDI program expenditures, because more workers with disabilities would receive return-to-work services.

Insurer efforts to help long-term claimants obtain SSDI benefits represent an important service to all privately insured workers, but the value of this service is often overlooked because SSDI benefits obtained by individual claimants are offset by equal reductions in private benefits. Helping long-term claimants obtain their entitled SSDI benefits reduces the insurer costs, and allows insurers to offer premiums that are considerably lower than otherwise. Put differently, if

the insurers did not help their long-term claimants obtain the SSDI benefits, insurer costs would be higher, insurers would charge higher premiums for their products, employers would be less likely to provide this employee benefit, and the higher cost of private coverage would likely be reflected in reductions in other forms of labor compensation.

Critics of the private disability insurance industry will point out that expansion in private coverage will increase the volume of complaints against private insurers (e.g., for denial of long-term benefits). It is important to recognize that such complaints exist, but they must be understood in the context of the nature of disability determination and the market forces that private insurers face. Determining ability to work and benefit eligibility is an enormously complex and difficult task, as is clearly demonstrated by the problems that plague the SSDI determination process. Market forces create strong long-term incentives for insurers to treat their claimants well.

Policy Innovations to Leverage Private Sector Capabilities

Changes in public policy could potentially leverage the private sector's clear advantages with respect to delivery of return-to-work services in ways that would benefit workers, their employers and taxpayers. Workers would retain greater self-sufficiency after disability onset, employers would retain more of their productive workers, and the flow of workers with disabilities into public programs would slow down. Such changes might reverse the long-term decline in the economic fortunes of people with disabilities. 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 (2006b) calls for the development and use of capabilities that already exist in the private sector. Although there is no

guarantee, it is possible that efforts to leverage existing private sector capabilities could be tested and implemented quickly enough to mitigate the impending crisis.

The federal government could potentially harness the capabilities of the private sector in many different ways. In what follows, we present three options that merit further consideration. Our intent in presenting these options is to stimulate discussion and further analysis only. We are not prepared to recommend any of them, for reasons we discuss in our closing comments, but we do think they are all worthy of serious consideration.

Payroll Tax Incentives and Return-to-Work Subsidies. One way to align employer incentives more closely with the social costs and benefits of disability onset would be to experience rate the employer component of the payroll tax – an approach that employers are already familiar with from unemployment insurance, workers’ compensation and health insurance. This would increase the incentive for employers to invest in actions that reduce/delay disability onset and/or help their employees continue to work thereafter, because employers would bear a greater cost of the long-term public benefits paid to workers who did not return-to-work.

The experience-rating system could be designed to be revenue neutral if there is no change in the number of workers entering SSDI relative to the number expected under the current system. However, firms whose employees enter SSDI relatively frequently would be penalized by increases in their payroll taxes, and firms whose employees enter SSDI relatively infrequently would be rewarded by reductions in their tax payments.²³ All employers would have a greater incentive to prevent disability onset and retain workers after disability onset. If the number of workers entering SSDI were to fall, as expected, payroll tax revenue would decline, but the system could presumably be designed so that the drop in revenue would be substantially

smaller than the decline in benefits. Further, increased return to work would increase federal and state income tax revenues and reduce Medicare expenditures.

Another approach is to increase federal subsidies and tax breaks for employers on accommodations and return-to-work services, which are currently very limited. Burkhauser, Butler and Weathers (2002) show that employer accommodations can significantly delay a worker's application for SSDI benefits following the onset of a disability. Presumably other types of services can as well. Such subsidies presumably would increase return-to-work and reduce the flow of workers into SSDI, but the benefit reductions might not be sufficient to pay for the subsidies, in part because some share of the subsidies would be a windfall gain to employers; i.e., they would help employers pay for accommodations and services that they would have purchased in the absence of the subsidies. If such subsidies are attractive, one financing option would be link their introduction to an introduction in experience rating for payroll taxes that, combined, would be revenue neutral if there is no change in the flow of workers into SSDI.

