Lessons from SSA Demonstrations for Disability Policy and Future Research

Edited by

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Overview

Over the past several decades, the Social Security Administration has tested many new policies and programs to improve work outcomes for Social Security Disability Insurance beneficiaries and Supplemental Security Income recipients. These demonstrations have covered most aspects of the programs and their populations. The demonstrations examined family supports, informational notices, changes to benefit rules, and a variety of employment services and program waivers.

A "State of the Science Meeting," sponsored by the Social Security Administration and held on June 15, 2021, commissioned papers and discussion by experts to review the findings and implications of those demonstrations.

A subsequent volume—*Lessons from SSA Demonstrations for Disability Policy and Future Research*—collects the papers and discussion from that meeting to synthesize lessons about which policies, programs, and other operational decisions could provide effective supports for disability beneficiaries and recipients who want to work. This PDF is a selection from that published volume. References from the full volume are provided.

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Chapter 1

An Introduction to Disability Policy and SSA's Demonstrations

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The Social Security Administration (SSA) administers the two largest federal disability insurance programs in the United States: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Within the scope of its congressionally mandated authority, SSA makes a variety of policy choices that affect the economic well-being of SSDI beneficiaries and SSI recipients. This includes promoting the employment of beneficiaries and recipients through a multitude of work incentives policies and programs.

Over the past four decades, SSA has also conducted many tests of new policies and programs to improve participants' outcomes. These tests, called "demonstrations," address many policy-relevant topics including family supports, health insurance, transition to adulthood, informational notices, changes to benefit calculations, and a variety of employment services and waivers of program rules, as detailed in the Appendix.

At the outset, it is useful to distinguish a demonstration from an intervention or evaluation. An *intervention* is a policy or program change intended to affect participant outcomes; an intervention may or may not be evaluated. A *demonstration* is a temporary intervention or a package of interventions of limited scale (i.e., not rolled out nationwide or to all beneficiaries or recipients), implemented for the purpose of being evaluated. An *evaluation* generates the information by which a demonstration can inform decisions about whether the tested intervention (or some version of it) should be implemented permanently or more broadly.

SSA's demonstrations have generated dozens of documents reporting how policies and programs worked, and for whom. However, in 2004, the Government Accountability Office (GAO 2004) critiqued the impact of the demonstrations, stating that "SSA's demonstration projects have had little impact on the agency's and the Congress' consideration of [disability insurance] policy issues" (3). GAO reported that even though "SSA has used methodological designs that GAO determined were strong or reasonable when assessed against professional research standards for 11 of its 14

[1] The views expressed in this chapter are those of the authors and do not necessarily represent the views of the Social Security Administration or the US federal government.

projects,…these projects have yielded limited information on the impacts of the program and policy changes they were testing" (2008, inside cover). As of its 2008 report, of the 14 projects GAO reviewed, 5 had been completed and 5 canceled. SSA subsequently instituted new policies to improve future demonstrations, including those covered in this volume.

This volume synthesizes the findings of many of SSA's demonstrations to identify cross-demonstration lessons about which policies, programs, and other operational decisions could provide effective supports for SSDI beneficiaries and SSI recipients who want to work. It also identifies lessons for the design and use of demonstrations for future learning. This chapter provides an overview of the SSDI and SSI programs, SSA's demonstration portfolio, and selected lessons from the remaining chapters in the volume.

By taking stock of the lessons learned from prior demonstrations, policymakers can better understand what has been tested and whether and why the tested interventions were effective. These demonstrations have informed policy discussions and proposals, although not always in expected ways, and this volume brings together findings that typically have been discussed in isolation. This synthesis will enable SSA and other stakeholders to implement policies and programs that work in multiple settings, propose alternatives to them that might not have worked for identifiable reasons, and identify policies and strategies to test in future demonstrations.

FEDERAL DISABILITY INSURANCE PROGRAMS

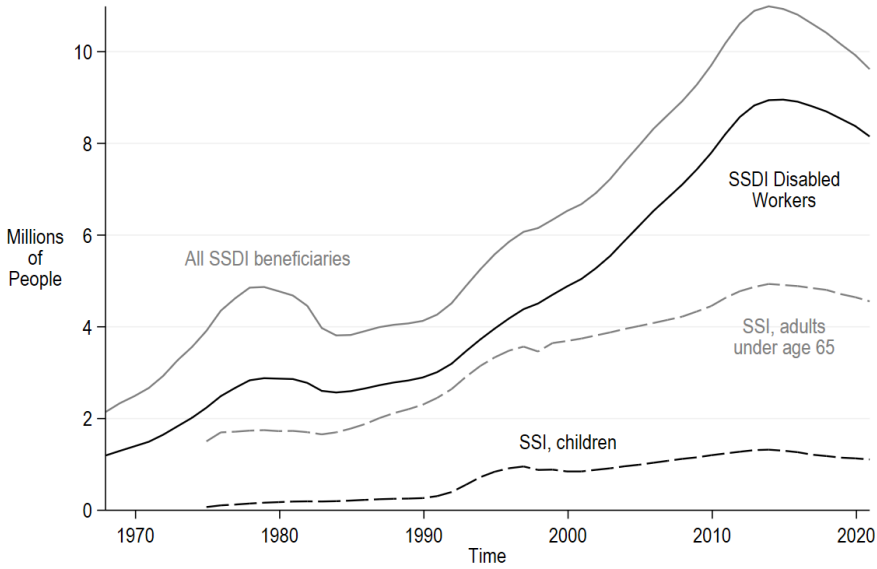
The disability programs run by SSA paid more than $130 billion to 9.6 million SSDI beneficiaries in 2020, $9.6 billion to 1.1 million youth receiving SSI, and $35.7 billion to 4.5 million adult SSI recipients younger than age 65. Most SSI recipients have no other income sources (CBPP 2021), and half of SSDI beneficiaries and about two-thirds of SSI recipients have income less than the poverty threshold when SSDI benefits and SSI payments are not included (Bailey and Hemmeter 2015). These programs provide economic security to people with barriers, enabling them to pay for food, housing, and other necessities if they are unable to work or rely on somebody who is unable to work due to a disability. Further, SSDI benefit receipt is associated with reduced mortality (Gelber, Moore, and Strand 2017) and SSI receipt is associated with improved childhood outcomes (Guldi et al. 2018).

In December 2020, nearly 10 million individuals, of whom 8.15 million were disabled worker beneficiaries, received monthly SSDI payments averaging $1,260.[2] Eight million individuals received monthly SSI payments averaging $576, of whom

[2] SSDI recipients can be categorized as Disabled Workers, who receive benefits based on their own earnings, or as Disabled Adult Children or Disabled Widow(er)s, who receive benefits based on a parent's or spouse's earnings.

4.56 million were adults younger than age 65 and 1.11 million were children.[3] About 11 percent of SSDI beneficiaries also received SSI. The numbers of total SSDI beneficiaries, the number who are disabled workers, and SSI recipients younger than age 65, both adults and children, in December of each year since 1967, are shown in Exhibit 1.1.

Exhibit 1.1. All SSDI Beneficiaries and "Disabled Workers," SSI Recipients Adults Younger than Age 65, and Children, 1967-2020



Source: Data maintained by SSA, reported in *Monthly Statistical Snapshots* and annual statistical supplements to the *Social Security Bulletin*.
Note: SSI was established in 1972, with payments beginning in 1974. Numbers reported here are only for federally administered payments, including some state-supplement-only recipients, but not SSI recipients receiving no federal payments.

Liebman (2015) characterized changes in SSDI participation as due primarily to increased eligibility among women and declining mortality among SSDI beneficiaries. Between 1993 and 2007, he finds that population aging and increased eligibility among women accounted for two-thirds of the increase in SSDI benefit receipt, with rising incidence among women accounting for one-quarter and declining mortality accounting for one-sixth. He concludes, "the case for [disability insurance] reform is not primarily a fiscal one—up until the 2007–2009 recession, spending on the

[3] Payments for child recipients averaged $675 and payments to adults younger than age 65 averaged $606, whereas payments to older adults averaged $468, bringing down the overall average. For more detail, see the *SSA Monthly Statistical Snapshots* and annual statistical supplements to the *Social Security Bulletin*.

program…had increased by only 0.13 percent of [Gross Domestic Product] over 30 years" (124).

Policymakers have had an interest in the growth in the SSDI and SSI programs in the last several decades, and particularly in the relationship between disability and work. Scholars (e.g., Parsons 1980) have long argued that the availability of disability benefits lowers labor force participation among program participants. Bound and colleagues (1989, 1991, 2003, 2014), among others, provide evidence suggesting that the availability of disability benefits or changes in policy do not fully explain declines in labor force participation. Parallel to a focus on work outcomes, demonstrations have examined impacts on health and other dimensions of well-being. This led to legislation and policies (and demonstrations) focused on supporting beneficiaries' efforts to return to work.

The Social Security Disability Amendments of 1980 established the Extended Period of Eligibility for SSDI and added several other work incentives to the SSDI and SSI programs. The Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) created new programs for individuals who receive disability benefits. These and other policy changes were motivated by the idea that many SSI recipients and SSDI beneficiaries have the capacity and desire to work. However, use of these work incentives has been low. Because of widespread concern that the availability of disability benefits could lead some beneficiaries not to work, and the perception that many beneficiaries might prefer to work given the incentive to do so, most SSA demonstrations have tested how to encourage work among persons with disabilities. Whether the disability benefits crowding out work or the strict definition of disability for SSDI and SSI is the reason for low return-to-work outcomes is an ongoing debate.

