Testimony before the Ways and Means Human Resources Subcommittee

U.S. House of Representatives

Hearing on "Moving America's Families Forward: Lessons Learned from Other Countries"

Increasing the Market Income of Working-Age People with Disabilities via Work-First Policies

This testimony is based on:

Burkhauser, Richard V., Mary C. Daly, and Nicolas Ziebarth. 2015. "Protecting Working-Age People with Disabilities: Experiences of Four Industrialized Nations." (July) IZA Discussion Paper No. 9186.

Burkhauser, Richard V., Jeff Larrimore and Sean Lyons. "Measuring Health Insurance Benefits: The Case of People with Disabilities." October 2015. NBER Working Paper w21629.

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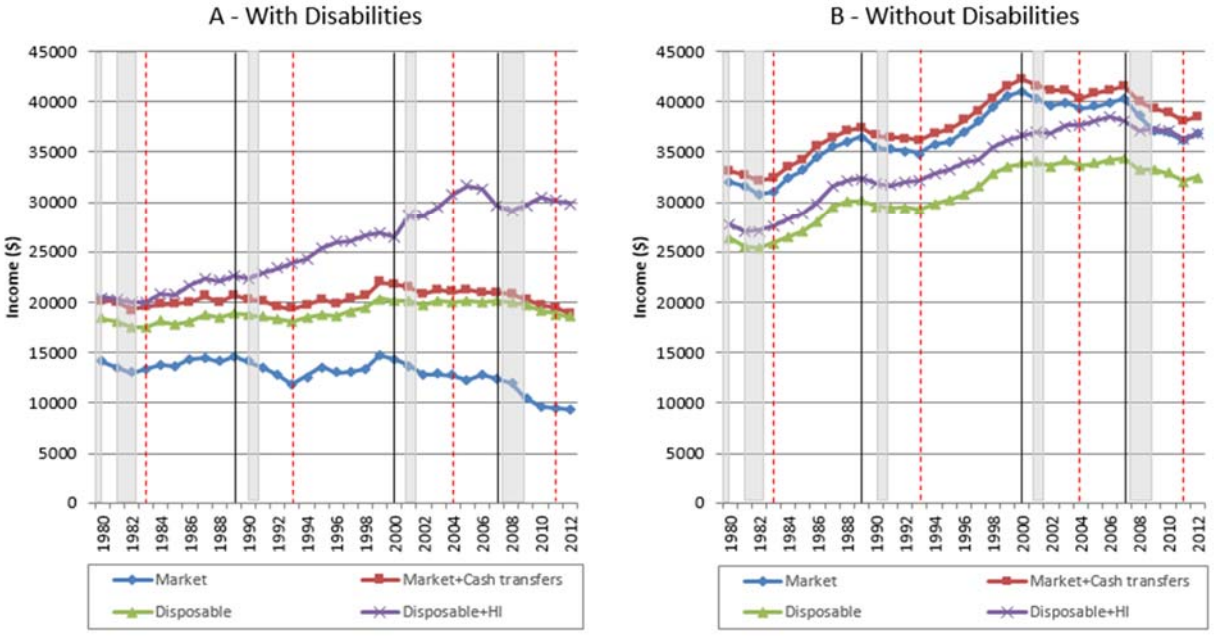
Thank you Chairman Boustany and members of the Human Resources Subcommittee for the opportunity to testify today. My major research areas are: the measurement of income and its distribution, and how public policy, especially OASDHI (Social Security), affects the economic well-being of working-age people with disabilities. My testimony today is based on recent work my co-authors and I have done that links these two research areas.

Figure 1 comes from Burkhauser, Larrimore and Lyons (2015). In it we use data from the Current Population Survey (CPS) to show how the median income of working-age Americans (aged 18-64) with disabilities (Panel A) and without disabilities (Panel B) have changed from 1980, the year work limitation questions were first asked in the CPS, and 2012. All incomes are adjusted to 2010 dollar amounts using the Consumer Price Index Research Series (CPI-U-RS). The numbers reveal the elephant in the room behind the title of today's hearing.

Figure 1. Trends in median size-adjusted income by income definition for working-age people with and without disabilities (1980-2012)



Source: Author's estimation from March CPS data.

