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2015 DRC Conference_Day 1 Part 1

2015 Disability Research Consortium Annual Meeting Transcript

2015 DRC Conference Day 1 Part 1

Good morning, everybody.

Good morning.

I'm going to tell you something I want you to remember today. My name is David Stapleton. My staff didn't make a name tag for me. I think that was a message of some sort. So you just remember.

Welcome to the third annual meeting of the Disability Research Consortium. This is a partnership between my company, Mathematica Policy Research; its Center for Studying Disability Policy, the National Bureau of Economic Research; and our sponsor, the Social Security Administration. And I'm particularly glad to welcome the people who are here from all of those organizations.

Before we get started, we expect to have a great turnout today. We had to close registration because we were oversubscribed. We also have a lot of people listening in on the Web. So please be cognizant of that if you are a speaker. Please speak into the mic because they are not going to hear you if you don't. And also during the question and answer periods, if you're a member of the audience, please wait for the mic to come to you. We will have two roving microphones so that you can just put your hand up, and we'll get a mic to you so you can be heard on the Web as well.

I've heard the National Press Club has restrooms. There are some way around over that way, and I think some over this way too. I'll leave you to find those on your own, though.

I think we have a really strong lineup of research papers today. I want to emphasize that they are research papers. And I also want to point out that many of them are works in progress. I'm sure the authors, as well as you, wish that they had their full set of results today. But this is really bleeding-edge research, and you just never know how much is going to be ready on time and how much isn't. Many people are working with data that have security restrictions, and it's hard to get through those.

I also want to be sure people understand that the researchers were not charged with solving the pending exhaustion of the SSDI Trust Fund. So if you're here looking for a solution, you may be a little bit disappointed. Although I'm sure that many of the researchers and the discussants will have comments about the relevance of research to SSDI policy, as well as disability policy more generally.

Without further ado, I want to introduce the Deputy Commissioner for Retirement and Disability Policy and my long-time friend Virginia Reno. Prior to her fairly recent appointment in her current position, she was the Vice President for Income Security at the National Academy of Social Insurance. And I suspect most of the people in this room know full well who she is and what her background is. So she's going to make a few remarks, and then we'll get started with our panel.

Thank you, David, for that warm welcome.

And welcome, everyone. I'm delighted to see everyone here. I would like to, of course, thank Dave Stapleton and Gina Livermore and all of their staff for helping put together the program this year, and of course to welcome the leaders of the NBER Consortium as well: David Weiss, David Otter, and Jeff Liebman. Thank you for all you do to get the research done so that we have findings for conferences such as this.

I'd also like to acknowledge the SSA staff who are responsible for managing the day-to-day operations of the Research Consortium. That would be Ted Horan, who is the Deputy Associate Commissioner for

MPR
2015 DRC Conference_Day 1 Part 1

Research, Evaluation and Statistics, ably supported on this activity by Lynn Fisher and Nick Love. And thank you for all that you do.

I would also like to introduce Tom Hungerford, who recently joined us at the Social Security Administration as our Associate Commissioner for Retirement Policy. And he is temporarily heading the research activities as we search to fill the position of Associate Commissioner for Research, Evaluation and Statistics. That position is now posted; and if you know people who would be good candidates, do encourage them to apply for the job.

The DRC is entering its fourth year, and we are building on a tradition of really top-quality research on issues that are important to the disability community and to the Social Security at the program. As Dave mentioned, the Disability Program is critically important. It provides income support to people when they most need it, when they face the onset of a severe disability. It currently provides benefits to about 11 million people each month. That's 9 million disabled workers and 2 million of their dependent family members, most of whom are children.

Supplemental Security Income, or SSI, provides benefits to an additional 4.6 million low-income individuals with disabilities or blindness. And it also supplements disability insurance benefits for about 1.6 million individuals who receive DI, but their benefits are less than the amount provided by SSI.

The Social Security Program, as we all know, has a very strict definition of disability; and that applies to both programs. Consequently, people who receive benefits from Social Security or SSI have very significant impairments that impose significant impediments to their capacity to earn a living. The people who receive these benefits, it is important to keep in mind, are only a subset of the much larger population of Americans who have some kind of disability and, in fact, are also able to work.

As Dave mentioned, the disability programs are under sharp scrutiny now as lawmakers will need to act soon, within the next year, to adjust the financing of the DI Program. The trustees project that it will be short of funds about a year from now, in the final quarter of 2016. After that time, income coming in would cover about 80% of the projected benefits.

President Obama in his most recent budget has proposed a temporary reallocation of the contribution rates of the Social Security tax rate that workers and employers each pay, that 6.2% of earnings, allocating somewhat more of that to the DI Program for the next five years as a way to equalize the financing of the two funds so that both would have sufficient reserves to pay all scheduled benefits until 2034. Obviously, additional adjustments are needed to ensure that the combined program has adequate finances to match what its projected benefits for the rest of the next 75 years.

The Office of Management and Budget recently issued a report on the DI population, and copies of that report are available on the table outside. That report profiles the beneficiaries; it reviews trends in the DI Program; and explains the President's proposal.

As far as the conference today, I am delighted with the array of topics that are up for discussion. Among the critically important issues, in my perspective, are to have a clear understanding of what are people's experiences prior to applying for disability benefits. Better understanding what happens to people before they apply for benefits can help suggest pathways to suggest interventions that would help people get back to work instead of coming to apply for benefits.

Better understanding of those antecedents of disability application could also help indicate that many of those interventions we think should have occurred may have been tried and did not work. So it's important to understand just what has happened before people reach Social Security's door.

Additional questions include: How do beneficiaries and their families fare once they are receiving benefits? And perhaps equally important: How do individuals fare who applied, but did not receive benefits? And I think more than half of people who do apply for benefits end up not receiving them. And

MPR
2015 DRC Conference_Day 1 Part 1

the outcome for denied applicants is also, I think, an important public policy issue that we need to be aware of.

And then finally, how can we better coordinate both financial support and services and supports for individuals with disabilities to maximize their independence and capacity to work, where that's possible?

We have a full agenda that touches on many of these topics today. And I look forward to hearing your research findings on beneficiaries and their families; on work outcomes, including for SSI children; and on the costs and consequences of new approaches to finance services and supports for some of that subset of individuals who have significant disabilities but are, in fact, able to work and are not in need of Social Security.

Later today, we will hear from two distinguished members of the Social Security Advisory Board. That's Alan Cohen and Jagadeesh Gokhale. Tomorrow morning, we are fortunate to have a discussion among our Federal partners that share SSA's mission for improving the lives of individuals with disabilities. And they come from a variety of other Federal departments besides the Social Security Administration.

Over lunch tomorrow my colleague, Doug Walker, who heads our Office of Communications, will share with you some of SSA's new products to help educate the public about the Social Security disability programs.

In closing, I'd just like to welcome you. And I look forward to hearing the research and the discussion that will follow today. Thank you.

[Applause]

Thank you, Virginia.

We'll be getting started with the first panel as soon as we can get them up here.

Please come on up and take your seats, and we'll get going.

[Pause for panel to assemble]

This first panel, whose title is Return to Work and Early Intervention, is all about early intervention. And I think this is going to be really interesting research. But I know a lot of it is in progress.

I'd like to particularly thank Mark Cullen for being here. He wanted to pull out because his group wasn't far enough along. I persuaded him to come in to do that. He also had a five-hour plane trip from – was it Albany? – to Washington, D.C., yesterday; so I'm particularly grateful that he's here. He's going to be the first speaker. He's from Stanford University; and his co-author, Amal Harrati, is here as well. And David Wittenburg, my colleague is going to be their discussant. Each speaker is going to be speaking for 15 minutes and then the discussants have 10.

The next speaker is David Cutler from Harvard University. His discussant is David Otter – this is a lot of Davids up here. And then the final speaker is my colleague, Yoni Ben-Shalom, Mathematica, the paper that he's working on with myself and also Frank Neuhauser from Berkeley. And then his discussant is Jennifer Christian.

So let's go ahead and get started.

Good morning, everybody. And I also would like to thank the sponsors, Mathematica and NBER and Social Security Administration.

MPR
2015 DRC Conference_Day 1 Part 1

What I'd like to do this morning is to present to you some preliminary ideas and basically some study designs that have emerged in our group over the past year. We have – as I think some of you know – had the enormously valuable opportunity of studying the population of workers at Alcoa across the country for almost two decades now, and have gotten very interested in issues of disability and leaving the workforce, especially brought on by the changes that occurred in the Great Recession.

With that, let me just dive right in to the motivation. I think you're all well aware that despite substantial changes societally in the incentives for workers to stay at work longer and generally improved health within the workforce at all levels and, in fact, success in increasing the retirement on average quite a lot over the past decade, there has been a perhaps unexpected countercurrent of rather dramatic increase in claiming behavior and in disability occurring at all levels.

And so the question is: Where along the way might there conceivably be some opportunities to intervene? The tact that we've taken – and you'll see in a moment the datasets that we have to play with – is to look at a couple of areas where we think there may be just such opportunities. And one of those, which we'll talk about, is the acute hospitalization. And I'll talk about why I think it creates an opportunity for intervention at multiple levels and a little bit about what we have learned in our preliminary work.

There have been a variety of studies of acute health effects that I'll summarize briefly in the next slide. But the focus that we place, and what we think our potentially unique advantage with this population may be, is that we do – as Virginia suggested – we do have the opportunity of long observation of workers before disability occurs. And in that context, we know both a great deal about the jobs they've had and the work they do, as well as the slow progress of their health and can actually tease out the relative importance of health as a background condition. Not just the acute hospitalization, but what's been going on prior to that, as well as specific (inaudible) characteristics and aspects of the jobs that people do because we think there may be substantial variation across the workforce, in particular because of the nature of manufacturing that we study, those who have manual jobs and those that are physically more demanding. And we know that they are way overrepresented in SSDI roles.

By way of background, some of you may be aware of a remarkably well-done study by Garcia-Gomez and colleagues in Netherlands published a couple of years ago in which the group was able to link, using national health and the equivalent of IRS records basically, the relationship between hospitalization and outcome, and were able to very substantially an interesting long-term declines in productivity, a lot of resultant disability consequent to that. And they also were able to study, as we hope to someday, the impact of that on family behavior, spouse behavior, and so forth.

The problem is when we look at their situation compared to trying to study it in the U.S. context that we rarely have such easy linkages between the health data, certainly not at a national level, and income and productivity data. But we also know very, very little in the U.S. situation about the incentive structure that people face. Virtually all of our workers are looking at rather different retirement incentives, different disability incentives.

It may look from an SSA point of view that everything is the same because in the end of the day, they all apply. But in reality, at the employer level, people are looking at quite different incentives to stay and work or leave. And one of our unique opportunities within the Alcoa dataset is because we've following these people, know a great deal about their jobs and a great deal about the incentive structure in each setting, that we can tease apart some of those relationships.

I'm not going to belabor this, but I frankly think this is the most interesting thing I'm going to show you this morning, which is starting with Paul O'Neill's idea in the mid-'90s to start an academic/corporate relationship in order to study these kinds of issues. He was, as many of you know, a safety fanatic; and he thought we could bring Alcoa into the same position in health as well. And over the almost now two decades, we have been able to assemble an enormous trove and link data that are, in most other contexts, unimaginable.

MPR
2015 DRC Conference_Day 1 Part 1

I do point out down in the lower left corner the linkage to Social Security data, which ultimately will be critical to do the things I'm talking about this morning. We don't have it yet. We are in the midst of working on that relationship with a lot of help from many of you sitting in the room. But it is one of the big limitations of what I'm going to be able to tell you in the next couple of minutes.

So it is because of this we've been following – I'll just show you. This is where the larger workforce is, so it's a very diverse workforce even though they're all involved in one or another aspect of production of aluminum and aluminum products. It ranges from very heavy work to much lighter manufacturing. One-third of the workforce is salaried with lots of professions. We don't have any very poor people; we do have a few very rich people. But it's shockingly more representative of the U.S. population than you might otherwise guess.

This is just an example of the kinds of cohorts we count. We have dates on a couple hundred thousand workers who've ever worked a day since 1985. But typically, we will define panels for various purposes. This is just one panel that we used for one of the studies. It's not important – just to show you what the characteristics of the population looked like.

There are data issues. And in the work that I'm going to – when I show you the little studies that we're proposing, you can see that lacking the claiming behavior, lacking the ability to look at household rather than individual level income and work, which we still don't have. We have Social Security numbers for spouses, but we don't have their data yet. And we don't know who ends up claiming in the end of the day, although we know what they do within the Alcoa system.

The final point I just want to make is that a broader threat – we're going to solve those points shortly, I hope – but the broader threat to all of us is the legitimate and reasonable concern people have about privacy. But it's actually becoming very problematic so that the possibility of doing more Alcoa's in the future may be less, and even Alcoa is beginning to get nervous about some of the data that they have routinely shared with us as part of a national perception of privacy.

So these kinds of studies – administrative data studies that rely on linked data do, in fact, require sharing rather intimate health and other information -- potentially may be less readily achievable without some public intervention over the next couple of years.

Very briefly, we are proceeding in four different directions, the first couple of which we've just made some initial steps on. The third one my colleague, Amal Harrati, is going to talk about in a second. And the fourth, I'm just going to come back at the very end to tease you with in the era of Big Data new approaches to looking at data, which includes unstructured data, the kind that most economists historically have not had either access or much sort of strategic approach to. And we'll talk about how we're looking at that.

Anyway, the first one is just to see what happens to people when they get hospitalized. And so we took hospitalizations within a five-year period in the mid first decade of the century, and it was about 3,500 hospitalizations, to just get a sense of what matters. When do people get back to work was the first question. It turns out there's a very clear social gradient. Many of my colleagues in medicine think that it's all about why you got hospitalized and what your disease is. It turns out, that's one of the least important things.

Social factors matter a lot. And by six months, about 12% of the population is gone and will end up on another pathway. Now, some of them may find work elsewhere. But we suspect since we lose them at that point – they have Social Security's help – we suspect that they are, many of them, on long-term disability.

Eighty-eight percent do return within six months. And unfortunately, they don't do so well either. And I'm going to show you a little bit just about what happens to them. So you can see, the older workers eventually leave. By about the five-year point, half of them have left the workplace. And again, we don't

MPR
2015 DRC Conference_Day 1 Part 1

know for sure whether they've left work altogether or just left Alcoa. But that's what it looks like. But you can see that even among younger workers, it's huge attrition after they return to work.

The determinants of this – the one factor we looked at because we knew it was of some relevance during the recession, and we have tons of cool natural variation to play with, was whether or not the relationship between this attrition and regional unemployment rates was close. And it turns out that regional unemployment is actually positively correlated with leaving work, which was surprising. We haven't gotten under it. There are many possible interpretations for that, including the possibility in many locations that regional unemployment is actually being driven by Alcoa, which would badly confound this.

So we have moved into a second study design in which we're going to try and duplicate the Dutch study in a case controlled manner, in which because we know exactly what work people are doing and we know what their baseline health is, we can match all the workers with hospitalizations against similar workers equally sick in a chronic way and doing the same work.

And the point there is that hospitalization may just, in the Dutch data, be a surrogate for declining health, so that the hospitalization may not be very interesting or important. And if it's going to be an intervention point, we do need to distinguish gradual decline in health from health that is meaningfully interrupted by acute shocks and if they are going to be a point of intervention.

So we are looking at that. We've done the first match. It's a relatively small dataset. I think we have about 1,500 good matches so far in that. We have been able to duplicate the basic finding of the Dutch study, which is that there is a substantial income decline. It's about \$500 net lost income per year going out six years in comparing those that were hospitalized against those equally sick people who are not hospitalized. So being hospitalized is bad.

The third study, I'm going to let my colleague say a little bit about.

[Pause for change of speaker]

Hi, everyone.

For the third study, we wanted to step back a bit from hospitalizations specifically. I'm a demographer by training, and so my perspective on things is to think about life courses. And when I entered this group and saw the Alcoa data, I thought to myself, "We literally know what everybody is doing on an eight-hour, shift-by-shift basis." I mean, this is a pretty incredible way to think about a life course, if we think about the life course as a working period of time.

So I used data for 17 years and followed individuals from 1996 to 2013, looking literally shift-by-shift, at whether they were in one of a variety of what I'm calling states. And these states are either working regularly, short-term disability, long-term disability, on leave, or Worker's Comp, or out of Alcoa. And again, we don't know out of Alcoa if that's retirement or if they've gone somewhere else.

And with this, I had two larger goals. The first, I won't spend any time talking about but it was to think about a sort of life expectancy in different states – so the same way we think about this, again, over the life course thinking a working life expectancy. How many years can we expect somebody to work healthily, at least in this population? How many years or months does one spend, on average, in short-term disability or long-term disability or any number of states? And then the sort of probabilities of transitioning between these states.

The second, which I'll emphasize now, is to think about these trajectories look like. So we have data on tens of thousands of people. We know what they're doing every shift. Are there some common characteristics across certain groups of individuals? Do people have these trajectories across their work life that either share or don't share common characteristics? And so that's what I'll emphasize today.

MPR
2015 DRC Conference_Day 1 Part 1

And then the final point to that, which we have not yet developed, is to the extent that these trajectories exist, thinking about the starting point and to what extent these entries into these trajectories differ. And are there ways we can think about that period of time or the time before it as ways to possibly think about intervention; or at the very least, at this point, just sort of characterizing what those look like?

So what I did to do that – this is my tiny, tiny technical term – is I used a sequence analysis. And essentially what that does is the algorithm will look through all the data. It will look at every possible sequence of events – so work, short-term work, long-term – these sorts of things. And then it will create clusters. So it will take all the individuals and cluster them to a number of common trajectories. I've kept the trajectories down to 10.

And then before I get into a few of the finding slides, I do want to point out about 68%, almost 69%, follow one of two trajectories. They either work continuously for the 17 years in which we see them in the data, or they work and then they leave.

I'm going to skip this slide to get to the good stuff.

Just to give a sense of what some of these trajectories look like, I've put work in boxes and short-term disability in circles. About 16% then of the remaining sample has something that looks like one of these samples. So work a short time in short-term disability, and then from there either can continue to work, maybe get on short-term disability one more time, or eventually leave the workforce.

What was incredibly surprising to me was 11% of the working population has something that looks like this. Which, if you imagine this is a 17-year period – this is an incredibly disruptive way to live. And you'll notice that there are triangles in there, which represent long-term disability. And again, this is over a 17-year period.

And then finally, looking at long-term disability, the trajectories are a little bit simpler. This is 4% now of the remaining sample, and this gets us to 100%. Typically, long-term disability looks more like regular work in the sense of this one larger episode that allows people to either eventually get back to work, at least for the time in which we see them, or we'll then have them leave the workforce.

I'll wrap this up quickly just to say there are immediate next steps. There are two that are on my horizon. The first is thinking about the time periods in which people spend, so this is a way to characterize the trajectories. But we don't actually know, based on this analysis, how long people are spending in each one of these states. And then the second is to link this to the health claims, so thinking about what health conditions are related to certain disability states as well. And then, as I mentioned, eventually then thinking about the antecedents to some of these trajectories and how they differ across populations.

I promised I'd leave you with a little tease. And I think in economics and social sciences, as well as in biomedical sciences now, there is a huge emphasis on the explosion of Big Data and new techniques for thinking about increasingly large sets. About a year ago we, for the first time, did a collaboration with bioinformaticians in our institution. We've now had one join our group, Suzanne Tamang. And although we've not gotten very far yet in the analysis, we now have the opportunity of looking at parts of the data trajectory story that would previously have been very, very hard to manage in the way we handle structured data – regressions, and utility functions, and that sort of thing.

We are now beginning to look at such things as pathways of the workday and the way people work, early characteristics in the workforce that may result ultimately in long-term disability using machine-learning techniques and other unsupervised strategies in the hope of identifying some of the clues. Again, going back to Virginia's comments about SSDI – what's happening very early on in the workforce that may elude some of our current hypotheses about who these groups of workers are that end up in the clusters that you just saw.

I'd love to show you what we've learned. We haven't learned much yet, but stay tuned. Thank you.

MPR
2015 DRC Conference_Day 1 Part 1

[Pause for change of speaker]

Good morning.

I'm delighted to talk about Mark and Amal's work, which is tracking pathways through services and programs using a proprietary data source from Alcoa, which Mark correctly noted dovetails very nicely with some of the things that Virginia talked about this morning about tracking pathways of people before they come on to the DI program.

The interesting thing about this work is that they're really breaking new ground and looking at employer data on hospitalizations and use of short-term and long-term supports. While it's important to note that their work admittedly is still in its exploratory stages, the descriptive findings provide new evidence on the dynamics of health shocks at a single employer, showing that there are losses in earnings after those shocks.

They also show a connection between individual characteristics, such as age and the type of worker and impairment, and the risks of shocks and the eventual outcomes. Substantively, they find that there are shocks to employment following hospitalizations and that their flows through the employer pathways can be quite complex as some only use basic supports, whereas others use multiple supports over time.

One particular statistic struck me, which was the one that Amal presented, that 68% of the workers never use these supports. They either go from work to leave, or they remain censored at work. But 32% do in some way, which suggests people are flowing through these return-to-work programs in very complex ways and that there is no single pathway to DI.

In some, their findings are useful in characterizing the complexity of the past and the characteristics of workers who experience adverse health events. However, as I noted, they're still in their early stages; so many of their results should be viewed as correlations rather than impacts. Hence, it's not possible at this point to draw definitive conclusions, such as whether hospitalization impacts or the designs of plans might influence ultimate outcomes that we're particularly interested in, such as work.

Let me talk about some of the technical notes, as I begin my talk. And often as researchers, we don't get to use proprietary data. So the first question is: How did these data come about? And Mark alluded to this. And I think there is a special history here with Alcoa that informs not only the types of circumstances that is needed to develop these data at other employers, but also how we think about the data outcomes from Alcoa.

And for those of you that may have read Charles Duhigg's book about *The Power of Habit*, there is a big example in there about how Alcoa made a unique commitment to safety. And this safety habit permeated the entire workforce, and it was something that was discussed by all employees. So it was a way of connecting employees around this singular issue. But it also likely led to the development of a data system like this one.

And so flash forward 30 years, and we have this big focus with this original focus on safety. And perhaps it's not surprising to see this same company also using data to track outcomes to measure progress to adverse health outcomes.

Turning to the slides, methodologically they're taking the approach of going from any shock, defined as acute hospitalization in Study 1, that might have effects on employment to tracking people through the use of longer-term supports. They use a combination of descriptive methods, case control studies, multistate tracking, and data mining, to examine these different pathways.

In Study 1, they start with acute hospitalizations and track how the factors are related to those hospitalizations. Things like health to baseline and age are strong predictors of shocks, with particularly strong findings for those with musculoskeletal impairments, which is perhaps not surprising.

MPR
2015 DRC Conference_Day 1 Part 1

They also show relations to the unemployment rate.

Mark, you had mentioned the focus on employment.

But actually, there was a relationship between the unemployment rate and hospitalizations, which I found interesting because it could be suggesting that workers are taking more risks during tough economic periods.

However, it's also something that I'd like to push the authors a little bit harder on by looking at variations in Alcoa's plants nationally because there are large cross-state variations. And specifically, is the hospitalization rate truly influenced by unemployment conditions; or is it something related to higher-risk plants operating at high unemployment rates or other conditions by sites? Regardless, I think this variation is very interesting and is something that exists in the environmental differences that can influence outcomes.

In Study 2, they use a case control trial to show the potential adverse shocks on outcomes. They matched those with hospitalizations in the first studies to a control group to assess the effect of these hospitalizations on outcomes. They assert that the adverse shocks do, indeed, play a major role, with losses ranging up to \$500 following an acute hospitalization.

Two notes here – first, it would be interesting to assess how earnings loss changed generally for the overall population so you have a comparison to understand your adjustment for the case control trial. And second, and I'm not sure that you called them impacts, but caution should be used in calling these things impacts because there could be important unobservable differences that are driving differences between the case controls such as underlying health prior to hospitalization, for example, that might lead the \$500 to an upper bound estimate.

In Study 3, they began to look at variations at entry into different programs. They show to flow from work to leave to short-term disability and long-term disability very substantially within groups, with variation in entries in each of these things that Amal called states. Understanding the relative size of these pathways is a bit challenging, though the large number of different interactions indicates the fact that, indeed, there are multiple states.

I liked the framework, and would encourage the authors to push it further to understand both the size of this group – are any of these particular interactions really notable from a substantive policy perspective for Alcoa – and for larger groups to (inaudible) descriptive analyses to assess whether there are key differences in the groups that are receiving those services so that we can predict who is going to flow through these pathways so we can design interventions to serve these populations.

In their last study, they're attempting to correlate pathways to worker characteristics. This is still exploratory, as Mark says. But what they're trying to show is that job and impairment characteristics matter to long-term disability participation. This analysis moves a bit from the life framework approach that Amal had used. And I have some more questions about using data mining or machine-based learning here to identify correlations because it's hard to identify whether these correlations are truly going to be meaningful across different subgroups.

And I would continue to push to look at how people are flowing into the long-term disability program and looking basically at the characteristics that separate those people from people that do not flow into the program, as well as the subgroups that use different supports, such as short-term disability to long-term disability.

So more generally, going forward, I think a strong option to consider now that they have the data infrastructure is to do something hopefully pretty cool, which is to examine other variations within Alcoa's operations that might influence outcomes; for example, identifying whether modifications in Alcoa policies

MPR
2015 DRC Conference_Day 1 Part 1

or variations in plants might offer opportunities to examine more causal effects. Conversely, if there is a lack of regional variation in and of itself, that may be a testament to the consistency of Alcoa's policies.

As the findings become more refined, it would be useful to understand how Alcoa itself can use this information to refine their own policies and if they are using it to refine their own policies, as well as particularly in understanding their own policies of trying to avoid things like adverse hospitalization with the menu of outcomes that they listed in their paper, such as short-term disability and long-term disability.

More broadly, the findings can potentially inform policy proposals interested in early intervention to promote work, such as the various proposals that are out there to expand private disability insurance, and whether those interventions have cost implications for SSDI, as well as one program we haven't talked about today, which is Worker's Compensation. This is more of a reaching comment though it represents the potential value you have in your data vault, which is you ultimately have SSA administrative data.

And for example, once you get those data linked, you could look at the link between Alcoa's short-term and long-term disability programs in SSDI, which could be important for identifying the time train and characteristics of workers who entered SSDI and how those who enter SSDI differ from those who did not. And what can we learn from those differences?

So, a few questions going forward that relate to the policy interactions for you for the discussion sections. First of all, I was wondering if you can plan to discuss how you will integrate the SSA administrative data to extend some of your analysis? Second, are there natural experiments that exist that we can use your data set to test various outcomes to find causal impacts? And third, and finally, are there general policy conclusions to be drawn from this work related to employer policies in general that seek to promote employment after an adverse health shock? And specifically, what can we generalize the results from Alcoa to other companies, which at first seems to be a challenge at first glance, given the company's unique history and characteristics of the workforce? Thanks.

David – one of you?

If you say David, you get the whole group.

[Pause for change of speaker]

Thank you so much for coming to hear. This paper answers an age-old question, which is: How many co-authors do you need to make sure you get a copy to your discussant on time? The answer to which seems to be greater than five, or it might be less than five. I just haven't figured out the sign of the effect yet. So we apologize to David for putting him under some strain here. Fortunately, it's a topic that he knows well, which is the interaction between unemployment and disability.

There are several motivating facts; but among them is this one here, which is that, as everyone in this room knows, applications for disability insurance rise in recessions. And the question is why that's the case. And, in particular, who are the people who are applying for DI in recessions but not in expansions? And so we're going to tell you a little bit about that by demographics and by medical conditions.

And then we're going to ask the question: What happens to comparable people, like those who apply for DI in recessions but who are ill in the same way but not in a recession? So can we figure out what happens differently to people in a recession than in an expansion? And so that's where we're going. We're going to take advantage of the recent Great Recession to do this, both the time period before and the time period during the Great Recession.

I will start very briefly just telling you a little bit about the aggregate data on recessions in DI, although the people in this room know that this set of facts and literature much better than I do. And then I'll tell you about the heart of our analysis, which is looking at who applies for DI in recessions but not expansions. And then, what does the high-risk group of people do in expansionary time periods?

MPR
2015 DRC Conference_Day 1 Part 1

The data that we're going to use are from the HRS, the Health and Retirement Study. And we're going to look by and large over the 2000s for reasons that I will tell you about.

Because our motivation is going to be based on looking at the time period before and during the Great Recession, let me first just highlight the aggregate picture in terms of what's going on in that period of time and whether the Great Recession is unusual in this extent of DI application or awards. We're just basically going to look at the time series of DI applications first and DI awards second, and to try and see how those relate to the business cycle and in particular use that to predict what we would expect based on the historical record should have happened in the Great Recession and then compare that to the actual experience in the Great Recession. So we used from 1965 on. We're going to analyze things through 2005 and then forecast beyond that and compare the actuals to the predicted.

Let me just show you a little bit about that. I'll skip the regressions and just show you in pictorial form. You can see that by and large, applications track the economy very well. The one exception is in the early 1980s, when there was a lot of change in the disability insurance program rules. And so we, in essence, dummied that out. But other than that, when unemployment goes up, DI applications go up.

The red line is the predicted DI application rate, and the blue line is the actual DI application rate. And if anything, actually applications did not go up nearly as much as one would have guessed in the Great Recession, given how large the recession was in comparison to past recessions. But actually, generally it fits pretty well. So the Great Recession was roughly in line with what one would have thought.

If we look at awards, actually DI awards as best we can tell probably increased a little bit less than one would have expected. Or equivalently – and this is a fact that has been noted by many other researchers – which is that the share of applications that are approved actually goes down in recessions, and it went down a little bit more in this recession.

Our sample is going to be based on older workers, so the first thing I want to do is just show you what this looks like for both older and younger workers. There was an increase in DI application for both older and younger workers. It was slightly greater among the younger workers as a percent than among the older workers. Nonetheless, certainly it suggests that the older workers are a good summary group to be looking at.

So the Great Recession is not unusual; the applications were what were expected. Awards were slightly lower. But what we really want to get at it is, well, what does that mean? What's going on to people? And so we've spent a fair amount of time trying to look at the issue of who winds up applying for DI in recessions that does not apply in expansions. And for this, you really need to know about characteristics of people, not just characteristics of applications; so you need another sort of database.

The data that we go to is the Health and Retirement study which, again, I would guess most people in this room know about. The study itself goes from 1992 on up through 2012. In the early 1990s, there are two data issues that limit our ability to use that. First is it doesn't separate out DI from SSI applications. And then second is because of welfare reform in 1996, a number of people had to reapply for SSDI or various components of that in order to keep benefits. And so there is a spike in applications that one season in 1996, which seems like it's related to older people caring for younger individuals.

Rather than trying to make some ad hoc adjustment for that, we're just going to get rid of those years. And the years that we're going to look at are 1998 to 2012. Our basic idea is to focus on the population that's over 50, which is where the HRS is generally representative.

I'm going to mostly show you things by figures rather than any regression results. And for the figures, I'm going to show you the population age 55 to 61. I'm going to leave out the lower 50s population because the HRS is not representative of that population in every year. It depends on when they replenish the sample, and I don't want to get into changing age composition within the sample figures that I want to show you.

MPR
2015 DRC Conference_Day 1 Part 1

And then if you look at the figures, after age 61 people increasingly retire rather than go on disability insurance. And again, I don't want to get into modeling the retirement decision here. Not that it's unimportant, but I just want to show you a cleaner sample of things. So that's what we're going to look at, people 55 to 61. Even still, there are a number of such individuals. There are about 5,000 of them a year, and they're surveyed every other year.

In terms of applications, the survey asks about whether the individual applied for SSDI since the prior survey wave. We've done some work – not just did you apply over the previous two years, but trying to use the data to identify exactly when the individual applied and what was going on in terms of their own employment history around that time. I'm not going to show you about that here, but that's sort of things that are ongoing.

There are two health conditions that I want to tell you about. One is functional limitations, which is going to turn out to be extremely important here. These are difficulty with either walking or getting up from a chair or sort of basic kinds of things that one needs to do in life. And then the second thing we're going to look at is a major health shock, which is a new diagnosis since the previous wave of a number of serious conditions, including cancer or stroke or heart or lung disease or psychiatric problems.

So let me show you a little bit about the trends. Remember, these are going to be noisier than the national application data just because the samples are smaller, but I will show you what it is one can infer from them. You can see that by and large, with the exception of, say, 2004, by and large this seems to follow the cyclical pattern. That is, applications were somewhat higher in 2002. Remember, this is over the previous two years; so it's reflecting the recession in the early 2000s. And they're higher in the 2010 wave and the 2012 wave, which is during the period of the Great Recession.

We are going to show you some charts, and I'm going to show you the change in the DI application rate. And the years I'm going to show you, the changes are from the last two waves, which are since the surveys are conducted throughout 2008. It's effectively the period 2009 to 2012. And I'm going to compare that to the earlier period post the 2000 recession. So I'm going to show you from the 2004 to 2008 surveys, which are roughly 2003 to 2008. So think about these as during the Great Recession and before the Great Recession.

And if you do that, there is actually an increase of about one-third in the DI application rate if you just sort of average those – slightly higher than the national data, but generally tends to look pretty close to it. So we're feeling pretty good about this.

Now what I want to do is I want to show you who it is that applies more for DI in the recession than had applied in the expansion. And I'm going to first show you a little bit about demographics, and then I'm going to show you a bit by health condition.

By demographics, we have done it by gender and education. By gender, actually, there's not an enormous difference. Actually, the increase in DI applications is slightly greater among women than among men, although in both cases it's relatively constant. And somewhat interestingly, actually the effect of the Great Recession on application rates was a little bit higher for the better educated than it was for the less educated. Less educated people, on average, applied more; but the rates did not go up more during the Great Recession. It may be that this factor is relatively well-known. I, at least, found it interesting to see that.

Let me look at the two medical sorts of events. The first one is whether the person has a functional limitation. So this is looking at in that wave, do you report a functional limitation? And what's not particularly surprising here, but kind of is telling you what's going on, is that the increase in the applications is all among people who say that they have difficulty with those activities.

Now, at one level, that's sort of obvious when you hear it because, of course, you better have difficulties with that or you're not really going to get DI. But what's interesting about this is to contrast that with

MPR
2015 DRC Conference_Day 1 Part 1

people who have had major health shocks. And there is actually no increase in the application rate among people who have had major health shocks in the Great Recession. What seems to happen is that these are people with ongoing functional limitations who, come the time of the Great Recession, then decide to apply for DI.

And just to show you a little bit more about that, you can see here if you trace out people who report, find the first wave in which an individual reports having at least one functional limitation, and then trace out what happens to them, in that first wave, they're about 2% likely to apply for DI. But if you go out four years after that, the rate has increased to about 5%. So effectively what happens is people develop these functional limitations; they stay in the workforce a bit. But then sometime over the next two to four years, they wind up applying for DI.

It's not particularly associated with having had a major health shock. What it is, is a sort of long-standing recurrence of functional limitations. And in fact, just to complete the story a little bit, what's different about recessions here is not actually that more people are reporting that they have functional limitations. In fact, if anything, the share of people who are reporting that they are functionally limited is actually falling in the Great Recession. It's that the application rate of people who have functional limitations is going up. So these are people who have some difficulty doing stuff. And come the Great Recession, they then apply for DI.

The question that then leads to is: What happened to these people not in recession times? Is it just a slower process? Do they ultimately apply for DI but at a slower rate? Do they leave the labor force at a less rapid rate? What happens to their earnings as they move through the labor force?

So what I want to try and do is draw a picture of what's going on for people, particularly these functionally impaired people. We observe them having a functional impairment; and sometimes it's in a good economic environment, and sometimes it's in a bad economic environment and what sort of happens to them.

So here's what we're going to do. We're going to find people in the first wave in which they report a functional limitation. So just like I showed you back here, we're going to find people in that first year. We're going to characterize them by the first year, and then we're just going to follow them over time. So we're going to create cohorts of people by the first year that we observe them having a functional limitation. What we're going to do is we're going to look at their DI application rate, and then we're going to look at their labor force participation.

For the DI application rate, we can follow everybody. For the labor force participation and earnings, we're going to condition on having worked in the wave before we first observe your functional limitation. That's not everybody by the way. That's not everybody even who applies for DI. As the previous paper was showing us, there's a lot of heterogeneity in those transition paths. But it's at least a way that we can get at this.

Here is an example of the analysis, and I'm going to focus mostly on the DI part. What this is showing you is the cohort of people who have reported their first functional limitation in the year 2000. What in that wave of 55 to 61 – remember that's our sample restriction – and then what share of them applied for DI, and that's about 2%.

And then if you follow those exact same people, they age by two years each time. So if my ability to add two is still accurate, then that shows them aging. And you can see their DI application rate going up. So by 2008, when they're roughly at Social Security full benefits retirement age, it's about 5%. You can't follow people after because you're not going to go on DI after that. You're going to go on old age insurance. You're going to go on Social Security. So this is about what we can observe.

Now, I then want to trace that out for each subsequent cohort. So what this picture shows you – here is, again, the 2000 cohort. And now what I've added is the 2002 cohort. The 2004 cohort, we have

MPR
2015 DRC Conference_Day 1 Part 1

somewhat fewer people there, so that's why it gets dashes; the 2006, 2008, 2010; and then there's the 2012 cohort. And the biggest conclusion that comes out of this is that any cohort that had functional limitations in the time period of the Great Recession wound up being much more likely to apply for DI. This doesn't seem to be a bunching up during the recession of people who would have otherwise applied, but otherwise applied later. Rather, it seems to be that some people who would never have applied for DI – they would have left the labor force somehow – wind up applying for DI in the Great Recession.

So that's the first biggest implication of this, is that it seems like it's an overall increase in the DI application rate.

I'll just go very quickly through a couple of the other slides because these are things we're still working on. If you look at the labor force participation rate, it's actually not much different in the Great Recession. It seems like all of these cohorts are declining in the labor force participation. It's not a question of whether you would be in the labor force or not. What seems to happen though is that earnings see a steeper decline for this group in the Great Recession. So somehow, what's happening is that there's a greater decline in earnings, which is coincident with a greater increase in DI for that cohort during the recession. I have tried to avoid any statement about causality in that, but just to sort of say that seems to be what's going on.

That's at least where we're going with this, is to try and understand more about those people who have these preexisting health conditions and how does that differ in good and bad economic periods. Thank you.

[Pause for change of speaker]

Thank you very much. It's a pleasure to discuss this work. I think it's a really productive avenue that they're pursuing. We know surprisingly little about, as Deputy Commissioner Reno was saying in her introductory remarks, about the trajectory, the set of things that happens first that leads people to apply for SSDI. How is the role of adverse health shocks? What's the role of chronic conditions? What is the role of job loss and perception of the difficulty of finding a new job? We know DI applications arise during recessions. That may be partly because people lose jobs; it may be partly because people perceive that they're not going to find jobs when they're looking for them.

The role of the awareness of the program itself, for example, family or friends, state agencies, and contractors or law firms and other paid advocates who advertise vigorously – what role do those play in getting people to decide to apply for SSDI?

So this paper fills an important gap in our understanding by trying to help illuminate the role of functional health limitations and health shocks in catalyzing DI applications. And kind of the bottom line of the paper is that the combination of an existing functional limitation plus a recession greatly speeds the time to application. And you can see, something we know very well here is this figure from their paper shows you applications and awards. And there is a big increase in applications and awards during the Great Recession as is well-known.

And I should say, their data also predict a large increase in applications and awards during the Great Recession. However, so now let me sort of restate their three conclusions and then just remark on them.

One conclusion was that the Great Recession was not unusual. Applications were about what you would have expected, or even slightly less. And awards were about what you would have expected, although less again. The second is that DI applications increase in recessions among those with functional limitations. And the third is that outside of recessions, people's functional limitations are more likely to maintain earnings and less likely to apply. So probably one connection between those is the faster decline in earnings among those with functional limitations during recession catalyzes or speeds the time to DI application.

MPR
2015 DRC Conference_Day 1 Part 1

I want to talk about each of those conclusions. The first about whether the Great Recession was unusual – and here I would say, there is actually more going on than is visible from the HRS. And one way to see that is there are two real standout periods in the history of DI applications in the last 30 years. One is the early 1980s recession, and the other actually is the Great Recession.

As you know, during the 1980 recession, there was a tremendous increase in unemployment, extremely steep, and yet no increase in disability applications. In fact, they fell. And everybody is aware why that was. It's because there was a dramatic clampdown on the program and widely publicized. Allowance rates were going down, and many people were being removed from their roles. And applicants understood that, and they stopped applying.

During the current recession, what you see is a very steep increase in applicant rates but a much less steep increase in actual allowance rates. And that's a topic that's come under some discussion. So the Office of the Chief Actuary in 2013 issued a technical note, a fiscal note. And they said, well, this can probably be understood as a consequence of when more people apply, fewer of them have meritorious or strong applications. And so more of them will be disallowed, will be rejected. And so probably what's going on is the recession has increased the number of applicants; fewer of them are qualified. So it's not surprising that the allowance rates would fall as much as they did.

I don't think that's the full story. One way you can see that is the allowance rate at the administrative law judge level, and it's pretty stable through about 2008. And then it falls by about 20%, so from 71% to 54% between 2008 and 2015. And that's not coming back even though the application rates have come way down, which suggests that there may be something of a regime change going on in adjudication.

Another way you can see that is if you look at different cohorts of administrative law judges and what their allowance rates are. So these are cohorts higher from 2005 forward. And you can see, their allowance rates start to decline around 2008. Then you look at each subsequent cohort that is higher –new administrative law judges. These are judges who have made at least 100 determinations. And each one comes in at a lower level than the prior cohort and then declines along with it, suggesting that newly-hired administrative law judges are applying more stringent standards than prior cohorts of administrative law judges.

A final piece of evidence suggestive of this is if you look at the DI awards by diagnosis – it would be 3 in '89, '99, (inaudible) – these are all going up and especially mental and musculoskeletal, as we know the leading drivers of the growth of SSDI. And yet, all of these flatten out or fall. But the largest fall by far is in allowances for mental health; and that falls from 1.4 per 1,000 to about 0.9 per 1,000, which is a huge decline, again suggesting that the way cases are being allowed is changing or being determined. And that certainly will feed back into the application process as well and who applies and when.

Okay, I don't think that would be visible from the aggregated; but I think there is something really important going on during the recession, and it's not all economic conditions. It's also the way that the agency is administering the system.

The second conclusion of the paper, DI applications increased in recessions among those with functional limitations, I fully agree. And this is a really important finding. What you see here is the advent of a functional limitation by cohort and then the probability of applying for DI. And the important thing to note as you go to the right of that figure is that those get steeper, meaning that the cumulative time from onset to application has fallen.

Similarly, the third finding is that outside of recessions, people with functional limitations maintain earnings longer. And you can see that in the steepening of the downward trajectory on the right. And again, that means the most recent cohorts develop functional limitations/experience more rapid earnings losses. So putting those things together, what they suggest is the recessions, although they are transitory, have permanent effects because if you develop a functional limitation during a recession, it's much more likely to be career ending, to lead to SSDI application. And of course once people are allowed onto SSDI, it's unlikely that they will return to the labor force.

MPR
2015 DRC Conference_Day 1 Part 1

To conclude, this helps us to understand how economic conditions interact with health shocks and move people on to the roles who in different conditions might have been able to stay working. It's costly for them; it's costly for the program.

And I finally want to emphasize, there really isn't a normal course of events for SSDI's interaction with the business cycle. It has changed enormously over time as the program has changed, and I think it's changing now. And we're seeing that not only in falling allowance rates, but also in the surprising fall off in applications. Thank you.

[Pause for speaker change]

Good morning. I'm very happy to be part of this panel on early intervention and to be able to share with all of you what we have learned about the prospects for early intervention, specifically in California. This is joint work with Frank Neuhauser at UC Berkeley and Dave Stapleton. And I'd like to thank SSA for supporting the project.

In my 15 minutes, I'd like to cover first what we mean by early, early intervention -- that wasn't a typo on my title -- as compared to just plain early intervention. Second, the challenges involved in implementing any such intervention; third, the prospects of implementation in California, specifically; and finally, some preliminary findings using California's Worker's Compensation data.

I think everyone here agrees that early intervention has the potential to slow SSDI growth by stemming the flow into the program. But there are different interpretations of what the word "early" means in this context. And here we are explicitly defining early to be when the worker is still connected to an employer. Some reform proposals, such as experience rating SSDI and mandating private disability insurance, share the same definition. And the connection to the employer is really very important.

Numerous studies point to employer/corporation as key to keeping the worker in the labor force. And a recent study by David Otter and others I think there here in the room have shown that the longer an SSDI applicant is not working, the less likely he or she is to work again.

Early intervention is, of course, not a new idea. The novel part here in looking at state temporary disability insurance and Worker's Compensation was suggested by the Social Security Advisory Board back in 2006, when it suggested testing the prospects for early intervention in one of the five states with mandatory disability insurance. The Board also emphasized the importance of still being connected to the employer. And we are not aware of any study that has since then considered this possibility.

So as we see it, there are three main steps that need to be accomplished for any such early intervention to succeed. First, we need to be able to identify candidates for intervention as early as possible. And when I say identify, that also means screening for those who would actually benefit from early intervention. We need to avoid intervening with those who would not benefit, either because they might return to work without any help or might not return to work no matter what the intervention is.

Second, we need to be able to effectively recruit those candidates to actually participate in the intended intervention. And finally, we need to intervene effectively, meaning increase the chances that participants actually remain employed and not enter SSDI.

The focus of our paper and this presentation is really just on Step 1, early identification. What are potential places and programs where candidates can be identified for early intervention while they're still connected to their employer? And can we use data collected by these programs to really operationalize early identification? And this includes implementing the effective screening I had just mentioned.

So what is so special about California in this context? In California, most SSDI applicants are presumably eligible to receive state-based disability benefits before they knock on SSDI's doors. The Worker's Compensation system in the state covers occupational injuries and illnesses, and basically this applies to

MPR
2015 DRC Conference_Day 1 Part 1

all states. But in California, the short-term disability insurance program, called simply state disability insurance, covers non-occupational cases. There are four other states and Puerto Rico that have mandatory short-term disability insurance. I think it includes Hawaii, New Jersey, New York, and Rhode Island. The California program is the most comprehensive by far. It is fully funded by workers and offers benefits for up to 52 weeks, about twice as much as any of the other programs.

So what we set to do in this study is see can we predict likely SSDI entrants already when they enter California's Worker's Compensation or short-term disability assistance or at least very shortly thereafter. This is not merely a theoretical exercise. We know that tens of thousands of Californians enter SSDI and SSI each year. And previous research by SSA has found many of them were either receiving Worker's Comp or SDDI benefits or had pending applications for those benefits when they were on SSDI.

Let's take a look at the statistics in 2013. According to the SSDI Annual Report, over 70,000 California residents began receiving SSDI as disabled workers in 2013. That's over 8% of all disabled worker awards that year and more than any other state – not surprising, of course, because California has the largest population. In addition, more than 60,000 Californians began receiving SSI payments in 2013. Of course, there is some overlap between SSI and SSDI in those numbers.

Back in 2008, SSA found that many SSDI beneficiaries in California were receiving Worker's Comp or STDI. In December of 2008, over 70% of the more than 600,000 Californians on the roll were found to have such a connection. So we're talking about 100,000 in a cross-section view. But this captures relatively new entrants because the Worker's Compensation and STDI benefits are temporary. The STDI benefits are paid only for up to a year. So this 100,000 figure certainly captures entrants for more than one year; but still, in the case of the flow into the SSDI Program from California from people that interacted with those programs is large. It also doesn't capture those Californians who entered SSDI sometime after they exhausted their Worker's Comp or STDI benefits.

I want to briefly cover the basic features of the California programs to clarify who may enter these programs and later enter SSDI. California's Worker's Comp program is financed by employers. It pays temporary disability benefits primarily to workers who cannot work due to an occupational injury or illness. The benefits are roughly two-thirds of the worker's base wage and in most cases are paid for up to two years. And the Worker's Comp payments also include covering the medical costs related to the injury.

In 2013, across all industries and government agencies in California, there were about 150,000 Worker's Comp claims with at least one day away from work. The short-term disability insurance program pays up to 52 weeks at a somewhat lower replacement rate, 55% of the base period wage. The program does not cover any medical benefits. In the state, fiscal year 2014, there were close to 470,000 non-pregnancy STDI claims were paid. And I say non-pregnancy because that program also covers pregnancy-related benefits. I don't have these numbers for other states but, as I mentioned earlier, the benefits in other states are less generous than they are in California.

To better understand the nature of these programs and the extent to which they already provide return-to-work services and the potential for the intervention, we interviewed in-person representatives of a few state agencies and some other organizations in California that are very much involved in the disability landscape in California. We talked to the Employment Development Department, which administers the Temporary Disability Insurance Program; the Department of Industrial Relations, which administers the Worker's Comp Program; the Department of Rehabilitation; the State Compensation Insurance Fund; the World Institute on Disability; and Integrated Benefits Institute.

And what we found is that in Worker's Compensation, particularly the State Fund, which is the Work Comp insurer of last resort, is implementing an innovative and promising approach for early intervention in which they do triage and assign case managers that aggressively manage the cases and help people return to work. Other insurers do take some aggressive measures to reduce liability, including monitoring it through physician reports and encouragement of traditional work. But they do little once it becomes unlikely to them that the worker will return to his or her previous job.

MPR
2015 DRC Conference_Day 1 Part 1

In contrast, no return-to-work services are systematically provided to California's SSDI payments. The program just administers the payments.

To effectively identify Worker's Comp and STDI claimants who are likely to enter SSDI, we would ideally have had access to administrative records for both these programs' claimants that are matched to their SSA records. But we do not have such data; and, frankly, I don't think we will be able to. Instead we plan to use just the program administrative data to identify the characteristics and medical conditions associated with three proxy measures: receipt of the benefits for up to 3 months, 6 months, and 12 months.

We're still talking to the State Temporary Disability Insurance Program to see if we can get their data. And we still hope to be able to do something with their data at the aggregate level, but we will not be able to get individual-level data from them. We might have been able to if this project was funded through the University of California, for example; they might have been more open to it.

The file we received from the Division of Worker's Compensation contains 3.7 million Worker's Comp claims with months of injury from January 2007 to 2012. About 18% of them received temporary disability payments for lost time, so that is the sample that we analyzed. The mean duration for men was around 140 days and for women around 150 days. We found that they were highest for those ages 45 to 54 and for those with musculoskeletal or psychiatric conditions. And we also know that the mean durations generally fall with the weekly wage.

More than 20% of cases were related to lower back pain, another 15% at least to other musculoskeletal conditions. This closely mirrors the entrance to SSDI, where we know that 36% have musculoskeletal conditions. More SSDI entrants have a primary mental impairment, around 16%. And in this data, that percentage was much lower. So I think that would suggest that those who enter with a mental impairment are really on the STDI side.

The preliminary descriptive statistics that we do have, just from the Worker's Compensation data, suggest the following. Those with musculoskeletal or psychiatric conditions are associated with relatively long periods of disability and are very likely to exceed the 12 months of temporary disability payments. We're talking about 20% to 28%. Within each of these two categories, certain sub diagnoses, such as lower back pain, illnesses, depression, or Post-Traumatic Stress Disorder, are associated with much longer periods of disability than other sub diagnoses.

Having a secondary psychiatric condition is associated with much longer-lasting disability and a 50% higher chance that disability will exceed 12 months. And some traumatic conditions, such as burns and concussions, are associated with short periods of disability on average. But if they're still receiving disability after 3 months, the probability that they will exceed the 12 months is much greater.

To conclude, we think California and other states with short-term disability insurance are good candidates for what I called here early, early intervention – interventions that begin when the worker is still connected to his or her employer. We also think it's important to note that the Federal Government has a much larger incentive than the State to fund such an intervention. The potential savings in terms of SSDI and SSI and Medicare and Medicaid that the Federal Government can see, the States simply have much less options for realizing these savings. And I think this realization also bears out when you talk to the State agencies about this.

A third type of identification, effective targeting (inaudible) we think possible; but they do require access to the relevant data. We were able to obtain Worker's Comp data; but the data that we really wanted, the STI data, we're really having trouble getting that data and we're still working on it.

Finally, if we had matched data to SSA records, that will be even better because you could then estimate a model that predicts actual SSDI entry instead of the proxies we've been using. And as I mentioned, I

MPR
2015 DRC Conference_Day 1 Part 1

think that might turn out to be impossible in California. But we are still trying to do that with other states. Thank you.

[Pause for change of speaker]

Hi, I'm Jennifer Christian. I am not a researcher in any formal sense of the word. I am a licensed physician, and I happen to be licensed in California. I have worked there. I have practiced medicine there. I have been the Medical Director for a large health care delivery organization developing a Worker's Compensation practice there. And I currently still do some physician case management there. So I'm here to talk about California from the point of view of an actor in that system.

And I do think that the California Work Comp system, as you listen to this when we're talking about it as a feeder for SSDI, it's one of the worst Work Comp systems in the country. It has the longest durations. It's not No. 1 necessarily because some states vie for the booby seat every year. But it's one of the ones with the longest durations, highest costs, most adversarial, and thought to have the highest rates of fraud particularly in Southern California compared to Northern California.

But I think I want to start with the fact that the data difficulties that Yoni and his colleagues have had are really emblematic of the opacity of the stay-at-work and return-to-work process. And you used a word in demography about – what is it?

Life course?

Life course – the course of events from the time that someone has a health condition which is interfering with their ability to work and the time when they enter onto SSDI -- that is a very opaque process at this point. But it is also a very real and very human one because people have a predicament, and they are going steadily downhill. There's a set of kind of predictable things that happen.

And unfortunately, at this point, no one, no party, no stakeholder, is being held responsible for actually providing assistance with the stay-at-work or return-to-work process to any person. And no one, no party, no stakeholder, is actually being accountable when they lose their jobs. And so the dataset that you're going to be looking at lacks information that would help you really figure a lot of this stuff out.

So I strongly feel that sunshine is needed on this process. And I think that the research you're doing is perfect. And the ridiculous obstacles to accomplishing the research need to be overcome. And part of how it will become overcome is when we come to a shared understanding across all our sectors and silos that people have really unfortunate stuff happening. And the fact that we're in sectors does not mean their life is in sectors. They are a whole being, right?

I also want to salute Dr. Ken Mitchell from Unum, who years ago, with a much less fancy methodology, was the first to really document how people flow through these systems – that it is a waterfall from one thing to another. And I have looked, actually, to try and find my copy. His study must be at least 10 or 12 years old. If any of you guys have ever seen it, we should all uncover it.

So my advice about the research that I've heard today though is if you're really trying to find how people go on SSDI, I think you should really be focusing more on preventable or avoidable reasons why people go on SSDI. Because if some people basically are fated to have something really unfortunate happen and they're going to end up with a terminal disease, we don't actually get much public benefit out of you telling us that because we can't do much about it.

But what we can do is help the people who don't need to enter SSDI. So that's where the research ought to really be focusing. And the part that has been surprising to me in most of the research on SSDI these days is that the lack of attention, the really specific focused attention on musculoskeletal and psychiatric conditions because that's where most of the rise has been occurring.

MPR
2015 DRC Conference_Day 1 Part 1

And if you're a clinician, what you know is that's where preventable, avoidable discretionary disability is occurring. So I just think it needs to be combed down tightly because that's where the rise is; that's where the most common things are happening. And it's also where discretionary disability is.

I actually just this week found a study from the United Kingdom. It was a very careful chart review study done in a whole geographic region, where they looked at the medical records of people had sought specialty care in a variety of specialties. And they were looking for how frequently when you went to see a neurologist with a complaint about a headache, when you went to see a gastroenterologist with a complaint about bowel problems, when you went to see a musculoskeletal specialist with complaints about joint problems or back problems, how often did the doctor end up saying, basically, "There's no real medical reason for your symptoms"?

Now, there are a lot of cover diagnoses we have those cases. We call it irritable bowel syndrome; we call it fibromyalgia; we call it – I can't remember what are the other things we call it – general headache. But what the doctor is saying is, "There's really no biological thing I can find. There's no evidence of any tissue pathology or disease." And for low back pain, it was 67% -- 67%.

Okay, so we have a whole lot of people coming on to Social Security Disability, coming on to Worker's Comp, coming on to STD and LTD for low back pain. And the doctors are telling us in the charts, a lot of times there's no real pathology to go with it. And even if you have real pathology, those same factors that are causing the symptoms are there because the factors are arising out of the whole human, out of the context they're in, the bio, psycho, economic context in which they're living, their existential dilemmas – whatever it is.

And so we have a lot of opportunity to improve outcomes in this group because their disability, their impairment, is not inevitable. It is not immutable, and it is not irrevocable.

So just in terms of contrasting the two programs to orient you a little bit, if you have a non-occupational condition and it's going to end up with you on SSDI, it can either start as in exacerbation of a chronic condition you've had for a long time; or it can be an acute health shock. And in the private sector, they have been documenting how an increased use of casual sick leave, increased use of FMLA, predicts going on to STD and using more FMLA; going on to LTD.

And in general, as a rule of thumb, one of my pals who is a Medical Director at a disability carrier said, "Most people have lost their jobs by six months." Often, since the FMLA only protects jobs until 12 weeks, they've lost their jobs by 12 weeks. And the use of lawyers in the non-occupational world is very rare until you get to SSDI, when I guess it is kind of common.

In contrast, in Worker's Comp and particularly, since we're talking about California, there is usually a clear date of injury. There certainly is a clear date when the claim of inception starts. There is a clear date when somebody leaves work. And as Yoni said, there are two years of TTD, temporary total disability, that can be paid. But during that period, you may or may not go back to what they call light duty or go back to transitional work.

And at a certain point – and this is an oddity of the Work Comp system – the doctor has to declare that the patient is either they call it "permanent stationary" or at "maximum medical improvement." And that's a declaration they're as good as they're going to get, and at that point the claim can start to go into the claim resolution process.

Now, for people who are going to have some what they call "permanent impairment," some objective evidence of permanent change in their health, 80% of them have a lawyer in California; 80% of them have a lawyer. And the result of this claim resolution process is they're either going to be found to have no impairment; or, if they have an impairment, they will get a cash payment, which is only between \$10,000 and \$20,000. And a very small number of them end up on what's called "permanent and total

MPR
2015 DRC Conference_Day 1 Part 1

disability." And I actually didn't hear, in your dataset you were looking for the match between the people that got permanent and total and the people that went on SSDI.

Now, just in terms of – I'm talking about artifacts that are operating to distort the data. And so in litigation in California, the lawyer gets a percentage of all the medical that has been paid already. And apparently, some of them have worked it out so they can get a share of the future medical, although there now is a Medicare set aside that's in a trust. But apparently, some of those lawyers have figured out a way to get into that money. And they get a share of all the temporary total disability that's been paid; and they get a share of the permanent disability, a cash award.

I have my own little mini version of Deep Throat. I have a friend who worked for a large California insurer who sent me the results of a study they had done on the impact of litigation in their cases. And he had controlled for diagnosis. And what he found was that every single outcome was worse if the person had a lawyer, except the size of the permanent disability award, which was the only cash that went to the worker.

But with more respect though to the specifics of this study, I was a little surprised that there were fewer STDI claims than there were Worker's Compensation claims because our general rule of thumb is it's like 3 to 4 to 1 of non-occupational to Worker's Comp claims. I'm not very good at math, so I'm just working off Yoni's paper. But I thought that ratio of how many non-occupational versus Worker's Comp claims was odd.

And then in terms of the understanding of the programs and being able to really compare what's happening in these earlier private sector and public sector programs compared to SSDI, I really do suggest you talk to employer organizations and medical organizations because they're going to tell you what's really happening on the ground.

One of the things that really struck me – and this may be a little politically incorrect – but I'm pretty familiar with the State Compensation Insurance Fund to California, and I would not believe them then they say they are actively providing early return-to-work services. And any time you talk to any insurance company, as a researcher I would definitely ask to see any evidence that they're actually doing what they say they are doing because they are going to market their early return-to-work services as part of the reason why you're paying them money. But from the inside, what I'll say is they're not.

In my physician case management work and in my consulting work, I have had clients that are case management companies. And they talk – the case management companies talk in Worker's Comp about early intervention and being on the phone with the employer or the worker and the doctor within 72 hours and starting the case management process right away. But actually, that depends on when the claims adjuster gives the case manager the file; and it is typically seven to nine months later.

So there's a disparity between the speaking and the doing. And if you're doing to research, I want you to find a way to figure out what's actually going on. And the way that Work Comp works is the adjuster controls the file. So even if a company has a philosophy or a practice or has said, "We are going to do this," it is up to the adjuster to decide whether to actually do it.

It's time.

Beg your pardon?

It's time.

Oh, I'm sorry; I didn't watch my clock.

It's there.

MPR
2015 DRC Conference_Day 1 Part 1

Oh, is that mine – that I'm already two minutes over? Bye.

