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## Reducing Job Loss among Workers with New Health Problems

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Every year, millions of Americans lose their jobs or leave the workforce because of a medical condition (including injuries and diseases, both physical and psychological), at least temporarily (Hollenbeck 2015). Approximately 2.5 million apply for Social Security Disability Insurance (SSDI) benefits, about 1 million receive awards, and 24 months later are enrolled in Medicare (SSA 2017, Table 60). Very few awardees ever exit SSDI for work, and many denied applicants never return to work (Liu and Stapleton 2011; Maestas, Mullen, and Strand 2013).

By definition, “working-age” adults are those who are mature and capable enough to engage in the kinds of productive activity that ultimately support the entire population, including those who are not of working age or are dependent—the young and the aged. Thus, working adults are the economic engine of human society. At the individual level, paid work enables independence and economic self-sufficiency. A comprehensive review of the scientific literature on the health consequences of work has validated the assertion that work is usually good for human well-being, including for people with chronic conditions (Waddell and Burton 2006). However, loss of livelihood has not generally been recognized as the devastating outcome of a health condition it is. Work disability worsens subsequent physical and mental health status and increases mortality (Strully 2009; Waddell and Burton 2006). Even if workers obtain SSDI benefits and Medicare, their families’ standard of living will likely go down substantially (Ben-Shalom and Burak 2016; Schimmel and Stapleton 2012).

A strong and growing body of research indicates that many workers who might otherwise be able to stay in the labor force are losing their jobs and livelihoods today because no one provides the prompt and practical extra support they need, especially those with greater risk of long-term or permanent departure from the workforce. As a result, these workers fall through critical gaps in the social support system, often leading to suboptimal medical and functional outcomes as well as preventable work disability.

After just a few weeks or months off work due to their medical problems, at-risk workers are likely to lose their jobs if they are not yet fully recovered and lack either the confidence or actual ability to do specific tasks required by their jobs. Too often, no one helps them manage this predicament. Moreover, even if they receive some kind of disability benefits, payments are rarely sufficient. Faced with financial hardship, a sense of desperation grows. Some workers begin to worry they will never get back to “100 percent” or will never be able to find another job because of their limitations and then start thinking of SSDI or other government programs as the safest solution. But going on SSDI means a permanently stunted future for workers and their families and higher government expenditures for SSDI, Medicare, and other public programs. Ironically, once workers are out of the labor force and receiving public benefits, access improves to employment supports financed by the Social Security Administration (SSA), the Department of Education (ED), the Department of Labor (DOL), and states. As will be discussed below, however, the passage of time has already significantly eroded the chance that such supports will result in work retention.

In this chapter, we first present two hypothetical examples that illustrate these problems. We then briefly synthesize a growing body of evidence that shows that many of those who leave the workforce with health problems could have been prevented from doing so if certain events had occurred as their illness or injury unfolded. Much of that research has focused on very common conditions such as lower back pain, other musculoskeletal conditions, depression, and anxiety. Despite the fact that these conditions do not typically cause any noticeable absence from work—let alone prolonged work disability—people with these conditions now make up nearly half of new SSDI entrants (SSA 2017).

We then go on to describe how common health conditions progress to needless work disability; synthesize evidence on how well-designed, timely, and practical services can substantially reduce such disability; consider the systemic barriers that impede efficient expansion of such services; and describe policy proposals to address the systemic barriers. We conclude by making the case for investment in further development, testing of, and eventual scaling up of policy proposals that prove effective.

