

The Unsustainable Rise of the Disability Rolls in the United States: Causes, Consequences, and Policy Options

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Abstract

Two ailments limit the effectiveness and threaten the long-term viability of the U.S. Social Security Disability Insurance program (SSDI). First, the program is ineffective in assisting the vast majority of workers with less severe disabilities to reach their employment potential or earn their own way. Second, the program's expenditures on cash transfers and medical benefits—exceeding \$1,500 per U.S. household—are extremely high and growing unsustainably. There is no compelling evidence, however, that the incidence of disabling conditions among the U.S. working age population is rising. This paper discusses the challenges facing the SSDI program, explains how its design has led to rapid and unsustainable growth, considers why past efforts to slow program growth have met with minimal and fleeting success, and outlines three recent proposals that would modify the program to slow growth while potentially improving the employment prospects of workers with disabilities. Because these proposals depart substantially from a program design that has seen little change in half a century, their efficacy is unproven. Additionally, even well-meaning efforts to place the SSDI program on a sustainable trajectory run the risk of creating additional hurdles for claimants who are truly unable to work. Nevertheless, the imminent exhaustion of the SSDI Trust Fund provides an impetus and an opportunity to explore innovative solutions to the longstanding policy challenges posed by the SSDI program.

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1 Introduction

Despite dramatic reductions in the physical demands of the workplace in recent decades and significant improvements in medical care, workers in industrialized economies face a substantial lifetime risk of developing a work-limiting disability. The U.S. Social Security Administration estimates that a 20-year-old U.S. worker has a three in ten chance of becoming disabled before reaching full retirement age.¹ Since 1956, the U.S. Social Security Disability Insurance Program (SSDI) has served to insure workers and their families against impoverishment and loss of medical care in the event of disability. At present, the program provides disability insurance to 153 million non-elderly Americans and pays monthly benefits to 8.4 million disabled workers and 2.0 million dependent spouses and children.² Although the majority of insured workers will never suffer from a work-limiting disability, it is arguable that most benefit from the SSDI program nevertheless because it provides economic security and, potentially, peace of mind that would be difficult to obtain from any other source.³

While the SSDI program is a central component of the U.S. social safety net, it suffers from two substantial ailments that limit its effectiveness and threaten its long-term viability. First, the program is ineffective in assisting the vast majority of workers with less severe disabilities to reach their employment potential or to earn their own way. In fact, the program provides strong incentives to applicants and beneficiaries to remain out of the labor force permanently, and it provides no incentive to employers to implement cost-effective accommodations that would enable disabled employees to remain on the job. Consequently, large numbers of work-capable individuals voluntarily exit the labor force, apply for, and ultimately receive SSDI annually. In 2010, fully 2 percent of the SSDI-insured population—2.9 million workers—applied for SSDI benefits.⁴ Somewhere between 50 and 60 percent of applicants will eventually receive an award. But even those who are ultimately denied benefits will spend substantial time—typically one to three years—out of the labor force before they have exhausted all appeals. At that point, their reemployment prospects may be substantially worse than they were at the time of initial application.

¹U.S. Social Security Administration, “Disability Benefits,” SSA Publication No. 05-10029, July 2011.

²Data on current SSDI insured and beneficiaries from <http://www.ssa.gov/OACT/STATS/dibStat.html>, accessed 7/29/2011.

³Approximately one-third of U.S. workers are covered by employer-provided, private long-term disability insurance policies (PDI). These policies work in tandem with SSDI by supplementing its wage replacement component. Unlike SSDI, wage benefits in PDI policies are generally time-limited, are typically not indexed for inflation, and do not include medical coverage. PDI benefit payments are offset by SSDI benefits one-for-one.

⁴<http://www.ssa.gov/OACT/STATS/table6c7.html>, accessed 7/30/2011.

Second, the program's expenditures are extremely high and growing rapidly (Figure 1). In 2010, SSDI cash transfer payments totaled \$124 billion, while the cost of Medicare for SSDI beneficiaries was \$59 billion. These outlays, exceeding \$1,500 for every U.S. household, comprised 7.3 percent of federal non-defense spending last year—a sum that is larger than interest payments on the federal debt. In the last two decades, outlays grew at 5.6 percent in real terms, compared to just 2.2 percent for all other Social Security spending. As a consequence SSDI's share of total Social Security outlays has risen from one in ten dollars in 1988 to almost one in five dollars at present (Figure 2). Perhaps most ominously, SSDI expenditures now exceed by 30 percent the payroll tax revenue dedicated to funding the program. The Trustees of the Social Security Administration project that the SSDI Trust Fund will be exhausted between 2015 and 2018, at least two decades ahead of the trust fund for Social Security retirement benefits.

The two ailments facing the SSDI program are closely linked, as discussed below. The SSDI program is growing in size and cost in substantial part because it is supporting a rising rate of dependency and a declining rate of labor force participation among working-age adults. Addressing the twin policy challenges of poor incentives and mounting expenses will require amending the flawed incentive structure at the SSDI program's core.

This paper discusses the challenges facing the U.S. Social Security Disability Insurance system and considers options for addressing them. After laying out the rudiments of the program's operation, the paper explains how the basic design of the SSDI program, in concert with Congressional modifications to the program in 1984 and developments in the U.S. labor market over the last three decades, have led to the program's rapid and unsustainable growth. The paper next considers why past efforts to slow program growth have met with minimal and fleeting success. Finally, it discusses three recent proposals for modifying the SSDI program to slow growth while potentially improving the employment prospects of workers with disabilities. Because these proposals depart substantially from a program design that has seen little change in half a century, their effectiveness is unproven. Additionally, even well-meaning efforts to bring the program into equilibrium run the risk of creating additional hurdles for claimants who are truly unable to work. It is unlikely that any set of reforms, no matter how well crafted, will be Pareto-improving. Nevertheless, the experience of other advanced economies that have implemented similar reforms—the Netherlands in particular—provides some reason for optimism. The imminent exhaustion of the SSDI Trust Fund provides an urgent

need and, perhaps, a rare opportunity for exploring innovative solutions to the longstanding policy challenge posed by the SSDI program.

2 The SSDI program: Operation and causes of expansion

To be insured by the SSDI program, an individual must have worked in at least five of the ten most recent years prior to the onset of disability. Once insured, a worker is qualified to receive SSDI benefits if SSA determines that due to a medical condition that has lasted or is expected to last for at least one year or result in death, the worker is unable to either engage in her previous work or to adjust to a different type of work. If benefits are awarded, SSA begins making monthly cash payments to the beneficiary five months from the onset of disability.⁵ Monthly benefits currently average \$1,150 for new awardees and are indexed to the Consumer Price Index. Two years following the onset of disability, beneficiaries also become entitled to Medicare benefits. Both cash and Medicare benefits continue until the beneficiary experiences a medical recovery, passes away, or reaches the Full Retirement Age. In the latter case, she transitions to Social Security retirement. Autor and Duggan (2010) estimate that in 2009, the present value of cash and medical benefits for a new SSDI awardee at the average age of enrollment of 48.8 years was \$270,000.