Notes: Median household size-adjusted income in 2010 dollars of working-age (18-64) people with and without disabilities by income definition (1980-2012).

Source: Burkhauser, Larrimore, and Lyons (2015).

Median market income, the income that Americans get from labor earnings, rents, dividends, and interest in the marketplace, varies over the business cycle, falling during recessions and their aftermath but then rising with economic growth. Over the business cycles of the 1980s and the 1990s median market income fell and rose but nevertheless grew from one business cycle peak to the other, hitting an all-time high in 2000 for working-age people without disabilities (Panel B). It then fell during the recession of 2001 and its aftermath, rose somewhat over 2004-2007, and then fell dramatically over the Great Recession and the slow economic recovery that has followed. Their median income finally rose slightly in 2012 but remains far below its 2007 pre-Great Recession high.

The news with respect to the median market income of working-age Americans with disabilities is worse. Median market income rose slightly over the 1980s and the 1990s business cycles, hitting a peak in 1999 that was only slightly higher than 1980 and peak year 1989. Thereafter, their median market income has fallen almost continuously every year.

The good news is that government tax and transfer policies are not only counter-cyclical (lowering taxes collected and increasing transfer benefits during recessions and increasing taxes collected and lowering transfer benefits during periods of economic growth) but they have increasingly redistributed market income from the top half of the distribution to the bottom half of the distribution. As can be seen in Figure 1, once government transfers are added to market income (Market+Cash transfers) and taxes subtracted (Disposable income), the falls and rises in median income during the business cycle are reduced and growth in median disposable income of working-age people without disabilities is greater.

Since 2012 the Congressional Budget Office (CBO) has included an estimate of the market value of government-provided health insurance coverage (Medicare and Medicaid) in its measure of household income to more fully identify how government taxes and expenditures (transfers) are distributed across the income distribution. These estimates reflect the additional market price individuals would pay for this health insurance in the private market. A small academic literature shows that the inclusion of the market value of health insurance will primarily affect U.S. income levels but have a smaller effect on their trends except at the bottom tail of the distribution.

As we see in Figure 1 Panel B, when we follow the same CBO methods and include the market value of Medicare, Medicaid, and employer-provided health insurance to our disposable income measure we find that median income of working-age people without disabilities rises, but there is not much difference in its growth and that of disposable income.

But this is not the case for working-age people with disabilities. Past research has identified the drop in market income of working-age people with disabilities seen in Figure 1 Panel A as well as the importance of government transfer (Market+Cash transfers) and taxes (Disposable Income) in offsetting this decline. But previous research has not included the market value of Medicare, Medicaid, and employer-provided health insurance to a disposable income measure as we do here. The results dramatically change not only the level but also the trend in median income of working-age people with disabilities.

To get a sense of how the growing access to Medicare and Medicaid (via entry onto the Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) programs or both) has effected median income, look at the change in median income across the four trough years that describe the three business cycles captured fully in the CPS data (1983-1993), (1993-2004) and (2004-2011).[1] Median market income falls from $13,304 in 1983 to $9,448 in 2011, with most of the decline occurring in the first and third business cycles. Over the three full trough-to-trough business cycles that Panel A captures, median disposable income rose slightly from $17,529 in 1983 to $18,347 in 1993 and $19,989 in 2004 before falling to $18,840 in 2011, for an overall increase of 7.5%. This small rise in income growth was primarily propelled by increases in the share of working-age people with disabilities receiving SSDI benefits, SSI-disabled benefits, or both and the growth in their average real value over this period.

Including the market value of employer- and government-provided health insurance dramatically changes the trajectory of median income for this population. In 1983 there is very little difference between our median

[1] Trough years are defined as the last year in which median size-adjusted market income of all persons falls following a recession—1983, 1993, 2004, and 2011—and peak years are defined as the highest median market income year between these troughs—1989, 2000, and 2007. With the exception of 1983, the median market income trough years follow the official NBER recession ending years—the shaded years in this figure. This is the case, because the major component of market income is labor earnings and it is a lag indicator of business recovery.

disposable income and median disposable income plus health insurance measures. But the substantial increases since then in access to government provided health insurance and in its value to those it covers profoundly increases the gap between these two measures of income. Using our most complete measure of income we find that the economic resources available to the median working-age person with disabilities have grown substantially over the past 30 years. Over the entire three-business-cycle period (1983-2011), median disposable income plus health insurance increased by 51% from $19,978 to $30,137.