## **TWO HYPOTHETICAL EXAMPLES THAT ILLUSTRATE THE PROBLEM**

Consider two contrasting scenarios that illustrate some of the systemic barriers that cause so many workers with medical conditions to remain outside the workforce. The first is a sheetrock worker (wall-board installer) who injures his shoulder at work, causing him to stop work, seek medical care, and file a claim for workers' compensation.<sup>1</sup> The three subsequent events occur:

- 1) His claim for benefits is accepted, so his medical care is paid for and he receives a cash stipend to cover his living expenses.
- 2) A doctor promptly provides effective, evidence-based medical care; sets expectations to either remain at work or resume work quickly; encourages the injured worker to recover while working at tasks appropriate to his current capabilities; and sends work capacity information to the employer.
- 3) His employer is willing and able to waive essential functions of his job in the short term so he can work while still recovering, and to make long-term reasonable accommodations in case his eventual recovery is incomplete. The sheetrock worker therefore is on track toward the best possible recovery of function in his shoulder and maintaining his livelihood.

The odds of a good recovery and continuing to work become significantly worse if any of those three circumstances are different. In the second case, consider a sheetrock worker who is unlucky enough to have

the identical type of shoulder injury at home, but has no disability insurance coverage for off-the-job medical problems.<sup>2</sup> Even though he has health-care coverage, his physician, like most physicians, is unaware that prolonged time out of work jeopardizes job retention (Jurisic et al. 2017). When his condition improves enough to allow some work, his doctor prescribes overly protective work restrictions. The employer has no “light duty” policy, will not accept him back until he is fully recovered, and discharges him when his Family and Medical Leave Act protections expire. The worker is desperate for cash but is not sure what is medically safe for him to do at work and, in any case, is unsure where or how to look for a new kind of work. Because he is still recovering from his injury, neither he nor the professionals he encounters consider him a person with a disability and thus a candidate for vocational rehabilitation (VR) services. He will not request VR services himself because he is unaware that they even exist. Discouraged, he sees no good options other than to pursue SSDI benefits. For months or even years, he will attempt to prove to SSA that he is unable to do substantial work, and eventually is coached by a lawyer or advocate. As a new beneficiary, he will be offered an SSA performance-based voucher (a Ticket to Work) for services designed to help him return to work (e.g., vocational rehabilitation or job placement and training) and eventually give up his hard-won SSDI benefits—months or years after such services would have been timely.

The worker in the first example experienced a better long-term outcome because his physician was work aware, his employer was open to on-the-job recovery, and his injury was covered by workers’ compensation. Long-term or permanent job loss is often the result of unfavorable circumstances in these three domains during the critical early period of a medical condition. In the sections below, we describe reasons for these disparities and offer some strategies for government at the local, state, and federal levels to positively influence the behavior of stakeholders and thereby increase workforce retention.

## HOW COMMON HEALTH CONDITIONS BECOME NEEDLESS WORK DISABILITIES

As shown in the scenarios above, prolonged work absence is frequently due to a mix of medical and nonmedical factors, rather than just medical conditions themselves. Certain conditions are often diagnosed but inappropriately treated (e.g., lower back pain), while others (e.g., psychiatric conditions) may be undiagnosed, inappropriately treated, or simply untreated (Anand and Ben-Shalom 2017; Wang, Demler, and Kessler 2002). The uneven quality of and access to medical care in the United States has been well documented (Institute of Medicine 2001; Rosenberg et al. 2016). Many employers, especially small firms, remain unwilling to allow workers to return to work until they are “back to 100 percent,” especially if their health problems are not work related. The majority of U.S. workers are not covered by any kind of disability benefits program during the critical early period after onset of injury or illness.<sup>3</sup> While unable to work, they receive neither a paycheck nor expert help to stay at or return to work.

Many frontline professionals dealing directly with the workers (i.e., health-care professionals, employers, and sometimes insurers) do not see it as their responsibility to help workers keep their jobs (Christian 2015). Moreover, these professionals typically operate in isolation, as well as with many institutional barriers and little incentive to collaborate. Many workers and their families know little about how to navigate these complex systems, nor do they understand their own role in recovery and return to work. Without coordinated support to help them get their lives back on track, they get lost in the various health-care and benefits systems available to them. With every passing day away from work, the odds of returning to the same job decline (Franklin et al. 2015). Eventually they lose their jobs, such that returning to the workforce is even harder.

