Transcript: 2013 Disability Research Consortium Annual Meeting

Disability Research and Policy: New Evidence and Promising Ideas

Tuesday, October 15, and Wednesday, October 16, 2013

Funded by the Social Security Administration, the DRC is a collaborative effort of the Mathematica Center for disability policy and that national Bureau of economic research. The policy research on a variety of topics related to Social Security disability insurance and supplemental oral -- supplemental insurance income and other policies as well. To better understand the interaction between the programs and other federal programs, and the broader social economical content of the administration of the operation or imported. We also try to disseminate information on disability to relevant policymakers adjust a colder organizations and the general public

And with rights of opportunities for creating education and [Indiscernible] practitioners and research area as well as Social Security and disability issues.

So as we launch the DRC in a time where the fiscal pressure is on its own disability program as well as on other open programs, it serves the same population -- are just enormous. The deletion of the Social Security disability insurance trust funds in 2016 and is the most physical -- visible [Indiscernible] and the challenges of the government basis for the disability population. At the sametime there was widespread dissatisfaction and the status and that disability. Employee in disability -- have been falling further and further behind. Those are counted by the [Indiscernible] for decades. And quite rapid growth in census for their support. With it -- far in excess of the demographics of the basis alone. Economically this group is falling further and further behind its peers.

So it's no coincidence that the DRC -- is building everything bellow that he -- under policy programs. For reforms for better rocket -- economic opportunities and simultaneously reduce the reliance on public programs. That is what we're all about.

So I am pleased to welcome here are and be ER operators to the program -- -- collaborators at David Wise -- various. Along with Jeff Lieberman who is on the panel and David [Indiscernible] I have not seen arrived yet but I know you will be here later in the day.

So I am glad they are able to join us in person today and maybe other people the audience from the NBER group that I'm not familiar with. I would also like to take a moment to recommend a few members of the SSA leadership team and the staff that work closely with us on the DRC and they can them for their support and the support work that is a little bit difficult. And the federal please are not supposed to be here so they could not come today. And I'm sure they're very disappointed not to be here.

I will mention their names in case any of them are here incognito or perhaps listening on the telephone.

Manual [Indiscernible] the assistant deputy commissioner for disability but [Indiscernible] has played a major role in the DRC up and running although it is most current from this position which is less of a role. Ted Arend who is now the associate Commissioner for oh RES off, research your valuation statistics taking place. And dumber house, disturbing as a special visor. And of course the person that we have grown to love -- [Indiscernible] heaters is a project officer.

And at this point I would have the honor of introducing Marianna [Indiscernible] who is the current deputy [Indiscernible] and acting deputy commissioner for the disability policy -- she obviously, Peter. So I will just be cutting short right into directory remarks and ready for the program. And you -- I think you should know we have had to cancel the luncheon panels because they're all featuring several speakers -- so it gives us a little bit of time to go over in the morning and alumina time to start early in the afternoon. And a little bit more time for the panel. But we do have a lot more time to eat lunch together and enjoy talking to each other.

Sarge will note on the agenda, we have is central program ahead of us. Over two days are speakers will present the latest ESC research findings. And their applications for the future disability policy program at it is important to note that many of the research programs that we appear -- [Indiscernible] are works in progress at which this research is really early in the stages and have not been refined and polished. Please keep in mind of the individual studies of various stages -- and not all of the findings that we have presented to rub the two-day meeting our final at

I also have a few housekeeping items to make you aware of before we get started. And so each session includes the in person and audience -- be alive to see live webinar and I suppose we have more people online or do the room. To help ensure that the possible down quality for the webinars [Indiscernible] we ask that there is room to [Indiscernible] is quite as we -- you reasonably can to make sure all of your electronics and devices are turned off during the presentation.

Please note also that we are video recording the entire two-day meeting. And we may capture individuals and some of you in the audience. Some of you -- this will be posted on the website in a week or two. And you will also be able to access presentations like the materials on that setting.

We will have a 15 min. intermission period between each of the sessions -- actually we can revise it because at the end of the session we will just go right into lunch and have a longer intermission period and that we will start this afternoon.

At which time we will be starting the second session.

So finally we get to the end -- and I will come back to this tomorrow -- actually you can do this today for those of you who are here today specially. We encourage it to fill out the survey -- for those of the Web it is an online survey. That you will receive and we really like to get the feedback on how this is going. This is the first annual meeting. We hope it is not the last. And we would like to of course -- like to make it better the future.

Now it is my pleasure to turn the program over to my colleagues -- [Indiscernible] Gina Livermore -- who is the moderator for the first session which we trends and disability training [Indiscernible] [Indiscernible - muffled speaker] >> Are right thank you Dave at good morning. My name is Gina Livermore. I am a senior researcher here at Mathematica. And it's my pleasure to help it off today's meeting with our first session on transit disability claims and benefit receipts. Our first speaker is J Bhattacharya -- at the Stanford University and a researcher at NBER .and he will describe his work for Social Security outlays. And that health status of the population over the next decade.

Our second speaker is Jeffrey Liebman. He is a leader professor at the policy at Harvard school of government. And he is going to discuss the study of the 30 year trend of spending on [Indiscernible] so the research can continue.

And finally, Nora Gordon, it associate professor at Georgetown University she will describe her work on the rhesus -- increases in child pesos and growth across the state.

Finally David Stapleton will provide commentary on the prestudy and then we will take questions from you in person and the webinar audience is.

And with that, welcome to the podium.

Thank you for having me. I will talk to date that results from a study called the future elderly model and the idea is that I want to use the -- we want to see how far [Indiscernible] can see on Social Security Scriptures and as well as other Social Security Senators.

Is adjusting probably because most traditional Social Security [Indiscernible] don't rely on that as well so the spirit of this exercise is to say how far can tomography alone take us. So we get to the sense of the problem -- what I mean by demography -- in the medical school, tomography need healthy as well as aging. It is important problem because the population of people that are relevant to Social Security today and in the future, in many ways are getting less healthy.

So here are some results from a paper -- 2008 paper on just reporting trends in a whole bunch of chronic conditions in the US he could see the big red up arrow's which means the problem of pre-vascular disease, obesity, lung disease and diabetes are getting worse over the last 10 years. At the

same time, the interesting thing is even as the population has gotten less healthier, we have got more long-lived. So here for instance is the age mortality relationship in 1874.

If you sought out the age mortality elation ship it comes out to every single age -- people are less likely to die between the ages of [Indiscernible] and trends consider -- continue in 1994 2004.

And a dramatic affect -- that should not happen -- but here it is the death rate in 2004 was 14.6. For a population -- that his force of the five-year-old. If you look at -- if you can say okay what with the death rate in 1974, that same death rate applied to 58-year-old. And in a sense we gain seven years and is free decade. So now it is -- 65 now is not the new 58 is the bottom line.

Okay. The problem -- so why do this -- one just rely on traditional forecast. Will first -- accounted for the changes the future health of the population I think is an absolutely critical input which means basically everything Social Security does.

And the traditional forecast accounts for differences -- changes in mortality rates among the different causes. Because they don't excessively account for trends in the future health of the population. >> And the second motivation is that there are some controversial assumptions about future governments in mortality that are really important. For how much -- the Social Security will have to pay out in the future. You can give sense of this -- if the mortality trends continue the way it is to see the way they are, there will be a lot more people around surviving much longer needing Social Security allies at but on the other hand, in the future population is less healthy, and can be blunt about it -- to be blunt about it, they die off more. It will be bad news for the country, the good news for Social Security is the bottom line.

And so what we really want also is a approved way to forecast mortality at one of the problems I believe the Social Security forecasting now is they use the -- the Social Security and musician uses cause for or tell you but it is one cause at a time. Cause specific mortality. And they will have multiple reasons. There will be diabetic and have hypertension. So -- and so it is really important that they interact with each other and have a much higher or tell you rate than you would expect if it is just one of these alone.

And there is a huge competing risk model. If you increase the risk of dying from diabetes you might getting take -- cancer said.

So it is really important to patient interactions across the [Indiscernible] and it will have a big effect on future Social Security benefits. So as I said getting the spirit of this is to see how far we can get with, -- demography alone. We need help with demography alone. And have different assumptions about trends and [Indiscernible] to affect these effects.

That future elderly model is a model that my colleagues and I have worked on for more than a decade. The basic idea to use nationally presented data -- and constructive microsimulation forecast of the future population at

Not let me [Indiscernible] over this time. So you get a sample from the kind of study that a representative sample of the population of the United States. Say 2004. Is that microsimulation model so it represents the joint submission of health status and a bunch of other things in the population.

Based on the health status you estimate the regressions that predict for each person in the population based on the health that is what they will cost in terms of Social Security.

You also can predict mortality rates of the population want to have the predictions for the model, you can to supply the model forward over time. So the survivors are going to live to 2005, but they will change in health status. So the models will did with health status will be if they have -- if they are obese now but not diabetic -- the problem is what is the [Indiscernible] of getting diabetes or hypertension in the next year.

In focus with health status will be.

Will be a module in the model to forecast to the next-generation -- 2000 -- generation -- there will -- essay about models as you can trek them over time and apply the model over and over again. As you see that I will apply to more areas that I should probably apply to. But it is a nice way to ask questions about the future effects of demography and also other things. Because it allows you to play with the various parameters. So for instance I can reduce the death rate at the same levels we have seen in the last 10 years or the last 30 years -- and what they have on Social Security benefits. And a mortality close in place from now to the future. And what effect will that have for future outcomes.

So the model includes lots and lots of health conditions and inputs at heart disease, diabetes -- all the major chronic diseases. It has optional status outcomes and obesity rates in smoking -- and those of the major inputs in the model. And outputs of the model include lots of things. Most of the models have -- I will talk most of today about Social Security related outcomes. I will focus entirely on the Social Security benefit and amounts. I hope to get a version of the model -- there are other outcomes that I will not go through today.

And I have to get a version of the model Social Security

But unfortunately I did not get that intimate it in time. I think the results will just be provocative enough. I will run the model with three different fatalities is to get some sense of how important the various senses are on future outcomes.

So the first is a baseline scenario where we assume that all the improvements that we have seen up to the last 30, 40, 50 or hundred years in mortality in today. Now on I will share -- individual -- when I'm 60 years old allows a mortality rate as 50-year-old said. Conditional on my health status.

There is no future technological change. It will happen but it will be as a baseline -- interesting as a baseline to see what the comparisons will look like.

The second assumption is we at implemented the Social Security mortality area. That basically says that the mortality improvement that we have seen over the past few decades continuing into the future.

So the mortality rate for someone with diabetes 10 years from now will be less than a mortality rate for the same that a person who has diabetes today the same age. So that is the second scenario and the third scenario is the same as the second. The declines in mortality effects the only -- over 50 population. With the ideas that we want to isolate with differences that the differences and changes in health status and that under 50 population and dependent on mortality.

So first up I just went to get some sense of that the model actually does something. The main purpose of the model originally was a forecast of Medicare [Indiscernible] and in fact this the forecast of Medicare centers for the model that we have at any matches almost to the point of the pre-ACA open -- CBO long-run forecast for future Medicare patients. It does really well and affect matches the population [Indiscernible] [Indiscernible - muffled speaker] And I see not entirely by accident. We can tweak the parameters to work that way.

So one thing to -- with Social Security expenditures -- one way to do that is casting. The model is based on the health and climate study which means that climate is based on people who are at the one and above the Sheena people under 50. So that's actually a limitation -- not just for Medicare but the O ASI expenditures Social Security but also -- [Indiscernible] [Indiscernible - muffled speaker] It is actually quite well -- if the model is based on data from 2006, -- [Audio cutting out] and critics about $125 billion in expenditures. And in 2012 it ends up being six injured 37 billion.

-- It ends up being $637 billion.

Is if you are age 51+ it is an underestimate but hopefully this is something that the IBM team is working on -- the under 51 population. So let me get the results. So here the mortality forecast -- you can see number tally rates and the forecast has declined up to about 2020 and then -- this reflects entirely the aging population. The population will get older and so as a result from 2020 on you see in much higher mortality rate of population that we have seen.

The secular assumptions is the sum -- assumptions about [Indiscernible] may have a huge effect on how mortality will avoid. And so the topline is a Social Security intermediate area. I'm sorry -- the topline is assuming no mortality adjustments whatsoever. The bottom lines are assuming continuing fertility improvements. The state -- shape is similar.

Here are the population forecasts. You can see the mortality rate improvements. They will make a huge difference in the population in one 60 -- that's about 20 million extra people around -- if mortality permits continue. The population age structure is something that you can expect -- the forecast -- population from 55 to 54 with the client fairly substantially. It will reach a peak in 2020 but 36% of the

population and will drop to somewhere between 28 to 30% of the population by 2030. Where the 85+ population will increase very sharply.

Of health status forecast is just all around. This is true even if you assume that the mortality rates are going to say the same.

Diabetes rates are going to go up. Hypertension rates will go up. Hypertension and cancer. And I'm not showing -- but people with multiple diseases will very sharply rise.

The similar things for strokes. The only thing that has a sunny population going down as the obesity rate in the smoking rates have come down at and even they go up as mortality goes up -- if -- more people will survive -- if mortality rates decline.

Let me get to the forecast itself. Not this is not rising maybe she'd be OASI forecast as a sharp decline in the proportion of age 51+. And that forecast goes up very sharply. The mortality has a future effect on what the effective -- on what the -- forecastle me the future. So if you look over here -- is roughly going to be $2 trillion -- the projected expenditures if majority rates continue to improve. If they stagnate, it will all be 1.7 5 trillion.

