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ENSURING SUCCESS FOR THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM AND ITS BENEFICIARIES

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BEFORE THE

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JOINT ECONOMIC COMMITTEE

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CONTENTS

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WEDNESDAY, NOVEMBER 4, 2015

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to call, at 2:31 p.m. in Room 106 of the Dirksen Senate Office Building, the Honorable Daniel Coats, Chairman, presiding.

Representatives present: Paulsen, Schweikert, Grothman, Maloney, Delaney, Adams, and Beyer.

Senators present: Coats, Lee, Cotton, Cassidy, Klobuchar, and Heinrich.

Staff present: Connie Foster, Harry Gural, Paige Hanson, Colleen Healy, Kristine Michalson, Viraj Mirani, Brian Neale, Thomas Nicholas, Brian Phillips, Stephanie Salomon, and Aaron Smith.

OPENING STATEMENT OF HON. DANIEL COATS, CHAIRMAN, A U.S. SENATOR FROM INDIANA

Chairman Coats. The Committee will come to order. We are delaying here just a bit. I'm just saying I feel like the referee at an NFL game waiting for the signal from my staffer who is on the phone with the House.

We have to obviously set these meeting schedules with some advance notice in time and lock them in. It just unfortunately happens that the House seems to be teeing off its voting schedule at the same time we hold these meetings.

So we are trying to see where they are. We know several Members will be coming over from the House and joining us, but I think we ought to get started. We can go through some of the opening statements.

As I speak, Members are arriving.

I would like to thank Senator Cotton here, first, for asking the Committee to take up and see how we can improve the Social Security Disability Program. Following the Ranking Member's opening statement, after mine, if she arrives, I am going to call on Senator Cotton to also deliver a brief opening statement. And then we will go back to Regular Order and recognize individuals on a bicameral bipartisan basis.

The SSDI Program was originally created as a safety net for primarily older workers whose disabilities prevented them from working. In subsequent decades, we have witnessed an expansion of the

program eligibility accompanied by a sharp increase in the number of claimants.

As of today, nearly 9 million Americans receive Social Security Disability Insurance benefits, including almost 5 percent of working age adults. In total, SSDI accounts for about 15 percent of benefits paid through the Social Security Administration.

Interestingly enough, 1.3 million of those beneficiaries are under the age of 40—not the original intent I think of the program, but one example of how the program has been expanded.

While the SSDI Program was originally crafted to maintain the principles of rehabilitation and return to work, statistics show that this rarely happens today; and the program's underlying structure disincentives provide disincentives for many from working.

The Bipartisan Budget Act passed by Congress last week did take some steps toward improved SSDI Program operations. For instance, the SSDI Program will begin to test an alternative to the program's current disincentives to work. Let's hope that test program shows some positive results and can help us in putting permanent provisions in place that give us more efficiency and effectiveness of this program.

The bill that we passed also includes program integrity reforms such as enhancing fraud enforcement and deterrence measures, as well as requiring regular case reviews to confirm claimant eligibility.

So it is a start to correct a disturbing and ever-growing problem with SSDI. And while these actions are useful, they do not address the long-term solvency questions facing this program.

As a result, last week's budget agreement only temporarily shored up the program by redirecting funds from the Old Age and Survivors' Trust Fund. Robbing Peter to pay Paul is hardly the way to address a fiscal issue, especially when the Old Age and Survivors' Trust Fund is also headed toward the very same financial insolvency problems as SSDI, even though that may be years down the road.

Today we want to examine how we can achieve a more efficient and a more effective Social Security Disability Insurance Program. We hope to learn about measures to assist the successful transition of individuals to the workplace which impacts their personal well being as well as the fiscal sustainability of the program.

We must also ask how current administrative processes can be reformed. The current SSDI program review and appeal system is burdened by a backlog of increases, risk of fraud, and slow awards of benefits to individuals who need them.

The SSDI Program is also plagued with improper payments. Just last week, the Government Accountability Office revealed at least $11 billion in overpayments over the last 10 years.

The Social Security Administration Inspector General, who is here with us today, found in June that 44.5 percent of sampled claimants received an overpayment.

The waste, fraud, and abuse of SSDI is unacceptable. Yet another mismanaged and failing federal program. There is clearly much work to be done to improve the administration of this program and protect taxpayers' dollars from being wasted through fraud and abuse.

I want to welcome our witnesses and thank them for being here today to discuss how we can address all these issues, and leave hopefully with a better understanding of steps we should consider to improve the SSDI program for both current and future claimants.

I now would like to recognize Senator Cotton for his statement, and then we will resume with the introduction of the witnesses and allow you to go forward with your testimony.

Senator Cotton. Thank you, Mr. Chairman, and thank you to our witnesses for your appearance today.

The Social Security Disability Program is critical to Arkansas, as my State has some of the highest rates of disability in the Nation.

I want to focus on how we can help improve this program by helping those who can recover return to work.

Social Security Disability is open to applicants with temporary disabilities. Disability judges estimate between 15 and 30 percent of beneficiaries should recover, but almost no one exits the program anymore.

In the 1980s, up to 6 percent of beneficiaries returned to work every year. Now it is less than one-half of one percent. The odds of a disability recipient returning to work today are about the same as playing roulette and hitting black eight times in a row.

There is nothing compassionate, in my opinion, about condemning someone who can recover to a lifetime of disability status and poverty-level income. I intend to introduce legislation to fix this problem.

In my bill, those eligible for disability but expected to recover can receive rehabilitation training and can earn wages while on the disability program. After a few years, this group can exit the program and return to work, or reapply if still disabled.

Increasing the return-to-work rate by even one percentage point will save hundreds of billions of dollars over time. Also, fewer people will receive benefits, more people will pay into the benefit program, and more people will benefit from the dignity of work.

It is time to reform the Social Security Disability Program to help those who can recover, and to protect those who cannot.

I am looking forward to discussing these issues with our panel today. Thank you all for joining us, and thank you again, Mr. Chairman.

Chairman Coats. Thank you. I would like to introduce briefly our witnesses.

Mr. Patrick O'Carroll, Jr., currently serves as the Inspector General for the Social Security Administration, having been appointed on November 24, 2004. Mr. O'Carroll received a Bachelor of Science from Mount St. Mary's College and a Master of Forensic Sciences from George Washington University. He also attended the National Cryptologic School and the Kennedy School at Harvard University.

Dr. Mark Duggan is the Trione Director of the Stanford Institute for Economic Policy Research, and the Wayne and Jodi Cooperman Professor of Economics at Stanford University. He is a research associate at the National Bureau of Economic Research, and serves on the Editorial Board of the American Economic Journal. Dr. Duggan received his BS and MS degrees in Electrical Engineering

at the Massachusetts Institute of Technology, and his Ph.D. in Economics from Harvard.

Ms. Rebecca Vallas—is that correctly pronounced?

Ms. Vallas. Val-las.

Chairman Coats. Vallas—I'm one for three on this. I apologize. [Laughter.]

Ms. Vallas is Director of Policy Research for the Poverty to Prosperity Program at the Center for American Progress. Before joining the Center for American Progress she served as Deputy Director of Government Affairs at the National Organization of Social Security Claimants' Representatives. Ms. Vallas received her Bachelor's Degree from Emory University and her Law Degree from the University of Virginia.

I welcome our witnesses, and I think we will just go in the order of introduction. We look forward to hearing your testimony. If you can confine it roughly to the five-minute rule, it gives us, my colleagues here and I, a better opportunity to enter into a dialogue and address questions.

Mr. O'Carroll.

[The prepared statement of Chairman Coats appears in the Submissions for the Record on page 36.]

STATEMENT OF MR. PATRICK O'CARROLL, JR., INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION, WASHINGTON, DC

Mr. O'Carroll. Good afternoon, Chairman Coats and Members of the Joint Committee.

Thank you for the invitation to testify today. Last year SSA provided about $144 billion in Disability Insurance, or DI, to about 11 million people. However, there is much more to the story of the DI Program than just those numbers.

Given the importance of the safety net for millions of people who depend on it, SSA must ensure the integrity of this critical program. The Agency can do this by continuing efforts to improve service to its beneficiaries and stewardship over taxpayer funds.

My written statement includes many of our recommendations for how we believe SSA can best achieve these goals. These recommendations can be summed up in three main points, as I will explain.

The first point: DI Program policy is complex and should be modernized to reflect medical advances and the current occupational environment. For example, some of SSA's listings of impairments which are used to ensure that disability decisions are medically sound have not been updated in many years.

Without regular updates, the listings lose their effectiveness as a screening tool. The Dictionary of Occupational Titles is outdated and should be replaced. SSA needs occupational data tailored for its disability programs.

When SSA learns a beneficiary has work activity, stopping benefits is difficult and time-consuming. Simplifying these policies could have a positive effect.

And on return-to-work efforts, SSA should develop specific goals and analyze costs and benefits to assess these projects.

The second point: SSA must continue efforts to make timely and accurate claims decisions. On average, disability claimants will wait more than 100 days for an initial decision on their claim. If they appeal, they will wait about 500 more days for a hearing.

Additionally, SSA's level of pending initial claims stands at about 620,000, while more than 1 million claimants are awaiting a hearing. We have paid close attention to SSA's efforts to reduce wait times and pending levels.

At the initial level, SSA should refine policies and procedures to improve efficiency through automation. It should reduce processing time and make accurate and consistent decisions.

And at the hearing level, SSA should continue to expand the use of the video hearings, emphasize quality decision-making, and ensure timely decisions.

The third and final point: SSA should regularly review beneficiary information to ensure that people remain eligible for DI payments. SSA does this through continuing disability reviews, or CDRs. For many years we've identified medical CDRs as a highly effective guard against paying benefits to people who no longer are disabled according to SSA's Guidelines.

Medical CDRs provide a 9-to-1 return on investment, according to SSA. Although the Agency completed almost 800,000 CDRs last year, a backlog of 726,000 remains.

SSA also performs work CDRs to review beneficiary earnings and prevent overpayments. A change in federal wage reporting processes for employers from annual to quarterly would identify substantial gainful activity more quickly.

Also, SSA can improve payment accuracy by verifying self-reported information about wages or other benefits, such as Worker's Compensation or government pensions.

We have recommended that SSA pursue data-matching agreements with other government agencies to obtain such claimant data.

Finally, improving the DI program is a multi-faceted challenge for SSA. It is critical that Congress and SSA continue to focus on the program's management and long-term sustainability. My office has long held that SSA must strike that critical balance between service and stewardship.

I appreciate your interest in improving the DI program. We look forward to collaborating with SSA and our oversight committees on the best ways to do this effectively.

Thank you again for the invitation to testify, and I will be happy to answer any questions.

[The prepared statement of Mr. O'Carroll appears in the Submissions for the Record on page 90.]

Chairman Coats. Well thank you. Thank you for a succinct presentation here, and we will look forward to getting into the details of what you have described.

Dr. Duggan.

STATEMENT OF DR. MARK DUGGAN, THE TRIONE DIRECTOR OF THE STANFORD INSTITUTE FOR ECONOMIC POLICY RESEARCH, AND THE WAYNE AND JODI COOPERMAN PROFESSOR OF ECONOMICS, STANFORD UNIVERSITY, STANFORD, CA

Dr. Duggan. Chairman Coats and Members of the Committee, it is an honor to be here with you today.

My name is Mark Duggan. I am the Wayne and Jodi Cooperman Professor of Economics at Stanford University, and the Trione Director of the Stanford Institute for Economic Policy Research.

The SSDI Program represents an extremely important part of our Nation's safety net, as it protects workers and their families from the risk of disability that prevents or greatly inhibits a person's ability to work.

I show in the first figure in my testimony enrollment in the SSDI Program grew steadily from the mid-1980s until the present day, with 2.2 percent of adults aged 25 to 64 receiving SSDI benefits in 1985, rising to 5.0 percent by 2014.

In my testimony today I will briefly summarize the factors that are responsible for the growth in SSDI enrollments since the mid-1980s. I will then discuss some of the implications of this growth for the U.S. labor market. And finally, I will conclude by discussing the potential for changes to SSDI to increased employment and economic well being among individuals with disabilities.

One contributor to the growth in SSDI enrollment since the mid-1980s has been the aging of the Baby Boom Generation. Individuals in their 50s and early 60s are significantly more likely to receive SSDI benefits than their counterparts in their 30s and 40s.

However, as the first table in my testimony demonstrates, the percentage of adults receiving SSDI has risen sharply even within age groups. Consider adults in their 50s.

In 1989 4.3 percent of adults in this age group were receiving SSDI benefits. By 2014, this had almost doubled to 8.3 percent.

A second contributor to the growth in SSDI has been an increase in the fraction of women who are insured for SSDI benefits. To be insured for SSDI, a person must have worked in at least 5 of the 10 most recent years. Because employment rates have increased among women since the 1980s, the fraction of women insured for the program has risen as well.

This explains why SSDI has growth more rapidly among women than among men during this period.

A third determinant, a third and more important determinant of the growth in SSDI since the mid-1980s has been an increase in the award rate caused by a liberalization of the program's medical eligibility criteria, resulting from 1984 legislation.

I show in the second figure of my testimony there has been a substantial increase since that time in award rates for mental disorders and diseases of the musculoskeletal system. This rise is important because, as shown in recent research, the employment potential of SSDI recipients with these more subjective conditions can be substantial.

I outline several additional factors in my written testimony that have contributed to enrollment growth in the SSDI program.

While providing valuable insurance to tens of millions of Americans, SSDI reduces the incentive to work both for individuals on the program and for those applying for SSDI benefits.

To receive an SSDI award, a beneficiary must be deemed unable to engage in substantial gainful activity defined by the Social Security Administration to be $1,090 per month. Once on the program, an SSDI recipient has little incentive to return to work as earnings above the SGA threshold will lead to a termination of benefits.

The growth in SSDI enrollment since the 1980s has coincided with a substantial reduction in employment rates among individuals with disabilities. For example, from 1988 to 2008 the employment rate of men in their 40s and 50s with a work-limiting disability fell from 28 percent to 16 percent.

The steady increase in SSDI enrollment in recent years has reduced labor force participation in the U.S. below what it otherwise would be. While there are of course many factors to influence labor force participation, previous research indicates that SSDI is an important factor as well.

The disability determination process used by the SSDI program awards benefits to individuals deemed unable to engage in substantial gainful activity. This reduces the incentive to work among those who have filed an initial application for SSDI and among those appealing a rejection.

In recent years, nearly 40 percent of SSDI awards were made on appeal, and the time between the initial application and the ultimate decision is substantial for those appealing initial rejections.

This was problematic because those initially rejected are likely to be in better health on average than those receiving an initial award, and thus likely to have higher employment potential. And the longer that a person remains out of the work force, the more their earnings' potential declines.

Therefore, even if an applicant never receives an SSDI award, the application process can permanently harm his or her employment prospects.

One way to improve incentives in SSDI is to intervene sooner for individuals with work-limiting conditions so that they can continue working. The payoff to keeping an SSDI applicant in the work force is high. The average present value of an SSDI award is approximately $300,000.

While many awarded SSDI benefits are completely unable to work, previous research makes clear that a substantial fraction could work.

More generally, increasing employment among individuals with disabilities could improve their economic well being and increase their autonomy while reducing the fiscal strains on Social Security.

Past efforts to achieve this goal within Social Security, within SSDI, have unfortunately had little impact. The lack of progress in improving work incentives in SSDI stands in marked contrast to the Temporary Assistance to Needy Families program. Reforms introduced in the mid-1990s, along with expansions in the Earned Income Tax Credit at that time, led to substantial gains in employment among past, current, and potential future TANF recipients, and to a steady drop in program enrollment and expenditures.

Based on my own research and that of many others, I believe that similar progress is possible within the SSDI Program.

I thank you again for the opportunity to testify today.

[The prepared statement of Dr. Duggan appears in the Submissions for the Record on page 97.]

Chairman Coats. Dr. Duggan, thank you very much for your testimony.

Ms. Vallas.

STATEMENT OF MS. REBECCA VALLAS, DIRECTOR OF POLICY, POVERTY TO PROSPERITY PROGRAM, CENTER FOR AMERICAN PROGRESS, WASHINGTON, DC

Ms. Vallas. Thank you, Chairman, and thank you Members of the Committee, for the invitation to be here today.

My name is Rebecca Vallas. I am the Director of Policy of the Poverty to Prosperity Program at the Center for American Progress.

Imagine that tomorrow while you are cleaning out your gutters you fall off of a ladder. You suffer a traumatic brain injury and spinal cord damage, leaving you paralyzed and unable to speak. Unable to work for the foreseeable future, you have no idea how you are going to support your family.

Now imagine your relief when you realize that an insurance policy that you have been paying into all your working life will help keep you and your family afloat. That insurance policy is Social Security.

I have seen first hand more times than I can count what this program means in the lives of its beneficiaries because, prior to joining the Center for American Progress, I spent several years as a Legal Aid attorney, helping workers who had experienced a life-changing disability or illness access the benefits that they had earned.

Social Security protects more than 9 in 10 American workers and their families. And all told, more than 160 million American workers are protected. Of those, about 8.9 million, including more than 1 million Military Veterans, receive DI, as do about 2 million of their spouses and dependent children.

DI is coverage that workers earn. With every hard-earned paycheck, American workers pay into the system through payroll tax contributions which serve more or less as insurance premiums. DI benefits are incredibly modest, typically replacing less than half of prior earnings, and the average benefit in 2015 is less than $300 per week, just over the federal poverty line for an individual.

But DI is vital to the economic security of disabled workers and their families. And for more than 8 in 10, DI is their main or only source of income. To qualify, as we've heard, a disabled worker must be unable to engage in substantial gainful activity due to a severe physical or mental impairment or combination of impairments expected to last at least 12 months, or to result in death.

Now unpacking that, in practice what this means is that a worker must not only be unable to do his or her past jobs but also unable to do any other job that exists in the entire national economy in significant numbers at a level where he or she could earn even $270 per week.

According to the OECD, the SSDI program and its disability standard is the strictest eligibility criteria for a full disability benefit in the entire OECD.

As we have heard from Chief Actuary Goss repeatedly in testifying before Congress, this standard, this strict standard remains the same whether or not job openings are plentiful at the time.

Now the vast majority of applicants are denied under the strict standard, and those who qualify often have multiple serious impairments. Many are terminally ill, and one in five beneficiaries die within five years of receiving benefits.

For those whose conditions improve, Social Security's policies include an array of strong work incentives and protections to encourage beneficiaries to attempt to return to work. That is described more fully in my written testimony as well as the proposal included in the Senate—in the budget deal.

However, most beneficiaries live with such debilitating impairments and health conditions that they are unable to work at all. And even denied applicants exhibit extremely low work capacity after being denied, reflecting the strictness of DI's eligibility criteria.

The reasons for the program's period of rapid growth which has now come to an end are well understood, and they are chiefly demographic, as we heard from Dr. Duggan. The Baby Boomers entering the high-disability years of their 50s and 60s, and the rise in women's labor force participation.

In sum, this is a program for hard-working Americans who have worked all their lives but who by and large are no longer able to do substantial work.

The typical beneficiary in fact worked 22 years before needing to turn to benefits. I will quickly note, in closing, that the recently passed bipartisan budget deal strengthens the Disability Insurance Program in several important ways.

In addition to preventing sharp across-the-board benefit cuts that would have been devastating to beneficiaries' financial security, the budget deal also includes a number of important measures to enhance program integrity, putting cooperative disability investigation units, or CDIs, in all 50 states, as well as cap adjustments to support more continuing disability reviews. We can discuss this more in the Q&A, I am sure.

Additionally, the budget deal restores SSA's DI Demonstration Authority so that it can test ways to further strengthen the program, including its work incentives and supports.

But supporting work for people with disabilities is more than about the Disability Insurance Program. As we continue to work together on a bipartisan basis to boost work among people with disabilities, we need to acknowledge the much broader policy landscape affecting those workers and enact public policies to give workers with disabilities a truly fair shot.

And these policies must include insuring paid leave and paid sick days, as well as access to long-term supports and services, to name just a couple.

In closing, when it comes to our Nation's Social Security System, the will of the American People is clear: They value it and support it highly and want to see it strengthened.

DI is a core pillar of that system, and it offers critical protection against the hazards and vicissitudes that we encounter, including life-changing disability and illness.

Thank you so much for the opportunity to testify today, and I am happy to answer any questions that you may have.

[The prepared statement of Ms. Rebecca Vallas appears in the Submissions for the Record on page 112.]

Chairman Coats. Thank you. I appreciate that. I am going to turn now to opening questions.

Mr. O'Carroll, let me start with you, if I could. As you know, GAO last week sent out the information relative to the improper payments totaling, they said, nearly $11 billion over a 10-year period of time.

Would you—then following up from that, as I noted in my opening statement, you did some sampling of that and came up with a statistic that 44½ percent of sampled claimants received over-payments. Could you give us some more details about this over-payment situation and what we need to do to try to avoid this and put this on a much better path?

Mr. O'Carroll. Yes, Chairman. A couple of things on it. I guess the first one is that, as you had mentioned, in the GAO report where it was talking about the $11 billion.

As we keep saying with SSA paying out billions of dollars, when you say $1 billion, in percentages it might not be a high percentage, but our concern is that when you are dealing with the billions of dollars that go out in payments, then the overpayments become a large dollar amount.

And to the normal taxpayer and citizen, a billion dollars is a lot of money. We are very concerned about that, and we are concerned about the percentage of overpayments in SSA.

And so we did a study on it, and we looked at people that were on benefits for 10 years. And in that 10-year period, they came on benefits. They went off benefits. They went back to benefits. And in that time period, we found that 45 percent had overpayments, and underpayments, there were improper payments.

And we brought those to SSA's attention, and we asked them to focus on those areas in terms of identifying the improper payments and fixing them in the future.

So we have been trying to give information through our audit work to SSA on different ways to prevent overpayments and improper payments in general.

Chairman Coats. And what are some of those ways that you are going to attack this? I mean, what needs to be changed? And do you need legislative authority to do it?

Mr. O'Carroll. Well, a lot of what can be changed is in terms of the information that SSA is being given by people that are applying for benefits.

A lot of times that information is not being checked. So amongst other things we are telling SSA is to be using other databases that are out there, and to be taking a look to see if people have resources that they are not reporting; to be also checking, with other government agencies.

The biggest one really is comparison of information between government agencies. One government agency has information about

a person and does not share it with the other one because of concerns over the Computer Matching Act. But there is a lot of data analysis and information out there that can be used that would be very effective in preventing improper payments.

Chairman Coats. It was not that long ago that I was speaking on the Floor about some waste that occurred between the Unemployment Insurance Agency and the Social Security Disability. There was a significant number of people who were drawing checks from both entities.

I mean, either you can work, or you cannot work. Either you are disabled, or you are not disabled. And yet people were applying for and receiving checks from both agencies. It is one thing—you would think you could pick up a phone, or send a note, but today all we have to do is push a computer button basically to establish some type of link between the two before a decision is made as to the integrity of the applicant and the claim and being paid by one of the agencies, but not both of the agencies.

And so there appears to be a lot of dysfunction. Of course you were talking about the ability to facilitate these checks before the decisions are made, and these claimants before the decisions are made. So I appreciate what you have said in that regard.

You also talked about facilitator fraud—in your opening statement which I read—facilitator fraud investigations. Can you describe what they are and to what extent they impact the program, and what steps possibly could be taken to address that?

Mr. O'Carroll. Yes, Chairman. That is one that is very important to me, because there are people out there in positions of trust that the agency relies on for information. And if those people decide to defraud the government, they already have an edge on being trusted and their information being taken.

So as an example we have found that in some cases former Social Security employees that understand the way the system works then conspire with unscrupulous medical providers and attorneys, where they will use improper information and facilitate getting a person on benefits.

And then the word goes out that this is the way to do it, and it becomes almost like an underground conspiracy where by word of mouth you are being told if you want to get on disability when you are not disabled, go see this person. They will introduce you to a doctor. That doctor will then introduce you to an attorney that will then represent you.

And so we have made that a priority of ours. We have, in about 10 different locations now, a pilot where we are going out just trying to work cases on facilitators that are doing this. We have asked for increased penalties against these people that the government trusts, so that the word will get out there: Don't break that trust and try to defraud the government.

Chairman Coats. Well I commend you on that work, and we thank you. I am awfully glad that we have inspector generals that are looking into these kinds of things. You may need some legislative authority relative to the penalties, or relative to having the resources available for these investigations, but it undermines the confidence and trust of the American Taxpayer, the American Public, when they see this kind of fraud taking place, this kind of fa-

cilitation for this, when we hear examples of people gaming the system.

They are not disabled, yet they are drawing checks. They are unemployed and they are drawing checks from the Unemployment Insurance at the same time, saying they are able to work but they cannot find jobs. And so it continues to really undermine the integrity of these programs.

As Ms. Vallas said, there are legitimate claimants out there that need these payments and claims to provide for themselves. They qualify under the standards and criteria of the Disability Insurance fund. And yet the public becomes very skeptical in terms of the inability of the government to run an efficient, effective program and weed out the billions of dollars of fraud.

So we thank you for your work for that. I am a little over my time. Our Ranking Member has arrived. I know the House has a way now of scheduling votes every time they see there is a Joint Economic Committee hearing, but we welcome you and I will turn to you for your opening statement.

Representative Maloney. I am going to put my opening statement in the record and read it into the record at the end of the hearing, because I feel that we do not know when votes are going to be called again and we need to just keep going.

I certainly want to be associated with all the statements, being against any type of waste, fraud, or abuse that games the system or hurts the credibility of the system. And if we can put a man on the Moon, we have got to have some computer system where we could check whether or not there are duplicate applicants and some of the problems that the IG raised.

But I want to know how hard it is, or how easy it is, to get SSDI. And I would like to hear your thoughts on it, Ms. Vallas. But first could you tell us briefly why you are familiar with the process, and then tell us the process and any ideas of how to make it more fair and more fair to people who need it, and also to stop any type of abuse. Because any abuse undermines the credibility and the ability of people who really need the service to get the service.

[The prepared statement of Representative Maloney appears in the Submissions for the Record on page 36.]

Ms. Vallas. Thank you so much for the question.

So you asked why I am familiar with the process. Well I mentioned in my opening statement that I was a Legal Aid attorney for a number of years, and I worked directly with individuals with significant disabilities who needed help accessing the benefits that they had earned through this system.

So that was how I learned how the program works. And it was my first exposure over a number of years to the various layers of the process.

So the way that the process works is that an individual applies for benefits. They must go through an initial determination stage. And this is done by the state agencies called Disability Determination Services.

They are funded by SSA. They are governed by national policies and procedures. The vast majority of people at this stage are denied. And just about one-third, or even a little bit less than one-third, are actually awarded benefits at this level.

And in order to mount a claim for disability benefits, it is not about just signing up. It is not about getting a doctor's note, as it might be made to sound sometimes in the media. It requires mounting every piece of medical evidence that you possibly can. And sometimes the files that I would help my clients to accumulate could be almost as tall as I am—I am not a tall person, but tall files.

And the reason for this is that it is incredibly, incredibly hard to demonstrate that you meet that really strict definition of disability that we have been talking about today.

If you are denied at that initial level, what you then have to do is file an appeal. In some states there is a level called reconsideration, which is a paper review of that case. In some states there is no reconsideration level and you need to go to a hearing before an administrative law judge.

And unfortunately, as the Inspector General mentioned, we are seeing catastrophic backlogs right now with more than a million people waiting to see an administrative law judge. And people can wait as long as two years. And unfortunately, as a result, thousands of American workers are dying each year waiting for the benefits that they earned. Not something that we tolerated in the VA system, and I would hope something that we would not tolerate in the Social Security system. And purely the result of under funding that system.

Representative Maloney. And how would you respond to the IG's statement that there are doctors out there waiting to fill out the forms, that there are basically mills out there that are processing them. And basically how likely is it that a person will have their application accepted?

You are saying it is very difficult to get accepted. But say out of 10 people how many would have their applications accepted?

Ms. Vallas. So fewer than 4 in 10 applicants are approved even after all levels of appeal. And I did not even mention going past the ALJ stage. There's the Appeals Council, and then even federal court. After all of those layers, fewer than 4 in 10 people are approved.

Representative Maloney. And how do our disability benefits compare with other countries?

Ms. Vallas. So in addition to having the strictest definition of disability in the world, we also have incredibly meager benefits. I mentioned that the benefits average less than $300 per week, and replace less than half of prior earnings for the typical beneficiary.

So it can be incredibly difficult to make ends meet. Even though these benefits are very vital, they are incredibly modest and they barely keep people out of poverty. And that compares internationally to many nations have replacement rates as high as 80 percent of your prior earnings.

Representative Maloney. Okay, is my time expired?

Chairman Coats. Six seconds.

[Laughter.]

Representative Maloney. I've got six seconds left. So basically how much will he or she earn in the system? Basically, how much a month would you say?

Ms. Vallas. On average, it's $1,165 per month, which is just over the federal poverty line for one person.

Representative Maloney. My six seconds are up.

Chairman Coats. Thank you.

Senator Cotton.

Senator Cotton. Thank you, Mr. Chairman.

Mr. O'Carroll, I want to go back to a point you made about the facilitators of disability applications. I remember as a kid growing up in Arkansas, billboards, the back pages of yellow pages, cable TV ads, lawyers would advertise for big-rig accidents, or medical malpractice, and so forth. Now it seems like all those ads are about disability. You know, "Call this number, I'll get your disability check for you."

What is your perspective on why that legal advertising shift has happened, at least anecdotally to me in Arkansas, over the last 20 years?

Mr. O'Carroll. Well I'd say anecdotally, the word is out there that your odds of getting onto benefits are higher if you are represented by someone. And that's more than just anecdotal information. The record is out there, if you are represented, you're going to probably have somebody assisting you in getting your records together and everything else.

So the word is out there that you've got a better chance. The ones that we are concerned with are the ones that the word is out there, if you go to this person, he or she knows how to scam the system and get this doctor that would exaggerate what your injuries are.

For example, we had a case in one of our districts where we sent an undercover agent in. The agent went in, and was introduced by a facilitator to a doctor. The doctor said to our agent: Hey, are you having trouble with your back? And the agent said, well, not really. Why? And he said, well, let me send you over to a specialist and we'll have him take a look at your back. And we took an X-ray of the agent's back before she went to the specialist.

She goes to the specialist. We get an X-ray back from the specialist that has like an S-curve in the back, which had been normal according to government doctors. And that X-ray was what was used for her disability claim.

And then when she went back to the doctor, he said to her, don't you feel depressed now that you know your back is so bad? And, he said, let me send you to another doctor to attest to the fact that you have mental problems over it.

And so, that is the type of word that gets out there that facilitators will help you.

Senator Cotton. Let's shift to the statistical evidence here, Dr. Duggan. You presented some fairly rigorous evidence here that shows that only about 40 percent of the rise in disability insurance is due to things like population growth, or the Baby Boom, or women entering the work force in the last three or four decades, all of which are healthy and predictable.

Could you explain a little bit more about those findings, and the import of the findings for us?

Dr. Duggan. I'll be happy to. I think it is helpful to just look at some of the numbers that I have summarized in the first table of my testimony on the second page.

You can see there, it is true that SSDI enrollment has growth as more people have reached their 50s and 60s, where enrollment rates are higher, and as more women have entered the work force.

But a bigger factor is that, sort of looking at a specific individual with specific characteristics over time, their likelihood of being on SSDI has gone up quite significantly. So let's take men, for example, men in their 50s.

So from that table, and this is pretty simple. This is just the number of SSDI recipients in the numerator, and the number of men 50 to 59 in the denominator. And you can see that in 1989 that fraction was 5.8 percent. So, and we don't—and there has not been an increase in the fraction insured for the program among men in their 50s. And so for 25 years later, that has growth by 50 percent, from 5.8 percent to 8.7 percent. That is a pretty large increase.

Similarly, if you look for women the increase has been from 2.9 percent to 7.9 percent. It is true that the fraction of women insured for the program has grown, but that cannot begin to explain the magnitude of that increase.

So a much bigger contributor to the growth in SSDI enrollment has been, that if you look within a specific category, look at men in their 50s, look at women in their 40s, and so forth, controlling for those things, so it is not vulnerable to that sort of compositional change, there has been this quite significant increase. And that is sort of taking a snapshot of things from the mid-1980s to today.

Senator Cotton. In Arkansas we have looked at disability enrollment rates vs. population growth. Our State has 75 counties, and there is almost an exact inverse relationship. As the county's population declines, disability insurance enrollment goes up.

Do you have any thoughts on why that might be the case?

Dr. Duggan. I think it is the case, so it is—previous research that I have done and that others have done have sort of demonstrated a link between economic conditions and applications for, and ultimately awards for the program.

So, for example, if you look at the third figure of my testimony you can see that the unemployment rate and the SSDI application rate moved together quite closely. And so in general it tends to be the case that places where the population is declining, those tend to be places where the local economic conditions aren't so great. And in general when local economic conditions are declining, you see a big, a pretty significant uptick in applications to the program.

And it is pretty clear from Figure 3 that—the connection between economic conditions and applications for the program.

Senator Cotton. Thank you. My time has expired.

Chairman Coats. Senator Klobuchar.

Senator Klobuchar. Thank you very much, Mr. Chairman.

Inspector General, those who are seeking disability insurance already are experiencing a level of hardship most Americans do not. And then there is an average wait time of 114 days before an initial decision on a claim.

You talked about increased funding to help with that. How much of a decrease in wait times can we expect from this increase in disability determination services staff?

Mr. O'Carroll. Well unfortunately I didn't talk about the extra funding for SSA on that. One of our dealings with SSA is that I am monitoring what SSA does with the appropriation that they get, and the decisions that they make. And one of the things that we are always trying to do is get a balance between service and stewardship.

We are trying to get SSA, one, to keep the wait times down. But, two, to make sure, while keeping the wait times down, that they are also doing as much due diligence as they can to make sure that the right person is getting the right benefit.

Senator Klobuchar. And has there been a trend of increasing wait times over the years? And has that changed at all? Or do you see it changing?

Mr. O'Carroll. Well there are a couple of things. Yes, the wait times are changing. Two, what we're telling SSA to do, and what we do, is look at the different steps in the process and we rate them, and we try to make sure that all of them are doing the same delivery to the public.

What we are finding is that in some states, the wait times are lower. And we are trying to address what they are doing in those states to try to bring it down in those states, that we are identifying as being longer.

We try to keep that balance not only on the initial, but also on the hearing, level.

Senator Klobuchar. Okay, thank you.

Dr. Duggan, just quickly, in your testimony you noted that the recently passed Bipartisan Budget Act that I supported would establish demonstration projects to look at improving work incentives in the SSDI program.

How do you think those should be designed? Because I know there's been some problems with them in the past.

Dr. Duggan. Well as an economist, I think a great way to design a project and to really isolate its effect would be to have some kind of a randomization in the allocation of the—in the incentives.

So if it is the case that we have demonstration projects in which everyone in an area, or just nationally has the opportunity to sign up for changed incentives, let's say a lower SGA threshold and different phase-out rate, or what have you, if everyone has that option, it is very, very, very difficult to reliably disentangle the effect of the incentive change from the very factors that are correlated with the decision to opt in.

So it would be nice if—you know, I am not the one making these decisions—but as someone who will probably want to evaluate it one day, it would be great if there was a way to randomly—and that one can sort of mimic randomization in other ways, but that would give more hope. And we really do have a scarcity of evidence on the effects of these kinds of reforms. Whereas, in other countries——

Senator Klobuchar. We have——

Dr. Duggan. Yeah, Norway, for example, has done some stuff recently.

Senator Klobuchar. Are you going to bring up Denmark? That was a Bernie Sanders one.

[Laughter.]

Dr. Duggan. Okay.

Senator Klobuchar. I will follow up with you in writing, because I wanted to ask one question—it wasn't sarcastic, it was a little joke—one question of Ms. Vallas over there.

And that is, thank you for talking about Veterans in your testimony. As we know, Veterans Day is upon us, and I believe that we have an obligation to these women and men who have signed up to serve us. And can you discuss what the Social Security Disability Insurance Program means to our Veterans?

Ms. Vallas. Absolutely. Thank you for the question.

The Disability Insurance Program is absolutely vital for Veterans, and more than one million of its beneficiaries are Military Veterans.

I will share a story of someone that I'll call "Mr. G" to protect his confidentiality. He is a Military Veteran. He was a tunnel rat in Vietnam. And long after his service, he ended up being in a car crash, a terrible, debilitating car crash that left him severely injured both cognitively and physically.