2.1 The origins of the current policy challenge

To understand how the SSDI program reached its current scale, it is useful to understand its origins. When Congress created SSDI in 1956, disability and employability were viewed as mutually exclusive states. Reflecting this understanding, the 1956 law defines disability as the “inability to engage in a substantial gainful activity in the U.S. economy”—in other words, the inability to work. The SSDI program still uses this definition. It provides income support and medical benefits exclusively to workers who are out of the labor force and, based on SSA’s criteria, not expected to return.

The Social Security definition of disability was arguably appropriate in 1956 when a substantial fraction of jobs involved strenuous physical activity, technologies to assist the disabled were limited and crude, and medical interventions rarely prolonged life significantly or improved its quality. If

⁵If the disability award takes longer than five months, as is typical, the claimant will receive back payments for months six forward following disability onset. There is no set time limit following the onset of disability by which applicants must apply for SSDI benefits, but SSA will not make back payments for more than 12 months prior to the date of SSDI application.

at that time a bright line between disability and employability was visible, however, five decades of advances in the workplace and improvements in medical care and assistive technologies have obscured this line considerably. Given appropriate workplace accommodations—such as flexible hours, physically non-strenuous tasks, and adaptive technologies—many individuals with work-limiting disabilities can potentially participate in the labor force and maintain economic self-sufficiency.

The Americans with Disabilities Act of 1990 (ADA) forcefully articulates this contemporary understanding of disability, stating that “The Nation’s proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency. . .” The SSDI program has not been altered to reflect this changed understanding, however. Two decades after the ADA’s passage, SSDI remains unable to provide assistance to workers with disabilities until their condition has made it infeasible for them to work.

The challenges currently faced by the SSDI program did not commence immediately following its inception. In its first two decades of operation, SSDI outlays grew steadily, as would be expected of a new social insurance program. Concerned that program growth had become excessive, the Carter administration began tightening the criteria for new disability awards in the late 1970s. The Reagan administration reinforced this clampdown with an aggressive program of “continuing disability reviews,” which led to the summary termination of close to 400,000 SSDI recipients. Taking place against the backdrop of the severe early 1980s recession, these steps provoked a national backlash. Congress responded by halting the reviews and, in 1984, liberalizing the program’s screening criteria along several dimensions. Most important, Congress directed the Social Security Administration to give additional weight to pain and related subjective factors in making its disability determination decisions, and to relax its strict screening of mental illness by placing less weight on diagnostic and medical factors and relatively more weight on the ability to function in a work setting. A key consequence was that applicants with difficult-to-verify disorders such as muscle pain and mental disorders could more easily qualify for benefits.

The impact on program enrollment was not immediately evident as the U.S. economy strongly rebounded from deep recession in the years following these reforms. But when economic conditions deteriorated in the early 1990s, the program resumed its rapid growth (Figure 3). Between 1989 and 2009, the share of adults receiving SSDI benefits doubled, from 2.3 to 4.6 percent of Americans ages 25-64. In the same interval, cash payments to SSDI recipients (adjusted for inflation) tripled to

\$121 billion, and Medicare expenditures for SSDI recipients rose from \$18 billion to \$69 billion. This growth coincided with a dramatic change in the characteristics of SSDI recipients, with a steadily increasing share of awards made to individuals with musculoskeletal conditions and mental disorders, and a corresponding decline in the share of awards for cardiovascular disease and cancer, the two most common diagnoses prior to the 1984 liberalization (Figure 4).

The growth of the SSDI rolls is not solely due to changes in the program’s eligibility criteria, however. The labor market has played a key contributing role. Previous research has established that workers are most likely to apply for SSDI benefits following job loss, a fact underscored by the pronounced positive correlation between the national unemployment rate and the SSDI application rate (Figure 5). The secular decline in earnings and employment opportunities for U.S. workers with high school or lower education over the last three decades has also made SSDI an increasingly attractive option for job losers and long-term unemployed. As highlighted by Autor and Duggan (2003), the effective replacement rate of labor earnings with SSDI benefits has also risen in recent decades due both to the rising value of in-kind Medicare benefits and to a subtle interaction between the SSDI benefits formula and rising income inequality in the U.S. This interaction causes SSDI’s effective generosity for low-wage workers to rise as wages in the lower deciles of the distribution fall relative to the mean. Hence, absent any changes in the SSDI program, it is a near certainty that the deteriorating U.S. labor market for less educated workers would have caused SSDI applications to rise in recent decades. The Congressional liberalizations of the program enacted in 1984, however, allowed this surge in demand for benefits to translate into a substantial growth in the SSDI rolls.

2.2 The role of population health and aging

The expanding size and cost of the SSDI program would not be inherently problematic if this expansion reflected a rising rate of disability among working-age adults and, moreover, if the program’s mounting expenditures enabled these individuals to maintain employment and self-sufficiency. Neither appears to be the case. Figure 6 shows that the fraction of middle-age adults reporting a disability has been roughly stable over the last two decades, averaging approximately 10 percent among both men and women.

Moreover, there is little evidence that the underlying health of the working-age population in the U.S. is deteriorating. For example, one of the most common and rapidly expanding diagnoses for

individuals receiving SSDI awards is mental illness, which comprised more than 20 percent of SSDI awards in over the past decade. A recent study in the *New England Journal of Medicine* (Kessler et al. 2005) reports that the prevalence of mental disorders in the U.S. population was unchanged between 1990 and 2003. In the same interval, the rate of treatment of mental illness substantially increased—which in turn should have contributed to improved work-readiness among individuals coping with mental illness.

Using self-reported health data from the National Health Interview Survey, Duggan and Imberman (2008) find a substantial *improvement* between 1984 and 2004 in the average health of U.S. adults between the ages of 50 and 64. This age group is especially relevant because it accounted for 62 percent of all SSDI recipients in 2004. Reinforcing these conclusions, demographers Kenneth Manton and XiLiang Gu of Duke University (2001) find that the share of the population ages 65 and older suffering from a chronic disability fell by one-third between 1982 and 1999 (from 26.2 to 19.7 percent), with the largest drop between 1994 and 1999. In net, there is little reason to believe that the work capacity of adults with disabilities has declined in recent decades.

Perhaps surprisingly, the aging of the U.S. population—in particular, the passing of the baby boom generation into middle age—has made only a modest contribution so far to the growth of Disability Insurance. Calculations from Duggan and Imberman (2008) reveal that, holding age-specific rates of receipt of disability benefits at their 1984 base, the aging of the population between 1984 and 2004 explains only 6 percent of the increase in the fraction of non-elderly adults receiving Disability Insurance through 2004. The contribution of aging to program growth is numerically overwhelmed by the growth of SSDI recipients within given age groups. For example, if one divides males between ages 25 and 64 into five-year age groups, SSDI receipt increased within each group by an average of 41 percent. This increase was especially sharp for males ages 40 to 49, for whom the rate of receipt rose by 65 percent.⁶ As shown in Figure 7, the fraction of middle-aged males ages 40 to 59 receiving SSDI benefits rose by 45 (from 3.9 to 5.6 percent) between 1988 and 2008, while the fraction receiving benefits among females rose 159 percent (from 1.9 to 5.0 percent).⁷

More recent calculations in Stapleton and Wittenburg (2011) find that, holding SSDI enrollment

⁶Ironically, the only male age group for which disability receipt did not increase by more than 20 percent during this period is those aged 60 to 64.