We were doing great up to that point. But we still – I didn't know you were vision impaired.

We do have 10 minutes though for Q&A, I think. And we've got two mics somewhere. There they are. Questions, please? Yes, right here – go ahead.

Is this on?

Yes, and please say who you are and if you're with an organization.

Joanne Schneider, George Washington University. I have questions for Mark Cullen and also for David Cutler.

Mark, two quick questions. First of all, we know how unique Alcoa is. So can you talk about how you're going to analyze this to talk about what's comparable and what's not? But the more important question I have for you is you very quickly mentioned social factors as a major factor here. And I'm wondering if you could expand on that?

Let me very briefly take a swing at the first one because it comes up in – as you can imagine – every grant, every paper, and every discussion like this as to whether or not we're looking at something that is so atypical as to be fascinating but of no general value. And all I can say is we've spent a lot of time both trying to harmonize our data with, for example, survey data like Health and Retirement, Jeanette Haynes, and so forth. We looked at such things as the pattern of disability claims by age, by occupation, and so forth, by diagnosis. They more or less perfectly mirror what's going on in the rest of the population.

So whatever the cultural differences are – and indeed, there probably are some cultural differences – I don't think they're overwhelming in terms of what we can learn from the dataset. It's a long discussion, but I'll leave it at that.

In terms of social factors, again, because of the richness of the data, we don't talk to the people. So we don't have the equivalent of what HRS has in terms of, for example, people's self-description of their ADL limitations and things like that. But we get to observe their overtime use, their application for job changes over time. We look at their payroll patterns. We know a ton about their absenteeism behavior very early on, from which we've begun to develop some paradigms in which we know – in addition to we know their address. We know a lot about them. We know what their savings behavior looks like and their savings. So we've begun to – dare I say it – profile them in many different ways. We work very closely with a psychology group on campus because they are also interested in many of the same questions.

We also look at incidentally contextual factors. So we recognize huge differences in the workforce in some counties compared to others because of the richness at the level of the county and so forth – different from individual social variations. I'm not quite sure where you're going with the question, but we have both access to a lot of that data and great interest in how it determines behavior at the individual levels.

But no specific factors that you can discuss now?

Nothing yet has jumped out. I can tell you the ones we're interested in; but, no, I have no answer for that.

Joanne, I'm going to let somebody else ask a question. And if we have more time, we'll let you come back and ask your second question. We have very limited time. And actually, somebody right next to you has a question so if we can go to them.

Paul (inaudible). On the Alcoa study, could you describe the extent of unionization and whether that's changed over the course of the period? And second, for the Cutler paper, I'm curious. We're talking about

MPR
2015 DRC Conference_Day 1 Part 1

effectively preexisting conditions when someone loses a job. Is there a way that we could use or encourage job sharing and partial unemployment benefits to perhaps mitigate some of those impacts on DI applications?

Mine is easy. About 35% of the workforce is unionized. It's essentially one union, steel workers -- one contract across all those plants. And it gives us yet another level of variation. We haven't talked about it.

On the issue here, I think it's a very good question. One of the policies one might think about is what is the impact of something like extended UI benefits? So for example, if you allow the person to keep more UI, do they ride it out through the recession? And there were, of course, extended UI benefits in the Great Recession. The difficulty is that they were pretty uniform across the country, and so we don't have a lot independent variation that would allow us to answer the question. If you made some workers eligible for extended UI, does that then have a savings in terms of lower DI application and permanent DI enrollment for those individuals?

Back to Joanne.

Really quickly, I'm wondering, David, about whether you have data that shows actual lengths between UI and applying for benefits?

If you look at it at the individual level, the people who tend to be losing their job around the time that they're applying for DI, some of it is individuals saying they had job loss; and some of it is people saying they are retired, which is I think a catch-all for I'm not doing anything else and then they apply for DI.

We haven't been able to then link that up with something like what is, say, the replacement rate on the UI benefits that you receive and how does that then influence the DI application. I think that's on our agenda to do, but it sort of gets very messy at doing that. And it's sort of related to the question that the gentleman just asked, which is about if you think about other kinds of temporary policies, would those avoid the permanent increase in DI? I think that's something that we probably should pay more attention to, although just working through it is very difficult.

Others? Yes, way over here.

Hi, Stacy (inaudible) from (inaudible). And this is for third article's authors and for Dr. Christian. Dr. Christian mentioned that mental and musculoskeletal are among the most preventable impairments. But the return-to-work data show that even among this population that has access to a lot of good health care and early intervention that these are the impairments that lead to the most time out of the labor force. So I'm curious about what are some of the effective early intervention strategies that have been tested that do get people, particularly with mental illness, quickly back into the workforce? Are there any? How much do they cost? How could they be expanded?

I'm less good at the mental illness ones as a standalone issue because it just isn't my area, so much, of expertise. The data they have from California though is typical, which is that when you combine a musculoskeletal impairment problem with a mental nervous issue, then you actually have a particularly toxic combination. And the early interventions that have been shown to be effective are actually prompt normalization of daily schedule and getting the person back into a transitional work position so that they aren't learning they're disabled. Because in these particular conditions, once one defines oneself as unable to work, that makes a really big difference.

So early return to safe activity -- I'm in the specialty of Occupational Medicine, and we actually promote early return to safe and usual activity as rapidly as possible. That is like the No. 1 intervention.

The second thing is effective treatment as opposed to treatment. There is a whole lot of variability in medical care in America. If you haven't seen the Dartmouth Atlas of Healthcare, I suggest you look at it. And really, the more work that I have done on trying to figure out who it is that goes on to SSDI, it's

MPR
2015 DRC Conference_Day 1 Part 1

people who are falling through the gaps in the system for various reasons. And inappropriate and ineffective medical care is a perfect example. In fact, early opioid treatment with narcotic medication has been shown to worsen outcomes in musculoskeletal conditions. So that's one example -- is getting people the right medical care as opposed to medical care.

And actually, that's one oddity I find in the whole discussion about trying to improve care for people in SSDI is the focus is often getting people services as opposed to getting them the right and effective services.

We have time for one more. Yes? Not enough Davids in the conversation yet, another David.

This is for Mark Cullen. Have you been able to wrap in other similar kinds of multifactorial studies? I'm just thinking there's a firm called Options & Choices, Hank Gardner, I think, that did a similar kind of effort with FedEx data a long time ago. I'm just wondering how much other research is out there and whether there are things to blend in?

We have relationships with lots of organizations. I do personally, and my research group has worked with a bunch. To my knowledge, there's no other organization that's invested as long and deeply in one relationship that's allowed the accumulation of this kind of data trove, if you will. But there are a lot of other organizations that are quite interested in going in this direction.

So again, with the privacy concern on the one hand being a potential show stopper -- and it is a serious issue -- there really are a lot of organizations that are actually, because they have their own incentives for wanting to address parts of this problem. They don't unfortunately, like the state of California -- the employers in the end of the day don't have a huge incentive to hold on to employees that are far out in one of these bad trajectories -- far down the waterfall. But they do have lots of other incentives earlier in the pathway.

So I think the possibility exists for doing more of this, especially in the era where the data themselves are easier to manage.

Okay, thank you very much.

[Applause]

The next session will start promptly at 10:30 a.m. In the meantime, you may wander around and find the bathrooms.

MPR
2015 DRC Conference - Day 1 Part 2

2015 DRC Conference – Day 1 Part 2

This is a session on health and health-related supports. Again, there are three papers, and the first one is by Alexander Strand, and we'll just proceed down the line.

Hi. I'm Alexander Strand from SSA. My co-authors for today's research are Alexander Gelber. How's that sound? A little louder? Okay. My co-authors for today are Alexander Gelber from Berkley and Tim Moore from George Washington University. And on their behalf, I'll say that they're grateful for funding from the DRC.

We're motivated in this paper by the contrast between how much research there is about the disincentive effects of the disability insurance program and how little research there is about the benefits of the disability insurance program. It's really sort of the understated or assumed sort of thing, so we hope to add a little bit about the benefits of the disability insurance program, particularly on the beneficiaries' health. So, given this contrast, it's difficult to make a cost benefit analysis when all the evidence is on the side of cost.

Okay. These are the things I'll cover today. I'll give some descriptive information about mortality among DI beneficiaries. I'll talk a little bit about what we can learn from prior studies, about the effective income on mortality. I'll speak very briefly about previous papers, about the disincentive effects of DI, and I'll cover a couple papers about the health benefits of DI, and talk about the methodology and present some results.

Starting with the descriptive information, the first thing to notice is that mortality rates are very high among DI beneficiaries. Here we show the cumulative rates over a ten-year follow-up period for a cohort that entered DI in the late 1990s. And you can see that around by two years the mortality rate is around 25%, but four years, it's up to -- sorry, it's hard for me to read that from that far -- 25%, and at the ten year follow-up period, it's almost up to 40%. So that's the grim news.

The solidly more encouraging news is that the mortality rates are coming down rather rapidly. The blue line there, we see mortality rates for the 2002 entry cohort, and we can see that by the four years it's gone from, say, 25% down to 18% or so, and then in the purple line you see the 2007 cohort, and we see that it's declined even further. We make no assertions about whether this is due to composition change and technical change, or perhaps both, and a number of factors are driving this.

Mortality varies a lot by diagnosis. Overall rate for the first four years is 16.6 %. That's a combination of some low mortality diagnosis categories including mental and musculoskeletal conditions, some moderate diagnosis categories, including circulatory conditions and all other conditions, and one very high category, which is literally off the chart neoplasms, which has a mortality rate of 71.7 % over the first four years.

The change is also somewhat uneven over the -- this is the 1997 to 2007, so we can see over all that 43% decline, and it doesn't necessarily correspond to high and low mortality groups. It's mixed among the low mortality categories, smaller for mental conditions, and larger for musculoskeletal conditions. The largest for circulatory condition. All others are smaller. And for neoplasms the percentage change is small because it starting from such a very high rate.

Okay, from a previous studies, what can we say about the relationship of income and mortality? There's sort of a general trend and there's exceptions to this trend, but the general trend is that across many contexts, higher income is correlated with better health and lower mortality. Okay, so higher income lower mortality, except for when it isn't, and often it isn't. So causation is unclear, mechanisms are unknown. There's an extensive literature, but it's ambiguous.

There's few causal studies. This one I like particularly from Lindahl in the 2005 Journal of Human Resources, and it talks about the random distribution of income through the Swedish lottery, and they conclude that using lottery earnings is exogenous variation in income gives results in income, suggesting

MPR
2015 DRC Conference - Day 1 Part 2

income to be very protective against death. So that sort of sums it up. Protective against death is what we're interested in here. However, the effective unearned income is much more ambiguous. So I mentioned that there's exceptions to this trend of higher income lower mortality, and a lot of them have to do with social security benefits.

So there's this famous study by Snyder and Evans in 2006, "Review of Economics and Statistics," looking at the social security notch, comparing people just before the change and the way benefits were calculated, and just afterwards, and they find that higher benefits are associated with higher mortality.

There's another great study by Evans and Moore. That's the same Evans as the first paper, and the same Moore who is a coauthor on this paper, and they look at the timing over the calendar cycle of mortality risk in relation to the time of the month that payments show up. They do this for lots of different kinds of payments but social security is one of them that they do, and they find that mortality risk increases by quite a lot right after the payment arrives. And the lowest mortality risk is just before. So there's a lot going on with income and mortality, and something about the actual payment itself seems to increase the risk in a short-term sense. Then there's the result that recessions, mortality declines during recessions, which is also an exception to this.

Okay, there's lots of studies of the disincentive effects of DI, and the tone of many of these studies is that the effects are large. We can argue about that. I'll really just make the point here that there's many of these studies. You'll hear from one of them, the Otter Coastal and the Mogstad paper, after lunch today.

By contrast -- oh, sorry, let me mention one other paper, which I did with my co-authors, where we're talking about the effect of variation and disability insurance benefit amounts and that effect on work disincentives. And in that paper we found that relatively large effect at high pre-onset earning levels and nothing at low pre-onset earning levels. There's a lot of other papers I don't mention here. And I'm sorry if you're in the room and I didn't mention your paper.

Prior studies of health benefits, there's a couple I'll mention here. There's a great one by Bob Weathers and Shelly Bailey looking at the accelerated benefits demonstration, and they have experimental evidence on providing health insurance during the waiting period for Medicare. They find that health insurance improved reported health; however, they concluded that their sample was too small to detect a mortality effect, so there may be one. So this is indirectly relevant to our topic, but most of the evidence is indirect.

There's another study by Pilar Garcia Gomez and Anne Gielen released in 2004 as Tilberg and working paper, which is also indirect. They're asking the same question that we are; however they're looking at the Netherlands and their evidence relates to the Netherlands. They have evidence from a quasi experimental research design that had to do with the change in 1993 to the disability insurance program in the Netherlands.

So there's two dimensions that they can look at in their quasi experimental design. Should I speak like that or like this? Right in? Okay. Good. Sorry. And there's two dimensions, so they can look at people who are just below the age this new regime applied and compare them just above, and they look at people just before the time period that it went into effect, and just afterwards. And they find that lower benefits increased hospitalizations and mortality among women; however, they also find that lower benefits in decreased mortality among men.

So I think the take-home message of this, actually, and a lot of the other studies, is that the relationship between income and mortality depends very much on the context that we're looking at, and I don't think, before looking at our data, it would be reasonable to have an expectation of what the relationship would be in this context of people receiving disability insurance, but that's what we're doing today.

We use a regression kink design. We use the disability analysis file previously known as the ticket research file. We look at all entry cohorts from 1997 to 2009, and we have 3.6 million observations, which

MPR
2015 DRC Conference - Day 1 Part 2

amounts to around half a million for each of the points we're looking for. So this is the essence of our research design here.

There are bend points in the formulas that relate earnings, as measured by average index monthly earnings or AIME, and the prior insurance amount. And so in the lower left-hand corner you see that the marginal replacement rate is around 90%, and that there's a regime change. Here we're showing 2013, so there's a regime change at \$892, where the first bend point is, and after that, the marginal replacement rate shifts to 32%.

There's an upper bend point where it goes down further to 15%, and there's a further one, which we've added here which we call the family maximum bend point, which is applied by the rules that determine benefit amounts. And I'll just quickly note that's not the same family maximum bend point that you could look up on the SSA website, but we call it that. And so at these three bend points we're going to looking at the regression discontinuity design, and it works something like this.

Suppose there's a relationship between earnings and mortality, and it looks something like this. Here we have AIME, earnings over the good part of the lifecycle on the horizontal axis, and it might be related to mortality in a lot of ways. AIME is strongly correlated with lots of things that you look at in a social science context, including age, gender, education, ability, and so on. But the basic idea is that if you were to observe a kink there around the vertical line, which is one of these bend points that looks something like this, you might think that, okay, either that has to do with what's happening at the covariates at that point or you would think it has to do with what's happening in the change in the benefit regime, which happens at that time. And we're going to assert that it's due to the regime, and we have quite a bit of evidence to show that.

So the regression kink estimator is essentially the magnitude in the kink and mortality by the magnitude in the kink in the benefit formula, and there's a number of conditions that have to hold, and we go through that in the paper, and I won't necessarily go through that here.

But one of the first things we do is look at the covariates to see if there's something happening at that point to see if the kink that we observe could be due to something that's happening, say, between the relationship between education and earnings at that point, or something like that, and so here's some example where we show the relationship between AIME and gender, and we can see that nothing's really happening there. And I have lots of these that you can see in the paper.

But the essence of the results that we compare what we can see among DI beneficiaries to what we see in the general population of people who are not subject to the DI benefit formulas. So that looks like this. So on the left we have beneficiaries and we do observe a kink. This is now around the lower bend point, and in the right we have the general population where we don't see anything. That's measured in the continuous work history sample.

And so the way you'd interpret this is in the left-hand chart there, all the way on the left you have, as income is increasing, you see relationship that income, as it said in the Swedish study, is protective against death: And more AIME, lower death at a relatively rapid rate. Then when we shift to a new regime, as we're increasing AIME but at the same rate, you see that it's less protective against death, and you so that's the kink that goes into our metric estimator.

So one thing that I'll say is that if you're looking at these, here's the next bend point, and if you're looking at that dots, there's no reason to assume that there's a linear relationship on two sides of that, and we try lots of different specifications, and we find the results to be quite robust to the specification.

Around the family maximum bend point, we do find a smaller result and somewhat less robust, and at the upper bend point we find no result. So in that case it looks like there's even the opposite sign result; however, it's not statistically significant in many specification, and it changes a lot over different

MPR
2015 DRC Conference - Day 1 Part 2

specifications, so we conclude there's no effect at the upper bend point, and what effect there could be is not robust.

So let me talk about how we would interpret the magnitude of the estimator. Around the lower bend point where we saw the large effect -- and I apologize for going so quickly -- annual DI payments are around \$8,300, annual mortality rates over the first year where mortality is very high, are 3.61%, and we estimate that an addition an thousand dollars of DI benefits would reduce mortality in this localized area by 0.47 percentage points, and those can add up to elasticity of minus 1.11 % -- I mean not %, minus 1.11. So there's a strong effect at the lower bend point. There's a less strong effect at the family maximum bend point, and we find no detectable effect at the upper bend point.

We are able to do diagnosis categories. We have a large enough sample to do that. And we find some strong effects in the low mortality diagnosis categories, mental condition, we find the strong elasticity there. Not much for musculoskeletal conditions. Strong effect for circulatory conditions, and my time is up. And a detectable type for cancers and not much for others.

So let me summarize. We find a robust effect around the lower bend point, which is very low in the earnings distribution; that higher benefits lead to lower mortality. We find mixed evidence at the family maximum end point, and we find no effect at the upper bend point. Thank you.

[Inaudible].

Okay, so this is an interesting paper, quite technical, so more than, I think, at least the papers we've had so far, so I'll make some comments about that, but also comments on larger issues here. Let me just briefly summarize what this paper's about. It's actually about the effect of the level of DI benefits on a particular health outcome, mainly the mortality. If you know the economics literature in this area, the bulk of it has been on the effect of participating in SSDI, whether you go on on a whole lot of different kinds of outcomes. These were all very difficult problems of causality. But there's a lot less literature on the effect of the level of the benefit, conditional being on various outcomes, and this paper falls into that category.

The basic problem from just, you know, scientific point of view here is that the benefit, the level of benefit you receive obviously ties directly to your earnings over your lifetime, and specifically to the average index monthly earnings, the AIME. And so we know that income and earnings are correlated with health. That's been established many, many times. So if you're trying to tease out the actual effect of benefits on an outcome like health, disentangling that from the effects of your lifetime income on health is a hard problem.

So this is an interesting paper that follows a certain strand of literature in economics. It's attempting to tease out effects like this, particularly new methodologies, and this one, which Alexander explained, is a particularly newer branch, called "Regression Kink Design," where you're using these non-linearities in your relationship between your AIME and the benefit to kind of tease out whether or not there might be some change in the effect of -- really, the effect of AIME on mortality, but you're inferring that it's probably the effect of a change in benefits.

It's an interesting methodology, and given the difficulty of the problem, I congratulate the authors in making the attempt. It's a very challenging problem on a lot of technical grounds, which I won't go into in great detail, but just to mention a few, everything revolves around making sure you can isolate just the effect of that change in benefits or, really, the change in the slope of benefits in relation to AIME from AIME itself. And we know that AIME is a complicated quantity, as the authors -- I don't know if you mentioned in your remarks, but in the paper they say that's not something you probably cannot manipulate. Well, actually, people do manipulate that a little bit.

I think the most well known case of manipulation of the AIME is you're getting older ages and you're deciding whether to continue to work or how much to work, and you know there were a lot of low earnings years in your lifetime, and you're at your peak earnings, so usually when you get older, a lot of people are

MPR
2015 DRC Conference - Day 1 Part 2

actually aware that every extra year they work, if it knocks out so low years, it actually is going to increase their PIA. So it is -- but leave that aside.

Then of course, even if you can't manipulate it, you know, your lifetime earnings average is correlated with a lot of other things about your health, and probably potential mortality. There is some possibility of selection there. So the authors here are looking for a particular kind of non-linearity, and they do a lot placebo tests, we'll call placebo tests, tests to kind of make sure that they are teasing out the causal effect there. And those are all good.

Another problem that Alexander didn't have time to really talk about is SSI. So at this particular range of benefits we find, in effect, is also where most people were eligible for SSI, and, actually, the paper doesn't mention this, but as your SSDI benefit goes up your SSDI benefit goes down, because it's dollar for dollar taxation, so there is definitely an effect there. They try some sensitivity to SSI. The argument still has to be that there's no non-linearity right at this point where the benefit formula has a kink, you know, that there's no change in the SSI participation rates, or right around that, whether that's the case or not, you know, I don't know. You're kind of relying on their not being particularly kinds of non-linearity. These are all in the class of particular comments. Just trust the difficulty of the problem not to, you know, disparage the interesting methodological contributions here.

So let me stop, you know, on these kind of technical issues and just move on to the larger issues. One of the puzzles I think you've got to ask in the paper is if you got the results, let's summarize the results, they find that benefits, DI benefits, do reduce mortality but only at these lower level of benefits. As the AIME goes up and as you get the higher level of benefits, no effect on mortality. Okay, so you've got to ask, you know, well you've got to ask why is that. I'd like to hear some stories on why that might be. I could make up some, but, you know, I think that's a clear question.

Like I said, we know there's a very strong gradient, you know, between the SES and mortality and other datasets, many datasets. It's not showing up here, you know, why not? What is it about those? So we believe the results. What is it about those very low earnings and low benefit people where you would find, are they in worse off condition or is this something where mortality is more sensitive the to income down there? Do other studies show there's more sensitivity of mortality to income at those very low levels? Those are all kind of questions.

As Alexander emphasized, they don't really have the data, but naturally if there is an effect here you'd like to know something about the mechanisms. I mean how is that effect occurring, you know. Is it through the effective income on medical care or is it from some other kinds of health treatments one has or just general lifestyle or a combinations. It's very important. And that bears on, of course, why there might be an effect down at the bottom and not a little bit higher up. If you could actually figure out what's going on, that may give you some clues. And so I think that should be on the research agenda.

And then, you know, the policy implications here, I'm trying to put my hat on as a policymaker here, you know, what do you make out of this paper and what would you take away from it? And I think probably, you know, so I would say that if you're coming from a non-research point of view here, you kind of hope, you know, that DI would -- the money would help something. And that, you know, it would be nice if health were one of the impacts of the DI benefits, you know, your placement income for those who are severely disabled, and you hope it does have some positive effects. And, you know, notwithstanding the difficulty and kind of teasing that out scientifically, I think you would expect there to be effects.

So, to me, I think I would be a little bit disappointed, actually, in the paper, that there aren't effects at other places. In fact, he has three different kind of regions that he's looking at. Two out of the three have no effect on mortality, and, you know, you might say well maybe in health in general, who knows. I'd like to know why is that and what could we do about that. If the extra benefits are not improving health or mortality specifically, you know, what kind of interventions could we do? Is it a problem with the health care they're getting? These people down there by the way, are probably -- I should just as an aside, in this very low earnings region may also be more likely be the ones who are getting Medicaid in the first couple of years of DI, before they switch to Medicare.

MPR
2015 DRC Conference - Day 1 Part 2

You know, you might wonder about the Medicaid/Medicare connection down there at the bottom. That's something that's very different than up at the higher income ranges of DI recipients. Well these are all just kind of questions that I would want to know about why there's no effect. Actually, I should say, that would be my question about it, and I would put that on the research agenda, you know, for things in the future that I think policymakers would want to answer. I'll stop there.

[Inaudible] Melom [ph] will present the next paper.

This thing is still counting down, 40 seconds. Aha. Okay, thank you very much for having me here and for attending today. Let me get this in the right direction. So today I'm going to talk about some work on unmet needs for workplace accommodation, which has been a topic of interest for many people recently, and this is work with Nicole Maestas, a colleague of mine, formerly at Rand, who is now at Harvard. And we would like to thank the DRC, the NBAR Research Center for funding this project.

So understanding accommodation has been rising in importance in terms of thinking about disability policy in recent years. So a number of recent proposals target employer incentives to retain workers to become disabled -- oh, sorry, when they become disabled, and a natural way to do this would basically be to accommodate the disability in some way by providing some sort of, you know, equipment or, you know, breaks or some kind of job training assistance, you know, potentially to, you know, retain that connection with the worker.

But unfortunately there's a limited evidence base on a couple of sort of key questions that we need to answer before we know whether we know in is a productive route for reform. So the first question, which is sort of what we address here today, is there unmet need for workplace accommodation. So there have been some papers looking at this literature, and so we'll add to that by providing some new evidence on that topic.

And then, you know, once we kind of understand that and figure out who was getting accommodation and why, we can think about does accommodation prolong employment and deter disability insurance claiming. So in this project we collected some new data, and we estimated the size of the population that was sensitive to accommodation, the degree of unmet need for workplace accommodation, and we will be looking at some employment outcomes. So I should be saying that this is definitely work in progress, so, but it's also particularly a nice time to get some comments and feedback. So I will show you where we're at right now and we're going.

So, you know, just a quick primer on the background. When you're thinking about workplace accommodation you obviously want to be thinking about what's the sort of legislative mandate for accommodation. So accommodation is required under the Americans with Disability Act as long as it's, you know, reasonable accommodation and doesn't cause undue hardship to the employer. So if it's relatively costless and something the employer can do without sort of putting them completely out of whack, if this is something -- they become aware of it, then they are sort of mandated by law to do something about it. The question is sort of whether they do even become aware of it or not. And there is this tension in the literature where, when you see surveys of employers about this issue, they say that they accommodate, you know, virtually a hundred percent of all requests that come to them, and when you look at the employee side of things, which is what we'll be doing, you see kind of much lower accommodation rates.

So employers don't have to provide the specific accommodation requested by the employee, they can work with the employee to figure out a different way, you know, that could help them retain their work capacity. And then the reach of the ADA was initially limited by very strict interpretation of disability by the courts, and so, you know, for many of the early years the ADA was sort of ineffective in that regard. So the 2008 amendments to ADA attempted to correct this. And I haven't seen any, you know, papers on whether or not that was effective or not. I can tell you in ADA that we don't see any change around before and after 2008.

MPR
2015 DRC Conference - Day 1 Part 2

So the data that I'm going to be talking about we collected in the Rand American Life Panel, or ALP, which is a nationally representative Internet panel of the U.S. individuals ages 18 and over, and we limit our sample to ages 18 to 70, and we selected a group of about 2,500 people and asked them several questions about workplace accommodation, and we randomized the order of the questions, which I'll get to in the next couple of slides.

And then so I'll talk to you about some of the findings from that first survey today. And just sort of keep in mind that we just recently fielded a follow-up survey, you know, essentially one year later, in June of 2015, and we limited that survey to the 1,400, or so, respondents who were working the last time that we talked to them in May. And, you know, so far we do have about 75% response rate just after about -- so this was two weeks when I had to sort of get the slides. It's been more now. And we look at health and work transitions, so we'll be able to do some really interesting follow ups to see whether identify an interesting group of people that can tell us something about, you know, is this group more or less likely to sort of see their health problems exacerbate over time.

So this paper was actually sort of originally the idea I guess, the genesis of it, came from some work that Nicole and I were doing with a co-author, looking at the rate of accommodation in the health and retirement study -- and, wow, that's really tiny. I guess I can use my notes here. So the way that the HRS is structured -- you know, and this is a popular dataset for many people -- first, they asked people, do you have any impairment or health problem that limits the kind of amount of paid work that you can do, and if the answer to that question is, yes, then you're given a bunch of follow-up questions and a disability module, which is kind of an underused module as far as we can see.

And then the next question is, were you employed at the time that your health began to limit your ability to work and so if the self-employed are excluded and the unemployed at the time, their health began to limit their ability to work, so whether or not that is sort the same kind of interfere is the question. But I won't get into that.

And then finally, you know, if you sort of answered yes to these questions, then they asked at the time your health started limit your ability to work, did your employer do anything special to help you so that you could stay at work. And then, you know, the answer to that is yes or no. And then they ask about sort what are some of the types of accommodations. And so you could look at this.

So our question was whether or not this sort of skip pattern and question sequence might be, you know, basically ignoring a group of people who were accommodated for a health problem at work and this accommodation led them to say that their health does not limit their ability to work. And so, you know, they wouldn't be asked the question in the first place.

And then we also worried about the question order, whether or not asking someone, first, if their health limits their ability to work might sort of prime them to think about very narrow health problems. And, you know, as was mentioned a couple times already today, we're really interested not in the very severely disabled people. We want to kind of think about how health evolved over time, and so when you're thinking about, you know, when to interfere, you might want to be kind of seeing people who have lesser health problems that, you know, progress over time, and so you might miss some of those people.

So in our survey we replicated the sort of HRS question sequence at a static level now. So we asked people first -- is that tiny for you for you? No? Okay. You can see it, hopefully -- do you have any impairment or health problem that limits the kind of amount of paid work you can do, then we ask are you currently working for pay. Then, regardless of whether you're working for pay or not, we say many people need special accommodations for health problems. We give a number of examples of these types of accommodations. And then ask, does your employer currently do anything special to make it easier for you to work. Sorry, so that's if you're working for pay, obviously. But not if you said you didn't have a health problem.

And then lastly, we asked, if you didn't say that you were accommodated, would a special accommodation make it easier for you to work. And then we randomized half the group to get that

MPR
2015 DRC Conference - Day 1 Part 2

question sequence and the other half to get obviously are you working for pay or not, which will determine the wording of the next two questions, and then we asked them, you know, if they're working if they're receiving any kind accommodation for their health at work and give examples of that. But we haven't already asked them if their health limits their ability to work. And then, you know, again we ask, if not, would a special accommodation make it easier for you to work. And then finally, we ask does your impairment or health problem limit the kind of or amount of paid work you can do. So we wanted to see kind of how those questions, you know, played out.

So I our first finding -- I'm going to run out of time, I can tell already -- is that question order does matter. So here I'm showing you the percent that we estimate report a work limiting health problem, you know, for the two different groups. So the first column shows you the group where we ask the health-limiting question first, and the second group when we asked the work health-limiting question last. So here we actually see, you know, the title is question order matters and that's just a preview, because here we see that it doesn't matter for the percentage of people who say that their health limits their ability to work.

So if we ask them right up front or, you know, if we tell them -- we ask them a whole bunch of questions about accommodations, things like that, you know, they're not any more likely statistically to say that their health limits their ability to work. However, when we add, you know, people who are accommodated at work to that group, we see, you know, that there are some differences. So you're much more likely to report that you are accommodated at your workplace if you haven't already been asked if your health limits your ability to work, and regardless, you can see in the first group, that even if you have been asked if your health limits your ability to work, there is an extra 4.3 percentage point increase in this group. So you have some people who say that they are accommodated who didn't say that their health limited their ability to work.

And then finally, you know, when we look at, you know, whether an accommodation would help or not, again we see that question order matters. That first, if you ask them if their health limits their ability to work, it sort of narrows them down to sort of think about, you know, potentially, I mean very severe health problems and they don't report an accommodation, and this is especially the case for the employed.

So this is just repeating what I showed you, and now showing you, you know, subgroups for, you know, working for someone else -- I cannot see. Maybe I have a health problem -- the self employed and those not working. Sorry. So the little asterisk there is to remind me to tell you that we did check to see if more or less people said that they were working or not if we first asked them if their work limited -- their health limited their ability to work, and we didn't find any differences there.

So the big increase here, we're finding, is coming from people who are accommodated at work or would be -- or an accommodation would help who are currently working. Okay, so I'm going to shift in my last sort of part of the talk to just focus on those where we asked the work-limiting health question last so that we kind of have the most expansive definition of people in these different categories and think about, you know, how does this affect our view of work disability and prevalence of work disability. So if we look at this group where we asked the work-limiting health question last and we just look at who says the health limits their work and who says that health does not limit their ability to work, we find that about a fifth of this group says that their health does limit their ability to work.

And then when we kind of break that up into, you know, the people who say their limits their ability to work, we find that about 60% say an accommodation wouldn't help. They're not being accommodated, and an accommodation wouldn't help. So this could be because their accommodation -- sorry, their health impairment is so severe that they can't think of any accommodation that would help them, or that, you know, they just sort of aren't aware of accommodations, and so this could be something that we could think about in future research. About 10% of this group is accommodated and about 32%, a third, say that while they're not accommodated an accommodation would help them work, whether they are working or not working.

If you flip this around and look at those who say the that health doesn't hinder their ability to work, then, not surprisingly, 80% of them say that, you know, they're not accommodated for any kind of health

MPR
2015 DRC Conference - Day 1 Part 2

problem at work and an accommodation wouldn't help them. But interestingly, about 11%, you know, the same kind of percentage of the people who say their health limits their ability to work, say they're accommodated for some health problem at work. And we also find 9% of this group say an accommodation would help. So, you know, this is an interesting group that, you know, certain studies that limit, you know, the questions are going to miss.

So overall, we find that 35% of this of our sample we estimate has a work-limiting or accommodation-sensitive health problem, so they either say their health limits their ability to work or they are accommodated or an accommodation would help, so -- sorry. Right, this is the 35%, and they're made up of these heterogeneous groups. And so if you kind of want to pull out, you don't necessarily want to do this, but if you pull out those who say their health limits their work and their not accommodation sensitive, so they can't think of any kind of accommodation that would help them, we take them at their word. We just focus on the group that is accommodation sensitive, we find that about a quarter of the population either are accommodated or say an accommodation for the health problem would help them, and of these 46% are accommodated, so about half:

And I neglected to mention earlier that studies using data like the HRS find that basically a quarter of people say that they were accommodated for a health problem at onset if they were employed at onset and answered these questions. So we're actually kind of doubling, you know, doubling the prevalence of accommodation, you know, when you kind of factor in the people who would potentially both benefit from it. But on the flip side we're still finding that there is this very large scope for increasing accommodation, you know, potentially.

So thinking about implications for measuring work disability and unmet need, so we find only 10% of those who say that their health limits their ability to work are accommodated. But interestingly, most people who are accommodated actually say that their health doesn't limit their ability to work. And this makes some sense; right? When you think about, you know, a lot of health studies that measure things like blood control or blood pressure or HBA1C, you basically you don't just limit it to people who, when you take the measures, you know, have adequate out-of-control blood pressure, you also ask them if they're taking some kind of medication for blood pressure and you add those people in your estimate.

So we're basically proposing something similar when you think about people with work-limiting health problems. So adding the accommodation sensitive does increase the prevalence of work disability, you know, when you think about this much broader group you get from about 20% of the population to 35% of the population, so it's a pretty big increase. And then as I mentioned, about a quarter of the population are accommodation sensitive under our sort of preliminary estimates of this concept, which, of course, will be refined in future work, and of these, you know, about half are accommodated, which means that half could potentially receive some sort of accommodation that could, you know, potentially help them stay at work and avoid potential disability claiming. I see it. So, but I am almost done. You know, they told me I had 20 minutes.

Okay, so just in terms of next steps and where, you know, your feedback would be sort of the most helpful, so our next steps are to match the data with this May 2014 survey with this June 2015 follow-up survey and see, you know, how many of these people are still working, you know, how much of that differs by the sort of their health and accommodation reports from the previous survey, and then we also -- so we measured their health and work transitions a year later among those who were working, and we also added some measures of just more general changes and working conditions, so, you know, we didn't just limit it to the types of accommodations that people typically ask.

We also tried to see if we had more sort of flexible, you know, work environments in terms of when they could arrive or, you know, leave, how they controlled their schedule and things like that. And then we also asked them basically what they did on their own to try to accommodate their work environment around their health problem, not just, you know, what they asked about employers. And then we also added this measure of cognitive flexibility to -- must stop. All right. Thank you.

MPR
2015 DRC Conference - Day 1 Part 2

Thanks very much. If you knew the superficiality of my discussing comments, you would have been quite happy to have loosened her constraints.

[Inaudible].

Yes. The last time I saw David Weiss, he was my instructor in a Masters-level Econometrics course, so any errors in my presentation are due to him. I should say that I actually do have a vision issue, so I will be looking back like this. The only good thing about my vision issue is that it occurred in about February of 2009, and I take a lot of credit for the subsequent recovery of the U.S. economy based on my left eyeball.

So, you know, this is -- let's see, this is -- I am experiencing -- there is -- ah, this way? Ah, there we go. So what do you say? It's a very simple paper, which has a very nice result, and, you know, so I could sit down right now. So, in a sense, I'm the superfluous after dinner mint on a paper that I think it's really important that we understand the necessity but also the inherent limitations of household surveys in looking at a lot the issues that pertain to workplace accommodation and just people's self conception and reporting about what it means to have a limiting condition.

So, you know, I'm going to start with a tangent, which, as somebody -- you probably can't read this part that's small. It says, "We begin by boarding anyone who needs a little extra time or who has a little extra money," which actually, it's almost verbatim the southwest script of course.

So I take care of a gentleman who has an intellectual disability, and I'm going to describe Harold and Vincent's great adventure to give you a sense of some of the issues I think are going on in people's heads when they fill out a survey like this. So Vincent and I go on a lot of vacations together, and, you know, basically all the things that I wouldn't be caught dead doing by myself but are actually fun, like the celebrity house tour and things like that. And I know more about Lindsay Lohan and her various traffic accidents than anyone in this room does probably.

And so last week we went to Boston. We went on vacation to the Cheers bar, and we went and we went through the Airport and, you know, Vincent doesn't like to stand still, so we go through the x-ray machine, and he's doing a little interpretive dance when you're supposed to standstill like this. And all the people at TSA who are really obnoxious to you are actually really nice to him, and they pat him down. For the parts that were blurry because he wouldn't sit still, they sort of pat him down, and people in the restaurants are, you know, very nice to us. And we go to the hotel and he runs up to \$200 by accident on the pay-per-view movies, and they just take it off the bill.

And the things is that if you ask me what life is like and you say, were we accommodated on that trip, did we receive any special accommodation, I would have said, "No." In fact, the only specific accommodation that we got was that we got to pre-board the plane first. And but, of course, all around us in the world we were being accommodated in lots of way that even the people doing the accommodating might not have paid particular attention to. And I think that that's an important point. Obviously each person with a challenge faces their own unique issues, but there's a lot of accommodation that goes on in the world, and, you know, in this post-ADA world we don't even notice a lot of what's happened. What stays in Los Angeles -- you know, what happens their stays there. That's one of our tours. That's an undoctored picture by the way. That's all I'll say about it.

So, you know, I just think it's important to understand that the word accommodation, like the word disability, it has specific legal definitions sometimes when we're litigating it, but a lot of what's happening is just what's happening. So this is just -- you know, I would just mention all the things that happened on our trip that are part of the environment that make it possible to be more independent. You know, there are all sorts of ADA compliance aspects to the hotel room that we were easier, and all sorts of stuff was happening. And the world of 1989 we don't go on this vacation. And, you know, Vincent doesn't do escalators, so there's always an elevator when there's a long escalator that we can do, all these things.

MPR
2015 DRC Conference - Day 1 Part 2

So I just want to make that point clear as a framing for what this paper is trying to grapple with. Now let's get to the survey a little bit. So this is Joe Whistle [ph]. Some of us may know Joe. He's a health policy analyst in Chicago who is a C4-5 quadriplegic, and I asked him, how would he have answered the questions on the HRS? Would he have said that is a work-limiting condition. And he said, "No, I checked 'no' to that question." And, you know, he's a full-time worker. That's why he checks "no." He happens to have a \$45,000 wheelchair and so on, but there's an element of realism in this -- in the Moineto [ph] paper that a lot of people are going to check "no" to this question. They check "no" because they don't believe it's limiting their work and because their self conception also leads them to answer no.

One of the things you might think about is the role of stigma in people's understandings, as well as, I think a lot of the way that you discuss the paper focuses on just people's trying to answer that question and focus on how can I give a factually accurate answer to this. But it's a psychologically rich arena for people as well. And so I think it's important that we understand that concrete limitations are not the same as a work-limiting condition.

And particularly, I think if we take seriously the idea that disability is really a multidimensional and continuous set of limitations, it's just, I think that the people who run the HRS are really hard pressed to ask a tight set of questions that are really going to get to this. And, in fact, one of the things that I draw from this paper is it would be nice if there were some complementary surveys that were much more detailed, maybe with a subset of HRS respondents that could really get in a more refined way at some questions that you could never ask given the short period of time you have in the typical household survey. I do think that -- you know, Joe was telling me to take quite a long to fill out surveys accurately when there's actually a census worker there trying to help him work through it with all the issues that he has.

It's also easy to see how workers and employers don't notice a lot of the accommodations that are going on, especially accommodations for the large population of people with minor impairments. You know, there is this sort of very large group of people who have some degree of functional impairment, and if you actually look at the handbooks that employers have of what the accommodations look like, many of them are almost -- are very, very cheap. The average price is less than \$500, and they're often unnoticeable.

So, you know, here's something for people with back issues and with gross motor problems, and if you look at the bullet points of the suggested accommodations, many of us actually have these in our workplaces right now, but we just don't particularly pay any attention to it. We should buy ergonomic desks and things like that. That's something that we all have. But those are actually -- those are accommodations. And so we need to take that into account. So it doesn't surprise me that many people don't notice these.

And, in fact, one of the issues that I think we should focus on is the disparity between the incredible amount of accommodation that occurs inside the workplace and the low level of accommodation that occurs outside the workplace for many things that are real obstacles for people's work. If you can get into the workplace it's amazing how many things will be done by the employer who is legally obligated under ADA. Many, many, problems that people with disabilities face that are -- you know, curb way before they can even get into the door of the employer. And it would be nice for surveys to ask more about out of-work base barriers that might be accommodated.

So where does this leave us in our final minute and one second. One thing, I actually took this paper in a pretty hopeful way when I finished it. There's a lot more accommodation going on in the world than we recognize, and even than people with functional limitations might recognize, and that's something that we should really be proud of. You know, we really do live in a world where many of the things that we have to do we have to be more inclusive, we are doing in a way that doesn't require us to officially do them, and specifically do them in a way that identifies particular people as beneficiaries. You know, we all benefit from elevators with big buttons that have numbers that are readable on them. You know, if you're a single mom and you've got some grocery packages and you're pushing a baby carriage, a lot of those ADA compliance things are really pretty nice.

MPR
2015 DRC Conference - Day 1 Part 2

And I think we have to understand that individuals are not going to specifically identify themselves as the beneficiary of many of these accommodations, either because they don't notice or they don't care to self identify in that way. So I think that I'll just end with the usual I'd love to find out more about this accommodation-sensitive group, and I look forward with future work by this team. Thanks very much.

Henry, you have the next paper.

Good morning. Before I start, I'd like to acknowledge my co-authors who are here in the audience with me. Jack Gettins [ph], who is my colleague from New Mass Medical School, and Denise Hoffman, who is over there from Mathematica. So what I'm going to talk to you about today is the next in a series of studies that we've been doing to better understand the relationship between health-care services and employment and the ability to work for people with disabilities. Just make sure I've got the -- oh, let me go back just a little bit.

Okay, so some of the things that we've learned in the work that we've done so far are that health-care services and related supports can play a really critical role in helping people with disabilities to work. These are services like durable medical equipment, personal assistance services, physical and occupational therapy, mental health services, medications. In prior work that we have done, people have told us that these services have been really critical to helping them get back to work and to stay at work.

We also know that some employed people with disabilities have health-care service needs and supports that are generally not covered by private health insurance, and for the most part, we don't really expect that the new insurance that's available under the Affordable Care Act will change this. So one of the things that we've been pondering is the possibility of a wraparound coverage or some other kind of policy option that could be made available to people with disabilities that could be a viable solution in helping them to stay at work and to provide coverage for services that are not currently covered by primary insurance and private insurance.

So the goal of our study was to estimate the wraparound cost and utilization of employment supportive health-care services among a group of people who were employed or potentially employed, people with disabilities who are currently employed or potentially employed, and we're using Massachusetts as an example. That's where we're from, so made it easy for us. So Massachusetts, as probably everybody knows, implemented health-care reform in 2006, the Massachusetts Health Care Reform, very similar to the Affordable Care Act. And in Massachusetts we have a very low rate of uninsured. So virtually everyone is insured.

And the overall goal is really to, again, help us to estimate the cost in utilization of services and to inform a policy development and this idea of developing a wrap around program for people. Oh, yeah, I really can't see that over there.

[Inaudible].

Oh, that's not fair. Okay. So you'll let me know about that. Okay. All right.

[Inaudible]. I just talk, I'll try not to talk that fast. So we used as a case study a program called Common Health Working, which is the Massachusetts Medicaid buy-in program. I'm sure most of you are familiar with Medicaid buy-in programs. There are about 40 or more in the country. And buy-in programs are an optional program for people with disabilities who qualify on the basis of disability but have income that's too high for the standard Medicaid program in the state.

The Massachusetts Medicaid buy-in program, Common Health Working, uses a disability standard that's very similar to Social Security Administration. Our buy-in program has a requirement, a work requirement of a minimum of 40 hours per month. The Massachusetts Medicaid buy-in program is the oldest in the country, and it is one of the most generous, maybe the most generous buy-in program. It has no income or asset limit. Members buy into the program through an income-adjusted premium, and the majority of

MPR
2015 DRC Conference - Day 1 Part 2

participants use Common Health Working as a wraparound. Most people in Common Health Working have another source of primary insurance. Coverage is comparable to standard Medicaid. And for this analysis we used Common Health Working's administrative claims and eligibility data. So we looked at fee-for-service claims data for our analysis.

So the sample that we looked at included over 15,000 individuals with disabilities who were enrolled in Common Health Working for at least one month in 2012. This was about 77% of all the people in Common Health Working, so very large majority of people who are in Common Health Working have another source of primary insurance. We included people ages 21 to 64, and, again, most people are using Common Health as wraparound coverage. The overwhelming majority of people, their primary insurance coverage was from Medicare, 84%. A small number, about 9%, had private insurance, and about 8% had both private and Medicare.

So for our analysis, again, we looked at people who were enrolled for at least one month over the 12-month period. We did a monthly analysis. If people were -- and there is some, you know, churning in and out of these programs, so if people were in Common Health for a month, they were included. If in the next month we saw no evidence of them being enrolled, they were excluded. If they were back again the subsequent month, they were included. And also, we looked at, you know, if there was a difference in their primary insurance during that month, you know, if they were in Medicare in the month that we were observing them, they were included in the Medicare group. Within the next month we saw them not in Medicare, they were not in that group.

So what we were able to pull from the Common Health administrative and eligibility data was their primary insurance type, age, gender, monthly earnings, their monthly old-age survivor and disability insurance benefit, which we assume for this group was primarily SSDI, and their family income, which was their federal -- an indication of federal poverty level. We didn't actually have family income itself, but we had FPL.

The cost and utilization measures, we looked at total costs. We looked at per member per month costs, per user per month costs, and an unduplicated count of users within, and we classified the claims into various service categories, which I'll show you in just a second. Using procedure codes and service provider types we categorized the services into different categories.

So let me just -- excuse me. This just shows you a little bit of the participant characteristics. As you can see overwhelming majority were in Medicare. Just under half were male. Most of them were in the age of 50 to 64, so a somewhat older age group. The majority were -- income was relatively low in this group. The majority were earning -- you know, only a small percentage, 9% of the group in total was earning more than 2,000 a month, and about more than 70% had earnings of under a thousand dollars a month. Again, most of them had DI income, the DI benefit. About a third had a DI benefit of greater than \$1,400 a month, and only about 15% were over 300% of federal poverty level. And most people were between 150 and 300 % of federal poverty level.

I think the thing that you can see from this is that people who had private insurance only tended to have higher earnings. They were less likely to have DI income, and they had overall higher FPL. So people who had private only were higher income than the others.

So this shows you the total cost per user per month costs and the unduplicated percent of users across these service categories. So overall, if you can see in the bottom, total expenditures for the year were just over 55 million and the two largest groups -- and I'm going to give you a little bit more detail on these groups in a minute -- were for community-based services and supports non-mental health community based services and supports at 30 million, and the next largest group was behavioral health supports, which included community-based mental health supports, inpatient/outpatient psychiatric treatment, and substance abuse. And, again, I'll get into the details of that in a bit more.

So obviously, by far, the largest was the community-based services and supports at 30 million. That was also the highest per user per month cost, relatively low percentage of members using those kinds of

MPR
2015 DRC Conference - Day 1 Part 2

community-based services at about just under 11%. The behavioral health services, the second largest group at 10 million, per user per month cost relatively modest, at \$170. But a much larger percentage of people were using the behavioral health services, 41%.

So this gives you a little bit of a breakdown of those non-mental health community based services and supports. We categorized them as personal assistant services, home and day health, adult foster care and day habilitation services. So you can see these are the ones that total the 30 million annually. By far the most expensive of these service were personal assistance services. I do have an extra five minutes; right? Personal assistance services at \$2,200 a month, very small percentage, only 6.5 % of people using that service, but that was by far the most expensive service.

Let me go to -- for behavioral health services, again, this totaled 10 million over the year. The community-based mental health services were the most expensive of these at 444 per user per month, relatively small percent of users at 7.8%. Community-based mental health service, this is primarily comprehensive community-based psychiatric rehabilitation services that are provided primarily to people who are eligible for our state department of mental health services and include things like supported housing, supported employment, you know, a full range of psych rehab services. Psychiatric treatments were relatively modest but used -- and that includes both inpatient and outpatient psychiatric treatment used by about 37%, almost 38% of members.

So here we're looking at -- this shows you the PMPM by service type and by insurance type, so we're just looking at the differences across the three insurance group people who had Medicare, people who had private, and then people who had both private and Medicare combined. Community-based services, the non-mental health community-based services were the highest for people who had private insurance with or without Medicare, considerably higher than for people who had Medicare. And then for behavioral health services, it's sort-reversed. People who had Medicare had the highest compared to people who had private insurance have the highest per member per month expenses.

And then this shows you the relationship between monthly earnings and per member per month across the three groups. And there's a U-shaped relationship going on here where people with the lowest earnings or the highest earnings tended to have the highest expenditures. So you can really see that. It's most prominent in those individuals who had private insurance, either people who had quite low earnings the blue bar, less than a hundred dollars a month in monthly earnings. And the yellow bar is \$2,000 a month or more in monthly earnings, and we see that those people who have private insurance, you know, expenditures were high for the low earnings but then really ramp up again for the -- high for the low earnings and then high again for the high earners.

Okay, so just to summarize, the majority of our sample had primary insurance coverage from Medicare and had earnings below \$2,000 a month. The wraparound expenditures overall were relatively modest, at 425 per member per month. The high expenditures were for services that are generally not covered by private insurance or by Medicare, and that's the non-mental health community-based services, and then mental health community-based services. Relatively low proportion of people use these community-based services. The non-mental community-based services overall was about 11%, and for the mental health community-based services about almost 8%.

Some of our members are incurring additional expenditures for services. You know, people are incurring expenses for services not covered by primary insurance, and we saw this cost in utilization varying across insurance type and across employment levels. So just very quickly, just point to the limitations of their study. It doesn't include services not covered by Common Health Working. There are other people who -- it doesn't reflect the health service uses of people who aren't meeting Common Health Working eligibility requirements who are not enrolled in the program. It doesn't include with people only private market-place-based coverage and Massachusetts may not be representative of other states.

So our next step, we're currently analyzing data. We've done a follow-up study in 2014 to the Massachusetts Behavioral Risk Factor Surveillance Survey. It's what we call the "Employment-Related Health Insurance Needs Survey," so people who identify themselves as having a disability in the BRFSS.

MPR
2015 DRC Conference - Day 1 Part 2

We followed them up to understand more about their use of health-care services and any unmet service needs that they have, and I'm going to stop. And I'm going to turn it over to Henry who is going to talk about policy action.

[Inaudible].

Great. First, thanks to the group from U Mass for actually doing the work, to NPR for asking me to be the discussant here, and to social security, most importantly, for funding the work. And I really urge you to delve deeper into this intersection between disability insurance, even, you know, SSI, and, you know, health care needs more broadly. I mean this is really rich terrain that I don't think gets enough attention. So thanks again.

I just want to cover a few quick points in the piece of work. It I think rightfully points out that there are kind of two issues that these populations experience with kind of concept of a wraparound coverage. And, first I should note that the Medicaid buy-in in Massachusetts, while noted as unique, there are a couple of other states that have moved in this direction more recently. But what's important to know about Massachusetts is that this is the original. This is the longest running buy-in that exists in a country. It was really the model for legislation that was passed in the very late '90s. You know, most states haven't replicated it, for a variety of reasons, but I do think it's a good place for us to be looking to learn about participant experience.

So, first, the study quickly identifies two issues around coverage and expanse, where wraparound appears to be necessary. Medicare and -- excuse me -- private insurance, in terms of coverage and expense, they might be very similar in terms of coverage. There are certain coverage gaps when we compare the needs of this population to the type of insurance that they have when you look at Medicare and commercial or private insurance. And certainly issues of expanse are very real, the idea that individuals are facing deductibles, that they have premiums to pay, and there is, of course, co-pays that come along with things. So this concept of cost sharing really is something to bear in mind when we're thinking about this population.

One thing I think the study and future could do a better job of is looking at the coverage issues. There are actually services that are just outright not covered by private insurance and commercial insurance and the paper notes that. But there are coverage gaps, I would say, with certain other benefits, and there alluded to in the paper, and they're often very subtle, but they're important distinctions when we look at the two distinct populations that I'm going to argue are covered or addressed here. I've got to check my time.

So the coverage gaps, most notably you could look at something like durable medical equipment or prosthetics and orthotics. Oftentimes you might find a state only covering one limb per lifetime. Well if you're a double amputee that's not going to be very helpful, and so you're going to need something to wrap around to fill these gaps. They may have a limited formulary if you're living with mental health issues, and you may not be able to access the drug that, you know, is most effective for you. And so, again, we're looking at this need both with Medicare and with commercial or private insurance, the need for their to be a wraparound. And Medicaid is the most comprehensive kind of health care available to people. It's not exactly an insurance program, but, you know, it's a great thing to have, and so I wouldn't denigrate it at all. It's essential.

One challenge in applying this to other states is that some of these covered services it's really a unique thing, and I probably won't spend much time on it here. But not all the services that are uncovered in commercial and Medicare insurance, like personal assistance, are available through the state plan service, so when you buy into a Medicaid program you might find it still difficult to get things like personal assistance. Not so much with the mental health population and it's rehabilitation services. Those are often made available through the traditional state plan. So sorry to get so detailed.

Most of these personal assistance services, in probably half of the state, are uniquely made available through what are called home and community-based services waiver programs. So there's a lot of variation here. It's kind of murky, but it's important to understand these distinctions.

MPR
2015 DRC Conference - Day 1 Part 2

So the coverage gaps are very real. The wraparound coverage of Medicaid is a really potentially viable gap filler. And now to move to one of the primary motivations of, I think, people to participate in these buy-in programs, which is, you know, they get buffered from the extraordinary cost that they might experience. Even in the Medicare program, the types of co -- not just co-pays but the cost sharing can be extraordinary if you're hospitalized, some of these other issues. So having something like Medicaid to buffer someone that's very low income from these expenses is extraordinarily important.

Now the central issue, I think that we're facing if we're going to go into this as a potential policy solution is the definition of work, what are we really trying to do here. I would argue the U shape distribution of expense really relates to the kind of -- I'll argue there are two populations, but I'm not fairly treating people with mental health issues, which we'll have to address at another time. But there are a number of individuals, the vast majority in this study, that are participating in this wraparound coverage really have very modest earnings. There are large numbers of them. They're older. They need the wraparound coverage. That's just the reality of their lives. And so they've found a way to participate in this program. I would argue they're more a medically needy population, and they happen to work a little bit too, which is often a stabilizing thing, particularly when you're living with mental health issues. So that's the bulk of the participants in these programs, and it's not just in Massachusetts. It's true in many other states that offer this Medicare buy-in program.

And then you get to this relatively small population, but I think quite important for us to focus on, as a real path to the future, where you have people with significant disabilities that have the potential to achieve significant earnings, they have extraordinary out-of-pocket costs because many of the services they are looking for aren't covered by their health insurance, and so Medicaid could provide a unique wraparound for them. And this, I think, really identifies that population well.

There are a very modest number of people in this cohort, and this other population is quite large. So, for a policy solution, I'll throw out why don't we think about a national program that would be more attached to something like the exchange, pie in the sky here. And we're shooting for the opportunity to actually see these individuals move from state to state with their high needs, but they would be -- they would have access to wraparound coverage wherefore they ended up, and we would force the states to honor their needs through their Medicaid program, which is a whole other issue. But I think there's real opportunity there to start talking about that as a potential policy solution. SSA could fund some of the research that could support that.

And then we're left with this huge problem in this country, where we have, you know, the other population. We have a large number of people that are having difficulty staying attached to work. Their health conditions are not well managed. They are kind of pressed to look towards other opportunities because they have difficulty getting to work and staying at work. Their health-care issues are bringing them down, and what are they going to do. They end up retiring because they certainly qualify for social security, so this isn't a debate over whether or not they meet the definition.

These individuals are living with multiple chronic conditions that cause them to lose their attachment to earnings. They are going to have needs that both private insurance and Medicare might not adequately address, and they certainly, in many cases, can't afford it with the meager income supports that they're receiving through their retirement programs, be it disability or, in some cases, the old age account. So what do we do about that? That's huge.

We've just passed the Affordable Care Act. So, what, another 30 years we'll get around to addressing the needs of this population that's living with chronic conditions, and hopefully finding new ways to buffer them from some of the expenses that they have.

I wouldn't abandon them in terms of their work capacity, but I certainly think that if we're looking to invest in areas where we're going to see continued attachment, that once someone actually kind of meets the definition of social security disability, the likelihood of them returning to work is low, again, except for this small population that has these significant disabilities, huge earning potential, you know, run out of time. Thanks.

MPR
2015 DRC Conference - Day 1 Part 2

[Inaudible]. A few minutes for questions.

Yes?

[Inaudible].

I think there's a microphone coming.

Hi. I'd first like to -- Dr. Jennifer Christian, and I would like to request, plea, that you not define work disability as having a disability that has an impact on work, because we in occupational medicine have been very carefully making a distinction between impairment disability and work disability. And we've been defining work disability as not working or not pulling full weight at work that's attributed to a health condition. Because if the EEOC -- if we make an accommodation, the impairment disappears. If you make a successful accommodation to an impairment, it disappears from the point of view of the work. So that's why people are reacting to you that way. Is they're very happy that their impairment is irrelevant in their work, right? So we have to be very careful and not create further vocabulary confusion by you guys now starting to use work disability that way, when we in occupational medicine have been working so hard to distinguish the issue of whether you're working from whether you have an impairment.

My comments on the first paper in the discussion, first paper. I thought the results were stunning about the relationship between income and mortality. And I think we should be very, very surprised by this. We know that people of higher income, yes, have longer lives, but we don't generally think that's the direct effect of their income, per se. Also, they, in fact, part of the reason they have higher income is their in better health, they're able to work longer and work more, and they have lots of other reasons why that you see this correlation in the population.

I don't think most people who study this issue would have expected a very small kink in earnings at that level to have a very large impact on mortality. So I think that's an amazing finding. I don't think we should be disappointed that we don't find higher levels. I think we should be stunned that -- you know, remember that everyone in this population is receiving health insurance; right? They all have Medicaid and/or Medicaid. So it's not that this was allowing them to buy health insurance, they have it. And yet, still additional income, especially for people with cancers and other severe disorders is improving their longevity substantially. So I think that's startling. It needs to be better understood. It tells us that, you know, the cash benefits really, targeted correctly, are making enormous difference, and I the next step on that is, I think, to say why? What is that money allowed them to do? Is it that they're supplementing out-of-pocket expenses, or they just have better diet, better health habits. You know, really would be valuable to understand that better. But I think that's a really impressive result.

[Inaudible]. Let me get some questions first:

Yeah, just quickly about work disability, when we were talking about these questions on our national surveys, I often wish we could separate the questions about whether you have a condition that affects the type of work you do versus whether it affects the amount of work you do. And I think by merging them together, that's why we're using the term work disability, because somebody who works full time and more in a job that they've been accommodated to be able to work in might still be unable to do other kinds of work. So I wish we would separate those questions.

I also just wanted to mention, in response to Henry's remarks about those individuals with severe disabilities that have productive capacity but may not be able to stick with the workforce. If there's any possibility of -- and maybe with some data we could do it -- of moving social security away from the notion that disability is a yes/no question. In order to retire gracefully you actually have to just stop. If you're going to get any kind of disability income, either from social security or even from your employers short and long-term disability policies, you have to be 100 % incapacitated in order to get any benefits. And if there was a way that we could recognize that people's capacity work is reducing as they age with a disability, and have them stick to the work force as a part-time employee and get partial disability, then

MPR
2015 DRC Conference - Day 1 Part 2

they would be able to continue to have earnings instead of having to turn off their earnings completely in order to get any kind of benefits.

