Transcript: 2013 Disability Research Consortium Annual Meeting
Disability Research and Policy: New Evidence and Promising Ideas
Wednesday, October 16, 2013

Good morning everyone, I am Jody Schmidt -- Jody Schimmel, as you are aware DRC is a cooperative agreement, this DRC is to help disability policy decisions, welcome back to those have attended yesterday, for those of you that are new today welcome. We will highlight the findings into the service needs to support people with disabilities and the comp? Interactions across these programs, as was the case yesterday, unfortunately we had to cancel our lunch staff, due to the government shut down. We will have people set up in the kitchen, it will be shortened to one half hour. This morning section -- session focuses on disability related sport -- Disability-Related Supports and Program Interactions. We will talk to Henry, -- Alexis Henry -- within the context of health care reform and the wraparound coverage that the coverage will provide to those individuals. Next we will hear from hundreds familiar -- Andres Mueller. Our discussion will -- we will be joined by Michael Wiseman, he has a difficult task connecting the dots between these broad studies. As for questions from the often -- audience we support and welcome questions from both audiences after the discussion. Yesterday we had lack of questions from the webinar, to encourage them today, they are able to submit questions via the web chat. Those of you in the room are not so lucky, we will have questions, we will limit questions to one question per person, we will get everybody to speak and then you can ask another question. >>Please keep in mind that they are at the various stages of completeness, I am pleased to bring got John Kregel to the program.

Thank you Jody, thank you everybody. I am very grateful to have the opportunity to be with you today representing my colleagues at Virginia Commonwealth University, our work as a part of the disability research consortium is a combined effort, in the school of education, at Virginia Commonwealth, and the school of medicine at Virginia Commonwealth as well. The colleagues are a -- I am working with is Virginia -- Lucy Miller who is they lead author on the paper Steve West from the Department of rehab, and also Dave who is the chair of the Department of physical medicine and rehab he is also the national director for physical medicine and rehab for the Department of Veterans Affairs, he basically directs rehabilitation programs across the VA hospital network, some of our work comes out of our clinical experiences at Maguire medical center down in Richmond. They see 1500 veterans with TBI every year. They have 525 people who are seeing in the inpatient with patients with spinal corn -- cord injuries. They serve in the lots of the critical laboratory work. And also for the work we are doing in our physical disabilities -- work with our physical disabilities department. >>I am happy to work with the Mathematica policy research, I value the collaboration with them that goes back 15 years, back to 1998, I have -- I am so lucky to have so many mentors, Craig, Gina, Bobby -- Bonnie, I appreciate them putting up with me for all of these years it has been a delight to work with them. >>The purpose of the presentation is not to give you a

comprehensive detail description of the VA programs, if you can imagine describing SSA programs and 15 min., this would be equivalent has to that. We have a basic overview of the basic descriptions of the multiple programs, we will compare and contrast these programs with the SSA disability benefit programs, looking at the purpose, eligibility determination, benefit amounts and use of contrast their. We will look at the interactions of veterans that receive benefits from both programs. With Social Security and with veteran benefit -- benefits. >>There are five basic programs let's describe them. Department of Defense military separation and retirement Based on Disability program. VA Veterans Compensation, VA Veterans Compensation, -- pension, SSA Social Security Disability Insurance, SSA Supplemental Security Income. -- Let's look at them one at a time. >>The first of the DOD -- DoD separation based on this ability -- what they're determining is level of fitness for duty. We are determining whether somebody is fit to go back into military service, if not they can get benefits in a lump sum, permanent disability a grandma or temporary, if it deems to be not stable for long periods of time. We will tell you people in the military sustained an injury, they do not want to go on benefits, they want to go back into act to service. -- Active service. They do not want to be separated from the military, that is why they join the Army is to get out of their hometown, they do not want to go back. -- To their hometown. >>Separation was Severance Pay, one-time payment the account against SSI disability, we will talk about partial disability, right now on the next life that is coming up. >>Eligibility as opposed to fitness for duty this is about the individual's medical condition and how it is expected to diminish their earnings capacity in the billion -- in a civilian economy. >> Individuals disability compensation is only available to individuals who have sustained a service connected disability. There are broad definitions and narrow definitions in terms of what service means. These terms go back to 1917, all of the archaic terms are going to come from legislation in 1922, 23, -- 1923. You will see this going forward. Disability is rated on percentages on a continuum of 0%-100%. The higher the disability rating the greater the benefit paid. People say wouldn't that be great -- efficiency is the concept it is based on, somebody with the 60% disability only has 40% of their health left. Is the actual terminology that is used. This is applied to both return to duty and earnings capacity within the civilian economy. These notions go back a very long time. If you have multiple disabilities there is a complex formula, you take 60%, you have 40 left, and you have a percentage of that and then a percentage of that. There is a great Darrell of difficulty in assigning disability in a consistent way across to multiple examiners and multiple determination programs. VA Disability Compensation is a bag program. -- Big program. They're working with advising Social Security disability compensation -- the payments are high in relation to SSA's programs, you can go with 100% disability, you can go over $3000 on a monthly payment. If you are an individual with a spouse and a child. The benefits for one person really start at $16,000, and go up from there pretty -- go up from there. >> It is a maximum of $2533. Most people do not get to that particular level. In terms of compensation, the VA program are considerably more generous, then the SSA disability payments for DI and [Indiscernible] Because they are permanent and non-service

disability for a surviving spouse or child, this is a pension program, there is extensive work benefits to this program every dollar that you earned producers that [Indiscernible]. >>A lot of things are triggered in terms of federal property rate for at one individual. Individually unemployable the notion of, is a concept that goes back 80 years it really focuses on VA's efforts to move to something close to total disability basically if you have totally -- total disability rating of 70 or above, and if you have legitimate, you have been determined to be unable to engage in what they call in substantially gainful employment, as opposed to STA. You can be rated with total permanent disability. The commonality in terms of the relationship of this program and the notion is gainful activity in the SSA program, they probably borrowed the language 40 years later. From the veterans programs. The compensation benefits are not -- the disability pension program is means tested. Employment in some incidences may lead to veterans disability, they can go back and look at your rating, if you are individually unemployable at 70%, your soon to be 100% disabled. If that doesn't work out, if you just -- start earning above a level, above poverty level in this particular instance, then they do not have a former -- formal plan like SSA does, it will need future research, it is means tested and earned income from employment, for the veterans eligibility. >>There are huge benefits within that particular program. >>That is the perfect amount of time okay. Interactions between Social Security it and DoD benefits. They do not affect the monthly amount of the benefit, the DoD separation will result in an offset of the veterans SSDI benefit. The SSI program is means tested and in most cases eligibility for programs really affect one another, veteran pension will be counted under income under SSA's role. -- rule. Two things that I want to emphasize well I close here. -- While I close here. >>In terms of eligibility determination, gainful substantial employment, in terms of payment structures in relation to the property -- poverty level. We are looking for ways to streamline interaction between these programs, it is definitely well worth investigating. Its efforts to expand to DoD , and VA facilities have not been evaluated, it appears to be successful. It is to prioritize and expedite the process of veterans applications. In effect the evaluation is needed, it is really important to emphasize that there are possibilities that are hampered by electronic data from the VA, although DoD has electronic transfer capability, these avenues should be explored. And increase the efficiency of dual eligibility. The other thing I really want to point out, is that -- okay sorry. >>The other thing I want to point out is there are interactions between the two programs that lead us to believe that individual veterans that receive disability compensation can and should be applying for DI benefits in much greater numbers. We want to focus on, and look at the outcomes of outreach activity. These are people who could benefit from DI benefits, could benefit from health insurance, available through the SSA program, and really move things lowered if we can -- move things forward if we can improve. In terms of relationship that the SSA, and veterans health care coverage, it may benefit if states adopt Medicaid expansion, the 500 uninsured veterans are less than 130 Pitt -- 138% of poverty level, this comes from the Institute that was cited, it is access to the long-term services and supports for individuals for community-based living, the new program option may be greatly a veterans and prove to have difficulties of

meeting their needs and they are homeless at the time, they are accessing Medicaid benefits and Medicare benefits for veterans, it would add to their overall insurance coverage. >>In conclusion it is really possible to understand all of this stuff. We do it all the time, there people who are a Visine BAA -- advising the I benefits, -- DI benefits. >>The VA system wants to be like SSA disability system, if they have their act together and is less arbitrary, left up to the examiners more formal, it continuing disability review mechanisms, looking at SSA as the standard, for disability determination there is a lot of things that can move forward in the coming year we will be looking at the RC collaborations. At the at eligibility -- looking at it at the DRC collaborations. At the eligibility of these programs. Thank you very much.

Good morning everyone, I am very glad to be here. I just want to thank our funders and the Social Security Administration and Mathematica policy research for hosting a session, and inviting us here. I want to acknowledge my co-author Jack Gittins -- Gettens , who sit in the back of the room, as opposed to the in front as instruct it. >>To understand the employee related health insurance disability, this is a line of research that we have been doing within the disability how the and employment unit, at the center, of the University of Massachusetts, we have lots of layers. >>We have been conducting a lot of inquiry to understand the role of healthcare services in employment for people with disabilities. The study is just another in the series. We do know that health care services and related supports can play a critical role in helping people with disabilities to continue working, or going back to work. It includes durable medical equipment, personal medical services, mental health services, medication, these can all be very important for people. We also expect that the affordable care act will reduce uninsurance, people will become newly insured as the affordable care act rolls out. Medicaid expansion, and the new marketplace plans me are for -- may offer coverage for people who have not previously had it. It is unclear whether they will cover sufficiently employment related services that people -- that help people work. >>And optional wraparound plan that could provide coverage for the critical services they need that are not covered by either standard insurance. >>The goals for this study is to describe the employment healthcare related needs of people with disabilities, we wanted to understand the types of services people use. Particularly those critical to employment, what is their experience of out-of-pocket expenses, and just the delivery system in general, their interactions with careful -- care providers. And the delivery system, we are doing this to inform policy deployment -- development. It is an opportunity to look at this potential option for people with disabilities, we are hoping that this research and the research that we plan to do under the DRC, will help perform development. >>Studying the phenomenon of healthcare services for people with disabilities in Massachusetts, it is something we are pretty proud of, the reform in 2000 the reform in 2006 resulted in very low rates of uninsurance among people with disabilities, this study we were able to purposely -- everybody in Massachusetts is insured, the problem with people and insured is a big problem. We focused on people who have insurance and really trying to understand whether the insurance was sufficient to meet the leads -- needs particular to employment. >>We decided to use focus group as a way to address this question, focus groups