The Disability Insurance Trust Fund has repeatedly been in imminent danger of depletion, most recently in 2016 when its depletion was averted by a temporary repurposing of funds from the Old-Age and Survivors Insurance Trust Fund and a downturn in the number of beneficiaries. The long-term consequences of the pandemic and recession that began in 2020 could present new challenges to the programs. Currently, the Disability Insurance Trust Fund is expected to be depleted in 2057 (Board of Trustees 2021).

The growth in children receiving SSI benefits in the 1990s, particularly for mental impairments, also spurred interest in that program. However, recent research has suggested that the growth of SSI may have been less than would have been expected given the growth in the poverty rate and number of children with disabilities (NASEM 2015).

Work Disability Insurance, Not Disability Insurance

Even though SSDI is explicitly an insurance program and SSI is a transfer program that is not technically insurance, both are forms of the broad concept of social insurance that protects individuals against the loss of earning capacity. It is important to note that these SSA programs insure work disability, not any kind of disability. That

is, a functional impairment that does not affect an adult's ability to work will not result in an award of benefits. Like other forms of insurance, the optimal amount of insurance balances marginal well-being across people's different potential experiences, or states of the world, but it is not intended to make up for any loss that could be incurred.

The Social Security Act[4] Sec. 223(d)(1)(A) defines this work disability for adults:

> inability to engage in substantial gainful activity [SGA] by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

In 2020, SSA considered an individual earning at least $1,260 a month (or $2,110, for statutorily blind individuals) as engaging in SGA. This is adjusted for inflation annually, and in 2021 the SGA threshold is $1,310 a month (or $2,190, for statutorily blind individuals).

Note that this standard involves an individual's functional capacity, their job qualifications such as work history and completed education, and attributes of the labor market. A change in the labor market that led to someone being unable to engage in SGA, such as recessions or technological displacement, even with no change in functional limitations, could mean that person now has a qualifying disability. As a result, one should expect work disability rates to rise whenever wages decline or job opportunities dry up (Autor and Duggan 2000; Black, Daniel, and Sanders 2002; Charles, Li, and Stephens 2018; Nichols, Schmidt, and Sevak 2017; Vachon 2014). This is sometimes framed as induced entry by economic conditions, but is inherent in the statutory definition of disability.

Like other forms of social insurance in the United States, SSDI and SSI are not designed to make individuals with disabilities as well off as they were before the onset of disability, but designed to mitigate the personal and societal losses in an equitable manner. Numerous authors have sought to ascertain whether SSDI and SSI policies are designed to attain the greatest net benefit to society or could be improved (e.g., Bound et al. 2004).

The costs of providing social insurance arise from the full social cost of providing cash and noncash benefits, which includes distortions to labor markets (Chetty 2006). The benefits include the value of insurance (Eeckhoudt and Kimball 1992; Kimball 1990) and the value of redistribution (Finkelstein and Hendren 2020; Hendren 2016, 2020; Hendren and Sprung-Keyser 2019). These economic ideas about social insurance and its value are quite distinct from the accounting framework typically adopted in a benefit-cost calculation of an intervention, but rough adjustments are often made to account for factors such as distributional effects or opportunity costs. For example, in the Benefit Offset National Demonstration (BOND), the benefit-cost

[4] There is a special definition for people who are blind and at least 55 years old in section 223(d)(1)(B). SSA's regulations, consistent with the Social Security Act, define work disability in 20 CFR 404.1505.

calculation allows for greater weight on a dollar flowing to a low-income SSDI beneficiary, counts the value of time spent out of the labor force, and inflates net government outlays by the excess social cost of raising funds (Gubits et al. 2018a/b).

SSDI and SSI Programs

The SSDI program requires a 10-year history of work of most applicants, and the SSI program requires very low earnings and assets. This means the SSDI and SSI populations differ substantially on average, with SSDI beneficiaries having greater education, incomes, assets, and other attributes associated with better labor market experiences than do SSI recipients (SSA 2020d). Most SSDI applicants have earnings that fall dramatically in the three years prior to application, whereas most SSI applicants have little to no earnings in the year prior to application (Bound, Burkhauser, and Nichols 2003; Costa 2017). SSDI benefits pay a fraction of prior average earnings, which ranges from 90 percent for very low earnings to about 15 percent for higher earnings, with a five-month waiting period after disability onset. In contrast, SSI pays a fixed amount offset by countable income (with slightly more than half of earnings excluded, so the effective marginal tax rate on earnings is slightly less than one-half).

The typical SSDI beneficiary qualifies for Medicare after 24 months, and the typical SSI recipient qualifies for Medicaid immediately. Those dually eligible for both SSDI and SSI, called "concurrent beneficiaries," have their SSI payments reduced once SSDI payments start, and they are eligible for both Medicare (after 24 months) and Medicaid. In most cases, a state pays the Medicare Part B premium for those eligible for SSI and covered by Medicaid. For concurrent beneficiaries, Medicare is the primary payer and Medicaid is the secondary payer.

For adults, the eligibility rules for both SSDI and SSI are the same regarding medical standards, but the programs have different financial eligibility rules. Both SSDI and SSI screen out applicants who work and earn more than the SGA threshold. To qualify for SSDI, an applicant must generally have 40 credits (formerly "quarters of coverage"), 20 of which earned in the last 10 years. (As of 2020, workers earn 1 credit for each $1,410 in wages or self-employment income, to a maximum of 4 credits per year.) Younger workers may qualify with fewer credits. For SSI, an applicant must have countable resources of less than $2,000 for an individual and $3,000 for a couple, which notably excludes the value of a home and one vehicle, among other exclusions.

The medical standards for both programs are strict, with rigorous reviews of medical evidence initially conducted by Disability Determination Service (DDS) agencies in each state in a five-step process. Applicants who pass the financial screen and have a severe impairment could qualify for award if they have a condition(s) on the Listing of Impairments, comprising more than 100 impairments such as cancers, adult brain disorders, and rare disorders that affect children. SSA's Quick Disability

Determination model also quickly identifies diseases and other medical conditions likely to meet SSA's standards so applicants may receive a faster decision.

In that five-step process: For applicants who are financially eligible (step 1) and have a severe impairment (step 2) but do not have a listed condition (step 3), state DDS offices ascertain whether those with severe impairments could work in their past job (step 4) or do other work in the national economy (step 5).

At step 4, the DDS denies applicants whose "residual functional capacity" meets the requirements of past relevant work. At step 5, DDS considers the applicant's remaining capacity, along with other vocational factors—age, education, and work experience—to determine whether the applicant can work in jobs other than that previously held. This determination often involves the use of the Medical-Vocational Guidelines (a set of tables sometimes also known as the "vocational grid") and "medical-vocational profiles."[5]

Over the years, Congress has enacted various rules to incentivize the return or attempted return to work. The Trial Work Period (TWP) allows SSDI beneficiaries to test their ability to work and still be considered disabled. Beneficiaries retain their full disability benefit until their monthly earnings exceed the TWP earnings threshold ($910 in 2020) in at least nine months (not necessarily consecutive) in a rolling 60-month period.

SSA applies various work incentives, such as subsidies or disregarding earnings used to cover impairment-related work expenses, before determining whether net earnings exceed the SGA threshold. When net earnings exceed the SGA threshold after the TWP, SSDI beneficiaries still receive benefits during a three-month Grace Period; but after the Grace Period, SSA suspends benefits in any months of SGA during a 36-month Extended Period of Eligibility (EPE). SSDI beneficiaries who return to work can keep Medicare coverage long after the TWP and EPE have expired—for at least eight and a half years after return to work. SSI recipients may use other work incentives, such as SSA's Plan to Achieve Self–Support; continue to receive Medicaid coverage while working; and have other income exclusions.[6]

In addition to rules supporting return to work, an array of services supports individuals who wish to return to work. SSA's Ticket to Work program supports SSDI beneficiaries and SSI recipients ages 18–64 who want to work by connecting them

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[5] For more detail on the vocational grid, see the Program Operations Manual System: https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview &restricttocategory=04250. For more on medical-vocational profiles, see the Code of Federal Regulations: http://www.socialsecurity.gov/OP_Home/cfr20/404/404-1562.htm and http://www.socialsecurity.gov/OP_Home/cfr20/416/416-0962.htm.

[6] More information on all SSDI and SSI work incentives can be found in the *Red Book* (SSA 2020e) at https://www.ssa.gov/redbook.

with employment service providers including Employment Networks,[7] Vocational Rehabilitation agencies,[8] Work Incentives Planning and Assistance programs,[9] and Protection and Advocacy for Beneficiaries of Social Security organizations.[10] There is a wide range of other private and public return-to-work services across employers and states (Epstein et al. 2020), but little evidence on their impacts (Nichols et al. 2020).

Work and Disability Benefits

Although SSA's demonstrations have addressed multiple issues, the vast majority have dealt with disability and employment. In this section, we highlight the dominant economic theory common to these demonstrations.