Again the good news is that once fully counted, the declines in median market income of working-age people with disabilities have been profoundly offset by the combined benefits of SSDI, SSI-disabled benefits, as well as Medicare and Medicaid.

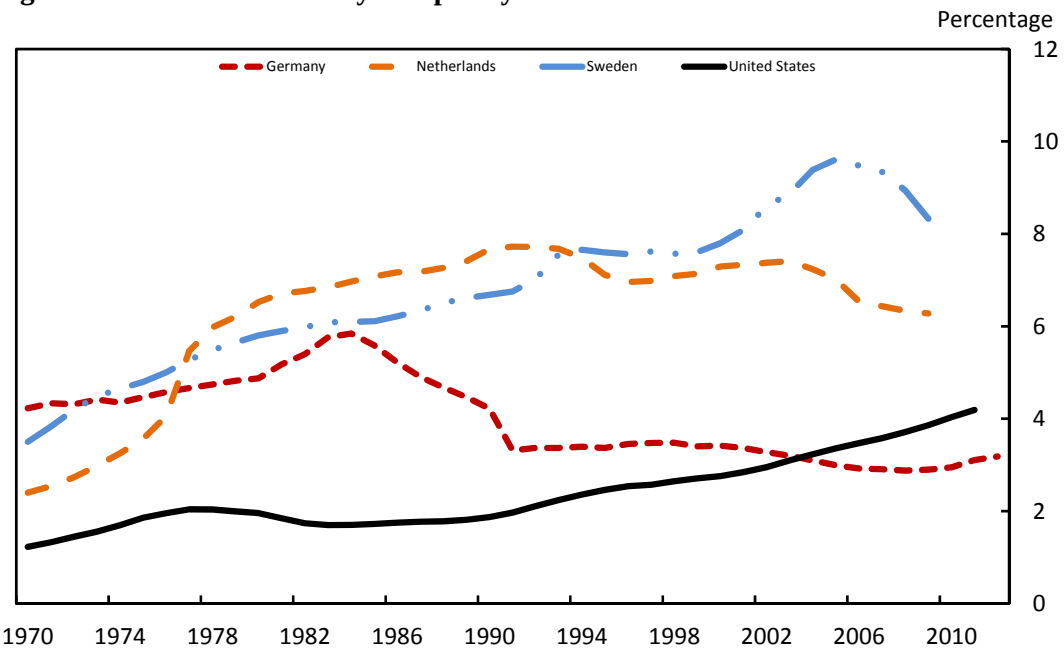
But the bad news is that access to these programs all require that the beneficiaries demonstrate they are unable to perform any substantial gainful activity in the marketplace. Only then are those who gain SSDI and/or SSI program benefits provided with systematic incentives to work via access to rehabilitation. Such a process can mean a long time gap from the point a worker first experiences the onset of a work limitation that affects his or her ability to work in their current job and acceptance onto the disability rolls. This and other flaws in U.S. disability policy are preventing a substantial number of Americans with disabilities from "moving forward," and policymakers interested in them doing so can "learn lessons from other countries." The discussion below is based on Burkhauser, Daly, and Ziebarth (2015).

Moving Americans with Disabilities Forward: Lessons from Other Countries

The number of workers receiving disability-based social insurance has increased substantially in most industrialized nations over the past 40 years. Population growth accounts for part of this increase, but disability caseloads as a share of the working-age population—the disability recipiency rate—also have risen substantially. This can be seen in Figure 2, which shows disability recipiency rates in four countries—Germany, the

Netherlands, Sweden and the United States—beginning in 1970 through the last year of public data in each country.[2]

Figure 2. Growth in Disability Recipiency across Countries



Source: Deutsche Rentenversicherung (2014), Statistisches Bundesamt (2014), Social Security Administration, US Census Bureau; Statisitics Sweden and Swedish Social Insurance Agency yearbooks, Statistics Netherlands, and the Institute of Employee Benefit Schemes

Source: Burkhauser, Daly, and Ziebarth (2015)

In 1970, disability recipiency rates in our three EU nations were considerably higher: 4.2 percent in Germany, 2.4 percent in the Netherlands, and 3.5 percent in Sweden, than they were in the U.S. (1.2 percent). Since then disability recipiency rates have risen substantially in each country with the exception of Germany. However, as the figure highlights, they have done so along significantly different trajectories.