can be very in for derivative -- informative. We started with six groups across the state, the criteria for participating in the group, they had to be working age 21 to 64, English-speaking, and leaving -- living in the community. >>They had to selves -- self-report physical or psychiatric disability, they are currently employed or actively looking for work, and we recruited people who have private insurance or Medicare, they could've had Medicaid as a secondary insurance, but we excluded people who had Medicaid only, the reason for that is Medicaid is a rich set of services particularly for people with disabilities, it provides coverage were talking about in of wraparound plan. We excluded people who had only Medicaid. >>We included participants through various needs, we sent out invitations flyers through state agencies and community-based agencies, we had long standing relationships and recruited from MS society, the spinal cord injury, -- epilepsy foundation and other groups like that. >>Can I just ask you to pass me the bottle of water? >>The general approach we use for the focus group is that we have a strep dirt guide -- structured guide. We provided refreshments, we provided accommodations as needed included ASL interpreters, large print format and other accommodations. The day that we analyzed using a qualitative approach we transcribed all of the audio verbatim, we use that list to help manage the data analysis and applied this constant comparative approach to the data. >>These are our participants we had 54 people who participated in the focus group, a little bit more women than men, the average range was 26, 8% were white, -- 84% were white and 8% were Hispanic. >>29% had some college, 56% were college graduates are more. We ask people a series of questions related to disability using these questions from the American community survey, 80% reported a physical, mental, or emotional disability, 59% recorded a learning concentration problem, 20% ADL limitations, 48% reported I ADL. I will put my glasses back on the screen is little blurry for me now. >>Almost 45% work 21 hours a week or more. With the annual income little less than half earned $10,000 a year, 29% had private insurance only, 4% had private and Medicaid. 14% had Medicare only, 46 Medicare and Medicaid, and 14% reported other. >>These are some of the results, many of the participants probably the majority described their overall health care experience as frustrating, inadequate. These were high service users, here is a quote to illustrate that. >>I had back surgery so I had durable equipment, I have hospital bed. I had a brick brace -- back brace. I have a walker I use at times, I have a cane and a mobile wheelchair I use at times. >>This was fairly representative of the level of services that the people in the group used. We bucket it it -- bucket it in services, medications, behavioral health services, long-term services and ports, these are more typically provided by Medicaid, personal assistance services in the home healthcare services, and people talked about other disability services, like supported employment, dated call modification, training, and peer supports these were not -- vehicle modification. >> People identified services that were critical to work, using services typically covered by private insurance, I see my provider, without the antidepressants she gives me I would not be able to work, there is no way I can get through the day without them -- services typically covered by Medicaid, here is another quote, I do need it, to cover primarily, but also to cover durable medical equipment, use the I use aim -- a will

chair. >>In general we see that people who did not have Medicaid retired -- required an unmet need, if they had physical therapy certain DME, or medications the limitations on that coverage was perceived as an unmet need. Limited number of PT sessions, not covered in the formulary. People talked about services not covered by insurance, dental and vision services, chiropractic care, things like that. We found that they were lower among bees with Medicaid. >>Here's a quote. I have Medicaid -- Medicare and Medicaid, I have no problem with my medications they cover everything. >>People talk about out-of-pocket expenses co-pays, deductibles, etc., they are greater for those with higher income, generally reported by Medicaid, here is another quote. >>Professionals with a good salary also faced difficulty, it's a constant juggling deciding what to pay for what food to a, my rent is quite high where else my going to live? >>We experienced pocket at expense -- out-of-pocket expense, for those people more things were covered. Here is another quote, >>In the discussion I haven't been able to say much I have no trouble with co-pays. >>People talk about challenges with coordinating, with the service delivery system, this quote I manage my own care, that is a job in itself. That is pretty typical people working full or near full time, this is so unstable that you work and work and finally you get it to come together and the next thing you know it is falling apart, this reminds me on how we try to do the medical aspects of things how do we find time to work on top of this? >>We found people your participants had discussions with primary care providers, this encouraged people to work. >>I am right at my two-minute warning, in summary healthcare services can be critical to employment. Both covered by private insurance such as medications, typically covered by Medicaid, like personal assistance services, and not typically covered by insurance, but job coaches, people talk about all of these things being important. >>People with disabilities want to find healthcare related challenges, they include the notations on services, unmet service needs, the difficulty of managing work and healthcare, and their disability demands, that careful balancing of work particularly if you want to work full-time, a lot of people talked about the important role that work plays in their lives for them. >>Productivity satisfaction, feeling that they are making a contribution and the income are all critical people -- critical pieces for people who work. The challenges seem to be greater for people who are working full-time or near full-time and only had private insurance. We worry about work, and these challenges and the burden of coordinating that care may be an incentive, for people they mainly employment to get war services covered in the services that they need, thinking about what the policy questions are for wraparound coverage, can a wrap plan alleviate disincentives and make work pay? What services should be covered? They can -- can wraparound provide the services that people need? What cost protection should wraparound coverage offered? There is a lot of research and needs to be done. Are next to studies under the DRC was help us continue this line of inquiry, to more directly quantify what the employment related healthcare needs are, and to assess feasibility and what the design options will be for a wraparound program. Here is some contact information and references, I am done. Thank you.

Thank you for having me here to present this research with Jesse Rothstein, with the extent of the caseloads they keep rising at the same time there is documents that Anna -- that discussion could arise, here a period from 2000 2003 -- 2003 it shows the applications and the unemployment rate, here is another picture going back to 1965. This is been around, more recent profession that is at the same time the application did not rise as much and did not respond as much in previous recessions, I think it is fair to say that this behavior application and for response, it is not yet fully understood. Some explanations for this pattern include the mindset factors, loose labor markets, they do not offer the types of jobs that they need. They do not make the accommodations they need. Another is related to supply, marginally eligible workers preferred DI when working -- when market wage fails -- falls. >>DI is a maternity of , for example this could explain the time response of the application of the session you may know the insurance, the length has been over the recession. >>I would like to show the simple model of disability insurance interactions to benchmark our results, I will not go into details but basically the model a person who becomes unemployed loses their job, have three options, they search for work, exit the force, and the third is to apply for disability insurance, the crucial point in this model is that changes from employment, as you approach the exhaust of the insurance, it will change. The model pictures -- features five strategies. >>X ALF immediately -- exit Al at -- LF immediately. Job search until UI is exhausted, then exit LF, job search until fine job. Apply for DI immediately if rejected search for idleness. And then the fifth is job search until UI is exhausted then apply for DI. The strategy five casual effective UI durations on DIA. -- DI. >> -- They will fall if a lot of people choose the last option. The simulation of the model, the main implication of the model is that people who go on unemployment insurance, if it is extended for a number of weeks, during that period people continue looking for jobs. And multiple disability insurance, extending employee -- that unemployment disability -- unemployment insurance has a benefit. >>The costs providing additional unemployment insurance to the cost savings of having multiple people apply for disability insurance, based on their rough estimates, $300 per week in the unit -- UI insurance, based on extending unemployment it should be substantial. >>As I mentioned before, the main question is , do they apply for DI applications? We follow four different approaches each with its own benefits. It pains a very clear and concise picture. The first is approach.

-- >>The second strategy is to do the same thing state by month panel, very controlled for the states. Third approach is to look over the state level, look at the DI applications before, and after UI extensions. Finally we will look at the micro data, and the analysis to look at whether in a given year will lead to DI income. >>Now for the first two approaches, we need a measure of UI exhaustion, it becomes the official measure. We build our own measure of UI exhaustion, based on the number of people that start a claim, and we basically based on the roles, it is similar, how many exhaustion's are given in a given month? The main data sources on SSDI applications and awards. By state and month, you actually get access to SSA disability research file, to study the work rates and they are leaned to the original application -- linked to the original application. >>This is related to tremendous increase, for UI extensions, you see

them minimum, maximum and the average duration of the unemployment insurance. It increased up to 26 in some states, it can be tremendous variation that crossed states. -- Variation across states. In terms of the timing, this is the kind of variation for this program. Right here we see here the solid line measures the few exceptions that come out, that is not the one we use, then we show a measure that is one we constructed. There is a lot of variation. To measure a few, there is not relation in 2008 and then it drops it down, this is all driven by the extensions. They tend to drop very Dasd click -- drop very drastically. >>Up to 500,000 in the fall of 2010, we also plot SSI applications over a period of 2010, there is very little changes in the applications. Between exhaustion and applications. This conclusion is also shown in aggression, the number of applications -- shown in regression in the number of applications, the employment rates, and time insurance. We do not plot for him entities. >>-- We do not plot for this. >> The number of Excel sheets on this application we also looked at the affect of the number of exhaustion's which is possible because of SSA disability research based on, data and the application we do not see any relation between number of exhaustion's and DI awards rates. We also look at the event studies and we look at what happens to be at -- to the applications before and after. We can see two types of extensions, we try to focus on the most relevant extension. It is really has the most profound impact on your exhaustion's, they drop drastically, we do not see any response in the applications comma after the date of the expansion. >>We also see across age groups, we did not find any dynamics around this information. >>Finally we have micro data analysis, I do not have time to go into detail too much, basically we did an analysis of the likelihood of receiving disability insurance in a given year. Whether a person exhausted unemployment insurance, by June of that year, or earlier. Looking at people on an employment insurance, debate -- unemployment insurance, debate receive -- did they receive disability insurance that year. >>I would like to turn your attention to the bottom numbers here, in this analysis, you will see there is a positive effect, relatively small, it is the percentage of the profitability of applying for disability insurance increases by 0.23% points, when people eggs all -- when people exhaust their insurance. If you have additional 10,000 exhaustion, and people could apply for disability insurance, this also complex and it is our analysis and we cannot reject analysis at the national level, or at the state level. >>Let me conclude here, our model features some possibility to action to unemployment insurance and disability insurance, the main way to think about interaction is to think about people who qualify for extension on the unemployment insurance, they may continue to search for job, and not apply for disability insurance, they would have applied for disability insurance. It does have implications for this however, shows no effect to be a bit more careful we could rule out the applications with UI exhaustion, .02 it means if there is an expansion, or in exhaustion, decreased from a normal level down to zero, then disability insurance applications only go down by 2%. This is a relatively small number, and it is a balance of art estimated numbers. >>We perform simple benefit cost analysis, basically to sum up we found that they are the same numbers earlier, basically we found if you extend unemployment insurance the cost is $12 million, because only few disability insurance

applications, the cost savings would only be $3 million. You also have to keep in mind the wraparound. Trivial effect on DI caseloads. And I think also looking at the trends and explaining, the lack of, in the more recent session, it is to look at the expansion and not the interaction between UI and DI insurance.

>>Thank you to all of our speakers, staying within the allotted time.