Okay. So demography -- these fertility forecast seem to matter.

As a side forecast the model for just a very sharp increase -- I mean sharp enough increase in the claiming behavior over the next few years and the plateau over the decades after that.

Again this is just based on trends and help in demography alone. Not in a employment rates or other short-term economical variables. But the payment rates will go up sharply larger because the amount of the severity of claiming conditional [Indiscernible] love but [Indiscernible] will go up.

The TI forecast interestingly in contrast to what the other forecast are projecting ejected eight decline in DI claims. I think that's an interesting contrast with the people forecast -- with an increased of the importance of DI forecast in the past. And I think is interesting is you compare this and the DI claiming forecast which is driven mainly by health status and demography versus the forecast driven by economic folks wish and.

With the suggested is it is based on demography and health status alone which you can expect to decline in 2030 DI claims -- although an increase in payment.

Again because the DI claim is or severely ill.

I have got 2 min. -- I am almost done. So -- it is an interesting contrast to say you think about demography contrast or that rate in which the contrast that affect, the DI forecast are depicted on the screen are now rising the DI rate is likely to go down the future.

As long as certain getaway from the economic situation.

Okay let me just finish by summarizing.

So the population rate -- changes status -- that -- the change in the population alone -- the mortality will decline until 2025 and then rise sharply until about 2050.

And the size of the population will agree steadily throughout the coming years regardless of the forecast and reach about reach about 45 million people.

The aged rupture will shift dramatically with aging populations to 85+. Which will apply a huge [Indiscernible] stress on Social Security.

Of status -- the forecast basically -- bad outcomes for hypertension, diabetes, stroke, heart disease and cancer. The only one sees that there is any good news is COPD. And effective mortality rates -- in the past with that means is the forecast you have two [Indiscernible] surviving around.

For OASI populations -- the -- they will reach up to two reach up to $2 trillion in payouts.

For SSI -- similar sharp increase in the populations through 2020. And they fight over 2060. Again old driven by demography alone.

And this shows you a big decline.

And I will end on the detail slides -- [Indiscernible - low volume] but I think is interesting to think about how democracy plays a role and I think it is distinct -- on the usual forecast -- largely because the usual forecast and have -- put an emphasis on economic situations.

If you want to look about long-run forecast I think demography and how -- at [Audio cutting out] and the outcomes and it is sort of expected. >> [Pause]

Good morning. I want to talk today about the rise in federal spending disability insurance benefits. That has occurred over the last 30 years.

-- About 30 years ago we were spending 0.7 cent of GDP on disability and if it's and as a side benefit -- with disabilities. Today we are on the verb -- on the verge of recession we are spending 0.9% of GDP which was an increase of about zero point [Indiscernible] 0.2 over the 30 year time and it does not count roughly 1% of GDP that is spent every year on Medicaid and Medicare benefits for individuals who are receiving disability insurance that fits.

Although with the affordable care act we would not take about all the health-related spending is incremental spending by being disability insurance according to the state.

So in the Social Security -- insurance world eight spending rate of 0.2 GDP is not a big number. In fact every year in the decade there spending Medicare, Medicaid and social security benefits will go up by more than the 30 year increase that we have had in spending disability insurance benefits.

On the other hand, an increase from 0.7% of GDP to 0.9% of GDP is about 9% increase. But in fact the Medicare increase is not the reason I wrote this paper. The reason I wrote this paper is I have two sets

of friends who basically look at this data and came up with very different interpretations of what is going on and different folks, different interpretations.

So my colleagues -- [Indiscernible] -- ICU -- have look at these trends of rise in spending and rising disability insurance laming -- and have concluded that there is something seriously wrong and they described the physical crisis unfolding. And said that the screening opus -- process is effectively broken.

And colleagues of mine have look at the same trend in data and said simply the baby boomers are aging in their.

Ages of which the [Indiscernible] was most prevalent and also the increase of women in the labor force and more women being insured for disability benefits. This was really a one-time phenomenon. And it was likely to reverse itself. And the Congressional Budget Office -- on, -- [Audio cutting out] spending on disability insurance benefits coming down a bit over the next -- [Indiscernible - low volume]

So I was puzzled at how this affected -- on my good friends at, different traditions of what is going on. And that's why I decided to write this paper.

And there was some heated controversy and insert yourself in the middle of it both folks are wrong and I would say with a range of patients are. What I will tell you as a colleague will write that paper. But -- I now think both sets of folks are right. And I will show you affect can be the end of his presentation.

So first the basic backs -- that I can taste and conclusions. One thing I know is that the increase of spending disability insurance benefits and the share of EDC is all often about women. If you look at the spending on men, it was 0.4% of GDP in the late 70s. 0.4% of the GDP in the Bergevin recession.

If you look at SSI it that's another goal -- it is 0.2 of GDP today.

A little increase -- in SSI spending on children which we will hear about in the next session. And the increase in spending in the GDP -- the second thing that she although spending in the share of GDP has been constant but for men and adults SSI -- that is a measure to big trends going on.

And the benefits of GDP ratio and average benefits are coming way down. And their phone by also 10% -- having to do things like earnings being a lower share of GDP. Health insurance benefits and driving income inequality.

So have these benefits and this happens at the same time the number of people and the population receiving benefits and [Indiscernible] have canceled out in the fiscal burden constant during the two populations.

Those are still -- just background facts and or to provide everyone really helping the baby boom is. Shows that people in the late 50s and -- [Indiscernible - low volume] in 2010 art twice as many people going through the aging years as there were 30 years ago.

So much of this paper is built the most simple model you can imagine. It basically says the people who are getting disability insurance benefits today at a certain age are the people who are getting disability insurance benefits a year ago at the age -- one year prior. And [Indiscernible] and new words and determination. So no words basically the exposed population of people insured for disability insurance were not already getting benefits. Times instant rates times -- and determination -- termination comes on data recovery from conversion to the benefits.

So a very simple model of how this evolves at and have single years of age. And if you sort of -- started in 1980 and take the actuary benefit rates and insert coverage rates and death rates and just run the world forward you can actually get the actual results.

So the actual is supposed to happen when you have an identity -- but [Indiscernible].

So basically that's what I do., To have that model you can do interesting things like say what would happen if you just rate had been different to what was or what would happen if they just to be sure in the population have not [Indiscernible] over time and because the various sources of the same thing.

And I will start looking at men here. And basically in them that in the four things that are driving everything and recovery rates -- death rates [Indiscernible] insurance rates -- and I will talk about the interesting going to see thing going on for men at the first is the insurance rate in the second of the death rate.

When you have instant -- instant rates for -- incident rates for men you see [Indiscernible] overtime -- [Indiscernible - low volume] you have fluctuations from the business cycle.

So that a sort of back number one above men -- -- about when -- -- about men.

And the second thing about men is they -- the extraordinarily decline in death rate over disability insurance beneficiaries. Is a very linear time with two big aviation's -- first of all the early 80s, a lot of people were [Indiscernible] on disability rolls many people who were on average [Indiscernible] getting benefits -- and he can see the death rates and the receptions in the 90s -- [Speaker moving from microphone] and overall you can see the decline. Cermak

And this is a particular trend having to do a disability system or is it simply the overall health improvement of the population over time.

So think about that and you want to compare those trends to the rates of the general population. We see here on the left of the opposite numbers there is also a decline in the death rate for the overall population -- but it starts a lower level and it climbs to a lower level. And you can get almost the same proportional in mortality rate. For the general population and [Indiscernible] population.

And I just want to point out today -- while there is this incredible -- [Audio cutting out] in terms of incident rates for men -- if you look at the incident rates by condition you can look at them muscle claims -- and there are two big trends that are canceling each other out overall. >> And I said one thing you can do with this model is decomposed the changes over time and lots of things would've happened -- what would happen if the population stayed constant and the insured rates at state constant -- what if the death rates have not changed, one of recovery rates had not persuaded -- for the level like like but say -- what would've happened over time.

And other assumptions you make including the base year's -- while I am doing the exercise for men, and the findings at about 60% of the increase in the ratio of beneficiary's working in the population comes from the population aging and there will be more people over time and work insurance clams over years. The other insurance doctors here are -- April are [Indiscernible] over the years after they receive benefits. The other thing securely but the incident rates -- is not nearly as big a factor as these other two factors.

So in one sense I think the table shows and actually while I shave women without going through all the -- luminary slides. -- [Audio cutting out] for women combined [Speaker moving from microphone] [Indiscernible] in the population aging counts for about two thirds of the race in the ratio of beneficiaries for the working age population.

Phillies about a quarter for SUVs about a quarter for rising incidence.

So when you look at these tables -- it is instinctive to say [Indiscernible] you will have five year results -- they say the interpretation for the population erred in -- aging and what were women being covered -- and I think these figures are consistent with that.

So that the sense in which you can do these compositions -- it is true that most of what is happening in terms of the number of people receiving benefits can be attributed to that sort of demographic that -- factor.

But that come position makes an assumption for the baseline should have been incidents over time. And if instead -- we should see declining incidence.

And your tribe with a mental impairment -- if you look at -- it if you have this increase in the conditions are harder to verify and you can say 25% or so lower than it is -- and therefore the changes in the eligibility in the 80s did play a big role for the number of people on benefits today that may or may not have been a good thing but clearly there is a ratio number of people on benefits of the working population and so the spending is going.

So that is something the interpretation of something big happened in the mid-80s that changed certainly the composition of what people were saying the same benefits for and if that was quantitatively significant from a budget standpoint and they claim the big chair of disability receiving population.

Is as accurate as well.

So the end of the day I think there are two big open research questions -- for looking at these data.

So first we go back to the change for both men and women and the conditions that people are claiming benefits for, away from things like [Indiscernible] and intentional related conditions or muscular -- musculoskeletal. The changes and he was getting benefits or are the same people applying a getting classify in a different way. People in the mid-80s would have said by health rates are work status and opportunities are not great and I will prefer benefits the way that I apply the plan is under the rules of when I am there. Which is circulatory related. Are basically the same individuals today claiming but applying it having different conditions -- and that is the story of what is going on -- the stable incidents is a reasonable way of looking at what is going on. In a way there are different populations in Moscow's Kelly tour is a different phenomenon" unrelated to the senatorial conditions of people claiming earlier. And they can claim the change in benefits are sizable number of people to come on -- had they not changed those rules.

So I think that the research question is what extent is the impairment that you claim benefits based on [Indiscernible] and sort of similar people have many options of what the [Indiscernible] being a well-defined thing in the populations.

The other thing I think big research question that I am up to this analysis is how to extend the increase in incidence among women. But I am like [Indiscernible] [Speaker moving from microphone] the instance over time -- women in the 90s -- [Indiscernible - low volume] buffer men [Indiscernible] and it never came back down for women.

But the question is why -- [Speaker moving from microphone] men in the disability rates and they all got there but now. Another view is the upward trend that you have seen --

But understanding the time the 90s direct conflict of recovery I think is an important question to try to understand going forward whether you should spend -- expect rising incidence or [Indiscernible] incident rate.

So let me conclude with one final point. At the end of the day the fact that as I said at the beginning the increase we have seen in spending benefits shared -- over 30 years is basically what we see in a single year and the other special insurance program. Makes you think there is a session on what to do with updating disability insurance primarily of the policy of the budget policy. It is really primarily an issue about how to be prepare a bunch of bad incentives in the system that cause firms to have incentives to get rid of disabled workers rather than accommodating them to try to sign as many people up as possible for federal disability benefits so they don't have to pay for shorter terms. Public assistance funded by the state level. And the Social Security ministration to understand -- out of the discretionary budget and the budget cost at a rate of greater expenditures and benefit expenditures. And cause people who -- struggling to adapt patient process to have to get as far away as possible to go through that process.

So when I think about the issues that are facing us from a policy standpoint I think -- how to we -- particularly had we target the the disability pool -- so we can better help if we can get some assistance getting back on our feet rather than offering them a package that says if you promise basically never to do gainful appointment again will give you benefits for the rest of your life and how they come up with a package that provides that.

That as a better more promising project re-for folks who are able to get back in the labor market to write the right set -- [Indiscernible - low volume] >> [Pause]

Good morning. Thank you for -- [Indiscernible - low volume] good morning. Thank you for the opportunity to present this work -- this joint work with [Indiscernible] was here from the University of Maryland and [Indiscernible] who may be on the webinar.

And thank you to SSA for supporting work and we are sorry not to be able to meet those of you helping us with the data.

And thank you also for two Mathematica for organizing this and it is fun for us to be here because we are a team of the former mathematical employees for the MBR contortion -- NBER Consortium.

To the project today is a descriptive project. We are adjusted in exploring the growth of the child SSI they slowed. And specifically we are focused on what is going on in the past decade.

So what we have now is about 1.3 million children enrolled in the SSI program. This is work fold increase since 1990. -- Fourfold increased. And looking at the deadly decision in 1996 and welfare reform when the case was tripled. And welfare reform removed about 100,000 children from the SSI rolls by tightening the medical eligibility requirements.

But what we have seen is an upward trend since 2000, and that is what we're going to focus on here so that his entire time period that we will be talking about his post-welfare reform area --.

So starting in the first part of this presentation just documenting at national and state level children SSI level and that time. And the second part is dark -- start to explore the possible court [Indiscernible] of the growth of people populated.

