



Statement before the United States Senate Committee on Finance

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## SSDI Program Growth Will Continue Unless Fundamental Reforms Are Implemented

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*The views expressed in this testimony are those of the author alone and do not necessarily represent those of Cornell University or the American Enterprise Institute.*

This testimony is primarily based on: Richard V. Burkhauser and Mary C. Daly. 2011. *The Declining Work and Welfare of People with Disabilities: What Went Wrong and a Policy for Change*, AEI Press: Washington DC, and extensions of that work in Burkhauser and Daly (2012), Daly, Lucking, and Schwabish (2013), Daly (2014) and Burkhauser, Daly, McVicar and Wilkins (2014).

Chairman Wyden, Ranking Member Hatch, and esteemed members of the Committee: Thank you for the opportunity to testify before the United States Senate Committee on Finance on workers' disability insurance.

The Social Security Disability Insurance (SSDI) program is growing at an unsustainable pace. Since 1970 the number of disabled worker beneficiaries has increased nearly six-fold, rising from 1.5 to 8.8 million in 2012. This rapid growth in the rolls has put increasing pressure on program finances. Inflation-adjusted SSDI expenditures have risen by more than six-fold from \$20 to \$137 billion (in 2012 dollars) over this same period. Based on current growth, the SSDI program is projected to be insolvent by 2016 (Social Security Administration, 2014).

The rapid rise in caseloads and costs are made more worrisome when put in the context of the broader goals of the SSDI program—to protect the economic well-being of people with disabilities. Since the passage of the Americans with Disabilities Act of 1990 (ADA), the employment of those with disabilities has declined considerably and their household income has remained flat. Increasingly, people with disabilities are substituting SSDI benefits for labor market earnings, making them net withdrawers rather than net contributors to the tax base during their working age. This outcome challenges the finances of the SSDI program and is at odds with the view of disability codified in the ADA that people with disabilities are able and willing to participate in the labor market.

### **WHY HAVE SSDI CASELOADS RISEN?**

Possible explanations for SSDI program growth can be broadly classified into two groups: (1) those that are focused on one-time events not directly related to the program itself—the aging of the population, changes in the underlying severity of disability, the entry of women into the labor force, or the increase in the normal age of retirement from 65 to 66 in the Social Security Old-

Age and Survivor Insurance program (OASI); and (2) those that are focused on changes in program rules or their application—the cyclical nature of application rates, the growth in SSDI benefits relative to wage earnings, and specific changes in rules and their interpretation and implementation over time.

Recent work by Daly, Lucking and Schwabish (2013), updated in Daly (2014), using shift share analysis argues that once these one-time unrelated factors are accounted for, 43.8 percent of the growth in SSDI reciprocity rates between 1980 and 2012 is program related and will continue to affect program growth in the future. Research by Duggan and Imberman (2009) and by Autor and Duggan (2006, 2010) looking at somewhat different periods, find that these program-related changes affected individual behavior and accounted for an even larger share of program growth. More importantly all these researchers predict these program-related factors will continue to do so in the future.

### **Non-Program-Related Growth Factors**

#### *Changes in the age distribution*

The most obvious potential driver of SSDI growth is the aging of the population. Since SSDI benefits are conditioned on having a disability, and disability generally rises with age, the aging of the baby boom generation will, on net, push up the SSDI rolls. A simple way to gauge the impact of this change is to fix SSDI reciprocity rates by age group in some period and let growth in the rolls evolve based on changes in the age structure of the population. Autor and Duggan (2006, 2010) do this and find that between 1984 and 2003, changes in age structure accounted for about 6 percent of the increase in SSDI receipt among the non-elderly population over the period. Daly, Lucking and Schwabish (2013), updated in Daly (2014), find that between 1980

and 2012 the aging of the population accounted for 17.9 percent of SSDI reciprocity growth. (See Figure 1.)