And because it was not a service-connected injury, he was not able to access Veterans benefits. But Social Security Disability Insurance was there for him. And because of his DI, he is able to keep a roof over his head and food on the table and live independently.

That is what DI means to Vets.

Senator Klobuchar. That is a great example. Thank you. And thank all of you. And I will follow up as the State with the most Scandinavians of any State. I will follow up with you, Dr. Duggan, about your analogy with Norway. Thank you.

[Questions for the record from Senator Klobuchar to Dr. Duggan appear in the Submissions for the Record on page 147.]

Chairman Coats. Thank you, Senator.

Senator Cassidy.

[No response.]

Chairman Coats. Senator Heinrich.

[No response.]

Chairman Coats. He's gone. Let me see if I can catch somebody here.

Congressman Grothman.

Representative Grothman. I guess I will just ask some general questions of Dr. Duggan. We just did pass some things, as you know, in the Budget bill, but overall, you know, over time we've seen this growing, Social Security Disability caseload, and you certainly hear a lot of anecdotal evidence of people on disability who you would not think were on disability, or who you do not expect are disabled.

Could you list, if you had your dream bill to kind of get things back to where they should be, maybe three top recommendations that we could do to get some people back to work, or to get some people off the program that probably should not be on the program?

Dr. Duggan. Sure. I am delighted to answer a question about my dreamwork. So I think it is, just to—thanks very much for the question.

I think it is important to recognize that SSDI is a complicated program, and it serves many, many very vulnerable individuals with severe disabilities.

I do think that intervening sooner with people before they are on the program, so that they do not end up applying for, or do not end up enrolled in the program, is—has a lot of promise for the program.

So David Autor and I in a 2010 proposal put together some ways to try to stem the flow of people applying for and ultimately receiving the program. My sense is that intervening sooner with people before they apply has even bigger bang for the buck than trying to give incentives for people already on the program to return.

So that is step one. Step one is intervening sooner and designing innovative ways to keep people who may consider applying for SSDI engaged in the work force and keep them working. Because the payoff for that is extremely, extremely high.

A second one is regarding the Continuing Disability Reviews. It is the case that they have been pretty infrequent in recent years. There has been an uptick as the Inspector General was mentioning, but they have been at a much lower level in recent years than in previous years.

And I think it is important for the program, for the integrity of the program, for us to sort of perform CDRs on people, especially those whom we think—where their health is likely to improve. And I am not a lawyer, so I do not understand the exact details of CDR's work, but I do think there is a sense that there needs to be evidence of improvement, as opposed to the question of is the person disabled today or not.

There is—I mean I think one thing about the process, about the disability application process, it seems plausible that with 2½ million applications per year, sometimes mistakes are made. Clearly people who are applying think mistakes are made because they appeal the decisions.

If a mistake, though, is made and an award is made when a person checks in with a CDR, it is more difficult to reverse that initial decision given the way the legislation is currently written.

So in any case, I just think improvements in the number and sort of functioning of CDRs would have a big payoff to the program as well.

And then I think on the ALJ front, as I mentioned almost 40 percent of SSDI awards were made on appeal, if you look at applications in 2010 for which we have relatively complete data.

And one of the things about the hearings before ALJs is that typically a person is there with their representative but there is not—SSA is not necessarily—SSA is there in the form of the judge, but there is not a person there making the SSA's case for why the decision was made in the first place.

So I think sort of putting on a level playing field those hearings would be useful. That is a third.

And then I mean just generally I think reforms to increase the incentive to work among current SSDI recipients, we can learn a

lot from I think welfare to—what happened with the TANF program in the 1990s about incentivizing people to return to work.

And I think there is a way. It is a delicate balance, and it is important to be careful that we do not unwittingly harm people. But I think improving the incentives for people on the program, and hopefully these demonstration projects through this recent Budget Control, this recent budget that was passed, will lead to improved financial incentives for those on the program.

Because right now with the cash cliff, you have a number of people who basically may be able to work but have a strong incentive not to because they risk going over the precipice and permanently losing their benefits.

So I think it is—that combination of intervening sooner, CDRs, and incentives would be great.

Representative Grothman. You are a really good witness. You gave me exactly a five-minute speech.

Dr. Duggan. Oh, I'm sorry, I didn't mean——

Representative Grothman. You practiced that last night.

[Laughter.]

Dr. Duggan. Thanks.

Chairman Coats. You will be called back. We keep a list of people who go right at five minutes.

Congressman Beyer.

Representative Beyer. Thank you, Mr. Chairman.

Inspector General O'Carroll, you noted that the Cooperative Disability Investigations have saved a lot of money, over $3 billion since—$3—$2.2 billion since 1998, $400 million alone in FY 2015. So the latest budget deal gives us a CDI in every state. Will there be enough money in these caps to fund them adequately? And how much difference will that make in the fraud?

Mr. O'Carroll. Thank you, Congressman. For two reasons. One is, that's something we're very proud of in terms of a program that we have. With the CDI program, it's a pre-fact situation. So before people start getting benefits, as we had mentioned before, as Dr. Duggan had mentioned, once you're on it, it's very difficult to take a person off it, especially if they scammed in getting it.

So by having the CDI program before you get on, if there's a suspicion, we can, investigate to see whether or not, what the person is attesting to is correct.

Oftentimes we'll validate the claim, if it is correct. But we find that CDI works very well. We think it is very good in all the states that we have it.

Expanding it, I've got to admit, is going to be difficult for two reasons. One is, in the 37 that we have now, we've picked the states where we have the most cooperation with local law enforcement and the state DDSs. We have a presence of my agents there. We are able to roll them out.

As we start looking at the other states we are going to be running into funding issues. It also becomes an issue in terms of securing cooperation with the states.

To give you an example, in some states where we use state troopers to assist us, if we take those state troopers off of whatever is their regular daily assignment, they can't replace them. So they

don't want to send state troopers for these programs, even though it saves a lot of money for the state.

So we are running into a lot of different resource issues.

Representative Beyer. Thank you. Thank you, Inspector General.

And, Ms. Vallas, in your testimony you talked about from 2013 to 2014 SSDI enrollment declined, and that the share that actually qualified is the lowest ever. Does this suggest that we have turned the corner on SSDI growth? Or is it closely aligned with either demographic factors or the economy?

Ms. Vallas. Thank you so much for the question. You are exactly right, and another data point that I will mention is that the growth in this program right now is the slowest that we have seen in 25 years.

So we knew that because of the rise of Baby Boomers into their high disability years of their 50s and their 60s, of women entering the work force in greater numbers, that we were going to see growth in this program. And in fact the actuaries projected back in the mid-1990s that 2016 would be the year when we would need—when Congress would need to act in order to prevent reserve depletion. And they predicted it right on the nose.

What they could not have predicted, and what they did not predict, was the Recession. It was mentioned earlier that the Recession was alleged to have played a significant role in the growth in this program. The fact is, the Recession actually caused only 5 percent of long-term growth in the program.

And that is largely not because of additional people receiving benefits, but actually a reduction in covered workers because of unemployment rates.

So I just wanted to mention that I think it is important to note that while recessions are associated with application increases, what they are not necessarily associated with, and what we did not see in this past recession, was a rise in awards. We saw a decline in awards, as people were properly screened out who didn't meet the strict definition of disability.

Representative Beyer. Dr. Duggan cited some of his work to show that from 1989 to 2014 only a third of the growth of SSDI was due to demographic changes. But your written testimony has very different conclusions. Can you explain the difference?

Ms. Vallas. So the paper that I will point you to that I think clears up a lot of the confusion about what the drivers of the growth have been is by Harvard Economist Jeffrey Liebman and a colleague of Dr. Duggan's. And he took a look at the reasons for the program's growth, and he looked back all the way to 1977.

He looked using 1980, which was an unusual troth and a historic low point in the program because people were being thrown off the roles left and right for reasons we can go into if there are more questions about this. And he also looked at 1993. And what he found is that, whether you look at 1977, 1993, the lion's share of the growth is explained by those demographic factors.

Representative Beyer. Great. Thank you very much.

Mr. Chair, I yield back.

Chairman Coats. Well I'm going to—since you had a little bit of time left, I am going to let Dr. Duggan respond to that. I think it is important that we hear both sides on that.

Dr. Duggan. Right. No, I know Jeff Liebman well, and I know the study to which Ms. Vallas is referring. And I think it is important, when you think about what is happening with the growth of the program, it is really important to think about when do you start—when is time zero?

So if you look from the first figure of my testimony, in 1977, if you looked at where SSDI enrollment was, it was growing quite rapidly. So basically it was on track to rise to much more than 2.7 percent, which is where it was then.

So if basically those award rates had persisted, the program would have grown to be much bigger, perhaps as large as it is today. But the thing is that in 1977, partly because the award rates were so high, there was a sense that the program needed to be reformed, and some reforms were undertaken during the Carter Administration to tighten up the eligibility standards.

And you can see that actually the program enrollment started to decline in 1978 and 1979 and 1980, and then declined somewhat a bit more in the early 1980s.

Then there was a change in policy in 1984 which increased the award rate. So it basically made it easier for people with more subjective conditions, things like back pain, things like mental disorders, to get on the program.

That 1984 policy change led to an increase in the award rates. That increase in award rates had largely played out by let's say the early 1990s, but you had then—the program was out of equilibrium. More people were coming on than were exiting it, so it grew.

And then, so if you take, if you start looking at the program in 1977 when it was growing really rapidly, or in 1993 when that policy change had taken effect, you can say, oh, the award rate, if we just hold the award rate at that level we're right where we would expect to be. But if instead you look in 1985, right after that policy change, and you can see this from the figure from the first table of my testimony, that really what is driving it is this uptick in the award rates.

And you can see that as well in Figure 2. If you look at sort of awards for musculoskeletal conditions. So the most common condition in musculoskeletal is back pain, and you can see there that the award rate for musculoskeletal is six times higher. So that's musculoskeletal awards divided by people insured for the program, six times higher today than in 1983, and also substantially higher now than it was even in the late 1990s. Whereas things like heart conditions, circulatory neoplasms, cancer, have been pretty flat.

So I think it is really important. I am very familiar with the Liebman study. If you start in 1977 and if you start in 1993, then what Ms. Vallas said, the award rates were high in those years, in one case before a big policy change to tighten it. In another case, after this policy change that had liberalized the criteria. But if you start instead in 1985, then it is the case that the majority is driven by the growth in the award rates.

So I apologize for the long-winded, but hopefully that sheds some light on it.

Chairman Coats. Thank you. I just think it is important for the record as we look at it after we are done with all this and have to make decisions about going forward.

Congressman Paulsen.

Representative Paulsen. Thank you, Mr. Chairman. It has been referenced that SSDI is a critical and very important safety net for millions of Americans with disabilities. Unfortunately because of years of inaction, we came right up against the brink of having it be the first trust fund that essentially was set to run out of money.

Now the recent budget deal, which has been referenced several times corrects that, it, had some really common sense reforms that were included to make sure we strengthen oversight. And integrity of SSDI, and a lot of those changes are actually aimed at simplifying the complex web of regulations that currently plague the program.

Because for a lot of these beneficiaries, it is the confusion and the fear of having their benefits cut off that have prevented them from even testing out going back into the work force.

That is despite 40 percent of these beneficiaries indicating they would like to return to work. So my question is, Dr. Duggan we took corrective action recently, but we have just prolonged—now we extended the trust fund until 2022. What happens if we wait another six years before we decide to fix SSDI again, versus trying to keep the momentum going and adopt some other reforms, preparing for the future?

Dr. Duggan. Thanks so much for the question.

So I think that it is, you know, SSDI reform is inevitably somewhat complicated and one needs to be careful about the possibility of unintended consequences.

I do think the budget deal clearly pushes out the expiration of the trust fund several years. And that is something that I think is agreed is a good thing that that trust fund doesn't hit zero and we see this automatic benefit cut across the board.

But I do think the program has to a large extent been on auto pilot for decades. There have been some changes here and there, but I view them as kind of tweaks to the fundamental system.

And so I think really there are opportunities to significantly reform the program so as to stem the flow of people enrolling initially, and to expedite the flow off of the program among those initially enrolling.

And I don't pretend to have all the—you know, a sense of what is the absolute perfect way to do that, but I think doing—trying hard to improve the work incentives both on the front end and on the back end could dramatically improve not just the fiscal health of the program but also the economic well being of people with disabilities.

I mean to me it is really unfortunate that we look from let's say 1988 to 2008 employment rates among individuals with disabilities fell relative to those without disabilities. And along with that, their economic well being declined. And I think there is really a lot of scope for improving the incentives to return to work. And I think,

you know, the welfare reform there were mistakes made, and it's not like every reform that was made was perfect, but I think we learned a lot about how to get people engaged in the work force.

And there are gains not just—I mean, I think it is really important when thinking about the effects on work to think not just what's it going to do next year, or the year after that. It can have really big lifetime effects on people's aspirations, on their psychological health to be working, and also on, you know, their family members and so forth.

So I think there's really a lot that we can do, and I sort of take heart in looking at what happened in the 1990s. And by no means was it perfect, but I think incentivizing work—and I think that's especially important when I look—I mean, I sort of feel each month, you know, to me the fact that we've got a labor force participation rate of 62.4 percent, and we have a demographic change that is just going to—it's like the wind at the back of that thing continuing to fall. I think it is really important as a Nation for us to do more to get us incentivizing work.

Representative Paulsen. All the more reason to have it be comprehensively looked at sooner rather than later.

So, Inspector General O'Carroll, real quick, you know I think it was referenced earlier, but this GAO Study or report found that the Social Security Administration had overpaid beneficiaries who returned to work by like $11 billion over 9 years. And the SSA wasn't able to recover like $1.4 billion of it because it was the agency's fault.

What can be done to make sure that the SSA is managing this program effectively? Do you think some of the changes in the recent budget deal, like allowing the SSA to use payroll provider data, is going to help?

Mr. O'Carroll. Yes, Congressman. One of the things, as I had mentioned earlier, is that there's a lot of available information that SSA should start using, from other government agencies.

An easy example would be that one government agency is sending out a tax refund because a person is working, and at the same time SSA is sending out a check because they are indigent.

That is the type of information government agencies have to be comparing. So that's one of the concerns.

The other part is, again, is just the due diligence and to be very cautious in terms of the benefits that are going out. What SSA says, and we applaud, is making sure that the right benefits go to the right person.

And that's the type of due diligence that we're looking for to make sure that there are enough checks and balances, and that they are all being used.

And that is in this bill that you just talked about. There are different due diligence requirements that we applaud and we like. It's a step in the right direction, to start finding ways to identify where taking advantage of the system, and to block it. And then also to try to prosecute those who are taking advantage.

Representative Paulsen. Thank you.

Chairman Coats. Thank you, Congressman.

Dr. Adams.

Dr. Adams. Thank you, Mr. Chairman. Thank you, Ranking Member as well, and thank you to all of you for your testimony.

Mr. O'Carroll, even with the excellent work your office is doing, some people still cheat the system. How does the fraud in SSDI compare to IRS fraud, or improper payments in other programs, government programs?

Mr. O'Carroll. Wow, Dr. Adams, a very good question. The reason it sets me back is that I had mentioned this earlier when we had talked about looking at improper payments with Social Security.

One of the things we've been trying to do is identify what is the amount of fraud in SSA's disability programs. I applaud SSA's anti-fraud initiatives that are very important to them. They are making a lot of effort to identify and avoid fraud in the programs.

But what we would like to do is to be able to estimate the fraud rate, so we can tell when we start doing different things and putting more money and more attention into the programs, which ones are effective at avoiding fraud.

And as a result of that, we have looked at other government agencies. And unfortunately I can't give you an answer as to how SSA compares to, for example, IRS, in that none of the other government agencies want to go on record saying that this is the amount of fraud in our agency.

We can attest to the amount of improper payments in comparison to some of the other government agencies. SSA's improper payment level is low, lower than a couple of the higher improper payment agencies. But I can't give you an answer in terms of saying which program has more fraud, one amongst the others.

Dr. Adams. Okay.

Mr. O'Carroll. We would like to, and in a year I would like to come back and be able to tell you. So we are working with SSA and our oversight committees to do that.

Dr. Adams. Okay. But with diligence and proper oversight and sufficient resources, are we making good progress in ensuring that this vital program is serving those who need it, and identifying those who don't need it, Mr. O'Carroll?

Mr. O'Carroll. In most cases, yes. I think those that need it are getting the benefits. I think that the system could be perfected so that it would be speedier for people to get it, so that there would not be a need for as much due diligence and as much attention that is being paid.

As we said before, it is important to make sure that if a person is not entitled to the benefits, they don't get them. And because of that, there are a lot of steps in the process. And I applaud them because it is keeping the system as good as it can be. But it can be better.

Dr. Adams. Thank you. Dr. Duggan, in keeping on this topic of eligibility standards, many critics of the SSDI program say that an increase in SSDI cases contributed to a reduction in the labor force participation rate.

So what are your predictions for the labor market and the SSDI program in the near term, given the improvements in the economy and the changes in the program's entry and exit rates?

Dr. Duggan. Thanks so much for the question, Dr. Adams, Congresswoman. So the program has, as Ms. Vallas mentioned earlier, has actually flattened out in growth in the program. In fact, in 2013 to 2014, the percentage of adults 25 to 64 actually declined somewhat.

I talk a bit in my written testimony about the reasons for that. One that I think I want to draw your attention to is that there's a recent report from the Technical Panel on Assumptions and Methods to the Social Security Advisory Board.

What they are finding is that it appears that the medical—the decision making within SSA is becoming somewhat stricter, which is to say a smaller fraction of awards are being made today than two years ago, than four years ago, than six years ago.

And so as Ms. Vallas also mentioned, a fraction of applications resulting in an award in 2014 was at its lowest level actually in the history of the program. So it is I think—and I don't know exactly what is driving that, but there has been a decline in the award rates for the program.

And I think that is causing the program to flatten out, along with the fact that aging has sort of run its course somewhat. I do think that—so I look to that Technical Panel. They tried to project where SSDI enrollment was headed, and the actuaries do this as well.

I don't think, based on current trends, it is set to explode over the next 25 years the way that it did over the last 25 years. I think that, absent some sort of policy change, it seems plausible that it will remain in the neighborhood of 5 percentage points plus or minus half a percentage point for some time.

That is not to say that that necessarily is the right fraction to have, but that is I think where it will stay.

As for the economy, I really hope that the labor force participation rate starts moving in the opposite direction. We have seen—you know, I sort of keep hoping for that thing to stop trending down. It's down 3.7 percentage points from several years ago. And that is a big deal. So I hope—you know, we have seen steady, consistent job growth but not sufficient job growth to break this trend of a declining labor force participation rate.

So I am hopeful, but I am troubled by the trends that we see in that measure.

Dr. Adams. Thank you. I yield back.

Chairman Coats. Dr. Adams, thank you.

The Ranking Member has a UC request here.

Representative Maloney. I ask unanimous consent to place in the record a Policy Futures Report from the Center on Budget and Policy Priorities. And also Understanding the Increase in Disability Insurance Benefit Receipt in the United States by Jeffrey Liebman.

And the Policy Futures shows that the disability insurance rules largely reflect democratic—demographic factors, and that it is highest among older workers, which is understandable. So both of these are important reports for the record.

Chairman Coats. We will make sure both of those are admitted into the record.

Representative Maloney. Thank you.

[The report titled "Chart Book: Social Security Disability Insurance" submitted by Representative Maloney appears in the Submissions for the Record on page 39.]

[The report titled "Understanding the Increase in Disability Insurance Benefit Receipt in the United States" submitted by Representative Maloney appears in the Submissions for the Record on page 63.]

Chairman Coats. Congressman Schweikert.

Representative Schweikert. Thank you, Mr. Chairman.

Inspector General, you have commented that SSA's data sets are thin, or their ability to compare to other sets of data. Have you actually had the opportunity to do some geographic testing for why there may be a concentration in some areas with much higher acceptance, participation, claim rates than other areas? Have you seen that?

Because there used to be a Member who retired last year named Spencer Bachus, and he used to claim that in his State he had two counties that had more people on SSDI than actually were holding jobs.

First off, do you use those geographic concentrations to understand outliers and problems within the program?

Mr. O'Carroll. Yes. The easy answer is, yes, we try to use that information. What we're always looking for is the outlier. We're looking at the bell curves. We're trying to find which outliers on the bell curves are the ones that need attention.

And that is one of the tasks of an audit staff, looking for those irregularities.

Representative Schweikert. But for you to be able to do your job better, you actually need much more communication of data sets?

Mr. O'Carroll. Absolutely.

Representative Schweikert. Whether they be IRS data sets, or much of the private sector data sets that may be used to create credit scores, or other things where they are collecting tremendous amounts of consumer data down to the individual. If you had the ability to match up against those, would that actually give you tools?

Mr. O'Carroll. Yes. It would give us tools. We are trying to use it, but we're not using as much as we could. There's a lot of information out there; that type of mapping that would help us a lot, and we haven't used it as much as we should.

Representative Schweikert. Okay, Doctor, I was earlier hearing a little back and forth that was sort of questioning your math. But, let's see. Your Masters is from MIT, and your Doctorate is from where?

Dr. Duggan. From Harvard.

Representative Schweikert. Okay. So I assume somewhere around here you qualify as the freaky smart category of our population. Just because earlier in the year we had one of your kind in my office working with us, looking at some of these original data sets, and if I remember we were actually looking, saying why is the population within the program seems to be flattening out?

And all of you who remember your quant classes, on the downside of a spike is a mean or a normalization. So from your demo-

graphics, okay, you have a demographic trend moving to actually benefits, Social Security, Medicaid, but you also had the downside spike. And now you've just shared with us that there may have been some policy set changes.

Dr. Duggan. Yes.

Representative Schweikert. Would those, if I lined those up, be pretty explanatory that we're actually not in the downside, we're just sort of moving back to the mean?

Dr. Duggan. Yes, thanks very much for the question, Congressman. I think given the current environment, the program is to some extent close to being in equilibrium, which is to say given the current award rates, the current demographics, what's coming down the pike on the demographic front, I think we are somewhat in equilibrium.

I think that equilibrium rate would be higher if award rates did not seem to have gotten tougher.

Representative Schweikert. But theoretically with our demographics getting older, we should be actually moving in the other direction. If I have a substantial portion of my population that's actually moving into earned benefits right now, shouldn't actually my participation in SSDI actually be falling?

Dr. Duggan. Yeah, I think if we sort of look ahead and see what the proportion, let's say, of people 25 to 34, 10 years out will be relative to the people 55 to 64, I think there may be a bit of that, but I don't think it will—so I think I agree that this could push it down somewhat.

But to some extent the age distribution is somewhat flatter now. We've got sort of 4 million people at many of these ages, so 61-year-olds, 51-year-olds.

Representative Schweikert. Hasn't some of the authorship said, though, the change in the way we work also should have also flattened out or reduced these numbers, you know, the number of folks who are out there actually doing truly hard labor, with the automatization, something is just not lining up?

Dr. Duggan. So, yeah, so if you look at how physically demanding jobs are, I think they have become less physically demanding over time. And that is reflected, if you look let's say at Workers Comp as a share of payroll. That has actually come down somewhat.

Representative Schweikert. I have like 15 seconds, and I wanted to throw two questions. The Liebman, that report was out last year?

Dr. Duggan. Yep, or this year.

Representative Schweikert. I think it was in our office earlier, and I think wasn't the problem with that was it was doing smoothing, even though there had been policy changes, and obviously some fairly substantial economic cycles within that——

Dr. Duggan. Right.

Representative Schweikert [continuing]. And you cannot do that without doing adjustments to see your trend line?

Dr. Duggan. Right.

Representative Schweikert. I mean that was just basically, the term "garbage in/garbage out" fits that?

Dr. Duggan. Yeah. I think very highly of Jeff Liebman. For the reasons I mentioned and some others, I think it is important to sort of look at the whole study. And I think if you look at it from 1985, you get a very different story.

Representative Schweikert. The last thing, and forgive me, Mr. Chairman, if a policymaker truly wanted to do the right thing here, and a powerful belief that work is incredibly honorable both for the human spirit but for just life in general, where do I reach and see where there's been policy adopted where folks who were on disability actually had an on-ramp back to what you and I might refer to as sort of normality? And what do we have to do policy wise to make that practical, both from the rational actor thinking themselves economically to even society, and our labor force participation. What would be the approach we should take? Where can I find that history?

Dr. Duggan. So on the front end, I would say improving—so right now we have this cash cliff. If you go above $1,090 a month in earnings, you risk being terminated from the program permanently. So I think sliding out the benefits somewhat beyond that point so that there isn't this sort of sense of I don't want to go over the precipice, I just want to park below $1,090 and not earn above that amount. I think that would be one piece of low-hanging fruit that would incentivize work.

On the front end, though——

Representative Schweikert. So it is——

Dr. Duggan. Oh, go ahead.

Representative Schweikert. No, please.

Dr. Duggan. So on the front end, though, I think there are a number of things. So, one, we talk a lot about lag times. So there is research, when a person is applying and they are waiting to hear back, they are staying out of the labor force because you need to not be working if your application is going to be considered unless you're doing—you know, we talked about some program integrity type stuff. Those long wait times, especially for the people on appeal, those are problematic because they're reducing the employment potential even on people who never get on the SSDI program.

Representative Schweikert. So from both ends.

Dr. Duggan. Right.

Representative Schweikert. We seem around here quite willing to do pension smoothing, and we all know how, let's face it, a fraud that is. Maybe we could do something that is actually useful, and some pension smoothing on that cliff.

Dr. Duggan. Right.

Representative Schweikert. And be—I think benefit smoothing.

Dr. Duggan. And we can learn something. You know, the population served by welfare, temporary assistance to needy families and the SSDI population are somewhat different, so it's not like—but I think learning somewhat from that experience, and trying to translate some of that knowledge to this program so that we can improve our work incentives both for people—there's people on the program, and then there's people who might go on the program in the future.

And those are two different groups. And the interventions, moving away from this kind one-size-fits-all approach to approach that is somewhat more flexible and nimble I think could, you know, really substantially increase employment among, of this group.

Representative Schweikert. Thank you for your patience, Mr. Chairman.

Chairman Coats. Thank you. I am told Senator Lee is on his way back. While he's not here yet, the Ranking Member would like to I think——

Representative Maloney. I would like to make some points that are in my opening statement. But first, if I could, ask Ms. Vallas if she would like to respond to Duggan's points about work incentives.

There has been a lot of talk about it today. How many can we expect to return to work? Personally, I love to work. I've got to think most people want to work. This is just a problem that is a life raft to many people that are out of work.

But I would like you to respond to his points—and really, realistically in the work that you have done, how many can we expect to return to work?

Ms. Vallas. Thank you so much for the question. I really appreciate it.

You mentioned that SSDI can be a life raft for people. I think what we need to be careful not to do is to blame the life raft for the floods.

So it is important on the one hand to be aware of the work incentives that already exist, and to understand how they work. I think it is also important to understand what other types of policies we need that do not necessarily lie within the Social Security Disability Insurance Program, and which could help stem that flow of people onto the program.

So just to quickly explain the work incentives that do exist. Individuals receiving these benefits are allowed to earn up to $1,090 per month and keep every one of those dollars, and not lose a single dollar in their benefits. They are allowed to do that. And about one in six beneficiaries do do some work at any given point during the year.

However, fewer than one in six have earnings of even $1,000 during the entire year. And just 3.9 percent earn more than $10,000 during the year. Hardly enough to support themselves.

So extremely limited work capacity of the vast majority of people who are on this program. I would agree wholeheartedly with Dr. Duggan that what we need to be doing is looking at earlier in the process before people get to the doors of the Social Security Administration.

And I will read you a quote from the National Council on Disability that I think sums this up really well:

"Receipt of Social Security Disability Benefits is merely the last stop on a long journey that many people with disabilities make from the point of disability onset to the moment at which disability is so severe that work is no longer possible. All along this journey, individuals encounter the policies and practices of other systems involved in disability and employment issues."

So I welcome this bipartisan conversation about how we can support employment among people with disabilities, but we will be incredibly myopic if we limit our focus only to the DI program. We need to be thinking about policies that are critical for workers with disabilities such as paid leave, and paid sick days, and ensuring access to long-term supports and services.

These are the kinds of policies that will make it possible for people to stay at work longer and not need to access DI benefits. And I would hope that they will be part of the mix as we continue to look at this important program and issue.

Representative Maloney. Okay. I want to thank you for all of your perspectives, and particularly Chairman Coats for calling today's hearing. The Social Security Disability Insurance Program is a critical part of our safety net that protects each of us in the event of a life-changing injury or illness prevents us from working to earn a living.

We all have an interest in making this program as strong and successful as possible. And the recent Budget Agreement extended solvency of the Disability Insurance Trust Fund through 2022, and took important steps to bolster anti-fraud programs and to strengthen program integrity.

But today we did hear concerns about the SSDI. We did hear that SSDI is plagued by fraud and abuse; that the program is growing at out-of-control rates, that it is easy to get on SSDI and that it discourages work.

These assertions are largely not supported by the facts. SSDI is an insurance program. Workers earn benefits by paying a small tax, less than one percent of their taxable income, over years of work. The typical disabled worker worked for 22 years before becoming disabled, and none of us knows if he or she will need disability benefits at some time in our lives.

But a young person starting her career or his career today has a one in four chance of needing SSDI before reaching retirement.

Today there are nearly 11 million SSDI beneficiaries, including nearly 9 million disabled workers, and almost 2 million spouses and children of disabled workers. Those who receive benefits face severe and long-lasting impairments, including Alzheimer's, cancer, blindness, lupus, multiple sclerosis, and many other diseases.

SSDI benefits are modest, but critical. The average monthly benefit, as Ms. Vallas has said, is $1,165, slightly over the poverty line. SSDI is the only source of income for one in three beneficiaries, and it is the main source of income for more than four in five.

There are several misconceptions about SSDI. I hope that today's hearing has cleared up some of these misconceptions. I would say the number one is that it is rift and filled with fraud, and we have seen vivid cases of fraud in the media, for example, a man doing yard work while collecting disability.

And let's be clear that any fraud or misuse of the system is a waste of taxpayer money. It is unacceptable and really needs to stop. However, SSDI fraud is rare, according to the Social Security Administration, the improper payments rate was less than one percent in fiscal year 2013.

The IG of the Social Security Administration is here today to tell us about successful fraud fighting initiatives like the Cooperative Disability Investigations, and Continuing Disability Reviews.

Every dollar spent on CDI efforts to investigate initial claims, for example, saves as much as $17. So these are powerful programs, and I am pleased that the Budget Agreement doubles CDI capacity to track down people who are trying to claim disability unfairly.

And it is a credit to Mr. O'Carroll and to the IG's office that this work is tracked carefully so as policymakers we are not forced to make decisions on the basis of anecdotal evidence.

So let us use hard data to make sure that SSDI serves the people who really need it.

The number two misconception, I believe, is SSDI is growing at out-of-control rates, driven by people who did not really need the benefits. The overwhelming body of evidence shows that the growth in SSDI beneficiaries and program costs is largely due to demographic changes like the aging of the Baby Boomers and the huge increases in the number of working women.

As the Baby Boomers have aged, they have moved into age brackets that are more prone to disability. A worker is twice as likely to be disabled at 50 as 40, and twice as likely at 60 as 50. This alone drives a large part of the increase in the number of people who receive disability benefits.

Likewise, as women have entered the work force in greater numbers, they became eligible for SSDI. While women accounted for less than 40 percent of those insured for SSDI in 1980, they make up close to half of those insured for benefits today.

The Center on Budget and Policy Priorities finds that nearly 70 percent of growth in SSDI beneficiaries since 1980 is explained by demographic factors. New peer-reviewed research from Harvard Economist Jeffrey Liebman confirms the key role demographic factors have played. But these trends have generally played themselves out. As Baby Boomers continue to age and move from disability to retirement, the increase in beneficiaries has reached its lowest level in more than 30 years.

The third misconception is that SSDI is easy to get. Not so, as Ms. Vallas pointed out. The United States has among the most stringent eligibility criteria. Applicants must provide extensive medical documentation of the disability, and show that they are unable to do their prior job, and any job in the national economy. And that is a high bar.

In fact, about two-thirds of disability insurance applications are denied. And as Dr. Duggan notes in his testimony, in 2014 the share of applicants approved for SSDI was at the lowest level in history.

Another large misconception, number four, once on disability beneficiaries have no incentive to return to work. In fact, SSDI allows beneficiaries to earn $1,090 a month with no impact on benefits. In other words, beneficiaries who receive disability have a very high incentive to work.

The Budget Deal calls for more initiatives to test whether smoothing out the so-called "cash cliff" and replacing it with a gradual offset would help more people to increase their work and earnings. And the Obama Administration has advocated for early

intervention strategies to help keep disabled workers employed and off the DI rolls in the first place.

And both ideas are worth exploring. But we must recognize that most SSDI recipients simply cannot work. They struggle with injuries and illnesses. They have earned those benefits, and any one of us could be in that situation. And that is why we need and must protect Social Security Disability Insurance.

And I thank the Chairman for allowing me to put my comments in the record. And I see the Senator has returned.

Chairman Coats. We welcome Senator Lee, because we would have closed out thinking that perhaps you weren't going to come, but we are glad you did. And the timing is perfect.

Senator Lee. Thank you very much, Mr. Chairman. And thank you, Representative Maloney, for accommodating my schedule.

Chairman Coats. Let me just state this, also, for the benefit of the Ranking Member. The hearing record will as usual remain open for five business days for questions to be put in the record.

Senator Lee.

Senator Lee. Thank you very much. Thanks to all of you for being here.

Dr. Duggan, I would like to talk to you for a minute. You, along with David Autor, talked about the role that private disability insurance might be able to play in alleviating some of the pressure that is currently brought to bear on the SSDI program.

While I personally don't think that mandatory private disability insurance is an appropriate, feasible path forward, I have been working on a proposal that would provide an incentive by a payroll tax reduction for employers and self-employed individuals to purchase private disability insurance, creating something of an incentive for them to buy it.

Relative to your proposal of universal private disability insurance, I would like to get your perspective on an incentivized employer option to provide private disability insurance for two years of insurance coverage at 50 percent, at a rate of 50 percent of a covered individual's income.

The incentive would be a reduction in payroll tax liability by 0.25 percentage points of the employer's side payroll taxes, would last no longer than two years, and may require medical treatments for plan participants if such treatments may provide the—may improve the individual's ability to work.

Can I just get your thoughts on that, whether you think that would help?

Dr. Duggan. So I think—so, yes, David Autor, Professor Autor and I put together a proposal that involved private disability insurers, partly because private disability insurers are able to move away from a sort of one-size-fits-all approach, and instead tailor somewhat whatever interventions they make with individuals to the specifics of the person.

So to give you a sense of what we had in mind, just to give you a quick recap and then to connect to yours, was the idea that private disability insurer would have a vast amount of experience with getting people back to work, covering people let's say for disabilities that they incur, but helping them get back to work and working with the employer because both then the private disability

insurer and the employer have skin in the game to some extent to get this person, to help this person's health improve and to keep them engaged in the work force.

And the Netherlands has had some experience with this, and Richard Burkhauser at Cornell has written some on this, and the evidence from the Netherlands indicates that this has led to reduction in enrollment, ultimately, in their public disability programs because the private disability insurers can sort of help individuals address whatever disabilities they have, improve their health somewhat, and stay engaged in the work force

So there are lots of examples of things that an insurer can do. But to some extent that kind of rapid early intervention that insurers are good at, that the private insurers can be good at, can be a way to keep people from going into public disability insurance for a long time.

Senator Lee. Okay, so you think there is a possibility that this kind of thing could work, if you provide some incentive for the employer, or for self-employed individuals that might help?

Dr. Duggan. Yes. You know, with something like this the devil is in the details, but I think part of the reason that Autor and I looked into that was based on our own research and reading of the research out there, was that this would be a good way to stem flows to the program by moving away from somewhat of a one-size-fits-all approach.

Senator Lee. Right, right. And incentivizing the kind of behavior that will lead to fewer risks for the system.

Dr. Duggan. Yes, exactly. I mean I think that's part of the reason that Worker's Comp, for example—Worker's Comp isn't always working perfectly, but it is the way that it's designed. And I know it's mandatory and this wouldn't be mandatory, but basically the insurers and the employers are on the same page with respect to wanting to keep people off the program in the first place. And if they get on it, get them back to work as quickly as possible.

