Expanding Early Intervention for Newly Ill and Injured Workers and Connections to Paid Medical Leave

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*October 2018*

This brief is part of A New Direction for Disability Policy, a series exploring how federal policy could improve the employment of people with disabilities by expanding the use of early intervention. The series begins by examining how federal policy’s focus on Social Security Disability Insurance led to missed opportunities to effectively support the employment of people with disabilities. A review of recent research and program data shows that the Social Security Disability Insurance program is now on a more stable path, opening the door for a stronger focus on early intervention. In this brief, we examine the capacity of federal programs to intervene early with newly ill or injured workers. The next brief will summarize the evidence base supporting early intervention. The series concludes by exploring how a new universal paid family and medical leave benefit could be paired with grants to states to test promising models and scale up federal early intervention programs over time.

Social Security Disability Insurance (SSDI) is the cornerstone of federal disability policy. SSDI provides social insurance for people with disabilities, replacing lost wages and ensuring that individuals and families have a strong safety net when work cannot be a primary source of income. SSDI also aims to support the employment of people with disabilities. While the Government Accountability Office (2012) estimates that there are 50 federal programs, including SSDI, that support employment for people with disabilities, the number of programs masks a fundamental weakness. These programs often fail to serve people when they could benefit the most, particularly just after the onset of a potentially disabling illness or injury, which is when evidence suggests interventions could be most effective.

Research on strategies to support the employment of people with disabilities indicates that intervening early, at the onset of a new serious illness or injury, is critical for allowing a person to maintain their connection to work (Autor and Duggan 2010; Burkhauser et al. 2014; Christian, Wickizer and Burton 2016; Gimm, Hoffman, and Ireys 2014; Liebman and Smalligan 2013; Livermore, Wittenberg, and Neumark 2014; OECD 2010; Stapleton, Ben-Shalom, and Mann 2016; Wickizer,
Franklin, and Fulton-Kehoe 2018). Early intervention efforts aimed at people who are still employed allows for workplace accommodations that let them to stay in their current jobs. Even among workers who leave the workforce because of a disability, early intervention could assist them before their skills are eroded, their employment expectations undermined, and their health further declines.

Early intervention can take many forms. Some of the most promising approaches to early intervention for at-risk workers provide better coordination, communication, and improved services across different domains, including the workplace, the health care system, the workers’ personal environments, and understanding of their medical condition. Breakdowns in coordination across these domains can lead to prolonged unemployment. Early intervention programs have been shown to have positive effects across a range of conditions, whether the at-risk worker is in pain from a musculoskeletal condition developed later in life or responding to the first signs of serious mental illness, often occurring in one’s twenties. Further, work itself has important health and social benefits (Waddell and Burton 2006).

Despite evidence supporting early intervention as the best way to support labor force attachment for newly ill and injured workers, federal disability policy has not done enough to expand the use of those strategies within existing programs. As discussed in a previous brief, the focus of disability policy over the past two decades has been on the SSDI program, particularly on concerns about program cost and work incentives for people already receiving benefits. This narrow focus on SSDI misses other key employment support programs, notably vocational rehabilitation (VR) and workers compensation (WC) and, to a lesser extent, American Job Centers (AJCs), that are designed to assist disabled workers earlier, before they apply for SSDI.

A new approach is needed that emphasizes early intervention with newly at risk workers and incorporates employment support programs other than SSDI for people with disabilities. This brief explores the relative capacity of four key programs (SSDI, VR, WC, and AJCs) that could be used to expand early intervention strategies to assist workers with disabilities. We find that SSDI is the program worst targeted to newly at-risk workers because services are generally limited to current beneficiaries. By comparison, the VR, WC, and AJC programs engage workers earlier but face significant programmatic constraints that limit their ability to fully serve the target population and evaluate and expand promising models. Other constraints include significant state variation in the VR and WC programs and relatively weaker federal leadership. And although some promising models for early intervention exist, there is not a solid evidence base to support aggressive expansion of one particular model across all states.

Beyond programmatic considerations, significant political and institutional barriers make reforms to these programs unlikely in the near term. One approach to overcoming these obstacles is for policymakers to consider expanding and evaluating early intervention programs to more effectively support the employment of people with disabilities by pairing it with proposals for a national paid family and medical leave benefit. An approach that includes grants to states to fund experimentation could allow states to identify promising models for early intervention that could be replicated and scaled up over time.
Employment Support Programs for People with Disabilities

The federal government has many programs across several agencies that are designed to assist people with disabilities. These programs provide a range of supports, such as income assistance, health care, and employment support. Most federal spending goes to income assistance and health care, which are the cornerstones of the federal safety net for people with disabilities. As shown in Table 1, broad-based federal and state programs provide about $182 billion in income support in 2018 and only $4 billion in employment supports. Livermore, Shenk, and Stapleton (2018) examined federal spending on working-age people with disabilities in fiscal years 2002 and 2014, including broad-based programs, means-tested programs, and programs targeted to specific populations, such as veterans and miners. They found that federal spending on income support and health care has grown 70 percent from 2002 to 2014 after adjusting for inflation, while spending on employment supports and education has increased only 4 percent.

