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The SSDI Trust Fund: New Solutions to an Old Problem

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"The current Trustees Report again reflects what we have long known to be true—we need changes to ensure the long-term solvency of Social Security and to restore younger workers' confidence in the program."

Michael J. Astrue, Commissioner of Social Security, May 13, 2011 (Social Security Administration 2011)

Social Security Disability Insurance (SSDI)—the main federal program providing cash assistance to workers with disabilities—is facing a major fiscal crisis. Social Security's trustees expect the SSDI Trust Fund to be exhausted by 2018, leaving the government unable to pay the full benefits promised to beneficiaries and their families. Some SSDI beneficiaries also receive Medicare benefits, which is putting a similar financial strain on Medicare; trustees expect the balance in Medicare's Hospital Insurance Trust Fund to fall to zero by 2024 (Social Security and Medicare Boards of Trustees 2011). One promising solution to SSDI's fiscal dilemma is to implement a work-support policy designed to keep more workers with disabilities in the labor force and off the SSDI rolls. This brief presents three possible options for such a policy.

Restoring Fiscal Balance

Past efforts to address SSDI's fiscal problems have forestalled insolvency for short periods but have failed to do so in the long term. These efforts have included tightening eligibility requirements, boosting program revenues, and encouraging SSDI beneficiaries to leave the rolls and return to work. A major limitation of these efforts, however, is that they did not address the problematic incentives that push workers with disabilities out of the labor force and into SSDI.

A work-support policy, on the other hand, would re-align these incentives in a manner that encourages workers to remain employed or to quickly return to work following the onset of a disability. Evidence strongly suggests that this approach could boost the economic status of workers with disabilities while curbing growth in federal expenditures needed to support this population.

In this brief, we describe three work-support policy options designed to re-align incentives, promote employment, and reduce SSDI entry. All have the potential to restore SSDI's fiscal solvency and improve the economic outlook for workers with disabilities, but much work remains to flesh out the options and to demonstrate that they will achieve their potential. Consequently, even if a work-support policy is eventually put in place, stop-gap measures like those used in the past might be necessary to stave off immediate insolvency.

We begin by summarizing the challenges policymakers face in attempting to sustain the SSDI Trust Fund. These challenges include the rapid growth of the SSDI caseload and federal expenditures, the declining economic status of working-age people with disabilities, and the failure of previous attempts to shore up the program's financing. We then present the three policy options and discuss the urgency of testing them immediately. Failure to do so will almost certainly mean economic harm for people with disabilities, taxpayers, or both.

Rapid SSDI Growth

The number of SSDI beneficiaries under age 65 rose substantially during the early and mid-1970s (blue line in Figure 1). This growth led to a series of administrative and policy changes, most notably the 1980 Amendments to the Social Security Act, that tightened eligibility criteria (Congressional Budget Office 2010).[1] These changes reduced the number of beneficiaries, but

[1] Before 2002, SSDI benefits were automatically converted to full retirement age (FRA) benefits funded through Old-Age and Survivors Insurance (OASI). From 2002 through 2009, the FRA was gradually increased to 66, which in turn increased the upper age limits for SSDI benefits. To maintain consistent age comparisons across these periods, we limit our analysis to beneficiaries under age 65.

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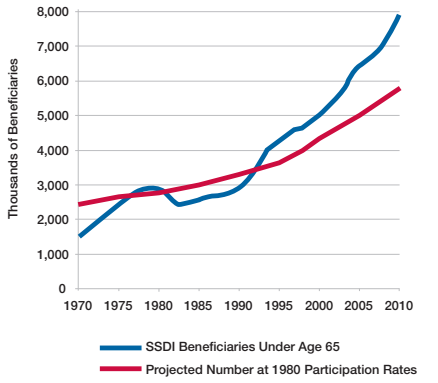
Figure 1

SSDI Beneficiaries Under Age 65, 1970-2010



Sources: Numbers of beneficiaries by year, age, and sex are from http://www.socialsecurity.gov/policy/docs/statcomps/di_asr/2009/sect01c.html#table19, except the 2010 numbers, which are from http://www.ssa.gov/oact/ProgData/benefits/da_age201012.html. Numbers of disability-insured workers by age and sex are from http://www.ssa.gov/oact/STATS/table4c2DI.html. All web pages were last accessed February 28, 2011.

