

Disability benefit reform in Great Britain from the perspective of the United States

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ABSTRACT

In 2008, Great Britain overhauled its disability benefit program by introducing a new disability determination process called the Work Capability Assessment (WCA) and a new earnings replacement program called Employment Support Allowance (ESA). This paper examines the British reforms from the perspective of the United States, which may consider changes to the Social Security Disability Insurance (SSDI) program in the near future. The paper provides an overview of the steps leading to the reform in Britain, details how the new system operates, and reviews research on its initial implementation and effects. The paper concludes by identifying lessons for the reform of the SSDI program in the United States.

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I. INTRODUCTION

The Social Security Disability Insurance (SSDI) program is the largest earnings replacement program for working age adults in the United States. In 2012, 8.8 million disabled workers (not including their dependents) received SSDI payments that averaged \$1,130 a month (SSA, 2012). Expenses exceeding revenues, the Disability Trust Fund that finances the SSDI program is projected to default in 2016 (Board of Trustees, 2013). Subsequently, many have argued that the SSDI program is on an unsustainable path and requires reform (Burkhauser & Daly, 2012; CBO, 2012; Liebman & Smalligan, 2013).

Given the possibility that SSDI reform will be on the legislative horizon in the near future, there is considerable interest in learning from disability benefit reforms in other countries. The Netherlands is perhaps most frequently identified as the exemplar for disability policy reform. In the 1990's, a so-called "Dutch Disease" (Arts, Burkhauser, & De Jong, 1995) saw an excessive share of the working-age population receiving disability benefits. Reforms put forward in 2002 significantly reduced the caseload size by among other changes incentivizing employers to invest in the rehabilitation and accommodation of their disabled workers. Burkhauser, Daly, & De Jong (2008) posit that similar employer oriented reforms hold promise for the SSDI program. Others looking internationally for lessons have noted the financial incentives created for recipients to return to work in Norway (Kostøl and Mogstad, 2013), as well as the liberal work rules for disabled beneficiaries in Japan (Rajnes, 2010). Though the Incapacity Benefit (IB) program in Great Britain was perhaps the most similar to the SSDI program in the world, the reform of the IB program in 2008 has received relatively sparse attention in disability policy circles in the United States. Burkhauser, Daly, Mcvicar, & Wilkins (2014), for example, provide an excellent examination of reforms in other OECD countries in search for lessons for the United States. Though they include Britain in their analysis, they provide only a broad review of the reform of the IB program and do not examine its early effects. A report by Mathematica researchers did draw this country comparison, however, this research identified lessons for Britain from the United States (Rangajaran, Wittenburg, Honeycutt, & Brucker, 2008). This paper, on the other hand, will examine the recent disability benefit reforms in Great Britain in search for lessons for the United States.

II. BACKGROUND

The SSDI program provides earnings replacements to all nonelderly adults – below the full retirement age (currently 66 years of age) – who have a work history and are judged incapable of work because of a medically determined physical or mental condition. The primary guideline for qualifying for SSDI is to receive a medical assessment confirming that the individual's impairment makes them, "unable to engage in a substantial gainful activity", which is defined as earning no more than \$1,070 per month in 2014. The impairment, moreover, is expected to last more than a year or to result in death. Monthly benefit payments are made to the disabled beneficiary based on lifetime pre-disability earnings. Beneficiaries are also eligible for public health insurance (Medicare) once enrolled on the SSDI program for two years. The program is supported by the federal Disability Insurance Trust Fund, which is based upon a shared tax on 0.9% (1.8% in total but subject to a maximum) of annual earnings of all employees and employers.

Prior to the 2007 Welfare Reform Act, the comparable contribution-based disability benefit program in Britain was called Incapacity Benefit (IB). IB provided earnings replacements to those below the state pension age (age 65 for men and 60 for women), who had a work history and were determined unable to carry out “any” work due to a medically diagnosed incapacity. Unlike SSDI, IB was distributed based on three different pay scales, which depended not on previous earnings but on the length of time the recipient was impaired. Many beneficiaries of IB also received Disability Living Allowance (now called Personal Independence Payments), an extra cost of living benefit, of which there is no comparable national program in the US. Nevertheless, the IB and SSDI programs were far more similar than they were different. In 2006, for example, the IB program provided benefits to a comparable share of the working age population as the SSDI program (2.97% in the U.S. and 2.87% in Britain), and in both programs more than half of the disability caseloads were composed of those 50 years old or older, more than half were male, and more than half were diagnosed with musculoskeletal or mental health impairments (SSA 2012; DWP 2014).