So here we can see the top line here is the child SSI caseload. And we can see there that 40% increase since -- from 2002 to 2011.

And we have broken it down -- SSI tag rises so the -- top line of the total in the redline is the caseload of children with their primary diagnosis of mental disability. And we can see is that redline really attracts the total.

And that yellow line in the middle and for those of you who may not have noticed yet -- at the copies of the slides in the folders -- if you're not already following along with your hard copy and would like to.

And the bottom line here -- the green line is intellectual disability.

And so what we see is that the number of children with mental disabilities on the caseload more than doubled -- and [Indiscernible] increased by 24% in cases of primary diagnosis of intellectual ability decline by 40% box of the -- they discuss subjecting of the caseloads and the caseload in disabilities and other mental disabilities that could be tainted and diagnostic practices -- and increase [Indiscernible] of autism. But even if all that decline that that would not be explained what we see in terms of increased in the caseload of children. With mental disabilities.

To what I am going to show you now is the breakdown by state. And you might want to look at the handout. And so the bottom part -- the great parts at the bars is the 2002 level of the caseload and share of child population. So how many recipients for thousand children in the state in 2002. And the first thing I would just point out here is that there is quite a bit of variation at the starting point for the analysis 2002.

That means they caseload there -- had about all participants per thousand children. But there were 21 states that had fewer than 10 10,000 on SSI and seven states with more than 20. Per thousand of the largest caseload here in DC -- and remained in 2011

So in Columbia here had 32 kids out of 1000 on SSI in 2002 before we see the growth over the next decade.

Within every state the national average increases in the caseload from 2002 to 2011 that reduce -- due to mental disability which is the dark blue part of the bar Park -- bar. Where the physical disability -- the dark loop part was smaller than the increase due to mental disability which is the purple part.

And then in addition to this variation that you see in the starting point in the gray bar, if you add up the blue part in the purple part that is telling you the increase from 2000 to 2011 at the total height of the bar is the caseload share in 2011 and so we also have a lot of variation across the state in the growth and in the levels that we see now.

So -- in DC that share went from 32 to about 43 that share went from 32 to about 43,000 and also want to went out Arkansas to you there with the caseload more than doubling. Texas -- I will focus on and I will stop turning away from the microphone.

And exes darted out with only about nine kits per thousand and more than doubled its caseload.

So there have been high-growth states that have turned out low and other states that started out high. And what we are interested in this morning is -- this is just another way to see a.

Hate to the states 2002 caseload per thousand children along the horizontal access and the percent change in the caseloads. From 2002 to 2011 on the vertical access and does not look like much of a relationship.

So basically looking at these types of figures, made us think about why some states have higher growth than others.

And given the nature of the program -- were wondering about how much demographics between Jeff.

And finishing up a descriptive part on the caseload before we start to look at this I want to size sheet emphasize that the caseload has come from new and continuing cases. We will focus on the cases with the primary diagnosis of mental disability. Going forward.

And there has been a lot of discussion about these continuing disability reviews.

And how budget cuts have decreased the number of these reviews as we move forward. I will talk about -- we don't have dated in the analysis -- so we will focus a lot on the number of new cases per year. In the allowances for mental disability. And I will show you everything that comes next -- the variables that I will be talking about is the initial allowance rate for mental disability for children.

And everything I will be showing you also is for all children. Zero 217 -- I have not raking it down further by age or by gender because we did not see any big change in the composition of the caseload at

So here are a couple of things that people have discussed as possible factors that can be driving the caseload growth -- certain things were mentioned in the 2012 G AO report -- and basically this is when people see this trend and say is a big, or if it is -- not big and one of the reasons -- one of the reasons it is not big maybe we would expect for the following reasons and the number of children in poverty. Increasing rates of diagnosis. Increased health insurance -- insurance coverage. Rise in special education services or the perceived rise. And the GDR's which we were not the focusing on.

The hero show you a number that she will go through the desk and they go through the potential factors one by one and then each of these factors will be the same where on the vertical access is the percent change in the initial allowance is. For thousand children and the education with mental disability.

So the first one showing you the relationship to the initial allowances on the property rate at and were interested this in the second program -- but but also have been shown to lift you out of poverty so it is a perfect measure -- and without for every 100 children who enroll in SSI, 22 children are lifted out of poverty.

So we're looking at the rate of growth in property room correlates with the growth rates of the initial allowances disability on the vertical access.

And what we see is basically a lot of correlation and the overall direction is negative.

And you can look in the top left corner -- and they both ran away -- and you look at the top left -- that one is Arkansas. And it had the biggest percentage it -- decrease in the poverty rate and the largest percent increase in the rate of new SSI cases for children with mental disabilities.

So even if we consume -- conclude that the overall reaction is not negative.

So now the thing set up -- with the vertical access -- we are trying to not be one of those papers that we were talking about that does not look at health. So we hear we are looking at the percent change in share of children at the state level that we code as having a mental disability from the survey of children health.

And using the 2003 and that data their and deriving that, combined answers for the different questions in the survey.

And here again it is sort of a caveat. With -- with the disabling conditions causing the rate but also in reverse it heightens awareness of disability and changes the reported behavior of participants in other settings.

So want to interpret this rate and the two [Indiscernible] I had protect you -- and appeared -- Texas and Arkansas in the top right corner.

So with the exception of those two states, there does not appear to be a strong relationship between the measures. So suggested to us the rise in the new initial allowances for mental conditions is not driven primarily by NTC of diagnosis.

Benefactor of the blood discussed is health insurance expansion. That operates through a couple channels. Through increased access prepared diagnosis. Also providing increased documentation in the application process.

And so here we are looking at -- are subtle access -- the SCHIP recipients. And it looks like more children are gaining [Indiscernible] through SCHIP -- and the initial growth rates in these allowances. What we're going to do next is look at what happens with Vicki about Medicaid and SCHIP -- because Medicaid and [Speaker moving from microphone] SCHIP -- [Indiscernible]

Here we're looking at the poor children only and changes and insurance rates. Percent change on the share in any children with any health insurance at all. And here we do not see a relationship tween getting any health insurance coverage for the poor and those initial allowances.

Here though we look at the [Indiscernible] so children between 100 and [Indiscernible] sent of the federal poverty level and was he the positive relationship through that. So something to keep in mind there again is more generous mental health coverage. So they say the medicated as chip -- so any health insurance for these are also correlated with people switching from private insurance service, operating here as well.

And then we will talk about special education.

This is interesting -- in the GAL report they had that instances of 63% of the SSI termination for children with -- with mental disability and school testing being used in 43% -- and like SSI there is a lot of state-level variation in participation in special education both the levels and growth rates over the past decade, although I'm like SSI aggregates we have not seen big aggregates -- [Indiscernible] in the last decade it is sort of an up-and-down but flat.

So here we see what looks like a positive relationship -- between changes in special education and allowances for mental disabilities and this is true -- with the top left point here. And having both the greatest increase in this rate of SSI participation for children and the largest drop in the share of enrollment with the individuals with disabilities act with -- month Allstate. So the dropper Texas is really interested because they were not starting from a high place. They were starting with low participation and then dropped.

And I want to mention that -- and interesting forthcoming paper by Julie Colin and Michael Schmidt were they -- within Texas and that Kurt -- they grew up in Texas in the period of healthcare reform and they show that in Texas expansion children at the 500 participation was greatest -- where they have the strongest set of classified students in special education.

Answer that participation in special education independence -- the children underlying disabilities lead to increased likelihood of participating in SSI.

And so what I'm showing you so far is looking at these factors one at a time. And what we want to do is try to serve them altogether and special analysis and the only factor that is significant here is prevalence of special education in the state. And we only see this with me either don't break by population or exclude [Indiscernible] on the analysis which makes sense if you remember the last graphic in terms of the Texas outlier.

Interestingly social education is predictive of these initial allowances. But not the application rates.

So nothing like maybe that supporting the idea that the way of working by the documentation challenge rather than awareness.

And draw your attention replete to what is not predictive -- and health insurance coverage -- health diagnoses that we saw the survey that were not predictive in the state-level cases. >> Cyclically we were a bit surprised to see if these variables six playthings a little. At this point really are interested in seeing some of the case studies of some of the states our outliers in terms of the growth for special education of children with mental disabilities and in Texas and Arkansas in the districts -- and were also interested in doing more work on the legs between social education and SSI. >> [Pause]

So these are -- all making substantial contributions to growth of disability program. This is a topic I have been addicted to for over 20 years. And their feeding my addiction.

So [Indiscernible] paper first -- with the effort to examine growth -- and benefits for causative growth -- [Indiscernible - muffled speaker] I thought was something overdue -- and they also know you are just getting started and hope you will continue.

I am a little surprised that were not finding more evidence on the state-level package -- [Indiscernible - muffled speaker] With the state-level data. And I have one suggestion that I think you could get more out of that analysis by following the lead of the substantial literature of similar data and explanations for the allowances in a patient's as well as providing a benefit especially with respect to the business cycle.

Because that literature has or shown the increase in DIF occasions and [Indiscernible] not as much as application but it also shows that takes a long time for the four session to play out. The initial impact on [Indiscernible] is not substantial the first year after the recession starts. And he continues to go for at least another two years. Summit would basically looked at our broken system at that point.

[Indiscernible - muffled speaker]

I think you'll find the business cycle if you allow for substantial lag and the impact particularly if you could construct quarterly data which will allow you to do a better job with timely [Indiscernible] [Indiscernible - low volume] [Indiscernible - muffled speaker] Over the period that you're looking at.

But I think the legs might be in the longer for children and for adults because the business cycle -- [Indiscernible] with the entry as it does -- [Indiscernible] on adults and employment and the implement for the parents which is different from adult.

So it is hard to get her in mind to point out how many SSI children there are in the population and household income above the poverty line.

And they have these rules which allow for the income and resources of the parent to be not counted as SSI for the child.

So if the child in the household -- is not to be in poverty for the child to qualify for SSI.

So with that said, I think the number of households containing a child with a disability with experience job loss during the recession might be quite a large number. And a might take time for unemployed -- for parents to come across other opportunities including employment insurance for the actually get around to buying for SSI.

But I would really be surprised if they [Indiscernible] back there.

With that said I also like the strategy of identifying and rising natural [Indiscernible] in the future and instances revolving -- involving a few states and you can identify shifts in the factors that are expected to affect SSI child caseloads and like the study I alluded to concerning special education is one such study. So I would be adjusted in seeing that.

I want to get back to the slide -- can I do that? >> So this is the decomposed men's slide -- I want to use this analysis to illustrate a point. And actually I think Jeff made this point -- and so in a little bit different way. And I should tell you that it did not see a paper from Jeff -- I just saw a slide -- so spent a lot of time looking at this and interpreted himself -- and said that other sites I came up with a little different interpretation but we end up at the same point. [Indiscernible] in 1985 in the year that Congress passed legislation it was designed to store -- restore eligibility for substance of members who were ineligible during the late years of the Carter administration. And essentially during [Indiscernible] and 91 and 1982.

So for men when I look at this graph, I see the labor force demographics and SSI talent and that's my shorthand for mortality -- occurs over the participation rates in 1985 through 1996. And if you take all those factors out, you still get very high levels of growth during that time.

Instead what we had was incidents going on agents of the

Going up.

And that she go from 1996 forward you see a very large share of growth from that point forward accounting for [Indiscernible] for demographic factors. And once you get those factors out of there there is very little growth.

So I have always also thought that 1980 was an interesting year to start an exercise like this is a 1996 or 1985. That was the last time that Congress was so concerned about the cost of disability program that they actually -- substantially tightened eligibility criteria.

And I suspect that it is [Indiscernible] I'm sure every start in 1990 every start in 1995 and 7085 you'll find that it is a very high share of growth in the percentage population disability is -- and mail [Indiscernible] dude demographics. If you start 1980 think you would get something in between in 1985 and starts in 1995.

So they could be really interesting if you actually do the simulations at the starting point to show that much of an effect that has. Because I think it is really central to the debating is going on in Congress now about what to do with the program. And I think that alluded to this as well.

And it's clear that those who urge Congress to make the problematic forms -- and the [Indiscernible] serving the exercise of what happened in the past in the mid-1980s. Because if you do that, then something cannot be if labor demographic factors. And those of you who urge Congress to protect that program for major [Indiscernible] since 1995 which indicates that almost all the growth in 1985 was predictable through demographic package.

At least for them.

But I think this debate raises a very interesting question with which is the right way to start -- and there is no right year. The choice of year is really just a normalization -- and you have to pick a starting point. Whatever year we use if we use this model to start the simulation and also with

backward as well as forward, then you're going to see that there are things of times where [Indiscernible] pays -- plays it graphic were old in the prevalence rate in other lazy period where the public policy with an out -- anonymous.

So what that allows you to do is identify those periods of what's going on -- and say there is a right year is really to imply getting back to the prevalence rate for this -- that year a sensible policy goal. And I don't think that's really what want to do and I also want to briefly take a look at an earlier slide on the incident rate time talking about this -- I call this the economy stupid slide. One might conclude by looking at the older age group between 1990 and 89 and 1996 that it is really just the economy account to run up the incident rate and the decline thereafter. Actually think of to simple explanations for several reasons. First the suggested incident rates of the two lower age groups in the level of 1980 to 1990 -- and [Indiscernible] pointed out that has been a gradual increase throughout this period. And he could see that it is [Indiscernible] because of the scale. And that's a relatively low incident but remember to take it on they will be on for a very long period of time those who get on later.