Notes: Statistics are for December of the specified year. Projections are based on the actual number of disability-insured workers by age and sex multiplied by the 1980 participation rate (beneficiaries per disability-insured worker) within the age-sex category. Beneficiaries age 65 and over are excluded starting in 2004, when some first became eligible for benefits because of the increase in the FRA.

public backlash led to the 1984 Amendments, which essentially reversed the earlier changes. When the economy deteriorated in 1990, rapid growth in the number of beneficiaries resumed. The SSDI caseload has nearly tripled in size since 1980, from 2.8 million to nearly 8.0 million in 2010—a 175 percent increase.

Figure 1 also shows the projected number of beneficiaries each year, assuming that SSDI participation rates within age-sex groups remain at their 1980 levels.[2] The red line shows this number rising due to general population growth; the aging of the baby-boom generation (more SSDI applications come from older workers); and growth in female employment, which increases the number of women eligible for SSDI benefits. The projected number of beneficiaries in 2010 is 2.2 million (28 percent) lower than the actual number; this difference is the result of growth in SSDI participation rates within age-sex groups.

Due in part to this rapid growth, expenditures for SSDI and Medicare, as a share of federal outlays, have risen substantially. Stapleton (2011) showed that total expenditures for SSDI and Medicare beneficiaries under age 65 were $178 billion dollars in 2009—5.1 percent of all federal outlays. (If SSDI participation rates within age-sex groups had stayed at 1980 levels, total costs would have been 28 percent lower in 2009, or about $128 billion.) But the growing number of beneficiaries isn't the only factor in these rising costs. Inflation-adjusted SSDI expenditures grew faster than the number of SSDI beneficiaries—rising 247 percent from 1980 to 2010, compared to a 175 percent increase in beneficiaries—because wages have grown faster than prices. Inflation-adjusted Medicare expenditures grew by 470 percent from 1980 to 2009 due to the soaring cost of health care and the introduction of Medicare Part D.

Economic Hardship

These large expenditures notwithstanding, people with disabilities and their families have continued to struggle; indeed, their economic status has been on the decline for more than two decades. Figure 2 shows the employment rates and household incomes of working-age people with disabilities, compared to those of people without disabilities, based on data from the Current Population Survey. In 2009, the employment rate of people with disabilities was only 23 percent of that for people without disabilities, down sharply from 38 percent in 1989. The household income of people with disabilities was only 54 percent of that for people without disabilities, down from 60 percent in 1989. The relative decline in household income was smaller than the relative decline in employment because growing benefits made up for some (but by no means all) of the decline in wage income.

Previous Policies

Policymakers have used several strategies to resolve SSDI's fiscal problems, but they have yet to achieve long-term success. As previously noted, the tightening of eligibility standards in the late 1970s and early 1980s cut the number of beneficiaries (Figure 1) and expenditures, and perhaps even boosted the relative employment of working-age people with disabilities (Figure 2). However, public reaction to the consequences for beneficiaries and potential beneficiaries, many of whom were already in fragile economic circumstances, led to a policy reversal within four years. It is unlikely that policymakers will want to go down this path again.[3]

Another approach that policymakers have used several times is to increase SSDI Trust Fund revenues. In the past, this approach has involved raising payroll taxes or re-allocating funds from the OASI Trust Fund. Both methods were used in the 1983 Amendments, with more funds transferred from OASI to SSDI in 1995. Based on trustees' projections, transferring funds now would exhaust the OASI Trust Fund two years earlier than expected—in 2038 rather than in 2036 (Social Security and Medicare Boards of Trustees 2011). Another increase in payroll taxes would provide additional funding but is unlikely to win support from those who see unchecked growth in entitlement spending as the primary cause of the mounting federal deficit.

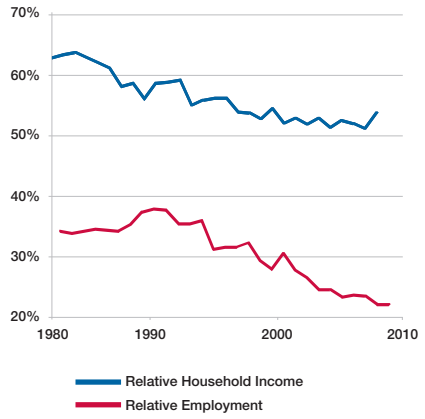
Policymakers have also invested more in helping SSDI beneficiaries leave the rolls and return to work. Since 1999, the Social Security Administration (SSA) has funded several efforts to promote employment among beneficiaries, but none have led to substantial caseload reductions (Stapleton et al. 2006; Wittenburg et al. 2008). This disappointing outcome at least partly reflects two major challenges to this approach. First, most workers spend many months, if not years, demonstrating that they qualify for SSDI—that is, that they cannot work. During this time, they may lose many of their job skills and may also become used to not working. Second, efforts to help beneficiaries earn enough to give up SSDI and Medicare benefits can be very expensive, especially given the severity of many people's disabilities.