Both SSDI beneficiaries and SSI recipients face the possibility of losing benefits if they work, consistent with the intention of the programs to support individuals who are not able to perform SGA. Broadly speaking, SSDI beneficiaries can lose benefits if they earn over the SGA threshold for too long; and SSI recipients lose $1 of benefits for every $2 they earn over $65 in a month. Reductions in benefits are like taxes on earnings—the amount of an individual's income increase is less than the full amount of their earnings, reducing the net gains to work. Receiving the benefits themselves can also reduce their labor market activity by lowering the need to work.

As previously noted, an SSDI beneficiary earning above the SGA level during the EPE can lose all benefits. This "cash cliff" has long been considered a barrier to work because of the potential for losing benefits altogether. Though SSI recipients face a gradual reduction of their payments as they earn more, eventually they, too, lose eligibility. The loss of eligibility is not just for SSI benefits; because most SSI recipients receive Medicaid, they also risk losing access to health insurance. As Livermore, Wittenburg, and Neumark (2014, 3) point out, other barriers include "fear of job failure…lack of job qualifications, lack of reliable transportation, inaccessible or inflexible work environments, and negative employer perceptions of disability."

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[7] Employment Network (EN)s are private or public organizations that can help with career counseling and assistance with job placement, including helping an individual understand how benefits could be affected by work. This includes ENs that are also part of a state's public workforce system, also referred to as "workforce ENs."

[8] Vocational rehabilitation agencies usually work with individuals who need more substantial services. In some states, this includes intensive training, education, and rehabilitation. Agencies could also provide career counseling, job placement assistance, and counseling on the effect that working could have on Social Security disability benefits.

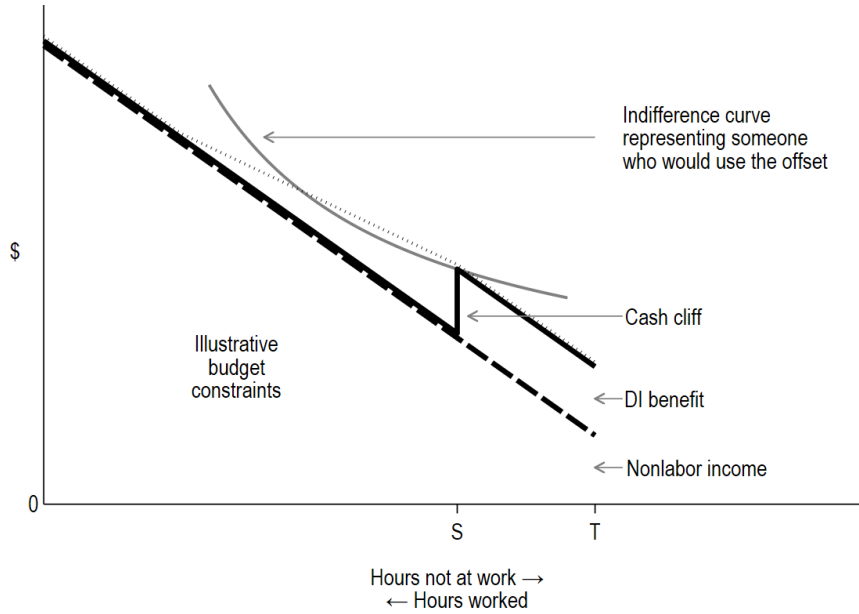
[9] Work incentives counseling is provided by staff who work for the Work Incentives Planning and Assistance programs. Community work incentives coordinators provide counseling about the effect of work on benefits and reach out to beneficiaries who are potentially eligible to participate in federal or state work incentives programs.

[10] Protection and Advocacy for Beneficiaries of Social Security organizations represent eligible beneficiaries to remove barriers to successful employment and will help beneficiaries understand their rights regarding conditions of employment under applicable laws and regulations.

Additionally, many SSDI beneficiaries could simply believe they cannot work because of their impairment or social and familial expectations about what people with disabilities have historically been considered capable of doing.

One way to think about how these demonstrations might function is to consider a simple economic model of behavior (Exhibit 1.2 below). Assume an SSDI beneficiary can earn a given wage per hour, which defines the tradeoff between time spent away from work (on the *x*-axis) and earnings (*y*-axis), along the budget constraint, shown as a thick solid line. During the TWP and Grace Period, the beneficiary's income is their SSDI benefit amount plus their earnings. Once an individual works above the SGA level for nine months, though, they lose all of their SSDI benefit, producing the sudden drop in the thick solid line (the cash cliff).

Exhibit 1.2. Illustrative Work and Earnings Tradeoffs



Note: As hours not at work increase, hours worked decrease, and at T (total number of hours available), hours worked equal zero. At S hours not at work (T−S hours worked), this individual earns exactly the SGA threshold. The first vertical gap at T shows the income level at zero hours worked; that is, nonlabor income. The thick solid line shows a budget constraint for someone eligible for SSDI in the Extended Period of Eligibility (after completing a Trial Work Period). The thick dashed line shows a budget constraint for someone not eligible for SSDI. The thin dotted line shows a budget constraint for someone eligible for SSDI but subject to different rules that impose a benefit offset for earnings above the SGA threshold.

As represented in the exhibit, the beneficiary must choose their hours of work based on this budget constraint and their personal preferences for work, represented by a curved, thin solid line showing all combinations of work and earnings that the

beneficiary values equally—the indifference curve. An individual with these preferences would work to earn exactly at the SGA threshold when eligible for SSDI, and not more when subject to the cash cliff. They might, however, work more with a benefit offset above the SGA threshold (a budget constraint with the offset is shown as the dotted line in Exhibit 1.2); this benefit offset, reduces benefits slowly above the SGA threshold, rather than zeroing them out.

In economic terms, disability benefits will decrease hours worked, due to both "income effects" and "substitution effects." The income effect refers to a reduction in work when workers are slightly richer and therefore desire slightly more time away from work, whereas the substitution effect refers to a small reduction in the relative benefit of working. But disability benefits are not small changes to the budget constraint, and they produce very different nonlinear changes. That is, the budget constraint looks quite different in shape for someone eligible for disability benefits (the solid line in Exhibit 1.2, rather than the dashed line for someone not eligible for benefits). Conceptually, we can measure both income and substitution effects of providing disability benefits if we limit our attention to the EPE and adopt a very generous interpretation of smoothed budget constraints.

There are many areas where policies, programs, and services can influence the barriers to, and net benefits of, working. The SSA demonstrations reviewed in this volume have tested a variety of interventions. Counseling or information campaigns can change an individual's expectations about work, or preferences for work. Employment-related services can reduce the barriers to accessing a job, better prepare an individual to self-advocate, identify appropriate and reasonable accommodations, or otherwise support employment. Program rules can be modified to reduce, delay, or smooth the perceived negative consequences on benefits of work or reduce any administrative burdens related to working while receiving benefits (e.g., reporting requirements). Interventions can operate via direct subsidies, rule changes, employers, or other ways to produce changes in labor demand.

Several SSA demonstrations have explicitly attempted to change the budget constraint by offsetting SSDI or SSI benefits by a smaller amount, so that an individual never sees a drop in total income due to work. The most prominent example is a benefit offset (the thin dotted line in Exhibit 1.2) of $1 lower SSDI benefit for every $2 in earnings above the SGA threshold, but other demonstrations included starting to offset benefits at a lower earnings level or altering the offset in SSI rules. Demonstrations have also shifted the budget constraint by providing services, reducing the costs of services, or supplementing wages—allowing the beneficiary to effectively keep more income for any given level of work.

Some counseling services provided in the demonstrations serve to change the information available to a beneficiary or recipient, often specifically focusing on explaining the incentives inherent in the budget constraint and the various work incentives available to them. The theory of change embodied in this type of intervention is that an SSDI beneficiary may face a budget constraint such as in

Exhibit 1.2 but not fully understand it. Survey results in the demonstrations support the idea that many participants do not fully understand the current-law rules they are subject to, suggesting a role for information provision.

Still other demonstrations have approached the issue by attempting to change the participant's perceptions of work, by providing information and counseling about the advantages of work. A change in perceptions or preferences favoring work might involve "lowering the disutility of work" (as an economist conceives of utility). This would then change where an individual locates—or believes they can locate—on the budget constraint line or even change the utility curves themselves. Compared with modest changes in the budget constraint, modest changes in preferences can, potentially, produce very large changes in observed behavior. There is very little research on what forces act to produce the type of indifference curve seen in Exhibit 1.2, but society at large and media representations, local communities, habits formed from past experience, and family members may play important roles.

Other federal programs and policies try to address similar issues. For example, the Earned Income Tax Credit changes a worker's budget constraint by subsidizing work, which tends to increase hours worked (Nichols and Rothstein 2016). The Administration for Children and Families within the US Department of Health and Human Services has created a Pathways to Work Evidence Clearinghouse[11] with information on programs designed to support low-income workers succeeding in the labor market. Two other clearinghouses covering relevant interventions[12] are the US Department of Labor's Clearinghouse for Labor Evaluation and Research[13] and the US Department of Education's What Works Clearinghouse,[14] the latter focused on youth.

SSA'S DEMONSTRATION AUTHORITIES

To provide a common understanding of what SSA can and cannot do in its demonstrations, this section provides details about SSA's relevant statutory authorities.

