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Statement by

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Reforming Social Security Disability Insurance: Lessons from European Nations

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THE STATE OF THE SSDI PROGRAM

The Social Security Disability Insurance (DI) program is growing at an unsustainable pace. Over the past 40 years the number of disabled worker beneficiaries has increased nearly six-fold, rising from 1.5 million in 1970 to 8.8 million in 2012. This rapid growth has put increasing pressure on program finances. Since 1970 real DI expenditures have risen from $14 billion to $127 billion (in 2012 dollars).[1] Based on current growth, the DI program is projected to be insolvent by 2016 (Social Security Administration, 2013).

WHY HAVE CASELOADS RISEN?

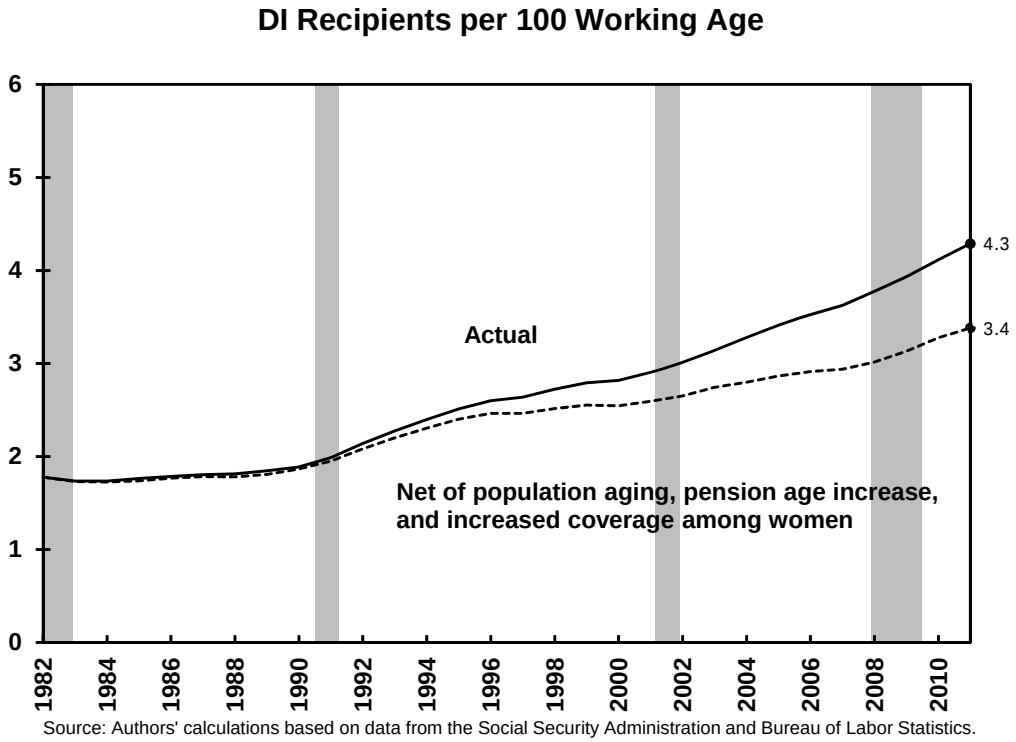
Eligibility for DI benefits requires applicants to be "unable to perform any substantial gainful activity on any job in the economy for at least one year." In principle, this criterion is quite strict and was meant to make DI a last resort program for those with permanent and total impairments.

Although the words describing eligibility criteria have not changed over time, implementation has, and in a direction that has increased the number of working-age adults receiving disability benefits. Figure 1 shows growth in the DI program from 1982 through 2011 as a share of the working age population.[2] The shaded years represent official U.S. recession periods as denoted by the National Bureau of Economic Research.

[1]Nominal values converted to real dollars using the CPI (Consumer Price Index-All Urban Consumers. U.S. All Items, 1982-84=100 – CUUR0000SA0).

[2]The definition of working age used by the OECD is 16-64. We adopt this definition to allow comparisons between the U.S. and other OECD nations.

Figure 1. DI Caseload Growth 1982-2011



Source: Authors' calculations based on data from the Social Security Administration and Bureau of Labor Statistics.

The upper line of Figure 1 shows that in 1982, 1.73 percent of the population aged 16-64 received DI benefits. By 2011, this percentage had reached 4.28 percent. Some of the growth since 1982 is beyond the control of the DI program. The aging of the workforce, the increase in eligibility age for OAI retirement benefits from 65 to 66 (and hence an additional year on the DI program for beneficiaries before they are automatically shifted to the OAI retirement program), and the rise in the employment rate of women and associated increase in DI coverage all drove up disability recipiency among the working age population.