[2] We defined the participation rate within an age-sex category as the number of beneficiaries in that category divided by the number of all working-age people in that category. In our projections, we applied the 1980 participation rates to the number of working-age people in each age-sex category.

[3] A related approach is to devote more administrative resources to reviewing the eligibility of current beneficiaries, but the effect of doing so would be small compared to the magnitude of the caseload (Office of the Inspector General, Social Security Administration 2010).

Figure 2

Relative Employment Rate and Household Income of Working-Age People with Disabilities, 1980-2009



Source: von Schrader et al. (2010).

Systemic Problems Remain

SSDI is often the "first" source of public assistance under current policy because incentives for employers, workers, and others push workers out of the labor force and into SSDI. Past efforts to address growth in SSDI and Medicare expenditures have failed to re-align these incentives.

Previous approaches, for example, have not addressed the incentives that encourage employers to lay off workers with disabilities. Unless these workers have special skills and cannot be easily replaced, employers may well terminate them, both to minimize productivity losses and to limit the company's liability to pay for their health care. Of course, if work is the cause of the medical condition, the employer's workers' compensation (WC) insurer is liable for health care costs and wage replacement, but the insurer and employer have a strong incentive to deny that work is the cause or to otherwise limit liability. Unlike with WC, the employer incurs no liability for the worker's SSDI benefits. Some employers also offer private disability insurance (PDI) which creates incentives for them to help some workers continue to work, but it also encourages workers who leave their jobs to enter SSDI.[4]

After losing a job, a person with a disability has a strong incentive to apply for SSDI. One reason is that the person's disability might make it difficult to quickly find a new job at anything close to comparable pay. The SSDI benefit might be low compared to the worker's past earnings but high compared to what the worker is able to earn now. This is especially true after considering factors such as favorable tax treatment of benefits relative to earnings;[5] eligibility for Medicare after a 24-month waiting period; provisions that allow nonblind beneficiaries to earn up to $12,000 a year ($19,680 for blind beneficiaries); and eligibility for SSA-funded employment services.

Finally, members of Congress and state officials have a political incentive to help their constituents obtain federal benefits. States can also save money by helping constituents transfer from state-funded programs like Temporary Assistance for Needy Families, Medicaid, temporary disability, and General Assistance to federally funded programs like SSDI and Medicare.

The Patient Protection and Affordable Care Act (ACA) of 2010 will affect some of the incentives described—if it is not amended in future years—but not always in ways that would steer workers away from SSDI. Employers that subsidize insurance would still have an incentive to lay off those with high health care costs. Availability of individual coverage via a health insurance exchange should help workers obtain the health services they need to return to work, which might discourage them from obtaining Medicare through SSDI. However, the availability of such coverage might also make SSDI entry easier because workers will be able to readily maintain insurance while applying for SSDI. This policy may therefore lead to more applications for benefits.

Resolving Systemic Problems

A well-designed work-support policy would curb federal expenditures for SSDI while improving the economic well-being of people with disabilities. It would increase incentives for (1) employers to retain or rehire workers with disabilities, (2) workers with disabilities to continue working or to return to work quickly, and (3) state and private programs to promote employment rather than entry into SSDI. A work-support policy would also protect access to existing SSDI and Medicare programs for those truly unable to work.

Any such policy would, however, fundamentally change how the SSDI and Medicare programs are financed and/or change how and when people can apply for SSDI. To illustrate, we briefly describe the three work-support policies identified in Table 1. Some have been developed in more detail than others, but none have been fully designed or tested.

MacDonald and O'Neil (2006) propose a new social insurance program called "work insurance." Work insurance would provide short-term supports to help people remain at their jobs or find new jobs after the onset of a disability. These services would be temporary and paid for by payroll taxes, and workers would be required to apply to this program before applying to SSDI. The program would triage applicants based on their conditions and needs, sending some directly to SSDI; providing cash, health, and employment assistance to those who need it to return to work; and providing no assistance to those who do not need it. The program could also engage employers to provide job-retention services for workers with disabilities.

Autor and Duggan (2010) propose a mandatory program called universal short-term private disability insurance (UPDI). This program would require workers and their employers to jointly purchase PDI. Workers who experience the onset of a disability would have to receive 24 months of benefits from the PDI before they could apply for SSDI. This proposal emphasizes employer incentives to retain workers and to provide accommodations and return-to-work services, similar to the services provided by WC or PDI. Employers (and their WC and PDI insurers) would be motivated to retain workers because UPDI, which is funded with experience-rated tax payments, would have to pay for up to two years of benefits, even for workers who leave their jobs. UPDI would also encourage employers to implement wellness programs for their workers.