I think we would save a huge amount of money in the disability insurance business by maximizing people's earnings potential who can't earn completely. And right now you can do. If you're already on disability then it's okay for you to gradually work, but it's not okay to gradually not work if you're not on disability.

[Inaudible].

David, thank you for that comment. So at the lower end point experiment, where we see that large effect, it's not that surprising in the sense that these are people with very, very low earnings. So that's around the third percent of their earnings distribution that that little experiment takes place. So these are people who have worked enough to be insured for a disability insurance, but just have very, very low, so I think they're financially constrained in a lot of ways, and we don't know what the mechanism is, but it's easy to imagine lots of things about co-pays or hiring services such as home health aids and things like that applying at that earnings level.

[Inaudible].

Just to respond in some way, I would agree entirely with it, and I think that if the advocacy community would really focus its efforts on creating a program like that, that would be a good use of energy. The challenge is trying to change SSDI and SSI into programs that they weren't created to be, where we end up in this mess between trying to, you know, have a program that gives you attachment to income supports and health care, and then calibrates them down as your earnings go up. I just don't think it's realistic to try and do them with attachment to like SSDI. I think we need to have people asking for a new program, and the research needs to be done for it.

Going, going, -- oh, yes.

Thank you. I have two questions. One is about the Kink analysis, and I'm still concerned about the causal relationship, because it seems like people who have a 90% replacement rate might just be going onto a program when they're less sick than people who have, say, a 32% replacement rate, and it seems to me that that might be causes the difference in mortality. But I don't know that much about the statistics, though. It might not make any sense. But anyway, that was my thought.

And also, in talking about the accommodations, when we talk about accommodations, I wonder, like, are we counting parents who are have time accommodations so that they can pick their kids up at school? Like, are we capturing people for whom the accommodations have nothing to do with potential disability?

[Inaudible].

I can be quick on mine. So we specifically asked them if they were being accommodated for a health problem at work. So obviously if they had missed that little "for health," then they talked about other things and we gave them some examples and things like that. You know, we could be picking some of those things up. But we have a bunch of different questions, and so maybe we can try to pin that down in follow ups or something. It's a good point.

Thanks. As you say, there's lots of ways that the population varies across the income distribution. But I'll just say that sort quasi experiments that we're doing are very localized to one part of the income distribution, so there's ways that we try to assure that it's locally valid.

[Inaudible]. Well one more question.

MPR
2015 DRC Conference - Day 1 Part 2

Actually, follow up for Alexis. Is there a difference in the impairment mix at the lower bound, at the lower kink then at the upper kink? Did you look at that?

I haven't looked at it, but I would expect them to be, yes.

Ours is [inaudible]. So that's fine.

Just thank the panel very much. Thank you.

MPR
DRC Day 1 Part 3

DRC Day 1 Part 3

All right, looks like everybody's gathered except whoever was these first tables. There's plenty of seats up front. If you thought you got a seat in front row, it's still available.

All right. I'm Craig Thornton from Mathematica Policy Research and glad to welcome people to lunch. You know, why do we do all the research that I presented here today and will be presented tomorrow? And partly you do the research because it's just interesting. We like to figure out why something works, why it is. But we also, I think, hope to influence the public policy debate, to help shape the policies and influence, make people's lives better. And researchers tend to be doing this and doing research, and, you know, we talk to each other all the time about methods and data, but we often don't get a chance to really get involved and hear up more close the public policy debate, and that's what makes this afternoon's -- this lunchtime session, I think, so interesting and so appropriate for this conference.

So we have two people who are not only influential policy advisors but also researchers, and so it's appropriate that they're here today to talk about kind of public policy and how they see disability policy moving forward. And they come at it from different perspectives. We're first going to hear from Alan Cohen, you know, who I said they're researchers. Alan has a PhD in Economics from the University of Wisconsin. Had a lot kind of career mostly advising various senate committees on budget issues, culminating in 11 years with the Senate Finance Committee, where he was the chief counselor for the democratic staff. He's now at the Center for American Progress, and he's also on the Social Security Advisory Board.

The second speaker, Jagadeesh Gokhale, is also a researcher, and PhD in Economics from Boston University. A distinguished career in a number of places, most recently AEI and CATO Institute, and now Wharton University of Pennsylvania Center for Innovation -- or Public Policy Initiatives. Like I said, they both have these different perspectives, come at these issues from imaginative, creative different perspectives, and but they're both now on the Social Security Advisory Board.

The Advisory Board, for those people who aren't closely tracking it, was created in 1994 when Social Security became an independent agency. At the time there was a big debate about how you would have social security led? Did you have a strong administrator running the agency or did you have it led by a board that could reflect different kind of perspectives in all the different kind of pressures that you might think of that are emerging in running something like social security.

Well obviously we can see how the compromise of that debate worked out. There's a commissioner who has most of the power, subject to appropriations and the trustees. And the Social Security Advisory Board, which actually gets the pleasure or the liberty, the freedom, to look at pretty wide range of long-term policy issues but doesn't actually have the power to do very much. But the freedom to look at broad issues is, I think, what makes them really interesting here, because they're the ones who can look forward, think about things that might not be practical to be suggested by the Social Security Administration, but these guys can take it on and think a little bit about.

The board lives the debate. It's, by design, a very diverse set of people, and Alan and Jagadeesh represent not the board, just their own opinions here, but the kinds of different debates, issues that you'll hear raised at the board. So Alan is going to go first. He's going to talk, 15, 20 minutes. Jagadeesh will go, talk about the same amount of time, and then we'll open it up for discussion. All right, Allen.

Thank you very much, Craig. As Craig indicated, the views expressed here today are my own and not those of any organization that I'm a part of. And my understanding was the topic today was social security solvency, but the pending insolvency of social security at the end of 2016, in which benefits would be cut about 20% across the board if we don't take any action before that. And so I'm going to talk in general, and more specifically about that situation. And there was another conference yesterday, the McCleary Pomeroy Social Security Disability Solutions, and I had the good fortune to be able to speak at that. I'm going to say a few of the same things I said yesterday and other things that are new. So if any of you heard this before, I apologize, but there was no getting around this.

MPR
DRC Day 1 Part 3

I'd like to begin my discussion of the Social Security Disability Program by bringing attention to the fact that there are currently more than one million disability claimants waiting for their appeals to be heard by administrative law judges. Even after taking into account the need to have some hearings in the pipeline there is still a backlog of many hundreds of thousands of hearings. This huge backlog results in huge processing times for these appeals, an average of one year and four months across all of the claimants, and appeals in some hearings office could take almost two years to come to fruition. And these hearings are only one piece of the appeals process.

Claimants who exercise all of their appeals rights can wait as much as four years for final determination of their claims. Now during these four years, or whatever number of years this is, most of these claimants have no earnings. They have nothing to live on in terms of earnings, and this obviously creates incredibly severe hardships for them, and thousands of claimants actually die waiting for their decisions to be made.

Now one of the primary causes of these delays is inadequate funding of SSA's, Social Security Administration, administrative costs. I should add that inadequate funding also results in poor service to the public in other ways. This also is something that has a direct affect on social security beneficiaries, because, for example, there are often significant delays in processing the beneficiary's earnings reports. The average processing times for these reports is 270 days, and this results in large and preventable overpayments to beneficiaries. Beneficiaries can be hit with sudden notices of huge over payments through no fault of their own. This can be a significant work disincentive. Imagine if you did everything right, reported your earnings month after month, and then received a notice many months later saying you had been overpaid, \$30,000 and you now have to pay it back. This would obviously be a strong work disincentive for any attempt you might make to work in the future.

Now rather than being given added funding in recent years SSA as suffered a net loss of about \$5,600 employees since fiscal year 2011. The bottom line is, the agency simply needs more resources. Unfortunately, and I repeat unfortunately, neither the house or senate appropriations committees' bills provide enough funding for the upcoming fiscal year, fiscal year 2016. The house appropriations bill is a whopping \$700 million under the President's request, and the senate appropriations bill provides less funds. It's about \$900 million under the president's request. These big short falls need to be eliminated as these bills move forward in the congress.

Now let me start by remarks by clearing up a couple of misconceptions about the Social Security Disability Insurance Program. First, benefits are modest. They're not lavish. Average benefit is \$1,165 per month. This was in December 2014. That amounts to about \$41 a day. The average benefit is not far above the poverty line. In fact, one in five beneficiaries live in poverty. Now, poverty rates are particularly high for women, African Americans, and Hispanics, among others, and one in three beneficiaries have less than \$900 a month, which is very, very low income.

Also, SSDI benefits, on average, replace less than half of wages lost due to disability. So we can see that benefits definitely are very modest. Second, one point I'd like to make is that most beneficiaries are seniors not younger individuals. Seven out of ten disability beneficiaries are in their 50s and 60s, the average age is 53. And beneficiaries worked hard to earn protection from social security in case of disability. The typical beneficiary worked and paid into social security for 22 years before needing to turn to SSDI.

Okay, now I'm going to focus specifically on solvency, the social security solvency and the problem coming up at the end of 2016. I would begin by saying that cutting benefits is not a good option for achieving solvency. Benefits are critical to beneficiaries. SSDI is a high percentage of income from many beneficiaries. In fact, for eight in ten beneficiaries it is either their primary or their only source of income. Without disability benefits, half of beneficiaries would be poor.

Now beneficiaries are already struggling to make ends meet with their very modest benefits. There's no room in their budgets for further cuts. It would be devastating if benefits were cut at all, let alone by 19% if congress takes no action by December of next year. And I want to add this, congress should not wait until the last minute, in my opinion, in 2016, the last minute in 2016 to deal with the solvency problem. As we

MPR
DRC Day 1 Part 3

get closer to the deadline next year, beneficiaries should not have to deeply worry about whether or not their benefits are going to cut across the board.

Now my second point about solvency is this; there's a lot of discussion about getting beneficiaries to return to work in order to improve the solvency of the system. Supporting beneficiaries and working up to their capacity must be a priority, but we need to set realistic expectations on how many beneficiaries are really capable of work. I submit that most beneficiaries are not capable of work. Here's my evidence.

First, beneficiaries, in order to be on the program, must not only be unable to perform their current job or any of their past jobs, but considering their age, education, experience, they must also be unable, unable to perform any job that exists in significant numbers in the national economy to do so at a level where that could earn even \$270 a week. Thus, benefits are available for only those beneficiaries with the most significant disabilities and the most severe illnesses and health conditions. In other words there are very strict eligibility criteria for the program.

Now there's much further evidence of the strict eligibility standards. Many SSDI social security beneficiaries are terminally ill. SSDI beneficiaries are three times more likely to die than others their age. Indeed, one in five, and one in six women, die within five years of getting benefits. 62% of beneficiaries have multiple impairments. Fewer than four in ten claimants have their benefits approved under these very strict standards, and as was mentioned earlier today I think, even denied applicants have extremely limited work capacity. Of those who apply and are rejected, rejected for benefit, barely half have any earnings two years after application for SSDI and their average annual earnings is low, and only one in four earn more than \$1,090 per month.

Furthermore, international comparisons show how Strict the U.S. eligibility criteria are. The OECD describes US. Disability benefits system, along with those of Canada, Japan, and South Korea, as having the most stringent eligibility criteria for a full disability benefit. And that includes the most rigid reference to being able to not do any of the jobs in the labor market, as I mentioned earlier. The U.S.'s strictness on that is the most of any OECD countries.

The United States spends comparatively less on disability benefits than other OECD countries. In 2009 U.S. spending on social security disability insurance equaled 0.8% of GDP. This, again, put the United States near the bottom at 27th out of 34 OECD member countries. In spending on equivalent programs, on average, OECD member country spend 1.2%, compared to the 0.8 in the U.S. And many countries, such as Denmark, use 2% the UK, 2.4%, and Norway 2.6%, spend significantly more.

The conclusion I draw from all this is that eligibility standards from SSDI are very strict and that most beneficiaries cannot work. So while helping some current beneficiaries to work up to their capacity should be a priority. There are not enough such beneficiaries to make these benefit cuts a discernible part of a strategy for improving solvency.

My third point about solvency is to talk about early retirement, and we've talked about that some today here. Through early intervention -- did I say early retirement? I meant to say early intervention. Excuse me. My point about early intervention by the employer, this would be preferably before the worker applies for SSDI, and with assistance provided by skilled government agencies, it may be possible that we can get some workers who would not need to apply for SSDI who otherwise would apply for SSDI. Obviously this would be an excellent outcome, and I think we should do as much as we can to find these solutions and to implement them, although we need to test them first, and we need to get a body of evidence on how they work before we move forward with them.

Now there are several points I want to make about early Intervention. One is it should not be funded by the Social Security Administration trust funds. Trust funds are for benefits for social security disability. We should not be funding early intervention across from that. We have other agencies that can do that. And, in fact, it should be implemented by federal and state agencies, with expertise in improving employment outcomes, maybe perhaps the Labor Department. SSA, Social Security, should not be the provider of this service of early intervention.

MPR
DRC Day 1 Part 3

So what is the solution to the SSDI solvency problem that moves at the end of 2016. For the short term, reallocation is one answer. This is where we reallocate a little bit of the payroll tax that's now going into the retirement, OAS retirement trust fund and reallocate a little bit of that into the disability trust fund. That's what reallocation is. It's simple, it's routine, and it's been non-controversial. Reallocation has occurred on a bipartisan basis 11 times in the past, about half the time to shore up OASDI and about the other half the time to help shore up DI, the SSDI. Reallocation could put both trust funds on the same financial footing, and that would be very good.

Alternatively, we could deal with the solvency problem by combining the two trust funds in recognition of the fact that we all pay into one integrated social security system in order to be protected in case of death, disability, or retirement. Now this merging the two trust funds would remove the need for congress to act whenever reallocation is needed in one direction or the other, and this combining the two trust funds would also remove the ability of some in congress to hold social security benefits hostage, hold them hostage to having a reallocation take place. Now excuse me for one second.

What I was trying to say in my last point is that if we move to having the two trust funds combined it would remove the ability of some in congress to hold social security benefits hostage to benefit cuts as the price of letting reallocation occur when needed. I would also note that without reallocation or emerging the two trust funds, without any of these options, a series of short-term fixes would be needed. But beneficiaries are already terrified that their benefits are going to be cut across the board.

A series of short-term fixes, such as interfund borrowing would be unfair to beneficiaries because it would keep them continually in fear of across-the-board benefit cuts. And I would add, this is just one of many reasons why interfund borrowing, which is another solution that has been suggested, why interfund borrowing is unacceptable. Interfund borrowing is when one of the trust funds, loans, as opposed to switching some of the payroll tax, they give a loan to the other trust fund. That's what interfund borrowing is.

But social security disability should not be addressed alone. It shares a benefit and eligibility formula with the retirement program and it is an integrated system. Changes to one program affect the other, and people frequently move across the two programs. Social security disability should be addressed in the broader context of the entire social security system. And I want to conclude by saying that reallocation or emerging the two trust funds would put social security's trust funds on sound financial footing for the next two decades. Now that's not good enough. We've got to fix that problem so that it's sound for 75 years. But if we make this reallocation or merging the two trust funds it will provide ample time for us to work together in the near future to find common ground on policies to achieve comprehensive solvency for the entire social security system, and that's what we're going to need. Thank you.

Good afternoon and thank you for inviting me to participate in this discussion session. First of all, before I begin, I have to say that we have at the Social Security Advisory Board highly appreciate all the research that you folks do, which helps us understand how government programs, in this case, social security disability system, work and make progress towards improving them. So your work is really highly appreciated and welcomed, because it informs us at the board in our deliberations and discussions.

I've been at the advisory board for six years, and my current term ends this September. And even though I was interested and engaged in social security research and issues before I joined the board, I've learned a lot while being on the board, and I've learned a lot, especially about the Disability Insurance Program, because most of our time at the board is spent discussing the DI program rather than the retirement program.

So over the years the one thing that really stood out, and I think it stands out for most people, given the discussions that I hear in these types of sessions all over the country, is that DI's current rules are not how an economist would set them up. I think that's quite clear, and when I say this to the general audiences, people say thank God, but there is an audience of economists so I'm safe over here, I think.

MPR DRC Day 1 Part 3

So DI's sole objective is to provide an economic safety net to workers by providing cash benefit after the onset of a sufficiently serious and adverse work-limiting medical disability. So how do I turn the slides? Oh, here. But I don't know what I do. Okay. Thanks.

Okay, so it's clear that when we craft policies to address one or other of the policy goals and we establish an agency or an institution to implement that policy, it often interferes or it's often likely to interfere and reduce our ability to achieve other important policy goals. In DI's case it's the difficulty of determining who deserves to be allowed onto the DI roles and the potential for large errors in making these determinations that interferes, I think, with our ability and reduces our ability to preserve economic opportunities and incentives for individuals with disabilities to remain in the workforce and to return to the workforce after being allowed onto DI.

So chart kind of shows the growth in the share of people who self report having a work-limiting disability in the current population survey. The trend is for people to leave the workforce and join or enroll or apply for and enroll into SSDI. That's a pretty striking trend over the period, especially as the number of people in the population reporting a work-limiting disability hasn't shifted much at all. Those are the lines below 10% for both males and females. So it seems like we will be losing -- there is an anti-work incentive that is built into the system. We would like to describe it as SSDI is like a gravitational force peeling workers in this group away from the workforce and absorbing them into the system.

So the current system presents a one-way street out of the workforce when individuals have disabilities because it pays them to remain idle and penalizes return to work. So such a benefit structure is really inherent in the very mandate of social security, the sole mandate being to provide these safety net benefits to individuals who are deemed to be disabled, and it's in the very definition of disability that must be implemented according to the law, and this type of an incentive is, therefore, in the operational rules of the program that logically result from this sole mandate of providing a safety net benefit.

So many reform proposals have been made by researchers and other lawmakers to provide all kinds of early interventions for workers to create employment promotion systems and provide counseling and assistive supports and so on, but none of them really directly address the key issue, which is that the current DI system presents strong incentives to leave the workforce and enroll into DI for those with even minor health impairments, and such incentives gather a special significance in strength during times of recession and high unemployment. So you can see during recessions the enrollments -- allowances into DI spike up and have remained up. I think they've remained up because of population aging and so on. The spike is especially significant, the increase especially significant during time of high unemployment.

Changes to DI's laws during past decades have also made applying to DI more attractive by making eligibility rules more lenient and especially as allowance to DI's now possible for health conditions that are difficult to verify under objective medical testing and criteria, such as low back pain and anxiety and depression and so on. There's also pronounced trend in the systems, the way of adjudicating cases or determining whether someone's eligible for the system. More of the allowances are based on vocational criteria, and less of them are based on exclusively medical criteria.

So the correlations are applications and allowances. This is for DI awards of mental and musculoskeletal diagnoses, and, again, you can see during the past three recessions what the trend has been for people age 50 and younger to especially claim mental impairments, less so musculoskeletal impairments. In this case it's the opposite for people older than age 50, and the correlations with spikes up during recessions for musculoskeletal impairments in this case, so the significance of the allowances and the attraction of being on disability is magnified during these times. And because of the way the system benefits are structured, it's a one-way street. You get absorbed permanently into the program.

So I think, therefore, while DI provides important safety net benefits to people who suffer disability, it's gone in the direction of now preventing us from actually preserving opportunities for workforce participation by people who could because of the way the benefit is structured. So I think DI safety net goal, therefore, should be augmented with the goal of preserving and enhancing work incentives for DI beneficiaries and applicants.

MPR
DRC Day 1 Part 3

So a system which would have two objectives rather than just one objective would need two instruments rather than just one instrument. So we need a different benefit structure, which has two elements. One would be a safety net element, and the other would be a work incentive element to encourage return to work, without the threat of being ejected from the program when earnings exceed the SGA level.

So this work incentive or the subsidy to earnings, actually, I think should increase with earnings for a long segment of earnings above SGA, with the costs being offset with a fixed rate decline in the safety net benefit as earnings increase. This is kind of a simple picturization of what I'm trying to suggest. The cross line, the line we cross is current law, where you can see the cash level SGA. The yellow line is the 45-degree line that just converts earnings into income one for one. The blue line is the safety net benefit, which is reduced at a fixed percentage rate as earnings increase, and the green line, which is initially negative for low earnings levels, but then it becomes positive and rises up to a certain earnings level, and then the earnings subsidies phased out, that's the earnings subsidy element. So the blue line and the green line are offsetting components of the benefits that I would propose, all of which, the earnings, the safety net benefit, and the work incentive benefit would result in the red line, the total take home income that the beneficiary would receive.

And as you can see, the total income level rises at a faster rate than earnings for a long segment beyond SGA. So I think if you had a benefit structure something like this, this would be an incentive compatible benefit structure, where those who could take advantage of the earnings subsidy and work and earn and participate in the workforce would take advantage and move up the red line, up to a point, and then they could continue moving up, but then that kink marginal increase in benefits is very low, so the benefits would be phased out, but at least you'd have those who could work more be able to take advantage of the earnings subsidy.

Those who couldn't work would receive -- would be a zero earnings or low earnings and would receive the safety-net benefit. They would be taxed to some extent, and the tax is necessary, and I can't explain exactly why right now. It's a little complicated. But the tax is on low earnings so the absolute amount of the tax that you have to pay is low, but you get a high benefit for the safety net. So this combination of two element benefit structure, I think, would be beneficial to reveal information, really, about who can and cannot work. Right now the problem is, because of the way the benefits are structured, we don't really know who among the disability enrollees can or cannot work. There's tremendous incentive to not work because they're afraid of their fear of being kicked out of the program.

So I think a very important element to combine with this type of benefit structure might be a guarantee that beneficiaries who work and take advantage of the earnings subsidy would not be ejected from the program because of earnings. The only reason for removal would be a documented medical improvement. So under a system that, for example, Senator Colburn calibrated, in his bill, job separation for any reason results in a gradual removal. If someone is working at a high level and taking income along the red line at the high level has a relapse of their disability or the health condition and they slide back down to the red line, they wouldn't go back to zero because they'd been removed. The subsidy would be removed but the safety net benefit would be restored. So that's a flexible system, whereby you would have a separation, allow complete freedom for those disability beneficiaries who could work and augment their income, but then if you cannot work you get protected by the safety-net benefit.

So there's several advantages to this kind of system. One is it eliminates a cash cliff. Two, it automatically generates key information that we lack today about who can and cannot work. It increases national output and productivity, reducing underemployment and labor resources. Enables beneficiary free choice to work without fear of removal because of work and earnings and would help them to be included and help them to participate in work and community life, something that they claim as high priority and interest to many of them.

And two additional advantages I think, which I would like to mention are that the cost to the budget, there would be some cost to the U.S. budget for providing the subsidy. It would not be quite as high as the earned income tax credit because it would be offset by a reduction in the safety net benefit as you work more. But there would be some costs, but the costs would not be realized without a behavioral change by

MPR
DRC Day 1 Part 3

beneficiaries. So if there was no movement along the red line, people continue to work just as much as they are today, there would be no additional cost to the government.

So finally, I think this reform -- this type of benefit structure is complementary to every other reform that's been proposed. It's just a change in the post-retirement benefit structure. All the other supports, medical coverage and so on, could be exactly as it is under current law or under an alternative proposal. There's nothing conflicting with any of the proposal. And a final thing to note is that most reform proposals that propose some new coverage or private disability insurance or employment support services require an initial investment to garner future benefits, future savings and costs of the program.

But in this case the costs will not emerge until there is some demonstrated effect in the outcomes where beneficiaries are induced and have the freedom and can actually take advantage of the subsidy and work more. So there's no element of you have to give me money now for a benefit later. You will have to give me money only if there is a benefit visible in and will become automatically. So I would like you to consider this. I don't know if I'm talking -- if I'm off the wall. I haven't actually described this proposal in detail here, but there's papers you can read. Thank you very much.

Thank you to our two speakers who not only remit diverse views on a variety of issues but have raised different issues today in what they're going to talk about. I thought I'd open it up for questions to see if anybody has questions. The two producers have agreed to take questions if people want to know anything that they were working on or thinking about. Yes, please, David. David's a good call in the middle of the room.

Great. Thanks. Jagadeesh, I really like your proposal. I'd just like to add an extension a little bit, and this came up yesterday in the CRFB session, that you might want to define what SSDI delivers more than just a cash benefits. I've got business background, as opposed to economics, and one thing that's been pretty clear in management science is that money, although it's a strong motivator, is not necessarily the most powerful one. I mean there's studies about salary levels being secondary to other aspects of job satisfaction, so it's kind of along those lines, I think, a way to extend what you're doing is more powerful and less easy to implement, but it is defining the benefit to be helping restore function and quality of life to some degree.

I mean, you have to play a little bit with exactly how you define that. But someone may not go back to gainful employment but find a spot in society volunteering, or many other ways that you can reengage with life, and on a longer arc get yourself back on. I think what you're doing is an excellent step and I just think if you're going to try to expand the definition, see if, over time, you can include that broader objective for the second objective since money alone is not going to necessarily be the winning thing.

I appreciate your comments. Of course, I'm an economist, I tend to think in terms of dollars and cents. But I take your point that it's more than just dollars and cents and we need to be reminded frequently that, you know, these programs provide -- just by providing the safety net, the security that you'll be supported even if you need. I think disability insurance should be a pro-work program, but it's turning out to be mandatory work program. So I thank you for your comments.

Did you want to add anything?

I don't have any comment.

I mean, the interesting thing is that early on people who listened to Ed Berkowitz talk about the history of social security and rehab is that this was the whole debate, should social security be focused rehab, returning people to work, or was it an early retirement program where you turned the switch and they left the workforce. And Altmeyer was the big proponent of the its like early retirement and the social security headquarters is the Altmeyer building, and Mary Switzer was the big proponent of the rehab bill, and RSA headquarters is in the Switzer building. And these are on opposite sides. They're not even in the same city, which kind of reflects how our policies develop along the same lines. Yes, please.

MPR
DRC Day 1 Part 3

Oh, hi. Linda Tomsburger [ph] from Impact International. As we're talking about the two to four years it often takes people to get benefits, we're talking about people who have spent two to four years convincing their spouses, their employers, themselves, their lawyers, and the Social Security Administration that they are 100% incapacitated, and then we're surprised they don't go back to work. So I'm just wondering, has the Social Security Advisory Board even considered the possibility that we should look at the extent of a person's disability rather than assuming that disability is an all or nothing.

I'm sorry, that we should look at the extent, did you say?

At the extent of disability, rather than considering disability an all or nothing question. Right now, it's yes/no, and people come in all the different shades of gray. And we're so invested in convincing the system that we're a hundred percent incapable, why would we ever expect somebody to go back to work after they've just been through that process.

Well I understand what you're saying, and there are proposals out there for partial benefits. We heard one yesterday --

There are? Okay.

-- at the McCleary Pomeroy SSDI Solutions. I would add, however, that administering a partial benefit would not be easy. It's already difficult enough to administer the what we have in the law now, where it's all or nothing. And this could create a very unwieldy administrative situation, so I think that's something we'd have to consider if we wanted to move forward with what you're describing.

Yeah, it seems as if it would save the trust fund an enormous amount of money if people were encouraged to work to their maximum capacity instead of being encouraged to consider themselves unable.

But it almost might encourage some people who would not be applying for disability insurance to now apply for it, and the idea of trying to get the partial benefit. So it cuts both way, I think. You know, any time you make one move you've got to consider the impact on some other areas though. But I think it's an interesting proposal.

Denise.

Hi. Denise Hoffman from Mathematica. Alan mentioned overpayments as one possible work disincentive. And just my initial reaction, Jagadeesh, looking at your graph, it seems like overpayments under your proposal would perhaps be smaller in size but more frequent, but, again, that's just based on my quick read of your graph. So I was wondering if you've given any more insight into how overpayments might factor in under your proposal.

Did you say overpayments?

Related overpayments by which security pays the beneficiary more than he's due in that month for work. Yeah, so under my proposal the information about how much someone's worked and earned would come from state unemployment agency reports on a quarterly basis. These data are already available to social security. And if you read my proposal in detail, I also have the software package you could walk through and experiment with if you want, which I could provide you, which tells you exactly how the benefits would be completed. It involves a six-month lag in the computation and delivery of benefits in these adjustments. It's just the way social security reporting of data. It would be great if we could get this data monthly, on a monthly basis to reduce on all things.

In my case it doesn't -- this reform nothing is based on self-reported earnings or income, unlike the SSI program. It's all going to be based on administrative reports from state unemployment agency on a quarterly basis. It involves some lag, but even those lags have some advantage. For example, if you lose

MPR
DRC Day 1 Part 3

your job, if you had a high-paying job and you lose it, that's a bad thing for this individual. But then the vast earnings would provide you with a subsidy, because the subsidies provided with the lag, so just then you lose your job might actually help the fact that you were employed in previous employers. So there are advantages and disadvantages of that lag, but it doesn't result in overpayments, because everything is based on administrative data. David, oh, the other David.

Just since we're talking about this idea of partial disability -- and we do have a federal program that is a partial disability program, it's the veterans Disability Compensation Program, and it seems like a much better idea in theory than it is in practice, in fact. And the experience of veterans when they get on the Disability Compensation Program, they call it the "escalator." Basically you get on at some step, and then people repeatedly reapply to go up, because the benefit schedules feed the index. And many people who are well meaning people trying to reform the Veterans Disability Compensation Program were very afraid of people taking that very first step on the escalator.

So, although I fully agree that the notion that disability is a discrete state, you either are or are not, is totally out of date. It's not clear from an administrative perspective that making a graduated benefit schedule where people have an incentive to, you know, move up the steps. It works very well. I absolutely endorse the idea that there ought to be things, aside from disability insurance, that are trying to assist people to stay in the workplace, and assist people and accommodate them and so on. Whether that's the same program or a different program, I think is going to be figured out.

But, clearly, the DI system is well designed for someone who has a severe impairment that is going to prevent them from working and needs income and health supplementation. It's really not well designed for the continuum of cases, and that's what I think a lot of the discussion is about, and the right policy for that, I think is a mixture [inaudible], speaking of and many other types of assistance, but it's really challenging to figure out what works and what's administratively feasible.

We'll do David and then (inaudible).

Yeah, Dave (inaudible). So this is to both of you, and one thing that Alan said triggered a thought concerning not unwillingness to pay for employment supports out of the social security trust fund, which I think is the original position to take, and many other people have taken it as well. And then thinking about Jagadeesh's proposal -- and I understand from previous conversations with Jagadeesh that it involves beneficiaries sort of moving between one set of rules versus another when they go in and out of the labor force. And it brought to mind a proposal that was made by Brian McDonald and June O'Neil, I think originally in 19 -- I'm sorry, 2006, called "Being American," and they were proposing starting basically a new social insurance program called "Employment insurance," and so it would create a separate trust fund for providing support for workers who had medical conditions but could continue to work, at least partially.

And, you know, it might look in terms of its benefit structure, like Jagadeesh's proposal. It wouldn't be funded out of the SSDI trust fund. It would be funded out a different payroll tax. It might be a new payroll tax. It might involve, in the long run, transfers between the funds as you learn how, you know, the employment trust fund is saving benefits from SSDI, or reducing SSDI benefits or something like that. I would like to know what either of you thought about that idea and whether it's compatible with both your ideas.

No, I have not. But, I mean, I don't understand when you say moving in and out of two different systems. This is just one system here. You just put it in place and it goes. It's just one system. I'm not sure what two systems you're talking about.

Well, right. I mean, I think the way you've described it, that would be accurate in the Social Security Disability Program, but sometimes they're an employment state and sometimes they're just not employment state; right?

MPR
DRC Day 1 Part 3

So what? There's a schedule you face.

No, I understand that. I understand that.

It's just one system. It's the employment may change, that's why.

Right.

I mean, that's the whole purpose of this, to get people to work.

Right. And I wasn't being critical of that feature, but you could see how you could define that as a separate benefit; right? Where people could move.

It is a separate benefit.

People could move between the two benefit structures without --

Both benefits are paid at the same time. It's not that one is paid and the other is not. Both benefits are paid, if you have the right point in your earnings, depending on where your earnings are. It's not two systems. It's one system with two benefit elements.

I understand that.

We've probably reached marginal returns on this point. Do you want to come back? Alan, did you want to say something?

No, no thanks.

Hi. This partial -- going back to this partial benefit discussion, actually, I a published paper and journal in risk insurance, so following Alan's comments, you know, the concern is, yeah, some people who are currently applying and receive full benefits being made -- so under a partial disability benefit, they may go to a lower level of benefit. That's good. And at the same time, you worry some people who wouldn't have applied under the current system would have applied for some lower-level of disability benefits. That's going to be costly to the system.

So, actually, I did, in my published paper, I did policy simulation, because we don't have the system -- we don't have the data, so I did a theoretical simulation on a very sophisticated structure model. I find that under certain conditions, you know, the results could be positive, both for individuals and the government. For the individuals, because the people who currently have partial disability, they could receive some partial benefit composition while staying in the labor force, keep working, you know, have a kind of, you know, decent living. For the government, you know, they could kind of shape to some of the current full disability case load to a partial disability payroll that lower in cost. At the same time, the people who stay in the labor force, they can keep working and keep contributing to the system by paying tax from their work. So that's good.

So I also look at some European countries, many advanced European countries, actually, they do have this partial disability benefits. So their practice, like David said, it's far more complicated and complex than, you know, in theory. So, actually, I think there is a key there, you know. In theory, we think those people who receive partial benefits, we hope they can keep working, stay in the labor force. But, you know, even they want to, can they find a job, you know. So that needs a lot of cooperation from the employer side. So I think it comes down to like a cost sharing kind of thing, you know, like employer, they try to provide some accommodation to people with some partial work limitation, and for those who have to leave the job, employer cannot accommodate, they go to the government program, SSDI, SSI, you know.

MPR
DRC Day 1 Part 3

If the government could provide them partial benefit, that's a kind of a second layer to help them stay in the labor force kind of thing. So, yeah, that's -- also, another point I want to make is --

Just there's a question in here?

Sorry, last thing, one minute.

Get the red light on here.

Sorry. The bond program, the benefit of that program now social security is already, you know, seriously considering and conducting this demonstration project on it, so it's like ex-post partial benefit; right? For people who agree to leave the DI program and start working, they keep partial benefit and supplement it with their working income; right? That's like ex-post partial benefits already. Now I think if we do that, but without doing the partial benefit at the interest, the system is an asymmetric system, so that can cause a lot opportunistic behavior, you know, as you could imagine. People enter with full benefits but then suddenly they could claim that they are just partially disabled, they could go back to work, things like that.

So actually in Sweden, you know, they recently -- sorry, they have these partial benefits but recently they compensate their partial with the bond like, so make the system symmetric. Sorry.

We may have time -- there was one more person over here I think wanted to say something, and then we'll break because the next session will start at 1:15.

This is a question for Jagadeesh. I took a look at your proposal and I very much agree, in principle, with the idea of some sort of graduated offset. Though one of the issues that I see day to day with beneficiaries is the complexity of the current work incentives. And I have to admit when I read your proposal, even though I agreed in principle, the complexity of the details, I just couldn't imagine from the beneficiaries I meet day to day explaining it to them. And have you put some thought into simplifying your proposal. So the beneficiaries would face a schedule of earning subsidies.

The message to beneficiaries would be that, well beyond SGA, if you worked and earned you would get more take-home pay than your earnings. If they understand that, I think that's sufficient to incentivize them to work if they can. And if they still cannot, despite this incentive, then you separated the two groups, those who can and cannot work. Those who can work will work up to the limit of their capabilities if they find the benefit subsidy worthwhile.

I don't think they have to understand. It's very complicated to understand if you work and earn you'll get more. You're getting a subsidize essentially. That's the word we use. But, you know, it's beneficial more than what your employer is paying you. The government is going to kick in 20, 40 cents in addition to every dollar you earn. So, you know, social security retirement benefit formula is complicated, [indiscernible] with 2,600 rules. This is just one schedule with two elements, and I don't think it's complicated, and I don't think it's actually difficult to implement, but that's my view. We could talk more.

All right. Any of you want to have the last word on anything else?

I don't.

All right. Thank you very much. We'll reconvene about 1:15.

[BREAK].

Would the speakers for the next panel please start making your way to the front. Thank you. I'd like to ask everyone to please go ahead and take their seats and all presenters and discussants to come up to the front. I'm glad to see so much discussion in the audience. If everyone would just have their seat so we have time for the discussion after the panel.

MPR
DRC Day 1 Part 3

Okay, we're going to go ahead and get started. Our next panel is on household composition and income, and we're going to have three different presentations in which we're going to learn about the characteristics of an important subgroup of DI beneficiaries, factors affecting DI benefit claiming behavior, and also, evidence of the effects of disability benefits on household impacts and fiscal impacts from Norway. First up, we're have Gina Livermore who is the co-director of the Mathematica DRC, and also Mathematica's Center for Studying Disability policy.

All right, I am going to talk today about the characteristics of SSI and SSDI beneficiaries who are parents, and this is a paper -- or it's actually a data brief that's part of a series of data briefs that we've been doing under the DRC to profile different subgroups of beneficiaries and to get information out there about different types of beneficiaries and to highlight information that's available from SSA's National Beneficiary Survey.

So why might parents be interesting. Well parenthood has been shown to be linked with poverty among disability beneficiaries, and having dependence introduces even more complex decision-making and behavior-related program participation and labor force participation, and parents may face some unique incentives as such, related to employment and also different employment barriers. And they're also a potential target group for employment supports because, as you will see, a large share of them are young, and a large share of them also say that they have an interest in working.

So this is for -- we use data from four years. The National Beneficiary Survey, pooled them together so we'd have more parents to look at, and more parents who are employed to look at. And we defined parents here, and every time I use the term, it's beneficiaries who have a child under the age of 18 that either lives with them or does not live with them. So they're either residing or not residing with the child but it's not adult children, it's only children minor age children under 18. All right.

So just a little background on the disability benefits for dependents. Under SSDI there's auxiliary benefits for children under age 18, and up to age 19 if they're in school, up to a family maximum that's roughly equivalent to 150% of the primary insurance amount, and under SSI there are no dependent benefits at all.

And there's some interesting interactions with other programs that parents might experience with their disability benefits. In most states SSI does not count as income in determining child support payments of parents, and this is relevant, because, as you'll see, a lot of the parents that are beneficiaries are unmarried or not living with spouses. But under SSDI it does usually count as income and can be garnished for child support payments, but the auxiliary payments to kids don't count as part of the parent's liability so it's like a payment to the kid who doesn't get counted in that calculation.

And there's a long -- with respect to temporary assistance for needy families and other programs serving low income families with children there's long history -- or large research going all the way back to the AFDC about the interactions between SSI and TANF AFDC. There's TANF's for states to get people onto the federal programs. There's also incentives for the individual to be on SSI rather than TANF because the benefits are higher. There are no work requirements and time limits.

So what share of beneficiaries are parents? Yeah, I can't see anything here. Okay, so overall 20% of all beneficiaries -- I'm talking about SSI only, and SSDI concurrently. And beneficiaries are parents, and in the SSI -- among those receiving SSI, it's a little higher, about 24%. So minority of the parents are actually married, 39%, and about half have only one child, and half more than that. And about two-thirds of them actually live with at least one or more of their children. What's the last one? Oh, and 21% have very young pre-school age children under the age of six.

So parents do differ from non-parent beneficiaries in a lot of ways, and I've only put up a couple here. But the biggest one, in terms of their age, they're a lot younger than other beneficiaries. 40% are under the age of 40. There are somewhat more likely to be non-white. Somewhat more likely to have not completed high school. And even though only 39% are married, they're a lot more likely to be married than other kinds of beneficiaries, and they are a lot more likely to be in poverty than other beneficiaries.

MPR
DRC Day 1 Part 3

And then the red ones are things they're less likely to be. They're less likely to report being in excellent or very good health to be SSDI only and to have experienced childhood onset of disability. And what's the last one? Oh, to have been on the disability programs for ten or more years. So they've been on a shorter time, but that's partly due to they're younger as well.

So what share of parents want to work or actually do work? The first set of bars there shows the percentage that say they have work goals or expect to work in the next five years, and 53% of parents compared to 39% of non-parents say that they would like to work or expect to work in the near future, and parents are slightly more likely to have ever worked for pay, and but at a point in time, they're somewhat less likely to actually be working. 7% are working when they're interviewed, versus 9%. But over an annual period they look the same as other beneficiaries. About 12% in each group have works at any time the year before they were interviewed.

So some of the reasons for not working, among parents and non-parents, so this is among people who said, yes, I have work goals, I'd like to work, but they actually weren't working when they were interviewed, so these are the reasons they say they can't work, and the reasons for parents don't really differ much from the reasons of non-parents. Health is always the first one. Being discouraged by work attempt, these are the top ones that usually have been reported in the survey all along. The one that does differ is that 25% of the parents indicate that they're not working because they're taking care of kids or caring for others.

And I put the last one up there, does not want to lose cash. These are just some of them. I didn't want to list them all. But the last one does not always cash or health insurance benefits, I put that up there because it falls really low on the list of reasons. And people say a lot that's the reason why people don't work. But when you actively ask them, they won't say that. But these are also people -- this is a subset of people that have work expectations and say they want to work, so it's a different group than beneficiaries in general.

So job characteristics of the parents who are employed and non-parents, these findings here kind of surprised me at first because it shows by every measure up there, parents are higher earners, they work more hours, they're really likely to be working above SGA if they're working. 44% are earning above the monthly SGA amount, so this surprised me. And, you know, I thought that being a parent would interfere with the productivity and that would be reflected in their wages. I mean I see how it affects my co-workers' productivity all the time, but this isn't the case. But it's probably because the characteristics that make them parents are also things that would make them successful in the labor market.

And they also have characteristics such as -- well if you look right there, the percent in shelter or support employment, that's driving a lot. Only 16% of them are in supportive employment, versus 44% of other beneficiaries, so their disabilities are different. They may have more human capital or have been able to acquire the human capital before they become disabled, and so if they're able to get over those barriers of having children and be in the workplace, then they're able to actually do quite well. And there's selection going on. The ones who it actually pays to work are the ones who are going to arrange for child care and possibly pay for it and so forth, so we might only see high earners among that group.

So, in terms of income assistance and poverty, parents are more likely to receive non-government benefits from various sources, and I just have a few up here. And they also get higher average social security benefits, and part of that is that auxiliary dependent benefit is playing into the average here. But at the same time, they're getting greater benefits and as we saw, if they're working they also have higher earnings. They also have this higher rate of poverty, as I showed before. 58% are still in poverty, and, you know, it's likely because they have more mouths to feed. So, by the official definition, they're more likely to be poor.

So to summarize, a substantial share of beneficiaries have children. I think I didn't know what to expect, but 20% overall may seem not that many, but when you think about the program and how we normally think of older workers being the majority in there, it's probably a substantial share, and among SSI it's even quite a bit bigger. It's about one in four. And they do differ from other beneficiaries in many ways.

MPR
DRC Day 1 Part 3

They're younger. They are somewhat less educated and they receive higher levels of government support and yet are also higher chances of being in poverty. And this group, given their, you know, expressed or a lot of their expressed interest in employment and, actually, the successful statistics on ones who actually do become employed, employment may be an option for improving economic wellbeing of parents, but, you know, they have -- well I already said that.

But, you know the other thing about that is because they're so young, investments in employment may pay off in the long run if they're able to reduce their reliance on these public benefits, not just SSI and DI, but the other slides show they're in food stamps and other programs like TANF. But even beyond that, the savings to the government, you know, we know that children in poor families fair poorly in all kinds of societal outcomes. So investments in this population where, you know, it's high poverty and their parents are on the welfare programs and receiving disability so even improving their parents chances to earn and improve their income may have longer-term impacts for their children as well.

But there are significant barriers, education and training, you know, the low levels of education, having child care, you know, none of these things -- well education training might somehow be supported through ticket to work, but child care isn't an SSA thing and never will be. And then there's the disincentives associated with the programs and not just the disability programs, all the other programs that they might be participating, such as food stamps and TANF.

All right, so just to conclude, gosh I'm way ahead. I always do that, go to fast, so maybe I'll just sit here for a second. But I think it's interesting when we do these studies and we look at these little populations, you know, to think about the diversity of the people on the disability programs, and like I said before, you don't think of parents and supporting children and SSI and SSDI playing a big roll in that, but they do, and if the designers of the program, particularly SSDI, had had this population in mind back in 1956, I think it might be a very, very different program. So thank you.

And Jeffrey Hemmeter from Social Security Administration will be discussing this paper.

Thank you. So I want to say thanks to Gina and her co-author for a very straight-forward paper. Part of a series of statistics and briefs that are coming out based on the National Beneficiary Survey and very helpful and cover a wide range of topics. Of course anything else, I want to strongly encourage everybody, when they're available, to look at the underlying tables that went into making the slides I guess. It kind of breaks out all the results by SSI-only, concurrent beneficiaries and DI only. It really shows a lot of breadths to the statistics, you know, ranges from -- 20%, 30 percentage point ranges between SSI and DI in terms of the outcomes that Gina had mentioned. As one might expect, employment and income are generally higher for DI-receiving parents than SSI parents. But, again, the range is fairly large.

I want to say, I think this is a really important topic for several reasons, but two I want to mention right now. One is that I think it speaks to the adequacy of benefits. And even though they do have higher mean monthly benefits, I found that parents are more likely than non-parents to be in poverty, which is kind of counterintuitive to me.

So I was looking through the data and I was a little confused by the measures of income, whether or not they were personal or household income. I know some of the statistics that Gina pointed out were for SNAP use and things, which kind of cover the whole household. Other ones were personal income. And I think clarifying that would help, because the percent that were in poverty were substantially higher than I've seen in other estimates using the survey income program participation, two-thirds higher than I've seen there. So I'd just like to see that clarified.

The other reason I think this is important is that I think it reminds people that beneficiaries are responsible for others, and those responsible for others tend not to just think about their own wellbeing, and when we think about work incentives and DI, particularly, you have to think about the family maximum, you have to think about benefits that are received throughout the family or that are available elsewhere. Also, in

MPR
DRC Day 1 Part 3

addition to parents, you could say the thing holds for spouses or other people that are in the household as well.

One extension of the work presented today I think would be to look at benefit receipt of the children themselves, and the other family members, and to look at the relationship between their benefit receipt and that of the parent. You mentioned that there is no child benefit for SSI based on the parent's benefit for SSI. But there are a lot of children receiving SSI in households with parents receiving SSI, and similarly there are disabled adult children and others receiving auxiliary benefits on the child on the DI side of the house?

And so the question is what does that mean for the working orientation of parents, and further, what does it mean for that child's eventual own work activity or work orientation. If a parent works, is a child more likely too? The child, him or herself that has a disability, does that factor in. If one thinks of the various earned income tax credit or even the moving opportunity finding, the impact of having a parent working could last for a very long time on the child, and I think that looking at it more from a broader perspective of the whole family can be very helpful.

I would like to highlight one particular interesting finding, to me at least, I think ties back into policy implications and that was the child care as a barrier that needs to be addressed. I don't know if you caught it on the slide but about 7% of non-parents with work goals reported caring for children or others as a reason for not working compared to 25% of parents. And so my big question is who are these others that they're taking care of. Are they taking care of their own parents? Are they taking care of a spouse? Are they the other children in the household? It wasn't clear to me. But I think it's becoming more common for parents to have to take care of non-children, and the question is, is it necessarily child care that needs to be the issue or, or is it just other caregiving arrangements.

But I think in terms of policy recommendations, in terms of child care, one of the things would be how does this compare to parents who have jobs but still find child care to be an issue? The statistics that were presented were for -- was it those who are work oriented but are not working and not seeking work, so that's kind of a couple layers down from the whole population. So to kind of expand that out what else do we know about other parents? What about those who are looking for work but have found child care to be an issue? Are there different ages and different numbers of children? Does that matter to the difficulty in finding child care whether or not the child has a disability? And then basically how does this compare to the population without disabilities or with disabilities but not on DI or SSI. I know that's not in the National Beneficiary Survey, but it would be interesting to kind of pull all that in together to kind of make the whole policy argument for that.

And the question is -- and I have no doubt that child care is a significant issue and a barrier to employment. But I think it would be useful just to have a more complete picture if you can take, like, the TANF or the TANF subsidies that come out, or the child care and development block grants that can make some child care accessible, more accessible.

Finally, I just want to mention one kind of technical issue, if you didn't notice -- you made a point of it -- the pool, that 2004 '05, '06, and '10 National Beneficiaries Survey, there was a slight recession during that time period, and I'm wondering how that affected the results. I know it's kind of hard to do that, to tease that out, but you might think that there could be some changes over time and including them for the reason for not working. And that's it. I think that's good. And I beat your time.

Great. Thank you. And I'd like to encourage our other panelists to stick to the time so we have plenty of time for discussion. But next up we have Day Manoli, who is an assistant professor with the Economics Department at the University of Texas at Austin.

Oh, reset, the timer reset. I was hoping to get those additional minutes. But, all right. Well thank you all very much for the opportunity to present. Before I get started I just want to mention that this joint work with Shauncy Romanoff at Treasury who is also here, and I also want to highlight our disclaimer in case

MPR
DRC Day 1 Part 3

the big red bold letters didn't do this enough. But this research does not represent the views of SSA, IRS, Treasury, or any other government agency. It just represents our research efforts.

Okay. So, you know, I feel a little bit silly motivating this audience, but, you know, as many of you are aware, there's increasing dependence on social security and disability in countries around the world, and the U.S. is no different. So SSDI has become a key feature of the U.S. labor market and, as a result, there's increasing pressure to understand trends in this program and develop potential reforms.

So, in this project we're going to be bringing a relatively new data source to inform these topics, and that data source is population tax information. So we're going to be using information that covers the population of the United States, so the large samples really allow us to look at variation across age, income, and geography, as well as other dimensions, but I'm going to be focusing on those dimensions in today's talk. So we have detailed information on income, both the household level, as well as individual level, and we have panel data so we're able to track individuals from 2001 to 2013 roughly.

There are also some important limitations to keep in mind so we don't have information on SSDI applications for example, but, you know, hopefully we'll be able to talk with people at SSA more and hopefully build some cross-agency collaborations and some data-sharing opportunities. But overall, you know, I want to highlight our goals here today, but first we're going to set up and verify the information that we're seeing in the tax data and then we'll get into some descriptive analysis. So just to give you a brief idea, I'll talk a lot about the data sources and the data that we see on the IRS side, and then I'll talk about characterizing the SSDI population with the information that we have and then SSDI entrants, and finally, I'll talk about some plans for further research.

So our data is coming from, as I mentioned before tax information, and I want to highlight in particular administrative data from the form 1099 SSA or the SSA 1099. This is a form that's reported by SSA to IRS for all beneficiaries. So this is an example of the form here. So this is sent from SSA to beneficiaries. It's also sent from SSA to the IRS, so you have the name and the social security number of the beneficiary. You have benefits paid to the beneficiary, benefits repaid from the beneficiary to SSA, as well as net benefits. Then you also have address information, which will also be very important for sort of geographic or spatial heterogeneity.

Now I also want to highlight that this form, you know, that in addition to the information that is in those boxes, we also see the trust fund or the source of funds that are being used to pay those specific benefits, and this is what we're going to be using to identify disability recipients in particular. So we can see whether a person is getting benefits from the disability insurance trust fund or if they're getting benefits from the old age and survivors insurance trust fund, so we're going to restrict our population to individuals on the DI trust fund.

So I want to highlight that this is information that's originally coming from SSA to the IRS, so it's not self-reported information, and this information will also cover individuals that are receiving benefits as spouses or children. So, you know, naturally we want to benchmark our data and make sure what we're seeing in the tax data is similar to what SSA is seeing, and so that's sort of the first point. So I'm going to focus on data from 2011, and we'll talk more about -- think about other years in particular towards the end and in further research, but overall, I want to highlight that, you know, starting with 2011, we're doing pretty well in terms of aggregate matches. So you can see that we're within less than 1% of a difference between the IRS counts and the SSA counts, and when we split by gender, we're also seeing pretty similar characteristics.

Also, you know, as I'm going to be talking about geography in a lot more detail, I want to highlight that we also benchmark the state counts, and we're within plus or minus 5% on the counts for 48 out of 51 states plus D.C., so we do a pretty decent job of matching those. I should mention the other three. We're just above 5% on one of them, and then the remaining two, we'd like to talk to SSA more about help us figure out what's going on there. In terms of the fractions of individuals claiming SSDI, we have just about 4.5% in the tax data, and that's similar to what we're seeing in SSA as well.

MPR DRC Day 1 Part 3

So now let me turn to characterizing the SSDI population, and then we'll talk about entrance as well. So first we're going to be looking at just information on the population and merging, then, information on who's receiving SSDI benefits. So here we have the fraction of the population on SSDI by age and gender, so you can see here that the fractions are pretty low, at about ages 25 to 30, and then increasing pretty significantly, so on the order of about 15% or a little bit higher as we get closer to age 60. And you can also see that the fractions of men and women are pretty similar up until about age 50 where the series increases much faster for males.

Now, you know, I want to highlight the spatial variation in particular when we start looking at age. So this is looking at the fraction of 30-year-olds that are receiving SSDI by age and you can kind of see a pattern that's going to be continuing throughout this talk. You can see that the South has relatively high rates of individuals claiming disability, so amongst 30-year-olds, you see about 3 to 5% in areas with high disability, and then below 1% in areas with relatively low disability.

Now the spatial heterogeneity is pretty correlated across age. So this is now looking at the fraction of 50-year-olds in each location that are on SSDI, and it continues to be the South as kind of the very high disability rates. You also see some elements in Northern California, Arizona, New Mexico, and Florida as well. But here I want to also highlight the fractions are -- you know, the high disability areas are getting to on the order of 12 to 15%, so similar to what we were seeing with the previous fractions.

Overall, the geographic heterogeneity is pretty persistent across age groups, as I mentioned before, so we have the fraction of age 30 individuals that receive SSDI on the X axis, and then on the vertical axis, the fraction of 60-year-olds receiving SSDI, and you can see that there's a pretty strong correlation here across, so location isn't that important when we're thinking about the fractions of each age group on SSDI.

So now we're going to start to think about merging in the tax information, and one thing that jumped out to us is the match rate between 1040s or individuals that are filers and individuals that are receiving SSDI benefits. So here we have the fraction of individuals filing tax returns by age and gender, and you can see that about -- so below 50% of individuals between 30 and 50 are filing tax returns. So there's a pretty significant disconnect. Some of this is because, as was mentioned earlier, that individuals are out of the labor force when they're applying for benefits. And so, you know, as a result, if they don't have earnings, they might be below the filing requirement. But there is still some spatial heterogeneity that I think is very striking when we're thinking about individuals who file tax returns.

So you can see people in the Midwest, the Great Plains states are much more likely to be filing tax returns conditional on receiving SSDI benefits, so above the 50%, whereas individuals in the South these are, you know, areas that have less than 40% rates of filing a tax return. You might be concerned that these are individuals that don't have filing requirements, particularly in the South, but even when we condition on individuals that have more than \$25,000 of benefits, so starting to get into the filing requirements, these, we still see a similar pattern that in the North we see a higher probability of filing to beyond 75%, whereas in the South, we still see, you know, rates below 50%.

Okay. We see that in the tax filing there's a lot of spatial heterogeneity, but, you know, as I mentioned before, there's reasons to think that these individuals might not have to file returns. But I also want to highlight that the spatial relationship correlates with general patterns that we're seeing in non-filing by location. So in some other work that I've been doing with co-authors at the IRS, we looked at non-filing fractions by location, and, again, you can see that the South has pretty non-filing fractions, so we'd very much like to try to partner with SSA to see if we can do some outreach and sort of increase tax filing, particularly amongst disability recipients or applicants, since these could be populations that could have filing requirements or could receive some money back in withholding.

The last point I want to make in terms of characterizing the SSDI population is thinking about interactions with EITC. So you can see here the fraction of individuals that are interacting with EITC conditional on filing a tax return by age and gender, and so, you know, pretty consistent with the last paper. You know, for ages 30 to 40, you can see that about 50 to 60% of individuals are interacting with the EITC. As

MPR
DRC Day 1 Part 3

individuals age, or at higher ages we see less interaction with EITC, and much of this because individuals lose their eligibility for EITC because they lose qualifying children as the children also age, so the single EITC doesn't go that far off in the income distribution, and as a result, we see lower rates of interaction with the EITC.

All right, so now we're going to switch and focus on SSDI entrance, and in particular we're going to take individuals that were not receiving benefits in 2010 and have a tax return in 2010, and then look at their entry into disability or SSDI in 2011. So by looking at individuals that have tax returns in 2010, we can look at their household income characteristics prior to entry into disability. We'll also be able to adjust for age by computing AGI percentiles or adjusted gross income percentiles within each age group within the population, and we'll look at spatial variation by fixing income percentiles and looking at entry rates across different locations.

So, first, here we have the hazard rates or the entry rates by age and gender. You can see that the entry rates here are pretty similar for men and women at low ages, and then there's some continuous steps up or step up increases at ages 50, 55, and 60. These step ups correspond to changes in the medical vocational rules grid, so the eligibility conditions change. As a result, you can see increases in the hazard rate.

Now these areas, you know, so this is for the full population, but we can also look at heterogeneity by income. So in particular here, we have two series here, looking at the bottom 5% of the AGI distribution and the top 5% of the AGI distribution. You can see things are relatively flat for very high income earners, which is perhaps not too surprising. But you can also see that for the lowest income earners, they're very significant entry rates into disability, and the steps now are the step increases at the changes in eligibility or those ages that correspond to changes in the eligibility rules are now pretty significant.

Now we're going to start to look at some heterogeneity by age. You can see this is now looking at AGI percentiles within age group on the X axis, and then entry rates on the vertical axis, and you can see that for all age groups, as you get into the higher percentiles, basically the entry rates are become pretty flat, so you're converging to zero pretty quickly. But between -- at the very low end is where you see a lot of the action or the differences in entry into disability, and that's true at any age, whether you're looking at 30-year-olds or 60 year olds. It's always the low income population where we see entry into disability.

Now this is looking at geographic variation or spatial heterogeneity SSDI, and in particular, looking at individuals in the zero to 5th percentile of the AGI distribution within age group, okay. So this is adjusted for age. You can see that amongst the low income earnings there's still a lot of spatial variation. So individuals with \$10,000 of income whether you're in California, Los Angeles versus Jackson, Mississippi there's significant differences in the likelihood of entering disability.

As you move up in the income distribution -- so this is now the 5th to the 10th percentile -- you can see that that spatial variation drops out pretty quickly. So as you move up in the income distribution, this is now the 20th percentile, so you're still at about \$20,000 to \$25,000 of income, rates are below 1% for most areas in the United States. So the spatial variation really seems to be particularly important for the lowest income percentiles. So we divide areas with very high disability rates versus areas with very low disability claiming rates amongst low-income earners, and then we look at the disability patterns across income distribution within those locations.

So here we have the lowest SDI locations and the highest SDI locations, and you can see if you're within the -- if you're at the bottom the income distribution but you're in a very low disability claiming area, you have a pretty close rate of claiming disability versus above 3% for individuals that are low income and in high disability areas. That falls off pretty quickly, you know, as you move up in the income distribution, so this is just sort of echoing the same kind of result that we looked at in the maps.

All right, so overall, we think that it's pretty important to kind of highlight the importance of geographic variation. So geographic variation doesn't seem to be as significant when you're looking at patterns across age groups. So areas that have high disability amongst 30-year-olds also have high disability

MPR
DRC Day 1 Part 3

amongst 60-year-olds. But, you know, when we're thinking about SSDI entry, geography seems particularly important when you're thinking about the low income population in particular, less important for thinking about higher income individuals. Those individuals just tend to have low disability entry rates across location. In term of immediate plans, what we're planning to do is, you know, the great recession was mentioned, we'd like to add the additional data and benchmark that data, so SSA counts, to make sure we're on the same page, and then look at how the recession effected entry rates and, you know, look at that by space, as well as different age and income groups.

We'd also like to start to think about the mechanisms that are causing these variations locally so we can start to think about correlating with industry composition as the local levels, health factors or other demographics and see what that sort of leads to as a sort of smoking gun on causes for some of the spatial variation that we're seeing. And in terms of future plans beyond this, we'd like to think about, well what programs and environmental features can causally impact labor force attachment, as has been highlighted in this conference throughout. So thinking about wage subsidies or program interactions with the EITC, the minimum wage or Medicaid, you know, how this might affect delaying entry into SSDI, and also possibly evaluating programs or pilots that target return to work, so take it to work programs with a benefit offset, national demonstration, seeing if we can use the tax data or this new data source to sort of study these pilots and see if we can develop some effective strategies for reform.

So I'm seeing the red light blinking, and I just want to American that I'm 20 seconds ahead, so I will stop here and I will turn it over for discussion. But thank you all very much.

Robert Moffitt from Johns Hopkins will be giving the discussant comments.

