

The Future Role of Private Disability Benefits in the Disability Safety Net

Testimony to the ERISA Advisory Council

June 12, 2012

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I have been conducting economic research on public disability programs and policy for 20 years. That includes research on the intersection of public programs with private programs that is relevant to your deliberations and will be the focus of my remarks today.

I will start by providing some background on challenges faced by the mostly public, partly private safety net for working-age people with disabilities, with an emphasis on the safety net for workers who experience disability onset after they have established careers. I will then talk about how the structure of that safety net is out of synch with social changes that have occurred since its structure was established some five decades ago. Public policy will eventually adapt to those changes, but it will likely take a very long time to do so. I will share my expectations about the direction of policy change, which includes an expanded role for private insurers. Those expectations lead to guidance that I hope you will find useful as you proceed with your current deliberations.

Background

My view, which is shared by many other experts, is that the safety net for working-age people with disabilities is failing people with disabilities. One symptom of this failure is that the household incomes of such individuals, which has always been low relative to others, has been falling further and further behind the household income of their peers without disabilities for roughly three decades (Slide 2¹). According to the best available estimates, the mean income of households headed by working-age people with disabilities was 63 percent of that of other working-age households in 1980; by 2009 that figure had fallen to 52 percent.

The proximate cause of this decline is the concurrent relative decline in employment of working-age people with disabilities (Slide 3). Relative employment was fairly stable in the 1980s, and peaked at 38 percent in 1989, but has declined almost every year since then, to just 21 percent in 2010.

As further evidence of the safety net's failure, working-age people with disabilities experience very high levels of poverty. Based on a series of studies conducted by my colleague Gina Livermore and several collaborators,² we know that:

¹ Slides 2 and 3 are from: Stapleton, D., and D. Wittenburg. "The SSDI Trust Fund: New Solutions to an Old Problem." Policy Brief 11-02. Washington, DC: Mathematic Policy Research, Center for Studying Disability Policy, March 2011.

² See: Livermore, G., D. Stapleton, and A. Roche. "Work Activity and Use of Employment Supports Under the Original Ticket to Work Regulations: Characteristics, Employment, and Sources of Support Among Working-Age SSI and DI Beneficiaries." Washington, DC: Mathematica Policy Research, 2009; She, P. and G. Livermore. "Long-Term

- The annual poverty rate for the households of working-age people with disabilities is 2.5 times as high as for those without disabilities—25 percent versus 10 percent in 2008;
- Working-age people with disabilities constitute a very large share of all working-age people who live in poverty for long periods. One study found that 65 percent of those in poverty for at least three years had a disability;
- In 2006, the poverty rate for SSDI-only beneficiaries—those Social Security Disability Insurance who do not also receive Supplemental Security Income (SSI)— was 31 percent
- For concurrent beneficiaries—those who also receive SSI—the poverty rate was over 70 percent;
- Finally, their research shows that those with disabilities who live in poverty are much more likely to experience material hardship, such as missing meals or not receiving needed medical care, than those in poverty who do not have disabilities.

I think it is also fair to say that the safety net is failing taxpayers. Taxpayers have always demonstrated a strong willingness to support the working-age population with disabilities. But they are getting less and less for their money while paying more and more. That is, as economic outcomes for this population have been declining, the costs to taxpayers have been growing in real terms, faster than growth in the economy and faster than all other expenditures.

One study we recently completed found that that the federal government spent \$375 billion to support working-age people with disabilities in fiscal year 2008 (Slide 4), through 63 different programs.³ That represents 12.0 percent of all federal outlays and 2.5 percent of gross domestic product (GDP). It also represents an inflation-adjusted increase of 30.6 percent from fiscal year 2002, when this set of expenditures represented 11.4 percent of all federal outlays and 2.1 percent of GDP.

About 47 percent of these expenditures are for income support—primarily SSDI, SSI, and Veterans' Compensation. An approximately equal share is for health care—primarily Medicare, the federal share of Medicaid, and Veterans' Health Benefits. Less than 2 percent are to help this population work and be more self sufficient.

Disabled workers who obtain SSDI benefits are of special relevance to your work. They are all eligible for Medicare after 24 months of SSDI receipt. Their SSDI benefits and Medicare expenditures accounted for over 40 percent of the expenditures reported in the table. Some SSDI beneficiaries also receive SSI, Medicaid, and other benefits as well. We do not know total federal expenditures to support all SSDI worker beneficiaries, but it is clear that this group accounts for more than half of all federal expenditures for the working-age population with disabilities.