>>We were told not to bring the overheads for our discussion, I didn't realize that if I didn't bring an overhead we would have to look at my picture? [Laughter] once is enough, three times is probably more than justified, I apologize for this. This is a very interesting group, it is a very mixed bag, there are not too many connections to be immediately drawn between the issues. I will try to look at each one in the order they were presented and look beyond. >>Extraordinary paper on benefit and assets, I decided long ago never to enter, and I appreciate John's last note, it is possible. I also appreciated the statement that there are advisors out there that understand the system, and can help navigate it. I teach students the details of TANF, I point out advisors that can help people receiving that assistance, and how it works, and the connections to their benefits, we asked them to explain that on the midterm. They fail. The notion that these students speak in public policy can't manage this, over substantial weeks opens their eyes and the problem of it vice in this environment. -- Of the advice in this environment. We appreciate the nature of this paper, we have a strong sense everybody in this room, all these issues and the assessment of disability, cliffs what have you. I was disappointed because I heard rumors that in the disability assessment and the department of defense and moving on to Veterans Administration, there was more something than the cliffs of gainful employment or the capacity of the percentage of disability, and I thought the inverse of that is -- there may be lessons learned there. A different approach to assessment of capacity, it doesn't look like we're going to find that here. Not right away. Instead of substantial gainful employment, we have substantially gainful employment which confuses me more. >>The missing numbers it is remarkable that the, it is possible statements here. We call this feature a problem for some, but how many? The objective of this paper is as it evolves the work, where the priorities should lie in data collection. This may not be the job of the DRC, we need a vision of really how many should think about veterans compensation in the future, as John pointed out these go back 80 to 90 years, things have changed. Uphold the mention of things. The time is, I think hopefully, we extract ourselves from the last of our it ventures, to think about the way the compensation package for our service people should be composed. Some separation from the way that you compensate for service related injuries and that package, and then the basic benefits package that goes with being GI -- I looked up what this means and it means galvanized government employee of some sort. We are talking about employees, public servants, particular environment that experience risk, they are compensated for that, effort needs to be given as to how that should be managed. On the issue that John mentioned, people are not getting all the benefits under existing law, it coins out for something a little bit more

than usual approach, is to give one more counselor or navigator place to give a little bit more help, that never answers the question about how much is the need? That is an essential question, is it possible to think small-scale of randomized efforts? To take a group having left the service, or identified disabilities within the service, to monitor them, to assess their eligibility for benefits for the whole range of benefits. They have identified, this is a critical step. Regarding Massachusetts and Alexis Henry paper, I'm starting to think about these issues in Massachusetts, it is an exciting thing to open up they're then you have to ask ourselves -- then we would have to ask ourselves, highly selective focus groups like this, I want to begin someplace by think and about the population that I am interested in, I'm trying to make inferences about, and then what does this focus tell me about that population? I'm having a hard time describing the mesh between the two. At least they can be told something about that. When we learn about the focus groups there are some things we know about focus groups, people will have needs. One reason to expunged in the highly educated group is, you're pissed off about things, you want to Tell Your Story, that is good, what about the surprise you learn from this group that should inform any more systematic information, I would mention the notion of the surprise. Some sort of distinction between the unemployed, the difference between the needs of those seeking work and those that are employed, are necessary, pulling them together, a may have been a good place to start, what bothered me, was the decision to eliminate Medicaid only group. The Medicaid only group are supposed to have the wraparound combination, if there is an evidence in the joint Medicaid, plus other insurance, they seem to have the fewest deficiencies, if Medicaid is supposed to be comprehensive, we need the base line of knowing how those people feel about their circumstances, to compare against these others. The impression that comes across to on this, again this is nothing new it goes back to my colleague in 1972 Rota paper -- he wrote a paper, the and Norma's tax on one's time. It up places -- the enormous tax on one's time. >>The executive functioning is demanding on your time, the disability really taxes that at the same time, I appreciate very much what was saying about therapeutic value of work. We see that. If we think about these kinds of services whatever wraparound it eventually leans to, the benefit is in part that therapy. The exceptional cost of these things which we do not seem to broach very often, not just the wages that are earned, but all sorts of consequences for well-being down the road. This paper is exciting, it makes us think about that. >>Let me talk about Miller, Rothstein -- you here in the presentation we are aware of the increases in SSDI and for that matter, the SS I applications, do the extensions which we have seen so dramatically over the past years, are they diminishing this affect? As an dress -- as on the rest -- >>As Andreas Mueller pointed out, the model I think based on the baseline the key is stationary be -- stationary, you who are finding employment which you start and chose that option you continue to look for a job till UI is exhausted and then you apply for DI. We do not talk about saving or borrowing, or where you're getting the wherewithal, aside from the UI, I am an economist and I appreciate simple utility. I do not want to be too critical, it is easy to come up with slightly different models with different implications if we think of our model being [Indiscernible], uncertain about the

opportunities elsewhere in the economy for finding a job you begin searching as time progresses, the probability that you can find employment continuously declines. Admittedly coin flipping, now you have a bad run, that is the nature of this random process. You are also learning things, as you learn things you may be Jrgen to make that option on the other hand, because you learn and perhaps see that you do not have the option for substantial gainful activity. That doesn't mean that the question being addressed in this paper is not important, the way it is three just -- the way it is addressed raises the question. >>I am old but not as old is David Weiss -- wise. In the recorded history I learned when you and regression, if it is measured very well on the left-hand side for applications for disability assistance, the variable on the right-hand side which is exhaustion's, is measured with a lot of noise. There are a lot of variance there. Many dimensions in this paper, nonetheless it is very difficult to come up with the number of exhaustion's on a monthly basis, or the like, especially in the curious nature of UI, I want to know the differences of errors of the problems that exist. A separate issue talked about children on SSI, we lose track of the fact that in any state persons receiving already, the set of people who are available to apply depends upon history up to that point, maybe the potential applicants are very lasting, and they decide that they have disability, or maybe some states Arkansas and Texas, you just have a more permissive state disability, or something like that. The stock symbols you at a go for it. It looks easy. We do not know. We very rarely see attention to that process. In the aggregate. Pointing out two things. One there is an important connection here, I want to see more of it done, about the use of all of our modes of social assistance during the great recession. SSDI is one, we know for example that TANF temporary assistance for needy families program, it was notably unresponsive to the rice in unemployment, -- rise in unemployment. The food stamp program as NAP -- SNAP, there has been things done on the timing of connection of the take out of food stamps in connection to UI exhaustion. That might be something useful to compare. And finally that last example which I did not quite understand seem to put the estimate in a world without UI, which is zero, right? The last simulation that you did? I am always concerned about these counterfactual when outside the range of our experience used for modeling. Much more restrictive UI program will produce a different situation in the labor market, in which a person with disability would be searching for, it would be very hard to have much confidence in inferences that are made in pushing the model to be's limits. >>Thank you very much.

Thank you very much to the panelist, if you would like to ask a question we can go to -- go in order? Anybody else? We have a web question. >>We do. >>Okay first of all thanks a lot for your talk. It was certainly on point, let me take response to a couple of your comments with the model I agree it is a simple model and we need to be fully realistic. And then the problem of stationary change of applications, it is dropping. Maybe people apply for disability insurance before they exhaust UI insurance. I think that the bigger question here is somehow the empirical specification it is really between the type of applications. If they are long between

applying for the disability it could be possible to somehow underestimate the effect. Cautions we try to be also -- we try to be cautious as well. >>-- Looking for unemployment data from SSA to see precisely to what extent disability, unemployment recipients apply for disability insurance. That would show some evidence if we pull that off. Finally I think your point about measurement there, it is well taken. I think it is true there is a fine measure of insurance exhaustion, there is measurement there. This is why we do an event study. We just look basically at the treatment, whether there is a response to the extension of unemployment insurance. We do not rely on the exhaustion, we don't find affect on the applications to these extensions. The measurement may be biased to our estimates. I did not fully understand your comment about the stocks, maybe we can talk about that later. Thank you. >>I could respond. If I could make the microphone work , just to some of the points you made. In focus groups there is a limitation of the project, people definitely volunteer for focus groups and they have something to say that is actually true, we plan any follow-up study coming up in the following dear, we plan hopefully there is a project we can -- in the following dear -- year. We hopefully there -- hopefully there is a plan. >> We did this intentionally for people who add Medicaid only, for two reasons on assumption that Medicaid does provide comprehensive set of services, that they may have coverage, akin to what we are conceptualizing. We wanted to make sure that we included in the focus groups people who are higher wage workers. Working near full-time , we were concerned about making sure that we had good representation of that group of people that were not on Medicaid. In the study sample. Giving it back to Jack in the back row, do you want to add anything? >>Let's turn it over to the web question first. >>Our first question is for John Kregel, this is to a Mathematica employee, she wants to know do you have a sense of problems between the concurrent statements between the DOD programs? Let me read this verbatim -- from the DOD and programs for disability related reasons? >>Say one more time? >>Do you have a sense how frequently from a DOD and VA programs for these reasons, I was also wondering between SSA and disability program. >>The answer for DoD and other programs rarely, but sometimes. There will be occasions where that occurs. Basically , one with the individual moves and becomes eligible for disability compensation, then there military benefits do not continue, or they withhold disability compensation payments until the payments paid under military separation program are in effect, the terms between concurrent and SSA disability program and the VA program, in terms of the DI program, the number most readily cited this 3% of the title II programs, would be individuals who are veterans as well. You can also look at the representation of veterans, the Ticket to Work Program, is lower than 3%. The number of individuals with concurrent benefits within the program databases, would be about 2%. We are talking about a small number, but really a large number in terms of overall people who receive veterans benefits. >>We will start over there. >>Hi, I am with able Americans and I have my first difficult question of the day. If I do not phrase this well ask for clarifications. I want to know how long did all of you do a study in individual cases, especially in people returning to work, I am here to tell you that it is arbitrarily enforced, in Social Security depending on what sure case manager is. And how

much of an ex--- ask they have to grind. I will be blunt in saying that because I think our soldiers deserve far more than that. Especially our wounded warriors, I want to know the debt and the length of the study, it is arbitrarily enforced between agents depending on who the person or the claimant is, whether they have congressional interests backing them up, or whether they don't, whether the letter of the law is followed with the spirit of the law is followed. >>We looked at policy manuals, and that type of thing, in terms of assumptions, when you think about veterans, with disabilities, you think about 1.3 million veterans with disabilities, we are talking about 500,000 veterans, that do not have healthcare insurance, and have incomes between -- incomes below the poverty level. The VA runs national programs called homeless reintegration project. Our veterans deserve better than that. It is a huge problem obviously, you cannot really deny the fact that the idea of the veterans that are taking care of. They are not true. >>[Indiscernible - multiple speakers] >>[Indiscernible-speaker away from microphone] >>Completely interested. >>Justin your -- just to answer your question we did not talk about experiences with Social Security administration certainly in other projects that we have done we have heard people, and the seemingly arbitrary nature, Social Security and local offices, and filling that rules are quite varied depending on what you know and who you talk to in my unit and program , we have done results on this program, we have a project of certain projects, -- that people have. >>Thank you for your question. Looking at any specific cases and the way to return to work I think it is important

