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Abstract:
The disability system in the United States spends approximately $120 billion a year to keep millions of working-aged people on poverty-level stipends while essentially banning them from working. A reinvented system would focus on moving people from dependence to independence with flexible vocational rehabilitation vouchers, work-oriented assessments, and simple rules that guarantee that nobody would ever be made worse off by working. A problem with creating a system that combines work and partial disability benefits is that it may attract new entrants onto the disability rolls. A key insight of this proposal is that these generous work incentives can be tested on the current six million working-age recipients without inducing entry that raises costs.

Reinventing Disability Policy

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ABSTRACT

The disability system in the United States spends approximately $120 billion a year to keep millions of working-aged people on poverty-level stipends while essentially banning them from working. A reinvented system would focus on moving people from dependence to independence with flexible vocational rehabilitation vouchers, work-oriented assessments, and simple rules that guarantee that nobody would ever be made worse off by working. A problem with creating a system that combines work and partial disability benefits is that it may attract new entrants onto the disability rolls. A key insight of this proposal is that these generous work incentives can be tested on the current six million working-age recipients without inducing entry that raises costs.

The disability system in the U.S. spends over $120 billion a year, yet most people who receive benefits from it consider it a failure. This attitude is understandable because the system typically pays stipends near the poverty level, but makes work not only not pay, but just short of illegal.

Every American, including the able-bodied, has a large stake in the disability system. Most directly, everyone who lives long enough will eventually have numerous physical impairments.

In addition, the disability system in the United States is exploding in costs and reducing work incentives for millions of Americans. Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) for the low-income disabled now have over 6 million working-age claimants, double the number in the early 1980s. The Social Security Administration predicts that with current trends the rolls will more than double again in the next decade, largely due to an aging workforce and rising retirement age for Social Security retirement pensions. To put these figures in perspective, the disability system costs more than the welfare system in the U.S., even though the latter is much more controversial. (This statement counts the means-tested programs for disabled people as both disability and welfare programs.)

To understand the disability system, consider the programs an injured worker encounters after a work-related injury leads to long-term disability.

A newly injured person will need to prove his or her disability a number of times. Many of these "proofs" will use a different one of the 43 definitions of disability that appear in federal regulations, as well as different standards for workers' compensation and perhaps private disability insurance. Many of these definitions are needed: for example, temporary disabilities

have different consequences than permanent ones, and perceptions of disability suffice for someone to be discriminated against under Americans with Disability Act. Nevertheless, 43 definitions reflects a lack of coordination of services.

Workers' Compensation: After a waiting period of a week or so (varying by state), an injured worker is covered by state-run workers' compensation insurance. These benefits typically cover medical expenses and about two thirds of lost wages. Benefits last about six months in most states.

Workers' compensation insurance programs have several desirable incentive properties. For larger companies, insurers typically reduce insurance rates when injury rates decline. This experience rating provides employers incentives to reduce injuries. Some insurers give assistance to employers (often with some implicit coercion) to improve safety. In states that permit it, many large companies self-insure, providing them even stronger incentives to increase workplace safety.

The workers compensation system also has several severe problems. Rising medical costs, a large increase in claims related to stress and other hard-to-measure injuries, and rising time lost from work per injury, are increasing costs in many states. In a 1991 survey, small employers reported that workers compensation is their second largest problem, second only to the cost of health insurance (and ahead of low sales, high taxes, or burdensome regulations [National Federation of Independent Businesses, 1992]). Many workers must jump through many expensive hoops to receive benefits, and some are denied benefits when actually disabled. Conversely, some workers who are not disabled claim workers' compensation and then enjoy vacation or work another job, adding to the system’s cost.

Applying for SSDI: After six months, if the disability is severe, the worker is eligible to apply for social security disability insurance (SSDI). This social insurance program only covers workers who have worked roughly five of the last 10 years and who appear totally disabled. Applicant without a sufficient work history can apply for the lower benefits of SSI. Applicants with a long work history but low wages can receive benefits from both SSDI and SSI. After a two-year waiting period SSDI recipients receive medical insurance under Medicare, the same insurance program that covers recipients of old-age social security recipients. SSI recipients

receive health insurance under Medicaid, the means-tested insurance program that covers primarily people on welfare.