After prolonged absence from work, workers may start to view themselves as too sick or disabled to work, and begin to seek alternative sources of income such as SSDI and Supplemental Security Income (SSI),<sup>4</sup> possibly on the advice of relatives, physicians, insurers, lawyers, or worker advocates. These parties may truly believe that applying for benefits is in the workers’ best interest to meet their immediate financial

and medical needs. However, misaligned financial incentives also likely play a role: lawyers stand to gain from successful SSDI applications (SSA 2018), benefits paid by any private insurers are usually reduced by SSDI benefits on a dollar-for-dollar basis (Salkever, Shinogle, and Purushothaman 2001), and health-care providers have an interest in helping uninsured workers access funding for their care.

## **EVIDENCE SHOWS THAT EARLY SUPPORT RESULTS IN BETTER OUTCOMES**

Regaining the capacity to work and remain in the labor force often leads to better overall quality of life for workers with medical conditions, as compared to leaving the labor force and becoming dependent on disability benefits. To reduce current levels of work loss and SSDI entry in the working population, work disability prevention services must be systematically applied soon after the onset of a health condition that threatens the worker's ability to work—while the person is still employed and long before they apply for SSDI (Waddell and Burton 2004).

Health-care services that restore capabilities required for work may not be enough. Optimally timed, well-targeted, quick interventions taken by other stakeholders (including the worker) during the first few weeks after the onset of such a condition can also have a major influence on whether the worker ultimately returns to work or leaves the labor force (see, for example, Franklin et al. 2013; Loisel and Anema 2013; Shaw et al. 2013). Even a few telephone conversations between the worker, health-care provider, and employer can make a big difference. Evidence has shown that the window of opportunity during which simple approaches can significantly impact the worker outcomes typically closes around 12 weeks after the onset of work disability (Christian, Wickizer, and Burton 2016). The best approach is to intervene immediately and avert any noticeable work absence.<sup>5</sup>

Most of the promising, evidence-based interventions were first developed and tested in the private sector by employers, private disability insurers, and workers' compensation insurers. For example, workers' compensation insurers emphasize safety programs to reduce

injuries, and stay-at-work/return-to-work (SAW/RTW) programs to reduce work disability after medical conditions arise. Private disability insurers also devote resources to early return-to-work programs. When these services are properly designed and delivered, many workers with newly acquired common health conditions can avoid prolonged work disability, job loss, and use of SSDI benefits (Bowling 2000; Caruso 2013; Franklin et al. 2015; McLaren, Reville, and Seabury 2010; Waddell, Burton, and Aylward 2008; Wickizer et al. 2004, 2011). Unfortunately, only a small proportion of workers currently have access to such assistance.

Evidence shows that tailored support services lead to greater job retention, particularly for workers with musculoskeletal conditions (especially lower back pain), mental health conditions, and other chronic conditions for which adherence to treatment is critical (Anand and Ben-Shalom 2017; Stapleton et al. 2015).<sup>6</sup> In the public sector, Washington State's Centers for Occupational Health and Education (COHEs) have demonstrated that providing a tightly defined set of immediate-to-early, evidence-based, and uncomplicated services to workers' compensation claimants can dramatically reduce long-term work disability (Stapleton and Christian 2016). The state agency that manages the public workers' compensation fund contracts with COHEs housed in the private health-care delivery system. COHEs recruit community physicians as members and educate them on four specific best practices in SAW/RTW for which they are paid. In addition, every newly injured worker who sees a COHE member physician is automatically assigned to one of the COHE's health services coordinators (HSCs). Both member physicians and the HSCs have access to data in the payer's claim system. The HSCs use the system to monitor their cases, looking for issues that might lead to long-term or permanent exits from the workforce. About 75 percent of cases receive no active intervention. As needed, HSCs communicate with workers, physicians, employers, and claims staff; obtain, clarify, or share information; expedite medical care; or facilitate arrangements for return to work on either a temporarily modified or regular work schedule.

