

Discussion of Early Intervention Proposals

Lisa D. Ekman

This discussion is a summary of the comments made by the discussant at the SSDI Solutions Conference on August 4, 2015 before chapters were made final.

Workers with chronic conditions that affect functional capacity to work and who have significant disabilities can often stay at work or return to work when they receive affordable medical care and access to the services and supports they need to live independently and work. Unfortunately, many workers currently lack timely access to affordable medical care and work-based services and supports. For some workers with disabilities, this lack of access can hasten both their departure from work and application for Social Security Disability Insurance (SSDI). In addition, the programs and systems we have in the United States designed to support workers with disabilities are underfunded, have waiting lists, or impose eligibility rules that often exclude the workers who need them (based on resources, income, or severity of disability).¹ The papers in this section advance proposals to provide better access to services and supports to workers with disabilities and chronic conditions that create functional impairments.

What is clear to me from all three papers in this section is that there is neither completed research nor an evidence base upon which to enact nationwide early intervention or work support programs. Additional study and evaluation will be needed to generate this evidence; certainly before making changes to the SSDI program. Where examples of early invention do exist, it is also not clear how applicable they are to those who would otherwise receive SSDI benefits. For example, “The Employment/Eligibility Service System: A New Gateway for Employment Supports and Social Security Disability Benefits” by Stapleton, Ben-Shalom, and Mann points to private disability insurance’s stay-at-work efforts which, for a number of reasons (including differences in educational attainment, skill levels, types of work performed) between individuals covered by private insurance and workers who generally end up on SSDI, do not appear likely to me to be translatable to SSDI. Given the lack of an evidence base, most disability advocates support piloting new ideas to gather evidence rather than making substantial changes based on a presupposition that pilots will prove effective.

As another note of caution, several of the papers in this section point to the experiences of other countries without fully recognizing many important differences that limit the transferability of policy choices. For example, the Netherlands, which is referred to in “The Employment/Eligibility Service

¹ For information on Medicaid waiting lists, see Terence Eng et al., Medicaid Home and Community-Based Services Programs: 2011 Data Update, Kaiser Family Foundation, table 14, December 22, 2014, available at <http://kff.org/report-section/medicaid-home-and-community-based-services-programs-2011-data-update-eligibility-and-cost-containment-policies-used-in-medicaid-hcbs-programs> For information on State Vocational Rehabilitation services, see University of New Hampshire Institute on Disability, Annual Disability Statistics Compendium, Table 12.7: Vocational Rehabilitation—State Agencies on Order of Selection: 2008 through 2012, December 2014, available at <http://disabilitycompendium.org/compendium-statistics/vocational-rehabilitation/12-7-vocational-rehabilitation-state-agencies-on-order-of-selection>.

System,” has universal health coverage and very different relationships between employers and employees.²

Finally, I believe it is important that as the proposals for early intervention and work support contained in this section are piloted, no Social Security Trust Fund dollars should be used for any purpose other than administering and paying benefits to people already determined eligible for benefits by the Social Security Administration. While providing work supports and medical care to workers is extremely important, the link between these services and avoided entry into the program is unproven and too indirect, in my view, to justify using Trust Fund dollars for pilots for non-beneficiaries.

Beyond these general principles, I have a number of questions and concerns regarding “The Employment/Eligibility Service System: A New Gateway for Employment Supports and Social Security Disability Benefits.” To begin with, the paper essentially proposes a new definition of disability and an additional process before workers with disabilities would be able to access benefits. Despite advances in civil rights, technology, and medical care for individuals with disabilities, there is a strong case that the current definition and process remains appropriate for the purpose of replacing wages for individuals with significant impairments that prevent substantial work. I, along with most disability advocates, believe that creating additional hurdles to entry is unfair and unwarranted given SSDI benefits are paid for and earned by workers through payroll tax contributions.

The cost and savings estimates in this paper also appear extremely optimistic. Given severe underfunding of current disability employment support programs, establishing EES services in each state would likely require a significant increase in administrative spending, not to mention income support payments. As a result, it is quite possible that this new system would greatly increase spending in both the short and long run – particularly if the availability of the EES and new work support services led to significant increases in SSDI applications.³

The authors also fail to present any convincing evidence that return to work – and therefore SSDI savings – is possible at the magnitude they suggest. Past demonstrations and pilots, although they have improved quality of life, have not resulted in significant numbers of individuals leaving the SSDI rolls and going to work.⁴ The authors’ assertion that a 15-percent reduction in SSDI applicants of all ages is plausible vastly exceeds past results, especially when it comes to the above-40 population which is highly unlikely to return to work. Assuming instead that 15 percent of applicants under 40 went back to work (which is still probably too high by a large margin based on past research findings) and there

² See Elaine Fultz, *Disability Insurance in the Netherlands: A Blueprint for U.S. Reform?*, September 16, 2015, Center on Budget and Policy Priorities available at <http://www.cbpp.org/research/retirement-security/disability-insurance-in-the-netherlands-a-blueprint-for-us-reform> for a fuller discussion of the differences.