The process of applying for SSDI has several problems. Staying off the job six months and appearing sick enough to win SSDI benefits depreciates work skills, while the gap between the end of workers' compensation and the start of SSDI can lead many workers to poverty. Importantly, people may not be able to pay for rehabilitation services until they have Medicare of Medicaid, but in many cases early interventions will be the most cost-effective means of returning to work.

Delays in the application process can also often be substantial. In California, a disabled worker typically faces a 18-24 month delay after applying before receiving his or her first check. (States differ by a 3:1 ratio in average speed of processing a claim.)

The application process often works much like a lottery. On average, about half of all denials are appealed, and administrative law judges reverse almost half of the Social Security Administration's denials of SSDI benefits. (Administrative law judges do not follow the forty thousand pages of Social Security Administration rules on how to determine benefits.) Furthermore, some administrative law judges reverse 25 percent of the denials of SSDI benefits; other judges reverse 75 percent (Parsons, 1991). While not conclusive, such divergences (which also occur for other gatekeepers into the disability system) suggest both a lack of equity across people with similar disabilities, and a lack of accuracy.

Many truly disabled are denied benefits, and others who could work are given benefits. For example, John Bound provides evidence that many truly disabled are denied benefits, because the rate of returning to work of those denied benefits is quite low (1991). Conversely, Jonathan Leonard provides evidence some beneficiaries could work, because the increase in SSDI rolls has been paralleled by a decrease in labor force participation (1986). If applicants to the SSDI rolls were truly unable to work, expanded rolls should consist of people who were not working; it appears some of those entering the rolls would have been working if the SSDI system were less generous. Moreover, a number of studies (many carried out by the Social Security Administration) find that reexamination of SSDI determinations would reverse the initial findings, with reversals in typically one in four or five cases of both acceptances and denials. (Donald O.

Parsons reviews this evidence [1991].) Such studies do not show whether the initial findings are too lax or not sufficiently severe, but do indicate that one of those two cases (or both) must frequently obtains.

The rules for admission are quite outdated. Some diagnoses lead to automatic approval, even if new computer and other technologies make the impairment irrelevant for many jobs. Currently, about half of the U.S. workforce uses a computer at work (Krueger, 1993), and it no longer makes sense that physical impairments that preclude some forms of construction or industrial work are considered automatically disabling from employment.

The lifetime nature of the benefits also often makes no sense. If someone is clearly disabled enough to need benefits for the next year, for example, but is then expected to recover, the SSDI benefits are still granted as a lifetime benefit, although the file may be marked for early review. At that review, the Social Security Administration must attempt the disruptive and difficult process of taking away a lifetime benefit previously granted.

Some disabilities such as certain forms of depression are debilitating in the short run, but the work-related impairment can be controlled or eliminated with proper medication. Other conditions such as AIDS and some psychiatric disorders become more and then less severe over time. Many people cannot afford the medications unless they are classed as disabled and given Medicare or Medicaid, but these are lifetime programs poorly suited to the potentially temporary or recurring nature of the work-related impairments. Even worse, SSDI recipients must wait two years to receive Medicare benefits. (Medicaid benefits for SSI recipients have no waiting period. No policy reason exists for the difference.)

Other disabilities will never go away *medically*, but can stop being impediments *vocationally* with appropriate training or technology. Nevertheless, the standard for ending SSDI benefits requires medical improvement, not cessation of barriers to work.

Vocational Rehabilitation: After admission to the SSDI or SSI program as incapable of working, a Social Security Administration employee may determine the individual is potentially capable of working (using definitions that differ by state). The new enrollee's name is then sent to the state Vocational Rehabilitation Agency, and the individual is informed he or she is eligible for services such as physical therapy, equipment such as wheelchairs, and retraining. About one in 12

entering files is sent to Vocational Rehabilitation each year, yet Vocational Rehabilitation Agencies place only a tiny fraction of that number, often not even because of the referral (Berkowitz and Dean, 1996).

Vocational Rehabilitation is funded by over $2 billion in grants each year from the federal Department of Education to the states. Although this assistance is statutorily targeted on the severely disabled, almost none of those served are SSDI or SSI recipients, presumably because less severely disabled populations are easier to serve. Yet those on the SSI and SSDI rolls are precisely the ones with the largest social product and savings to the government from returning to work. (At the same time, their substantial disabilities may make it not cost-effective to try to return some on the disability roles to work.)

