

**The Declining Work and Welfare of People with Disabilities:
What Went Wrong and a Strategy for Change**

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Introduction

United States disability program expenditures are rising at an unsustainable pace. Real costs for the disability insurance program—Social Security Disability Insurance (SSDI)—have increased substantially over time with especially rapid growth over the last decade (figure I-1). Both the Social Security Trustees and the Congressional Budget Office project that the system will be insolvent before the end of the decade.¹ Real costs for the means-tested disability program—Supplemental Security Income (SSI)—also have risen and growth in both the disabled adults and disabled children components of the program has accelerated over time.

Table I-1 identifies what is driving these costs—an increasing fraction of those with work-limiting disabilities are out of the labor market and on federal disability benefits. In 1981, the first year the March Current Population Survey (CPS) collected such data, 7.3 percent of the working age population (ages 25-59) reported having a health condition that affected their ability to work. Of this group, roughly 35 percent reported working in the previous year. Slightly fewer, 32.6 percent, reported receiving either SSDI or SSI benefits. In 2010, the most recent available year of CPS data, the percent of the working age population with a work limiting disability was approximately the same—7.8 percent—but the percent employed—22.6 percent—and the percent receiving SSDI or SSI benefits—51.4 percent— were substantially different.²

In this book, we examine whether declining employment rates and rising disability rolls are inevitable consequences of worsening health or an aging population. Reviewing the research literature on the nature of disability, the evolution of health status, and the role of incentives in individual decisions, we conclude that this is not the case. Instead we argue that these outcomes are consequences of changes in SSDI and SSI-disabled adults and -disabled children program rules and how they are administered by program gatekeepers.

Fortunately, since past policy changes are the cause, future policy changes can be the solution. Drawing on lessons from two recent policy initiatives—the reform of U.S. welfare policy and the reform of Dutch disability policy—and using evidence of how program incentives affect behavior, we suggest fundamental changes in the way disability is insured and managed in the United States.

To understand and consider the proposals we offer it is important to keep in mind the data in table I-1 which shows that the population with disabilities is a heterogeneous one and that many of its members can and do work. Although the Social Security Administration, for the purpose of receiving SSDI or SSI benefits, requires applicants to demonstrate an inability to perform substantial gainful activity, researchers and advocates have long realized that such incapacities can have as much to do with social, cultural, and physical barriers as with the capacities of people with disabilities. This recognition culminated in the Americans with Disabilities Act of 1990 (ADA) which mandates, among other things, that people with disabilities are provided access to and accommodation in employment.

Unfortunately, while the ADA was removing barriers to work, changes in the federal disability transfer programs including SSDI, SSI-disabled adults, and SSI-disabled children were making work less attractive and less profitable. Consequently, the share of adults with disabilities on either SSDI or SSI continued to grow, as did the share of poor children with disabilities on SSI-disabled children benefits.³

These changes in the program incentives and the growth in the disability transfer rolls they have produced are undesirable for a number of reasons. First, by predicating disability

benefits and support on demonstrating an inability to work, the system encourages individuals with health-based impairments to invest in not working in order to qualify for benefits. As we will show, this choice imposes real economic consequences on the decision maker, since average benefits are lower than average wages and reentering the labor market after the absence required to receive benefits is generally difficult.⁴ Second, by expanding disability cash transfer programs at the same time that other non-work transfer programs (e.g., welfare) were declining, the system unintentionally increased the relative value of moving onto the disability rolls even for those who might otherwise choose to work. This has in turn increased the administrative burdens associated with determining which applicants qualify for benefits and which do not, ultimately boosting costs for taxpayers relative to other program designs. Finally, abstracting from the individual and social costs of the programs, the focus on cash assistance in lieu of earnings ignores the value of work itself. Work links individuals to the economy and to the returns to its growth. Work also connects individuals socially and culturally, which is a goal of advocates for those with disabilities. Importantly, work is also a social expectation; this means that exceptions to working generally come with a cost and are not granted lightly or without ongoing cause. The value of work—both to individuals and to the society that depends on everyone’s productive effort—suggests that work, rather than benefits, should be the primary means for assisting and insuring those subject to disabilities and other negative economic shocks.