Since October of 2008, however, the program in Britain changed significantly. At this time, Britain began directing all new IB applicants to apply to the Employment Support Allowance (ESA) program. The major change that came with the ESA program is a new medical assessment process called the Work Capability Assessment (WCA). The WCA measures capabilities to work and thus distinguishes between two types of eligible disability benefit claimants: those who are considered to have limited capability for work and those that are found to have limited capability for work and limited capability for work related activity. Those who are found capable of work-related activity are placed in a Work Related Activity Group (WRAG) and are subject to work-conditions and, as of May 2012, time limits (52 weeks) for benefit receipt. However, time limits apply only to those with a previous record of work. For those found to have limited capability for work and limited capability for work related activity, they are placed in a Support Group (SG) that is exempt from the work conditions and time limits. All IB recipients were also reassessed onto the ESA program. The reassessments began in 2011 and were planned to conclude by April 2014, however, there are reports of delays.

A. Work-promotion efforts for SSDI recipients

Though all SSDI beneficiaries receive eligibility by way of a disability determination process finding them incapable of substantial gainful activity, in recent decades Congress has advanced a number of initiatives to encourage the re-employment of disabled beneficiaries. This work-oriented turn corresponds with the ideas advanced by the disability rights movement toward promoting the greater social inclusion and self-sufficiency of disabled people (Oliver, 1990). The landmark Americans with Disabilities Act (ADA) marked the major legislative breakthrough in this regard. The ADA consisted of comprehensive anti-discrimination legislation, as well as host of federal regulations that required public entities to ensure for the full participation of disabled people in mainstream society. For SSDI recipients, Congress has introduced a number of employment support provisions. Recipients are eligible for a trial work period of nine months to test their abilities without the risk of losing benefits, for example, and can receive Medicare for up to 93 months following a successful return to employment. The Ticket to Work program – signed into law in 1999 – is likely the largest employment oriented

initiative. This program seeks to expand access to employment services and vocational rehabilitation to recipients by providing a voucher (or a “ticket”) to receive such services from third-party providers on a voluntary basis. Yet, with just 2% of recipients utilizing their tickets and less than 1% of SSDI recipients leaving the rolls for employment each year, the Ticket to Work program is generally found not to have had a significant impact on employment (O’Leary, Livermore, & Stapleton, 2011).

The prospects for future interventions are encouraged, however, by econometric research that finds that many recipients – particularly younger recipients on the SSDI program who are made eligible upon appeal – are likely to have considerable work abilities (Maestas, Mullen, & Strand, 2013; Wachter, Song, & Manchester, 2011). Moreover, many disability benefit recipients themselves also express the desire and expectation of returning to employment. In a nationally representative survey of disabled beneficiaries in 2004, for example, 40% stated that they either had personal goals that included working or that they expected to be working in one to five years (Livermore, 2011). Yet research examining the factors preventing more beneficiaries from leaving the rolls notes the “benefits trap” (Olney and Lyle, 2011) that exists for recipients who would like to return to work but fear losing medical and cash benefits. To this end, the SSA is currently evaluating a benefit-offset program that reduces benefits for SSDI recipients by \$1 for every \$2 earned over the Substantial Gainful Activity (SGA) threshold. The idea being that this will reduce the penalty to work for SSDI beneficiaries. While demonstration projects such as this may hold promise for minimizing the disincentives for current beneficiaries to return to employment, further action is likely necessary to reduce expenditures and boost employment.

III. METHODS

In order to provide an examination of the British disability benefit reforms from the perspective of the United States, a case study methodology is applied. The research involved an in-depth review of major government publications and reports in Great Britain on the ESA program, including a country specific report published by the OECD (2014) that covered the ESA reform extensively. The researcher also surveyed academic literature and media reports on the recent reforms in Great Britain. The aggregate data that is presented in the analysis was compiled by way of the publicly available statistical dashboard made available by the Department for Work and Pensions (DWP) in Great Britain. This is at times compared alongside data retrieved from the *Annual Statistical Report on the Social Security Disability Insurance Program*. The researcher further conducted an interview with a member of the Work Capability Assessment Policy Team at DWP headquarters in London in September 2013. The interview served to clarify concepts and findings identified in the literature and lead to additional publications and evaluations reviewed in the final analysis.

IV. FINDINGS

The findings are presented as follows. First, a brief historical overview of disability benefit reform in Great Britain is provided that details the steps leading to the 2008 reforms in Great Britain. Second, the report describes the Employment Support Allowance (ESA) program and the Work Capability Assessment (WCA) in some detail. Third, the report examines data from the implementation of the program and reviews research on its effects. The subsequent

section will present lessons for the reform of the SSDI program based on the experience in Great Britain.