So I think that is important change during this time that may be secured by [Indiscernible] of this graph.

Another point that in the late 1990s a lot of people argue that the economy was substantially stronger than it was no late 1980s and you measure that by [Indiscernible] or appointment rates or on deployment rates. And the incident rate just barely -- in the older age in the pre-1980s and late 1990s -- and did not do that for the younger age groups.

There were a number of policy changes that went on and the incident rates in this time starting in 1984 amendment that basically brought back eligibility that had been eliminated or eligible for the early years. [Indiscernible - muffled speaker] And it ends with the elimination of eligibility for those -- [Audio cutting out] so I think there are some other things to explain this -- matches the economy.

This [Indiscernible] so J remind us that long-term trend in the health status of the population are likely to have long-term effects on the age jacket incidents participation rate in all of the Social Security programs.

And the main point is the gradual trends of the population under 65 E. -- we would expect to have underlying trends -- [Indiscernible - low volume]

[Indiscernible - muffled speaker] But these are much much higher perceived. In the long run however I think that [Indiscernible] is much more important.

There are other long-term factors that are receiving less attention but maybe more important from the [Indiscernible] growth J points to one of these and they're partly behind the increase in longevity. And also account for why we have higher prevalence of something to survive.

But if you think about the improved medical treatment available -- availability of the accommodations, the amazing increases in those things the last 30 years. It really seems like that I would be an increase

in the ability of people to work who do have a medical condition even if it's a chronic condition or impairment.

Some my colleagues have very severe impairments but the other types of health and taking care of themselves are working very productively.

So to me the big question is why aren't we seeing a drop into the rates. And maybe we would have seen the drop [Indiscernible] and that would've showed up into -- Jeff Stata. But it seems like we should be expected that long-term decline for incidents for disability benefits adjusting for age and some other factors that seem to be occurring.

The second point is that trends -- [Indiscernible - low volume] the data as starkly are not very good. And the people with psychiatric disorders found Delmon to -- develop mental disorders were found gave the go before the 1990 instead decision.

So more of those people are in the population. But at the same time we have to increase in incarceration rates in the incarcerated population. And we know that a very large share of the incarcerated population or on disabilities -- but also a number of others.

So to my mind I wonder how these trends have affected capacity. But also things that we can expect in the future such as what is happening as a result of [Indiscernible] of 1999.

Who further try to help people stay out of the [Indiscernible] and also I think there is a very strong movement now to reduce the size of the incarcerated population. And the implications of what those things will be in the future.

The final trend is the supply and demand of autoworkers -- and [Indiscernible] knows much more about that than I do. But I think this largely affects And the economy.

That has been very difficult to -- for people with certain conditions and skills to compete.

And Jay's paper also focuses on those age 51 or older. And I think the focus reminds us all including me that the SSI was originally conceived as a medical retirement program for workers age 55 and older. Back in 1956 -- and policy changes however desert to expand the program who do not fit this description at all.

And I think instead of asking whether the country can afford the SSI program that we have, I think Congress needs a -- and others need to be asking whether a program that was designed to pay for Medicaid -- retirement resents the best long-term local conditions in terms of decade security.

I doubt that it is but we don't have the means to do better right now. And what is being presented today -- I hope what is present day will help you the way. Thank you.

Alright, before starting the Q&A I want to invite the speakers if they would like to respond to any of the comments in the discussions and if you would like details and turn the mic on in front of you.

You don't have to but if you have any thoughts.

I don't have anything but I think David pushed the problem in the perspective -- it's a matter of both health, demography and economics. And I think all three at once is a good way to go.

If you go back to the slide -- [Indiscernible - low volume] so thank you David for your thoughtful comments and I agree with almost all of them.

Something I want to point out is the model we are doing here is not really sensitive to the start year. The 1995 is out steady-state. A set of incidents and recovery rates and everything else.

And don't stay at the same level of prevalence.

And so what is happening -- and I will stand up for the video -- but what is happening here is this is just going [Speaker moving from microphone] -- [Indiscernible] and what is happening relative to the state at and [Indiscernible] in 1980 or 1990 -- but it's actually [Indiscernible] [Speaker moving from microphone] but ways that were generally is that I think is right that the parameters and the results are certainly depended on that.

But it is really more than a study issue.

Thank you David also for your comments and we will definitely follow up on that -- as a work in progress. And you have looked at employment rates at we had not experiment with the lab structure of that. Think that would be good for us to do.

Alright. I would like to start the audience Q&A and to let people know one question -- Dublin about five questions together because of the speakers will lose track of it and the audience does not want to hear that either.

And also to please state your name and affiliation. To answer the questions. Will start over here.

Hello. I am [Indiscernible] with [Indiscernible] by question is for Nora. Did you classify autism as a mental or intellectual disability and how do you [Indiscernible] the two because it is such a broad spectrum talk

I am relieved to say that we are in the process anything on the SSA classified.

And -- it is all the analyses that I showed you for the second half.

We're looking for the state level -- we group intellectual and mental together.

-- And how the definitions I shifted over time >> In the second part of the analysis. My understanding is that autism has not -- should not have been in the intellectual disability at the beginning.

But it may have been in some cases -- depending on Agassi's.

But could have been missed earlier.

[Indiscernible] -- do have one -- [Indiscernible - low volume]

No.

[laughter]

Anybody else on the webinar? Mike

That is a first by the way.

-- [laughter]

Gail --

[Indiscernible] from George Mason University. With a question for J. Thank you for that very interesting presentation forecast.

One of the drivers of G.I. enrollment -- DI romance seems to be mental health conditions -- from Nora's presentation as well as Jeff. And I was wondering if the HRS data allows you to pick up than to health conditions, and if so -- and I was -- if not in your micro simulation how do you think your results would have differed for the DI [Indiscernible].

The answer to the question as a comment. The HR does not include the institutional population.

So that is one major I think limitation of those data for the purpose.

We do actually have mental health commissions as a contributor model -- so it is in the model -- but I think as a matter of medicine, it is harder -- if you have diabetes now we're pretty sure it's on this you don't die you will have it, whereas mental conditions are not necessarily like that. On lots of things.

So the kind of model -- I am [Indiscernible] with modeling the [Indiscernible] for mental health that I am for some of the more other kind of health concerns. That is probably why the projected decline in the rates -- [Indiscernible] now how much that matters, I could speculate. I think it is most likely for the 51+ population I don't think they be guilt. My guess is if we have worked careful mental health projections of still be similar to what we have. Forget that they would be a really different matter unfortunately.

-- -- [Captioners transitioning] >>

Edit think your results would have differed >> >>Over here in the front? >>Hi I'm Melissa Ortiz, I am a one-woman the take -- tank, thank you for bringing up that last thing about asking up the right questions, all the data in the world will not happen unless we asked the right questions. >>-- This may not be something you might want to address, what are we doing as far as private partnerships?

Bringing in community problems -- March of Dimes, church and state base, synagogues, mosques, some of people want to be a part of the conversation, wet is helping to bring them in -- what is helping to bring them in? >>She is asking you. [Laughter] >>The rest of you I am interested to hear what you found in your research, if anything. >>[Laughter] sorry guys. >>It is not really related to the research, something we have been thinking about, at the end of the day they will come up with a solution to the problems, how will we provide a package of benefits to people who they have -- it is unlikely that whatever the solution is will be specified in any useful detail. The thing we could do in Washington that will be helpful, is find a way to pay for both innovation, to come up with solutions, it will be provided in the community, who is providing whatever service it is. It is a matter of how well that government prepare for the services to exist. I think looking at things that recent problems where they are fostering innovation at the state level and they will collaborate with the state, governments, who are helping them make successful transitions into the research. -- Into the program. Then what we really need to do is entrepreneur is going out and develop solutions in the first place, right now there are decisions made about going out and paying for these models, I'm not sure if they all exist yet we will have to create the environment to which these start happening. >>I will take a stab at it I really like your question it highlights the key limitation of essentially -- Abbeville sign comes to my head you can't buy me love. All of these figurative insurance aren't necessarily -- they are not in complete, what is absolutely necessary they are, but they are not sufficient. If we're going to do right by the population, there will need to be not just government efforts, but efforts by lots of parts of society. To cope with what I think will be an increasing problem. Not especially SSI -- DI, but SSI. I think it will take more than government effort, -- ever. >>One of the unfortunate things about the way disability policy is run in this country, there are a lot of interest at the federal level as well as the state level, we are focused on the Social Security programs, a lot of money is being spent by Medicare and Medicaid, which is a different agency. We have four or five other agencies that have significant state in supporting the population, we have already heard some of the discussion at the state level to get federal dollars to pay for the population. That stood in the way of the type of progress we like to see. In creativity, people and the private sector response to the laws that are, in such we would not always like them to be. I think I know just as well we have been encouraging people to think about how to change that, how to put funds together in ways that will give states incentives ways, to stave -- save money. It is very hard to do it took years to get progress in place, it is just starting now. I think we really need a period of rapid experimentation testing out new ideas, coming from the bottom up, not just things we think in Washington, we do not have that. >>One other example, although it is not proud of it -- it is not public-private, it is public. -- Perhaps we are more hopeful there is a place where to find them in school often. There has been public schools can use Medicaid to space -- to pay for special education, and those kind of things, can re-eight uses -- can create uses of funds, that is happening locally. >>There's been a few hands going up there in that part of the room? May be over there? >>Sean from the center a policy research, the child with -- chart with the SSI grows, if you look at the beneficiaries from 2000-2 2012, -- 2000-2012, I just wondered why it looks so different in terms of your numbers, where it is crystal clear at the national level looks >>-- Over the national level? >>Over that time period, till 2011 it was about a 33% increase, in these initial analysis, one thing that is different, we aren't -- are talking about these new cases of disability, you could see looking at the total caseload. You may not see numbers because of that. We are looking at those changes within

state, so I think it is asking a different question, then about the national aggregate. Within the state, maybe we are a high priority -- poverty state where we have high participation and thinking how it is evolving in that state, and participation in that state, you think potentially there is a role for state in this process of enrolling new applicants. It is not surprising to me that there is that variation. >> Thank you I am Caroline Coffman I'm from the University of South Florida, and various places. I had a question, I would like to have Jay, Jeff and Nora to respond to this if possible. Whether it is clustering with this mental disabilities or just mental health, wherever it is coming from, it seems to be tried been a portion of the increase. One of the problems with mental health, the nature of the disability is essentially what the extent it of functions of the brain -- with the executive functions of the brain, there are good paying jobs being generated by our nuke -- new economy. A lot of the other jobs that are available require the approves lens -- approved men's -- >>Improvements that we are needing. -- If you are going into a position for service economy for much is required and we do not have the assistive technology developed in that way, if J -- Jay can comment on that whether, technology can affect Social Security? The second -- maybe the third point, you identify children early and provided them with special education in schools, the home issue and aging out of the system becomes a problem and many of these kids are falling into the autism spectrum disorder, and way it is generating increasing to those diseases. Could you comment on how we might deal with kids who are interning the label floors -- labor force. The shift on Medicaid and the SSI, as we create a lifetime of dependence, I forgot why your comments would be per net I'm sure you will have something to say on this issue. >>That is to questions but we will allow it. [Laughter] >>You have a great point about the difficulty of providing assisted technology to a lot of mental health, especially with adults, the way that I think about it, the change in technology allow them to live longer. They do not necessarily result in people being able to function better in the economy. I think this shows up in the model with SSI forecast, the I forecast you see declines, and the changes of ups and downs -- Di forecast you see declines, and the changes ups and down. The forecast is more severely ill in the future than they will . It is partially driven by success, we are keeping people alive longer, but it also means there will be stress on Social Security and other social mechanisms to support the mechanism of more severely and mentally ill patients as you say it is difficult to do this. If you just have physical disability, you can get an think of technology that might help, the combinations that -- accommodations, it is really how we as a society cope with this. It will be an increasing problem and will require more expenditures. >>Okay you may answer -- I may answer just a slightly different question than what you asked. Kids that are not covered by these programs as well is a much bigger problem, with special education, your question assumed that well kids are in school, they would be in special education, I don't think we can feel that way about it? So when you talk about the importance of executive functioning, if we had high-quality special education we could be improving executive functioning, and a lot of pages -- a lot of these cases. It wouldn't be that you are aging out of this program. It is changing the condition. We know remarkably little about the advocacy of special education. It is not held accountable in the same way. Other parts of education, and second education are being held accountable, what we do know about it, is it is about who gets treated and put into special education, and what we know from that, troubling as well, it seems that there is so much variety for given child, and whether or not they are going to get an IEP, depending on what state they are in, but with schools within the district. All these things really affect whether child gets an IEP, and questions about what it means to have an IEP, and

