Lessons Learned from SSA Demonstrations: A State of the Science Meeting

June 15, 2021

Transcript of Panel B: Return to Work & Early Intervention
Panel Chair: Sarah Prenovitz, Abt Associates

12:35 – 1:10 p.m. EDT: Return to Work

Presenters: Robert Moffitt, Johns Hopkins University
Jesse Gregory, University of Wisconsin – Madison
Discussants: Hilary Hoynes, University of California, Berkeley
Kathleen Romig, Center on Budget and Policy Priorities

Thank you. Welcome back to the state of the science meeting on lessons learned from SSA demonstrations. This is session 3 on return to work. We have a paper prepared by Robert Moffitt and Jesse Gregory and Robert is going to present on that paper for the next 15 minutes. After that we will have a discussion first by Hillary Hoynes, and then Kathleen Romig. After this, we'll have a 5 minute break, and we'll have a next session, which will be session 4 and then at 1:50 Eastern we'll have 20 minutes of general discussion. So, at any point over the next between now and 1:50 Eastern, you can submit any questions you have in the Q and A box on Webex as Austin just explained and we'll discuss questions for both papers at that time. Now, we have Robert Moffitt on return to work. Take it away Robert. Thank you Sarah. Happy to present today. I want to start off by just saying who I am.

My name is Robert Moffitt. I'm a professor of economics at Johns Hopkins University. Baltimore and my Co author, Jesse Gregory professor. Uh, out in the wilds of Wisconsin, Madison, and we want to thank SSA for inviting us to do a paper a report on this subject. I should say that I thought I knew a lot about social security programs. I realized after doing this how little I understood. I also realized how a lot of the easy pat solutions that the Congress comes up with to meet particular challenges are not so easy to implement. Once you understand the complexities of these programs, quite a few challenges. So, let me 1st, start off by saying something about the scope of the program. So, sorry, the scope of our paper, the scope of our paper is concerned primarily with how to encourage those who are already beneficiaries of DI, or recipients of SSI to return to work. And preferably to return to work at moderately high levels, at or above the SGA, the substantial gainful activity level. So significant earnings. That's the goal. We have a couple of demos, which we review, which cover reforms and attempts to intervene at the application process.

Those are exception to the rule, those overlap a little bit with the next paper by Kevin Hollenbeck, which is more exclusively concerned with early intervention. So that's the scope. Next slide please. Okay. So what do we do in this paper? We review 11 demonstrations based focused on returning to work on the topic I just described. We also summarize 10 broad lessons from the demo review then we suggest 7 programmatic changes. That is to say, kind of the kinds of reforms that one might want to run demos in the future. And then we also talk about the design of demonstrations and based upon the lessons. We drew also suggest 5 considerations for new elements and considerations when designing demos. We're only going to talk about a few of those, we have 10 lessons, 7 changes and 5 design issues. We cannot

talk about them all I'm afraid you have to read the paper, you can highlight a few. Next slide please. So, when we start off with listing the demos.

Next slide. Uh, so we have quite a few here. I'm not going to take the time to read the names of all those acronyms. We have an alphabet soup here, but we do divide them into 4 categories. 1 is financial incentives primarily allowing recipients and beneficiaries to not have their benefits completely eliminated once they work beyond a certain level, but instead to have them only partially reduced. That's the classic type there. We also review some VR programs. Not going to talk a lot about those in this presentation, but they're all in the paper. Uh, we talk about 3 about which attempted return to work for people with mental impairments. 1, quite old one, TETD, one more recent, MHTS, and one that's actually underway right now, the SED. They're very interesting demonstrations and I to encourage you to read about those. If you haven't already, if you don't not familiar with them. And then 1 we'll do, which is about expanding health insurance benefits that was called the accelerated benefit demonstration.

Next slide please. Okay. And so, 1st, lessons learned, uh, next slide please. So, as I said, we have 10 of them, I'm only going to pick out 5 here to highlight. Number 1. As I quote, here, it is a quote from the paper, most of the efforts to increase employment earnings and labor force engagement of beneficiaries in general have been disappointing. Primary case in point there is the so called BOND demonstration, which reduced what we call the marginal tax rate to 50% allow recipients to have their benefits only reduced by 1 half for every extra dollar they earn. That had no impacts on the earnings, at least high earnings of beneficiaries who were in the experiment that is to say the experimental group compared to the control group. Um, it seemed to be that the effects were the result of offsetting effects, some people increase their earnings and other people decrease their earnings. But the net effect was 0, statistically insignificant, there was also a counseling component to it that did not really have any additional impact. No findings are right that they're too as well. Another case in point is being the so called POD demonstration in which intervened and reduced that marginal tax rate earlier in the beneficiary's time on DI. That also had null impacts according to the interim report that has just been released. We have to wait for final report to see what the final results are.

So, if we say there, if you're worried that the low employment rates and earnings levels of the beneficiaries are the result of the cash cliff or some kind of financial work incentives, you can't say that, these demos provide any evidence that that's the case. So, it's just kind of a negative finding perhaps. Slide please, secondly, where earnings do rise, they never almost never rise above the substantial gainful activity level, which is part of the point of these demonstrations. By and large they provide incentives to work at or above. SGA Employment does sometimes increase and sometimes significantly. But not earnings enough to go up above. Uh, we raised the question here to more policy question when we realize this finding whether or not, uh, that should be a value. Should the, the, uh, social security administration and Congress put value on getting. Uh, DI t beneficiaries to work to simply work any amount, or at least a moderate levels of earnings. Even if it's not above SGA. We pose that as a question.