**Table 1**

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<tr>
<th>Income support</th>
<th>Employment support</th>
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<tr>
<td>Social Security Disability Insurance&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Vocational rehabilitation&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Workers compensation&lt;sup&gt;c&lt;/sup&gt;</td>
<td>American Job Centers&lt;sup&gt;d&lt;/sup&gt;</td>
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<td>Unemployment insurance&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Workers compensation</td>
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<td>SSA Ticket to Work Payments</td>
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<td><strong>Total</strong></td>
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Sources: Urban estimates compiled from sources listed with notes below.

Notes: NA = not applicable. Table excludes means-tested programs and programs targeted to specific jobs or industries. Data are for fiscal year 2018 funding unless noted.


<sup>d</sup> Unemployment insurance and American Job Center estimates apply methodology used by Livermore, Shenk, and Stapleton (2018) to funding allocated for fiscal year 2018.

<sup>e</sup> Office of Management and Budget (2018).

In the next section, we review the federal employment support programs for people with disabilities and evaluate their ability to target workers with newly acquired medical conditions that could lead to a work limitation or long-term disability.
The Social Security Administration: Social Security Disability Insurance

PROGRAM BACKGROUND
SSDI is the largest program serving people with disabilities who are unable to perform “substantial” work. It provides income support payments totaling $148 billion annually to 8.7 million workers and 1.7 million children and spouses. The average monthly benefit in 2018 is about $1,200 per beneficiary, or $14,500 a year. To be eligible to apply for SSDI, a beneficiary must generally have worked for at least 10 years, and 5 of those years must have occurred in the 10 years before applying for benefits. Once a person has been determined eligible for benefits, they also become eligible for a range of employment support services.

TARGET POPULATION
Because employment supports in SSDI are limited to current beneficiaries, the ability of SSDI to intervene early with newly at-risk workers is inherently limited. How the Social Security Act defines disability and the difficult, lengthy process of determining whether a worker is disabled and eligible to receive benefits contributes to how long an applicant is disconnected from the workforce. The Social Security Act defines a work disability as the “inability to engage in substantial gainful activity (SGA).” The Social Security Administration (SSA) quantifies SGA as the ability to earn $1,180 a month in 2018. Further, the inability to engage in SGA must be because of a “medically determinable physical or mental impairment.” The condition must be both severe and expected to persist for at least 12 months or result in death. Benefits cannot begin until five months after the onset of the condition.

Determining disability often requires consultation with medical providers and evidence to support the case. In 2017, the average wait time for an initial determination was 111 days, and the wait to be awarded benefits based on an appeal hearing takes on average 605 days (Morton 2018). The determination process requires applicants to prove they are not capable of significant work consistent with SSDI’s mission to provide wage insurance for workers who experience a severe long-term impairment and are unable engage in SGA. Consequently, the disability determination process also often erodes the work capacity of people who apply for benefits and are denied SSDI (Autor et al. 2017).

Data on SSDI beneficiaries indicate that very few people return to work after receiving benefits. Each year, approximately 0.5 percent of disability insurance (SSDI and Supplemental Security Income, or SSI) beneficiaries work enough such that they are no longer eligible for cash benefits (O’Leary, Livermore and Stapleton 2011; Schimmel and Stapleton 2011). Even over a 10-year period, only 2.7 percent of SSDI beneficiaries left the program because of work (Liu and Stapleton 2010). This low rate of exit from disability insurance is not unique to the US. The OECD (2010) examined experiences across many of its participating countries and found that “once a benefit is awarded, the probability of return to work is close to nil” (57).
BOX 1
SSA’s Five Step Sequential Determination Process

To operationalize the statutory definition of disability, SSA uses a five-step sequential process and a listing of medical impairments to determine a person’s eligibility for SSDI benefits. The first two steps are designed to disqualify applicants who are earning more than the SGA amount or who do not have a severe impairment (or combination of impairments) that is expected to last 12 months or result in death. The third step compares the applicant’s impairment to a listing of impairments that are considered severe enough to prevent a person from doing any gainful activity and therefore produce automatic eligibility. For applicants who have impairments which do not meet the listings, SSA assesses the person’s residual functional capacity and, in the fourth step, considers whether their impairments prevent them from doing their past work. In the fifth step of the process, SSA considers the applicant’s residual functional capacity, age, education and work experience and decides whether the applicant can do other work that exists in the economy. In the fourth and fifth step, an applicant is declared eligible for benefits if they satisfy thresholds on the overall combination of these factors.

CURRENT PROGRAMS AND DEMONSTRATIONS

SSA’s current work incentive programs and demonstrations cannot generally be thought of as early intervention. They traditionally engage people only after they have been awarded SSDI benefits (with one exception that target denied applicants), which is often too late to be effective. Despite this, concerns over disincentives to work in SSDI, as well as concerns about growing program costs, generated substantial investments in programs and demonstration projects aimed at helping beneficiaries return to work. These efforts are described below as well as the results from evaluations of their effectiveness. A review of evidence reveals their limited impact and underscores the need for early intervention. In addition to the demonstrations and projects below, SSDI also has several rules intended to encourage employment, including a trial work period and exclusion of impairment-related work expenses from earnings.