Okay, thanks, Denise. Okay, well, yeah, found this an interesting paper, or I should say slides, no paper, slides, and so but I think, as you could tell, and as Dave said, this project is in a pretty early stage, is still really getting into the data, don't even have all their data yet. So I think what I'm going to do is use that an opportunity to kind of speculate on, you know, the value of this data and what you might be able to do with these kind of data that hasn't been done before for DI and maybe think out loud a little bit about what some more questions might be able to use these data to address, you know, going forward.

So first of all, I used to think I'd read all the important papers on SSDI, and that's hopeless now. So there may have been other people who used IRS data for SSDI, but I'm not familiar with it if it has. So my first question, when I first thought about this, but what's the IRS data going to do for you? Now as they described for tax purposes, SSA has to report whether or not someone received benefits and if they did, how much the benefits were. So you've got a single variable now on the IRS data with all the associated tax return and information that are on those returns. Now you've got an additional variable, knowing within that particular calendar year, a tax filing unit received someone -- an individual or individuals received benefits in that calendar year, in that tax filing unit. So what can you do with that?

Well of course most of the research I think in this area, I think is used, administrative has used SSA data, and compared to SSA data you do have some things you don't have here. You've got a lot of information on the 1040 about family income, about the household composition, about other forms of earned and unearned income that would be more difficult to get, or at least not on the same form, probably from anything that SSA has, so that's one thing I can think of you might use, use this for, and I'll come back to that. But I can see that.

The other reason a lot of people use SS IRS data for other purposes, if you followed any of the research in economics and some other fields lately, there's quite a large body of literature now on people who are using IRS data for a number of other research questions, and by and large, I would say that one of the chief reasons to use it is that you have such huge sample sizes. Now you're also going to have SSA data if you have the universe, so that maybe, per se, is not the same thing, but it's a larger coverage than SSA. Obviously a lot of people file returns who may not have SSA earnings for example or even receive benefits. So it's a larger population. But never the less you have huge sample sizes in IRS data, and that's been exploited in a lot the research that's been done.

MPR
DRC Day 1 Part 3

So let me take off a couple of things that Dave mentioned that he does use it for. As you could tell from his slides and make a couple remarks, and my reactions to those, and then, you know, ask about a couple of other things. What is the geography? That's been used before with IRS data, so you have a lot of observations here. You can get down to the state level for sure easily, and you saw all those very interesting graphs on geographic variation in SSDI, kind of take-up rates relative to the total population, filing rates among people who had, you know, SSDI, and also this entry. I'll come back to the entry rates differently by geography.

Other people have used these data, as I said, for geography, geographic variation. I'll tell you my reaction is that you always find amazing geographic differences that are very, very striking and very stark. And, however, not easily explainable with the data at hand. It's a pretty well known set of studies recently intergenerational mobility of earnings and income by geographic area showing my city of Baltimore has one of the lowest rates, you know, of mobility, but very interesting stuff. But the data themselves don't really allow you to get very far and explain it. You pretty much have to go to other datasets to really provide causal explanations for that.

You know, why are you finding these very large geographic differences in SSDI take-up rates, you know, out of the whole total population in a state? I mean, obviously there are many, many things that are different in both the labor markets, the health conditions in the South for example, versus the non-South, and these data just don't have anything on those variables. So very interesting and stimulating, I would say more hypothesis raising than answering questions. But I think there are just limits onto how far you can go after you establish the facts on that.

The same way for the SSDI entry. Now there's been a lot of work on SSDI entry uses administrative data. At least with SSA data you've got earnings histories so you know something there for the administrative data, and then you observe people go on, and then you also observe application denial. So many times here, my reaction was the entry analysis, you know, is pretty crude here. You've got in one year, 2011, the IRS data you know who received DI benefits, and then because you have linked IRS data, that's the advantage here, you know what, in the previous year if they were not on the DI, you know everything that's on a 1040, so you know their AGI and family composition and things like that. And then you can do these things, calling entry rates out to have total population, you know, how many of the people in particular AGI or AGI classes enter in SSDI.

Again, amazing geographic differences there, but, you know, my view is, you know, the SSA is better at addressing that kind of question. You don't have anything about even within that previous year. They were waiting -- they had already applied and were waiting around for a decision, which we know is probable for many of those people, so even their AGI, the previous year is not really what you want to look at. You want to go back farther than that. You don't know anything about their health. You don't even know whether they've applied or not. So all the intervening variables that are going to say out of the total population of a given age and income class, how many of them ended up on SSDI one year later, I think they're going to be very difficult thing to really provide answers to, so I think it's interesting.

But let me just mention two other things that I think might be interesting here. One is just to explore a little bit more, as I said a minute ago, the family income differences here, because you've got an enumeration of spouses; earnings, earnings of other people in the household. You've got unearned income. You've got a lot of things on the IRS data that you don't easily have in social security data, and I view that as a real advantage.

You could also look at geographic differences in all those things and maybe that might give you a little bit of leverage, although Dave has done a little bit of that already, a little leverage, perhaps on explaining some of these geographic differences. But I think that's interesting. You could do a lot of things, like the poverty calculations and AGI income distributions and all kinds of things you can do there that I think you can't really do with SSA data as easily. And, you know, given the sample size you've got here for the IRS, you could really do fine categories of other forms of income. You can really have enough observations to look at really detailed age, income, you know, marital status, household composition kind of patterns that you really couldn't do, I think, as well with other datasets.

MPR
DRC Day 1 Part 3

And let me just say another idea I have, I guess I went throughout, and Dave has already thought about this and dismissed it, but EITC, you know, very important program. Again, I'm not on top of the literature as I should be. But to me, EITC and DI might be a very interesting thing to study with IRS data. There you've got, you know, IRS data, you've got the EITC exactly, you know, what they reported, whether they received it.

And the IRS data have been used actually also by Raj Chetty for studying the EITC more generally. There's some interesting work there. You could even imagine kind of doing a Raj Chetty. You know, he has geographic variation, the IT receipt. He comes up with a measure of knowledge of EITC based upon self-employed individuals who might know more about the ABCs, you know, or the econometrics side of it. But it's an interesting study.

The EITC and DI is a much more complicated -- again, I don't know all the rules, but it's more complicated than everybody else, and whether you count DI benefits toward the EITC, lots of complications there, but I think that makes it interesting to. You know, EITC has its familiar structure with a subsidy of earnings up to a level and then a decline -- you know, phasing out of the EITC after that. That's an interesting question. It's relative to all the stuff we heard at lunchtime, about whether money, you know, induces work effort. And I can imagine, you know, really grabbing that with these data and being able to make some progress on it. As I said, maybe he's already thought about that, and figured it couldn't be done.

But I think it is worth really thinking hard about, you know, what the best uses are and kind of pushing on those. And the others, kind of putting them out there, and not necessarily going as far with those. It's a rich dataset and I'm looking forward to seeing a lot more results come out of it.

And for our final presentation, this panel will have David Autor who is a professor and associate head of the MIT Department of Economics and also a research associate of NBER.

Great. I'm just waiting for my slides to appear.

[Inaudible].

Don't do that. Great. Okay. Thank you very much. Pleasure to be here. This is joint work with Magnus Ogdstad [ph] from Chicago, and Andres Opdahl at the University of Bergen, And this is about a Norwegian disability system, not one you probably have studied quite as closely, but actually a surprising number of parallels with U.S. SSDI system, and also a system that has grown rapidly. And what we can do with the Norwegian system that is very difficult to do in the U.S. is link a large number of administrative data sources to answer some questions that are difficult to explore here but I think very relevant to thinking about disability policy.

So the question that we're asking is how do households adapt to DI allowance or denial, and we're thinking, actually, of applicants being at comparable health. I'm going to use sort of quasi random variation within the Norwegian system and look at the contrast among people who are similar ex-ante but receive different allowance decisions and how this affects their receipt of benefits, both from disability and from other public transfer programs, also their work behavior, and then also their spouse's work behavior, how much their spouse worked, and finally the whole household consumption, and it's going to turn out the answers that we find are going to depend, very importantly, on people's marital status. There's a lot of household insurance not available to individuals who are unmarried. I'll go into that in more detail.

So just by stepping back, this shows you receipt of disability among the non-elderly in Norway and in the U.S.. You can see the program is much larger in Norway as the share of population. It's also the case that it has flattened out more or flattened out sooner. The U.S. program is now also -- population of -- fraction of recipients is actually declining at this point. But disability programs generally across the OECD are large transfer programs, generally bigger than the U.S. and many of them have experienced substantial growth. Many of them are in the process of undergoing various changes. Norway is actually not one of them. Norway's system, I think, is pretty stable right now.

MPR DRC Day 1 Part 3

We know -- there's a big literature now that says receipt of disability reduces work among people who receive disability. That's not shocking. But consequences are what are the welfare consequence of that? Is that a good thing? Is that a bad thing? How do we think about that. Well that's going to depend on a number of things. Two of them, is how valuable disability benefits are to people, how much does it improve their lives relative to what they alternatively would do? And, of course, also, what does it actually cost the public to make those transfers? It's not just the benefits themselves, also the foregone tax income, especially if it affects work behavior. Also, transfers from other public programs.

So, to date, there's little credible evidence on these questions, mostly because of measurement. It's hard to link all these data sources. That's why we invented northern Europe, to produce all that data. And then also because you need experimental evidence that, you know, allows you to make compelling contrast between people who do or do not have benefits. They need to be similar health.

So in Norway many denied applicants decide to appeal the decision. They are actually randomly assigned to judges. Some of those judges are more lenient than others, a strategy first used by [indiscernible] and Melanie Strand, also by Jay Song and Eric French. And in Norway it works terrifically. It actually says in the law that people have to randomly assigned to a judge. The judges don't actually interact with the claimants at all. It's all done on paper. And the evidence is very, very clear that, one, there is random assignment, the case is assigned to different judges looked comparable; and, two, that judges appear to just have different views of what disability is as, you know, any human judge would, and so that gives rise to variation, who receives benefits among people who are equally, you know, deserving, equally sick or healthy.

And it's important to understand that this is not randomization at the level of people who were, you know, either perfectly healthy or on the verge of death. Those people are always going to get the same decision; right? Some will definitely be rejected, some will definitely be allowed. These are people who are at the margin. In fact, they're all people who have been denied initially and then appealed. And so then basically the way it works in Norway, about 70% of people are allowed initially. Then about 30% of those who are denied appeal, and of those who appeal, about 15% are allowed. So it's relatively small, and so you should think of these as cases that are hard to adjudicate. These are not clear-cut cases where subjectivity would be more important. So it's actually a policy-relevant group.

In this group, many of the people who are at the margin have a higher incidence of back pain and mental disorder than the average applicant disability population in Norway. They also have lower earnings. So they look more like or somewhat more like the appellant population in the U.S.

Okay, so I'm going to summarize our results. Then I'm going to walk through then quickly. There's many of them, and I'll try to be coherent rather than comprehensive. So if an individual is denied DI, his or her earnings increase by about \$7,000 per year, that's about 40% of the annual benefit denied, and so it's a substantial, though not enormous, increase in earnings. This is what we would expect based on data from other countries. DI denial lowers household income and consumption by about 15 to 16%, so on average, a household that is denied, its consumption falls, consumption measures -- I should say, consumption is based on all expenditure.

Remember, again, this is Norway, so we can sort of measure that pretty much. So we can effectively, knowing from people's incomes and assets and return on assets and home ownership and value of their house, we can infer what they're spending based on what they're receiving income and then what they're saving and what they're spending. What they're spending is the difference between those.

So, on average, consumption falls by about 15 to 20% if people are denied. However, the consequences hinge, terribly importantly, on marital status. For people who are married when they're denied disability, they have actually no impact on the consumption of the household, and the reason is because spousal labor supply increases to fully offset the loss of disability benefits. Basically women go -- or I don't -- I should say spouses, primarily women, increase earnings by about 50% when their spouse is denied disability benefits. For single individuals, not married individuals, there's a very large drop in consumption. They don't make it up.

MPR
DRC Day 1 Part 3

And so the way the program works differs greatly, not by design but, in reality, across these types of households. Now let me make sure, when say the spouse offsets the loss of income and increases -- you know, so consumption insured, that's not costless; right? Because of course person giving up leisure and having to enter the workforce. So don't think of that as full insurance. It's not. You're left unharmed but it is a mechanism that households engage in.

Okay, so I'll just say there's a literature on this on the labor market impact, on the consumption impacts, and on household responses. And in Norway it looks a lot like the U.S. It's designed to provide partial income replacement. There is actually an SGA level of about a thousand dollars a month. The disability criteria are like the U.S. I think they're modeled on the U.S., unable to engage in a substantial gainful activity, not in the U.S. economy but in the Norwegian economy, and the level of benefits is progressive.

The system looks also like the U.S. There's a DDS review. You can be allowed. You can be denied. If you're denied there is no second DDS review. You appeal directly to the Court of Appeals, and they can either allow, deny, or remand. And they use the same criteria as the initial allowance stage. This is not a multistage. There's no specialization of judges across types of cases, and everything, as I said, is done in writing. And let me just skip all this. Lots of data, as I mentioned.

What you -- I don't know if you can see this very well. So these are all the applicants in our sample. There are 240,000 applicants, 78% of them who are allowed initially. There are only 15,000 appellants, so of the 22% who are denied, about a third appeal, and only 13% of them are allowed. So it's a much different population. It's a much smaller population. You can also see, they're more likely to have musculoskeletal disorders. Their liquid assets are considerably lower, 40,000 versus 11,000. These are all in U.S. dollars. And they are -- I want to say, they are more likely to be high school dropouts for example. So it's a less advantaged population, probably more economically needy but health is -- probably somewhat healthier disability applicant.

What our strategy does is this on the axis shows you judge leniency measured by the fraction of other cases to which a judge is assigned that he or she allows, and on the Y axis is the probability that someone else assigned to this judge receives an allowance, and this slope just tells you that judges who are more lenient with other cases are more likely to award the next case assigned to them, so judges who have higher allowance rates in the past have higher allowance rates in the future, and, again, the case characteristics are balanced across judges. And then this histogram just shows you the proportion of judges in those categories. So the average judge is allowing about 14%. We have some judges who allow 26%, some who allow as little as 6%, a fairly substantial range.

I will say that there's every reason to think it's approximate. It's a very good experiment. Moreover, it's also the case that judges who are lenient in one category of decisions tend to be lenient in others as well. It's not that some -- you know, the data suggests that it's not that judges who were lenient towards circulatory disorders are very hard on musculoskeletal disorders. If you look at their leniency in other cases, it's strongly predictive of their allowance rates than any other disorder.

Okay, so let me show -- let me familiarize you with the table format and then go [through some results. So these are outcomes in years one, two, three, and four, after your appeal, after the appeal decision comes down. So we're comparing -- so this is the effect of being allowed DI. So in the first year, people who are allowed DI are 99% more likely to receiving than the people who are denied. And then going out four years, that falls to 50% or 47%. Why is that? Well many people who are denied appeal again; right? So a lot of them actually get back on the program. So within four years, half of the people who are denied have entered the program. And, again, we're using here -- this is not strictly -- we're using the variation across judges. This is an instrument variable, a quasi random experiment approach.

If you look at the effect on benefits, of course, being allowed the first year increases your benefits by about \$16,000, that declines over time. Again, it's declining because the people who are not allowed are getting benefits. The contrast is contracting. And then if we look at earnings, it appears to reduce earnings by about \$65,00 and that doesn't change much over time. People who leave the labor force,

MPR
DRC Day 1 Part 3

some immediately rejoin and the rest do not. So there's just a small step increase. Okay. So that's consistent with U.S. data. That just sort of passes the consistency test. And let me skip that.

So now we the next thing we want to look at is connection to other transfer programs in Norway, and it's a generous social welfare state. There are many other income supports. Health insurance is universal. We don't have to be concerned about that. So if you look at the effect, here's the effect on disability benefits being allowed. Here is the effect on total transfer payments. You can see that difference, about \$5,000, implicitly there being taxed back on other programs. So when you go on disability, the net cost is lower than the gross cost, because, of course, you're disqualified for other programs. And so you can see this is for -- these are people who are allowed. These are people who are denied. This is the effect on transfer, the effect on DI benefits, and then other transfers, and you see DI benefits rise, other transfers fall. Okay.

So this actually produces a very interest pattern. So this figure shows you, number one corresponds to the gross disability benefit allowed. And then you can subtract off the effects of other margins of adjustment to get the net effect. Well one margin of adjustment is reapplication; right? Over time reapplication effectively shrinks the contrast between people who are allowed and denied. another is benefit substitution, you lose other benefits. And then, of course, the other is reduction in labor earnings. So for every 80 cents awarding in disability benefits it reduces only a percent net benefit, a net increase in household income for individuals, because a lot of the rest is being absorbed by declines in labor force participation and crowd out of other programs, and then, of course, the reapplication itself. That also holds for consumption by the way, that 20 cents on a dollar, that is the average effect on consumption.

So now let me talk about households. So and I'm wondering, from Day's discussion earlier, whether he can use the IRS tax data as well to look at households, as Robert suggested, and that's what we're doing here. So here is the -- this is the earnings of married appellants. So when they're allowed, their earnings don't really fall. It's not significant, and it bounced around. However, if they're allowed their spouses earnings change a lot.

So in terms of if you flip this -- and think of this as denied -- spousal earnings, they rise about \$6,000 the first year, and about \$18,000 after that. And you can see that here. This is the earnings of the person who was allowed versus denied. This is the earnings of the spouse if the spouse is allowed versus denied. So the interesting thing is that it's not that spouses stop working when their, you know, disabled spouse receives benefits, it's that ones who are denied, their spouse enters the labor force or increases earnings. Now that may be much more feasible in Norway than it is in the U.S. Norway has high labor force participation but relatively short hours. Many people probably have a lot more opportunity to adjust earnings.

Okay, I see I'm running out of time, so let me say that the effect on married households as a result of the spousal responses, no change in net income after you adjust for taxes and transfers, and no change in consumption either. Okay, so let me just -- so that's kind of the big bottom line of the paper. And I will say the other thing that we do is we actually go through and calculate the fiscal cost of the program, because when people adjust labor supply, they also adjust the taxes that they pay. If they work less they pay less in taxes and so on, and then determine how much of those fiscal costs goes into household consumption. And I'm going to just say that for non-married households it's pretty close to, you know, 50, 60, 70 cents on the dollar. For married households it's kind of zero on the dollar, measured in terms of consumption, because the income effects are totally offset.

Okay, so let me just conclude. So the Norwegian context provides an unusual opportunity to kind of more comprehensively look at the benefits and costs of how disability system works. We actually make an estimate. We make an attempt to estimate the value to households, what they'd be willing to pay for those benefits in cash rather than the constraints associated with them. We find for non-married households, they'd be willing to pay a lot. For married households, less so, because they have other margins of response. And the important margins of adjustments that are normally not seen are, one, substitutions across other benefits programs; two, reapplication programs; and the third being household labor supply. And so this, I think, you know, gives us some sense of I think incomplete but the sort of the in trying to evaluate how these programs insure people, we need to think not just about the dollar values or the

MPR
DRC Day 1 Part 3

transfer but all the other margins of adjustment that may or may not be available to them, and one final takeaway to the paper, the sicker people are at the point they're denied, and we have variation in that that we can use in our analysis, the less they're able to use these other margins, particularly if they're single. So it really does matter, clearly, that the less healthy the applicant, the less opportunity they have to adjust labor supply and do other things, the more consumption falls off when they're denied. Okay, great, thank you very much.

And our discussant will be Phillip Armour from Rand.

All right, well I just want to thank Mathematica for inviting me to discuss this great paper, and the DRC more generally, and Social Security Administration for putting on this great conference. So this paper is kind of part of the latest in this unfolding line of work from Mogstad and Kostol, looking at kind of the Norwegian DI system, which is similar in many ways to the U.S. system. David kind of joins the fray of this line. So, you know, it uses this plausibly exogenous variation in acceptance of DI appellants and it's this random assignments of these administrative law judges who have this sort of inherent leniency, which doesn't seem to be correlated with a lot of other things. And if you kind of look into the paper, you know, they run the tests, do the checks, all that. I'm pretty convinced of that.

They find that acceptance on the program means to crowd out of other social program benefits and earnings, both kind of owned. And then as a result of the net income is much smaller than the gross DI benefits from DI acceptance. I mean, we'd imagine there to be some crowd out, but it's really kind of quite remarkable how much it is.

And the crowd out is really total for married couples, because these rejected appellant spouses start working to kind of make up for these lost benefits. And lastly, they measure kind of disposal income/consumption expenditure drops, and find them to kind of drop also, although not on the married side of things. So I think that, in general, this is kind of the paper's part of emerging literature in disability research that is showing that these disability programs don't exist in isolation; right, that there's a whole social safety net that exists there, as well as sort of family responses that can either kind of be enough to offset some of these lost benefits, sometimes not nearly enough to offset them.

And I'm going to be a little critical coming up here on kind of how this applies exactly to the U.S. context, but I wanted to be kind of really clear, whatever weaknesses kind of drive from, like, the sample size and the context are really made up for by just the quality of the data and the instrument that's used. Like there's remarkable results that are coming here, kind of own income from programs and earnings, you know, spousal incomes and earnings, you know, wealth and they construct this sort of measure of consumption, which, you know, you could quibble about the details, but I think it's a pretty sensible approach, and they have this great instrument; right? Like it's a really solid paper.

So, as far as, as David said, the similarities that kind of crop up; right, both Norway and the U.S. have experienced a secular rise in the size of their DI rolls over the past few decades. The benefit calculation between the two, you know, it's a progressive formula with average indexed earnings. It's similar in that regard, and a very similar disability determination system itself. So, you know, where it differs actually kind of helps enhance some of the internal validity; right, in as much as the judges don't actually have these face-to-face meetings it's just all on paper; right, and there's no specialization.

So as far as the concerns with the comparability go, you know, first off, there's the declines in transferring come from other sources, and what I'd really love to see is kind of the top transfer programs and tax programs, things like earned income tax credits, things like that in kind of Norway. And the corresponding programs in the U.S. can look at the size of these things and the incentives. Like is there a program like SSI that will require you to apply for DI; right? Are these offsets kind of similar? Just to get a sense of, you know, when you're seeing that transfer coming down so much, are there direct correlates in the U.S. that would help us put that in that context. I think kind of another thing is, you know, this is sort of a local estimate based on appellants and kind of leniency over these judges over the use of kind of marginal cases. And it would be kind of really nice in the sense of where in the disability applicant population are these sort of Norwegian appellants, marginal appellants, what kind of U.S. DI applicants do they look like;

MPR
DRC Day 1 Part 3

right? Because you see these kind of important differences, where the allowance rate kind of, for the first-round application in Norway is much higher, but then the U.S. system, but then on the appeals side it's much lower; right? So, you know, you're looking at AOJ in the U.S., you know, proving upwards of 50%, and this example is under 15%; right? So when you're even kind of putting in context with kind of French and Song, the previous U.S. paper, looking at administrative law judges, you know, is it even the same kind of leniency? Like, how do we consider those two when, you know, U.S. AOJs might have this kind of tremendous case load and they're just trying to get through it all, is there kind of a similar system with the Norwegians, just to, again, kind of get a context, because, you know, when eyeballing the French and Song paper next to these descriptive statistics from their sample; right, there's kind of more likely to be kind of women in the sample, much more likely to have mental and musculoskeletal conditions in this sample than in the U.S. sample.

But I think, again, like there's, you know, coming back to that question of what segment of this population is closest to this one, because although it's absolutely true that, you know, when you're looking at changes in stringency, you know, the most likely affected population is going to be this marginal group but kind of the marginal Norwegian group is probably not the same as the marginal American group.

The other kind of big differences between the Norwegian and U.S. system; right, one is that there is partial disability allowed, and I'll come back to that in a second. But replacement rates, I mean, if you look at a previous paper by Mogstad and Kostol, they're kind of typical worker they look at, the replacement rate is almost twice as high in Norway compared to the U.S. The wait times are much lower, so it's a quicker system. And when you're thinking about the populations that might be applying for this, in the U.S., right, it's sort of less money and you have to wait longer for it; right, so you're kind of already sort of screening in people who are ex-ante, kind of finding work very burdensome, right? So these are people who might not be having enough sort of earnings capacity to fall back on.

So in this paper, maybe it's not as much a strong point as maybe the research on this line, how exactly you apply the sort of labor supply effects when in the U.S. I think applicants that we're kind of screened for are just -- yeah, work is just can be much tougher for them.

There's not new comment, David brought up. Health and insurance is universal in Norway. I can imagine the impacts on disposal and consumption in the U.S. when looking at, you know, being accepted onto a program that carries with it medical benefits compared to not. I think that that's something that we might want to just bring up when trying to think about that.

One point that kind of was brought up in the paper and it was unclear exactly because of how they went about doing this, I mean, there was an issue of, you know, they can see married couples, but among the single and unmarried, they don't always kind of do a separate analysis for this, partly because of cohabitation concerns, so they can't directly observe this. I think kind of one approach that you might take to that is just looking at the survey data, you know, what among this kind of group demographically, what are the cohabitation rates, kind of assume that that fraction acts just like married couples and kind of do a bounding exercise to see kind of if you subtract now. I'd be surprised if it made a big difference. But I think that would allow you to put in a couple tables to have a parallel analysis for those people.

And then kind of the lastly, getting back to it. So, you know, on previous work on the Norwegian system I've seen that they mention their partial disability awards that can be made. Are they like, in that kind of secular rise trend, that Norway has a much larger system? Does that include the partial disability people or is that total people, because I don't know if that's sort of an apples to apples comparison when trying to think about the size of these things? Maybe you should also be throwing in the worker's comp population on partial disability or like that if you want to, again, make them a little more comparable and then the question being maybe -- we're about to get into Q&A here -- were they included in this analysis; right, because I think that might start affecting using kind of levels of benefits and responses there, if, you know, they're not total benefits. And that's all I have. Thank you.

MPR
DRC Day 1 Part 3

Okay, great. We're going to start our question-and-answer portion. We have about 15 minutes or so, but -- well, actually, I think we're two minutes ahead of schedule, so given that, do any of the presenters want to respond to any of the discussant comments? Okay. Well then I'll turn it over to the audience. There's a question in the back here. I think there's a microphone circulating.

Lucy Schmidt, Williams College. This is a just a comment for David's paper. When you talk about the spousal labor supply response you say it's reduced to leisure. I might interpret that as reduced household production, and Norway does have universal child care, so just thinking about, again, how we can extrapolate those findings to the U.S. context. It might be difficult in the U.S. context to get a similar response.

Can I respond?

Yes, please.

Yeah, so a lot of the comments, also Phil's comment, you know, were in the direction of, A, Norway's not the U.S. I agree. And also, you know, what's the external -- what's the generality of these findings, and I think the answer is we really don't know. There's so many reasons that we do not know that I have no confidence in extrapolating them to the U.S. I think it's fascinating. I think it provides insight, but the institutions here are quite different. The populations are different. I think the labor market is also extremely different. I think that is probably one of the biggest differences. You know, the labor force participation rates are lower in the U.S. than in Norway, especially among less educated individuals, many of whom are overrepresented in the disability applicant population. It's not clear that they have the kind of flexibility on the labor supply margin to work more.

I think, you know, absolutely the institutions that the health care and child care institutions -- so I think, you know, my hope is that this research will, you know, help others see a way to do similar work in other countries to try to answer these questions. You know, hopefully the combination of SSA data and IRS data will actually permit similar analyses, and then we'll get a different answer -- I mean, get a better answer that is accurate for the U.S., and I wouldn't be surprised if it's, you know, 180 degrees from this one.

Hi. I've got two quick questions. The first one for Day. I took one look at that maps and said, welfare diversion, because a lot of those states, I think, are states that have very low welfare benefits. And so I'm wondering if you have any data and have done any work on welfare benefit levels and welfare received versus SSDI. And let me just ask a second question quickly. Gina, did you look at type of disability and find anything interesting there?

Yes. But in a multi-variant context, the likely hood of being a parent, a lot of it didn't -- the only thing that was significant was people with sensory impairments were more likely to be parents. That was really the only thing that jumped out.

Yeah, just to get at the sort of welfare diversion question and the geographic heterogeneity. You know, I think that's definitely on our to-do list to look at, you know, how TANF and other programs vary and how that correlates with the spatial variation that we're seeing. A lot the data on these programs at the state level but a lot of the variations that we're seeing are within states, there's a good amount of variation. So you know, we thought about state EITC programs and, you know, sort of state-level programs initially, but the level geographic variation is so rich that even within state there's so much, so I think that, you know, we'd like to look at additional sort of local-level factors as well. But it's definitely on our to-do list to think about the welfare programs.

I think I saw Amal's hand.

Amal Herrati [ph]. I had two questions, but one was to Gina, so thanks for that. So my second question is to David. I'm just wondering, on the spousal compensation, if there are any gender differentials, and the

MPR
DRC Day 1 Part 3

reason I ask is that the Dutch paper that Mark alluded to earlier, the disability of onset for the spouse meant that the wife was much more likely to work but meant that the husband was more likely not to work. I wonder if the same --

Yeah, it's a surprisingly hard question to answer in Norway, not because sex is unavailable in the data set, but because the country is really small. Hard to appreciate how small Norway is until you see the data. So every time we try -- whenever you cut the sample you just lose an enormous amount of decision. So we're trying, but we're making kind of a last-ditch effort to split by the gender of the spouse, by the prior earnings of the spouse, by the education of the spouse. And I think that, you know, the question we want to answer is this average effect that we're finding, is it, you know, sort of mostly true or is it some spouses can increase a lot and some are, you know, constrained, either because they can't find work or because they're already maxed out. So I hope we'll have a better answer to that question. I agree that the answer, in its present form, is not fully satisfying.

Jack.

Jack [inaudible]. I was wondering what sub-state geography you were using? I didn't catch that in your discussion. And also, I was wondering on your to-do list, I think it would be interesting to look at how the IRS data compared in the aggregate for income SSI participation, et cetera, compared to something like the American community survey, and whether you've considered doing that?

So, okay, yeah. So, first, the SRA, I should have mentioned this in the talk. I'm sorry I didn't earlier, but we're using three digit Zip Code when we constructed these maps. You know, there's a variety of ways we could construct them. We sort of aggregated up. The basic idea for the level of aggregation is to avoid any disclosure concerns or, you know, we could think about county level or things like that as well.

As far as benchmarking to the ACS, we haven't benchmarked to the ACS yet. I think that, yeah, maybe thinking about, like, household composition or some of the demographic variables that we're seeing, that can be like a useful benchmark to consider. I think people have benchmarked the income data that we're seeing with, you know, GDP measures or even income measures from census data, so we feel pretty confident in the income measures. And naturally, you know, I think it's reasonable that the IRS would want to feel comfortable with that. But benchmarking to the ACS on the demographic side could be useful, and we just haven't done that.

[Inaudible].

Yeah, so the benchmarking, people I think have done both on W-2 income or income that can be third-party verified. And so that the IRS does pretty well. The non-third party verified income, there's definitely reporting issues that the IRS is aware of; for example, with self employment income and, you know, those sorts of issues. But, yeah, we definitely are on the same page with you. And there's a question over

Here on the side.

[Inaudible]. With social security in regard to the paper on the employment expectation and experiences of parents with significant disabilities, I think it might be extremely useful to make [inaudible].

Yeah, I agree with all of that. One of the problems, at least with the dataset that we're using here, it focuses on individuals, so there's not a lot of household information, and there's not a lot of delving into supports. And we don't even know if their spouses are working among people who are married from this dataset. And the instrument's actually under redesign now for going to the field in 2017, and it is trying to focus on -- there will be an over sample of successful workers, so it's trying to get more deeper on the work barriers and those sorts of things, and I don't think we've talked about expanding on the household and household composition front. But that is something I can certainly raise with the project officers.

MPR
DRC Day 1 Part 3

There's a question in the center.

[Inaudible]. I have a question to ask Dave about the clarification about how do you count the SSDI income? Do you include spouse benefits and dependent benefits in your account of benefits?

So the benefits are -- yeah, so we're using the benefits that are reported on the 1099. So these are -- it's the total amount of benefits paid to the individual, and any benefit payments that are coming from the trust fund. So if an individual is receiving benefits from the trust fund because of their were spouse, then they would also be counted in the counts that I showed you. So as a result, we benchmarked accounts of disabled workers, plus spouses from SSA.

Okay, I just wonder, like, because of your data you actually observed the spouse income and also the worker income. You can actually distinguish then because of income is, like, less than 50% of the worker's income, depending on the, like, earnings. So maybe can be separate at least, not [inaudible].

So I'm not sure I follow. But that's correct that we can see the spouse's income separate from the beneficiary's income, and so we could see, for example, if a spouse has income beyond the SGA limit or something like that, you know, for example, one person in the household starts to receive benefits and then if we see, you know, increases in spousal labor supply, that's something that we can sort of follow over time. Is that what you had in mind?

Yeah.

That's right.

Any other questions? We still a couple minutes remaining. Okay. Then we'll conclude this session. The next session will be promptly at 3:00 o'clock, so it's about 20 minutes from now. Thanks.

MPR
2015 DRC Conference _Day 1 Part 4

2015 DRC Conference Day 1 Part 4

All right. We're going to get started with our last panel of the day, Beneficiary Work and Program Participation. Our first speaker is David Mann from Mathematica, otherwise known as Mr. Mann but he's actually got a Ph.D. in Economics. But he's going to talk about state variation in benefit receipts and the work outcomes for child SSI recipients up to Age 18 Redetermination. Take it away, David.

Okay. Good afternoon.

(Inaudible) the mic.

I've got it.

You've got it there.

Yep.

Okay.

So thank you, everyone, this afternoon, for attending. I'm going to be talking about state variation in the child SSI program. This is joint work with Jeff Hemener from the Social Security Administration, and my colleague David Wittenburg at Mathematica. If any of you are keeping track, I am the sixth David on the stage today.

In addition to – nope.

Do you want me to –

There we go. Okay. Great.

Okay, in addition to more traditional transition issues, child SSI recipients face unique important decisions that have the potential to strongly influence their future outcomes. One of these decisions, which they do not make themselves, is the Age 18 Redetermination decision. The Age 18 Redetermination decision places child SSI recipients on one of two tracks, the track to continue benefit receipt or the track to benefit termination.

Our study looks at state level variation in the Age 18 Redetermination decisions to explore whether there are a multitude of different state-dependent tracks for former child SSI recipients. We find that, indeed, there is substantial state variation in the Age 18 decisions as well as regional patterns. However, we also find that regardless of cessation rate, within each state there are substantive and consistent differences in employment and benefit receipt outcomes by Age 18 Redetermination status.

So what is the Age 18 Redetermination decision? So the Age 18 Redetermination decision came about as a part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and it assesses whether child SSI recipients meet adult SSI eligibility criteria. And this is done at age 18. Hence the name Age 18 Redetermination. This process mirrors the adult SSI application process. So as the state field offices collect relevant medical, functional and other information, which they then send to a state-administered disability determination service, of DDS, which examines the information and makes the initial decision.

There are two outcomes from an Age 18 Redetermination. Benefits can either be ceased, or they can be continued. Those who receive a cessation decision have the right to appeal. The appeals process mirrors the adult SSI application appeals process. Approximately 34% of former child SSI recipients have their benefits cease. The initial cessation rate is 43%, but after all appeals, the rate goes down to 34%.

MPR
2015 DRC Conference _Day 1 Part 4

So what did we do in our study? We looked at state variation in several outcomes. First we looked at the Age 18 Redetermination decision itself. And then we looked at several outcomes at age 24. First we look at employment, which we define as earning \$1,200.00 or more in the calendar year that an individual turned 24. And we picked \$1,200.00 a year because this corresponds to a quarter of coverage.

We also look at what percentage of former child SSI recipients work above the annualized SGA amount in the calendar year that they turn 24.

And then finally we look at SSI and SSDI receipt in the month that a former recipient turned age 24.

When we look at our results, we look at them by state as well as by cessation status.

So SSI is a federal program, but this study is looking at state variation in the federal program. So it's important to think about what factors could be potentially driving this state variation. And we thought of some examples, which I'm going to share on this slide.

One is variation in the DDS administration. As I said a moment ago, DDSes are administered by the states. So these DDSes have different processes, different caseload size per worker, or adjudicator I should say, they have different personnel, different turnover rates, and even different compensation. And all of these things could potentially lead to differences in how they adjudicate redeterminations and lead to state variation.

There are also the potentials for other programmatic factors to have a role as well. For example, there could be state differences in impairment distribution. If one state has a disproportionate number of recipients with a certain impairment, and that impairment is more associated with having benefits ceased, well then that state might be more likely to have their benefits ceased.

Also non-SSI programmatic factors could be playing a role as well, such as variation in other supports and programs. For example, special education and vocation rehabilitation programs are administered at the state and local level, and they serve transition-aged youth including some of whom are child SSI recipients. And if some of these programs are relatively more or less effective in (inaudible) employment for these individuals, well that could affect the Age 18 cessation rate in those states as well.

So our data is drawn from SSA administrative sources. Our analysis sample includes all former child SSI recipients who received an Age 18 Redetermination between 1998 and 2006. And they also needed to receive their final decision by age 24 so we could look at their outcomes at age 24. The sample, we used the years 1998 through 2006 because that includes just about everyone in our data that we could observe their outcomes through age 24. Our sample has just under 430,000 individuals.

So our methods, our methods are descriptive in nature. We produce regression-adjusted means for our key outcomes. We also are planning, however, in the final paper to include in the appendix unadjusted results for those who would be interested. We also use national maps to highlight state and regional variation and patterns.

Speaking of those maps, here is one that shows cessation rate by state. In this figure, each state is categorized based on its cessation rate. Relative to the rest of the nation, the states in the southeast of the United States had the highest cessation rates. The four states with the highest rates, South Carolina, Arkansas, Louisiana and Mississippi, are all in the southeast. Also if you look, most of the states in the southeast have a cessation rate above 36% placing them in the second highest category on the graphic.

There are some states, however, in the Midwest and in the mid-Atlantic, such as Ohio and New Jersey, that also have relatively high cessation rates as well. But if you look at the rest of the country, the west, with the exception of Colorado, most of New England, actually all of New England except New York, as well as Alaska and Hawaii, you see that they all have rates at or below 30.6%.

MPR
2015 DRC Conference _Day 1 Part 4

It's also worth noting that though we don't show it in these slides, that if you were to look at the unadjusted results and create – the unadjusted cessation results that is – and create a similar map, it would look essentially the same as this regression adjusted one that I'm showing here.

This chart reports the national SSI and SSDI benefit receipt distribution at age 24 for former child SSI recipients. This chart reveals that having benefits ceased was strongly correlated with benefit non-receipt at age 24 and vice versa. Summing across the SSI Only and Concurrent columns, you see that about four in five continued recipients were still receiving SSI benefits at age 24.

SSDI receipt at age 24 was about six percent for ceased recipients and about 22% for continued recipients.

I am having – Gina, can you (inaudible). Okay.

Like the benefit receipt chart, this chart shows another national pattern. Employment rates, whether they are measured by a quarter of coverage or by annualized SGA amount, are relatively highest among those whose benefits were ceased nationally. Just less than 50% of ceased recipients were employed at age 24 relative to 20% of continued recipients. SG employment was just over 20% with those who ceased benefits, and just over 6.5% for those with continued benefits.

So the last two slides show that nationally there was a gap between benefit receipt and employment outcomes of ceased and continued child SSI recipients. Relative to those who were continued, ceased recipients were less likely to receive SSI and SSDI benefits and were more likely to work.

Interestingly, these gaps and outcomes were present in all states independent of the state cessation rates. So across states, receiving a cessation decision places recipients on a similar track relative to continued recipients. However, linking cessation rate variation to interstate variation and outcomes is complex. And I think Robert Moffat (sp) spoke of that earlier today.

State-level factors, such as caseload composition differences, differences in labor market conditions, and differences in policy environments should be adequately accounted for before computing correlations between these variables. Though we were tempted to present the correlations we have thus far computed, which are preliminary, we are not yet satisfied various state-factor controls are adequate. We hope to include these correlations between cessation rates and outcomes in the final manuscript. But again, at the end of the day, those correlations are only descriptive in nature.

So what can we say about the implications of the findings that I've presented here today? Okay. Well, it is clear that although SSI is a federal program, there is substantive state variation in Age 18 Redetermination rates. There are several important potential sources for this variation such as DDS administrative differences, to child SSI caseload composition differences, to non-SSI programmatic factors, and other factors that I have not mentioned. Given that the Age 18 Redetermination has the potential to strongly influence the employment and benefit outcomes of former child SSI recipients, further investigation of cessation rate variation and its implications is warranted.

In addition, our findings also suggest that developing and testing new mechanisms to help SSI youth understand and prepare for the Age 18 Redetermination process and its potential consequences years before they turn age 18 may be helpful in all states.

Two minutes to go. He wants to get out of here.

All right. So Jack Denton is from University of Massachusetts Medical School – no, that one's not on - will provide comments.

Is this (inaudible).

MPR
2015 DRC Conference _Day 1 Part 4

No, you can go up here. This one should be on.

Hello. Good afternoon. And it's a pleasure to provide comments on this interesting paper.

And this is forward, right? Ah, here we are.

So I wanted to just start by talking about the key findings. There are two key findings. The first is that individuals that lose SSI at Age 18 Redetermination are working more, they're earning more, and participating in SSI and SSDI less than their continued individuals. And as David mentioned, this is true in every state. However, the earnings are low and the employment are low.

And this finding has been explored in other research, but extends other research. This estimate is at age 24 at the final determination. Some of the prior research was at age 19 and prior to the appeals. And these are regression adjusted estimates, so even though adjusting for things that are known to be related to cessation, things like primary diagnosis, age at initial SSI eligibility, or prior CDRs, even with those adjustments we still see wide disparities between those that are ceased and those that are not.

The second key finding, and this is new and was previously unknown, is that cessation rates vary substantially across states. A very wide range, 20% to 47%. And, again, this is after regression adjustment. So this is somewhat surprising and large.

I think there – I'm not sure how far the authors will go with this research, but I think there's some potential next step findings. The association that David was mentioning between outcomes and cessation rates could be important. It could show how they're related and what factors may be important to outcomes and cessation rates. And also I think largely the reasons for those cessation rates varying that much are unknown, and the explanations for that variation could be important.

This is very policy-relevant research. The study adds to the prior evidence that ceased individuals on average are not successfully transitioning to adult self-sufficiency. And this, again, is controlling for that. This has been explained in the prior research. This affects many families, many individuals at age 18. The 34% cessation rate is high. And as other researchers and prior researchers have noticed, there is need for policy changes or new programs are needed to increase the employment of individuals that lose SSI at redetermination and improve their economic self-sufficiency.

Whether or not there will be policy relevance for that state variation at this point is unknown, but I think it is an important new source of variation, both in variation and cessation rates. And as David mentioned, there's also variation in outcomes. So perhaps this variation can be used to better understand the employment of people that are ceased at age 18. In particular, if some states are doing better than others, we may be able to learn from those states. Perhaps those states have better special education programs, better voc rehab, better employment conditions for people with disabilities, or something else. So I think it is a population that's having trouble, and this new source of variation may help us understand that.

So I'm going to, as David mentioned, there's some uncertainty in why this outcome occurs, and the researchers didn't speculate on why that is the case, but I'm going to stick my neck out and speculate a little bit.

As David mentioned, it could be because of disability determination services, just purely exogenous variation in how the disability determination is done. It could be because of differences across states in SSI children, better human capital or better employment, less severity of disability. Or it could be just state and regional differences. Better special education programs, access to employment, access to TANF. There's a whole variety of reasons that could be explaining this.

When I first looked at this map, you know you always try to speculate, look at a map, what might be causing it. It's a tough map to even make conjecture about. Some of the normal patterns we see where

MPR
2015 DRC Conference _Day 1 Part 4

disability prevalence is high in southern states is true here, but there's some states that don't quite fall into that pattern. Looking at West Virginia, Kentucky, Tennessee, those are three states that are often aligned in disability statistics, and that's certainly not the case here. New Jersey is also kind of an outlier that isn't often grouped with Alabama and Mississippi.

But in the South you do see some what looks like a regional pattern. Is there something going on in the South? Could it be SSA regions but the SSA regions don't quite align with that. So it's kind of a difficult map to even speculate about.

So what I think – what I'd suggest and might help, and I'm not sure that the data will support it, is going the next level down and look at county-level variation. County-level estimates might be helpful in that we can see within-state variation. We can see county variation that may or may not align with state borders. If the county variation aligns with state borders, it may be an indication of state policy or program differences. Or we may see regional variation that doesn't really align with state borders that indicates perhaps there's regional conditions that are not really state conditions.

So I borrowed a map from David Wittenburg and ASPE brief that he did, thank you, David, to show how that might line up. This is a map of child SSI participation. It's controlling for poverty, so it's a ratio of children in SSI divided by children under 200% of poverty. So this map I think is fascinating in that we see – oops, wrong pointer – I'll never get back. It wasn't that fascinating. We see some county-level variation in the South here, excuse me, where you see Arkansas, Louisiana, Mississippi, Alabama, Florida, and there's a lot of regional variation but there's a lot of within-state variation also. It makes me wonder if it really is state policies in the South or if it's something regional going on.

However we see some things, like you see the border there of Pennsylvania and Ohio, which is really a straight line. If you're in Pennsylvania you're high, if you're in Ohio you're low. And it makes you wonder, and it's all speculation, is there something policy-driven between those two states that's lining it up. We also see that here in what looks like a bit of a base of a hockey stick shape with Kentucky with the border of Tennessee and Virginia where the participation rates are high in Kentucky and not so high in Tennessee and Virginia. So I think if you are able to do a map like this, it may give you an indication of what's going on.

And that was all speculation. I don't know, David, if you've looked into this more and any of those things line up. But I think it would be fruitful to take that next step if the data supports it.

So the other thing I'm speculating on is could DDS administration explain the variation in cessation rates. With such wide variation in cessation rates, there'd have to be a lot of subjectivity in the DDS determination. I don't have much depth of knowledge in this area, but I borrowed a table and revised it a bit from a publication of Jeff Hemener in 2009 in Journal of Voc Rehab. And just tried to look at the cessation reasons at age 18 and the continuation reasons and see if you could get an indication of how much of those decisions were somewhat subjective and how much of them were more objective. And my interpretation is those decisions that would be based on continuing to match the listing would be fairly objective, whereas the decision of nondisability or decision of residual functioning are more subjective. So from this, and I may not be interpreting it right, it looks like about half the decisions are relatively objective, half the decisions are relatively subjective, so there could be quite a – because of the degree of subjectivity, there could be quite a bit of variation in DDS. And I would think that using statistics like this and across state nature might allow us to get to that.

And I'm getting to the final slides and I'm over. Just about that geographic variation in cessation. I think that's a very important question. I also think just looking at the geographic variation and outcomes and trying to explain that would also be important regardless of whether it's related to cessation or not. And along that line I just wanted to call people's attention to a map that they've probably seen, and this is the geographic variation of employment of adults with disabilities. This is the source of the ACS. And the range here is very wide. I apologize for the small print. But the lightest color is labor force participation of less than 30%. And the darkest color is between 50% and 80%. So very wide variation of labor force participation among adults with disabilities. And I'm very curious to know if among those ceased

MPR
2015 DRC Conference _Day 1 Part 4

individuals we see these types of patterns that are drive, I'm not sure by what, but maybe whatever is driving these patterns may also be driving employment patterns of ceased individuals.

So in summary, I think it's a great paper. Important evidence of the needs of people who are ceased and the needs for programs to improve their self-sufficiency. New descriptive statistics and new source of variation. And potentially next steps, taking a look at that geographic variation which may prove to be very relevant.

And that's it. Thank you.

All right. Next up is Carrie Shandra (sp). She's going to talk about nonmarket work among disability beneficiaries using American Time Use survey data.

Thanks, Gina, and thank you all for staying for the afternoon session. It's good to see so many folks in the room. I'll be under at about ten minutes, so hopefully get us to happy hour quicker.

So my talk today actually couples well with a lot of the other talks we've heard so far in that I'm going to focus on the nonmarket aspect, so what beneficiaries do outside of formal employment. So the child care and the leisure questions are some stuff that I'll touch on in my presentation.

So I want to begin by thanking the DRC for their support of this project. This is a descriptive component, so I am fleshing out a lot of the questions that will probably come up about what you see here in a broader project.

Okay. So as we know, over eight million working-age adults in 2012 had work disabilities severe enough to qualify them for Social Security Disability insurance. So this number is growing with the majority of beneficiaries not participating in the formal labor market. However, a lack of labor market participation does not preclude beneficiaries from engaging in other forms of labor inputs which can contribute to economic production. Activities such as housework, care work, and volunteering all have exchange value. And, like transactions measured in the market, these activities have the potential to increase the value of purchased goods and services and to help develop and maintain human capital.

Time diary data is often used to estimate the economic production of nonmarket work, particularly as contributed by populations that may be less attached to the labor market. So previous work by economists in this area have focused on mothers spending nearly nine hours per day in child care on average. So in 2003 this equated to a market value of \$33,000.00. And likewise the value of nonmarket work for retirees is estimated to extend a household's average money income by up to 48%.

However the question if DI beneficiaries do with their time or how much of this time is spent in nonmarket work is largely unknown.

So existing literature suggests several reasons why nonmarket participation might be high despite low participation in market work. First, many respondents in the national beneficiary survey indicate that they want to work. So almost one-third include getting a job, developing new skills, or career advancement as goals, and many see themselves as working for pay in the future.

And while we don't know much about time use among beneficiaries specifically, a handful of studies consider patterns of time use among people with disabilities more broadly. Recently some folks in this room found that men and women with work disabilities and functional limitations were found to spend up to 144 minutes in household labor, 38 minutes on child care, and 11 minutes in daily volunteering. Many of these nonmarket investments were comparable to or exceeded those for adults without disabilities.

So the common study extends this literature by considering time use among adults who receive DI as a result of their own disability and estimating the macroeconomic contributions of these individual-level patterns. More specifically, I'm first going to estimate daily nonmarket time use among beneficiaries. Next

MPR
2015 DRC Conference _Day 1 Part 4

I'm going to calculate replacement wages that would be earned if nonmarket activities were compensated in the market. And third, I want to understand how replacement wages would translate into macroeconomic contributions. And I'll do this by comparing the relative contribution of those nonmarket labor inputs to GDP and aggregate DI payments.

So I'm going to leverage three data sources to try and do this.

The first is going to focus on individual-level data. And that's going to draw from the American Time Use Survey, which is the nationally-representative survey sponsored by the Bureau of Labor Statistics. So for folks who are unfamiliar, respondents were sampled from households that had undergone their final interview for the CPS. So while the ATUS doesn't include information on disability benefits, what that does allow me the ability to do is to match a subset of the ATUS sample back to their final CPS interview. So that's where I'm able to take the DI information from.

Now in addition, these respondents provide a detailed time diary of activities during a 24-hour period enabling estimates of multiple forums of nonmarket time use.

Next, at the occupational level for question two, replacement wages are assigned by matching each type of nonmarket time to a three digit census occupation. I follow previous work in assigning the hours weighted mean wage for each occupation from the CPS. And efficiency adjustments are made for corresponding occupations based on skill level data from the Occupational Information Network.

Finally I'm going to compare beneficiaries' total labor inputs to GDP and aggregate DI payments using World Bank world development indicators and SSA's annual statistical report.

A few more notes on method. The final sample after we go through all the data does not give us a lot of DI beneficiaries. We have 1,028 across all years, so that's 2003 to 2012. And this is working age individuals, so age 18 to 64. And we're going to define nonmarket time use as previous research has to include household activities, care work, so both inside the household and outside the household, consumer purchases, volunteering and obtaining services. Pretty much anything you could do, you could pay somebody else to do for you.

And replacement wages are going to be estimated according to three calculations, which I'll talk about momentarily.

So this bar graph presents average daily nonmarket time use among DI beneficiaries. Aggregate time use categories are arranged horizontally with average minutes arranged vertically starting at zero. And of all types of nonmarket work, beneficiaries spent the most daily time on average in household activities. If we take a look within that category, most of this time is spent in housework and food and drink preparation with various types of household management also common.

Beneficiaries also spend substantial time in care work. Over an hour-and-a-half in all types each day. Fifty-six minutes is spent in secondary childcare, meaning it occurs in tandem with other primary activities that won't otherwise qualify as nonmarket work. And interestingly, more time is spent caring for non-household members than for household members.

If we were to break that up further, we'd also see that types of care work also vary across household context, with the majority of household care directed toward children and the majority of non-household care directed toward adults.

Now of the remaining categories, consumer purchases comprise 32 minutes, obtaining services 18, and only five minutes is spent in volunteering.

So if we were to add all of these together, we get a little over four hours and 20 minutes per day.

MPR
2015 DRC Conference _Day 1 Part 4

Next I'll use these estimates to calculate replacement wages. So I'll do this in three ways, one of which is more conservative than the other. A generalist, a specialist, and an adjusted specialist. And so what you see in the table is just a snippet of the crosswalk that I use to match the time use categories to market occupations and wages.

So you see type of nonmarket activity in the left column. This is directly from the ATUS. We see census occupation next matched with previous work by Frazus (sp) and Stewart (sp). The year specific wage in current dollars is listed in the third column, with necessary preparation used for the efficiency adjustment in the final column. And I dock wages ten percent for level of participation after Level 1.

So to put all this information together to actually get a calculation, a generalist wage is calculated by multiplying total annual nonmarket hours by the average hourly wage for a general laborer. So this is typically considered to be a maid or a housekeeper. And that's multiplied by the number of beneficiaries per year.

A specialist approach substitutes specific hours per nonmarket activity matched to market occupation wages. And the adjusted specialist is going to pretty much do the same thing but adjusts wages downward according to level of preparation.

Now because some of our time use categories only have a small number of cases, I'm going to hold the time use category constant but I'm going to allow GDP and SSDI payments as well as wages to vary by year.

This next table displays select aggregate results. So the first three data columns after Year present total labor inputs in billions of dollars by type of wage calculation, so G is Generalist, S is Specialist, and AS is Adjusted Specialist.

In the next three data columns, the values are used to estimate labor inputs as the percentage of that year's GDP.

And in the final three columns, I present labor inputs as the percentage of total aggregate DI payments. All values, like I said, are expressed in current dollars.

So focusing on 2012, the most recent calculation, beneficiaries' labor inputs were valued at \$150 billion when assigned a generalist wage, \$153.6 billion with a specialist wage, and \$139.7 billion with the efficiency adjustment. So this translates into .93, .95, and .86% of GDP and 132, 135 and 123% of total average DI payments.

Now accounting for variation across all years, inputs are valued to .98% of GDP in 2011, and 146% of DI payments in 2003.

So to summarize, at the individual level beneficiaries spend a significant portion of their time in productive work. Total average nonmarket time adds to more than 30 hours per week. And while the majority goes toward household activities, much is devoted to care for others. This last finding is particularly interesting given that people with disabilities are typically considered recipients and not benefactors of care. It's also interesting because the rate of parenthood in the sample is typically lower than people who don't receive DI.

Moving to aggregate results, relative to other industries, value added is a percentage of GDP over the same period. Labor inputs are comparable in size with that of farms, educational services and nursing facilities, all of which have pretty substantial market power.

And finally, at least from a replacement wage perspective, inputs surpass DI payments across all years. Depending on methodology, nonmarket work is valued at 23 to 46 percentage points higher than the aggregate average monthly DI payment.

MPR
2015 DRC Conference _Day 1 Part 4

So in sum, beneficiaries are (inaudible) a substantial amount of work, although not in the market. But two additional comparisons are also worth mentioning. First, between those who do and do not receive DI, beneficiaries spend a similar percentage of time in nonmarket work as non-beneficiaries. The largest discrepancy occurs among time spent in market work, as we all know, where beneficiaries spend only two percent of their day compared to 20% for non-beneficiaries. Beneficiaries also spend 36% of their day in leisure and 48% in personal care compared to 21 and 44% for non-beneficiaries.

And second, among those who receive DI, so looking at variation within that population, women engage in more nonmarket work than men. Those who are more educated do more than those who are less educated. And those in good health report more than those in poor health. I'm trying to disentangle the associated demographic versus the health contributors to that gap in an extension of this work.

But regardless, even when looking at averages, those who do and do not receive benefits look similar in their nonmarket time, so results suggest the potential for coordinated market opportunities for the types of activities that beneficiaries are already performing outside the market.

And you can see the full paper with the full set of calculations in the citation below. Thank you.

All right. People really do want to get out of here early.

John Kregel, Virginia Commonwealth University, will provide comments.

Thank you, and thank you for the opportunity to be here. And thank you very much for the opportunity to comment on this very innovative paper and, in my view, a very important paper particularly a very timely paper given the discussions that are going on about the motivations of people who are on SSDI, their willingness to work, why they get on SSDI. Some people argue is it a choice to be on SSDI and a variety of things, and this provides very good information to contribute positively to the discussion that's going on at the present time.

So this paper is about the value of unpaid work. And it's monetized and looked at in relation to other industries, other sectors of the economy. But this is something that's been going on for a very long time. If you go quickly back into the seventies, and who wouldn't like to go back to the seventies, the U.S. Department of Education at that time, or for the U.S. Department of Education, really talked about this notion of career and vocational education. And they talked about career education as a group of activities through one which learns to engage in work as a part of one's way of living. So people live, and a part of that is the work. They identified work as conscious effort aimed at benefitting one's self or one's self and others. So it opened up volunteer work. It opened up homemaker work and a variety of other activities of which paid work is just one option.

Now remember, this is the 1970s and the government is really worried about people tuning in and turning on and dropping out, so they really wanted to reintroduce people to the notion of the values of a work-oriented society. And this really perpetuated this. And this discussion in another form is really happening today.

There was another issue for a long time, for decades, vocational rehabilitation would allow individuals to be closed successfully into a homemaker status. Now this wasn't done frequently, and in recent years it impacted negatively the performance ratings of a state vocational rehabilitation agency, but it definitely was something that was valued for some individuals for some individuals who met certain selection criteria. Has the skills and abilities to maintain a household, may free up another individual to work, may provide care to other individuals. And that was part of the closure effort. Now interestingly, the proposed (inaudible) regulations say that given the new definitions of employment outcomes, it will really basically do away with the notion of homemaker closures as the regulations are being written in their proposed fashion at the present time. But this is something that has been going on, has been a component of the service programs, for quite some time.

MPR
2015 DRC Conference _Day 1 Part 4

So there's an acknowledgment, I think, and there's an acknowledgment that's less obvious today that some people live their lives and have a vocation which may not be paid employment. We have an individual just retired after – just didn't retire, she's in her forties, she just stopped working at our rehabilitation research and training center because she wanted to take care of a family member and she wanted to devote hours to volunteering for her church. That's a career. Okay. It's no longer unpaid work, but it is exactly the decision that individuals make, and that's an appropriate lifestyle.

Then there's my son, so – who basically is a musician. What he wants to do is play his French horn in various ensembles all over the (inaudible). He has three jobs, none of which pay very well, so that he is free at certain times to do all the practicing that is necessary. So there are different choices that people make that aren't necessarily based on addition and subtracting to a spreadsheet in terms of what they do and what they emphasize in terms of the life decisions that they make. And unpaid work, as it applies to individuals who are SSDI beneficiaries, they're making the same decisions that all individuals within our society do as well.

Now, the problem is is that the tone of the times as it exists right now, and how it impacts how we talk about SSDI population. Because what is the general view, the popular view, of individuals who are on SSDI at the present time? They engage in fraud. They scam the system. They really could work if they had to. All of these different kinds of things set a notion up that they could be productive, they could work, and they make the choice not to work.

Now I think what's – Dr. Shandra's research points to the fact that there are beneficiaries who are quite productive, and, as she alluded to in prior research, may want to work, but they're just a segment of that population that is being viewed as it's their fault that they're on SSDI because it's a choice that they make. We need a better message. We need to combat the notion that beneficiaries are scamming the system. And we look at the sociology of the problem which is really brought out well in this particular paper. We're blaming the individual, and that is something that is consistent if you look at the history of individuals with disabilities going back 200 years in our country. That there is something wrong with their parents, that's why the son or daughter has a disability is what they said 150 or 200 years ago. Now they're saying there's something wrong with the individual because he wants to remove himself, or she wants to remove herself, from the work population.

Now our response has been, and it's definitely the response of the Democratic members of the House Ways and Means Committee, is to emphasize how disabled SSDI beneficiaries are. But one in five work. Benefits are very frugal. It's very hard to get on disabilities. It's very, very difficult for individuals to engage in any kind of activity after they've been proven to not be able to engage in substantial gainful activity and meet the residual functional capacity criteria across all sectors of the economy.

But this may have unintended consequences. Talking about how disabled our SSDI beneficiaries are is something that I'm not sure is the long term best way to look at the situation. If you refer back to the National Beneficiaries Survey, what we find is the people want to work. They face many obstacles to work. But they have done activities that engaged in looking for work in a period of time. They also, as is shown very much in this paper, is that they are highly productive. So we have people who want to work, highly productive, and that describes a large percentage, and no one really knows, of the SSDI population.

