As this issue goes to print, Republicans and Democrats are maneuvering for the high political ground on deficit reduction. And though there is little prospect of a grand bargain before the election, it’s hardly too early to think seriously about a major makeover of the federal budget.

In the pages that follow…

- David Autor and Mark Duggan explain how the $200 billion-plus Social Security Disability Insurance program could be reworked to save a lot of money – and still yield better outcomes for claimants.
- Linda Blumberg and John Holahan tackle the question of how to contain the costs of Medicare and Medicaid (not to mention private health insurance) without reducing the quality of care.
- Michael O’Hanlon explores ways to cut defense spending by $60 billion annually, at minimal risk to American security.
- Eric Schansberg argues that the most effective way to cut outlays for health care, private as well as public, is to reverse the trend toward ever greater government involvement.
A CURE
Social Security
FOR WHAT
Disability Insurance
AILS IT

With deficits front and center in Washington, most of the attention of would-be budget cutters has focused on the three giant entitlement programs: Medicare, Medicaid and Social Security retirement pensions. One other major program, though, has virtually escaped notice: Social Security Disability Insurance, which currently pays monthly benefits to 8.3 million disabled workers and 2 million dependents of disabled workers.

Federal spending on SSDI recipients in 2010 totaled $203 billion: $128 billion in cash and $75 billion in Medicare benefits (to which SSDI recipients are entitled). These outlays, almost $2,000 per household, represented 7.3 percent of federal non-defense spending last year – a sum exceeding interest payments on the federal debt. What’s more, the program is ballooning. In the past two decades, spending has grown at 5.6 percent annually in real terms, compared with just 2.2 percent for all other Social Security spending.

SSDI expenditures were not always a large portion of the budget. As recently as 1988, they accounted for only one of every 10 dollars of Social Security
outlays. However, from acorns do mighty oaks sometimes grow. By 2009, SSDI amounted to one-fifth of all Social Security spending. Perhaps most ominous, SSDI expenditures now exceed the payroll tax revenue dedicated to funding the program by more than 30 percent. Indeed, analysts project that the SSDI trust fund will be exhausted in 2018, some 22 years ahead of the trust fund for Social Security retirement benefits.

So why is SSDI absent from current discussions of the fiscal mess? Understandably, there is no political constituency for resolving America’s budget problems by squeezing disabled workers. But we think that reform should be part of the fiscal discussion – and not because the program rates a reduced priority in the federal budget. Rather, benign neglect of SSDI represents a missed opportunity. For in spite of its high price tag, the program does a poor job of supporting adults with work-limiting disabilities in ways that enable them to maintain employment and economic self-sufficiency. Indeed, despite its good intentions, the SSDI program needlessly fosters long-term dependency by doing little to assist the disabled to remain self-sufficient.

The silver lining: because the SSDI program is so badly out of step with our contemporary understanding of disability, there are straightforward reforms that would make both SSDI beneficiaries and taxpayers better off. Adding to the case for optimism is the fact that many within the disability advocacy community share our conclusions. Thus, there is common ground for fiscal watchdogs and disability advocates to agree on changes.

SSDI AS CAREER ENDER
A wealthy, compassionate nation should provide disability insurance that protects workers and their families from poverty and loss of medical care in the event of work-limiting disability. In the United States, SSDI has played this role since its inception in 1956, 21 years after the Social Security retirement program was created.

Yet, while SSDI is effective in providing income replacement and medical care to individuals with career-ending disabilities, it is ineffective in assisting the vast majority of workers with less severe disabilities to earn their own way. In fact, the program provides strong incentives for applicants and beneficiaries to remain out of the labor force permanently, and it creates no incentive for employers to create cost-effective accommodations that would allow disabled employees to remain on the job. Consequently, large numbers of work-capable individuals involuntarily exit the labor force and ultimately receive SSDI. How did this come to pass?

Opening and Closing the Floodgates
When Congress created SSDI, 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, providing income support and medical benefits exclusively to workers who are out of the labor force and – according to SSA’s criteria – not expected to return.

This definition of disability may have been suitable five decades ago, when a substantial fraction of jobs involved strenuous physical

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activity, technologies to assist the disabled were limited, and medical interventions rarely prolonged life significantly or improved its quality. But today, most individuals with work-limiting disabilities can participate in the labor force if given appropriate support. The Americans with Disabilities Act of 1990 (ADA) is built around this conviction, 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.”

For the first two decades after the program’s inception, SSDI outlays grew steadily. Concerned that the growth was 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 halted the reviews and in 1984 liberalized the program's screening criteria along several dimensions. Most important, the legislators directed the Social Security Administration to give additional weight to pain and related 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 on the ability to function in a work setting. A key consequence: applicants with difficult-to-verify disorders like muscle pain and mental disorders could more easily qualify for benefits.

The impact on program enrollment was not immediately evident since the economy strongly rebounded from deep recession in the years after the legal changes. But when economic conditions deteriorated in the early 1990s, the program resumed its rapid growth. From 1989 to 2009, the share of adults receiving SSDI benefits doubled, from 2.3 to 4.6 percent of Americans ages 25 to 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 drastic change in the characteristics of SSDI recipients, with a steadily increasing share of awards made to individuals with musculoskeletal conditions and mental disorders – as opposed to cardiovascular disease and cancer, the two most common diagnoses before the 1984 liberalization.
Rather than assisting applicants to stay employed, the rules bar them from working while seeking benefits at pain of an automatic denial.