History of Authorities

Congress first authorized SSDI and SSI demonstrations related in Section 505 of the Social Security Disability Amendments of 1980. Section 505 specifically created a new, permanent Subsection 1110(b) of the Social Security Act allowing SSA to test

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[11] See https://pathwaystowork.acf.hhs.gov/ (accessed May 30, 2021, at which time it showed 176 interventions in 244 studies reviewed).

[12] SSA's Interventional Cooperative Agreement Program (ICAP) prioritizes evidence from these three clearinghouses; more information on ICAP can be found at grants.gov under Opportunity Number ICAP-ICAP-21-001.

[13] See https://clear.dol.gov/ (accessed May 30, 2021).

[14] See https://ies.ed.gov/ncee/wwc/ (accessed May 30, 2021).

changes of *SSI* program rules ("waivers"), one kind of intervention that can be tested in a demonstration. This waiver authority complemented the existing general research authority provided by Subsection 1110(a). Section 505 also authorized SSA to test changes to *SSDI* program rules, but because it did not create a new permanent authority (as Subsection 1110(b) had), this provision sunset after five years. Throughout the 1980s and 1990s, Section 505 was renewed for various periods (with some lapses), until Congress created a specific SSDI demonstration authority as part of the Ticket Act.

The Ticket Act contained two demonstration provisions. Section 301 of the Ticket Act created Section 234 of the Social Security Act, which very closely mirrored the language of Section 505 of the 1980 Amendments. Section 302 of the Ticket Act directed SSA to conduct a $1 for $2 benefit offset demonstration (which eventually became BOND).[15] Section 234 initially sunset on December 17, 2004, after which SSA could not initiate any new SSDI demonstrations or continue existing ones. The Social Security Protection Act of 2004 extended demonstration authority through December 18, 2005, and allowed SSDI demonstrations initiated by December 17, 2005, to be completed thereafter. Once those projects ended, all SSDI demonstration activity stopped (with the notable exception of BOND).

Congress last renewed Section 234 as part of the Bipartisan Budget Act of 2015, allowing SSA to begin SSDI demonstrations until December 31, 2021, and requiring these demonstrations to end no later than December 31, 2022. This tied closely to the projections at the time of when the Disability Insurance Trust Fund would become insolvent. In Section 823 of that Act, Congress also instructed SSA to conduct a second $1 for $2 offset demonstration (the Promoting Opportunity Demonstration, or POD), specifically creating Section 234(f) of the Social Security Act.

Specific Rules and Changes over Time

Section 234 and Section 1110(b) each have specific rules for how SSA can conduct demonstrations. There is some commonality between the two, but also distinctions. One important distinction is how SSA funds projects. SSA requests an apportionment directly from the Disability Insurance Trust Fund for projects authorized under Section 234. Projects authorized under Sections 1110(a) and (b) are instead funded from the general Treasury and are included in SSA's annual budget request to Congress.

In addition to requiring that a project be related to the SSDI program (or the Ticket to Work program), Section 234 specifies that demonstrations be about changing the SSDI program in some way. They can cover topics related to alternative treatments of work activity and other rules, such as changing the 24-month waiting period for

[15] As a result of this, BOND is technically authorized by Section 302 of the Ticket Act and *not* Section 234, although their general reporting, funding, and other provisions closely mirror each other.

Medicare. Projects conducted under Section 234 are required to "be of sufficient scope and carried out on a wide enough scale" to allow SSA to adequately test the policy while ensuring that "the results derived…will obtain generally in the operation of the disability insurance program…without committing such program to the adoption of any particular system either locally or nationally." Section 234 also requires that projects be "expected to yield statistically significant results." Although this does not require nationally representative participation in a statistical sense, it does mean that the policies tested should be relevant to sufficiently broad situations to inform national policy.

In the Bipartisan Budget Act of 2015, Congress included specific language that limited the scope of demonstrations under Section 234. Congress inserted specific language that such projects be "designed to promote attachment to the labor force." Additionally, SSA had previously signed onto the federal Common Rule for human subjects protections,[16] which includes Institutional Review Board review and limits instances where there could be compulsory participation. Even so, Congress inserted language in the Social Security Act specifically requiring that SSDI demonstration participation be voluntary, including revocable informed written consent. This effectively restricts SSA to testing only policies that are more generous to the beneficiary or recipient.[17] Our review of demonstrations for this volume leads us to believe SSA is meeting a substantially higher ethical standard than required. To protect participants from harm, SSA abides by the Common Rule and other procedures. But equitable evaluation and formulation of the causal models to be tested also call for a focus on equity and inclusion. We anticipate this will be a priority for SSA moving forward.

Section 234 also has specific reporting requirements. Ninety days prior to implementing a demonstration, SSA must notify Congress of its plans for the demonstration. SSA must also provide Congress with an annual report by September 30 on demonstrations covered by Section 234, as well as final reports to Congress 90 days after a project ends.

As noted, Section 1110 has two parts. Section 1110(a) is a general research authority allowing SSA to enter into contracts, grants, and jointly financed cooperative agreements. These projects cover a large swath of topics

> relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies or which will help improve the

[16] At least 16 federal departments and agencies have issued final revisions to the Federal Policy for the Protection of Human Subjects (known as the Common Rule). A revised final rule was published in the Federal Register on January 19, 2017, on pages 7149 to 7274 (https://www.govinfo.gov/content/pkg/FR-2017-01-19/pdf/2017-01058.pdf).

[17] An exception is POD, under which some beneficiaries could be made worse off; however, as noted, Congress mandated that SSA conduct POD.

> administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto.

This is the broad authority that SSA has used to conduct projects related to early intervention and other topics that do not require changes to program rules.

Section 1110(b) allows SSA to waive program rules related to the SSI program. Like the current version of Section 234, under Section 1110(b), when SSA wants to waive program rules, it must obtain revocable informed written consent. Projects under Section 1110(b) must also not "result in a substantial reduction in any individual's total income and resources as a result of his or her participation in the project."

Although Section 1110 does not have any specific notification or reporting requirements (the budget process alerts Congress to what SSA is planning to do), SSA cannot enter into contracts or jointly financed cooperative arrangements without obtaining "the advice and recommendations of specialists who are competent to evaluate the proposed projects." SSA typically satisfies this requirement by holding technical expert panels before awarding new contracts; for jointly financed cooperative arrangements, the award process includes reviews by experts.

Recent Legislative Proposals

SSA's Fiscal Year (FY) 2018 through FY 2021 budgets included a legislative proposal to extend Section 234 and *require* participation of recipients and beneficiaries, when appropriate. As previously alluded to, many policy proposals, such as time-limited benefits or triage systems suggested in policy circles, could be very difficult to recruit for, limiting the usefulness of results based on voluntary studies. Mandatory participation would allow SSA to test these types of interventions in implementable demonstrations.

As part of that legislative proposal, a new expert panel would be established to identify changes to program rules based on the results of successful demonstrations and other evidence. These changes would be expected to reduce SSDI and SSI outlays by 1 percent as of 6 years after the new authority is passed, increasing to 5 percent after 10 years. Savings of that level are unlikely without policies substantially different from current law, if the cost-benefit analyses and findings of SSA's existing demonstrations hold generally.

As discussed later in this chapter, to achieve a 5 percent savings in total program cost, SSA would likely have to make changes outside the scope of anything allowed under current law or anything tested in prior demonstrations. Whether such changes would be attractive to volunteers is uncertain, and evaluations to test such changes would likely be difficult.

SSA's more-recent legislative proposal in its budget does not request the ability to conduct mandatory tests, requesting instead a simple extension of the existing authority.

Recent Developments

In January 2019, the Foundations for Evidence-Based Policymaking Act of 2018 (Evidence Act) became law. Among other requirements, the Evidence Act requires agencies to increase their use and documentation of evidence-building methods and approaches. Demonstrations, such as those conducted by SSA and summarized in this volume, address many of the requirements of the Evidence Act. They are rigorous tests of new policies, services, supports, procedures, and the like, intended to inform policymakers whether the change has the intended effects.

As such, even if the specific policies tested by demonstrations are found to not work as intended—especially then—demonstrations serve a valuable role in the evidence-building process. SSA's demonstration experience positions it to be a fruitful partner to other federal agencies developing these capabilities.

SSA'S DEMONSTRATIONS

In this section, we provide an overview of SSA's many demonstrations. The remaining chapters in this volume delve deeper into their cross-cutting themes and lessons.

Overview

In the 1980s, SSA tested the effectiveness of transitional employment as a means of helping SSI recipients with intellectual disability become more self-sufficient, in the Transitional Employment Training Demonstration (TETD). In the 1990s, SSA tested in Project NetWork whether different forms of outreach and case management increased participation in Vocational Rehabilitation services.

Since the early 2000s, SSA has completed many new demonstrations. SSA conducted the Accelerated Benefits (AB) demonstration to test whether earlier access to health care improved employment among new SSDI beneficiaries. SSA conducted the Youth Transition Demonstration (YTD) to test whether providing employment services and other supports to youth receiving or potentially eligible to receive benefits improves self-sufficiency. SSA conducted the Benefit Offset Pilot Demonstration (BOPD) and BOND to test whether alternative benefit structures increase employment among SSDI beneficiaries. SSA also conducted the Mental Health Treatment Study (MHTS) to test whether supports to beneficiaries with mental impairments improve their employment outcomes.