⁷The rapid growth of SSDI among women is in part explained by the rising fraction of women with sufficient work history to qualify for benefits.

rates constant within age and sex groups at 1980 rates, the number of beneficiaries would have been projected to rise from 2.8 to 5.8 million between 1980 and 2010, with a significant fraction of this growth due to an increase in the U.S. population. In reality, the number of beneficiaries reached 8 million in 2010—i.e., 2.2 million (75 percent) more than the projected 3.0 million increase—implying that more than 40 percent of program growth in this interval is explained by rising SSDI enrollment rates within age and sex groups.

This steep increase in SSDI receipt coincided with a substantial decline in the employment rates of the disabled.⁸ In particular, the gap in the employment rate between Americans with disabilities (ages 40-59) and their counterparts without disabilities widened by 10 percentage points between 1988 and 2008 (Figure 8). The employment rate of males in their forties and fifties with a self-reported disability fell from 28 percent in 1988 to 16 percent in 2008 (approximately a 40 percent decline). The employment rate of comparably aged males without a disability held roughly constant at 87 to 88 percent. For females in this same age range with disabilities, the employment rate declined slightly (from 18 to 15 percent) while the employment rate of their counterparts without a disability rose from 66 to 76 percent.

The simultaneous occurrence of these two trends—declining employment among working-age people with disabilities and rising SSDI receipt—underscores that the two key policy challenges of the SSDI program are two sides of the same coin. The SSDI program is growing in size and cost in substantial part because it is supporting a rising rate of dependency and a declining rate of labor force participation among adults with disabilities.

3 Employer and worker incentives under the SSDI program

The SSDI program provides strong incentives to employers to terminate employment and to workers to seek SSDI benefits following the onset of a work-limiting disability. Distinct from state Unemployment Insurance (UI) and Worker Compensation (WC) programs, which experience rate employers for the costs that they impose on these public insurance programs, the payroll tax that funds the SSDI program does not depend on the employer's firm-specific or industry-level claim history. At one level, this appears logical. Firms directly affect their workers' UI and WC claims by choosing

⁸See DeLeire (2000) and Acemoglu and Angrist (2001) for discussion of the role that the ADA may have played in reducing the employment of workers with disabilities.

whether or not to engage in layoffs and by providing safe or risky working conditions. Conversely, employers typically have limited influence over whether workers develop work-limiting disabilities, such as mental disorders, cancers, heart diseases, and back injuries. One might therefore conclude that employers should not be subject to any degree of experience-rating for SSDI premiums.

What this argument overlooks is that when a worker develops a work limitation, the employer has considerable discretion about whether to implement accommodations—providing assistive technologies, permitting flexible hours, or funding vocational rehabilitation—that may enable the worker to remain on the job, even when such accommodations may be far less expensive than the social costs of an SSDI claim.⁹ Moreover, workers are particularly likely to seek SSDI benefits following job loss, meaning that layoffs affect both UI and SSDI claims. At present, employers have no incentive to weigh the costs that they impose on the SSDI system through layoffs against their costs of accommodating employees with work limitations. It is therefore likely that many workers who could be cost-effectively accommodated in the workplace are instead terminated and eventually become long-term dependents on the SSDI system.

The incentives that the SSDI program provides to individuals with work-limiting disabilities are equally counterproductive. It is widely understood in the disability advocacy community that the first months following the onset of a disability is when professional assistance may have the greatest efficacy in enabling individuals suffering work limitations to adapt to their disabilities while maintaining employment. Yet the SSDI program effectively bars workers with disabilities from participating in the workforce while seeking benefits—by law, the SSDI program can only award benefits to those who are “unable to engage in a substantial gainful activity”—workers who participate in significant employment during the application period, even on a trial basis, are automatically denied benefits. This potentially creates a Catch-22 for workers who develop health limitations that are significant but not necessarily career-ending: it may be difficult or infeasible for them to remain employed and economically self-sufficient absent disability assistance, but is impossible under current law for them to obtain assistance from SSDI without first leaving the labor force.

Adding to the economic cost of the SSDI application process is its substantial duration. In recent years, approximately 35 percent of SSDI applicants have been awarded benefits at the first

⁹Although the ADA requires employers to implement “reasonable accommodations” for disabled workers, this provision of the law is vaguely defined and difficult to monitor or enforce. Small employers in particular are unlikely to have human resource staff that are aware of the law’s requirements and can ensure compliance.

stage of applications. The average time to a decision in this stage of the process is 4.3 months. More than half of the 65 percent of applicants rejected at this stage appeal their decision. This appeal leads to a reconsideration, which takes five months on average. This lengthy reconsideration process is mostly pro forma, however. The SSA awards only 10 percent of appeals at this stage. The vast majority of applicants who are rejected at the reconsideration stage appeal their rejection. They ultimately appear before an administrative law judge (ALJ) who adjudicates their claim. The average wait time from the initial application to an ALJ decision is two years and three months. Notably, ALJs overturn SSA's initial rejections in approximately 75 percent of cases that reach them. Many of those rejected at the ALJ stage will appeal again, first to Social Security's Appeals Council and ultimately to the federal courts, with average overall processing times of 35 months and 57 months, respectively. During the applications and appeals process, claimants receive no income support, workplace accommodations, or medical benefits from the SSDI program. But they face strong incentives against participating in the labor force—even on a trial basis—since evidence of gainful employment would disqualify their claim. Moreover, recent work finds that claimants who experience longer administrative delays during the SSDI application process are less likely to return to work after the process is complete—even if they are denied benefits.¹⁰

On net, the SSDI determination process unintentionally serves to reduce the work capability of individuals with disabilities by failing to provide supports when they might be most effective, barring work during the application process, and requiring an extended period of non-employment while a determination is rendered. If the SSDI determination leads to an SSDI award, the claimant faces strong ongoing incentives to refrain from substantial labor force participation so as to maintain benefits. If the SSDI claim is denied, the claimant faces the daunting prospect of returning to the labor market after many months or even years of extended absence. It is difficult to overstate the role that the SSDI program currently plays in discouraging the ongoing employment of non-elderly adults. During the past three years, SSA has received more than 8.5 million applications to the SSDI program, representing more than 5.5 percent of the U.S. labor force.

¹⁰Autor, Maestes, Mullen and Strand (2011).

4 The failure of past reforms

SSA administrators and the U.S. Congress have attempted to slow or reverse the growth of the SSDI program over the past fifty years with three categories of reforms: tightening the program's screening criteria; aggressively removing beneficiaries deemed work-capable from the rolls; and providing financial incentives for current beneficiaries to return to the work. None of these efforts has had a lasting impact on the program's growth trajectory, nor have they slowed the steady decline in the labor force participation of adults with disabilities. These efforts have been largely fruitless in my assessment because they make one or more fundamental mistakes: limiting SSDI awards by denying applicants rather than reducing applications; revoking benefits of individuals who have no other means of financial support and thus strong incentives to get back on the system; and reducing the penalties for gainful employment when these are, by and large, too late to matter.