A. Historical overview of disability benefit reform in Great Britain

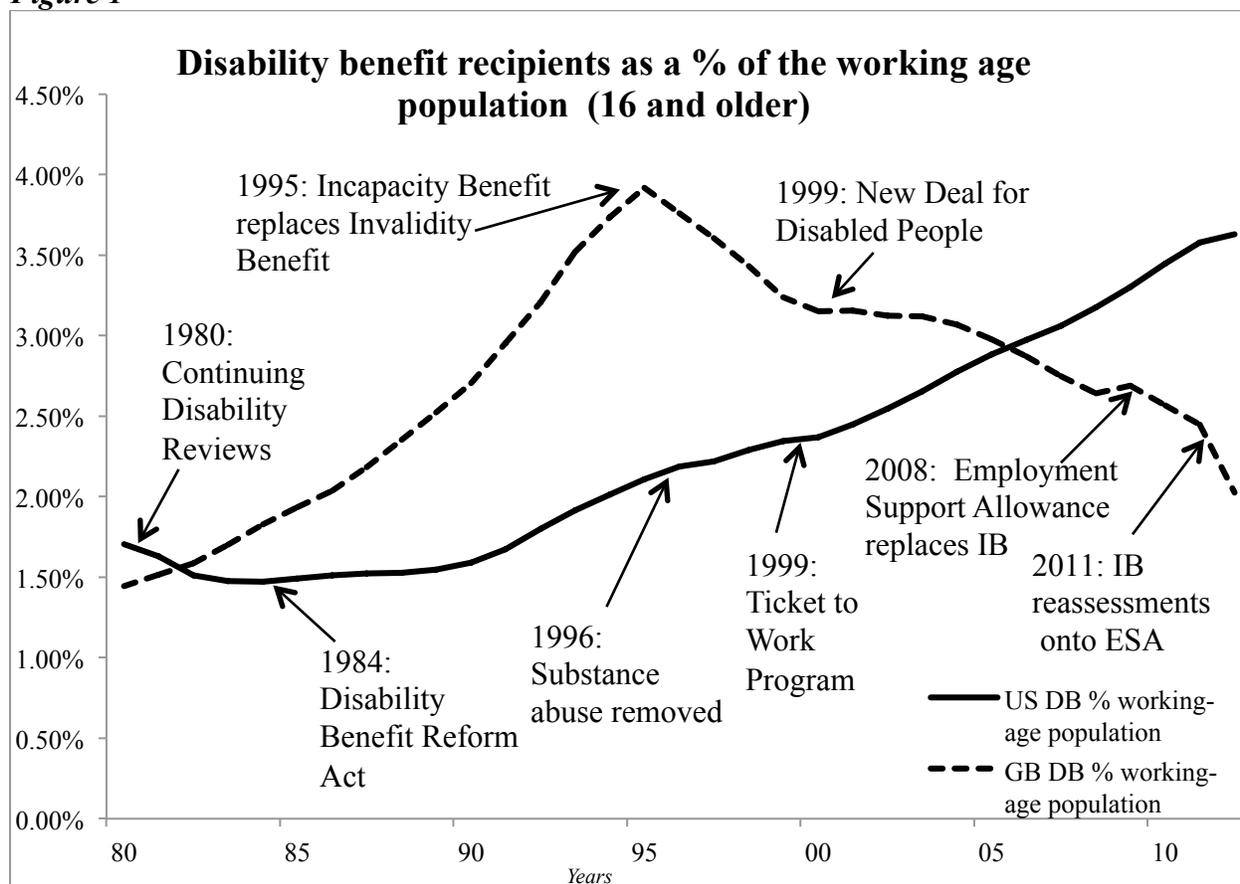
Disability benefits were first provided in Great Britain in 1948 as part of the Sickness Benefits program, which did not differentiate between long-term and short-term impairments. The Invalidity Benefit (IVB) program was introduced as a long-term disability benefit program in 1971 with more generous replacement rates and included benefits for dependents. The determination process to receive IVB consisted of a medical assessment administered by a personal doctor concerning the individual's ability to conduct his/her "own occupation" (Adam, Bozio, & Emmerson, 2010). Over time, the IVB program grew significantly in size and more rapidly than the SSDI program in the US (see, Figure 1). By 1995, nearly 4% of the working age population received IVB benefits in Britain having grown from 1.5% in 1980. With claimants tending to concentrate geographically in areas of industrial decline, Beatty and Fothergill (1995) found that the rapid dismantling of the coal industry during the late 1980s and early 1990s led to growing numbers of male IVB claimant as a means of "hidden unemployment". It also appears that employment service providers in the late 1980's and early 1990's may have had a financial incentive to enroll recipients onto IVB, as opposed to unemployment benefits (Campbell, 1996).

Following this period of rapid growth, the Conservative government of John Major replaced the IVB program with the new Incapacity Benefit (IB) program in April of 1995. The IB program included a new and stricter assessment of incapacity that was based on "any" work the claimant could perform regardless of employment history. The new Personal Capability Assessment also shifted the responsibility of medical determination from personal doctors to regional medical doctors commissioned by the DWP. As Figure 1 makes clear, the reform effectively reduced the caseload size. Similar in nature to the Ticket to Work program in the U.S., a "New Deal for Disabled People" (NDDP) created by the Blair government in 1999 consisted of a concerted effort to improve the return to work rates of beneficiaries. This initiative offered voluntary support for IB recipients to return to work through a combination of incentive measures and personal advisor services.