We begin the book by reviewing the context of our current situation. We show how patterns in disability program growth have been affected by policy changes that made access to disability benefits, conditioned on limited or no work, easier to obtain. We suggest that these changes encouraged workers with disabilities and the families of children with disabilities to move onto federally funded long-term disability transfer programs. Moreover, they encouraged employers and state governments to assist individuals with disabilities in obtaining federally provided benefits rather than investing in their work and work-related activities. We argue that these policy changes and the incentives they created for individuals, employers, and states have driven the rapid decline in employment and rise in disability benefit receipt among the working-age population with disabilities documented in Table I-1.

Two recent reformations of long-standing government programs—U.S. welfare and Dutch disability policy—offer support for the view that policy can affect outcomes and guidance about how changes to U.S. disability policy might proceed. A key lesson from the 1996 federal welfare reforms is that pro-work incentives can increase employment and improve household incomes for vulnerable populations such as low-income single mothers. While welfare reform was not a panacea, the fact that large numbers of low-skilled single mothers, with support, could move into the labor market and reduce their dependence on federal welfare, suggests that some number of adults with disabilities and nondisabled low income parents of disabled children could also make this shift. Additional lessons come from recent disability reforms in the Netherlands, which curbed costs in its disability insurance system and reduced the size of its disability transfer population without increasing its other social welfare program rolls. The Dutch reforms suggest that pro-work strategies can increase the employment rates of those with disabilities and decrease the disability insurance beneficiary population without leaving those who experience a health shock unprotected. Both reformations and the outcomes they produced highlight the power of incentives on the behavior of individuals targeted by government programs.

Although change is clearly possible, it is never easy. The 1996 welfare reforms occurred only after a consensus formed around the idea that the long-standing program was failing everyone, costing more for taxpayers while delivering fewer opportunities to single mothers. The

same consensus of understanding led to the disability reforms in the Netherlands. Prior to its reform, the Dutch disability system was considered the worst in the industrialized world with respect to both its expenditure growth and its ability to keep people with disabilities in the labor market. In both the U.S. welfare and the Dutch disability cases, rapid growth in program rolls and expenses, coupled with long-run negative outcomes for the targeted population, produced a willingness to entertain large-scale and fundamental changes to restructure the programs. The fundamental change that defined reforms in both programs was the shift in focus towards work. In the case of U.S. single mothers, this meant providing them with the incentives to work and state governments with the funds to make work profitable. In the case of the Dutch disability system, this meant providing workers and their employers with incentives to focus on a return to work following the onset of a disability. The lesson from both of these policy reforms is that coordinated efforts to encourage work and make work pay can have significant effects on the composition of income going to vulnerable groups and can slow the growth in publicly provided cash benefit programs.

Book Overview

Chapter 1 reports the growth in SSDI and SSI caseloads and examines how the increased use of these programs has affected the income of working-age people with disabilities over the past twenty years. The data show that despite large increases in the prevalence of government benefits among Americans with disabilities, their household incomes have stagnated. This pattern contrasts sharply with that of single mothers, who experienced sizeable reductions in benefits after welfare reform but saw their household incomes increase.

To learn from the relative economic progress single mothers made following welfare reform, chapter 2 explores the changes in public policies targeted toward them and examines how these changes altered the incentives for both individuals and states to invest in work over benefit receipt. The chapter concludes with a brief summary of how welfare reform affected single mothers.

In chapter 3, we return to the main focus of the book—the population with disabilities. We begin by describing what we mean by disability and how trends in health and functional limitations, which have not discernibly worsened, are at odds with data on disability benefit caseloads, which have grown rapidly in the last twenty years. The rest of the chapter shows how changes in disability eligibility rules and changes in the interpretation and implementation of those rules have affected these trends. Of the three forces driving the growth in disability expenditures—demographic changes, economic conditions, and program changes—we argue that program changes have had the greatest effect. The key message in this chapter is that a health condition, impairment, or disability does not in itself define an individual's ability to work or determine the rise and fall of disability caseloads in the United States.