But as the lower line in Figure 1 shows, controlling for these exogenous factors does not completely explain the increase.[3] The adjusted lower line shows that, even when controlling for these factors, growth is still considerable—a near doubling of the 1982 DI population ratio to 3.38 percent, with the fastest growth coming since 2007. All together, about two-thirds of the

[3]See Daly, Lucking, and Schwabish (forthcoming) for details of this calculation.

growth in DI recipiency in the working-age population can't be explained by factors outside the program's control.[4]

Autor and Duggan (2010) and Burkhauser and Daly (2011) argue that this residual growth in DI recipiency is not explained by changes in the underlying health of the working-age population or in the percentage of that population with work-limiting impairments. Rather, they find that the easing of eligibility rules, a greater willingness of disability program gatekeepers to accept applicants based on these new standards, and the growing tendency of low-skilled and unemployed workers to apply for and gain entry onto the DI rolls primarily contributed to the rise.

As evidence, these authors show that the fastest growth in new beneficiaries comes from: 1) increases in medical listing categories that are the most difficult to objectively measure—muscular skeleton (back pain) and mental illness; 2) increases among those who have an impairment that is not sufficient in itself to gain entry but who do so based on vocational characteristics—older age, lower education, manual work history; 3) increases among those who qualify only after being denied benefits at the initial level of review. In addition, recent evidence by Maestas, Mullen and Strand (forthcoming) show that the outcome of the eligibility determination of 23 percent of those evaluated for the DI program was decided by whether the evaluator was a strict or less strict interpreter of the evaluation criteria.

Importantly, the stage for many of these trends was set in the mid-1980s with an easing of eligibility standards. But due in part to a strong economy, the easing resulted in only small increases in the rolls during the second half of that decade. When the next recession hit in the early 1990s, movement onto the disability rolls accelerated substantially. In the boom years of

[4]Daly, Lucking and Schwabish (forthcoming) show that setting women's disability recipiency rates to those of men in 1982 adds another 13 percent to estimates of the impact of women's increased eligibility. Adding this term reduces the unexplained portion of DI growth since 1982 to one-half.

the second half of the 1990s through the early years of the next decade, growth slowed somewhat but increased again after the Great Recession. Since those who go onto cash disability programs rarely return to the labor market, even temporary increases in program inflows can lead to fiscally unsustainable program growth.

These trends are symptomatic of categorical disability programs whose beneficiaries are increasingly coming from a pool of unemployed workers with some level of work limitations, but who, under a different set of disability policies, could work and did so before 1990. They underscore the contradictions of current DI policy and the transformation of the DI program from a last-resort cash income program for those not able to hold any substantial gainful employment to a long-term unemployment program.

ECONOMIC AND SOCIAL COSTS ASSOCIATED WITH RISING DI CASELOADS

The changes in program incentives and the growth in the disability transfer rolls these changes have produced have real economic and social costs. First, by predicating disability benefits and support on demonstrating an inability to work, the system encourages individuals with health-based impairments not to work in order to qualify for benefits. Since average benefits are lower than average wages and reentering the labor market after the absence required to receive benefits is generally difficult, this choice has real economic consequences for decision makers. Second, by expanding disability cash-transfer programs while other nonwork transfer programs (such as welfare) have been declining, the system unintentionally increased the relative value of moving onto the disability rolls, even for those who might otherwise choose to work. This, in turn, has increased the administrative burden associated with determining which applicants qualify for benefits and which do not, ultimately boosting costs for taxpayers relative to other program designs. Finally, abstracting from the individual and social costs of the

programs, the focus on cash assistance in lieu of earnings ignores the value of work itself. Work links individuals to the economy and to the returns of economic growth. Work also connects individuals socially and culturally, which is a goal of advocates for those with disabilities. Importantly, work is also a social expectation. Not working generally comes with a cost. It's a serious matter to leave the work force and should generally happen only with an ongoing cause. The value of work—both to individuals and to the society that depends on everyone's productive effort—suggests that work, rather than benefits, should be the primary means for assisting and insuring people with disabilities and those who have experienced negative economic shocks.