In 2003, the Blair government introduced a pilot program that aimed to further support IB recipients in their return to work. This was called the Pathways to Work (PtW) program. The PtW program was piloted in many parts of the country and served as a precursor to the ESA program. The major features of the program consisted of requiring IB recipients to attend mandatory work focused interviews with job specialists, the providing of financial incentives to return to employment, as well as an array of voluntary services to boost employment readiness and rehabilitation. Evaluations of the PtW program were generally positive (See, Clayton, Bambara, & Gosling (2011) for a systematic review). Adam, Bozio, & Emmerson (2010), for example, apply a difference-in-difference research design that compares employment outcomes for IB recipients in similar regions of the country that either did or did not have the pilot PtW program. They found a significant positive effect on re-employment rates (5.8% increase) in regions that did have the PtW program but found little to no significant employment effect on male recipients, those aged below 40 and those with mental illness, though the bulk of IB claimants shared these characteristics. Nonetheless, the Labour government in 2006 announced

its intention to expand the PtW program nationally for all disability benefit recipients beginning in 2008 with the establishment of the ESA program (DWP, 2006)

Figure 1



Sources: Authors calculations based off DWP (2012); SSA (2012); Evans and Williams (2009); Department of Labor (2010).
Note: *The data for the years 2008-2012 represent the combined caseload size for those remaining on the IB program and those who enrolled onto the Employment Support Allowance-Contributory (ESA-C) program. *GB IB figures do not include those claiming IB credits or those claiming IB short-term. *There was missing data from 1981 and 1991 for Britain so an average from the year before and after the missing year is provided. *The ESA data is taken as the caseload figures for those receiving ESA-C, as well as those receiving both Contributory and Income Based ESA.

B. The IB and ESA programs compared with the SSDI program

As of October 27, 2008, all new claimants onto the disability benefit program in Britain are referred to the ESA program, which has subsequently merged the means tested and contributory programs into the same core program. The overall intention of the reform was to reduce the caseload size by tightening the disability assessment for incoming claimants and improve the return to work rates of beneficiaries. Figure 2 describes the major characteristics of IB and ESA programs and compares them with the SSDI program. As noted the major change that came with the ESA program is the introduction of the Work-Related Activity Group (WRAG) and the Support Group (SG) for all claimants found not to be “Fit for Work” (FFW). Decisions for the WRAG group are based on a score of 15 points or more against the functional descriptors described in the legislation. Those in the WRAG group may also have non-functional impairments, such as suffering from a life threatening disease that is seen as controllable or

another recoverable medical condition. Placement into the SG, on the other hand, depends on the existence of a severe condition (e.g. chemotherapy, terminal illness, pregnancy risks, and those who meet functional criteria for severe physical or mental health risks.)

The claimant journey onto ESA begins with the filing of a limited capability for work questionnaire, which inquires as to the individual's specific capabilities for work-related activity. Unlike the SSDI program, in Britain claimants receive benefits throughout the assessment process that are financially equivalent to Jobseekers Allowance (unemployment benefits) but lower than ESA payments. Once completed most claimants are invited to a face-to-face assessment with a trained healthcare professional working for a private health contractor, Atos Healthcare. The new assessment is meant to take place at three months into the claim, as opposed to the previous benchmark of six months. As in the US, fast track procedures are in place allowing claimants with severe conditions quick access into the SG (DWP, 2014). Decisions makers at the DWP base their determinations on the assessment provided by Atos, as well as other available evidence, such as medical records from the claimant's general practitioner. Following a FFW decision, the claim is closed and the individual may be referred to Jobseekers Allowance. The individual can consider appealing to a tribunal if they are placed in the WRAG group or, as occurs more often, if they are found FFW.

Figure 2
Selected characteristics of major disability benefit programs in the United States and Great Britain