So what should the message be? We need to be careful in how we describe the population of SSDI beneficiaries so that we don't equate them to welfare beneficiaries, or recipients of welfare. I think a much better model, as has been pointed out, these people are all – the average age is 53, they've paid in for 22 years. These people are early retirees. And who are they similar to? Well, they average here in their fifties, they're similar to people who take early Social Security at age 62. And so we need to think of them as comparable to the early retirement population as much as we think about them comparable to people that get lots of other disability benefit programs.

MPR
2015 DRC Conference _Day 1 Part 4

So thank you to Dr. Shandra's work. I really found it very interesting and very valuable, and it really documents the importance and the value of unpaid work, particularly as we go through the discussion of new programs for people with disabilities and SSDI reform. Thanks for this opportunity.

All right. Jody Schimmel from Mathematica will talk about SSA payments to VR agencies.

Well, the good news of getting out of here fast is I talk notoriously fast, so there's a good chance this light will be green when I'm done as well.

I want to acknowledge by co-author who couldn't be here today, Paul O'Leary from SSA. And as Gina alluded to, I will be looking at the payments that the Social Security Administration makes to state vocational rehabilitation agencies for beneficiaries who work. Being the last speaker of the day, I don't have to motivate that – oh, I should figure out how to use this. I don't have to motivate to this room that relatively few Social Security disability beneficiaries return to work, though many claim that they would like to do so. But many who do want to work require services to be able to engage in employment. And the federal-state VR program is a very wide-reaching program that offers employment supports to people who have disabilities, significant disabilities, but this isn't solely limited to SSDI and SSI beneficiaries. About a quarter to a third of case closures need care by VR agencies are disability beneficiaries, but the VR program does serve individuals who aren't necessarily receiving benefits.

So there's two ways that SSA makes payments to SVRAs, both of which are small relative to the way that VR agencies get the majority of their funding. The majority of their funding comes from block grant formula, grants to approximately 80 agencies in the U.S. In the last fiscal year, the funding was about \$3 billion spread across these agencies. So that's where the substantial bulk of the funding comes from.

In addition to that federal RSA funding, states are required to match those grants about a one to four rate, so states are kicking into this as well. But there also is additional funding that SVRAs can receive from SSA if they serve disability beneficiaries who return to work. And there's two ways that this occurs. The first that I refer to as the traditional cost reimbursement system has been in place for decades. And this provides reimbursement to SVRAs if a beneficiary receives services and goes back to work to a pretty significant extent. They work nine out of 12 months above substantial gainful activity. So they have nine out of 12 months that they're earning over \$1,000.00 a month.

So under that traditional cost reimbursement system, in fiscal year 2013, SSA paid about 9,500 cost reimbursement claims with an average value of \$15,500.00. So the total value of payments made by SSA to SVRAs under that payment scheme was \$141 million compared to that \$3 billion figure above. So it is a small source of funding, but it is a significant source of funding, too.

In addition, SVRAs can operate as an employment network under the Ticket to Work program, and I think I probably don't need to go into the details here. There are two different payment systems under Ticket to Work that SVRAs can assign beneficiaries to and receive payments from that as well. And the most recent information I found about that suggested that it was about \$20 million annually to SVRAs under that source of funding. So it's about \$160 million of funding from SSA in addition to this funding that comes from RSA.

So the three questions I want to touch on here today that are part of a broader research paper are first, what proportion of applicants who are beneficiaries that seek services from SVRAs, generate a payment from SSA, and what's the average value of those payments. I mentioned before the average value per year. SSA publishes statistics each year that are very aggregated and don't provide a lot of information about beneficiary subgroups and the share of beneficiaries who sought services who generated a payment. So we did the deeper dive into looking at that.

The bulk of our work really was focusing on how those payments compared to the benefits that were foregone for work by these beneficiary clients. So I mentioned that under both payment schemes the SSA has beneficiaries work in order to generate such a payment. And so we were really interested in looking

MPR
2015 DRC Conference _Day 1 Part 4

at the relationship between the payments that SSA made and the benefits that were sort of saved because the beneficiaries were working. Or were at least not paid out.

And finally we wanted to look at how SSA payments and benefits foregone for work varied by the agency that provided services.

And I should mention that states either have one or two VR agencies. In some states there is a separate agency that serves individuals who are blind. And in those states they would have both a blind agency and one that serves the more general population with disabilities. And in some states there's a single agency combined. So what I'll show you today really only highlights two agencies. We looked at agency-level differences. But I think this gets into a lot of what the talks have shown earlier today that there is a lot of variation at the state level, or the agency level in this case.

So quickly talking about the data we used. We merged information from two administrative data sources. We used the SSA's 2012 disability analysis file that Alexi (sp) mentioned earlier. From that we were able to obtain information on monthly program participation in DI and SSI. This measure of the dollar value of foregone cash benefits due to work and VR payments that SSA made to SVRAs. And we use the RSA 9/11 data, or the case service report data, to drive beneficiary characteristics and to find the dates of services.

And so together we were able to aggregate these two sources of information to identify when beneficiaries applied for VR services and the extent to which they generated payments after receiving those services.

So in particular we identified the first time that an individual sought VR services between 2002 and 2007 and was a beneficiary receiving SSDI or SSI at any point during the VR spell. And so we took a pretty broad definition of beneficiary here. We identified anyone who we could say was a beneficiary between the time they applied for a VR and the time that their VR case was closed. And the reason for doing this was because we wanted to ensure that we captured anyone who really could have generated a payment.

VR agencies ask individuals about their beneficiary status at application, and there's a sense that that's probably the best information they have when they decide whether or not to seek payment from SSA, that that's when they're a beneficiary, but we wanted to make sure that we took a broad view in case there were any cases that they went back or found out that the person was a beneficiary.

So looking across these six years, we had 1.2 million beneficiary applicants. What I'm going to focus on today are the 266,000 who applied for VR in 2002. The nice part about looking at the 2002 cohort is we're able to follow outcomes through 2012, and so we have up to 132 months, or 11 years, to follow people after they initially sought VR services.

The cohorts were actually remarkably similar on observables across these six cohorts. The reason that we don't focus in the paper on the later cohorts as much is especially the most late cohort, 2007, they were affected by the recession that immediately followed them applying for VR services, and there are also issues with the completion of VR services, requesting a payment from SSA, and receiving a payment from SSA even though we do have data as late as 2012. But by and large we think that the experiences of the 2002 cohort really do represent what we would expect for these later cohorts.

So just a couple more details that I think are important for the rest of what I'm going to show. We considered the sum of these traditional cost reimbursement payments and Ticket to Work payments for what I'm going to present. Ticket to Work payments were about ten percent of the total payment dollars during this time, but the bulk of payments to SVRAs from SSA are still under this cost reimbursement model. And we count all payments that are made from the time a person applies for VR through the end of December 2012. And I'll come back to why this is important later, but we really identified the time that the person applied for VR and followed them through the end of our period of observation.

MPR
2015 DRC Conference _Day 1 Part 4

We did the same for benefits foregone for work, and this is a monthly measure that's contained in the DAF (sp). It's constructed separately for SSI and SSDI to take into account the different program features and how benefits are foregone based on SSDI versus SSI program rules. But we sum them together for a single measure.

And, again, this is the dollar value of how much higher a beneficiary's cash benefits would be had they not returned to work.

So overall among the 2002 cohort, relatively few beneficiaries who sought VR services ultimately generated a payment. 3.6% generated a payment under cost reimbursement in the traditional payment system, and .6% generated at least one Ticket to Work payment. There's some overlap, so the total share who generated payment is slightly higher than this, but across all the cohorts it was between three and four percent.

The per-beneficiary payment values that we found for our cohort aligned relatively well with what's in the SSA published statistics. On average we found that the payment was about \$13,500.00, and the median payment value was about \$9,000.00. And in the paper when it's available, we did find some pretty interesting differences in subgroups. In particular, beneficiaries with sensory impairments tended to have larger payment values. And that's true for agencies that served individuals with blindness as well.

So what we were really interested in doing here is looking at how payments compared to BFW. And I thought I had this slide animated, but apparently my Excel skills are not great.

On the left-hand side here you see the benefits foregone for work among the 2002 applicant cohort, and it was \$1.5 billion from the time they applied in 2002 until the end of December of 2012. And you can see that this is relatively large. It's about 11 times larger than the payments that SSA made on behalf of these individuals. So that alone, you know you can interpret that, there's a very large difference between these two. But as I mentioned earlier, the bulk of outlays for these beneficiaries are actually coming through the block grant RSA funding. And I drew a dashed line here to show two things. I mean the main thing is the stuff on the right is outside of the scope of what we did in our analysis. We really were focused on estimating the two bars to the left. But I did want to provide some context for these numbers. If you add in the federal share along with SSA payments based on our best estimate of what, you know, the proportion of total applicants who are beneficiaries, the federal dollars that are spent on case closures. If you add the SSA and federal share, you come up with a value that is approximately similar to the value for the BFW. Because we were doing this sort of back-of-the-envelope calculation, I was careful to not assign a dollar value to this. But approximately the magnitudes are about the same. And then if you add in that additional approximately 20% state share, you end up with total outlays being higher than the BFW estimate. But I think the core of our analysis was really focusing on those left two pieces. And it does show that SSA's payments relative to the benefits foregone for work are substantially – the payments are substantially lower.

So there are a couple of caveats that I think are important to make about our BFW estimate. As I mentioned, we counted from the time an individual applied for VR onward. Not all beneficiaries who apply for VR services receive them. And actually it's a pretty substantial amount, 40% who apply for services never receive what's known as an Individualized Plan for Employment which is really sort of the start of service delivery. This is true overall and it's also true for beneficiaries in our group. What was really interesting to us, and what caused us a lot of difficulty at first, is this group actually went on to generate payments. And the reason this was happening is many of these individuals sought services in that period I talked about, 2002 to 2007, ultimately weren't served when they sought services for that first time, but went back again to the VR agency and received services to the point that they went back to work and accrued ten percent of the total payments in what we were looking at.

They also accrued 28% of the benefits foregone for work. And so this really is an important group that sought services, showed that they had an inclination to work, and were able to work at a pretty significant level, but ultimately weren't served when they first sought VR services. And I think probably most people in this room know many VR agencies are pretty significantly financially constrained, have waiting lists,

MPR
2015 DRC Conference _Day 1 Part 4

operate in order of selection. So this isn't completely surprising, but it is interesting the share of what we found, that ultimately went on to generate a payment.

And I think the other thing to be cautious about is we're not trying to assume that the benefits foregone for work can be causally attributed to the receipt of VR services. Many who seek VR services are work oriented, and as we see, some of the people who don't receive services ultimately generate benefits foregone for work. So we aren't trying to attribute that, but we were trying to compare the two. And one of the things we do in the paper is consider a shorter time period around the time a person has their case closed. So we look four years after VR case closure. The reason for that is that's the time that most payments are made. And you do see a reduction, but the substantive story doesn't change that BFW relative to SSA payments for this group stays at about the same magnitude. It's somewhere between seven and 11 times regardless of how conservative we try to make the BFW estimate.

Wow, I got to yellow. I feel like it's a badge of honor.

So I want to focus on two particular agencies, not to highlight these agencies in particular. I could have picked any number of agencies among what we looked at, but I thought these agencies were particularly interesting. California and New York together, each were the two largest agencies among the 2002 application cohort. Each served about eight percent of the applicants that we considered. So they were similarly sized agencies. I think one thing to note is that California was a combined agency which meant that they were also serving blind individuals. We only looked at the New York general agency for this.

But we see that these two agencies were not quite the same on the amount of benefits foregone for work, but they were within sort of a ballpark of what was similar. And so their beneficiaries are working. But what we see that's really interesting is that 4.4% of applicants in California ultimately went on to generate a payment compared to 1.8% in New York. And so there really are significant differences in the extent to which these agencies generate a payment even when it appears that the beneficiaries that they're serving may be working at similar levels. Overall the total payment dollars are obviously very different because of the share who are generating a payment, and there's also California had a higher average payment value.

And so, again, these aren't meant to sort of call out these two states in any particular way. This could have been a lot of states. But it does show that there are – that SVRAs vary pretty substantially even if BFW doesn't differ that much in the receipt of payments.

So just some thoughts. Even under conservative estimates, the BFW values that we found significantly exceeded payments made by SSA. We can't attribute BFW to the receipt of VR services, and we weren't trying to do that. In fact many who seek VR services do so – generate BFW without receiving a payment. And SVRAs vary to the extent in which beneficiary clients generate a payment. And I think this highlights that there may be room for additional service – oh, no, the blinking red light. All right.

One thing I do want to highlight that I think is important to note is that our analysis ended in 2012, and in 2013 SSA implemented changes to the process by which they notified SVRAs that their beneficiaries that they were serving may be eligible for a payment. They made it a little bit more automated. And if you look at just the published statistics from SSA, the number of traditional VR payment claims rose 80% between fiscal year 2012 and 2013, and the dollar amount of payments increased by a similar amount. Unfortunately that, of course, happened the year after our analysis period, but I think it does show that there was at least some improvement by SVRAs in identifying opportunities to file claims with SSA. We don't know, obviously, whether or not BFW changed during that period, but I think it does show that there has been some of the things that we had identified as potential problems do seem to have been at least partially resolved in the year after our analysis.

So thank you.

MPR
2015 DRC Conference _Day 1 Part 4

All right. James Smith from the Vermont Division of Vocational Rehabilitation will talk about this. And according to his bio he oversees the budget there, so maybe he'll have something to say about payments to VR agencies by SSA.

Hi, yes. So my name is James Smith, and I'm going to sort of react to this from the perspective, not as a researcher but as a voc rehab administrator. And I think the first lesson is obviously that we have to triple the VR budgets to get a greater BFF – not BFF – excuse me.

So there are a few things I wanted to comment on, but first I wanted to give a bit of context from our small state in Vermont. We are a voc rehab agency that primarily uses the Ticket as our payment mechanism, not the cost reimbursement program. So we're slightly different but we still generate payments from both systems. And just a bit of context or in terms of the value of the Social Security Ticket and reimbursement, for last state fiscal year we received about \$1.5 million, and that compares to our base federal award of \$9 million. So it's a significant chunk of change in a small state.

And about ten percent of beneficiaries in Vermont are being served currently by the VR program, so it sort of reflects on a couple of things I've heard throughout the day which is the question is do beneficiaries want to work. Even in our small state, one out of ten have raised their hand and volunteered for the voc rehab program. I'm sure many more are trying to go to work without VR, and so it sort of reflects on that.

And then while the – well, obviously, we can't have sort of causal attribution to the – you didn't say the number, the great number you have in there of like 7.9 – like the – the payments to state voc rehab agencies were – the return on investment, Social Security was as high as 7.9.

(Inaudible.)

You can't really say that, but I'm not restrained by your ethics, so – but it's certainly – for me it's sort of – it's certainly a starting point for a case, a return on investment case, for the public VR system. And also thinking about that, two-thirds of the folks that public VR agencies served are not on the SSI or SSDI programs but are potential eligibles from my perspective. And so as folks talk about early intervention and so on, you know, I worry that existing programs like the voc rehab program are being overlooked and maybe aren't necessarily the best advocates for themselves but are perhaps having an impact on delaying folks' entry into the DI or SSI programs. And that, for me, would be certainly an interesting area to look into in addition to this.

The troubling piece, obviously, from your data was the 40% of folks who had been determined eligible but not gotten to a plan. And I'm honestly a little baffled by that, and maybe folks with a more national perspective may have better understanding, you know, but for even though our state and many states (inaudible) order of selection folks who receive SSI and SSDI are always at the top of that order of selection, or from my understanding should always be at the top of that order of selection, so I'm a little surprised and concerned by that number. Perhaps (inaudible) may help address that in that we now have a tighter requirement to get people into plan status within 90 days than we did previously.

I was, and this was more in your paper than in your presentation, but I was pretty shocked by the variation in the number of states, or the variation in states that are getting either cost reimbursement or Ticket payments, from the amounts. And it certainly didn't seem to correlate with the population size, or the size of the agency. And in your paper you say well perhaps – I'm paraphrasing you, and maybe this is too simple – you say that perhaps Social Security could make it easier for agencies to generate cost reimbursement or Ticket payments. But I would actually throw my colleagues a little bit from those states that are lower a little bit under the bus in saying that Social Security has done a great deal. And when I looked to the most recent data on cost reimbursement payments, I still saw wide variation and very large states, like New York, getting less money than much smaller states like ourselves, which just does not make sense to me.

MPR
2015 DRC Conference _Day 1 Part 4

And I think there's probably three factors involved. I think states that have access – state VR agencies that have access to Department of Labor Unemployment Insurance wage data can much more easily make the match and identify folks who have met the earnings thresholds to submit a cost reimbursement claim to Social Security. I'm sure that is probably one factor.

Automation is another factor. There are off-the-shelf solutions to enable agencies to easily do the cost reimbursement billing without having to go through a manual effort.

And probably staffing is another issue is those states perhaps have not figured it out that I think there was a quote in there that the cost of taking advantage outweighed the value. And that just is not a credible explanation to me. It was clear even when Vermont did a manual process, the amount we generated in cost reimbursements far exceeded the cost of hiring a person to do it.

Okay. Just bumping on. And then I just wanted to say a couple of things that are not covered in your paper but I think will relate to this issue. As everyone knows, the (inaudible) was passed last July. And one feature of (inaudible) that may impact the ability of the voc rehab program to serve the adult SSI and SSDI beneficiaries or potential adult SSI and SSDI beneficiaries is that (inaudible) has broadened the voc rehab mandate now to require 15% of our federal award be targeted specifically to serve students. And so students who are still in high school. And so as a practical matter, and my colleagues around the country are all trying to figure out where to take from adult voc rehab services, where to take money from those services and then shift it into services for students. Because even some of the most progressive agencies, which we consider ours progressive but others may disagree, that provided services to students pretty consistently, that 15% threshold is quite a high threshold to reach. And so there has been a shift of – there's going to be or there is – a shift in resources going to serve students. And so that may exacerbate your 40% problem and not help.

Let me see. The other observation you made, you didn't say it here but you made it in your paper, was that you thought perhaps that (inaudible) the requirement under (inaudible) that state agencies have partnership agreements with employment networks would expand the use of the Ticket. And I have to take issue with that. I think that's probably not credible in that there's such a paucity of employment networks out there, that even if VR agencies, like in our state I don't think there's a single active local employment network. There are national employment networks that say they serve Vermont, but they don't serve Vermont. But I think it's well known that there's a paucity of private EN, and so it's unlikely that just us having an agreement is going to expand access.

So with that I think I'll leave it at that, and thanks very much for the opportunity to speak to you.

All right. So do any panel members, before we go to the audience, have anything they want to say to their discussants? Nope? Okay. Does anyone have any questions?

I want to come back to the question about what happens to SSI child recipients. And it seems to me that a lot of the issue that these folks face is not really so much in the SSI system but that they spend their first 18 years within school systems that really are trying to prepare them for an integrated – to participate in the community. And then just at that moment when they go into that adult transition, all of a sudden the entitlements and the services and that whole world outside of SSI is taken away. And suddenly they're in an adult world where their services are much more constrained and the expectations are much more constrained. And when I talk to parents of intellectually disabled people, they talk a lot about how they really had a much different experience while their kids were in school. And there's this idea that they're going to somehow successfully launch at age 18 or 19 or depending on what state, it might be a little older. And that's not the way transitions to adulthood work. There are multiple transitions that need to be done. And we really have, you know Stan (inaudible) speaks of the disability cliff where we really just have fundamentally different systems for children and adults that fails people at that transition point. And I just wondered if the panel wanted to comment on those aspects of the situation.

Does anyone?

MPR
2015 DRC Conference _Day 1 Part 4

I have a comment if you don't.

Go ahead.

Is my mic on? Okay, great. I concur with your comment. I think that from my own experience and the experience that I have heard from others when you're transitioning from secondary education to adulthood, whether that be at 18, 21, you're going from a system that you're entitled to these benefits where you are going to a situation where you have to become a self-advocate. And I think that for some people that transition is harder than others. Especially I think you were saying people with intellectual disabilities, I think, I've heard in my experience have had a particularly difficult time making that transition. And that does intersect with my research as much as my personal experience and the experience just as someone who has been involved volunteering on VR councils. But yes, I agree.

And SSA is right now doing this Promoting Readiness of Minors in SSI, PROMISS. And that in a lot of the state applications for that demonstration grant they point out these gaps in the transition going from the schools. And then also the huge variation across the school systems, like particularly ones in rural areas or that may not have the services. So that demonstration, or at least as they say they are intending to do, is trying to address some of those issues.

Bob?

Is this one? Yeah. Being an old VR guy, I have to react to Jody's paper. And I guess the good news is that the return on investment – James and I are going to call it the return on investment – \$11.00 or \$8.00 for each dollar reimbursed I think is terrific. That's the good news. The bad news is only four percent of our cases meet SGA, so a lot of work to be done there.

But I'd like to follow up on Jane's point to drill down a little further on the state variations in cost reimbursement. Is there an ability for you to do that, to go in and look at the variables that could affect that, including the ones James mentioned and other ones like state funding of the VR program?

We've talked about doing it.

Mic, mic.

(Inaudible).

Web people can't hear you.

We've talked about doing it under future work, but not under this project. I mean, that is one of the lingering questions I think maybe we didn't expect – well, we did expect to find that much variation. I think we were even a little bit more surprised at how great it was by – I mean, there were some pretty significant differences even holding constant what looks like sort of similar BFW, which would sort of suggest that they're working, you know, it's not a perfect measure, but it sort of gives you some sense of the beneficiaries are working at comparable levels, and you do really see less variation in the average dollar value of payments. But where the variation seems to primarily come is the shares that are generating a payment at all. So we have talked about doing that, but we haven't yet.

The only reason I bring that up is I think that would be of tremendous value to the field if they could see what a high performing agency is doing, or the elements in their cost reimbursement program, versus a state that struggles with that. So I think that would be a very – a lot of utility for public VR agencies. Thank you.

David.

MPR
2015 DRC Conference _Day 1 Part 4

Um, I want to follow on the last question. Anything that has an employment level that low always makes me nervous. But then there's something special about this population. Depending on where they are, if they had (inaudible), they could be in high school through 21, right? And so I'm wondering at 24 what percentage of them might still be in vocational education or college or something, and I'm wondering if you have any data on that.

Okay. My mic's on now. They're turning the volume up and down I guess. So to answer your question, I don't think that the SSA administrative data that we're using for our study has that kind of information. I'm sure that it's available in other household services, but it is a good point that if you're – especially if you're transitioning out of secondary education services at age 21, by age 24 you might still be – you might just be transitioning into – I see a bunch of different stories, but you could see several stories under which those people are starting to receive adult services to help them transition to employment.

All right. I saw Stapleton has one, but does anyone else have a question first?

Yeah, so this is to Jody and James. And one idea I had had was to change the reimbursement system for VR agencies so that SSA paid the agencies involved as opposed to responding to individual claims using the BFW measure as a measure of performance. And then also, you know, that would, I think, simplify the administrative process. It might introduce some other problems, but it would also allow SSA to experiment with the size of the reimbursements to see if actually increasing that reimbursement does lead to a seven fold increase in BFW. Any reaction?

From a small state perspective, I always get nervous when people talk about like standardizing something because I think we always end up getting the short end of the stick and I always prefer performance (inaudible) approach, but that's a highly selfish response. I think given the amount of money that's being left on the table for the benefit, you know, and that should be going back into VR services to help beneficiaries, and I think what you're suggesting has some merit.

And I think, just sort of getting back to your concern, one of the things that was hard in the paper was sort of standardizing states. Vermont looks very different from California and the magnitude of BFW, so one of the things we did just for ease of presentation was sort of normalize everything as a share of the total. And so there could be a way to sort of allay those concerns. We looked at California as a share of total applicants. We looked at their BFW, it was a share of total BFW. So there could be a way to, I know, I would see your concern that if you're only .1% of the nation BFW, but there may be ways to do that I think that could work.

Anyone else? All right. So before you go, there's a couple of announcements. Tomorrow, if you're attending, the meeting will be over here in the Holman Room. And if you are one of the external scholar panels for MBER or Mathematica, the MBER group will be meeting right now, or in a few minutes, starting in the Morrow Room, and the Mathematica group will be in the Lizigor Room, which is across that way.

Oh, and thank you.

MPR
2015 DRC Conference_Day 2 Part 1

2015 DRC Conference Day 2 Part 1

Good Morning. We're going to get started, I understand there's train issues so we may have people trickling in late today but we want to get going. Welcome to the second day of the disability research consortium annual meeting. My name's Gina Livermore, I'm the co-director of the Mathematica Center. This morning we have two panels with staff from federal agencies and they're going to talk to us about some of the programs and target populations they serve and also we're hoping to hear areas and issues where they would like to see more research.

So, first up, we have, David Weaver. He's the associate commissioner for research demonstration employment support at the social security administration and he started his career there in 1992. From 2004-2011, he was the Deputy Associate Commissioner for Retirement Policy, overseeing SSA's use of micro simulation models to analyze effects of SSA options and proposals. He's authored several articles in professional journals on the economical being of social security beneficiaries and the effects of alternative policy proposals on that population.

David has a PHD from Duke University, and take it away. Is the timer set for twenty? These are twenty.

Okay. Well, Good Morning, everyone. Can you hear me okay? As Gina said, I'm, David Weaver, I'm the Associate Commissioner for Research Demonstration and Employment Support at Social Security Administration. We're sort of a good applied research on disability topics.

For my remarks today, I want to spend some time talking about four general areas; one as Gina mentioned, target populations or populations that the agency's interested in for purposes of programs, research and policy analysis. Mostly, I'm going to talk about some of the programs and initiatives to serve working age populations that have health impairments or disabilities. I'll cover some policy issues facing the agency and perhaps of great interest to this group, some areas of future research that we're interested in.

Let me start with the idea of a target population, that's a little hard to narrow down at social security because our programs cover really, everybody. There are about 64,000,000 Americans who receive payments from the Social Security Association each month through our Social Security and SSI programs. Our programs cover really, all the age ranges. We have retirees, spouses, widows, children, individuals with disabilities but drilling down a little bit for purposes of this discussion, I want to focus on three specific populations. The first one I'll talk about is children and youth with disabilities, adults with disabilities who are likely to return to work and individuals who have health impairments who are not yet on our rolls.

First, children and youth with disabilities, some of this is just going to be some broad discussion because I think these are some important points and hopefully they'll foster some ideas and feedback. I want to hit a couple things when we talk about children and youth with disabilities. First, I want to really flag the seriousness of the issue and also, I want to highlight the need for some additional analysis and research on the health impairments of this population, particularly for those who are younger ages.

My agency and other federal agencies had voted a number of resources to what we call youth transition and what we're -- Oh, okay, I'm sorry.

On the webinar, sorry, so maybe move the microphone.

Oh, sure.

Does it go up? You're too tall.

MPR
2015 DRC Conference_Day 2 Part 1

Okay. Let me closer. [Laughter] I hope this is a little bit better. Does that sound better? Okay. So, I was saying, we focus on individuals that we call youth transition issues. These are really individuals we often talk about who are between the ages of 14 and 24 and who are on our SSI program and there's been a lot of research and demonstrations and policy around, how do you help those individuals have a successful transition to adulthood? We had some interesting findings in the demonstration, so for example, we ran a demonstration called, "The Youth Transition Demonstration". One of the findings from that, we did find that you gave the individuals on SSI who have a disabilities, these youth, if you gave them good employment support, aggressive job placement and good benefits counseling, how our rules worked, you can actually move the needle. So, individuals who received those services had much higher rates of success in the competitive labor market than did the control groups in that demonstration.

We've had demonstrations in focus on this area and there have been some interesting findings, but I want to step back because it seems like a lot of times we talk about this issue with, in terms of employment success or educational attainment and those are widely viewed as good goals but I want to drill down a little bit on this population because I do want to emphasize the serious issues this population faces. Just a few statistics on this population, 1/3 of the children on SSI, that is, those who are under age 18, are in poverty, even with the SSI payments. 2/3 of children on SSI reside in one parent households. 12% there is no parent in the household, that means some family figure like a Grandmother is taking care of these children. 40% of the children on SSI are African American, about a quarter are Hispanic of any race. When you look at the statistics on school success, educational attainment, employment outcome for this population, some of those outcomes are pretty discouraging.

One of the things when we think about research and policy around this population, I do think there needs to be an appreciation of just the difficult, complex family and economic situations that this population faces. I do think one of the continuing goals we'll have at the agency is sort of, increase attention on the youth population on SSI. I also want to note that a lot of the youth transition work, particularly that is done in the social science community, focus on the late teen years and has focused on promoting education attainment and employment outcomes.

But, there are nearly 1,000,000 between the ages of 0 and 13 so we have a lot of children on SSI who were low birth rate babies or who have other pretty serious health problems. One of the things I want to flag is that the success of a youth on SSI in the teen years depends on them having some level of health that allows them to have success so one of the things I am interesting in as flagging as an issue is more attention to the younger population on SSI, in particular, health outcomes and what influences good health outcomes among that population.

The next population I'm going to talk about are adults with disabilities who are likely to return to work. In SSA, we run a number of employment support programs and quite a few work incentives for adults in our disability programs. One recurring theme we have is, among individuals who meet the strict definition that social security has for assistability program, who is likely to work? If you look at cross sectional statistics in any given year, about 85% of the disability insurance beneficiaries have zero earnings in a year. There's no rule that requires them to have exactly zero earnings, that likely reflects the serious health impairments they have and that prevents work. If you look at individuals over time, the figures are a little bit better and they're strongly correlated with a demographic such as age.

For example, we look at individuals coming on the SSDI roles, about 26% might have some earnings over a 5 year period. If you look at recipients under 40, that might be 42%. You can do more complicated statistical analysis but at the end of the day, we're often left with very general information that it's younger workers, it's younger beneficiaries who are likely to return to work. While that's useful, it's not highly targeted and so one of the things I want to put out there is something that's of interest and may offer some breakthroughs going forward is that, there seems to be enough new focus on data analytics or unstructured analysis of data. One of the things that may develop that helps us in this area is whether an analysis literature develop identifies very specific populations that are highly likely to return to work. I'll just make up an example, you may find things where it could be individuals who are highly educated,

MPR
2015 DRC Conference_Day 2 Part 1

have a certain diagnosis, have living expenses, such as kids in college, where they simply cannot maintain their standard of living with the modest DI benefits. That's a simple example but I do wonder if some of the data analytic techniques and other unstructured analysis will reveal just very specific populations that if they receive them employment support from us, might be very likely to return to work.

The next group I'll talk about, I'll call early intervention populations. These are individuals who have started to have health problems and problems in the labor market but have not yet turned to the SSDI or SSI roles. At SSA, since the ticket to work legislation, we've embarked on a number of programs and demonstrations and research around getting individuals who are on our roles to return to work. That's probably been more successful than people may assume but I think there's a general agreement that we need to reach individuals before they are on our roles. There's this intense interest on, how do you identify individuals who are starting to experience health problems and have a continuous connection with the labor market? That's an active area of research but I want to flag a couple of real world issues.

Large scale research projects or demonstrations are expensive and you have to provide congress with actionable information. You could certainly identify populations where there were health problems and labor market problems in some specific local or some small program but because these research endeavors are expensive, sometimes that doesn't get Congress the information they would need to either create new programs or to address the issue from a policy perspective. For example, one of the really good demonstrations actually that was done on early intervention was the demonstration to maintain independence and employment. That targeted individuals in different states, for example, one location in Texas, they recruited individuals in the hospital system of Harris County, Texas. They provided support and then the research documented whether individuals were more likely to apply for benefits and have good outcomes. That's been a very good study but that gives you a sense of how would would Congress scale something like that up. When we talk about these populations, I do think it's important for people to have the real world policy environment in mind, that you have to be able to scale something up, given the expenses, in running these large projects.

Let me talk about some of the programs that serve working age populations who have disabilities. At SSA, we actually have a pretty substantial structure to support working age people with disabilities. For example, last year, about 400,000 Social Security Disability Insurance for SSI beneficiaries received services from a state vocational rehabilitation agency or from an employment network. We reimbursed state VR or the employment networks if beneficiaries achieved certain employment outcomes. Beneficiaries who work with VR or employment networks, actually have in some respects, pretty good outcomes, these aren't causal outcomes I'll talk about but when you look at the descriptive outcomes, we've tracked individuals who received services from BR, for example, we follow them for 5 years. We notice that a large majority, 64% are employed at some point, that's pretty remarkable given the severity of impairments. The reimbursements we paid to BR in this 5 year look were about \$52,000,000 but the Social Security and SSI benefits that were forgone due to work from these beneficiaries totaled about \$268,000,000. Findings for the employment networks were qualitatively similar. I don't want to state nor what we have in place, we actually have partners out there in VR and the employment networks who are doing good work and providing some muscle for us to actually have beneficiaries return to work.

We also have two grant programs, the work incentive planning and assistance or WIPA organizations and the protection and advocacy of beneficiaries of Social Security or PABS organizations. These organizations are community organizations, they serve about 40,000 Americans each year. They help our disability beneficiaries if they've been discriminated in the work place or if they need explanation of our work incentive roles and help to get them started in the path to work. With an SSA, we also have SSA employs who are area work incentive coordinators, we call them AWICS or work incentive liaisons out in the field.

One of the things I do want to leave people with, we actually do have a structure at SSA, on the ground that does allow us to serve disabled individuals who are trying to work. There's also, as many of you may know, there are a number of complex work incentive roles in the law. These are again, tools that our

MPR
2015 DRC Conference_Day 2 Part 1

beneficiaries can use to try work, in addition to programmed, there are specific incentives in our programs that helps individuals who want to work. We have a trial work period, we have an extended period of illegibility, an expedited re-reinstatement period, a period where Medicare continues if you work. SSI has it's own set of rules. We have extensive support to encourage work in addition to the programs that actually serve beneficiaries.

That's a good topic to lead into some of the policy discussions. Work incentives in the DI, our Disability Insurance and SSI program help individuals so any change in the law, in that area, would have winners and losers. There's a fair bit of policy interest in the work incentives and in particular, whether taken as a whole, they're too complex for the public to understand. With that, I think we sometimes hear a concern that in the face of complexity would individuals choose simply not to work because they're unsure of what would happen to their benefits. There's also in the policy community, press related, there's a fair bit of interest in thinking about benefit offset features as part of the disability insurance program. The idea is that, that would replace what some people call the, "The Cash Cliff". In the DI program, after you get through the trial work period, if you earn up the substantial gainful amount, your benefits wills seize. A benefit offset feature would have a more gradual reduction in benefits. I'm not advocating for or against it but that is one of the policy ideas that there's a fair bit of attention on.

We also have large scale demonstration project in that area, testing a benefit offset at levels above SGA, a one for two offset. That work's ongoing and although we continue to produce snap short reports, we'll have a final report on that project in 2017. There's also a fair bit of policy discussion around what I'll call, practical efforts to help beneficiaries return to work. For example, even legislative policy interested in very practical things such as referring denied applicants to state VR or other outlets where they might be able to receive help. There's a lot of policy interest in, can we give our beneficiaries better tools, online tools or other practical guides that would actually help them understand the complex rules in our programs?

With regard youth, I think the policy interest again is tide to some practical issues. What could we do to help families with young folks on SSI better understand our rules? For the young population, Social Security actually has a number of very good work incentives that if it were better widely known, might really help serve these families. For example, for students on SSI, we have a special rule called the student earned income exclusion and that allows youth in high school or college in the summer months or in months not in school, as much as \$1800 approximately a month and not have their benefits affected so it's a really powerful tool that's in the law that allows these young folks to try work and get exposure to the competitive labor market. There's a real issue as well, is how well do families know about that rule? Do we need to do a better job communicating to them?

In addition, there are other rules where individuals who are on our SSI program as children, as long as they're working with VR or another approved program through the school system or elsewhere, they can continue to receive benefits at age 18 as long as they're making progress in that program. Again, even when I talk to audiences with expertise, these rules are not perhaps as well-known as they should be so I think some of the interest is, the federal government needs to think harder about how we educate the public and others about these so that they can take advantage of them.

There are some policy proposals we sometimes hear of for individuals in the space of young folks on SSI. I mentioned student earned income exclusion which is pretty generous. Sometimes we hear proposals that given that it's so generous, maybe you shouldn't even have an earnings limit for students on SSI because by having something in place, they still have to be aware of it. They may have to come in contact with the agency, they may fear, they may not understand the roles so sometimes we do see proposals on liberalization on SSI policy for young folks.

Finally, since this is a research conference let me turn to some of the research topics that I think are of interest. First, researched on work incentives, I know before this scenario, the increasing interest in policy makers do need to know the effects of changes in programs. One thing I'll say is that in the past, there seems to be a focus on looking at the purely economic or financial effects of specific work incentives but I

MPR
2015 DRC Conference_Day 2 Part 1

think some of the theme I detect when we're engaged in these policy discussions is really -- our beneficiaries are real people. They don't face one isolated provision of the Social Security act, they face a whole set of work incentives and the issue is about the complexity of the system as a whole. I think research even if it's qualitative in nature, that tries to get at how complexity influences decisions about work. In and of itself, quite apart from the financial and economic incentives of the specific work incentive I think is interesting, I think there's a building theme about people face a whole set of rules, how do they deal with complexity and how does that affect their behavior?

We also are interested in innovative research on populations that would successfully return individuals to work. I looked at this earlier but I think any kind of analysis that would help us identify populations that are highly likely to take advantage of employment support programs and return to work, that could be actual information for an agency such as ours where we actually have an operational structure. As I mentioned before, there's a fair bit of interest on early intervention issues and finally, I'll flag this again with the last 20 seconds. We are interested in research on the determinance of health among younger children on SSI. So, we often focused on youth transitions on education employment but, this may be a little bit of a stretch in the social science field but I think there's some real value into looking at the determinance of health outcomes among our younger members of the SSI program.

So, let me stop there and I hope that gives you a sense of some of the issues we're thinking about and I'm looking forward to the discussion. [Applause]

Thank you, David. Our next speaker is Jamie Kendall, she's the acting Director of Independent Living at the Administration for Community Living in the Department of Human Services. She also serves as the Director of the Office of Policy Analysis and Development at the Center for Policy and Evaluation at ACL. Jamie began her federal career working at the Administration for Children and Families and has also worked at the Social Security Administration developing policies for low income families and people with disabilities. Previously, she served as deputy Commissioner of the Administration on Intellectual and Developmental Disabilities. Jamie has a Master of Policy from Georgetown University.

Thanks, Gina. Can you guys hear me? Okay, great. I want to thank David and Gina for having me here today and just say the work of the DRC is really critical to moving the employment conversation for people with disabilities so I'm happy to be here and contribute and share what the department of Health and Human Services is doing at the Administration for Community Living. I have about 50 slides and I am not going to focus on all of these because we do not have enough time but I will try to highlight, especially our disability portfolio. ACL, we are the newest federal operating division at the department of Health and Human Services and we're really built around a vision of independence and allowing and supporting individuals with long term services in support so they can remain in the community and be productive and have quality lives.

In April 2012, we were formed, you heard Henry Klipfel yesterday, he was then our Senior Advisor in Disability to the Secretary and he along with Kathy Greenley, the Assistant Secretary of the Administration on Aging and Sharon Lewis, our Commissioner for the Administration and Development Disabilities, came together and brought a single agency with these three portfolios. Just to give you an idea, HHS has about 80,000 employees, ACL, we're tiny, about 200. We are largely a grant making organization. We give out about 1200 grants a year. Our budget is just shy of 2,000,000,000. We're small and we're mighty and we represent the consumer voice so we work a lot with our colleagues across HHS and across the federal government, in order to really embed the conversation around insuring that we're keeping our eye on the ball with the consumers being friends.

So, why is this important? One is that we saw that states were really organizing themselves in this fashion so we sought the state level, there was a lot of common interest with the aging and the disability population and that there were a lot of shared, overlap with providing supports that could facilitate communication living for both aging individuals with functional limitations and individuals with disabilities so there's a lot of commonality. You'll hear our administrator sometimes talk about a multicultural vision

MPR
2015 DRC Conference_Day 2 Part 1

because there is common interest but there are some things that will always remain separate. For example, our youth transition discussion and hearing from David, we focus a lot on youth and there are different populations and have different needs than 90 year female who is needing some long term services and support. The main thing to focus on is full participation, dignity and consumer control.

We do look at things through a non-medical lens. Often when we talk about disability we will say we are looking at the social model of disability so the conversation is around how attitudes and social barriers can be more detrimental to impeding progress for people with disabilities. Then, if we move those barriers, we can increase full participation for individuals. The vision is that all people, regardless of disability live with dignity, make choices and participate fully. It is a civil rights lens that we also employ.

Here's an organization chart, you can see the 4 main boxes are what we can our 4 business lines. We have the administration on aging, the center for integrated programs, the administration on disabilities and the national institute on disability independent living and rehabilitation research, which was just transferred over to us. We also do a fair amount of policy work, you'll see that up at the top and our regional offices down below, they're actually currently funded only, right now to do administration on aging work. The administration on disabilities has 2 boxes under it, first is the administration on analectual and developmental disabilities and the second is the Independent Living Administration. ILA was one of also the program transfers from the department of education to HHS a year ago with the workforce innovation opportunity act.

The Administration on Intellectual and Development Disabilities has 4 programs. They are State Councils on Developmental Disabilities, our State protection and advocacy agencies, our projects of national significant and our university centers for excellence and developmental disabilities. Also within this organization we have some systems change money to protection and advocacies on voting access to the help America vote act and our protection advocacy for assistive technology work, also a new program transfer and our president's committee for people with intellectual disabilities. Just to highlight the overall purpose of these programs, they're really to assure people have design and access to community support and all forms of assistance that promotes self-determination, independence, productivity, integration and inclusion.

Very important foundational values that come out of the act. Since we're the federal government, we all operate with different statutes which define populations. You are aware we have many definitions of disability so we have one specifically for the work we do here and that is that you must have 3 of the 8 identifying factors on this list. You must have some sort of challenge in 3 of the following 8 areas. They may be self-care, comprehension and language skills, learning, mobility, self-direction, capacity for independent living, economic health sufficiency or ability to function independently without support. The DD Act has been around for a long time -- it has a rich history. You may be aware of controversy with Willow Brook in the 1960's. There was a public outcry, this was a state run institution in New York, housing over 6,000 people with intellectual disabilities and [inaudible] with abuse and neglect. There is a big spot light on what were we doing to support these populations and was the genesis for this work?

Briefly, I'll touch on each of these programs, our state councils and developmental disabilities, our system change grants are about \$70,000,000 that we funnel through these grantees, we have 56 of them. One thing that's noteworthy is that not less than 60% are individuals with DD parents, children or guardians so it's definitely engaging with participation of individuals with disabilities and their families. Our protection and advocacy systems, we have about \$38,000,000 going into this funding and David Weaver mentioned PNA, SSA also runs these programs. They are to provide legal services both to individuals and to systems. We have these services occurring in order to increase the capacity to promote the civil rights. Protection, they also do information and referral, investigation of complaints and work for alternative resolutions when we can't.

Our University Center in Excellence and Developmental Disabilities is about \$36,000,000 in funding. They have braided funding, we will see if you met, one you said you'd met, one you said, there's folks here

MPR
2015 DRC Conference_Day 2 Part 1

nodding their heads but they are research the practice grants and they really take on a different lens based on where they're housed on the University. For example, some are in public health schools, others are in department of education but they are really important part of the DV network. We have a little bit of discretionary funding that comes out of this portfolio as well. One thing to focus on here is our project with integrated employment. These are in 8 states and really work to improve statewide systems change to have integrated employment for people with developmental disabilities.

I mentioned the help America vote act and our assistive technology PNA funds, the presidents committee for people with intellectual disabilities, this has also been around since the 1960's, the names have changed over the years. They are a federal advisory committee, they provide a annual report to the president and advise on improving the lives with intellectual developmental disabilities. The Independent Living Administration, again a program transfer but \$100,000,000 that goes out to this work through two state grantees or state independent living services grant and our centers for independent living. At the local level, the Independent Administration also has the paralysis research center and the limb loss program. The IO philosophy just briefly is, "Nothing about us, without us". This is really funding for full participation of individuals with disabilities. It is as much a program as it is a movement.

We fund 77 state independent living services grants, 55 of them to the state through our agency and we have some separate funding that goes to the blind agencies. Our centers for independent living, there are 354 of those, they do 5 core services which include: information and referral, skills training, peer counseling, individual and systems advocacy and we actually just added a new 5th core service with the new law which is services that facilitate transition from nursing homes and other institutions to community and to provide assistance of those at risk in entering institutions and finally, to facilitate transition of youth.

Our paralysis research center, this was a program transfer from CVC. Again, this funding is to promote full participation of individuals who are experiencing paralysis. It's about \$6.7,000,000 and currently the grantee is the Christopher Reeves foundation. Also, program transfer, our limb loss program and this supports a national research center to provide resources to improve the health and well-being of people who experience limb loss.

How am I doing on time here?

Six minutes.

Okay, so I'm going to go very quickly through the administration and aging so I can also talk to you about Night Alert. The administration on aging is about \$1.3,000,000,000, what you should know is it really focuses on health and independence, nutrition programs. You've all heard of meals on wheels, caregiver and family support services and really funding that ensures older Americans can participate in the community. This gives you an idea of how the funding goes through the DV network or the older American's network. Again, the value's around supporting independence of older American's. We serve through these programs, 1 in 5 older Americans. Go from this slide, folks were disproportionately in lower income. We serve more individuals who live in their home alone and people with multiple chronic conditions.

I'll skip through these in the interest of time. We do have a national caregiver's family support program, again, this is providing support to family caregivers who assist people and provide relief from care giving respite. Okay, I do want to note that the older Americans act re authorization is going on now. There's some links, I think you all will have access to these slides later, if you're interested. The national institute on disability independent living and rehabilitation research, this was also a program transferred to our office. The mission is really to generate knowledge and promote the use of this knowledge to improve abilities of individuals with disabilities. We serve people across a lifespan with this funding. We focus a lot on research collaboration so you may be familiar with this effort, we do a lot of inter-agency agreements, with the DA, CDC, SAMSA, the access board, the HRQ department of transportation. We make strategic investments. For example, you may be familiar with our annual coming pending disability statistics.

MPR
2015 DRC Conference_Day 2 Part 1

The 3 main domains which is, funding support, our employment participant in community living and health and function. We do both, field initiated research and agency directed research through this funding. Just to give you some ideas of our FY15 priorities, community living, knowledge translation on employment, knowledge translation research to practice and Universal design. You can see by this list, there's a number of employment initiatives that neither one is involved in. The inter-agency committee on disability research may be also something you're familiar with and essentially, this is increasing the capacity on the federal level to look at data collection and research on disability and see how we can continue to collaborate.

With my remaining time, I will also just touch on our center for integrated employment, our integrated programs. We call this the middle center because these programs work across both aging and disability and really look for person that are models to support populations in a number of areas. We have a dual [inaudible] technical assistance program, this is part of the financial alignment initiative for the affordable care act. The goal is to develop more integrated ways of paying for and delivering care to our dual eligible population. You may be familiar with our aging and disability network development and in this capacity, we're really reaching out to our network of grantees to provide technical assistance to our community based organizations and really focus on topics such as developing service packages, building value propositions, collecting and using data in meaningful ways.

We have an office of health care information and counseling, in these programs within this office, focus on our senior medical patrol program, our state health insurance assistance program and our Medicare improvement program. [Beeping]

I'm sorry about that.

I think that may mean I'm out of time. [Laughter] The main take away I'd like to leave you with is that, this funding really works again to support consumer access, to work on person centered planning and control and to assist people with having full information and making informed choices.

All right. Well, thank you, Jamie. [Applause] I don't know how you keep track of all those initiatives [Laughter] Quite a lot going on for a new agency.

[inaudible]

Yeah, all right. Our next speak is Marlene Simon Burroughs. She's the Associate Division Director in the Research Practice Division of the US Department of Education's office, it's special education programs. In this position, she provides leadership to develop and administer OSEP's initiatives related to improving outcomes for youth with disabilities and secondary education transition and post-secondary education. Prior to joining OSEP, she worked for the national transition network as a technical assistance provider, implementing community based vocational programs and at San Francisco State University as the research associate conducting studies on inclusion in community based instructional programs. Marlene has a PHD in special education from the University of California at Berkeley.

Thank you. Good Morning. Can folks hear me okay? All right -- I'm very happy to be here this morning. I appreciate the opportunity and the invite from the consortium organizers to talk to you this morning. I'm with the [inaudible] special education programs and as many of you know, we administer the individuals with disabilities education act, IDEA. I'm going to talk to you about a little piece of IDEA that while it's a little piece, but it's big. It's the transition services requirement so, the first part of my slides may be really basic for many of you and those of you that aren't familiar with what the transition services requirements are in IDEA, the first set of slides will certainly let you know that.

IDEA's purpose includes that, it's to insure that all children with disabilities have available to them a free and appropriate public education that emphasizes special education and related services designed to

MPR
2015 DRC Conference_Day 2 Part 1

meet their unique needs and prepare them for further education, employment and independent living. That's a real clear purpose of what we're shooting for, for all of IDEA. The IEP requirements, the Individualized Education Plan requirements that talk about transition, say that beginning when the child turns 16, the IEP has to include appropriate measurable post-secondary goals based on age appropriate transition assessments related to training, education, employment and where appropriate, independent living skills. We're shooting for that, we're really working at it but I think we've got a long way to go.

IEP requirements, it's also says the transition services, including the courses of study of which you take in school needed to assist the child in reaching their goals and a statement that the child has been informed of their rights under part B. The transition services, these will be posted, I understand, later, these slides, so you can look at them later, if you need to. It's defined as a coordinated set of activities for a child with a disability of that is designed within a results focused process, really looking at improving the child's movement from school to post school activities. What are transition services? There's a wide array of services that are considered transition services. Post-secondary education, vocational education, integrated employment, including supported employment, continuing an adult education, adult services, independent living, or community participation.

The thing is, with transition services, VR the legislation that the VR operates from has the exact, identical definition, I'm not sure about [inaudible] it may have changed a little bit but it had the exact identical list of transition services and so states and local school districts are supposed to figure out, coordinate, come up with a plan for how they're going to pay for these services and there in kind of lies a little bit of the problem in that we have to work together to identify who's providing which transition service and that goes across the board with other agencies besides VR that are providing some of these transition services.

Okay. Transition services must be based on the individual child's needs, taking into account their strengths, preferences and interests and it includes instruction related services, community experiences, the development of employment and other post school adult living objectives and if appropriate, acquisition of daily living skills and provision of a functional, vocational evaluation.

This is the transition services flow chart -- which really lays out how that process is supposed to work, starting with the age appropriate transition assessments that identify the needs, strengths, preferences, interests. Going down to writing measurable post-secondary goals, there should be a goal for education and or training and employment and if appropriate, independent living. Then, identify the transition services, including instruction related services, community experiences and development of adult living objectives. Write the course of study or in other words, what does the school system provide in terms of course work that would help the child meet their needs? Coordinate services with adult agencies, always a challenge, always has been a challenge, and write the annual IEP goals.

I spoke about the challenge of trying to implement transition services requirements, one of the great tools that we have in our toolbox is the ability to provide some technical assistance and we recently funded the national technical assistance center on transition intact, which we did in collaboration with RSA so there is a natural, we've always asked that our center worked collaboratively with other centers, funded by other agencies but the joint funding of this center sends a very clear message that folks will work together to solve some of these issues. Our TA center is funded at \$2.5,000,000 a year and under the direction of David Tess out of North Carolina, University of North Carolina, Charlotte.

Their purpose, stated purpose -- is to assist state education agencies and local education agencies, state VR agencies and VR service providers to implement evidence based and promising practices, including those insuring that students with disabilities graduate prepared for success in post-secondary education and employment. Their partners, some of whom you might recognize, of course, Charlotte, Oregon, University of Oregon, Western Michigan University, University of Kansas, Tran send and they have a cast of many, many content experts and advisors.

MPR
2015 DRC Conference_Day 2 Part 1

In text outcomes, they have a number of outcomes but I'm going to focus on the second one. Which is, increased access participation and participation in career related curriculum so students are prepared for post-secondary employment and careers. That's one of the key things we'd like for them to do, increase students access to participation in career related curriculum. One of the things our center is really focused on and has had to work on quite a bit was figuring out what the evidence was out there, what evidence can we point to, what is the research based practices? Then, looking at how we, using implementation, science, how do you scale up those evidence based practices and strategies?

One of the first things they did and this was in an earlier cycle of this grant, the same folks did this work, was in identifying in school predictors of post school outcomes. They identified 16 and this was done through a systematic review of the secondary transition correlational literature to identify in school predictors of improved post school outcomes. You see, this career awareness, community experiences -- Things having to do with their exit exam requirements or high school diploma status, inclusion in general education, inter-agency collaboration, occupational courses, paid employment and work experience, parental involvement, of course the paid employment and work experience is one of the most highly regarded predictors of post school outcome of success in employment post school -- Moving on -- the rest of them, the other 8, the program of study is connected to employment outcome, so the better you can connect that program of study in school, it can really improve or it does, it is -- predictive of employment. Self-advocacy and self-determination, self-care, independent living, social skills, student support, transition programs, strong evidence based transition program, vocational education and work study.

The one thing about our in-school predictors is, they're not considered really strong research or really strong evidence given the sort of rigorous criteria that we're looking at these days. One of the things that I think we really need is research, rigorous research that connects post school outcomes, connects in school activities directly to post school outcomes and that has been one of the criticism of the research that we have in the field is that -- our research should be measuring post high school outcomes directly, so, many of our studies didn't do that. In fact, they identified, for example, something on career awareness, you do a pre-test, post-test, but we're not really linking it to what happens, post-school. These are, as I said, core relational research and I think that's important but it is not the rigorous research that we've been looking for these days.

Our institute for education science is at the US Department of Education, has basically put out some studies where they've identified research, what we should be doing and what they're saying is that, we need to measure post school outcomes directly. Measure employment directly, independent living directly and post-secondary education, so, how do you connect what goes on in school to post school outcomes? Building on what we do know, because we still have to work with kids, school districts are still trying to figure out what to do. What do you do when we're working to really build on work based learning experiences because that is the strongest area of evidence that we do have.

In fact, in their previous iteration, also developed a link on their website to help, it's called the youth to work coalition and it is looking at, how do you put these resources together so that educators, VR providers, others can figure out how do you build these work based experiences with youth who are in school? The link is here, you will see that it's got a number of work based experiences identified, career exploration, job shadowing, work sampling, service learning, internships, apprenticeships, paid employment and mentoring. That is available. Also looking again at outcome two, we know that we have those, as I've said, evidence based predictors and you can find out more information about the evidence based predictors at these links and the youth work coalition certainly, access that link for that information.

We are working on model demonstration projects and that has been something that our office has been very pleased to be doing over the past several years. Where you take an intervention that you know you have some evidence of ethnicity in a research context and you learn by doing what it takes to install it in a real world setting with real world practitioners. We talk quite a bit about identifying evidence based practices and scaling them up and -- looking at -- things like the important questions, can practitioners learn the intervention and implement it with infidelity?

MPR
2015 DRC Conference_Day 2 Part 1

What supports are needed to establish that learning and the quality of the implementation? Are the outcomes achieved in a more controlled setting? Are they able to be replicated in a model demonstration project context? Is the intervention sustained after the project finishes its work and what conditions support that statement? We've done several sets of model demonstrations over past years, we used to do a number of field initiated model demos where a lot of wonderful strategies and approaches, practices were identified but over the years, that's kind of been, whittled down to a very few model demos and so we tend to do a set of 3 or 4 and have them do common measures across the models so one set that is finishing up now is our juvenile justice model demonstration projects. We did 3 of those and they went out to Universities who worked with communities, working with the juvenile justice center. The education folks, folks in mental health and folks in VR and coming up with an approach for transitioning kids from juvenile justice, back to the community.

More recently -- We've been working on PROMISS. Promoting the Readiness Of Minors In Supplemental Security income and PROMISS is a huge model demonstration project and it is an inter-agency collaboration from the onset so this is a collaboration of education, social security administration, department of Labor, HHS and actually, several offices within all of those agencies. We collaborate it from the inception, I'd say about -- a year and a half, two years, prior to actually putting an NIA notice inviting applications on the street and we continue to collaborate weekly in some instances and monthly on the implementation of these grants which were first funded in FY2013.

What is PROMISS? Under this competitive grant program -- State agencies have partners to develop and implement model demonstration projects that provide coordinated services and supports designed to improve the education and career outcomes of youth with disabilities receiving SSI, including services and supports to their families. The projects are designed to improve the coordination and increase the use of existing services for which youth receive SSI payments and their families are eligible such as those available through IDEA, VR, Medicaid, job core, head start and WIOA programs. WIOA programs now. The partners are -- First, I have to say, we did build strongly on all the evidence that we could find before we put that notice out inviting applications, what should this model demo look like? Certainly accessed information from the -- Thank you. Information from the youth transition demonstration projects that were funded under SSA and -- SSA's actually the -- doing the evaluation through a contractor, Mathematica.

The players or the federal partners, we've got the federal partners I talked about and then of course, the association for University Centers on Disabilities is the national technical assistance center that's funded to provide all the TA except for the evaluation related TA and then the PROMISS model demonstration project's themselves and the Mathematica policy research that does the national evaluation. Three minutes. As I said, the population as youth who are 14 to 16 years of age who are enrolled in SSI, there are 6 grant awardees who will recruit 13,172 participants. All of them will recruit 2,000 participants except California will recruit a little over 3,000. Half of the participants will receive the intervention, the other half will be the control group, they receive services as usual.

Who are the grantees? Aspire is a consortium of states that make up one project so that's Arizona, Colorado, Montana, North Dakota, South Dakota, Utah. Then we have the state projects, Arkansas, California, Maryland, New York and Wisconsin. What's important about these? What the model demonstration projects had to do, they -- It includes customized interventions, they have to provide partnership amongst state agencies, responsible for program that serve the target populations. Required state agencies, or their equivalence that are responsible for VR services, special ed, workforce development under WIOA, Medicaid, TANIF, developmental intellectual disability services, mental health services, family outreach. It's essential to provide coordinated individual and family centered interventions that use evidence based transition support services. Case management, benefits counseling, career and work based learning experiences, including a requirement for paid employment, parent guardian training and information.

Let me -- Thank you. [Applause]

MPR
2015 DRC Conference_Day 2 Part 1

All right. Do you have any questions for our panelists? Nobody has any questions at all? Okay. All right, we have one up here. I'm not sure where the mikes are. Please speak into the mike and say your name and where you're from so the webinar folks know who's talking.

Thank you, John Taberner, now SBHHS, this is a fascinating dialogue and I wanted to press what seems to be kind of a tension between David's presentation and Jamie's and Marlene's in that, when people think about DI and SSI, normally they're observing that overall, very few people have conditions that improve, leave the program, have substantial earnings. The implication being, there needs to be more active engagement, really of these individuals, at least for some of them. David, you're correct that there are resources available even through SSA, there are incentives that are embedded in the programs and yet many of the participants are not responding to the incentives, at least as much as one would expect.

The implication is more active engagement would seem to be in order and what Jamie and Marlene really convey is this tremendous landscape of services and programs that are certainly available in my locals and are engaging these individuals so, let's sort of press that. Normally we don't get those two perspectives together, we tend to talk about DI and SSI in isolation. Within the programs themselves, they're primarily just providing the cash benefits so general point, in particular, when you think about targeting and what not, I wonder the extent to which you have the ability to look at the individuals whose conditions are improving or who are earning above SGA who are leading the roles. Whether they're availing themselves of this array of services or not or rather [inaudible] their portions of the case loads that are not for whatever reason, accessing this tremendous array of services that Marlene and Jamie are bringing to our attention.

You guys can join in after I -- I'll think of two groups, first the adult population, I do think it's interesting, who succeeds at returning to work and one of the things that will be coming out this fall is, we run the national beneficiary survey which is a survey of the DI and SSI population, so it's a high quality household survey but one of the interesting things this year is there were semi structured or qualitative interviews of individuals who had success at returning to work and I think [inaudible] kind of narrative feel about who's using which programs, why do some people succeed even more than the standard statistical analysis so that may open up some leads to some of the issues you're raising there. For the youth population, one interesting thing is that for children on SSI about 1/3 of them have their benefits terminated at age 18 because they don't meet the adult standard.

That's pretty serious. You have families with disabled children and then age 18, it could be a very sudden and abrupt change in the situation. Part of this is, there are programs out there that serve the public and I think one of the issues is, sometimes we talk to our partners in Government and we're aware of the programs and how do we think about them but I think there really has to be more of a focus on, not that there isn't any focus, but there has to be more focus on educated consumers because when our beneficiaries are educated, they can be noisy consumers and that's okay, in the government, we can take that.