To see these dynamics more clearly, Table 1 provides average annual growth rates in disability recipiency by decade and over the entire sample. As the table shows, disability recipiency rates rose in all countries during the 1970s, with especially rapid growth in the Netherlands and more modest growth in Germany. In contrast, in the 1980s, recipiency rates grew more modestly and even fell in the U.S. and Germany. By the 1990s, growth in the Netherlands and Germany ended and disability recipiency rates, on balance, fell over the decade. During the

[2]The U.S. disability recipiency rate only includes beneficiaries receiving Social Security Disability Insurance (DI). When SSI-disabled adults and DI program beneficiaries are combined, the level of the U.S. disability recipiency rate is higher, but the patterns over time are roughly the same.

2000s, disability recipiency rates continued to fall in the Netherlands and Germany and grew less quickly in Sweden. Growth in the U.S. slowed slightly but remained quite high relative to the EU countries in our sample.

Table 1. Average Annual Growth in Disability Recipiency by Decade and Country

	Germany	Netherlands	Sweden	United States
1970-1979	1.69	11.45	5.49	5.65
1980-1989	-1.79	1.79	1.59	-0.91
1990-1999	-2.30	-0.34	1.44	4.10
2000-Final	-1.61	-1.25	1.00	3.71
1970-Final	-0.93	2.69	2.30	3.10

Source: Social Security Administration, US Census Bureau, , Statistics Sweden and Swedish Social Insurance Agency yearbooks, Statistics Netherlands, German Statutory Pension Insurance, German Federal Statistical Office, and the Institute of Employee Benefit Schemes
1.) See appendix for a summary of data years utilized across countries . 2.) Average is computed as the average year over year percent change in the recipiency rate within the given time period. For missing data a standard linear interpolation is used .

Source: Burkhauser, Daly, and Ziebarth (2015)

The final average (1970-final) shows that smoothing through the fluctuations in growth that have occurred over the decades, the U.S. experienced the highest average annual growth rate over the sample period. The rapid growth in our three EU countries brought on program reforms and a tempering or reversal of the path of disability recipiency. In contrast, with the exception of the 1980s, growth in U.S. disability recipiency has been nearly continuous over the sample period.

What accounts for these trends? Burkhauser, Daly, and Ziebarth (2015) argue that neither changes in underlying health nor in population characteristics can account for all of the cross-country differences in disability recipiency rates, either levels or trends. They then show how changes in disability policy and its implementation in each country are correlated with the dynamics of disability recipiency rates in Figure 2. While their comparative descriptive analysis falls short of establishing a causal effect of policy on the disability rolls, it is suggestive of the potential impact of policy design on the trends in disability benefit receipt across and within these countries.

A systematic look at the policies in place during the disability recipiency growth years in Germany, the Netherlands, and Sweden reveals disability programs focused on providing cash assistance in lieu of full-time work without a careful consideration of the unintended consequences of such a policy. This design was based on

several assumptions: a) People with disabilities are incapable of work; b) It is easy to determine who is and is not disabled; and c) The behavior of individuals, program managers, and employers is not affected by program rules/incentives.

For instance, in both Germany and the Netherlands those with only partial disabilities who were unemployed were admitted onto the disability rolls with full benefits. This mission creep increasingly made their disability programs "unemployability" programs and resulted in very rapid increases in recipiency rates as these assumptions proved to be incorrect.

The single most important factor in reducing recipiency rates in all three countries was a shift to work-first policies that slowed the movement of disabled workers onto the rolls by insuring that accommodation and rehabilitation were explored before workers were even considered for long-term disability transfer benefits. This was done in Germany by substantially increasing the bar for entry onto the public disability program and reducing benefits—but also by requiring employers to implement a workplace reintegration program. The ratcheting up of the eligibility criteria for government provided disability benefits resulted in major growth in the private disability market. In 2012, 61 percent of employed men and 42 percent of employed women were covered by private disability insurance).[3] Because private disability is experience rated, it encourages workers and employers to look to rehabilitation and accommodation first since they now more directly bear the costs of a movement onto the disability rolls.