4.1 The 1980s clampdown

As noted above, a substantial contributor to the growth of SSDI since the mid-1980s was the Congressional liberalization of the program in 1984. This liberalization was in turn spurred by efforts at program retrenchment during the preceding five years that were widely perceived as draconian. Thus, the net effect of the retrenchment was to make SSDI benefits accessible to a larger set of claimants.

4.2 Revocation of benefits for drug and alcohol addiction

More recent efforts to terminate benefits for current beneficiaries have had a similar trajectory. Following passage of a 1996 law outlawing the provision of disability benefits for drug and alcohol addiction, the SSA removed from the rolls approximately 210,000 beneficiaries whose primary impairment was drug and alcohol addiction (Moore, 2011).¹¹ Between 50 and 60 percent of these terminated claimants re-qualified for SSDI benefits under other impairments, primarily mental illness.

¹¹Roughly 40 percent of those terminated were SSDI beneficiaries, while the balance were beneficiaries of the Supplemental Security Income (SSI) program. SSI is a second major federal disability entitlement program that applies the same medical criteria as SSDI but, unlike SSDI, does not require prior work history for eligibility. Cash transfers under SSI are substantially smaller than under SSDI and are contingent on the beneficiary having very low income and assets. Medical coverage under SSI is provided through Medicaid rather than Medicare (which accompanies SSDI).

The examples of the 1980s SSDI retrenchment and the 1996 clampdown on drug and alcohol addictions suggest that efforts to reform the SSDI program by simply tightening the program's medical eligibility criteria or aggressively terminating beneficiaries are unlikely to succeed in slowing program growth or raising the employment rates of individuals with disabilities. Revoking benefits en masse from needy beneficiaries is not politically viable, whether or not this would be desirable from an efficiency standpoint. A second lesson, evident from the drug and alcohol addiction experience, is that highly motivated applicants in many cases will eventually succeed in obtaining benefits, particularly because of the 1984 liberalization of the criteria for pain and mental illness. While this latter observation highlights that the SSDI disability determination system is badly in need of modernization, my main conclusion is that better gatekeeping cannot be the centerpiece of effective SSDI reform.

4.3 The Ticket to Work program

It appears plausible that SSA and Congress have internalized the lesson that wholesale benefits terminations are futile, as more recent reforms to the SSDI program have focused on improving the incentive for SSDI recipients to rejoin the workforce. In 1999, Congress authorized the Ticket to Work program that permitted SSDI beneficiaries to engage in a trial work period of up to nine months without forfeiting their benefits, provided them with eight years of ongoing Medicare eligibility following return to work, and guaranteed three years of automatic benefit reinstatement if claimants' workplace earnings fell below the Substantial Gainful Activity threshold. Each step reduced the implicit tax imposed by the SSDI program on beneficiaries' labor force participation. Despite these incentives, fewer than 1,400 tickets (0.01 percent) of 12.2 million tickets issued in the first seven years of the Ticket to Work program led to successful workforce integration. And as shown in Figure 9, the medical recovery rate on SSDI has trended steadily downward over the last decade.

At present, SSA's policy efforts are focused on a Benefits Offset policy for SSDI beneficiaries, which Congress mandated that SSA study as part of the Ticket to Work authorization. Under this policy, an SSDI recipient's benefits would be reduced by \$1 for every \$2 of earnings above a disregard amount, following a trial work period and a grace period. Thus, SSDI recipients would be able to keep fifty cents of every dollar of labor earnings. The goal of this policy, as with the previous Ticket to Work provisions, is to stimulate workforce reentry by current SSDI beneficiaries by reducing the

penalties to working.

While the objectives of the Benefits Offset policy are laudable, history suggests that it will be at best moderately more successful than prior components of the Ticket to Work program. The simple reason is that the financial inducements (or, more precisely, penalty reductions) for workforce reentry under such a policy arrive too late to be relevant for the bulk of SSDI beneficiaries, including those who might have been able to work at the time benefits were awarded. After individuals have been out of the workforce and receiving benefits for several years, their readiness and enthusiasm for reentering the labor market are likely to have severely eroded. The best chance for assisting these individuals to remain in the labor force is likely to have passed several years earlier. Moreover, it deserves emphasis that the SSDI award is equivalent to an annuity that pays inflation-adjusted monthly income plus full medical benefits until the time of retirement. One would not expect many individuals with marginal employment prospects to forego this valuable asset in favor of a precarious labor market.

4.4 A new direction

My conclusion from this review of 30 years of SSDI reform efforts is that a different approach is needed to increase the employment of individuals with disabilities and to stem the growth in program enrollment and expenditures. Specifically, the goal of SSDI reform should be to increase the odds that individuals with work-limiting disabilities remain in the labor force and reduce the odds that they apply for long-term SSDI benefits. It is my view that a well designed policy can increase the well-being of individuals with disabilities by facilitating ongoing meaningful labor force participation and reducing unnecessary dependency. Accomplishing this goal will require both changing the incentives faced by firms and workers and modifying the disability program so that it can assist individuals with work limitations to remain employed.

This sharp departure from current practice will face two key hurdles. First, providing assistance to workers struggling to adapt to disabilities would necessitate programmatic and likely statutory changes to the SSDI system, which currently is unable to offer financial or medical support to workers until they have both exited the labor force and demonstrated to SSA's satisfaction that they are unable to work. Second, even a well designed set of reforms will not be Pareto-improving. Evidence from Autor and Duggan (2003) suggests that a substantial share of the growth in the

SSDI system following the 1984 reforms reflects the program’s increasing role as a de facto safety net for individuals whose primary barrier to employment is limited labor market opportunities rather than debilitating health conditions. Reconfiguring the SSDI program to support the ongoing employment of individuals with health-related work limitations would do little to benefit individuals whose primary reason for seeking disability benefits is a lack of employment opportunities. To the degree that these proposed reforms improved the efficiency of SSDI gatekeeping or divert would-be beneficiaries away from the program, this latter group of claimants could be made worse off.

5 Policy options: Three recent proposals

This section reviews three recent proposals for reforms to the SSDI system that attempt to change the incentives faced by firms, workers, or both. The proposals also differ along key dimensions: whether they change incentives for firms only, workers only, or both; whether they operate only by changing incentives or whether they also provide services to help workers with disabilities retain employment; and if additional services are provided, whether these would be publicly or privately provided.

5.1 Experience rating the SSDI payroll tax

The SSDI system is currently funded by a flat-rate 1.8 percent payroll tax on covered earnings, with this tax nominally split between employer and employee.¹² Although employers pay into the SSDI system, they face no marginal incentive to minimize SSDI claims since their payroll taxes are independent of the claims their workers make against the system. In a recent book, Burkhauser and Daly (2011) propose experience-rating the SSDI payroll tax so that employers will recognize the cost of SSDI claims. Under this scheme, employers whose workers make more frequent claims on the SSDI system would pay higher SSDI payroll taxes.