Washington State's Department of Labor and Industries first tested the COHE model in the early 2000s. A series of rigorous evaluations found substantial reductions in lost work time and improvements in worker satisfaction as well as job retention, leading to statewide expan-

sion of the program.<sup>7</sup> Based in part on this documented success, the President's 2018 Fiscal Year Budget includes substantial funding for a new demonstration project that will test key features of the COHE model in several jurisdictions, which are not restricted to workers' compensation settings (OMB 2017).

## **SYSTEMIC BARRIERS IMPEDE EFFICIENT EXPANSION OF EVIDENCE-BASED SUPPORT**

Society has both economic and humanitarian interests in reducing the incidence of prolonged work disability and job loss, but multiple systemic barriers stand in the way of achieving that goal. Notable impediments include misaligned economic incentives among the various stakeholders; lack of dedicated resources coupled with fragmentation of responsibilities, capabilities, and accountability for delivering the necessary supports; and legal barriers to communication among those who need to cooperate in providing supports.

### **Misaligned Incentives**

The stakeholders who accrue most of the economic losses from work disability differ from the stakeholders most well positioned to prevent disability. If a median income worker exits the labor force because of work disability at age 50, the worker's family stands to lose on average \$420,000 through retirement age, mostly because of lost earnings, which are only partially replaced by public benefits (Ben-Shalom and Burak 2016). State governments stand to lose \$83,000 per worker during those years, primarily because of lost tax revenues. The federal government stands to lose over \$290,000 per worker through retirement age, due to the cost of cash benefits (SSDI and SSI), health insurance (Medicare and Medicaid), and lost tax revenues. Although workers and their families have the highest financial stake, they may be misinformed about the financial consequences of work disability and have little knowledge about how to prevent it. The federal government has the second highest financial stake, but it is not well positioned to help workers directly.



Stakeholders in the best positions to facilitate workforce retention are private disability, workers' compensation, and health insurers; health-care, rehabilitation, and other professionals; employers; and state and local health and human service agencies. Yet, these actors are typically limited in the degree to which they can intervene, or are even disincentivized to so. Although self-insured employers do have a clear stake in work disability outcomes, roughly half of the workforce is employed by organizations too small to self-insure for workers' compensation or disability benefits.<sup>8</sup> For employers that do not provide disability benefits, it will often *not* be in their financial interest to invest in interventions to retain workers with medical conditions—especially if the enterprise is small or if the employee can be readily replaced.

In the case of the health-care delivery sector, professionals derive financial benefit by maximizing service delivery, but they tend to focus only on patient diagnosis and treatment and not on return to function and work (Jurisic et al. 2017). In fact, health-care payment systems today typically favor services that may *increase* the chance of work disability, such as prescribing medications and performing surgery, rather than spending time educating patients and employers on accommodation strategies to assist workers' return (see, for example, Franklin et al. 2008).

### **Lack of Dedicated Resources**

Across the governmental, charitable, and nonprofit or for-profit private sectors in the United States, there is no substantial organization dedicated to the proposition that work disability is often preventable and requires active steps to avoid whenever feasible. On an incidental basis, programs funded by both the DOL and ED provide services to workers struggling with medical problems that may ultimately lead to their application for SSDI benefits. However, none of these programs focus specifically on helping workers with new medical conditions or diminished functional abilities retain their jobs or find new employment. For example, DOL-funded state programs target services to unemployed individuals, but those out of work due to new or still-evolving medical conditions are not typically included. ED-funded state vocational rehabilitation (VR) agencies deliver employment services to individuals with disabilities regardless of current or past employment, but by law

must give priority to those with the most severe disabilities. Hence, few VR clients are those who recently began experiencing medical problems and who are still employed.<sup>9</sup>

### **Fragmentation of Responsibilities**

Lack of resources dedicated to reducing work disability stems from a fragmentation of public sector responsibilities. This issue interacts with the misalignment of incentives in major ways. Fragmentation starts at the federal agency level. The two agencies that operate the programs most likely to experience savings from reductions in work disability, SSA and the Centers for Medicare and Medicaid Services (CMS), have no statutory authority to invest in prevention of work disability. SSA does make substantial investments in work supports for SSDI and SSI recipients, but only after months or years of work disability.