services provided in a way that is consistent with it. So, I hate to say various so much we don't know, but there is so much we don't know. It is interesting in a policy context, where there have been some demands for accountability for other parts of the education system, and you do not see that happening in the same way with special education. >> Hey, my question is mostly directed at Jeff, in terms of thinking about the incidence of disability, the factors you are adjusting for is age and sex, another factor is some would suggest education, that is long-term participation, disability may be in the mental health category in particular, if you were to do that you would find that growth much more surprising. Given the rise of the population in this period. As you pointed out, we have to offsetting things going on one is the decline. For disorders and neoplasms, the other is the rise in mental health. Musculoskeletal, this ties into the question earlier, although executive functions is critical , we have gotten better at managing mental health conditions, there are pharmacological treatments that were not available before. I think it is valuable to recognize how surprising it is. That if we were to look at at -- if we are looked -- are to look at it from it -- this perspective. I was wondering in terms of thinking how to interpret that in light of what you did, what are the nuances that you would in this size there or take away? >>David would you like to introduce yourself? >>David otter. >>Your question is a good when -- one, it is why is it to find, one has to -- why is it to be defined? >>-- Other things are going on, they have less opportunities, obviously you understand that as much as anyone has, I think that the other thing that is challenging with education categories over long periods of time, is that the percentile and the distribution people are getting more levels of -- higher levels of education. Whether it is the actual level of education as the occupational make sure -- occupational mix. The big picture is a question of why did spending rise to the result of the original level, and to prevent it from fall, this is definitely a good question to ask. >>Great JoAnn, you are the biggest offenders -- you are the biggest tran12. >>I want to piggyback on something David said earlier when I look at this, yes healthcare is getting better, what about access to it? People with disabilities supports and other things, is there some way that one can program into these models access to health care, treatments, what does that tell us? >>Let me just speak for the [Indiscernible], it treats output, it is not well designed to answer your question it is important. >>All right anyone else? That was short JoAnn. >>One more and maybe we will break and have a longer lunch hour. >>Thank you my name is Teresa Lincoln, I am with Brown's services, to follow up on the quote from David. It is the brain stupid that is a quote from Chief of Staff -- are we aware of the benefits in neuroscience that are impacting the rates in discovery of mental health disability? On a larger scale are our models taking into effect the impact of the work of the brain injury program, unique models, social entrepreneurship this is the largest disability partnerships -- they have not been accounted for, I am one of those survivors of the severe brain injury, I did not receive services close to a decade. >>I think it is very important that there have been advances, I think that will have important implications. One thing I have learned, from this modeling exercise, these advances unless they occur in lots of different areas all at once, you end up with this competing risk problem that is more it -- that is more than I thought. So that we are better than -- at taking care of people with brain injuries, what happens is that the other diagnoses, because people are living longer will become more important, how much will become the math of the model. It is a weird thing this model, big advances in one area advance -- in one area, then they are worse than other areas. The question is what is Social Security going to be on the hook for? You just have to be careful about those things technology is important, but they will not solve the problems. >>I think

your question raises a point for the broader agenda, more cases we do not have good data for, people are slowing -- showing up in the slides, and buckets of improvements. If you think about where we hope to be in five years, people have medical records -- electronic medical records. If we set up the right research agenda we would know more. Various buckets and what is going on in terms of the purge Navy of -- in terms of [Indiscernible] , we are pointing to something that we will need to get done, we are away from a world that is going into records, and then you do not have a big enough sample to look at many conditions , in a sample of 1000, it is a get -- very good point. >>Let me just add that that issue -- let me just add the issue that Jesse Dems -- that Jeff is referring to, the states are collecting data in terms of their own categories, and then making them the into federal categories, and report act, it is -- to report back, and it is very hard to know what is going on in states over time. It would be better if data was collected more uniformly. >>I want to thank our panel members for their interesting studies. [Applause] for our in person audience if you go out these doors and around the corner there are box lunches, you can need in here, or the room around the corner. For our in person audience we will be back at 12:30 PM, with early intervention and employment. Thanks. >> [The event is on a Lunch Break. The session will reconvene at 12:30PM EST, Captioner on stand by.]

[Captioners Transitioning]

>> Okay, why do we get started. I want to welcome everybody back from lunch, and this morning we talked a lot about the problems of the current system. And on this panel today we are going to talk about hopefully some of the potential solutions in the area of problems. And the title of the panel is early intervention and implement. My name is David Wittenberg, and I am a region here at Mathematica and have a long-standing interest in early intervention at and today we have for papers that look at target population and/or interventions that are designed -- that have been targeted for early intervention services. And these include youth, employers and people with 16 -- psychiatric appointment -- psychiatric problems.

At Mathematica research we describe the potential effects of changing financial and extensive [Indiscernible] from [Indiscernible] to retain workers after the onset of disability. They will be followed by Judith Cook who is a psych [Indiscernible] at the end of -- University of Chicago. Who would discuss the preliminary data on the standing of the type of work separation -- voluntary or involuntary. Impacts future outcomes with people with psychiatric disabilities which is one of the fastest-growing disabilities.

Finally the last two presentations focus more specifically on you. My colleagues Todd Honeycutt for Mathematica discusses the youth and receiving services from rehabilitation services into youth.

The following Todd will be a discussion by Manasi Deshpande -- which will show the disability review and the effects of the variations on disability reviews on -- ultimately [Indiscernible]

Finally David Weiss will tile this together. David is a professor of local economy at the Kennedy school and a research at MBR.

And his discussion focuses particularly on the importance of education on the outcome of many of these target populations.

As in the previous session, we will withhold comments until after all the presentations and we will be accepting Q&A from the audience as well as the web. So that intro let me turn it over to the second David of the presentation which is David Mann. To talk about his work.

Good afternoon everyone. Would like to acknowledge Mike co-authors -- David Stapleton of Mathematica and Jae Song -- in our funding.

Said many ways -- [Indiscernible - low volume] the presentation that the motivation for the study. Sometimes you see how an idea pans out and you just have to build up. And sometimes what you thought was going to happen -- does not necessarily turn out talk

So there are many focuses out there for reforming [Indiscernible] -- one set of proposals internalizes the cost of recent employees for the entry forms. So each firm works for the cost varies basic during the EI benefits -- [Indiscernible - muffled speaker] To the recent employees. So firms that relatively -- many were first to the girls would have higher benefit liability whereas [Indiscernible] relatively few individuals to the DI rolls would have a lower benefit liability.

There are two prominent examples of this approach. There is a 2010 paper bite David [Indiscernible] and Mark Duggan. And they propose short-term disability insurance to assign benefit liability whereas a 2011 book by Richard Burke Hauser and Mary Bailey propose experience reading Pyro -- payroll factors.

So we will give you an art study as we discussed specifics about potential liability for EI benefits varies by employers. NSA potential because these are statistics that we had galloped to liability and not currently used by FSA or any federal agencies.

So develop these measures and that we use them to measure how the reformed puzzle would affect workforce cost by firm size and firm benefit liability.

Just give you a quick preview of what we find -- we find that small firms -- and those with low annual wages have relatively high BI liabilities. We also find that the financial burden of reform was -- Woodberry by proposal but we found that across all proposals. It seem that the burden may fall especially on firms that employ temporarily low skilled and part-time workers

Let me just give you an overview of these proposals. Short-term disability insurance -- would require all employers have short-term disability insurance for their employees. To provide the insurance -- date for by this insurance and cells of the bite on the private insurance market. The claim for the insurance -- the claimant -- needs a wage replacement -- typically [Indiscernible] percent of wages -- and vocational rehab in other sports are meant to get the individual back to work.

And after two years they may apply for DI benefits and they may not be able to return to work in the next two years and made reply -- apply for DI benefits immediately.

And it starts with the observation and the Social Security tax has allocated to the DI trust fund does not vary by employer.

So currently 1.8 percentage point of the 12 point -- 12% work tax is allocated to the trust fund of this proposal simply suggests changing that and instead experience rating -- work percentage goes of each firm's tax goes to trust fund based on the firm's historic DI incidence rate

Primarily due to time constraints today, I will just focus -- on this puzzle short-term disability insurance. For puzzle.

To our data from resources -- uses the master earnings file to track wages of individuals not only receives wages, but who they are paid by. This allows us to aggregate across employees to produce for global statistics -- firm level statistics. For analysis and the determination file to extract applications BI benefit amount.

And then these to track data current, data [Indiscernible] when applicable and gender.

The key statistic for the short-term disability analysis is the benefit liability to wage ratio. That we create or BL WR. This is a firm level annual statistic and it is the ratio of benefit liability in total payroll.

So the numerator we have the liability occurred [Indiscernible] for the first 24 months of BI didn't -- DI benefits to the workers who enter DI in year T, T +1 or 2+2.

So we look at all the firms workers and you look at the subset to successfully apply for DI benefits in York T, T +1 or 2+2 and then we sum up all the DI benefits paid to those individuals in the first two years.

The benefit light to see that is the benefit liability. For the statistics we have the denominator paid by the firm -- in year detox overtaking the benefit with -- and applying it with the squirms -- with the firm's payroll.

The BL WR -- medium BL WR is equal to point double 07.

The liability is what it means -- is the liability in your tea is 0.7% -- just under 1% of Social Security wages paid.

So let me spend a few minutes talking about the characteristics of BL WR

We find that some firms have a very high BL WR. For example the 95th For example the 95th percentile for BL WR is equal to 18.6%. White high.

We find the high BL WR firms have the highest applications and allowance rates which is perhaps not pricing. We also find that as BL WR increases, mean wages tend to decrease.

We find out that has a couple of different ideas and DI is progressive. So the which is the rate to kind of wages. And that derives different results. But also could be the high WR firms -- field of your firms have temporary, part-time and low skill workers.

It can also be a combination of the two.

Moving onto some other characteristics.

Would find that larger firms tend to have relatively low BL WR and higher mean wages than most large firms have the deal -- BL Debbie are between zero and 1%.

Would find that the smallest firms with 1 to 50 employees have wide variation in their BL WR. Just over a quarter have BL WR at zero between 2% out of BL WR of over 6.5%.

Refine firms with the highest yield of yours -- typically small so for example firms with the BL WR over 6.5 are -- their mean firm size is just 11 employees.

Every find that the majority of DI among applicants are from firms that are relatively low BL WR -- that is surprising because most firms including the large firms have a relatively -- relatively low BL WR. That's where employees are concentrated. And that's where DI allowed applicants are very concentrated.

Only 6% of all-out applicants are firms with relatively high BL the rear.

So to calculate the premiums for the short-term disability insurance puzzle -- we regress certain years she yelled the BR set of characteristics and each these characteristics are consistent with what the short-term disability reformed puzzle says which would determine the premiums. And that we use the predictive model to predict expected liability from the highest rate ratios or EL WR.

And if we divide the EL Debbie Arbeit loss ratio to compute the short-term disability expected premiums. And we get the loss ratios from the actuaries. Insurance industry actuaries.

So this table shows the short-term disability premiums as a share of Social Security wages but we have three sets of columns -- one for all firms. One for firms with 1 to 50 workers at and one for firms with over 5000 workers.

For the rows we have a total row as well as a row that corresponds to a low EL WR category -- and high EL WR category.

You can see that across the categories, small firms have -- will be paying the highest premiums. For example in the medium EL WR category small firms -- the premium of 2.2% of their wages whereas large firms pay 1.4%.

If you look at the high yield of you are category the contrast is even more dramatic as they're paying an average of the premium going up to 20% relative to 18% for all firms.

And finally this shows distribution distribution -- distribution and dispersion of EL WR and BL Debbie are. It shows the benefit liabilities that details relative to medium and allows us to compare it -- the difference across the statistics that we have created.

And that we see that at the upper table the dispersion of EL WR is dramatically less than the dramatic -- dispersion of EL WR -- BL the rear. So the 90th percentile we have a dispersion of eight point I can see it -- sorry -- 6.6 compared to 13.4. And at the 95th percentile we have a dispersion of -- on the EL WR of 9.4 as compared to over 28 four BL WR.

With this shows us is that the variance of the distribution of benefit liability is less for EL WR which is the firms that find themselves with relatively high benefit liabilities.

So to conclude, if it did against minority of firms have a relatively high benefit liability to age ratio these firms tend to be small and main playmate temporary or part-time or low skill workers. And for these firms, the burden of internalizing these costs is going to be quite high.

So keeping that in mind, we see that policymakers need to consider the potential fax of such proposals that internalize each cost codes it can disproportionately affect the current firms.

Thank you.

Thank you David. Right now on schedule -- thank you very much David and I would like to college are funding to the FSA DRC and also my collaborators rock -- collaborators.

[Indiscernible] Miller Dennis [Indiscernible] are here with me today. Our data comes from a national multi-case study conducted in the late 1990s early 2000 called the employment intervention demonstration program. It was funded by the substance abuse and mental health administration and connected in eight states, Maine, Massachusetts, Maryland, Pennsylvania, South Carolina, Texas and Arizona.

And in that study people -- the people psychiatric his abilities were recruited from the top programs. 1455 were randomly assigned to receive evidence-based doctor supported in a Plymouth services or to a control condition.

They were followed for two years, employee -- employment was tracked weekly and the planet was tracked on a monthly basis and subject were interviewed I -- biannually.

During the study time, 2086 jobs were ended by 892 workers. And these jobs comply for job separation that were analyzed in the research.

We is the Bureau of Labor results definition with the labor turnover survey. And with the voluntary versus involuntary separations with involuntary separations characterizes

And involuntary separations characterized by one of three ways -- firing, the ending with every job and layoff.

The policy significance here have needs for stability employment ability in order for them to achieve and penance from public benefits talk

Return to work process avoided separations for all reasons except to quit and in order to assume a higher paid vision at at least as the formal way that we understand the process.

Here we see that the majority of job endings -- this is 9% white -- meaning that most separations in this study were voluntary.

Firings comprises 70% of all job separations. The end of temporary position comprised of 14% of all separations. And layoffs comprised of 10% of all job separations.

An average of two jobs per worker but only to fit the workers held only one job or he this 24 month time. The large majority of the time jet -- jobs paid minimum wage or higher than average wage of $5.77 an hour. To refresh everybody's Emory -- everybody -- minimally truck that was $5.60 an hour.