Senator Lee. Right, right. I thank you for your response to that and for your input. And I would love to continue to get your input as this idea is developed.

Dr. Duggan. Yeah, if I can help in any way, it is an area—disability is an area I have been working on for a long time, and if I can help with my own research on anything I am happy to help anyone on improving the program.

Senator Lee. That is very helpful. I think it is important to talk about other reforms to SSDI, but I do want to highlight the fact that the private group long-term disability insurance, according to one study, already saves federal programs $2 billion a year.

And so I think this is an area that is very much ripe for exploration and am glad to have had this discussion with you. And I thank you for your input.

Dr. Duggan. And just one last thing on that. One-third of workers do have private disability insurers through their employers. So right off the bat there is a set of people who already have a private disability coverage. So it's just worth nothing.

Senator Lee. Great. Thank you very much.

Thank you, Mr. Chairman.

Chairman Coats. Thank you, Senator. I want to thank my colleagues. As the witnesses and those who are here have seen, there is a significant interest in this subject. I particularly want to thank our witnesses. I thought it was a very constructive discussion. All three of you participated and gave us a lot of information I think that will be helpful in dealing with reforming a program that is a necessary program for obviously those who qualify, and something we want to show that we have taken the efficiencies and the effectiveness to make this a program we can all be proud of.

So thank you very much for this. And with that, this hearing is closed.

(Whereupon, at 4:12 p.m., Wednesday, November 4, 2015, the hearing was adjourned.)

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF HON. DAN COATS, CHAIRMAN, JOINT ECONOMIC COMMITTEE

The committee will come to order.

First, I want to thank Senator Cotton for asking the Committee to examine how we can improve the Social Security Disability Insurance program.

The SSDI program was originally created as a safety net for primarily older workers whose disabilities prevented them from working. In the subsequent decades we have witnessed an expansion of program eligibility, accompanied by a sharp increase in the number of claimants.

As of today, nearly nine million Americans receive Social Security Disability Insurance benefits, including almost five percent of working age adults. In total, SSDI accounts for about 15 percent of benefits paid through the Social Security Administration.

While the SSDI program was originally crafted to maintain the principles of rehabilitation and return to work, statistics show that this rarely happens today and the program's underlying structure disincentivizes many from working.

The Bipartisan Budget Act, passed by Congress last week, did take some steps toward improved SSDI program operation. For instance, the SSDI program will begin to test an alternative to the current "cash cliff" in an effort to address disincentives for claimants to return to work. The bill also includes important program integrity reforms, such as enhancing fraud enforcement and deterrence measures as well as requiring regular case reviews to confirm claimant eligibility.

While these actions are useful, they do not address the long-term solvency questions facing the SSDI program. As a result, last week's budget agreement temporarily shored up the program by transferring funds from the Old Age and Survivors Trust Fund.

Today, we want to examine how we can ensure success for the Social Security Disability Insurance Program and its beneficiaries over the long term. This includes measures to assist the successful transition of individuals to the workplace, which impacts their personal well-being as well as the fiscal sustainability of the program.

We must also ask how current administrative processes can be reformed. The current SSDI program review and appeal system is burdened by a backlog that increases risk of fraud and slows awards of benefits to individuals who need them.

The SSDI program is also plagued with improper payments. Just last week, the Government Accountability Office outlined billions of dollars in overpayments. The Social Security Administration Inspector General, here with us today, has also studied this issue, finding overpayments to 44.5 percent of sampled claimants.

There is clearly much work to be done to improve the administration of the SSDI program.

I would like to welcome our witnesses and thank them for being here today to discuss how we can address all these issues and leave with a better understanding of steps we should consider to improve the SSDI program for both current and future claimants.

I now recognize Ranking Member Maloney for her opening statement.

PREPARED STATEMENT OF HON. CAROLYN B. MALONEY, RANKING DEMOCRAT, JOINT ECONOMIC COMMITTEE

Chairman Coats, thank you for calling today's hearing. The Social Security Disability Insurance (SSDI) program is a critical part of our safety net that protects each of us in the event of a life-changing injury or illness that prevents us from working and earning a living. We all have an interest in making this program as strong and successful as possible.

The recent budget agreement extended the solvency of the Disability Insurance Trust Fund through 2022 and took important steps to bolster anti-fraud programs, strengthening program integrity.

Nevertheless, it's likely that some concerns about SSDI will be raised this afternoon. We may hear that SSDI is plagued by fraud and abuse; the program is growing at an out-of-control rate; it's easy to get SSDI; and the program discourages work.

These assertions are largely not supported by the facts.

SSDI is an insurance program. Workers earn benefits by paying a small tax—less than 1 percent of their taxable income—over years of work. The average beneficiary worked for 22 years before becoming disabled.

None of us knows if we will need disability benefits sometime in our lives. But a young person starting her career today has a one in four chance of needing SSDI before reaching retirement.

WHO RECEIVES DISABILITY BENEFITS

Today, there are nearly 11 million SSDI beneficiaries, including nearly 9 million disabled workers and almost 2 million spouses and dependent children of disabled workers.

Those who receive benefits face severe and long-lasting impairments including Alzheimer's, amputations, cancer, congestive heart failure, blindness, lupus, gastrointestinal hemorrhaging, cerebral palsy, multiple sclerosis, traumatic brain injury, intellectual disability, schizophrenia and severe depression.

SSDI benefits are modest, but critical. The average monthly benefit is $1,165—slightly over the poverty line. SSDI is the only source of income for one in three beneficiaries. It is the main source of income for more than four in five.

There are several misconceptions about SSDI. I hope that today's hearing can help to clear up some of the more common ones.

MISCONCEPTION #1: SSDI IS RIFE WITH FRAUD

We have seen vivid cases of fraud in the media—for example, a man doing yard work while collecting disability payments. Let's be clear—any fraud or misuse of the system is a waste of taxpayer money and is unacceptable.

However, SSDI fraud is rare. According to the Social Security Administration, the improper payment rate was less than one percent in FY 2013.

The Inspector General of the Social Security Administration is here today to tell us about successful fraud-fighting initiatives like Cooperative Disability Investigations (CDI) and Continuing Disability Reviews.

Every dollar spent on CDI efforts to investigate initial claims, for example, saves as much as $17. These are powerful programs and I'm pleased that the budget agreement doubles CDI capacity to track down people who are trying to claim disability benefits unfairly.

It is a credit to the Inspector General that this work is tracked carefully, so as policy makers we aren't forced to make decisions on the basis of anecdotal evidence. Let's use hard data to make sure that SSDI serves the people who really need it.

MISCONCEPTION #2: SSDI IS GROWING AT AN OUT-OF-CONTROL RATE DRIVEN BY PEOPLE WHO DON'T REALLY NEED DISABILITY BENEFITS

The overwhelming body of evidence shows that the growth in SSDI beneficiaries and program costs is largely due to demographic changes like the aging of the baby boomers and the huge increases in the number of working women.

As the baby boomers have aged, they have moved into age brackets that are more prone to disability. A worker is twice as likely to be disabled at age 50 as at 40, and twice as likely at age 60 as at 50. This alone drives a large part of the increase in the number of people who receive disability benefits.

Similarly, as women have entered the workforce in greater numbers, they became eligible for SSDI. While women accounted for less than 40 percent of those insured for SSDI in 1980, they make up close to nearly half of those insured for benefits today.

The Center on Budget and Policy Priorities finds that nearly 70 percent of growth in SSDI beneficiaries since 1980 is explained by demographic factors. New peer-reviewed research from Harvard economist Jeffrey Liebman confirms the key role demographic factors have played.

But these trends have generally played themselves out. As baby boomers continue to age and move from disability to retirement, the increase in beneficiaries has reached its lowest level in more than 30 years.

MISCONCEPTION #3: IT'S EASY TO GET SSDI

This is not so. The United States has among the most stringent eligibility criteria in the OECD.

Applicants must provide extensive medical documentation of their disability and show that they are unable to do their prior job and any job in the national economy. That's a high bar.

In fact, about two-thirds of disability insurance applications are denied. And as Dr. Duggan notes in his testimony, in 2014 the share of applicants approved for SSDI was at its lowest level in history.

MISCONCEPTION #4: ONCE ON DISABILITY, BENEFICIARIES HAVE NO INCENTIVE TO RETURN TO WORK

In fact, SSDI allows beneficiaries to earn $1,090 a month with no impact on benefits. In other words, beneficiaries receiving disability have a very high incentive to work.

The budget deal calls for more initiatives to test whether smoothing out the so-called "cash cliff" and replacing it with a gradual offset would help more people to increase their work and earnings.

And the Obama Administration has advocated for early intervention strategies to help keep disabled workers employed and off the SSDI rolls in the first place.

Both ideas are worth exploring.

But we must recognize that most SSDI recipients simply cannot work—they struggle with debilitating injuries and illnesses. They have earned these benefits. Any one of us could be in that situation. And that is why we need and must protect Social Security Disability Insurance.

Center on Budget and Policy Priorities | POLICY FUTURES

Updated October 19, 2015

Chart Book:
Social Security Disability Insurance

Introduction

Disability Insurance (DI) is an integral part of Social Security. It provides modest but vital benefits to workers who can no longer support themselves on account of a serious and long-lasting medical impairment. The Social Security Administration (SSA) administers the DI program.

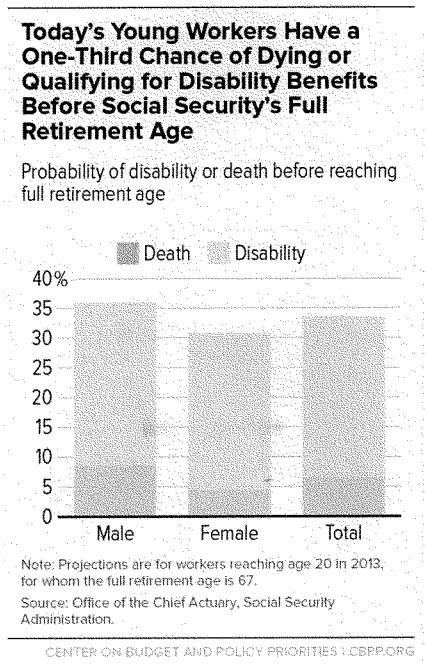
In December 2014, nearly 9 million people received disabled-worker benefits from Social Security. Payments also went to some of their family members: 150,000 spouses and 1.8 million children.

DI benefits are financed primarily by a portion of the Social Security payroll tax and totaled about $141 billion in 2014. That's 4 percent of the federal budget and less than 1 percent of the gross domestic product (GDP). Employers and employees each pay a DI tax of 0.9 percent on earnings up to a specified amount, currently $118,500. Financial transactions are handled through a DI trust fund, which receives payroll tax revenues and pays out benefits and which is legally separate from the much larger Social Security retirement fund. Under current projections, the DI trust fund will need replenishment in 2016.

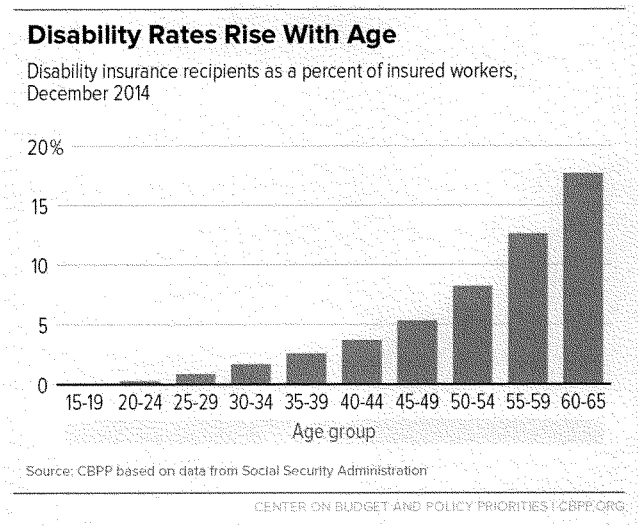
The following charts provide important background information about Social Security Disability Insurance.

Part I: Why Is Social Security Disability Insurance Important?

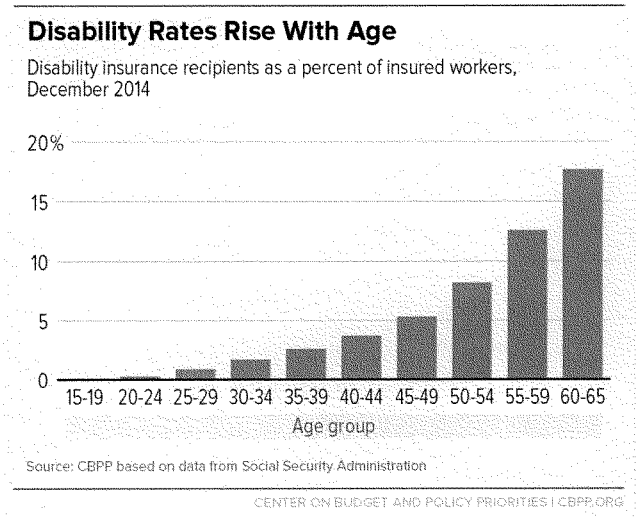
Social Security is much more than just a retirement program. A young person starting a career today has a one-third chance of dying or qualifying for Social Security Disability Insurance (DI) before reaching Social Security's full retirement age.



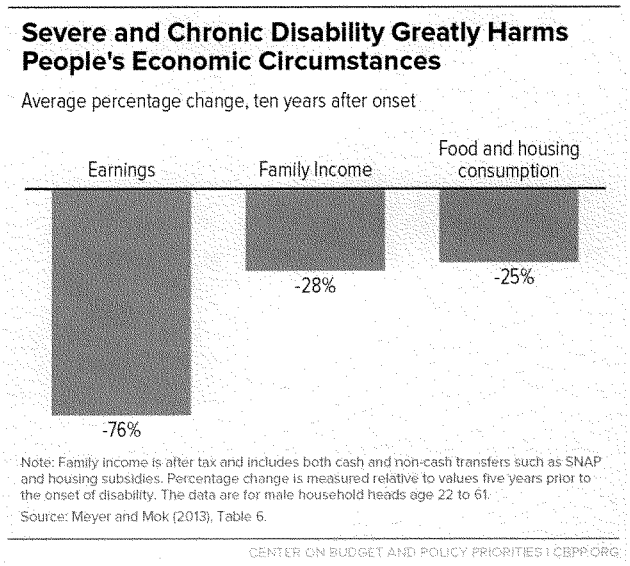
DI is an earned benefit that offers vital protection to millions of workers. Through their payroll tax contributions, more than 150 million workers have earned DI protection in case of a severe, long-lasting medical impairment. Nearly 9 million of them receive disabled-worker benefits from DI.



The risk of disability rises with age. People are twice as likely to collect DI at age 50 as at 40 — and twice as likely at age 60 as at age 50.



Disability can have devastating economic consequences. Not only can disability happen to anyone — especially with advancing age — but it greatly harms people's economic circumstances. Reductions in the worker's earnings, total family income, and purchases of essentials like food and housing are deep.

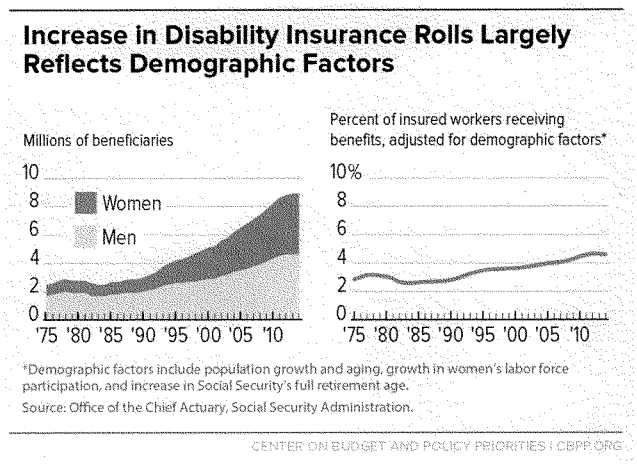


Part II: Why Have the DI Rolls Grown?

Recent growth in the DI rolls stems mostly from well-understood demographic factors. The number of DI beneficiaries has grown significantly in recent decades, but that growth chiefly reflects four factors:

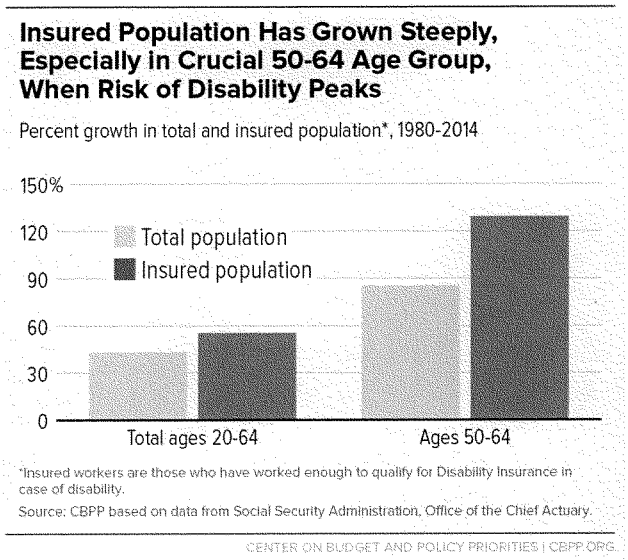
- Population growth
- Aging of the baby boom
- Growth in women's labor force participation
- Rise in Social Security's full retirement age from 65 to 66

When adjusted for these factors, the share of insured workers receiving DI benefits has grown only modestly.

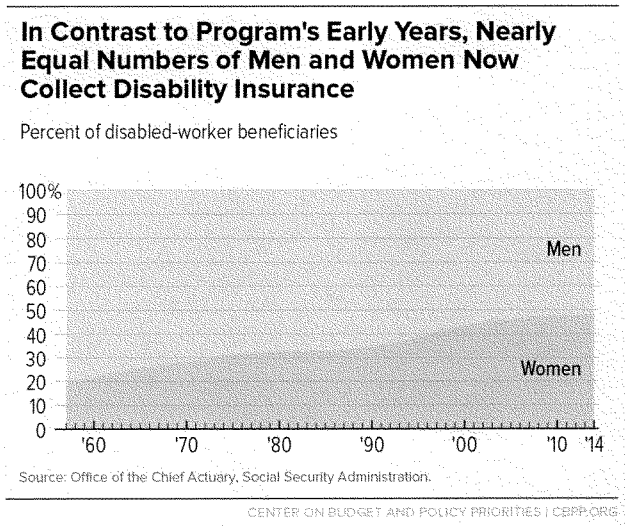


Not only has the population grown, but the DI-insured population has grown even faster, especially in the 50-64 age group. Population growth, aging, and women's labor-force participation have boosted the eligibility pool for DI. Baby boomers — born between 1946 and 1964 — have aged into their 50s and 60s, years of peak risk for disability. And female boomers, unlike earlier generations of women, are overwhelmingly likely to have worked enough to be insured for DI.

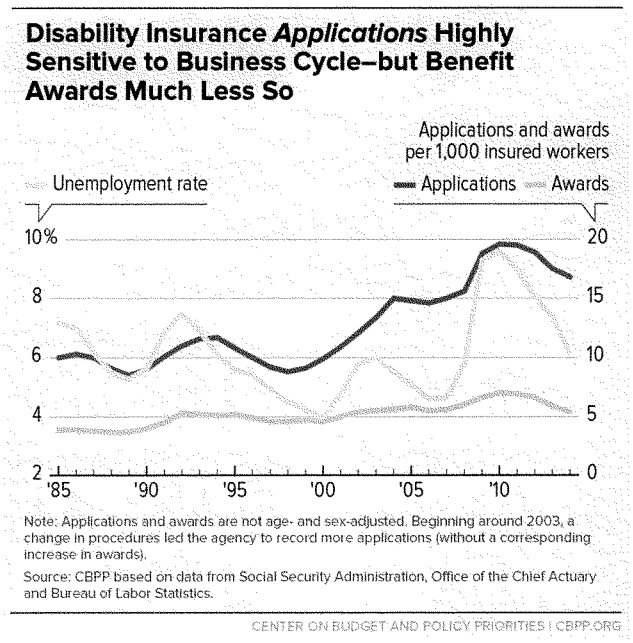
Those demographic pressures have already begun to subside, as later charts show.



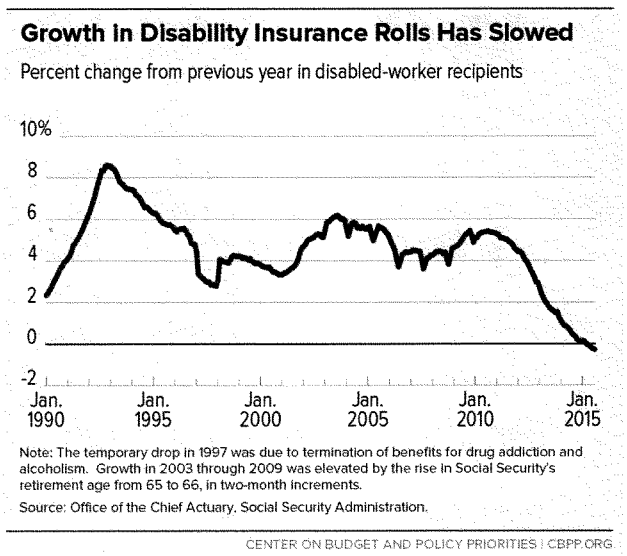
Women DI beneficiaries have caught up with men. In DI's early years, male beneficiaries vastly outnumbered women. As late as 1990, that ratio was almost 2 to 1. Now, with the growth of women's participation in the labor force, nearly equal numbers of men and women collect DI.



The Great Recession, like previous recessions, swelled DI applications much more than awards. Higher unemployment leads more workers to apply for DI, but that doesn't translate into a proportionate rise in awards; approval rates fall when unemployment is high. News stories that focus on "soaring applications" for DI omit that crucial fact.



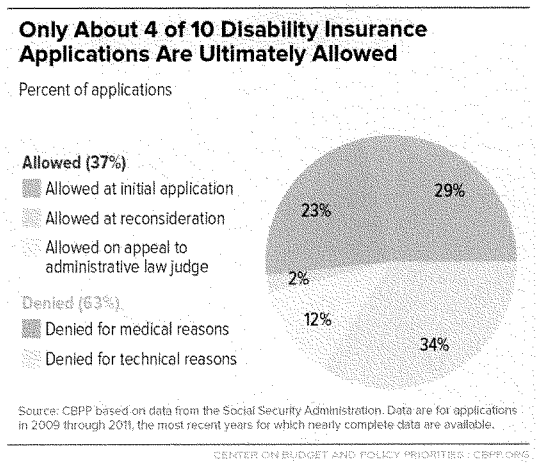
Growth in the DI rolls has slowed. In recent months, growth in the number of DI beneficiaries has slowed to its lowest rate in 25 years. Both demographic and economic pressures on the program are easing.



Part III: Who Receives DI?

Eligibility criteria are strict, and most DI applicants are rejected. Applicants for DI benefits must be —

- Insured for disability benefits (essentially, they must have worked for at least one-fourth of their adult life and five of the last ten years).
- Suffering from a severe, medically determinable physical or mental impairment that is expected to last 12 months or result in death, based on clinical findings from acceptable medical sources.
- Unable to perform "substantial gainful activity" (any job that generates earnings of $1,090 per month for most people, $1,820 for blind people) anywhere in the national economy — regardless of whether such work exists in the area where the applicant lives, whether a specific job vacancy exists, or whether he'd be hired.

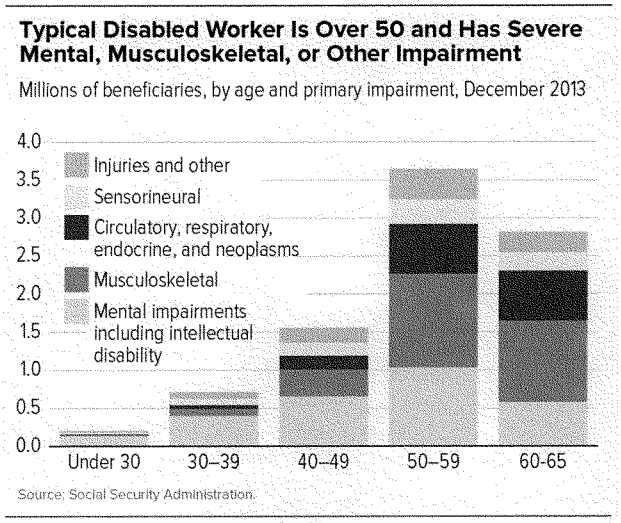


Lack of education and low skills are considered for older, severely impaired applicants who can't realistically change careers.

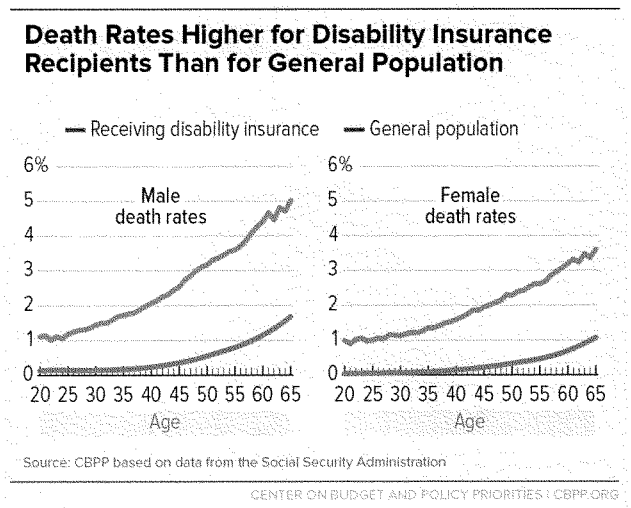
The Social Security Administration (SSA) weeds out applicants who are technically disqualified (chiefly because they haven't worked long enough) and sends the rest to state disability determination services for medical evaluation. Applicants denied at that stage may ask for a reconsideration by the same state agency, and then appeal to an administrative law judge at the SSA. Ultimately, only about four of ten applicants are awarded benefits.

There is a five-month waiting period for DI, but Supplemental Security Income may be available during that period for very poor claimants with little or no income and assets.

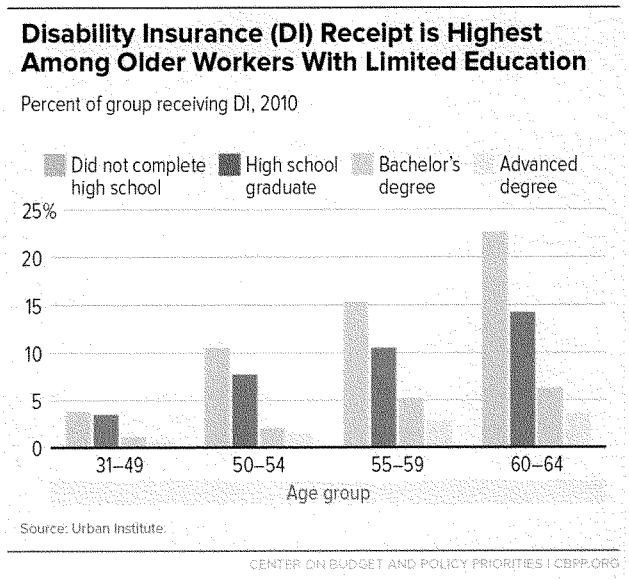
DI beneficiaries are mostly older and have severe physical or mental impairments. The typical DI beneficiary is in his or her late 50s — 70 percent are over age 50, and 30 percent are 60 or older — and suffers from a severe mental, musculoskeletal, or other debilitating impairment. Mental disorders — including intellectual disability (formerly called mental retardation), mood disorders such as bipolar disease and crippling depression, organic mental disorders associated with brain disease or damage, psychotic disorders such as schizophrenia, and other mental impairments — account for almost half of beneficiaries under age 50. Physical disorders dominate among the far greater number of beneficiaries who are 50 or older.



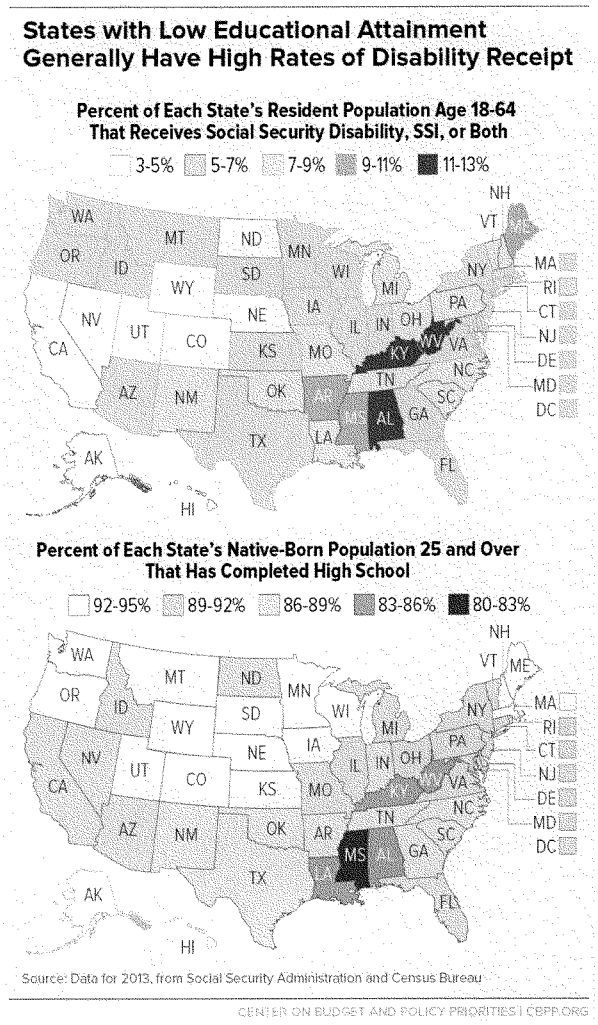
DI beneficiaries experience high death rates. Mortality among older DI beneficiaries — who dominate the program's rolls — is three to six times the average for their age group. Many die within a few years of qualifying for DI.



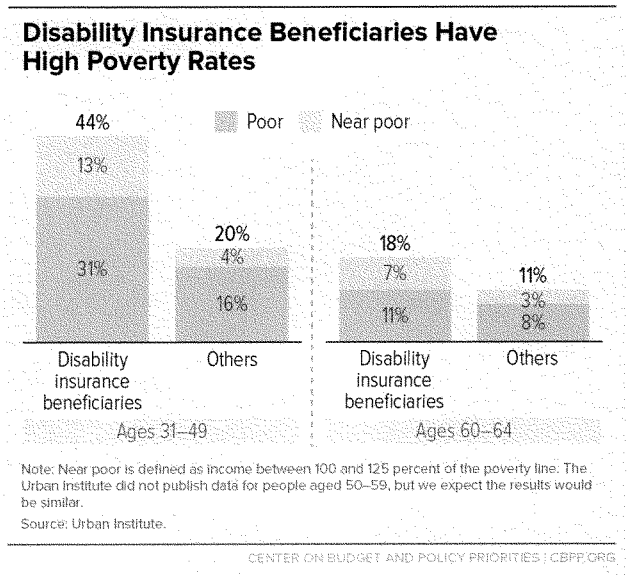
People with limited education are much likelier to collect DI. Those with limited education and skills generally have to do arduous work and can't switch to something sedentary. Thus, people without a college degree are far more likely to collect DI.



Disability beneficiaries exhibit a distinct geographic pattern. States with low high-school completion rates, high median age, few immigrants, and a blue-collar industry mix tend to have more DI beneficiaries. Isolated pockets with unusually high rates of receipt are extreme outliers.



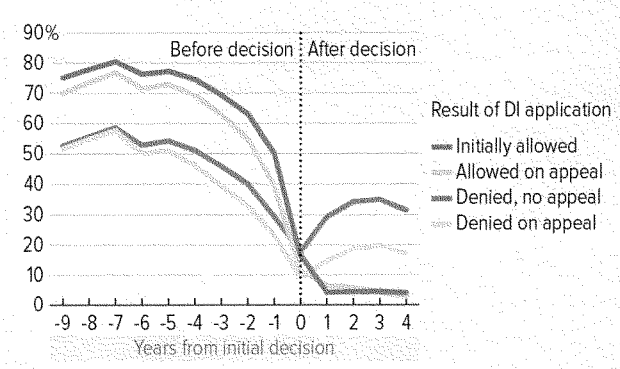
Many DI beneficiaries are poor. Poverty rates are about twice as high for DI beneficiaries — even after taking their DI benefits into account — as for others. Overall, about one-fifth of all disabled-worker families are poor; without DI, nearly half would be.



DI beneficiaries have limited work capacity. DI applicants typically suffer a sharp drop in earnings before turning to the program. The most severely impaired — who are awarded benefits — seldom work afterward. Even rejected applicants fare poorly in the labor market afterward, more evidence that the program's eligibility criteria are strict.

DI Applicants Experience Sharp Drop in Earnings Before Application; Few Work Afterward

Percent of DI applicants performing substantial gainful activity before and after initial decision



Source: Nicole Maestas, Kathleen Mullen, and Alexander Strand, "Does Disability Insurance Receipt Discourage Work? Using Examiner Assignment to Estimate Causal Effects of SSDI Receipt," Michigan Retirement Research Center Working Paper 2010-241. Additional plot points, through 4 years after decision, courtesy of the authors.

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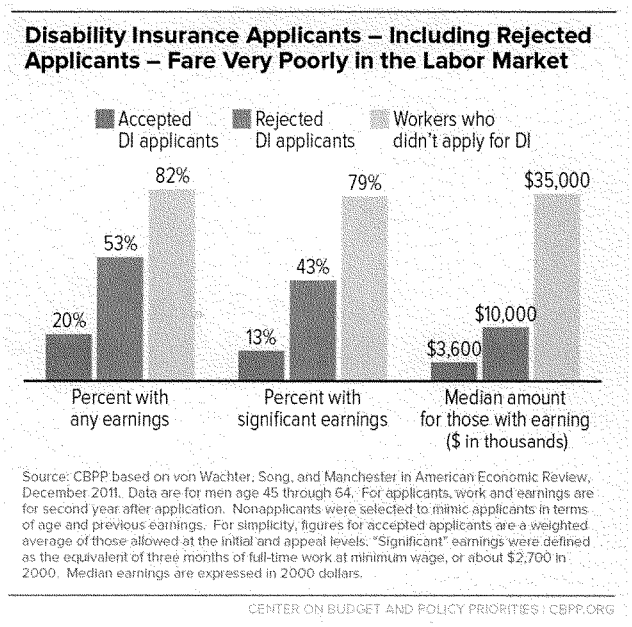
Although DI allows beneficiaries to supplement their benefits through work, few are able to do so. Program rules allow and encourage DI beneficiaries to earn up to the "substantial gainful activity" level ($1,090 a month in 2015, about 40 percent of average earnings for a high-school graduate with no college). Beneficiaries may earn unlimited amounts for a nine-month trial work period and a subsequent three-month grace period before benefits are suspended. Even then, they may return to the DI rolls if their earnings fall. And former beneficiaries who've returned to work may keep their Medicare (which is available to DI beneficiaries after two years on the rolls) for seven and a half years after their cash benefits stop.

But most DI beneficiaries can't work. Only about 28 percent *ever* work after starting to receive benefits, 7 percent have benefits suspended for at least one month because of work, and 4 percent have benefits terminated because of sustained work.

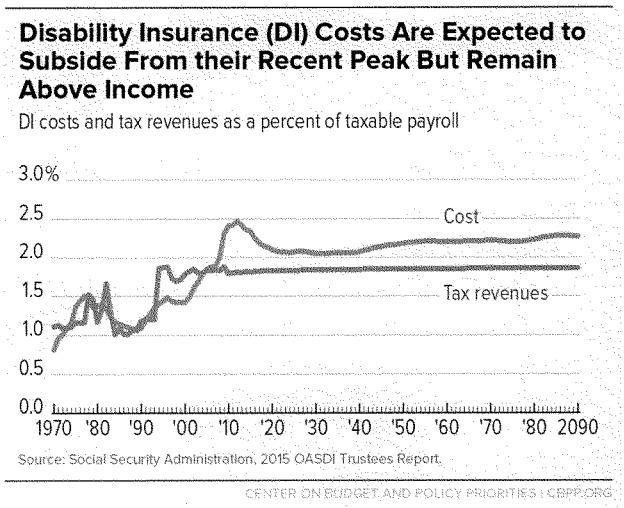
In contrast, workers of the same age who don't seek DI benefits are likely to work and have substantial earnings.