*Changes in health and work disability*

Another potential driver is health. To qualify for SSDI benefits, individuals must have a medically determinable ailment expected to last for at least 12 months or result in death. If the health of the insured population has declined over time this would influence program enrollment and growth. Surveys asking about activity and work limitations point to a relatively stable pattern in these measures over the last two decades. Although work and activity limitations rise with age, there is little evidence that the prevalence within an age-group of such limitations has increased over time. (For additional discussion see: Burkhauser and Daly 2011)

*Entry of women into the workforce.*

Changes in the labor force participation of women also have influenced program growth. Since SSDI is an insurance program, eligibility for benefits requires a fixed number of quarters of covered employment. The substantial increase in the labor force participation of women has increased both their SSDI coverage and their receipt of disability benefits. It is straightforward to compute the magnitude of this change on the total growth in SSDI rolls. Autor and Duggan (2006, 2010) make these computations as do Daly, Lucking and Schwabish (2013). They both conclude that the increased number of women in the paid labor force can only explain a fraction of the total rise in SSDI caseloads since the mid-1980s. For instance, Daly, Lucking and Schwabish (2013), updated in Daly (2012), find that between 1980 and 2012 the increased number of women in the paid labor force can explain 16.5 percent of growth.

However they recognize that in 1980, women's SSDI reciprocity rate was well below that of men, even after accounting for the lower eligibility of women. Analysts don't agree on what

explains this gap. Some argue it reflects underlying health differences between men and women. Others maintain that women eligible for SSDI were not representative of the entire population of women in 1980 and that a more representative sample of women would have had a reciprocity rate similar to men's. They quantify this assumption by setting the reciprocity rate for women equal to that of men in 1980. As Figure 1 shows, this adds another 12.8 percent to their estimates of how much the greater eligibility of women has contributed to rising reciprocity rates. Daly, Lucking and Schwabish (2013), updated by Daly (2014), then add a final non-program-related factor—the increase of the normal retirement age to 66 over this period. Doing so accounts for another 9.1 percent of SSDI growth.

Combining the estimated contributions of population aging, changes in health, the entry of women into paid work, and the change in the OASI retirement age, Daly, Lucking and Schwabish (2013), updated in Daly (2014), still find that 43.8 percent of SSDI caseloads over the last three decades are accounted for by program-related factors. (See Figure 1.) These are factors whose changes have encouraged workers to increasingly apply for, and Social Security gatekeepers to increasingly determine them eligible for, SSDI benefits. And, most importantly, these are factors that will continue to do so and continue to be missed in projections of SSDI program growth that do not account for them.

### **Program-Related Growth Factors**

#### *Changes in SSDI rules and their implementation.*

Caseload fluctuations line up with changes in Social Security Administration (SSA) policies that make it easier or harder to gain entry to the SSDI rolls. In the late 1970s and early 1980s relative caseloads fell, first because program gatekeepers were urged to more strictly interpret existing rules and then because Congress, in 1980, required SSA to reevaluate all current recipients to see

if they still met the medical standards. This rule change, which was rigorously enforced by SSA at the start of the new Reagan administration, resulted in a drop in the SSDI rolls despite a major recession. By 1983 the widespread reevaluation of those already on SSDI was halted as the courts and then Congress restricted the SSA's power to reevaluate beneficiaries. Furthermore, in 1984, responding to a backlash against restrictive cuts imposed in the Social Security Disability Amendments of 1980, policymakers expanded the ways in which a person could medically qualify for the SSDI program. The 1984 legislation moved away from a strict medical listing determination of eligibility to one that also considered an applicant's overall medical condition and ability to work. These changes meant that applicants could qualify for SSDI based on having multiple conditions, even when no single condition would meet the SSDI eligibility threshold. In addition, the legislation allowed for symptoms of mental illness and pain to be counted when assessing SSDI eligibility, regardless of whether the person had a verifiable medical diagnosis.

The expansion of eligibility to more difficult-to-measure impairments that do not precisely meet the medical listings means that SSA has increasingly been tasked with making more subjective decisions about the impact that presenting impairments might have on an applicant's work ability. For applicants who do not meet or exceed the medical listings, program administrators consider a set of vocational criteria. While these criteria have not changed over the history of the SSDI program, their use by program gatekeepers to determine benefit eligibility has risen dramatically since 1991. Currently, they are used to justify the majority of new awards, especially among those with the more difficult-to-determine conditions of mental illness and musculoskeletal conditions—the primary condition of more than 50 percent of all newly enrolled beneficiaries. (See Burkhauser and Daly, 2011 for fuller discussion.)