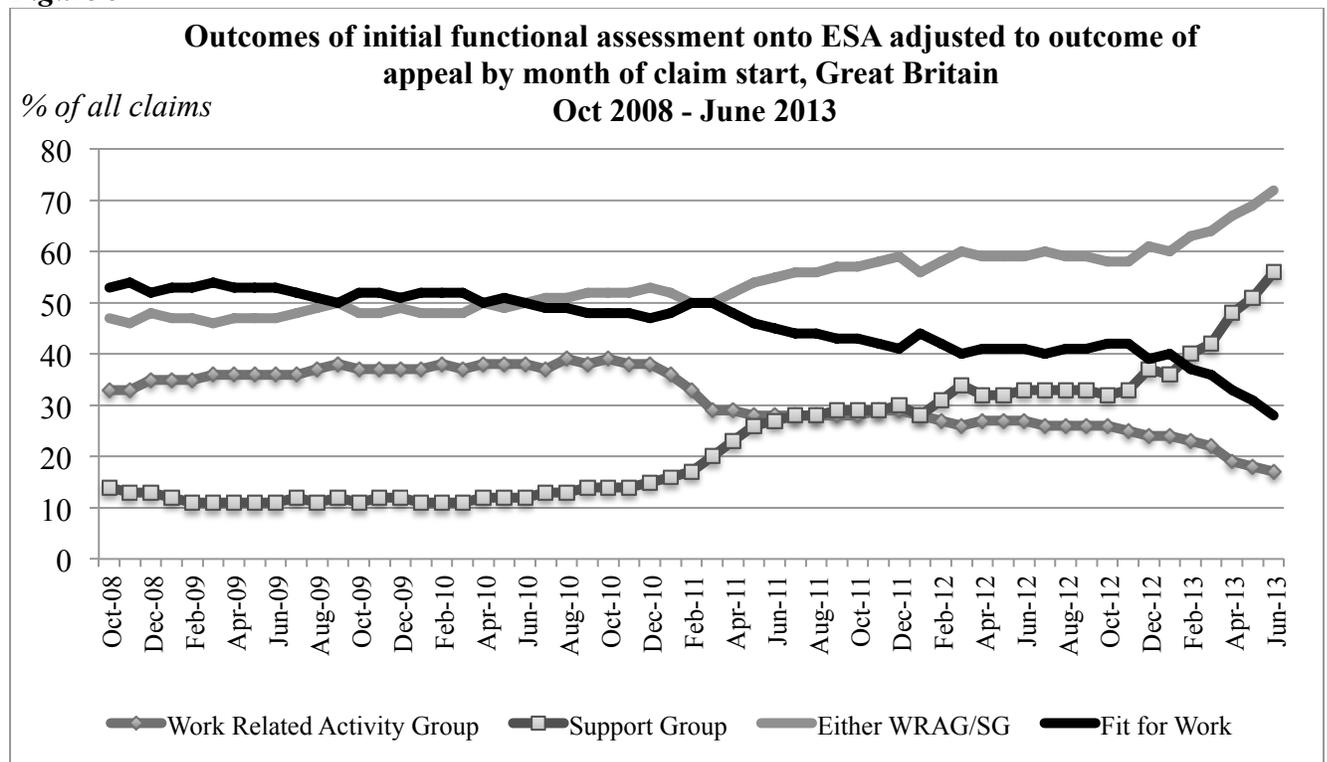
	SSDI	IB (phased out in 2014)	ESA (introduced in 2008)
Definition of disability	Inability to engage in substantial gainful activity because of medically determinable impairment expected to last 12 months or longer or result in death	Incapacity determination based on 15 point scoring system that assesses abilities to do physical activities, as well as mental health	Same as IB but adds two possible outcomes for eligible claimants: (a) limited capability for work, and (b) limited capability for work and limited capability for work related activity
Eligibility	Insured status depends on length and recency of employment.	Depends on national contribution credits received prior to disability onset.	ESA awarded on the basis of low-income (ESA-IR) or work credits (ESA-C). Only ESA-C in work related activity group (WRAG) is subject to 12 months-time limits.
Work criterion	Number of work credits needed to qualify depends on age; need to show significant work history within the past ten years	Number of work credits needed depends on the amount paid into the system	The ESA program combined the low-income and contributory schemes. Contributory amount for ESA-C determined like IB.
Age criterion	Up to age 66	Up to age 64	Up to age 64
Benefit calculations	Based on insured's average covered earnings since 1950 and is indexed for past wage inflation up to onset of disability excluding up to 5 years of lowest earnings	Standard rates depend on length of time as recipient. Lowest weekly rate was paid for the first 196 days of sickness; higher rate paid for the next six months; and highest rate paid after a year.	Weekly benefit allowances vary on phase of claim. Lowest rate during assessment phase, higher rate for WRAG, and highest rate SG.
Treatment of work while disabled	There is a monthly substantial gainful activity threshold adjusted to changes in national average wage index. There is also a trial work period.	Permitted work allowed for less than 16 hours a week and subject to maximum income.	Same as IB.
Benefit conditionality	No	Yes, but in PtW pilot regions only	Yes, for ESA-C WRAG group
Dependent Coverage	Yes	Yes	Yes
Determination services administered by	State administered determination services uphold federal criteria for disability.	Administered by DWP; additional medical examinations contracted to Atos Healthcare, a private multinational healthcare provider.	Expanded responsibilities to Atos Healthcare. Performance issues resulted in Atos losing the contract in March 2014. Government is currently seeking new provider.

Sources: DWP (2013); SSA (2012). The framework is adapted from Rajnes (2010).

C. The implementation of the reform

Figure 3 presents the latest available information on the outcomes of the WCA. The data is from October 2008 to June 2013 and is adjusted to the outcome of appeals decisions. It is worth noting that as of March 2014, 36% of all FFW decisions were appealed (DWP, 2014). While the rate of appeal was higher in the initial years of the new assessment, over time the new assessment process seems to have continuously improved with the rate of initial decisions overturned on appeal declining from 40% in 2008 to 19% in 2013 (DWP, 2014). This drop is also likely related to the decline in the percentage of claimants found FFW. As Figure 3 makes clear, in the first two years of the program, the ESA caseload consisted solely of in-coming claimants. At this time, about twice as many of these clients were placed in the WG than the SG and a little over 50% of all claimants were found ineligible or FFW. This trend noticeably began to shift in 2010 with many more clients found eligible for the SG and less than 30% of clients found FFW as of June 2013. This shift in the caseload composition and allowance rate appears to be explained by two primary factors: the reassessment of IB claimants brought forth more clients with severe health impairments who were more likely to be found eligible for ESA, and, second, changes to the decision making and assessment process effectively loosened the criteria to receive ESA and made it easier to be placed the SG.