Both of these approaches are "price" approaches; one increases the price to the employer of an employee's exit for SSDI; and the second reduces the price to the employer of goods and services needed to support return-to-work. One feature of these price changes is that they do not directly involve private disability insurers or disability management vendors, and could presumably be applied to employers that do not offer private disability benefits or engage disability management vendors. They would, however, increase the demand for return-to-work services. They would also increase the incentives for employers -- and any private disability insurers or disability management vendors they might engage -- to prevent disability onset, encourage return to work after onset, and help workers avoid or delay entry into SSDI.

Private Insurer Administration of SSDI. A more direct way for government to involve private disability insurers is to pay them to administer SSDI benefits for workers with private coverage in a manner that integrates the public and private benefits. The premise is that integrated administration of benefits, if well designed, would provide the worker with better employment and financial options than are currently available – sufficiently better to slow the flow of workers into SSDI.

More specifically, SSA would hire private insurers to administer the current SSDI program rules for workers who also have the private insurer’s short- or long-term coverage. For these workers, the insurer would handle all the eligibility determination, continuing disability review, earnings verification and other processes currently conducted jointly by local SSA field offices and state Disability Determination Services. The insurer would also make SSDI benefit payments to the worker; the worker would receive a single check each month for the combined public and private benefit.

Success would require a strong performance-based payment system that aligns the private disability insurer’s financial interests with public policy objectives. Private insurers would continue to do what they do now: work with the claimant and employer to return the claimant to work if that is feasible, and pay long-term benefits if it is not. The difference is that, under a well-structured payment system, the private insurer would have a greater incentive to return the claimant to work and less incentive to encourage and support entry into SSDI. That should translate into, among other things: more return-to-work services; more return-to-work cash incentives for claimants (i.e., short-term payments and long-term partial payments); more investment in worksite accommodations, equipment, and job restructuring; and reductions in private premiums to reward employers that successfully cooperate in these efforts. The payment

system could include incentives for the private insurer to provide return-to-work services that will truly benefit claimants, not just reduce the cost of disability. A well-designed system would presumably reduce claimant and advocate complaints against private insurers.

Because the success of an integrated public-private benefit would require the private insurer to determine the claimant's SSDI eligibility, this idea will generate negative reactions from two sides that are often in conflict with each other: those concerned about growth in SSDI benefit payments and those concerned about protecting the rights of workers with disabilities. The former will fear that this approach will "pave the path" onto SSDI for workers with private coverage. The latter will fear that private insurer greed will deny workers with disabilities the benefits to which they are entitled. These well-founded concerns will have to be addressed. In principle, though, they could be. A more fully integrated disability transfer system that provided more accurate signals of the true social costs of the onset of a disability would give private insurers much greater incentive to not allow SSDI benefits for those who are ineligible, would give greater incentives to workers who experience the onset of a disability to take advantage of work options provided by their employer rather than apply for SSDI benefits, and would give employers stronger incentives to retain those workers. To prevent abuse, SSA would presumably have to audit the private insurer decisions, and those denied SSDI benefits would presumably have the right to appeal to SSA. SSA already has an extensive audit and appeal systems in place for DDS decisions, in part to counter incentives that DDSs have to make allowances,²⁴ and in part to protect the rights of claimants.²⁵ Presumably these systems could be adapted to address the same concerns with respect to decisions made by private insurers. Further, the payment system itself could include explicit financial incentives to make accurate decisions.

In a well-designed system, processing times for the relevant set of cases would likely fall and decisions might well be more accurate, in part because of competition and in part because of early interactions between private insurers and claimants. The initial determination would be conducted in the context of return-to-work assessments and rehabilitation efforts. In the many cases for which eligibility cannot be determined on the basis of SSA's Listings of Impairments alone, the private insurer would likely have better information than SSA about the claimant's ability to earn above the SGA level.