*Effects on behavior and implications for work capacity*

The effect of this growing share of marginal applicants is a substantial variation in the flow of applicants onto the rolls. This variation comes both from fluctuations in applicant inflow and variations in decision making among SSDI gatekeepers. For example, Maestas, Mullen, and Strand (2013) using SSA administrative records find that at the initial Disability Determination Stage (DDS) of decision making, 23 percent of new applicants in 2005 were marginal cases whose admittance into the program was determined by the luck of drawing an easier rather than a stricter DDS gatekeeper. Importantly, when they compare the subsequent work histories of those who entered the program in this way with a matched set of applicants who drew a stricter DDS gatekeeper, they find the latter group's employment was on average 20 percentage points higher. This difference is even greater for those with less severe medical conditions. This research suggests that, increasingly, applicants admitted to the SSDI rolls on these looser criteria have greater work capacity than assumed for those receiving SSDI benefits.

The differences in allowances are important, especially when one considers how application rates fluctuate with economic conditions. Plots of the SSDI application rate and the national unemployment rate show that, with the exception of the double-dip recession in the 1980s, application rates are highly correlated with the business cycle. They rise during recessions and fall during periods of economic growth. Disability application rates hit record highs during the Great Recession and have only modestly declined since then. Most research on the consequence of business cycles on application rates finds that economic conditions play a substantial role in SSDI application and award patterns over time. (See Burkhauser and Daly 2012)

In sum, a large share of SSDI growth (43.8 percent based on Daly, Lucking and Schwabish, 2013, updated in Daly, 2014) has been driven by factors other than an aging workforce, health declines, the increasing SSDI coverage of women, and changes in the OASI normal retirement

age. Loosening of program rules in the 1980s has made it more difficult for gatekeepers to judge eligibility and increased the likelihood that applicants facing rising replacement rates or declining economic opportunities will apply for SSDI benefits. A growing number of individuals being allowed onto the rolls could work in some capacity and would do so if they were not judged eligible for benefits.

One clear indicator these program-related factors have an independent effect on program growth can be seen in Figure 2. While it is certainly the case that aging baby boomers have increased program growth as they have become a larger share of the work force, Figure 2 shows that the growth in the prevalence of SSDI program receipt compared to 1970 has been far higher at younger than at older ages. The most rapid growth has been among those ages 25 through 39. Because these recipients are likely to stay on the rolls many more years than those who enter at older ages, their lifetime impact on program costs will be far higher.

Not factoring in the important role policy changes have had and will continue to have on program growth can importantly affect SSDI program growth projection. Figure 3 is based on official Office of the Chief Actuary (OCACT), Social Security Administration, historical and projected SSDI beneficiary populations (Social Security Administration, 2014). Beneficiary numbers were obtained from <http://www.socialsecurity.gov/OACT/STATS/DIbenies.html> and projections from <http://www.socialsecurity.gov/OACT/TR/2013/tr2013.pdf>, accessed 7/22/2014.

The data from 1977 to 2013 nicely documents the rapid growth in the SSDI rolls discussed above. There is no disagreement among scholars with respect to these numbers. The data from 2015 to 2035 are based on OCACT projections of future growth. They are remarkably optimistic projections that suggest that the one-time events that have propelled SSDI growth since the early 1980s have, for the most part, run their course. There is very modest growth between 2013 and

2025 and little or no growth over the following 10 years. Hence, a one-time increase, for instance, in the SSDI payroll tax will solve both the short- and longer-term SSDI solvency problem.

Figure 4 comes from Daly, Lucking and Schwabish (2013), updated in Daly (2014), and based on Social Security Administration, 2013, OCACT projections. It shows actual SSDI prevalence rates between 1980 and 2012 and OCACT projections of future prevalence rates at various times in the past as well as their 2012 projection. In almost all cases, these projections have substantially underestimated future SSDI program growth. The reason is that OCACT has not fully taken into consideration the influence of program effects on past behavior that accounts for the 42.8 percent of program growth discussed above. This is program growth that will continue into the future unless fundamental changes are made in SSDI policy. My guess is that absent this policy change, OCACT's current projections will once again underestimate actual SSDI program growth.