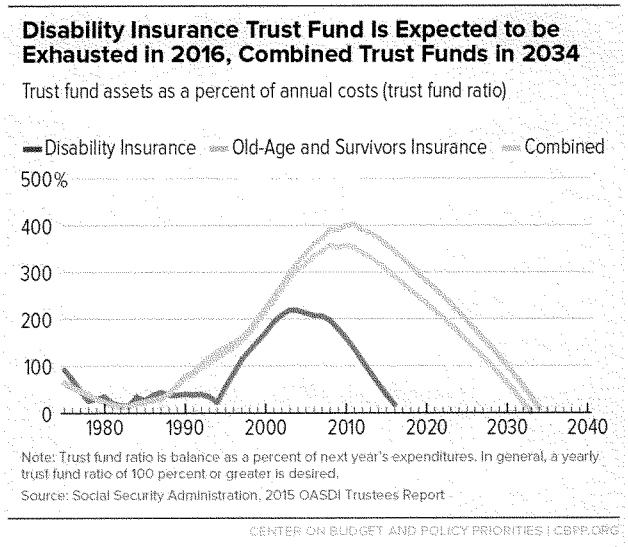
Part IV: What Financing Issues Does DI Face?

DI costs will level off, but the program faces a long-run funding gap. DI costs will subside in coming years and then level off as the economy continues to mend and baby boomers who receive DI move from Social Security's disability rolls to its retirement rolls. (Disabled workers are converted to retired workers at the full retirement age — currently 66 and scheduled to rise to 67 — and the oldest baby boomers are fast reaching that milestone.)

But DI costs will still exceed revenues. For both the DI and retirement programs, the shortfall over the next 75 years is about one-fifth of income or one-sixth of costs.



The disability and retirement programs have financial challenges but don't face "bankruptcy." The DI trust fund is expected to be exhausted in 2016, the much larger Old-Age and Survivors Insurance (OASI) trust fund in 2035, and the combined funds in 2034 (if legislators shifted money from the retirement fund to the DI fund as needed to keep it solvent). Even after those dates, the programs could pay 75 to 80 percent of scheduled benefits; they would not go "bankrupt." DI's 2016 depletion date is no surprise — the trustees projected it back in 1995.



Disability Insurance Trust Fund Is Expected to be Exhausted in 2016, Combined Trust Funds in 2034

Trust fund assets as a percent of annual costs (trust fund ratio)

Note: Trust fund ratio is balance as a percent of next year's expenditures. In general, a yearly trust fund ratio of 100 percent or greater is desired.

Source: Social Security Administration, 2015 OASDI Trustees Report

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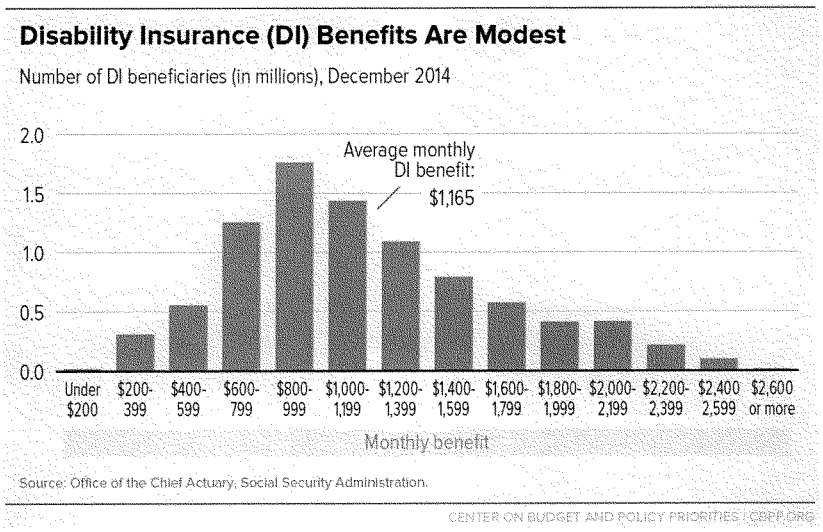
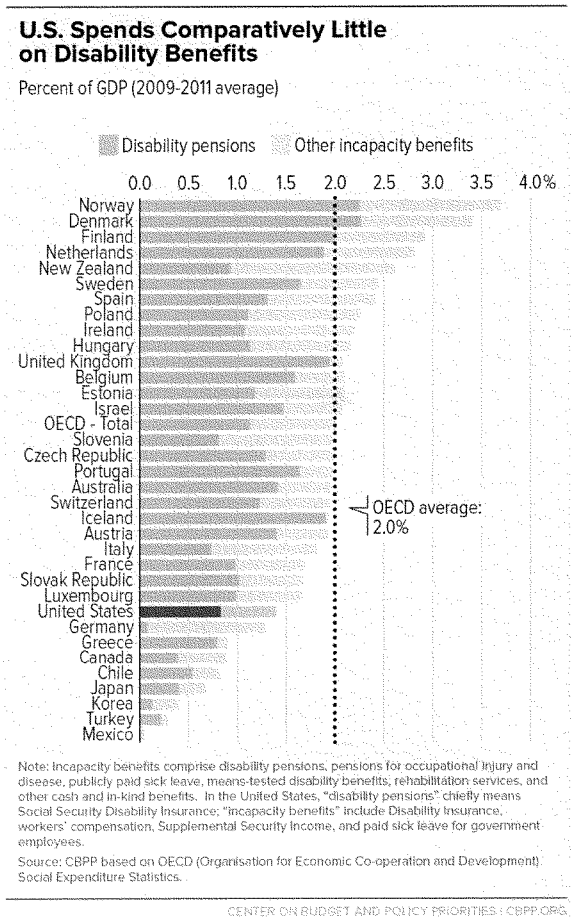
DI benefits are modest. The average disabled-worker benefit is about $1,165 a month; 92 percent of beneficiaries get less than $2,000 a month, and only 0.6 percent get more than $2,500.

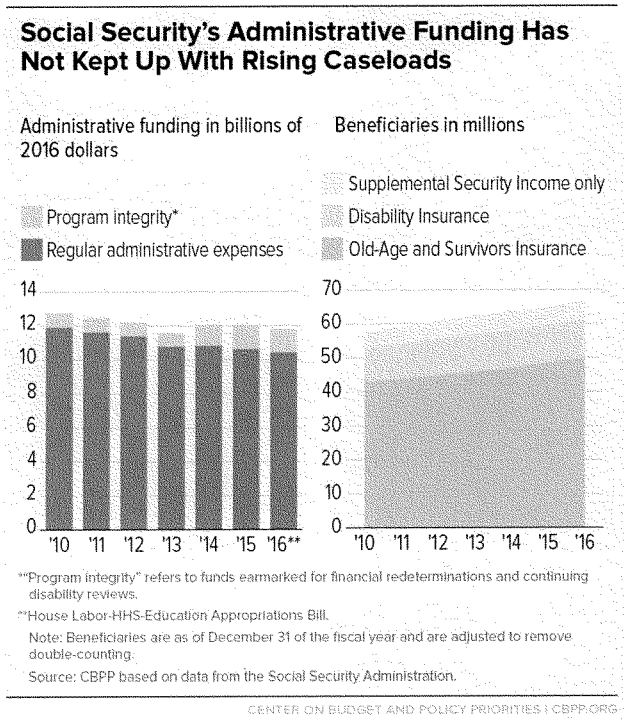
Most beneficiaries — especially unmarried ones — rely on DI for most of their income. DI benefits replace about half of past earnings for a median beneficiary.



Most other advanced countries spend more than the United States on disability benefits. U.S. eligibility rules are strict, and benefit levels are modest. The Organisation for Economic Co-operation and Development (OECD) reports that the United States has some of the most stringent eligibility criteria for disability benefits among advanced economies. OECD statistics confirm that, as a corollary, the United States spends less on disability benefits (as a share of the economy) than most other advanced countries.

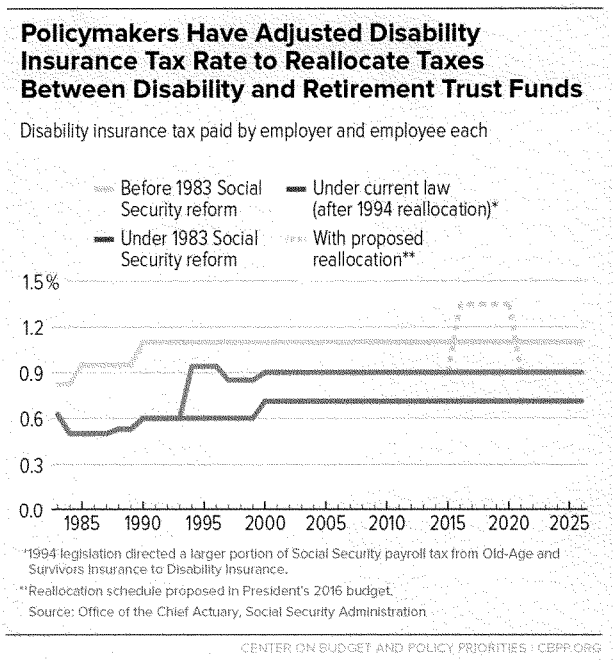


Social Security's administrative funding is inadequate. The Social Security Administration's administrative funding (which, unlike retirement and DI benefits, is subject to annual appropriation) has declined in real terms since 2010, even as caseloads have climbed. That has not only reduced the agency's ability to keep up with vital program integrity work to weed out improper payments, but has also impaired customer service.



Reallocating taxes from the OASI trust fund to the DI trust fund — by raising the DI tax rate and lowering the OASI tax rate — is necessary to avoid a nearly 20 percent cut in DI benefits after 2016. Under current law, workers and employers each pay 6.2 percent of taxable wages — consisting of 0.9 percent for DI and 5.3 percent for OASI — to Social Security. Raising the share of that 6.2 percent tax that goes to the DI trust fund for a few years would enable both the DI and OASI trust funds to pay scheduled benefits until 2033 while policymakers craft a balanced and comprehensive solvency package for all of Social Security.

Such reallocations have often occurred in the past — in either direction — and have not been controversial. Modifying the last two reallocations, enacted in 1983 and 1994, would replenish the DI fund while aiding seniors and barely affecting the larger OASI fund. Coordination between retirement and disability reforms is essential, since the two programs are closely linked.



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Corrections made May 6, 2015, in green.

Understanding the Increase in Disability Insurance Benefit Receipt in the United States[†]

Jeffrey B. Liebman

The share of working-age Americans receiving disability benefits from the federal Disability Insurance (DI) program has increased significantly in recent decades, from 2.2 percent in the late 1970s to 3.5 percent in the years immediately preceding the 2007–2009 recession and 4.4 percent in 2013.

Some experts have interpreted the increase as evidence of a need for significant reform. In this journal, Autor and Duggan (2006) describe the growth in the disability insurance rolls as "a fiscal crisis unfolding," report that "abuse [has] reached unsustainable levels," and conclude that "the DI screening process is effectively broken." In their view, changes in program rules enacted in 1984 made it easier for applicants to receive benefits for hard-to-verify impairments like back pain and depression. In conjunction with labor market developments that increased the incentive for low-wage workers to apply for benefits, these new program rules led to an increase in disability receipt.

Other experts attribute most of the increase in beneficiaries to baby boomers reaching their peak disability-claiming years and to increased labor force participation by women, which has made more women eligible to claim disability benefits (Reno 2011). Under this interpretation, disability enrollment rates and spending are unlikely to rise much further, because these demographic trends have largely run their course. Indeed, both the Social Security Administration actuaries (OASDI

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[†] To access the Data Appendix, visit
http://dx.doi.org/10.1257/jep.29.2.123

doi=10.1257/jep.29.2.123

Board of Trustees 2014) and the Congressional Budget Office (CBO 2012) project that spending on Disability Insurance will fall as a share of GDP in the coming decade as baby boomers convert from DI benefits to retirement benefits and are replaced in the peak disability-receiving ages by smaller cohorts.

With the federal Disability Insurance Trust Fund currently projected to be depleted in 2016, Congressional action of some sort is likely to occur within the next several years. It is therefore a good time to sort out the competing explanations for the increase in disability benefit receipt and to review some of the ideas that economists have put forth for reforming US disability programs.

The resolution of the competing explanations is a tale of two time periods. During the 1980s, policy changes caused receipt of Disability Insurance benefits first to plummet and then to rebound. In this period, the overwhelming majority of the change in disability benefit receipt came from changes in "incidence rates" (of new awards among the insured not already receiving benefits), though increased eligibility for benefits among women also played a role. Since the early 1990s, incidence rates among men, adjusted for the population age distribution and the business cycle, have been steady, while those for women have been gradually approaching those of men. In this period, population aging and increased eligibility among women account for two-thirds of the increase in DI benefit receipt, rising incidence among women accounts for one-fifth, and declining mortality rates account for one-sixth.

While adjusted incidence rates have mostly leveled off, there has been a change in the composition of DI recipients, with more recipients claiming benefits for hard-to-verify impairments and with the program playing an increasingly important role in providing income for low-skilled workers whose economic prospects have stagnated. Thus, the case for DI reform is not primarily a fiscal one—up until the 2007–2009 recession, spending on the program as a share of GDP had increased by only 0.13 percent of GDP over 30 years. Instead, it is about re-optimizing the program in light of the changing characteristics of the beneficiary population.

The US Disability Insurance System

The Social Security Administration projects that one-quarter of today's 20 year-olds will become disabled and receive benefits from the Disability Insurance program for some period of time before reaching age 67 (Social Security Administration 2014b). Thus, disability is a major economic risk—typically combining less ability to earn income with higher health-related costs—against which people should desire insurance. In theory, one could imagine a private system in which workers voluntarily purchase disability insurance throughout their careers; in practice, many if not most workers would fail to purchase such insurance. Moreover, the challenge of regulating a private disability insurance market to minimize both adverse selection and litigation over eligibility for insurance payments would be significant (Mashaw 1983). Thus, there is a rationale for a compulsory disability insurance system based on the myopia of consumers and the problems that would

be faced by private insurance markets in this area, just as there is for Social Security retirement benefits (Feldstein and Liebman 2002).

There are two main federal disability benefit programs in the United States that assist individuals with severe impairments. Social Security Disability Insurance (DI), the focus of this paper, is a contributory social insurance program that replaces lost wages of people with significant work histories. Supplemental Security Income (SSI) is a means-tested program that provides benefits to low-income disabled, blind, or aged people regardless of work history; SSI spending on disabled individuals accounts for approximately 80 percent of all SSI benefits.[1] In addition to cash benefits, these programs confer eligibility for government-provided health insurance—Medicare in the case of SSDI and Medicaid in the case of SSI.

The Social Security Act defines "disability" as the inability to engage in substantial gainful activity because of a medically determinable physical or mental impairment that is expected to last at least 12 months or result in death. To operationalize this definition, the Social Security Administration uses a five-step sequential process. The first two steps disqualify applicants who are currently earning above the substantial gainful activity limit ($1,090 per month in 2015) or who do not have a severe impairment or combination of impairments that is expected to last 12 months or result in death. The third stage compares the applicant's impairment to a listing of impairments, for each major body system, that are considered severe enough to prevent an individual from gainful activity. For example, someone with aggressive lymphoma will meet the listing level of disability and automatically qualify for benefits. For an applicant whose impairments do not automatically meet the listings, the SSA moves to the fourth stage, which involves assessing the person's residual functional capacity and considering whether the individual's impairments prevent the person from doing his or her past work. If so, the individual then moves to the fifth stage of the process, where the SSA considers the applicant's age, education, and work experience—known as the "vocational grids"—and decides whether the person's residual functioning capacity together with his or her place in the vocational grids prevents the applicant from doing other work that exists in the economy. For example, a 50 year-old applicant who is restricted by his impairment to do no more than sedentary work, has no transferable skills to do other work, and has a high school education or less will be found to be disabled, whereas a 50 year-old with more education and with transferrable skills to do other work would not be found to be disabled.

These standards are applied in three main stages. Disability examiners at state Disability Determination Service (DDS) offices make an initial determination. An applicant who is denied can appeal to be reconsidered by another disability examiner at the same DDS office. If the applicant is denied a second time, the applicant can appeal for a hearing before an Administrative Law Judge (ALJ).

Determining whether an individual is eligible to receive disability benefits is much more complicated and requires significantly more administrative judgment

[1] There are also more narrowly targeted disability benefit programs for veterans, railroad employees, and federal civilian employees.

than the determination of eligibility for other large social insurance programs like Social Security retirement benefits, where eligibility is triggered by reaching the eligibility age, or Unemployment Insurance benefits, where eligibility is triggered by an involuntary job separation. The administrative complexity of the disability system, combined with limited agency resources, has resulted in long delays in determining eligibility and in disability allowance rates that vary significantly depending on the office, examiner, or Administrative Law Judge to which a case is assigned (Rupp 2012; Maestas, Mullen, and Strand 2013).

Approximately 65 percent of Disability Insurance applications are resolved at the initial determination stage, while 35 percent are appealed. Most of those who appeal eventually have a hearing before an Administrative Law Judge. In 2008, out of every 1,000 initial applications, 366 were allowed at the initial determination, and 283 of those who were denied did not appeal. Of the 351 applicants who appealed (a 55 percent appeal rate among those who were initially denied), 215 were ultimately allowed at the reconsideration or appeals level. Overall, 58 percent of applicants were allowed benefits, 28 percent were denied without appeal, and another 14 percent were denied after appeal (Social Security Administration 2014a).

For applications that are resolved at the initial stage, average wait times for a determination are generally between 100 and 120 days. However, for those receiving an Administrative Law Judge (ALJ) hearing, the delays are often quite long. When the backlogs were at their worst in August 2008, applicants had to wait 532 days on average for an ALJ hearing, in addition to the time spent waiting for an initial decision and a reconsideration. Management focus and additional resources for ALJs reduced the average wait times to 340 days in October 2011, but recent budget cutbacks and the surge in applications during the recession caused wait times for ALJ hearings to climb again—to 396 days at the end of 2013.

Benefit levels for Disability Insurance are determined by the same benefit formula used for Social Security benefits: that is, benefits (in 2015) replace 90 percent of the first $826 dollars of prior monthly earnings, 32 percent of monthly earnings between $826 and $4,980, and 15 percent of monthly earnings above $4,980. The calculation of prior earnings for disability benefits is based on a worker's average indexed earnings in the years before the person became disabled.[2] In addition, DI benefits are not reduced when claimed earlier in life, whereas approximately 80 percent of Social Security retirement beneficiaries claim benefits before the "full benefit age" and have their benefits reduced accordingly. The average monthly benefit for a disabled worker is $1,146 and the interquartile range on the share of pre-tax lifetime indexed earnings that is replaced by these benefits extends from approximately 45 percent to 80 percent (Muller 2008). Accounting for taxes and

[2] In calculating the average indexed earnings, only the highest y years of indexed earnings count, where y is the number of years between the year the person turned age 22 and the year the person became disabled, minus between two and five "dropout" years (those with greater elapsed time between age 22 and becoming disabled are entitled to more dropout years).

the Medicare benefits associated with DI receipt would increase these replacement rates (Autor and Duggan 2006).

Several major legislative changes in recent decades have altered disability eligibility criteria and how the criteria are administered. During the 1970s, spending on Disability Insurance benefits increased rapidly as Congress raised Social Security benefit levels and made an error in setting the inflation indexing formula that was particularly significant in that high-inflation era. During this period, the median DI replacement rate increased substantially, creating an increased incentive for workers to apply for DI benefits, and administrative cutbacks reduced the review of state disability awards (Kearney 2005/2006). Concern about program costs led to a tightening of medical eligibility standards and to the Social Security Amendments of 1980. Among other provisions, these amendments required the Social Security Administration to conduct Continuing Disability Reviews to reevaluate beneficiary eligibility every three years except for those beneficiaries whose disability was expected to be permanent.

In the early 1980s, these Continuing Disability Reviews terminated benefits for 490,000 beneficiaries, with 200,000 of the terminations reversed upon appeal (Kearney 2005/2006). These terminations brought a strong political backlash. By 1984, 17 governors had suspended the reviews in their states. One reason that the terminations were perceived as unfair is that medical standards had been tightened, and the reviews applied the new standards—causing beneficiaries to be removed from eligibility even though their medical conditions had not improved. The fact that the bulk of the terminations occurred during a deep recession added to their unpopularity.

Congress reacted with the Social Security Amendments of 1984, which restricted the circumstances under which disability benefits could be terminated. Under the new law, benefits could be terminated only if the beneficiary experienced a medical improvement or if the government could demonstrate that the initial determination was in error. The Amendments also required the Social Security Administration to develop new standards for individuals with mental disorders, to evaluate pain as part of the disability determination process, to consider the effects of multiple nonsevere impairments in determining disability, and to place greater emphasis on evidence from the applicant's treating physician in the disability determination process. In the wake of these reforms, the disability rolls expanded, reversing the trend of the preceding years. Since then, the basic framework for Disability Insurance has remained much the same.[3]

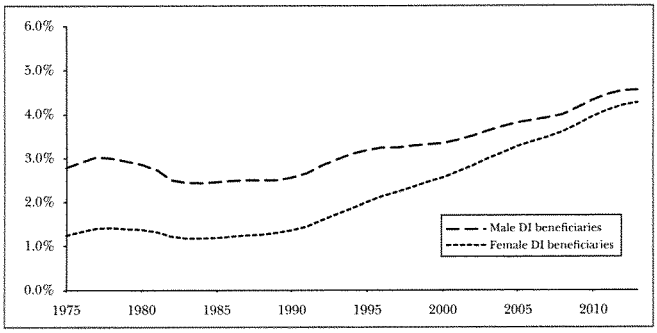
The Rise and Shifting Composition of Disability Enrollment

The share of working-age Americans receiving disability benefits from the federal Disability Insurance (DI) program is shown in Figure 1 for the years 1975

[3] One other significant change occurred in 1996, when legislation was enacted that made individuals ineligible for benefits if drug addiction or alcoholism played a significant role in their disability.

Figure 1

Percent of Working-Age (20–64) Population Receiving Disability Insurance (DI) Benefits, 1975–2013



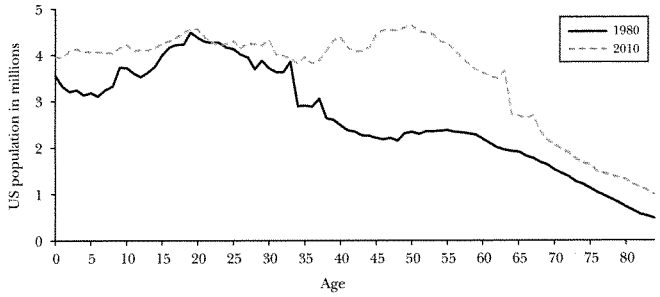
Sources: Social Security Administration, Office of the Chief Actuary; and author's calculations.

to 2013. The fraction of men receiving DI increased from 3.0 percent in the late 1970s to 3.8 percent in the years immediately preceding the 2007–2009 recession and 4.5 percent in 2013. Among women, DI receipt increased from 1.4 percent in the late 1970s to 3.5 percent in 2007 and 4.3 percent in 2013.

Over the same period during which these increases in disability enrollment rates were occurring, major demographic changes were occurring as well. As the baby boom generation born after World War II has moved through the work force, it first increased the number of young workers, who are less likely to be disabled, and then in recent years has swelled the number of workers in their late 50s and early 60s, who are the group most likely to be receiving disability benefits. Figure 2 shows the number of Americans of each age in 1980 and 2010. In 1980, there were approximately 23 million individuals between the ages of 50 and 59. By 2010, there were over 42 million. Figure 2 also shows that the cohorts behind the baby boomers are somewhat smaller, partially explaining why the Social Security Administration is predicting spending on Disability Insurance to decline over the coming decade. Americans who are between the ages of 50 and 64 are four and one-half times as likely as those between the ages of 20 and 49 to be receiving Disability Insurance benefits (that is, about 9 percent for the older age group compared to 2 percent for the younger age group). Thus, an increase in the share of the working-age population that is at the peak disability-claiming ages can result in significant changes in overall disability enrollment rates.

The other relevant demographic change occurring over this time period is the increase in the fraction of women with significant labor market experience. To be eligible for Disability Insurance benefits, a worker generally needs to have worked

Figure 2
US Population by Age, 1980 and 2010



Sources: US Census Intercensal Population Estimates (accessed via NBER.org) and author's calculations.

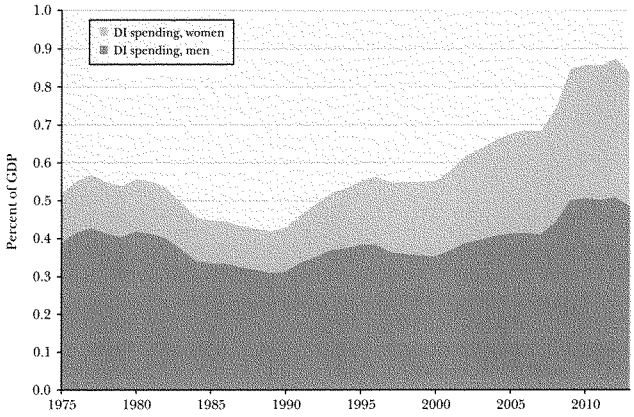
in five of the past ten years.[4] As women entered the labor force in large numbers, the fraction of women ages 50 to 64 "covered" by Disability Insurance—that is, eligible by their work history to receive disability benefits—rose from 46 percent to 72 percent between 1980 and 2007.

The increase in spending on Disability Insurance has not been as great as the increase in enrollment rates. Figure 3 shows spending on DI benefits from 1975 to 2013. DI benefits for men were 0.4 percent of GDP in the late 1970s and were also 0.4 percent of GDP in the years leading up to the 2007–2009 recession. In between, spending fluctuated with the business cycle and legislative changes. For women, spending increased from 0.14 percent of GDP in the late 1970s to 0.27 percent of GDP in 2007, with spending as a share of GDP increasing steadily from 1989 onward. Overall spending on DI benefits increased by 0.13 percent of GDP between the late 1970s and the years preceding the 2007–2009 recession: specifically, from 0.55 to 0.68 of GDP. In comparison, spending on Medicare and Medicaid increased by 3.2 percent of GDP over the same time period, increasing every year by approximately the same percent of GDP as DI spending increased over the entire 30 years.

The reason that spending relative to GDP has risen by only 22 percent when enrollment rates have risen by nearly 80 percent is that benefits have not kept up with productivity growth. Average benefits from Disability Insurance have fallen relative to per worker GDP because these benefits depend on the prior earnings levels of recipients, and there has been: 1) a decline in the worker compensation share of GDP;

[4] To be eligible for disability benefits, a worker generally needs to have earned 40 work credits, 20 of which need to be earned in the last 10 years ending with the year the worker became disabled. In 2015, workers receive one credit for each $1,220 of annual earnings with a maximum of four credits earned in any calendar year. The credit requirements are reduced for workers who become disabled at younger ages.

Figure 3
Spending on Disability Insurance (DI) Benefits, 1975–2013
(as percent of GDP)



Sources: Annual Statistical Report on the Social Security Disability Insurance Program (Social Security Administration 2011); Annual Statistical Supplement to the Social Security Bulletin (Social Security Administration 2012, Table 7.A5; 2013, Table 4.A2); 2013 Economic Report of the President; and author's calculations.
Notes: Allocation between males and females is based on December data from each year. Benefits for spouses and dependents are allocated between the sexes in proportion to worker benefits. The male–female split in DI benefits is interpolated between 1975 and 1980 and between 1980 and 1985.

2) an increase in health benefits as a share of compensation (and a decline in the earnings share); 3) a decline in the ratio of earnings "covered" by Disability Insurance to total earnings resulting from a rise in earnings inequality; and 4) a shift in the earnings distribution of the DI-claiming population toward those with lower earnings.[5]

[5] Specifically, spending relative to GDP can be decomposed into average benefits relative to per worker GDP and the enrollment rate, where the growth in per worker GDP can be thought of as analogous to productivity growth:

$$\frac{Spending_t}{GDP_t} = \frac{\overline{Benefits}_t}{\overline{GDP}_t} \times Recipients_t = \frac{\overline{Benefits}_t}{\overline{GDP/WAPop}_t} \times \frac{Recipients_t}{WAPop_t}.$$

For example, from 1977 to 2006, DI recipients as a share of the working-age population (WAP) grew by 68 percent, while average benefits relative to GDP per WAP fell by 26 percent. Spending relative to GDP rose by 24 percent ($1.68 \times 0.74 = 1.24$). See Liebman (2014) for further details.

Spending on Medicare benefits provided to recipients of Disability Insurance is about two-thirds as large as spending on cash benefits. It has also risen faster than the disability enrollment rate—from 0.12 percent of GDP in the late 1970s to 0.39 percent of GDP in the pre-recession years—because health care spending per beneficiary has historically risen faster than GDP. That said, given the expansions of Medicaid eligibility and subsidies for insurance purchase enacted as part of the Patient Protection and Affordable Care Act of 2010, many DI recipients would today be receiving free or heavily subsidized health insurance even if they were not receiving disability benefits.

Decomposing the Rise in Disability Enrollment

The rise in disability enrollment has resulted from a mixture of factors: major demographic trends, changes in program rules and implementation, and evolving economic conditions. But how much of the change in disability enrollments can be attributed to each factor?

The methodology I use to answer this question is straightforward. I model the number of people of age a who are receiving benefits—"in current payment" (ICP)—in year t. The number of people in current payment increases with new disability awards and declines with terminations. New awards are the product of the incidence rate and the number of exposed individuals (the insured population minus those already receiving benefits). Terminations come through death or recovery.[6] "Recovery" is often an involuntary removal from benefit status that occurs when the Social Security Administration performs a Continuing Disability Review and determines that benefits were awarded in error or that the individual's health status has improved. In the model, a represents single years of age from 20 to 64.

$$ICP_{at} = ICP_{(a-1,\,t-1)} + new\ awards_{at} - terminations_{at}$$

$$new\ awards_{at} = incidence_{at}((population_{at} * \%insured_{at}) - ICP_{(a-1,\,t-1)})$$

$$terminations_{at} = (death\ rate_{at} + recovery\ rate_{at}) * ICP_{(a-1,\,t-1)}\ .$$

The model can be used to examine counterfactual scenarios in which one or more parameters are held constant so as to analyze the share of the change over time that can be attributed to changes in the age distribution of the population, the insured rate, the incidence rate, the death rate, and the recovery rate.

The data for the model come from the Office of the Chief Actuary at the Social Security Administration. The raw data contain all of the elements in these three equations, aggregated to five-year age ranges. I interpolate linearly between

[6] At the Social Security full benefit age, terminations can also occur from individuals transitioning to retirement benefits. The results in this paper are limited to individuals 64 and younger. This avoids complications associated with the on-going increase in the Social Security full retirement benefit age from 65 to 67.

the midpoints of the age ranges to produce data at the level of individual years of age. The model successfully captures the evolution of the number of individuals in current payment over time.

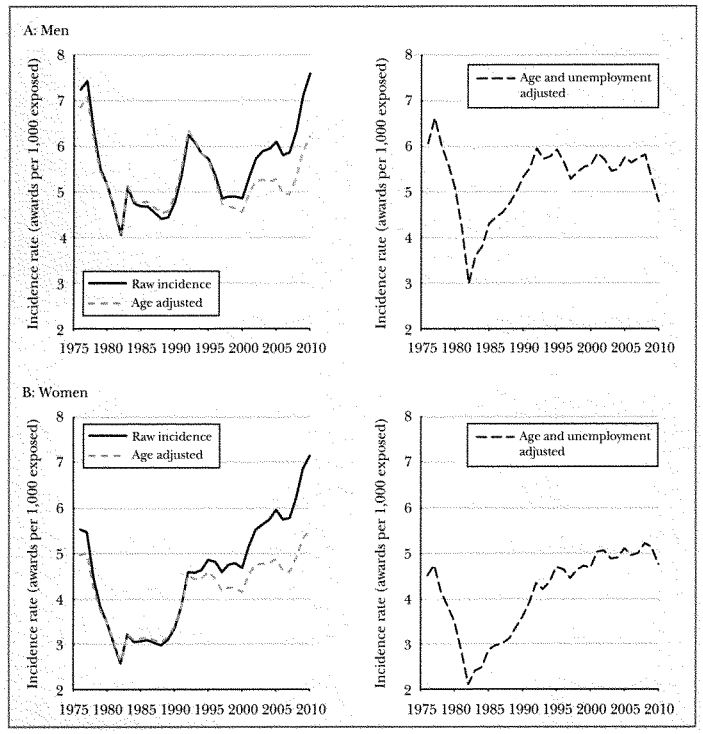
There are several decisions to make in choosing which counterfactual scenarios to analyze. First, which time period to analyze? As discussed above, Disability Insurance enrollment plummeted in the early 1980s before rebounding in the second half of the 1980s. An analysis that takes 1985 as the base year will attribute much more of the change over time in enrollment to incidence than one that takes 1980 or 1990 as the base. In this analysis, I focus primarily on the 1985–2007 period in order to inform discussions about how enrollment rates have evolved since the 1984 legislative reforms. However, I also present results for 1977–2007 and for the 1977–1985, 1985–1993, and 1993–2007 subperiods to highlight the fact that different factors are responsible for a different share of the rise in DI enrollment in different time periods. I stop the simulations in 2007 because my focus is on the long-run program trends rather than the particular impact of the deep 2007–2009 recession. The DI enrollment rate increased by about 1 percentage point during the recession. Cutler, Meara, and Richards-Shubik (2012) find that the recession-induced increase in DI claiming was similar to that in prior recessions. My own estimates described in Liebman (2014) indicate that the rise in DI claiming during the 2007–2009 recession was somewhat lower than would have been predicted by the previous relationship between unemployment and incidence. It is possible that the availability of extended unemployment insurance benefits in the recent recession prevented some DI claiming (Rutledge 2011). However, Mueller, Rothstein, and von Wachter (2013) find "no indication that expiration of UI benefits causes DI applications."

A second analytic choice is how to stack the various parameters. The impact of rising incidence on the Disability Insurance enrollment rate will be greater if demographic changes such as population aging and increased female labor force participation have resulted in more insured individuals in the age range in which disability receipt is most common. Similarly, the impact of demographic changes on the enrollment rate will be larger if incidence is higher. To address this issue, I attribute to incidence the increase in enrollment rates that would have occurred absent population aging and changing insured rates. Separately, I estimate the effect of population aging and changing insured rates under a counterfactual scenario in which incidence rates remained constant. The sum of these separate estimates is smaller than the total effect when all three factors are held constant together. I classify the difference between the separate effects and the total effect as "interaction effects." For simplicity, I stack the two quantitatively less-important factors—mortality rates and recovery rates—at the end of the analysis and do not estimate separate interaction effects for them. This results in my methodology attributing somewhat less impact to declining mortality rates than would occur if I stacked that parameter earlier in the analysis.

A final analytic choice is which year to treat as the base year for each parameter. It is not possible to choose a single year like 1985 as the base year for all of the factors, because some of them exhibited extreme values immediately after the 1984 reforms. Most of the choices are straightforward, and I describe them as I present

Figure 4

Incidence Rates for Men and Women, Ages 20–64



Sources: Social Security Administration, Office of the Chief Actuary; and author's calculations.
Notes: In Figure 4A, the graph on the left shows the actual incidence rate for men, along with an age-adjusted rate that holds the age distribution of the population constant at its 1980 level, while the graph on the right shows the predicted male age-adjusted incidence rate, under the counterfactual assumption that unemployment rates were constant at the 1976–2010 mean value of 6.3 percent for the entire period. Figure 4B presents a parallel analysis for women.

the results below. However, the choice of a base for the incidence rate requires more discussion because applications for disability benefits vary considerably over the business cycle (Autor and Duggan 2003).

The top left panel of Figure 4A shows the actual incidence rate for men, along with an age-adjusted rate that holds the age distribution of the population

constant at its 1980 level. Four patterns are evident. First, incidence rates are highly cyclical, rising sharply in response to the 1990–1991, 2001, and 2007–2009 recessions. Second, incidence plummeted after the late 1970s and early 1980s reforms that tightened eligibility and increased the number of continuing disability reviews (CDRs), before rebounding after 1982 and particularly after the 1984 legislation that altered eligibility rules and standards for CDRs. Third, since 1985 there appears to be an upward trend in the actual incidence rate. Fourth, the post-1985 upward trend is less steep in the age-adjusted incidence rate, but it is hard to isolate the trend visually given the large business-cycle-related fluctuations that are occurring throughout this period.