[4] Long-term PDI benefits offer higher wage-replacement payments than SSDI does. PDI insurers therefore have a strong incentive to help long-term beneficiaries obtain SSDI because each dollar of SSDI benefits reduces the PDI benefit by a dollar.

[5] The SSDI benefit is not subject to payroll taxes; is not subject to federal income taxes for individuals with incomes below $25,000 ($32,000 for couples); and is taxed at a lower rate than earnings for those with higher incomes.

Table 1.

Three Work-Support Proposals

Work Insurance	New temporary program that would provide cash and employment supports funded by payroll taxes.
Universal Short-Term Private Disability Insurance	Required short-term insurance provided by private insurers and funded through mandated employer and employee premiums.
Experience Rating	A new formula used to determine the allocation of SSDI payroll taxes to employers, based on SSDI use by former employees.

Sources: MacDonald and O'Neil 2006; Autor and Duggan 2010; Burkhauser and Daly (forthcoming).

Burkhauser and Daly (forthcoming) make the case for "experience rating" the payroll tax for SSDI. Experience rating would bring SSDI in line with rate-setting methods used for other workplace insurance, including private health insurance, unemployment insurance, WC, and PDI. With this approach, employers with relatively low SSDI expenditures for former employees would pay lower payroll taxes, and those with relatively high expenditures would pay higher taxes. If implemented, this proposal would motivate employers to retain workers with disabilities, ensure that they have rapid access to services, expand the purchase of PDI coverage, and encourage workers to remain healthy.

There are, of course, many other ways to transform the incentives that currently push workers out of the labor force and into SSDI. Some are less bold than these three options, such as changing federal health insurance subsidies to limit the liability of employer-provided health insurance. Others are bolder, such as providing allowances to pay for the extra cost of disability, equal to a portion of SSDI benefits, under which workers could earn much more than they can under SSDI. None of these approaches have been developed in detail or rigorously tested.

Would a Work-Support Policy Succeed?

Evidence suggests that a sound work-support policy would cut growth in the SSDI rolls while boosting employment and earnings among people with disabilities. Maestas et al. (2011), for example, show that approximately 18 percent of SSDI beneficiaries would be earning more than the maximum allowed by the program if they had not entered SSDI. Several studies also indicate that early intervention services, especially those that immediately follow the onset of a disability, can improve outcomes (Burkhauser et al. forthcoming, 1999; Hunt 1996). In addition, the Netherlands has made considerable progress in curing what was once known as the "Dutch disease"—an extraordinarily large number of working-age people on the public long-term disability rolls—through tighter eligibility standards and better work-support policies (Burkhauser et al. 2008). Under these new policies, employers must provide short-term disability benefits, and employer taxes are experience rated. Several elements of these policies—the direct involvement of employers and PDI as well as the temporary nature of benefits—are reflected in the three work-support policies described earlier.

A significant challenge to implementing any work-support policy is the number of unanswered questions about the design and efficacy of such policies. One concern is that increasing employers' incentives to retain workers who might otherwise enter SSDI will lead employers to avoid hiring those perceived to be at high risk for SSDI entry. Another is that people who are truly unable to work may find their path to SSDI strewn with even bigger hurdles than under current policy. There is also concern that implementing these policies could reduce the competitiveness of U.S. employers in a global economy. But the most fundamental concern is whether these policies would improve the economic status of workers with disabilities *and* reduce growth in public expenditures to support this group.

Looking Ahead

Given the federal government's fiscal situation, policymakers will need to make some difficult decisions as they work to restore solvency to the SSDI Trust Fund. In the past, policymakers have used an array of options to increase SSDI revenues, tighten eligibility, and help beneficiaries leave the rolls. These efforts have met with limited success, however, because they failed to address the complex incentives that push workers with disabilities out of the labor force and into SSDI.

Because the SSDI Trust Fund is expected to run out in just 7 more years, there is not enough time to design, test, agree on, and implement a work-support policy that would improve the economic status of workers with disabilities while reducing federal expenditures for SSDI. It would take at least 10 years, and probably longer, to do that. Policymakers could buy time by shifting OASI revenues to SSDI, but in any case, they must take immediate action to address the systemic incentives that are at the root of SSDI's long-term fiscal problems. Failure to do so will almost certainly make it impossible to provide full SSDI and Medicare benefits to those who will soon need them.

References

For the full list of references, go to www.disabilitypolicyresearch.org/brief11_02_ref.asp.

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