Examining the Impact of Disability Insurance on Health Outcomes: The Efficacy of A Partial Benefit Option

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Introduction:

In 2018, 26% of adults –61 million people– in the U.S. were living with a disability.[1] Social Security Disability Insurance (SSDI) provides cash benefits to individuals incapable of working due to severe disability. While SSDI is the largest income replacement program for nonelderly adults in the U.S., only 8.5 million were SSDI beneficiaries as of 2018 with an additional 5.3 million disabled, low-income adults enrolled in Supplemental Security Income (SSI).[2,3] The absence of rehabilitation requirements provides little incentive or opportunity for beneficiaries to improve their health or return to work once on SSDI.[5] Prior research focuses on this substantial reduction in employment that results from SSDI, but it does not analyze the critical health restraints of the policy that contribute to such a decline. The Old Age, Survivors, and Disability Insurance (OASDI) Trust Fund that finances Social Security is predicted to be depleted by 2034, so policymakers must address funding challenges and potential options for reform promptly.[4] In addition to financial benefits, policymakers must consider assistance for people with disabilities in improving their functional, mental, and educational capabilities.[5]

SSDI provides some financial support, but its neglect of rehabilitation can be debilitative for health outcomes which are the core value of the Americans with Disabilities Act (ADA).[6] Issues of expanding coverage and improving program effectiveness have major implications on economic efficiency and health outcomes; disability reform efforts of other countries should be considered when deciding the U.S.'s next steps. The purpose of this brief is to discuss current research on SSDI in relation to international disability insurance programs and to explore policy recommendations for improving enrollment and health outcomes of disabled individuals.

Background:

As part of the Social Security program, SSDI ensures 80% of adults.[7] However, receipt of benefits requires an inability to work or participate in "substantial gainful activity" due to a medically confirmed impairment expected to last longer than a year or to result in death.[7] Such strict vocational criteria is found to have the largest impact on cross-national variation in DI enrollment with no evidence of health in association.[8]

Beneficiaries remain eligible for SSDI until returning to work, retirement, or death; a study finds that less than 1 in 500 SSDI recipients return to work.[5] Allowing able individuals to work while receiving benefits would increase labor force participation. Eligibility rules are strict and complicated, yet cash transfers are based on average lifetime earnings as opposed to severity of disease. Benefits based on degree of disability would enable looser eligibility criteria. Of those who are denied benefits due to work capacity, few have been found to continue working at significant levels and nearly two thirds successfully appeal their case.[9] Wider eligibility would reduce appeals and make the application process more efficient.

Individuals become eligible for Medicare once approved for SSDI, but receipt of services begins two years after the date of entitlement. Access to health insurance and necessary financial and medical resources is critical at the onset of disease for promoting health and potentially preventing long-term adverse outcomes.[6] The Accelerated Benefits (AB) demonstration provided randomly selected enrollees with immediate health insurance to show promising reductions in unmet medical needs, yet the outcome effect was lower than expected.[10]

Strict eligibility criteria for DI and disparities in benefits are not global phenomena. Most other high-income countries provide DI

regardless of ability to pay or work. European disability programs also tend to provide comprehensive health insurance, including any services to promote independence or improve an individual's quality of life.[11] While other DI policies of the Western world are culturally and structurally comparable for this brief, it is important to remember the population of the U.S. is much larger and more diverse.

Research Findings:

Impacts of DI on Health

On top of high direct costs, the indirect costs of disability can have added negative health effects. A study by Hawleya et al. (2009) found prolonged absence from work or normal activity to adversely affect disabled individuals' physical, mental health and overall well-being.[5] Another study found even the time spent out of work during the SSDI application process to independently impact health.[12] Analysis of supportive employment efforts for people with mental disabilities in the U.S. suggests returning to work reduces disability and medical costs.[12]

A loss of DI benefits has similarly been found to negatively impact health. García-Gómez et al. (2017) examined the effects of stricter eligibility requirements and reduced benefits of Dutch DI.[17] The study found that a 1,000 euro decrease in annual benefit was associated with a 2.4% greater probability of death for women within 10 years.[17]

Recent Trends in DI

Antidiscrimination laws like the ADA (1990) were passed with the intention of formally integrating individuals with disabilities into the workforce. SSDI also implemented its Ticket to Work program in 1999 to provide employment services that facilitate the transition to work. Although removing employment barriers was intended to reduce SSDI enrollment, benefit rolls continued to rise.[13] Some researchers pose the lack of necessary rehabilitation and support provided by SSDI as explanation for why people are still unable to transition back to work.[13]