Ticket to Work. The Ticket to Work program is SSA’s main program to encourage work among beneficiaries. Ticket to Work provides beneficiary a “ticket” to a private VR provider or a state VR agency. If the organization successfully helps the beneficiary find a job and earn enough to leave SSDI or SSI, SSA will pay the agency or provider a substantial portion of the benefits that would have been paid to the beneficiary had they not returned to work. In essence, Ticket to Work was an early attempt at a “pay for success” strategy. Ticket to Work was intended to be self-financing, but early on, interest from the private sector was very low. Private rehabilitation entities complained that the outcome-based rewards were too small and came too late to make interventions profitable. Further, tension arose between private entities and the state VR agencies. During early implementation, state agencies held the primary role in developing the modest system that came to exist, and it ultimately fell short of the aspirations of many advocates behind the 1999 law creating it.

In part because of low participation and the delayed interventions, results from Ticket to Work have been disappointing. In 2008, SSA revised the program with new regulations, such as raising the
amount of early milestone payments and revising rules that permitted compensation to both the private entities and state VR agencies for assistance to the same beneficiary. Unfortunately, although the more generous compensation structure has increased beneficiary use of services, there is no evidence that it has increased their employment compared with what they might have pursued outside the Ticket to Work program (Livermore et al. 2013; Schimmel et al. 2013).

SSA has hoped to tap the private sector’s return to worker expertise through Ticket to Work, but that has yet to be achieved. The private sector disability management field largely serves employers, either in response to worker’s compensation cases or to supplement a private disability insurance benefit. Experts in this field report they do not see SSDI beneficiaries as a prime market because by the time someone has been determined eligible for SSDI, it is often too late for successful intervention.

**Mental Health Treatment Study.** SSA established the Mental Health Treatment Study (Frey et al. 2011) to test the utility of supported employment services and systematic medication management services for those on SSDI with a mental illness. In a randomized controlled trial across 23 sites, the evaluation by Westat found the 24-month employment rate was 61 percent for the treatment group compared with 40 percent for the control. Earnings gains among participants were modest, however, and not enough to leave the SSDI program. Westat found that participants in the program had fewer hospital stays and fewer psychiatric emergency visits (overall health care costs were not tracked).

**Accelerated Benefits Demonstration.** SSA completed the Accelerated Benefits (AB) demonstration, a randomized controlled trial in which newly awarded beneficiaries received accelerated access to health benefits with employment and benefits counseling (known as AB plus) or the health benefits only. Results after the first year of the intervention show no statistically significant employment impacts (Michalopoulos et al. 2011). After the demonstration’s second year, 15 percent of participants in the AB plus intervention were employed compared with 10 percent in the control group. Annual earnings of the AB plus group, however, only increased by $773 (Weathers and Stegman Bailey 2014). The treatment group receiving only health benefits did not have any gains in employment or earnings. The evaluation of both AB and AB plus show the limited potential to produce earnings gains among those already receiving benefits.

**Benefit Offset National Demonstration.** In the Benefit Offset National Demonstration, a random national sample of SSDI beneficiaries continued to receive their SSDI benefits when their earnings exceeded the SGA level ($1,180 a month) rather than losing all of them, which is commonly known as a “cash cliff.” The cash cliff ostensibly gives SSDI recipients an incentive to keep their earnings below the SGA level. For those in the demonstration, benefits are reduced at a rate of 50 cents for every dollar in earnings once earnings exceed the SGA level. In other words, if someone earned $1,280 in a given month, his or her benefit would be reduced by 50 cents for each dollar between $1,180 and $1,280. Unfortunately, results from the evaluation found no improvement in earnings (Hoffman et al. 2017).

**Supported Employment Demonstration.** Most recently, SSA initiated a demonstration project targeted to people who had applied for and been denied SSDI or SSI benefits. This approach moves in
the direction of earlier intervention and represents efforts to think creatively within the constraints of SSA’s existing demonstration authority.

**SSA’s Evaluation Capacity.** Although SSA does not currently have early intervention programs, the agency does have significant experience and expertise in program evaluation that could support expansion of evidence-based early intervention. SSA’s statutory authority to test new programs under its demonstration authority is stronger than other agencies’, but its limited focus makes it challenging to lead and inform federal efforts at early intervention. SSA’s authority to test new approaches can draw upon both mandatory and discretionary funds that are substantial relative to other programs’ resources. However, the SSDI mandatory authority is historically limited to current beneficiaries, and program advocates have long valued this approach. The SSI program’s research and demonstration authority is broader in scope, but funding is more limited.

