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Chairman Coates, Ranking Member Maloney, and members of the Committee, it is an honor to be here with you today. The Social Security Disability Insurance (SSDI) program currently provides insurance against the risk of disability to more than 151 million American adults. This program represents an extremely important part of our nation's safety net as it protects workers and their families from the risk of a disability that prevents or greatly inhibits a person's ability to work.

Nearly 9 million adults received SSDI disabled worker benefits in September 2015 and total program expenditures exceeded $145 billion during the 2014 calendar year. SSDI recipients also receive health insurance through the Medicare program (after two years from onset of disability), with those costs financed by Medicare. SSDI expenditures exceeded program revenues by 26 percent in 2014 and as a result the program's trust fund is rapidly being depleted, having fallen from $215 billion at the end of 2007 to $42 billion in September 2015.[1] Recent projections from the OASDI Trustees' suggested that the SSDI trust fund would decline to zero in late 2016, though the recently passed Bipartisan Budget Act of 2015 should extend this until 2022.

As shown in Figure 1, enrollment in the SSDI program grew steadily from the late 1980s until 2013, with 2.3 percent of adults aged 25-64 receiving benefits in 1989 rising to 5.0 percent by 2013. This increase coincided with a reduction in employment rates among individuals with

[1] The ratio of SSDI trust fund assets to annual program expenditures fell from 2.2 to 0.3 during that period.

disabilities (Autor and Duggan, 2010). As this same figure shows, SSDI enrollment actually declined slightly as a share of the population from 2013 to 2014 after rising in every year since 1984.

In my testimony today, I will briefly summarize the primary factors that are responsible for the growth in SSDI enrollment since the late 1980s. I will then discuss some of the implications of this growth for the U.S. labor market. Finally, I will conclude by discussing the potential for changes to the SSDI program to increase employment and improve economic well-being among individuals with disabilities while also reducing the fiscal burden of the program.

Why Has SSDI Enrollment Increased?

One contributor to the growth in SSDI enrollment has been the aging of the baby boom generation. Individuals in their fifties and early sixties are significantly more likely to receive SSDI benefits than their counterparts in their thirties and forties. However, as the following table demonstrates, the percentage of adults receiving SSDI has risen sharply even within age groups.

Age Group	% of Adults on SSDI		% of Men on SSDI		% of Women on SSDI	
	1989	2014	1989	2014	1989	2014
25-39	0.8%	1.4%	1.1%	1.4%	0.5%	1.3%
40-49	1.9%	3.6%	2.5%	3.6%	1.2%	3.6%
50-59	4.3%	8.3%	5.8%	8.7%	2.9%	7.9%
60-64	7.8%	13.2%	11.0%	14.5%	5.0%	12.0%
25-64	2.3%	5.0%	3.0%	5.3%	1.5%	4.8%

Consider individuals between the ages of 50 and 59. In 1989, 1 out of 23 adults in this age group was receiving SSDI benefits. But by 2013, this had almost doubled to 1 in 12. The increase was similarly dramatic for adults in their forties and also substantial for adults in their early sixties and those between the ages of 25 and 39. Because of these age-specific increases, the aging of the population explains only about one-fifth of the increase in SSDI enrollment from 2.3 percent to 5.0 percent during the 1989 to 2014 time period. Put another way, if age-specific rates of SSDI enrollment had

remained unchanged from 1989 to 2014, the percentage of adults aged 25 to 64 on SSDI would have increased from 2.3 percent to 2.8 percent.

To be insured for SSDI benefits, a person must have worked in at least five of the ten most recent years. Because employment rates have increased among women since the 1980s, the fraction of women aged 25 to 64 insured for the program has risen as well, from 66 percent to 75 percent during the 1989 to 2014 period. This has also contributed to enrollment growth in the SSDI program and partially explains why SSDI has grown more rapidly among women than among men during this time period. But this factor explains just 12 percent of the rise in SSDI enrollment. Taken together, the aging of the baby boom population and changes in the fraction of adults insured for SSDI can explain only about one-third of the growth in the program depicted in Figure 1 from 1989 to 2014.