In the Netherlands disability eligibility standards were also raised and benefits reduced but an even larger shift to work-first policies took place. Employers are now mandated to provide the first two years of disability benefits to their disabled workers. In addition, employers must demonstrate an effort to provide accommodation and rehabilitation to their workers and their workers must show a willingness to use them. Only when such efforts shown not to be affective are workers allowed to apply for government disability benefits and their employers allowed to stop directly paying their private disability benefits. This change in policy has also resulted in major

[3]Beneficiaries of private disability insurance may also receive government-provided disability benefits if eligible. In contrast, in the U.S. private insurers may reduce payments dollar for dollar for recipients of public SSDI. This means that private insurers in Germany have more of an incentive to return beneficiaries to work than do those in the U.S.

growth in the private disability market and these experience-rated payments further insure that accommodation and rehabilitation are tried before a worker moves onto the disability rolls. Furthermore, even the government run disability program is now financed by experience-rated payments by firms.

In Sweden, despite considerable opposition from various advocacy groups, significant reforms were put into place whose driving principle was that work support, rather than cash assistance in lieu of work, was the primary goal of disability policy. To achieve this, the government merged the sickness benefits and disability systems and began a series of changes to standardize and enforce the administration of these now joint systems. Most notable among them was the centralization of screening processes. This allows policymakers to better regulate the gatekeepers and enforce the strategy of promoting participation in work before offering cash benefits. Employers are also required to work with disability administrators to create a rehabilitation plan. And gatekeepers now have the power to demand that employers prove they provided worker accommodations. Most recently Sweden has established a timeline for the provision of rehabilitation services under the sickness absence program with checkpoints at 3-, 6-, and 12-month increments to align assessment of work capacity and a reduction of the cash value of sickness benefits for those who did not return to work.

What lesson can the U.S. learn from these experiences? An important issue that policymakers face in all countries facing the challenges of providing protection for workers with disabilities is that, disability programs, even if not generous, are essential income for many individuals. In the U.S. where other components of the social safety net are weaker or less generous, disability benefit programs are even more difficult to challenge.

However, the policy outcomes of Germany, the Netherlands, and Sweden show this is a very static view which assumes that in the absence of benefits, individuals with disabilities would remain out of the labor market, dependent on other forms of public or private assistance for support. Disability reforms in these countries over the last decade provide suggestive empirical support that increased employment will occur when pro-work policies replace policies that have had the opposite effect. Their reform experience shows that a significant number of people with disabilities, who would otherwise have moved onto long-term cash benefits, were able, with reasonable levels of support, to return to work. While it is always the case that tightening the criteria for disability benefits runs the risk of denying disability benefits to those who will not be able to find work, on balance the EU

experience suggests that reasonable pro-work policies will both substantially reduce disability recipiency rates and increase the employment of those who would otherwise have been on the long-term disability rolls.

Another concern is that programs like disability insurance are especially important in economic downturns where individuals with limited work capacity are not only more likely to be laid off but less likely to find a new job. Past experience of EU countries, especially Germany and the Netherlands, which intentionally or unintentionally used this logic to turn their long-term disability programs into more general unemployment programs, suggests that it can be a very expensive and ultimately ineffective policy decision. Indeed, many EU nations continue to struggle to regain control over their disability systems which for many decades have been used as long-term unemployment insurance programs. A key message from the EU experience is that explicitly divorcing long-term "unemployability" insurance from disability insurance is critical to effectively targeting resources towards both populations.

Together the experiences of other nations suggest that it is possible to balance the competing goals of providing social insurance against adverse health shocks during working-age and maximizing the work effort of all working-age adults with and without disabilities. Past disability policies in both the United States and EU countries have focused more on the former than the latter, resulting in rapid growth in disability transfer populations that outpaced growth in the economy. Efforts to shift to more pro-work policies over the last decade in Europe suggest that fundamental disability reforms, if done well, can lower projected long-term costs for taxpayers, make the job of disability administrators less difficult, and importantly, improve the short- and long-run opportunities of Americans with disabilities to work.