To isolate the underlying time pattern of incidence from business cycle fluctuations, the top right panel of Figure 4A shows the predicted male age-adjusted incidence rate, under the counterfactual assumption that unemployment rates were constant at the 1976–2010 mean value of 6.3 percent for the entire period. These predictions use coefficients obtained from separately regressing the annual incidence rate for each of nine five-year age ranges on the contemporaneous unemployment rate and a one-year lag in the unemployment rate, using a methodology similar to that of the Social Security Technical Advisory Panel (2011).[7] The unemployment-adjusted series reveals a much more pronounced increase in male incidence in the years following the 1984 legislation—a pattern that was obscured in the top left panel by the high unemployment rates of the 1980s, which inflated disability incidence rates relative to what they would have been with more typical unemployment rates. In addition, the unemployment-adjusted series indicates that there has been no increase in incidence among men since the early 1990s.

Figure 4B repeats this analysis for women. The unemployment-adjusted series similarly exhibits a steep rise in incidence after 1984. It also shows that, different from men, incidence has continued to rise for women since the early 1990s, but at a slower rate than during the 1980s. Indeed, incidence for women is now approaching the level for men.

Next we will look at some counterfactual simulations to interpret the impact of various factors on the percentage of the working-age population receiving disability insurance. The analysis of Figure 4 demonstrated that to interpret the impact of incidence correctly, one needs to adjust for the business cycle. Simply using the 1985 incidence rate as the base year for simulations would lead one to understate the contribution of rising incidence rates to the increase in the disability insurance beneficiary ratio because, as just noted, 1985 was a high unemployment year. So to begin, I first modify the actual beneficiary to working-age population ratio to provide an alternative series that projects the path that the ratio would have taken if the unemployment rate had remained steady at its average value for the entire time period analyzed for the simulation. This is done by allowing all of the parameters other than incidence to take on their actual values in each year,

[7] To fit the underlying time trend in incidence, the regressions also include two-part splines with a break point in 1992. Full details of these regressions are available in Liebman (2014).

while adjusting the incidence rate in each year using the coefficients from my regressions of incidence on the unemployment rate.[8] This modified beneficiary to working-age population series is used as the benchmark for the counterfactual simulations. In addition, when I conduct simulations holding incidence constant at the value from a base year, I hold it constant at the unemployment-adjusted value from that base year.

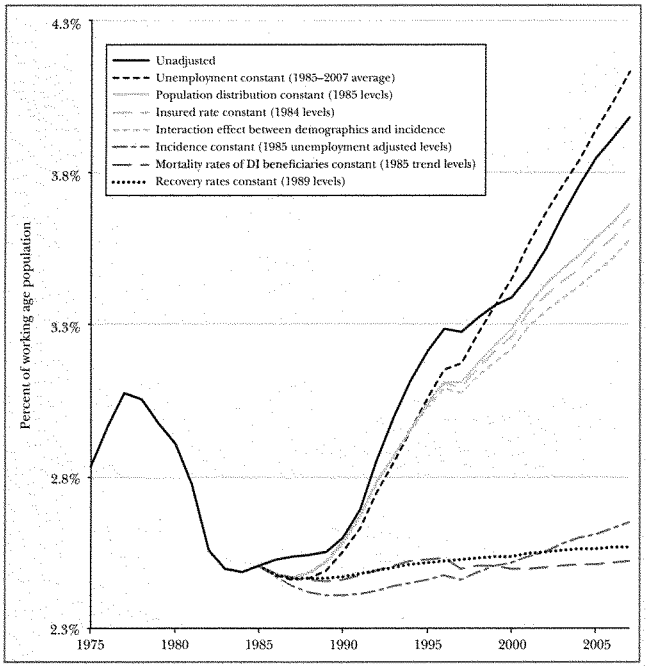
Men and women are analyzed separately, because of the very different evolution of their labor market experience in recent decades. Figure 5 shows the results of the simulations for men during the 1985–2007 period while Figure 6 will do the same for women. In Figure 5, the solid dark line shows the actual evolution of the men's DI beneficiary ratio, rising from 2.46 to 3.93 percent between 1985 and 2007. The rise in disability rates during the second half of the 1970s, the fall after the late 1970s and early 1980s policy changes, and the subsequent rise starting around 1985 all appear clearly. The next line in the key shows the beneficiary ratio with the actual incidence for each year adjusted to the value predicted if unemployment had remained steady at 5.6 percent in each year. Because the unemployment rate was relatively high for most of the late 1980s and early 1990s and low in the late 1990s and early 2000s, this unemployment-constant series is below the actual values in the early part of the analysis period and above it in the later period. The 2007 value for this adjusted series is 4.08 percent. The next line in the key holds the population age-distribution constant at its 1985 values (chosen because it is the initial year of the simulations). Absent the aging of the baby boomers, the DI beneficiary ratio in 2007 would have been 3.65 percent. The next line in the key shows that additionally holding the male "insured rate" constant at its 1984 level (chosen because it is approximately the average level in the 1985–2007 period) has little impact on the DI beneficiary level, reducing it only to 3.60 percent—because the share of males eligible for DI did not change much during most of this time period. To examine the impact of incidence, I adjust 1985 incidence to the value that my regressions predict would have occurred if unemployment had been 5.6 percent in that year; then I hold incidence constant at this unemployment-adjusted 1985 value (this is in addition to holding the age-distribution and insured rate constant). Doing so reduces the beneficiary to worker ratio in 2007 to 2.60. Compared to the insured-rate constant line, the reduction from 3.60 to 3.53 percent is attributable to the interaction effect between the demographic parameters and incidence, while the reduction from 3.53 to 2.60 percent is the direct effect of rising incidence if the population distribution and insured rate had not changed.

Holding mortality rates of DI beneficiaries constant—in addition to holding the earlier factors constant—further reduces the simulated 2007 Disability

[8] Specifically, I replace the incidence rate, I_{at}, for age a and year t, with an unemployment-adjusted incidence rate, $I^*_{at} = I_{at} + \beta_{g0}(\bar{U} - U_t) + \beta_{g1}(\bar{U} - U_{t-1})$, where β_{g0} and β_{g1} are the coefficients from the regression of incidence on contemporaneous and lagged unemployment for the 5-year age group that a belongs to. This assumes a simple additive relationship between changes in unemployment and incidence. It would be valuable to do additional research, perhaps using state-level data, into the best functional form for the relationship between unemployment and DI incidence.

Figure 5

Impact of Various Factors on the Percentage of Working Age Men (Ages 20–64) Receiving Disability Insurance, 1985–2007

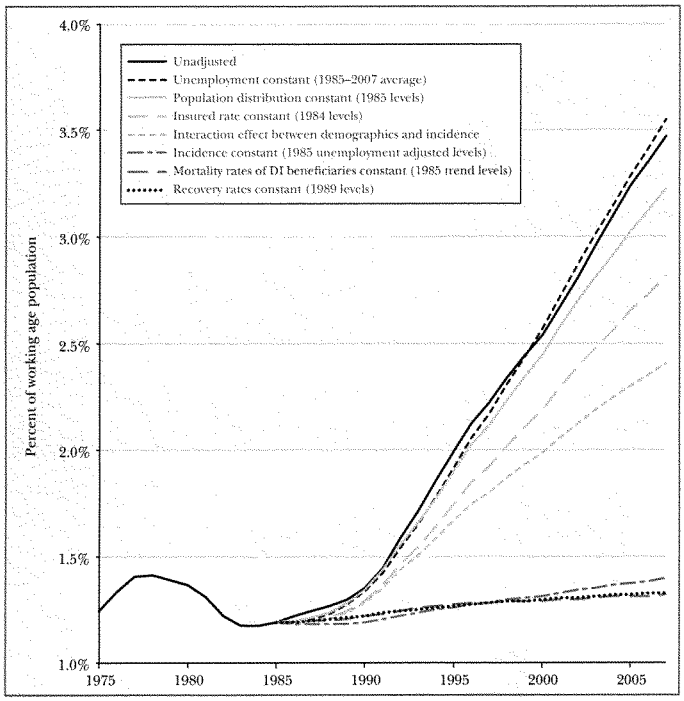


Sources: Social Security Administration, Office of the Chief Actuary; and author's calculations.

Notes: In this analysis, each factor is analyzed sequentially relative to all of the other factors that are listed before it in the key. Thus the vertical distance between a line and the line that comes before it in the key represents the additional effect of holding the factor constant on top of holding all of the earlier factors constant. I attribute to incidence the increase in enrollment rates that would have occurred absent population aging and changing insured rates. Separately, I estimate the effect of population aging and changing insured rates under a counterfactual scenario in which incidence rates remained constant. The sum of these separate estimates is smaller than the total effect when all three factors are held constant together. I classify the difference between the separate effects and the total effect as "interaction effects." I stack the two quantitatively less-important factors—mortality rates and recovery rates—at the end of the analysis and do not estimate separate interaction effects for them. Also, I first modify the actual beneficiary to working-age population ratio to provide an alternative series that projects the path that the ratio would have taken if the unemployment rate had remained steady at its average value for the entire time period analyzed for the simulation. The unemployment adjustment uses the mean unemployment and lagged (1 year) unemployment from 1985 to 2007. See text for details.

Figure 6

Impact of Various Factors on the Percentage of Working-Age Women (Ages 20–64) Receiving Disability Insurance, 1985–2007



Sources: Social Security Administration, Office of the Chief Actuary; and author's calculations.
Notes: In this analysis, each factor is analyzed sequentially relative to all of the other factors that are listed before it in the key. Thus the vertical distance between a line and the line that comes before it in the key represents the additional effect of holding the factor constant on top of holding all of the earlier factors constant. I attribute to incidence the increase in enrollment rates that would have occurred absent population aging and changing insured rates. Separately, I estimate the effect of population aging and changing insured rates under a counterfactual scenario in which incidence rates remained constant. The sum of these separate estimates is smaller than the total effect when all three factors are held constant together. I classify the difference between the separate effects and the total effect as "interaction effects." I stack the two quantitatively less-important factors—mortality rates and recovery rates—at the end of the analysis and do not estimate separate interaction effects for them. Also, I first modify the actual beneficiary to working-age population ratio to provide an alternative series that projects the path that the ratio would have taken if the unemployment rate had remained steady at its average value for the entire time period analyzed for the simulation. The unemployment adjustment uses the mean unemployment and lagged (1 year) unemployment from 1985 to 2007. See text for details.

Insurance beneficiary rate to 2.47 percent. Age-adjusted mortality rates for male DI beneficiaries fell from 4.9 percent in 1982 to 3.2 percent in 2007 a phenomenon that is discussed further below. In holding mortality rates constant, I use a base that is a weighted average of 1982 mortality rates and 1998 mortality rates, with 80 percent of the weight on the 1982 rates. Doing so provides a base level for 1985 that is on the longer-term mortality trend line, avoiding the spike in actual mortality that occurred after the removal of less-impaired individuals from the DI beneficiary rolls in the early 1980s and the spike in HIV-related mortality that begins in the 1980s and continues into the mid 1990s. In the final step, additionally holding "recovery rates"—that is, the rate at which eligibility for benefits terminates for a reason other than death, typically an improvement in health—at their 1989 level has only a small further impact on the simulated 2007 DI beneficiary rate, increasing it to 2.52 percent. 1989 was chosen because recovery rates were quite stable over the time period and it is the year with approximately the average recovery rate for the 1985–2007 period, excluding the one-year spike that occurred in 1997 when beneficiaries whose main impairment was related to drug or alcohol use were removed from the rolls.[9]

The left-most bar in Figure 7 and the first column of the top panel of Table 1 summarize the simulation results for men by showing the percentage of the distance from the 2007 unemployment-adjusted beneficiary ratio of 4.08 percent, to the simulated ratio of 2.52 percent with all of the factors held constant, that is attributable to each factor. For men over the 1985–2007 period, population aging is responsible for 28 percent of the increase in the DI beneficiary ratio. The insured rate is responsible for a negligible 3 percent. Actual incidence being above the 1985 unemployment-adjusted level is responsible for 59 percent, with the interaction between the demographic factors and incidence responsible for 4 percent. Falling death rates are responsible for 8 percent. The recovery rate being higher than the base value is responsible for −3 percent.

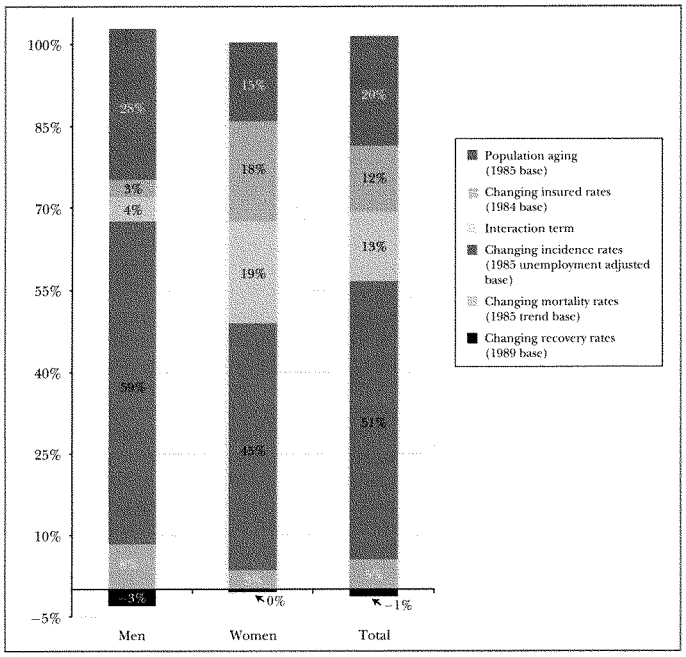
As I emphasized above, the decomposition results are highly sensitive to the incidence base year. Column 6 of the top panel of Table 1 shows that if I had begun the analysis in the high incidence year of 1977 (rather than the low incidence year of 1985) and studied the entire 1977–2007 period for men and women combined, I would have found that changing incidence reduced the DI enrollment rate and that population aging accounted for approximately 40 percent and rising insured rates accounted for just over half the rise in enrollment over the 30-year period.

There have really been three distinct subperiods, as shown in the bottom panel of Table 1. From 1977 to 1985 the male beneficiary ratio fell sharply with falling incidence rates explaining 62 percent of the decline and higher recovery rates explaining 31 percent. From 1985–1993, rising incidence is responsible for 125 percent of the increase in male benefit receipt, while population aging is responsible for only −6 percent. Mortality rates exceeded their trend level during this

[9] Liebman (2014) contains additional details on the time-path of each of these parameters.

Figure 7

Decomposition of Various Factors' Impact on the Percent of the Working-Age Population Receiving Disability Insurance, 1985–2007



Sources: Social Security Administration, Office of the Chief Actuary; and author's calculations.

period, reducing benefit receipt and accounting for −20 percent. From 1993–2007, population aging accounts for 94 percent of the increase in benefit receipt for men and falling mortality rates account for 36 percent. Incidence was on average below its 1993 level and accounted for −23 percent of the increase for men. The spike in recovery rates from eliminating eligibility for those with impairments related to drug and alcohol addiction also contributed −23 percent. Given the result presented in Figure 4 that age- and unemployment-adjusted male incidence rates fell sharply in the early 1980s, rose steeply in the second half of the 1980s, and have been steady

Table 1

Decomposition of Various Factors' Impact on the Percent of the Working Age Population Receiving Disability Insurance

	A. Full time periods with two different base years					
	1985–2007			*1977–2007*		
	Men (1)	*Women (2)*	***Total (3)***	*Men (4)*	*Women (5)*	***Total (6)***
Change in beneficiary ratio to be explained	1.6	2.2	1.9	0.4	1.7	**1.1**
Percent explained by:						
Population aging	28%	15%	20%	111%	22%	39%
Changing insured rates	3%	18%	**12%**	12%	61%	52%
Interaction term	3%	19%	**13%**	18%	17%	**−2%**
Changing incidence rates	56%	45%	51%	83%	7%	−16%
Changing mortality rates	8%	3%	5%	91%	9%	25%
Changing recovery rates	−3%	0%	**−1%**	−15%	−1%	−3%

	B. Three subperiods								
	1977–1985			*1985–1993*			*1993–2007*		
	Men (1)	*Women (2)*	***Total (3)***	*Men (4)*	*Women (5)*	***Total (6)***	*Men (7)*	*Women (8)*	***Total (9)***
Change in beneficiary ratio to be explained	−1.4	−0.6	**−1.0**	0.9	0.4	**0.4**	0.4	1.0	**0.7**
Percent explained by:									
Population aging	11%	12%	11%	−6%	−2%	−4%	91%	29%	**46%**
Changing insured rates	1%	−20%	**−5%**	−1%	28%	15%	11%	25%	20%
Interaction term	−3%	5%	−1%	0%	10%	5%	4%	6%	5%
Changing incidence rates	62%	71%	**64%**	125%	68%	93%	25%	38%	22%
Changing mortality rates	1%	1%	0%	20%	−6%	−13%	36%	7%	**15%**
Changing recovery rates	31%	31%	31%	2%	1%	2%	25%	−3%	−8%

Sources: Social Security Administration, Office of the Chief Actuary; and author's calculations.

Notes: I first modify the actual beneficiary-to-working-age population ratio to provide an alternative series that projects the path that the ratio would have taken if the unemployment rate had remained steady at its 1985–2007 mean value of 5.6 percent. I then hold factors constant, using the same sequential method as in Figures 5 and 6. Each column represents one run of the model, where the top row gives the difference in percentage points (for the final year of the simulation time period) between the alternative beneficiary ratio, which holds only the unemployment rate constant, and the last counterfactual beneficiary ratio, which holds all factors constant. The other rows represent the percent of this difference that can be attributed to each factor, including the interaction between incidence and population factors (aging and insured rates). The effect of population aging is found by holding the population age distribution constant at its distribution in the starting year for each model run (1977, 1985, or 1993). Similarly, I hold insured rates constant at their values in each of the three start years and hold incidence rates constant at their unemployment-adjusted values in each of the three start years. For mortality rates, I attempt to find values on the long-term trend line, so that my results are not distorted by the spike in actual mortality that occurred after the removal of less-impaired individuals from the DI beneficiary roles in the early 1980s and by the high rate of mortality among men with HIV in the 1980s and early 1990s. Therefore, I hold mortality constant at 1977 values in the model runs that begin in 1977; at a 1985-trend value, which reflects a weighted average of 1982 and 1998 mortality rates, in the model runs that begin in 1985; and at a 1993-trend value, which is found by averaging 1996 and 1997 mortality rates, in the model runs that begin in 1993. Recovery rates are the final factor I hold constant, and I do so at 1989 values for all three scenarios, because recovery rates have remained quite stable over time, and 1989 is the year with approximately the average recovery rate for the 1985–2007 period, excluding the one-year spike that occurred in 1997 when beneficiaries whose main impairment was related to drug or alcohol use were removed from the rolls.

(or falling slightly) since the early 1990s, this time pattern of results should not be surprising.[10]

I next perform an analogous set of counterfactual simulations that ask how the Disability Insurance beneficiary ratio would have evolved for women, holding constant the various factors for the 1985–2007 period. The base years used for each factor are the same as they were for men.

In Figure 6, the dark line shows the actual evolution of the female Disability Insurance beneficiary ratio, rising from 1.20 to 3.47 percent between 1985 and 2007. The next line in the key shows the adjusted ratio, with unemployment held constant. As with men, this results in a series that is somewhat lower in the first half of the period and somewhat higher in the second half. The 2007 value of this series is 3.55 percent. The next line in the key, additionally, holds the population age-distribution constant at its 1985 level. Absent the aging of the baby boomers, the female DI beneficiary ratio in 2007 would have been 3.23 percent. The next line in the key shows that additionally holding the female insured rate constant at its 1984 level has a fairly large impact on the beneficiary rate—lowering it to 2.82 percent. This factor is larger for women than for men because of the large-scale entry of women into the workforce starting in the 1970s that has resulted, over time, in a much larger share of women being covered by disability insurance. Additionally, holding incidence at its 1985 unemployment-adjusted average reduces the simulated beneficiary rate to 1.40 percent, with 30 percent of the reduction resulting from the interaction effect. Holding mortality rates constant at their 1982 level, on top of holding all of the earlier factors constant, has a somewhat smaller impact than for men because female mortality is lower; it reduces the simulated 2007 Disability Insurance beneficiary rate to 1.32 percent. Additionally holding recovery rates at their 1989 level has essentially no further impact on the simulated 2007 DI beneficiary rate.

Figure 7 and column 2 of the top panel of Table 1 summarize these results, showing that for women population aging and rising insured rates combine to account for one-third of the increase in the beneficiary ratio over the entire 1985 to 2007 period. Rising incidence accounts for 45 percent, and the interaction between the demographic factors and rising incidence accounts for 19 percent. The impact of changes in mortality and recovery rates was negligible.

The decomposition of results by subperiod in Table 1 shows that the time pattern of results for women is somewhat different from that of men, primarily because rising insured rates are a more significant factor for women. From 1977–1985, falling incidence rates explain 71 percent of the decline in enrollment

[10] The change in the beneficiary ratio for the 1985–2007 and 1977–2007 periods is greater than the sum of the changes in that ratio for the relevant subperiods. This occurs because it can take decades to reach a new steady state beneficiary ratio after, for example, a change in the incidence rate. Thus the increase in incidence after 1985 was still causing the beneficiary ratio to rise throughout the 1990s when compared to a 1985 incidence base, and this is reflected in the simulations for the full 1985–2007 period. But the impact of the 1980s increase in incidence is not captured in the simulations for the 1993–2007 subperiod, which use a 1993 incidence base and reflect only the impact of further changes in incidence relative to the 1993 level.

for women, rising recovery rates explain 31 percent, and rising insured rates (which increase enrollment) are responsible for -20 percent. Whereas rising incidence accounted for nearly all of the increase in the beneficiary ratio for men in the 1985–1993 time period, for women 68 percent of the increase was the result of rising incidence and 28 percent was the increase in insured rates. Whereas population aging and declining mortality rates accounted for nearly all of the increase in the male beneficiary ratio for the 1993–2007 time period, for women population aging, rising insured rates, and rising incidence all played a role. In particular, as we saw in Figure 4, incidence rates for women have continued to rise even after those for men leveled off.[11]

The impression in policy circles that disability enrollment and spending are "out of control" appears to be the result of confounding the legislatively induced bounce-back of incidence rates in the late 1980s and early 1990s with the largely demographically induced increases of the past two decades. There have been three different phenomenon, each with its own time path and economic origins. The first is a legislatively induced rise in disability incidence rates that explains the bulk of program growth between 1985 and the early 1990s. The second is rising female labor force participation, which enabled a greater share of women to qualify for SSDI benefits. The third factor, and the largest contributor to rising SSDI rolls between the early 1990s and the onset of the Great Recession, is the entry of the baby boom generation into its peak disability years. All three factors have now arguably run their course in terms of increasing the share of GDP spent on DI benefits. But changes in the characteristics of the beneficiary population in recent decades could augur future changes in the program. I turn to this subject next.

Changes in the Beneficiary Population

Much of the policy attention to the Disability Insurance program is motivated by a concern that higher enrollment rates may be the result of an expansion in benefit receipt by individuals with less-severe impairments. According to this perspective, the 1984 legislative reforms and the way in which they have been administered loosened eligibility criteria, and the impact of the altered eligibility standards was magnified by challenging labor market conditions for low-skilled workers, which increased their incentive to claim benefits.

While it is difficult to directly observe whether eligibility standards have shifted over time, we can find clues by looking at trends in the age distribution of claims, the medical impairments triggering eligibility, and the mortality rate of beneficiaries. Such clues need to be interpreted with care. One cannot assess the standards

[11] These results attribute a larger share of the increase in DI enrollment to demographic factors than do Duggan and Imberman (2009), who examine the period 1984–2003. They attribute 15 percent of the rise in enrollment among men and 4 percent of the rise among women to changes in the age structure of the population.

applied to disability benefits simply by looking at the age-adjusted rates of disability incidence, because incidence rates are affected by factors beyond how the program is administered. For example, declining relative demand for low-wage workers and stagnating real wages at the bottom of the income distribution increased the incentives for low-skill workers to apply for disability benefits during the 1980s and 1990s (Autor and Duggan 2003). These changes in incentives would be predicted to increase the rate of disability benefit claiming, which suggests that stable disability incidence rates in the post-1990 period could be indicative of tighter eligibility standards being applied. Conversely, if the overall health of the population is improving, then we would expect declining incidence of disability, and a finding of stable incidence rates could reflect looser eligibility standards. Moreover, greater take-up of disability insurance in an era of declining economic prospects for low-skilled workers could be socially optimal since the economic cost of workers foregoing labor force participation depends on the marginal product of their labor relative to their disutility of work (Diamond and Sheshinski 1995).

Some observers have cited a shift in the age composition of the disability beneficiary population toward younger ages as evidence that disability determination standards have become more lenient. Among both men and women, the mean age of new beneficiaries fell by more than three years between 1980 and 1993. However, between 1993 and 2011, the mean age of new beneficiaries increased by three years, returning to early 1980s levels. The complication in interpreting these trends is that as the baby boomers moved through their life cycle, they first swelled the number of younger workers, which mechanically increased the share of younger workers claiming disability benefits, and then later increased the share of older disability claimants. Indeed, when the ages of new recipients of disability benefits are adjusted to hold the age composition of the insured population constant, the average age fell significantly from the early 1980s to the early 1990s, but has fluctuated around a relatively stable trend since 1990. This pattern is consistent with an interpretation that eligibility standards expanded significantly in the aftermath of the 1984 legislation, but have been relatively stable since the early 1990s.

Another piece of evidence comes from examining the incidence of specific medical impairments. The stability of the overall (age- and unemployment-adjusted) disability incidence rate in the post-1990 period masks substantial changes in the incidence of individual impairments. For both males and females, the incidence of circulatory- and cancer-related benefit awards has been falling, while the incidence of musculoskeletal and, to a lesser extent, mental conditions has been rising. One possible interpretation of these trends is that overall health has been improving as reflected in the declining circulatory and cancer incidence rate, but that improving health has not produced declining incidence rates because the program has become more lenient in approving claims for musculoskeletal and mental conditions. Using my simulation model, I find that if the incidence rates for musculoskeletal and mental benefit awards had remained constant at their 1985 levels, while all other conditions followed their actual path, the beneficiary ratio would have been 21 percent lower in 2007 than it was.

However, there are other possible interpretations for the shift in the distribution of impairments. For example, it could be that standards for determining disabilities have remained constant, but that a greater number of individuals with musculoskeletal or mental health conditions have applied for benefits, either because the prevalence of the conditions has increased over time or, more likely, because labor market conditions for low-skilled workers have increased the incentives for individuals with these conditions to apply for benefits. It is also possible that some of the shift in the distribution of impairments was the result of individuals who would have been eligible for benefits under other categories (possibly a few years later) instead claiming benefits under the musculoskeletal and mental impairment categories after the 1984 reforms made such claims easier.

The fact that the relatively stable rates of (adjusted) disability incidence during the past 25 years were the result of large offsetting trends in incidence rates for different conditions suggests that there should be no presumption that rates will be stable going forward. For example, if incidence rates for musculoskeletal and mental health impairments continue to rise, but the offsetting declines in the other conditions level off, overall incidence could rise. Relatedly, while female disability incidence rates have leveled off since the mid-1990s at a rate slightly below male rates, giving the appearance that the earlier rapid rise in female incidence rates was largely a phenomenon of female rates converging to male rates as female labor market behavior became more similar to male behavior, incidence rates for particular conditions are quite different for men and women, suggesting that the appearance of convergence in the aggregate patterns may simply be a coincidence.

A final piece of evidence comes from mortality rates among Disability Insurance recipients. These rates have continued to fall, even during the period in which adjusted incidence rates have mostly stabilized. This observation is consistent with an interpretation that there has been a shift in the composition of disability beneficiaries toward impairments like musculoskeletal and mental impairments that have lower mortality rates. Although it is conceivable that medical progress has significantly reduced mortality for a wide range of conditions without improving functional capacity, it seems likely that a significant portion of the decline in mortality rates among DI recipients is the result of a change in the composition of the beneficiary population.

Priorities for Reform of Disability Insurance

By international standards, US spending on disability benefits relative to GDP remains low. The OECD provides data on total public expenditures on disability and sickness cash benefits for its member countries. In 2011, average spending in the OECD on these benefits was 1.9 percent of GDP. In the US, it was 1.3 percent of GDP. The Netherlands, a country often heralded for its aggressive disability benefit reforms, spent 2.8 percent of GDP on these benefits in 2011 (down from 6.5 percent in 1980). Despite the relatively modest US expenditures on these programs, there

is a strong case for treating the coming exhaustion of the Disability Insurance trust fund as an opportunity for improving the US Disability Insurance system.

Social insurance programs need to be designed to balance the protection they provide with the economic distortions they cause (Feldstein 1976). Disability insurance benefits provide protection against the risk of a severe medical impairment, while they also generate disincentives for labor force participation. But economic research suggests that some significant aspects of the disability insurance system are so far from the optimal policy frontier that reforms may exist that can simultaneously improve the well-being of impaired individuals and reduce the fiscal and efficiency costs of the program.

Improved Incentives for Returning to Work

The current disability benefit package essentially provides lifetime cash benefits and health insurance in exchange for a promise never to do substantial work again. That is, given that only about 1 percent of beneficiaries per year are removed from the rolls based on health improvements, so long as a beneficiary does not have significant labor earnings, the individual is unlikely to lose eligibility for benefits. A sizable portion of the disabled beneficiary population might be better off with assistance that helps them return to employment. Changes in the disability insurance programs and in low-skill labor markets, along with the decline in other forms of public assistance, have made this group a larger fraction of the Disability Insurance and Supplemental Security Income population (Autor and Duggan 2003).

The evidence that a significant number of disability beneficiaries have the capacity to work comes from a line of research that began with Bound (1989) and examines the earnings of applicants who are denied disability benefits to assess the earnings potential of marginal beneficiaries.[12] A welcome evolution in this literature uses the random assignment of disability cases to examiners or Administrative Law Judges with different propensities to approve awards to generate a causal estimate of the effect of Disability Insurance awards on labor supply (Autor, Maestas, Mullen, and Strand 2015; French and Song 2011). It also accounts for the fact that the lengthy DI application process can erode labor force participation even among applicants who are eventually denied disability benefits (Maestas, Mullen, and Strand 2015). This literature finds that applying for and receiving DI reduces employment rates by over 30 percentage points overall and by more than 50 percentage points among those with lesser impairments. Roughly one-quarter of applicants are on the margin of program entry in the sense that they receive benefits if their case is assigned to a lenient examiner, but not if they are assigned to one with a lesser propensity to award benefits (Maestas, Mullen, and Strand, 2013). However, the subsequent earnings levels of denied applicants who return to employment are generally below $20,000, suggesting that without further assistance

[12] See von Wachter, Song, and Manchester (2011) for a more recent application of the Bound (1989) methodology and Moore (2015) for an analysis of the impact of terminating DI benefits on subsequent labor supply.

the labor market prospects of individuals on the margin between receiving and not receiving benefits is quite limited.

Incentives for Employers, States, and the Social Security Administration

Several of the key actors in the disability insurance system have misaligned incentives that cause them to encourage people to apply for disability insurance (Liebman and Smalligan 2013). A number of the ideas for reform of the US Disability Insurance system seek to alter these incentives.

For example, when an employee experiences a health problem, an employer may find it easier and less expensive to push an employee toward applying for Disability Insurance benefits than to make accommodations that would allow the worker to remain employed at the firm. Similarly, it is often less expensive for private disability insurance companies to help workers sign up for public Disability Insurance benefits than to help them get back to work.

Several reform proposals target incentives for employers, in part based on the observation that intervening early, before someone becomes detached from employment, is more effective than trying to connect someone later to a new job. For example, Autor and Duggan (2010) propose that employers be required to provide private disability insurance coverage to all of their workers and that this insurance would cover the first two years of a person's disability. Eligibility for federal benefits would begin only after the two years of private benefits were exhausted. In their formulation, benefits would be 60 percent of prior earnings and would also include vocational rehabilitation and workplace accommodations. Because employers would be charged different rates by the private insurance companies depending on the benefit claims of their employees, employers would have an incentive to find ways to keep their disabled workers employed. In order to create greater incentives for firms to retain workers with health impairments, Burkhauser and Daly (2011) propose experience rating for the employer share of Disability Insurance taxes in a way that is analogous to how worker's compensation and unemployment insurance contributions are experience rated. Thus, if an employer had a larger number of its workers claiming disability, that employer would face higher Disability Insurance premiums.

Other important decision makers who affect whether workers end up receiving Disability Insurance, or not, include states and the Social Security Administration itself. States have incentives to encourage low-wage workers to sign up for Disability Insurance and Supplemental Security Income because doing so has the effect of shifting both cash assistance costs and health care costs to the federal government and away from state programs. A change in federal funding formulas could alter this incentive.

The Social Security Administration's administrative budget comes from capped discretionary spending while benefits are mandatory. As a result, the Social Security Administration often ends up underinvesting in administrative capacity—failing to do continuing disability reviews, for example—even when doing so increases total program costs. Thus, the Social Security Administration has a backlog of 1.4 million

continuing disability reviews even though its actuaries estimate that every $1 spent on continuing disability reviews saves $10 in future benefits (Social Security Administration 2013). Additional administrative capacity would lead to more timely and accurate initial disability decisions, possibly reducing the number of cases that are appealed. In Liebman and Smalligan (2013), we propose that the funding for state disability determination services be switched to the mandatory side of the budget, which would be in accord with how the administrative costs of TANF, Medicaid, and Food Stamps operate.

A Pilot Program Approach

In most cases, we lack the evidentiary base necessary to judge whether specific disability insurance reforms would do more good than harm. Are the earnings gains that can be produced from employment supports for partially disabled workers sufficient to be cost effective when compared with simply providing cash transfers? Would experience-rating of Disability Insurance benefits discourage firms from hiring either disabled workers or workers from demographic groups with higher incidence of disability? In Liebman and Smalligan (2013), we propose three federal pilot demonstrations to generate the needed learning. Because research has consistently shown that it is far less effective to intervene after a person has begun receiving disability insurance benefits, all of the pilots would be early intervention programs.

A first pilot program would test whether employer incentives can reduce Disability Insurance enrollment. Specifically, we propose a demonstration program that would provide a tax credit against firm DI payroll tax for firms that can reduce the disability incidence of their employees by at least 20 percent. A second demonstration would screen disability applicants and target those who appear likely to be determined eligible for benefits but who also have the potential for significant work activity if provided with a proper range of services. In exchange for suspending their disability insurance application, these applicants would be offered a package of benefits including targeted vocational and health interventions, a wage subsidy, and perhaps a few months of an emergency cash diversion grant. In this way, the demonstration would find out whether it is possible to improve the well-being of applicants while simultaneously achieving near-term cost neutrality and long-term savings. The third demonstration would allow several states to reorganize existing funding streams to target populations that are likely to end up receiving a lifetime of DI or Supplemental Security Income benefits in the absence of assistance. States would receive incentive funding if they demonstrate success at improving outcomes and reducing participation in DI and SSI. Similarly, Mann and Stapleton (2011) propose state-based disability insurance pilots analogous to the welfare waiver experiments of the 1980s and 1990s that informed the 1996 federal welfare reform.

As the Disability Insurance Trust Fund heads toward exhaustion in 2016, legislative action of some sort will be necessary. While it is possible to delay substantive changes to the DI program for another decade or more simply by raising the share

of the OASDI payroll tax that is directed to the DI trust fund and lowering the share that is directed to the retirement trust fund, more significant changes will ultimately be needed. It would be wise, therefore, for the upcoming legislation to authorize a series of demonstration projects that can increase the chance that when it becomes time for more significant reforms, we will know enough to make smart choices. Economic research over the past two decades has suggested a set of changes that, by addressing some of the misplaced incentives in the system, offer the possibility of saving funds in the disability insurance system while potentially making people better off. These changes include altering the disability benefit package in a way that focuses on helping a larger proportion of the disabled return to work and reforming misaligned incentives that currently lead firms and state governments to encourage too many people to apply for federally funded disability benefits. It will take additional creative economic thinking in the next few years to design and evaluate the research and pilot projects that are needed to provide the evidence to guide broader reforms.