A key virtue of this proposal is its simplicity. Experience-rating has been used for decades in state Unemployment Insurance (UI) and Workers Compensation (WC) systems. Employers understand the basic mechanics of experience-rating and the incentives it creates. Moreover, adding an

¹²The Old-Age, Survivors, and Disability Insurance (OASDI) payroll tax is currently 12.4 percent of the first \$107,000 of wage and salary income, and the DI component is 1.8 percentage points of this 12.4 percent. This tax is insufficient to cover the program’s current costs, as evidenced by the fact that the SSDI Trust Fund is nearing exhaustion. The Medicare component of OASDI is funded by a separate payroll tax.

experience-rating scheme to the SSDI payroll tax system would probably not necessitate new data collection since employers currently report payroll tax data to the federal government for each employee. Linking these data to SSDI awards would not be challenging for SSA. Indeed, when a worker applies for SSDI benefits, SSA first reviews the worker's payroll tax history to determine if she is insured by SSDI. It therefore seems plausible that SSA could implement an experience-rated SSDI payroll tax without imposing substantial new reporting requirements or administrative burdens on employers.

A number of important questions about this scheme require careful evaluation. A first is whether experience rating can provide sufficiently powerful incentives to slow SSDI growth and raise the likelihood that workers with disabilities remain employed. The answer will in part depend on the extent of experience rating. As above, the present value of a typical SSDI award is approximately \$270,000 and is rising rapidly. Charging employers the full present value of an SSDI award when a former employee enters the SSDI system would have a dramatic effect on employer behavior. Firms would presumably respond by offering wellness programs, vocational rehabilitation, and workplace accommodations in the hope of deterring workers from applying for SSDI. This level of experience rating would clearly be undesirable, however, for two reasons. It would expose firms to substantial, potentially crippling liability for medical conditions over which they have limited control (e.g., acute heart disease, metastatic cancers, renal failure, etc). Moreover, it would surely make firms wary of hiring workers whose medical history put them at risk for work limiting disabilities. Hence, a challenge for this proposal would be to calibrate the level of experience rating so employers gain meaningful incentives to accommodate work-limited employees but do not face disincentives to hiring certain workers.

A second question is whether this proposal provides incentives to the right parties. experience rating changes incentives for employers but does not directly affect incentives for workers who might seek SSDI benefits. These incentives are important because workers with potentially manageable work limitations often face a choice between attempting to maintain employment or instead foregoing work and applying for SSDI benefits. It is possible, however, that employers facing experience-rated SSDI payroll taxes would in turn provide incentives to their workers to reduce SSDI claims. For example, employers might choose to purchase private disability insurance (PDI) policies that provide workplace accommodations, vocational rehabilitation services, and partial wage replacement when

workers develop work-limiting health conditions. Still, since many SSDI claims are filed after job loss, the impact of experience rating on worker incentives would be limited.

A third question is whether the Burkhauser-Daly proposal adequately insulates employers from worker moral hazard in filing disability claims. Much evidence shows that workers are disproportionately likely to apply for SSDI benefits when they involuntarily lose work—even if their job loss is unrelated to their health. For example, Black, Daniel and Sanders (2002) providing striking evidence that disability applications from the Appalachian coal mining regions of the U.S. spike when energy prices fall. Since it is unlikely that energy prices directly affect disability, this evidence highlights that when firms engage in layoffs—e.g., by closing mines—it greatly increases the odds that their (former) workers seek and ultimately obtain SSDI benefits. This evidence is relevant for the Burkhauser and Daly proposal because it underscores that experience rating the SSDI payroll tax would in effect increase the degree of experience rating in the UI system. Since a firm’s SSDI payroll taxes would rise when workers who were terminated for reasons unrelated to disability subsequently sought SSDI benefits, firms engaging in layoffs would have to anticipate that their UI costs would rise in the short term as workers sought UI benefits and their SSDI costs would rise over the longer term as a subset of workers sought SSDI benefits.¹³

Is this link between layoffs and SSDI costs desirable? Though it would provide firms with an incentive to limit disability claims by their current employees, it would provide firms with essentially no economic or legal tools to influence moral hazard by workers who have been terminated. By comparison, both the UI and WC systems attempt to insulate employers from worker moral hazard by making employer liability contingent on the merits of the claim: workers who are fired for cause are not entitled to UI benefits, and workers who are injured outside of work are not entitled to WC benefits. The SSDI experience rating scheme proposed by Burkhauser and Daly does not appear to provide similar protections.

This potential downside to experience rating is not unique to the Burkhauser-Daly proposal. Any SSDI reform that makes firms partly liable for workers’ SSDI claims faces the delicate task of creating incentives for firms to accommodate workers with disabilities when appropriate without penalizing firms for either bad luck (e.g., a worker developing heart disease) or worker moral hazard.

¹³It is likely that in many cases, employers would be unaware that workers who applied for SSDI suffered from any work limitations at the time they were dismissed.

A simple experience rating system that makes no distinctions among the different causes of SSDI claims would not provide employers much protection against the risks that the SSDI system was intended to bear, nor would it provide incentives for employers to find ways to reduce the number of individuals whose disabilities prevent them from working. At some cost in administrative complexity, however, one could potentially implement a modified SSDI experience rating scheme in which a firm’s SSDI experience rating depended not only on its SSDI claims incidence but also on the medical impairments that led to an SSDI award, the extent to which these impairments can be accommodated in the workplace, and the precipitating events that led to these claims.

5.2 Reducing SSDI inflows by offering comprehensive in-work supports

A recent, detailed policy proposal by Autor and Duggan (2010) takes a more comprehensive—but also more complex—approach to providing a mixture of incentives and supports to increase the likelihood that individuals with work limitations remain employed. Their proposal envisions adding to the SSDI system a “front end” insurance policy that offers two main sets of provisions. The first set of provisions consists of workplace accommodations, rehabilitation services, and partial income replacement for workers who suffer work limitations, with the goal of enabling them to remain in employment. The second set of provisions consists of financial incentives to employers to accommodate workers who become disabled and minimize movements of workers from their payrolls onto the SSDI system. Thus, this proposal would attempt to reduce inflows into the SSDI system by offering a set of short to medium-term employment supports and financial incentives that increase the attractiveness of remaining in employment relative to entering the long-term component of the SSDI program. Autor-Duggan argue that this proposal will reduce systemwide disability costs because enabling individuals with work limitations to remain in the labor force is less expensive than offering them financial and medical benefits in lieu of employment for the remainder of their working lives (as currently occurs in the SSDI program).

Building this work support capacity onto the large and overtaxed SSDI system would, however, appear a daunting task. Autor-Duggan instead propose leveraging an existing private sector institution that already serves this purpose: private disability insurance. Their proposal would extend PDI coverage to the vast majority of U.S. workers in much the same way that UI and WC benefits are universally provided to workers who participate substantially in the labor market. PDI coverage

under their proposal would form the first line of defense in the U.S. worker disability system. In contrast to the traditional SSDI system—but similar to the PDI plans numerous employers purchase—its primary goal would be supporting work, and hence it would treat disability and gainful employment as potentially compatible conditions rather than mutually exclusive states.