Figure 3



Source: DWP (2014)

Incapacity Benefit reassessments

Beginning in October 2010, claimants that received Incapacity Benefit were re-assessed under the new Work Capability Assessment. As of June 2013, 1,224,520 IB claimants had been referred for reassessment. The reassessment process for IB recipients was set to conclude in April 2014, however, there are reports of delays. Since the reassessments began, on average 30% of all IB recipients have been found FFW when accounting for appeal decisions. This is considerably lower number than for in-coming claimants, though still suggests a considerable amount of work-ability identified among IB recipients. Subsequently, on average about 40% of reassessed IB claimants have been placed into the WRAG and 30% into the SG with the other 30% found FFW (DWP, 2014).

Just as the uptick of Continuing Disability Reviews proved highly controversial for the SSDI program under the Reagan administration in the early 1980s (Berkowitz, 1987), the reassessment process for IB clients has proved perhaps the most politically controversial part of the ESA reform. Disability rights groups and other charities have protested that the re-assessment process is inhumane, and Atos Healthcare is often accused of implementing an overly harsh assessment process. One former Atos doctor, for example, has blown the whistle in suggesting that he was forced to amend his medical reports by Atos executives so as to make fewer clients eligible for ESA (Gentleman, 2013). It is often suggested that the DWP has incentivized Atos to make more clients ineligible for benefits, though the contracts themselves do not include such language. Nonetheless, the political pressure on Atos and the DWP has mounted as a result of the IB reassessments with media accounts of IB claimants committing suicide upon finding they were not entitled to ESA (Traynor, 2013). The public scrutiny and general dissatisfaction with the performance of Atos appears to have led to the recent decision to not renew Atos's contract in 2015 (Morse, 2014). At the time of writing, the DWP was in the process of selecting another private entity to replace Atos to implement the Work Capability Assessment.

Independent reviews

The Welfare Reform Act of 2007, which established the WCA, included a requirement that the new assessment process be reviewed independently on an annual basis for the first five years. This legislative feature appears to have proven useful in practice, as a number of changes have been implemented in direct response to the recommendations of the reviews. Among other changes, these recommendations have sought to improve the assessment process by enhancing communications with claimants and by ensuring decisions are made with high quality information (Harrington, 2012). The reviews have also investigated whether current medical/functional criteria are adequate and suggested changes to these criteria. Indeed, following a review recommendation, the DWP widened the eligibility criteria available for people with physical or mental health risks. Placement into the SG group for this population was also made easier. In late 2008, for example, just 17% of clients in the SG had a physical or mental health risk. Yet by late June of 2013 nearly 40% of all clients in the SG had a physical or mental health risk (OECD, 2014). Changes to the decision-making process can then partly explain not only the decline in claimants found Fit for Work but also the observed increase in the amount of clients placed in the Support Group.

D. The effects of the reform

Though the ESA reform is still recent, early research is available examining its effects. As noted above, the reform can be said to have had two primary objectives: to reduce the number of incoming claimants by creating a tighter assessment process, and to increase the outflow rates by increasing the number of current beneficiaries returning to work. In terms of inflow rates, the data suggests a slight uptick in new claims from 2008 to 2009 that appears related to the economic recession. Since 2009, however, the number of new disability benefit claims has declined in small increments (OECD, 2014). Notably, this does not take into account whether claimants denied ESA moved onto other government programs such as Jobseekers Allowance, and thus it is unclear whether this decline has induced net fiscal savings. Comparative data further reveals that despite the reforms Britain continues to have the highest incoming claimant rate in the OECD with about 10 new claims for every 1,000 workers in the year 2012 (down from 12 in the year 2000) compared to about 8 for the United States and an average of 5 across the advanced economic countries in the OECD (OECD, 2014).

Outflow rates, furthermore, appear to have increased temporarily as a result of the large-scale reassessment of IB claimants but have flattened over time (OECD, 2014). The total outflow rate as a share of all ESA recipients was 3% in 2012, which is higher than the 1% for the United States (OECD, 2014). The outflow rates, however, do not appear to be driven by recipients returning to work and are more likely the result of recipients moving to Jobseekers Allowance or Old Age Pensions. A new Work Programme, which was introduced in 2011 for beneficiaries of a number of programs including the ESA WRAG, has sought to provide a more tailored service than the previous employment service programs. The program follows a "black box" approach that allows private employment service providers freedom in their choice of intervention, as they are judged solely on employment outcomes. In its first year of operation, the Work Programme saw only .6% of ESA claimants achieving a positive job outcome and with not a single job outcome for an ESA ex-IB claimant (OECD, 2014). Also concerning, in a qualitative evaluation of the new Work Programme, researchers found evidence to suggest that the private employment service providers are targeting the most job-ready, while devoting less attention to those in greater need of support (Newton et al., 2012). This accords with a nationally representative survey of ESA claimants, which found that the ESA program is least effective at helping the most challenging cases return to employment, particularly those who were previously inactive before their claim (Sissons & Barnes, 2013). While it is too early to suggest that the ESA program will not ultimately yield improved return to work rates, early results are certainly sobering and suggest the need for further changes.