I think there has to be some focus on, just a little more energy on getting back to the basics when we talk to these families on our programs, to make them very aware of how these program rules help them, where do they go for help, can they turn to VR, the school system? It's a little complicated because it's spread out and there are a variety of services but I think one of the things I'm very interested in, getting back to your point, it's just sort of a return to basics, we know we interact with these beneficiaries all the time, how do we tell them about our programs? How do we make them aware of all the partners who can help them, again, sort of, an educated consumer may be an effective beneficiary.

I'll just chime in here with my two cents, I agree with everything that David just articulated in terms of, part I think of this struggle in this conversation and David and I were talking about it earlier is, you don't know what you don't know so, communicating effectively to populations and helping to support them to understand, for example, the work incentives that are available and utilize them. I think it's noteworthy as well, that the populations on the SSDI and SSI are a sample of people with individuals with disabilities,

MPR
2015 DRC Conference_Day 2 Part 1

they do not encompass the universe of individuals and so, I think it is worth noting that as well and I think the more we can look across federal government and talk about our vision and our messaging and in our policies and looking at how we can improve things holistically for individuals and families.

I think is the direction we need to go into and you know we're trying really hard to do that so, I sit in conversations with Marlene and conversations with Jennifer Sheeve on the next panel and SSA's always at the table, Bob Williams, we have a lot of conversations around trying to holistically address the complexity of supporting our population to be as self-sufficient and get the long term services and supports that they need. I think it's definitely a work in progress but I appreciate your question, John, because I know you personally and tackled this from a number of different seats as well and I think a lot of it is continuing to communicate effectively both the vision and coordinate the array of services.

I'll add my two cents in, I think, we've been talking for so many years about inter-agency collaboration, especially when we talk about transition age youth and of course if we're talking about kids and families receiving SSI. Inter-agency collaboration is hard, it really makes me think about implementation financing, what does it really mean to make that transition plan work to make the plans work at the state level, the local level, the youth at the level of the child, the youth themselves. How do you make that plan work and how do you make the system clearer for youth and families? I think we're really looking at, PROMISS, I think will help us figure some of this out but hopefully the case management will help to make that clearer. It's a huge array of services that need to be somehow coordinated and made into one cohesive picture for the family and for the youth.

I think the family services are also important. As a part of kind of clearing that up for the family and providing services and support so that they can clearly see what's going to be best for them and for their family and there's receiving some help with that. PROMISS is a \$211,000,000 model demonstration project. We're looking at these projects to really tell us if they can figure out, what are some of the ways that we can make this work? We've been talking transition for a long, long time but it's still quite murky and difficult and as you've said, John, how do you make that something that works for families?

All right, I saw a couple hands back here. Ugh -- Stapleton, again. [Laughter] All right, we'll let him have it but it better be quick.

Hi, I'm Dave Stapleton, Gina's boss. [Laughter] I'm also the director of the DRC for Mathematica but we, for the DRC, we were asked by the SSA to put this panel together exactly because of the cross agency issues that have come up in all over your presentations and the discussion and John's question. I guess we'd like to know what other things the DRC could do that would support inter-agency collaboration, particularly in the area of policy research. Are there other things that this organization, even though it's sponsored by SSA and I know SSA wants us to do this. Are there other things that we could be doing to really support the development of knowledge that would help on these many, many cross agency issues?

Anyone?

Okay. David, thanks for the question, I'll go first and then folks can weigh in. We have a lot of interaction, David, with you guys because Social Security is the main funder of this so I'll let my colleagues weigh in on how other agencies can participate more but one thing I think is sort of to stretch a little bit in terms of - I'm going to count us by training and a lot of the folks in the DRC are social scientists so we focus on issues related to labor supply or incentives and I think that's appropriate but to sort of expand the focus, again, I think sometimes the general point, the main underlying issue in our disability programs but sometimes we don't talk about it, is health. The intent to which there's more focus on sort of the issues related to health and disability, I think you would draw in a wider extension with other federal partners.

I'll mention one thing, this is not exactly on point but maybe it's a good example, one demonstration we were in was the mental health treatment study and in that demonstration, we provided our beneficiaries both employment support, which is traditional things we talked about, social security but individuals which

MPR
2015 DRC Conference_Day 2 Part 1

mental impairments were also given really good rap around health care, very highly coordinated health care, systematic medication, management, nurse care coordination and this was delivered by Community Mental Health Centers around the country.

What's interesting about that is the things we often talk the most about, employment outcomes, there were some positive employment outcomes but some of the really interesting results of that demonstration were related to the health interventions where you had lower rates of hospitalization, less emergency room visits, due to the provisions of services. When we think about either, our beneficiaries and their roles or the youth population, I think is sort of an expanded focus on some of the health issues might draw in agencies other than just the Social Security Administration. Let me let my colleagues weigh in on their thoughts.

David, I think that's a really good and important question, I guess from my perspective, I think what is going to be hopefully is the knowledge to practice piece. The research that DRC is conducting is extremely valuable to help inform future policy decisions in terms of moving it's conversation forward. I think it really is a knowledge translation piece and building upon the research that is conducted under this grant. How do we learn from it in a way that's very tangible and informed recommendations from proven outcomes. Because that's the end goal.

I agree with what my colleagues have said, I guess one of the pieces that I would add would be, we need a lot more really, rigorous information around inter-agency collaboration. I think we're not operating with the best evidence and I think we're sort of floundering out there and when we do have good results, we don't really know what happened well enough to be able to share that around with others. I know there are some studies out there but I don't think we have nearly enough.

All right. Steve, right back there.

Hi, I'm Marsha Katz from Montana and I am a 30 year on the ground advocate and activist in disability rights and I will tell you that when you talk about inter-agency collaboration, I certainly, strongly support that but I suspect just as each of you up there probably only knows a little bit about what each of the other person does and you're all professionals and you've been at this for a long, that when it comes to people, particularly students and their families in this schools, this is a herculean, it's not like that you can put it all in a book or something. There has to be potentially, a con jury of people that gets trained who learn over years not only all over these different services and possibilities and the rules and regulations. I did this for a long time but then to be able to sit down one person at a time, one family at a time, look at what their aspirations are, the kinds of things that they choose in their lives and then looking at how do you pull together from those resources that all of you provides well as letting people know that there are these other things available. Sometimes that get called first and center planning. It certainly has to happen in an authentic way not a performer way.

I can't even imagine how inside the adult way devil you can made that all happen but believe me, I support you 110% but I would look at community organizations that are already doing a lot of this and see what you can learn out in the streets that you can potentially bring back up inside the belt way.

I'll start and then turn it over to my colleagues. First of all, thank you for all the work you've been doing in Montana. I whole heartedly agree with what you just said, I think community based organizations are the boots on the ground working in the local communities with families and individuals day in and day out. We see that in some of the local community based organizations that we fund at the administration for community living and so I think the complexity of multiple programs are very complicated and can be very stressful for families and individuals to navigate and so, helping people to unsort those things and focus on their goals, I think it what I've heard you say and I think that's right because at the end of the day, we want to keep our eye on the ball which is supporting individuals to lead the lives that they want to lead and what does that look like? It really is a very individual experience and your comments on first and center planning, we have a lot of conversations about this at the administration for Community Living.

MPR
2015 DRC Conference_Day 2 Part 1

One of my colleagues, Shawn Tarrell does a lot of work in this area in terms of really thinking through as we use these words and have government systems, how are we actually supporting people in a way that allows for that? Thank you for that comment.

I'd also like to say that a lot of what we do, I think inside the beltway, I agree with everything you said, is really focused at, how do we provide the resources that are needed at the local level to make that happen? How do we influence our colleges and universities that are preparing personnel who are going to work with folks who have disabilities so that they're doing person centered planning so that they're providing, working with a cross agencies and it's a very tough job but I think trying to match what goes on in Washington with what happens at the planning table at the local school with families and professionals and it's hard to reach that but definitely see that that's where the change has to take place.

All right. I think we have time for one more question. I'm [inaudible] I'm director of employment policy for the Maryland department of disabilities and I'm also the project director for Maryland PROMISS, thank you, Marlene and thank you to all of the partners. It's been a very interesting experience working in the front lines and some of it comes down to your front line staff and I have to give a shout out to one of our Maryland PROMISS recruiters, we go door to door and the day of the riots in Baltimore, he called and said, I just drove past a burning car, I'm thinking that maybe today I'll stay home and do calls but that's part of the challenge, is finding people who are that committed and that in the street but I also think that we need to re-think our strategies from a disability perspective because this population that we're dealing with, does not identify first and foremost as having a disability. Yes, they're on SSI but they identify first and foremost as being in poverty, and dealing with violence.

I think there are a lot of lessons that we, the disability community can learn from some of the poverty based initiatives and how can we get the poverty based initiatives to particularly begin to understand and think about hidden disabilities and how do we support and serve them? The other thing that I would add is, how can we get our state agency partners and this is where we need federal help, to share data? HIPPA is constantly lifted up as a barrier and why they can't share information and it's down to mislegal interpretations, I can tell you with PROMISS, we're having an issue with one of our partner agencies and my EAG says, absolutely not, they're misinterpreting it, but how do you tell a lawyer that they're wrong?

Is there a way, even lawyers to lawyers? Is there a way at the federal level that we can really start to push the partner agencies at the state level to say, hey, you guys have to share this information a little better if we're ever going to generate some meaningful outcomes in research and data and that's where I really see that you all can help us in shaking that data loose for your purposes.

Yep. This is a very, very good point and thank you, it's nice to see you again. I will reference something briefly that I mentioned in my presentation, was the projects for integrated employment grants that are run out of the administration on intellectual and development disabilities and we actually required in that funding that states have an MOU in order to submit a grant application and we required partners so we required our state DD council, the state Medicaid agency, serving individuals with DD, the department of education and the state vocational rehabilitation agency to come to the table and have an MOU to be a part of the project.

These are system change grants, so some of the outcomes that we were proposing and looking at -- supporting states and doing more things such as, collaborative efforts on state data sharing so there is some good work coming out of these projects in the 8 states. I can share more of it with you outside of this forum but I think the more we can push our federal funding in ways like that, to leverage the collaboration and really intensifies the collaboration and that is one way we can be helpful.

The department of education has funded state longitudinal data systems grants and I'm not sure where they are in that process, that's in another office but those grants we're looking at linking data of the K12 data, the IHE data from institutes of higher education and later, workforce data but the workforce data, my understanding was sort of slow in coming on board to these kind of comprehensive data systems and I'm

MPR
2015 DRC Conference_Day 2 Part 1

not certain how many states all though I think it was more than 20, less than 40 and those grants may indeed be finished at this point. I think there's some good reason to say that the federal government can start to incentivize that kind of data sharing and I think all of us as a nation are starting to get or need to get more comfortable with data sharing. My healthcare data is online, I love it. I know that's a big problem for a lot of folks but just in general, if we can start to move that down the road, that conversation and those activities, I think we'll be better off and we'll know a lot more about outcomes, we'll be able to track outcomes better. I couldn't agree more, we need to do more.

All right. I'd like to thank our panelists and we will come back here at 10:15 to talk with the next panel coming up. Thank you. [Applause]

MPR
2015 DRC Conference_Day 2 Part 2

2015 DRC Conference Day 2 Part 2

Good morning. I'd like to start the second panel of federal representatives. We have three representatives here from the Department of Labor, the office of disability employment policy. Can you hear me now? Thank you. We have Jennifer Sheehy from the office of disability employment policy of the department of labor. Raun Lazier from the US department of veterans affairs. And Ruth Katz from the office of disability aging, and long-term care policy, and office of the assistant secretary of planning and evaluation at HHS.

Jennifer Sheehy will be our first speaker. She's the acting assistant secretary at ODEP at the department of Labor. Before her current position, she spent 10 years at the department of education in many roles, including director of policy and planning, and the office of special education and rehabilitative services, acting director of the national institute on disability and rehabilitation research, which now has a new name and a new home. Acting deputy commissioner of the rehabilitation services administration, and special assistant to the assistant secretary of OSERS.

Before that, Jennifer staffed the presidential task force on employment of adults with disabilities, where she was a senior policy advisor and served a detail as associate director in the White House domestic policy council. Before she joined the task force staff, she was vice president of the national organization on disability, and director of its CEO council. Jennifer earned a BA from Cornell University, and graduated from the Georgetown University where she received her MBA. Jennifer.

Thank you so much Yoni. Yoni worked on our return to work/stay at work project, which I'll talk a little bit more about. We're very grateful for it.

As you can see, I've had many acting jobs, which is kind of funny because I have two actors in my family, but I've spent more time acting than they have. It is always a point of discussion at Thanks Giving and Christmas.

ODEP is -- Who has the slides? Thanks. Oh, great. Do you mind doing them for me, Yoni. Ah, thank you. Okay, great. Actually, Yoni, if you can advance them for me, that'll make it easier.

Is this the one?

You can leave it there. Yep. Yep. Yep. Let me tell you a little bit about our office, office of disability employment policy. As Jamie Kendall, Jamie Kendall said ACL was small but mighty, so if the federal disability programs are a lion, and ACL is the cat compared to the lion, we are the flea on the cat of disability programs, but we hope to have a positive impact, instead of a negative one. ODEP is \$38 million. We are a federal policy agency. We look across federal programs, we look across the disability employment programs, we look at regular mainstream job and training programs, to really make recommendations for policy changes that would improve services. We don't move forward with step one without partners. Those include our agency partners that you've heard from today, but we also partner with states, we partner with business organizations, and employers, to really make sure that what we are proposing, and then what we test and then try to validate, has some buy in by the partners that we work with, to implement.

As Mark Twain said, in theory, theory and practice are the same, in practice they are not. We do try to do demonstrations and research to validate what we've heard, and then our ultimate outcome is for entities, like states, or federal agencies, employers, even congress, to adopt policies that we've worked with others to identify and recommend.

MPR
2015 DRC Conference_Day 2 Part 2

Next slide. Our target population. Again, small but mighty, we really do hope to affect the full population of people with disabilities looking for and going to work. Then we also look at youth with disabilities in the transition space, going into post-secondary education and employment.

Next slide please. Our general approach, so our theory of change. We look at research and demos, we evaluate those, we identify effective practices and policies, then we do outreach, we disseminate information, work with partners, provide technical assistance, and ultimately lead to adoption. I'd like to credit our wonderful new director of research and valuations, Abby Zwick, if you would identify yourself please. She's really helped us refine our theory of change and is responsible for our research and evaluation portfolio.

We also very closely work with our chief evaluation office in the department of labor. They actually provide substantial funding to help us do some of our third party evaluations of our demonstrations.

Next slide please. Ah, so this is an easy one for you to see. Let me just tell you about our five technical assistance centers. This is really where we do try to see if some of the policies and effective practices really work in practice. One of our technical assistance centers is the partnership for employment and accessible technology. We're looking at making sure that software, hardware, technology that's used in the workspace, either for application or doing your time sheets, or using statistical software that's necessary for your job, so the technology that's used in the employment space is usable by people with disabilities. In this technical assistance center, we have a community of practice, we also work with developers, technology companies, and employers to identify those best practices and then try to have people adopt those.

Our next technical assistance center is called the job accommodation network. This is a center that's logged in more than 300,000 calls by employers and individuals on specific accommodation needs. I've used it. Many of you may have used it. It's probably the best known among employers, of our resources, and they do one-on-one calls, they will actually come out to a work site and they will have many online resources.

Our employer technical assistance center is engaged in several activities. One priority they have right now is really helping federal contractors implement new regulations called section 503 of the rehabilitation act, that set an aspirational goal of 7% of their workforce on a federal contract be employees with disabilities. It requires new data collection, and reporting requirements so that we can track and see progress of federal contractors using this new aspirational goal. Employers aren't sanctioned if they don't meet the 7%. They can face sanctions if they don't show progress towards meeting that 7%.

We also do employer research through this employer TA center. We started with Wharton Business School, and we've engaged Georgetown Business School on our next phase. It's really to set up effective models for engaging employers and compelling employers to include disability in their general diversity and inclusion agendas. We've learned a lot. We've actually been able to modify many of our TA strategies and our messaging strategies based on that research.

We have a youth technical assistance center that takes what we've learned in transition and helps entities adapt it for their purposes. We've had success with our guideposts for success. These have all been developed in conjunction with the department of education, social security, HHS, and other agencies. We have, through this center, and with this center, we've also been able to advance our federal partners in transition that several agencies worked with us on. We developed a strategic plan for 2020 that includes recommendations and strategies for all of our four department programs that serve youth with disabilities, to streamline those services and coordinate a better outcomes for students with disabilities.

Finally, our lead center is a technical assistance center that looks at employment and employment support, but also pulls together technical assistance centers on employment for several agencies, to

MPR
2015 DRC Conference_Day 2 Part 2

make sure that we know what each other is doing and that we can build on the information that is out there, so to improve technical assistance in general, on employment of people with disabilities.

Next slide please. I'm just going to talk about some of ODEPs initiatives and then some areas for research that we would like to see in the future, or maybe explore. We have the employment first state leadership mentor program. This is a contract, but does provide intense technical assistance, operates a community of practice of 40 states, and helps states look at their funding sources and make sure that they know that they can be used together to prioritize competitive integrated employment versus sheltered employment, for people with significant disabilities. We've had great success here. Some of those successes have to do with states implementing executive orders, or even passing legislation that pushes and promotes employment first strategies, or competitive integrated employment.

We have our pathways community college demos. These are grants that are in community colleges that help them learn to serve students with indispensability better, so that they stay in school, and then they complete school. The lessons learned through our small grant will apply, then, to the larger TACT grant. One of ODEP strategies is to take seed funding with a small group of projects that maybe part of a larger, much larger system, like the TACT grants that are billions of dollars to community colleges, so that then they can better serve the students that they're already serving. We're not talking about new students. Most community colleges have a larger prevalence of students with disabilities than other institutions. This is just to help that larger community.

The state intermediary initiative. This is where we really work with state organizations like National Counsel on -- or NCSL, of state legislators, national governors association, and other, so that states adopt practices that have been validated and improves employment within their agencies so that they're agencies can serve people with disabilities better, but also so that the states themselves can employee people with disabilities, similar to the president's executive order that increased hiring in the federal government.

The return to work/stay at work initiative that -- You know actually, I think I have slides on each of these individually, so I'm just going to move to those. Can you go to the next slide please.

I've talked about -- okay, thank you. Our return to work/stay at work. We love this initiative because there -- we have, of course, in the department of labor, we have the office of workers compensation program that really deals with the federal space, but we collaborate with them, we certainly collaborate with social security on this. This is an attempt to look at what is happening in the private sector in the states, and early intervention so stay and work and quick return strategies, and this is part of the whole approach to decreasing entry and reliance on SSDI. We've run this for two years. We have a community of practice also of return to work professionals and researchers, and we will have some policy papers that will be coming out shortly. We've had three published already, and we will have more. This year we're focusing on policy into action. We look forward to those.

Next slide please. Our disability employment initiative is our largest initiative. We do this in partnership with the employment and training administration. We've put out more than \$96 million in grants to 26 states, to increase the capacity of the American Jobs Centers, or one stops, to serve people with disabilities. I think there had been a feeling that people with disabilities did not go to mainstream training programs. Of course they do. VR only served about a million people with disabilities at any one time, and then helped find actual employment opportunities for approximately 200,000 a year, but there are many more that go through the mainstream job training programs. This initiative is to really make sure that those training programs serve people with disabilities, they're going to be instrumental in successful implementation of the new workforce innovation and opportunity act as well.

Next slide please. They also require the HACs to become employment networks. It's to try to get the employers to use the ticket and for the service providers to use the ticket. Of course, we work with social security very closely on that as well.

MPR
2015 DRC Conference_Day 2 Part 2

The next, okay, we have an initiative called disability.gov that is cross maybe 12 to 15 different federal agencies. That website pulls together information from all the agencies and tries to make it accessible in a one-stop shopping spot for families, employers, people who are looking for educational support, healthcare information. It's a portal. They don't do original content, they take the content from all the other disability programs, and try to centralize it or provide a space for people to search and then get directed to the place that they really need to go. We, again, do that with several agencies.

Next slide please. From our outreach perspective, we try to do quite a bit of outreach to advance our policy initiatives. The campaign for disability employment, one very successful arm of the CDE, is our public service announcement. This year we are doing our third public service announcement. The most recent one before that, and these air on television and cable stations, was ranked in the top 1% of Neilson ratings for PSA. This one has exceeded that already. Since January, it's been aired more than 40,000 times. It's promoting the self-identification and owning and appreciating disability as one part of an individual employee identity. It's used by employers. Employers can put their own logos on it and adapt it, use it internally. We have no ownership. We'd love people to adapt it. It's available to anybody.

What are our big policy issues? Going forward, at least through the end of this administration, we are really focusing our efforts on the successful implementation of [WEOWA], successful implementation of the President's executive order on improving employment in the federal government of people with disabilities, improving federal contractors capacity to hire and retain individuals with disabilities, and then we have a unique niche in the accessible technology space in the work environment. Those are our four focus areas.

Going forward, next slide please, areas for future research, bridging the gap between labor force needs and labor supplies. That's very broad. We're really looking at, for example, what is successful in the federal contractors space. What is the effect of an aspirational goal on hiring and retention of people with disabilities. What are some possible work incentives and employer incentives that drive hiring and retention. Looking and continuing research on early intervention, stay at work/return to work, strategies. Looking at how we can do analysis or increase the quantity, quality, and the use of disability data. In 2009, we helped make sure that there were more than a billion new data points, labor market information on people with disabilities. We really want to explore some targeted analysis of specific disabilities, specific industries, specific age groups, economic indicators, there are so many great research questions that could help us in the employment of people with disabilities. We would love to see more research in those areas.

That is about it. I'm happy to answer questions later. Thank you.

Thank you, Jennifer. Our next speaker is Raun Lazier. He's the director of policy at the US Department of Veterans Affairs, office of policy and planning. He has a lead role in enterprise wide policy, strategy, and planning, and manages the veterans policy research agenda. He served on the White House committee partnership inter-agency policy committee, and made key contributions to the development of the White House's building partnerships best practices guide. Before joining VA, he worked at the US government accountability office, where he supervised assistance of the executive branch agency operations and made recommendations about ways to improve agency operations and save the government and tax payers money. His work focused on education, work force, and income security issues.

He also has experience in the local government and non-profit sectors, and served as an executive project manager for the non-profit [inaudible] workforce investment board, as an employment and training supervisor for the Montgomery county department, department of economic and workforce development. He currently serves on the boards of two non-profit associations focused on executive leadership and public policy, and he was appointed to the national -- to NBRs researchers -- NBRs panel of outside scholars, I'm assuming for this DRC, for the NBRCRC.

MPR
2015 DRC Conference_Day 2 Part 2

He holds an MPA and MSW from the University of Pittsburgh and a bachelor's degree in psychology from [inaudible] College, and has been awarded the Meritorious Civilian Service Award for his outstanding contributions.

Just making sure I don't mess things up so [inaudible]. Good morning everyone. It's a pleasure to be here today. What I'm going to actually talk to you about today is to give you --

[inaudible].

Okay. All right. Okay, if you look, I just want to first give you an overview of the issues that I'm going to talk through today. I'm going to first begin by telling you a little bit about the VA, and more about who we are and who we serve, highlight some of the benefits and services we offer for disabled veterans, and talk about VA's policy initiatives. There's so many initiatives going on throughout the VA across its various business lines, but at this point in time, there's no initiative bigger than the My VA initiative. I'm going to highlight some of those current events for you, and then discuss areas for further research.

The VA has a sacred mission, as I'm sure you all know, which is to care for him, whom have worn the battle, and for his widow and his orphan. VA has three main service areas administered by the Veterans Health Administration, which handles health care, the Veterans Benefits Administration, which handles VA's benefits programs, namely VA's disability programs from a programmatic level, and then the National Cemetery Administration, which administers VA's program to services for burial and memorial services.

The office that I work in is the office of policy and planning, and just to give you some idea of where that fits within the VA, it's more the strategic think tank for the VA. It's the office within an office of the secretary. Our office provides advice and counsel on policy and organizational strategy issues for all VA leaders. Our role is more from an enterprise wide approach, but when you look at the administration of benefits and programs, those are done by our, and three administrations, BBA, VHA, and NCA.

We currently, regarding the veteran population right now, there's over 20 million veterans, and an ever increasing number of female veterans, which is currently 1.6 million. When you think about disability issues, they cut across so many profiles of veterans, and can be complicated or enhanced by other issues facing veterans, such as those living in rural areas, lacks of benefits and services for, and women veterans, and other groups of veterans as well. It's very important for us to make sure that we address issues for all veterans as we take a system approach to solve these issues. We can't look at things within a vacuum.

Just to provide you some stats about our disabled veteran population, currently there's nearly four million veterans receiving VA disability compensation, which is our largest compensation program. We have a little more than 330,000 veterans receiving individual unemployability benefits from the VA. Veterans receiving service connected disability benefits tend to have a lower poverty rate compared to disabled non-veterans. We're also looking to see how does that influence the likelihood of a veteran to have an income at or below the poverty line.

Another fact too, and that I want to highlight, is that we have nearly 1700 OEF/OEIF amputees which receive disability benefits. Lastly, there's about 450,000 veterans that receive 100% disability rating. This is for service connected disability, which as you all know, is different from being assessed on your ability to work, but based on your service connected disabilities.

This graphic here, which I hope you all can see, basically highlights VA's relationship with the veteran. It looked a lot better on my computer screen than it does now, so I'll quickly go through it. Just the main takeaway I want you to take away from this graphic is that as a matter of policy at the department, and as a matter of our mission, we have a lifelong relationship with the veteran community, and the family

MPR
2015 DRC Conference_Day 2 Part 2

community. This graphic depicts it in terms of programs and services offered throughout the lifecycle of a veteran, beginning when they enlist in service and enroll into their e-benefits account, till burial. As you walk through this trail, you'll see some programs highlighted, not only for disabled veterans, but for all veterans, such as disability compensation, home loan guarantee programs, things of that nature as well.

The VA has numerous programs for disability veterans and for disabled veterans. I just want to highlight five. The first being our disability compensation program, which in FY14 we issued over \$50 billion in payments for disability compensation. This benefit is paid to veterans because of injuries or disease that happened while on active duty, or may worsen by active military service. I'd also like to note that these benefits are tax free as well. The VA does this because of the unique circumstances of military service. If one of these conditions is diagnosed in a veteran in more, or one of these groups, VA presumes that the circumstance in his or her service is caused by the condition and disability compensation can be awarded. If you think of examples, it would be for service connected disability, such as Agent Orange, exposure to ionized radiation, or PTSD, for example.

We also, as part of our disability compensation program, we also have an individual unemployability program, which we call it IU. In fiscal year 2013, we awarded \$11 billion in payments for this program. This program pays certain benefits to veteran compensation at a rate of 100%, even though the VA has not rated their service connected disability at 100%. We have specific criteria for this program. When I talk about areas for further research, I'll talk about this program in a little more detail.

Our second biggest program is our vocational rehabilitation and employment program. This program is VA's comprehensive program to support service members leaving active duty do to medical issues, and veteran service connected disabilities. As part of this program we provide various services, including vocational, counseling, training, career placement, and veteran service members receive what we call a rehabilitation plan. The rehabilitation plan is centered around five key service delivery options, with the first being re-employment with a previous employer, the second, rapid employment services for new employment, the third, self-employment, fourth is employment through long-term services, and five is independent living services. With that said, the goal is to have this plan be individualized for each veteran and each service member as well.

To show you the range of programs that we offer, I want to also talk about VA's special adaptable housing program, which offers grants to service members and veterans with sever service connected disabilities, to assist them in building, remodeling, and purchasing homes, and depending on the type of grant they receive under this program, they can be awarded anywhere from 2000, up to \$70,000. Also, that trends tend to have a very high rate of entrepreneurship. The VA has a vets first contracting program, which provides certain benefits to veteran own businesses and services abled veteran owned businesses that are competing for set asides, and also ensure that they're credited by VA's large prime contractors for their achievements and their contributions to larger contracting options, because in contracting, as you know, past performance is really important. To be successful in that field, you need to be able to show that. That's a partnership we work with throughout the government on that, namely SBA, as well.

Also, there's also financial incentives for hiring veterans. Veteran employment is a major initiative, and VA also pays incentives for companies that hire veterans. For example, a company can receive a \$9,600 incentive for hiring a service connected disabled veteran, unemployed for at least six months in the year before being hired. In addition to the services VA provides, there's numerous partnerships out there as well, that also support veterans employment and that the VA partner with, in the federal non-profit and public sector.

I alluded to earlier our big policy initiative. This has been labeled as My VA. This is our secretary's initiative, which is a top down, bottom up driven approach to transform the VA to focus on certain aspirational goals, such as putting veterans in control of how and when and where they want to be served, measure success through veteran outcomes, not just numbers served, and also to optimize VA's productivity and efficiency, which definitely ties into how we administer benefits and services in a timely,

MPR
2015 DRC Conference_Day 2 Part 2

accurate, and fair way. Under this initiative, there's four broad work streams/policy areas. The first is to design a veteran experience organization for the department that will monitor the performance standards for customers service, provide training, and resources for VA employees who interact with veterans, establish processes to assist veterans with needs that require special handling or special attention, and there's nothing more sensitive than disability issues or bereavement issues with someone coming from service and complicated by having families and caregivers involved in that whole process. Also it's something Jennifer eluded to in her presentation, is to make sure that we have good data sets and authoritative data sources that will help inform policy and programmatic decisions that we make, so we don't have analysis by antidote.

Second is to improve our internal support functions to ensure that our processes support VA employees serving veterans and that we are effectively balancing exceptional veteran centric service with operational efficiency. Customer service is a very high priority. Also to launch performance improvement teams, which we started, to look across all of VA programs, not just disability programs and share ideas that demonstrate serving veterans in an excellent way, but also ways that help us achieve our strategic goals.

Lastly, we're looking to explore opportunities to enhance our strategic partnerships to ensure that the best and most effective organizations work with VA to best serve veterans.

To highlight this for you, there's over 51,000 organizations through our rough analysis, that either have HERO, that are in a war, are in their title. It's very complicating for veterans to navigate those partnerships. As a rough estimate, VA has over a quarter of a million partnerships, and we have partnerships with over 26,000 non-profit organizations, not just serving disabled veterans, but across all of VA's programs.

Before I jump inter areas for further research, I want to briefly talk about our veterans policy research agenda, because this is the vehicle that we use to convey within the office of policy and planning, those strategic veteran policy research priorities that we're looking at, which I'll talk about on the next slide. In this agenda, which is our first agenda, was developed in FY15, is a list of research priorities that require independent and multi-disciplinary research analysis to help us achieve our strategic goals. As you can see on the slide, or probably can't, those three goals are to look at how VA is to look at producing and disseminating research to assist VA and its partners in improving service delivery and linking complimentary programs that serve the veteran community, to encourage and support research that looks at issues from a broad perspective, and also to foster collaboration. In today's interconnected world, it's hard to achieve positive outcomes alone, and in a vacuum, and the veteran community and the VA touches so many organizations that it's critical to our success and to the success of the veteran community that we partner.

When you look at areas for further research, if I had to kind of sum it up in one phrase, it would be a focus now on looking at outcomes and success of disabled veterans, moving beyond just out puts, but looking in terms of outcomes across programs and policies, issues related to self-sufficiency, and our partners. What I've done is, I just want to convey to you five or six different broad research questions to give you a sense of some of the strategic veterans policy issues that we're looking at. Keep it in mind that there's also a lot going on at the tactical and operational levels, to help improve benefits and services to veterans and their families.

The first is we want to look at how advancements in medical treatment and technology affects disabled veteran's ability to become or remain economically self-sufficient and what does that mean today. Second, we also want to look at, broadly, to what extent are federal disability policies and VA's internal disability policies keeping pace with changes in society and the veteran community, which ties into what you had mentioned before about looking at assistive technologies.

Third is we also want to look at other models of success, or best practices, not only within the United States, but also other industrialized countries with similar labor markets, and which are social protective

MPR
2015 DRC Conference_Day 2 Part 2

systems, and look at how they evaluate policies and how they're disability systems are run. Fourth, another area is we want to learn more about veteran labor market outcomes and how the utilization of education benefits, influences, decisions about that. At the VA, we have a lot of data and information on where veterans are, they're utilization of benefits, but we have less about the choices they make and the outcomes of the community that serves them, not just the VA. That's an area for us that we're interested in doing additional research on.

Fourth was we want to look at the relationship of an SSDI to DOD and disability retirement and VA and state disability compensation and learn more about those relationships and usage rates, and see how those influence veterans success and their ability to become economically self-sufficient, or self-sufficient in general. Also, as it relates to our IU program, we want to reexamine what constitutes unemployability and the influence that other factors, such as age or vocational assessments, had when you're trying to determine what an unemployability is. There was some work done actually by advisory committee some years back, and those are things that we want to reexamine as we look to improve our program and services of our veterans.

Lastly, I touched on partnerships earlier, and this is an area that we see that can really help inform what we do as a department. There's a big sea of good will regarding veteran issues, for example, through partnerships with philanthropy and joining forces, this year alone there's been pledges of up to \$300 million to serve the veteran community. There's a lot of organizations that touch veterans and families, by statute, we can only do so much for families. Our main programs and services right now are focused on veterans. What we're hoping to do is learn more about our partnerships, learn more about those outcomes, so that we can communicate that, and how they influence planning, what does it mean from a budgetary perspective beyond "we serve X number of veterans." How do you communicate and what are those outcomes for the veteran community, and that will allow us to determine how we vet our partners, who do we want to partner with, and how do we work collaboratively across the various sectors.

It's a aspirational goal that's not as easy as it sounds, but that's something that we need to do, and we're putting processes in place to help us work towards that right now. For example, the office of policy and planning, this year alone as a first step, just published an issued VA's first policy on public/private partnerships, and we're looking to put in other processes in place to help us work towards that broad strategic goal of ours. Thank you for your time. I'm more than happy to answers questions after this session. Thank you.

Thank you Raun. Our third speaker is Ruth Katz. She's the deputy to the deputy assistant secretary for the office of disability, aging, and long-term care policy, in the office of the assistant secretary for planning and evaluation at the US department of Health and Human services. She oversees a range of policy and research activities related to the disability and ageing, with over 25 years of experience with disability and long-term care issues, including managed care and other health and long-term care delivery systems, financing, structure and quality, home and community based services, nursing home and post-acute care financing and quality, Medicare/Medicaid and private insurance policy related to people with disabilities and chronic conditions, alternative residential systems, and health information technology as it relates to post-acute and long-term care.

Thank you. That's actually an old intro. I was wondering -- I thought, I didn't send you guys something, because in the George W. Bush administration, my title changed. I used to be the deputy to the deputy assistant secretary, but now I'm the associate deputy assistant secretary. That Bush administration did help you with improving government. Actually listening to you guys and to the panel before this, I am really proud to work for government, and as taxpayers, we should all be really pleased, because I think we're getting our money's worth. We've got some of the best people working on some really really hard issues.

Like Raun, I work in a policy shop. We just celebrated our 50th birthday in the office of the assistant secretary for planning and evaluation. I don't have slides, but let me run through what I'm going to talk to

MPR
2015 DRC Conference_Day 2 Part 2

you about over the next 10 or 15 minutes. First, I'll talk to you about what we're doing in the employment space. I thought your animal totem of being a flea, like what's our animal totem, and I think in ASPE it's like the eentsy weentsy spider, because we sort of keep on going back up the water spout, and everything changes and we go back up again. And here we are, going back up again.

We mainly focus our employment, in my office on employment work, in the behavioral health realm. Not because other aspects of it don't matter, but more because we have very small resources, that's where we identified some gaps where we thought we could bring something to the table. I want to talk to you about what we've learned in our research, what we are learning in our ongoing research related to employment supports, particularly for people who are difficult to employ.

I want to talk about RAISE, which is National Institute of Mental Health initiative, Recovery After an Initial schizophrenia episode. That actually drives -- it's very important, and it drives a lot of what we are doing in ASPE in the employment area. I'll talk to you a little bit about how we're using the RAISE findings, and our collaborative work with SSA that you all have been hearing about, and also some other initiatives we're doing in our department. We aren't the Medicaid agency. We aren't CMS, but I thought it would be useful, maybe, to review some of the ways that Medicaid pays for employment and point out some things about CMS's support for this important work. Briefly mention the ACA because it's hard to talk about anything without mentioning that. And I want to talk about supported education. I don't know if all have talked about that in the last day in a half now, but it's something that we are fairly committed to and would like to seem more work on. Then I'll summarize and offer some observations.

Briefly, ASPE, assistant secretary for planning and evaluation, as I said, we're 50 years old. We kind of see ourselves, and I think we are perceived, as having the secretary's back on policy, we're her policy analysis, policy research organization. Our budget is so big you can't see it with the naked eye, but we do have a little research budget that we can bring to question, so in our policy analysis, when questions come up, we can go down that road a little bit and do a little bit of policy research. Generally, we like to think of it as quicker turn around, we're not doing long 10 and 12 year experiments and then writing them up for the next five years. We're trying to do things more quickly, but things do take time in government.

In my office, disability, ageing and long-term care policy, we have three divisions, one is aging and disability, one is long-term care policy, and the newest one, which is about going on three years old, is a division of behavioral health and intellectual disabilities policy, and that is where, these days, most of our work on employment takes place.

One of the big things, and it's like bringing coals to New Castle to come talk to people from MPR about work that MPR did for us, but a lot of our research is done through contractors, and MPR certainly has important work in the employment area. One of the things that we did in the last few years was a paper with MPR on what works. What is the evidence on employment supports for hard to employ people. The literature review that MPR did for us is on our website. If you go to ASPE.hhs.gov, you'll see our brand new website that we just rolled out because we needed to do that because our website was impenetrable before. You'll see this report, improving employment outcomes for people with psychiatric disorders and other disabilities.

The most important findings that are in that report are that people with severe mental illness, I'll use SMI from now on, the acronym SMI as I talk about it, who participate in evidence based supported employment do find jobs, but they tend to be low wage jobs that don't significantly improve their financial well-being. That's really important. It's important to think about. It doesn't mean we need to dismiss it, obviously, at all. There's strong evidence for improved independence, greater autonomy, and reduced healthcare utilization. Those are all great outcomes. If we want to be committed to the outcome of people having more financial independence and more financial earnings, we need to go down that road as well. That's a place to think about.

MPR
2015 DRC Conference_Day 2 Part 2

The absence of long-term impacts on income may be due to the SSA programs, to the work disincentives, but it's really notable that very few people get to the maximum earnings. That has always boggled my mind, in talking about employment and talking about work disincentives, I know that there are a lot of reasons why people don't get to the top, but people don't even get near the top, in terms of earnings, and it's really something that I would love to see more thought put into. As I think most people in this room are well aware, there's not a lot of financing options for supported employment.

Just to unpack this a little bit more, a number of supported employment models seem to work, in particular for people with SMI, the evidence based supported employment, particularly individualized placement and support, the IPS model has probably been the most effective, way more than traditional voc rehab, at helping people find and keep competitive employment, but again, wages tend to be low. It could be that they don't focus on job tenure and economic self-sufficiency, maybe that's not the focus, as some of the programs play out, could be the work disincentives, could be -- don't know. Hypothesis. It's important, really important not to lose sight of these other benefits, and we need to look more closely, and I think we need to be tracking people over longer periods of time to get a better sense of it.

There's also some evidence that is reported in this literature review about return to work supports, like modified job duties, modified hours, and how effective they are in retaining workers with general health conditions. This does not apply as much to the SMI population that I'm mostly focused on today. Ditto on disability management programs that appear to have impact for people with certain musculoskeletal disorders, not as much on the SMI population.

As promised, let me talk a little bit about RAISE. Again, that's Recover After an Initial Schizophrenic Episode. It's an NIMH initiative. It was launched in 2009, and it's a really promising intervention. The findings have been really promising. It emphasizes that early identification of people that are experiencing a first episode of psychosis, and engages them in a package of evidenced based treatments, and supports that seek to attenuate the disabling effects of their severe mental illness. The components are psychotherapy, addiction treatment, case management, family education and support, supported employment, and supported education and low doses of certain medications. The early findings from RAISE have been very promising and suggest that symptoms and quality of life are improved more for the intervention group, than for those who receive usual care, and the people in the intervention group were more likely actually to be working or be in school.

The July issue of the journal Psyches Services, featured articles on early intervention, so probably if you're interested in reading more about RAISE and reading more about early intervention that would be a good place to go. It's available online. A big finding was the thing that gets people most engaged is help finding a job. More than therapy, what people said was helping me get back on track. Helping me get back on my feet, that's the kind of help I want. I walked in at the end of a talk about individualized supports, what people are looking -- family support is nice, all these other interventions are great, and they're evidenced based, helping me get back on track. Helping me find a job. Helping me get into school or stay in school, that's what people want.

Because we have these really powerful findings about early intervention and about intervening early, the idea is that by intervening after the first episode, as in RAISE, you can either prevent or delay what happens after the first episode. A more classic thing to happen is first episode, let's make it at age 21, that would be a typical time for that to happen, you go into the hospital. You maybe have insurance, you're on your parents insurance. You get some services, you get some treatment, you get some meds, and you go back to college. You go back to work, and then things fall apart again. You're better, you're on -- not better, but you're on track. Then things gradually, you have more and more episodes and things gradually go down. The idea of RAISE is to intervene with this package of supports early, and either delay, or even maybe prevent that ultimate decline down into disability, into a deeper level of disability.

That is powerful stuff. How can we apply it? One of the ways that it's been applied is in the last two appropriations to our department, the substance abuse and mental health services administration mental

MPR
2015 DRC Conference_Day 2 Part 2

health block grants, which are relatively small part of state mental health service funding, but an important part. A driver of what happens, congress directed that they use 5% of their funds, specifically, on SMI and on early intervention. That's fabulous. That is a really really useful thing to see. Take the findings, apply them. Whoa, what researcher could have a better dream than that.

We are in the early stages, in ASPE, of studying of what's going on with the 5% set aside, and there's a couple bills on the hill, and there's talk on the hill, of increasing that set aside. 5% of a tiny block grant, in some states, in a state that gets a really it'sy bitsy one, it's hardly any money, and with a few \$100,000 it's hard to make a difference. 10% or some floor -- some of the proposals under discussion now, a little more set aside might be a useful thing. Keep an eye on that.

SANSA has a small grant program that also employs some of the findings of RAISE, transforming lives through supported employment. Seven 5 years grants were awarded last year.

The SSA work that I know you all have been chatting about, I'm sure, for the last day and a half, is really critical and really, an amazing thing. Kudos to David Weaver and folks at SSA and Jack. It's really amazing that congress made the decision to invest \$35 million. It's really incredible. Early intervention is the way to go. How early can you get to people and how much can you help this SMI population keeping them employed. We've been very pleased and happy to work with SSA and our other federal colleagues on that.

On a smaller lever, in 2009, the institute of medicine put out a report on prevention of mental, emotional, and behavioral disorders. We are participating in a federal work group that will be hosting a workshop in December with IOM on early interventions, specifically, what are the various parts of it. Employment will be a piece of that. That will be open and will be announced publicly. I think in all these programs, the biggest challenge is how do you find people before they hit bottom. How do you find people at the beginning of -- I mean, obviously, if you could find them before the beginning of their trajectory, that would be great, but how do you -- where do you go? We've all struggled with how do you -- where do you go to find people at the beginning of a disability trajectory that may go downhill and have a not great outcome.

I said I'd talk a little bit about Medicaid. I think we were in a conversation with our colleagues in the disabled and elderly health programs group in CMS, and the Medicaid group yesterday, and they are, I'm here to tell you, doing a lot in the area of employment and supported employment. I watch for things coming from -- they aren't my things to talk about, so I'm not going to talk about them, but they are really engaged in this area. They recognize the importance of keeping people working, keeping people in school. The Medicaid program is kind of the biggest game in town, for a whole lot of things related to disability, the state federal Medicaid program.

Just briefly, I'll run through some of the ways that supported employment gets paid for by Medicaid. Medicaid is a state federal program. Most of what happens in Medicaid is driven by the decisions that states make, so as my former boss Bob Williams used to say, the states are all over the map, and -- I love that. I quote you all the time Bob, I think that's so funny, but they are. They make different choices about how they want to put their Medicaid programs together. It's still a lot of this thinking and a lot of the experimenting. These are natural laboratories, these are also natural places where the outcomes happen. But states do make these choices.

The first big option is regular state plan Medicaid services. Clinic services, the rehab option, targeted case management, pharmacol therapies, and actually supported employment can make a big difference, and you can do a lot of that using the state plan services. The 1915B managed care authority is a way that some states have done it. It's a way to get around some of the limitations of the rehab services state plan options. A few states have used the 1915C waiver to provide supported employment. This tends to happen more in the intellectual disability space than in the SMI space because you have to be otherwise eligible for institutional services and the IMD exclusion makes it so that people with mental illness

MPR
2015 DRC Conference_Day 2 Part 2

generally are not going to be able to get those 1915C home and community based services, but that can be pretty valuable in a state that wants to do supported employment.

1915I, the newer authority, offers states the opportunity to offer home and community based services, including employment supports without that reference to being otherwise eligible for an institution. That is a place to look at, if you're looking at Medicaid as a place to fund employment supports, that is one of them. States can define a population and define a set of services and needs based criteria. Then some states have used the big kahuna, the 1115 demonstration authority to cover supported employment. You can do expansions to populations that might not traditionally be covered. You can provide services that Medicaid may not traditionally cover.

Again, I just want to mention the ACA, Medicaid expansion, insurance expansion. I know that over the years I have heard and read that people say that they worry about that if they work too much they will lose their Medicare and Medicaid. Losing their SSI, a benefit, and then losing their Medicare and Medicaid. The ACA can make a really big difference in that. It would be great to look long term and see what happens long, does that really make a difference and does it really help people. Having insurance security, health security, is -- It's a right, and it's also something that 10 million new people are insured that didn't have insurance before. The Medicaid expansions have added additional people, it's pretty amazing, and it certainly is not the -- obviously health insurance does not give you employment support, supported employment services, but it give you supports you need to work and to stay employed with security.

Then I wanted to talk about supported education because maybe we don't hear enough about it. Supported education being mostly in colleges, technical schools, mostly post-secondary education, secondary education. College graduation rates for students with mental illness are not great. One of the things that happens when kids are in school, when young people are in school is there's a lot of demand on them, there's a lot of demand on the schools, when they begin to experience behavioral health disorders, there's a lot of demand on college counseling services. There are many programs providing different forms of supported education, which are designed -- The ultimate goal of supported education is to keep you in school, because the more school you get and the more you learn and the more you get qualified and trained and certified, the better your life's going to be. The better job you're going to be able to get. The better income stream you're going to be able to have, and the more stability you're going to have in your life. Keeping people in school is about getting people working. The longer -- RAISE, another point from RAISE, if we can get you back in school, if we can get back in school and keep you on that track, you're going to have better employment outcomes.

We are just finishing now, a literature review on supported education. One of the things is there are not standards about it, there are not definitions about it, there are not -- Like you think supported employment is all over the place, supported education is like in another solar system all over the place. It happens too all kinds of different providers, there's literally no standardization, and it would be good to know what works, what doesn't work. We'd love to see some demonstration work on that.

I wanted to offer one last observation. It really -- maybe listening to the coverage today of the bombing in Japan and thinking about all the anniversaries, that's not a 50th one, but it made me think of this whole month how we're celebrating these historical events, and that historical event of Medicare and Medicaid, like "What happened 50 years ago that made Medicare and Medicaid," and by the way ASPE, like, "Those are big huge changes. What were the politics?" Is it the same as [inaudible]. Things were -- it's not like politics are hard today, and they didn't used to be hard. They were hard 50 years ago. I don't know what it is, but watching the hill, I think it's important to watch the hill and see what happens.

Right now, on both sides, there are big big mental health bills. Both sponsored by someone named Murphy. Tim Murphy's bill has been out for a while, Kris Murphy's, I think, was just introduced this week. The interesting thing about these very comprehensive reforms about our mental health systems, is that there's nothing in these bills on employment. What's that about. I get that there's a lot to change and a lot

MPR
2015 DRC Conference_Day 2 Part 2

to reform in our mental health services, and I don't mean to at all minimize that, but employment is a piece of this. It's just an observation, and probably something worth thinking about.

Just to summarize, most of the work we do is in the SMI area in employment. We generally feel like let's go where we have evidence. It almost sounds like a cliché at this point, but ASPE is kind of dedicated to helping support the building of evidence so that policy decisions can be made, at least in part, based on what we know works and what we know doesn't work. Go where consumers want help. There are lots of places to go but one of the places to go is where consumers are asking for, which is help getting a job, help getting prepared to get a job, help staying in school. We should apply that to our programs and we certainly look for opportunities to do that in our policy work.

Again, the affordable care act holds incredible promise, and it should be at the center of almost everything. Probably is. We do need fundamental coordination. You probably heard a lot of it today, to make any of these things go, a human being is not a Medicaid beneficiary. A human being is a human being who needs a place to live and needs family support and needs friends and need a job and needs -- No one's going to come to you and say, "Hi, I'm an SSI beneficiary." That's not a human way to describe yourself. We need coordination at the federal level, but we shouldn't get obsessive, I don't think personally, inside the beltway about having lots of meetings. I don't know that that's the way to make it happen, but coordination is critical, and enabling the coordination, like what Jamie was talking about to happen out in the field, in states, in towns and cities where people live. Then finally there's action and interest on the hill, so it seems like a great time to make some real progress. Thank you.

Thank you to the speakers. We have quite a bit of time for questions. Question over here.

Hi, I'm Pat [Owenton], I'd like to say I'm a student of disability. I've been around a long time doing a lot of things in the disability field, both public and privately. I think that the flea and the spider and the elephant all made wonderful commentaries and zeroed in on three important issues. One is the employment. The employer and the employment. We can prepare people for jobs all over the place, but if we don't place people in jobs, and I think VA has some placement, more placement activities, I think I heard you say that, but the idea of employers and placement, not just employment, is important and I'd like to hear you all maybe say something about that.

The third thing was the individual. I've always had a dream that when a person with a disability interacted with the system, it would be a personal interaction. I know Dr. Katz back there feels the same way, that they would come in and everything would be based upon that particular person, how they lived, who they were, and whether SSA got involved with them or the VA or whomever and whatever that was, but that individual evaluation and that person centered evaluation.

The other thing is health care, and I'm so excited about the ACA, but I think there's so much work to be done and I know there are wonderful researchers out here that can begin to do that. How do we make ACA work around this whole issue of staying at work and keeping at work and that kind of thing. I guess it's just a comment from a long time player in the field, but also a question, how can the three of you individually, but more importantly, cooperatively address those three issues, which I think are very very important. Thank you.

I can start on, first of all, your employer question, and hello Pat. It's nice to see you. We do interact a lot with employer and employer organizations, and we have heard for a long time, and it's getting a little better, but it's not perfect yet, that there's a disconnect between how service providers interact with employers and employer vocabulary need and how they want to operate. I think bridging that gap, there's still a great need to do that. Business organizations can help with that as well, because they think they are often the actual employees of business organizations, sometimes come from both arenas, and know how to make the -- help service providers interact better with employers and vice versa. We've seen pockets in vocational rehabilitational programs where they are actually learning how to do job

MPR
2015 DRC Conference_Day 2 Part 2

development from entities like Man Power Staffing organizations, professional organizations that do this for everybody, not just people with disabilities. I think that's promising practice.

I definitely think we're learning more about what brings employers to the table and unfortunately, what we did learn from our Wharton research, is that often, in fact most of the time, it is still having a champion that has a personal family relationship with disability in that organization. As much as we all maybe we are all part of the choir, we think it's self-evident now that it's a good business thing to do to open your doors to everybody, no matter what difference they have. Employers still aren't there, in the majority. We need to recognize that and meet them where they are, and then bring them up that learning curve and, what we are calling the diversity spectrum, where you come to them because they want to do a good thing, but they get to know that it is a good for them thing and it helps them with their competitive advantage.

I'm going to mention a few points regarding your point regarding employment verses placement. One is, I just want to say that that issue is inner connected in the sense that, at least within the VA, where you can't find someone meaningful employment if other issues aren't addressed, especially if that person has a caregiver or children and you look at their own mental and physical health, employment, housing, and all of those other issues as a package that needs to be addressed, and not just finding that person a job.

Another, I think, policy issue to look at is education the only path to employment, and what does that mean. How does the individual choice fit into that. Third is that all the great changes and innovations don't really, in my personal opinion, don't really start in government, they start from the community and from the private sector, from philanthropy, and to a great extent, employment is a community based thing. Partnerships are really important in doing that, and also having a lexicon to be able to translate the skills that a person brings to the table. A great example of that is when a person leaves service and they have a specific skill or MOS, what does that mean to the government sector? What does that mean to the private sector? If you're a JAG officer, a lawyer is a lawyer, but what if you're infantry and you want to move to a different field. I think that's a good kind of example, and also recognizing, in terms of working together, you'll have shared goals. Some of the challenges of working across organizations is that when you have shared goals, you have shared responsibilities, and it's tough at times, but also what that means too is that you have a lot of best practices and examples from various communities that can be leveraged for different populations as well.

Those are the three points, then, also your question related to individual evaluation is a point of actually doing more evaluation. I know in 2009 an O and B issued a letter basically saying, "Look, the government needs to include evaluation in its processes, in its budgeting." I think the more we do of that, the more we use recommendations from congregational watch dogs, such as [EAO] and other organizations and look towards program improvements, will build that capacity. I think for budget strapped organizations, those resources and recommendations from the IEG's office, from places like GAO, serve as, in essence, free labor and free evaluation to help you fix your programs, and to a great extent, it's a leadership issue, but to another extent, it's making sure you have those processes in place that allow you to communication across administrations, across transitions, so you don't have that knowledge loss when regime changes shift.

I wanted to address the individualized services. It's like, "Could we have like Geno McMedicine of disability services?" Right? Actually, I know it's crazy, but true, but it might be that in disability services, maybe we have led the way in terms of, we're not there yet, but we seem to be kind of ahead of a lot of other fields. Certainly ahead of medicine in terms of individualizing, in terms of -- It's not perfect yet, and we have a ways to go. That was one thing.

I also think that there's maybe some thinking to be done about the work space too, and the changing nature of work. People have jobs now that don't have offices. People do all kinds of versions of integrating work into their lives in different ways, and jobs are really really changed. As we think about what does this individual bring, we should be thinking about that changing nature of the other half of the equation too. Employers are not all traditional employers anymore.

MPR
2015 DRC Conference_Day 2 Part 2

Then thank you for your comments on the ACA. It's a heavy lift to do long long long term research to look at the impacts on people, but I do think that's very important.

[inaudible] that the organization of health for people with disabilities, APHD or some -- I can never get all the initials. They do have a network now for helping persons with disabilities choose various plans, or helping them shop the various plans. I think that's a terrific thing and I don't know whether you both are contributing to that, but it's a super idea.

It is great, and people need to get help. It's not an easy thing to do, and people need to know too, that 80% of the people that get their insurance through an exchange are getting a subsidy, are getting help to buy it. It's available and accessible.

Any other questions? Right here.

I'm Dale Brown, I do a lot of speaking and writing and working on job search. I had a question. What research has been done about how people with disabilities actually find work? I have an anecdotal observation that very successful strategies, interviewing for information, is mentioned by Richard Nelson Boles. I hardly see any of that. I hardly see any of encouraging people with disabilities to do research, to do homework, to figure out what they want to do, figure out which job they'd match with, and then hopefully find the person who has the power to hire them and then find a job. A really self-directed approach, but my question is just more basic. What do we know, and what should we know, about how successful people with disabilities actually find work? In particular, I'm responding actually to what you just said about how work is changing, because now many jobs aren't even covered by the ADA because they're actually individuals doing work.

That's a really good question. Hi Dale. I think, I don't know about the research, but I do know that we struggle, even internally, we talk about transition. What other population do you have whole conferences and research projects on transition to employment, a student with a disability or a young person with a disability, is a young person first, and believe me, they identify much more as a young person than as a young person with a disability. Part of it is raising those expectations very early and working with families. I think that's what's so great about the PROMISE grant, is that it's a family intervention. And that it really starts, it can start as early as 14. Yes, we need to start earlier than that, but 14, talking about work and raising expectations and making sure that the goal is not only integrated employment, but it is also in line with their skills and interests.

We had, with all this ADA anniversary celebration over the last month, we went to several panels where we heard from young people with significant disabilities and barriers that they're facing, and one that struck me so hard was a young woman who is getting her PHD at the University of California in Santa Barbara and is -- she's brilliant. She has parents who were immigrants -- Bob is smiling because he introduced her to me, but she was told her whole life -- she's completely blind. She was told her whole life, by her teachers, that she would be able to work doing piece work in a facilities based environment, and those were some of the opportunities they were talking to her about for her work based opportunities.

We don't think a lot of work that we do together at this department of education and with labor, we see a lot of the good things that are going on, and we are really happy and encouraged by the positive practices and the good programs, but there are still many many many people who aren't involved in those. We need to reach them, I guess that's a long way of saying my main point is that we really need to reach students first. Students as students first, and then as disabilities, to make sure their expectations are for themselves, and that the people around them have for them the same as any other student or young person.

Sure, [inaudible].

MPR
2015 DRC Conference_Day 2 Part 2

I think kind of where you were too, Jennifer is I'm not sure I know how people who do not experience disabilities get a job. I think it's an interesting question that you raise. I think it's a really good question, and how, where's the overlap? People with disabilities and people without disabilities, because I'm sure there's a whole lot of commonalities about how people do a job search and get help and get a job. There's also a million paths, maybe, to get there, for a million people.

It made me think that there's probably a data collection opportunity. Like you maybe want to somehow figure out the barriers and see if you could get some agreement and name some of the barriers that are specific to people with disabilities and then understand what strategies people have used to address and overcome those barriers. Data collection is big and long and expensive, but it might be a way to make some real progress if you could get some answers.

I just want to echo [inaudible] comments as well, and just to add that I realize there's significant challenges to data collection, but there's also opportunities for interviews and focus groups and things of that nature to find out information to help bridge that gap in the interim.

Second is one thing personally, I don't know if there, and if it's the case of where you have a person with disabilities that is taking a different path to find employment, or if everyone generally is on the same path, but there's different obstacles in the way or other challenges for people. I say that to say is that I think there's opportunity to look in other areas and other challenges that, for example, a person that may not be classified as having a disability, but they have other challenges or barriers of finding employment, and the solutions to that, or at least insights, could be similar.

Other questions? Bob Williams.

Raun.

Yes.

Building on that point what is missing from this conference, and the larger policy discussion is we focus on services and supports, which are extremely necessary of course, but there is no mention of opportunity, hope, or how a young person builds the self-image, the advocacy, and persistence, to know just get the job just get and sustain a successful life and career and that being said, the knowledge and directness if [inaudible] there much of it did outside the disability, for instance, we are on the job, viewed to, [for instance] we are used to.

Raun, building on that point, what is missing from this conference and no larger policy discussion is we focus on services and supports, which are extremely necessary of course, but there is no mention of opportunity, hope, or how young a person builds the self-image, the advocacy, and persistence to know a [inaudible] just job with demands, to sustain a successful life and career as you said, but knowledge and [inaudible] but [inaudible]. For instance, we are used to.

Are you saying, Bob, that we have all the services and supports, but we're not intervening early to help student build their self-empowerment and advocacy skills and all those necessary things they need to do the self-directed planning and -- Yeah. And there's no specific program that does that. Students learn these things through leadership opportunities in clubs and in sports and on teams and some of the opportunities that students with disabilities don't necessarily have. It's certainly been validated through research that you need those in order to be successful, and we need to be focused on that as part of the skills that we help students with disabilities get.

One of the things, I think too, is that just getting a job is good. Yes, everybody wants to have a meaningful career, but most students just get a job. Their first job might be in McDonalds. Their first job might be filing, their first job might be a lifeguard, but a lot of people here didn't have their first job in the field that

MPR
2015 DRC Conference_Day 2 Part 2

they wanted to end up in. I definitely don't think there's always a push for kids with disabilities just to get that job to learn soft skills and experience, so that's part of it too.

Anyone else want to ask a question? I'd like to thank the speakers for a great discussion.

I just want to announce we are having a luncheon speaker, so the lunches are supposed to be outside and then at 12:15 we'll get started again. Oh, they're here. Okay. Thank you, Gina.

MPR
2015 DRC Conference_Day 2 Part 3

2015 DRC Conference Day 2 Part 3

Well, I hope everybody's enjoying their lunch. It's my pleasure to introduce Doug Walker, who's the Deputy Commissioner for Communications at the Social Security Administration, who's going to be our luncheon speaker. Continuing our theme of cross-agency or inter-agency issues, I want to note that he is responsible for planning and coordinating the agency's relationships and communications with other federal agencies, as well as state and local governments and special interest and advocacy groups, and of course, the general public. So very appropriate for the theme of this morning's round tables.