Fragmentation extends to state and local governments. In every state, a number of agencies are in a position to provide support to workers with medical conditions before they lose their jobs, but have neither the mandate nor much incentive to do so, either individually or collaboratively (Ben-Shalom 2016). For example, five states and Puerto Rico have mandatory short-term disability insurance (STDI) benefits, including three that provide insurance to most workers via public funds (California, New Jersey, and Rhode Island).<sup>10</sup> The three state-funded STDI programs could potentially modify their service approach to include proactive job-retention strategies, but they have pursued only modest efforts to date. State health agencies also could modify Medicaid benefit programs, influence health insurers, and health-care delivery organizations through their regulation of insurance and the Health Insurance Exchange, and adjust their public health programs. State departments operating ED-funded VR programs and DOL-operated employment and training programs could better coordinate their efforts across agency boundaries. State-operated Disability Determination Services make the initial medical eligibility decisions for SSDI and SSI applicants under the aegis of SSA, but they might be able to expand their service repertoire to workers still on the job.

One important source of fragmentation is that a worker with a medical condition attributed to work is usually eligible for cash benefits as well as medical and other services financed by workers' compensation,

as governed by state law, while the same worker with the same condition *not* attributed to work would need to seek assistance from other sources. Workers have strong incentives to claim that their condition is job related, while employers and insurers have strong incentives to deny their claim. A frequent result is litigation, which may delay assistance or otherwise cause needless work disability. Furthermore, even though the majority of workers' compensation expenditures are health related, the agencies that oversee those claims are different from those that oversee and regulate other health-related state activities. Hence, efforts to ensure delivery of high quality care to workers' compensation claimants seldom extend to workers with nonoccupational conditions.

### **Legal Barriers to Communications**

Privacy protections, particularly under the Health Insurance Portability and Accountability Act (HIPAA), prevent multistakeholder communication and coordination to help workers remain at work and employed. Such protections are necessary and appropriate, but the logistical challenges posed by authorization procedures and fear of potential liability often make it extremely difficult for the involved parties—workers, providers, employers, insurers, and SAW/RTW specialists—to exchange basic nonmedical information such as estimates of current work capacity and to collaborate on return-to-work planning. Although HIPAA does waive some privacy protections when a medical condition is covered under workers' compensation, health-care delivery organizations are typically unwilling to vary their procedures (Hodge 2003).

## **POLICY PROPOSALS THAT ADDRESS SYSTEMIC BARRIERS**

We begin by looking at several existing proposals that address the problem of misaligned incentives, each focused on strengthening employer and private insurer incentives to invest in programs that reduce work disability. We then present two other proposals developed

by the authors of this chapter, in collaboration with others, that address various aspects of the aforementioned systemic barriers.<sup>11</sup>

### **Improving Employer and Insurer Incentives**

Several policy proposals aim to reduce work disability primarily via major changes in incentives for employers and private disability insurers. Autor and Duggan (2010) suggest a federal requirement for employers to purchase medium-term disability insurance coverage that includes 24 months of cash benefits for workers before they are eligible for SSDI. Premiums would be experience rated, so that they would increase or decrease based on the number of individuals entering SSDI whom the employer had employed at the time of work disability onset. Burkhauser and Daly (2011) recommend adjusting the rate of the federal SSDI payroll taxes in a similar manner. Although these proposals might drive more investments to prevent work disability, the policies would place significant burdens on some employers, particularly small ones. They would also make the employment of low-skilled workers relatively less attractive, because such workers are much more likely to experience significant medical problems.<sup>12</sup>

Other proposals would strengthen private disability insurer investments in workforce retention in more modest ways. Anand and Wittenburg (2017) suggest a federal requirement for private disability insurers to pay the first 24 months of SSDI benefits for their eligible claimants in exchange for a payroll tax deduction. The payroll tax deduction would offset the expected increase in premiums that insurers would need to charge due to increased losses in those first 24 months.