Although the Vocational Rehabilitation program is over 75 years old, no formal evaluation of its effectiveness exists. The existing evidence is scarce, but suggests that most vocational rehabilitation programs are of limited effectiveness. Only about one out of each thousand SSDI and SSI recipients become employed and leave the rolls each year with the assistance of state vocational rehabilitation agencies.

Work Disincentives: According to a recent Louis Harris poll, 79 percent of people with disability who were not working claimed they wanted to work. At the same time, SSDI defines disabled worker as an oxymoron: if you can work, even part time, you are not disabled enough to receive *any* SSDI. Anyone earning $300-500 per month for much of the preceding 3 years is at risk of losing SSDI. The result of this system is that only one half of one percent of the SSDI population exit the SSDI rolls for employment each year (Social Security Bulletin, 1993, p. 60).

SSDI typically provides an income below the poverty line. Nevertheless, individuals who work even a few hours a week are likely to lose SSDI, Medicare, eligibility for housing subsidies from the Department of Housing and Urban Development, and other benefits. If they take a job for a few years and then lose it, they will have lost their eligibility for all of these benefits, and must show their condition has worsened substantially since they first applied to re-establish eligibility.

Supplemental Security Income (SSI) is available to disabled individuals who do not have sufficient work history to receive SSDI, or whose SSDI leaves them with a very low income. The

number of disabled SSI recipients increased 49% between 1975 and 1991. This increase far exceeded the increase in disability rates in the population.

Unlike SSDI, SSI has some meaningful work incentives. Most importantly, SSI stipends decline by only fifty cents for each dollar recipients earn above a minimum level, in contrast to the over 100% benefit reduction rate for SSDI. In fact, there is an entire book describing the numerous SSI work incentives (Social Security Administration, 1995). Unfortunately, although I have a Ph.D. in economics, I was unable to follow much of the material in this book.

The Complex Web of the Disability System
(An Incomplete Summary)

Program	Agencies
Workers Compensation: Partial wage replacement for the initial months after a disabling work-related injury.	Varies by state. Typically the state, private insurers & employers are involved, with use of the courts for some appeals
Temporary wage replacement after partial disability	Some state workers' compensation systems; Some private insurers and employers.
Wage replacement after complete disability (if with a work history): SSDI	Social Security Administration & state-run Social Security gatekeepers Disability Determination Services. Independent Administrative Law Judges and federal courts handle appeals. Some employers and private insurers provide supplements.
Wage replacement after complete disability (if low-income or short work history): SSI	Social Security Administration & states, as with SSDI
Medicare provides some health insurance for SSDI recipients	Dept. of Health and Human Services Health Care Financing Authority and states fund the state-run Medicare systems. Claims processing by 80 HCFA contractors
Medicaid provides health insurance for SSI recipients	State-Federal partnership, with a core set of benefits and others that states can agree to cover (or not).
Vocational Rehabilitation	Dept. of Education funds state Vocational Rehabilitation Agencies. Social Security Administration funds can go to private providers
Job placement	Dept. of Labor funds state employment service. Also Vocational Rehabilitation providers
Job training	Dept. of Labor funds states that fund local Private Industry Councils that fund education providers; Dept. of Education funds state agencies that fund local Vocational Rehabilitation providers

Subsidized Housing	Dept. of Housing and Urban Development and states fund local Public Housing Authorities that own housing set aside for the disabled. Some recipients receive housing vouchers.
Holistic social service providers such as a local Center for Independent Living	Multiple Federal and state agencies as well as private funds from foundations and other sources.
Note: Most veterans, Native Americans, railroad employees, Federal employees, and many state and public employees have distinct systems that provide some combination of disability stipends, medical care, and vocational rehabilitation services. Many employees also have private insurance to provide many of these benefits, often supplementing those provided by the public sector.	

