



August 2015

Improve the SSDI Program and Address the Impending Trust Fund Depletion

Consensus Recommendations of BPC's Disability Insurance Working Group

Members of the Bipartisan Policy Center's Disability Insurance Working Group share an urgent concern to avert the exhaustion of the Disability Insurance Trust Fund and to improve the program to better meet the needs of Americans with disabilities. There is shared recognition that a bipartisan approach will be necessary to address program solvency and that there are ways in which the program could be improved.

The impending depletion of Social Security's Disability Insurance Trust Fund is what brought the working group together, but finding cost savings for the program was not the uniting goal. Rather, consensus was sought and achieved on proposals designed to improve Social Security Disability Insurance (SSDI) beneficiary wellbeing, program operations, and program integrity, and having potential to yield higher employment and reduced reliance on benefits in the future.

The group met numerous times over the course of the past year and discussed a multitude of topics related to the SSDI program, including but not limited to program design, operations, beneficiaries served by the program, interaction with other programs that serve SSDI beneficiaries (such as Supplemental Security Income and Medicaid), and efforts to maintain workforce attachment. The group's deliberations on potential policy recommendations were guided by a set of consensus principles, which are listed on page 5.



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Background

The SSDI program serves a diverse group of individuals with disabilities with a wide-ranging set of needs. Public policy and practice have come a long way in making the nation more accessible to the needs of individuals with disabilities since the program was created in the 1950s. There is also now a broader range of work opportunities and supports for those individuals with disabilities who wish to work and who have the capacity to do so. The SSDI program, however, remains a vital lifeline for workers unable to do substantial work due to disability or illness. While SSDI program rules contain an array of work incentives and supports for those whose conditions improve and who wish to test their capacity to work, certain program rules—such as the “cash cliff”—work counter to the desire of some who wish to remain in, or return to, the workplace when able to do so.ⁱ

The trust fund for the SSDI program is on course for insolvency next year. This upcoming deadline is a focus of policymakers and a source of concern for SSDI beneficiaries and their families. Reallocation of funds between Social Security’s Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund is one policy option that has been used on many occasions, in both directions, in the past. Some policymakers have expressed a desire to enact meaningful reforms to strengthen and improve SSDI along with addressing solvency, rather than reallocation alone, which does not address underlying issues within the program or improve long-term sustainability.

Federal expenditures for the SSDI program exceeded \$142 billion in 2014, while dedicated payroll taxes to fund the program totaled only \$106 billion. Expenditures for the program have grown rapidly over the last decade, increasing from \$57 billion in 2000, in large part due to the aging of the baby boomers into their high-disability years, and the increase in women’s labor force participation resulting in women being insured for SSDI in case of disability. The Disability Insurance Trust Fund, which reflects historical program revenues net of costs, is expected to exhaust its reserves by the end of 2016. Absent action by policymakers, current projected benefits to disabled workers would be cut across the board by approximately 20 percent.ⁱⁱ

The SSDI program provides [insurance against work-limiting disability](#) for about 167 million American workers and their families. Roughly 11 million disabled workers (who are younger than their Social Security full retirement age) and their children and spouses receive cash benefits through SSDI; the disabled workers themselves also receive access to Medicare after two years of SSDI eligibility. The vast majority of beneficiaries (almost three-quarters) are between age 50 and Social Security’s full retirement age (currently 66). About 10 percent are under age 40.¹

The Organisation for Economic Co-Operation and Development (OECD) has published two disability policy indicators. The first covers compensation measures and benefit programs, considering a range of factors, such as eligibility criteria and benefit levels, and ranks OECD member countries by system generosity. In this compensation ranking, the United States is second from the bottom, just ahead of South Korea and just behind Canada. The second indicator covers measures of integration of people with disabilities in the workforce, such as anti-discrimination legislation, supported employment programs, and work incentives (including allowing the combination of work and benefit receipt). The United States is ranked higher, but still below the OECD average, in this employment disability policy indicator.²

ⁱ The “cash cliff” refers to the substantial gainful activity threshold, which is \$1,090 per month in 2015. When earnings exceed this amount by even one dollar, the entire SSDI cash benefit may be suspended and beneficiaries can be terminated from the program.

ⁱⁱ “Disabled worker” is a term of art, used extensively in the law and by the Social Security Administration. The term is used in this document for the purpose of identifying Title II beneficiaries who worked, paid payroll and/or self-employment taxes that finance the SSDI program, experienced the onset of disability, and were awarded benefits from the SSDI program. People-first language is used in all other contexts when referring to the general population of Americans with disabilities.

Americans who experience a work-limiting physical or mental disability and who have enough work experience to qualify for the SSDI program must prove: (1) that their disability will last for a year or longer or result in their death; and (2) that they are unable to engage in substantial gainful activity (SGA) in any job that exists in the national economy. Just over half of the people who apply are accepted. Consistent with [global health trends](#), more than 60 percent of disabled workers receiving SSDI live with either mental disorders or disorders of the musculature, skeleton, or connective tissue.

Disabled workers, who account for more than 80 percent of SSDI beneficiaries, receive an average benefit of \$1,165 per month. Other beneficiaries—the children and spouses of disabled workers—receive smaller benefits that average between \$307 and \$735 per month.ⁱⁱⁱ About one-in-seven beneficiaries has an SSDI benefit that is small enough, along with limited resources (less than \$2,000 for individuals or \$3,000 for couples, with limited exceptions for home equity and some other assets), to also receive means-tested cash benefits and access to Medicaid from the Supplemental Security Income (SSI) program.³

In 2013, about 9 percent of disabled workers had their benefits terminated. More than 90 percent of these terminations were because the disabled worker died or reached their Social Security full retirement age and started receiving benefits from the Old-Age and Survivors Insurance program. Data show that between 8 and 10 percent of men and between 6 and 8 percent of women who become eligible in their 50s die within their first year of eligibility, and mortality is much greater within five years of eligibility (22 to 30 percent of men and 16 to 24 percent of women, for those who become eligible in their 50s).⁴

The SSDI program has several rules that are designed to encourage work. When initially attempting work, the Trial Work Period allows SSDI beneficiaries to continue to receive full cash benefits, even if they work above the SGA level (\$1,090 per month in 2015), for up to nine months (not necessarily consecutively). The Extended Period of Eligibility, which lasts for 36 months after the end of the Trial Work Period, allows beneficiaries to remain on the program if they earn above the SGA level. During the Extended Period of Eligibility, beneficiaries do not receive benefits in months that they earn above the SGA level but receive their full benefit in other months. Beneficiaries who exhaust their extended period of eligibility and earn above the SGA level are terminated from the program.