Figure 5 from Daly, Lucking and Schwabish (2013), updated in Daly (2014), provides an alternative projection of program growth that shows how much more program growth will be if the 42.8 percent of that growth estimated by Daly, Lucking and Schwabish (2013) and updated in Daly (2014) continues into the future at the same average rate it has occurred since 1980. To the degree that this unexplained growth in the OCACT projections once again occurs, any one-time increase in Social Security taxes to solve the SSDI deficit problem through 2035 will only be a down payment on future tax increases.

## **THE CASE FOR FUNDAMENTAL CHANGE**

Evidence that growth in U.S. disability rolls has to a large extent been driven by policy and associated behavioral responses among gatekeepers and workers with disabilities are consistent

with those found for the Netherlands during a period when it was known as the “sick country of Europe.” (Aarts, Burkhauser and de Jong, 1998). Following many failed attempts to modify the system from within, in 2001, the Netherlands decided to fundamentally restructure the system. As can be seen in Figure 6, the results have been notable; the share of the Dutch work force receiving disability benefits has declined significantly and has done so without raising the rolls in other transfer programs at the same time that the share of the U.S. work force receiving disability benefits has grown. (See Figure 6 based on Figure 5.1 in Burkhauser and Daly, 2011).

Burkhauser, Daly, McVicar, and Wilkins (2014) extend this analysis to Great Britain, Sweden, and Australia and show a similar pattern of disability prevalence rates that are highly sensitive to disability policy changes. After major increases in their disability prevalence rates, Sweden and Great Britain also introduced fundamental reforms into their systems that have reduced their disability prevalence rate over the last decade.

The Dutch reforms focused on reducing inflows onto long-term disability benefits by making employers more directly bear program costs. The reforms required all Dutch firms to fund the first two years of disability benefits to their workers and to pay an experience-rated disability tax based on the number of workers they subsequently moved onto the long-term Dutch disability insurance program. These reforms provided incentives for employers, who are in the best position to offer accommodation and rehabilitation, to do so in lieu of moving workers with disabilities onto cash transfers. Research shows that the reforms led to the development of a private sector market for disability insurance and the management of impaired workers, which is credited, in part, with a significant decline in inflows to disability cash benefits. Importantly, the research shows that the reduction in inflows owes to the fact that workers with disabilities are more regularly returning to work (de Jong, 2008; van Sonsbeek, 2010).

In the spirit of the Dutch reforms, recent proposals by Autor and Duggan (2010) and Burkhauser and Daly (2011) call for prioritizing supported work over cash benefits for people with disabilities. Like the Dutch, both proposals focus on slowing the movement of workers with impairments onto the SSDI rolls, rather than attempting to reduce the current beneficiary population via the stick of greater enforcement (tried in the 1980s) or the carrot of changing the incentives for current beneficiaries to return to work (impetus for Ticket to Work). Such fundamental reforms would end the archaic and counterintuitive policy currently in place that provides access to work-focused support only after SSDI applicants have gone through an extended process of demonstrating that they are unable to work.

Autor and Duggan (2010) propose a new mandate on all firms to provide the first two years of “short-term” disability insurance. This would increase the willingness of employers to provide additional accommodation and rehabilitation by more directly linking the cost of disability payment to firms. It would also create growth in the private insurance market and greater case management of workers following the onset of a work-limiting impairment and hence greater return to work. However, it could result in substantial added costs to the system.

Alternatively, Mary Daly and I (Burkhauser and Daly 2011) argue that like the Dutch, the United States should impose some form of experience rating on firms paying into the SSDI system. Raising the SSDI payroll tax of firms whose workers enroll in the system at above-average rates and lowering the SSDI payroll taxes on firms whose workers enroll at below-average rates via experience rating would more directly link the costs to the firm of one of its workers moving onto the SSDI program. Employers who bore the costs for both options would be more incentivized to make the investments in accommodation and rehabilitation that could prolong the employment tenure of a worker with a disability. This is currently the system used to

fund state workers' compensation benefits, and the best practices from these state programs could be considered for SSDI as well. Alternatively, employers who provide short-term private disability insurance for employees and whose private insurance agents cooperate with SSDI gatekeepers in managing their cases could be granted a reduction in SSDI tax rates, while firms that did not offer such private insurance could be charged higher SSDI tax rates. Either of these reforms would bend the cost curve of projected SSDI program expenditures by reducing incentives for employers and employees to overuse the system.