A Vision for Change

Several recent proposals focused on shifting the disability system from one that provides lifetime poverty-level stipends to one that helps people into the workforce (NASI, 1996; Batavia and Parker, 1995; GAO, 1996; World Institute on Disability, 1996). All of these proposals are consistent with a common set of goals for the disability system. First, nobody should ever become worse off by working. Second, the disability system should be both integrated and comprehensible. Integration requires coordination among gatekeepers and service providers in schools, rehabilitation services, health care, as well as integration among work incentives. Third, disabled people must have choices concerning and how to acquire needed assistance for employment. Fourth, service providers must be freed from detailed regulations, but must be accountable for results. Finally, the system must focus on people's capabilities and what help they need to function fully, not just on medical impairments. This list of goals is widely agreed on; the challenge is to find cost-effective proposals that satisfy most of them.

In spite of these common goals, the recent proposals differed along a number of dimensions. This proposal draws heavily on these ideas, but makes extensions to improve work incentives without induced entry; to create integrated work incentives, to improve the application procedure; and to improve incentives for reducing long-term disability in the first place.

A key problem with effective work incentives is that they are likely to raise the costs of the disability program, as new entrants are induced to apply for benefits. Millions of Americans have

some partial disability, and many would like to combine a part-time stipend with part-time work. (This induced entry is sometimes referred to as the "woodwork effect," as people come out of the woodwork to apply for benefits.)[1] Actuaries at the Social Security Administration are very concerned that reform proposals may lead to costly induced entry, potentially bankrupting the Social Security System. No policy for reforming the disability system is likely to be politically palatable unless it addresses the problem of induced entry (at least to the satisfaction of these important policy gatekeepers.)

People already on the rolls cannot, by definition, be induced to enter. This proposal differs from its predecessors by exploiting this simple fact. Thus, work incentives can be focused on current enrollees with little concern for induced entry. The experience of helping move a substantial fraction of the current population into employment (at least part time) should provide important lessons for creating a work-oriented system for new entrants as well.

Past proposals have also focused on the work incentives within the Social Security system. They have ignored that many disabled people receive subsidies and face work disincentives from multiple programs. This article proposes a simple integrated work incentive that ensures that disabled people always find that working leaves them better off than not working.

This proposal also differs from its predecessors by reinventing the disability application procedure to minimize delays while maximizing accuracy. The insight here is that unusually low rates of employment by applicants after they are rejected for a disability pension is an indicator of overly severe gatekeeping. Using post-denial employment rates as a benchmark, the Social Security Administration can determine combinations of gatekeepers and diagnoses that have low error rates, and permit these gatekeepers to approve applications with low levels of oversight. SSA staff would be reserved for the more difficult cases to decide and as back-ups for gatekeepers without successful track records.

Finally, this proposal differs from its predecessors by its more comprehensive view of the disability system. Past reform proposals typically have focused on a single element such as social security work incentives. In fact, disabled people may face complicated work incentives, assistance, and disincentives from up to a dozen separate agency. A coherent plan must create an integrated work incentive system. Moreover, an integrated system must create incentives to

reduce rates of injuries and illnesses, especially those that lead to job loss, not just systems to repair the damage at minimal cost.

For Six Million Current Enrollees: Make Work Pay

The work and disability systems described below provide incentives and the ability for the six million current SSDI and SSI working-age enrollees to return to work, and for new enrollees get a first job, a new job, or (best of all) to stay on their current job. Because current enrollees already have entitlements to lifetime cash stipends and medical care, almost any work incentives will save the government money. At the same time, generous work incentives can increase costs by motivating some people who want to mix part-time work with a partial stipend to join the SSDI rolls. Thus, for new enrollees it is important to dramatically alter the system to ensure all disabled people have the ability to work, without providing disincentives for work.

The system described in this section encourages those currently on the rolls to return to work. Because so few SSDI recipients currently return to work, these changes will save money as well as increasing the standard of living of those currently on the SSDI rolls.

Improving Work Incentives: SSDI and SSI could offer three forms of incentives to work that ensure nobody is worse off working than not working. The basic goals is ensure that the cash stipend and the value of the health insurance subsidy decline by less than a dollar each time a disabled person earns a dollar; conversely, they should rise back up if the disabled person loses his or her job.