These costs, as well as the financial burdens they place on taxpayers, are more worrisome when put in the context of the broader goals of the DI program to protect the economic well-being of people with disabilities. Since the passage of the Americans with Disabilities Act of 1990 (ADA), the employment of those with disabilities has declined considerably and their household income has remained flat. Increasingly, people with disabilities are substituting DI benefits for labor-market earnings, making them net withdrawers rather than net contributors to the tax base during their working age. This outcome threatens the finances of the DI program and is at odds with the view of disability codified in the ADA that people with disabilities should be able to participate more fully in the labor market.

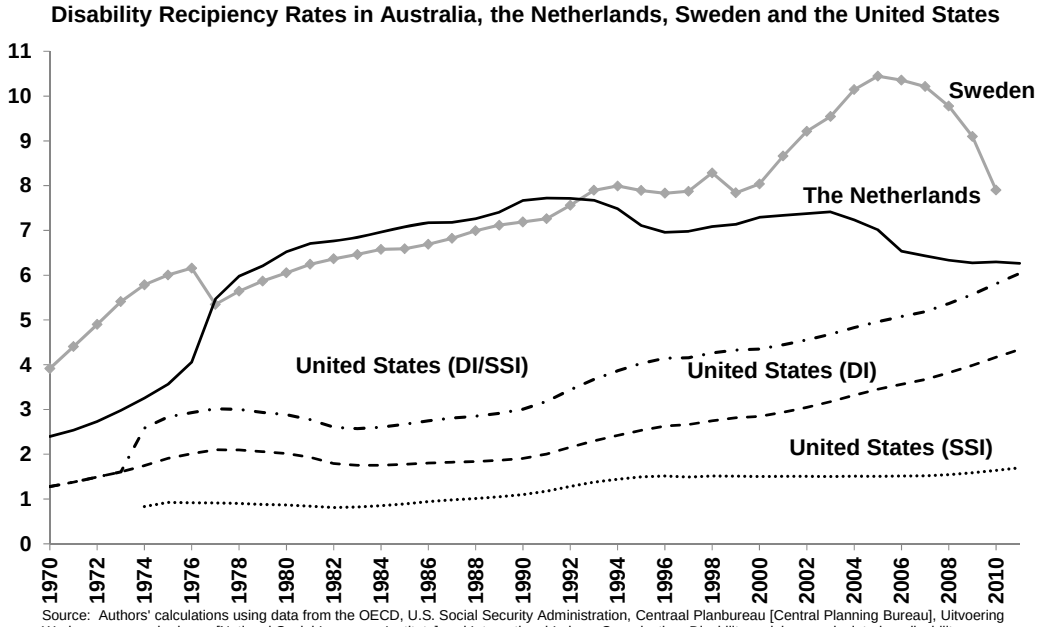
EXPERIENCES IN OTHER NATIONS

The United States is not the first country to experience the trends described here. Many European nations, with more expansive and generous disability systems than we have, experienced rapid and unsustainable growth a decade or more ago and have already begun to

reform their systems to curb caseload growth and costs.[5] The Netherlands and Sweden are useful examples and provide insights into fundamental reforms the U.S. may consider.

To illustrate the challenges in the Netherlands and Sweden and their relevance to the U.S. experience, Figure 2 plots the total number of persons receiving long-term categorical disability income benefits as a share of the working-age population in the three countries. To make comparisons with other countries accurate for the United States, the figure shows the disability rate reported for DI beginning in 1970, (as reported in Figure 1) as well as the rate when combined with Supplemental Security Income for disabled adults (SSI).

Figure 2. Disability Benefit Caseload Growth in the U.S., the Netherlands, and Sweden



Source: Authors' calculations using data from the OECD, U.S. Social Security Administration, Centraal Planbureau [Central Planning Bureau], Uitvoering Werknemersverzekeringen [National Social Insurance Institute] and International Labour Organization. Disability recipiency calculated as disability beneficiaries per working-age adult: 16-64 in Australia and the U.S.; 15-64 in the Netherlands; 20-64 in Sweden.

Note first that the difference in levels and trends across countries cannot be explained by health or demographics. Rather they reflect deliberate policy choices. In Sweden and the Netherlands, disability programs replace a much greater share of past earnings for workers who

[5]For a detailed review of the European experience see OECD, 2010.

exit employment due to a work disability. Consequently, the shares of their working-age populations on these categorical transfers programs are greater than in the United States. Moreover, changes in disability eligibility rules and their enforcement played an even larger part in the fluctuations of disability cash transfer populations in the Netherlands and Sweden than in the United States.