In addition, the private disability insurance industry is promoting a proposal to expand private coverage by allowing employers to automatically enroll workers in their private disability insurance plans by default (at no cost to the government), similar to programs designed to increase employee participation in 401(k) retirement plans (Babbel and Meyer 2016). Presumably, this change would increase employee take-up rates for employers that offer disability insurance as a benefit option, and make private insurance more attractive to employers by lowering per-worker premiums. Premiums would decline because newly covered workers would be less likely to file claims. Once covered, workers would be eligible for whatever work retention services

are already offered by the carrier. However, since wage replacement rates for private coverage are often substantially more generous than for SSDI, more workers with medical conditions may leave the labor force in favor of long-term disability benefits, countering the positive impacts of increased work retention services.

### **Health and Work Service (HWS)**

Christian, Wickizer, and Burton (2016, p.1) recommend the “establishment of a community-focused Health & Work Service (HWS) dedicated to responding rapidly to new health-related work absence among working people due to potentially disabling conditions.” Modeled in part on Washington’s COHE design, the HWS would directly address the lack of dedicated resources and limited responsibility across federal, state, and local levels for reducing work disability. It would also address barriers to communication due to system fragmentation and privacy protections. To be successful, it would require the support and cooperation of federal and state agencies that have interrelated responsibilities.

The HWS would establish relationships at the local community level and actively elicit referrals from physicians, employers, and insurers, as well as self-referrals of workers with medical issues. Eligibility for HWS intervention would begin when work absence is expected to last or has lasted more than four weeks. The HWS would be charged with providing basic, low cost, evidence-informed services known to quickly improve long-term health and employment outcomes for common health problems. Typically, HWS staff would deliver services primarily by telephone or by Internet for no longer than three months (extended if necessary).<sup>13</sup> However, workers with unusual or catastrophic illnesses or injuries would be referred immediately to organizations providing comprehensive rehabilitation or more intensive services.

HWS staff would quickly evaluate each individual’s situation, screen for known risks for long-term or permanent unemployment, help to develop a return-to-work plan, and ensure coordinated delivery of the medical, rehabilitative, and other services needed to carry out that plan. The HWS would operate in a multisystem/multipayer environment, accepting referrals of employed patients with disability benefits coverage, workers’ compensation claims, health-care insurance, Medicaid, Medicare, or no benefits at all. A mixture of government subsidies,

charitable contributions, and fee-for-service revenue would support the service provisions.

### **Employment/Eligibility Service (EES)**

Stapleton, Ben-Shalom, and Mann (2016, p. 1) propose “the development, testing, and adoption of a nationwide system of integrated employment/eligibility services” (EESs). A state or local government could establish this approach, potentially in partnership with the private sector. EESs would fundamentally restructure the fragmented paths that workers currently take to enter SSDI if they think they are unemployable due to a medical condition. The EES would integrate timely provision of reemployment support services with a new process to determine SSDI eligibility.

EES outreach activities would encourage workers and their representatives to contact the EES immediately upon the onset of a work-threatening medical condition—preferably while the worker still has a job. Triage would be a central function of the EES, to quickly identify the group of workers needing assistance to return to work. A first group with serious medical conditions would be “fast-tracked” into SSDI. A second group would be offered employment supports—both temporary cash benefits and services. A third group would not be eligible for support.

The work supports would be conditional on the worker’s good faith effort to return to substantial work. If the worker’s medical condition becomes worse, or the worker is unable to return to work after a substantial effort, the worker’s eligibility for SSDI benefits will be reconsidered. The employment supports serve a dual purpose: on the one hand, they aim to improve employment security; on the other hand, they allow the worker to try out his or her work capability, build confidence, and earn money while provided with support. SSA would assess the reasonableness or sincerity of the applicant’s work attempts when reconsidering the application.