Those who leave the program due to work, however, can utilize an expedited reinstatement (EXR) procedure if they stop work within five years of when benefits ended. Under EXR, up to six months of temporary cash benefits can be received while a medical review is conducted to determine whether to reinstate full benefits. Extended Medicare coverage, lasting up to seven years and nine months after the end of the Trial Work Period, is also available for SSDI beneficiaries who successfully return to work.^{iv}

Yet, very few beneficiaries leave the program because of work or medical improvement. In 2013 (the latest data available), fewer than 60,000 workers (about 0.5 percent of all beneficiaries) had their benefits terminated because they successfully returned to work, experienced medical improvement, or were not complying with program rules. Within a particular cohort, the numbers successfully returning to work are higher but still a small percentage of the total. For example, of the cohort that became eligible in 1996, 2.7 percent had their benefits terminated due to work and remained off the rolls ten years after becoming eligible.⁵

ⁱⁱⁱ In this case, “children” includes minor children and dependents who receive disabled adult child (DAC) benefits on the disabled worker’s record.

^{iv} For more information on employment-related provisions of the SSDI program, please see the Social Security 2015 Red Book. Available at: <http://www.ssa.gov/redbook/>.

Exit rates due to work vary by age; younger entrants are more likely to return to work successfully than older entrants. As the average age of entry to the program increases (with the aging of the baby-boomer generation), new cohorts will likely have lower ultimate return-to-work success rates than the 1996 cohort. Additionally, many of those who leave the SSDI program due to medical improvement do not stay off for long; about 20 percent return to the program within eight years.⁶

Principles

The working group members agreed to the following principles to guide their deliberations on policy recommendations:

1. Avoid program insolvency and seek to achieve long-term actuarial balance.
2. Do no harm: no changes to primary insurance amounts for current beneficiaries and no changes to eligibility standards at the current time.^v
3. Allow beneficiaries to choose whether or not to participate in pilot projects and work-incentive programs.
4. Create employment opportunities for those individuals who want to work, and remove and avoid barriers to work.
5. Design a benefit offset that encourages work and improves the economic security of beneficiaries.
6. Simplify the administration of SSDI and SSI in ways that will more closely align work incentives.
7. Prevent fraud in the program, but recognize that eliminating all fraud will not yield significant cost savings; fraud is not the reason for the current funding shortfall.
8. Improve the recording and processing of earnings to reduce the number and amount of overpayments. Hold beneficiaries harmless for overpayments if earnings reports are made properly.
9. Continue attachment to the SSDI program regardless of work activity if a beneficiary continues to be medically disabled.
10. Provide adequate resources to administer the program.
11. Recognize that SSDI serves a diverse population and disability can be dynamic.

^v There was no consensus on this topic in regard to future beneficiaries.

Recommendations

I. Address Trust Fund Solvency

As part of this package of recommendations, by the end of 2015, policymakers should enact a reallocation of the Social Security payroll and self-employment taxes between the Disability Insurance Trust Fund and the Old-Age and Survivors Insurance Trust Fund to ensure that benefits continue to be paid as scheduled. The working group members could not agree on a recommended reallocation length, with some supporting an equalization of the trust funds to 2034 and some supporting a shorter-term reallocation.

II. Improve Work Incentives for SSDI Beneficiaries

Over the years, bipartisan congressional efforts have attempted to encourage people with disabilities receiving SSDI benefits to return to work or, if already working, increase their work effort to the extent of their abilities. Many of these efforts have been directed at removing barriers and establishing better incentives in a variety of programs, such as the addition of a benefit offset to SSI and the addition of the Trial Work Period and Extended Period of Eligibility to SSDI.

Much has been learned from these and other efforts, and there is more that can and should be done to support beneficiaries to return to work or to increase their work effort to the maximum extent that their health and disability allow. The following recommendations would build on those efforts, improving work incentives for beneficiaries within SSDI and across other programs in which many SSDI beneficiaries participate.

Replace the SSDI Cash Cliff and Related Reforms

As noted above, the SSDI program contains many work incentives and supports for beneficiaries who wish to test their capacity to work; these policies are particularly important to beneficiaries with episodic conditions or whose conditions improve over time. But these efforts to help beneficiaries return to gainful employment have had limited success. The so-called “cash cliff”—the fact that during the Extended Period of Eligibility, a beneficiary receives a cash benefit only in months when he or she has earnings under the SGA level (\$1,090 per month for non-blind beneficiaries in 2015)—may present a work disincentive for some beneficiaries. Beneficiaries may refrain from work or limit their work activity due to the fear of losing essential cash supports and access to medical care and long-term services and supports. The anticipated ordeal and uncertainty of potentially having to go through the SSDI approval process again represents another barrier.

Additionally, the Social Security Administration (SSA) has struggled to process earnings reports made by beneficiaries who do work and often fails to adjust benefits accordingly in a timely manner. The Government Accountability Office (GAO) issued preliminary findings indicating that more than half of the \$20 billion in SSDI overpayments that occurred in the last ten years (fiscal years 2005 to 2014) were related to the work activity of beneficiaries.⁷ Each year, an average of 96,000 beneficiaries were overpaid due to work activity, with an average overpayment of nearly \$12,000. GAO cited weaknesses in the agency’s earnings-report processing, the complexity of SSDI work-incentive rules, and the lack of automated systems (such as automated telephone reporting or a smartphone app) for beneficiaries to report earnings

as reasons for the pervasive problems with preventable overpayments.^{vi} SSA is required to attempt to recoup its mistaken payments well after the fact, which can result in beneficiaries owing tens of thousands of dollars through no fault of their own. The negative word-of-mouth that results from these burdensome circumstances can be a further disincentive to attempt or expand work activity.

The working group recognizes the importance and desirability of a benefit offset beginning at a level that would both encourage work and provide needed support for beneficiaries. There was widespread interest in establishing a benefit offset for all SSDI beneficiaries beginning at a threshold in the range of \$700 to \$800, along with guaranteeing continued program attachment except in the case of medical improvement. However, preliminary estimates suggest that this proposal would increase program costs significantly. A lower-cost benefit-offset package for all beneficiaries would require the offset to begin at a threshold so low that the income security of current beneficiaries would be threatened.

Therefore, the working group recommends starting with a smaller proposal focused on beneficiaries dually eligible for SSDI and SSI. These program improvements would be especially impactful for dually eligible beneficiaries who currently face the challenge of navigating two programs with different rules. For example, SSI has always featured a gradual benefit offset, and since the 1980s, it has included rules that guarantee continued program attachment unless medical improvement occurs. The package of proposals below would improve and better coordinate SSDI work incentives with other programs.

- **Eliminate the SSDI cash cliff and establish a gradual benefit offset for dually eligible beneficiaries (current and newly eligible).** For dually eligible beneficiaries, disregard earnings up to the greater of: (1) a threshold of \$700 per month in 2015, indexed to wages going forward; or (2) whatever level the SSI benefit phases out completely.^{vii} For every \$2 in earnings above this threshold, SSDI benefits would be reduced by \$1. The SSDI benefit offset would not affect the calculation of SSI benefits.^{viii} For SSDI beneficiaries, earnings should be counted when they are paid, which would align with the current rules for SSI beneficiaries. With regard to auxiliary beneficiaries, the benefit offset should apply to total worker, spousal, and child benefits for those living in the same household.^{ix} The benefit offset should apply first to the benefit for the disabled-worker beneficiary, then it should apply to any auxiliary benefits in equal shares.^x
- **Establish a nationwide pilot program to test a benefit offset for SSDI-only beneficiaries at thresholds below SGA.** This voluntary pilot would be open to SSDI beneficiaries who qualify for the program before the age of 50 and who are not dually eligible. The pilot would be available to beneficiaries between two and five years after their initial award. SSA should be directed by Congress to test a range of thresholds, at which point the \$1 benefit offset for every additional \$2 of earnings would apply, explicitly including thresholds below the SGA level. Potential enrollees should be offered benefit counseling and should be clearly informed of the provisions of the pilot, including any potential benefits that they might forgo by participating. SSA has

^{vi} Some overpayments, such as those to beneficiaries who are appealing a termination following a medical CDR who ultimately do not prevail, are not preventable.