Most were in service occupations were clerical in sales occupations. This price 70% -- of all jobs.

A third of the jobs were obtained by use of formal job placement and two thirds were found by the worker -- on his or her own.

Rehabilitation all service providers within responsible for a third. Half of all jobs were worked 20 hours a week or more. And have lasted two months or less.

So much of the employment of the study is relatively short-term and much was her time.

Reasons for job separation was measured using a checklist of reasons with the primary reason indicated by the service provider or the program staff.

Here we stop quite different reasons for which versus firing. That that here we have just limited the involuntary separation requirements only because the other involuntary separation like layoff and ending a temporary job do not really correspond well with some of the other job endings.

The most common recent requests are job satisfaction. That is the orange plate. Here because workers were to set aside with pay or benefits, their working commissions, the work -- relationships with coworkers or supervisors. This accounted for 34% of all job satisfaction. But only 60% of firings contributed to the workers job satisfaction.

Another common reason for quick is related to the workers psychiatric condition this is the yellow plate. Here where referring to the percent [Indiscernible] at the job -- they are being psychiatrically hospitalized. Problem with the medication that perform the job, etc. And that reason accounted for 20% of all clicks but only 30 -- 13% of all firings.

Countering the notion that many people with mental health are fired because of their condition.

The most common reason for firings is psychiatric -- low job -- performance.

Only 60% of output. Some people did indeed quit their job because they were performing poorly and sometimes that is a hedge against being fired.

Third most common reason for quick -- are [Indiscernible] new jobs -- that is the goal plate. That is the only one considers the eight positive one and of course this did not occur at all in separations due to firing.

Lack of access to the job -- that light can take is due to issues such as tradition or problems with Goodling difficulties. 12% of all with or 2% of all firings contributed to this reason. And finally the workers concern over loss of benefits -- is a ground plate -- this was a concern about reduction in training due to work or loss of [Indiscernible] for SSD I -- reasons for only 12% of quit and 1% of firing.

One planet is not shown on the plate is being fired from a job during the two-year period was significantly which will -- rely her -- related to subsequent firing.

We conducted a multivariable regression analysis with associations of voluntary separation. We were not it would have a multivariable analysis -- so we settled for waiting for the number of jobs held by respondents. We controlled the prior work history, diagnosis with schizophrenia or other disorders. Job tenure, beneficiaries or so so -- and fishery of this pocket on involuntary separations were more likely for low-wage jobs that you are those with the worker -- workers akin to the job on his or her own verses and arranged job system. Were job to which a reasonable job accommodation [Indiscernible] and for competitive jobs versus noncompetitive work such as sheltered work or transitional job training.

Is where explored the likelihood of disclosure of the workers with disabilities Junior employers -- the employers that occur only by the work of him or herself to the player or two by the service provider for the working service provider pocket without the majority of all jobs or 56% of all jobs where the employer was aware of the workers with the help disability. Used jobs involved voluntary disclosure tended to be more of a tenure. Lower wage and work fewer hours per week then jobs for disclosure had not occurred.

This disclosure was likely more [Indiscernible] for workers with job history -- or workers that have not had a job in the past five years. Disclosure was more likely for SSI and DI beneficiaries then non-beneficiaries. The disclosure was not associated with voluntary versus involuntary separation.

Finally wanted to look a phenomenon that requires disclosure of the workers disability and that is the granting of her request for reasonable accommodation. And here you see a 21% of all jobs have one more reasonable accommodation for the worker.

Most common reasonable accommodation was the schedule change. Followed by on-site assistance from the healthy professional other than a job coach. Followed by a job coach being in the work

setting. Another common reason was lowering the worker to take time off for medical reasons. And all of these were granted in more than 20% of all reasonable accommodations made in the study.

Less common accommodations were provision for transportation and employee she changes in the employees [Indiscernible]. Less common were taking breaks, job sharing, changes in the job environment -- additional training for the worker, changes in job staff. And all of these occurred in less than 5% of all reasonable accommodations grant.

Took a look at what was associated with having a reasonable accommodation granted and we found that jobs with reasonable accommodations were frequently ended in voluntary separation involuntary. They also had some job tenure that work for fewer hours and paid lower hourly salaries. Then those without reasonable accommodation.

I might close by mentioning some of the policy implications of the preliminary analysis. One of the major ones is a continuing challenge that workers keep -- keeping faith in employment that has a chance to reduce property and enhance their independence from public benefits.

Even the provision of evidence-based practice vocational rehabilitation models like affordable claimant result in lower wage, part-time short tenure -- and not the career launching appointment that we would like to see you the ideal.

Second -- finding that firing was related to later firing in the worker's career points to the importance of preventing both firing and the conditions that lead to firing. And remember the major condition leaving was poured job performance on the part of the employee.

Next they're finding that longer job tenure was associated with lower pay and fewer hours would support the findings for many years ago. And the work of Gunderson and his employees in the 90s. They found that injured workers actually paid for reasonable accommodation in the form of lower wages. This of course was not the attention of the 88 and the creating a reasonable accommodations. And the policy implication here that you need to be alert to this when formulating policies such as employer tax credit or tax rebates.

You need to design the policies [Indiscernible] for the markers [Indiscernible] as much as the workers did.

We also saw that job tenure was enhanced by disclosure and job accommodations that are about as she associated with lower pay and lower our hours -- and that's related to the point that I just made. Sorry about that. We also saw that a low percentage separations were due to benefits concerned I think that is something we all worry about. In the field of return to work model building. For workers incentive. Here I think this may be due to the fact that the lower earnings in the job 10 years that were held by these individuals did not come anywhere near substantial influence activity levels or even trial work period levels.

And finally saw that most jobs and involuntarily bike waiting due to low job satisfaction is psychiatric issues. And this point is the need for greater access for mental health care. And also the career building opportunities for education and training and supported education is the model that was developed to help people with psychiatric disabilities, to school and complete their 88 degree in important elements. But would have to approve the success of the approach. >> [Pause]

Todd Hunnicutt.

Thank you. I will be talking today about the experiences of tradition age youth with vocational rehabilitation agencies at and I would think and acknowledge my colleagues on this budget -- Allison Tompkins, Mara partners, Stephanie MacClade [Indiscernible].

So there are lots of reasons for better understanding transition process for youth with disabilities as they move from childhood to adulthood.

Particularly with guarding the towers that they have in the state rehabilitation system. The first motor transitions for this population improving -- improving outcomes in education outcomes. The second -- to be sufficient knowledge we don't know enough about what works best or transition what -- in terms of promoting out,. Especially in the rehabilitation context.

And third -- and I think this is something that is relatively on recognized or emphasized is the fact that we take off -- one out of every 33 -- is a -- [Indiscernible - low volume] trellis ages are aged 24.

So we have several research questions. The first one is how the state VR agencies vary in the way they serve youth? And the second is what to do state VR agencies used to serve youth in studies in Milwaukee through [Indiscernible].

Of course the first that he would looked at RSA K service records -- RSA K service records are individual level records of people who was her complete services for the agency.

And may contain information on graphics, on services received, on outcomes. Over the agency.

And bike, writing the data over multiple years or can identify accident at awards -- so we apply to use for this is disability in 2004 through 2006. Was supplement this information with additional data from the administration or the American survey pocket with developed three transition [Indiscernible] ratio -- in the prostate -- in the agency undergo -- the first is on application. And application ratio. For the application ratio would identify the number of individuals to apply through state agency. And compare that to a number of youth with disabilities the general population

In the community survey.

We next calculated services received -- and the proportion actually got to the white -- [Indiscernible - low volume] to the agency.

And the third appointment ratio in the services for portion close successfully in the DR -- are closed with the employment of, they were employed at the time the services.

And we have a working paper available on the web for the result.

So the slide summarizes the results of the study. That we find nationally a percent as -- of youth with disabilities applied to the VR agencies every year. And that makes things relatively small but over the number of years that number can get quite [Indiscernible].

We find a fair amount of state variations -- the lowest applicant ratio in the portion of all youth with visibility in the state with 4% in the number that we resolved -- and the number was [Indiscernible]

The service ratio nationally without a 56% of people that apply for services received the services. So the youth that apply or are found eligible for services -- date complete the individualized land from climate they start receiving some sort of services from the agency.

Nationally this embrace of the 6% to those who apply and we find a large variation on the state level. We went from 30% [Indiscernible] -- 1% to fragile.

In the final statistic -- number three is the employment ratio nationally 56% of youth that receive services closed each year -- not associated with service ratio but 40% with the state with the lowest ratio to 70%.

We can take three numbers of three ratios and apply them together and have a transition ratio and we do that because the nominators [Indiscernible] the ratios are the numerator of the others -- and by applying them together will begin in the sense of the extent to which people in its ability in the state apply for services, receive services and disclose employment outcome.

So nationally his number is 2.3 per cent in a given year. Supposed to receive services closer by Malcolm.

And State Senator. might arrange from 1% to the process -- [Indiscernible - low volume] our youth specific disabilities compared to the height 7% at I can show this graphic in two ways.

So the first figure -- the US map -- initially the state by [Indiscernible] in terms of summary transition. The highest summary transition ratio are shaded in dark gray. The states with the lowest score in the lowest for trial are [Indiscernible] [Indiscernible - muffled speaker] And the thick with this picture is there's a lot of geographic variation. For both the high and scores in the low scores. PC concentration [Indiscernible] in one area.

Here is simply a bar chart. It is hard to read. You may want to put your handout. And we wind up the states from highest to lowest in terms of the summary score. Summary ratio. You could see on the right-hand side -- Alabama, Delaware, West Virginia -- visit the states with the highest ratio. [Indiscernible] is a 1% greater than any other state. The lowest factor was Indiana, Washington, all those are below one of the statistics.

We want to turn to the second SETI. And so given that we have agencies that are -- relatively high scores and low scores on this metric, what we thought to do was take a stand -- sample of eight

agencies and tie to understand the profits that they use -- process that they use. With the state agencies by the which had relatively high ratios and three that had relatively low ratios. And we conducted interviews with 2 to 4 staff from each agency asking questions about the organization, the service they provide. The programs they offer to you disabilities and how they work with schools -- to understand broadly what states are doing and second whether there were some characteristics that differentiate relatively high scores.

The findings that I present here are preliminary and the final report is currently under review.

So very broadly we found that across the state agencies that we have collected, that they had a lot of similarities based on similar issues in the characteristics. And they each had collaborations with other agencies in the state. They had developed programs of other states of the programs were sharing funding or resources of some sort in developing programs for review in their state.

Second they were highly involved in their secondary schools. Not only with trying to identify you that apply for services but also sitting in on [Indiscernible] transition meetings in terms of just educating youth and families about what the vocational rehabilitation agencies offer at for the youth.

And all of them have programs that work or get it to youth. They all have programs specifically to help youth with the claimant that has some kind of data intensive self -- work experience and followed several challenges.

When they recognized that they can easily exceed the resources that they have. A lot of these agencies are [Indiscernible] as they are. Think about the size of the population and the services of this group and say yay or Section 508 or disabilities -- is really more -- quite a bit more with these agencies that [Indiscernible] services to.

But there is a lot of confusion -- to be some confusion about dinner syndicators they should be regarding how agencies work with transition age youth. And the framework that does not get counted in terms of their statistics because they're working with families and schools these individuals are not yet applicants at they are not completing services yet. Reconnecting the outreach activities.

And third, all of the states we interviewed at specific rooms for youth and it is interesting to see how small these programs are at in a year. So it is not a very big reach -- just a drop in the bucket or university services.

And taking to the next step to prepare agencies with high ratios with the flow ratios without you characteristics to differentiate them. And I will present for here.

One of the states with high ratios tended to be involved in statewide or local transition coordination activities. So by that I mean that either the state level or the community level there were -- that DR agency was at the table with the other providers and schools in the youth. To talk about the transition system more broadly -- how to improve it or more specifically on how to adjust the [Indiscernible][Indiscernible - low volume]

Second the agencies with high ratio talked about ways that they conduct outreach to youth out of school -- so you dropped out of school complete or you graduate from school when their 19 or 21 and the things that they are doing to conduct a reach to be used for things that partners with other agencies for the correctional system to walk -- talk with you -- those of you who have a mental health condition. And working with other agencies to serve the population sitting in or conducting a reach to community colleges. To people who are engaged in GED programs.

Third -- the states with higher ratios have a higher portion of their position to apply that before age 18 -- so they were getting you a disservice is a relatively early point when they were still in school settings rather than waiting until they graduated to buy them afterwards.

And finally these agencies have higher physician ratios are more likely to have programs for youth. Some of them have programs that were embedded in schools or the cook to do their. And they also have employment programs.

So in terms of limitations and caveats on the research I think with the first study it is important to understand the surveys for sucking problems in the state. Certain factors, affect the ratios that are outside an agency can control at with the resource limitations to serve everyone who is in need of services -- [Indiscernible - low volume]

And also is important that the fact that agencies have many demands and many different facets of roles they play in the role transitions. Relations -- uses one of those roles and even communities have to make a decision on how to allocate the resources.

So the second study -- other practices that we compare on a number of agencies -- and the number of perspectives -- are people that we talk with at the state agencies. That are extremely knowledgeable about an issue.

In a collusion we find large variation in transition ratios that are copulated. And there is a need for better federal items and measure to report on you -- and with the goals of the regarding how they serve you. And what should be measured publicly and how to create statistics that can be impaired across the state.