-- and to search for jobs it is easier for them to return to work when they receive disability insurance, I think this is a really important question. It is still relatively -- it is still relative, we will have to look it up to see how important it is to find jobs. We will try to determine that in the current kind of environment it is challenging . >>My question is for and just -- is for Andreas Mueller, I hope you are successful, I was convinced by your analysis that they do not affect DI applications, we are not at all convinced that that means recessions are not creating awards and allowances, partly the biggest issue for me is, the transactions that apply for DI benefits and the administrator issues in the programs, as far as I know there is nothing preventing somebody for applying for DI well they have unemployment insurance benefits, if I was a person with disability, and I knew I was waiting to get allowance. In it might take -- if it might take a year I would apply as soon as I can. My guess is you will find that there is a lot of UI recipients that are among applicants when you match the data and you eventually get onto DI it is important to do I am glad you are doing it, maybe you can make it a question. >>Once you mentioned that basically there is a link between them, I am saying the fact the disability appliquéd -- applicant, they have more opportunity for disability insurance. That cannot explain the DI applications there are other explanations, the other explanations are more promising than the one you studied here. The concurrent applications being able to study this to merge data, on the records, I did actually -- in New Jersey I did mention this before, on the plug workers, at asking about their job search, we have preliminary data there, it is the dataset but it shows roughly 2 to 3% of recipients also receive disability insurance. It is the relatively low number. It is not conclusive, but that is some evidence we have. [Captioners Transitioning]

My question is for [Indiscernible]. Heavyset but look again to about what the prolonged period of unemployment is on health status in terms of lack of health insurance during those prolonged periods and -- and medications as well as the impact for people of mental impairments on the whole process of being unemployed and the inability to find a job can exasperate mental health conditions such as depression and other serious mental illnesses. If you have not thought about it I would encourage you to think about trying to look at that as a potential reason why people end up on disability after a long periods of unemployment. >> Thank you for the question. I think it is a very relevant question. Again, unfortunately I have not studied this question so I cannot give a very detailed answer. What people have found is that with unemployment in general has a profound effect on health particularly people for high rate of depression among people who become unemployed but there is also [Indiscernible] people overtime. Fighting health insurance I believe might be very relevant. Again I cannot give you any more evidence on that. >> Joe from George Mason University my question and brief comments is for Alexis Henry. Alexis thank you for your presentation sharing the results of the focus group. It has concerned about [Indiscernible] focus groups can be very helpful both in illuminating stories and surprises also in policymakers, when they do not listen to evidence which can happen from time to time. [Laughter]. Stories sometimes can be very influential in changing policy. One of the observations were things that jumped out was this comparison of the dual eligibles which is 46% of your sample and then everyone else. One of the takeaways or themes I came away with was that even where health insurance is provided, care coronation is still a problem and I think as Medicaid expansion moves forward in 2014, we're likely to see that in other states where care coronation will continue to be a problem. My question is, were there any lessons learned in the stories you heard from the dual eligible participants versus everyone else that might be applicable for other states in a particular financial alignment demonstrations that are starting in 2014 in a number of states and I think Massachusetts has received approval from CMS to move forward with this demonstration.

I do not know that there were some specific findings that from that subset of people who were dual eligible -- is actually in every focus groups of you may be able to answer this. Is hiding in the background. I think the question that care coronation is really a critical one and as these , in Massachusetts we are just rolling out an integrated care demonstration for dual eligible that is targeted to the working age population of 21 to 64-year-olds. It is literally just rolling out, people are just getting enrollment packet in the mail. The camera does a patient centered medical home model and the thing that we have been really interested in is how we can encourage these integrated care teams that are supposed to be integrating both primary care behavioral health call, long-term support services and other community services, how we can encourage these new integrated care teams to pay attention to employment in that process. That is a piece of work that we started to do with our state medicated agency as these demonstration

was just to me, states coming out is rolling out. I think these are opportunities to provide coordinated care for people who are dual eligible in these models and I do not know what, where the other states are in the lineup of states that are doing these demonstrations. >> I am Chuck. The one thing I think Alexis mentioned in the top disintegration of behavioral health and primary care so a number of people that did get some level of care coordination talk about employment it was likely to come from the behavioral health side rather than the primary care site. -- Site. >> I thought you forgot me, thank you very much. [Laughter]. My name is Teresa with great injury services. I was wondering among the panel members, keep asking the question, have you had an opportunity to see data coming from other or innovative projects come from other federal agencies. One primary example is the department of agriculture led by rent Elrod the [Indiscernible] bedroom program had a unique funding mechanism for the United States Army medical command and I'm thinking close to 20 military bases, the University of Wisconsin school of social work Dr. Ronda Montgomery who already has nine states that have totally implemented systems changes to her model called PCare . What they're using her model for was to educate the social worker's and the soldier family assistance centers that these large military bases so that for every individual and family who want to and through the door were not to be excluded based on a fragmented number from DoD or MVA disability so that the safety net was , when you go to your state, the state already has a system in place in the state of Washington, Oregon, Florida, Georgia, Dr. Ronda Montgomery has spent the last 20 years developing this model that is now funded I the U.S. Army called PCare military. Another example is from 20 years ago and it the the funding came from the Robert Johnson foundation, the first international conference on self-determination so moving away from a percentage number of how disabled are you into focusing on self sufficiency in understanding the mechanisms that control your life. Did report that came out of that and I was part of the advisory team I think has had significant impact again to self [Indiscernible] organizations that do the education and training . What that ties back into is the United States Department of treasury. Extraordinary work of Colonel. Pretorius, the financial literacy is a skill base that so often individuals with disabilities do not have. Thank you. >> Karen, Florida. I would like to address my question two Dr. John Kregal. As you well know [Indiscernible] has implemented 800 here specialist throughout the system by presidential Executive Order. This is a really hot item, I have been working with Pennsylvania's network. Can you comment, one thing that [Indiscernible] does, both men and women is service health navigators because they have been there, done that, got the T-shirt and now they have got a job and can sit down with the self disclosed and from their within the boundaries of their professional scope function as navigators for the events to this whole collaboration of services. I am wondering if you or [Indiscernible], you are dressing that here specialist function and how extensive it is, how or where people are of it and whether they take on health navigation functions? >> There has been systematic outrage from the Social Security Administration to DoD into VA. VA it is like any program, there is a lot of good in there is a lot of bad . They will provide information on healthcare, though provide information on benefits as well as the VA benefits. I had the

personal experience in the last year of watching as a significantly injured and hospitalized veteran had one of these representatives who was reading the Redbook to them while they're very concerned about their immediate health. The trick is, I should point out, is to catch people when they are right in terms of vocation signing as well as health care planning so going downstream, the medical services in looking at people who come back after a. Of time as opposed to people with acute care is really important. With that there are obviously a lot of services available within the VA Hospital system, just like any system, this completely overwhelmed with the numbers. Please understand, when we talk about this population, we're talking about people who have the latest fax due to their experiences, disabilities may rise not necessarily on the battlefield but anywhere as individuals go forward in that kind of thing. I think your question is well stated.

Is as a follow-up, guess what wanted to put on the table for all the panelist is this notion of peer support and how , those of us that have been in the business for 20 years and we started out saying, they will never pay any attention to peer support, forget it. And then here we are at the beginning of the 21st-century and it is now the hot ticket. I was crucified for trying to demonstrate, maybe crucifixion is too strong of a term. [Laughter]. I retract that. That was considered in credibly unimaginable that somebody who has been through a severe [Indiscernible] the post abuse problem, God knows who knows what has happened to you in your life could actually reach down and help somebody else out of the pits because they know the way out. This is now embedded in something as historical as the VA system as the peer specialist as the professionalized [Indiscernible] Annette is a and interesting process as well. I am wondering, is seized -- for Alexis and for John's presentation, the mention of health navigation and coordination of services and for yours as well you are talking about people moving from one area of support to another and 1014 had a faster did talk. If you could comment on the lull that we are rediscovering as people with [Indiscernible] experience which is the current term, the peer support, self-help, all of those mute advocacy things that have really come to the forefront now as we expanded and dismantled some crucial parts of the service delivery system and how that might fit in. Is it catching on for example at the VA. Is that catching on in the Massachusetts system? Are people finding that one thing they can do with their experiences find a job in the service system helping other people get on with their lives.

Absolutely. The value of peer support came across in the focus groups but beyond that , Massachusetts and the mental health system has undergone a pretty significant transformation in the last couple of years to adopt not just a recovery model but to build out the gear support services in the state, and the development of what are called recovery learning communities and the value of peer services and in the new demonstration, the integrated care demonstration

for people who are dually eligible, peer services are one of the community support services that can be purchased by these integrated care organizations for people and navigators are a critical part of the care coordination team and really helping people to access the whole range of community services. I can really speak for the Massachusetts system, I think the last 10 years have seen a huge emergence of peer operated services and an option of recovery philosophy and orientation for people with psychiatric disabilities. Is actually spilled over into these integrated care, into the integrated care model in the development phase of the demonstration, it was the mental health advocacy groups and the peer programs that really pushed for this service to be included as one of the covered services .

I am sorry to be so many questions on the floor. We are out of time. I encourage everyone, we have 45 min. for discussion at lunch about you can reach out to the presenters than. Thank youfor the panel for a lively discussion.

[Applause]

For those of you listening the the webinar we invite you to stay on for the next 45 min. or login at 12:30 PM. For those here in person, lunges around the corner. >> [The DRC Annual Research meeting is on lunch break. We will reconvene at 12:30 pm ET. Captioner standing by. Thank you.]

Welcome back. Thank you for coming back to our last panel for this afternoon. My name is Crystal Blyler and I'm a senior researcher at Mathematica. The panel we have heard from, we heard from yesterday and this morning has provided a lot of great information and ideas, food for thought regarding issues pertaining specifically to disability and related systems and services within the US. In truth, at least some of the challenges that we are facing in the US are common to countries around the world. These are, there are potentially great lessons to be learned from approaches other countries have taken to addressing these issues. This afternoon, we are going to turn our focus to our international counterparts on disability policy programs and research and lessons that we here in the US can learn from their experiences . Maybe they will also have something to say about what you do when other governments shut down. I really do not know. I cannot comment on that.