Poverty and Disability Among Working-Age Adults." *Journal of Disability Policy Studies*, vol. 19 (4), pp. 244-256, 2009; She, P. and G. Livermore. "Material Hardship, Disability, and Poverty Among Working-Age Adults." *Social Science Quarterly*, vol. 88 (4), pp. 970-989, 2007.

³ Livermore, Gina A., David C. Stapleton, and Meghan O'Toole. "Health Care Costs Are a Key Driver of Growth in Federal and State Assistance to Working-Age People with Disabilities." *Health Affairs*, vol. 30, no. 9, September 2011, pp. 1664-1674.

Over the last three decades, growth in the number of SSDI beneficiaries far exceeded growth expected from growth in the labor force and change in its age and sex composition. I like to examine the period from 1980 to the present because the number of beneficiaries was growing so fast in the late 1970s that Congress passed amendments to the Social Security Act to slow that growth down. The amendments made medical eligibility requirements for SSDI more stringent. Along with administrative actions, these led to a short-term *decline* in the number of beneficiaries during a major recession (Slide 5).⁴ Congress essentially reversed these changes in 1984. By 2010, the number of beneficiaries was almost 3 times the number in 1980. The red line (Slide 6) shows the growth that can be attributed to growth in the size of the labor force, including rapid growth in the labor force participation of women, and the aging of the large baby boom generation. As you can see, these changes in the labor force account for the majority of the growth in SSDI beneficiaries over this period, but far less than all of it.

If the proportions of disability insured workers within age-sex groups receiving SSDI benefits in 2010 were the same as the corresponding proportions in 1980—proportions that were considered excessive at the time—the number of SSDI beneficiaries in 2010 would have been 2.2 million *lower* than the actual number—a difference of 28 percent. That difference represents about \$50 billion in SSDI and Medicare expenditures.

It is also important to note that the so-called Great Recession and slow recovery are having an enormous impact on entry into SSDI. The figures we have looked at so far only reflect the very beginning of the recession. This graphic (Slide 7), which I obtained from Steve Goss, SSA's chief actuary, shows the trajectory of the annual incidence rate—the percentage of disability insured workers entering SSDI—from 1995 to 2010 compared to what the actuaries had expected it to be in 2007, before the recession occurred. In 2010, the incidence rate was 6.3 percent, nearly 20 percent higher than the expected 5.3 percent.

The effect of the recession on SSDI entry is extremely important for two reasons. First, it dramatically illustrates that SSDI is now more than just a safety net for those unable to work because of a medically determinable condition, as originally intended. Instead, it is also serving as a special unemployment insurance program for people who work despite significant medical conditions. Workers induced to enter by the recession were, in fact, able to work despite their medical conditions when jobs were available. It is the downturn in the labor market, rather than a medical condition *per se*, that now prevents them from working.

The second reason that the effect of the recession on SSDI entry is important is that it is hastening the day when the SSDI Trust Fund will be exhausted. SSA's actuaries and the Congressional Budget Office both project exhaustion in 2016, just four years from now. Congress will be forced to increase revenue, reduce benefits, or both if it wants to avoid a situation where SSA must delay benefit payments while waiting for the accrual of payroll tax revenues.

⁴ Slides 5 and 6 are based on Stapleton and Wittenburg, *op cit*.

Times Have Changed

The reason the safety net for working-age people with disabilities is failing is that its basic structure has not changed to keep up with fundamental changes in our society. Its structure was created at a time when “disability” meant a medically determinable condition that made it impossible for a person to support him or herself through work. Hence, the safety net was fundamentally designed to take care of working-age people who are unable to work because of a medical condition—to provide income support, health care coverage, and various in-kind benefits.⁵

This structure is badly out of synch with medical, technical, and social changes that have occurred since it was created. That’s why it is failing people with disabilities. And that’s why it is failing taxpayers.

The paradigm of what constitutes a significant disability has changed in a manner that reflects these broader social changes. It used to be understood that a significant disability is an inability to do a major social activity, such as work, because of a medical condition. This *medical model* is plainly reflected in the definition of disability used by SSDI and SSI. Now, however, researchers, practitioners, disability advocates and others in this country and, indeed, all over the world, recognize that a significant disability reflects the interaction of a medical condition with an individual’s other characteristics and the individual’s environment; it is not the product of a medical condition alone. In 2002, the World Health Organization promulgated such a model, known as the ICF model—a shortened version of the initials for International Classification of Functioning, Disability and Health.

This paradigm shift clearly reflects broader societal changes. First, advances in medicine and technology make it feasible for people with very significant medical conditions and impairments to be quite productive. Second, the nature of work has changed, away from physically demanding tasks toward mentally demanding tasks. That makes work less challenging for many with physical disabilities, but perhaps more challenging for those with intellectual, cognitive and psychiatric disabilities. Finally, people with disabilities themselves are demanding better economic opportunities.