Fine there is a need for more rigorous commonality between agency policies and outcomes of change [Indiscernible] [Indiscernible - low volume]

Thank you.

Here is a link to the work [Indiscernible] that we have available.

Thank you very much Todd. I will target over to [Indiscernible].

Thank you.

I could talk about the work on effective programs -- just to provide some brief run of the seven mental supplementary children's program. This program a transfer payments to work families with disabled children. We spent about $10 billion a year on payments to 1.3 million children. That is about 10% of people living in poverty in the United States. So this is a large proportion of a hype policy organization.

There's been a recent increase in enrollment driven by mental conditions other than intellectual disability including ADHD, speech delay and [Indiscernible] spectrum disorder.

And the children share many characteristics with these broader outreach population's. So the vast majority grow up in single-parent households with very low income. These children have high dropout rates, higher at death rates and low lifetime -- [Indiscernible - low volume]

There's been a lot of policy debate around the SSI program at since it is welfare reform and it is heated up in the last few years. Just to summarize that on one hand they might think that transfer payments to the families that can help them care for disabled children. The SSI children's program also provide health insurance to children in a form of Medicaid although most children would qualify based on low income.

On the other hand critics of the program that -- argue that -- [Indiscernible] [Indiscernible - low volume] an argument that is get the most attention in the media is that the families rely on the child's disability to receive a relatively generous welfare check and they encourage perverse behavior to get that ability.

So they are medicating their children and necessarily to get them in the program, Jill -- parents should put their children out of literacy classes because they are afraid that if it shall do good in school they market the benefit.

So the -- extent of these are purely anecdotal but have some perverse behavior.

So the question that I ask of this paper is what is the effect of the SSI children's program on household earnings and unearned income, and on a long-term outcome of the enrolled children.

And to answer the questions, I use variation and continuing disability reviews, which are medical reviews that are used to verify that children are still medically eligible for the SSI program at

These medical reviews increase a child's likelihood of being removed from the SSI.

So the idea here is that -- if I could find the quasi-random variation -- and comparing the children to -- the children who do not get reviewed to understand the effect of the removal to the SSI program.

-- As I would take advantage of in a mistreated Ajit cut -- between 2004 and 2005. In the CDR's. And I mean identification strategy is the regression this community -- regression discontinuity and validity with this report and minutes relation of the variable. I also use several alternative eye dedication 70s for [Indiscernible] and those are consistent with the main [Indiscernible] [Indiscernible - low volume

I did, so the Social Security ministration I want to thank SSA for providing this data access.

I start with the supplemental security record for children which includes demographic and benefit information.

I then move that data to data on continuing disability youth. And children with the parents -- which allows me to link children to several household outcomes including parental earnings, rental disability application and [Indiscernible] and sibling disability applications.

So that is the extent of the evidence that I will say today. What I am -- I can -- based on the outcome I can see the adult outcome and -- including their earnings and application of -- [Indiscernible - low volume]

I'm also interested in making these children to data outside the Social Security demonstration and this will be my data plugged for representatives of federal agencies who are not here today.

[laughter]

But what I would really like to do is I think important question is the effect of SSI in educational achievement -- I am working on linking children to their education records.

Another import question to the extent would be awful to -- have at other SSI programs including [Indiscernible] -- and an important very -- a very import question is Medicaid enrollment and went back [Indiscernible - low volume]

-- [Captioners transitioning] . >> >>

This is a if I could find I could compare the review That is to which the child is the program, to given cash enter SSI for a given week. What I am plotting here is each of the children in the award wake -- week what you can say is that there is a sharp drop, at the fiscal year to. -- Fiscal year cut off. You are almost 100% likely to receive a review you are less likely to receive a disability rate get -- review. To demonstrate the children on either side of the cut off, they are exactly the same, the children on the left-hand side are likely to get PDR, -- CDER -- the -- CDR. >>Children's who receive CDER, -- CDRs, they spend less time compared to the children just of the right, of the cut off, just amount the -- of time that they spend it results in the reduction and the amount of money that their families receive kids on the left-hand side are more likely to be removed from the program, they're getting less money just to the right of that cut off. What I will do from here is shown that these kids are identical on either side, except areas discontinuity on how much time they're spending, to evaluate outcomes, the first outcome I will look at, is parental earnings. What this graph shows is that the laws of the payment results in a dramatic increase in parental earnings the parents of kids who get on just before the cut off, has significantly lighter -- higher learning then those that get on after the cut off. They are doubling their earned income and making up this lost SSI income. With earned income. I also find that the laws of guys -- laws of payment -- the laws of payment -- loss of payment. >>Then household children that get on just to the right of the cut off. Interestingly although the SSI discourage family disability applications, it does not reduce disability payments. This suggests that the law discourages

them from applying, but it is mostly discouraging them that would not be allowed on the program otherwise. -- Anyways. >>I see it is remarkable that this graph shows there are statistics that are different between the total incomes household, that loses the disability payment than those, that remain on the child program, the parents of the children who are removed, they are making up the loss of income in the earned income. >>I find that the margin is highly responsive to the loss of SSI payment, annual loss of the thousand dollars, to increase annual earnings to $600, this is higher than the estimates we have. In the current work we are exploring reasons for this large estimate, some possibilities include this population have a high cost of work because they have disabled children at home, it could be that it is very valuable that it is a guaranteed income stream. They are adapting to having payments in the past, when they removed the payment they want to maintain a steady stream of consumption. >>This appears to be for marginal applicants, in evidence I did not get to share today, I find that members apply for disability together, this shows the household level shocks in individual household shocks, this may be a parental job loss, and multiple members apply for disability together. It may be a shocker if they learn about the disability insurance and make apply together. 15% of SSI children have a parent or sibling who applies for either the I or -- DI or SSI, or they finally have a sibling or parent that applies. >>One important application -- implication, I find the earnings response is driven by income effect rather than substitution effect. What that means is that families that receive disability are reducing their labor supply not because they are afraid they will work -- that they will work more, but he cut his -- because generally we by more things we like, and less of what we don't like, they are just shifting, work incentive programs operate through the substitution market. By earned income, these incentive programs have low pickup rates come the finding that the families are reducing their labor supply not in response to marginal tax rates, but income level itself, may explain why these are not more successful. >>I want to stress this is positive analysis of the SSI program so far -- children's program so far. We cannot say anything about the merit based on this response it could be the case that it is good for families, and they are becoming more self-sufficient, but it could be the case that this is bad for families and children, they are leaving house -- the house to work, and leaving disabled children. >>To get a normal understanding, we really need measures of household well-being, and that is what I'm working on now, looking at the effective SSI on children outcomes, including earnings, when adult, and comparing children who were removed at a Gallagher age -- a younger age, versus this other issue. >>Thank you. >>David. >> There is a lot of information in these four pages by the authors, I was asked each of our integrated themes in these papers, it helps to put the idea in a wider context. First who is the interventions aimed at? Who is affected by the interventions? One you've heard about his families of young children, others before they entered DI, one integrated thing it seems to me, is an important one, the interventions are aimed a large part to portions -- to persons with large education. I will try to explain. I will try to explain why I draw this conclusion. In general, about interventions before people enter DI, it is not to be key -- got to be key. Let me just say a word or two about each of the papers. >>Just one word about what we just described, very early intervention of course, a well done analysis, this finding that if you take away $1000, a large part the earnings of the families is really quite striking. Now a caution that does come to mind, we have an intervention with income stream will continue till 18, and last -- unless the child's health improves. The question comes to mind, it is interesting to note what the effect is of the income on the health of the child as it perceives, you might think well G, -- gee, there will be an improvement in health -- just

to get back to education, here is a program that says single parents, well income parents, with children with disorders, in the education environment. To go down to what David Mann has talked about, the interventions to internalize the cost of DI increase of people who leave firms. I think it is really important, and very striking to me, that is thinking about these, which firms affected the most of this -- with this type of plan? The authors calculate the benefit to age ratio, they find that small firms, would play temporary part-time, low skill I would say, high turnover employees, and most highly effective by the program -- affected by the program. I do not know the answer, somebody may have thought about it and it is more, the program to employee more education, low skill workers to be affect the but effective at higher -- effective to be hired at these kind of positions. >>Now we will talk about the age and the experience with rehabilitation across the state. The one particular number that struck me, 56% of you receive employment -- unemployment. If they got to this level, [Indiscernible - low volume] it is clear to me what exactly works. Again the problems on more education, as described, jobs help people with psychiatric disabilities. I was aware of the quote, there our field of jobs in this study, that employees are moving on to other jobs. There is a lot of room for making it better. Again I think largely education deals with

jobs,

so it is news to me that all of the agencies are direct did or affected in particular persons with low levels of education. Actually this is seen to me, part of the reason I say that, education appears to me to be fundamental, an understanding DI participation, in future trends in DI participation. Just as I said before, if you want to intervene, education seems to be quite central. To remind us of why this is, it will just play out from these two sets of numbers.

DR participation, who retires through -- who retires through DI? Less than a high school degree, 26% retire through disability insurance. Those were the college degrees were about 5%. We know education is strong, it is also related to how and DI is related to women's health, dividing how the I will not describe how, describe how quintile of health, most retire through DI most have a high school degree 14% retire through DI, those with the college degree 5% retire through DI. This second set of numbers that we occur each relationship that I just described that is participation and education, each relationship are in part to education and employment. Again as an example, consider people in the age range 50 to 54, men first, 90% of men in these raids -- age range, 51% that have a high school degree are unemployed. It is more extreme for women, for women in this age range, only 45% of those with a high school degree. Each relationship between education and employment, are not likely to get better, because the DL -- DI, change in education , between skills and jobs and their requirements, will likely get worse. Finally, with the education suggests, two things that come to mind, the first is when men want to think about innovation to the education groups in general, in addition in place is the disability programs instead of these slice -- slices of people, they will target and appear to be different I think the appropriate long implications for DI and participation. In terms of education in general, it seems to me that if we do not change the resources we put in education, by education level,

thank you. >>Thank you David, and all the panel, I am going to follow the same format from this morning, this worked quite well, I will open it up to the pet -- up to the panel first to see if there are any responses to David's comments, and then we will open it up to the audience participation. Just raise your hand if the question comes in and I will call on you. We will turn it over to the panel to see if they have any thoughts. Thoughts on David's comment. >> Quickly thank you David for your comments, I agree that help comes are very important to look at, it is a broader point, that research -- in research we do not know very much about health, on a number of outcomes other than labor supply, in large part that is because of data constraints, one thing we could do is we could bring agencies together, and hopefully engage in more data sharing, it would result in a huge boom in looking at the effective disability on lots of important issues including health and education. >>Thank you, David for those comments, you almost sound like you come from the psychiatric disability field, that has gone under two changes one of which recognition today gave the go, many people with these disabilities have high orbit it is, they are unaddressed, -- then people without controlling disabilities. Regardless of that, ignoring the health of people because they have mental health disabilities, does not make sense. It is been taking quite a toll, the other is an increasing call in support of education. Acknowledging at the onset of mental illness being mobile -- more severe, they prevent people from finishing a high school or entering college and getting degrees. That is dooming them to entry level employment at the time that they come in. Jerk -- your -- >>Your comments are inviting related to the disability field. >>I have a few questions , let me see what the audience has to say before I asked my questions. >>David. >>David, MIT, it is directed to David Mann, the exercise you are doing is invaluable there is a lot of discussion about potentially getting people in turning disability and other countries have taken the lead in doing this they have seen a change, in the disability regime by making employers jointly responsible for disability professions, for the first two years, once a worker lames disability the employee or -- employer is responsible to develop a plan to take -- keep the individual in the labor force. People often refer to the Netherlands, they call it [Indiscernible], over 10% of the overage population resume disability benefits, so the proposals that are out there, suggest that this is one direction, not the only, as a way to prevent that kind of needless individuals, going to disability when there is opportunity in the market. Recognizing that it is risky, you make it too expensive to employers, if they have risk you could have the opposite effect, rather than keeping them employed you can prevent them from being employed. What those costs will be is fantastically important, they have been working in the dark speculating what the costs would be, I have in general questions about the results you have. I could not actually determine what they implied payroll cost would be on average relative to what we pay for disability? The median was .007, it was 5% is that correct? >>I don't think that it was that high on average. >>The reason that it is important to aspartame, employers only pay 1.8%, you are just calculating the first two years, let's imagine it is 5%. The system is underfunded severalfold, even if we look at these cost you would say well it would be so much higher for these employers, at some level it has to be paid or. If it is not being paid for out of the payroll tax, then the general revenue, we would not want to say this is too expensive simply on average of course it will be paid out of payroll taxes, that is the first point. I'm trying to get a sense of the scale that is important. The second point, is that the version you calculated, since the employer would bear all of the burden of those first two years, if a person goes on disability, you would take those disability payments that the workers receive and ship them back to the employer. -- Shift them back to the