Currently, SSA is conducting POD to test the effect of additional changes to the SSDI structure on beneficiary employment and benefits; the Supported Employment Demonstration (SED) to determine whether providing services and supports to denied applicants reduces the need for future benefits; and the Promoting Readiness of Minors in SSI (PROMISE) demonstration, in concert with the Department of Education, to test whether family-based supports improve adult employment outcomes in families

with child SSI recipients.[18] In each of these demonstrations, SSA has engaged contractors to help with implementation and evaluation.

SSA also conducts demonstrations without contractors, often with the help of government partners. In the 2010s, SSA partnered with local government agencies in the Homeless with Schizophrenia Presumptive Disability (HSPD) Pilot demonstration to test whether presumptive SSI payments improve the application process for a hard-to-serve homeless population. SSA also conducted several pilot mailing studies with the support of the Social and Behavioral Sciences Team, formerly in the White House and now the Office of Evaluation Sciences at the General Services Administration.

SSA's recent demonstrations typically involve both contractors and government partners. SSA's ongoing Retaining Employment and Talent after Injury/Illness Network (RETAIN) demonstration is a joint project with the Department of Labor to help individuals with recent impairments remain in the labor force. Another new project is the Promoting Work through Early Interventions Project (PWEIP) with the Administration for Children and Families to identify ways to support the self-sufficiency of low-income individuals. SSA also recently convened technical expert panels to help provide feedback on selected ideas for future demonstrations.[19]

Aside from SSA's demonstrations, many other federal government research projects have generated evidence on SSDI and SSI benefits. For example, the Structured Training and Employment Transitional Services (STETS) demonstration, sponsored by the Department of Labor, produced findings comparable to TETD. More recently, the Demonstration to Maintain Independence and Employment (DMIE), sponsored by the Department of Health and Human Services, produced findings comparable to SSA's AB demonstration.[20] A variety of welfare-to-work experiments in the 1990s examined a population overlapping the SSI recipient pool. Many evaluations of labor market policies (Card, Kluve, and Weber 2010; Klerman 2020), including those related to Unemployment Insurance (Klerman 2020; Meyer 1995), have relevant findings. In social policy research, evaluations that are part of projects—such as Building Evidence on Employment Strategies for Low-Income Families and the Next Generation of Enhanced Employment Strategies (Martinson et al. 2021), both

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[18] See www.ssa.gov/disabilityresearch for more information on existing SSA demonstrations. SSA also produces an annual Section 234 report on demonstrations authorized under one of its two demonstration authorities (Section 234 of the Social Security Act) that includes a summary of findings and papers based on those demonstrations. The most recent version of this report can be found at https://www.ssa.gov/legislation/other.html.

[19] See https://www.ssa.gov/disabilityresearch/demos.htm for these technical expert panel reports.

[20] The DMIE, authorized under the Ticket Act, included random assignment demonstrations in Hawaii, Kansas, Minnesota, and Texas. The intervention paired comprehensive health insurance coverage with employment supports to help to maintain participants' employment, health, and independence from public assistance. The states could provide health insurance coverage that was equivalent to their standard Medicaid benefit package or "wraparound" coverage that supplements public or employer-sponsored coverage.

run by the Administration for Children and Families with support from SSA as part of PWEIP—will have relevant findings, as well.

Evaluating Demonstrations

Evaluating policy changes in disability programs has proven challenging because of the myriad programs that serve individuals and numerous agencies involved in their administration. Wittenburg, Mann, and Thompkins (2013, 4) claim

> [E]ach individual program plods along, trying to improve its part of the overall system in ways that add up to very little overall progress. In reviewing evaluations of 27 federally sponsored employment programs, policies, and initiatives conducted since 2000, Livermore and Goodman (2009) found that many were not rigorously evaluated due, in part, to their limited focus and lack of a planned evaluation framework.

There are other pressures that lead to evaluation challenges; for example, the design of POD was mandated by Congress, with elements that made the evaluation design challenging.[21]

There is a large body of related quasi-experimental academic literature. Gelber, Moore, and Strand (2017), for example, estimate that the change in slope at the upper bend point of the SSDI benefit formula implies that if SSDI payments were increased by $1, beneficiaries would decrease their earnings by about $0.20. The authors conclude that most of the drop in earnings associated with receipt of disability benefits (measured in Bound 1989; Bound, Burkhauser, and Nichols 2003; French and Song 2014; Maestas, Mullen, and Strand 2013; von Wachter, Song, and Manchester 2011) is due to income effects. Another example, using a difference-in-differences approach (Mullen and Rennane 2017), has several possible interpretations of the relative importance of income and substitution effects. As important as this distinction is to disability policy, it seems we do not have decisive evidence. But what evidence we have points to substitution effects not driving much of the low employment rates among those receiving disability benefits.

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[21] The legislation authorizing POD required a demonstration that would be externally valid; that is, results would apply generally to the operation of the disability program. But the study was required also to use only volunteers, advise them in detail of their incentives, and allow volunteers to leave the demonstration at any time. Because some volunteers who earned between TWP and SGA would be worse off, those induced to earn between TWP and SGA amounts can be expected to be differentially underrepresented in the treatment group, compromising external validity. Per Hock et al. (2020), "the evidence suggests that a key motivation for POD withdrawals to date is the potential for POD to reduce income compared to current SSDI rules, but early withdrawal rates were not high enough to make this a concern for the impact analysis." Wiseman (2016) highlights some of the design challenges inherent in the legislative authority for POD.

SSA has tended to rely on experimental studies to isolate the effect of interventions. The SSA demonstrations all had distinct target populations and involved multiple partnerships, as depicted in Exhibit 1.3. The interventions were of varying types; the findings, therefore, varied across demonstrations, settings, and populations. (The next section describes key findings on a more comparable scale.[22])

Exhibit 1.3. Overview of Prominent SSA Demonstrations, by Initial Year

Demonstration Name and Date	Design Features	Findings
Transitional Employment Training Demonstration (TETD), 1985–1987	Randomly assigned SSI recipients ages 18–40 with intellectual disability who volunteered to potentially permanent competitive jobs and specialized on-the-job training and supports for 1 year	Increased monthly earnings $64, and decreased monthly SSI payments $7, on average, after 3 years (Thornton and Decker 1989; Thornton, Dunstan, and Schore 1988)
Project NetWork, 1992–1996	Randomly assigned SSDI beneficiaries and SSI applicants and recipients who volunteered to case management, employment, and rehabilitation services	Increased average annual earnings by $220 per year over 2 years, but no discernable impact on benefit receipt (Kornfeld and Rupp 2000; Kornfeld et al. 1999; Rupp, Wood, and Bell 1996)
State Partnership Initiative (SPI), 2003–2005	Included 12 projects funded by SSA (of which only 10 reported impact estimates and only NH, NY, and OK reported usable estimates using random assignment) that gave SSDI beneficiaries and SSI recipients information about the effect of work on benefit receipt and work incentives, and modified program rules to allow SSI recipients to earn and save more	Either no effect or a negative and statistically significant effect on annual earnings (Peikes et al. 2005)
Benefit Offset Pilot Demonstration (BOPD), 2005–2006	Randomly assigned SSDI beneficiaries in CT, UT, VT, and WI who volunteered to receive a "benefit offset" in SSDI benefit payments rather than their payment stopping when earnings exceed SGA	Earnings indistinguishable but benefit payments about 5% higher in the treatment group; treatment group had about 4% more beneficiaries with earnings above annualized SGA (Weathers and Hemmeter 2011)

[22] We do not include in the next section demonstrations without publicly available evaluation findings, such as the SSI/SSDI Outreach, Access, and Recovery (SOAR) demonstration started by SSA in Baltimore in 1993. SOAR aims to increase the award rate and reduce the time from application to decision for adults who are homeless or at risk of being homeless and have a mental illness, medical impairment, and/or a co-occurring substance abuse disorder. It is comparable to the HSPD Pilot and to PWEIP's projects BEES and NexGen. The SOAR program is now funded by the Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.).