First were going to have Lorenzo Moreno. He will be highlighting policy and program innovations in 10 countries involved with the organization for economic cooperation and development that were designed to improve employment outcomes for youth with disabilities. Next it, Magne Mogstad will describe the effects of an attempt in Norway to use financial incentives to induce a disability insurance recipients to return to work. Addenda, Jonathan Skinner will compare the efficiency with which the disability programs with 12 different countries screen applicants and minimize errors in providing or denying benefits. Then, finally our discussant, Daniel Mont will round out the perspective of provide insights on how to verbal or not the interventions and initiatives by our panelist may be in the American context. >> As always we will look forward to audience questions following the presentation and we will also take questions from the webinar if there is anybody that is not glued to C-SPAN instead. With that, will hand over my might to my colleague Lorenzo Moreno Thank you Crystal. The course of the study as noted in the abstract of this presentation are to, first of all we review the policy and programs of 10 countries belonging to the organization for economic cooperation and development, OECD , that is a promote transition of youth with disabilities. Second we have served the chance of -- cuts for Bill to promising policies to the United States based on the policies of to of the pain countries.

As further review we have identified four policy barriers to the transition of youth was disability. As listed on the slide, several of which have been addressed by demonstrations sponsored by SSA such as the use demonstration projects and the new [Indiscernible] demonstration. Furthermore, as noted in the recently released hardens report, it is anticipated that the federal government would take bold steps, to improve one of the most salient barriers that the employment of the so-called ADA generation.

Our study approach consists of two components. The first one is a review of a broad range of documents in the [Indiscernible] and literatures as well as the input of international and local experts on the experiences of countries with well-developed benefits and rehabilitation programs. In addition, we conduct in-depth case studies of constant programs and policies of to countries, Germany and the Netherlands.

Both the review of the consistent research and the in-depth examination of the experiences of the case study countries were contrasted with experience of the United States. Given the for barriers for the transition of youth was disability shown on this slide, the disability to adult services Shawntee slide, we have the slide for the [Indiscernible] framework we organize that were firmer ground for policy themes which are most likely to address these barriers. In the next two slides, we will provide details about to of the sets of policies, first, oh grams

promoting employment for people with disabilities and second, programs promoting coordination of transition from youth to adult services progress at second but actually the fourth bullet on the slide.

Let me get started with our review of programs promoting employment for people with disabilities. Our review of the evidence reviewed that wide range of efforts to address the following issues, one, the transition from shelter employment to support with employment, the financial incentives offered to workers with disabilities as well as those tied to vocational training and a third, expand and deploy of supports.

Many of these efforts which focus on all people was disability, this import glorification have resulted in [Indiscernible] policies that promote employment in some countries that were seen operating elsewhere. For instance the United Kingdom requires income support beneficiaries to undergo vocational training in order to continue to receive a national income support in a vocational training program. Second, the Netherlands away supplements for beneficiaries who were to maintain a minimum standard. Finally, Germany's requirement that employers with at least 20 workers employed individuals with disabilities as of 5% of workers is the third example.

In contrast, for instance, in the United States, policymakers may not be willing to invade that employers higher a minimal percent of people with disabilities. More details on these review programs promoting employment for people with disabilities are provided in the working paper released at the end of this presentation.

In terms of policies promoting coordination of transition from it used to adult services, all of the countries in our review have actively pursued solutions to the problem of inadequate coordination of youth and adult services. For instance, France has impacted guidance counselors for all secondary education students to help them make informed choices of postsecondary education, future occupations and career opportunities. Second, Norway's requirement that institutions provide [Indiscernible] planning. Third, Australians national program to help youth with disabilities to transition from school into postsecondary education and strengthen the connection among participants of demonstrations.

In the United States, [Indiscernible] disabilities and secondary education who receive services under the individual with disabilities education act, are required to have a transition plan often in coordination with community providers. The extent to which this plan is successful by -- vary from state by state and locality to locality.

As I mentioned with focus on to countries to promote the case studies. There were reasons for doing this. First of all, both of these countries have a breadth of programs for youth with disabilities at second, both have interviews with the changes and reforms to them a which make them the most promising for transferability to the United States.

Before conducting our segment we reviewed the underpinnings of the system with disabilities in the to European countries and the United States. Not surprising there are important obstacles and political differences to keep in mind when considering a program transferability. For example, Germany guides all youth with disabilities through their transition to adult services whereas the United States leaves them to their own path. Second example, the Netherlands guarantee services and opportunities and coordinates service delivery whereas the United States neither guarantees nor coordinates targeted services. Third, finally, both Germany and the Netherlands emphasize employment support for both youth and employers whereas the United States is more ambiguous about integrating employment supports with other supports.

Let's a focus on these two countries that I mentioned have the potential for transferability of the programs to the United States. Among the eight German strategies that we will review, they're listed in the appendix table. Three are particularly promising for transferability. The first one is the specialist integration services. A joint operation between the federal employment agency and the state or lender which provides support for individuals with disabilities in finding and obtaining employment for employers in training and for employment opportunities. Second, in addition to special integration services, job 4000 and initiative inclusions and national goals and poses for using younger adults with disabilities which along with finding encourage states to develop resources to serve that population.

In the Dutch program, among the eight, the same number as Germany we also list them in the appendix table, three are particularly fond missing for transferability. The first one, the Institute for implementing insurance, [Indiscernible] for the acronym in touch which contract with private sector integration companies and provides used was disability access to employment and vocational services. This companies implement work oriented support for

people with disabilities aims at , one, encourage people to work instead of receiving services and second, encourage employers to hire [Indiscernible] individuals. The appeal for these market-based approaches is that the program could be built on the system and employee networks for SSA future to work program.

The first strategy is Wajong the flagship Dutch program which provides an array of employment support for participants and their employers. Many are accessible for a long. Go to promote labor force participation. The work truck also has the responsibility to take up work eight even if it is not 100% of their basic earnings.

To wrap up, the evidence that we have is about 10 OECD countries and particularly Germania and the Netherlands could be considered an evidence-based building process in the United States. This Possis, -- this process, for evidence-based policy maker has [Indiscernible] in the early 1980s suggest several pathways for [Indiscernible] in the US to consider in formulating. One, the objectives for directing the needs of youth with a disability, second they are thinking about potential solutions, third, a process for gathering evidence about the best approaches for effectively and efficiently serving youth with disabilities.

Of course were not naïve to assume that the SSA or other federal state or local US agencies responsible for regulating financing or delivered services to youth with disabilities would and brave the Dutch and the German strategies given system constraints.

A summary of our study, the first part of the presentation am a you can find that in the publication that appears on your screen. Findings from the in depth case studies for Germany and the Netherlands will be available soon. If you have any questions or additional information you can contact myself or my colleague, Todd Honeycutt at those addresses. Thank you. >> Hello, [Indiscernible] I am Andreas Ravndal Kostol. Over the past few decades , countries in [Indiscernible] population [Indiscernible]. In many countries there is a discussion about whether we can centralize some of these recipients in the labor markets. In the UK for example computers [Indiscernible] allowing assistance to keep about 50% of their -- in the US a few years ago, whether or not the idea was to keep some of the benefit to start working more [Indiscernible].

Advocates of such reforms argued that many recipients return to the market [Indiscernible]. We also [Indiscernible] may include [Indiscernible]. At the same time, if you allow -- the ideas to keep some of the [Indiscernible] some are more generous or for potential applicants and for service assistance. You might see perhaps [Indiscernible].

In the case of the evidence [Indiscernible] how [Indiscernible] provide the national incentives for the recipients in Norway. And particularly [Indiscernible] sharp of [Indiscernible] this is able in change of election. In general -- in generated as a by the government allowed the recipients to keep around 40% of their benefits if they return to work. The only persons admitted to the I before January 2004 were eligible for the return to work for Graham. Those -- generate 2004 had to rely on [Indiscernible] after generative as of four day [Indiscernible] return to work program.

What is nice about this timing is the whole thing that the applicants can manipulate this system. The way they do that is a timed application and eight sure they applied to get the award just before January 1, 2004 and just after. The program [Indiscernible] late November 2004 that actually [Indiscernible] experiment. It allowed people just before January 1 and those just after generate first. [Indiscernible] comparable in terms of [Indiscernible] there is no change in award so it also suggest that by and large we will have a limit their [Indiscernible]. It allows us to compare income, earning, both [Indiscernible] January 2004. We will discuss some [Indiscernible]. We will skip that today.

We will show how this has changed. If you take a typical [Indiscernible] wage rate and compute the constraint [Indiscernible]. On the X factor this is the hours worked per week. On here we have total [Indiscernible]. This is the typical [Indiscernible]. The black solid line is the budget of strings under the current rules and the red dotted line is expense slow to change because of the return to work program. Two things to note is this looks around $10, the influx [Indiscernible]. If you work more on this, then one third of your benefits is [Indiscernible]. Also, the part with 50%, [Indiscernible] keep the same benefit. You would change [Indiscernible] many people. There are multiple peoples that either are not working at all or [Indiscernible]. [Indiscernible]. More about the [Indiscernible] changes. [Indiscernible]

Let me summarize the key findings. Many recipients have considerable capacity to work I can be effective Billie induced by financial work incentives. All the change in the program whether our national incentives. There is no change in argument three participation or [Indiscernible].

We found the effect of a laborforce perspective increased over time, [Indiscernible] a 20% is higher in the [Indiscernible] group as compared to the control group. Youths from 3.4% of population are not in the control group working as compared to almost 12% in the [Indiscernible] group.

If you compare that to rejected applicants in regards to [Indiscernible] in 2003 about 30% of these are working. [Indiscernible] participation between people on DI as those that are not on DI. [Indiscernible] purchase patient we expect the purchase a patient tax rate of .3. [Indiscernible] reduce the purchase patient tax rate by 10% you would expect to see 3% of an increase in [Indiscernible] supply.

At the same time because there was [Indiscernible] they'll also look at what happens to [Indiscernible] total family income, program cost and so on. What we found was that the return to work program lower the program cost and include the disposable income. Those are gains in earnings of which are large enough to offset the reduced benefits and extra taxes paid.

Be substantial [Indiscernible] are coming from young recipients. At of -- there is no impact reports. [Indiscernible] retirements, a lot of people [Indiscernible]. This can be either the cause of the [Indiscernible] working or because [Indiscernible]. Also within the group of the recipient age 18 to 49, in particular [Indiscernible] are much more responsive as we would expect them, people in a tougher labor markets. We think that [Indiscernible] may suggest that targets that [Indiscernible] reducing the labor markets.

[Indiscernible] we should learn something about this. First of all, there is really no evidence that [Indiscernible] insurance. Samaras go we came from SSA to take on the experiment, this has been conducted and [Indiscernible] so now their are [Indiscernible] take them a while for them to search for a job, find an employer and so on. We saw the increase in the labor response, we leveled off for three or four years. Except for the experiment that was [Indiscernible] more credible evidence.

Also I think we think about people who are personally disabled or they are partially disabled. [Indiscernible] database. This is an individual that talks about [Indiscernible] we're looking at people who are partly or totally disabled and even in this group, we find a very large response to [Indiscernible]. We found that participation useful.