Despite the availability and scope of these authorities, SSA has not aggressively used them (Hart, Fichtner and Smalligan, forthcoming). One practical reason for this is that the SSDI demonstration authority is only available for five years, making it difficult for SSA to stand up and complete any new projects. The current authority is scheduled to expire in 2022. Legislation to permanently authorize SSDI demonstration authority could remove this obstacle.

Yet SSA’s past demonstrations have not led to policy interventions that would slow the program’s growth nor to improvements in the employment of people with disabilities. One study reviewed SSA’s past demonstration projects and concluded that “none of the demonstrations we reviewed have the potential to lead to substantial caseload reductions that could reverse program growth” (Wittenburg, Mann and Thompkins 2013); Romig (2016) reached a similar conclusion. The Government Accountability Office (2012) has also raised concerns about SSA demonstration projects aimed at increasing work among SSDI beneficiaries.

**New Proposals.** In addition to programs already implemented by SSA, a large body of research and policy proposals support reforming SSDI and encourage work among people with disabilities. This literature has contributed to a better understanding of the program and potential improvements that could be made. The majority of these proposals are fundamentally limited in that they focus almost exclusively on SSDI and do not incorporate other federal and state employment programs. This is despite evidence that before applying for SSDI, applicants interact with many other programs (Honeycutt 2004). However, there are some notable exceptions (Autor and Duggan 2010; Christian, Wickizer, and Burton 2016; Liebman and Smalligan 2013; Stapleton, Ben-Shalom, and Mann 2016). These proposals take a range of approaches, such as introducing a new employer-funded temporary disability insurance benefit or providing new services and supports. To date, these proposals have gained little traction. The reasons for this are many, but an important obstacle is the division of legislative oversight and lead agency responsibilities between SSDI and the other employment support programs for people with disabilities. With separate congressional committees and budget allocations, incentives in the legislative system perpetuate a fragmented approach to policymaking. This is an important challenge that must be navigated carefully. SSA is not the best agency to lead on early intervention. Even policy makers focused on SSDI need to understand that other programs and agencies
may be in a better position to advance policies that can increase the employment of people with disabilities by leveraging the evidence around early intervention.

Department of Education: Vocational Rehabilitation

PROGRAM BACKGROUND
The US Department of Education’s Rehabilitation Services Administration has responsibility for VR state grants, which provide nearly 80 percent of the funding for state-based VR programs. The VR programs provide services to people with disabilities that are tailored to their specific circumstances, with the goal of helping them find employment and achieve self-sufficiency. The programs achieve this through a mixture of direct services and referrals to other providers as part of a coordinated plan. VR programs serve roughly 1 million people a year.

To be eligible for VR services, a person must demonstrate that he or she has a physical or mental impairment that presents a substantial barrier to employment. He or she must also have the potential of benefiting from VR services to achieve employment. People receiving SSDI and SSI are automatically eligible provided the VR agency decides they also have the potential to benefit. As such, the VR program has the clearest responsibility for helping people with disabilities both enter and stay in the labor force.

TARGET POPULATION
The VR program could effectively target newly at-risk workers for early intervention services under current program authorities. In practice, however, funding constraints and prioritization rules heavily constrain the program’s ability to help workers who have recently left the labor force and have, at least initially, a less severe health limitation (Kennedy, Olney, and Schiro-Geist 2004). Demands on the VR system have increased while funding has been relatively flat, with adjustments only made for inflation. Congress has required VR to prioritize those with the most serious disabilities as well as certain other vulnerable populations, such as youth with disabilities. Further, VR agencies receive incentive payments from SSA when a beneficiary achieves certain employment milestones or outcomes. After serving these prioritized groups, most VR programs have few resources left to assist other workers with health-related work limitations. Consequently, a segment of the population is caught in the middle by not having access to private disability insurance through an employer and not falling within one of VR’s priority populations. Some of these workers may have access to workers compensation benefits and services, but many do not.

EARLY INTERVENTION
The benefits of targeted VR services are supported in the literature, but because the program has performed very few rigorous evaluations, the academic literature is not definitive about the effectiveness of additional VR assistance. Analysis using administrative data by Schimmel Hyde, Honeycutt, and Stapleton (2014) concludes that when VR services are readily available, without long waiting lists, the likelihood that people can return to work improves and the likelihood of application for SSDI declines. Stapleton and Martin (2012) found that among the applicants for VR services who come to the program from other pathways than SSA, a large share eventually receive SSDI and SSI benefits,
though rates vary widely by state (as with SSDI and SSI receipt generally). Dean and colleagues (2017) used administrative data from the Virginia VR system and take advantage of variation in the provision of services across both offices and staff workers to estimate a return on VR services. Focusing on improved employment, they find a substantial return on VR services for people with mental illness, but they find no reduction in receipt of SSDI or SSI.