^{vii} This feature of the offset design is important in order to avoid the poor work incentives that would be created if separate SSI and SSDI offsets were to overlap across a range of earnings and cause beneficiaries to lose \$1 of combined benefits for every \$1 of earnings. For most dually eligible beneficiaries under current law, SSI benefits would phase out before the \$700-per-month threshold, but some would effectively have an individualized SSDI offset threshold.

^{viii} For example, beneficiary earnings beyond the general earned-income exclusion would first apply to the offset of SSI benefits. Once earnings reach either \$700 or a level at which SSI benefits are completely phased out (whichever is greater), the benefit offset would apply to SSDI benefits. At that point, reductions to SSDI cash benefits due to the benefit offset would not cause SSI benefits to be recalculated. (SSI benefits would remain at zero until and unless earnings drop to a level at which the full SSDI cash benefit is restored and the cash SSI benefit starts to phase back in.)

^{ix} This is different than the implementation of the Benefit Offset National Demonstration, which only offsets the disabled-worker benefit and continues to include a cliff for auxiliary beneficiaries (i.e., the auxiliary benefits drop from the full amount to zero once the disabled-worker benefit goes to zero).

^x For example, suppose the benefit for the disabled-worker beneficiary has been completely offset and auxiliary benefits for one spouse and one child remain. For every \$2 in additional earnings (of the disabled-worker beneficiary), each of the two auxiliary benefits would be reduced by 50 cents.

been directed to test benefit offset policies in the past and has either failed to do so or has implemented them in ways that have compromised the ability to learn from the demonstration. For example, the recent Benefit Offset National Demonstration (BOND) is testing a benefit offset that begins at the SGA level, offering no insights on the response to offsets that could begin below that threshold. It is important that SSA be given clear direction and authority to implement a benefit-offset pilot according to the aforementioned specifications. SSA should be required to report to Congress on the progress of planning for pilot implementation no later than one year, and begin the national pilot no later than two years, after enactment of the legislation authorizing and requiring this demonstration.

- For dually eligible beneficiaries and benefit-offset pilot participants, eliminate the Trial Work Period and Extended Period of Eligibility. Corresponding changes to the Ticket to Work payment formulas may be necessary in order to maintain appropriate incentives for Employment Networks.
- For dually eligible beneficiaries and benefit-offset pilot participants, guarantee continued SSDI (as well as SSI and Medicaid) and Medicare program attachment except in cases of medical improvement. Beneficiaries who earn enough to have all cash benefits offset would have their checks suspended; if earnings dropped below that threshold, cash benefits would be automatically reinstated.
- For all SSDI beneficiaries, allow SSA no more than six months to adjust benefits due to overpayments for beneficiaries who report their earnings accurately and in a timely manner. Hold beneficiaries harmless for SSA overpayments if benefits are not adjusted within that time period due to no fault of the beneficiary.
- Direct SSA, and provide the necessary funding, to establish an electronic process, such as online and/or through a mobile app, for all SSI and SSDI beneficiaries to report earnings online and to receive confirmation that the earnings report has been received.
- Allow SSA to implement a quarterly adjustment of benefits, instead of monthly, if the agency finds that this schedule would result in operational efficiencies.

Once the benefit-offset package has been successfully implemented for dually eligible beneficiaries, and once new empirical evidence of behavioral response, such as induced entry, is available, policymakers should consider expanding this program improvement to all SSDI beneficiaries.

Improve Long-Term Services and Supports

Many SSDI beneficiaries rely upon long-term services and supports (LTSS) that are paid for by the Medicaid program. For these beneficiaries, a successful attempt to reenter the workforce could cause them to lose their LTSS—an untenable outcome for individuals with disabilities. This is a serious work disincentive. The Medicaid Buy-In (MBI) was intended to address this disincentive; in some cases, it does so successfully, but in other cases, it is insufficient. The MBI should be improved to enable people with disabilities, including SSDI beneficiaries, to attempt work without fear of losing critical LTSS. The Bipartisan Policy Center's [Long-Term Care Initiative](#) is conducting modeling and developing policy recommendations in this area, to be published in 2016.

III. Emphasize the Dynamic Nature of SSDI Benefits, Increase Outreach to Beneficiaries about Work-Support Programs, and Pilot a Voluntary Partial-Disability Benefit

Continuation of SSDI benefits is contingent upon a beneficiary's lack of medical improvement or achieving employment earnings above the SGA level. Because few beneficiaries demonstrate medical improvement when reviewed, most stay on the program for extended periods. The reviews to determine whether such improvement has occurred, however, are chronically delayed—at least in part because Congress has not appropriated sufficient resources to conduct the reviews—which has led to concerns that there may be some people on the program who are no longer eligible. Additionally, there is little communication to beneficiaries about the work supports and incentive programs that are available to them, both from SSA and other sources. A beneficiary who desires to attempt work may not know what resources are available to them or may have misconceptions about how earnings might affect their benefits.

The existing work incentives within the SSDI program, while important and valuable, have much room for improvement. Policymakers have repeatedly enacted changes to the program that attempt to encourage SSDI beneficiaries to work to the degree they are able—or even leave the program for a full-time return to the workforce. While all of these efforts have been well-intentioned, there are many reasons that they have been less successful than many had hoped. To begin with, SSDI beneficiaries typically have severe disabilities combined with health conditions that can make daily living difficult, let alone working. For those who have residual work capacity, the combination of scant evidence upon which to base program design and poor implementation decisions have stymied both the success of these programs and their ability to contribute to a future evidence base.

A combination of better information for beneficiaries, adequate resources for program administration, and a strong oversight framework for implementation of new work-incentive pilots and programs will be necessary to develop effective program improvements for beneficiaries and the public.

Emphasize that Continuation of Benefits is Contingent on Continued Medical Impairment

SSDI benefits are widely perceived as permanent—and they often are. Most individuals who are awarded SSDI benefits stay on the program for the rest of their lives or until they attain their full retirement age and qualify for Social Security retirement benefits. Each beneficiary is supposed to undergo a Continuing Disability Review (CDR) at regular intervals to determine if medical improvement has occurred.^{xi} Beneficiaries and the public would gain considerable value if the contingent nature of benefits were made clearer.

- Indicate clearly in SSDI award letters that benefits are contingent upon continued medical impairment. The initial award notifications should emphasize that SSDI benefits are contingent and will be discontinued if medical improvement occurs, which will be determined by regular CDRs.