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United States Senate

Joint Economic Committee

SOCIAL SECURITY ADMINISTRATION

OIG

Statement for the Record

Ensuring Success for the Social Security Disability Insurance Program and Its Beneficiaries

The Honorable Patrick P. O'Carroll, Jr.
Inspector General, Social Security Administration

November 4, 2015

Good afternoon, Chairman Coats, Ranking Member Maloney, and members of the joint committee. Thank you for the invitation to testify today, to discuss ways to improve the Social Security Administration's (SSA) Disability Insurance (DI) program. My office oversees SSA's management of the DI program, so I appreciate your interest in these issues of critical importance to American workers and taxpayers.

Social Security DI is the nation's primary Federal disability program. According to SSA, in fiscal year (FY) 2015, the Agency provided about $144 billion in DI payments to more than 10.8 million citizens across the country. That total represents more than 8.9 million disabled workers, and about 1.9 million spouses and children.

Managing such a large and complex program has long been a challenge for SSA, particularly given resource constraints and demographic changes. However, given the importance of this safety net for the millions of Americans who depend on it, SSA must continue to innovate and seek ways to improve upon good service to the American people, and good stewardship over taxpayer funds. Today, I'll discuss our ideas for how we believe SSA can best achieve these goals. These ideas fall into three broad categories: updating the DI program and claims process; making more timely and accurate determinations; and ensuring that current beneficiaries remain eligible.

Update the DI Program and Claims Process

Decrease Complexity and Increase Consistency

We believe reducing the complexity of the DI program, without sacrificing its intent, would help reduce millions of dollars in improper payments that occur each year. For example, because SSA has to evaluate earnings and work incentives before stopping benefits when someone works—and cannot simply stop paying benefits because wages are reported—simplifying these provisions could have a positive impact. Undoubtedly, reforms to simplify SSA's programs would be difficult to implement in the short term, but the long-term benefits to both beneficiaries and taxpayers could outweigh the costs.

Still, regardless of how complex the DI rules are, SSA should strive to apply them consistently across the country. Currently, inconsistencies in claims allowance rates, processing times, and other aspects of the program exist across the country, at both the initial and appeals stages. Various factors affect State Disability Determination Services (DDS) performance—such as local demographics and economic conditions, different business processes, and State hiring freezes or furloughs. For example, in FY2013, DDS average processing times ranged from 45 to 140 days for DI claims.[1]

However, SSA could take a significant step to increase consistency by moving forward with its planned modernization of the technology infrastructure that supports initial claims decision-making. The Agency's Disability Case Processing System would replace 54 independently operated systems across the DDS agencies. In our May 2015 limited distribution report, *Observations and Recommendations for the Disability Case Processing System*, we made five recommendations we believe will increase SSA's chances for a successful rollout of this initiative—including emphasizing and incorporating user feedback into the development process. SSA agreed with all of our recommendations.

[1] SSA OIG, *Disability Determination Services Processing Times*, May 2015.

Incorporate Advances in Technology and Society

As the number of beneficiaries and claims grow, and SSA's workforce stays the same, the Agency must turn to technology to improve efficiency with tools that can accelerate the decision-making process.

- SSA has committed to using technology to improve and expand its online services; in FY2014 more than 52 percent of Social Security benefit claims were filed online. SSA has also made many efforts to promote the *my Social Security* account, so that beneficiaries can manage their Social Security information online. More than 21 million people have signed up for a *my Social Security* account with the Agency.
- SSA in recent years has expanded the use of health information technology (IT), the electronic management and secure exchange of medical information. We recently reported that SSA has partnered with 38 health care organizations and exchanged electronic records in 30 States and the District of Columbia. Health IT has shown to help SSA receive electronic health records faster and make disability decisions sooner than with traditional records.
- At the hearings level, SSA should continue to use video conferencing technology, so that claimants can participate in a hearing near their homes. In FY2009, SSA conducted about 18 percent of all hearings by video; that number increased to 28 percent in FY2014.

SSA should also continue efforts to modernize disability policy to reflect medical advances and the current occupational environment. The Agency's Listing of Impairments (more than 100 listed impairments covering 15 body systems), for example, is supposed to ensure that disability determinations are medically sound. However, we recently reviewed the listings and found that some have not been updated in many years and do not reflect recent medical and technological advances—for example, the mental and neurological listings were last updated in 1985 and 1986, respectively. We understand it takes time to develop policy and publish regulations, but without regular updates, the listings lose their effectiveness as a screening tool in the disability process. SSA plans to update several listings within the next year and agreed with our recommendation to ensure all of the listings are reviewed and updated no later than FY2020.[2]

SSA is also working with the Department of Labor to test occupational data collection methods that could lead to the development of a new occupational information system tailored for use in the disability programs. The new system would replace the outdated Dictionary of Occupational Titles; however, SSA acknowledges that many developmental and implementation challenges exist in this complex undertaking. We will begin a review of SSA's progress with this initiative later this year.

Reimagine Return to Work

Many efforts have been made by lawmakers and SSA to develop incentives that effectively encourage disability beneficiaries to return to work; the *Ticket to Work and Work Incentives Improvement Act* authorized SSA to test alternative work rules designed to provide disability beneficiaries an incentive to work and reduce their financial reliance on Social Security. Going forward, we believe SSA should develop clearly defined metrics and conduct cost-benefit analyses to appropriately test and assess the viability of such projects.

[2] SSA OIG, *The Social Security Administration's Listing of Impairments*, September 2015.

For example, we previously reviewed the Ticket to Work Program and determined that program implementation did not appear to increase the percentage of disabled beneficiaries who returned to work, nor did it realize the outcomes and savings envisioned by previous lawmakers.[3]

More recently, we reviewed the Benefit Offset National Demonstration (BOND) project, in which SSA is testing and evaluating the treatment of earnings for current DI beneficiaries; the project allows a gradual reduction of benefits ($1 for each $2 additional earned over the monthly SGA threshold) and offers some participants enhanced work incentives. We found that less than 3 percent of 85,000 BOND project participants had used the offset for one or more months; as of January 2015, the project's total cost was almost $87 million.[4]

Make More Timely and Accurate Eligibility Determinations

At the end of FY2015, SSA's level of pending initial claims stood at more than 620,000. The average disability claimant will wait about 114 days for an initial decision on his or her claim. These numbers are troubling to us; they can be devastating to those who will ultimately receive benefits but must wait for months at a time when they may be struggling to meet basic needs.

We have paid close attention to SSA's efforts to reduce the initial claims backlog. Last year, we reviewed the Agency's progress in fulfilling stated objectives to address the backlog, which included:

- increasing staff at DDSs and in Federal disability processing units;
- improving efficiency through automation;
- expanding the use of screening tools to identify claims likely to be allowed; and
- refining policies and business processes to expedite case processing.

Since FY2011, when the number of initial disability claims peaked at about 3.3 million, the number of applications has decreased each year (SSA received more than 2.7 million initial disability claims in FY2015). Still, a large backlog remains, and we have identified actions SSA can take to address it.

SSA also has a large backlog of appealed disability claims. Currently, more than 1 million claimants are awaiting a hearing on their appeal; the average disability appellant will wait 480 days for his or her case to be heard. We have done, and continue to do, significant and wide-ranging work to assist SSA in reducing the hearings backlog.

We recently issued a report on SSA's efforts to eliminate the hearings backlog and found the number of pending hearings has increased due to:

1. an increase in hearing requests from FY2007 to a record-high in FY2011 (hearing requests leveled off in FYs 2012, 2013, and 2014, but remained near the FY2011 high level);
2. a decrease in Administrative Law Judge (ALJ) dispositions since FY2011;
3. a decrease in senior attorney adjudicator decisions, due to quality concerns; and
4. a decrease in the number of available ALJs since FY2013.

[3] SSA OIG, *Ticket to Work and Self-Sufficiency Program Cost Effectiveness*, August 2008.
[4] SSA OIG, *Oversight of the Benefit Offset National Demonstration Project*, September 2015.

We have reviewed several ongoing initiatives that SSA has to address the hearings backlog, including hiring ALJs to reach a targeted staffing level of 1,800 to 1,900 ALJs by FY2018, transitioning to an electronic business process, expanding video hearings, emphasizing quality decision-making, and prioritizing decisions for claimants who have been waiting the longest.[5]

Additionally, we have reviewed ALJ decision-making and adherence to Agency policy, estimating significant benefit payments to claimants who were approved by ALJs even though their decisions were not supported by medical evidence in the claimants' records. SSA, we believe, should continue its oversight efforts and monitor ALJ decision-making and quality-reviews.[6]

A key tool disability examiners and ALJs have at their disposal in many states to ensure decisional accuracy is our Cooperative Disability Investigations (CDI) program. For 18 years, CDI has been extremely successful in preventing fraud at all levels of the disability claims process. When decision-makers find claims suspicious or questionable, they can refer them to a CDI Unit, which is composed of OIG, SSA, DDS, and state law enforcement personnel. Using the various skills and expertise of the Unit members, CDI Units analyze and investigate claims, gathering evidence that can lead to a more accurate claims decision. CDI currently consists of 37 Units in 31 States, the District of Columbia, and the Commonwealth of Puerto Rico. In FY2015, the CDI program reported $406 million in projected savings to SSA's disability programs. Since the program was established in FY1998, CDI efforts have prevented a projected $3.2 billion in disability payments.

Furthering the CDI mission, we and SSA are currently analyzing data from fraudulent disability claims present in large-scale schemes we have previously identified. We are working with SSA personnel to identify trends and patterns, and will apply those findings to existing and future claims to identify and prevent fraud. Based on our and SSA's work thus far, we believe predictive analytics can be an effective fraud-fighting tool.

Ensure that Current Beneficiaries Remain Eligible

Medical Continuing Disability Reviews

Just as it is critical that SSA make efforts to improve how it adjudicates claims, it is equally important that the Agency regularly review beneficiary information to ensure that people remain eligible. For many years, we have identified full medical continuing disability reviews (CDRs) as highly effective guards against paying DI benefits to individuals who have medically improved. If SSA determines the person's medical condition has improved such that he or she is no longer disabled according to its guidelines, it ceases benefits. The Agency estimates that every $1 spent on medical CDRs yields about $9 in savings to SSA programs as well as Medicare and Medicaid over 10 years.

Last year, we reported that SSA was performing less program integrity work than it had in the past. For example, SSA completed about half the number of medical CDRs in FY2013 than it did in FY2002, leading to a significant backlog.[7] According to SSA, in FY2014, the Agency completed 525,000 medical

[5] SSA OIG, *The Social Security Administration's Efforts to Eliminate the Hearings Backlog*, September 2015.
[6] SSA OIG, *Administrative Law Judges with Both High Dispositions and Allowance Rates*, November 2014.
[7] SSA OIG, *The Social Security Administration's Completion of Program Integrity Workloads*, August 2014.

CDRs; about 25 percent result in a cessation of benefits.[8] The medical CDR backlog stood at 906,000 at the end of FY2014. SSA used dedicated funding to complete 792,000 CDRs in FY2015; we are awaiting an updated backlog figure from SSA for the end of FY2015.

Work Continuing Disability Reviews

SSA also performs integrity reviews related to beneficiaries' earnings, called work CDRs. Although disabled beneficiaries are required to report work activity, they do not always do so. Therefore, SSA compares Internal Revenue Service data to the DI benefit rolls. However, even when earnings indicate a beneficiary has returned to work at the substantial gainful activity (SGA) level, SSA cannot simply stop payments, but reviewing work activity and earnings is a complex process that requires staff to consider all of the return-to-work provisions of the *Social Security Act.* Therefore, SSA must perform a work-related CDR.[9]

We have found that SSA has made improvements to this process in recent years, and we have consistently recommended that SSA prioritize the use of available resources toward CDR workloads so it does not miss opportunities to realize potential savings.[10] We support a previous legislative proposal to change the Federal wage reporting process from annual to quarterly reporting. A change of this nature would increase the frequency that employers report wages to SSA, improving the timeliness of the work CDR process. Currently, work alerts are not generated until the year after the earnings are posted to SSA records. This change would permit many alerts to be generated and processed in the same year as the work is performed, provided the Agency has the resources to process the work—thereby reducing the number of overpayments made that result when beneficiaries fail to report their work activity timely.

Ensure Payment Amount Accuracy

Finally, even when beneficiaries continue to be eligible, SSA can improve its efforts to calculate the right benefit amount by verifying self-reported information about wages or other benefits, such as worker's compensation or another government pension. We have recommended that, to improve payment accuracy, SSA should pursue data-matching agreements with other government agencies to obtain claimant data. For example, we previously worked with the Department of Labor to compare workers' compensation data to SSA records. We identified Federal employees who received DI the same year they received Federal Employees' Compensation Act (FECA) payments; SSA in some situations did not consider the beneficiaries' FECA payments when calculating their DI payments. This data match identified about $43 million in overpayments.[11]

Legislative Proposals

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[8] The initial cessation rate on medical CDRs ranged from 26 percent to 27 percent from FY2011 to FY2013. The ultimate cessation rate—after all appeals—would be lower than this.

[9] The monthly SGA amount for statutorily blind individuals for 2015 is $1,820. For non-blind individuals, the monthly SGA amount for 2015 is $1,090.

[10] SSA OIG, *Work Continuing Disability Reviews for Disabled Title II Beneficiaries with Earnings*, May 2014.

[11] SSA OIG, *Federal Employee Receiving Both Federal Employees' Compensation Act and Disability Insurance Payments*, October 2010.

I've reviewed several of our recommendations to improve the DI program, and to further this discussion, I'd like to mention several DI-related legislative proposals for your consideration.

- The Social Security Subcommittee this year introduced the *Social Security Disability Insurance and Unemployment Benefits Double Dip Elimination Act*. Currently an individual can receive unemployment insurance, which requires that a person be willing and able to work, while also receiving DI (for which they must claim they are unable to work due to disability). The legislation would end the ability to receive both benefits concurrently.

- The Subcommittee this year also introduced the *Social Security Fraud and Error Prevention Act*. The legislation requires Social Security to conduct pre-payment quality reviews of hearing decisions, excludes medical evidence in disability cases from physicians or health care providers barred from practice in any State or assessed a penalty for Social Security fraud, and implements new and stricter criminal and civil penalties for fraud. These last two provisions are included in the *Bipartisan Budget Act of 2015*.

- The *Improving the Quality of Disability Decisions Act*, also introduced this year by the Subcommittee, would require SSA to review ALJ decisions to ensure that judges are following the law and Social Security regulations and policy. SSA would have to report its findings to the Committee on Ways and Means annually.

Conclusion

Improving the DI program is a multi-faceted challenge for SSA. We are encouraged that pending legislation would avert the projected depletion of the DI Trust Fund reserves, but it is critical that Congress and SSA now turn to the program's management and long-term sustainability. My office has long held that SSA must find that important balance between customer service and stewardship over limited funds. This will continue to be SSA's primary challenge into the future, but based on extensive audit and investigative work, my office has recommended concrete steps the Agency can take to overcome this challenge and improve the program for both claimants and taxpayers.

I appreciate your ongoing interest in these issues. The OIG will continue to work with SSA and our oversight committees in Congress to ensure the effectiveness and integrity of the DI program. Thank you again for the invitation to testify, and I am happy to answer any questions.

Testimony before the Joint Economic Committee

United States Congress

November 4, 2015

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Chairman Coats, Ranking Member Maloney, and members of the Committee, it is an honor to be here with you today. The Social Security Disability Insurance (SSDI) program currently provides insurance against the risk of disability to more than 151 million American adults. This program represents an extremely important part of our nation's safety net as it protects workers and their families from the risk of a disability that prevents or greatly inhibits a person's ability to work.

Nearly 9 million adults received SSDI disabled worker benefits in September 2015 and total program expenditures exceeded $145 billion during the 2014 calendar year. SSDI recipients also receive health insurance through the Medicare program (after two years from onset of disability), with those costs financed by Medicare. SSDI expenditures exceeded program revenues by 26 percent in 2014 and as a result the program's trust fund is rapidly being depleted, having fallen from $215 billion at the end of 2007 to $42 billion in September 2015.[1] Recent projections from the OASDI Trustees' suggested that the SSDI trust fund would decline to zero in late 2016, though the recently passed Bipartisan Budget Act of 2015 should extend this until 2022.

As shown in Figure 1, enrollment in the SSDI program grew steadily from the late 1980s until 2013, with 2.3 percent of adults aged 25-64 receiving benefits in 1989 rising to 5.0 percent by 2013. This increase coincided with a reduction in employment rates among individuals with

[1] The ratio of SSDI trust fund assets to annual program expenditures fell from 2.2 to 0.3 during that period.

disabilities (Autor and Duggan, 2010). As this same figure shows, SSDI enrollment actually declined slightly as a share of the population from 2013 to 2014 after rising in every year since 1984.

In my testimony today, I will briefly summarize the primary factors that are responsible for the growth in SSDI enrollment since the late 1980s. I will then discuss some of the implications of this growth for the U.S. labor market. Finally, I will conclude by discussing the potential for changes to the SSDI program to increase employment and improve economic well-being among individuals with disabilities while also reducing the fiscal burden of the program.

Why Has SSDI Enrollment Increased?

One contributor to the growth in SSDI enrollment has been the aging of the baby boom generation. Individuals in their fifties and early sixties are significantly more likely to receive SSDI benefits than their counterparts in their thirties and forties. However, as the following table demonstrates, the percentage of adults receiving SSDI has risen sharply even within age groups.

Age Group	% of Adults on SSDI		% of Men on SSDI		% of Women on SSDI	
	1989	2014	1989	2014	1989	2014
25-39	0.8%	1.4%	1.1%	1.4%	0.5%	1.3%
40-49	1.9%	3.6%	2.5%	3.6%	1.2%	3.6%
50-59	4.3%	8.3%	5.8%	8.7%	2.9%	7.9%
60-64	7.8%	13.2%	11.0%	14.5%	5.0%	12.0%
25-64	2.3%	5.0%	3.0%	5.3%	1.5%	4.8%

Consider individuals between the ages of 50 and 59. In 1989, 1 out of 23 adults in this age group was receiving SSDI benefits. But by 2013, this had almost doubled to 1 in 12. The increase was similarly dramatic for adults in their forties and also substantial for adults in their early sixties and those between the ages of 25 and 39. Because of these age-specific increases, the aging of the population explains only about one-fifth of the increase in SSDI enrollment from 2.3 percent to 5.0 percent during the 1989 to 2014 time period. Put another way, if age-specific rates of SSDI enrollment had

remained unchanged from 1989 to 2014, the percentage of adults aged 25 to 64 on SSDI would have increased from 2.3 percent to 2.8 percent.

To be insured for SSDI benefits, a person must have worked in at least five of the ten most recent years. Because employment rates have increased among women since the 1980s, the fraction of women aged 25 to 64 insured for the program has risen as well, from 66 percent to 75 percent during the 1989 to 2014 period. This has also contributed to enrollment growth in the SSDI program and partially explains why SSDI has grown more rapidly among women than among men during this time period. But this factor explains just 12 percent of the rise in SSDI enrollment. Taken together, the aging of the baby boom population and changes in the fraction of adults insured for SSDI can explain only about one-third of the growth in the program depicted in Figure 1 from 1989 to 2014.

A more important determinant of the growth in SSDI enrollment since the 1980s is the liberalization of the program's medical eligibility criteria that occurred in the mid-1980s (Duggan and Imberman, 2009). As shown in Figure 2, there has been a substantial increase since that time in award rates (defined as the ratio of number of awards to SSDI-insured population) for mental disorders and diseases of the musculoskeletal system (e.g. back pain).[2] In contrast, award rates for neoplasms (cancer) and circulatory conditions (e.g. heart attack, stroke) have remained roughly constant. This shift is important because, as shown in recent research (von Wachter et al, 2011), the employment potential of SSDI applicants with these more subjective conditions is substantial and it is often difficult to verify the severity of these conditions (in contrast to cancer or heart conditions). Recent research by Liebman (2015) suggests that the rising incidence was the most important driver of the growth in SSDI enrollment since the mid-1980s.

A fourth contributor to the rise in SSDI enrollment has been the reduction in the generosity of OASI retired worker benefits. Individuals born in 1937 or earlier could receive 80 percent of their

[2] The figure shows that award rates for mental disorders declined significantly from 2009 to 2013 after a steady rise in the preceding years.

full retirement benefit if they claimed retired worker benefits at the age of 62. But as a result of legislation passed in 1983, this has gradually fallen to 75 percent for individuals born from 1943 to 1954 and will soon fall to 70 percent for individuals born in 1960 or later (with an associated increase in the full retirement age from 65 to 67 as well).[3] No corresponding changes were made to SSDI benefits and thus SSDI has become relatively more attractive financially. More specifically, SSDI benefits were 25 percent more generous than retirement benefits at age 62 for those born in 1937 or earlier but will be 43 percent more generous for those born in 1960 or later. Previous research demonstrates that the falling generosity of retired worker benefits has induced a substantial number of adults to apply for and ultimately receive SSDI, and this explains a substantial share of the growth in SSDI enrollment since the late 1980s (Duggan et al, 2007).

Another important driver of the growth in SSDI enrollment is the sensitivity of the program to economic conditions. As shown in Figure 3, applications to the SSDI program are highly responsive to the unemployment rate, with applications rising during economic downturns and falling when the economy improves. Previous research has shown that the SSDI program became more sensitive to economic conditions after the 1984 change in the program's medical eligibility criteria. Relatedly, individuals who lose their job or are unable to find a new job became increasingly likely to exit the labor force and apply for SSDI benefits (Autor and Duggan, 2003). Thus the program is to some extent serving as a form of long-term unemployment insurance for some workers, which is troubling when one considers the low exit rate from the program back into the labor force. In 2014, just 0.8 percent of recipients left the program due to improved health or to return to work.

A sixth contributor to the growth in SSDI enrollment is the rise in replacement rates for the typical low-skilled worker, which is caused by the interaction of two factors (Autor and Duggan, 2003). First, SSDI (like OASI) uses a progressive 90-32-15 benefit formula with "bend points" that

[3] Individuals born in 1955 can collect just 74.17 percent of full retirement benefits if they claim at age 62. This then falls by 0.83 percentage points per year until reaching 70 percent for those born in 1960 or later.

increase each year with average earnings growth. Second, earnings for low-income workers have grown more slowly than the average, and as a result workers replace an increasing fraction of their earnings at a 90 percent rate rather than a 32 percent rate. This has increased the financial incentive to apply for SSDI benefits and subsequently the enrollment in the program.[4]

Other factors have also contributed to the steady rise in SSDI enrollment since the late 1980s. Individuals who are initially rejected when they apply for SSDI have become more likely to appeal those decisions and are increasingly likely to be represented by a lawyer or other professional if/when they ultimately appear before an administrative law judge.[5] Meanwhile, the fraction of recipients receiving a continuing disability review and exiting the program for no longer meeting SSDI's medical eligibility criteria has also been lower in recent years.[6]

The steady rise in SSDI enrollment shown in Figure 1 has slowed down recently, with a decline actually occurring from 2013 to 2014. This is partly because the effect of an aging population has now "run its course", with the oldest members of the baby boom cohort reaching Social Security's full retirement age (and thus converting to retired worker benefits). Additionally, the fraction of applications resulting in an SSDI award has been declining, with the ratio of SSDI awards to SSDI applications in 2014 at its lowest level (32.2%) in the history of the program.[7] This appears to be at least partly driven by much lower award rates by Administrative Law Judges, who consider appeals from those whose SSDI applications have been rejected twice. A report by the Social

[4] Additionally because wages for low-skilled workers have grown more slowly than the average, their average indexed monthly earnings tend to be higher than current earnings. This has further increased the ratio of potential SSDI benefits to potential earnings.

[5] In the average year from 2000 to 2008, administrative law judges made awards in 72 percent of their decisions (SSA, 2012). This is striking when one considers that ALJs consider appeals only among those rejected twice previously by SSA. One potential contributor to the high award rate is that SSA is not represented at the hearing – only the applicant and/or his/her representative are typically present with the ALJ (Autor and Duggan, 2006).

[6] The contribution of health changes to this enrollment growth is difficult to assess. On the one hand, mortality and morbidity rates have declined substantially for non-elderly adults during this period. On the other hand, recent research suggests that health has deteriorated for certain groups. In a recent paper, Case and Deaton document a substantial increase in mortality rates among white non-Hispanic men since the late 1990s (Case and Deaton, 2015).

[7] This is not a perfect measure because awards in one year may result from applications in previous years. Preliminary data for the first 3 quarters of 2015 suggest that the award rate will be even lower this year, with the ratio of awards to applications slightly below 32%.

Security Advisory Board's Technical Panel demonstrates that more recently hired ALJs have substantially lower award rates than their predecessors (TPAM, 2015). Furthermore, award rates among ALJs hired in 2005 or earlier have also been falling substantially. These changes suggest that the medical eligibility criteria for the program have become stricter in recent years.

A third contributor to the slowdown in SSDI enrollment growth is that the fraction of individuals insured for SSDI benefits has been steadily declining (or growing more slowly) in recent years. To be eligible for SSDI, an individual must have worked in at least five of the ten most recent years. For example, the share of men in their forties insured for SSDI fell from 90.3 percent in 2000 to 85.2 percent in 2014, and this will mechanically reduce inflows to the program. And finally, the improving labor market has – as shown in Figure 3 – resulted in fewer SSDI applications and thus a lower flow of new recipients into the program.

Labor Market Effects of the Rise in SSDI Enrollment

While providing valuable insurance to tens of millions of Americans, the SSDI program reduces the incentive to work both for individuals on the program and also for those applying for SSDI benefits. In order to receive an SSDI award, a beneficiary must be deemed unable to engage in substantial gainful activity (SGA, currently $1,090 per month). Once on the program, an SSDI recipient has little incentive to return to work, as earnings above the SGA threshold will lead to a termination of benefits. Given that the present value of the average SSDI award is about $300,000 (including Medicare benefits), that is a risk that many SSDI recipients would be reluctant to take (Autor and Duggan, 2006).

The growth in SSDI enrollment has coincided with a substantial reduction in employment rates among individuals with disabilities. For example, from 1988 to 2008, the employment rate of men in their forties and fifties who reported a work-limiting disability fell from 28 percent to 16

percent while the corresponding rate for men without a disability rose slightly from 87 to 88 percent (Autor and Duggan, 2010).

Previous research has shown that workers have become increasingly likely to respond to adverse labor demand shocks by applying for SSDI rather than seeking a new job (Autor and Duggan, 2003). This serves to reduce both the unemployment rate and the labor force participation rate below what it otherwise would be. It also reduces the eventual employment rate as SSDI recipients rarely leave the program to return to the workforce. For example in 2014, only 0.8 percent (8 out of 1,000) of SSDI recipients left the program for improving health and/or to return to work.

This responsiveness of the SSDI program to economic conditions can be seen visually in Figure 3, with increases in the unemployment rate leading to large increases in the SSDI application rate. An examination of this application data suggests that there have been substantially more SSDI applications since 2008 as a result of the economic downturn, with the application rate declining with the unemployment rate during the past few years. Many of these recent applicants have withdrawn from the labor force, either because they have been awarded SSDI benefits or are still in the process of applying given the long lags in the process (especially at the appeal stage). Still others have likely withdrawn because their attachment to the labor force has declined during the application process (even if ultimately denied) and thus their potential wages as well.

The steady increase in SSDI enrollment since the late 1980s has contributed to a differential decline in labor force participation among both men and women in the U.S. relative to other industrialized countries. For example, the labor force participation rate declined by 4.7 percentage points (from 93.4% to 88.7%) among men 25-54 in the U.S. during the 1990 to 2011 period while falling just 1.5 percentage points (from 93.6% to 92.1%) among the EU-15 (OECD, 2013).[8] Similarly while the labor force participation rate was almost unchanged among women 25-54 in the

[8] These differences are even larger when focusing on men between the ages of 25 and 64 and are somewhat smaller when restricting attention to the 1990 to 2008 period. Declines in labor force participation among men aged 25-54 were also much lower in Australia, Canada, and Japan than in the U.S. during this same period.

U.S. from 1990 to 2011 (rising slightly from 74.0% to 74.7%), it increased by 14.8 percentage points (from 63.7% to 78.5%) among women in the EU-15 during this same period. Thus labor force participation rates for both men and women in the 25-54 age range were in 2011 substantially higher in the EU-15 than in the U.S.[9] Perhaps even more striking, the labor force participation rate in the U.S. is currently at its lowest level (62.4%) since October 1977. The corresponding participation rate a decade ago was 66.1%. While there are of course many factors that influence both the level and the trend in labor force participation, previous research indicates that the SSDI program is an important factor (Autor and Duggan, 2003; Maestas et al, 2013; French and Song, 2014).

Improving Work Incentives in the SSDI Program

The disability determination process that is currently used by the SSDI program awards benefits to individuals who are deemed unable to engage in substantial gainful activity. This reduces the incentive to work among those who have filed an initial application for SSDI and among those appealing a rejection. In recent years, nearly 40 percent of SSDI awards were made on appeal and the time between the initial application and the ultimate decision is substantial for this group.[10] For example, the average lag for an applicant who appeals to an Administrative Law Judge (ALJ) is 27 months (SSA, 2008). This is problematic because those initially rejected are likely to be in better health on average than those receiving an initial award, and thus likely to have higher employment potential. And the longer that a person remains out of the workforce, the more their earnings potential declines. Therefore even if an applicant never receives an SSDI award, the program's application process can permanently harm his/her employment prospects (Autor et al, 2015).

[9] The labor force participation rate for men in the U.S. aged 25 to 54 declined further to 88.4 percent by 2013 and for women in this same age range fell to 73.9 percent.

[10] According to SSA's Annual Report on the SSDI program, there were 968,744 awards for SSDI applications filed in 2010 (most recent year with more than 98 percent of decisions finalized at the time of publication). Of these, 61,885 received an award at the reconsideration level (appeal #1) while 298,170 received an award at a hearing (or subsequent) level. This represents 37.2 percent of awards. Given that 52,111 applications were still awaiting a decision on appeal, the actual number would likely eventually be closer to 40 percent. For example if half were awarded then the share would increase to 38.8 percent.

One way to improve incentives in the SSDI program is to intervene sooner for individuals with work-limiting conditions so that they can continue working. Many individuals with more subjective disorders – such as back pain – could benefit from such early intervention. In a recent paper, David Autor and I proposed adding a "front end" to the SSDI system that would include early intervention through rehabilitation and related services with the goal of keeping workers with work-limiting disabilities in the labor market (Autor and Duggan, 2010). Employers would contract with private insurers to administer this coverage and would have a financial incentive to keep their workers off the SSDI system (much as the Unemployment Insurance and Workers' Compensation programs provide employers with these types of financial incentives).

The payoff to keeping a potential SSDI applicant in the workforce is very high. The average present value of an SSDI award (including Medicare expenditures) is approximately $300,000. Additionally, to the extent that the program reduces employment, it also reduces tax revenue and GDP. While many awarded SSDI benefits are completely unable to work, previous research makes clear that a substantial fraction could work (Autor and Duggan, 2003; Burkhauser and Daly, 2011; von Wacther et al, 2011; Maestas, Mullen, and Strand 2013; French and Song, 2014).

Increasing employment among individuals with disabilities could improve their economic well-being and increase their autonomy while also reducing the fiscal strains on Social Security. Past efforts to achieve this goal have unfortunately had little impact. For example, the Ticket to Work program, which was authorized by Congress in 1999, allowed SSDI recipients to have a trial work period of 9 months during which they could retain their benefits. But takeup of the program was close to zero, perhaps because these incentives arrived too late after most SSDI recipients had been out of the labor force for years. Recent efforts to increase work incentives among disability insurance recipients have had some success in other countries (see Kostol and Mogstad, 2014 for evidence in Norway). The Bipartisan Budget Act of 2015 gives the Social Security Administration authority to

fund demonstration projects that may alter work incentives and provide evidence about the effects of potential reforms to SSDI on employment and labor force attachment among recipients.

There are other potential reforms that could improve the functioning of the SSDI program. For example, currently only the applicant and his/her representative are present at appeal hearings before ALJs. Thus SSA does not have someone present explaining why they rejected the application twice and this may partially explain why about 70 percent of those initial decisions that appeal a second time are overturned by ALJs. Additionally, there has been a substantial decline in recent years in the share of SSDI recipients receiving a continuing disability review (CDR) with this partially explaining the lower exit rate from the program (SSAB, 2012). Careful consideration of the appropriateness of the program's medical eligibility criteria also seems warranted given the major shift in the conditions with which individuals qualify for SSDI benefits as shown in Figure 2. And to the extent that economic (rather than only health) factors are considered when making an SSDI award, one could consider a form of time limit or a mandatory CDR for certain awardees.

The lack of progress in improving work incentives in the SSDI program stands in marked contrast to the Temporary Assistance to Needy Families (TANF) program. Reforms introduced in the 1990s (along with expansions in the Earned Income Tax Credit) led to substantial gains in employment among past, current, and potential future TANF recipients and to a steady drop in program enrollment and expenditures. Based on my own research and that of many others, I believe that similar progress is possible within the SSDI program. The pilot programs funded by the Bipartisan Budget Act have the potential to provide useful evidence about the effect of improved work incentives on earnings and return-to-work among SSDI recipients.[11] Additional evidence is also needed about the effects of other potential reforms to the SSDI program on the health and economic well-being of current and potential future SSDI recipients.

[11] To realize this potential, it would be important to design any pilot so that both a treated and control group are included. This would allow researchers to separately identify the effects of the incentives from other factors.

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Figure 1: % of Adults 25-64 Receiving SSDI Disabled Worker Benefits: 1957-2014

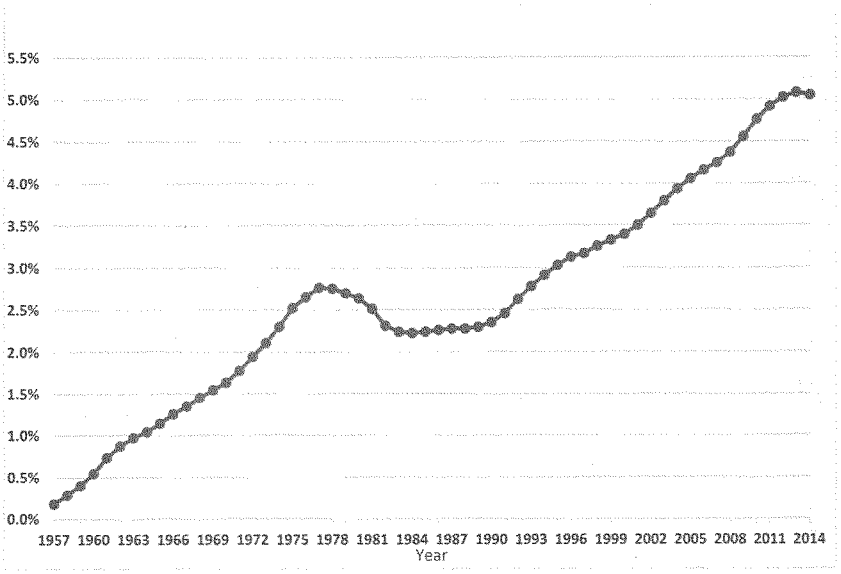
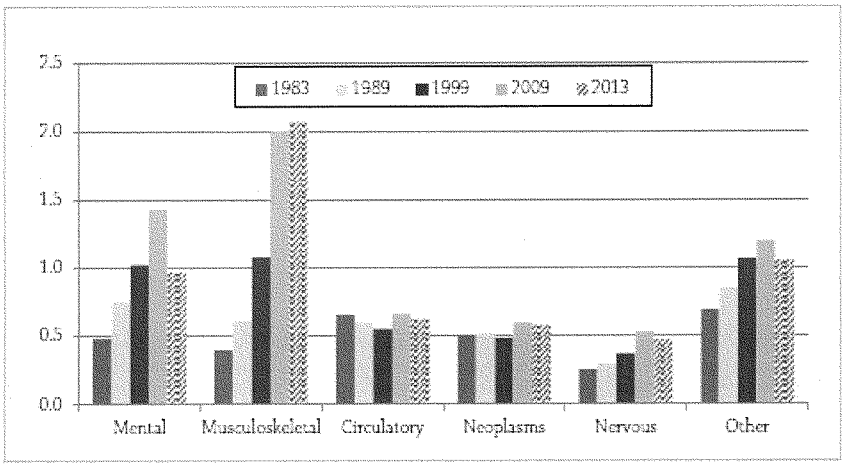
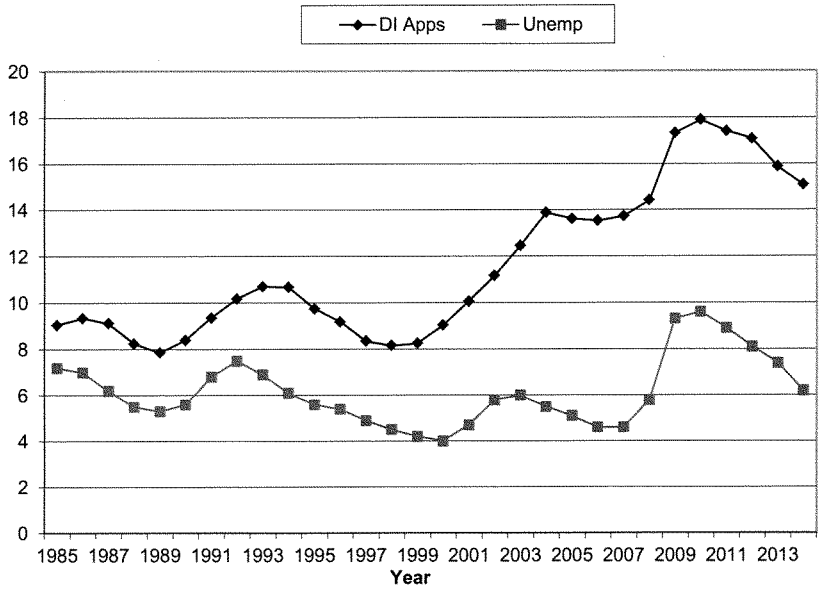


Figure 2: Awards per 1000 Insured for SSDI by Diagnosis Category in Selected Years



Source:Social Security Advisory Board. 2015 Technical Panel on Assumptions and Methods.