Although creative use of administrative data provides insights, it cannot replace more rigorous evaluations of VR early intervention programs to justify scaling them up. Unfortunately, evidence of VR effectiveness based on rigorous evaluation methods, such as random assignment, is limited. A team at the University of Massachusetts Boston (Institute for Community Inclusion 2010) reviewed the VR literature and found only a limited number of randomized controlled trials and a “limited depth of knowledge” to support what works. An effort to compare disability programs internationally found that “information on the effectiveness of vocational rehabilitation is scarce and often inconclusive” (OECD 2003, 112). It is encouraging that the Rehabilitation Services Administration recently funded a random assignment demonstration project in Kentucky and Minnesota to test whether service innovations, including expedited services and job placement that could improve employment outcomes for SSDI beneficiaries. So far, Kehn, Livermore, and Morris (2017) found the initial results to be encouraging in Kentucky but inconclusive in Minnesota.

VR-led early intervention practices lack a solid evidence base. Further, federal oversight of the program is limited, with substantial flexibility given to states and significant variation in the quality of VR programs across states. Moreover, the VR program competes for funding and attention with other higher-priority programs within the Department of Education, prompting some to argue during the program’s reauthorization that VR should be moved to the Department of Labor. The program will require reauthorization again in 2020, possibly offering another opportunity to strengthen the program and enhance its focus on early intervention with workers with disabilities.

**Department of Labor: Workers Compensation**

**PROGRAM BACKGROUND**

WC provides resources for wage replacement, medical care, and rehabilitation for workers who are injured on the job or who become ill from a work-related cause. WC is a largely employer-funded, state-run program with only limited oversight by DOL. How much access workers have to WC benefits and services depends heavily on the state-specific requirements on employers, and these rules vary widely. WC policies covered 138 million workers and paid $61.9 billion in benefits in 2016, divided evenly between cash benefits and health and medical expenditures (McLaren, Baldwin, and Boden 2018). Data are limited on the amount of funds employers spend on employment supports and rehabilitation services to workers with workplace injuries or illnesses. Employer expenditures in this area depend upon many factors, including state laws, union agreements, and employment benefit policies.
TARGET POPULATION

WC is designed to assist the portion of newly at-risk workers whose impairments are job-related and who are covered by WC. However, WC claims have been declining for decades. In sharp contrast with trends in the SSDI program, WC program costs have declined over the past 25 years. Cash benefits peaked in 1991 at an average of $0.99 per $100 in wages for covered workers, dropping to $0.41 in 2016. Medical benefits dropped more modestly, from $0.69 to $0.42 per $100, during this period.

Experts disagree over whether this decline signals problems in the WC program and whether the program is underserving the target population. Evidence suggests that the declining number of new claims is partly caused by a significant drop in the incidence of occupational injuries and illnesses because employment has shifted to less hazardous occupations. The incidence of injuries or illnesses requiring days away from work or a job transfer dropped from 8.1 cases per 100 full-time workers in 1995 to 3.0 cases by 2015 (McLaren and Baldwin 2017).

Many states also tightened eligibility rules during the 1990s so that a WC claim had to be related to a specific accident, and states reduced liability when a preexisting condition is triggered. States also tightened evidentiary standards so that claims must be based on injuries that are primarily work related and based on “objective medical” evidence (Burton and Spieler 2001). Further, lower benefit levels may have also reduced overall demand for benefits (Krueger 1990).

Some researchers find evidence that the shrinking of WC benefits represents, in part, a cost shift to SSDI and a cost shift from employers and states to the federal government (Burton 2010; Guo and Burton 2008, 2012; O’Leary et al. 2012). Others see no evidence of cost shifting (McInerney and Simon 2010, 2012). Analysis of 1992 Health and Retirement Study self-reported data indicates that about 29 percent of disability insurance beneficiaries age 51 through 61 have an injury they report as having been caused by their work, but of this group, only 12.3 percent received WC benefits (Reville and Schoeni 2005). Analysis of WC cases in New Mexico and SSDI awards suggests 7 percent of disability insurance awards in that state are a consequence of a WC injury (O’Leary et al. 2012). More generally, DOL issued a report in 2016 noting that because of the weaknesses in the WC system, employers only incur a small portion of the overall cost of occupational injury and illness (DOL 2016). Additional costs are absorbed by the federal government through SSDI, Medicare, Medicaid, and the Affordable Care Act.

EARLY INTERVENTION

Similar to the VR program, WC policies around provision of employment supports vary widely by state. Further, the WC system suffers from weak federal oversight. For example, many states have limited requirements for employers to help ill or injured workers stay in the labor force. Burton (2004) notes that “many states do not require employers to provide vocational rehabilitation services that may be necessary to equip the injured worker to handle a new job.” Also, many state programs do not do as much as they could to require employers to provide adequate health care, rehabilitation services, and workplace accommodations to people who experience long-term impairments caused by a work-related
injury (Burton and Guo 2016). Poor health care and inadequate efforts at rehabilitation and work accommodation can cause workers to drop out of the labor force (Franklin, Wickizer, et al. 2015).