Under the PDI proposal, employers would be required to carry disability insurance policies, the cost of which could be partly charged back to employees. Policies would be competitively sold, and employers would have the option to self-insure. Premiums would be experience-rated for firms with fifty or more full-time equivalent employees. Premiums for smaller firms would be industry-rated. Insurers would be allowed to vary the premium with the average age of employees at a firm as well as with firm industry. The proposed policy would support workers from 90 days to 2.25 years following onset of disability, providing partial income replacement, vocational rehabilitation, and workplace accommodations geared toward helping individuals maximize work readiness and self-sufficiency.¹⁴ After receiving PDI benefits for 24 months, individuals who are unable to engage in substantial gainful employment would transition into the SSDI system. The screening criteria for SSDI would be unchanged.

This plan has clear strengths and weaknesses relative to the Burkhauser-Daly experience rating proposal. A key strength is that it combines incentives to employers to minimize disability costs—since private sector PDI policies depend in part on an employer’s claims history—while providing individuals experiencing work limitations with access to a sophisticated infrastructure for supporting ongoing employment and managing the financial toll of work limitations. Specifically, private disability insurers use three main tools to assist workers to remain in employment following the onset of a disability: workplace accommodations, vocational rehabilitation, and partial wage replacement (typically at 60 to 75 percent of the pre-disability wage). Partial wage replacement is particularly important: it relaxes liquidity constraints that might otherwise spur disabled workers to apply for

¹⁴Workplace accommodations are specific modifications made to the work site or work environment to enable workers with disabilities to perform critical job functions. Examples include purchasing specialized computer hardware or software, modifying the work site to improve physical accessibility, or providing infrastructure for certain medical equipment to be used at work. The Americans with Disabilities Act of 1990 requires employers to provide reasonable workplace accommodations for workers with disabilities. But many employers, particularly small employers, do not have the expertise to know what is required under the law. A key role of the PDI insurer is to guide clients in complying with the law and to pay the cost of mandatory accommodations. The proposed PDI coverage would not extend the ADA mandate—it would simply require that employers pay ADA compliance costs prospectively through the insurance policy rather than on a one-off basis. If insurance markets operate competitively, the policy cost of ADA compliance should be roughly comparable to the employer’s expected ADA compliance costs.

SSDI shortly after wage income ceases, but still encourages individuals to return to work to regain their full earnings. The specific PDI policy proposed by Autor-Duggan would commence within 90 days of disability onset—while the worker is still employed—with the goal of accommodating and redressing the disability before it leads to job loss and labor force withdrawal. Early intervention would leverage the existing economic and social ties between the worker, the employer, and his or her coworkers in service of supporting the worker’s ongoing employment. It is a widely-held view among vocational rehabilitation practitioners that maintaining the worker’s link to the current employer is critical to successful labor force reintegration; once the current employment tie is severed, the hurdle to reentering becomes substantially higher.

A second strength of the proposal is that it would partly or fully shield employers from risks over which they have little control. Under the proposal, PDI policies would hand off responsibility for ongoing disability coverage to the traditional SSDI program two years following the onset of disability. In addition, SSDI would step in to provide benefits almost immediately for medical conditions that are severe and readily diagnosed—specifically, conditions covered by the SSA’s List of Compassionate Allowance Conditions. Thus, employers would not be exposed to the long-term costs of a permanent, work-limiting disability. Nevertheless, employers would not be entirely insulated from the costs of disability. To the degree that their workers make multiple claims against the policy that are not absorbed by the SSDI program, their premiums would rise. This provides employers with an incentive to support individuals with work limitations to remain at their jobs.

As detailed in Autor-Duggan (2010), the proposal would also attempt to shield employers from moral hazard on the part of former employees, for example, when discouraged workers seek disability benefits for medical conditions that did not inhibit their prior employment. In the Autor-Duggan proposal, workers who sought SSDI benefits after leaving employment would receive a lower wage replacement rate, equal to the relatively low UI cap, than would individuals who developed work limitations and sought support while employed.¹⁵ The PDI policy would not pay wage replacement benefits while a worker is receiving UI. The virtue of using the UI payment scheme to set PDI

¹⁵The proposal suggests a 60 percent replacement rate on lost wages with a maximum monthly benefit of \$2,500, prorated for individuals who are able to work part time while receiving benefits, and a maximum duration of 24 months. This PDA replacement rate substantially exceeds state UI benefits, which are generally set at 50 percent of wage earnings and capped at \$300 to \$600 per month (though a few states have caps above and below this range). Simultaneously, this is well below the level of the typical PDI policy, which has median maximum monthly benefits of \$7,500 and often provides partial benefits to disabled workers until they reach the full retirement age.

payments to the unemployed is that it would protect employers from facing double indemnity from the UI and PDI systems. If these benefits are set at the same level for the unemployed and workers are not allowed to collect both simultaneously, an employer's UI experience rating would not rise if PDI paid wage benefits rather than UI, and the employer's PDI experience rating would not rise if UI paid wage benefits rather than PDI.¹⁶

The universal PDI proposal faces several practical challenges. A first is general employer and ideological opposition to employer benefit mandates, as seen in the recent debate surrounding the passage of the Affordable Care Act of 2010 (ACA). Notably, however, the expected costs of the universal PDI policy are surprisingly modest. Using data from the Bureau of Labor Statistics on the average hourly cost of PDI coverage (\$0.04) and the fraction of workers with long-term disability coverage (32 percent), Autor-Duggan estimate that average policy costs for PDI coverage of approximately \$250 per worker per year—about \$20 per month.

Why is PDI not more costly? The central reason is that PDI does not pay for medical care, which is instead separately provided through workers' health insurance plans. Although millions of low-wage workers currently lack health insurance, the vast majority should gain coverage over the next several years as the Affordable Care Act goes into effect. Thus, the price of universal PDI insurance would reflect the modest costs of providing earnings replacement, workplace accommodations, and certain rehabilitation services for workers who develop work limitations. Autor-Duggan posit that these costs would be more than fully offset by reductions in systemwide disability costs—which, after all, is funded by payroll taxes—though pilot studies are urgently required to test this proposition.

The second key challenge of the universal PDI proposal is its complexity. While the SSDI experience rating proposal requires only modest modifications to an extant payroll tax scheme, the PDI proposal would require specifying a policy standard, putting in place a verification system to ensure that these policies were provided and, perhaps most significantly, developing capacity at SSA to manage the interface between long-term disabled workers who are transitioning from the “front end” PDI system to the traditional SSDI system. Though this would not be nearly as complex an undertaking as the recently enacted ACA, it would still require a significant piece of social policy legislation.

¹⁶Thus, the employer's experience ratings for UI and PDI would both be affected only in the case where PDI benefits were paid after UI was exhausted.

It bears emphasis, however, that neither the PDI proposal nor the experience rating proposal has been ‘field tested.’ State level pilot programs would be an excellent place to start. In recent years, SSA has conducted similar state level pilots to field test policy innovations, for example the demonstration project to “prototype” a simplified SSDI determination process that eliminates the administrative reconsideration step when an SSDI denial is appealed.