Figure 3: SSDI Applications per 1000 Insured Workers and Unemployment Rate: 1985-2014



Center for American Progress

Social Security Disability Insurance: A Bedrock of Security for American Workers

Testimony Before the United States Congress Joint Economic Committee

Hearing on "Ensuring Success for the Social Security Disability Insurance Program and Its Beneficiaries"

Rebecca D. Vallas, Esq.
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Center for American Progress

November 4, 2015

Thank you, Chairman Coats, Ranking Member Maloney, and Members of the Committee for the invitation to appear before you today. My name is Rebecca Vallas, and I am the Director of Policy of the Poverty to Prosperity Program at the Center for American Progress.

The subject of today's discussion is of the utmost importance to all of us as Americans, because any of us could find ourselves in the position of needing to turn to Social Security Disability Insurance at any time.

Imagine that tomorrow, while cleaning out your gutters, you fall off a ladder. You suffer a traumatic brain injury and spinal cord damage, leaving you paralyzed, unable to speak, and with significantly impaired short- and long-term memory. Unable to work for the foreseeable future, you have no idea how you are going to support your family. Now imagine your relief when you realize an insurance policy you have been paying into all your working life will help keep you and your family afloat by replacing a portion of your lost wages. It is our Social Security system.

The American people time and again have made clear their strong support for Social Security and their strong opposition to benefit cuts. I look forward to discussing how we can work

together to strengthen this vital program so that it can continue to protect American men, women, and children for decades to come.

I will make three main points today:

- **Social Security Disability Insurance provides basic but essential protection that workers earn during their working years.** Social Security protects nearly all American workers in case of life-changing disability or illness. The modest benefits from Social Security Disability Insurance are vital to the economic security of disabled workers and their families.

- **Eligibility criteria are stringent, and only workers with the most serious disabilities and illnesses qualify for benefits.** According to the Organisation for Economic Co-operation and Development, or OECD, the Social Security disability standard is among the strictest in the industrialized world. The vast majority of applicants are denied, and those who qualify for benefits often have multiple serious impairments, and many are terminally ill. Few are able to work at all.

- **The recently passed Bipartisan Budget Act of 2015 includes several provisions that will strengthen the program.** The budget deal includes a temporary, modest reallocation of payroll taxes to prevent sharp across-the-board benefit cuts for beneficiaries, as well as several common-sense bipartisan steps to ensure program integrity.

Social Security Disability Insurance provides basic but essential protection that workers earn during their working years

Social Security was established nearly 80 years ago to ensure "the security of the men, women and children of the nation against the hazards and vicissitudes of life."[1] In 1956, the program was expanded to include Disability Insurance in recognition that the private market for long-term disability insurance was failing to provide adequate or affordable protection to workers.[2]

Today, nearly all Americans—90 percent of workers ages 21 to 64—are protected by Social Security Disability Insurance.[3] In all, more than 160 million American workers and their families are protected.[4] About 8.9 million disabled workers—including more than 1 million veterans—receive Disability Insurance benefits, as do about 149,000 spouses and 1.8 million dependent children of disabled workers.[5]

Social Security Disability Insurance is coverage that workers earn

Both workers and employers pay for Social Security through payroll tax contributions. Workers currently pay 6.2 percent of the first $118,500[6] of their earnings each year, and employers pay the same amount up to the same cap. Of that 6.2 percent, 5.3 percent currently goes to the Old Age and Survivors Insurance, or OASI, trust fund, and 0.9 percent to the Disability Insurance trust fund. Due to the interrelatedness of the Social Security programs, the two funds are typically considered together, though they are technically separate. The portion of payroll tax

contributions that goes into each trust fund has changed several times throughout the years to account for demographic shifts and the funds' respective projected solvency.[7]

Benefits are modest but vital to economic security

The amount a qualifying worker receives in benefits is based on his or her prior earnings. Benefits are modest, typically replacing half or less of a worker's earnings. The average benefit in 2015 is about $1,165 per month—not far above the federal poverty level for an individual.[8]

Average disabled worker benefit (May 2015):

$1,165 per month
$13,980 per year

Federal poverty level for an individual (2015):

$980 per month
$11,760 per year

For more than 80 percent of beneficiaries, Disability Insurance is their main source of income. For one-third, it is their only source of income.[9] Benefits are so modest that many beneficiaries struggle to make ends meet; nearly one in five, or about 1.6 million, disabled-worker beneficiaries live in poverty.

But without Disability Insurance, this figure would more than double, and more than 4 million disabled-worker beneficiaries would be poor.[10] Disabled workers use their Social Security benefits to meet basic needs, such as rent or mortgage, gas and electric, food, and co-pays on needed—often life-sustaining—medications.

Workers who receive Disability Insurance are also eligible for Medicare after a two-year waiting period.[11]

Social Security Disability Insurance provides protection most of us could never afford on the private market

And there is good reason to offer disability insurance through a public program such as Social Security: Private disability insurance is out of reach for most families. Just one in three private-sector workers has employer-provided long-term disability insurance, and plans are often less adequate than Social Security.[12] Coverage is especially scarce for low-wage workers—just 7 percent of workers making less than $12 per hour have employer-provided disability insurance.[13]

Workers in industries such as retail, hospitality, and construction are among the least likely to have employer-provided long-term disability coverage, and coverage is highly concentrated among white-collar professions.[14] Access is even more limited on the individual market.

While it is difficult to compare Social Security Disability Insurance with private long-term disability plans given that private plans often exclude certain types of impairments—as well as workers with pre-existing conditions or in high-risk occupations—purchasing a plan of comparable value and adequacy on the individual private market would be unrealistic for most Americans.

Eligibility criteria are stringent, and only workers with the most serious disabilities and illnesses qualify for benefits

Disabled workers face a steep uphill battle to prove that they are eligible for Social Security Disability Insurance. Under the Social Security Act, the eligibility standard requires that a disabled worker be "unable to engage in substantial gainful activity"—defined as earning $1,090 per month in 2015—"by reason of any medically determinable physical or mental impairment which can be expected to result in death or last for a continuous period of not less than 12 months."[15] In order to meet this rigorous standard, a worker must not only be unable to do his or her past jobs but also—considering his or her age, education, and experience—any other job that exists in significant numbers in the national economy at a level where he or she could earn even $270 per week.[16]

A worker must also have earned coverage in order to be protected by Disability Insurance. A worker must have worked at least one-fourth of his or her adult years, including at least 5 of the 10 years before the disability began in order to be "insured."[17] The typical disabled worker beneficiary worked 22 years before needing to turn to benefits.[18]

The OECD describes the U.S. disability benefit system, along with those of Canada, Japan, and South Korea, as having "the most stringent eligibility criteria for a full disability benefit, including the most rigorous reference to all jobs in the labor market."[19]

In practice, proving medical eligibility for Disability Insurance requires extensive medical evidence from one or more medical providers designated as acceptable medical sources—licensed physicians, specialists, or other approved medical providers—documenting the applicant's severe impairment, or impairments, and resulting symptoms. Evidence from other providers, such as nurse practitioners or clinical social workers, is not enough to document a worker's medical condition. Statements from friends, loved ones, and the applicant are not considered medical evidence and are not sufficient to establish eligibility.

Social Security's listing of impairments is organized according to 14 body systems

- Cardiovascular system
- Congenital disorders that affect multiple body systems
- Digestive system
- Genitourinary disorders
- Hematological disorders
- Endocrine disorders
- Immune system disorders
- Malignant neoplastic diseases
- Mental disorders
- Musculoskeletal disorders
- Neurological disorders
- Respiratory system
- Skin disorders
- Special senses and speech

Fewer than 4 in 10 claims for Disability Insurance are approved under this stringent standard, even after all levels of appeal.[20] Many wait a year—and in many cases much longer—before receiving needed benefits. Underscoring the strictness of the disability standard, thousands of applicants die each year during the eligibility determination process.[21] Of those who live long enough to receive benefits, one in five male and nearly one in six female beneficiaries die within five years of being approved.[22] All told, Disability Insurance beneficiaries have death rates three to six times higher than other people of their age.[23]

Beneficiaries have a wide range of significant disabilities and debilitating illnesses and many have multiple impairments

Disabled workers who receive Disability Insurance live with a diverse range of severe impairments. The Social Security Administration categorizes beneficiaries according to their "primary diagnosis," or main health condition.[24] As of 2013, the most recent year for which impairment data are available:

- 31.5 percent have a "primary diagnosis" of a mental impairment, including 4.2 percent with intellectual disabilities and 27.6 percent with other types of mental disorders such as schizophrenia, post-traumatic stress disorder, or severe depression.
- 30.5 percent have a musculoskeletal or connective tissue disorder.
- 8.3 percent have a cardiovascular condition such as chronic heart failure.
- 9.3 percent have a disorder of the nervous system, such as cerebral palsy or multiple sclerosis, or a sensory impairment such as deafness or blindness.
- 20.4 percent include workers living with cancers; infectious diseases; injuries; genitourinary impairments such as end stage renal disease; congenital disorders; metabolic and endocrine diseases such as diabetes; diseases of the respiratory system; and diseases of other body systems [25]

A fact not well captured by Social Security's data—given that beneficiaries are categorized by "primary diagnosis"—is that many beneficiaries have multiple serious health conditions. For instance, nearly half of individuals with mental disorders have more than one mental illness, such as major depressive disorder and a severe anxiety disorder.[26] Individuals with mental illness are also at greater risk of poor physical health: The two leading causes of death for individuals with mental illness are cardiovascular disease and cancers.[27] Musculoskeletal disorders commonly afflict multiple joints,[28] and individuals with musculoskeletal impairments—typically older workers whose bodies have broken down with age—commonly suffer additional health conditions such as cardiovascular disease, diabetes, and respiratory disease.[29]

The breakdown of impairment categories among Disability Insurance beneficiaries is consistent with global health trends. According to the World Health Organization, the leading causes of disability today in most regions of the world—including the United States—are musculoskeletal impairments and mental disorders.[30] The rise in mental impairments around the world is often attributed to increased awareness and reduced stigma of mental illness. Likewise, the global rise in musculoskeletal impairments is attributable to the aging of the population both in the United States and globally—since the risk of experiencing musculoskeletal impairments rises sharply with age—as well as to the drop in mortality.[31]

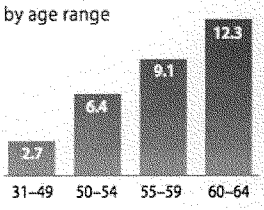
Most beneficiaries are older and had physically demanding jobs

Most beneficiaries of Disability Insurance—7 in 10—are in their 50s and 60s, and the average age is 53. The fact that most beneficiaries are older is unsurprising given that the likelihood of disability increases sharply with age: A worker is twice as likely to experience disability at age 50 as at 40, and twice as likely at 60 as at 50.[32] Before turning to Social Security, most disabled-worker beneficiaries worked at "unskilled" or "semi-skilled" physically demanding jobs.[33] About half—53 percent—of disabled workers who receive Disability Insurance have a high school diploma or less.[34] About one-third completed some college, and the remaining 18 percent completed four years of college or have further higher education.[35]

FIGURE 1

The likelihood of receiving Social Security Disability Insurance rises sharply with age

Social Security Disability Insurance prevalence rates by age range



Source: Melissa M. Favreault, Richard W. Johnson, and Karen E. Smith, "How Important Is Social Security to American Workers?" (Washington: Urban Institute, 2013), available at http://www.urban.org/UploadedPDF/412847-how-important-is-social-security.pdf.

Few are able to work at all

Disability Insurance beneficiaries are permitted and encouraged to work. They may earn up to the substantial gainful activity level—$1,090 per month in 2015—with no effect on their monthly benefits. However, given how strict the Social Security disability standard is, most beneficiaries live with such debilitating impairments and health conditions that they are unable to work at all, and most do not have earnings. According to a recent study linking Social Security data and earnings records before the onset of the Great Recession in 2007, it was found that fewer than one in six, or 15 percent, of beneficiaries had earnings of even $1,000 during the year.[36] The vast majority of those who worked earned very little, and just 3.9 percent earned more than $10,000 during the year—hardly enough to support oneself.[37]

For those whose conditions improve and who wish to test their capacity to work, Social Security Administration policies include strong work incentives and supports. Beneficiaries whose conditions improve enough that they are able to earn more than the substantial gainful activity level are encouraged to work as much as they are able to and may earn an unlimited amount for up to 12 months without losing a dollar in benefits. Those who work above the substantial gainful activity level for more than 12 months enter a three-year "extended period of eligibility," during which they receive a benefit only in the months in which they earn less the substantial gainful activity level.[38] After the extended period of eligibility ends, if at any point in the next five years their condition worsens and they are not able to continue working above that level, they can return to benefits almost immediately through a process called "expedited reinstatement."[39] This process allows them to restart their needed benefits without having to repeat the entire, lengthy disability determination process. These policies are extremely helpful to beneficiaries with episodic symptoms or whose conditions improve over time.

If a significant share of beneficiaries were able to do substantial work, one would expect a sizable percentage to take advantage of the previously described work incentives in order to maximize their earnings without losing benefits. But beneficiaries' work patterns indicate otherwise. Less than one-half of 1 percent of beneficiaries maintain a level of earnings just below the substantial gainful activity level.[40] Further underscoring the strictness of the Social Security disability standard, even disabled workers who are denied benefits exhibit extremely low work capacity afterward. A recent study of workers denied Disability Insurance found that just one in four were able to earn more than the substantial gainful activity level post-denial.[41]

How does the United States compare with other countries?

The Social Security disability standard is among the strictest in the industrialized world. As previously noted, the OECD describes the U.S. disability benefit system, along with those of a handful of other nations, as having "the most stringent eligibility criteria for a full disability benefit, including the most rigorous reference to all jobs in the labor market."[42]

Social Security Disability Insurance benefits are less generous than most other countries' disability benefit programs. With Disability Insurance benefits replacing 42 percent of previous earnings for the median earner, the United States is ranked 30th out of 34 OECD member countries in terms of replacement rates.[43] Many countries' disability benefit programs replace 80 percent or more of previous earnings.[44]

By international standards, the United States spends comparatively little on disability benefits. In 2009, U.S. spending on Social Security Disability Insurance equaled 0.8 percent of gross domestic product, or GDP, again putting the United States near the bottom—27th out of 34 OECD member countries—in spending on equivalent programs. On average, OECD member countries spend 1.2 percent of GDP on their equivalent programs, and many—such as Denmark at 2 percent, the United Kingdom at 2.4 percent, and Norway at 2.6 percent—spend significantly more.[45]

The share of the U.S. working-age population receiving Disability Insurance benefits—about 6 percent—is roughly on par with the OECD average of 5.9 percent.[46]

In drawing international comparisons, it is well worth noting that in addition to more generous disability benefit systems with less rigorous eligibility standards, European nations tend to have universal paid leave policies, more generous health care systems, higher levels of social spending generally, and more regulated labor markets than the United States.[47]

Growth in the program was expected and is mostly the result of demographic and labor market shifts

As long projected by Social Security's actuaries, the number of workers receiving Disability Insurance has increased over time, due mostly to demographic and labor market shifts. According to recent analysis by Harvard economist Jeffrey Liebman, the growth in the program between 1977 and 2007 is due almost entirely—at 90 percent—to the Baby Boomers aging into the high-disability years of their 50s and 60s and the rise in women's labor force participation.[48]

Importantly, as Baby Boomers retire, the program's growth has already leveled off and is projected to decline further in the coming years.[49]

Due to the importance of these demographic factors, Social Security's actuaries analyze trends in benefit receipt using the "age-sex adjusted disability prevalence rate," which controls for changes in the age and sex distribution of the insured population, as well as for population growth. The age-sex adjusted disability prevalence rate was 4.6 percent in 2014 compared with 3.1 percent in 1980.[50]

Key drivers of the program's growth include:

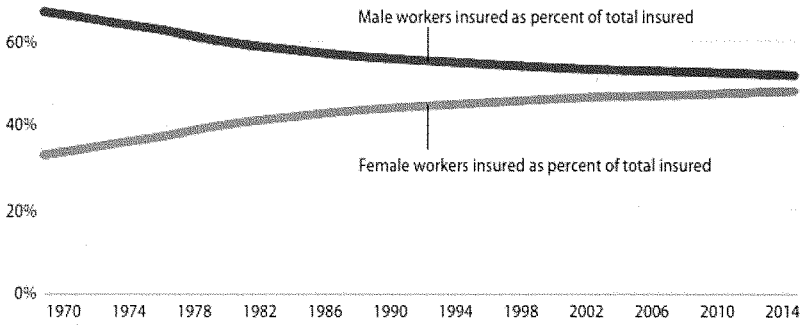
- **Aging population.** The risk of disability increases sharply with age. A worker is twice as likely to be disabled at age 50 as at 40, and again twice as likely at age 60 as at 50.[51] Born between 1946 and 1964, Baby Boomers have now aged into their high-disability years, driving much of the growth in Disability Insurance.

- **Increase in women's labor force participation.** Whereas previous generations of women had not worked enough to be insured in case of disability, women today have essentially caught up with men when it comes to being insured for benefits based on their work history.[52]

FIGURE 2

Women have caught up to men in insured status

Number of male and female workers insured in case of disability, in thousands, 1970–2014



Source: Social Security Administration, "Estimated number of workers insured in the event of disability, by age group and sex, on December 31, 1970-2014," available at http://ssa.gov/oact/STATS/table4c20.html (last accessed June 2015).

- **Population growth.** The working-age population—ages 20 to 64—has grown significantly, by 43 percent between 1980 and 2014.[53] The Center on Budget and Policy Priorities estimates that population growth alone—even if the population were not aging—would have resulted in an additional 1.25 million beneficiaries during that time period.[54]

- **Women's catch-up in rates of receipt.** Just as women have caught up with men in terms of having worked enough to be insured for Disability Insurance, the gender gap in rates of receipt of benefits has closed as well. As recently as 1990, male workers outnumbered female workers by 2-to-1, whereas today, nearly 48 percent of workers receiving Disability Insurance are women.[55]

- **Increase in Social Security retirement age.** The increase in the Social Security retirement age from 65 to 66, and ultimately to 67, has played a role as well, as disabled workers continue receiving Social Security Disability Insurance for longer before converting to retirement benefits when they reach full retirement age. About 5 percent of Social Security Disability Insurance beneficiaries are ages 65 and 66.[56]

The Great Recession in context

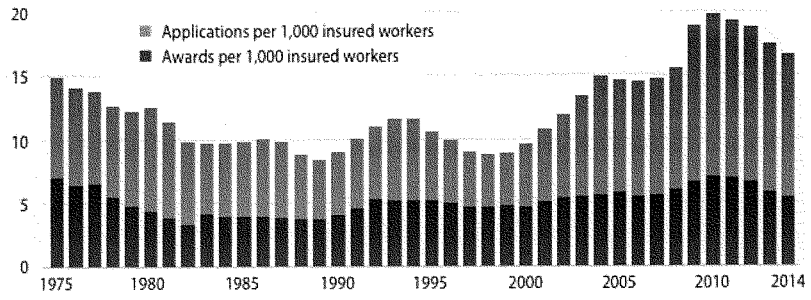
Social Security's actuaries note that the main effect of the recent economic downturn was lower revenue through payroll tax contributions—not an increase in beneficiaries.[57] While recessions are typically associated with sharp increases in applications for Social Security Disability Insurance, they have a much smaller impact on awards. The most recent downturn was no exception, and Social Security's actuaries estimate that just 5 percent of the program's growth from 1980 to 2010 is due to the recession,[58] likely due to workers with disabilities being disproportionately laid off from employer payrolls when times got tight.

It is important to note that while applications increased during the Great Recession, the award rate—the share of applications approved for benefits—declined,[59] indicating that applicants who did not meet the rigid disability standard were screened out. A study by Social Security's watchdog examined the 11 states with the highest unemployment rates and found that award rates had dropped in all of them.[60]

Moreover, a recent National Bureau of Economic Research study found "no indication that expiration of unemployment insurance benefits causes Social Security Disability Insurance applications."[61] Furthermore, a recent White House Council of Economic Advisers report examining labor force participation trends since 2007 found that the increase in the number of disabled workers receiving Disability Insurance has had a minimal effect on labor force participation, noting, "In fact, if anything, the increase in disability rolls since 2009 have been somewhat *lower* than one would have predicted given the predicted cyclical and demographic effects."[62]

FIGURE 3

Applications and awards, disabled workers, 1975–2014



Source: Social Security Administration, "Disabled Workers Applications For Disability Benefits & Benefit Awards," available at http://www.ssa.gov/oact/STATS/table6c7.html (last accessed June 2015); Social Security Administration, "Selected Data From Social Security's Disability Program," available at http://www.ssa.gov/oact/STATS/dibStat.html (last accessed June 2015).

The program's financial outlook

While the OASI fund and the Disability Insurance fund are technically separate, they are typically considered together due to the interrelatedness of Social Security's programs. For example, Social Security's programs share the same benefit formula, beneficiaries regularly move between programs,[63] and changes to one program—such as raising the retirement age—affect both trust funds. Since Social Security Disability Insurance was established in 1956, Congress has repeatedly, on a bipartisan basis, reallocated the share of payroll taxes that goes into each trust fund to keep both funds on sound footing amid changing demographics. Payroll tax reallocation has occurred repeatedly over the years whenever needed, roughly equally in both directions.[64]

1983 Social Security reforms worsened Social Security Disability Insurance's financial health to an extent that the 1994 adjustments only partially addressed

Prior to the recently passed budget deal, the last round of major changes to Social Security occurred in 1983. Notable components of the 1983 legislation included an increase in the Social Security retirement age from 65 to 67 and a cut in the share of the payroll tax allocated to the Disability Insurance trust fund.[65] At the time of the 1983 changes, the OASI fund was facing insolvency, while the Disability Insurance fund was healthy.[66]

The impact of these changes on the Disability Insurance trust fund has been significant. As noted above, increasing the full retirement age worsens the state of the Disability Insurance trust fund since it causes workers to remain on Disability Insurance for longer before converting to Social Security retirement benefits. Additionally, the cut in the share of the payroll tax allocated to Disability Insurance—which had been on schedule to rise from 0.825 to 1.1 percent

in 1990—has caused the Disability Insurance fund to receive significantly less revenue in the years since.[67]

In 1994, spurred by the worsening state of the Disability Insurance fund, Congress increased Disability Insurance's share of the payroll tax to 0.9 percent—an improvement over the 0.5 percent to 0.6 percent the fund had been receiving after the 1983 legislation but still significantly lower than the 1.1 percent it had been scheduled to receive prior to the 1983 changes.[68] Disability Insurance's share of the payroll tax remains at 0.9 percent. Had it risen to 1.1 percent as scheduled, we would not be where we are today, and action to shore up the fund would not be needed by late 2016.

Bipartisan Budget Act of 2015 strengthens Social Security Disability Insurance

The recently passed budget deal[69] includes several provisions to strengthen the program. Most importantly, it provides for a modest, temporary reallocation of payroll taxes to ensure that all promised Disability Insurance benefits can be paid through 2022, avoiding sharp and unnecessary across-the-board benefit cuts. While it is disappointing that the reallocation in the Bipartisan Budget Act falls short of the president's proposal to equalize the solvency of the trust funds and put both on sound footing until 2034, the reallocation provided for in the budget deal will prevent deep benefit cuts that would have been devastating to beneficiaries' financial security and well-being.

The budget deal also includes a number of important bipartisan measures to enhance program integrity, such as:

- Expanding Cooperative Disability Investigation Units, or CDIs, to all 50 states
- Boosting cap adjustment spending for program integrity under the Budget Control Act to support the expansion of CDI units and continuing disability reviews
- Allowing for the use of electronic payroll data from commercial databases to enable the Social Security Administration to reduce improper payments
- Closing unintended loopholes such as "file and suspend" to prevent individuals from obtaining greater benefits than Congress intended
- Requiring medical review—by a qualified physician, psychiatrist, or psychologist—of initial disability determinations

Additionally, the budget deal restores the Social Security Administration's demonstration authority for the Disability Insurance program. It also provides for a demonstration project to test replacing the "cash cliff" with a "benefit offset," such that an individual's monthly benefit would be reduced by $1 for every $2 of earnings in excess of a threshold.

Looking past 2022, there are a number of options for ensuring the long-term solvency of the overall Social Security system without cutting already modest benefits—something that polls consistently confirm most Americans oppose.[70] One frequently discussed policy option is eliminating the cap on earnings that are subject to payroll taxes so that the 5 percent of workers who earn more than the cap would pay into the system all year as other workers do. A

recent survey conducted by the nonpartisan National Academy of Social Insurance found overwhelming support for a reform package that included this and other revenue-enhancing features, while also boosting benefits.[71] An array of legislation introduced within the past few years has included this and other approaches to strengthen Social Security, reflecting their growing popularity.[72]

Adequate administrative funding is needed to address backlogs and ensure program integrity

The Social Security Administration's administrative costs are less than 1.3 percent of the benefits it pays out each year.[73] The agency requires sufficient administrative funding not only to process applications for and payment of benefits but also to perform important program integrity work, such as pre-effectuation reviews of disability determinations and continuing disability reviews to ensure benefits are paid only as long as the individual remains eligible.

In recent years, the agency's administrative budget has been significantly underfunded. Congress appropriated more than $1 billion less for the Social Security Administration's Limitation on Administrative Expenses, or LAE, than President Barack Obama's request between fiscal years 2011 and 2013. Additionally, in FY 2012 and 2013, Congress appropriated nearly $500 million dollars less for the agency's program integrity activities—such as continuing disability reviews—than the Budget Control Act of 2011 authorized.[74] As a result, during a time of increasing workload due to the Baby Boomers entering retirement and their disability-prone years, the agency lost more than 11,000 employees—a 13 percent drop in its workforce—hampering its ability to serve the public and keep up with vital program integrity activities.[75] In a positive step, the FY 2014 budget bill provided the agency with full funding at the FY 2014 Budget Control Act levels for program integrity activities.[76] But in FY 2015, the Social Security Administration received $218 million less for LAE than the president's request.[77] This directly translates into diminished capacity for program integrity efforts. President Obama's FY 2015 budget request would have allowed the Social Security Administration to complete 98,000 more continuing disability reviews during this fiscal year.[78]

Adequate resources are needed to support claims processing and disability determinations at the initial levels so that the right decision can be made at the earliest point in the process and needless appeals can be avoided. Additionally, adequate resources are urgently needed to address the tremendous backlogs that have emerged at the administrative law judge, or ALJ, hearing level. The average wait time for an ALJ hearing is well over one year—closer to two years in many hearing offices—and more than 1 million applicants are currently waiting for a hearing.[79]

Additionally, the agency requires sufficient administrative funding to conduct important program integrity activities, such as continuing disability reviews to ensure benefits are paid only as long as the individual remains eligible. Continuing disability reviews are estimated to save some $9 in benefits for every $1 spent on reviews, yet the agency reports a backlog of nearly 1.3 million reviews due to inadequate funding.[80] In an important step forward, the cap adjustments for program integrity funding included in the recent budget deal will provide the Social Security Administration with $484 million in additional funding between FY 2017 and FY

2020 to conduct continuing disability reviews and other critical program integrity activities.

Policies to give workers with disabilities a fair shot at employment and economic security

Supporting work by people with disabilities has long been a bipartisan priority, and considerable progress has been made toward removing barriers to employment, education, and accessibility over the past several decades. The Americans with Disabilities Act, or ADA, enacted 25 years ago, prohibits discrimination on the basis of disability and mandates that people with disabilities must have "equal opportunity" to participate in American life. The Individuals with Disabilities Education Act, or IDEA, enacted the same year, requires that students with disabilities be provided a "free appropriate public education" just like all other students.

The Workforce Innovation and Opportunity Act, or WIOA, expanded access for people with disabilities to education and training programs, programs for transition-age youth and young adults transitioning to adulthood, vocational rehabilitation, and more. And most recently, the Achieving a Better Life Experience, or ABLE, Act, which was signed into law at the end of 2014, permits people with qualifying disabilities to open special savings accounts without jeopardizing eligibility for programs such as Medicaid and Supplemental Security Income, or SSI.

But much work remains. In order to break the link between disability and economic insecurity, we must enact public policies that give workers with disabilities a fair shot.

A great deal of attention is often paid to the Social Security Disability Insurance program, with some calling for a fundamental overhaul of this vitally important program in the name of increasing employment among people with disabilities. Yet as noted by the National Council on Disability, it is often forgotten that:

> Receipt of Social Security disability benefits is merely the last stop on a long journey that many people with disabilities make from the point of disability onset to the moment at which disability is so severe that work is not possible. All along this journey, individuals encounter the policies and practices of the other systems involved in disability and employment issues.[81]

As noted previously, most Disability Insurance beneficiaries live with such significant disabilities and severe illnesses that substantial work is unlikely. Moreover, a great many Americans with disabilities who do not receive Disability Insurance face barriers to employment and economic security. To achieve the goal of ensuring that workers with disabilities have a fair shot at gainful employment and economic security, policymakers must step back and take a much broader look at the policy landscape and how it affects workers with disabilities.

In order to give people with disabilities a fair shot at employment, policymakers should:

- **Raise the minimum wage.** Raising the minimum wage to $12 per hour would boost the incomes of many workers with disabilities, who are especially likely to work in low-wage jobs, and would help reduce the disability pay gap.[82]

- **Strengthen the Earned Income Tax Credit, or EITC.** Boosting the EITC for workers without dependent children would benefit more than 1 million workers with disabilities, who are more likely to work in low-wage jobs and who are also less likely to have children.[83]

- **Expand Medicaid.** Expanding Medicaid—as 19 states continue to refuse to do[84]—would make it possible for more low-income Americans to access preventive care and reduce financial strain for low-income individuals with disabilities.

- **Ensure paid leave and paid sick days.** Ensuring paid leave—such as through the Family and Medical Insurance Leave Act, or FAMILY Act—as well as paid sick days—as the Healthy Families Act would do—would benefit both workers with disabilities and the one in six workers who care for family members with disabilities.[85]

- **Improve access to long-term supports and services.** Ensuring access to long-term services and supports for workers with disabilities through a national Medicaid buy-in program with generous income and asset limits would remove a major barrier for employed individuals with disabilities who are working their way out of poverty. An enhanced federal match could ensure that there are no additional costs to states. No person with high support needs should be required to remain poor in order to gain access to the services and supports they need in order to work.[86]

- **Institute a disabled worker tax credit.** This idea, which has received bipartisan support over the years,[87] would enable workers with disabilities to offset the additional costs associated with their disabilities, thus reducing hardship and making it possible for them to work. The credit should be made refundable to ensure that low-income workers can access its benefits. Other important questions that need to be explored include which eligibility criteria to use and whether to structure it as a credit with a flat amount for all workers who qualify or to tie its value to verifiable costs.

- **Adequately fund vocational rehabilitation.** Adequate funding for the vocational rehabilitation system is needed to ensure that all eligible individuals are able to access vocational rehabilitation services when they need them.

- **Create subsidized employment opportunities.** A national subsidized jobs program—modeled after states' successful strategies using Temporary Assistance for Needy Families Emergency Fund dollars in 2009 and 2010[88]—is a policy solution with bipartisan appeal. As outlined in the CAP report "A Subsidized Jobs Program for the 21st Century,"[89] subsidized jobs, in which government reimburses employers for all or a

portion of a worker's wages, offer a targeted strategy to help unemployed workers—including people with disabilities—enter or re-enter the labor force and bolster their credentials while alleviating hardship in the short term by providing immediate work-based income.

- **Leverage early intervention.** President Obama's FY 2015 and FY 2016 budgets outlined several potential approaches to early invention and called for a demonstration project to evaluate their effectiveness.[90] These or other approaches should be piloted to provide an evidence base for what works in this area.

- **Reform asset limits.** The ABLE Act,[91] which allows people with disabilities to open special saving accounts without risking their eligibility in a number of government income support programs, represents an important step in the right direction, but it only helps a narrow subset of people with disabilities. To remove barriers to savings and ownership more broadly for workers with disabilities, Congress must take action to update Supplemental Security Income's outdated asset limits, as the SSI Restoration Act would do.[92] Additionally, myRA accounts—a new type of retirement savings accounts established in 2014—should be excluded from counting against asset limits in income support programs such as SSI and Medicaid.[93]

- **Ensure adequate affordable and accessible housing.** Funding for public housing and the Section 8 Housing Choice Voucher Program should be substantially increased to meet the needs of low-income people with disabilities.[94] Additionally, policymakers should leverage federal and state funding sources to create and expand incentives for the inclusion of housing units for low-income people with disabilities, as well as compliance with accessibility standards, in new housing development and construction, such as through the Section 811 Supportive Housing for Persons with Disabilities program.[95] Ensuring the availability of affordable, accessible housing would enable more people with disabilities to obtain safe and stable housing, secure steady employment, and live independently.

- **Ensure adequate accessible transportation.** Funding for Federal Transit Administration programs such as paratransit, the Section 5310 Transportation for Elderly Persons and Persons with Disabilities program,[96] the United We Ride interagency initiative,[97] and other vital transportation programs should be increased to enable more people with disabilities to enjoy basic mobility and take jobs that they currently cannot travel to and from without spending hours in transit.

This list is far from comprehensive, but it would go a long way toward removing barriers to employment and economic security for workers with disabilities.

Conclusion

Social Security Disability Insurance has been a core pillar of our nation's Social Security system for close to six decades, offering critical protection to nearly all American workers and their families in the event of a life-changing disability or illness. The program's eligibility criteria are restrictive and benefits are modest, but for those who receive benefits, it is nothing short of a lifeline, providing critical economic security when it is needed most. The recent budget deal includes several important provisions to strengthen Social Security Disability Insurance, including a modest, temporary reallocation that will prevent sharp across-the-board benefit cuts, as well as an array of measures to enhance program integrity. In addition to maintaining and strengthening Social Security Disability Insurance, Congress should enact policies to ensure that workers with disabilities have a fair shot at employment and economic security, such as paid leave.

Endnotes

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[10] Authors' calculation based on ibid.
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[12] Bureau of Labor Statistics, "Table 16. Insurance benefits: Access, participation, and take-up rates, civilian workers, National Compensation Survey, March 2012," available at http://www.bls.gov/ncs/ebs/benefits/2012/ownership/civilian/table12a.htm (last accessed July 2014).
[13] Ibid.
[14] Ibid.
[15] This is the statutory definition of disability set forth in the Social Security Act, 42 U.S.C. 416 (i)(1). Substantial gainful activity is set at a different level for individuals who are blind. For 2015, this amount is $1,820 per month. See Social Security Administration, "Substantial Gainful Activity," available at http://www.socialsecurity.gov/oact/cola/sga.html (last accessed June 2015).
[16] *Code of Federal Regulations,* title 20, sec. 416 (960).
[17] National Academy of Social Insurance, "What is Social Security Disability Insurance?", available at http://www.nasi.org/learn/socialsecurity/disability-insurance (last accessed October 2015).
[18] Data provided by the U.S. Social Security Administration, May 2015, on file with author.
[19] Organisation for Economic Co-operation and Development, "Sickness, Disability, and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries" (2010), available at http://ec.europa.eu/health/mental_health/eu_compass/reports_studies/disability_synthesis_2010_en.pdf.
[20] U.S. Social Security Administration, "Annual Statistical Report on the Social Security Disability Insurance Program, 2012" (2013), table 59.
[21] Estimates range as to how many claimants die while awaiting benefits. A 2008 CBS News investigation reported that "over the last two years, at least 16,000 people fighting for disability benefits died while awaiting a decision."