Autor and Duggan (2006) offer three alternative reasons behind the increasing SSDI rolls since 1990: the 1984 reform relaxing screening for mental illness and non-severe ailments; a rise in the DI income replacement rate; and the exponential increase of women in the labor force.[7] Though as enrollment climbed in the U.S., it fell drastically for other countries. In an international comparison of the health of enrollees, Croda et al. (2018) highlight the reduction of DI rates in the Netherlands and Denmark from nearly double the rate of the U.S. in 2004 to an equal rate by 2012.[12] Change in the Netherlands came as a result of fundamental restructuring of the DI system in.[12] The study found the proportion of enrolled individuals in the bottom decile of health status decreased significantly as well.[12] A broader policy analysis by Burkhauser and Daly (2012) saw no corresponding spillover to other transfer programs in the Netherlands during this time.[14]

An analysis of DI in 7 European countries reveals the Netherlands, Finland, and Denmark require DI beneficiaries deemed capable of returning to work to participate in health and occupational rehabilitation activities.[15] Other countries including Sweden provide all voluntary rehabilitation services, and many include financial incentives for participation.[15] All 7 countries studied differentiate between individuals who continue to or may return to work and those who do not have such abilities. Such a distinction enables DI programs to have systems for both temporary and permanent benefits, with different levels of compensation for each.[15] When programs allow beneficiaries to continue working, DI receipt has been found to increase the probability of working part-time by 32% with

little effect on the probability of not working.[16]

DI Reform in the Netherlands

The Netherlands' DI reform restructured the system in 2006 to provide both full and partial benefit options.[17] Benefits were raised from 70 to 75% of previous wages for recipients with permanent disabilities, and those with temporary benefits receive 70% of the difference between pre-disability and current wages.[17] Admission criteria for both groups was tightened to reduce moral hazard, or the potential for misuse. The success of the Netherlands' reform has been attributed to the incentives for employers to provide accommodations and rehabilitation, but also the expectation to encourage prevention and early health intervention services.[14, 17] Still, with reform came a decline in the eligibility and resources for less-severely disabled workers. Lessons from a similar reform in Great Britain emphasize the imperative for continuous program evaluation to avoid any such adverse outcomes.[19]

Policy Recommendation:

Based on a thorough literature review, the best policy option for improving the health outcomes of individuals with disabilities in the U.S. by increasing access to and the effectiveness of DI is threefold:

1. Establish a two-part system offering both temporary and permanent benefits
2. Introduce health and occupational rehabilitation services
3. Develop a DI surveillance system that monitors the health of beneficiaries and the efficiency of the system

Designing a system that distinguishes between disability and ability to work enables assistance based on severity of disability rather than earned income. The ability to continue to work and receive partial DI benefits has both health and financial advantages. As continuation of work has been seen to be vital for health,[5] partial or temporary benefits also promote economic growth and expansion of coverage. With policy expansion comes concern of increased spending and funding sources. Provision of partial benefits reduces short term costs and long-term spending through new pathways for returning to work and going off of SSDI. Since the U.S. already does a fine job of targeting the severely disabled,[12] higher benefits can be reserved for this group. This policy would help disassociate having a disability with the ability to work.

The second initiative to provide and encourage participating in rehabilitation services incorporates the core values of the ADA into the DI system. Creating a more active system that works to improve health rather than merely compensate for disability would facilitate health improvement for enrollees and potentially reduce the duration of time individuals receive DI. An investment in rehabilitation prevents worse health outcomes and counteracts higher medical spending later on.

Finally, continuous evaluation and monitoring of the DI system is crucial for ensuring effectiveness and efficiency. There is currently very little research on the health of beneficiaries following their enrollment other than mortality rates. Several approaches have been developed for assessing the impact of health interventions on people with disabilities,[20] and such information would highlight a policy's success and shortcomings. Establishing strong evidenced based practices is critical for improving population health and ensuring financial and other health resources are used most effectively.

Additional Resources

- Disability in the United States https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

- Social Security Disability Insurance https://www.ssa.gov/disability/
- Affordable Care Act for Americans with Disabilities https://www.aucd.org/docs/policy/health_care/ACA%20People%20with%20Disabilities%20FINAL.pdf
- Social Security Programs Throughout the World https://www.ssa.gov/policy/docs/progdesc/ssptw/index.html

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