A more important determinant of the growth in SSDI enrollment since the 1980s is the liberalization of the program's medical eligibility criteria that occurred in the mid-1980s (Duggan and Imberman, 2009). As shown in Figure 2, there has been a substantial increase since that time in award rates (defined as the ratio of number of awards to SSDI-insured population) for mental disorders and diseases of the musculoskeletal system (e.g. back pain).[2] In contrast, award rates for neoplasms (cancer) and circulatory conditions (e.g. heart attack, stroke) have remained roughly constant. This shift is important because, as shown in recent research (von Wachter et al, 2011), the employment potential of SSDI applicants with these more subjective conditions is substantial and it is often difficult to verify the severity of these conditions (in contrast to cancer or heart conditions). Recent research by Liebman (2015) suggests that the rising incidence was the most important driver of the growth in SSDI enrollment since the mid-1980s.

A fourth contributor to the rise in SSDI enrollment has been the reduction in the generosity of OASI retired worker benefits. Individuals born in 1937 or earlier could receive 80 percent of their

[2] The figure shows that award rates for mental disorders declined significantly from 2009 to 2013 after a steady rise in the preceding years.

full retirement benefit if they claimed retired worker benefits at the age of 62. But as a result of legislation passed in 1983, this has gradually fallen to 75 percent for individuals born from 1943 to 1954 and will soon fall to 70 percent for individuals born in 1960 or later (with an associated increase in the full retirement age from 65 to 67 as well).[3] No corresponding changes were made to SSDI benefits and thus SSDI has become relatively more attractive financially. More specifically, SSDI benefits were 25 percent more generous than retirement benefits at age 62 for those born in 1937 or earlier but will be 43 percent more generous for those born in 1960 or later. Previous research demonstrates that the falling generosity of retired worker benefits has induced a substantial number of adults to apply for and ultimately receive SSDI, and this explains a substantial share of the growth in SSDI enrollment since the late 1980s (Duggan et al, 2007).

Another important driver of the growth in SSDI enrollment is the sensitivity of the program to economic conditions. As shown in Figure 3, applications to the SSDI program are highly responsive to the unemployment rate, with applications rising during economic downturns and falling when the economy improves. Previous research has shown that the SSDI program became more sensitive to economic conditions after the 1984 change in the program's medical eligibility criteria. Relatedly, individuals who lose their job or are unable to find a new job became increasingly likely to exit the labor force and apply for SSDI benefits (Autor and Duggan, 2003). Thus the program is to some extent serving as a form of long-term unemployment insurance for some workers, which is troubling when one considers the low exit rate from the program back into the labor force. In 2014, just 0.8 percent of recipients left the program due to improved health or to return to work.

A sixth contributor to the growth in SSDI enrollment is the rise in replacement rates for the typical low-skilled worker, which is caused by the interaction of two factors (Autor and Duggan, 2003). First, SSDI (like OASI) uses a progressive 90-32-15 benefit formula with "bend points" that

[3] Individuals born in 1955 can collect just 74.17 percent of full retirement benefits if they claim at age 62. This then falls by 0.83 percentage points per year until reaching 70 percent for those born in 1960 or later.

increase each year with average earnings growth. Second, earnings for low-income workers have grown more slowly than the average, and as a result workers replace an increasing fraction of their earnings at a 90 percent rate rather than a 32 percent rate. This has increased the financial incentive to apply for SSDI benefits and subsequently the enrollment in the program.[4]

Other factors have also contributed to the steady rise in SSDI enrollment since the late 1980s. Individuals who are initially rejected when they apply for SSDI have become more likely to appeal those decisions and are increasingly likely to be represented by a lawyer or other professional if/when they ultimately appear before an administrative law judge.[5] Meanwhile, the fraction of recipients receiving a continuing disability review and exiting the program for no longer meeting SSDI's medical eligibility criteria has also been lower in recent years.[6]

The steady rise in SSDI enrollment shown in Figure 1 has slowed down recently, with a decline actually occurring from 2013 to 2014. This is partly because the effect of an aging population has now "run its course", with the oldest members of the baby boom cohort reaching Social Security's full retirement age (and thus converting to retired worker benefits). Additionally, the fraction of applications resulting in an SSDI award has been declining, with the ratio of SSDI awards to SSDI applications in 2014 at its lowest level (32.2%) in the history of the program.[7] This appears to be at least partly driven by much lower award rates by Administrative Law Judges, who consider appeals from those whose SSDI applications have been rejected twice. A report by the Social

[4] Additionally because wages for low-skilled workers have grown more slowly than the average, their average indexed monthly earnings tend to be higher than current earnings. This has further increased the ratio of potential SSDI benefits to potential earnings.