Guarantee Timely Continuing Disability Reviews

A substantial backlog of approximately 900,000 medical CDRs (about 700,000 for SSI, 150,000 for SSDI, and 50,000 for dually eligible

^{xi} The Social Security Advisory Board (SSAB) recently released a report on the status of and outstanding issues with the Continuing Disability Review process. The working group's process and recommendations benefitted greatly from the report itself and the help of SSAB staff who worked on it.

beneficiaries), however, means that many beneficiaries are reevaluated years late or not at all. SSA is attempting to ensure that the CDRs most likely to end in benefit termination are completed first by assigning the beneficiaries most likely to improve to more frequent CDRs that include a full medical review. Those less likely to improve are assigned less frequent reviews that can take the form of a mailed questionnaire. SSA makes these assignments based on a profile score that accounts for whether the beneficiary is expected to improve or not and their age, and on the availability of agency and state Disability Determination Service (DDS) resources. Those who have a high CDR profile score are scheduled for a full medical review, to occur at least as often as every three years.

- **Guarantee beneficiaries timely CDRs by testing and evaluating a new approach to CDR funding for five years.** To ensure that CDRs are conducted as scheduled, they must be adequately funded. Funding for CDRs from 2016 through 2020 should be accommodated through appropriations and cap adjustments, meaning that SSA would have all necessary funds at its disposal to complete CDRs on schedule. Also, allow funding for each fiscal year to be spent through the following fiscal year to accommodate time lag in DDS hiring. GAO would be charged with auditing this new program and evaluating its performance. The 2020 end to the cap adjustments and appropriations would enable Congress to review the agency's performance, including the timeliness of CDRs and any remaining backlog, in light of the funding made available under this approach, and determine whether it should be continued.

Inform Beneficiaries about Work-Incentive and Support Programs

All beneficiaries should be informed that they are encouraged to work to the extent they can and that work incentive and support programs are available to help them reenter the workforce. Beneficiaries who are more likely to improve and/or have work capacity should receive regular communication about resources for return-to-work supports and work-incentive programs, since they are most likely to need them.

- **Experiment with additional communications to SSDI beneficiaries about available work supports.** Moreover, the agency should receive funding for, and be directed to provide to beneficiaries who wish to reenter the workforce, additional communication that work-support and incentive programs are available from SSA and other sources. The communications should specify where those resources can be located in-person, via telephone, and on the Web. Subjects of these communications should include SSA work-incentive programs, such as Ticket to Work, as well as non-SSA return-to-work-support programs, such as State Vocational Rehabilitation services.

Such communications could also include a reminder about earnings reporting, which would likely increase compliance and help the agency become aware of work attempts sooner, reducing the likelihood of overpayments. When SSDI beneficiaries begin to work, they should receive a congratulatory letter from SSA with offers of assistance.

All of these communications should be tested for efficacy in focus groups of SSDI beneficiaries. SSA should experiment with communications at different times (such as at program entry, and at six, 12, and 18 months after becoming eligible) and through different means (such as mail, electronic, and in-person communications), and these different approaches should be evaluated for effectiveness, both overall and among relevant subgroups of beneficiaries. After evaluation, the most cost-effective strategies should be implemented.

Provide Workforce-Transition Support to Beneficiaries Whose Benefits are Terminated due to Medical Improvement

In 2013, about 17,000 disabled-worker beneficiaries were removed from the SSDI program due to medical improvement.⁸ For these individuals, many of whom have not maintained any attachment to the workforce, returning to work could be challenging. While supports, such as state-based vocational rehabilitation programs, may be available to terminated beneficiaries, they sometimes have long waiting lists, and there is no formal outreach to these individuals to help them navigate available resources if they desire to attempt work.

- Direct SSA to submit a pilot proposal to the Workforce Attachment Venture Investment Board (described in the next section of this report) for funding to test making return-to-work benefits available to beneficiaries for one year after their benefits are terminated due to medical improvement.^{xii} Many of those whose benefits are terminated due to medical improvement end up returning to the program within just a few years. Making return-to-work programs (especially Ticket to Work) available to those who have recently been terminated from the rolls may reap program savings if those beneficiaries are better able to return to gainful employment.
- Provide transition support for beneficiaries whose benefits are terminated due to medical improvement. The Department of Labor's Employment and Training Administration, the Department of Education's Rehabilitation Services Administration, and the Department of Veterans Affairs programs should all be required to coordinate with this population. SSA must provide a firm handoff to these programs for beneficiaries who are terminated from the rolls due to medical improvement. These beneficiaries should be eligible and a high priority for participation in any available proposed Workforce Attachment Venture Investment Board demonstrations, as well as for State Vocational Rehabilitation programs. Funding for programs that assist people who are no longer SSDI beneficiaries should continue to come from sources other than the Disability Insurance Trust Fund.

Establish a Voluntary Partial-Disability Benefit Pilot for New Entrants and Existing SSDI Beneficiaries Who Attempt Work

Beneficiaries who experience medical improvement or who retain some ability to work and who wish to attempt work must currently navigate a very complex set of rules and work incentives. (Another proposal in this package would improve these work incentives for dually eligible beneficiaries by replacing the cash cliff with a gradual benefit offset and simplification of other work incentives.) Some beneficiaries may be more confident returning to work if they were offered the simpler, more-certain option of a partial benefit that would not be adjusted based on earnings. To learn if this approach could be viable and entail advantages for some beneficiaries and the program as a whole, the working group proposes a voluntary pilot:

- In up to three states, launch a voluntary pilot to offer both new entrants and existing (already eligible) SSDI beneficiaries who attempt work (as indicated by new earnings) the opportunity to participate in a partial-disability pilot. These working beneficiaries would be informed that they could stay in the existing arrangement, in which their SSDI benefits could vary each month (or quarter) based on their earnings. (This might include a benefit offset for dually eligible beneficiaries, as proposed separately.) Alternatively, beneficiaries could choose to enter the pilot and be guaranteed 50 percent of their SSDI benefit each month regardless of earnings (as long as earnings do not exceed \$4,000 per month, at which point cash benefits would be suspended,

^{xii} WAWI demonstration funding would come from general funds, not the Disability Insurance Trust Fund.

but Medicare benefits would continue).^{xiii} Dually eligible beneficiaries who enter the pilot would have all earnings up to \$4,000 per month excluded from calculation of SSI benefits. All pilot participants would be guaranteed continued attachment to the SSDI program (and SSI program, for duals) except in the case of medical improvement. For example, if a pilot participant earns more than \$4,000 in a month, their partial cash benefit would be suspended, but they would not lose eligibility for the program, and if earnings dropped below \$4,000, their partial cash benefit would be reinstated. Research has shown that ongoing benefit counseling plays a critical role in the success of implementing interventions to facilitate work. Benefit counseling would be made available to beneficiaries considering participation and to beneficiaries enrolled in the pilot.