See CBS News, "Disabled and Waiting," January 14, 2008, available at http://www.cbsnews.com/news/disabled-and-waiting/. *The Wall Street Journal* reported in a 2011 article that 15,043 claimants died during the application process between 2005 and 2011. See Damien Paletta and Dionne Searcey, "Growing Case Backlog Leaves the Terminally Ill Waiting," *The Wall Street Journal*, December 28, 2011, available at http://online.wsj.com/news/articles/SB10001424052970204296804577121401602777764?KEYWORDS=social+security&mg=reno64-wsj&url=http://online.wsj.com/article/SB10001424052970204296804577121401602777764.html%3FKEYWORDS%3Dsocial%2Bsecurity.

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[32] Ruffing, "Social Security Disability Insurance Benefits are Vital to Workers with Severe Impairments."

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[38] Social Security Disability Insurance beneficiaries remain eligible for Medicare for seven years no matter how much they earn and irrespective of whether they continue to receive cash benefits through Social Security Disability Insurance. See U.S. Social Security Administration, "The Red Book – A Guide to Work Incentives" (2015), available at http://www.ssa.gov/redbook/eng/ssdi-only-employment-supports.htm#a0=3.

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[46] Social Security's actuaries use the age-sex adjusted prevalence rate to analyze trends in benefit receipt. OECD data use percentage of working-age population, so that is the figure used here. See Organisation for Economic Co-operation and Development, "Sickness, Disability, and Work: Breaking the Barriers."

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[59] Social Security Advisory Board, "Aspects of Disability Decision Making: Data and Materials, February 2012" (2012), p. 12, available at http://ssab.gov/Publication-Details/ArticleID/217/IsPreview/true; Stephen C. Goss and others, "Disabled Worker Allowance Rates: Variation Under Changing Economic Conditions" (Baltimore: U.S. Social Security Administration, 2013), available at www.socialsecurity.gov/OACT/NOTES/pdf_notes/note153.pdf; Kathy Ruffing, "Disability Benefits Are Hard to Get – Even in Recessions," Off the Charts, September 3, 2013, available at http://www.offthechartsblog.org/disability-benefits-are-hard-to-get-even-in-recessions/.
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[69] *Bipartisan Budget Act of 2015*, "Section by Section Summary," available at http://docs.house.gov/meetings/RU/RU00/CPRT-114-RU00-D001.pdf.
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[71] The most popular reform package, preferred over the status quo by 7 in 10 individuals polled—across generations, income levels, and political affiliations—would: "1) Gradually, over 10 years, eliminate the cap on earnings taxed for Social Security; 2) gradually, over 20 years, raise the Social Security tax that workers and employers each pay from 6.2 percent of earnings to 7.2 percent; 3) increase the cost of living adjustment formula, or COLA; and 4) increase Social Security's minimum benefit." See Elisa A. Walker, Virginia P. Reno, and Thomas A. Bethell, "Americans Make Hard Choices on Social Security: A Survey With Trade-off Analysis" (Washington: National Academy of Social Insurance, 2014), available at https://www.nasi.org/research/2014/report-americans-make-hard-choices-social-security-survey-tr.
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Social Security Act, S. 960 and H.R. 1811, introduced by Sen. Mazie Hirono (D-HI) in the Senate and Rep. Ted Deutch (D-FL) in the House; and the Keeping Social Security Solvent Act, H. Rept. 2078, introduced by Rep. Paul Tonko (D-NY).

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predict with certainty which participants in an early intervention demonstration project would ultimately become Disability Insurance beneficiaries, such demonstrations should not be funded with trust fund dollars.

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Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

November 20, 2015

The Honorable Carolyn B. Maloney
Ranking Member, Joint Economic
Committee
House of Representatives
Washington, D.C. 20515

Dear Ms. Maloney:

I am writing in response to your November 12, 2015 request for me to respond to several questions for the record following the November 4, 2015 Joint Economic Committee hearing, *Ensuring Success for the Social Security Disability Insurance Program and Its Beneficiaries*. Thank you for the opportunity to provide more information about the critical issues and challenges facing the Social Security Disability Insurance (SSDI) program.

1. **In your testimony, you write that "resource constraints" have posed a particular challenge for the Social Security Administration (SSA) in managing the SSDI program. Please describe how budget levels in recent years have affected SSA's ability to ensure SSDI program integrity and combat fraud. How would additional cuts affect oversight and fraud prevention?**

As we reported in our August 2014 review on program integrity workloads, according to SSA, resource limitations and increases in its core workloads resulted in fewer program integrity reviews including full medical continuing disability reviews (CDR) and Supplemental Security Income (SSI) redeterminations. Specifically, without dedicated program integrity funding, SSA decided how to allocate its funding between program integrity and other core workloads. Spending on program integrity generally was lesser in years without dedicated program integrity funding, which resulted in the completion of fewer full medical CDRs and redeterminations. In fiscal year (FY) 2009, when SSA began receiving funding dedicated to program integrity workloads, the Agency increased spending on program integrity, as shown in the table below.

Program Integrity Funding, Spending, and Workloads FYs 2002 through 2013

Fiscal Year	Dedicated Program Integrity Funding (Millions)	Program Integrity Spending (Millions)	Full Medical CDRs Completed
2008	$0	$555	245,388
2009	$504	$715	316,960
2010	$758	$879	324,567
2011	$756	$909	345,492
2012	$756	$979	443,233
2013	$743	$1,098	428,568

Any cuts to that dedicated program integrity funding would likely result in SSA's completing fewer CDRs and SSI redeterminations. As a result, less savings would be realized from program integrity activities, and some individuals who may no longer be disabled would remain entitled to, and receiving, benefits.

How can investing in proper administration and oversight in fact save taxpayers money?

SSA has shown that investing in program integrity activities saves taxpayers money. For example, for FYs 2015 and 2016, SSA estimates the savings-to-cost ratio of performing full medical CDRs would be $9 to $1. For CDRs conducted in FY 2013, the most recent year for which actual savings information is available, SSA estimated that the savings-to-cost ratio of performing CDRs averaged $15 to $1. This is based on the present value of the estimated lifetime savings of $7.1 billion, which includes $1.9 billion in OASDI savings, $3.8 billion in SSI savings, $1.3 billion in Medicare savings, and $60 million in additional Medicaid spending. The increase in Medicaid spending is due to provisions of the *Affordable Care Act*.

2. One thing that struck me at the hearing was the disconnect between the vivid descriptions of individuals defrauding SSDI and your comments about how the system is generally working but "could be perfected." My concern is that stories about the relatively few people who abuse SSDI can undermine public trust in the program. I believe we should make policy decisions on the basis of data and not anecdotes.

What is the improper payment rate for the SSDI program? Please express this figure both in dollars and as a share of total payments. Of improper payments, what share are overpayments and what share are underpayments?

According to SSA's *Agency Financial Report*, the SSDI program had a 0.13 percent underpayment rate and a 1.13 percent overpayment rate in FY 2014 (the most current year available). SSA underpaid $181 million and overpaid $1.6 billion out of total DI benefit payments of $142.4 billion. The overall improper payment rate is 1.25 percent for the DI program (both over- and underpayments).

What share of the overpayments are due to fraud committed by recipients versus accidental or temporary overpayments by SSA? What share of overpayments are able to be recovered?

SSA reports that the major cause of overpayments relate to substantial gainful activity—either when beneficiaries fail to report earnings timely to SSA, or when SSA does not take the proper actions to process work reports. For underpayments, SSA reports that the major cause is computation errors. SSA does not report the percentage of improper payments due to fraud.

The Social Security Subcommittee, Committee on Ways and Means, has requested a fraud rate study, and we are currently evaluating the feasibility of conducting such a study to estimate the amount of fraud in the disability program.

In its *Treasury Report on Receivables Due From the Public*, SSA reported that it recovered $874 million of the $6.3 billion in overpayments that were outstanding as of the 4th quarter of FY 2015. On average, SSA reported that it takes 62 months to clear a DI overpayment.

Please compare the improper payment rate in the SSDI program to the federal tax compliance rate, both in total dollars and as a share of total revenue or expenditures.

Based on information in SSA's *Agency Financial Report*, the overall improper payment rate for the DI program was 1.25 percent in FY 2014.

DI Underpayments	$181.19 million	
DI Overpayments	$1,603.68 million	
Total DI Improper Payments (Underpayments + Overpayments)	$1,784.87 million	
Total DI Benefits Paid		$142,368.41 million
DI Improper Payment Rate		1.25%

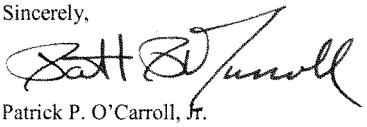
The IRS describes the tax gap as having three primary components—unfiled tax returns, taxes associated with underreported income on filed returns, and underpaid taxes on filed returns. The most recent tax gap estimate from the IRS is $385 billion, with a corresponding voluntary compliance rate of 85.5 percent. In other words, 14.5 percent do not comply. (Source: https://www.irs.gov/uac/The-Tax-Gap and https://www.irs.gov/uac/IRS-Releases-New-Tax-Gap-Estimates;-Compliance-Rates-Remain-Statistically-Unchanged-From-Previous-Study.)

Would you characterize SSDI as a failing government program?

No, but improvements could be made. SSA provides monthly DI benefits to eligible individuals who meet specific disability requirements as well as their eligible dependents. In FY 2015, SSA paid over $144 billion in benefits to about 10 million individuals. However, increasing levels of disability claims and beneficiaries in recent years have challenged SSA's ability to deliver world-class service, creating workloads that strain resources, causing delays and backlogs, and leaving the Agency vulnerable to fraud and abuse. SSA must find ways to balance service initiatives, such as processing new claims and appeals, against stewardship responsibilities, to ensure that DI beneficiaries continue to be eligible for the payments they are receiving.

Thank you for the opportunity to answer your questions for the record. If you have further questions, please feel free to contact me, or your staff may contact Special Agent Kristin Klima, Congressional and Intra-Governmental Liaison, at (202) 358-6319.

Sincerely,



Patrick P. O'Carroll, Jr.
Inspector General

Joint Economic Committee Hearing

"Ensuring Success for the Social Security Disability Insurance Program and Its Beneficiaries"

Questions for the Record

Congresswoman Carolyn B. Maloney, Ranking Member

November 12, 2015

Questions for Dr. Mark Duggan

1. In your testimony, you discuss changes in SSDI enrollment from 1989 to 2014. You write that "the aging of the baby boom population and changes in the fraction of adults insured for SSDI can explain only about one-third of the growth in the program" over this time.

   How would this share attributable to the aging of the baby boom generation and the increase in the share of working-age adults insured for SSDI change if you considered enrollment changes over different time periods? What would happen if you considered the period from 1977 to 2014? How about 1993 to 2014?

   Thank you for this interesting and important question. You are correct that the share of growth explained by these factors would be somewhat different if the base year of 1977 or 1993 were used instead of 1989. But the difference would not be all that large. Take for example the case of the aging of the baby boom population. If age-specific (using the 5-year age groups 25-29, 30-34, through 60-64) rates of SSDI enrollment were the same for both men and women in 2014 as they were in 1989, then the fraction of adults ages 25-64 enrolled in SSDI would be 2.80%. This would represent a 0.54 percentage point increase during this 25-year period (from 2.26% in 1989). The actual rate in 2014 was 5.05% and thus the aging of the population can explain just 19% (0.54 / 2.79) of the increase in SSDI enrollment over that period when using 1989 as the base year.

   Suppose instead that one used 1977 as the base year. If age-specific rates of SSDI enrollment for both men and women were the same in 2014 as in 1977, then the share enrolled in SSDI in 2014 would have been 3.13%. This would represent a 0.38 percentage point increase during this 37-year period (from 2.75% in 1977). This represents just 17 percent of the actual increase of 2.30% (from 2.75% to 5.05%) during this period. So the share of the actual growth from 1977 to 2014 explained by the aging of the baby boom is if anything lower when using 1977 as the base year.

   Similarly if one used 1993 as the base year, then the share enrolled in SSDI in 2014 (assuming the 1993 age-specific rates of SSDI enrollment for both men and women were the same as in 1993) would have been 3.39%. This would represent a 0.60 percentage point increase during this 21-year period (from 2.79% in 1993). This represents just 27 percent of the actual increase of 2.26% during this period.

*So the share of SSDI enrollment growth explained by the aging of the population is 19 percent using 1989 as the base year versus 17 percent with 1977 as the base year or 27 percent with 1993 as the base year. It is perhaps easiest to see this by focusing on some specific age*gender categories. Consider the two age groups 45-49 and 50-54 for both men and women. As the following table shows, the fraction of men and the fraction of women enrolled in SSDI in 2014 is substantially higher than in any of these three previous years.*

	% of the Population Receiving SSDI Benefits			
	1977	*1989*	*1993*	*2014*
Men 45-49	*3.2%*	*2.9%*	*3.7%*	*4.4%*
Women 45-49	*1.3%*	*1.5%*	*2.1%*	*4.2%*
Men 50-54	*5.2%*	*4.4%*	*5.3%*	*6.9%*
Women 50-54	*2.3%*	*2.3%*	*3.1%*	*6.4%*

As the table shows, the fraction of each group receiving SSDI benefits was substantially greater in 2014 than in these earlier years. The increases are larger for women than for men, with this partly reflecting the effects of a rising share of women insured for SSDI. But while SSDI enrollment doubled for women 45-49 and for women 50-54 from 1993 to 2014, during that same period, the fraction of women insured for SSDI increased by less than 10% (from 70% to 76%). As a result, the fraction of women insured for SSDI who were enrolled in the program increased rapidly during this period. Consistent with my testimony, this demonstrates that the increase in the fraction of women insured for the SSDI program is not the main factor driving an increase in their SSDI enrollment growth.

	% of the SSDI-Insured Population Receiving SSDI Benefits			
	1977	*1989*	*1993*	*2014*
Women 45-49	*2.8%*	*2.3%*	*3.0%*	*5.6%*
Women 50-54	*5.0%*	*3.7%*	*4.5%*	*8.5%*

You noted at the hearing that enrollment trends prior to the 1980s roughly corresponded to those same trends following legislation enacted in the 1980s. Would you consider the slower program growth in the 1980s to be a deviation from the historical trend? Why then do you believe that the 1980s are the appropriate baseline for assessing changes in SSDI?

SSDI enrollment was indeed growing rapidly during the 1970s and, largely because of this, the program's medical eligibility criteria were significantly tightened in the late 1970s and again in the early 1980s. The program's criteria were then liberalized in the mid-1980s and enrollment started to grow rapidly again soon after that. Using 1989 (or 1985 which would yield a very similar picture) as the base year has the advantage that it is soon after this most recent set of policy changes. One disadvantage to using 1993 as the base year is that much of the policy-induced rise in SSDI enrollment had already occurred given the medical eligibility criteria had expanded almost a decade earlier. One disadvantage to using 1977 as the base year is that one then assumes no net change in policy over this 37-year period, when in fact there were two major changes as described above.

In any case, whether one uses 1977, 1989, or 1993 as the base year, the fraction of adults aged 25-64 receiving SSDI benefits is significantly higher in 2014 (at 5.05%) than in any of those preceding years (2.75% in 1977, 2.26% in 1989, 2.79% in 1993). The increase for women is larger than for men, partly because of the rise in the share of women insured for the program. But neither the aging of the population nor the rising share of women insured for the program is the primary explanation for the growth in SSDI program enrollment.

2. While the hearing focused on the SSDI program, SSDI is not the only program that impacts disabled Americans and their ability and incentives to work. I'd like to get your opinion on how SSDI interacts with other federal programs.

   Could policies such as paid leave, paid sick days and ensuring access to long-term services and support help disabled workers stay at work longer before needing to turn to SSDI? Are there other policies or programs that could help?

   Thank you for this question. In recent research I have explored the interaction of the SSDI program with other federal programs such as the VA's Disability Compensation program. However, I have not studied the interaction of SSDI with paid leave, paid sick days, or long-term services specifically. It seems plausible that one or more of these could allow some workers to remain in their job for longer and perhaps to recover partially or fully. But the likely overall effect of any of these would inevitably depend on the details of each program – what period of leave (or how many sick days) would be supported, what level of illness / disability would be necessary to qualify, how this would be monitored, and so forth. Without these additional details, it would be difficult to speculate on the likely net impact.

   One topic that came up was the ability of individuals to receive SSDI benefits and unemployment insurance (UI) at the same time. SSDI recipients are permitted to work a limited amount without losing benefits, and should they work and lose their job they are able to qualify for UI. Do you think that eliminating an individual's ability to collect UI benefits in the event of job loss could serve as a disincentive for an SSDI recipient to seek out work?

   This is a very interesting point. As you note, SSDI recipients can earn up to the substantial gainful activity (SGA) level, which is currently $1090 per month. If a recipient was laid off from a job that paid (for example) $800 per month, this would likely reduce household income, with UI benefits potentially cushioning this income drop. If no UI benefits were paid, then it is likely household income would fall further. While this would potentially impose significant hardship on the recipient, it would if anything increase his / her incentive to find a new job, as the difference in income between having a job and not would be greater than if UI benefits were received.

   Thank you again for these questions and I hope that these responses are helpful to you. Please feel free to contact me in the future if I can ever be of further assistance.

   Sincerely,
   Mark Duggan

Center for American Progress

RESPONSES TO QUESTIONS FOR THE RECORD

From the Joint Economic Committee Hearing:

"Ensuring Success for the Social Security Disability Insurance Program and Its Beneficiaries"

Rebecca D. Vallas, Esq.,
Director of Policy, Poverty to Prosperity Program
Center for American Progress

November 30, 2015

Questions from Carolyn B. Maloney, Ranking Member

1. Several proposals to reform the SSDI program were discussed at the hearing. Please discuss how the following policy proposals would affect the SSDI program and its beneficiaries:

- **Providing an incentive in the form of a payroll tax reduction for employers and self-employed individuals to purchase private disability insurance.**
- **Setting timelines for those who are temporarily disabled to return to work and providing referrals to rehabilitative and work opportunity services for these individuals.**
- **Eliminating an individual's ability to receive SSDI payments and unemployment insurance (UI) benefits at the same time.**

RESPONSE

Supporting work by people with disabilities has long been a bipartisan priority, and considerable progress has been made toward removing barriers to employment, education, and accessibility over the past several decades, through landmark legislation such as the Americans with Disabilities Act, the Individuals with Disabilities Education Act, the Workforce Investment and Opportunity Act, and the ABLE Act, and more.

But much work remains. In order to break the link between disability and economic insecurity, we must enact public policies that give workers with disabilities a fair shot.

As discussed in my written testimony, most Social Security Disability Insurance beneficiaries live with such significant disabilities and severe illnesses that substantial work is unlikely. Moreover, a great many Americans with disabilities who *do not* receive Disability Insurance face barriers to employment and economic security. To achieve the goal of ensuring that workers with disabilities have a fair shot at gainful employment and economic security, policymakers must thus step back and take a much broader look at the policy landscape and how it affects workers with disabilities.

To that end, policies such as paid leave and paid sick days; strengthening the Earned Income Tax Credit for workers without minor children in their care; adequately funding our nation's Vocational Rehabilitation system; and ensuring access to long-term services and supports for workers with disabilities through a national Medicaid buy-in program with generous income and asset limits are but a few examples of the types of policies that would go a long way toward ensuring that workers with disabilities have a fair shot at employment.[i]

Additionally, the President's fiscal year 2015 and 2016 budget included several proposals for demonstration projects to test varying approaches to "early intervention" to help workers with disabilities stay attached to the labor force. These proposals merit careful consideration.

Meanwhile, some have called for a fundamental overhaul of the DI program in the name of increasing employment among people with disabilities. To that end, several of the proposals discussed at the hearing risk causing great harm to workers with disabilities and weakening the Disability Insurance program—while promising little in the way of cost savings or improved outcomes for current or future beneficiaries.

For example, while mandating or incenting employers to carry **private disability insurance, or PDI**—or switching to an "opt-out" enrollment model as some PDI providers are pushing for—would likely be a great boon to the PDI industry, these proposals are unlikely to significantly reduce the number of people receiving Social Security disability benefits.

Although PDI policies and the associated disability management programs can be effective in helping some workers remain attached to the labor force, available data suggest that the DI beneficiary population differs from the population of workers covered by PDI in several key respects.

Just one in three private-sector workers has employer-provided long-term disability insurance.[ii] Long-term PDI coverage is especially scarce for low-wage workers—just 7 percent of workers making less than $12 per hour have employer-provided disability insurance.[iii] Workers in industries such as retail, hospitality, and construction are among the least likely to have employer-provided long-term disability coverage.[iv]

In general, workers with PDI coverage tend to be skilled and highly educated, and to work in professional or "white collar" jobs. In contrast, about half of DI beneficiaries have a high school diploma or less, with just 18 percent having completed four years of college or having further higher education,[v] and most disabled-worker beneficiaries worked at "unskilled" or "semi-skilled" physically demanding jobs.[vi]

Disability management and other similar programs specialize in helping white-collar and professional workers keep and return to their positions. The likely success of these programs with a coal miner, construction worker, or storeroom packer is relatively untested and unknown. Additionally, these programs also typically require workers with the most significant disabilities and severe illnesses—workers whom they believe are unlikely to benefit from intensive stay-at-work services—to apply for DI.

Importantly, "experience-rating" Social Security Disability Insurance—a common feature of private disability insurance-related DI reform proposals—risks incenting employers to avoid hiring workers who live with disabilities or who may be viewed as at risk of experiencing disability or poor health, to avoid the risk of increased payroll taxes if their employees ultimately need to turn to Social Security Disability Insurance. This would represent a major step backwards, given the broad bipartisan interest in *increasing* employment among people with disabilities.

Another type of proposal that would have serious negative consequences for DI beneficiaries, and which would weaken the program substantially is **time-limiting benefits**. Importantly, DI does not award benefits to individuals with temporary disabilities. The Social Security definition of disability requires that the disabling condition or conditions be expected to last at least 12 months or to result in death; together with the five-month waiting period, workers with temporary disabilities or health conditions are intentionally excluded from eligibility.

The DI program already includes several mechanisms for terminating a beneficiary's eligibility upon medical improvement such that he or she no longer qualifies for DI benefits. SSA is required by law to conduct continuing disability reviews, or CDRs, to make these determinations for any and all beneficiaries whose conditions are considered likely to improve. Each beneficiary thus receives what is called a "diary date" upon his or her initial determination of eligibility; that is the schedule on which he or she will be reviewed for medical improvement. Additionally, for beneficiaries whose conditions improve enough for them to test their capacity to work, a CDR can be triggered if their earnings and work behavior suggests the possibility of medical improvement.

Unfortunately, SSA has received inadequate program integrity funding for many years, preventing the agency from keeping up with its scheduled CDRs. CDRs are estimated to save some $9 in benefits for every $1 spent on reviews, yet the agency reports a backlog of nearly 1.3 million reviews due to inadequate funding.[vii] In an important step forward, the cap adjustments for program integrity funding included in the Bipartisan Budget Act of 2015 will provide SSA with $484 million in additional funding between FY 2017 and 2020 to conduct continuing disability reviews and other critical program integrity activities. I would strongly urge Congressional appropriators to fully fund SSA up to this level.

Time-limiting DI benefits is not only unnecessary given that the agency already has CDRs in its arsenal—it is also impractical for a number of reasons, chiefly the immense difficulty of predicting which individuals with disabilities might be able to remain at work or return to work vs. those who will not. SSA's diary dates operate much like a tickle on the calendar—but importantly, they do not direct an outcome in advance (i.e. to terminate or to continue eligibility) in recognition that it is virtually impossible to predict with accuracy whether an individual will have experienced sufficient medical improvement that they can return to work.

Time-limiting DI benefits would thus have the effect of cutting off a desperately needed lifeline for vulnerable individuals who remain unable to do substantial work due to disability or ill health. Beneficiaries rely on DI to keep a roof over their heads, to put food on the table, and to afford needed, often life-sustaining medications. Abrupt loss of benefits for individuals whose disabilities or health conditions continue to prevent them from supporting themselves through work would be devastating and would cause great hardship. This is not just a theoretical risk; we saw what happened in the early 1980s when hundreds of thousands of beneficiaries—including individuals with static conditions such as Down Syndrome—were thrown off the program despite lack of medical improvement, and the DI program was thrust into chaos. The Medical Improvement Review Standard was implemented shortly thereafter, as part of bipartisan legislation that passed both the House and Senate unanimously, to protect beneficiaries from suffering a similar fate in the future.

Moreover, time-limiting benefits would also likely increase the program's administrative costs, given that it would lead to increased "churn" within the program. Individuals whose benefits are terminated but who remain unable to do substantial work would be forced to reapply for benefits and to go through the lengthy and costly disability determination process all over again. If denied, they would need to appeal—an even more lengthy and costly process.

If policymakers are interested in providing stay-at-work/return-to-work services to workers with disabilities, rather than weakening our Social Security system and cutting off a lifeline for beneficiaries who remain unable to do substantial work, they could explore the idea of a complementary program, perhaps administered by the Department of Labor, targeting workers with disabilities who are still at work or who have recently left their jobs—but who are not yet receiving DI—with temporary income support accompanied by supports and services to help them stay at or return to work. The Social Security definition of disability excludes those who would be most likely to benefit from such a program. Moreover, SSA is not an agency that specializes in providing work supports and services—its strengths are determining eligibility and delivering benefits.

A third proposal that was raised at the hearing would **eliminate concurrent receipt of DI and Unemployment Insurance,** or UI, benefits. This measure would represent a step in the wrong direction and would undermine the bipartisan objective of increasing work among people with disabilities. Proponents of this measure say it is needed to prevent "double dipping." However, cutting benefits for disability beneficiaries who lose a job through no fault of their own and must turn to UI to partially replace their lost wages would punish them for attempting to return to work and push them and their families deeper into poverty.

As detailed in my written testimony, DI contains strong work supports and incentives for those who may be able to return to work as their conditions improve. As a result, DI beneficiaries may experience job loss that would legitimately enable them to qualify for UI. If beneficiaries attempt to return to work and subsequently get laid off from their part-time jobs, they may qualify for UI just like any other similarly situated worker. However, eliminating concurrent receipt of DI and UI would punish disability beneficiaries for attempting to return to work—as they are encouraged by law to do—by cutting their Social Security benefits or by putting them at risk of losing their eligibility for benefits entirely.

As noted in my written testimony, DI benefits are extremely modest, averaging $1,165 per month, just over the federal poverty line, and 1.6 million disabled workers receiving DI—or one in five—already live in poverty. According to the Government Accountability Office, for the less than 1 percent of individuals served by DI or UI who qualify for benefits under both programs, the average quarterly combined benefit in FY 2010 was $3,300—or just $1,100 per month.[viii] These modest benefits provide nothing short of a lifeline for disabled workers and their families when they need it most. Yet the cuts proposed by eliminating concurrent receipt of DI and UI would push disabled workers and their families into or deeper into poverty, jeopardizing their ability to keep a roof over their heads and afford needed, often life-sustaining medications.

Finally, Americans must work and pay into the UI system in order to receive benefits in the event of a qualifying job loss. Yet this type of proposal singles out disability beneficiaries for second-class treatment under the UI program, denying them the protection they earned and penalizing them for trying to return to work. DI beneficiaries who lose a job and qualify for UI should not be treated differently from other workers; they should be permitted to access the modest benefits they have worked hard to earn.

2. At the hearing, there were several mentions of other countries that have been successful at reducing the share of their working-age population receiving disability insurance (DI) payments, and at increasing the share of people on DI who return to work. Countries referenced included Norway and the Netherlands.

Do you think that these countries' experiences can offer lessons to U.S. policymakers? Are there any cross-country differences that should be kept in mind when making such a comparison?

RESPONSE

The Organisation for Economic Co-operation and Development, or OECD, compares its member countries' disability benefit systems using a "compensation index."[ix] Using this indicator to compare disability benefit systems across member countries, it assigns each country a score and then ranks them accordingly. As the report explains, "the higher the score, the more generous and accessible the benefit system."[x] The United States ranks nearly at the bottom on the OECD's compensation index—reflecting the meagerness of its disability benefits and the strictness of the disability standard—with Korea the only nation receiving a lower score. The 2010 OECD report includes countries' compensation index scores for both 1990 and 2007; the United States (and Korea) fall at the bottom for both years.

The OECD further classifies countries' disability benefit systems into groups according to disability policy typology. It groups the United States with Canada, Japan, and Korea, and describes this group of countries as having "the most stringent eligibility criteria for a full disability benefit, including the most rigid reference to all jobs available in the labour market."[xi]

Moreover, by international standards, the United States spends comparatively little on disability benefits. In 2009, U.S. spending on Social Security Disability Insurance equaled 0.8 percent of gross domestic product, or GDP, again putting the United States near the bottom—27th out of 34 OECD member countries—in spending on equivalent programs. On average, OECD member countries spend 1.2 percent of GDP on their equivalent programs, and many—such as Denmark

at 2 percent, the United Kingdom at 2.4 percent, and Norway at 2.6 percent—spend significantly more.[xii]

The share of the U.S. working-age population receiving Disability Insurance benefits—about 6 percent—is roughly on par with the OECD average of 5.9 percent.[xiii] Of course, measuring recipiency rates as a straight share of the working age population misses important demographic and labor market factors, such as changes in age distribution (e.g., a surge of Boomers aging into their high-disability years), population growth, and the increase in women's labor force participation, all of which have had a significant impact on the DI program in recent decades. Due to the importance of these demographic and labor-market factors, Social Security's actuaries analyze trends in benefit receipt using an "age-sex adjusted disability prevalence rate," which controls for changes in the age and sex distribution of the insured population, as well as for population growth.[xiv]

Some have pointed to European nations—many of which have made changes to their own disability benefit programs in recent years—as potential models for reform in the U.S. However, even work by critics of the U.S. Social Security Disability Insurance program has shown that even after disability benefit system reforms in the Netherlands, the U.K., Australia, and Sweden, the United States still has the lowest disability recipiency rates as a share of the working-age population of the five nations studied.[xv] OECD data confirm this—as well as that the U.S. eligibility standards are stricter, benefits less generous, and spending on disability benefits lower than in most other OECD nations.[xvi]

Moreover, in drawing international comparisons, it is well worth noting that in addition to more generous disability benefit systems with less rigorous eligibility standards, European nations tend to have universal paid leave policies, more generous health care systems, higher levels of social spending generally, and more regulated labor markets than the United States.[xvii] There is no basis to assume that policies that have worked in other countries with universal health care and generous pension structures, as well as significantly more robust programs that provide these services and supports, for example, would work in the U.S., which lacks such policies and programs—and potentially could be catastrophic for people with disabilities.

In sum, the lesson to be drawn from overseas is not that we ought to strive to make what is already one of the least generous and most restrictive disability programs in the developed world even less generous and more restrictive—but that if we are serious about giving workers with disabilities a fair shot at employment and economic security, we should join the rest of the developed world by ensuring access to paid leave, long-term services and supports, and other key policies described above and in my written testimony.

[i] For a detailed discussion of these and other policies that would give workers with disabilities a fair shot at employment and economic security, see Rebecca Vallas, Shawn Fremstad, and Lisa Ekman, "A Fair Shot for Workers with Disabilities," (Jan. 2015), available at https://www.americanprogress.org/issues/poverty/report/2015/01/28/105520/a-fair-shot-for-workers-with-disabilities/

[ii] Bureau of Labor Statistics, "Table 16. Insurance benefits: Access, participation, and take-up rates, civilian workers, National Compensation Survey, March 2012," available at http://www.bls.gov/ncs/ebs/benefits/2012/ownership/civilian/table12a.htm (last accessed July 2014).

[iii] Ibid.

[iv] Ibid.

[v] Bailey and Hemmeter, "Characteristics of Noninstitutionalized DI and SSI Program Participants, 2010 Update."

[vi] Mark Trapani and Deborah Harkin, "SSA Occupational and Medical Vocational Claims Review Study: Final Results (for initial level cases), May 2011" (Baltimore: U.S. Social Security Administration, 2011), available at https://www.socialsecurity.gov/oidap/Documents/PRESENTATION--TRAPANI%20AND%20HARKIN--OIDAP%2005-04-11.pdf.

[vii] Acting Commissioner of Social Security Carolyn Colvin, "Social Security Testimony Before Congress."

[viii] U.S. Government Accountability Office, "Overlapping Disability and Unemployment Benefits Should Be Evaluated for Potential Savings," (July 2012), available at http://www.gao.gov/assets/600/593203.pdf.

[ix] Organisation for Economic Co-operation and Development, "Sickness, Disability, and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries."

[x] Ibid.

[xi] Ibid.

[xii] Ibid. The author compared Social Security Disability Insurance with other OECD member countries' equivalent programs, which OECD data refer to as "disability pensions."

[xiii] Organisation for Economic Co-operation and Development, "Sickness, Disability, and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries."

[xiv] See written testimony at 8-9.

[xv] Richard Burkhauser et al., "Disability Benefit Growth and Disability Reform in the US: Lessons from Other OECD Nations," IZA Journal of Labor Policy, vol. 3(1) (2014).

[xvi] Organisation for Economic Co-operation and Development, "Sickness, Disability, and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries"; see also written testimony at 7-8.

[xvii] See, for example, Alberto Alesina and others, "Why Doesn't the U.S. Have a European-Style Welfare State?" (Cambridge: Harvard Institute for Economic Research, 2001). This source discusses the generosity of European nations' social welfare systems compared with the United States. The OECD produces an "Overall Strictness of Employment Protection" index. See Organisation for Economic Co-operation and Development, "OECD Employment Outlook" (2004), chart 2.A2.1, available at http://www.oecd.org/employment/emp/34846856.pdf.

QUESTIONS FOR THE RECORD FOR DR. MARK DUGGAN SUBMITTED BY SENATOR AMY KLOBUCHAR AND RESPONSES

DISABILITY DEMONSTRATION PROGRAMS AND LESSONS FROM NORWAY

Dr. Duggan, in your testimony you noted that the recently passed Bipartisan Budget Act of 2015 would establish demonstration projects to look at improving work incentives in the Social Security Disability Insurance (SSDI) Program. Yet, past work programs have not had strong results. You also discussed the evidence from other countries, specifically Norway, which may be helpful in designing the demonstration projects called for under the Bipartisan Budget Act of 2015.

As we design these work incentive demonstration projects, what recommendations do you have for project design? What are the lessons learned from past efforts?

It would be important to work with an organization that has a demonstrated track record of successfully implementing large-scale interventions. Additionally academic researchers with relevant expertise should be involved, as they can bring additional insights from other disciplines and are focused on producing research that is of sufficiently high quality for eventual publication in peer-reviewed outlets (with this peer review serving as a useful discipline device to improve the ultimate product). It also would be important to have a large sample size in the study and to randomize individuals to a control group and to one or more treatment groups. Multiple treatment groups could be used to test the effects of alternative changes. For example, to investigate the effect of changes in work incentives for current SSDI recipients, there could be multiple treatment groups with different benefit offset rates.

As documented in a recent report by the Congressional Research Service, there has been limited success to date in implementing SSDI demonstration projects:

http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/RL33585.pdf

For example, the Benefit Offset National Demonstration (BOND) had several implementation problems, with the Social Security Advisory Board even calling for the termination of this demonstration.

What are the lessons learned from other countries, specifically Norway?

Recent evidence from Norway demonstrates that improving work incentives for individuals receiving disability benefits can increase employment and the exit rate from the program (Kostol and Mogstad, 2014). While the effects are substantial, the fraction that exits the program remains relatively small. This suggests there is limited scope for work incentives for SSDI recipients alone to improve labor market outcomes for individuals with disabilities. My 2010 paper with David Autor proposed additional efforts on the "front end" of the program to reduce the flow of individuals onto SSDI in the first place.

Thank you for these questions and I hope that my responses are helpful to you. Please feel free to contact me in the future if I can ever be of assistance.

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