However, several states are making noteworthy efforts to emphasize employment support and return to work strategies. Hunt and Dillender (2017) identify Washington, Oregon, New Hampshire, New Mexico, Massachusetts, New York, Ohio, and California as promising examples. Washington State, with a program called the Centers for Occupational Health and Education (COHE), is particularly notable. Established in 2001, the COHE intervention improves the focus on employment outcomes by working with the health care system to assist workers who have an occupational injury or illness. COHE staff improve communication between the injured worker, the physician’s office, and the employer. They also provide education on best practices. COHE identifies obstacles and misunderstandings that impede a person’s return to work whether they be on the part of the employer, physician’s office, or injured worker. The COHE staff help identify the ability to return to work as part of a successful health care outcome (Wickizer et al. 2011; Franklin, Wickizer, et al. 2015).

Wickizer, Franklin, and Fulton-Kehoe (2018) conducted an evaluation of workers eight years after participation in the COHE program and found, relative to a comparable group of injured workers, the workers receiving the COHE intervention had 30 percent fewer workers exiting the labor force because of a workplace-based injury or illness and a 30 percent lower rate of injured workers transitioning to SSDI. Franklin, Sabel, and colleagues (2015) have shown that the innovations introduced by the COHE program can also provide insights and inform responses to the opioid crisis. Leaders in the WC field have issued policy statements emphasizing the need to better focus on return to work and the lessons from Washington State’s experience (IAIABC 2016). Recognizing the potential of the COHE model, DOL included a request in its fiscal year 2018 budget to fund demonstration projects in other states that test strategies similar to COHE. The Retaining Employment and Talent After Injury/Illness Network in the DOL Office of Disability Employment Policy was funded by Congress, and the initial grant awards were announced this September. SSA is supporting the Retaining Employment and Talent After Injury/Illness Network with program evaluation funding provided under its research and demonstration authority.

In addition to state-initiated efforts, some large employers have established disability management programs to handle workers’ compensation cases, and evidence suggests these programs improve work outcomes for workers with less severe injuries, but these efforts have not spread to smaller employers (Hunt and Dillender 2017). The motivation for these programs can be mixed. Effective programs can increase work accommodations and employment outcomes for injured workers (Revill, McLaren, and Seabury 2010), but other, less effective programs are more narrowly focused on realizing cost savings for the employer, such as by discouraging a worker from making a WC claim.

The uneven response to occupational illness and injury is a missed opportunity. Although some promising public and private efforts are taking place, many workers do not benefit from them. After a workplace injury, workers often experience a permanent drop in earnings (Savych and Thumula 2016), an increased potential to drop out of the labor force, and a greater probability of going onto SSDI (Baldwin, Conway, and Huang 2009).
Department of Labor: American Job Centers

PROGRAM BACKGROUND
AJCs are a key feature of the local workforce systems under the Workforce Innovation and Opportunity Act. They offer training referrals, career counseling, job listings, and similar employment-related services to a wide range of workers, including those with disabilities (Eyster et al. 2016). Anyone is eligible for some level of services from AJCs. Priority populations, such as youth and veterans, are eligible for special services. AJCs refer people with disabilities to VR offices, and VR agencies often collocate with AJCs. When the Workforce Innovation and Opportunity Act was reauthorized in 2014, Congress increased AJCs’ emphasis on providing people with disabilities access to workforce services, especially competitive integrated employment.

TARGET POPULATION
In many cases, AJCs may interact with workers who have recently left the workforce because of a health-related impairment, including many future applicants to SSDI. AJCs often have “disability program navigators” to help at-risk workers connect with available programs, such as VR. These navigators specialize in helping workers with disabilities. Overall, however, only 5.1 percent of people exiting from AJCs had disabilities in 2014, a rate similar to that in 2008 (4.2 percent) and 2002 (5.2 percent; Livermore and Colman 2010; Livermore, Shenk, and Stapleton 2018; Livermore, Stapleton, and O'Toole 2011). With funding declines in real terms, many organizations have emphasized lower-cost services, such as automated and group services, while reducing optional or alternative services, such as training and one-on-one staff assisted services (Wandner 2013). Through linkages to VR agencies, many AJCs also provide referral services to newly at-risk workers. Without substantial additional services or a re-ordering of priorities among target populations, however, expecting AJCs to do more than this is unrealistic.

EARLY INTERVENTION
The AJCs could be a mechanism to deliver early intervention services, but it would require a reprioritization of resources that would be difficult given the importance of other groups they serve, such as dislocated workers. AJCs have shown they can assist workers with disabilities, but no rigorously evaluated AJC-based models for early intervention exist. Further, evidence is limited that AJCs could effectively provide early intervention services. Despite this, AJCs have shown they can assist workers with disabilities in a few ways. For example, in the context of their “rapid response” activities for workers who are at risk of being dislocated by a layoff or plant closing, a survey of 19 AJCs showed the programs had an awareness and ability to coordinate those services with others tailored to people with disabilities (Heidkamp and Mabe 2011). The AJCs also assisted many older workers with disabilities during the Great Recession, but requests for these services outstripped available resources and prevented them from being able to fully serve this population.