The expansion of SSDI would not be inherently problematic if it reflected a rising rate of disability, and the program's mounting expenditures helped these individuals to maintain employment and self-sufficiency. But that's not the case.

The portion of middle-aged adults reporting a work-limiting disability has been stable over the past two decades, averaging about one in ten. What has changed greatly, however, is the portion of people who receive disability benefits. From 1988 to 2008, the percentage of men aged 40 to 59 receiving SSDI benefits rose by 45 percent, while the percentage of women in the same age group rose by a whopping 159 percent (in part because a growing fraction of women now have sufficient work histories to qualify for SSDI). This steep increase coincided with a substantial decline in the employment rates of the disabled. In particular, the gap in the employment rate between Americans with disabilities, age 40-59, and their counterparts without disabilities widened by 10 percentage points between 1988 and 2008. SSDI is growing in size and cost because it is supporting rising dependency and declining labor force participation among adults with disabilities.

Who's Disabled?
At present, a disabled worker seeking income and medical benefits from SSDI is subject to a screening process with a variety of undesirable features. First, the process moves slowly. SSDI determination typically takes a full year, involving multiple stages of application, rejection and appeal. In fact, almost 40 percent of awards are now made on appeal. Note, too, there is a large element of chance in the outcome: the likelihood of receiving an award on appeal varies widely according to which administrative law judge decides the case, with some rejecting more than half of the appeals and others accepting nearly all. If a claim is ultimately denied, the claimant faces the daunting prospect of returning to the labor market after months or even years of absence.

While the SSDI application is under way, the applicant receives no assistance from the program. This is especially unfortunate because the first months after the onset of a disability are usually the period in which expert assistance could be most useful in enabling people to adapt while maintaining employment. Rather than assisting applicants to stay employed, though, the rules bar them from working while seeking benefits, at pain of automatic denial.

That points to the second dysfunctional feature of the process: those coping with a work-limiting disability must choose between striving to remain in the labor force while receiving no support from SSDI and forgoing efforts at maintaining self-sufficiency to be eligible for SSDI consideration.

It is difficult to overstate the role of SSDI in discouraging employment. During the past three years, the Social Security Administration received more than eight million applications to the SSDI program—more than 5 percent of the U.S. labor force! And recent research suggests that the application rate will rise in the years ahead: the shrinking value of Social Security retiree benefits (linked to the
**RISING AGE OF ELIGIBILITY FOR FULL BENEFITS**

The Milken Institute Review

rising age of eligibility for full benefits) is making SSDI benefits relatively more attractive.

**FIXING SSDI**

As discussed above, Washington attempted to slow or reverse the growth of the SSDI program over the past half-century by 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 work. None has had a lasting impact on the program’s growth trajectory, nor has any slowed the steady decline in the labor force participation of the disabled. We believe that these efforts have largely proved fruitless because they make one or more fundamental mistakes:

- Limiting SSDI awards by denying applicants rather than by reducing applications.
- Revoking benefits of individuals who have no other means of financial support.
- Reducing penalties for gainful employment only when it’s too late to matter.

An entirely different approach is needed. The goal should be to increase the odds that individuals with work-limiting disabilities will remain in the labor force. This could reduce the waste stemming from both too little spent on assisting individuals with disabilities to remain employed and too much on supporting unnecessary long-term dependency. To this end, we would add a “front end” to the SSDI system with three key provisions:

- Offer workplace accommodations, rehabilitation services and partial income support to workers who suffer work limitations.
- Provide financial incentives to employers to accommodate workers who have become disabled.
- Create financial incentives for disabled individuals to remain employed.

The idea isn’t to replace SSDI, but to reduce the demand for long-term support by offering flexible and responsive assistance upfront. (In that spirit, the changes wouldn’t affect the eligibility of current beneficiaries.)

There’s precedent here – along with some solid evidence that the approach would pay dividends – in the workers’ compensation and unemployment insurance systems. These two programs support workers in the event of injury and job loss, respectively, while screening workers to discourage overuse of benefits. They also discourage employers from passing the costs of workplace injury onto the system by charging higher rates to employers with a history of high claims costs – a practice known as experience rating.

**Private Insurance at the Front End**

Grafting this front-end capacity onto the large and overtaxed SSDI system would appear a daunting task. So rather than creating it from scratch, it would make sense to harness an existing private-sector institution that currently provides large-scale employment support and work incentives to both workers with disabilities and their employers. We have in mind private disability insurance, which already delivers long-term disability coverage to approximately one-third of U.S. workers.

We propose modifying PDI to support workers from 90 days to 27 months after the onset of disability, with the goal of providing partial income replacement and support geared toward helping individuals maximize work readiness and self-sufficiency. After receiving PDI benefits for 24 months, individuals still unable to work would transfer to the regular SSDI system. The screening criteria for SSDI wouldn’t change.