The introduction of benefit conditionality for WRAG claimants represents a distinguishing feature of the ESA program that makes it qualitatively different from the SSDI program in the United States. Current rules require claimants in the WRAG to have mandatory work focused interviews with Personal Advisers as part of the Work Programme and to carry out work-related activity deemed appropriate to their circumstances. Unlike those receiving Jobseekers Allowance whose benefits are also made conditional on work related activity, ESA WRAG clients are not required to look for work but only to attend training and rehabilitation sessions. The OECD (2014) has suggested that the lack of conditions for job search activities is a shortfall of the program and that adding such requirements could improve work outcomes.

Though sanctions are used relatively rarely in practice, there is concern that they may be overly severe. From 2011-12, 2.7% of ESA clients were sanctioned (OECD, 2014). Yet, a failure to attend a work-focused interview can lead to a 100% reduction in benefits. Even the OECD (2014), a think tank known to favor benefit conditionality, has suggested that Britain reduce the severity of the penalties, which they insist can be particularly harsh for those with mental disorders. The argument to reduce the sanctions is perhaps made more compelling when backed by experimental research that finds that the ex-ante effect of issuing multiple warnings of sanctions can be as effective as applying immediate sanctions at inducing job search and program participation for unemployed workers (Arni, Ours, & Lalive, 2009). Ultimately, the combination of an overly severe sanction regime combined with the introduction of time limits of twelve months for WRAG clients invites concern that some individuals may fall through the cracks. It is worth noting, moreover, that the time limits were never part of the Pathways to Work experiment and thus are largely untested.

In sum, early research on the ESA reform is not suggestive of a policy panacea or an outright failure. Strong conclusions cannot yet be drawn as to the effectiveness of the reform at improving return to work rates, for example. Just as the WCA improved over time, it is likely that the Work Programme with small changes will also perform better with experience. The selection of a new provider to administer the WCA, however, is likely to create turbulence for an assessment process that had just found smooth air. Not having to do the difficult work of IB reassessments will likely help the new provider avoid the political pitfalls of providing disability determination, but one might also expect an increase in appeals as the provider builds proficiency with the assessment process. Finally, in retrospect, the significant administrative and human costs involved with the IB reassessments do not appear to have been worthwhile. Indeed, the majority of reassessed IB recipients were found eligible for ESA, while the 30% found ineligible appear more likely to be on another government program than in employment. It would thus be difficult to make the case that the reassessments generated fiscal savings or lead to an increase in employment, though these were the government's objectives.

V. WHAT ARE THE LESSONS FOR THE REFORM OF THE SSDI PROGRAM?

This report thus far has introduced the new disability benefit program in Britain, compared its current features with those of the SSDI program, and examined the early research on its effects. While noting that the implementation of the ESA program is still in its infancy, the analysis has brought forth a good deal of criticism of the reform. The intuition of the following section, therefore, is that there is as much to learn from the faults of the reform in Britain, as there are its successes. In this light, the following section will consider what lessons the US can learn from the disability benefit reform experience in Great Britain.

Lesson #1: Experimentation can drive reform

The 2008 reform to the disability benefit program in Great Britain was clearly invigorated by and modeled after the large-scale Pathways to Work pilot initiative. A similar road to reform is certainly possible for the SSDI program. Indeed, it would mirror the path to welfare reform in 1996, which was itself preceded by widespread experimentation (Weaver, 2000). In this vein,

Liebman and Smalligan (2012) propose in a Brookings Institution report that Congress funds three additional demonstration projects. One project would provide flexibility for states to reorganize existing funding streams to target specific at-risk populations. Another project would seek to target employers by creating incentives for firms to keep their workers much like the Dutch reforms. A third project, “would screen disability applicants and target those who appear likely to be determined eligible for benefit but who also have the potential for significant work activity if provided with the proper range of services,” (2012: 2).