[Indiscernible] Andreas think about the [Indiscernible]. We are showing just a few slides on how the system did for [Indiscernible] similarities within the system. Here we take a typical analysis of Norway, his age, wage, [Indiscernible] and this is the Norwegian [Indiscernible]. This is the [Indiscernible] .

The key [Indiscernible] is much higher in Norway as compared to the US. If we start accounting for health insurance, that will not normally be the case. That offset some of the differences. You can see the similar [Indiscernible] use it quite similar offset. The only key difference is that once they earn more than they [Indiscernible] you will lose one third of your benefits. In the US you lose everything. You see the dotted line it is [Indiscernible]. The key take away from that is that the incentive provided by [Indiscernible] is much stronger than the Norwegian because there is a bigger share [Indiscernible].

This is taken from [Indiscernible]. You see the similar age, [Indiscernible] the vast majority, 60% had mental disorder, the other is 57%. [Indiscernible] parable. This is about trends. It affects the [Indiscernible]. You see [Indiscernible] and [Indiscernible]. The increases over time and this is mechanically driven by the decrease in X array. Is the the exit rate and the entry rates [Indiscernible] was the exit rate was driven by more and more young people getting on the system who have [Indiscernible] extra labor markets and normal [Indiscernible] rates. It seems to be the driving force in the two countries.

[Captioner's Transitioning]

Is this is is is, of the labor force, the people awarded, this objective is mostly stronger for those awarded. Between awarded and [Indiscernible], in the absence of the system. It is benchmarking, then the people have a different then the Americans. [Indiscernible-speaker away from microphone] this is just to accentuate, this is more likely that it is working. We will see the numbers are very similar. Somewhere between 26%. [Laughter] if you take this the people with growth, many young individuals from the FSA that are disabled, you take those statistics then you compare them to those statistics among people in the programs, [Indiscernible-speaker away from microphone] -- I will just take this paper.

[Jonathan Skinner]

Thank you this is our work with Enrica Croda, who has been quite a bit of work , with population development studies. >>The background is that there is rising disability as you know, enrollment rates that are pressuring does it -- budgets around the world, wide variations across the countries in disability spending, the key is it appears to be institutional factors and not differences in how for either growth in the percentage of people over time, in health differences across countries. This is a somewhat older graph comparing rates of people who are receiving disability insurance between ages 20-64, in other countries, the diamonds represent mid-1990s, while the bars represent the later data, you can get a sense of the direction of some company -- countries, other rates are falling and other are rising, they are rising quite substantially, there is a tremendous amount of variation, US is right there in the middle. >>On this paper, which is on the web right? We have a somewhat different question, how do they have disabilities programs that are too large or small, we are given the program and asking about how well this particular program seems to do in sorting people to receive these benefits. So we distinguish between type I and type II error , type I error pays DI benefits to help the people are able to work, type II error does not pay DI benefits to people who cannot work. We are guilty in splitting people into two groups, we know it is a multi-factorial concept so we understand this is -- we have to make assumptions to operationalize these numbers. In terms of assessing these performances or specific countries and changes over time and how they appear to be doing in terms of their screening process, we think it is at least a first step. In looking at house country comparison, currently the only way that it can be done now is what they said a pioneering old ECD -- OECD studies, by going through a variety of dimensions, for example programs to return to work, do they have this kind of program? How hard was it to get these benefits? Do have tab one Dr. letter, to -- 2 Dr. letters? Countries can have rules but they may not always enforce them with the same degree of seriousness, as other countries might. The opportunities here, it was there were data sets of a wide variety of countries that asked the same question, that is where we jumped in, I want to operationalize what we mean by type I, and type II. Sorry -- >>We also have an alternative method -- measure, the DI benefits received by people that are in the bottom quintile, of our health measure I will describe this in a minute. Let me first give you an example, let's imagine a perfect world, where we can exactly measure intrinsic health of individuals. We rate them in terms of health in the ability to work, the politicians and their wisdom have decided that the disability insurance program will be 10%, we take that is given, we do not question it. The graph you see shows only those in these core health category get the disability insurance, nobody above that bottom 10% get any disability insurance, this is really a very good screening approach to providing the benefits to the people who need them the most. >>Here is an imperfect world, this data is based on data from the Netherlands, we have a health status index in which there are obviously, the program is doing a pretty good job, where there are few number of people who are receiving benefits. A few people look like they are ready to run marathons, there are in the ninth, and the 10th, among the healthiest group receiving benefits for whatever reason. This is the stock of individuals that may have qualified individuals -- may have qualified years ago, this does not

affect the flow of new recipients or applicants. This is important to keep in mind, we see what is the current stock of recipients? >>This is type I error people who are receiving benefits, or shouldn't be and do. The red dotted bar, those are people who are in the worst health, and are not receiving anything. Maybe they could have not applied, they could be working happily, or they may have applied and been turned down. Given the way that we calculate type I and type II errors, they equal one another, because we assume that 10% is the right number, the people on the right there, in the stripe bar, those are exactly equal to the number of the people in the red dotted bar. We do not have to have two separate measures we just have one. Our second measure is again the percent of the DI Besson and fisheries -- DI beneficiaries, the to solid green bars, divided by the total accumulative number of people, there you could see it might be 60% or something like that, which is reasonable, as you will see. >>The daddy we use -- the data we use for the shared data, in order to make sure that we have a good sample size. For the US we use a health and retirement study, they are age 50 to 64, these are older recipients largely, they will probably be somewhat different from the younger recipients we heard earlier -- heard about earlier. >>The key thing is to get the health index correct, if it is wrong, these results are not really reliable, we used to measures. One is the health index, which includes all kinds of stuff, including body mass index, hospital nursing home stays, ADL limitations, mobility enclaves should not -- mobility and physical function, previous diagnosis our health problems. This is an actual -- actually a very good predictor of why people become disabled over time. Were very fortunate to have some early comments from our discussion Daniel Mont, that pointed out in a fact that disability has often very much contextual. He suggested that folks seem more functionality we created an alternative, the Monte mix. Which included the ADL questions, aiding a lot of functions, but also things like community map, can you shop for groceries, health, and also health problems that limit work. We will test both of those, are secure when it sensitivity. We use principle component methods, to fill out the court components -- court -- Core. >> Core components. There is actually a quite a bit of difference here, this is the shaded, United States you could see it does pretty well, it devotes more of the DI recipients, that are in very poor health, you could see actually almost maybe seven or 8%, of medium health are receiving disability health insurance. The US seems to come out on top. This is our first comparison, of how these two countries compare, if you're a cynic, you could say that the US disability process is so lengthily, and harmful to your health that by the time that people qualify for disability insurance, they are really sick. [Laughter] I have found some evidence for that and others have to, but we will not go there. [Laughter] >>It is a little bit more difficult to compare Denmark and Sweden, it is a quarter of this group 50-64, that are receiving DI benefits, Denmark seems to do a better job of targeting. Not quite as the same fraction in the bottom, a huge difference when looking at the sixth, or the this best I'll -- or the six. We will say in Denmark, the disability benefit is held to be permanently reduced to the extent that the flex job cannot be performed, this is respect, Denmark is a best practice the sample. Here are the numbers and what is happening in your world. You can pick out a few . You can see big differences across countries, the Netherlands and Sweden don't do as well.

You could see these are the our standards, our health index, this is the Mont index . They are quite similar, they are little different, the never the ones -- Netherlands, the percent of recipients and the bottom percentile, is about 56 are 53%, dashboard -- or 53%. You could see they are in the bottom of the quintile health index, Switzerland and the United States actually seem to do pretty well in terms of targeting. The people who receive DI benefits are pretty sick in those countries, Italy is a little odd. In fact the percent on DI is low, if you look at France it is remarkably 2.8%, we are missing the DI measure, because people transit too early retirement when they are in poor health. They had questions about whether they received any kind of passion -- any kind of pension benefits, here is the DI benefits. The dots here, the candy stripe, they are any pension to DI, and then the bars on top are for private pensions. As you could see even if you include all these different kind of pensions, we are still not doing a great Dobb -- great job of covering. >>I am not sure what this group is relying on. So in conclusion. It is difficult to measure what we call the efficiency of DI programs, how well do they target those most in need? We suggest this new simple approach using this wonderful collection of data on disability insurance, across 11 countries. They are fairly consistent questions, there is some data the will -- that we will be working on, scores that are not heavily reflected on this, we think is that -- a important component of disability. >>The US, Denmark, and Switzerland seem to be doing very well, France, Sweden, and Netherlands not so well. This is a stock of how the Netherlands is doing, and not float, they have made changes in disability programs, this is for older people as well. We have also developed an augmented model which captures that the countries may not be insuring people against poor health, but against bad market opportunities. That is hard to measure. We proxy that using education, how more likely are you to qualify for DI insurance if you have lower education versus higher education? More our responses than others but it does not change our basic conclusive. We hope this can be used in a practical way to monitor changes, to see whether that affects the distribution of people who are either receiving disability insurance when they should be, or receiving them perhaps if there are other alternatives. Thank you. >>Please feel free to contact us if you have any questions.

