Discussion of Interaction with Other Programs Proposals

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This discussion is a summary of the comments made by the discussant at the SSDI Solutions Conference on August 4, 2015 before chapters were made final.

This review summarizes three policy proposals intended to improve the interactions between Social Security Disability Insurance (SSDI) and other programs that serve people with disabilities. A common theme among the three proposals is that each describes a reform that, if properly calibrated, could improve employment outcomes, align incentives for service delivery, and reduce burden on the SSDI trust fund.

Burton and Guo

Workers who experience an injury on the job may qualify for both Workers' Compensation (WC) and SSDI. Burton and Guo motivate their proposal by identifying programmatic disincentives that shift costs from WC to SSDI. As one example, they cite state differences in the calculation of the benefit offset for dual entitlement cases. In most states, SSDI amounts are "offset" in most cases of dual entitlement between WC and SSDI, but 15 states have a "reverse offset" that reduces WC instead of SSDI.[1] Burton and Guo also note that the Social Security Administration (SSA) lacks procedures to ensure WC settlements include enough resources to cover future cash benefits.

Burton and Guo highlight three potential changes to address program fragmentations between WC and SSDI. The first is to simplify the offset provisions, including elimination of the existing "reverse offset." Second, they propose adjusting the calculation of WC liabilities to cover future benefits to SSDI beneficiaries following the Medicare Secondary Payer Act, which requires WC to cover medical costs in cases where a person is dually eligible for WC and Medicare. Finally, they propose a fundamental change to experience rating for the SSDI trust fund, modeled on WC experience rating.

A fundamental challenge in assessing the benefits and costs of these proposals is that it is difficult to define the overlap between WC and SSDI. For simplicity, consider two cases where the timing and severity of the workplace injury differs. In the first case, a WC claimant with a minor injury who, due to an unrelated impairment, transitions to SSDI several years later indicates no or very limited WC-SSDI program interaction. In a second example, a worker who experiences a severe work injury (e.g., paralysis) and enters SSDI immediately indicates a case where WC costs are being shifted to SSDI. While difficult to quantify the exact overlap, there appear to be opportunities to better align incentives between the WC and SSDI programs, particularly given state differences in the calculation of the offset. Three questions for future consideration include:

1. How should policymakers define and identify the overlap between WC and SSDI?
2. Would combining proposal components (e.g., offset and Medicare Secondary Payer) generate efficiencies, or do the alternative proposals function better independently?
3. How would experience rating be implemented, especially for small firms?

[1]The combined value of SSDI and WC are adjusted so that the total value does not exceed 80 percent of the worker's prior wages.

Babbel and Meyer

Babbel and Meyer motivate their proposal by highlighting the limited options for short-term income and work supports for people with disabilities. They argue that group disability insurance is a strong avenue for early intervention that may facilitate return to work. They note that approximately one-third of employers currently have this type of coverage, indicating an opportunity to expand to a much larger share of employers.

Babbel and Meyer propose to expand group disability through an automatic enrollment plan for employers with an "opt-out" arrangement. The opt-out provision would ensure the program is voluntary, while automatic enrollment would substantially expand knowledge and use of group disability plans relative to their current levels. They also suggest a public information campaign to further increase awareness of group disability programs and encourage enrollment.

Three general issues that could affect potential benefits and costs should be considered in expanding group disability plans, especially such an expansion's impact on the SSDI trust fund. First, the proposal does not address existing incentives for insurers to refer people to apply for SSDI when their injuries qualify for both group disability and SSDI. Without such a change, it is not clear that this type of expansion would necessarily lead to a decrease in reliance on SSDI as envisioned if insurers still have strong incentives to facilitate SSDI applications. Second, the demand for group disability plans might be limited for low-wage workers, particularly given their replacement rates in SSDI might be comparable (or higher). Finally, employers who offer these plans might be less likely to hire people with disabilities if these plans induce additional costs for employing people with disabilities. Three questions for future consideration:

1. Can insurer incentives be sharpened in ways to reduce burden on the SSDI trust fund?

2. Would group disability alter firm incentives to hire people with disabilities?

3. Who should pay for the information campaign: government or private industry?

Perriello

Perriello identifies potential gaps in the availability of health and long-term services and supports, such as behavioral health treatments and personal assistant services. He argues these gaps may negatively affect employment among people with disabilities. While some states offer Medicaid Buy-In programs to expand access to these services, nearly all of these programs exclude participation of workers with income above a certain threshold (albeit above the traditional Medicaid threshold), and some states do not have these programs. People with disabilities may also be able to deduct their out-of-pocket impairment-related work expenditures, including those for long-term services and supports, from their federal taxable income, but the usefulness of this provision is limited because it excludes some necessary expenses and because it is a tax deduction rather than a tax credit. The extent to which lack of access to long-term services and supports might impact employment and SSDI participation is unknown, and, as Perriello argues in the paper, difficult to estimate.

Perriello proposes three options to increase access to long-term services and supports among people with disabilities. First, he proposes a national Medicaid Buy-In program that would expand access to these services and supports in all states, with consistent eligibility requirements and coverage options. Second, he proposes the creation of a new program providing long-term support and services

coverage to working people with disabilities that would wrap around private health care insurance, which typically does not include such coverage. The combination of the first two options would increase access to these supports for working beneficiaries with a range of incomes above the traditional Medicaid eligibility threshold. Finally, he proposes a new tax credit that would allow individuals to out-of-pocket expenses for additional impairment-related work expenses including long-term services and supports, through a credit on their federal tax returns.

A general issue for the reforms outlined in Perriello is weighing the financial cost of these expansions, which could potentially be large for some states and the federal government, with their benefits. The costs are especially important if they represent new costs to state budgets, which could lead to strong political pushback. To illustrate the potential costs, the Massachusetts Medicaid Buy-In program spent $20.8 million providing personal assistant services (PAS) to workers with disabilities in 2012.[2] It is difficult to assess whether these costs are high relative to their potential benefits for work and SSDI, which are both difficult to estimate. The tax credit Perriello proposes would be relatively cheaper than the aforementioned Medicaid Buy-In expansions. Implementation of a tax credit would also be less of an administrative challenge because it could build on similar provisions already in the tax code. Three policy questions for further consideration include:

1. Is a national Medicaid Buy-In program politically viable?

2. What form should the tax credit take (refundable or nonrefundable)?

3. Is it possible to test the credit as a pilot within state tax systems to assess interest and costs before rolling it out nationally?

Summary

Each of the papers outlines an important program interaction or gap in the system serving people with disabilities that is part of a larger issue associated with program fragmentation in the supports offered to this population. A recurring theme in all of the papers is that many existing programs have unintended incentives that divert people toward SSDI as opposed to other options, such as shorter-term supports and employment. A challenge in implementing any of the proposals is the lack of an evidence base on how these reforms might operate, and uncertainty around who would bear the costs of their implementation. A lack of evidence indicates full-scale implementation of any reform could have potentially unknown adverse outcomes. Nonetheless, the gaps identified in the papers suggest a more proactive approach by policymakers to address the general issue of program fragmentation.

[2] See Gettens, John, Denise Hoffman, Alexis Henry. 2015. "Expenditures and Use of Wraparound Health Insurance for Employed People with Disabilities," Mathematica Policy Research, Washington DC.