PDI coverage would be provided to a vast majority of workers, much the same way unemployment insurance and workers’ com-
pensation are now part of the employment package. In contrast to traditional SSDI – but similar to the PDI plans that numerous employers purchase – it would treat disability and gainful employment as potentially compatible conditions rather than mutually exclusive states.

It is instructive to consider the average amount now paid for private long-term disability coverage in the market. We estimate that the average policy costs approximately $250 per year. This is probably more than our proposed coverage would cost, as current PDI policies are typically much more generous than the one we propose. For example, the typical maximum monthly benefit with private insurance is $7,500, three times more than the maximum in our plan. Additionally, our proposed coverage would pay benefits for no more than two years, while private policies may provide at least partial benefits to workers until they reach full retirement age.

The Nuts and Bolts
Any health limitation that prevents workers from carrying out normal job functions would trigger benefits under the policy, which would commence within 90 days of disability onset. Benefits would include vocational rehab, workplace accommodations, replacement of
60 percent of wages (capped at $2,500 a month) along with wage replacement at each state’s unemployment insurance rate for those who develop work-limiting disabilities while unemployed. (PDI would not pay medical costs of disability; that would be left to the Affordable Care Act of 2010.)

Benefits under the PDI plan would be limited to 24 months, no more 27 months after onset of the disability. Workers whose conditions continued to prevent employment into the 22nd month would be permitted to apply for SSDI. This would allow for a six-month transition in which PDI benefits are paid while the worker awaits an SSDI determination. Those with severe medical conditions covered by the Social Security Administration’s List of Compassionate Allowance Conditions could apply immediately for SSDI at the onset of the disability.

Based on the current 4-cent-per-hour average cost of PDI plans, we estimate that the policy would cost approximately $20 per worker per month. This is less than 5 percent of the cost of a typical employer-provided individual health insurance plan. There would be no added cost, of course, for the 32 percent of employers already covered by workplace PDI. And in any event, one goal of the PDI add-on is to reduce the cost of traditional long-term SSDI coverage by more than the extra cost of the short-term private disability insurance.

Employers would be required to acquire PDI coverage from private insurers (unless they chose to self-insure) but would be allowed to deduct up to 40 percent of the cost from worker pay. Premiums would be experience-rated for firms with 50 full-time-equivalent employees, while premiums for smaller firms would be industry-rated. Insurers would be allowed to adjust the premium to the average age of employees at a firm or the industry.

**Reality Check**

Such coverage would, of course, not come free. But several considerations assuage the concern that the cost would be burdensome for employers.
First, the plan would offer more limited—and, hence, less expensive—coverage than most PDI plans that private-sector employers currently purchase. (Employers already offering more generous coverage would be welcome to keep it.) Second, universal PDI coverage would shield employers from catastrophic insurance costs. As structured, private insurers would hand off responsibility for ongoing disability to the traditional SSDI program two years after the onset of disability. While employers would have financial incentives to minimize PDI claims, they would not be exposed to the costs of permanent work-limiting disability.

Five states already require employers to provide temporary disability insurance. And though little studied, the available data suggest that these mandates have not distorted labor markets by giving employers an incentive not to hire the frail. While our proposal is more expansive than these state programs, it has a similar flavor.

There are also international precedents. Faced with a disability system that was growing inordinately large and expensive, the Netherlands adopted a program similar to the one we envision. While it is too early to render a final judgment, there’s no doubt that the program has saved substantial numbers from entry into the permanent disability system. The potential for budget economies are large in the Netherlands. And here: the lifetime “present value” of an average SSDI award, including the Medicare coverage that comes with it, is approximately $270,000 in 2009 dollars.

Consider, too, a number of subtler advantages to adding this private front end to SSDI. It would take the pressure off administrators to review—and terminate—incumbent beneficiaries, because few marginal cases would make it past the private insurer phase. And it would reduce the “adverse selection” problem that employers currently face when considering whether to offer PDI. An employer now providing coverage incurs some risk that the benefit will attract workers who expect to become disabled. That leads to correspondingly higher claims rates and policy premiums, putting them at a disadvantage with respect to competitors.

The potential for adverse selection explains in part why employer-based private disability insurance is currently offered to just one worker in three. By requiring all employers to provide coverage, as is currently the case with unemployment insurance and workers’ compensation insurance, the adverse selection problem would evaporate.

**A RARE OPPORTUNITY**

In the half century since the introduction of SSDI, technologies for treating and accommodating work-limiting disabilities have advanced, the physical demands of the workplace have been reduced, and the societal consensus on the proper objective for treatment of disabled workers has greatly evolved. The SSDI program was designed to provide income support (and, after 1972, health insurance) to workers transitioning from employment to early retirement and, in many cases, death. This goal was progressive for its time, but no more.

How often does Washington get a chance to improve the quality of the social safety net, even as it saves money? How often can policy makers overhauling a major program offer reforms that please many interests and displease few? Changes to major social programs are never simple or painless. And we do not claim a miracle cure. But we believe that this treatment would be far preferable to the disease. And the sooner we get on the road to recovery, the sooner American workers and taxpayers will begin to feel better.