Four of my colleagues serve to illustrate the new disability paradigm. They all have impairments that would qualify them for SSDI benefits if they were not working. One is blind, one is deaf, and two are unable to walk. They all are smart, industrious, and have attained advanced degrees. And they were fortunate to have both supportive and capable families when they needed them. All four receive pay and fringe benefits that are commensurate with that of their colleagues without disabilities. In short, they are able to work, be self-sufficient, and have very full lives despite medical conditions that would make it very difficult for some with other characteristics, or living in other environments, to do so.

The general public is gradually figuring this out, but the stereotype of the medical model lingers on in public consciousness and, especially, in disability policies and public programs. The latter is

⁵ This material draws on: Stapleton, D. C., B. L. O’Day, G.A. Livermore, and A.J. Imparato. “Dismantling the Poverty Trap: Disability Policy for the 21st Century.” *Milbank Quarterly*, vol. 84, no. 4, 2006, pp. 701-732; and Mann, D. and D. Stapleton, “Fiscal Austerity and the Transition to a Twenty-first Century Disability Policy: A Roadmap.” Washington, DC: Center for Studying Disability Policy, 2011.

demonstrated by the fact that SSA would award SSDI benefits to each of my four colleagues were they to simply stop working, for any reason.

Policy change is difficult and slow for many reasons. There is tremendous inertia, especially in a politically divided society. There are high risks of trying something new and untested, in terms of both potential harm to people with disabilities and potential acceleration in public expenditures for their support. There are equity issues—there will be winners and there will be losers. A final point is less well recognized: the fragmentation of the disability safety net inhibits progress. Government responsibility for the safety net is shared across multiple federal agencies and with state agencies as well. Each tries to improve its own piece within the current structure, but opportunities for major improvements require changes to the structure itself. The fragmentation of responsibilities across agencies is reflected in fragmentation of responsibilities across Congressional committees, making it all the harder to undertake structural change.

Employers and the private side of the disability safety net are adapting more quickly to the new disability paradigm than government programs. In general, employers are interested in what a person can contribute to the company's bottom line. If an employer believes that retaining a worker following the onset of a medical condition is better for the company's bottom line than terminating employment, the employer is very likely to do that. Yes, many employers hold misguided views about the productivity of people with significant medical conditions, but the employer who learns the new paradigm quickly will be more successful than the employer who does not.

Similarly, private disability insurers have already figured out that helping some workers achieve economic success through continuation of work is less expensive than paying long-term benefits. They, and the disability management vendors that contract with them, have well developed systems and procedures for addressing the idiosyncrasies of the worker's circumstances. They are much more adept than public agencies at delivering services tailored to idiosyncratic circumstances. And employers are much more comfortable working with private insurers than with bureaucratic public agencies.

To illustrate these points, I return to my four colleagues. My company has private disability insurance, and I am almost certain our carrier would not pay benefits to these colleagues were they to stop working without a new medical problem—even though SSA would. Further, if these colleagues, or any of my other colleagues were to experience a significant new medical problem, our insurer would work with the individual and our human resources department to help the colleague continue to work productively. Not for altruistic reasons. Retention of experienced talent is valuable to our company. For the carrier, it might be less expensive to help the individual continue to work than to pay benefits.

Implications

So what does all this mean for public policy, private disability insurance, and ERISA?

First, I think we all have to abandon the idea that the primary function of the disability safety net is to take care of people who cannot work because of a significant medical condition. Instead, the primary function of the safety net should be to efficiently help those with significant medical conditions

achieve a reasonable level of economic success. For many, that will continue to mean providing income support, health benefits and other in-kind benefits, but over time the share in this category should be expected to decline, by a lot. Instead, we should see a growing share of individuals who receive less costly support, perhaps often on a temporary basis, enabling them to achieve economic success through work.

It will take decades for public policy to move in this direction, although it is possible that the country's current fiscal challenges will accelerate change. A compelling case can be made that it is less expensive for the government to help a significant share of people with disabilities achieve economic success through work than to provide them with cash, health insurance, and other benefits. But fiscal challenges or not, change in public policy will take a long time. In the meantime, new revenues will need to be allocated to the SSDI Trust Fund, or SSDI benefits must be reduced, or some combination of the two must occur.

Many people, including myself, think that public policy change will mean an expanded private sector role in the safety net, primarily for private disability insurers and disability management vendors. For instance, David Autor and Mark Duggan have proposed a mandatory private short-term disability insurance program, paid by employers and workers. Workers would not be able to apply for SSDI until they have received 24 months of benefits from the private insurer.