### **The HWS and EES Proposals Are Complementary**

The HWS would create a system at the community level that does not currently exist. It would make available basic SAW/RTW expertise

during the brief window when simple interventions have the biggest impact. HWS staff would prioritize and sort cases, and refer cases to the EES in which workers' obstacles to continued employment exceed the capabilities and time frame of the HWS.

From the national policy perspective, as well as the taxpayers' point of view, an HWS or EES system that effectively reduces labor force exit and SSDI entry is likely to result in large net benefits. Calculations by Stapleton, Ben-Shalom, and Mann (2016, p. 15) suggest that, in the long run—after a sustained period of annual investments in system development—“federal savings on the order of \$25 billion per year are certainly plausible,”<sup>14</sup> accounting for the \$7 billion in additional expenditures on work supports. The bulk of the savings would come from reduced SSDI expenditures, while other contributing factors would include decreased expenditure on Medicare, SSI, and Medicaid.

## **NEXT STEPS: DEVELOPMENT, TESTING, AND SCALING UP**

The dearth of public support for workers during the critical window of time after the onset of work-threatening health conditions leads to needless work disability. As a result, many workers unnecessarily lose their livelihoods and enter SSDI, Medicare, and other public programs. This lack of support is due not to an absence of evidence that well-designed assistance can reduce work disability, but rather to systemic barriers to efficiently expand the delivery of such assistance.

Policymakers are starting to pay more attention to the high public costs of the large numbers of workers experiencing needless work disability. As previously indicated, there is extensive evidence about services and other supports that can increase workforce retention for individual workers. The immediate challenge facing policymakers is how to develop and test proposals that would address the barriers before wholesale implementation. It is important to consider and readjust for unintended negative impacts of these proposals such as the hardships many workers with significant medical problems could experience, expenditures far exceeding expectations, or new administrative processes that may be dysfunctional.

Many have called for the federal government to support a series of multiagency development and demonstration projects for this purpose. For instance, the demonstration effort recommended by Liebman and Smalligan (2013) supports testing of the types of proposals described in the previous section, as would the multiagency efforts more recently recommended by the SSDI Solutions Initiative (McCrery and Pomeroy 2016b), the Bipartisan Policy Center (2015), and Office of Management and Budget in its budget proposal for fiscal year 2018 (OMB 2017). As we complete this chapter in early 2018, DOL and SSA are about to launch such an effort, the Retaining Employment and Talent After Injury/Illness (RETAIN) demonstration—an opportunity for states to develop and test workforce retention supports modeled after those used successfully in other contexts, including the COHE services described earlier. There is an enormous opportunity for such efforts to result in long-term, substantial reductions in both needless work disability and growth in public expenditures for disabled workers.

## Notes

1. Workers' compensation covers cash benefits and medical care to workers with job-related (or "on-the-job") medical conditions. In 46 states and the District of Columbia, employers may either purchase workers' compensation insurance in a competitive marketplace or self-insure. Four states—North Dakota, Ohio, Washington, and Wyoming—rely exclusively on state workers' compensation funds.
2. Short- and long-term disability insurance programs provide partial wage replacement to workers with medical conditions that are not job related. In 2014, less than 40 percent of all workers in private industry were covered by short-term disability income insurance, and 31 percent were covered by long-term disability income insurance; coverage rates were lower among low-paid workers (Monaco 2015).
3. Less than one-third of disabling injuries that result in work absence are caused by work and are potentially eligible for workers' compensation (Price et al. 2012). Although most workers are covered, not all are. For example, farm workers and sole proprietors are excluded in many states. Disability insurers play a less important role than one might think.
4. SSDI is a social insurance program that provides partial wage replacement to adult workers after the onset of a qualifying, long-term disability. To qualify for disabled worker SSDI benefits, the individual must be "disability insured" (i.e., have a sufficient recent work history), have a medically determinable impairment that has lasted or is expected to last for at least 12 months or result in death and prevent engagement in substantial gainful activity (SGA). In 2018, SSA considered SGA