The starting point is to provide a 50 to 60 percent benefit reduction rate for pay above impairment-related work expenses plus a minimum earnings threshold. (This is similar to the SSI work incentives ["Section 1619"], and unlike the current abrupt cut-off for SSDI.) This benefit reduction rate should include *all* income and payroll taxes and the loss of other welfare benefits (food stamps, housing subsidies, Temporary Assistance for Needy Families (TANF, formerly AFDC), state and workers' compensation disability payments, and so forth).[2] Current research shows some, but not enormous, work disincentives for total tax rates under 60 percent. For example, the current top combined rate of payroll taxes plus state and federal income taxes is

roughly 50 percent (varying by state), and medical doctors and most other high-wage professionals facing these tax rates typically work long hours. We should strive to keep the overall benefit reduction rate from rising much above 50 or 60 percent; eventually it causes more serious disincentives.

Maintain SSDI status for workers: Full-time work is risky for SSDI recipients because after a period of employment, reestablishing eligibility for SSDI is difficult. We could permit SSDI recipients to automatically retain the right to return to the SSDI rolls after employment ends, to promote reemployment without fear of losing a benefit stream. (An Extended Period of Eligibility exists for some SSDI enrollees, but is complicated, time-limited, and ineffective.)

Continue medical coverage: SSI currently continues Medicaid coverage with a sliding scale subsidy for two years; this benefit should be made permanent and a similar incentive provided for SSDI workers. After workers "earn off" their disability stipend, they should begin to pay for their medical insurance subsidy. (Because of the smooth nature of the phase out, only those who earn very high incomes or who have employer-provided health insurance will ever completely lose the subsidy, and even they will automatically regain it after any job loss.)

Ending the restriction of coverage for pre-existing conditions is key to providing effective health insurance for disabled individuals.

In addition to maintaining the option of retaining Medicaid or Medicare, people can have more choice concerning their health care provider. If a person has a disability that typically costs $5000 a year for the government, the person should be able to apply that sum to purchase private-sector insurance, or to subsidize the employer’s medical self-insurance, and so forth. (Alternatively, some portion of the funds could be used to purchase private-sector insurance, with the remainder retained for employing personal assistance.)

For example, in one pilot study the government gave disabled people who were members of the Kaiser Health Maintenance Organization before the onset of their disability the option of remaining Kaiser members. Patients must use Kaiser services, and the government covers medical costs that Kaiser does not pay. Results so far have been very positive, and very few people opt for Medicare alone. This pilot could be expanded to other regions.

More generally, SSDI and SSI recipients who begin working should be able to apply any full or partial company-provided health insurance toward buying their Medicare or Medicaid. Conversely, they should be able to mix the cash value of the subsidy they receive for Medicare or Medicaid to help pay for company-provided health insurance. Any system should be designed so if the employer of a half-time employee will pay half of a medical insurance policy, the health insurance voucher will pay the other half of the cost of the company's health benefits.

Vouchers for vocational rehabilitation: We should replace the state's monopolies on vocational rehabilitation services with a system of vouchers for the disabled to use to buy employment-related services. These vouchers would be flexible because people's needs are so varied. For example, some workers need therapy, others need adaptive equipment, others need specialized training, others need help at home, and many need combinations of all of these forms of assistance.

One possibility is to make the value of the vocational rehabilitation vouchers depend on the results such as job placement, wages and job tenure—most easily summed up by rewarding service providers with a portion of clients' earnings over several years. The value of the voucher to the service provider should be keyed to clients' earnings as well as employment, to reward services that assist clients in finding higher-paying jobs. Monroe Berkowitz has proposed a performance-related voucher in which the value depends on the savings the SSDI system realizes when a disabled person becomes employed (1996). Given that under this proposal the SSDI system's savings would also be proportional to earnings, the two forms of performance-related vouchers are quite similar.

The goal of moving to a voucher system for vocational rehabilitation is to provide more choice for the disabled. The needs of the disabled vary widely, and the means for helping them are often not well understood. We need a flexible system that rewards success to both experiment and evaluate those experiments in order to determine what works.

Importantly, the vocational rehabilitation voucher can be used by an employer or service provider to purchase adaptive equipment such as ramps or special computer interfaces, or as a wage subsidy if that is all employers need to hire a worker. As an added incentive for those employers who provide health coverage, the value of the Medicare of Medicaid coverage an

employee is eligible for can be applied to the cost of the employers' health care plan. Additionally, the voucher can be given directly to employers, acting as a wage subsidy to employers who hire the disabled. Such a subsidy could then be used by employers to defray needed costs of .