employer. They would not cover the hundred percent first part of the cost, extreme onset disabilities like cancer, neoplasm, where there would be no replay or role, for the discussion that is an extreme version, the last comment, was -- >>David can I ask you to -- >>Sorry I will now rephrase. [Laughter] my question is taking these results, in some cases to extreme burdens of employers, how would you want to modify the formula that is used to disperse those burdens while providing incentives, if that will be your goal? >>Okay. How would I? Okay I think to get after point, when we started creating the formula to create benefit liability, we were applying what we seen in your proposal, and then [Indiscernible] daily, we have not put formulas to the data, we were just doing that you're right, we found that there is wide variation of the statistics we created, if I had to do it differently, the problem is I could do it differently and it could be worse. So I think that going back to the last point of the slide, the policymakers through the implications of these policies, I think that eight good -- a good first step is to use a series of formulas. To see how they change over various formulas. For example you said two years of liability complete liability for DI benefits, you thought was high, that it was applied across the board regardless of the condition. If you have an individual applying for benefits when they are 30, the liability is long enough maybe for somebody who is soon to retire two years is a lot. I want to -- I will not pick a specific formula, I repeat -- agree with you there are a lot of formulas here that they need to be looked at. >>[Indiscernible-speaker away from microphone] they assume that they have no effect and that does not really affect them. To keep the people employed you have lower cost, they may not happen, certainly the policy was to reduce the number of people going on long-term disability and enable people to stay. If data recurred -- occurred it would also reduce the burden. >>Thank you. Do we have a question back here? >>Thank you, Nora Gordon from Georgetown University. I've a question, great paper. Thank you for sharing with us today. I have one question with two reasons for asking, it is just one question [Laughter]. I'm curious and thinking about interpreting your results about who the marginal person losing eligibility from the CDER -- CDR , and will that response be the same from parents with children with more serious disabilities? In terms of the question raised, in what do we think about these parents working? Really it is a descriptive question in terms of who is affected by the changes in CDRs. >>I think that is a great question, to read about who is marginal charge here, I am able to break it down by diagnosis, what I found was surprising in particular, I find that mental conditions which have been a condition that has a lot of play in the media, are actually not over disproportionately represented in the children that were taken off CDR, the improvement of criteria, that demonstrator has to demonstrate the CDR , it is difficult to do that for mental conditions. For conditions taken off CDR include

neoplasm, respiratory conditions, those have very clear outcomes, a very good or bad outcome, people will grow out of their asthma, go into remission from cancer, they're very clear no situations. I have looked at parental response by diagnosis, or severity. It doesn't -- my samples are a little bit small for a lot of the conditions, does not seem that there are a lot of parents responding. >> Hi, with able Americans my question is to all of you, the question I have is have any of you from any correlation of your work between students who have IEP's, and those who transition to work, with a reasonable accommodation? What I'm finding as I him developing, and consulting, I'm getting phone calls from employers that say I do not know what to do with this kid that has come out of college and has had an IEP, having to take tests under time situations, this kid does not understand deadlines,

things like that? Has that come up in any of your studies? >>I know that is not something that it is sufficient information in the outcome, I don't know if you have more to talk about with that , the accommodation issue? >>No not in relationship to what you are talking about. >> Okay. >>Thank you, Cathy from budget priorities, my question is directed to Todd Honeycutt, I appreciate the work you are doing, when I was at CBO at the time, it was just astonishing how little information there was about access to the work we have. My question is, you found nationwide about 50 -- 56% of the youth got it from state to state, were you able to track outcomes for the youth who fought the are -- who fought VR and did not get it? >>The study data that we use is from the rehabilitation agency, the only outcomes they have are for individuals who go through the system, and close with an point in. We do not have the ability in the 9/11 -- in the 911 data, you can look at outcomes there, to look at the patterns of Social Security benefit receipt. That would be something that we could look at in terms of what you're asking for. >>Another question up front? >>I am from Florida, I want to direct this particular to Dr. Hunnicutt and Dr. Weiss, -- Dr. Wise, in the context to address the issue of how to prevent people -- young people, from transition from special education going directly into SSD I? I am not entirely sure that education per se, about your degree in the heavenly supportive environment -- heavily supported environment, I know several colleges that have specifically targeted students like this, you can get a degree in mass communications and be unemployable, if you can talk a little bit about how if you could design the ideal system, that would take the benefits from the child's improvement in a special education program, and make the best use of those as they enter into employment. >>About that question I think it is a good question, and thinking about what David Weiss talked about -- David Wise talked about earlier, with general information about youth in disabilities, once they leave secondary school, when they are in secondary school they are receiving reports. I think one question is whether the schools are geared in terms of specific services, there is a Prado -- there is a wide range, with system is for them when they leave school? There is a lot of gaps in that system, especially if you want to pursue additional information opportunity there is not a lot out there education is expensive, there is difficulty in understanding the post secondary education system. Tomorrow there will be a presentation about a colleague -- from a colleague of mine, various countries have providing services in transition, and what they have to offer, things like vocational support so that every you is not guaranteed but has access to support once they leave secondary schools. It is providing time-limited, so that they can afford to go to school and be supported in that way. And maybe some policy options there. Maybe people in the US may want to consider. >> First, I would like to answer the question, why we have to send more people to college, we have to send more to college to get degrees, [Indiscernible-speaker away from microphone] that is the short come in the US education system, from my view the best higher education is in the US, we have 6000 -- 600,000 students, I think that the problem from not requiring preschool education, from high school to work this is the vocational education system, a lot of kids are lost in the shuffle. With that sort of college Presser, -- tessera -- >>With that sort of plethora of education, I think that the future are not focused on vocational education, it is just to get students going to college, part of that is that the vocational schools are terrific, but in general the point here, the general answer is this transition from high school to work in your case, was for specific people. I think there are things to think about. >> I will get there in a second. >>I have a question, based on the findings for the panel, it goes back to the presentation, one of the things we hear over and over again especially about children SSI recipients

and their families, and the needs, I was wondering if you could say little bit more about who you are identifying, this captures not only in the population but the services and support, I wasn't so much surprised that you found that effect, I was wondering if you could comment on that? >>Yes, it is to Nora's question, the conditions to overrepresented it, it -- overrepresented, and underrepresented included century -- century -- sensory. >>They obviously are likely to remove kids that have lower severity conditions, when children enter the program they have a prognosis of how often they are getting disability reviews, CDRs are removing children who are supposed to get reviews more often. In terms of earning -- earnings, I don't know that there was any thing particular there about who was overrepresented, or underrepresented. >>You couldn't look at state factors or even age factors with the youth, is that right? I am more interested in state given, -- given. >>My samples are small, is there something particularly that you would be interested in the state-level? >>When you look at state DR -- VR services were low, I would be interested in the higher prevalence, even if you had to group them, had approximately 4 better service reports for their parents and the outcomes. >>Special-education? >>The second question I should clearly state whether or not there is a variation in CDER -- in CDR reviews? >>There is a variation in the numbers conducted by the state. >>You can conduct them high versus low. Thank you. >> George Washington -- my question is for David. I'm curious in running these firms by industry, if you ran it by industry and not size what that would look like? >>We do not have industry information addicted we would run that analysis. >>I would like to make a comment without a question. >>Sure comment. >>If it is before a question [Laughter]. >>With VR, and the population of people who did have successful case closures, it is long as -- as long as we have a system paid based on hours, other than successful outcomes -- what I'm saying the system proves your eligibility instead of presuming people are eligible and then proving that. At the end of the days sheltered workshop or that kind of environment, what is happening in the current system, they are deemed an eligible after six months, and then shoveled off usually at the -- for the rest of their lives. If they go in when they are 22, in terms of cost, as long as the system allows Medicaid to pay for people to go to -- and it is set up the way it is, they are able to be powered up -- paid out in those incomes we will not see a shift. >>I will comment on your comments. -- Comment. Based on this there is a lot of variation based on what they do, some states have a model like you talk about where they may outsource the vocational services, to a community rehabilitation provider, and they are only paying that provider based on the outcome. They are not getting paid for the hour of service, that is interesting. >>I'm sorry? >>That may be a different issue. Whether sheltered workshop is appropriate, I am not sure, nationally they are turned away from the workshop environment. >> Thank you. Gentlemen still exist [Laughter]. >>My question is for -8 -- my question is for Manasi, I am curious on any comments you can offer about headed -- head of households with two parents. Whether they were working prior to the CDR, some kids are in households that there is some work happening, in a related comment in addition to the outcome, it is fascinating to see if you are able to quantify that, anecdotally represented clients for many years, people -- many of them are children receiving SSI, what would be interesting would be the lost SSI, for instance the roof overhead or food on the table, is not the best thing you eluded to this, not necessarily equal, household income have been replaced dollar for dollar, what is happening for the family to stay together and the roof over the head. I would be interested in hearing your comments. >>I agree this is a positive analysis, it is very important, we cannot judge anything about the SSI program from this response, if you say it might be a bad thing for

children in the and if parents are working, you have to look at household well-being doubt turn -- that outcome and the long-term well-being. The vast majority of these kids are growing up in single-parent households, my sample is small when I look at two-parent households, for single-parent households the absolute increase in earnings is equal to the two-parent households, which means the percentage increases much bigger. There is a huge response in parents with children receiving SSI. >>Evidence -- [Laughter] actually you asked part of my question, is also to Manasi, had to thought about matching Medicaid data to your record? I think it can be done, you have learned a lot about the kids, and their health in the past, also whether there is an impact on healthcare they receive following the CDR. >>That is excellent we will get back to this point as well, I am trying to link SSA and CMS data, that is something that is possible I would like to do it. Unfortunately I do not see parental education, I do see parental earnings before the child in Sears -- injures SSI program, -- before they enter the SSI program. >> Michael D from the Institute for community of inclusion, this is from -- for Dr. Cook, you do have fans out here. I wonder if your data shows Association with the more positive outcomes like higher earnings, longer hours, job satisfaction, your final slides on policy implication, suggest some possible solutions to those issues. I'm just wondering if your data showed any correlations? >>Can you just say a little bit more about correlations with voluntary versus involuntary separations? >>Let's take that hours and wages first. To show it Association between job accommodations, voluntary disclosure, and on one hand the longer tenure, but also lower rages -- wages and fewer hours on the job. Is copied -- Congress true fix -- true? Longer hours, I'm not sure where you would come up with data showing higher job satisfaction, that was the most common reason for separation. It was voluntary quitting -- quit, I wonder if you had saw any association with the opposite? >>I think a lot of the associations I am seeing here, are difficult to tease out, in terms of cause-and-effect. I think really what I am seeing is an effect on which workers that are better off in terms of their illness characteristics and their previous work histories, they tend to be able to get higher paying jobs, work them for longer hours, not need accommodations. Not disclose, not get there jobs through agencies that start them off by revealing to them for years that they have disabilities, and so in a certain way they kind of Hoover above a lot of their return to work at 2:30, that we are talking about -- return to work activity, that we are talking about. They get a lot out of the program, they are not necessarily individuals that are him habit he DI -- that are inhabiting DI, and [Indiscernible] , does that make sense? There is a multilevel that came into this study, we have to be careful to say that reasonable accommodation cause people to have low-wage jobs. Those who need reasonable accommodations are associated with low wages, and low hours, the job satisfaction question is really unusual in our study because people are more dissatisfied with more demanding jobs. They were more satisfied with part-time jobs, lower paid jobs, it is very interesting, I think this has to do with the fact that a large number of these people that came into the study were not working. The first two years was a real attempt for them to into the labor market. >>My name is John Cregger from the the University -- I have a question for Dr. Cook. You talk about some things that are not generally talked about particularly psychiatric disabilities in employment, the other notion in terms of people finding jobs on their own is a component that not a lot of other studies have, into killer -- in particular to light up people -- a size the number of these who find their own jobs, you really and cover some things that are very unique. The question is related to the lack of satisfaction as a primary cause of job saturation -- separation. With people who quit. For individuals who are voluntarily separated. I quit my job and I

think I am being discriminated against in that job, some of the reasons why, I cannot provide them the reasonable accommodations that are required under the American disabilities act, I am wondering if you can find discrimination in the overall context of the study? >>Discrimination is understudied in this whole literature, I do not think it is just true with people with psychiatric disabilities, it does not appear in large data sets in the way that it is easily operationalized. I want to say that our job separation is in the eye of the beholder, what is the most important reason you lost your last job? Or quit your last job? We have data from people who are working with an individual , if we ask employees the reason, we would've heard something different. May be we would've found dissatisfaction was very high even among the fired folks. I want to caution people about our data in terms of this. I present data on the most important reason, there were secondary reasons that people could check off as well. We have not looked at that data yet, I think there is not just one reason that people separate. There is a lot of influences going on it is just difficult to tease them out. >>We have about five more minutes now. Are there any more questions? We will end with one last question in the back. >>Hello, Tresa from bring -- Tresa from brainwork. >>-- Has anybody had an opportunity looking at data come from -- coming from education system, that tracks specifically for special-needs families, the second is looking at what type of data coming from rich programs in different federal agencies, the programs that cover from pediatric to elderly, access to SSI, SSD I, unique data I think would be United States of agriculture, throughout every state they have very extensive offices with disability sustained in agricultural settings. >>I think those are good opportunities for research, it is always getting access to data and approval to the data. I've bear it -- have been very lucky in getting the data for trucking -- tracking these things, it is more difficult to get those kinds of agreements. >>I think this point it is maybe not directly to your question, but one of the things we found in addressing, and crying -- trying to create formula, other Federal programs and agencies for example for the experience rating, I did not go into detail about what we did here, we basically looked at unemployment insurance formulas. That the states were using to assign benefit liability for employment insurance, we applied those formulas to DI, if there is inspiration, that there are other programs that could be applied to the disability world. >>On that note, I would like to thank the panel for a great session. [Applause] -- we are back in session tomorrow at 9:45 AM, for check-in, 10 AM is the first panel for tomorrow. There are two panels. Thank you. >> [Indiscernible - multiple speakers] >>

[Event concluded]