- **Review pilot participants at least every year or two, depending on the condition.** At these reviews, participants could be switched back to the normal, full benefit (with the potential earnings offset, as proposed) if their condition has worsened and significant work effort is no longer possible. Additionally, if a pilot participant experiences a worsening of their condition before this regular review, they could request an expedited, early review to switch back to the standard program rules. As under the current program, if medical improvement occurs to the point where beneficiaries are no longer eligible, benefits would be terminated. Participants would remain attached to the program, however, in case their condition once again worsens and they become eligible to restart program benefits.
 - A beneficiary considering this pilot would therefore be faced with a tradeoff. If she opts into the pilot, she would receive a smaller monthly benefit payment than in the regular program, but it won't be reduced if she works (as long as she earns less than \$4,000 per month). Also, if she is found to have medically improved and her benefit payments end, she can more easily resume cash benefits if her condition worsens than if she had stayed out of the pilot.
- **Subject implementation plans to the review of an independent board.** Approval of implementation plans for the pilot and ongoing oversight of this and any new pilots that directly involve the Disability Insurance Trust Fund should be the responsibility of a new SSDI Pilot Approval and Oversight Committee, described on the following page.

Establish a Special Office to Implement SSDI Work-Incentive Programs and Pilots and Establish an SSDI Pilot Review and Oversight Committee

The implementation of previous work-incentive programs by SSA has attracted widespread criticism. For example, many policy experts and advocates expressed concerns about SSA's implementation plans for Ticket to Work before it took effect. Many of these concerns were not heeded. This along with many other factors, including the health status and work capacity of SSDI beneficiaries, have contributed to the fact that the program has not succeeded at returning the substantial numbers of beneficiaries to work that policymakers and advocates had hoped.

We believe that, going forward, beneficiaries and the public would benefit from ensuring that implementation of SSDI-related work-incentive programs and pilots are led by a special office that reports directly to the SSA commissioner and that all pilots and implementation of new programs are supervised by an independent committee. Such a group would be charged with evaluating implementation plans for pilot

^{xiii} Dually eligible beneficiaries who elect to participate in the partial-disability pilot would receive half of their normal SSDI benefits (as long as earnings remain below \$4,000 per month) and would not be subject to the \$1-for-\$2 benefit offset proposed above.

programs and ensuring that they are both workable for beneficiaries and likely to contribute to an evidence base for future policymaking. The committee would provide oversight and guidance through the operation of the pilot program(s).

- **Establish an Office of Disability Work-Incentive Programs and Pilots** that is located within the office of the SSA commissioner or the principal deputy commissioner and is responsible for all SSDI-related work-incentive operations, and reinstate demonstration authority to SSA. This office, which would be charged with implementation of pilots using reinstated SSA demonstration authority, would provide a high level of visibility and authority within the agency to increase the likelihood that work-incentive initiatives are properly implemented. This special office would also benefit from the oversight of a new external committee, described below.
- **Establish an SSDI Pilot Review and Oversight Committee, staffed by the new SSA Office of Disability Work-Incentive Programs and Pilots.** The committee would have nine members with collective expertise in the areas of research design (including randomized controlled trials), demonstration implementation (including communicating operational changes within SSA), the SSDI program, the needs of people with disabilities, and rigorous evaluation. Specifically, members should have expertise to evaluate the proposed projects as to the soundness of their design—including scope, sample size, feasibility, and whether the project is based on legitimate social-science evidence—the necessity of waivers of SSDI program rules, the possibility of securing productive results, the adequacy of resources to conduct the proposed research or demonstrations, and their relationships to other similar research or demonstrations already completed or in process. Eight members would be appointed by joint agreement of the Social Security Public Trustees, and the ninth member would be the head of the Office of Disability Work-Incentive Programs and Pilots. Additionally, the committee should be directed to establish an advisory panel composed of SSDI beneficiaries—people with disabilities and their families—to provide ongoing advice about issues under the scope of the committee.
- **Require committee review before pilot implementation begins.** Any pilot requires some flexibility for the agency to operationalize. However, the SSA commissioner should be required to seek the committee’s advice on plans for implementation and receive the committee’s review before implementation begins. If the SSA commissioner chooses not to adopt certain recommendations of the Review and Oversight Committee, the commissioner must provide the committee with a written explanation of the reasons why recommendations were not adopted. Additionally, the committee should have ongoing oversight responsibility, with the commissioner required to submit periodic reports on pilot implementation and progress, and to comply with data and information requests from the committee. Any changes to the implementation plans would also require committee review. As part of the committee’s work, public hearings should be held before major decisions, and written records of decisions and reports should be made available to the public on the Internet.
- **Evaluate each pilot upon conclusion and make recommendations to the agency and Congress.** At the conclusion of each pilot, the SSA commissioner must submit a final report to the committee on the results of the pilot with the agency’s proposed recommendations. The committee would conduct its own evaluation and make recommendations to the agency and to Congress about whether the pilot followed the preordained implementation plan, and if credible evidence resulted about whether the tested policy can meet its goals if more broadly implemented, or whether other policy alternatives should be tested or implemented on a permanent basis. The committee should hold at least one public hearing as part of the evaluation process, and final evaluations and recommendations to Congress should also be made available to the public on the Internet.

IV. Develop New and Better Approaches to Help People with Disabilities Stay at Work and Return to Work, and Improve Interagency Coordination on Workforce Attachment

Innovative policies to help Americans with disabilities remain attached to the workforce or reenter the labor force could improve the quality of life and economic security for individuals with disabilities and their families, as well as potentially reduce costs for public programs. While the success of stay-at-work and return-to-work programs has a clear effect on the finances of the SSDI program, neither Disability Insurance Trust Fund dollars nor SSA administrative funding should be used to fund such activities.

Furthermore, SSA is not necessarily the best-positioned agency to lead such efforts. The necessary knowledge and operational expertise is, in fact, spread among many government agencies, the states, and the private sector. Other federal agencies—including the Department of Labor’s Employment and Training Administration, Vocational Rehabilitation programs overseen by the Rehabilitation Services Administration of the Department of Education, and the Department of Health and Human Services—are directly involved in this mission. As no clear evidence exists regarding which should be the focal point, the working group envisions the Office of Management and Budget convening all of these parties in a competition for seed funding to test promising ideas, thereby developing an evidence base for future policymaking to improve attachment to the workforce among Americans with disabilities. Additionally, this framework should be used going forward to improve interagency, intergovernmental, and cross-sector collaboration on workforce-attachment efforts.

- **Establish a Workforce Attachment Venture Investment (WAVI) Board.** This new, eight-member advisory board would include individuals with substantial relevant expertise from public- and private-sector backgrounds. The president would designate four federal agency officials who would: (1) have lead responsibility within their agency for improving workforce attachment among people with disabilities; and (2) be members of the new WAVI Board. These would include one official each from the Department of Labor, the Department of Health and Human Services, the Department of Education, and the director of the proposed Office of Disability Work-Incentive Programs and Pilots at SSA. Congress would be entitled to appoint four members, all of whom must be from outside the government, with the four appointments equally divided among the majority and minority leadership in the House and the Senate.
- **Provide \$400 million in seed funding for innovative workforce-attachment pilots.** The newly appointed WAVI Board would hold a competition to award \$400 million for up to five pilot projects, each to last no more than five years, which have potential to build the evidence base for effective interventions to help people with disabilities maintain attachment to the workforce or to reenter the workforce. Pilots must include study of how existing stay-at-work and return-to-work services, including those provided by public entities (such as the State Vocational Rehabilitation system) and private entities (such as disability-management companies and disability insurance providers), might be expanded to help maintain labor force attachment for workers with disabilities who currently lack access to such services. Potential applicants could be state or local governments, not-for-profit organizations, for-profit businesses, or partnerships that span these categories.