[5] In the average year from 2000 to 2008, administrative law judges made awards in 72 percent of their decisions (SSA, 2012). This is striking when one considers that ALJs consider appeals only among those rejected twice previously by SSA. One potential contributor to the high award rate is that SSA is not represented at the hearing – only the applicant and/or his/her representative are typically present with the ALJ (Autor and Duggan, 2006).

[6] The contribution of health changes to this enrollment growth is difficult to assess. On the one hand, mortality and morbidity rates have declined substantially for non-elderly adults during this period. On the other hand, recent research suggests that health has deteriorated for certain groups. In a recent paper, Case and Deaton document a substantial increase in mortality rates among white non-Hispanic men since the late 1990s (Case and Deaton, 2015).

[7] This is not a perfect measure because awards in one year may result from applications in previous years. Preliminary data for the first 3 quarters of 2015 suggest that the award rate will be even lower this year, with the ratio of awards to applications slightly below 32%.

Security Advisory Board's Technical Panel demonstrates that more recently hired ALJs have substantially lower award rates than their predecessors (TPAM, 2015). Furthermore, award rates among ALJs hired in 2005 or earlier have also been falling substantially. These changes suggest that the medical eligibility criteria for the program have become stricter in recent years.

A third contributor to the slowdown in SSDI enrollment growth is that the fraction of individuals insured for SSDI benefits has been steadily declining (or growing more slowly) in recent years. To be eligible for SSDI, an individual must have worked in at least five of the ten most recent years. For example, the share of men in their forties insured for SSDI fell from 90.3 percent in 2000 to 85.2 percent in 2014, and this will mechanically reduce inflows to the program. And finally, the improving labor market has – as shown in Figure 3 – resulted in fewer SSDI applications and thus a lower flow of new recipients into the program.

Labor Market Effects of the Rise in SSDI Enrollment

While providing valuable insurance to tens of millions of Americans, the SSDI program reduces the incentive to work both for individuals on the program and also for those applying for SSDI benefits. In order to receive an SSDI award, a beneficiary must be deemed unable to engage in substantial gainful activity (SGA, currently $1,090 per month). Once on the program, an SSDI recipient has little incentive to return to work, as earnings above the SGA threshold will lead to a termination of benefits. Given that the present value of the average SSDI award is about $300,000 (including Medicare benefits), that is a risk that many SSDI recipients would be reluctant to take (Autor and Duggan, 2006).

The growth in SSDI enrollment has coincided with a substantial reduction in employment rates among individuals with disabilities. For example, from 1988 to 2008, the employment rate of men in their forties and fifties who reported a work-limiting disability fell from 28 percent to 16

percent while the corresponding rate for men without a disability rose slightly from 87 to 88 percent (Autor and Duggan, 2010).

Previous research has shown that workers have become increasingly likely to respond to adverse labor demand shocks by applying for SSDI rather than seeking a new job (Autor and Duggan, 2003). This serves to reduce both the unemployment rate and the labor force participation rate below what it otherwise would be. It also reduces the eventual employment rate as SSDI recipients rarely leave the program to return to the workforce. For example in 2014, only 0.8 percent (8 out of 1,000) of SSDI recipients left the program for improving health and/or to return to work.

This responsiveness of the SSDI program to economic conditions can be seen visually in Figure 3, with increases in the unemployment rate leading to large increases in the SSDI application rate. An examination of this application data suggests that there have been substantially more SSDI applications since 2008 as a result of the economic downturn, with the application rate declining with the unemployment rate during the past few years. Many of these recent applicants have withdrawn from the labor force, either because they have been awarded SSDI benefits or are still in the process of applying given the long lags in the process (especially at the appeal stage). Still others have likely withdrawn because their attachment to the labor force has declined during the application process (even if ultimately denied) and thus their potential wages as well.