Although the details differ, the messages of the Autor and Duggan and Burkhauser and Daly proposals are the same: The current SSDI program built on the assumption that disability and employment are mutually exclusive states is both archaic and fiscally unsustainable. Fundamental reform is needed to restore solvency to the U.S. disability insurance system and to support continued employment and greater self-sufficiency among workers with disabilities.

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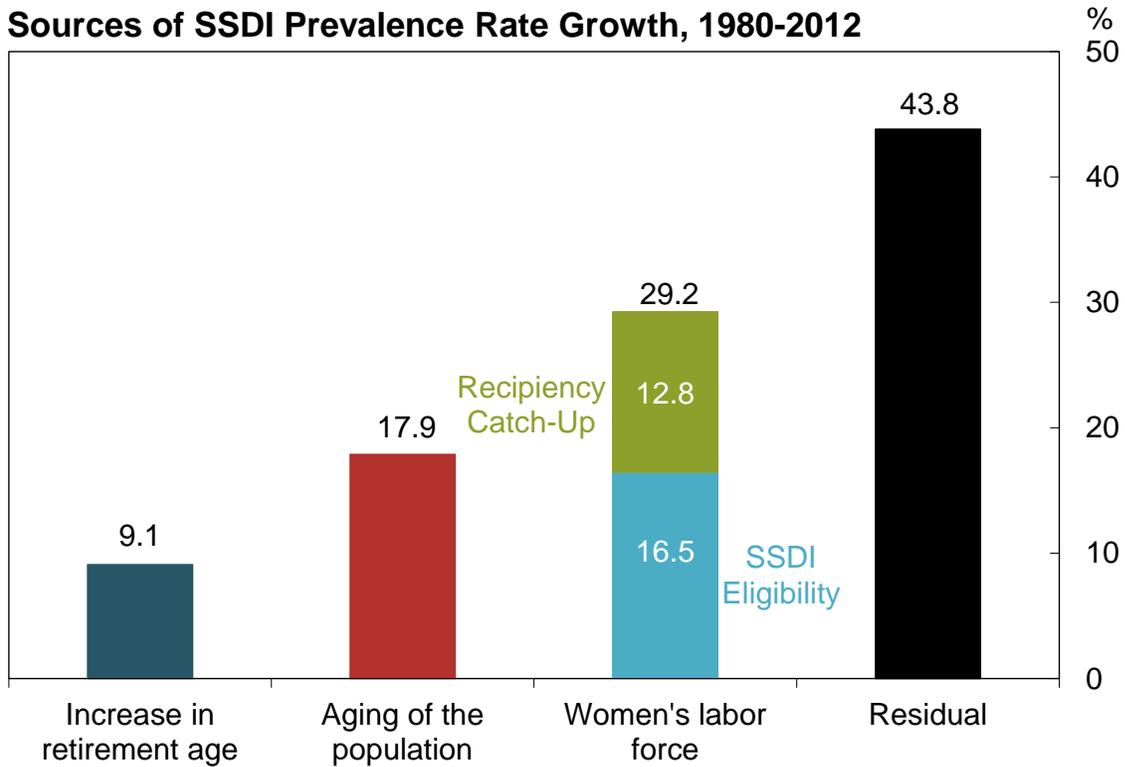
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### Sources of SSDI Prevalence Rate Growth, 1980-2012