For example, the WAVI Board could engage with the Labor and Treasury Departments to test the impact of offering a tax credit to employers that agree to hire and provide needed employment supports to people with very significant disabilities. These credits,

which would be refundable against corporate income tax or income reported on Schedule C of the individual income tax, would be evaluated for improved employment and earnings outcomes for people with very significant disabilities who need employment supports, as well as potential savings to public programs, including SSDI, SSI, and Medicaid.

Another pilot might engage private disability insurance (PDI) carriers. PDI increases access to workforce-attachment supports for those who experience the onset of disability, but just one-third of the workforce has coverage. Nearly all of those who are covered participate through employer-sponsored plans, also known as group plans. Employers pay the entire premium in many group PDI plans. In some employer-sponsored PDI plans, employees share the cost of premiums, while other plans are fully funded by the employees.^{xiv} A small number of plans where employees contribute, or fully fund the benefit, offer PDI on an automatically enrolled basis.^{xv}

A pilot could provide insight on whether the government should take action to expand PDI coverage. Such a pilot could evaluate different enrollment models for PDI, examine the impact on covered workers and whether additional disclosure and substantive plan and benefit requirements should be included for participants. Additionally, PDI experience with stay-at-work and return-to-work interventions could be leveraged in a pilot that might bring together carriers, states, and federal agencies to find ways to improve the effectiveness of public programs in maintaining workforce attachment. Participant interests and protections should be fully considered and built into the design of any PDI pilots, which should only be conducted with ERISA-covered workers.

A wide variety of pilots beyond these ideas could be considered, but participation in any pilot that could result in delayed access to SSDI benefits or a reduction in those benefits must be voluntary. The WAVI Board would have the authority to establish additional criteria for the competition (including application requirements), to recommend which pilots to fund, and to review the activity of pilots on an ongoing basis. At the conclusion of the pilots, the WAVI Board would be required to publish an evaluation of each pilot and make recommendations to Congress and SSA for future efforts to improve workforce attachment among people with disabilities.

- **Scale up demonstrably effective interventions with coordinated, interagency efforts.** After the conclusion of demonstrations, the WAVI Board would have continued responsibility to coordinate interagency, intergovernmental, and cross-sector collaboration to improve workforce attachment among people with disabilities. The Board's primary responsibility would be to scale up interventions that have been demonstrated to work. Additional activities could include, but are not limited to, advising on future demonstrations and future administrative or statutory changes to programs and services to promote workforce attachment, coordinating implementation of workforce-attachment initiatives across federal agencies, and developing partnerships between government and the private sector.

^{xiv} Depending on the data source, statistical information on employer-paid PDI coverage paints different pictures. For 2014, the Bureau of Labor Statistics found that employers paid the entire premium for 92 percent of participants. Information gathered in the same year by LIMRA, a research association, showed that 48 percent of employers with PDI pay the entire premium for their covered workers, 18 percent share the cost, and 34 percent ask participants to fully pay for the benefits (Keeping Up with the Times (2015)).

^{xv} Benefits are taxed in employer-funded plans, but are not taxed in employee-funded plans. Benefits are proportionally taxed in cost-shared plans.

V. Evaluate the Medical-Vocational Guidelines

Age, education, and work experience are considered as part of the disability determination process through use of the Medical-Vocational Guidelines, informally known as “the grids.” Much of the Medical-Vocational Guidelines has not been fully evaluated in many years.

Provide SSA with a specific appropriation for the purposes of evaluating the efficacy and performance of the Medical-Vocational Guidelines. The evaluation, which should be conducted by a third party with relevant expertise, should also examine whether and to what extent additional factors (other than age, education, and work experience, as contained in the definition of disability in the Social Security Act), such as functioning in the workplace, should be incorporated into this step of the determination process. The evaluation should be completed by 2020 at the latest. SSA should propose adjustments to this stage of the eligibility process based on the completed evaluation and issue proposed regulations, as necessary, without delay.

VI. Implement Reforms to Improve SSDI Program Integrity and Operations

Program Integrity

While the financing challenges of the SSDI program are not in any significant way attributable to fraud, the issue is still a very important one to address. In addition to wasting scarce resources, fraud has the potential to undermine public support for the program. The following proposals would help to make the program more resistant to fraud and increase legal sanctions for those who perpetrate fraud.

- Create a new felony for conspiracy to commit Social Security fraud, punishable by up to five years in prison and/or fines up to \$250,000.
- Increase civil and criminal penalties for fraudulent behavior by those in positions of trust (including medical providers, translators, beneficiary representatives, and current or former SSA employees) and index civil penalties to inflation.
 - Increase maximum felony penalty from five years to ten years and/or fines up to \$250,000.
 - Increase maximum civil monetary penalty to \$7,500 (from \$5,000) for each false statement, representation, conversion, or omission that a person in a position of trust makes or causes to be made.
 - Create new civil monetary penalty, up to \$7,500, for claimant representatives who knowingly charge or collect fees from claimants in excess of allowable amounts. Representatives who do so would also be subject to assessment of up to twice benefits received.
- Authorize SSA to expand Cooperative Disability Investigation units to additional states where doing so would likely be cost-effective. Ensure that the expanded units are adequately funded.
- Prohibit consideration of evidence—with the exception of factual evidence whose veracity is not in doubt (e.g., a doctor who was disbarred ordered a test at a third-party laboratory)—submitted by doctors who are unlicensed, sanctioned, barred, and/or have been assessed penalties for submitting false evidence.

- Allow SSA to suspend claimant representatives who have been disbarred, suspended, or convicted of a felony, subject to due-process protections through an expedited suspension or disqualification hearing.
- Require collection of proven fraudulent payments. Under current law, courts are allowed, but not required, to collect full restitution.

Program Operations

Initial Determination Process

The following proposals to pilot improvements to the initial determination process should be designed and implemented by the agency to allow for rigorous evaluation, including, but not limited to: significant sample size, data collection, and use of randomized controlled trials, if possible. The demonstrations should be designed to track and monitor measures of important variables, including but not limited to: impact on program cost, including return on investment; efficiency of adjudicating claims; and the completeness and quality of the evidence available to evaluators. Pilots that result in improved efficiency, accuracy, and savings for the program should be expanded.