The private insurer would also administer SSDI benefit payments; those workers who are eligible for payments would receive a single payment that reflects the combined benefit amount, and SSA would reimburse the insurer for the public portion of the benefit. The private insurer would be responsible for adjusting payments when the beneficiary's circumstances change, and for conducting continuing disability reviews.

It needs to be emphasized that workers with private coverage would maintain their public insurance; i.e., they would not have their SSDI coverage replaced by fully private coverage. They and their employers would continue to pay payroll taxes, and those taxes would continue to accrue to the trust funds and determine the size of their SSDI benefits if they are determined to be eligible. If a worker changes jobs or the employer changes or drops private disability benefits, the public benefit would remain intact, just as it does now. What is different is the administration of the initial determination and payment of benefits, which would now be fully integrated with the administration of initial determination and payment of the private insurance benefit. SSA would pay private insurers to administer current SSDI rules, rather than the States, but the rules themselves would not change. In a well designed system payments to private insurers would at a minimum have to be less than the combined savings from reduced SSA administrative expenses,

reduced growth in SSDI benefit payments, reduced Medicare expenditures, increased payroll tax revenues, and increased federal and state income tax payments.

Potentially, private administration of SSDI could be expanded to cover all workers, including those with no private coverage. In essence, private insurers or other qualified private entities would compete with each other and SSA to offer SSDI administration services to workers and their employers, in a manner that is conceptually similar to competition between employment networks and state vocational rehabilitation agencies to provide employment services to SSDI and SSI disability beneficiaries under Ticket-to-Work (TTW). The payment and regulatory features of such a system would presumably be quite different than those for TTW. Such a system might gain political support if it is first demonstrated that private disability insurers can effectively administer SSDI benefits for their own claimants.

Private insurers and other qualified entities might also become the cornerstone of a system in which SSDI is essentially preserved for those who truly cannot contribute substantially to their own support (possibly without the problematic SSDI work incentives), and a separate program designed to provide supports for those who can. MacDonald and O'Neil (2006) refer to the revamped SSDI program as Earnings Replacement Insurance (ERI) and the new program as Employment Support Insurance (ESI). Similarly, the Social Security Advisory Board (2006b) has called for a public support system under which workers with disabilities would be assessed and then directed toward either SSDI or an alternative program that is designed to help them return to work.

Such approaches to public system restructuring require an entity to conduct assessments, help the worker enter the appropriate program, and continue to administer and update the worker's benefits as the worker's circumstances change. That function could potentially be

conducted by qualified private entities operating under a payment and oversight system that would promote public policy objectives. These entities would have to establish links to workers and their employers before disability onset occurs, similar to those already established by private disability insurers and disability management vendors. Such links provide the opportunity to intervene early, help maintain the connection between the employer and the worker, and make it feasible to design and implement tailored work supports that benefit both the worker and the employer.

A “Ticket to Stay at Work” program. Under the final approach we consider, the government would pay private disability insurers for the results it wants to achieve for claimants who would qualify for SSDI, namely return-to-work and no entry into SSDI. This could be accomplished through a conceptually simple extension of the current TTW program. TTW provides performance-based vouchers that eligible beneficiaries can assign to qualified providers, known as “employment networks” (ENs). SSA pays the EN on the basis of earnings achieved, with full payment made only if the beneficiary earns enough to stay off the rolls for a full 60 months.²⁶

Under a Ticket-to-Stay-at-Work (TSW) program, the private insurer would identify short- or long-term claimants who would qualify for SSDI if their earnings were below SGA. With the consent of the claimant, the insurer would identify the claimant to SSA, and SSA would make monthly payments to the insurer to keep the individual at work. The insurer could use these funds in a variety of ways, including, in some instances, passing them directly to the employer or employee. If the claimant later applied for SSDI, and SSA became liable for benefits in some of the months for which it had made payments to the insurer, the insurer would be required to refund the Ticket payments for those months. SSA would also need to audit the

medical evidence presented by the insurer for a random sample of cases, and reduce payments to the insurer in proportion to the audited cases with insufficient evidence. If the private claimant eventually files an SSDI application, SSA could base its initial determination on an audit of the medical evidence provided by the private insurer, perhaps substantially reducing SSA's disability determination costs. Early Ticket payment amounts could also be tied to performance measures, such as claimant satisfaction and estimated SSDI benefit savings.