5.3 A new public insurance program

MacDonald and O’Neil (2006) propose a new social insurance program called Earnings Support Insurance (ESI) to support individuals with work limitations. One component of ESI would provide partial wage replacement for workers with disabilities who remain in employment or who find new jobs after the onset of disability. A second component would provide a dollar-for-dollar tax credit for employers to pay for the cost of reasonable accommodations. A third component would expand existing tax provisions to help offset the costs of disability-related health care expenditures for both employers and individuals. This proposal is arguably the most ambitious of the three considered here. While the Burkhauser-Daly experience rating proposal builds on the existing payroll tax infrastructure and the Autor-Duggan PDI proposal builds on an established private insurance industry, ESI would create a new public entitlement.

Because the MacDonald-O’Neil proposal as written is primarily a statement of principles rather than a detailed policy proposal, it is difficult to comment on the specific virtues and drawbacks of its design. Some high level considerations are immediately evident, however.

Distinct from the prior two proposals, the ESI plan would fully insulate employers from the direct costs of disability claims by current and former employees. Disability accommodations would be covered by tax credits and wage replacement paid by public sector insurance. Employers would not be experience-rated for these costs. MacDonald and O’Neil view this design feature as a central virtue of the proposal because it avoids the possibility of raising employers’ costs of employing workers with disabilities. From an incentive perspective, however, what MacDonald-O’Neil view as a chief virtue of their proposal is arguably a major flaw. Because ESI fully insulates employers from any costs they may impose on the disability program, it provides them with no economic rationale for minimizing unnecessary flows of work-capable individuals onto short-term (ESI) or long-term (SSDI) disability.

The ESI proposal fares better in terms of worker-side incentives, however. The wage replacement and health insurance components of the ESI plan would make it easier for workers with disabilities to remain engaged in employment or job search rather than turning to long-term SSDI benefits. And because ESI would pay for accommodation costs, employers would have no perverse incentive to terminate workers with work limitations to avoid these expenses. Thus, it is possible that even absent employer-side incentives, ESI would raise employment of workers with disabilities and slow flows onto SSDI.

It bears note that ESI is to a substantial extent, a mirror image of the Burkhauser-Daly experience rating proposal. Whereas ESI would provide positive incentives to workers to remain employed while shielding firms entirely from the marginal costs of employing workers with disabilities, the Burkhauser-Daly experience rating would provide negative incentives (in effect, tax penalties) to employers against imposing costs on the SSDI system while leaving incentives for workers unchanged.¹⁷ Whether it is wise to alter incentives entirely on one side of the market given that incentives are poorly aligned on both sides of the market at present is something that policymakers will want to consider.

A final potential drawback of the MacDonald-O'Neil proposal concerns its political feasibility rather than its economic merit per se. The U.S. Congress has shown little appetite in recent decades for adding publicly provided entitlements to the social safety net. For example, in crafting two major expansions of the U.S. social safety net in the last decade, Medicare Part D and the Affordable Care Act, Congress elected to subsidize private provision of these benefits rather than providing them through the public sector. While it is far from clear that private sector insurers are more effective at controlling costs and wringing out inefficiencies than are their public sector counterparts, the U.S. political system appears to strongly favor private provision of these services.

6 Is growth of SSDI inevitable? The example of the Netherlands

In 1990, the Netherlands devoted a larger share of GDP to disability cash benefits than any other country in the Organization for Economic Cooperation and Development (OECD).¹⁸ At 3.4 percent

¹⁷The universal PDI proposal, by contrast, provides positive incentives to workers, negative incentives to employers, and builds in mechanisms to partially shield employers from disability costs that are outside of their control.

¹⁸This section of the paper is excerpted with minor modifications from Autor-Duggan (2010). For additional detail, see Burkhauser, Daly and de Jong (2008) and de Jong (2008).

of GDP, the Netherlands' share of disability benefit payments was 150 percent greater than the OECD-17 median of 1.4 percent in that same year and more than five times greater than the U.S. share of 0.6 percent. Including sickness and work injury benefits in a measure of broad disability benefits in 1990, the OECD calculated that the Netherlands' share was 5.7 percent in 1990, versus an OECD-17 average of just 2.7 percent. Remarkably, the Netherlands' share of GDP spent on disability in 1990 was 20 percent *lower* than it had been five years earlier, in 1985, when the country commenced upon two decades of reforms.

In response to rapid growth in public disability expenditures and disability enrollment, the Dutch government undertook a series of policies in the 1980s and early 1990s designed to slow the growth in program expenditures. Many of these policy changes took the form of benefit cuts, including a reduction from 80 percent to 70 percent in the program's replacement rate in 1985 and a change in the method of indexing benefits in the same year. Benefits were reduced still further in 1993 for those whose disability onset occurred at an earlier age. During this time, disability expenditures as a share of GDP fell from a peak of 4.2 percent in 1985 to 2.6 percent in 1995, with a reduction in average benefit generosity driving this decline almost entirely. By contrast, the contemporaneous drop in disability enrollment as a share of the Dutch labor force was much less pronounced, declining by only one percentage point from 11 percent in 1985 to 10 percent in 1995.

The fraction of workers in the Netherlands claiming disability was so high that the popular press began referring to disability claims as "the Dutch Disease." The Dutch government responded by changing incentives so that employers would recognize some of the costs borne by the disability system when their workers made disability claims. Starting in 1994, the government required all employers to finance the first six weeks of their employees' sickness benefits. Two years later, they lengthened the time to one full year.

These reforms continued in 2002 with the introduction of the "Gatekeeper Protocol," which required the employer, worker, and a consulting physician to jointly draft a return-to-work plan within eight weeks of a disability claim and appoint a case manager to coordinate this process. In 2004, mandatory employer-paid sickness benefits were extended from one year to two years, as was the mandatory waiting period for access to public disability benefits. Thus, employers retained full financial responsibility for their employees' sickness benefits for two full years.

These two changes, along with the full phase-in of experience-rated disability insurance premi-

ums, appear to have generated a sharp drop in the inflow to the Dutch disability program, which fell by 40 percent from 2002 to 2004 and by another 50 percent from 2004 to 2006. The number of disability recipients as a share of the Dutch labor force fell from slightly more than 10 percent in 2002 to 8.4 percent in 2007.

Though 8.4 percent seems high relative to the United States, the difference is not as large as it appears. The number of SSDI program recipients as a share of the labor force (rather than the population) is 5.3 percent, which is only 65 percent of the size of the Dutch program. However, adding into the U.S. count the non-elderly adults who are receiving disability benefits from the federal Supplemental Security Income entitlement program, which is distinct from SSDI, would raise this number to 7.1 percent. With the Dutch and U.S. programs now trending in opposite directions, it is indeed possible that the U.S. will pass Dutch disability enrollment in the decade ahead.

The Dutch experience provides compelling evidence that policies causing employers to recognize the costs of disability claims can influence the trajectory of disability claims. The focus on employer incentives and mandatory return-to-work plans seems almost certain to have boosted employment among individuals with disabilities in the Netherlands. However, we know little at present about how the Dutch reforms affected the well-being of individuals with disabilities in the Netherlands. It would therefore be premature to conclude that the Dutch example is one that the United States should emulate.