In the past decade, the Netherlands and Sweden fundamentally reformed their disability programs by changing the culture and social expectations regarding people with disabilities, better aligning the incentives embedded in program design with these expectations, and reducing the flow of new entrants onto the system. From the U.S. perspective, the reforms represent an important success and relevant starting point for discussions about building a sustainable system.

In 2002, the Netherlands reformed undertook fundamental reform designed to reduce the disability cash transfer rolls while ensuring that a strong, albeit less generous, social minimum safety net remained for those who absolutely could not work. The 2002 reforms recognized that disability program rules, the administration of those rules, and the methods established to pay for disability programs greatly influenced the behavior of both employees and employers when a worker became disabled. Recognizing that the existing system did little to signal the true cost to either workers or their employers of moving onto the long-term disability transfer rolls, Dutch policymakers restructured the program so that both employers and employees more directly observed and bore the expense. The results have been notable. As seen in Figure 2, the share of the Dutch workforce receiving disability benefits has declined significantly. This has happened without swelling the rolls of other transfer programs.

The Dutch reforms focused on reducing inflows onto long-term disability benefits by making employers bear more of the direct costs of the program. All Dutch businesses are now

required to fund the first two years of disability benefits to their workers and to pay an experience-rated disability tax based on the number of their workers who move onto the long-term disability insurance program. These reforms provide incentives for employers to offer accommodation and rehabilitation in lieu of moving workers with disabilities onto cash transfer rolls.

The reforms also led to the development of a private-sector market for disability insurance and with it greater management of newly impaired workers. This shift in incentives is partly responsible for the subsequent decline in inflow of new beneficiaries to the Dutch long-term disability insurance program. Importantly, the reduction in inflows reflects that workers with disabilities are more regularly returning to work rather than moving onto other more general cash transfer programs (van Sonsbeek and Gradus 2011; de Jong 2012).

The acknowledgement that program rules affect how people with disabilities react to, and fare after, the onset of a health-based impairment is a necessary step to building a sustainable U.S. disability system. If individuals and employers are immune from the costs of providing long-term disability benefits, they have no direct financial incentive to accommodate and rehabilitate employees who could keep on working. Waiting until individuals are already on DI before engaging the private sector to help them get off loses a valuable opportunity to intervene early and to potentially prevent individuals from moving onto benefits in the first place.

Although both the Netherlands and Sweden reformed their systems when they became financially unsustainable, a key lesson from their reforms is that preventing problems is far easier than solving them once they occur. It is much easier to stem the flow of new beneficiaries onto the program than to return existing beneficiaries to work. This point is highlighted by Sweden's experience. In 2008, the Swedish government undertook a series of reforms to its

sickness and long-term disability programs to reduce the number of workers leaving the labor force for permanent disability benefits and return existing beneficiaries to the labor market.

Reforms were aimed at strengthening the incentives for individuals with disabilities to work and improving their opportunities to do so. The key reform was a new timeline for the provision of rehabilitation services under the sickness absence program. Checkpoints were closely aligned with assessment of work capacity and a reduction of the cash value of sickness benefits for those who did not return to work. In addition to adding more checkpoints, the reforms also front-loaded evaluations to do them at 3-, 6-, and 12-month increments. The earlier checkpoints provided rehabilitation, counseling and assessment much closer to the onset of an impairment, when return to work was more likely.

The reforms significantly increased the return to work of new sickness program entrants and reduced their time on the program. In contrast, few of those already on the sickness program when these new reforms were initiated returned to work. When sickness benefits ended, they simply moved onto other social assistance programs. These findings provide empirical evidence that early intervention matters. Waiting even one year following the onset of impairment significantly reduces the chance that rehabilitation will result in a return to work.

The Swedish experience also highlights the difficulties in reducing the stock of disabled beneficiaries. Even when strict time limits are put in place, movement off the disability system for longer-duration beneficiaries is difficult. And when it happens, most frequently it results in a shift to another public program rather than to employment.

A final lesson learned from the Dutch and Swedish experience is that disability programs are a subset of more general employment and transfer programs. Reforms to one program can affect the costs and caseloads of others. This means that policy reforms cannot take place in partial

equilibrium, but must be made comprehensively as part of a package of programs targeted on working-age adults. As European nations have demonstrated, doing otherwise pushes off, but does not solve, the long-term fiscal challenges of non-employment among working age adults.

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