One problem with vouchers is often cherry-picking, where the easiest to serve are served first. Given the negligible movements from SSDI to employment, the program would at least initially have little problem with cherry-picking—any movement off of SSDI will save the government substantially, and will increase opportunity and living standards for SSDI recipients.

Even the most generous work incentives will not move the majority of current recipients off of the disability roles. Many are too near retirement; others are too disabled; while others will fear that any work experience will lead to future rule changes that will eliminate their benefits. Nevertheless, moving to a work-oriented system for those already on the roles should induce a substantial number of the current six million recipients to work. Importantly, these work incentives for existing recipients will not induce new entry -- a problem that plagues most reforms of the disability system.

For New Applicants: Work First

SSDI is designed to give lifetime income support to those with permanent and total disability. Changes in the workplace, technology, and society make a diminishing share of medical impairments lead to permanent and total inability to work. Thus, we should create a system in which demand for cash benefits due to permanent and total disability is minimal—instead, most people with medical impairments receive the help they need to return to work.

Because it is unclear how many people can return to work, it may make sense to phase in this new system for younger applicants. For example, the first version could apply to applicants under age 25. (Importantly, these applicants have the longest expected stay on the disability roles.) The goal should be to extend the work-oriented system over time to whatever groups are cost-effective. Evaluations should be built in to determine the effectiveness of the new program for different age groups and disabilities.

Reinventing Assessments: The medically-based disability assessments used by the Social Security Administration should be replaced by a vocational assessment. This assessment should determine what impairments inhibit employment, and what assistance will lead to employment.

The assessment should not be solely to determine benefits; instead, it should be joint between Vocational Rehabilitation Agencies, school systems (when needed to establish benefits under the Individuals with Disabilities Education Act), and the Social Security Administration. SSDI should drop its five month waiting period, to permit assessments soon after the onset of disability.

Gatekeeping and assessments can be greatly improved, simplified, and made more accurate using two tools: conditional deregulation, and ongoing analysis of Social Security Administration data on work histories of those accepted and denied benefits.

Conditional deregulation involves reducing the number of assessments for many cases where it is likely that re-assessment would not change the result. Specifically, the Social Security Administration should examine its records of millions of applications, and identify diagnoses which are relatively simple to determine, and rarely appealed or reversed. In these cases, a doctor's diagnosis and description of vocational impairments should suffice to determine eligibility (subject to random quality control audits). Some diagnoses may require a board-certified specialist's opinion. Similarly, any private-sector gatekeeper such as a doctor, clinic, or vocational rehabilitation service provider with a record of assessments that are repeatedly found to be in accordance with what Social Security determines should also move to a system of random quality control audits.[3] In this fashion, the Social Security Administration can focus its limited resources on difficult cases. At least as importantly, disabled people will have fewer appointments re-performing the same tests.

Analysis of data on work histories of those accepted and denied benefits can also improve the gatekeeping function. Some gatekeepers deny benefits to a high proportion of applicants who then fail to return to work; such gatekeepers are probably too harsh. (This proportion should be standardized for the age, sex, and occupation of those turned down, as well as institutional factors such as whether the applicant had hired a lawyer.) Conversely, some gatekeepers deny an average proportion of applicants (controlling for characteristics of the applicants) and have an above-

average proportion of those denied benefits return to work. These gatekeepers appear to have especially accurate decisionmaking rules.[4] Computerized expert systems should be developed that help all gatekeepers learn from these especially accurate gatekeepers. Similarly, all gatekeepers should benchmark their procedures on those who process claims rapidly as well as accurately.[5]

Deeming: The grants for employment and training services for young adults (ages 18-25) should be decreasing in family income using a formula similar to that for other forms of education and training (Pell) grants. It is reasonable to expect family members to contribute financially to a young adult's vocational rehabilitation, just as it is the practice to expect family members to contribute for a college education. (Such a financial contribution is referred to as "deeming." Of course, many family members contribute both their time and money regardless of government practices.)

A political problem with a work-first disability system is that the start-up costs of the system and the initial assessments can appear as increases in costs, even if lifetime costs decline. An advantage of phasing in a work-first disability system first with young adults is that the ability to deem a small portion of parents' incomes can make the proposal budget-neutral even in its first years.