Accepting that health, inability to work, and disability caseloads are not completely correlated, in chapter 4 we show how the design of U.S. disability policy influences the likelihood that individuals who experience a health condition will apply for benefits over pursuing employment. We argue that a number of incentives have led to the following outcome as observed in the data: the population with disabilities has become increasingly reliant on cash transfers over earnings and is falling further and further behind the rest of the population.

In light of the U.S. experience, chapter 5 reviews the experience of the Netherlands, once thought to have the most excessive disability system in the industrialized world. At one time,

about one in ten Dutch workers received disability assistance. After several failed attempts at reform, in 2002, the Dutch initiated a series of measures intended to influence individuals and employers to strive for work over benefit receipt. The result—by 2009 the disability beneficiary-to-worker ratio in the Netherlands fell below that of the U.S.—suggests that fundamental changes in disability programs are possible and can lead to positive outcomes for both program costs and individuals with disabilities.

In chapter 6 we shift our focus from the adult population with disabilities to the SSI-disabled children program. We show that this program also has grown rapidly and is the subject of considerable concern, in part because of the program costs, but more importantly from its failure to better integrate children with disabilities into the workforce when they become adults. We review the provisions and rules in the SSI-disabled children program and show how, as in the adult programs; the incentives embedded in the program make it vulnerable to growth unrelated to any real changes in children's health.

Building on lessons from U.S. welfare reform and Dutch disability reform, chapter 7 outlines the themes of fundamental structural reform to the U.S. disability system. As this book shows, the population with disabilities is heterogeneous and no single program will be able to meet all needs. As such, our primary recommendation is that policymakers adopt a work-first strategy for people with disabilities and pull forward the investments in work that currently are targeted only on those already on the rolls. Doing so will eliminate the need for the counterintuitive policy currently in place in which the Social Security Administration (SSA) provides access to work-focused support only after individuals have gone through an extended process of showing they are unable to work. We argue that encouraging work rather than benefit receipt following the onset of a disability will slow the process that eventually leads to an inability to work and can solve a range of problems currently burdening the disability system. Work-first strategies are consistent with the goals of the ADA, which call for the integration of people with disabilities into the labor market. They also provide a long-term opportunity for people with disabilities to reap some of the rewards of a growing economy, an opportunity not granted by the current cash benefit system. Moreover, work-oriented approaches that make the returns to employment higher than the returns to benefit receipt assist program administrators in determining who really is unable to work, thus limiting growth in the rolls caused by changes in enforcement or measurement issues. Finally, work-first strategies promote a fundamental change in the structure of support for people with disabilities that allow them access to the full social safety net provided to working-age adults.

Although work-first strategies are simple to talk about they are much harder to implement. This difficulty is reflected in our proposals for SSDI and SSI, which are only sketches of possible paths to change. Since, as the book shows, SSDI and SSI serve different populations, we propose separate strategies for their reform.

For SSDI, we borrow from the lessons in the Netherlands to propose making cash benefits a last resort and available only after all attempts at accommodation and rehabilitation by both private- and public-sector service providers have failed. In our view this orientation will improve outcomes on a number of fronts including providing incentives for employers, employees, and private insurers to make continued employment a priority. Currently, the long-term SSDI transfer program does not coordinate federal and state government programs to provide short-term transfers or rehabilitation to workers who experience the onset of a disability. More importantly there is no coordination between the private-sector provision of accommodation, rehabilitation, and short- and long-term transfer payments to these workers at