³ For example, individuals with significant disabilities who are working but underemployed and earning less than substantial gainful activity, or individuals on waiting lists for VR or Medicaid waiver services who have not applied for SSDI might apply for work support through the EES.

⁴ See for example, the Mental Health Treatment Study, https://socialsecurity.gov/disabilityresearch/documents/MHTS_Final_Report_508.pdf, and the Youth Transition Demonstration, <http://www.ssa.gov/disabilityresearch/documents/YTD%20Final%20Report%20508%20Compliant%2012-29-2014.pdf>. While both showed increases in work of participants, neither resulted in significant numbers of participants performing self-supporting work, and both cost more per beneficiary. See also the Ticket to Work program evaluation, <http://www.ssa.gov/policy/docs/ssb/v71n3/v71n3p105.pdf>

DISCUSSION OF EARLY INTERVENTION PROPOSALS

was no significant change for older beneficiaries, the proposal would result in only about 2.2 percent of new awardees not receiving benefits.⁵

“A Community-Focused Health & Work Service (HWS)” by Christian, Wickizer, and Burton proposes to create a national health and work service (HWS) that would provide telephonic counseling, communication assistance, referrals to services, and coordination of services for people within 12 weeks of the onset of a newly diagnosed condition that could lead to impairments that prevent work. Providing access to assistance directly after a health incident is a promising idea. However, rather than piloting it to figure out how to best implement it national-wide, further testing and piloting would likely be needed first to determine *if* it should be expanded nationwide.

The authors’ examples of other programs, though encouraging, reflect situations that are quite dissimilar to those of most workers who end up receiving SSDI benefits. With regards to the authors’ first example of Washington State’s Workers’ Compensation program, it is important to note that a distinct event or incident signifies the beginning of the development of an individual’s disability. In SSDI, on the other hand, conditions often develop over time without any particular trigger incident. In this case as well as the authors’ second example—a similar program in the United Kingdom—a third party is responsible for the costs of health care, vocational rehabilitation, and other services (universal health care in the United Kingdom and employer responsibility in the case of Workers’ Compensation). Meanwhile, many workers in the United States still lack health insurance (one in seven in 2014)⁶ and might not have access to or the ability to pay for any additional services or rehabilitation needed to remain on the job. This proposal does not provide the additional access that would be necessary, and as such there may be little change in the number of people applying for or receiving SSDI as a result.

“Using Transitional Jobs to Increase Employment of SSDI Applicants and Beneficiaries” by Kerksick, Riemer, and Williams proposes to provide access to subsidized jobs and an earnings supplement to individuals with medical conditions that affect their ability to work. The idea of providing access to transitional jobs with an enhanced earned income tax credit (EITC) is a promising one worth testing – though policymakers should be wary of using trust fund dollars for reasons described above. In addition to the enhanced EITC, perhaps the project could test other tax improvements such as converting the deductions for impairment-related work expenses into a refundable credit and making it refundable. If the pilot proves successful after a number of years of testing, this proposal could be expanded and transitional jobs made available more broadly.

⁵ In 2013, 14.9 percent of men awarded benefits and 15.7 percent of women were under age 40. If approximately 15 percent of new awardees are under 40 based on 2013 awards (and that might be high because only 10.5 percent of male beneficiaries and 10 percent of female beneficiaries in 2013 were under 40) and they are the most likely to go to work, a much lower percentage of people would successfully achieve self-supporting employment. For example, there were 868,965 disabled workers awarded benefits in 2013. If 15 percent of them would become employed by receiving EES work supports, 130,344 would be working instead of receiving benefits. However, if only applicants under 40 were counted, there were 131,931 in 2013. If 15 percent of them went back to work, EES work supports would only have assisted 19,790 workers or 2.2 percent of awardees to work instead of receiving SSDI benefits. All data is from the Social Security Administration, Annual Statistical Supplement to the Social Security Bulletin 2014, available at <https://www.socialsecurity.gov/policy/docs/statcomps/supplement/>

⁶ See United States Department of Health and Human Services, Centers for Disease Control and Prevention, Center for Health Statistics, “Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2014” June 2015, available at <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201506.pdf>