The steady increase in SSDI enrollment since the late 1980s has contributed to a differential decline in labor force participation among both men and women in the U.S. relative to other industrialized countries. For example, the labor force participation rate declined by 4.7 percentage points (from 93.4% to 88.7%) among men 25-54 in the U.S. during the 1990 to 2011 period while falling just 1.5 percentage points (from 93.6% to 92.1%) among the EU-15 (OECD, 2013).[8] Similarly while the labor force participation rate was almost unchanged among women 25-54 in the

[8] These differences are even larger when focusing on men between the ages of 25 and 64 and are somewhat smaller when restricting attention to the 1990 to 2008 period. Declines in labor force participation among men aged 25-54 were also much lower in Australia, Canada, and Japan than in the U.S. during this same period.

U.S. from 1990 to 2011 (rising slightly from 74.0% to 74.7%), it increased by 14.8 percentage points (from 63.7% to 78.5%) among women in the EU-15 during this same period. Thus labor force participation rates for both men and women in the 25-54 age range were in 2011 substantially higher in the EU-15 than in the U.S.[9] Perhaps even more striking, the labor force participation rate in the U.S. is currently at its lowest level (62.4%) since October 1977. The corresponding participation rate a decade ago was 66.1%. While there are of course many factors that influence both the level and the trend in labor force participation, previous research indicates that the SSDI program is an important factor (Autor and Duggan, 2003; Maestas et al, 2013; French and Song, 2014).

Improving Work Incentives in the SSDI Program

The disability determination process that is currently used by the SSDI program awards benefits to individuals who are deemed unable to engage in substantial gainful activity. This reduces the incentive to work among those who have filed an initial application for SSDI and among those appealing a rejection. In recent years, nearly 40 percent of SSDI awards were made on appeal and the time between the initial application and the ultimate decision is substantial for this group.[10] For example, the average lag for an applicant who appeals to an Administrative Law Judge (ALJ) is 27 months (SSA, 2008). This is problematic because those initially rejected are likely to be in better health on average than those receiving an initial award, and thus likely to have higher employment potential. And the longer that a person remains out of the workforce, the more their earnings potential declines. Therefore even if an applicant never receives an SSDI award, the program's application process can permanently harm his/her employment prospects (Autor et al, 2015).

[9] The labor force participation rate for men in the U.S. aged 25 to 54 declined further to 88.4 percent by 2013 and for women in this same age range fell to 73.9 percent.

[10] According to SSA's Annual Report on the SSDI program, there were 968,744 awards for SSDI applications filed in 2010 (most recent year with more than 98 percent of decisions finalized at the time of publication). Of these, 61,885 received an award at the reconsideration level (appeal #1) while 298,170 received an award at a hearing (or subsequent) level. This represents 37.2 percent of awards. Given that 52,111 applications were still awaiting a decision on appeal, the actual number would likely eventually be closer to 40 percent. For example if half were awarded then the share would increase to 38.8 percent.

One way to improve incentives in the SSDI program is to intervene sooner for individuals with work-limiting conditions so that they can continue working. Many individuals with more subjective disorders – such as back pain – could benefit from such early intervention. In a recent paper, David Autor and I proposed adding a "front end" to the SSDI system that would include early intervention through rehabilitation and related services with the goal of keeping workers with work-limiting disabilities in the labor market (Autor and Duggan, 2010). Employers would contract with private insurers to administer this coverage and would have a financial incentive to keep their workers off the SSDI system (much as the Unemployment Insurance and Workers' Compensation programs provide employers with these types of financial incentives).

The payoff to keeping a potential SSDI applicant in the workforce is very high. The average present value of an SSDI award (including Medicare expenditures) is approximately $300,000. Additionally, to the extent that the program reduces employment, it also reduces tax revenue and GDP. While many awarded SSDI benefits are completely unable to work, previous research makes clear that a substantial fraction could work (Autor and Duggan, 2003; Burkhauser and Daly, 2011; von Wacther et al, 2011; Maestas, Mullen, and Strand 2013; French and Song, 2014).

Increasing employment among individuals with disabilities could improve their economic well-being and increase their autonomy while also reducing the fiscal strains on Social Security. Past efforts to achieve this goal have unfortunately had little impact. For example, the Ticket to Work program, which was authorized by Congress in 1999, allowed SSDI recipients to have a trial work period of 9 months during which they could retain their benefits. But takeup of the program was close to zero, perhaps because these incentives arrived too late after most SSDI recipients had been out of the labor force for years. Recent efforts to increase work incentives among disability insurance recipients have had some success in other countries (see Kostol and Mogstad, 2014 for evidence in Norway). The Bipartisan Budget Act of 2015 gives the Social Security Administration authority to

fund demonstration projects that may alter work incentives and provide evidence about the effects of potential reforms to SSDI on employment and labor force attachment among recipients.