[Daniel Mont]

It is great to be here, it is not great to have that picture up there. [Laughter] that is from 15 years ago, I sent a picture, they found one on the web somewhere, you could see the time warp between men -- then, last century and now. [Laughter] >>This focuses on very key issues, in determining who gets benefits and how to keep young people from getting benefits , cash benefits and getting them into work. Once people are on benefits is there some way to get them to work? The determination processes which I will talk about first, as you know it is very difficult task. To start a vision -- to start it efficiently, I forget which one is type I and type II, this issue has been really rising an important around the world. A lot of countries have gone from low income status to middle income status, as you mentioned income status, you build up

social protections there is a lot of countries around the world, that say we want to start giving disability benefits, they're very concerned about the process. This theme countries -- they have seen countries, and see things get out of control they do not know what to do, so they come to those of us working in the area and say where can we go for a good example? Now I know what to say, talk to Jonathan. >>So the attempt to measure the efficiency and the determination process, as you see the US comes out looking pretty good. The whole issue as Jonathan said boils down to what is your gold standard? How are you determining whether the person is on the program? We could say we have no type I, or type II, your survey measures are terrible? [Laughter] so how can we go about this? The best ways to look at multiple measures. So I think trying to look at functionality as well, is really the way to go. Whenever I see a paper analyzing disability I want to see more than one definition. I do not believe the results too much. I do think that the functional approach is a better approach, I might be little a bias -- little bias, I work in countries where I see they can very Germanic Lee. Having a moderate -- they can vary dramatically. Having a moderate approach, say the Hanoi city, in the country I worked in, versus living in a small village in a remote area with no roles -- arose -- no Roads. >>Maybe this is not quite as large, still I feel comfortable with the functional approach, one thing I'd be interested in is getting more information who are identified as type I, or type II errors. What does it look like? How do they respond to the health and functional quest? Did they fall into a certain pattern? Are the people getting on the program that you do not think they should be, to they have more in one area than in other areas? Another is that it is impossible to do, it is fascinating to see this based on first application versus getting in by appeal. You would think that they would be different. If you are able to do that on the program, I don't know if that sort of data is available. >>So turning to the paper on Lorenzo, and Todd Honeycutt, it is very interesting to look at all of these programs. Given the low exit rates from yes disability's program, thoughts of a young person getting on disability of rose early, affects the whole -- disability it rose early, affects the whole planet of the disability. The paper points out that there are a lot of problems with the US system in terms of lack of coordination, linkage to adult service, I think it is useful , a very useful enterprise to go off into other countries that are dealing with the same issues. The examples that were highlighted from Germany and Netherlands, they were on one hand it was not anything new in terms of the idea and types of the things they are trying, but it was very compelling to see a good documentation of these programs. And exactly what they are trying to do. The issue for me, I would like to have seen some data on how well the use, and how well they actually enter into the workforce in Germany, it is not a quantitative paper it is a policy review, and I understand that. It would make the case more compelling if we actually had some evidence, some in numbers showing that these countries are going back to work at a greater extent. Especially since there are only one I forget which one, there is only one expert they spoke to, another there were two experts they spoke to. I would feel a little more computer -- comfortable, if there were more people to rely on in terms of how those functions are working. >>I found the paper very useful it helps us be directed to programs that are up and running, and we can focus on where we can go to

look for information that can help us with our programs here. So finally, the paper by coastal amongst them -- the paper by [Indiscernible], is there just some way to get you back to work? There has been lots of attempts to do this. The trial work programs expediter reinstatement, a variety of other statements, they have been well studied, and had been shown not to have very much affected all, they're continuing to work just to stay below the SGA level, I think we have here which is a great experiment, to look at what the impact would be, if people keep most of their earnings. As the paper will show the educated ones living in strong economies, when they are allowed to keep a chunk of their benefits, they certainly to fairly large numbers they raise their income and make smaller demands on that income, to the budget. In terms of the government budget I would like to hear whether the onset of this program has there been evidence of induced entry codes -- entry, for the older people who aren't incentivized to go back to work anyway, is there induced entry for the people who the program seems to matter for? That I would like to have seen in terms of making estimates in terms of what would be the budgetary impact. That aside it is good to get people back to work. Question for someone that somebody could ask as well, if they're going back to work, why should they be getting benefits in the first place? Not that I would say that [Laughter], it is a question that we have seen in the news today, since they can work they should not getting them. The whole notion of not a total inability to work why should they get them. We can argue two reasons, even though they can work in the situation, they should still get benefits. I think that they could look at also, could it be that there position is tenuous, this is something that has been talked about a lot. You can go back to work, but what if you worsen your condition, or if you jeopardize your benefits? As I said with the extended period of work eligibility and everything it does not seem to be that there is a lot of evidence. It would be interesting if we could look at the data, I could -- would like to see to the extent people working in the marriage in case, if there is data on their work experience? Did they enter and leave? Is there evidence that basically what this program is doing, is allowing them to have spells of employment, and unemployment, where they can go back to benefits, is the program working in that fashion? It means that may be other types of programs that address that issue, could also be effective. >>I could get rid of my picture. I kid -- I did not realize that. [Laughter] >>A second reason that may be people should be getting benefits is the extra cross -- cost. To people with the same amount of money they are not living at the same standard of living, because they do not have the extra transportation cost, etc., etc. One study in New Zealand showed up for example people living with physical disabilities in the category that they classified as moderate need, cost it an extra $540 a week. That is very significant, as significant amount of money, it could be again, that as a social policy to subsidize the cost of having a disability. So, when you think about those not -- notch diagram, it could be getting a benefit you are here, you have to pay extra money to get to watch -- to work. -- So it would be interesting again to me if we could come up with estimates, there are ways of coming up with estimates of cost, of working with disability. If we can get those costs in Norway relative to the cost they can keep. Again if one of the reasons that are keeping people from going to work our the extra costs, is it possible to gauge the amount of benefits

and the structure, that you are covering those costs? In the New Zealand study there were type of disability in terms of cost, it was actually quite dramatic. I don't know if policy wise it would fly, it is something to think about. This takes us back to the Kroger Skinner paper, if we are looking at the benefits of under the Norwegian program, type I error category, in a program that is designed to say you cannot work, only get benefits may not be considered to be admitted into the program, type I and type II error thing, will change. As we change the structure and the program. It may be interesting to look at the structures of the country that was in this study. If there would be predictions relative to type I, type II, to the groovy -- to the agree -- degree people can work. >>I would like to thank all of the Mathematica for inviting me here today. [Applause]

Okay, so thank you to our panelists, as you think about your questions, remember it is a question. [Laughter] not multiple questions. The people on the webinar are encouraged to send in questions, we will read them anonymously for you so that you do not need to reveal your identity. Do we have any webinar questions yet? No. You will get -- give me a big motion if there are any? >>Let's start in the back second row. >>Hi my name is Nanette Goodman, I am an independent consultant, I have a question for magna, -- I have a question for Magne, it seems that the functional capacity or the work capacity would be different? I was stunned when comparing the two groups, you came up with something similar, I'm wondering if you think the difference in starting percentage affects the probability of them going back to work? >>That is a good question, if you're looking at the flow of people coming in to DI, they're comparable. There is something quite different about those entry -- interning DI, and those today. We will show those people are employing and being allowed in 2003, and people being allowed in the US, they are the same exercises with people interning into the service -- let me take this comment from over here? Let me talk about the [Indiscernible]. -- If you are on the program you have to refer to this, there is no way that you can go on the program. You will have to be a margin in order to increase the program expenditure it is very large. Thank you. >>Let's go to the back. I am not dissing you people in the front, I am a rebel by nature. >>I do not know exactly to whom to dress this, freak out when go at it. I was wondering in the United States at least, I will be quick, there have been three times the definition of disability in my life has changed, the definition of disability in special education, and then you get job experience, determines that definition. Been you get out -- than you get -- >>Then you get out of this group and it is a completely different definition of disability, later if you want to get supplemental support that definition changes, given those numbers, or did countries with uniform definition impact the employability, or the success of this program? >> The people on the webinar we are watching them think. [Laughter] >>That is a really good question. That is why I hesitate, I'm trying to think this through. We are using at least in the study we are using, we are using the wise measures of functionality, we are interning into a fourth measure of disability which has very little to do of how the government decides whether you qualify for

a particular benefit. So I think, the confusing part is whether the government does a good job of channeling people early on into supportive employment will actually change those measures, for example the wise measure includes physician visits, DMI things that can be affected by early interventions. So I think this is a deeper question then I can answer. That I can answer in 5 min., but it is a very good one. >>We will make our way back up to the front. >>Thank you all for your work my name is Teresa, I am with brain injuries and services.org, I should just get it tattooed on my forehead. -- What impact has this have on the health, and the understanding and flipping the definition of can a city, when we -- when we flip the definition, it is not old, chronic orders and illness can begin at birth and developmental, but I think perhaps if you can help us with that question of, World Health Organization and all of the UN efforts to understand emerging disability? >>Would anybody like to respond? >> In our particular study we even attempt to standardize or find a common definition, of disability, basically we listed them, use the definition in each country provided for different programs. They were in different stages of the development program, so from that perspective, I think that we never tried to, with this common definition, we are comparing to some instead cash -- to some extent the commonalities that we found are probably more in Germany and in Netherlands. >>Okay. >>Here in the front I thought I saw your hands, you didn't get your question answered in the last session. >>I am Cathy from the budget button budget and priorities, I am going to ask the same question that Nanette did, the percentage comparative population in Norway, you were asked if we receive disability benefits, in related to Jonathan's very healthy -- helpful graph, it appears in Norway about 10% of the working age population received disability benefits. In Netherlands a percent, and the United kingdom 7%, in our country about 6%. We hear a lot about particularly the Netherlands, and the United Kingdom, paring back their system of disability benefits, are they going to end up in a stringent of place as the United States is now? Will they be comparatively more extensive? >> The stock is very different, if you look at the rates in the determination process of northern -- L -- of the Netherlands. >>-- Looking at the rates in the initial application the process I am not sure if there is ground to say US versus Norway, so I'm not sure. >>Okay. >> Just press it once, lift your finger up. Okay. >>I think that is a great question, it would be wonderful to have international comparison, I believe in shoe leather research, where you got people , say group of physicians from a different country, or nurses that go to each country and sit down and just watch the process. They have a look themselves, I think that for example the Netherlands the part of the reform, I am not an expert in Dutch reforms, the company -- your employer is the first line of defense they have to pay for you before you can actually apply for the I benefits. To me that is in some sense, it would put more of the cost of disability off budget. It is that the private companies are beginning to, they have -- the private companies are picking it up. Well they are paying the person's salary they could be useful to the company. In a perfect world perhaps the flow rates would be quite similar, where the selection process could actually work a lot better. From what I know of the US system, it is not a pleasant experience for anybody. >>I will come back up to the front. >>This is for Magne, we are doing demonstration now, I think that the idea of implementing

it, it is not going to happen anytime soon because of the induced entry I think, maybe other things as well. Whether there might be a negative version of a tax holiday or a benefit holiday following the Norwegian experience, for people who are on the roles now, that would generate trust fund savings very quickly. I am wondering if you could think you could come up with what this would be if it is comparable in US experience, and the timeframe for that, whether you have any sense of what the savings might be? >>That is a good question. The whole idea goes to avoiding interests, we want to make sure that they are there. If you take our estimates 5% of the recipient. That is the -- three years? >>Three years, the firm we will have to see the savings of that three years after. That is something that we will want to look at. >>David with MIT. [Laughter] I would not release it until I get Obama care. [Laughter] -- also I apologize my question is for Magne, the labor opportunities that are available to them, it would be interesting I'm sure you have done this, to characterize, whether educational level worked. What type of employment they are moving into and also how long had it been? Prior to this policy going into place, I suspect there is a lot of people in the SSDI program that could work at their old jobs existed, but they don't, in terms of figuring out the comparability it is interesting to hear about your thoughts on that. >>Mostly it affects higher education, anything that makes the market