TSW seems likely to achieve more immediate success than TTW, because potential "participants" – in this case, private insurance claimants – remain attached to their employers and are already being identified and served by their "employment network" – in this case the private disability insurer in collaboration with the claimant's employer.

Employers that do not offer private disability insurance as an employee benefit could nonetheless participate in TSW, through engagement of a private insurer or other qualified vendor for just this purpose. Private insurers or disability management vendors could potentially offer a new product that is built around TSW – just as private disability insurance is currently built around SSDI.

Conclusion

The three approaches we have outlined for leveraging private sector capabilities to improve public disability programs, especially SSDI, have various strengths and limitations relative to one another. Details need to be discussed, developed, and analyzed, and any such program would merit significant testing before it is rolled out. A poorly designed and implemented system could be very harmful to the target population and/or accelerate, rather than slow, public expenditures for disability benefits.

In comparison to an entirely new public benefit, such as that to be tested under the Benefit Offset National Demonstration²⁷, it seems that such a program could be tested relatively quickly. A test that focuses on workers who have private coverage might be a logical first step, because such a test would primarily involve a change in the financing of services that are already provided by private insurers to the target population and their employers; changes to the services themselves would only be incremental. Early successes in such a test would build support for expansion to a system that is available to all workers and employers.

Among the issues that need to be addressed in the design and testing of any such system are:

- Protection of worker rights – will the system adequately protect worker rights without excessively costly litigation?
- Impact on government expenditures for disability benefits – will the system reduce growth in expenditures and sufficiently ensure that those who receive benefits are those who qualify?
- Complexity – will the system be too complex to understand and administer?
- Breadth of the target population – is it feasible to apply the approach to all workers, or just certain groups (e.g., workers with private disability coverage via their employer)?
- Worker choice, control and responsibility – to what extent will the system provide workers with meaningful options, support their ability to direct their own lives, and hold them responsible for their actions?
- Burden on employers – does the system impose new costs on employers that are not justified by any benefits that are likely to accrue to employers?

- Balance between investment in return-to-work and income support – will the system lead to too large a swing from a system that emphasizes the latter to one that emphasizes the former?
- The willingness of employers to hire people with disabilities – is the system likely to discourage or encourage such hiring?
- Adverse incentives – does the system create opportunities for insurers and employers to profit through undesirable behaviors?
- Redistribution of disability costs – does the system substantially transfer disability costs across industries, employers, or workers in desirable or undesirable ways?
- Political acceptability – will the system receive sufficient political support to permit implementation?
- Political stability – over time, is the system likely to be undermined because of the competing interests of various stakeholders?

At this point, none of the approaches we have outlined should be considered viable, because these issues have not been adequately explored. All are worthy of further consideration, however. Perhaps one or more can be developed, tested and implemented in time to mitigate the impending crisis for working-age people with disabilities and the public programs that serve them. More fundamentally, pursuit of these approaches might lead to a quantum leap forward in the transformation of the public disability support system, from one that discourages work and encourages dependency, toward one that offers better opportunities for people with disabilities to be self-sufficient and share in the fruits of the economy.

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¹ SSDI is the disability component of Social Security benefits. Workers who have had a sufficient earnings history and are determined unable to earn more than a low monthly amount because of a physical or mental impairment are eligible for benefits after a 5-month waiting period. After an additional 24-month waiting period, SSDI beneficiaries are automatically eligible for Medicare, the same federal health insurance program that is available to those over age 65. SSI is available to those who meet the SSDI medical eligibility requirements, but whose assets and income (including any SSDI benefit) are very low. Almost all SSI recipients also qualify for Medicaid, the federal-state health insurance program for low-income families and other vulnerable groups.