There are other potential reforms that could improve the functioning of the SSDI program. For example, currently only the applicant and his/her representative are present at appeal hearings before ALJs. Thus SSA does not have someone present explaining why they rejected the application twice and this may partially explain why about 70 percent of those initial decisions that appeal a second time are overturned by ALJs. Additionally, there has been a substantial decline in recent years in the share of SSDI recipients receiving a continuing disability review (CDR) with this partially explaining the lower exit rate from the program (SSAB, 2012). Careful consideration of the appropriateness of the program's medical eligibility criteria also seems warranted given the major shift in the conditions with which individuals qualify for SSDI benefits as shown in Figure 2. And to the extent that economic (rather than only health) factors are considered when making an SSDI award, one could consider a form of time limit or a mandatory CDR for certain awardees.

The lack of progress in improving work incentives in the SSDI program stands in marked contrast to the Temporary Assistance to Needy Families (TANF) program. Reforms introduced in the 1990s (along with expansions in the Earned Income Tax Credit) led to substantial gains in employment among past, current, and potential future TANF recipients and to a steady drop in program enrollment and expenditures. Based on my own research and that of many others, I believe that similar progress is possible within the SSDI program. The pilot programs funded by the Bipartisan Budget Act have the potential to provide useful evidence about the effect of improved work incentives on earnings and return-to-work among SSDI recipients.[11] Additional evidence is also needed about the effects of other potential reforms to the SSDI program on the health and economic well-being of current and potential future SSDI recipients.

[11] To realize this potential, it would be important to design any pilot so that both a treated and control group are included. This would allow researchers to separately identify the effects of the incentives from other factors.

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Figure 1: % of Adults 25-64 Receiving SSDI Disabled Worker Benefits: 1957-2014