Prior to his appointment at the Social Security Administration, he was the Executive Vice President for Operations at Integrated Media, Incorporated, and then from 1999 to 2012, he had several positions in the National Education Association. And his federal sector experience includes positions with the US Office of Personnel Management and the Department of Labor, and also with the House of Representatives and the Senate. So you can see, he's very skilled at the inter-agency stuff.

And another way to interpret this is that he can't hold a job, but that would be what you'd say if you looked at my resume, too. So anyway, he has a Bachelor's Degree in Communications and completed the Senior Executive Fellows program at Harvard University, the John F. Kennedy School of Government. So anyway, I'm pleased to welcome him here. He'll talk for 15 to 20 minutes, and then we'll have time for Q&A.

Thank you, David, and good afternoon. Thanks for the opportunity to tell the story of the Social Security Administration's Faces and Facts of Disability Campaign. Patricia Owens and I were just talking a moment ago about having trouble keeping a job, but we were talking about the importance of storytelling. It seems to me that perhaps we are from different sides of the street. You all are doctors of statistics and substance, and I however, am a doctor of spin.

But something we have in common. When we are doing our jobs well, when are at our communications best, whether we are conveying data or promulgating message, we're at our best when we're telling stories, and so I appreciate this opportunity to tell our story and what we are looking to do, essentially, with our Faces and Facts of Disability is kind of tell two sets of stories. One is to tell the story of our disability programs, SSDI, but the larger bit is telling individual stories, telling the stories of the very real people who are beneficiaries of this program and rely on it.

Faces and Facts of Disability seeks to educate the public and policymakers about the Social Security Disability Insurance program, SSDI, and the very real people it serves, and I have the privilege and responsibility of ensuring that we are doing everything possible to make our programs easy for the public to access and to understand.

As Social Security turns 80 years of age, there's been a fair amount of debate about the future of our programs, including SSDI. And through all the noise, it can be easy to lose sight of the facts and the role that this critical safety net plays in the lives of every worker. With this campaign and initiative, we hope to raise awareness about how SSDI protects workers and their families, and to spotlight some of the real people behind the statistics, and if you go to the second slide for me please.

If you haven't already, I urge you to check out our Faces and Facts of Disability campaign. It's easy to find. You can go to SocialSecurity.gov and click on Faces and Facts of Disability in the carousel at the top of the page, or you can go directly to SocialSecurity.gov/disabilityfacts. The website is chock full of

MPR
2015 DRC Conference_Day 2 Part 3

information about the Social Security Disability program, including an interactive quiz to test your knowledge. And why don't you take the quiz and give me a call, let me know how you did.

One of the key aspects of Faces and Facts is really the faces, which are so important in helping the public understand just why the program is so important and necessary. If you go to the third slide for me, please. Here, visitors can meet Charlotte and Larry, Kira, Christine, and others, and browse among the dozens of powerful videos and written stories about real people with severe disabilities who rely on Social Security for their daily needs. Next slide, please.

At the website, we have also given people the opportunity, invited people, actually, to tell their own stories, and add to that. The site also provides a list of facts about the program, which are key to showing how important the program is. Slide five for me.

SSDI workers earn – Social Security disability is a social insurance program that workers and employers pay, through their taxes on workers' earnings. This is not a gimme, not an entitlement program. People are paying into this program. People are investing in the program. It should be there if and when they need it.

The program provides benefits for disabled workers and their dependents, for those who can no longer work due to disability, this program is there to replace some of their lost income. The Social Security Act defines disability very strictly and narrowly. People who receive SSDI benefits must be unable to do types of work that they did previously, or adjust to another type of work, and the condition must be expected to last more than a year, or to result in death. Social Security Disability beneficiaries are among the most severely impaired people in the country. They are more than three times more likely to die than others within the same age group.

Among those who start receiving disability benefits at the age of 55, one in five men and one in seven women die within five years of the onset of a disability. Disability is unpredictable, and can happen to anyone at any age, and that's very, very important message. This can happen to you, it could happen to me, it could happen to anyone. 56 million Americans, or one in five, live with a disability. 38 million disabled Americans, or one in ten, live with severe disabilities.

And it's a sobering fact, and I actually challenged this when I first heard this, when I got to the agency a couple years ago, but it turns out, and Steve Goss, our Actuary, double-checked and triple-checked it for me, that one in four 20-year-olds insured for disability benefits, becomes disabled before reaching retirement age. So you're 20 years old, and paying into disability programs, one in four chance that you'll need disability benefits before you reach retirement age.

Social Security Disability benefit payments are modest. At the beginning of 2015, we paid an average benefit of \$1,165, barely enough to keep someone above the 2014 poverty level. For many beneficiaries, this monthly benefit payment represents most of their income. Even these modest payments can be a huge impact, can make a huge impact on people's lives, when they can no longer work, especially.

As experts projected for decades, and we've been talking about this for a while, the number of people qualifying for Social Security benefits has increased. Baby boomers have reached their most disability-prone years, between 1990 and 2011. More women have joined the workforce in the past few decades and have worked consistently enough to qualify for benefits, if they become disabled. Despite the 9 million or so people getting SSDI benefits represent just a small subset of people with disabilities, and that's a point we consistently make.

MPR
2015 DRC Conference_Day 2 Part 3

Social Security works very hard to prevent, detect, and prosecute fraud. This Acting Commissioner, Carolyn W. Colvin, has brought back a couple of programs that she worked with when she was at Social Security in Operations and Policy, back in the 1990s. She's re-stood up the National Anti-Fraud Committee, pulling together resources from across the Agency, to fight fraud. We have a goal of establishing more and more CDI units, Cooperative Disability Investigations units, which brings Social Security staff, staff from our Inspector General, local law enforcement, and local prosecutors to investigate and weed out fraud that is there. And much of the fraud that we – and we are messaging to front-line employees the importance of, if you see something, say something. And as you hear more and more stories of fraud, keep in mind that we are doubling down to find, and you are hearing more stories about fraud because we are making the effort to find it. That's being found by Social Security employees that pass those items to the Inspector General, and they are processed from there.

So let's take a look at the real story, if you take me to slide six, for me please. By shedding light on how the program works, and the people it assists, we are helping to shape the public conversation about the future of Social Security and the Disability Trust Fund. I'd like to speak for a few moments about this, as we increase the number of – an increase in the number of Social Security beneficiaries has strained the Disability Trust Fund. Now, again, it's not a surprise that the number went up. Again, the baby boomers have reached their most disability-prone years. The trustees predicted, and have predicted the increase since 1995, due to the aging baby boomer population, as I mentioned, and the fact that more and more women entered the workforce over those preceding years.

The ball is now in Congress's court, and unless Congress acts, we can only pay \$0.81 on the dollar, beginning at the end of next calendar, in 2017, I'm sorry, 2016, when the Disability Trust Fund becomes insolvent. We'll only be able to pay \$0.81 on the dollar, if Congress does not act.

Slide seven, for me. The President's budget for 2016 proposes a responsible plan for a temporary reallocation, reallocating a small portion, less than a percent, of the Retirement Trust Fund into the Disability Trust Fund, to make both good through 2033, 2034. This is not a breathtaking plan. This is not unusual. It's been done a number of times in the past, and, as it turns out, it's gone both ways in the past. Congress has reallocated from the Disability Trust Fund to bolster the Retirement Trust Fund. Taking the action that the President has proposed had no adverse effect on the current financial solvency of the combined Social Security Programs, which are right, according to our trustees, adequately financed to pay full benefits through 2034.

The President's budget also proposes allowing us to identify and test promising improvements to the disability program that Congress may want to consider as part of a longer-term solution. And of course, a short-term solution like reallocation is just setting the stage for work across both sides of the aisle, across both ends of Pennsylvania Avenue to get at a longer-term solution. These measures would enable us to pay full benefits through 2034, while establishing an evidentiary basis for Congress to evaluate potential changes to the program for long-term stability.

Slide nine. This is a safety net for some of our most vulnerable citizens. We must keep in mind that Social Security Disability beneficiaries are among the most severely disabled members of our community, and that's primarily due to our strict definition of disability. These folks survive on benefits that they've earned while working and paying Social Security taxes. We can't say that enough. Message is repetition, you can tell I'm a doctor of spin.

Modest benefits for these – these are modest benefits. The benefits pay less than \$1,200 a month, barely over the federal poverty level. One of my favorite examples of negative advertising, not in the political

MPR
2015 DRC Conference_Day 2 Part 3

realm, had to do with sandwiches. There used to be a billboard out going toward the Easter Shore of Maryland and Delaware, I think it was Royal Farms, a photograph on a billboard of a great big, beautiful overstuffed submarine sandwich, and it simply said, nobody's losing any weight eating our subs.

Nobody's getting rich on Social Security Disability benefits, and that's a message that we need to convey, that I hope you'll amplify, and certainly, Dave, we've talked about amplifying a message across the agencies. We are certainly working with our agency partners in conveying these messages, to ensure that we get the right thing, in terms of a solution to the Disability Trust Fund solvency issues.

Slide ten for me. It's also important the public and Congress understand that we take our stewardship responsibilities very, very seriously. We take very seriously overall at Social Security, being good stewards of the resources that the taxpayer entrusts to us, and that certainly applies to disability. We're making benefit determinations here, under our strict definition. We prioritize continuing eligibility reviews, according to their probable return on investment, and while we remain aggressive in our anti-fraud efforts, our Inspector General's own data showed that our fraud rate is a fraction of 1%.

And you've seen some of the headlines, and the raw number, the raw dollar figures are staggering. We're talking about millions of dollars. It's because we're talking about hundreds of millions of dollars and billions of dollars of the years as the IG's data has shown, and they have repeatedly demonstrated. Again, much of that fraud, and recently, most of that fraud is being caught by our own front-line employees who are working aggressively to take that off the table. Any thought that the Social Security Disability Funds are rampant with fraud is just not accurate. Again, you're hearing more, our IG is getting headlines, and I don't begrudge his headlines, I work in PR, as well. But again, as we increase our efforts to fight fraud, those stories are coming out, and they're showing that our efforts are having a positive impact.

Slide 11, we'd like to actually ask you to visit our Faces and Facts website again, with your associates and the public. With constituents, as well. We've added a link called Start a Conversation. We'd actually like to hear from you, but we've also provided some ready-to-publish material, blog posts, e-mail messages, social media content, for your organizations to use. So peruse that, if there's material that's useful to you. We'd also love to have your feedback, right? If there's – that works for you conceptually, but there's specific things that you don't see there, please let us know. And again, one of the big messages that we want to push is that it could happen to anyone, right? It could happen to each of us. It could happen to you.

Before I stop, I want to take a moment to reflect on why Social Security is so important to the nation. Next Friday, Friday of next week, marks the 80th anniversary of the signing of the Social Security Act. When President Roosevelt signed the act into law, he was determined to keep older Americans from ending up in the poorhouse after a lifetime of hard work. And I would think he would be pleased to learn that not only did the poorhouses quickly disappear, but Congress has acted to vastly expand the Social Security Act over the years to protect all Americans from falling into dire poverty, and to avoid illness due to old age, disability, and a lack of resources.

Together with our national, state, and local partners, we can also go a step further to help Americans stay out of poverty by ensuring the stability of the Disability Trust Fund. By promoting Disability and other programs and benefits, we emphasize the vital help to workers and their families, right? Not just to people with disabilities, but to members of their families as well, and help them to get the help they need most, when they need it most.

MPR
2015 DRC Conference_Day 2 Part 3

Of course, Social Security is also involved in many ways, too. The most obvious change has been in technology, as it's been changing. Most of our businesses, I used to be in magazine publishing, technology has transformed that. It's also transforming the work we do at Social Security. We've achieved – we've worked to achieve world-class customer service and administer our programs with great efficiency, but we're also looking to meet our customers where they are, and be available to them where they are, and when they need it. And so we are constantly expanding our online services through our MySocialSecurity hub.

And if in the room, we go to 12, it's saying 11 on the webcast, you can visit MySocialSecurity at SocialSecurity.gov/myaccount. This is a convenient, cost-effective and secure way to give people the option to do some of their business with Social Security online. And the more people do business online, the fewer people standing in line in our Social Security field offices. Our field offices are frequently in the news, and even our staff union has suggested that we're closing offices. We're not closing offices.

We've moved some offices; I know there's a case in Albuquerque going on right now, where we have relocated an office. We did the same thing in Sussex County, Delaware, recently, that has made some news. We are committed to meeting the public in public, but we are certainly expanding our suite of online services. Again, give people the option of meeting us on their timetable, whenever they need us, around the clock, and not having to come into a Social Security Office. Or not have to sit on hold on the phone. And these transactions are cost-effective for us. It means shorter wait times in field offices, and shorter hold times on the phone.

By promoting disability and our other programs and benefits, we emphasize the vital help that workers and families when they need it, when they get it most. Of course, Social Security has involved, and we've talked about that. Nobody knows. We don't know the new service options that Social Security will be offering 80 years from now, or how new advances in data management could revolutionize the way we keep track of workers' earnings, or further strengthen our already vigorous online anti-fraud efforts. But what we can say is that Social Security will continue to adapt, to innovate, and embrace change, as we've always done in the past. And it still remains a fact that we have never missed a payment.

We want to work with partners like you, to help keep working to improve the lives of American families, as President Roosevelt and Congress intended 80 years ago, back in 1935. I want to thank you for this opportunity, and thank you all for the challenging research work that you do and are involved in, in improving of lives of people with disabilities. Again, by working together to continually refine and reevaluate public policy, we're making a real difference for the nation's most vulnerable populations, and I know that's a theme that's important to Acting Commissioner Colvin. And Dave, with that, I'll stand down. Thank you very much.

Thank you.

So we have eight to ten minutes. If you have questions, we'd like to hear them. I can start by telling you about my great experience with Social Security this month. I'm going to be 65 next month, and I got a letter from Social Security that said, sign up for Medicare. So I did that. And then I got four more letters from Social Security, telling me about all of these retirement plans I had from these many employers in the past, including one I had no idea about. That was good news. The bad news, it was only worth \$56.

If you have not, you should get signed up for a MySocialSecurity account.

I did.

MPR
2015 DRC Conference_Day 2 Part 3

Right? Because it would be all there in front of you. When I signed up for mine, I discovered that for the year or so, year and a quarter that I was a press officer for the Chicago Public Schools, I was not paying in, right? But I do have an accurate record of what I've paid into the system. I didn't realize that I had that gap until I went there. And the best way to make sure that someone doesn't sign on to the account and use your account and your Social Security number is to go ahead and sign up and get it for yourself. It's parallel to what the IRS told you back in March and April. The best way to make sure that somebody doesn't get ahold of your refund, right, is to file online, file early, and go ahead and get the refund. That reduces the chance of someone defrauding you. We make the same case. The system is secure. It's cost-effective for us, but if you sign up now, you get this terrific information, including that Social Security statement, instead of mailing it every year, right? You can get it whenever you want.

All right. We've got a hand up. Yes, right here. Please introduce yourself.

Okay. I'm Dale Brown. We're a group of people who are working on employment, helping people who are on the rolls hopefully get off the rolls and become taxpayers. And as I was listening to you, I just wanted to get your thinking about how you could spin that, whether that's part of your Disability Faces and Voices, and what needs to be said and thought about the idea that some people on Social Security can work, are not fraudulent, through hard work, can become taxpayers.

Right. So that's a pertinent question, experience we've had with the campaign over the nearly two years we've run it. So early on, we actually had an emphasis on sorts of people who use the Disability benefits to back to school, make changes to their lifestyle, and a couple of them actually have gone back to work now, and are working as disability advocates and have actually come off the benefits, and those are some of my favorite stories. We've gotten now word from the Hill, and that's where ultimately on the Trust Fund reallocation and long-term stabilization of the Trust Fund are taking place, we hear from the Hill that we need to include or tell more stories of more severely, more permanently disabled people. So we, in fact, trying to strike a balance. And so again, we started with people who have used the benefits to get off of disability and do other things, and we're trying to get back to a more balanced bit of storytelling. That's where we are.

I saw another hand. Yes, way in the back.

Hi, Stacy Clyde.

Hey, Stacy.

I know often with government programs being promoted on social media, there are challenges with people commenting in ways that you might not otherwise want them to, so they're sharing PII, they're giving advice to other people. How do you deal with that within Social Security, when you talk about the programs on social media?

Right, so we, on our social media platforms, which are expanding, we just launched a block here within the last few months, we certainly are encouraging people not to put their personally identifiable information. We're constantly monitoring it, so if someone does, we actually snatch it down and take it down, and we have specific answers for folks. We find ways to reach them offline to give them answers, or direct them to somebody so they can get the answers. But yeah, that's a big concern, and we have constant monitoring to try to make sure that doesn't happen. And to correct it when it does, of course.

Other questions? Another one, way in the back. We've got the back benchers working now.

MPR
2015 DRC Conference_Day 2 Part 3

Good afternoon. Dan Bertoni, GAO. I appreciate your statement about finding multiple ways for folks to interact, whether it be web-based or the phone, or even the physical structure, the office. But doesn't it make sense to really be looking at sort of your physical brick and mortar footprint to sort of align that with a more 21st Century service delivery plan? This structure's been this way for many, many years, and I don't think it should be off the table. Where are you with that?

It shouldn't be off the table? I missed the last part.

I'm just questioning whether changing, closing offices, should be off the table, given the technology that's available today, how people, one, interact with agency. Does it make sense, just whole cloth, to say, we're not looking at our brick and mortar footprint, it's going to stay the way it is?

So we are, in fact, shrinking our footprint, as your colleagues will know. We're shrinking our administrative office footprint, and doing less and less with office space, but we are committed to, as long as we continue to get sufficient and continued funding, to provide office space for folks to come, if they need that. Because, in so many of our field offices, there are long waits, we're looking to knock down those waits before we look to close offices. And we're doing other things with the brick and mortar, right? You mentioned making brick and mortar more 21st century.

We're offering services at kiosks, and it's a really cool program that I saw in our facility which we actually moved into a larger office space. If you're at an office in Baltimore, where there's a line, and an office in Pocatello is less busy, a claims rep can get in front of a camera and help you by TV, right? And you hold your driver's license up to the camera on your end, they can positively identify you. They can help you there, print out what you need at the printer next to you. And if someone's sitting, waiting for the next person to come in is actually working and helping someone who's waiting in line, and shorten that line in Baltimore. So we're trying to think outside of the box with what we do with our own brick and mortar. But we are fully committed to shrinking our footprint, but we're doing it by cutting back on the administrative space.

And I should also give you guys a shout out, I think your press release came out yesterday, and I think I saw it today, we are working with you and Veterans and Treasury on some really customer service things, as well. And kudos to you for leading that and getting that word out.

No other comments? We've got time for one more? All right, well, you get 15 minutes to get back here, and we'll be continuing. Thank you very much.

Thank you very much.

MPR
2015 DRC Conference_Day 2 Part 4

2015 DRC Conference Day 2 Part 4

All right, welcome to the homestretch. We've made it to the last half day of meetings that have been fascinating so far. I'm delighted this afternoon to introduce our panel, which as you can see will be talking about workers at older ages with disabilities. And these individuals were tasked with providing unique perspectives of their thoughts on vocational factors and the extent to which workers who are at older ages may be able to mitigate some of their -- the onset of health conditions with work and what can be done. So, without further ado, I have been told Dave Stapleton, who at this point doesn't need an introduction, will be starting the panel off with setting the stage for the remaining speakers.

So I don't have any slides, sorry. I want to start by making it clear that the conclusions I will be drawing in my presentation which are intended to be provocative, are my own. They do not reflect the positions of our sponsor, the Social Security Administration, or any of the other institutions that have supported my disability policy research over the last 25 years. So I'm gonna be talking about the vocational factors, so that means: age, education, and experience; and how the Social Security Administration uses those vocational factors in the disability determination process. I'm gonna start by just describing that process and how they use them. I'm then gonna tell you about some research, the main finding from some research that David Mann and I did, which we concluded that there's no rigorous evidence to directly support how the disability determination process currently uses vocation factors.

And that may sound like, well, the emperor has no clothes, but the issue is actually a lot more complicated than that so I will explain why, but I'm also gonna tell you that I think there's no such possibility of conducting the type of research that we be needed to support the way the Social Security Administration uses them now. And my conclusion is gonna be that policy makers need to re-examine the role of factors other than medically determinable conditions in the eligibility determination process and adopt a new approach that is consistent with the fundamental objectives of the Social Security and Disability Insurance and the SSI programs, but that also can be supported by research so that it can be implemented in a practical manner.

So, in explaining about the vocational factors, it's really complicated, I have to strike a balance between providing enough information to those of you who are completely unfamiliar with the vocational factors so that you can understand the rest of what I'm gonna say, as well as what my colleagues are gonna say, but also giving you so much detail that I'm boring everybody else to death. So anyway, I hope I get that balance right and you can ask me questions later if you need to.

So what is the role of the vocational factors? Well, as probably you know, the Social Security Administration has established a detailed list of medically determinable impairments -- "the listings" as they're called -- that it accepts as sufficient evidence to conclude that the applicant for SSDI or SSI benefits is unable to engage in substantial work for at least 12 months or is going to die before that, provided that the applicant is not actually engaged in substantial work. So disability adjudicators are supposed to allow claims if they find the applicant is not engaged in substantial work, and the applicant condition meets or equals one or more of those listings.

But it's often the case that they don't, so then the adjudicator goes on to some next steps which involve the vocational factors. So if not, the adjudicator completes what's called the Assessment of Residual Functional Capacity, so they get a residual functional capacity score -- it's not a score but a set of information about it. And some of you may have been at the SSDI Initiatives Solutions Conference on Tuesday and Art Spencer, who used to be the head of the office for many years that is in charge of the eligibility criteria at Social Security, recently retired. He got up and was speaking in his comments and he said, and I'll quote, "You really need to use caution when suggesting that the RFC assessments are anything other than magic."

And I think you could say that to a lot of what I'm gonna be describing now in use of the vocational

MPR
2015 DRC Conference_Day 2 Part 4

factors, unfortunately, and that's not really to discredit what Social Security is doing at all, I think it's just an issue that they've always had to grapple with and that's very difficult.

So, what is the RFC? Well, it's really an assessment of what the applicant's remaining, specific, physical and mental capabilities are, given their documented medical conditions. And the adjudicator goes on then to determine if given the RFC, if their residual functional capacity is sufficient to meet or exceed, what SSA understands to be the requirements for working at any job that the applicant has had in the past 15 years. And if they conclude that the applicant can do those jobs, then the claim is denied. But if they conclude that the applicant no longer has the RFC to do those old jobs, then they go on to a final step, which is called Step 5 of the adjudication process and they compare the applicant's RFC to requirements for all other substantial jobs in the economy, not just the applicant's past jobs.

And here is where things get complicated. So, SSA has developed a tool that adjudicators use for this purpose, it's called "The Grid." The purpose of the grid is to make it easier to reach a decision and also to support uniformity of decisions across adjudicators. So based on their residual functional capacity, the adjudicator classifies the applicant to one of five physical exertion categories ranging from sedentary only to very heavy. And also looks at the applicant's age, puts them in an age group starting with under 45, and then there are 5-year age groups and the top one is age 60 or above. There are several education groups including one for illiteracy or inability to communicate in English.

Then there are three skill groups based on the applicant's past work experience. So now you have all these categories, four dimensions that people are in, and really the grid you can think of as a four dimensional matrix and you place that applicant in one of those slots in that matrix, and it tells you whether there are any jobs out there in the economy that an applicant with this set of conditions is supposedly able to do, and if it says there's none, then you allow the applicant.

However, many cases it says there's some, so what you've now done is you've narrowed down the sorts of jobs that that applicant is able to do. And then you go on to consider the mental capacity of -- the residual mental capacity of the applicant and whether that is consistent with doing any of those jobs, and you know, potentially you can further narrow down the jobs the applicant can do and if it comes out zero, then you allow the claim, but if it comes out that there's a substantial number that they can still do, then the claim would be denied.

So that's the way it works roughly. And I know there are people here who can tell you a lot more detail than I can. So the vocational factors play a very important role in the adjudication process and some of you saw (inaudible) speak at lunch yesterday and he had a nice graphic up there about how many allowances are made using the vocational factors and how that's increased in percentage terms over the years. It's well over 50 percent now and I think that doesn't count the many cases that are allowed at the appeals level, you know, by an administrative law judge where we have much less information about what the factors were that really led to -- you know, what the issues were in the appeal and what eventually led to an allowance.

So it's really, really important especially for those older applicants, those over the age of 50. And of course, a lot of denials are based on vocational factors as well. In fact, anybody who's denied, almost all of them get up to consideration of vocational factors. Well, at SSA's request, David Mann and I conducted an exhaustive review of the literature on the evidence to support the specific way in which SSA incorporates vocational factors into the disability determination process. And consistent with SSA's request, we define the research question very narrowly to match the way that SSA is actually using the vocational factors, specifically in the grid. So that is that we sought evidence on the extent to which age, education, and work experience affect the person's ability to perform substantial work that he or she has not performed before, new work, independent of all other factors such as health impairments, limitations, motivation, general labor, market condition, et cetera.

So in other words, to what extent do the vocational factors affect ability to successfully learn how to

MPR
2015 DRC Conference_Day 2 Part 4

perform new substantial jobs? And the main finding of that literature research is that there is no such specific research out there. That's not to say that there's no research about vocational factors. In fact, there's a ton of it, there's lots of research about the relationship between these factors and whether people are working are not, but the problem is that we really don't know what the causal parts of that relationship are. Whether it's ability to learn new work, whether it's something completely different about other things that affect people's lives and their decisions to work, and the decisions of employers to hire them, et cetera.

And it's really just impossible to disentangle the causes of that relationship in a way that would help SSA inform their use of the vocational factors and how they affect the ability of applicants to do their work. So our finding also doesn't mean that the adjudicators are making a decision that's completely devoid of evidence. There's a ton of evidence that goes into the decisions. They have substantial evidence about the functional capacity of the claimant, as well as age, education, and their past work.

They also have substantial evidence about what various jobs require, albeit the evidence they have about what jobs require always is needing to be updated because the nature of that changes all the time, and SSA has had a very hard time keeping up, I think they'll certainly acknowledge that, so -- But the more specific problem -- let me get my drink here --

(Audience laughing)

The more specific problem is matching up the evidence, right? So the problem is the inadequacy of the evidence from determining how age, education, and past experience, specifically affect a person's ability to perform new jobs. So for instance, we don't have evidence that a person who is 50 to 54 year olds, which is one of the age categories, is discreetly capable different, in terms of their capacity to learn a new job than the person who is otherwise the same except that they're only 45 to 49. But that's in fact, what the grid's do, right, that they tell you there are some people --

If you're 45 to 49, you still can work; if you're 50 to 54, you can't work; and you otherwise are exactly the same. So that's where the problem lies and we just think there's never gonna be the kind of research that can support decisions like that, no matter what we do. It's really hard to imagine how you'd come up with that research, you know, we can't take people and, you know, use them as guinea pigs and experiment where we change their age and see if they can do something that they suddenly couldn't do in the previous year.

So what we think is that we really need to consider, policy makers need to consider why vocational factors are needed in the first place, and come up with an approach that meets the need and can be supported by evidence and is gonna be practical. So I think it's helpful to think about what role vocational factors serve, and I think they serve really two roles. The first is that they're a way to address the well-established fact that the ability to engage in substantial work is not dependent on medically determining conditions alone. And the second is that they're a way to address the inequities that would arise if we only used listings up to the full retirement age, and then allowed full benefits the next day on the basis of the full age alone, right? There's confusion that can be there.

And I think it's been well established that the ability to work is not determined by medically determined conditions alone, everybody knows that now. It's a combination of that and many contextual factors, and the services and supports that are available to people that may have significant medical conditions and impairment, but with some appropriate services or supports or whatever, actually could, in fact, work. And you know, it does include the vocational factors, but it's really much more than that, there's many other environmental factors.

So SSA currently really only considers the contextual factors through the vocational factors and a little bit in terms of whether the person's own physician has said that, well, in fact, they've took this health treatment, or they got this assisted device, or something else, that they would be able to actually work. In

MPR
2015 DRC Conference_Day 2 Part 4

that case, SSA might deny them, but otherwise, there's really no consideration given to contextual factors. So there is another approach to considering contextual factors that's being used in a few countries in Europe, most notably the Netherlands, and that's basically looking at workers, seeing what they need to go back to work, giving them those things and seeing if they can actually do it. That's a real test of whether a person can work given the supports that are available to them and all the contextual factors that might affect their ability to work.

And of course, if they're successful and go back to work, that's great, they don't get benefits -- success is being denied benefits, but you know, if they're not successful, then you've got the evidence from that whole effort to go back to work to see whether or not the person -- you know, to help you determine whether they should get benefits or not. So my colleagues, you already met SHALOM and David Mann and I have an outline and an approach that we could do that in the United States, but there's a lot of research that would need to be done before. We can do that. But it is something that research could certainly inform. I also think the vocational factors can be, you know, are used to address this fundamental inequity that I already mentioned, and I think if you think about the reasons for that inequity, having to do with what happens to people as they approach the full retirement age but don't quite get there yet, they've got a medical condition, they can't do their old job anymore, and is it really fair to deny them benefits and then turn around and allow them benefits, or allow the same person, virtually the same person who is perfectly healthy full benefits at the age of 66 now, the full retirement age. And you know, part of it is -- one of the reasons it's inequitable as well, doing a new job requires investment and that can be very costly, right? And what we currently are considering is just whether after that investment is made, the worker is able to continue to do work, which we call substantial activity, but we don't consider the cost of the investment at all. And of course, the closer you are to full retirement age, the less and less return there's gonna be to any given investment, so I think we could consider that.

We also could consider the fact that employers are less willing to hire older workers, for some reasons that are legitimate and some that are not, and I think the legitimate ones have to do with the employer's willingness to invest in somebody they don't think is gonna be around in the labor force for very long. So finally, all other things equal, older SSDI applicants with medical problems that are significant but don't meet or equal the listings, are likely to die much sooner than a healthy worker who claims retirement benefits at the full retirement age. So now all of a sudden, we're in a situation that means the SSI applicant is likely to have the added misfortune of not only being sick and dying, but they're likely to receive fewer Social Security and Medicare benefits than the healthy worker who attains the full retirement age.

I think researchers can produce a lot of information, they already have about these issues, and if we looked at those issues, and I think actually you're gonna hear about some of that research, both in this session and the following one --

And if we thought about a different way to use all of this evidence in the decision making process, it would be very useful. Thank you.

(Applause)

Alright, next we'll hear from Judith Cook who is a professor of psychiatry at the University of Illinois at Chicago, where she directs the Center on Mental Health Research and Policy. She also directs the center that studies co-occurring psychiatric disabilities and chronic medical conditions, and directs a number of DRC studies.

Ok, did everybody follow everything that Dave just said? Ok, so vocational factors, physical exertion, age, education, and past work experience. And I'm mentioning those because that's what my presentation's going to focus on. And I'd like to acknowledge my collaborator in this work, Dr. Jane Berg Miller, and to acknowledge SSA funding through the Disability Research Consortium and Mathematica. And also to acknowledge SAMSA for funding the original multi-site study from which our data come.

MPR
2015 DRC Conference_Day 2 Part 4

Ok, so I think Dave Stapleton's provided us with a throw-up picture of the background issues. We sought to examine the relationships between employment and the three variables -- age, education, and recent work history -- among older versus younger workers. Our data come from the EIDP, a national multi-site study of labor force participation of people with psychiatric disabilities. Data were collected from over 1600 unemployed individuals in eight states who had a serious mental illness accompanied by severe functional impairment. The majority of our respondents were younger than age 50, but around 200 were age 50 and older at study baseline. We looked at their characteristics when they came into the study, and then at their subsequent work outcomes to see what we could learn about their ability to engage in new substantial work.

There we go. Around a third of study participants were residents of the Northeast, a quarter resided in Mid-Atlantic states, nine percent in the Southeast, and 35 percent in the Southwest U.S. We compared the older and younger cohorts and found that females were over-represented in the older group relative to the younger group, and also that the older group had a higher proportion of white non-Hispanics, and a lower proportion of black non-Hispanics. However, the age groups didn't differ significantly in the proportion of Hispanic Latinos, SSI or DI beneficiary status, geographic region, or interestingly, self-reported physical health.

Older participants, as we expected, had poor vocational outcomes, in terms of working at all -- and this is over a 24-month period -- engaging in any competitive work, number of hours to work, and earnings. Significantly fewer older participants than younger ones had a recent employment history, which in this study we defined as holding a job in the five years prior to study baseline.

There was also an age group difference in education, but here the older group had an advantage in that they were more likely to have education beyond high school than the younger group. Not only was the older group less likely to work than the younger group, when we examined age in ten-year increments, we saw that the likelihood of work also diminishes with increasing age. In this figure, the observed proportion of individuals employed by age group is shown in the blue columns. And you see that the proportions generally decline with age, except for a spike in the 61 to 65 year age group. The red line shows the predicted probability of working in each age group, derived from a logistic regression model adjusting for recent work history, education, gender, and race/ethnicity. So the decline in both observed and predicted employment is generally linear.

Next we wanted to see if recent work history mediated the effect of age on employment. In an I-multiple mediation model, we found that age is significantly related to both work history and education level. Work history is significantly associated with employment, but education is not. The total negative effect of age on employment is significant and only partially mediated by work history, as seen in the significance of the direct effect. The indirect effect of age on employment mediated by recent work history explains around 31 percent of the total effect, but age remains a significant direct effect. Next we wanted to look at job characteristics among those workers who subsequently did work, to see whether those could serve as a measure of vocational functioning. Remember, we're searching here for the elusive vocational functioning measure that's better than physical exertion, age, education, and work history.

Here we found that old workers tended to have fewer jobs and their jobs lasted longer. Older workers were less likely to quit or be fired from jobs, and they were more likely to be laid off. There was no difference in the presence of reasonable accommodations or hourly wage. To further look at job characteristics as a proxy for vocational functioning, we used the Department of Labor's Dictionary of Occupational Titles worker function ratings of different jobs. Every job in the U.S. labor market is given a rating on three dimensions to measure the level of ability required in manipulating data, working with people, and working with things.

Across both age groups, people held jobs with low ability requirements, which was not a surprise. But older workers' jobs were significantly more functionally complex on two out of the three dimensions. Older workers had jobs of higher complexity in working with data and working with people, but not working with

MPR
2015 DRC Conference_Day 2 Part 4

things. In addition, older people's jobs were more often in professional managerial occupations and clerical sales occupations than the younger cohort, but most jobs for both age groups were in the service industry. Finally, we wanted to see if clinical features of people's disability could serve as measures, again, proxy measures of vocational function, since many of these clinical features have been found to be related to poor vocational outcomes, such as: diagnosis, symptom severity, and presence of cognitive impairment.

A lower proportion of older participants had schizophrenia spectrum diagnoses, a diagnostic category that's typically associated with poor outcomes, and more often had mood disorders such as depression and bi-polar disorder diagnoses, which are typically associated with better vocational outcomes.

Older participants had lower positive symptomatology than the younger cohort, such as hallucinations and delusions. They were less likely to be non-adherent to psychiatric medications than the younger cohort. And a lower proportion, interestingly enough, of the older group had co-occurring cognitive or developmental disabilities. In general, compared to younger participants, older participants had psychiatric clinical characteristics that are associated with better vocational outcomes. So to summarize, we did find a direct and negative relationship between older age and employment among people with psychiatric disabilities, even controlling for factors on which the two age cohorts differed. We found that some of this relationship stems from the poor recent work histories of older people, but we also found that older people had more post-secondary education, we found that older workers who subsequently worked, had higher quality and more demanding jobs, they stayed in their jobs longer, and were less likely to quit or be fired than younger workers.

Finally, older participants had lower levels of psychiatric symptoms, better medication adherence, and were less likely to have cognitive impairments. All of which are related to more positive work outcomes. So, we conclude that even though there is a negative relationship between age and employment, older people with psychiatric disabilities may have better vocational ability and functioning in terms of their educational attainment, as well as more stable clinical symptoms, and experience in jobs that reflect more complicated abilities. And finally, our research and others suggest that older people with psychiatric disabilities may be subject to some fairly stringent age discrimination that may override their vocational functioning and any residual capacity they have.

Thus, as Dave noted before me, contextual factors are likely to play an important part in determining that elusive concept of an individual's ability to engage in future substantial work that is of interest both to SSA and to others of us. Thank you.

(Applause)

Thanks, Judith. Next we have Lauren Hirsch Nicklaus who is a health economist, and an assistant professor of Health Policy and Management, and Surgery at Johns Hopkins Bloomberg School of Public Health and School of Medicine, and is also a faculty affiliate of the University of Michigan Survey Research Center to which I say, "Go Blue."

You guys can all imagine some really beautiful slides coming any moment. Oh, there. Ok. Thank you. So to further inform our discussion about the potential work capacity of older adults and the extent to which age as a vocational factor may sort of proxy for some of the other difficult to measure cognitive and physical health characteristics of this population, I'm going to be summarizing several of our SSA and NIA funded studies looking at this age group, which again, do not represent the opinions of any of our funders, although we are very grateful for the support for the research. In particular, I'm going to be focusing on the population age 50 and above.

All of the data I'm going to be showing you are based on the health and retirement study, which is a large and nationally representative panel study that you guys have probably heard a lot about over the course of this conference, includes a lot of very useful information on self-rated health, self-reported disability

MPR
2015 DRC Conference_Day 2 Part 4

status, functional limitations, demographics, cognitive screening, which we haven't talked as much about in this conference, but I'll be showing you something about early signs of cognitive impairment in this group, and these survey data have also been linked to a number of other useful data sources, in particular, Medicare claims, which I'll be talking about in a few of our slides, as a way of capturing health status of this population through their health utilization, and we're gonna focus on spending as kind of a summary measure of utilization, (inaudible) common ages, 65 when you qualify for Medicare by aging in, and then 70 when all of our study members have been exposed to the same insurance program for several years.

This allows us to answer the question of whether early claimers are -- those claiming their Social Security benefits at earliest eligibility ages are too sick to work, so are people being correctly picked up and rejected by DI, or are these early claimers people who potentially should have moved on to benefits earlier. We're going to compare four groups of beneficiaries: those you enter the program as SSDI recipients, rejected SSDI applicants, those claiming Social Security between their earliest eligibility age and full retirement age, and those who wait for full retirement age. And these comparisons are basically making the assumption that if you use more healthcare, it's because you're in worse health and not because going to the doctor is really fun --

(Laughter)

And so we think that this greater need for healthcare is also going to suggest a lower work capacity. So what do these groups look like? We see health limitations are sort of extremely prevalent among both those who eventually receive SSDI benefits, as well as, in fact, all of our rejected applicants report that they have a health condition that limits their ability to work. When interviewed subsequently, in comparison, about two-thirds of those claiming benefits both early and at full retirement, make a similar statement, so sort of high levels of impairment among this group at age 65 across the board and somewhat striking differences coming into contact with SSDI.

We also see much higher rates of health limiting your ability to do housework among both the SSDI recipients and rejected applicants, and kind of much lower levels of limitation for general activities among all four groups. How does this manifest in terms of healthcare utilization? These bar graphs are showing mean Medicare spending at age 65 for each of our four groups. The blue bar represents unadjusted Medicare spending. The red bars adjust for demographics and other observable differences between these two groups, and as you all know, don't make very much of a difference. Medicare spending is sort of strikingly higher among the SSDI, particularly recipients that have an average of about 9500 dollars per year with a median that we'll get to on the next slide about 2,000 dollars, very typical of healthcare utilization, a small number of beneficiaries account for a large amount of spending so these mean spending figures that I'm showing you on this slide are going to be significantly larger than the medians, but we'll have similar patterns for both groups, markedly higher utilization of both our SSDI recipients and the small group of rejected applicants.

And this utilization is statistically significantly different from both the early claimers and the full retirement age claimers, no difference in spending among those delaying to full retirement age versus the early claimers, so we don't see, for example, a large group of sick people moving on to Social Security as soon as possible at age 62. And very similar patterns when we look at the median spending -- sorry, there it is. And I also worry that these differences are driven by the fact that people have different types of insurance coverage and prior to the Affordable Care Act, these data come from 2008 and earlier, so gaining insurance coverage through Medicare might make the disability beneficiaries different from others.

But when we look at age 70 when everyone has been exposed to the same insurance system for at least five years, we see this sort of continuing pattern. Now the SSDI recipients are using markedly more care than all other groups, and the rejected applicants are starting to catch up and look more like the early and full retirement age claimers. This is true in both mean and median spending. The other are that's gonna be important for thinking about work capacity of this group is cognitive functioning. So we can use the

MPR
2015 DRC Conference_Day 2 Part 4

health and retirement study data to look at a couple of clinically important categories of cognition. The first is mild cognitive impairment and so this is not full-blown dementia, but difficulties in some areas, for example, memory, counting backwards, so often still functioning in the community, and you see many of these people are even continuing to work, very low rates of full-blown dementia, but I want you to note the non-trivial rates, particularly of those who are already out of the labor force in each of these five year age intervals. We have approximately 20 percent of older adults not currently working at each of these ages already exhibiting signs of mild cognitive impairment or dementia, and this is clearly going to not only impact your ability to do a current job, but certainly be retrained or learn other skills.

So I think, finally, we want to think a little bit about the role of Medicare, and I think David touched on the importance of thinking about ways we might use some of these contextual factors in the future, both in terms of thinking of alternative ways benefits might be provided for example, with earlier access to Medicare or other health insurance. And particularly now that we have Affordable Care Act plans available and less likely that people are going to undergo persistent periods without health insurance. We've seen that older workers who receive joint replacement, for example, are 14 percent less likely to report that arthritis limits their activities after having the arthritic joint replaced. There are also surgical options for other disabling conditions, things like bariatric surgery and organ transplant, which may be relevant to some of these populations. Medicare is already covering 15 percent of the bariatric surgeries in the 50 to 64 population for people who have entered the program through disability. So I think this may be an important area, that we can think about future reforms, to the contextual factors. And just to sort of sum up some of the key findings, there are non-trivial levels of cognitive physical impairment that may preclude work or retraining among older adults. This is certainly not uniformly true.

And we don't actually see a lot of evidence that serious health needs are driving early Social Security claiming among those who don't have any previous contact with SSDI, right? So a large number of older adults who are sort of reaching old age benefits, in very good health, at least as captured by their subsequent utilization. So I'll turn it over to Kathleen.

(Applause)

Thanks, Lauren. And last but not least, is Kathleen Mullen who is an economist and the director of the Rand Center for Disability Research.

Now we just have to find my slides. Ok, well, thank you very much, Lynn, for inviting me to come and talk about some of the -- you know, my talk is actually gonna be a little bit more speculative, I think, because Lynn asked me to talk about the role of workplace accommodation and thinking about workers that are at older ages and the vocational factors and how they relate to people's ability to work and how that should relate to SSA's decision making in terms of whether somebody is, you know, eligible for disability insurance benefits or not. So I think this actually is a nice bridge between this session and the next session, which is talking about the employer side of things, so obviously, you know, figuring out whether an employer accommodation is possible, or what kinds of accommodations would be entailed, is the result of a partnership between the employer and the employee, and so I'm going to be focusing on the employee side of things.

You may hear more about the employer side later. So I was hoping that, I was kind of, you know, thinking during Dave's talk, I wished that I could lend him my slides 'cause I did just, you know, put this into my slide pack just in case it helped kind of contextualize things a little bit, so we're all focusing on the sort of Step 5 of the five-step disability determination process, where disability examiners and adjudicators are asked to consider these medical vocational guidelines indicating their decisions. So the medical vocational guidelines, aka The Grid, I thought, just sort of thinking, to prepare myself for thinking about this, let's kind of look up what Social Security says about, you know, what the role of the grid is online.

So you can find that basically, it says, the grid combines the vocational factors, which we know are age, education, and work experience, with the examiners assessment of the applicant's residual functional

MPR
2015 DRC Conference_Day 2 Part 4

capacity which is essentially their assessment of the applicant's sort of maximum sustained work capacity. So you know, can they sustain light sedentary, heavy, or very heavy loads?

So you know, the combination of these two things to evaluate the individual's ability to engage in SGA, and I thought this was particularly relevant, it says that basically -- it's specifically looking at vocationally relevant work, other than his or her past work. So what it does is it recognizes that people with different education and skills, you know, might have different ability to work with a sort of specific type of health impairment. So one thing that, you know, is why what I'm talking about is particularly speculative is the availability of an appropriate job isn't really supposed to be a factor here, right? It's whether the person can work, not whether they can find a job, find somebody who is actually willing and able to accommodate them. So I thought that was kind of interesting and so I'll be talking about I guess whether or not that would be something that would be, you know, something we should think about.

And as Dave mentioned, Step 5 determinations have been growing as a percentage of cases. We saw some evidence on that yesterday and also, you know, I have some recent work showing that Step 5 allowances and denials are particularly sensitive to economic conditions. So when the unemployment rate goes up, these types of cases are much more likely to apply for disability insurance and right now we're showing that virtually all of those cases are denied at the initial level so we still have yet to see what happens as they make their way through the administrative law judge process. But we also saw yesterday that there was sort of a less than expected increase in awards commensurate with that increase in applications during the Great Recession.

So we may not expect that some of these people have, many of these people have made it on the system, but it doesn't change the fact that they have been in serious contact with the system and, you know, not engaged in substantial gainful activity while applying, and so, you know, they may have still been affected by the system. So I just kind of wanted to think about how would we sort of put together, you know, what we know about this issue. So what I have here is basically, you know, on the Y axis we have the job demands of a particular job. This could be the mental demands or the physical demands of the job. And on the X axis, I sort of graphed the person's physical or mental ability to work by reason of their health.

And so, you know, if you kind of draw this 45 degree line, you divide this area into, you know -- so each kind of space here, each point in this space is a job match between an applicant with a given health level in a job with certain demands, and below this 45 degree line, you have sort of, you know, these matches where the person can work in that job; and above the 45 degree line, you have matches where the person couldn't perform the job at their level. So today I have a bigger printout. So here, you know, I'm just graphing, this is a person with some given, you know, level of ability and the Y axis is giving us (inaudible), sort of their level of job demands for some particular job and you can already see that basically the less demanding the job, the less likely that a health problem is going to kick somebody out of their ability to work at that particular job.

And when you think about people with different education levels, you know, you might think that people with more education, college education, can sort of do more things on that spectrum. Somebody with high school education, limited background, might only be able to perform particularly demanding jobs, and so they might be in a situation where more of this space is covered by that "can't work" part of the region. So when you think about how a health shock reduces a person's ability to work -- so here I'm just graphing, you know, what happens if somebody has a health shock that kicks them over from the can't work side -- or, the "can work" side to the "can't work" side of the graph, you know, for their particular job that they're in at the moment this happens.

And this doesn't actually have to be something that happens in, you know, one shot. It could happen very gradually over time where they kind of are dealing with a health problem and trying to figure out how to get it to work, and it sort of just, gradually their health deteriorates to the point where they can't do their current job. So what can be done to kind of kick that person back over to the "can work" space? So one

MPR
2015 DRC Conference_Day 2 Part 4

possibility is a case where your current employer can accommodate your health problem. And so you can do this in a couple of different ways. So here I'm basically graphing a possibility where the employer performs an accommodation that restores the individual's ability to work, just enough so that they can perform the job that they're in right there.

Another possibility is that the accommodation could -- maybe it couldn't fully restore this person's work capacity to the point where it was before, but they could also maybe reduce some of their job demands or sort of restructure things so that that side of the spectrum could be utilized.

And another possibility is that maybe the current employer can't do anything to work with the applicant, but maybe there's another job out there that the person can find that has kind of a job demand level that's commensurate with their skill level, or their ability level. So this is a slide that I just showed you, you know, word for word yesterday, and just to remind ourselves that when we're thinking about employer accommodation and the role of employers -- and this is definitely not something that's in a vacuum, so we have to think about, you know, other legislation, what's out there.

And so, obviously we know the Americans with Disabilities Act is out there, you know, and it mandates that employers provide reasonable accommodations except in cases of undue hardship, and they can work with the employee to figure out, you know, what's a way to do this? It doesn't have to be that they, you know, reject or accept the proposal of the employee. And they can list other people to help with this, too. We learned earlier about the Job Assistance Network, which provides free advice to employers about how to do this. And but, you know, the reach of the ADA is definitely limited by how the courts will interpret these laws and will enforce the laws, and so that's something that we need to take into consideration. And then, this is -- I think I'm gonna skip this, which is just what I showed yesterday.

So um -- I cannot see that far away -- so I'm reminding myself what this is here. Um, ok, so here I just wanted to kind of show some evidence on what types of accommodations. We have some data on what people are doing, so this is giving you some tabulations from the Rand American Life Survey that I talked about yesterday. So what we're looking at is the percent of people who are currently accommodated at work, they're working for someone else, so this is excluding the self-employed, we know what they do for themselves. And what we're doing is we're basically kind of plotting out and putting into different categories the different types of accommodations, so whether you allow more breaks or rest periods, allow the arrival or departure time to change, or shorten the work day, these are kind of manipulations about time, or the timing of work.

And you can see that, you know, there's quite a few of those accommodations. The next set of accommodations is whether you change the job to something the person can do, or you help them learn new skills that, you know, would help them be able to stay in the job, and so, we call this kind of like a work change accommodation. And then finally we have, whether you can get somebody to help you, get some special equipment, arrange for special transportation, so this is sort of the provision of some kind of equipment or job assistance. And you see that, you know, we've got quite a range of the different types of accommodations, which makes sense, you know, people have a lot of different types of problems. But we wanted to kind of see, you know, what is associated with kind of better outcomes?

So we don't have any of that right now in the Rand American Life panel, we're just sort of just now starting to dig into that data and it's like, just as of last year, so we'll have some updates on how some of these guys are doing a year later in our current DRC project, but I can show you some data from the Health and Retirement Study, which Lauren just described to you and which also is relevant here because it's dealing with older workers. So this is tabulations from the Health and Retirement Study of individuals ages 50 to 62, who report that their health limits their ability to work, you know, for the first time. And then this is the percent of people who are accommodated with these different types of accommodations at onset.

So remember that they were asked, "Were you employed at onset? And what were the types of accommodations that were provided?" So there are a couple of different things about these two columns.

MPR
2015 DRC Conference_Day 2 Part 4

One is age, although, I did check, I can tell you that age isn't really the big factor explaining these differences. But the big difference, I think, here is that the sort of right column is showing you what happened at onset, and the left column is showing you what types of accommodations are actually in force for a group of people who are currently working. And then finally, I thought it was interesting to show the results of another paper I have with Matthew Hill and Nicole Mastis, where we use data from the Health and Retirement Study on people who are ages 50 and above, but below the early eligibility age for Social Security benefits. And we're looking at new onset, so people who, between two waves, said that their health didn't limit their ability to work, and now their health does limit their ability to work. And what happens, you know, the next wave, in terms of, you know, how many of these people are still working, by whether or not they received an employer accommodation.

And what we did here is this is showing you the effect of the type of accommodation, so any accommodation, or whether it's one of these three types -- Sorry, I think there must be an omitted category and I'm not remembering what it is -- But anyway, so the mean dependent variable is 41 percent, so this means that 41 percent of this sample is working, you know, within two years of onset, so this is one wave later. And you see that any accommodation at all increases the probability of working by 15 percentage points. That's a pretty large effect. And then when you break it out by the types of accommodations, the only one that really shows up is this work change.

So it's whether your employer is changing the job to something you can do, or helping you learn new skills. If you add these two effects up, then you basically get that -- if an employer does one of these two types of accommodations, this increases your probability of working by 28 percentage points, or nearly 70 percent. So we were thinking that this might be an especially promising, kind of avenue of research to think about in future work. And then one caveat I did want to mention is -- so the good news is, this is huge, right? But the bad news is that it's temporary. So when we look at working four years later, we find this effect completely goes away. And actually, we don't see any effect in terms of these accommodations on applying for or receiving disability insurance. So this is a group of people who aren't really -- they're on the margin of working or not working, but they're not on the margin of applying for disability insurance -- yet.

So they may be on that path, but they're not there yet. So in thinking about the discussion and sort of what we want to be thinking about in terms of future research, I just sort of listed some things that I thought could be kind of fruitful. So one is, you know, how can we unpack this work change effect? Can we achieve the same thing with job training? You know, a lot of the discussions that we've heard in proposals have focused on, you know, retaining that connection of the disabled worker with the employer, but we haven't really talked as much about what happens if maintaining that connection isn't possible, you know, how can we move the disabled person to another job, like another employer match that would be good for them? And also, I think, it's worth thinking about when you think about how these types of reforms would potentially be able to weather business cycle effects.

You know, if your reform is really focused on maintaining that connection between the worker and the employer, in recessions, you're much more likely to lose that connection, and so, that might be much less effective in sort of worse economic times and better economic times, and so, that might be something to think about. Also, you know how many successful workers with disabilities change employers rather than obtain an accommodation from their current employer? I think that's worth, you know, looking at. And one of the things on our research agenda -- and this was, I think, actually a question -- Is there research on this? And I think the research is limited in the previous session.

And finally, you know, what are some predictors for who is most likely to successfully change jobs or adapt their current job to their situation? And so some of the things we've been thinking about are, you know, cognitive flexibility measures, you know, is that predictive of maybe an individual taking some more of a personal stake in their own circumstance and advancing their case before their employer, or taking actions on their own. And then of course, age, education, and work experience, which are sort of the traditional vocational factors that we've been thinking about, and maybe there are other types of

MPR
2015 DRC Conference_Day 2 Part 4

vocational factors that would be worth thinking about. So in fact, today, I end early, so I'm pretty happy about that, but thank you very much for your attention.

(Applause)

Alright, I think, actually all of our speakers ended early today so we have a fair amount of time for questions. There's one in the back. Maybe the microphones aren't ready yet. They weren't expecting this.

(Laughing)

Thanks. Marcia Katz, and my question's for David. Wake up, David. (laughter) So when y'all were doing the work on residual functional capacity and The Grid -- as was stated by one of the other speakers, you know, we know that this doesn't matter about whether jobs are available in the area where somebody lives, like Twodot, Montana. And there is a Twodot, Montana. But I'm curious about the jobs that don't exist at all, but still appear in the instrument that Social Security uses -- The Dictionary of Occupational Titles. I mean, I'm frankly surprised that there hasn't been a class action suit against Social Security because there are gonna be denials based on The Dictionary of Occupational Title decisions than jobs that don't exist, and yet, there could be people who could in fact work at jobs that aren't in The Dictionary of Occupational Titles yet because it's 473 years old. Did y'all look at any of that, or do you have any discussion about that?

I'm aware of the issue, certainly, but we were not asked to look at that specifically. You know, Social Security is going through an effort to try to update the job requirements it uses. And I also think it's fair to say that while they still do rely on the Dictionary of Occupational Titles, they also rely pretty heavily on vocational experts who have a lot more up-to-date information about jobs, just from their experience, and it's less symptomatic, and I think less satisfactory than having an up-to-date Dictionary of Occupational Titles. So I would say it is a significant problem and I think Social Security knows it's a significant problem, too. But I don't have any new information.

Because I've heard that now for more years than you and I have fingers, and so, I don't know when --

Right, if somebody here from Social Security has some information they want to share about the current effort to collect new information, that might be helpful, but I'm not able to do that.

I saw Denise's hand -- unless anybody from SSA wants to -- We'll go Denise, and then we'll go to that side.

I have a half question, half potential suggestion. For these, perhaps the DOT isn't the best source of occupational listings, but do you all know if Social Security does anything with the list? Because it seems to me like there's this identification of potential job matches for the beneficiaries, and we've learned so much about early intervention, and perhaps application isn't quite as early as we had hoped, but still perhaps for these denied applicants, this seems like a great opportunity for them to get like a list since effort's already been -- perhaps substantial effort with vocation experts has already gone in to identifying potential matches, it seems like it would be a great intervention. So again, this is half suggestion, half question -- to just provide the beneficiaries with this list to say, hey, maybe try these jobs.

Actually, I think it's the case that they do, but I would rather have somebody from Social Security answer this question. My understanding was that in the denial letter, they provide information about at least three jobs that they think the person could do.

I've not heard this, this is Pat --

Formerly from Social Security.

MPR
2015 DRC Conference_Day 2 Part 4

I'm not currently from Social Security.

She can talk about when the Dictionary of Occupational Titles was current.

(Laughter)

How dare you!

(Laughter)

Where is your cognitive ability? I love it. Thank you, David. I have been doing some work lately on looking at what Social Security has been doing about various things, and certainly about the vocational factors, and they are working with BLS and they don't -- Marcia, you stressed that old DOT as it is now. They have revised with some augmented kinds of information that they use in order to make those decisions. Now, I don't know how formal it is, but I do know that there are even some automated systems that they can use about jobs. I also know that in the Ticket to Work operations and WIPA, and so forth, that the feed-in, the kinds of jobs that they find that people could be able to do, the major, kind of major categories, that there is an attempt to work with employers -- to find employers in communities that have those kinds of jobs. So there is some connection. I'm not saying how perfect it is.

Do you know if any of those other -- include environmental factors or something in addition to the physical and mental capacity?

I only know that they are/have been working on a cross-government agency project that I've had a little work with them, on the ICF, and how does the International Classification of Function and the various things -- how will that eventually, could that eventually work into the evaluation system? We all know it's a classification system now, not an evaluation system, but certainly with IOM and others, there's been work on that. I have a question though. It's a question I think for you, I was just wondering in your group, when you had people who were denied for disability, there was that one group; and then people that went on disability at age 62, was there any feed over, you know, where some of the people who were in that denied category also people who applied at age 62?

So we took everyone as of age 65, so if you applied and were denied and then subsequently got accepted, you're in there with the other recipients, so -- So you can only be in one category. So you can either make it to age 65 having ever received benefits, having applied but never received them, or having neither applied nor received.

Thank you.

I'm gonna take the liberty to ask a follow-on to Denise's cause that's what I was wondering. Do you know, is any information provided to denied applicants, anything about connecting them to VR Services? I mean, we've talked a lot about fragmentation and people not being aware of what's out there, and especially for this group, I think DOL does offer some services.

(computerized voice) David mentioned this morning, there is legislation on the Hill that would enable us to make those types of repairs. I know that we have looked at being of more assistance and supportive of applicants that are denied. And there are statutory limitations against the legislation going forward.

Thank you. Apparently, I didn't pay enough attention earlier, or thought of the question later. Thanks for clarifying. There was a question right there.

Joann Schneider, GW. For an aside, I've been slowly but surely developing something called Keys to Successful Employment for a while and we've done some, a lot of reviewing and a little bit of preliminary interviews, and you know, some of the things that come up are networks and self-efficacy and then

MPR
2015 DRC Conference_Day 2 Part 4

there's a whole bunch of other things, so there's a lot -- I agree, there's not much research on this and there needs to be. But I want to switch to something else for a second. You know, when David started speaking, I thought, you know, now why would any employer, with all the other applicants out there, hire somebody who's over 50 and has never done this job before? You know, so I was wondering, from those of you who have these studies, Judith and Kathleen, you know, are those accommodations, Kathleen, in the same employer? Yeah, that's what I thought. And Judith, do you have data that says whether, when they're getting these jobs, again, it's a different kind of job as previously or not?

For the older group you're asking about? Yeah, typically, it's a totally different kind of job because they haven't worked at any jobs in the last five years and when this study was done, it was done in the '90s and the early oughts and so, people with psychiatric disabilities who are older seldom were encouraged to go back to work. So many of these people had not worked in decades. I mean, we only looked at the last five years, but -- what's interesting is that they really wanted to, and that when they did, they, in some ways, had better vocational functioning than we might have thought, from the indicators we can look at.

Dave? Sorry, this Dave. It's hard in this room.

So this question is for Kathleen. You had mentioned the temporary effect of accommodations and I was kind of struck by the fact that four years later, even those that were accommodated and immediately successful, were no longer working, but they weren't on DI either, so I was wondering if you could clarify that statement. And also, for the group that didn't get accommodated, where did they wind up, and do you have any evidence on where they wound up? Because ultimately, what I'm trying to get at is sort of both short term and long term effects of accommodations.

Yeah, it's a good point. I should have brought up that there are limitations to the study so, in fact, I talked at length about one of the big limitations of using HRS to look at employer accommodation yesterday, and the big one being that they only ask about accommodation if you say that your health limits your ability to work in some way. And so, we know from, you know, our evidence from the Rand American Life Panel that there are people who are working and who say that they are receiving some accommodation for a health problem from their employer, and you know, we asked them about the same types of accommodations. They say that their health doesn't limit their ability to work, and so obviously, we can't factor those people into those regressions. So you know, we're kind of dealing with a bit of a problem where we need to let a little bit of time go by before we can see what happens with the people in the ALP.

And we are looking at a one year follow-up, so we probably will be able to get some answers, you know, sooner or so. Of course, you know, there we're dealing with the fact that we have a small sample and we're unlikely to get a lot of new onsets in any given year and so, you know, following people as they transition from better health to poorer health is not necessarily feasible in that particular study. So I suppose that's a pretty unsatisfying answer, but I don't know. I guess the point of that is to say that this temporary effect, you know, it could be that it's not the case in a younger sample, and it could also be the case that we're just sort of missing those people in this data, and so that's why, you know, it's interesting and suggestive, but we need more research to really figure out what's going on here.