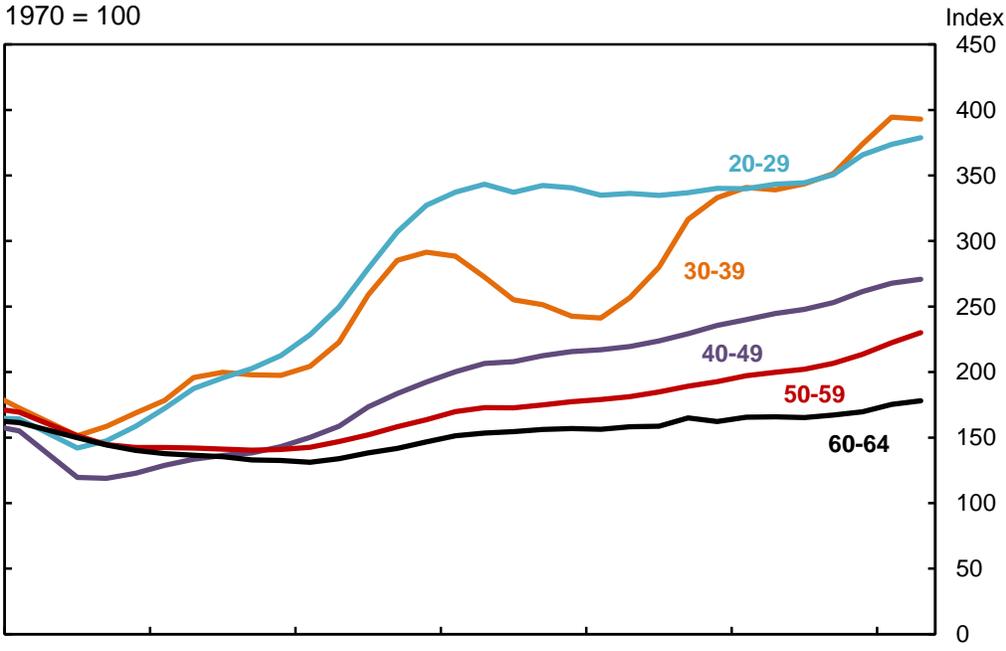


Source: Social Security Administration, Bureau of Labor Statistics, and FRBSF Staff Calculations. <http://www.frbsf.org/economic-research/publications/economic-letter/2013/june/future-social-security-disability-insurance-ssdi/>

**Figure 1. (Source: Daly 2014)**

### Normalized Growth in SSDI Prevalence by Age

1970 = 100

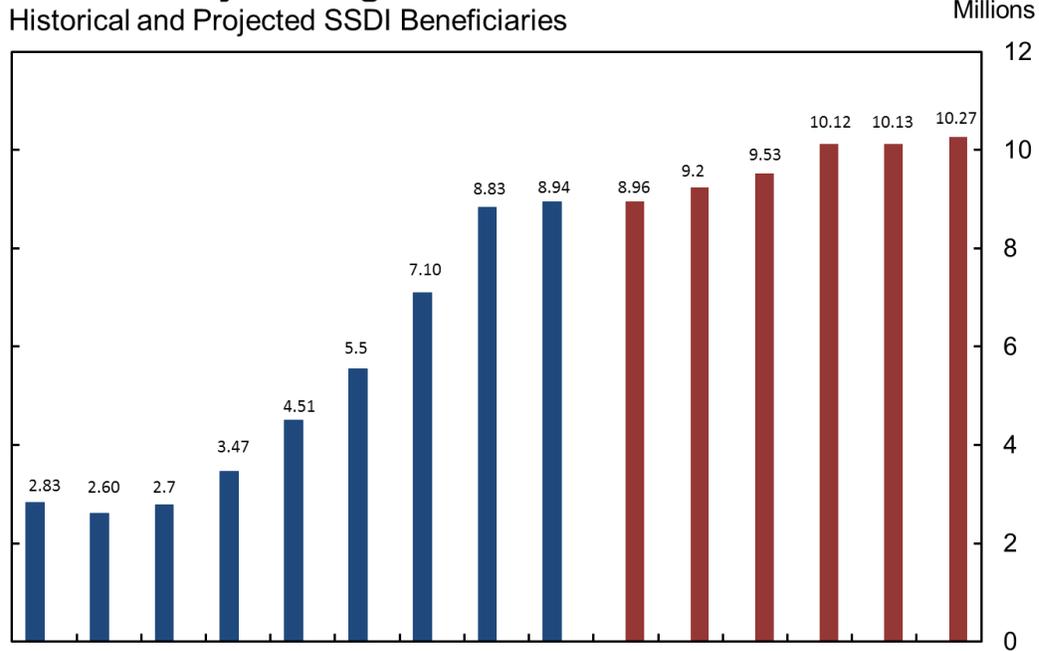


Source: Social Security Administration and FRBSF Staff Calculations. Note: prevalence calculation uses insured population.