to be the equivalent of the work required to have unsubsidized earnings above \$1,180 per month for nonblind applicants and \$1,970 for blind applicants. SSI is a means-tested benefit available to working-age adults meeting the same medical criteria who do not have enough work credits to qualify for SSDI, or whose assets, SSDI benefits, and any other income are low enough to satisfy the SSI means test. Countable asset limits, which have not changed since 1989, are \$2,000 for an individual and \$3,000 for a couple. The federal monthly SSI payment is the difference between countable income and an annually adjusted amount called the federal payment rate (in 2018, \$750 for an individual and \$1,125 for a couple). Children under age 18 may also be eligible for SSI, but the under-18 eligibility criteria are different; hence, SSA redetermines the eligibility of SSI children when they reach age 18. Some children with disabilities first become eligible for SSI at age 18 because their parents' income and assets are no longer germane to the means test. SSI eligibility for individuals over age 65 is based on the means test alone.

5. Under some circumstances, the window of opportunity may be extended beyond 12 weeks if the specific nature of the medical condition and its treatment still predict the ability to either remain at work or resume work quickly.
6. Examples of such successful interventions include the following: two states in Australia providing physicians with evidence-based guidelines for managing patients with lower back pain (Buchbinder, Jolley, and Wyatt 2001); a Canadian hospital using a multidisciplinary model of back pain management that includes both clinical and ergonomic approaches (Loisel et al. 1997); three health districts in Madrid, Spain, offering people with musculoskeletal conditions a program of education and protocol-based clinical management at their regular physician visits (Abasolo et al. 2005); and a Swedish occupational health-care center providing communication and problem-solving skills to workers with back pain and their immediate supervisors (Linton et al. 2016).
7. A rigorous evaluation of the COHE pilot found that the program, over 12 months, lowered medical costs by 7 percent, disability payment costs by 24 percent, and the jobless rate of workers by 21 percent; reductions in the latter two measures were even greater among workers with back sprains—34 and 37 percent, respectively (Wickizer et al. 2011). Preliminary follow-up results suggest that the COHE program reduced SSDI entry among participants by 26 percent in the eight years after they filed their workers' compensation claim (Franklin et al. 2015).
8. Virtually all employers who do not self-insure are still required to provide workers' compensation coverage through private or public insurance carriers.
9. A few state VR agencies (e.g., Alabama, Arkansas, and South Carolina) deliver services to the latter type of workers, but on a very small scale.
10. Hawaii and New York require employers to provide short-term disability benefits through self-insurance or a licensed carrier.
11. Both proposals were commissioned by the McCrery-Pomeroy SSDI Solutions Initiative, organized and managed by the Committee for a Responsible Federal Budget to identify "practical policy changes to improve the SSDI program and other services to people with disabilities." These proposals are described in detail in that initiative's book (McCrery and Pomeroy 2016b).

12. Stapleton et al. (2017) found that, in the absence of behavioral change, labor costs will rise substantially for many low-wage workers, whereas they will decline for high-wage workers. This finding points to a feature of SSDI's financial structure: the fact that low-wage workers are more likely to enter SSDI than those with higher wages makes SSDI more progressive than the program's wage-replacement schedule implies. The SSDI monthly benefit formula, based on an index of average past monthly wages that were subject to Social Security payroll taxation, is the same as that used for Social Security retirement benefits. In 2017, monthly benefits to new awardees replace 90 percent of the past wage average up to \$885, 32 percent from \$885 to \$5,336, and 15 percent for average wages in excess of that amount.
13. Service would largely be telephonic or Internet based because this method has been shown to be effective, feasible, and lower cost across wide geographic areas than face-to-face delivery in brick-and-mortar facilities (Burton et al. 2013).
14. Stapleton, Ben-Shalom, and Mann (2016), based on evidence from prior research, assumed, in the long run, a 15 percent reduction in SSDI entrants of all ages, and that the EESs would provide work supports for four times that many workers—that is, one in four workers receiving work supports would ultimately remain in the labor force and the rest would continue to SSDI.

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