Time-limited benefits: Those judged currently unable to work should create a plan with a counselor to alleviate the vocational impairments. (Lifetime stipends would still be provided for those who have very serious disabilities or who are near retirement age and do not want to work.) For those judged permanently and totally disabled unless they receive help, SSDI, SSI and Medicare should pay for needed services. For less severely disabled, Vocational Rehabilitation should pay for the services needed to return the person to work. SSI and SSDI should provide income support during the limited time of medical recovery, classes, and so forth. The income support should run out when the vocational disabilities have been alleviated, either due to medical improvement, therapy, equipment purchases, or training. Thus, this proposal replaces the current medical improvement standard with one based on removal of barriers to work.

One alternative is for the Social Security Administration to give performance-based vocational rehabilitation vouchers (as described above) to recipients of its time-limited stipends.

These vouchers can pay for longer than the period of stipend to motivate rehabilitation providers to help people stay at work.

All cash and medical care benefits during the time limit would have the positive work incentives described in the first section.

Health Insurance. As noted above, any work-oriented disability system must ban denials of health insurance coverage for pre-existing conditions. Only then will disabled people have true choice of health care provider.

Furthermore, we should provide SSI and SSDI recipients the lifetime option to buy Medicare or Medicaid, with the flexibility described above concerning the forms of medical assistance.

A simpler possibility: As noted above, a program that enhances incentives to work also enhances incentives to enter the SSDI rolls to receive benefits and return half-time to work. Given the long application process for SSDI benefits, it is unclear how many extra people would apply. If the work incentives in the first proposal are effective, it may be worthwhile extending them for new enrollees, at least as a pilot in a few states and perhaps after a waiting period.

Reward Successful Prevention and Early Intervention

Employers and workers' compensation insurance companies pay some of the costs of work-related injuries. While they do not internalize all safety costs, their incentives are pointing in the right direction.

Unfortunately, they can shed some of these costs by shifting people onto the Social Security Disability Insurance rolls. We should incorporate more of the incentives companies face to minimize short-term disability into the long-term disability system.

To improve incentives to reduce long-term disability, the federal government should create performance partnerships with any organization that can help prevent disabilities or that can intervene early to keep people on the job. At least three sets of organizations are relevant: schools and youth-oriented programs, adult-oriented programs, and employers.

Schools: The federal government's total expenditures on the disabled will be lower if states have low levels of entry onto SSI for youth, and high graduation rates from high school for disabled students (controlling for characteristics of the youth population). Thus, federal education funding should increase for states where many disabled students graduate high school, while few children and youth enter SSI.

Adults: Additional federal funding for state vocational rehabilitation agencies, employment and training, and state mental health and mental retardation programs should be granted to states with low levels of entry of adults onto SSDI and SSI, few people reapplying after the initial assistance period on time-limited SSDI and SSI, and high employment rates for working-age adults who report themselves as disabled. (One possible data source would be national surveys such as the Bureau of Labor Statistics' March Current Population Survey, which contains several questions on disability.)

Incentives for schools and states to reduce entry onto SSI and SSDI can lead them to discourage eligible people from applying for benefits, and provide incentives for gatekeepers into the disability system to be unduly harsh. Thus, increased incentives will need to be coupled with quality control measures such as sending out testers to ensure state systems for determining disability treat people fairly.

Employers: Employers have some discretion in how safe or dangerous the workplaces are. Employers also have some discretion concerning much they will assist employees remain in the workforce after accidents or illnesses. This latter discretion applies even to accidents and illnesses that have nothing to do with work. Employer behavior is particularly important because evidence indicates that early interventions that maintain links between an injured or ill person and his or her employer can be the most effective at returning the person to work.

Thus, the federal government should reward those companies that are proactive at keeping employees healthy and that are proactive at keeping employees with health problems on the job. For large employers, the Social Security Administration can calculate an expected entry rate onto SSDI given the age and other characteristics of the workforce. To provide incentives to avoid injuries and to return injured workers to work, SSDI tax rates should decline if the rate of entry onto SSDI at a company is low. Conversely, the rate should rise if the entry onto SSDI is

unusually high. (This experience rating is similar to the practice in some European countries of charging companies when employees become disabled.) The penalties should not apply to employers who hire workers who were previously certified as disabled by the schools, Social Security Administration, Vocational Rehabilitation providers, or the Veterans' Administration. Entry due to work-related injuries should have a larger effect on the tax rate than entry due to non-work-related injuries.