Demonstration Name and Date	Design Features	Findings
Mental Health Treatment Study (MHTS), 2006–2010	Randomly assigned SSDI beneficiaries with schizophrenia or an affective disorder to supported employment services and systematic medication management services. Some disincentives removed	Increased 24-month employment rate and earnings, improvement in mental health status and quality of life, but slight decline in physical health status; no detectable difference in earnings above the SGA threshold (Frey et al. 2011)
Youth Transition Demonstration (YTD), 2006–2012	Randomly assigned youth ages 14–25 receiving SSDI or SSI disability benefits, or at high risk of receiving benefits, to receive various work-promoting services and incentives, including work experiences, youth empowerment, family support, system linkages, social and health services	No detectable overall impact on earnings; increased employment about 4%, and disability benefits more than $500 a year higher, at the end of 3 years (Fraker, Mamun, et al. 2014)
Accelerated Benefits (AB), 2010–2015	Random assignment of new SSDI beneficiaries who volunteered and had no health insurance to comprehensive health insurance or to insurance plus medical care management and access to employment and benefits counseling	No detectable impact on employment in year one (Michalopoulos et al. 2011); higher employment and earnings in year two, but no detectable impacts on employment and earnings in year three (Weathers and Bailey 2014)
Benefit Offset National Demonstration (BOND), 2011–2016	Randomly assigned SSDI beneficiaries to receive benefit offset; Stage 1 included mandatory participation, and Stage 2 included volunteers only	No detectable impact on average earnings, 1% higher average benefits among treatment group in Stage 1 and 4% higher in Stage 2; more beneficiaries earned above annualized SGA threshold (Gubits et al. 2018a/b)
Homeless with Schizophrenia Presumptive Disability (HSPD) Pilot, 2012–2014	Compared SSI-eligible individuals with schizophrenia or schizoaffective disorder who got application assistance and presumptive disability SSI payments versus quasi-experimental comparison group that did not	Time between the SSI claim and first SSI payment shortened 3–5 months; higher initial allowance rate and payment status (Bailey, Goetz Engler, and Hemmeter 2016)

Demonstration Name and Date	Design Features	Findings
Promoting Readiness of Minors in SSI (PROMISE), 2016–2018	Randomly assigned SSI recipients ages 14–16 to different intensive case management and connection to community resources (e.g., benefits counseling and financial education, different types of career exploration and work-based learning experiences, promotion of self-esteem and self-advocacy, and parent training and information sessions)	Increased youth receipt of transition services, youth paid employment, family member receipt of support services during the first 18 months after enrollment, and youth receipt of job-related training or credentials. In four states (AR, CA, MD, and WI), increased youth total income from earnings and SSA payments; only in CA, reduced youth receipt of any SSA payments (Mamun et al. 2019)
Supported Employment Demonstration (SED), 2017–present	Randomly assigned denied applicants alleging a mental impairment to receive Individual Placement and Support (employment services integrated with behavioral health and other services)	No evaluation results yet
Promoting Opportunity Demonstration (POD), 2017–present	Randomly assigned SSDI beneficiaries who volunteered to benefit adjustment (offset starts at lower income than in BOPD and BOND)	No discernable impacts on earnings, employment, or benefits (Mamun et al. 2021)
Promoting Work through Early Interventions Project (PWEIP), 2017–present	Supports two existing Administration for Children and Families projects: Building Evidence on Employment Strategies for Low-Income Families (BEES) and Next Generation of Enhanced Employment Strategies (NextGen)	No evaluation results yet (Martinson et al. 2021); see also Chapter 5 in this volume
Retaining Employment and Talent after Injury/ Illness Network (RETAIN), 2018–present[a]	Intervention (case management and connection to occupational health services), target population, and evaluation method vary by state (CA, CT, KS, KY, MN, OH, VT, WA)	No evaluation results yet

Source: SSA (2020a) and works cited in the exhibit.

Note: This table includes only demonstrations described in publications that include evaluation results (or plans for evaluation) where outcomes included benefits, earnings, and/or employment rates; there are other demonstrations that do not meet this criterion, including two described in the Appendix: Benefits Entitlement Services Team (BEST) and Homeless Outreach Projects and Evaluation (HOPE).

[a] Ongoing as of publication (2021).

[b] Evaluation to be implemented in Phase 2. SSA (2020a) notes that "due to the impacts of the COVID-19 pandemic, DOL…delayed the publication of the Phase 2 Funding Opportunity Announcement until FY 2021" and "the evaluation contractor will produce an interim impact report in late FY 2025 and the final evaluation impact report in FY 2026."

A wide variety of non-SSA demonstrations that promoted training or work could be relevant to people who might apply for disability benefits. For example, the National Supported Work demonstration aimed at long-term welfare recipients (Hollister, Kemper, and Maynard 1984), and the National Job Training Partnership Act Study was designed to served economically disadvantaged adults and out-of-school youth (Bloom et al. 1997). The Health Profession Opportunity Grants (HPOG) and the Pathways for Advancing Careers and Education (PACE) interventions aim to improve employment for low-skilled adults (Gardiner and Juras 2019; Peck et al. 2019).

A handful of demonstrations are even more directly related to improving employment among persons with disabilities. The Structured Training and Employment Transitional Services (STETS) and the Demonstration to Maintain Independence and Employment (DMIE) are depicted in Exhibit 1.4 and subsequent exhibits, but there are many comparable demonstrations and experiments worldwide. There are also many state and local return-to-work initiatives (Nichols et al. 2020).

Exhibit 1.4. Overview of Related Non-SSA Demonstrations

Demonstration Name and Date	Design Features	Findings
Structured Training and Employment Transitional Services (STETS), 1981–1983	Two-armed random assignment in five sites (Cincinnati, OH; Los Angeles, CA; New York, NY; St. Paul, MN; and Tucson, AZ) for referred individuals with intellectual disability provided transitional employment building on the National Supported Work design: initial training and support, placement in on-the-job training, and withdrawal of support with follow-up services	Increased employment (31% vs. 19%) and earnings ($36 vs. $21 per week) at month 22 (Kerachsky et al. 1985)
Demonstration to Maintain Independence and Employment (DMIE), 2007–2009	Random assignment of population that varied by state (HI working adults ages 18–62 with diabetes; KS working adults ages 18–64 with various conditions; MN working adults ages 18–60 with serious mental illness; TX working adults ages 21–60 with either severe mental illness or behavioral health diagnoses) to receive services that varied by state (including case management, health coverage, and employment services)	KS and MN had modestly increased employment, but HI and TX did not; none discernably affected average earnings (Whalen et al. 2012)

Source: Works cited in the exhibit.

Average Findings on Employment and Benefits

The general findings in the demonstrations in Exhibits 1.3 and 1.4 above suggest relatively modest impacts. As a means of systematically assessing the state of the evidence, we conducted a meta-analysis of findings from these evaluations, reporting the results in Exhibits 1.5, 1.6, and 1.7 below. We order the demonstrations in the exhibits by the primary year of earnings data collection, to capture variation across the business cycle, but report dollar values in 2020 dollars. A diamond-shaped symbol at the bottom of each figure captures the "Overall" average effect across all those reported. Across these many demonstrations:

- Exhibit 1.5 shows the average effect on benefits is +$72 per year (with a confidence interval from 37 to 107) in 2020 dollars, but the heterogeneity in impacts suggests there is not a single common underlying effect across studies.
- Exhibit 1.6 shows the average effect on earnings is +$97 per year (with a confidence interval from 41 to 153); again, there is substantial variation across studies. The various effects on earnings are quite small, aside from the early STETS and TETD studies.
- Exhibit 1.7 shows the average effect on employment is +1.7 percentage points (with a confidence interval from 0.9 to 2.5). This is a relatively small average effect, but with some notable outliers; for example, MHTS, STETS, TETD, and some of the youth-focused demonstrations in PROMISE and YTD achieved meaningful increases in employment rates.

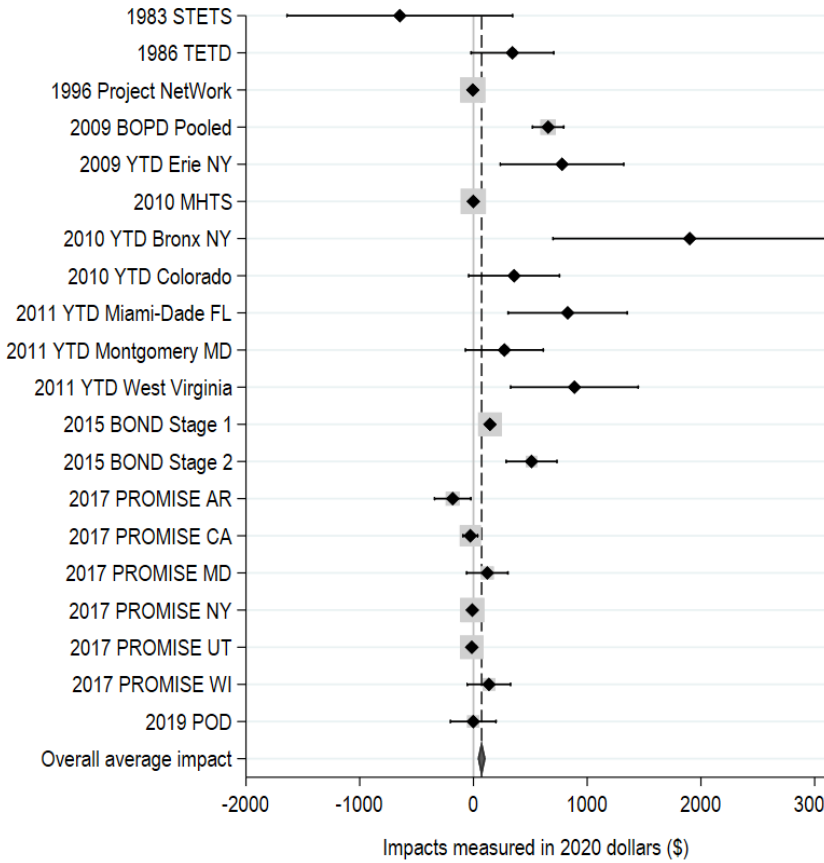
We have made some simplifying assumptions to put these various demonstrations on the same graphs, and different analysts could come up with a different overall average for each synthesis; but we are confident the overall averages would be qualitatively similar across alternative approaches. We do not suggest that there is any obvious pattern to be seen in the larger or smaller estimates.