- Provide funding and direct SSA to pilot, in one region, the establishment of a national corps of medical and vocational consultants to provide assistance at all levels of the eligibility determination process. More than half of allowances at the DDS level are made at step 5, in which the Medical-Vocational Guidelines are utilized. When occupational or functional medical expertise is needed for residual functional capacity assessments, DDS examiners and administrative law judges (ALJs) must rely on medical or vocational personnel who may not have the appropriate expertise, many of whom are compensated on a fee schedule that makes it challenging to secure qualified experts. Under this pilot, SSA would establish the corps, which would be a pool of medical and vocational consultants across the nation who contract with SSA to provide services when needed and would be paid for each consultation. This standing corps would replace ad-hoc procurement of medical and vocational experts for when examiners and ALJs need to evaluate complex impairments or occupational physicians for purposes of functional determinations. (Note: This corps is not for consultative examinations.) When an examiner or ALJ needs specialized expertise, a consultant with the necessary qualifications would be randomly selected to assist.^{xvi} Sufficient funding should be provided to offer competitive compensation that will attract qualified medical and vocational staff to this corps. The pilot should be evaluated after five years, using appropriate metrics, to determine whether the services of the corps have improved the efficiency and completeness of the determination process in the states served by the pilot and also the net cost or savings to the SSDI program.
 - At that point, policymakers should decide whether to continue the pilot (i.e., if more experience is needed), make the program permanent and expand it to additional states or nationwide, or discontinue the medical and vocational corps.
- Establish a five-year pilot in up to five states to test ways to improve the process of obtaining complete evidence for the record at the DDS level. Currently, many claimants are denied at the DDS level due to incomplete evidence. SSA should attempt to ensure that appropriate allowances are made as early in the process as possible by trying different approaches, which could include: improving the clarity of notices requesting medical records; establishing an automated system to send simple postcards and/or e-mails to claimants and medical providers about which materials have/have not been received by the DDS; and including claimants on requests for information to doctors and other specialists, especially second-contact attempts when they are

^{xvi} A corps member who also serves as a treating physician would be disqualified from serving in a case in which they are a treating physician. Corps members who serve as a medical or vocational consultant at the initial determination for a particular applicant would be disqualified from being selected to consult during any appeals for that applicant.

nonresponsive. Ensure that those materials inform applicants that their cases may be denied due to insufficient evidence if they do not produce the evidence. Evaluate the pilot after five years in a timely manner with specific criteria for determining success, with the acknowledgement that some limited additional processing time will likely be reflected in those offices that are attempting to improve initial determinations, such that they do not simply deny claimants with incomplete files. Provide SSA with authority to expand the pilot nationwide if the SSDI Pilot Approval and Oversight Committee finds that the evidence demonstrates improvement in the efficiency of the determination process. This pilot could also be helpful in collecting data that can identify patterns of causes for applications that are rejected due to incomplete evidence.

- **Convert to a Web-based system for signing representatives onto cases by 2018.** Right now, SSA field offices do not prioritize this task, particularly because it is a paper-based system. Not having the representatives attached to the cases causes problems for timely submission of evidence and can adversely impact claimants' cases.

ALJ Hearings

- **Send notices for ALJ hearings at least 75 days before the scheduled hearing date.** Include within these notices a request that every effort be made to submit evidence at least five days before the hearing. The notice should indicate that, while evidence will be accepted, at minimum, through the time of the hearing, submitting it at least five days before the hearing allows the ALJ time to carefully read the evidence in advance of the hearing. A similar approach for hearing notices is being piloted in one region and has been positively received.
- **Authorize and direct the Appeals Council to proactively conduct post-effectuation reviews of decisions from ALJs with unusually high or low approval rates, and provide additional funding for this purpose so that the Appeals Council backlog is not increased.** The Appeals Council is already authorized to conduct quality reviews of certain aspects of the determination process, such as to determine if a particular program rule is being applied correctly. **Provide additional funding for the Appeals Council to conduct additional quality reviews without increasing the backlog.**
- **Improve the ALJ hiring process.** The Office of Personnel Management controls most of the hiring process for ALJs despite the fact that SSA hires more than 95 percent of all federal ALJs. The process has made it challenging to fill open ALJ positions with qualified individuals. An interagency working group is currently reviewing ways to improve the process of hiring ALJs for Social Security. The working group should identify any statutory and regulatory barriers to streamlining the ALJ hiring process, and Congress and the administration should then take action to address these barriers.

Continuing Disability Reviews

- **Clarify existing policy and provide additional training to DDS examiners on the Medical Improvement Review Standards and its exceptions, which in limited situations, allow a finding that disability ceased without showing that medical improvement occurred.** These exceptions are for cases where evidence clearly shows that a person should no longer be, or should never have been, considered disabled.

Conclusion and Future Steps

This consensus product of the working group represents agreement on the entire set of recommendations; reallocation should occur in concert with recommended program changes and pilots, and all should be enacted by the end of 2015. Going forward, policymakers should monitor the outcomes of the pilots and demonstrations recommended in this document (after providing necessary demonstration authority to SSA and other agencies that would be involved, such as the proposed WAVI Board, and after providing funding for these pilots). The working group recognizes that it will take a number of years to initiate (including systems change, outreach, and enrollment), operate, and thoroughly evaluate these demonstrations to understand the longitudinal effects on beneficiaries and on the SSDI program. Policymakers should use that evidence base, as it develops, to inform future changes to the SSDI program and other programs outside of SSDI to improve workforce attachment among people with disabilities.

Who We Are

The Disability Insurance Working Group was originally convened by the Bipartisan Policy Center in 2014. The group includes members from across the political spectrum with a variety of backgrounds and viewpoints, including academics, policy researchers, advocates for people with disabilities, representatives of the labor and business communities, and former congressional and agency staff.

Working Group Members

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DISCLAIMER

This report presents the consensus recommendations of the working group. Achieving consensus required compromise. The working group members listed above participated in their individual capacities—not on behalf of any particular organizations for which they may work or represent. While many members of the group would not endorse every provision herein on a stand-alone basis, they have agreed to support the complete package. Moreover, the findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center’s founders or its board of directors.

Biographies

Pete V. Domenici is a senior fellow at the Bipartisan Policy Center, where he has co-chaired its Debt Reduction Task Force, Health Care Cost Containment Initiative, and Task Force on Defense Budget and Strategy. Domenici served as a senator from New Mexico longer than any other person. During his 36 years in the Senate, Domenici served as chairman and ranking member of the Senate Budget Committee and the Appropriations Sub-Committee of Energy and Water Development. In addition, he served as chairman and ranking member of the Senate Energy and Natural Resources Committee.

David Hoppe is a senior advisor to the Bipartisan Policy Center. He served as the chief of staff for Senator Jon Kyl in the Republican whip's office. Prior to joining Senator Kyl's office, Hoppe was president of Quinn Gillespie and Associates, after having served nearly 30 years on Capitol Hill. He has also held a number of important staff positions in the Republican leadership, including as chief of staff to then-Senate Majority Leader Trent Lott from 1996 through 2002.

Doug Badger served as senior health policy adviser to President George W. Bush during the creation of the Medicare drug benefit and health savings accounts. He also was chief of staff to the U.S. Senate Republican Whip and staff director of the U.S. Senate Republican Policy Committee. Doug is now retired but still offers his views on policy and politics as a contributor to The Hill and in a blog called Doug's Brief Case (dougbriefcase.com/blog/).