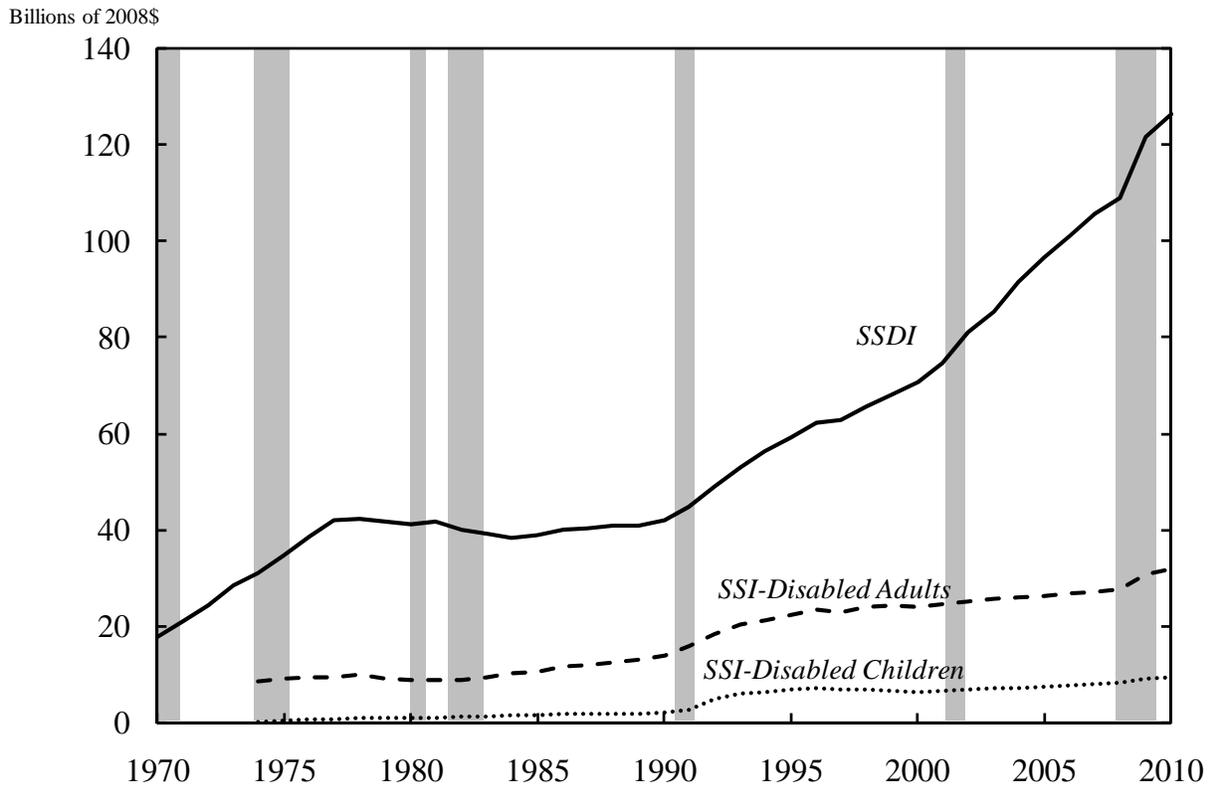
the onset of a disability and the SSDI program that ultimately bears responsibility for providing long-term transfer payments to those who do not return to work. Because SSDI contributions are not experience rated, the firms do not bear the full cost of their decision not to accommodate and rehabilitate employees to prevent their movement onto the SSDI rolls. Rewarding firms that reduce the likelihood that these workers will move onto the SSDI rolls by reducing their SSDI taxes and requiring firms that do not do this to pay higher SSDI taxes is a positive-sum game that can lower the costs of SSDI and increase the employment of people with disabilities.

The proposals for SSI build on the idea that, like AFDC/TANF, SSI is principally a welfare program targeted at low-income households whose members frequently have limited labor market skills or work histories that exacerbate any health shocks that they experience. As such, we argue that SSI would be optimally placed under state administration and control and integrated with other low-income support programs funded by TANF. The same holds for the SSI-disabled children program. Devolving the program to states would allow SSI to benefit from the experience gained from integrating low-income single mothers into the labor force. Moreover, we suggest that this devolution to states would more directly provide disabled children with the specific educational and rehabilitative support they require to progress through school with the expectation that, like all other children, they will enter the labor force as adults.