These syntheses suggest one clear takeaway. The findings reflected in these three exhibits lead to a general conclusion about what the field has learned about disability policy from the demonstrations we have examined: *It is much easier to increase employment than it is to increase net earnings appreciably or to reduce disability benefits.* Indeed, a 1.7 percentage point average increase in employment represents a meaningful increase for this population, where employment rates are relatively low. The corresponding implications of that employment gain for earnings and benefits—less than $100 over the course of the year—seem less life changing.

That said, there are non-monetary benefits to work that have personal and social value. For example, about 45 percent of beneficiaries and recipients reported in 2015 that their goals included working or advancing in their careers or that they saw themselves working in the near future (SSA 2020d). Even without much of an increase in earnings, greater employment could reflect improvements in well-being for some

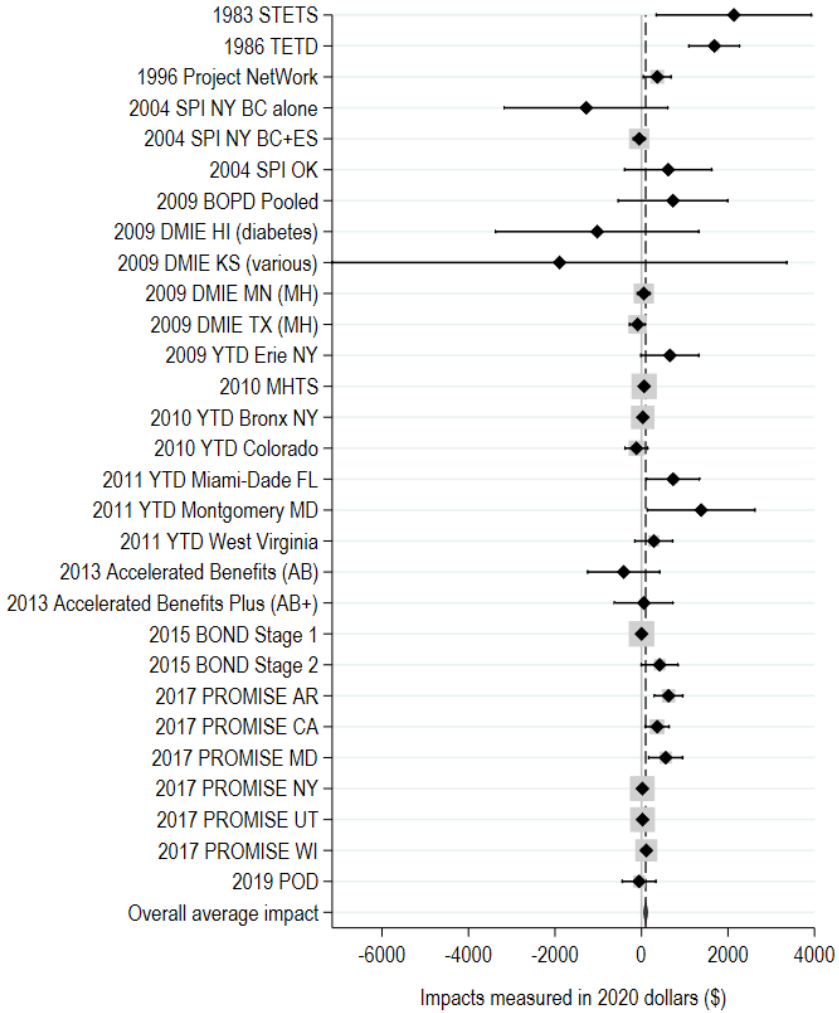
SSDI beneficiaries and SSI recipients. Moreover, as we noted above, the average values from the meta-analysis mask substantial variation in impacts. Not only is variation in the impacts wide, but importantly, the populations and purposes of the demonstrations also vary widely. These simple analyses do not capture the full range of questions relevant to policymakers. The remainder of this volume helps fill these gaps.

Exhibit 1.5. Average of Effects on Annual Benefits across Evaluations in Demonstrations



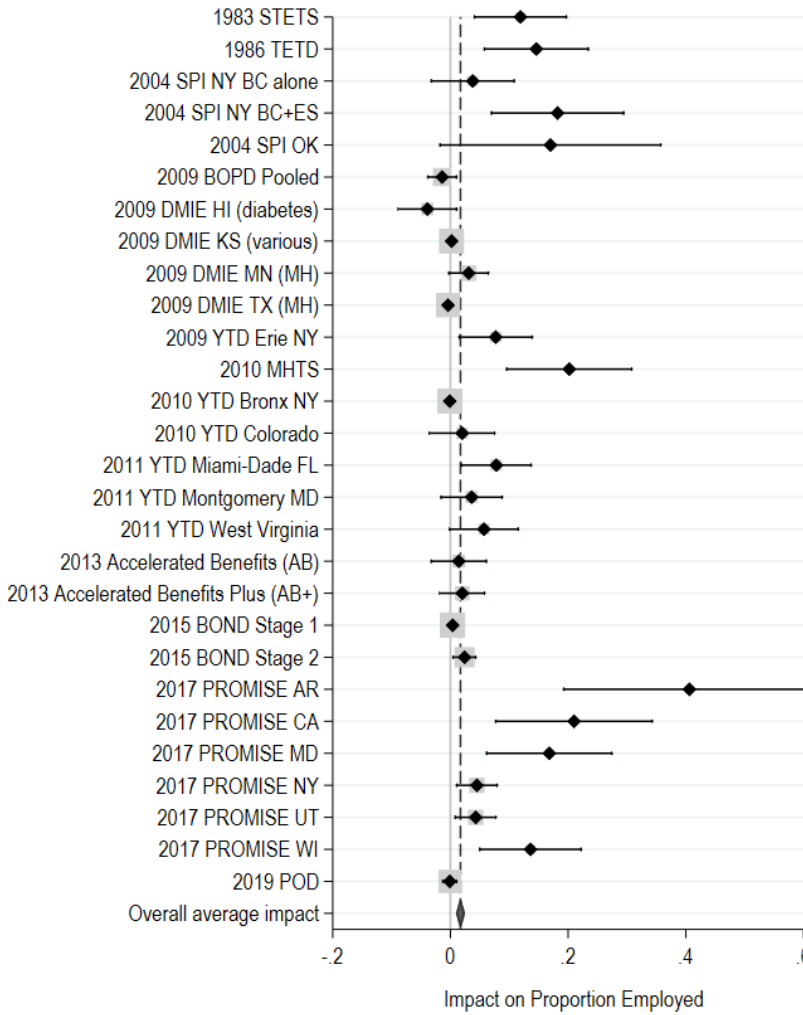
Source: Authors' computations from individual evaluations.
Note: All dollar values in inflation-adjusted 2020 dollars. In the exhibit, the more precisely estimated impacts have greater weight in the average, shown as larger boxes centered on the point estimates. The less precise estimates have wide confidence intervals and appear on either side of the zero line. The overall average impact and its confidence interval appear at the bottom. A measure of heterogeneity, I^2 (Higgins and Thompson 2004), shows that 92 percent of the variation is attributable to heterogeneity across studies. This heterogeneity suggests we should not interpret the average of +$72 per year (with a confidence interval from 37 to 107) as being the common effect across studies.

Exhibit 1.6. Average of Effects on Annual Earnings across Evaluations in Demonstrations



Source: Authors' computations from individual evaluations.
Note: All dollar values in inflation-adjusted 2020 dollars. In the exhibit, the more precisely estimated impacts have greater weight in the average, shown as larger boxes centered on the point estimates. The less precise estimates have wide confidence intervals and appear on either side of the zero line. The overall average impact and its confidence interval appear at the bottom. A measure of heterogeneity, I^2 (Higgins and Thompson 2004), shows that 73 percent of the variation is attributable to heterogeneity across studies. This heterogeneity suggests we should not interpret the average of +$97 per year (with a confidence interval from 41 to 153) as being the common effect across studies.

Exhibit 1.7. Average of Effects on Employment Rates across Evaluations in Demonstrations



Source: Authors' computations from individual evaluations.
Note: In the exhibit, the more precisely estimated impacts have greater weight in the average, shown as larger boxes centered on the point estimates. The less precise estimates have wide confidence intervals and appear on either side of the zero line. The overall average impact and its confidence interval appear at the bottom. A measure of heterogeneity, I^2 (Higgins and Thompson 2004) shows that 81 percent of the variation is attributable to heterogeneity across studies. This heterogeneity suggests we should not interpret the average of +1.7 percentage points (with a confidence interval from 0.9 to 2.5) as being the common effect across studies.

CHAPTER OVERVIEWS

To guide readers through the rest of this volume, in this section we provide brief overviews of all the subsequent chapters. We also provide a summary of selected lessons. Each chapter has a short introduction then discusses relevant history, policy setting, and current program rules. Their next sections discuss topic-specific relevant theory, summarize relevant empirical evidence, and then explore lessons both for policy and for SSA's future learning agenda.