DOL has also tested more intensive approaches to assisting workers with disabilities in the past. In 2001, DOL provided funding to some AJCs to test a Customized Employment strategy. The Customized Employment model involved negotiations with employers to establish customized job tasks that fit the
desires and abilities of the job seeker. Customized Employment was not rigorously evaluated, and funding was discontinued (Karakus et al. 2011). One key limitation is also that AJCs do not typically interact with medical providers as much as VR, WC, and SSA. Consequently, AJCs could play an important supporting role but are less suited to leading early intervention programs.

**Early Intervention and a New Paid Medical Leave Benefit**

Federal efforts to help people with disabilities stay in the workforce have broad support, and evidence strongly suggests that intervening early when someone has acquired a disabling condition is the most effective approach. As discussed earlier, however, the primary federal and state programs with responsibility for supporting employment for people with disabilities suffer from notable programmatic limitations that impede their ability to effectively use early intervention strategies. Further, federal policymaking leadership has been limited in this area and often focused on SSDI, the program where the costs of failing to intervene earlier are evident but that lacks the ability to target people before they enter the program. Legislative action to address these challenges is hampered by divided oversight and funding for disability employment support programs, making aggressive steps to advance federal policy in this area difficult.

Despite these challenges, new legislation could lead to meaningful change. In recent years, bipartisan support for paid family and medical leave has been growing. Three states currently provide paid family and medical leave, with one more beginning implementation this year and another three set to begin over the next three years. At the federal level, Senator Kirsten Gillibrand and Representative Rosa DeLauro first introduced their legislation to create a system of universal paid family and medical leave in 2013. Senator Marco Rubio introduced legislation in 2018 to finance parental leave through the Social Security program. The Bipartisan Policy Center also launched a task force in May to examine how bipartisan consensus around the need for paid family leave could lead to effective federal policy. Although support appears to be strongest for paid parental leave, there also appears to be interest in creating a paid medical leave program. A recent report issued by the Working Group on Paid Family and Medical Leave, a joint project of the American Enterprise Institute and Brookings Institution, called for a study of a new national temporary disability program.

The creation of a comprehensive paid leave program could be an opportunity to support an aggressive expansion of evidence-based early intervention strategies for workers at risk of long-term disability. The vast majority of workers who would benefit from a paid medical leave benefit will simply return to their job. However, some workers who are unable to return to work because of a more serious illness or injury are an important component of the overall decline in labor force participation (Fujita 2014). Research on existing short-term disability and state paid medical leave programs suggests that a universal paid medical leave program could play a critical role in identifying and targeting services to workers who would most likely benefit from early intervention services. For example, Neuhauser, Ben-Shalom, and Stapleton (2018) examined California short-term disability insurance and workers’ compensation data and concluded the data could be a valuable early intervention screening tool. Similarly, Bourbonniere and Mann (2018) worked with administrative data from the Rhode Island
Evidence also suggests that data from paid leave usage would be useful for targeting people at higher risk of eventually claiming SSDI. Mullen and Rennane (2017) surveyed the literature regarding workplace absenteeism. Although information in the US is limited, they found a strong body of research in Europe, where sick leave policies are more expansive. The European literature concluded that sick leave rates (which include use of paid medical leave, not just paid sick days, as is common in the United States) are a strong predictor of future enrollment in long-term disability programs. For example, Wallman and colleagues (2009) examined Swedish sick-leave records and found a strong correlation of patterns of sick leave and eventual awarding of a disability pension. However, the experience of other countries is inconclusive.

Establishing a new paid family and medical leave program offers a unique opportunity to overcome the current challenges faced by other federal programs to intervene earlier with workers after they develop a potentially disabling condition. A new early intervention program should draw upon the evidence supporting effective strategies and upon what has been learned from past efforts to scale up other large, evidence-based federal programs:

- **Target the right people at the right time.** A paid medical leave program would assist workers who are still connected to an employer. The evidence is strong that this is the best time to intervene with workers who have recently acquired a work-limiting medical condition. The right intervention can help both the employee and employer adjust expectations and identify accommodations while the employer has an investment and relationship with the worker. A paid leave program would create a new point of contact between newly at-risk workers and employers for providing early intervention services.

- **Allow state experimentation and build the evidence base.** Federal grants to states could provide an opportunity to pilot different strategies at the state level and build a more robust evidence base on what works and which approaches should be scaled up or replicated by other states. Recognizing the substantial variation across state programs, some states could propose to modify their WC system, others might try to innovate through VR agencies, and others could develop new interfaces with the health care system. Although some promising approaches exist, much more needs to be known. Grants to states could be coupled with requirements for states to rigorously evaluate their approaches, using randomized assignment and multiple treatment arms whenever feasible, to expand the evidence base on what works.

- **Expand knowledge of disabling conditions.** A new paid leave benefit could provide the opportunity to learn more about the kinds of health conditions that lead to shorter- and longer-term gaps in work and how best to identify and target services to workers most at risk of having a short-term medical impairment turn into a long-term disability. This could be done using administrative data on program participants while ensuring proper protection of personal health information. With the right research agenda, we can understand what kinds of
conditions lead to the use of paid leave and the trajectories of those people—how many return to work and after how long, how many ultimately qualify for SSDI benefits because their conditions do not improve, and what diagnosis and other differences impact these trajectories.