Alison Barkoff is the director of advocacy at the Bazelon Center, where she works on policy and litigation related to inclusion of people with disabilities, including Olmstead enforcement, Medicaid, employment, housing, and education. She serves as an appointed member to a federal advisory committee on employment of people with disabilities. She recently returned to the Bazelon Center after serving as special counsel for Olmstead Enforcement in the Department of Justice and as special policy advisor in the Department of Labor and the Department of Health and Human Services. Prior to her time in government, she worked at a number of public-interest organizations on disability policy and litigation.

Henry Claypool is an independent consultant whose work in public service includes his most recent role as a member of the Commission on Long Term Care, which President Barack Obama appointed him to in 2013. Prior to serving on the commission, Claypool also served as the senior advisor for disability policy to the secretary of health and human services. Previous roles in public service include work with the Social Security Administration on the Ticket to Work program and as an advisor to the administrator of the Centers for Medicare and Medicaid at the end of the Clinton administration. When not in public service, he has worked with disability advocacy organizations and with a Medicaid managed-care organization that serves people with disabilities in New York City.

Lisa Ekman is a disability advocate with more than 15 years of experience working to improve economic security for people with disabilities, focusing on the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs, Medicare and Medicaid, employment programs, and long-term services and supports. Ekman has an extensive background in SSDI/SSI program policy, with a focus on assisting beneficiaries to return to work, working for the Social Security Administration on implementation of the

Ticket to Work and Work Incentives Improvement Act, as a staff member to the Ticket to Work and Work Incentives Advisory Panel, and as disability policy advisor to Senators Edward M. Kennedy, Tom Harkin, and James Jeffords on the Senate Health Education Labor and Pensions Committee.

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Marty Ford is senior executive officer for public policy at The Arc, a national organization advocating on behalf of people with intellectual and developmental disabilities and their families. She is a recognized leader in federal disability policy, with expertise in Social Security disability, long-term services and supports, and Medicaid issues. She served three years as chairperson of the Consortium for Citizens with Disabilities, a coalition of more than 100 national organizations. Ford currently serves on the Board of Directors of the National Academy of Social Insurance.

Connie Garner is the policy director of government strategies at Foley Hoag Law Firm, executive director for Advance CLASS, and serves as policy advisor to United Cerebral Palsy. For 17 years, Garner was policy director for disability and special populations to the U.S. Senate HELP Committee, under the late Chairman Senator Edward M. Kennedy. She previously worked as a licensed nurse practitioner and hospital administrator at major medical centers in Philadelphia and Washington, D.C.

Martin Gerry currently serves as the vice president for strategic initiatives of SourceAmerica and as the executive managing director of SourceAmerica's Institute for Economic Empowerment. Before joining SourceAmerica in 2007, Gerry served for almost six years as the Social Security Administration's deputy commissioner for disability and income security programs. Gerry has also served as executive director of the Austin Project at the LBJ School of Public Affairs of the University of Texas, assistant secretary for planning and evaluation at the U.S. Department of Health and Human Services, special counsel to the Wednesday Group of the House of Representatives, and as director of the Office for Civil Rights at the U.S. Department of Health, Education and Welfare.

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Pamela Mazerski is currently an independent consultant focusing on projects related to improving social insurance programs. She served in numerous senior executive positions at the Social Security Administration, where she directed that organization's \$80 million disability and income security research budget and led the development and implementation of numerous research demonstration projects aimed at creating employment opportunities for individuals with disabilities. Mazerski also has extensive experience developing policy options in the areas of disability, means-testing, and health insurance programs. She also served as a professional staffer on the House Ways and Means Social Security Subcommittee, where she worked on disability and employment-related legislation.

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Jeanne Morin is a public policy advisor at Akerman, LLP, with more than 25 years of experience as an advocate on legislative and policy issues, including Social Security disability policy. Her clients include not-for-profit associations that advocate on behalf of people with disabilities.

Lauren Rothfarb has more than 25 years experience as an advocate on Capitol Hill for working men and women. For the past 15 years, she has been in the Government Affairs Department of the AFL-CIO, where her legislative portfolio includes issues related to Social Security retirement and disability benefits. Rothfarb holds a law degree from U.C. Hastings College of the Law.

Robert "Bobby" Silverstein has more than 40 years of experience conducting research and policy analyses from a disability policy perspective. Currently, Silverstein is a principal in the Powers, Pyles, Sutter, and Verville, PC, law firm. While previously working on Capitol Hill, Silverstein served in various capacities, including as staff director and chief counsel for the Subcommittee on Disability Policy, and he was responsible for drafting and facilitating 20 disabilities-related bills into law, including the Americans with Disabilities Act and multiple reauthorizations of the Rehabilitation Act and the Individuals with Disabilities Education Act.

James Smith is the deputy to the director for the Vermont Division of Vocational Rehabilitation. As budget and policy manager, he oversees the division budget and the Vermont Division of Vocational Rehabilitation's Work Incentives Initiative. This includes a statewide-benefits counseling program for SSI and SSDI beneficiaries across programs. Smith also served on the Adequacy of Incentives Advisory Group for the Social Security Administration's (SSA) Ticket to Work program in 2004 and participated on the Technical Advisory Panel for the SSA Work Incentive Simplification Project in 2012. Prior to his involvement in work-incentive issues, Smith worked for 14 years in the supported-employment arena in Vermont and New York City.

David Stapleton is a senior fellow at Mathematica and the director of Mathematica's Center for Studying Disability Policy. Since 1991, his research has focused on the impacts of public policy on the employment, income, and well-being of people with disabilities. He has a Ph.D. in economics from the University of Wisconsin–Madison.

Madeleine Will has led efforts to create national transition and supported-employment programs and post-secondary education programs for students with disabilities. She served as assistant secretary of special education and rehabilitative services in the U.S. Department of Education, as chair of the President's Committee for People with Intellectual Disabilities, and as vice president of Public Policy for the National Down Syndrome Society. In 2008, Will co-founded the Collaboration to Promote Self-Determination, a coalition of 22 national disability organizations.

Aliya Wong is the executive director of retirement policy at the U.S. Chamber of Commerce. She is responsible for developing, promoting, and publicizing the chamber's policy on employer-provided retirement plans, nonqualified deferred compensation, and Social Security. Before joining the chamber, Wong was a practicing attorney specializing in Employee Retirement Income Security Act and tax-qualification matters related to pension, health and welfare plans, and executive compensation.

Ethel Zelenske is an attorney who has specialized in Social Security and SSI disability issues for more than 35 years. She was a legal-services attorney in Baltimore, Maryland, for 14 years, where she represented individuals in administrative and judicial proceedings. For more than 20 years as a policy advocate in Washington, D.C., Zelenske has advocated on behalf of people with disabilities on Social Security and SSI policy issues.

End Notes

¹ Available at: http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/di_asr13.pdf (see: Chart 4, p. 14).

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⁷ Available at: <http://www.gao.gov/assets/680/670835.pdf>.

⁸ Available at: http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/di_asr13.pdf (see: Table 50, p. 128).

Notes







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