Chapters 2 and 3 focus on the methodological aspects of the demonstrations. In Chapter 2, Burt Barnow and David Greenberg review the design of evaluations that are typically part of a demonstration. They review the designs of past demonstrations' evaluations and discuss the implications for what questions those designs can address. They also offer thoughts on alternative designs that SSA might consider in the future for greater learning. They encourage SSA to consider multiple, varied treatment arms and factorial designs to help determine the role of the component parts of the interventions. Additionally, Barnow and Greenberg suggest additional designs—for example, "stepped-wedge"—that could help provide additional estimates. They also suggest going beyond the intent-to-treat (ITT) estimates that have been the default in SSA's existing demonstrations and encourage treatment-on-the-treated (TOT) estimates, as well. Finally, they note how important process analyses are and suggest that an increased use of fidelity measures could help SSA learn more about the specific interventions.

In Chapter 3, Robert Weathers and Austin Nichols discuss ways to improve the use of evaluation findings and implications for how demonstrations should be used. They focus on questions policymakers have historically wanted answered and how to better communicate findings to meet those needs. Weathers and Nichols encourage strong theoretical models (including logic models) to underpin the demonstrations and clarify their goals. While acknowledging the existence of tradeoffs, they also urge SSA to consider going beyond the single-intervention tests by looking at broad ranges of similar policy options. Looking inside the "black box," through multiple treatment arms, factorial designs, etc., is important to answering questions related to why something worked. The authors also encourage additional uses of qualitative findings and reanalyzing the data from past demonstrations to extend the analyses delivered in evaluation contract reports.

Chapter 4 reviews the lessons from SSA's return-to-work demonstrations such as BOND. Jesse Gregory and Robert Moffitt describe the incentives that individuals receiving SSDI and SSI benefits face. They describe the history of efforts to improve this population's work outcomes, including how the demonstrations align with economic theory and what researchers expected to find. They also propose several considerations for SSA's next generation of demonstrations, including ideas related to Chapters 2 and 3. One important lesson they note is that most efforts to increase employment, earnings, and labor force engagement (i.e., working or looking for work) do not have large effects. As a result, it may be necessary to reconsider expectations

about how many beneficiaries and recipients will go back to work. Promising areas to explore could include work incentives such as the Earned Income Tax Credit that provide additional income above and beyond the current benefit (as opposed to just not taking as much away) at first.

Next, Kevin Hollenbeck in Chapter 5 provides an overview of SSA's efforts to explore policies related to individuals not yet receiving disability benefits. This includes early interventions that might prevent some of them from needing the SSDI or SSI programs for support. Programs that effectively reduce the need for SSDI or SSI could both improve individuals' economic well-being and reduce government expenditures on these programs, allowing for a more efficient use of program resources. Hollenbeck shares lessons from his review of both US and international programs related to SSDI and SSI. He notes that Individual Placement and Support has been tested in several settings, and though it does appear to have some success in improving labor market outcomes, there is little evidence that this translates into reductions in SSI or SSDI benefits. He recommends testing interventions targeting older denied applicants rather than a large swath of potential applicants.

In Chapter 6, David Wittenburg and Gina Livermore review lessons from SSA's efforts to support youth receiving benefits in transitioning to a successful and more self-sufficient adulthood. These efforts generally estimate mixed effects on benefit receipt, but are promising in improving participants' social connections. Wittenburg and Livermore discuss new policy directions and partnerships SSA could explore. They note that youth needs are different from those of adults and are not separable from families. As a result, services that focus on family outcomes are important. Additionally, interagency collaborations, such as those used in the PROMISE demonstration are important. Given the large number of services and program models for youth, building on existing programs, such as Job Corps, could provide fruitful next steps.

Till von Wachter reviews the importance of looking at the heterogeneous impacts of the demonstrations in Chapter 7. He shows why subgroup impacts are important to estimate. He also provides some suggestions for groups that might be important to look at more closely. von Wachter notes that each demonstration uses different definitions for earnings outcomes, age groups, disability groups, etc., which hinders cross-demonstration comparisons. He notes that standardized outcomes and subgroup definitions would be helpful when comparing across demonstrations. He also describes the state of the art on identifying subgroups with different impacts.

In Chapter 8, Vidya Sundar reviews the use of benefits counseling and case management in SSA's demonstrations. Sundar explores the challenges in measuring the effectiveness of these commonly used but often differently implemented services. She notes that we need more information on the timing and nature of benefits counseling and its interaction with other services (e.g., Vocational Rehabilitation). Additionally, more information is needed on models that focus on sustaining employment rather than just getting a job.

Finally, Michelle Wood and Debra Goetz Engler draw lessons from demonstrations' implementation reports in Chapter 9. Wood and Goetz Engler delve into the qualitative and process analyses to glean lessons from how the beneficiaries and recipients were recruited, how the demonstrations were run, and how the interventions were delivered. They also highlight the importance of recruitment and measurement of fidelity to a program model. On recruitment, they note that dedicated recruitment staff can offer advantages over staff responsible for both recruitment and delivery. They also note that site selection and intervention fidelity are important for structured, specialized services. Wood and Goetz Engler point out tradeoffs between centralized and decentralized funding and implementation with respect to the feasibility of data systems, operational policies, monitoring, and other factors. They note that emergency and basic needs of participants may impede participation and engagement in the intervention. Their insights are helpful for understanding how SSA could implement future demonstration efforts, as well as conduct general outreach.

WHAT'S NEXT

It is our hope that this volume provides a path forward for creating evidence-based policy for SSA's disability programs. There are many important lessons in each of the chapters. Here we provide additional thoughts on four overarching lessons from SSA demonstrations.

1. It would be useful to reset expectations about how many SSDI beneficiaries and SSI recipients will return to work absent a very large program change. The interventions tested so far have not resulted in large numbers of people exiting these programs, even when the programs increased employment. Work can itself be a good outcome, though, even if doesn't constitute sustained SGA in a competitive labor market. It would be helpful to have a fuller conversation about what the goals of interventions should be—program savings or improving the well-being of SSDI beneficiaries and SSI recipients. These two goals are not necessarily mutually exclusive, but there should be discussions about what realistic and meaningful goals a demonstration could attain. It is also important to consider the value in testing the underlying assumptions about SSDI beneficiaries and SSI recipients, program incentives, and work. For example, an "Ultimate Demonstration" (see Gubits et al. 2019) eliminating any effect of earnings increases on benefit receipt (except for as any earnings increase affects medical improvement) could test the assumption that beneficiaries and recipients would return to work in large numbers if all financial disincentives in the program disappeared. Though it may not be a feasible policy to implement nationally, it could provide compelling evidence about how far work incentives simplification could move the needle.
2. Future demonstrations should, when feasible, include additional, meaningful treatment arms to allow SSA to determine the impact of specific intervention

components or alternative policies. Many demonstrations test packages of policies or services, and many of their evaluations have been unable to disentangle the effects of each piece. Understanding which parts of these packages work (and for whom) would enable policymakers to understand whether some parts of interventions could be implemented even when the full intervention could not (or should not). Similarly, knowing about variations of policies (e.g., different offset values or different doses of services) may be more informative than just knowing whether a single package works. Knowing only that a package works or not does not tell policymakers whether it is overprovided, in which case similar effects could be had with fewer resources, or whether the theory is good but the amount of resources necessary makes the package cost prohibitive.

3. New data matches, qualitative data, fidelity metrics, and other information about intervention implementation are often necessary to go beyond the impact analyses presented at the end of a demonstration. How services are delivered is important to understanding why there was or was not an effect. Knowing intervention dosages, how strictly the intervention followed the intended logic models or theories of change, or what the local context to the demonstration was can help policymakers better understand findings. Most SSA demonstrations have included process analyses, but few have included validated measures of fidelity of implementation. It is important to note that such fidelity metrics often require strong up-front planning and clear models that take time to develop and validate. Novel data matches can be pursued even for long-completed demonstrations, to learn more from past investments.
4. Different populations have different needs; targeting can be challenging, but also more effective. Though SSDI and SSI are national programs, some policies or services may be more of an incentive or otherwise effective for certain groups. SSA already acknowledges this in the disability determination process, where those older than age 50 are subject to additional considerations based on their education. Similarly, there are special work incentives for youth and blind individuals. Interventions that focus on specific groups, such as those in the MHTS, SED, YTD, PROMISE, and AB demonstrations might be more productive than policy changes or services that apply to everyone.

One topic not generally covered by the chapters, yet increasingly important, is ensuring diversity in researchers and participants in the demonstrations. Different perspectives bring new ideas to all areas, improving the work, and disability policy is no different. SSA has typically held expert panels prior to conducting demonstrations, and that practice should continue. Ensuring these panels include people with disabilities, people of color, and people with lived experiences in the programs would help improve the value of demonstration designs. Additionally, the teams

implementing and evaluating the demonstrations should be similarly diverse and representative of the populations being studied.

Overall, SSA has shown that it can conduct operational policy demonstrations, service-based demonstrations tailored to local conditions or the national program, nudge-style informational interventions, and a variety of other types of demonstrations. It has partnered with other federal agencies, state and local agencies, community health centers, schools, non-profits, and others. As SSA moves forward in developing new policies, demonstrations can clearly have a role. Used appropriately and judiciously, demonstrations provide rigorous evidence, testing whether the most well-meaning policies have the intended effects and helping to ensure that ineffective or harmful interventions do not become a permanent piece of disability policy.

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