Figure 2. (Source: Daly 2014)

### OACT Projects Significant Slowdown

Historical and Projected SSDI Beneficiaries

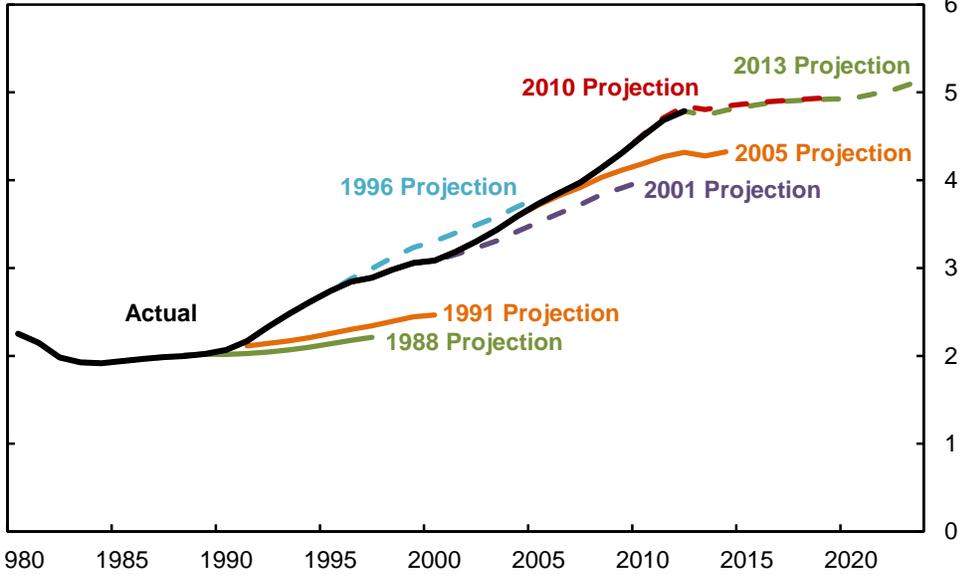


Source: Social Security Administration

Figure 3. (Source: SSA 2014)

### Past SSA Projections of SSDI Prevalence Rate

Beneficiaries per 100 age 20-64 insured population

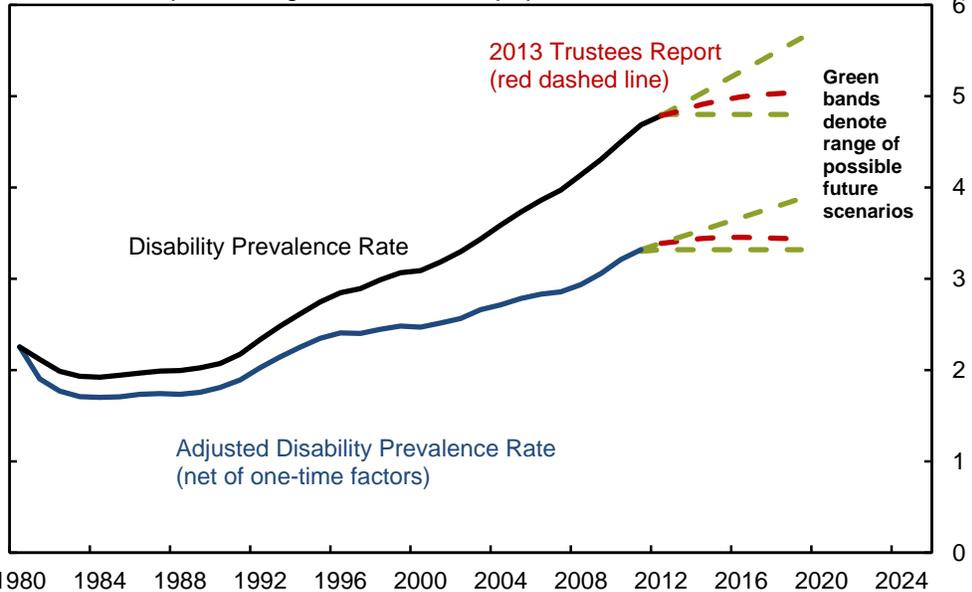


Source: Short and Long range Actuarial Projections of the Old-Age, Survivors, and Disability Insurance Program, (various years), Bureau of Labor Statistics, Census Bureau, and FRBSF Staff Calculations. <http://www.frbsf.org/economic-research/publications/economic-letter/2013/june/future-social-security-disability-insurance-ssdi/>