-- makes the labor market. We have the reasons why the older ones are responding, and the younger ones looking at that, muscular disorders, we do not find different responses, I feel that is a basic part of the program. Only for one year we cannot start extending the window, but we are trying to take the responsiveness, it within about four or five years they become smaller. -- [Indiscernible-speaker away from microphone] >>First of all to address the comment to Jonathan there is a special place in hell for the people who do examination, but my question is the guided process, I think Magne, you address this. Who is the guide, is it a guide by committee, somebody from the government plus the disability that create this process that this person is going to go from school to employment, who gets input into that? >>To the program? >>Who gets to be a part of the guiding process? >>I'm sorry. Lorenzo. One of you it is afternoon I am not thinking. [Laughter] sure. >>-- In a guided process who participates in guiding? These are students who are under their parents influence, from the United States the age is 18, this day and age you have kids under their parents influence till age 26, who is the guide when applying for benefits? Is it a guiding by group that the recipient, plus the parents, or whoever has quote, custody of that person". >>The person developing plans for you. So far from what we have, our review does not necessarily have found clear evidence that the parents have the direct impact on that for our review, it is the public representative of who guides the people through different processes. This is interesting we will probably need to go back and talk more about what the parents are doing as a part of this process? There were two extremes recipient and the provider of the services. Absolutely whatever happens we will want to know what happens to the youth that is very important to take into account. Thank you. >> Hi Alexis Henry, from US medical school. I have a thought in response to the comment about Daniel Mont, the disability program like child work period or eligibility extended period,

somebody who works on a program in my unit, the overwhelming complexity of our disability benefit rolls, I think it is -- Rules, I think that is why they do not use these incentives they are so freaking complicated. There is a lack of the understanding of the rules,, -- one of my questions is to the whole panel is that that complex? When people enter our disability program, they get cash benefits but also health insurance, I am interested what is happening in other countries where the health care system is designed differently, and how those things are applied? >>That is a great question, what part of failure of the future and the uncertainty which makes people respond. Early distribution of these people just think about the discussion it is like a bungee a people, -- bunching of the people, you look at the range, there are still people working in their. We have to understand how these people are getting a long-term job, we're trying to get information on board with having experiments, telling about the system, what will make it hard, given the large responses, a large fraction of the people seem to have economic models. That is a good question. We have no idea -- I have no idea at least. >>In the country I have worked at in Vietnam, once you are considered to have a disability to go to work your benefits are not affected at all you are only getting $20 a month, so some of these countries on lower income, these are the kind of questions that they are coming to us from it would be great to figure it out. >> Tran12 -- >>At the local level, did you find any policies that the US could implement in helping parents and how they implement them at a state or go violent -- state or local level? >>This is a challenging question because we did not find evidence necessarily to answer that kind of question, I think the parents are very much out of the picture. At least of our review of these countries. We will have to go [Indiscernible] to answer those questions. We see the extremes , the government responsible to make those decisions we did not pay enough eight Attn: -- we did not pay enough attention on what the parents are doing. >>I will get to you next. >> It is me again, I think in the United States we have an interesting system, it is required in our education laws, of people with disabilities you started to see asking questions in certain process, as the youth gets older, but basically it is designed to have Cooperative affect as student, parent, agency, government agency in future. It is not happening. It would be interesting to see what the issues are within the institutions, that are responsible for implementing those processes. I doubt the Department of Education would give you really good numbers. On how well they are doing get, but I just wanted to say the mechanism is actually there to have a collaborative decision-making process but often, because of government tax people are overworked, but I just wanted to put that out there, as far is a difference in countries as far as it being integrated within the in -- within the education system. >>Thank you anybody want to comment on that? >>There was a question somewhere over here? >>Okay go ahead. >>Just briefly I think this is extremely important. I think a lot of what really worries policymakers is that people that have been working for while, who become disabled, or something happens to them, it is an interesting question to know if there are acres is to that. If what was going on in high school predictive of later life issues with disability? Again, it is something that I do not know, that would be certainly a good question. Maybe some of the survey data share with us early experience in life, and maybe that is a good way to

see if early events early on affected disability. >>I am Wayne Anderson, thanks to all of you for your presentation, how fit does one have to be before you cannot work? -- You are not able to work? I'm getting ready to publish people who are on DI entry personal assistance services, and there is a question whether they are working for pay, or desiring to work for pay? The only difference between the two, is that the ones who are working for pay seem to have all transportation and existed -- assisted transportation needs met, they are healthier, half the people say they want to work for pay, they are not doing it right now. Two thirds of them are in fair or poor health status, they have chronic conditions on top of their ADL that make them sicker than the people that are working where's there is a quarter -- of the people that work, there seems to be a big difference between the two thirds that are in poor health status, they does not -- do not look any differently than the people who want to work, they are sicker than the people. -- I get this it is not lost on me at all, what about the other balance of people are they too sick to work? Even if they get the support they need? >>Which one of you guys can answer? How sick can you be before you cannot work? I think that is the big question. For all of us does anybody want to respond? A recommendation is something to think about. >>I think you have to take into context the environment of living, you cannot bring up a random person in the room and say this person is too sick to work unless I know everything about them, their personal resources, there family resources their environment of living, other supports. The kinds of skills that they have, the kind of work they want to do, think that is a very complicated -- I think that is a very complicated question. >>Dave? Patiently waiting. >>This is David. This is a question for Lexis, question -- this is a question -- >>The distinction we draw between SSDI and the SSI, one is viewed as Social Security -- social insurance program, and there has been a reluctance to emerge those two programs together in some way. Workers pay for one, the other is just a welfare program. A lot of the sources of the complexity have to do with the Work Rules for the two programs which are extremely different, and the people get benefits from both. I'm wondering if social concerns -- insurance programs exist in other countries and how that affects programs and how they are administered? >> I feel in the UK, there are some business insurance, and the structure you will see a lot of people with marginal choices with the programs they're. They are similar -- with the programs there. They are similar. >>[Indiscernible-speaker away from microphone] >>You mean that they do not pay? >>[Indiscernible-speaker away from microphone] >> In the UK also, welfare is not that big. They are pretty generous, quite generous for people who pay, if you do not, they have Social Security rates about 2%, the big problem is disability insurance, unemployment insurance, the vast of people that are in these programs. -- For the vast of people that are in these programs. >>Hi this is -- has been a fascinating two days, I am Heather, network for the Medicaid agency, I previously worked in the UK, for children with disabilities, looking at what I've learned in UK everybody had access to you healthcare, -- had access to healthcare, had treatment early on. I came back to the United States, Atlanta Georgia, it was assault, the people had to have disabilities, they had to be expressed very clearly before they could get intervention. The difference between the two certainly should have some impact

on adults with disabilities, I am wondering if you can comment on that. >>-- I am wondering if you can comment on that? >>Any takers? >> This would be one argument for why so many people are sick. Why the US to appears -- seems to appear to do a good job, the sickest people in part because I hate to come back to this, in order to qualify you have to live in purgatory, where you are not working, and you're unlikely to be covered for your problems. By the time you do get benefits, they are probably quite a bit disabled then when you started, I've looked at patients with back pain, we have access to sport trials, to see what happens as people with some of the people in the trial actually ended up on disability insurance, they have this problem and it stayed up really bad. Even when they qualified for DI it is not like they got better, somehow you not having to work and live things, meant that they did not have back pain, they still had debilitating back pain. Nothing was done early enough in the process. >>There is a lot of evidence coming out of the country's, early interventions are very expensive, in the UK they are optimistic about education programs, the extra trades, they are horrible, they're very expensive. So maybe you can think about how they have to stay a few years on a training program, those numbers look horrible. >> I think there is one at a you and that we will come up there. >>Lisa with disability advocates, I was going to follow up to your point not just health insurance, any United States access to services, for most people with disabilities you have to come through the income support door, to get healthcare, I think there has been evidence by Nicole Mestas at around. -- In the University [Indiscernible]. You may have to intervene earlier, how in working countries you can get access to services that might help you stay at work how early can you access them? Your point about it being expensive is a good point to make here, we have to spend money to do this, unfortunately we are in an environment that cut services, that support people. How early can you get services can you qualify for income support to qualify for them? >>In the typical halfway for most European countries they do not get sickness pay, they are generous and make transitions to business insurance, most people do it, if it is hard to verify then the vast majority will go on rehabilitation, or vocation training, it is very expensive. It is a big disappointment, very few people actually return to the labor market after these are very -- after these very expensive programs. >>Another place to look for an example in the United States is the workers compensation program and workers disability program, private firms are generally speaking, there is a business case for them, they do pay for themselves. Part of that in the disability, person makes a determination early in the game whether the person has been injured and can't get back to work, and they will he sent off to the disability insurance, the study is determining what kind of services get people back. And how they do that is a lot of information on that, you can look at the national Institute for disability Institute in Canada has a lot of information on that. >>This will be our last question. >>This is Karen Kaufman, in South Florida, -- for South Florida. If you control the degree, category disability, injuring the countries, do you have any data that individuals using this specific example, we are not collecting disorders together were dropping some of the high functions if you will, from a disability, somebody like that what is the career trajectory, if you can look at the cream if you will the folks with limitations

do they do better corks I am -- do they do better? I am grasping for hope here, if there is a this can see -- if there is efficacy in the margins? >>There is a study looking at partial disability efforts in disability, people who are related -- relayed 40% disability if there were relation between the two, people again, dependent on the context, what their skills were, what their particular situations where. There were people who lost 20% -- I hate the whole percentage thing. They took major hits on their ability to earn a living. Others had much higher percentage of disability were maimed -- disability were able to retain their

[Indiscernible] People are sure did their shoulders, okay. Thank you all. Please join me in thanking link -- thanking all of our panelists for this discussion.

Welcome back David Stapleton to the podium. >>I will not keep you here very long, first of I wanted knowledge the people who do all the logistics in the planning for this event, we have Janet Stein from MBR, where are you Janet? >>[Applause] >>My colleague Gina Rosenbach, over there Gina put your hand up? [Applause] >>Jennifer who is the head of our DC communications office, she has a big staff put your hand up all of you. Plus Max >>Also Laura -- go ahead and put your hand up all of you. [Applause] >>Also Laura she here? Thank you for all of you who are participating in getting this together, I want to encourage anybody who wants to provide feedback this is of the -- this is the first DRC meeting, we are interested in hearing if you like to set up here. In other words -- in other setups, we want to know if you want us to continue to keep going, other pictures you may like or not like, let us know what you think. >>Finally you may have heard during the lunch break there may be a deal that the Senate has worked to end the shutdown, maybe our project manager will be back tomorrow, that would be great. >>Low last time I was -- the last time I was conducting a session might this, it was when the Supreme Court loss the ACA, because of that they were from CMS and they were interested in -- in the intimations -- implications of their work, rather than what we were doing. This is a pretty good truck -- track record on my work. [Laughter] >>I can now announce that the next government shut down will be January 16 and the policy reform will be shortly after that [Laughter]. We appreciate you coming here today, thank you. [Applause] >>

[Event concluded]