This third proposed project corresponds with the research finding that many SSDI recipients are likely to have work capacities (Maestas et al., 2013). It is also conceptually similar to the ESA reform in Britain. The WCA could thus serve this demonstration project as a template for how to identify and target SSDI applicants and recipients that have significant impairments but who also have employment potential. The pilot project could choose what types of interventions it provides this work-capable group. The British case suggests that it may not be wise to emulate the strict sanctions policies for the ESA WRAG. As noted, these sanctions run the risk of causing undue hardships for beneficiaries. Rather a more lenient policy of issuing penalties for work-capable SSDI recipients may be a preferable strategy, as it could increase program participation onto the Ticket to Work program, for example, while reducing the risk of negative social welfare outcomes. This approach could also complement other initiatives that seek to incentivize recipients found to have work abilities via financial inducements to engage in employment related activities. Two of the current SSA demonstration projects could inform such a pilot project. The first is the benefit offset scheme, which seeks to eliminate the benefits cliff for claimants who are working beyond the trial work period. The second is an accelerated benefit program that provides SSDI recipients a health insurance package during the 24-month Medicare waiting period and also additional rehabilitative and counseling services. Both the benefit offset scheme and the accelerated benefit demonstration projects have been tested with randomized controlled trials and shown to lead to modest but significant improvements in employment related activities and return to work rates (Weathers II & Bailey, 2014; Chambless, Julnes, McCormick, & Reither, 2014). A pilot project that combines these “carrot” and “stick” approaches and intervenes as early as possible at a targeted work-capable group would appear to be a strong candidate for a future demonstration project. A related lesson from the British case concerns the benefits of incorporating a legislative provision that requires continuous evaluation and monitoring once a reform is adopted. As noted, the requirement to have annual independent reviews for five years following the introduction of the ESA program proved constructive in Britain. Such a provision helped to ensure that subsequent evaluative research did not focus solely on identifying treatment effects but also sought to identify practical recommendations that can improve service delivery and enhance the claimant experience. Future legislative reforms to the SSDI program would thus be wise to consider including a similar provision.

Lesson #2: Reforms should focus on prevention and early intervention - not reassessments

The IB reassessments were likely the least successful part of the ESA reforms. Conducting reassessments of claimants on such a large scale proved not only politically controversial but was also unlikely to have induced real fiscal savings. A historical perspective of the SSDI program suggests that such a process of re-assessments is also not likely to go well in the US. One recalls, for example, how early in the Reagan administration there was a concerted effort to increase the

termination rates of SSDI beneficiaries by subjecting millions of SSDI recipients, particularly those with mental impairments, to a Continuing Disability Review (CDR) process. The hundreds of thousands of terminations that transpired lead to a major public pushback that ultimately lead to President Reagan reversing his position by incorporating a medical improvement requirement that limited the ability of the CDR process to terminate beneficiaries (Berkowitz, 1987).

Most SSDI beneficiaries now have scheduled CDRs every seven years, though it can be every three years if medical improvement is expected. However, in 2012 there were 1.5 million SSDI recipients waiting to have their planned reviews, as the SSA lacks funding to keep up with scheduled CDRs (CBO, 2012). Thus, a possible strategy to reduce expenditures prior to the potential default of the Disability Trust Fund in 2016 would be to increase the administrative financing available for CDRs, as Liebman and Smalligan (2012) propose. While this approach might appeal to fiscally minded policy makers, the comparative evidence suggests caution. Indeed, the British experience with IB reassessments shows that reassessed individuals appear unlikely to return to employment and reassessments can also be a recipe for political controversy. Expecting an increase in the reassessments to lead to an increase in employment also appears to defy a basic principle of labor economics. That is, that the longer one spends away from the labor market the harder it is to re-enter. Indeed, longitudinal employment statistics for SSDI recipients suggests that more recently awarded beneficiaries are far more likely to leave the rolls and return to employment (Liu and Stapleton, 2011). It should be clear then that early intervention and preventative approaches are preferable to increased reassessments. While focusing on reducing the flow of claimants onto SSDI may not provide the immediate fiscal relief that is necessary to avoid a default, in the long run these kinds of policy approaches should lay a path toward a more sustainable SSDI program.

Lesson #3: Changing the definition of disability to receive SSDI deserves consideration

There is currently a contradiction in how the SSDI program defines disability as an irreversible and permanent condition and the way it later promotes the return to work of eligible recipients who already proved their inability to work. This definition of disability is also at odds with contemporary views of disabled people as possessing significant employment abilities. The massive disability appeals system in the US further speaks to the problematic nature of defining disability as an absolute and unchangeable condition. In 2011, for example, 26% of all disabled worker applicants were awarded benefits at the initial point of application but an additional 15% were awarded following a very expensive appeals process (SSA, 2012). While this is better than the current rate of 19% of decisions overturned in Britain, the disability appeals system in the US is far more onerous than the appeals system in Britain. The rate of appeals in Britain is also likely to decline further with the reassessment process complete. Empirical research further suggests that those who are accepted into the SSDI program at the appeals stage are the most likely to have work abilities (von Wachter et al., 2011). Experimenting with a disability determination model, similar to the WCA in Britain, that identifies individuals with some capacity to work at the same it identifies claimants with impairments could help to reduce the number of appeals by allowing clients at the margins of program entry access to a work-oriented SSDI group. This group would also be more likely to respond well to interventions that assist in the process of returning to work.

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