Figure 4. (Source: Daly 2014)

### Scenarios of Future SSDI Growth

Beneficiaries per 100 age 20-64 insured population



Source: Short Range Actuarial Projections of the Old-Age, Survivors, and Disability Insurance Program (2013), Census Bureau, and FRBSF Staff Calculations. <http://www.frbsf.org/economic-research/publications/economic-letter/2013/june/future-social-security-disability-insurance-ssdi/>

Figure 5. (Source: Daly 2014)

### Comparison of U.S. and Dutch disability beneficiaries per 1,000 workers

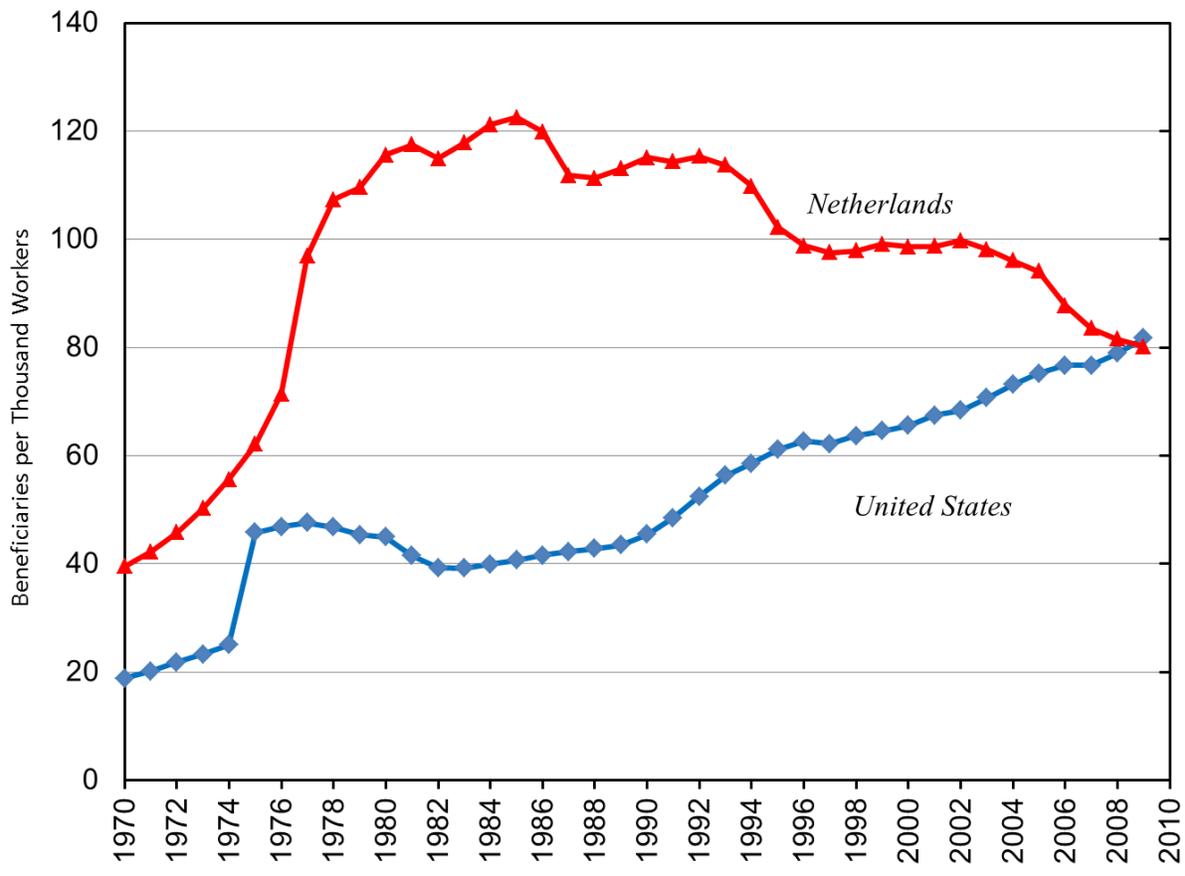


Figure 6. (Source: Burkhauser and Daly 2011)