Richard Burkhauser and Mary Daly have recently promoted an idea that has been around for years: to experience rate the SSDI portion of the payroll tax, just as unemployment insurance and workers' compensation are currently experience rated. This would presumably give employers a stake in reducing SSDI entry by retaining more workers following disability onset. That is expected to lead to more workplace effort to prevent disability and greater employer demand for disability management services.

Others have suggested various sorts of subsidies for employer retention of workers with disabilities and employer purchases of employment supports. One idea is an extension of a performance-based voucher program, called Ticket to Work, under which SSA is willing to make 36 monthly payments to an employer for hiring an SSDI beneficiary at a wage level that results in termination of SSDI benefits. We dubbed the extension Ticket to Stay at Work; employers of workers who meet SSDI's medical criteria would qualify for payments for every month the worker delays entry into SSDI. Another proposal would apply tax credits and surcharges to the employer's share of the payroll tax, encouraging employers to provide private disability coverage.

My colleagues and I have previously pointed out that the government already provides an implicit subsidy for private disability insurance.⁶ What we mean is that premiums for private policies that offer to replace 60% of lost wages due to disability, as many do, are quite a bit lower than they would be if private benefits were not reduced by \$1 for every \$1 of SSDI benefits received by the

⁶ See Stapleton, D.C., R.V. Burkhauser, P. She, R. Weathers, and G.A. Livermore. "Income Security for Workers: A Stressed Support System in Need of Innovation." *Journal of Disability Policy Studies*, vol. 19, no. 4, 2009, pp. 204-220.

claimant—I am told 25 percent lower, if not more. As I said earlier, insurers have an incentive to help claimants stay at work, but in individual cases the offset can tip the balance of the incentive in favor of helping the claimant obtain SSDI benefits rather than stay at work. An explicit subsidy of equivalent size coupled with reversing the direction of the offset would tip the balance in the other direction. In other words, the private insurer would pay the full benefit and have a stronger incentive to help the worker stay at work. SSDI would pay nothing and the worker would have no reason to apply for SSDI benefits. Such an explicit subsidy seems likely to expand private coverage as well.

I should also point out that other SSDI changes under consideration have implications for private disability benefits. Driven by the pending exhaustion of the SSDI Trust Fund, some of these proposals would reduce benefits. To the extent that such changes reduce the SSDI benefits of private disability insurance claimants, they will increase private insurer costs and drive up premiums. At the behest of Congress, SSA is currently testing a change to SSDI rules, called the \$1 for \$2 benefit offset. There has been strong interest in this change since at least 1980. The benefit offset is designed to encourage SSDI beneficiaries to earn more. The effect of the benefit offset on incentives for those beneficiaries who also receive private benefits will depend on how private insurers treat any increase in claimant earnings and any decrease in SSDI benefits.

These developments have multiple implications for the ERISA Advisory Council.

1. The Council needs to recognize that “disability benefits” no longer mean wage replacement only. Instead, they mean efficiently helping workers preserve their economic status through either work support or wage replacement, in an efficient manner.
2. The Council needs to consider what its role should be as the policy change process grinds forward.
 - a. On the one hand, the Council could play a leading role in helping the public/private safety net adjust to the new disability paradigm, or
 - b. On the other hand, the Council could play a reactive role, recommending changes to the provision of disability benefits under its jurisdiction in response to changes in public policy.

I would encourage you to do the former, because I think it would help accelerate policy improvements.

3. The Council needs to carefully consider key aspects of changes in the role of private insurers and disability service providers.
 - a. What steps will be needed to ensure that private insurers remain solvent?
 - b. What steps will be needed to ensure that increased incentives to help workers continue to work do not result in unfair denial of benefits or additional hardship to workers?
 - c. What should the balance between employment supports and wage replacement be, and what tools should be used under ERISA to monitor and adjust that balance as needed?
 - d. How might policy changes that increase employer incentives to retain workers after the onset of a medical condition affect employer willingness to hire job applicants who are

at relatively high risk for disability? What tools are available under ERISA to address any such incentives and how should they be used?

- e. To what extent should employers and private insurers continue to be liable for disability benefits after a worker is laid off for other reasons, especially during a recession? This is an important issue now, but would increase in importance under a plan like that proposed by Autor and Duggan, under experience rating of the payroll tax, or under a system of subsidies for private benefits.
- f. What steps might be taken to encourage integration of private disability benefits with workers' compensation? Health benefits? SSDI benefits? Integration of benefits has the potential for ensuring that workers receive timely employment supports regardless of the cause of their disability, as well as reduce wasteful spending.

I hope the Council members find this information to be helpful. I would be pleased to answer questions.