Pat?

(Laughter)

I should say that I've been working with David as long as I've been working on this problem, so that would kind of put us in the same --

(Laughter)

He was there when we were trying to fix the Dictionary of Occupational Titles. I think, you know, really what concerns me is that if the health of the population is getting so much better and people at age 60 are

MPR
2015 DRC Conference_Day 2 Part 4

now the new 40 or something like that, why -- I mean, we really do have to do something about this kind of discriminatory, or whatever issue about age being connected with the inability to work because more people are going to have to work at older ages and with impairment -- hip replacements, and -- I don't have one, but -- hip replacements -- So in any event, I think that some connection with the public health information, and the healthier the population is and the rights of older persons with disabilities, there's some disconnect here with not working on that particular issue, you know, that particular part of aging, that we're aging healthier and better and so forth, so should our age be used in any kind of a factor for inability.

I actually think in the next session that somebody will talk about how Labor Force participation for older people is changing, so it might be helpful.

In more recent years, we have started to reverse some of the trends toward better health, so -- with enough junk food and sedentary lifestyles and things, we'll be able to --

(Laughter and talking)

It's at least flat, leveled off; it's not done yet maybe.

(Laughter)

Does anyone else have anything or are we ready for a little -- Ah, Gina. Wait for the microphone.

I'm curious, in your four groups, how is death reflected, and I mean, I guess, because there will be differential death rates among those groups to make it there, but yet that significant disabilities are being reflected -- (laughing) -- or may be reflected somehow, I'm not sure what you did.

Yeah, so these results that we showed you were not adjusted for differential mortality, and we are trying, not only with this project, but a number of others, to find kind of a satisfying way of accounting for both the higher levels of utilization while alive, but potentially fewer life years. So sort of getting more broadly at the question of how progressive some of these programs are, also runs into the same set of challenges, and we talk about it in limitations for now, but if anyone in the audience has particularly good ideas --

I have a related question for Lauren. So as I recall, you had a really nice graphic that showed Medicare expenditures at age 65, I think, for the four different groups, right? And in a previous graph, you had showed the percentage you had -- not sure whether it was work limitation or a significant medical condition, or something -- at age 65. And for the groups that never apply for DI, you know, there was a substantial percentage who did, I mean, 30 percent, right, two-thirds of that --

Two-thirds reported work limitations.

Two-thirds, ok.

And then lower percentages reported housework and activity.

Got it, ok. So I was wondering whether you ever ran the Medicare expenditure means, differentiating between those who reported a condition at age 65 versus those who didn't, but again, within the group that didn't apply for disability benefits.

We didn't directly do that, we did do some sort of rewinding and adjustment to sort of directly compare members of the other groups who had the highest propensities to be disabled and looked most like our disability recipients and got pretty similar results.

Ok, that's what the advancement was, ok.

MPR
2015 DRC Conference_Day 2 Part 4

Yeah, and we did also compare the groups that we saw at all ages, and so when you look at this group with The Grid, as propensity to survive, again, we saw kind of similar patterns, but we can't go back and get the people who don't survive to 65 or to 70.

All right, any last words? All right, well, thank you to the speakers for a really engaging panel.

MPR
2015 DRC Conference_Day 2 Part 5

2015 DRC Conference Day 2 Part 5

Okay, we are going to wrap up the DRC with the relatively simple topic of the labor market and people with disabilities. I am excited to be moderating this panel and we're going to jump right into it. And I'm going to introduce David Newmark who is a chancellor professor of economics and director of the Center for Economic Policy at UC Irvine he's also research associate NBER and IZA. And just one side story there is a my son and I were driving in the car listening to the radio and turned up the radio cause David was talking about the living wage. And my son goes "Wow, that guy sounds cool, do you know that guy?" and I said "Yes I do" and I then asked him, "Am I cool?" and he said "No, you're not." So we had a little case-control study. So, with that I'm going to introduce the cool David so.

Did you ask him what the difference was? Okay, I can see the slides over there. So, I was asked to speak at this panel, and I hope to know why but the time it's over. But I think it actually came up, I walked in halfway through the last one and heard somebody talking about the role of age. So, I've been studying age discrimination from even before I was old. And I want to talk a little, I know, I'm not that old yet, but I want to talk about some new evidence. My understanding of where this fits in to this group's agenda is the question of how much one's age ought to be taken account of, thinking about somebody's employment probabilities. I don't know, as a policy matter, whether people doing disability determination should pay any attention to this, because if we have a problem with age discrimination, that we might think the way to fix it is to address the problem of age discrimination, but I will leave that for another day.

So, what I'm going to do today is actually give you a bit of an overview and then talk about some new research from a study I have in progress that directly addresses the issue of age discrimination. It's preliminary. I've asked them to destroy the slides as soon as I'm done because we're actually in the middle of processing the data. So, nothing leaves the room, okay. So, let me just talk a little bit about the problem. It's like small and there's this really bright light right over it. It's really hard to read, okay. I think I remember what I was going to say though.

So, the general issue of age discrimination pertains to the issue of barriers to older workers employment, right. We know there are strong fiscal challenges to both our public pension system and our disability programs, not just in the U.S. of course. And a lot of this, not all of this, but a lot of it is driven by population aging. And these kind of things have prompted some policy reforms already, in particular respect to Social Security, and a lot of discussion of what else we might do to try to keep older people working longer if they can, and if they want to. And perhaps even if they don't want to. And you could characterize those reforms as partly carrots and partly sticks. Labor supply incentives, changes in retirement ages, and the like. We haven't changed our early retirement age yet. Other countries have.

The extent to which these reforms will work, or at least something that will condition how well they work, depends on what kinds of barriers there are to older workers facing employment, in particular. There's a lot of discrimination against older workers and it's hard for them to find jobs even if they want to, responding to changed incentives or not. Then, obviously the effects of any of these reforms will be diminished. And I also think we run the risk of getting into a viscous cycle where we adopt reforms thinking a lots going to happen and not much happens, possibly because there's a lot of discrimination against older workers. And then we adopt even harsher reforms, and we know that these reforms, any increase in the retirement age, ratcheting up the standards for disability determination, etcetera. You know, some cases that may be the right thing, other people it's going to impose hardships on. So, in some sense, we all recognize we have a multi-dimensional problem to solve. But, in some sense, harsher reforms are always going to entail higher costs for, at least, some people.

So, let me now plunge into the age discrimination literature and tell you, sort of, what I know, and we know generally. And then talk about the specific studies. So, first of all, there's a lot of different views of age discrimination literature. The standard view of discrimination, used a lot with respect to race, and to some extent with respect to sex goes back to the old Becker model and it's about animus, dislike of a

MPR
2015 DRC Conference_Day 2 Part 5

certain group, of interacting with a certain group. With respect to race, certainly looking at our country's history, that's a pretty reasonable view to take. Respect to sex, not so clear. Respect to age, some people say animus doesn't make sense. We're all going to be old, we have parents or we had parents but, you know, I don't know. If animus just means discomfort, or something like that, it could be that people choose or would rather not interact with older people in the workplace, or somewhere else. So, that's one view of discrimination. A second view is stereotypes, right? And there are stereotypes held about the productivity or ability of older workers that may not be true, and may create a barrier to employment. There's an economic model, those are your models of long-term incentive contracts, which to some extent, it's a model where you, many of you are familiar with it, you know where workers are, kind of, underpaid when they're young, at least when they're low tenure, overpaid when they're older. It's not, one can argue whether it reflects discrimination or not, but it creates incentives, it creates a system where older workers are paid more than they're currently worth, and creates some incentives to, either get rid of older workers, or perhaps to avoid hiring them if you're in the business of hiring new workers.

Somewhat a philosophical question whether that reflects discrimination or not, and if you read legal interpretations in the courts, it's also ambiguous. Some ruling view behavior based upon these kinds of arguments as discriminatory, some don't. But, you might say, all these are all stories about discrimination, in one form or another. What makes age so difficult to study, and I think there's both far less work on it than there is on race and sex discrimination, and it's in a sense more ambiguous, is because age also matters, right? Something does change as we age, some capacities diminish for sure, and eventually of course, they all diminish. And the law recognizes this, right? The ADEA is separate from the civil rights act, and that was sort of, if you go back to the history, that was because Congress was not sure how to think about age in terms of sort of a, you know, is this sort of a characteristic stamped on your head and were going to say you can't treat people differently based on it, or is it something more complicated. And what we ended up with is a legal system what says it is a little more complicated. And that probably makes sense.

Okay, that was not the right button to hit. There, I'm sorry. Okay, what does the evidence say? Well, I guess I would summarize it as I say in the title of the slide here. There's a lot of evidence consistent with age discrimination. It's not decisive, I tend to lean towards there is discrimination. The new study I'm going to talk about takes that a bit further. Um, so what do we know? We know older workers have very long unemployment durations. If you look at durations for the young people have the longest. And then unemployment durations sort of come down, it's U-shaped, then they go back up at older ages, okay? That could be a lot of things, right? Could be higher reservation wages, who knows what? But, certainly it's been interpreted historically, in fact it was originally reflected in the language of the ADEA, as potentially reflecting discrimination. There's a lot of research in what's called Industrial Psychology on stereotypes where it's clear that co-workers, and employers as well, as sort of students responding in the lab have negative stereotypes of older workers and the research in the field says those stereotypes affect the decisions employers make, like selection for training programs, I mean hypothetically but affect, sort of, how real employers, not just students in the lab, say they would respond to these signals.

On scientific evidence, ageism language is all over the place, right? People who would never make a race joke will make an age joke. Happens all the time. I won't ask you to raise hands if you've made one in the last six months, but a long of hands would go up, I'm sure. There's just a lot, it's not the same cultural taboo to think about it. I have sat at faculty meetings, I've been at a few universities in my career so I won't say which one, and we have, sort of these distinguished professor things you can hire people for and they tend to be older, obviously because that's how they came to be distinguished. But I've heard people say in a faculty meeting, "He's too old", right? You wouldn't say it, "Can't hire a women", "Can't hire a black". People don't say that, so for whatever reason, it's a social category that isn't just, you know, that enters into conversation and peoples decision making a lot more freely than other categories. That's not evidence, that's what is unscientific evidence, but there's quite a bit of writing about that.

MPR
2015 DRC Conference_Day 2 Part 5

Worker's self-report age discrimination, again a problematic thing to interpret, but when they do, they're more likely to leave their job, they're more likely to retire earlier, they have lower future wage growth, they're more likely, less likely to have promotion's. So, there's something between what people are, at least, perceiving when they're asked about it, and worse labor outcomes. I'm going to skip that one. Because there's a clock ticking in front of me. And finally, I think in some sense more convincing evidence comes from what, in labor economics and housing economics actually call auditor correspondence studies. So, these are studies, which it's really hard to study discrimination and labor economists have done all kind of things to get at this, but this was a method that actually came out of the housing discrimination field. But, the basic idea is you have fictitious individuals who are identical in all respects, except the characteristic you're studying, in this case age. That may set off warning bells so we'll come back to that. But, they're identical to everything except age. They apply for jobs. When they apply in person that is you send out, sort of actors or students or whatever. It's called an audit study. When they're done on paper or online, it's called the correspondence study. But, the same idea. And in the audit study you observe actual hires, right? And you can say "Are the blacks getting fewer job offers than the whites?", "Are the older people getting fewer job offers than the younger people?" etcetera. In a correspondence study you don't get a job offer in response to an online application but you get a call back for an interview, so the outcome is, sort of, one step earlier than getting a job offer. The advantage of a correspondence study is you can generate a lot more data because you don't need to literally send people out to do job interviews. And you'll see that reflect in what I'm going to talk about. You can't read that, I don't think, maybe you can. I can't read that, but I'll tell you what it says.

These are all of the existing age audit, or correspondence studies that I'm aware of, and I think that's all of them. There aren't that many, there's five or six there. And they all, except the one at the bottom, find strong evidence of discrimination against older workers. This last column here is a measure of what's often called net discrimination, which is the percentage of applications in which the younger applicant was favored, relative to the older applicant. So, you're seeing numbers there like, they vary a lot, but they probably, but the mean is probably around 25 percent. So, big differences in, kind of, favoring the young over favoring the old in these kind of studies. And you can see these have been done on an entry level job because that's the only kind of job you can do these in realistically. Retail, waiters, wait staff. The top study actually is the more sophisticated jobs. But, that's kind of the state of the literature. And the reason I embarked on this new field experiment, was because I had a lot of reasons to be somewhat skeptical of some of the conclusions of these studies. Not that I thought the bias was necessarily one way or the other, but I thought there were some potential shortcomings that I wanted to get at, and that's why I actually worked for the Sloan Foundation, to develop this very large scale study we've done.

So, what we're trying to do in this work is improve on the existing studies in a number of ways. So, the first thing is something that might immediately jump out at you when you think about how do you do one of these studies for old versus young workers, okay? So, I'm doing black versus red for this, sort of, very famous Patronimo and Athan AR paper from around 11 years ago, which was meant to study race discrimination. Now, people don't usually put on a resume, I'm black or I'm white, but they did very black sounding names, right, based on Social Security data where you can see what kind of names people use. I forget what the name was, Jamal and Lakeisha less employable than, I figure two names that you would associate with very high probability being black and two names that are, sort of, very waspy, essentially on the resumes. So, you can do that with sex, it might even be easier to convey it based on, people have conveyed group characteristics based on your hobbies, interests, or things like that. And, once you do that, you can have the resumes be identical, because why would a black and a white, you know, have different experience, or whatever. But, old and young workers, you say wait a second. I can't give the young worker 50 years of experience, right, because that can't be. And, if I only give the old worker ten years of experience, they look a little wired, right?

So, how do you do one of these studies? So, most of the existing studies say, let's just send out old and young resumes, and we'll give them both a limited work history, kind of what would be a full history for a young person, maybe eight or ten years. But, only eight or ten years for the old person, and those studies

MPR
2015 DRC Conference_Day 2 Part 5

then find evidence of discrimination and it always, sort of, nagged at the back of my head a little bit. Well, maybe those old resumes look a little odd, because there's either a completely missing long period, or they would do something like say they were in some completely different field, or in the military, who knows what. But, it's just not entirely clear how to make these resumes comparable. So, one thing we do in the paper is, kind of wrestle with that. We, sort of, go through some of the legal arguments as to what you should or shouldn't be looking at, but most importantly, we construct a lot of different kinds of resumes for older people and see if it matters. Okay? The second thing we do is try to enrich the studies. There's so much work on aging and older workers that talks about the kind of career paths older workers take. Partial retirement, bridge jobs, whatever you want to call them. So, we wanted to know, is an older worker, should we think about a low skill resume of older workers, kind of, being in low skill jobs for his, or her, whole career. Somebody who has shifted recently to a lower skill job, or is with this application shifting to a lower skill job. So, create sort of, seven or eight different kind of resumes that distinguish the middle age and older workers based on the kind of career profile they had, again to see if it matters. Most of these studies that were on the previous slide, older is like 40's and 50's. That's not really the relevant age we're talking about here. A lot of the issue is we reformed Social Security, we push up the full retirement age, the early retirement age, what happens? So, we focus quite explicitly on people in their 60's here, which we think is quite important. And, finally, and I'll just say this here, I won't elaborate on it. There's a sort of technical issue in these studies, which is when groups have the, sort of, unobserved variation groups have, can lead to really serious biases in these kind of studies. So, we implemented a method to try to assess whether that's important, and if this were an hour and a half seminar, I'd go into that. So, I won't.

So, let me, at least, give you a few features of the study. This paper doesn't even have the results in it yet and it's already 80 pages because there's so many things that go into the design of one of these kind of studies. In general our approach was to really make this as realistic as possible by, kind of, empirically grounding everything we do. So, we don't just make up resumes. We downloaded thousands and thousands of resumes, and we scrambled them in certain ways and end up actually designing out of those thousands of other kinds of resumes that fit these different patterns we talked about. You know, the kinds of jobs we chose, all kinds of things, giving people addresses. There's a million and one details. You make these fictitious people, right? And you want them to be perceived as realistic by employers, right, for the study results to make any sense. We do a lot to try and bolster that. The one thing that we haven't done yet, but we just got permission to do is, I couldn't believe our human subjects group let us do this, but we're actually going to be able to post fake ads, and see what applications come in so we can actually compare our applications to those, which should be very nice and hopefully we'll find we did a good job. We'll find out. Okay, so the age ranges I said already. So, the young and old is, sort of mid-60's versus around 30. We also do a group around 50 to touch base with other studies. Targeting occupations to kind of pick occupations where, we don't want to pick occupations where an employer would, yeah it's a little tricky here because I'm going to say we don't want to pick an occupation where you never see an older worker because then you would never expect to see an application. Of course that could reflect discrimination, right, so it's a little unclear what to do. But we try to pick occupations where there's some representation of low tenure older workers.

Every occupation almost has some representation of low tenure young workers because young workers have low tenure. So, we do that before we choose a list at the bottom, then we do retail, the focus of a lot of studies, administrative assistants, janitors, and security guards we only do male applications and administrative assistants we only do female, and retail we do both. And that's kind of a reflection of what you see in the data. We picked a large number of cities actually. We wanted the results not to be idiosyncratic to a city, but we also had in mind a little bit of asking whether the demographics of the city matter, so we have very old and very young cities. Think Salt Lake City, which is a young city versus Sarasota, an old city. We also have cities distinguished under age discrimination laws. We only have 11 cities in this study, so we don't need to get anything except suggestive evidence. We have a proposal in to expand this to all 50 states and then we could, perhaps learn more. Here's all the resume types. So, we have one young type, because they're simple. We have the three middle age groups, then we sort of

MPR
2015 DRC Conference_Day 2 Part 5

have the low experience and the high experience, to kind of get at that question I talked about before. As well as whether you're bridging to a low skilled occupation. And then for the older resumes, even more types than that. Now you might say with 11 cities, eight resume types, four occupations, are you going to start slicing your sample pretty small? Well, we actually sent out over forty thousand job applications, right? We had a lot of support for this and a pretty good technology to make this work. This is almost an order of magnitude bigger than past studies, but it lets us really, even though we're in some sense disaggregating in many types of resumes, it all still got out pretty solid answers.

So, where are we now? We're still coding responses. We're done collecting data, what that means is the applications are sent out. Emails come in, phone calls come in. We set up email accounts, we purchased like 500 online phone numbers, and as you might expect the phone numbers take a long time to code because some people aren't really good at telling you exactly where they're calling from. So, we're coding up responses, so what I have now is as of a certain period all the data. We have most of the call-backs coded, but not all of them. So, the call-back rates I'm going to show you will be higher eventually when we figure out where some of these phone messages actually came from. I realize you can't see this either, can you? The numbers? Oh, pretty good, ok. So, this is a table of, I'm going to walk you through this real quickly, call-back rates by age. Let me just highlight them. So we look, I'm going to show you the two big occupations of this table, admin and sales and all combined. The call-back rates, the positive call-back rates for the young group here is ten and a half percent, drops to eight percent for the middle and drops to five and a half percent for the old, so by almost half, right? Pretty dramatic. .

All those strongly statistic significant, just doing an exact independence test. If I go to sales, the call-back rate is much higher across the board here, probably because it's a higher turn-over job, 22.7 percent for young people drops to a little bit, not very much, drops to 14 and a half percent for old people, so about a third decline, and if we, oops sorry. If we combine them all, about a 15 percent call-back rate for the young guys, about 13 percent for the middle age, and about ten percent for the old. So, strong statistically significant evidence of lower call-backs. In these kinds of studies everything is randomized with respect to age, so I'm going to show you the next table which is probate models with a lot of controls added. They don't matter and they shouldn't because you're controlling them, I mean you create these resumes and then you randomize with respect to age. So, these are for example what you'll see here is these kind of four, the admin, sales, and all categories, kind of five or six percent lower call-back rates on basis of somewhere between ten and 20 percent. Security we don't find anything, janitor we find discrimination only for the older guys, but security's pretty small for now. But, anyways except for security, quite robust evidence of discrimination against older workers.

Other results, I don't think there's any more tables. So, we did all these resume types, right? Bridge jobs, low experience, high experience. Both to assess whether other studies might have gotten too strong evidence of discrimination by using low experience for older workers. And then just to add to the richness of the results, it makes no difference, I mean the results are very robust across resume types, so we're less critical or less skeptical of the older studies, but also the whole bridge job thing doesn't really matter. Whether you've already down-shifted, you're down-shifting, or you've been a low skill occupation your whole career, because the resumes can affect all those things, the estimates are quite similar. For sales we had male and female job applicants because that's an occupation with a lot of men and women in it. There's this issue in the age discrimination literature about what they call inter-sexual discrimination, and it's a legal issue. The way to think about it is, if I'm a black female that's been discriminated against, I can file under the civil rights act under Title 7 with respect to both race and sex, because they're both covered under Title 7.

But if I'm an older female, right? Or an older black male, for that matter, I can't file both. So, you think about running, think about I'm a statistical consultant on a discrimination case, I have some lay-offs and I run a regression about whether you got laid off on age, on sex, and on age and sex. And maybe the company laid off more older women, than more older men, okay? I actually can't use the evidence based upon the sex/age interaction, right, because they're not, women and older people are not defined as a

MPR
2015 DRC Conference_Day 2 Part 5

protected class in the same law. So, if you thought that older women suffered more discrimination than older men, good example Hollywood, right? For example, the law might not protect women as well, right? That's the basic point. And actually when you do this in the sales occupations, which I have men and women, much stronger evidence of discrimination against women than men. It's one case, one occupation, but it's quite striking.

Okay, so what does it mean? Finish up real quickly, says ten seconds, I'll take 60, then I'll stop. Robust evidence of age discrimination in hiring, I think you get from the study. I really think there was some evidence before, and I think this really strengthens it in a lot of ways. It's especially true around the age of Social Security claiming, you know in the mid-60's, which is very relevant for policy. It's present even in quite low skill jobs, to which older people might be making transitions. And, where I might argue, if we're going to get big increases, it's going to come and people aren't going to stay in their career jobs forever, they're going to down-shift to other jobs because they want to work part time, they have health issues, whatever the case might be.

There's a recent paper that was just given at the NBER summer institute by Doug Cruz and a bunch of co-authors, doing one of these studies for disability. It's a lot harder to do in the disability context, but also finds pretty robust evidence of discrimination against, he's got like, he's got quadriplegics or paraplegics and people with some kind of Asperger Syndrome, I can't remember. You'd have to choose pretty narrowly there, but he does that. So, that suggests it's quite important, I'm not sure to take account of this in Social Security determinations, but it certainly suggests that we need to realize that our barriers to employment of older workers, and probably disabled workers as well, that may have something to do with the demand side, nothing to do with the worker's decisions about what they are, or aren't willing to do. Just real briefly, you know, isn't there a law against this? Don't the laws work?

Shouldn't we rely on the laws? Well, there are laws about discrimination, of course. The age laws do seem to have boosted employment of older workers. It's a little harder to think about how the laws have affected hiring of older workers. In general, people who study this topic, think discrimination laws don't work as well on the hiring side, because it's hard to define a class of who wasn't hired, and it's hard to define economic damages. I would say the evidence is sort of mixed on whether these laws are actually harmful to the hiring prospects. In this study, when we do just with our 11 cities, we actually find less discrimination in the states that have stronger age discrimination laws, so that's one sort of smidgen of evidence that the laws actually help a little, as opposed to they don't hurt. But, certainly we don't think the laws eliminate all discriminatory behavior, and I would say they're not designed to eliminate all discriminatory behavior. So, stop there.

All right.

Thank you.

Thank you very much, David. Our next speaker is David Otter, who is a professor and associate head of the MIT department of economics. And, for those keeping track, this is the fifth David of the day, bringing the total to 11 David's on the Disability Consortium Conference. I think we can officially, after your presentation call it, yeah DRC is Dave Research Consortium. As long as SSA's going for it. Go for it, Dave.

Okay, great. Do you want to restart the clock? Okay.

Let it reset somehow, magically.

All right. So, I'm just going to, this is really just an overview talk. This is not original research, just talking about the re-market for workers with disabilities, and I call it the puzzlement promise. And the puzzle is that we've had 25 years of declining employment rates for adults with disabilities in the U.S., coinciding

MPR
2015 DRC Conference_Day 2 Part 5

with the American's with Disabilities Act, and that is a startling fact. In just reviewing the data and preparing this talk, I just, I couldn't get over that. Even though I've known about that for a long time, I wouldn't, you'll see in a minute how startling, how clear that is, though it's not understood. Let me make it clear, it's not understood why that's occurred. So, then I'm going to talk just briefly about a couple potential ways of getting leverage on this. One is to ask about whether the education occupations of workers with disabilities make them especially vulnerable to the changing labor market, and I think there's only limited evidence that's true. It's worth comparing the employment rates of adults with disabilities in the U.S. to other countries to ask, well is our experience abnormal or unusual. Turns out it's unusual, not in a positive sense. And then talk briefly about, sort of what are some of the, how can we think about this and what are the opportunities going forward. So, many of you would have seen figures of this form, this is the, this is the employment rate of men and women who are ages 18 to 64. The upper lines are those who do not self-report disabilities, and the lower lines are those who report work limitations. So, these are not people receiving disability benefits, these are people who self-report limitations using current population survey data, that's the longest representative sample we have.

There's not in any sense a perfect correspondence between reporting work limitations and receiving disability. Some people receive disability do not report work limitations, some people report work limitations do not receive disability benefits. It is probably the case that the fraction of those reporting work limitations, who are receiving disability benefits has risen in this period. Simply from the fact that the fraction of the adults, ages 25 to 64, receiving disability benefits during this period has risen. But you can see that, that is relatively steady, not at a very high level, around 30 percentage points, until about 2000 and then it does start to decline around here and has declined slowly but truly over 25 years.

And, another way you could let me just zoom on that, you know, a little further. This shows you the upper two lines, which are on the right-hand scale, are the fraction of adults reporting a work limitation, and that's really quite steady at around eight percentage points. It fluctuates a little bit between seven and nine, that's the same for men and women, but it really hasn't changed by very much at all in this 35 year period, 34 year period. What has changed is labor force participation rates, or employment rates of those adults. And again, coinciding with the ADA There are other, this has been confirmed by a number of data sources. It doesn't, it's not an artifact of the current population survey, it's also true if you look in the National Health Interview survey. It doesn't appear to be an artifact of the way people are, or not, reporting themselves disabled again, because different surveys capture disability differently, and yet we still see the same employment decline. It's also really startling, or striking, that it occurs at all education levels.

So, these are employment rates, these are men with disabilities, with self-reported disabilities, age 25 to 64. I'm interchangeably using work limitation and disability, I hope that's okay. This is employment rates, this is 1995, 2000, 2005, 2008. And, you can see, if you look in any of these groups, these bars are trending downward. So, for example, college educated men goes from about 55 percent to about 40 percent. These are men with some college, men with high school only, and then for high school drop-outs it's just kind of bouncing around at a very low level. You do not, if you look at men who do not report self-disabilities, in the same education groups and the same time period, there's a little bit of decline, no question male labor force participation rates have fallen in this period pretty much across the board. But it's, you know, for college graduate it goes from 92 percent to 90 percent, let's say. It's not anywhere near as pronounced. It does not, there's no sense in which this is capturing just a general decline in labor force participation rates.

And one way you can verify that is to, to look at for whom the employment picture has been a lot more favorable, in the last 30 years. And, so this shows you the employment rate of women ages 25 to 64 with disabilities. Again, 1995, 2000, 2005, 2008, and again by education. And we see it again, so these are college educated women from 45 percent to 35 percent, some college, high school only, and high school drop-out, So, it's not explained by overall declines, it's not explained by educational, I'm sorry, overall declining labor force rates, it's not explained by, directly by educational composition. And I should also

MPR
2015 DRC Conference_Day 2 Part 5

say, although population aging could also contribute to that, since the older workers are getting relatively older in this period, just due to their aging and the baby boom. You also see it among younger workers 30 to 44 who self-report work limitations as well. So, there's no simple mechanical story. And, just to show you by the way, this is the employment rate of women who do not self-report disabilities in the same period, and you see, in general, it's pretty high, pretty stable and up until 2000 it was actually increasing. So, again we see, we don't see a comparable pattern for women or men of any educational level who do not self-report disabilities. It is important to note that employment rates vary, by age, among disabled to population rates again in the current population survey this is very recent, 2014, the red bars are people who do not self-report a disability, the blue bars are people who do, so this shows you the overall. So, 70 percent versus about 25 percent. And then you can see the highest participation rates are around 25 to 35 to 44, and then they decline from there. So, population aging would contribute somewhat to this pattern, but doesn't appear to be the primary explanation.

So, another question to ask is whether education occupations of workers with disabilities make them especially vulnerable to the changing labor market. As you know, individual disabilities often attain lower levels of education. This is from CPS. data, this presents the distribution of reported attainment, educational attainment for people with, and without, disabilities, and you can see in general less likely to have a, be at a higher, more likely to be a high school grad or less than high school. So, we know the labor market has not worked favorably for less educated workers, however we also know that this has occurred among adults with self-reported disabilities at all educational levels.

So, it's interesting to ask what kind of occupations people work in, and so this chart shows you the occupational distribution for people with, and without, a self-reported disability. This is from using the American Community Survey. And, these are ordered by the gap between adults with, and without, disabilities. So, this one has the largest gap, meaning that, so you see that 15 percent of adults without disabilities are in service occupations and 20 of adults with disabilities who are working in service occupations. And these are over-represented there. And you can see so, what you see from this is, adults with disabilities, when they are working, are over-represented in services, only personal services. We can be janitorial services, some of them will be health aides, those would also be service occupations. They're also in production and transportation and office administrative support. And then not much difference for farming, construction, military. But they're under-represented in sales and management, related occupations, direct managerial jobs, and professional and technical jobs.

So, in general, working age disabled are by and large are less educated and lower paid activities. And probably also worth noting, aside from administrative support, many of them actually have a fairly substantial physical component. These are not primarily sedentary jobs, right? So, service occupations almost never a sedentary jobs. Production occupations usually involve some motion and, of course, transportation is not a sedentary, well you could be driving, you're certainly not staying in the same place. All right. So, another way to look at this, and this is quite imperfect for reasons you may immediately see, but just quickly took the Department of Labor's Occupational Outlook Handbook, and compared employment of adults with disabilities in the fastest growing and fastest contracting jobs. Now the problem with that is that a fast growing job could be growing fast because it's small and it doubles in size by adding ten people. That's not primarily what's going on here.

So, just to give you a sense of it, these are the fastest growing jobs and on the left-hand side is the fraction of disabled adults in all occupations, they make up about five percent, and then if this bar is taller it means they're over-represented in that. Right, if they're above five percent in a given occupation that means they're over-represented relative to the work population. So, you can see they're over-represented in these fast growing occupations, janitors, personal aides, health aides, prep and food service, truck driving, retail sales person, and customer service. Then as we move in, administrative assistant a little bit and post-secondary teachers and nurses, they're under-represented in that. So, it's clear that adults with disabilities who are working are over-represented in fast growing low pay jobs. Right, these are jobs that are numerically relatively plentiful, but do not offer good employment and earning security, generally will

MPR
2015 DRC Conference_Day 2 Part 5

not offer healthcare, and some of them, obviously, may not be around also going forward. So, you would think for example a lot of driving occupations probably in the next 20 years, we'll see many fewer of those. If you look at the fastest shrinking occupations, adults with disabilities are tremendously over-represented in these occupations. Three of them are postal occupations. So, postal clerks, postal sorters, and postal carriers. Those are correcting and those are rapidly shrinking jobs. And also ranchers, this is a case where very small number, it's gone from a hundred to 25. Machine tool cutters, sewing machine operators, so these are production jobs, right? These are traditional production jobs that probably involve repetitive motion to some degree, but are relatively sedentary. These are jobs that are disappearing so that, and then typists and data entry, the office jobs, so let me make sort of a broader point. Leaving aside the postal service, if you look at these occupations, these production occupations, and then these clerical occupations.

These are actually two broad sets of type of jobs that all are contracting largely because of technological change, right? So, we know that office clerical jobs have been contracting since the 1980's pretty steeply and production jobs also have been in decline for a long time, but actually the ones that are in decline up until, prior to the 1990's were, many of them were kind of assembly line jobs, many of the production jobs that have declined more recently are also dexterous jobs, assembling things, so textiles, leather goods, precision electronic assembly, which probably would describe these, and many of those have declined as a result of International competition. A lot of that labor intensive dexterous work is now done in Asia. So, this is an area where I do actually think that the changing labor market probably is, has been disadvantageous because adults are over-represented in these two categories of previously middle paid jobs that are contracting. Contracting for everyone, but disabled adults are over-represented in them. So, do other country's labor markets look similar?

Well, it's, we unfortunately were not able to find a cross-country comparison that puts the U.S. on the same scale, so there's always a danger that the way disability is measured across countries could affect this comparison, but as far as we can tell, the U.S. employment rates of people with disabilities are considerably lower than most other E.U. countries so, you know, a typical here would be 40 to 50 percent. Hungary is lower, Ireland is lower, but in general if this is the E.U. 28, and the gap isn't nearly as large as it is in the U.S. Unfortunately, they don't classify the U.S. and maybe the U.S. would have a different definition, so I can't say absolutely that the U.S. is as bad in reality as it looks in this figure, but I think there's reason to think that it is an outlier. If you look at our neighbor to the north, the employment rates of adults with disabilities in Canada, they're also more favorable so, in general, you know, these are by degree of disability as defined by the Canadian data so, no disability, mild disability, moderate disability, severe or very severe disability. But, in general, these are the least educated, less than high school, high school diploma, trade certificate, university degree, and you have to look at the moderate to severe among the least educated in Canada to get anything close to the average rate in the U.S. And I'll also say for the short time periods which we could find, seven years, there's no decline in employment rates of those with disabilities in Canada, not following this period.

Okay, so let me sort of, so now I want to sort of summarize and I'm going to end a few minutes early. So, I think they're, you know, I'd say that we don't know why the employment of adults with disabilities has fallen for 25 years. I think no one would have predicted that 25 years after the passage of ADA, things would look substantially worse than they did when it was passed. And I, when the ADA was passed, there was an initial research by economists that argued the ADA had in fact reduced the employment of the disabled for exactly the reasons that David was mentioning a moment ago, is that it's very hard for a worker to sue for not being hired, because it's hard for them to figure out if they've been discriminated against.

But, once they are employed, they have the legal to exercise their rights about accommodation, about you know, if they're terminated they can sue for wrongful dismissal under the ADA And so, it's possible the employers perceive the ADA as very expensive and became less likely to hire working age disabled adults. That's a theory, it's not, there's no clear evidence on this. It's mostly just time series comparisons.

MPR
2015 DRC Conference_Day 2 Part 5

So, initial work by Tom Delear, by my colleagues Josh Angrus, and Joran Asomogru, concluded that the ADA was responsible. I think we don't know, but it is a painful coincidence to look at. You would think things would have gone better.

So, chronologically, you know, I think I was asked to this panel to talk about, think about the technological change in labor market and how it was affecting employment of working age disabled. You would think there's a lot of good things happening. Obviously we have much better assistive technologies, we have better health supports, work is much, much less physically demanding that it would be. So, if you had sort of said, you know, 25 years ago, "What do you think will happen?", you'd say, "Well, I would have thought this would become the heyday for employment for working age disabled", because all of a sudden there's all kinds of ways that we can accommodate, allow people to use their full capacities, and you know, all the dirty heavy lifting, there just isn't that much of that around so this ought to look good. And that hasn't happened. It could be that fewer jobs, it could be that the other side of this is the displacement of the types of work that disabled adults used to do in production, in clerical.

But, I don't think this is really the main story. I just, it's hard to believe that change suddenly in 1990 and has been going down ever since. I think it's unlikely. It's unclear what role SDI has played. It's certainly the case, has to be the case that more of the working age disabled is receiving SDI than they were in 1990. THS we know from the prevalence a disability benefits going up, it has to be true, however that we should think about as diagnostic innocence that those could both be the result of us changes in the labor market that would make it hard for people to find jobs take up the and therefore they'd be more likely to file for disability so even if those things are quite correlated that doesn't tell you cause and effect. Of course, all of us have been thinking over the last couple of days, what role, what additional roles could SSDI play in trying to help people stay in the labor force? Of course that's not the mandate of the program, but all of us share that goal.

Of course, this also creates a vast challenge for SSA, in trying to assess the ability of workers to engage in other types of work that exists in significant numbers in the national economy, that's the Stage 5 Determination decision, and as you're aware, it's not a case of the majority, I believe, of decisions are made at Stage 4, Level 4, Level 5. And that's a very hard call. I think there is a bit of a paradox that many jobs that one would evaluate based on the extent of occupational titles, based on the understanding of Labor Board Code. Adults with disabilities could potentially perform those jobs, but it doesn't mean employers will hire for them, them for them. And I think that, that's the situation we're in, that SSA faces a bit of a paradox in trying to make that decision. And I guess is not supposed to assess whether they can be hired, just whether the job exists, but obviously that some painful decision to have to make.

I think, you know, that we can learn from examples of other countries. Many other countries do actually have mandates for hiring adults with disabilities, require a certain quota and I'm sure employers kick and scream about those kind of things but they, you know, may be somewhat costly for employers, but there are costs of not employing those individuals, as well. There are social costs and there are costs to those individuals and so it's something that we should consider how other countries have managed to keep employment rates of adults with a disabilities so high.

And I just, you know, it just seems like there's so much opportunity and it is disheartening to see that we know that adults with disabilities want to work, we know that public understanding is light years ahead of where it was 25 years ago. People understand now that disability is in no way an intrinsic barrier to people engaging productively, meaningfully in work in the U.S. economy. And, so we don't think of disability anymore as a categorical phenomenon that prevents someone from working, and yet the labor market, somehow does not seem to reflect that understanding. So, I have to think that there's a great deal of opportunity, that 25 years forward, I'll be delivering much more, much more uplifting remarks, if you invite me back. But it is, I do think it's a concerning picture. Okay, thanks.

Thank you, David. Hopefully we won't discriminate on age in 25 years. Our final panelist is Jeff Stroll, who was the director of research of Georgetown center of education and workforce and is our one hope that

MPR
2015 DRC Conference_Day 2 Part 5

the DRC doesn't discriminate on the base of a first name, Dave. So, with that, he's my last triple-Dave panel.

In the tour De France, there's all that honored role, which is Lanterne rouge, and it's the last person along the line. It's good because you made it, the bad side is everybody else is scrambling over the finish line and I suspect many of you are in position, having been here for two days at the end of, probably a long day. So, hopefully I'll be able to keep your attention. And be invited here I kind of a little bit puzzled because I don't do disability I kind of feel like some of you got on a plane to go to Dulles and ended up in Dakar. And so on trying to figure out if fortunate we had some pre meetings as some things like that. And while it is that I don't know much about disability, I do a lot of work about how people move through the labor market. So, I really tried to conceptualize this particular problem on this frame by dislocated worker problem. So, hopefully I'll be able to pass some analogies across to you. Now is there any finger mate?

[inaudible] Oh, you want that?

Because all be embarrassed because I'll probably screwed up. So, anyways Okay. The real short story, which is really nice to punch to the summary and then you can fall asleep for the rest, is the idea that occupations come in groups. And if we think about the dislocated worker problem in economics, is when someone suffers what I'm going to call an employment shock, and needs to move between jobs. And so one way to think about this in his in terms of job of clusters, occupation, and occupational distance, and skills transfer ability. So what I mean here is that since jobs had, share some characteristics, we can think about someone who has added climate shop event, it is able to move a short distance between jobs if there's enough things similar about the jobs that you don't really require an awful lot of retraining or retraining for them to move. So if they are, textiles is a place where people had a huge employment shock in the United States and there wasn't a lot of textile jobs out.

So they had a large distance to move. You can really a match and someone who is in, say a nurse, moving from a surgical nurse to an admissions nurse she has a lot of the same sets of skills so in that sense we consider that kind of job movement to be very short distance. So I'm trying to think about moving from the work in the dislocated worker literature, to moving to how it might be applied to our thinking about how disability, and in particular what we would do when someone suffers employment shock to help them move to a new job. So that's the general frame of the thinking that I have and hopefully to add. So, anyways this idea of job clusters is the idea that we can aggregate jobs to a certain level based on a set of shared skill sets. And that he could widen that set but then you start to have an intervention necessary to move somebody within a job cluster. So very small pistons again would be geographic, you know if you're a welder, you run out of welding jobs in Florida but you move a spatial distance and an occupational distance since that's not very far. It has his own set of problems to move between jobs. So, just to clarify there. So, anyways as I'm saying I'm try to think about disability in the framework of dislocated worker problem. The idea that the person needs to be relocated in the economy and the type of work that they do. So how did we get to moving them?

So, the concept that I've worked with a lot in thinking about economic flexibility, help people move through the labor market, is this a idea of occupational distance. So as we think what is the, I'm going to define occupational distance as a sort of set of characteristics about what is necessary to realistically RE employs someone. And it's often determined by a large set of factors of skills transfer ability. Do you have what you do in your job, do you possess what you need and the other job, that's one way to look at the skills transfer ability, and do you need to be re-educated, do you need to have either retraining or additional education. I'm so the more that, that you need introduces a time function about how long it takes you, or how far away on other job is.

So, then thinking about job clusters, it really gives us this idea about the domain of shared jobs that enabled us to think about the, I keep framing it in the dislocated worker problem, is that if someone has lost a job because of a structural change or something else, where can we move to with the least cost and keep them employed added employable, right? And so we need to think that you don't have to

MPR
2015 DRC Conference_Day 2 Part 5

reinvent the wheel, because people come imbued with a set of educational characteristics, interest and characteristics, values, etcetra, that enable them to make a move hopefully with minimal amount of retraining. It's never easy. I think that's one of the things that people suffer in a dislocated worker problem that it's easy to change jobs. It's never easy to change the job, right? There's a lot of firms specific human capital that just doesn't transfer, there's other stuff that does. So, I never want to say that a job change is easy.

If so, how might we really start to think about addressing this problem? I'm really puzzled and this takes us to the young ladies issue with the DOT, is that we've got ONET, which is the occupational network, which is the modernization, you know of the DOT which enables us to really look at a large set of characteristics across occupations, and it's my understanding that Social Security is in the act of creating their version of ONET to enable us to start looking at occupations. And ONET has been created through a process of what we call functional job analysis which is looking at a job figuring out what the heck is necessary to be successful at the job. The unit of analysis, which is interesting, is actually the occupation and not the people and it, although of course you need to look at people to figure out what's necessary in the job. So, we have this great tool to define job clusters and it enables us to look, traditionally the shorthand is going to be knowledge, skills, and abilities, but ONET has about 16 zillion too many variables to enable us to characterize jobs, to create these ideas of job clusters. So, often and I'm guilty of this, we get lost in the detail of the data and forget about the usability, but there's been movement that's happened that really helps us use ONET to both measure transferability, but to think about it in a sense of how do we move, help people move between jobs.

So, couple of vendors, TORK, which I forget what it stands for and EMSI out of Moscow, Idaho, economic modeling specialists corporate have done work with this as well as many others, I'm not trying to support one vendor in anything. I just want to show you some examples. So what EMSI did, which I thought was really cool, is the following radar diagram. It's just like David Newmark's comments, you can't read anything here. Looks good on my paper but not on yours. Here is a set of occupations as the center of his radar chart, and it's the knowledge competencies for team assemblers, and cutting, punching, and press machine setters. I just happened to be able to swipe this off the Internet, and each of these colored grace that you say shows how close it is to another occupation.

Really starting to help us define it a sense of shared characteristics inside of a job cluster, so where you can move. In the bottom about 7:00 down there, you can see that team assemblers are very close in mechanical skills and as you move towards 6:00, they're very far away from having a set of skills from the job, or necessary requirements in geography, foreign language, food production, and the fine arts. So, this type of analysis of understanding where someone was before in employment shock helps us understand where we can move them with a lease cost intervention. Now, ONET also gets into a whole set of things that that work interests and values and I think is important to think about that, right? You never want to force somebody into a job just because they happen to share characteristics, right? We want to always have to keep a sense of the person's individual interests are going to be very important. So, all right here were just looking at knowledge competencies. So, anyways this type of thinking, I think helps us understand that where can we, with a lease cost intervention, move someone if necessary?

So, this space, the distance between occupations and the job change is not always short, and in those cases job change is not easy, and they require different levels of education and retraining, where we really start to get a lot of distance in here. And so again spatial relocation is really easy side of re-employment, you know move from point A to point B. It's not that easy, especially if you have a house or family, but in this sense of occupational distance that we consider distance to belong based on the duration of retraining or additional education that you need. So, the thing that I want to think about here and it will pull it to a quick end, is in my world there's a lot of work going on with stackable certificates and an idea of occupational competency models. But I want to try to bring these two together within the back of your brain, thinking about occupational transferability. The idea of stackable certificates is this idea that you give someone bites of education and you add another layer on top of it.

MPR
2015 DRC Conference_Day 2 Part 5

So, you can really think about stackable certificates as, kind of an accumulation of education from a foundational set of occupations going all the way up to a very occupationally specific set of occupations. So, if we think about job clusters parallel to stackable certificates, and we can see the job clusters are characterized by may be the top base for five sets of stackable certificates, and that the occupational specific knowledge ready comes from the final, let's say the eighth level of stackable certificates. So, when someone suffers at employment shop and is still employable within the same job cluster, we're really talking about moving back one or two stacks in a set of stackable certificates. So, that's the idea about how to minimize retraining if we really started thinking this framework, that education actually can come in bites and you don't need to go to school, go back to school for four or six years.

The occupational competency side of this is work that's been done by the Department of Labor and again, sorry that you can see this but the slides will be on the web site somewhere. DOL has created and occupational competency model clearinghouse, which they've done an awful lot of work across occupations to understand what the set of skills are that are required to do a job well. And the stack ability, the pyramid that you see here parallels nicely in my mind the idea of stackable certificates. So, as we look at job clusters or individual occupations, we can see that they most likely share but said a foundational skills and competencies and become much more focused as you get closer and closer to the occupational specific knowledge that you need.

So, they trunk it up, the bottom tiers are just personal effective competencies all the way up to industry sector, technical competencies, and the last layer are management competencies and occupational specific competencies up. My up hypothesis is that if someone suffers an employment shock they get knocked down a level and our job is to rebuild the next layer, if and where we can. Now that's really, as the practitioners of art here to actually doing that. The people in the dislocated worker field do it, I'm not sure exactly how applicable this but hopefully it would pass over to the disability framework, and this is just a schematic of some stackable certificate work Ohio happens to do an awful lot of work in this area, as well as some other states. So, this is just showing the idea of stackable certificates and again can read it but you can look it up on the Internet. So, I believe you with that and hopefully it will spur some discussions. So, shortened. Thank you.

Thank you very much. And now is the time for question and answers, actually I'm going to quit kick it off with the first question. I have a question for you, David Newmark. The experiment your running is very interesting, the sample size is quite huge, and -- But one question that I have is, you compare younger and older people, how do you make them comparable based on experience, given that older people will have different life course trajectories, and you could argue it's the experience that is differentiating them for younger workers and perhaps making them over qualified for the jobs that their applying?

Right, so I made that was the issue that we were dealing with, so as I said, so the existing studies tend to give them the same experience as the young people, right? And once you might take of that is that's why the studies find strong evidence of discrimination, because that seems like an unusual resume. So, I don't have, so, we did two things. One is we sort of pick apart the law and try to figure out what's the legal perspective, what's the policy perspective, and our sense is that's not what the law intended. The law intended, as a development policy question, to protect older workers who have experienced commensurate with their age. And when the time you take a simple example, the New York Times was writing about hard times older people find, were having finding jobs, like after the great recession, they weren't talking about older people who only had 10 years' experience, they were talking about real older people who tend to have 30 or 40 years of experience. And the laws written the same way.

So, then we just, we just have a lot of different kinds of resumes to see if it matters, and it turns out not to matter. I mean, you're conjecture was one that could have arisen. I mean, I don't know that, I don't actually know if employers ever passed people up because there over qualified, is not clear why employers would do that. But, they could. But, an alternative view is you have a lot of experience and

MPR
2015 DRC Conference_Day 2 Part 5

you're still in this kind of job, you know, might be a negative strike against you. It turns out the results are very robust two, to the different types of resumes. So, whether, in fact there was some people who, based on some of this, you know some people, you go to these web sites that they say how you should write a resume and there used to be the story about how you should only show 10 years of experience. You shouldn't show your whole career. I mean, in some sense the answer is there's nothing you can do right now, if you're older. It seems like any resume you could construct is going to be covered by our set of resumes, and average call back rates are lower.

Okay. Lie about your age.

Two, David Otter.

But if so, I know you showed that the disability or portion, among the population, is fairly stable. But I was thinking, after seeing Kathleen's presentation yesterday, that when a worker sees an accommodation, they start time saying that they're health doesn't limit their work. So, I was wondering if that proportion that sort of masks a change in the distribution of disability, and maybe those that are still saying that I have a disability are on average more severe in a way that cannot be measured in this CPS, and therefore their outcomes might be worse, in terms of work.

Yeah, no I mean I understand the question. You're saying that, you know, self-reported disability is sort of an outcome of whether you're able to work or whether you've been accommodated. I said not everyone who has a work limitation reports themselves to have that, not everyone that's received disability report themselves for work limitations. So, it could be sort of a just the compositional change, and to answer your question, the fact that this has been found to cause a large number of surveys makes me think that, that's not all that. But, I mean so, although I take the point the, I don't but I can't say it doesn't explain any other, but I don't, I think that there's been enough efforts to sort of assess this from different directions that lead to the same conclusion that in fact it has read the declined.

Back.

All the way back.

Hi, Jim Sears, Social Security. I have a question today for the cool David. So, as it economizer...

Could be either of us.

Basically, as any economist I find discrimination studies just fascinating. As a bureaucrat I find them very, very scary. And I start going, should we be touching these things with a 10 foot pole? Okay, you're sending out thousands of fake resumes, you know, possibly crowding out real applicants who need jobs, you know, let alone getting into the area if we apply this sort of study more specifically to people with disabilities and, gee we would not be wanting to do anything to protest the crowd out real applicants here. So, is there anything that you could tell me today about, you know, from an ethical perspective, what you do to sort of assure that you're not, you know, crowding out wheeled job seekers who might be getting actual positions?

So, when you take these kinds of studies to human subjects committees, these topics do come up. And you got to remember when you look at, sort of the guidelines, ethical guidelines for research and informed consent, and all this kind of stuff, there are tradeoffs. There's not absolutes, right? And so typically they want to see what ever case you can make, and I would say their standards of evidence are very high, but a case that the harm is very small and the social benefits are big. So, you know, suppose it were the case that, I'll take an extreme view here, this comes from Doug Cruz, that disability discrimination was keeping a half a million people whine as SSDI from finding jobs, you know, something about the financial gain from presenting, if we could try to nail that and figure it out and do something about it, you know the social costs are huge to that discrimination.

MPR
2015 DRC Conference_Day 2 Part 5

So, you know, then the question is what our store to the cost on the other side, posed on the people involved, you know, there are studies, I wouldn't call them great that suggest in the low skill layer mark a resume, spends 10, 20 seconds looking at a resume, right? So the crowd out is, you know, and we're sending three, right, to an ad. So, our sense is they're getting hundreds of applications so the crowd out is very tiny. Now, if we can actually put these ads up and see that their only getting six I might feel a little different about that. But I suspect that's not the case. I also know there's a lot of people who apply for jobs who are really looking for jobs and that's a case you could make as well. But these are, you know, these are the balances that come up. Turns out companies are not protected human subjects, so somebody issues them, the actually worried about the people whose resumes we read, right? To design a resumes as protected subjects and if somebody, one of these companies calls us back, so now we've made contact with the human and now they're human subject who's protected. The companies themselves are not.

So, you know, I mean I don't want to hide behind the human subjects committee, they seem to as the right questions, right? Tell us about the gains, tell us about the costs and if we're not satisfied, there's some back and forth and they make you do some things that, as a researcher with no constraints you might have preferred not to do.

I'm going to go here and Areef, you're second and Pat, if we have time.

Another question for David Newmark. I think one reason that companies do not want to hire old workers is because it's very expensive to provide Health Insurance for them. And under the American disability act, the companies cannot offer lower wages to compensate for the insurance premium difference. I was wonder could you collect more information about the employer side to see why the firm actually offer group insurance and separates the...

There's no way.

You know, we're going on a very popular website on which employers list job openings, and a lot of them you don't even know who the company is, you can't even tell. So, it's an interesting conjecture. I mean, it would be illegal anyways so, in some sense, we're doing, we're detecting this, I don't know the nature of discrimination we're detecting. It could be taste, it could be statistical, which innocence is what you're really about. They're all equally on illegal. But, yeah it would be, it would be hard to do the employer side, in fact really big employers, we might be able to get that information, tend to be left out of the study because if they require online applications, like somebody I work with, we don't do them is that obviously would, A take a long time to apply for any one job and B you can decide something at the end that says everything I've written here is truthful, which obviously we can do if it's not. So, my guess is we are tilted toward, there are some big employers in there, we do see them but there's many that we know are excluded and we probably have the prevalence of smaller employers who are unidentified.

Areef Mahmoot from Mathematica and piling on for David Newmark. First off, legal opinions corporations are people too, but that's not my question. I was wondering about productivity loss as a potential explanation and in that sense that, while we typically associated age with experience, in a positive sense but with new technology and particularly information technology in the two occupations that you showed results for, retail and administrative services, is it possible that old age is perceived as low productivity and that could be one potential source of explanation?

Sure, I mean it's possible. There's a lot of the resume, I mean, but what do these employers know? They know nothing because there's no interview, it's on the resume, right? So everything else, except this experience dimension we discuss if the same. And there are, we actually have low and high skill set resumes, but there's no, there's nothing on the resumes to lead you to believe that the young people know how to use computers versus the old people don't and everyone's applying for jobs online. And, you know, whether they're making an assumption beyond that, again you can't parse out this sort, of you know, expected difference is associated with age based on unobservable that are on the resume from I'd

MPR
2015 DRC Conference_Day 2 Part 5

just a light pole people. No way to sort that out in this context. People in the studies try to sort of keys out statistical verses taste discrimination. I think it's really hard because you don't know what they would be statistically discriminating on, right? So, it's very hard to will face in or out.

I'm not sure everyone here knows what you mean by statistical discrimination.

I'm sorry, statistical discrimination is what you're talking about and to some extent what you're talking about that I, it it's not that I, certainly in the classic Becker model discrimination I don't like associating with some groups, all only do it in a sense of the transaction price is lower. So, that's why an employer in the classic Becker model will only hire black if they can pay them less than a hire whites. Statistical discrimination is I make some assumption about the group that's irrelevant to my calculation, I might assume women are going to have higher turnover or I might assume older people are going to, you know, if not already use technology, or have higher healthcare costs. And those may or may not be true, right, in any of those cases that. But the code of Federal regulations is clear. You cannot use group averages to justify discrimination, even if those crib averages are different, right? So you're not allowed to discriminate based on those.

And you can choose to say I need a college educated worker. You're making a group averages assumption about their capabilities. I mean there's certain things you can, you can use age or race.

[over talking]

You can't statistically discriminate on many, many things. Yeah, I always tell it, people are amazed, I'm free to hire blondes and not brunettes, perfect right to do that, right? But, you know, age, sex, race, ethnicity.

[over talking]

The more things, weight and marital status, and all kinds of things.

So, I'm going to just said with the last question, which is Pat. The top of the, and I apologize for those who have other questions. And Dave, you can take that staple gun.

Discriminate against the David's now. But Jess, I was fascinated by what you do. Do employers to come to you to look at this? Is this something employers using trying to accommodate to their employees who have had an employment shock?

The way that I understand it, right now that this is most common in work force UI area, where you're trying to do re-employment. So, for employment services, of trying to help move somebody, and then through trade adjustment assistance act monies, you'll find some application. And then now with the new Tax Branch Trade Adjustment Assistance Community College, something, something grants that you see in a lot of these type of activities. Of really trying how to think about automating the process to help people move between jobs.

Well, I certainly think it has a relationship to the disability program, in thinking through it. So, I encourage people to think a little bit more about that, because I know why Social Security didn't use ONET, because it wasn't descriptive enough down to certain levels that they needed to make the decision. But, these ideas are very good as far as job placement and the early intervention. So, thank you very much.

Can I make one tiny comment on that? Actually, I think it would be, it's just need to, sort of, using the Internet, looking at the sort of clustering, you could use observe patterns of mobility across occupations, right? To say well, gee people have done days, you know, had a work limitation, this is what they tend to move into, and then we see does that job exist. I mean there's a lot of data that could inform this question based rather practically.

MPR
2015 DRC Conference_Day 2 Part 5

Yeah, and I'd actually like to reinforce what David Urder just said is that the Internet gives us a general sense in having better data, we're actually doing a lot of work with resumes also try to sort this type of a problem out, looking at that surely empirical patterns are going to help was understand when someone has a, something happens, what makes them succeed and where do they succeed and fail? And I'd really think what you're saying, David will really clench it, because Internet is in averaging of thousands of people in a job to give us on the mean characteristic. It doesn't, it's not real people, it's helpful a little bit there. But I actually, I've got a quick question for David Newmark about it.

Another two questions. One where you talk about sales discrimination.

[over talking]

When you talked about sales discrimination between men and women, are you able to get enough detail about occupation to differentiate things like man in pharmaceutical sales versus women in cosmetology sales so we know that, that's happening? And the second question that I had is about resumes as a whole. We know that there's a big movement to automated resume creation and on the employer side a lot of automated resume filter so that people are writing to what they know. So, are you able, or have you been able to approach any of that kind of stuff is happening in the resume field to automate your study?

On the latter question, no. I mean, we thought about this and it's probably a big company thing rather than a small company thing, but I'm not sure. On the first question, again what we have is we've retained the text of all the ads to which we applied and we're going to be scraping to try to code of certain things that might give us any clues, any clues as to what we can explain. So we can look for, that they were actually most interested and is probably ageism language and my army of RA's become what were doing this, you know report frequently same words that suggested you were looking for a young person.

Okay, what would that be? Oh, you know, hit and modern, or you know, up-to-date or things like social media savvy. Yeah, and we had thought it much about the sex related clues, but we can.

Cool, thank you.

All right for questions. Thank you very much to the panel. I'm great presentations. If the panelists would just stay here for a minute, under wrap this up in just a couple of minutes and then everybody can go home early, and this is what a panel of 80 percent David's would look like. So, I also wanted to thank David Newmark for helping me understand why my younger colleagues still like to recognize me when I put my hand up. Is clearly aids animas. Thank you. So, let's say, in terms of criticism, every buyer should see that on the table there are these forms, I hope some of the people happy to filling them out. Last chance to do it now. There's a box outside the door somewhere where you can leave off. We always would like to know how we can do this better and we'll be back next year although this time it will be David Otter and his friends from the NBER who are in charge. So, will make sure they know about how to fix our mistakes. I'd really like to thank everybody involved for organizing this. I think it's been a pretty successful two days, a lot of things we've learned about, I certainly learned a lot at like to thank Lynn Fisher, there she is. Ta Da. So she didn't want me to get her out here are anything but she's really, sees our program officer for the SSA for the entire DRC and she does an incredible job and I think has done a great job in actually improving what we have been doing since she took over this position, less than a year ago.

So, thanks to her. Is Ted Heran still here? I don't know if he's disappeared. Okay, well anyway he's from SSA and has also played an important role and I think some of the social security folks have been collaborators on various projects here with us and was people from NBER, if you're here as well, I'd like to thank the people are from NBER most of whom are not here now but David Otter certainly is, along with David Weiss, Jeff Liebman, and Janet Stein, who've really helped us a lot in, not just doing the presentation of course, but also in organizing this whole session. They're also responsible for the RRC mean that's going on at the same time, starting today. So, which is mostly why they're not here I think. And then finally I'd like to thank my own colleagues, Gina Livermore especially, who's the Associate

MPR
2015 DRC Conference_Day 2 Part 5

Director for the DRC and been with me for years to spite her animus. And Heather Freighter, maybe you can put your hand up, where are you, Heather? You were here a minute ago.

Oh I'm sorry. Oh yeah, things change. All right, Crysta Stone Valenzano, are you here, Crystal? They are over in the corner. And Steve Bruns is one of the microphone guys, our own Vanna White, and I also want to thank Ciolin Grey, who is a student of David's who's been manning the other microphone. Thank you, Colin. And then Jennifer Devalance, our head of communications, who's been here most of the time but I think may have disappeared, has played a big role. Lisa Walls, who's out in the hall` and is the one who forgot to do my name tag yesterday, but I don't think it was age discrimination. And then Lora Kosar, who's our internal administrator for the DRC. So, please give them all a big hand. And I thank you all for coming and I hope to see you again next year.