The message of this book is straightforward: the U.S. disability system is in need of systemic reform. Our analysis suggests that such reform would be widely beneficial, lowering projected long-term costs for taxpayers, making the job of disability administrators less difficult, and importantly improving the short- and longer-run opportunities for people with disabilities themselves.

Note to readers: To insure that this book is accessible to a broad audience we have attempted to keep the exposition free from technical details including discipline specific language, lengthy definitions, and discussions of methodology and data analysis. These details are available in the notes to the exhibits and in the data appendix at the end of the book.

Figure I-1. SSDI, SSI-Disabled Adults, and SSI-Disabled Children Program Costs over Time



Note: Gray bars denote National Bureau of Economic Research (NBER) recessions.
 Source: Social Security Administration.

Year	Work limitation prevalence	Employed more than 200 hours last year	SSDI/SSI receipt
1981	7.3%	35.2%	32.6%
2010	7.8%	22.6%	51.4%

Source: Authors' calculations using March CPS data
 Note: Sample limited to civilian noninstitutional population age 25-59

¹The 2010 Social Security Trustees Report on the Status of the Social Security and Medicare Programs, reports that the SSDI Trust Fund is projected to become exhausted in 2018, two years earlier than projected in the 2009 report. Noting SSDI's deteriorating financial condition the SSA Trustees conclude, "...changes to improve the financial status of the DI program are needed soon." Social Security Trustees Report , August 2010 <http://www.ssa.gov/oact/trsum/index.html>. The Congressional Budget Office report confirmed this view (CBO 2010).

² Any book that argues for systemic changes in a major government policy will be controversial. But one that argues for such changes in policies toward people with disabilities will be even more so. This is the case because of our country's strong social commitment to mitigate the negative impacts of health based impairments on this population's employment and income. But it is also because the data necessary to determine such fundamental facts as the size of the working age population with disability, its employment rate, its program participation rate, and the income of the households in which this population lives are not easily obtainable and are the subject of substantial dispute. For instance, in 2008, after a decade of study, the Bureau of Labor Statistics introduced a new six-question sequence of questions into the CPS-BMS for the purpose of determining the working age population with disabilities. (See: Bureau of Labor Statistics, 2011 for an example of findings using these data.) This set of six questions does not include the traditional work limitation question which the March CPS-ASEC has used since 1981 and which we use to obtain the statistics we report above and in the rest of the book. Burkhauser, Houtenville, and Tennant (2011) using data from both the BMS and ASEC components of the CPS show that levels of employment and income of this six question based disability population are substantially higher and their SSDI and SSI program participation substantially lower than those outcomes when using the work limitation question to determine this population. In large part this is the case because these six questions only capture 63 percent of the CPS population that reports receiving SSDI or SSI benefits. Once the work limitation question is added, the new seven-question based disability population captures 92 percent of the SSDI-SSI population in the CPS. For a discussion of the controversy surrounding the use of CPS data to capture the working age population with disabilities see: Hale (2001), Burkhauser, Daly, Houtenville and Nagris (2002), and Burkhauser, Houtenville, and Tennant (2011).

³ Between 1970 and 2010, the number of SSDI beneficiaries more than tripled, from 2.7 million to 9.7 million, far outpacing the growth in the working-age population. Between 1974 and 2010, the number SSI-disabled adults beneficiaries rose from 1.5 million to 4.3 million and the number of SSI-disabled children beneficiaries rose from 71,000 to 1.2 million (Social Security Administration).

⁴ SSDI and SSI beneficiaries are allowed to work in small amounts and even encouraged to do so once they have been admitted into the program. However, the data suggest that most do not work, in part because it is difficult to reenter the work force after a prolonged absence related to qualifying for benefits.