- **Leverage program data to address other critical challenges.** A new program could also prove useful in other important and related areas, such as addressing the problem of growing opioid abuse. Research by Krueger (2017) and Franklin, Sabel, and colleagues (2015) show some of the potential interactions between medical treatment for pain, opioid use, and employment rates that should be explored further.

**Conclusion**

Federal policies to support the employment of people with disabilities have centered around the SSDI program. This has led to many programs and demonstrations focused on incentivizing and assisting SSDI beneficiaries to return to work. However, evaluations of these efforts show they have yielded little to no impact. Because of the focus on SSDI program costs, little attention has been paid to improving the effectiveness of the other federal programs that support employment of people with disabilities. The result has been a missed opportunity to draw upon the evidence supporting the effectiveness of intervening early with workers who have recently developed a potentially disabling condition, before they apply for SSDI benefits.

Our review of the key employment support programs for the disabled, as summarized in table 2, reveals that SSDI is not well suited to targeting and delivering early intervention services because its mission and resources are limited to serving current beneficiaries, and the evidence suggests this is too late. There has been more experimentation and evaluation of SSDI-based approaches, however, because SSA has the broadest authority and funding to support research and demonstrations. SSA also has strong evaluation expertise that should be leveraged to study what works and inform expansion of promising models.

**TABLE 2**

**Capacity of Federal and State Programs to Deliver Early Intervention Services**

<table>
<thead>
<tr>
<th></th>
<th>Social Security Administration (SSDI)</th>
<th>Department of Education (VR)</th>
<th>Department of Labor (WC)</th>
<th>Department of Labor (AJCs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Targets newly at-risk workers</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Limited</td>
</tr>
<tr>
<td><strong>Promising models for early intervention</strong></td>
<td>No</td>
<td>Limited</td>
<td>Some</td>
<td>No</td>
</tr>
<tr>
<td><strong>Strong federal leadership</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Source: Authors’ analysis.*
We find programs other than SSDI are better targeted but suffer from challenges that make them unlikely leaders to expand the use of early intervention on their own. The most obvious alternative is the VR program, which has a mission and structure better targeted to newly at-risk workers, but in practice it does not broadly serve the target population because of limited resources and prioritization rules. Further, the evidence base on VR-based early intervention programs is weak. Additional pilots and evaluation are needed to build a stronger knowledge of what approaches should be expanded and replicated across states.

The WC program is well targeted to assist workers with work-related injuries and illnesses. However, the WC system has been shrinking, and federal oversight of state WC policies has historically been weak. This has led to wide variation in services across employers and states and is a barrier to the program’s ability to lead federal efforts in this area. Despite this, some states have developed promising models supported by strong evaluations, most notably the COHE model in Washington State. More testing is needed to explore the potential to replicate and expand this approach to other states.

The potential role of AJCs to reach people with disabilities before they leave the labor force is less clear. AJCs serve a large mix of dislocated workers, including some newly ill and injured workers. However, workers with disabilities represent a tiny fraction that must compete with others for services and resources. AJCs also do not typically interact with health professionals to provide the more intensive, coordinated services needed to effectively assist this population.

Significant political, legislative, and budgetary challenges also make enacting reforms to expand early intervention approaches unlikely in the near term. Divided oversight of the four key programs supporting employment for the disabled has led to misaligned incentives for action. Federal costs of inaction show up in the SSDI trust fund, but the programs that could most effectively intervene to support disabled workers are funded and overseen by separate congressional committees.

Consequently, proposals to create a new national paid family and medical leave benefit could represent the best opportunity to break through political inaction while also providing a framework to address programmatic challenges and gaps in the evidence base. A new paid medical leave benefit could provide a unique opportunity to identify newly at-risk workers and target services to those most likely to benefit from them. An approach that provides grants to states to experiment with different approaches to early intervention would allow states to find out what works and scale up efforts based on evidence over time. This approach would build a rigorous evidence base while more effectively intervening with newly at-risk workers in a way that moves the needle on employment of people with disabilities and leads to positive outcomes for newly at-risk workers.

As policymakers contemplate legislation on paid family and medical leave, they could consider how strong work supports could be incorporated into the program. Paid leave and disability policy experts
should come together to further explore how this approach and others could support employment of people with disabilities, bringing potential benefits to individuals' well-being as well as broader economic and social benefits.

Notes


2 SSA has a different substantial gainful activity level for a person who is blind.


5 These incidence rates are not strictly comparable because of changes in Occupational Health and Safety Administration processes.


References


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Acknowledgments

This brief was funded by the Laura and John Arnold Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at urban.org/fundingprinciples.

The authors appreciate the helpful suggestions of Greg Acs, Pam Loprest, David Mann, Kathleen Romig, Jonathan Schwabish, David Stapleton, Paul Van de Water, and David Wittenberg.

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