To ensure workers' compensation insurers face incentives to return people to work, not unload them onto the Social Security system, insurers should also face penalties when workers enter the SSDI system, and rewards when few covered employees become disabled.

Conclusion

No nation can afford to pay millions of people who want to work, not to work. Even worse, no nation should punish millions of people who want to work if they choose to work.

This article has outlined a disability policy that makes work pay. Each dollar of earnings lowers the total grant (combining SSDI, SSI, food stamps, housing assistance, subsidies for medical care, and so forth) by far less than a dollar. Furthermore, increased earnings could only expand choice of medical care provider, never lose current health insurance. The current complex system of assistance for vocational rehabilitation would be replaced by a simpler system of vouchers. Disabled people would enjoy choice of service provider. Conversely, service providers would be freed from many detailed regulations, and would face market incentives to help disabled people hold good jobs.

An important obstacle to providing work incentives is the fear that additional people with some impairments will be drawn onto the disability rolls, increasing costs. A key insight of this article is that a return-to-work system can be established for those already on the rolls, and not expanded to new entrants until (and unless) the system proves itself to be effective at helping disabled people hold good jobs. Thus, while many components of this proposal are familiar within the disability policy community, this proposal takes advantage of the fact that work

incentives can be particularly generous to those already on the SSDI and SSI rolls, because for them there is no fear of induced entry.

Ultimately, keeping people from needing long-term disability pensions is the key to improving the lives of disabled people, and in holding down costs. Thus, the incentives described above encourage schools, employers, and the public sector to all help avoid disabilities, and keep people with impairments attached to the labor market.

In short, the work-based systems described above hold the promise of moving a significant number of disabled Americans off of the disability rolls, and keeping many from ever joining the rolls of the permanently disabled.

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ENDNOTES

1. Hoynes and Moffitt discuss this problem (1995). Induced entry can occur when workers find mixing work and partial stipends appealing, so they reduce their hours. In addition, induced entry can occur because permitting partial disability payments while engaging in part-time or low-wage work automatically increases the number of potentially eligible applicants, even if workers do not change their hours of work.

2. When SSI or SSDI recipients earn more than expected, they must repay some of their stipend. The rewards for work would increase if these repayments were rare and small. The SSI and SSDI systems could be integrated with

employers' payroll system and withhold the estimated overpayment, just as the IRS integrates its withholding of the federal income tax. Alternatively, workers could submit their monthly paycheck (perhaps using a touch tone phone) and immediately have their next SSDI or SSI payment adjusted. Using the existing quarterly reports to the Social Security Administration would permit precise adjustments.

It is administratively difficult to run a phase-out that updates checks each month or two for changes in earnings. Federal, state and many local governments and some large employers can share data with the Social Security Administration within a month or so of the end of the pay period; state unemployment insurance systems can share data with a longer lag. Social Security Administration would need to make agreements with each data provider. Permitting people to update their earnings by mail, touch tone phone, Internet, etc. will help as well.

3. This proposal is more cautious than that of Batavia and Parker (1995), who would accept medical doctors' opinions in all cases. The government cannot automatically permit gatekeepers who make money off of the severity of diagnosis to also treat. Because health insurance is provided to those on the rolls, medical doctors have an incentive to exaggerate the severity of the diagnosis. In addition, the value of the proposed voucher for vocational rehabilitation services rise as severity rises; thus, vocational rehabilitation providers face incentives to exaggerate disability. Finally, corrupt gatekeepers can build a reputation for easy approval, and expand the disability rolls. The proposal here maximizes the ability of doctors and other gatekeepers, but ensures gatekeepers have incentives to establish good reputations for high-quality diagnoses.

4. Tracking the work history of applicants who are denied benefits should be straightforward for the Social Security Administration because they receive wage records of almost all of the U.S. workforce. (This proposal draws on the insight of John Bound that tracking the work history of those denied benefits can indicate harshness of the disability procedure [1991].)

5. Recall that some disability offices make disability determinations in only one third the time of others, indicating substantial room for improvement.