² See Stapleton et al. (forthcoming) for further description and analysis of the public system.

³ National Council on Compensation Insurance, Inc. (2005).

⁴ JHA (2006), Exhibit B.

⁵ The data summarized here are based on the Current Population Survey (CPS), the Bureau of Labor Statistics survey that is officially used to track the employment and income of the non-institutional population. The disability definition used in the survey, self-reported work limitations, has been heavily criticized (e.g., Hale, 2001), because of its subjectivity, lack of clarity, and sensitivity to the social environment. Burkhauser, Daly, Houtenville and Nargis (2002) and Burkhauser, Houtenville and Wittenburg (2003) have demonstrated, however, that CPS-based employment trends for people with work limitations parallel those based on disability measures that are less sensitive to the environment, from the National Health Interview Survey and the Survey of Income and Program Participation, especially after controlling for the business cycle, as we have done here.

⁶ Further evidence on the relative decline of household incomes for working-age people with disabilities appears in Burkhauser, Houtenville and Rovba (2006a and 2006b)

⁷ Stapleton, Houtenville and Burkhauser (2004) provide a summary of recent statistics on the decline in the employment of people with disabilities. See Houtenville and Burkhauser (2004) and Burkhauser and Stapleton (2004) for further analysis of the reasons for the decline.

⁸ Other analysis of employment rate trends has demonstrated that the decline in employment for those with long-term limitations (reported in each of two interviews, 12 months apart) started in the middle 1980s (Houtenville and Burkhauser, 2004).

⁹ The HRS is a longitudinal survey of older Americans, and their spouses (including those under age 51), conducted by the Survey Research Center at the University of Michigan on behalf of the National Institute of Aging. We examined two of the cohorts followed by the study. The original HRS cohort, consisting of adults born between 1931 and 1941, was first interviewed in 1992, when they were 51 to 61 years old, and then re-interviewed biennially from 1992 to 2004. The second "War Babies" cohort, consisting of adults between the ages of 51 and 61 in 1998, were first interviewed in 1998 and re-interviewed in 2000, 2002, and 2004.

¹⁰ Respondents were included if they were working and did not report a work limitation at their first interview, but did report a work limitation in each of two successive biennial interviews, and were under age 59 when they first

reported a work limitation. Spouses of the respondents were included in the sample if they met all the selection criteria, and a few of these were under age 51 when they first reported a work limitation.

¹¹ The statistics for those with Social Security benefits are necessarily based on the sample observed through six years after onset only. Within each marital status category, for those who obtain benefits the increase in mean Social Security benefits from two years before onset to six years after onset is necessarily much larger than the mean for all workers in the same marital status category, but mean earnings declines for those who obtain benefits are also much larger than for those who do not. In the sample, the mean benefit change (retirement and disability, combined) for the 51 single workers with benefits six years after onset was \$8,792, compared to a mean earnings decline of \$26,334; the corresponding figures for the 163 married workers with benefits six years after onset are \$9,884 and \$29,691.

¹² In addition to private disability insurance and pension income, we counted the change in capital income (for married workers, we counted only half of the increase), the change in income from workers' compensation or unemployment insurance, and other government income.

¹³ The numerator of the calculation for married workers includes half of household capital income, and the workers income from unemployment insurance or workers compensation, pensions or annuities, other private income, SSDI, and SSR.