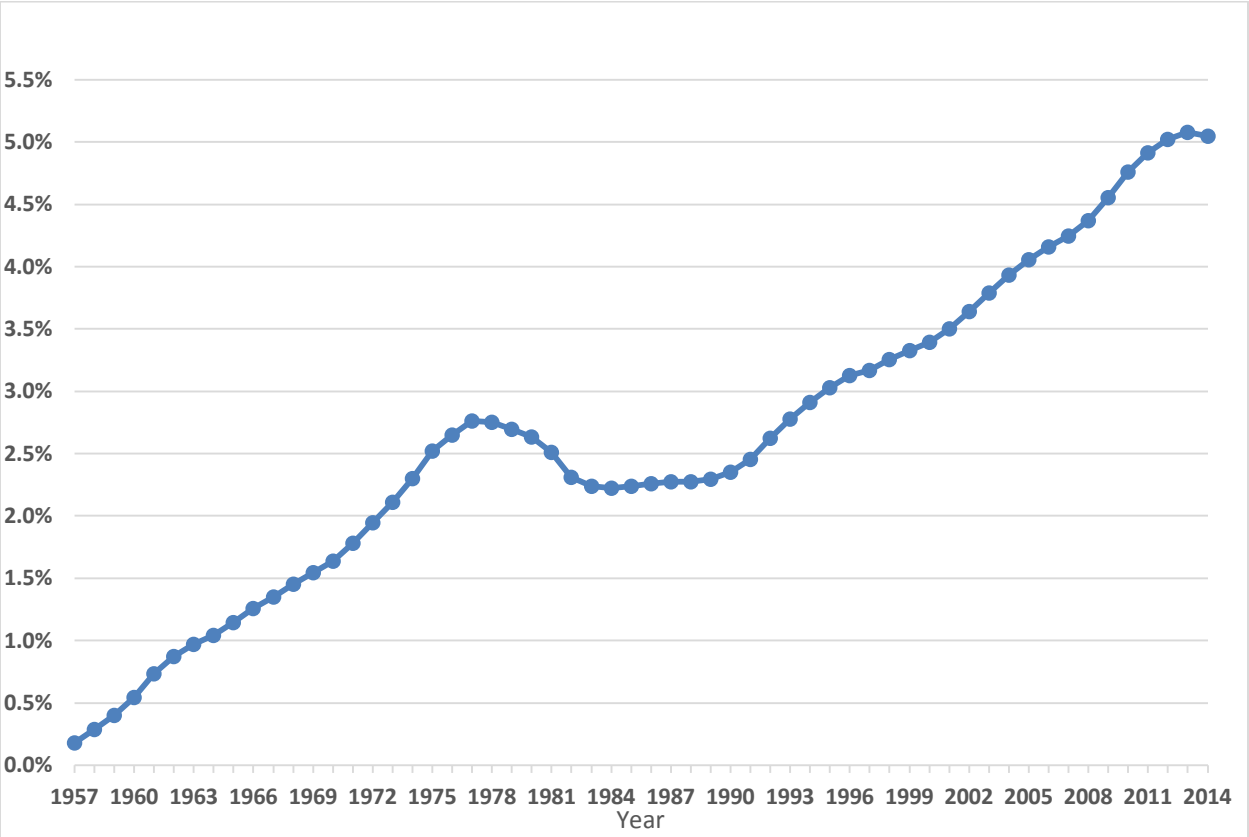
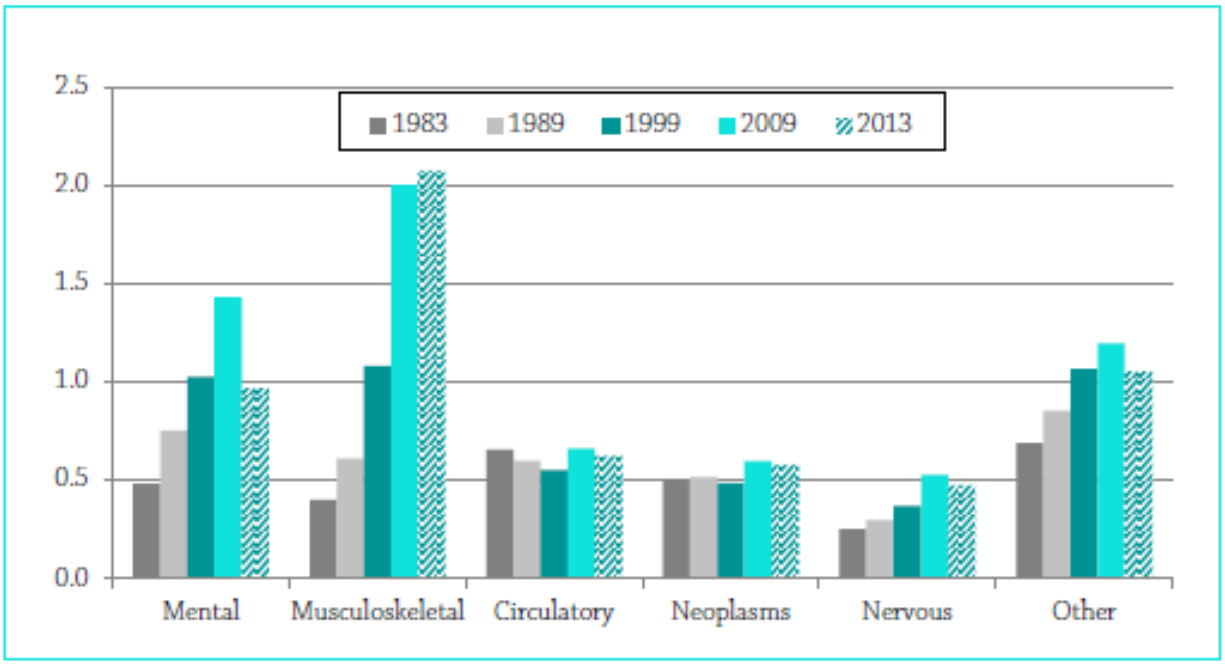


Figure 2: Awards per 1000 Insured for SSDI by Diagnosis Category in Selected Years



Source:Social Security Advisory Board. 2015 Technical Panel on Assumptions and Methods.

Figure 3: SSDI Applications per 1000 Insured Workers and Unemployment Rate: 1985-2014