7 Conclusions

Since its inception in 1956, the Social Security Disability Insurance program has served to protect U.S. workers and their families from poverty and loss of medical care in the event of work-limiting disability. The program has become a crucial piece of the U.S. social safety net, and it creates substantial net benefits for citizens.

The SSDI program was designed to provide income support (and, after 1965, medical care) to workers transitioning from employment to early retirement and, in many cases, death. This goal was progressive for its time but is no longer aligned with current societal objectives. In the fifty years since the program's introduction, medical care and assistive technologies for treating and

accommodating work-limiting disabilities have advanced, the physical demands of the workplace have lessened, and the societal consensus regarding the objectives of disability policy have changed—from facilitating early and permanent labor force withdrawal to assuring “equality of opportunity, full participation, independent living, and economic self-sufficiency.” These transformations in medical technology, workplace demands, and societal attitudes call for a disability insurance system that focuses on assisting individuals with disabilities to maintain economic self-sufficiency and to enjoy the many benefits of gainful employment. In its current incarnation, the SSDI program spends too few societal resources helping individuals with disabilities to remain employed and too many resources supporting the long-term dependency of individuals who could be self-sufficient with the appropriate accommodation and support.

Whether any or all of the three proposals considered above have the potential to enable this transformation of the SSDI system is yet to be demonstrated. The example of the Netherlands provides reason to believe that such a transformation is feasible. And the imminent exhaustion of the SSDI Trust Fund highlights that reform is urgent. Although the route forward is uncertain, the current course is clearly unsustainable, which suggests that changes to the program will not be forestalled indefinitely.

If reforms to the U.S. disability system do make it onto the legislative agenda, I see two reasons for optimism and one reason for caution. A first encouraging observation is that despite its high price tag and good intentions, the SSDI program is so badly out of step with our contemporary understanding of disability that one can readily envision feasible reforms, as outlined above, that would make both SSDI beneficiaries and taxpayers better off. A second reason for guarded optimism is that economists, fiscal watchdogs and disability advocates generally agree that the SSDI program should be reformed to assist the disabled to remain employed and economically self-sufficient rather than fostering long-term dependency. This widely shared diagnosis of the ailments that plague the SSDI system underscores that there is common ground for advocates for the disabled and fiscally minded reformers to improve the program.

Even under the best case scenario, however, policymakers should recognize that reforms to the SSDI program will create winners and losers among the beneficiary population. Since the Congressional reforms of 1984, the SSDI program has come to function—at the margin, not on average—as a de facto social safety net for individuals whose primary barrier to gainful employment

is one of poor skills and job opportunities rather than health limitations per se. Reconfiguring the SSDI program to support the ongoing employment of individuals with *health-related* work limitations would do little to benefit individuals whose employment barriers are primarily non-medical; indeed, it could plausibly create additional hardship for individuals in this category. It is thus worth considering whether reforms to the U.S. disability system should be paired with complementary policies that would better support the many discouraged workers who turn to the SSDI program as an option of last resort.¹⁹

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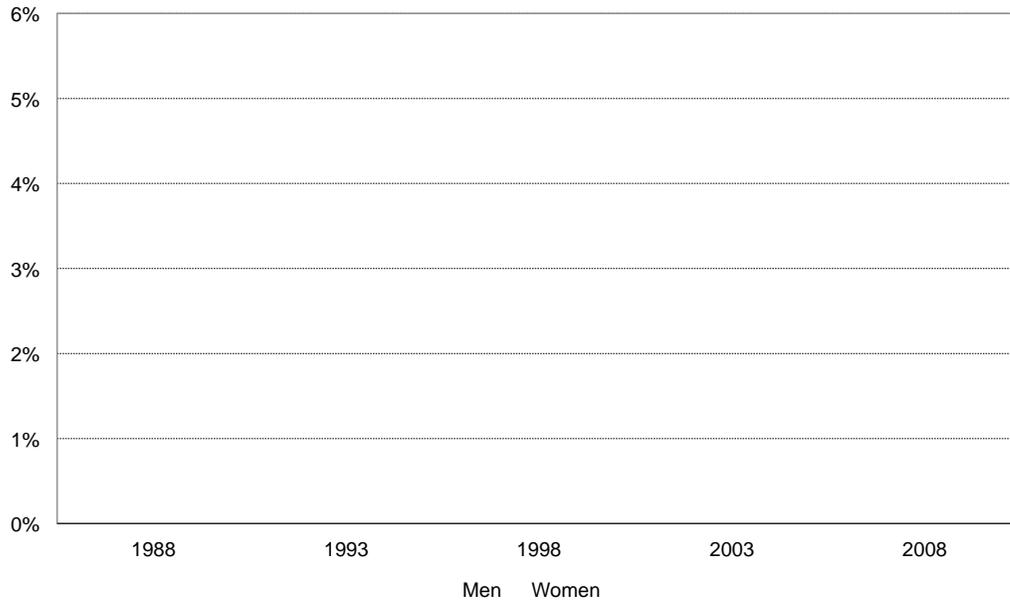
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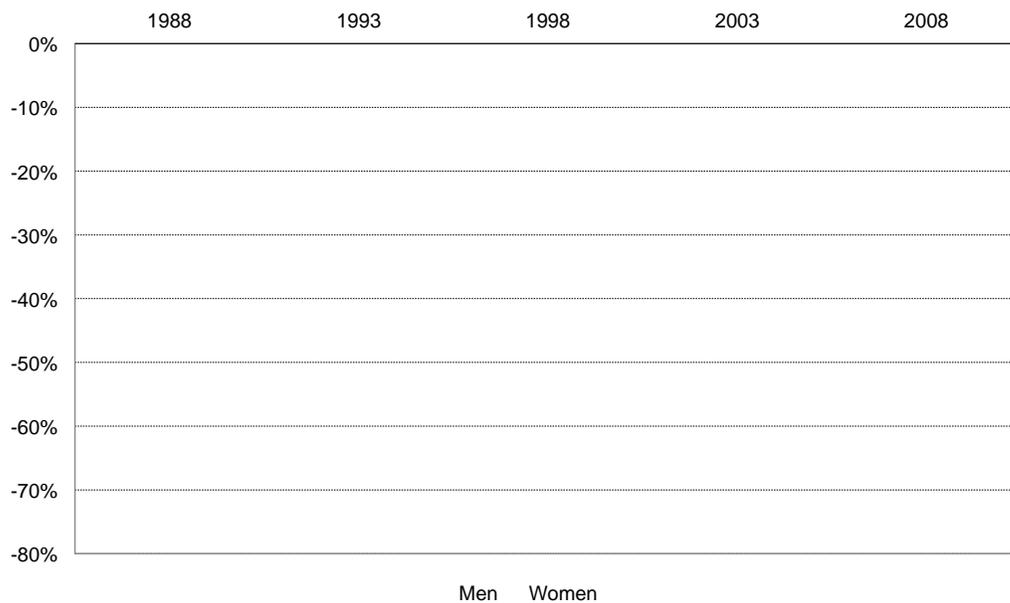


Figure 9: Percentage of SSDI Recipients Leaving Program for not Meeting Medical Criteria, 1964-2009