¹⁴ Tax data are not available for HRS respondents. The effects of differential taxation can, however, be illustrated for the hypothetical "average" single and married workers in our sample (i.e., workers having the average income that we report in each income category) based on 2002 tax law and reasonable assumptions about their households' circumstances. Whereas the average single (married) worker experienced a 27 percent (23 percent) reduction in pre-tax household income as of the sixth post-onset year, we estimate that both experienced only a 15 percent reduction in after-tax household income. We assumed that: all earnings are subject to the full Social Security and Medicare payroll taxes for employees (7.65 percent), all reported Social Security benefits are subject to the rules that exempt part or all of the benefits from taxation, depending on the amount of the household's other income; reported capital income is taxed at the 15 percent capital gains rate; all other income is fully taxable; the single worker had no dependents; the married worker and spouse had no other dependents and filed federal taxes jointly; both used the standard deduction for their filing status; and that state and local income taxes are equal to 5.0 percent of federal taxable income. Note that WC income is not taxable, although UI income is. Pension and annuity income is generally taxable unless original contributions to the plan were taxed.

¹⁵ Although non-income benefits might compensate for the effect of some of these factors on individual and household wellbeing, recent evidence suggests that they only partially do so, at best. She and Livermore (forthcoming) find that adults with disabilities living in low-income households are much more likely to experience material hardship (e.g., go hungry) than those without disabilities in households with comparable income and other characteristics. Extraordinary expenditures might also help account for the substantial reductions in wealth after work limitation onset found by Johnson et al. (2005) in their own analysis of the HRS data – comparable in magnitude to the declines associated with a job layoff, and much larger than those associated with the death of a spouse.

¹⁶ 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.

¹⁷ See Stapleton et al. (forthcoming) for further discussion of these two characteristics of current public programs. See Bound and Burkhauser (1999) for an economic analysis of the public disability programs.

¹⁸ This is the Social Security Administration's substantial gainful activity earnings level for most beneficiaries in 2006. A larger value, \$1,450, applies to blind beneficiaries. The poverty guideline for a family of one is \$817 per month. The federal minimum wage in 2006 was \$5.15 per hour; at that wage rate, monthly earnings based on a 40-hour work week would be \$893. Automatic cost-of-living adjustments apply to each of these amounts except the minimum wage. Source: Social Security Administration (2006).

¹⁹ See Goodman et al. (2007) for a detailed description of fragmentation that people with disabilities face in the health care system.

²⁰ See Thornton et al. (2006), Liu and Ireys (2006), and Goodman and Livermore (2004).

²¹ See Autor and Duggan (2006) for further discussion of the potential for tightening eligibility and reducing benefits.

²² Bureau of Labor Statistics (2006), Table 5.

²³ Experience ratings might be age adjusted, so as not to discourage employers from hiring older workers. Adjustments for other factors deemed exogenous to the behavior of workers and employers might also be warranted.

²⁴ SSDI awards result in transfers of federal payroll tax revenues to state residents, and state politicians have an interest in pleasing their applicant constituents. In addition, an SSDI award can reduce state expenditures if the applicant would otherwise be eligible for benefits from a state or federal-state program (e.g., Transitional Assistance for Needy Families and Medicaid). State SSI supplements and state financial obligations under Medicaid reduce the incentives to allow benefits for low-income applicants who are not already receiving cash or health benefits from the state.

²⁵ See Stapleton and Pugh (2001) for a description and review of these processes and their implications for allowances.

²⁶ See Thornton et al. (2006) for additional details. Most ENs are private entities, but all state vocational rehabilitation agencies also participate in the program.

²⁷ This demonstration will test a work-oriented benefit design that includes: replacement of the “cash cliff” (100 percent reduction in benefits) when earnings equal SGA with payments that will decline gradually for each dollar earned about a specified amount; a special financial account to facilitate benefit administration, provide additional incentives to work, and ensure that participants who do not work for lengthy periods lose their eligibility for the new program; replacement of Ticket to Work by a system that is compatible with the new benefit and allows greater flexibility in beneficiary use of funds; and low-cost options for health insurance that are not currently available to beneficiaries who are not yet eligible for Medicare. Further, qualified applicants can elect to suspend their application and enter a modified version of the benefit.