Next slide please, we also found that these demonstration by large have no significant impact on exit rates from the program, which, of course, would be 1 of the desirable attributes of the outcomes. That simply did not happen. Correspondingly. The benefits received either did not change at all, or they went

up. Uh, they tended to go up because if you offer beneficiaries and more benefits, if they work beyond a certain level, well, that's going to increase the benefit expenditure of the program. And that was not offset at all by exits from the roles, which might have saved money. Next slide please, uh, in general, we concluded the financial incentives, at least those have been tribes this far don't seem to work. So well. Uh, and then we have to make we make an our report. Uh, an important point that does it not always realized. Everyone takes the cash flip. Everyone hates having benefits reduced from some positive amount to 0. if you are 1 dollars more above some cut off threshold. Well, there's a big research literature on there, some other programs, other than disability programs. And that literature has consistently shown that when you reduce smooth out of benefit left, and you reduce that sharp production. Uh, there's no expectation that labor supply work levels will increase on average. Uh, that's because they provide work incentives to some recipients incentives to others. And that appears to be what happened in the bond demonstration.

The 2 effects were opposite sides and they netted out to 0. That's established theoretically, and it's a real world possibility that as occurred in many other programs. So we think for the whole smoothing out, the benefit cliff , the cash cliff needs to be rethought from day. 1. Um, and we have no evidence that it's really going to have a major impact. No possible that those tax rates and 50%, maybe that's still too high. Maybe you just simply do not want to take advantage of that. Now we don't have demos with lower marginal rates to 50%. So that's a question that slide. Please. Take up, right so very important point here is that, uh, the only a small number of the beneficiaries actually take up these programs, the financial centers are provided if you work above a certain level very small fractions took advantage of these at least in these benefit. I'm talking about the financial incentives demonstrations here. You're talking about 3 to 4% of the experiment group actually went into the benefit offset region. No. More than 5,015 Christianity 1 of the bond stage 2 experiments. These are small. So not many. People are taking advantage and so we have to the question, our report. What is the real residual work capacity of any beneficiaries? How much they really work? No matter how much incentives you offer them do you suggest to perhaps the. Residual work capacity is not extensive for a very many people in the case load and maybe we should lower expectations about what kind of impact we think we can get to the kind of demonstrations, financial incentives.

That we've been trying, next slide. Please. Okay. So, now, that was 5 lessons learned. So I'm going to move on the programmatic changes. There were 7 of them and mentioned 1. so next slide please. And it has to do with the earned income tax credit. So, the earned income tax credit is a reform has been tried a number of other programs and particularly in the United States income tax code, the UK tried it for a while. Instead of taxing people, instead of reducing their benefits ,and no 1 likes to get their benefit reduced, no matter what the marginal rate is to where you’re worse off and you lose those benefits. The earned income tax credit actually supplements earnings. And the evidence is that particularly on individuals who are on the margin, were really looking at whether or not to work and really looking at the dollars and cents saying is it worth that? Or is it not worth it? The evidence out there is that if you provide them a supplement, at least up to a certain level, we can’t increase it forever. Supplement to a certain level, you get pretty significant work incentives, increases and work and earnings for those who are able to work. So, we suggest that be considered for future demos and that's the main 1 we discussed. next slide. Please. So, demonstration designs out of our file, I'll mention to here in next slide. 1, is volunteer. Our view on the volunteers is that they are different than other people.

The usual objection to volunteer experiments is that they are not representative of the caseload, the only people who volunteer here who are likely to want to work, or they can take advantage of it we don't see anything wrong with that. We don't think that's a problem at all to be perfectly honest. We think that even if you had a permanent program, which offered financial incentives, that would still be the case. Only a fraction of the caseload would take it up. That's based upon those take up rates. We've already discussed. In fact, we think that this whole issue about volunteer should be rethought. We should think about it we should think about permanent programs that are only intended. To effect and encourage a relatively small fraction of the of the beneficiary caseload to actually go to work at significantly high levels. In fact, why not have permanent programs that target people. Target people from day 1 on t people who are most likely. To be able to take advantage of these programs and restrict these programs. And give up on this idea that 1 day, you're going to have 100% of the beneficiary in caseload working. we think this is very important point when we come back to it several times in our next slide please.

More than intent to treat. I know that's been mentioned at least 1 of the other presentations. Most of these programs only compare the average outcomes for the experimental group to those in the control group. Averaging over people who did not respond, and those people who did. But if you only have 3 to 4% of the experiment group, even responding. The intent to treat estimates are going to be small, uh, no matter what you do. So we strongly encourage in future demos to add more outcomes to be looked at, probably the effect of the treatment on the treated. That is to say, what's the impact for that? 3 to 4% that didn't respond? How much did they increase their earnings? Uh, and take a look at that so we think that's important and we going to add that to the agenda next slide please. Other suggestions next line, so we have a lot of things in the report and I see my revised slide didn't get up here. So, let me just tell you, we have number of other comments and suggestions and if you'd like to read about them, encourage you to read our paper. Next slide. Okay. So, what's our conclusion? We did summarize the demonstrations here as I started off saying, and we summarized the lessons learned 10 of those. We had a 57 program attic, suggestions and 5 demonstration design questions and we'll just give you with 1 bottom line, which I've already mentioned this watch, if not twice. And that is 2 things. 2 things a couple with each other. 1 is perhaps our expectations for the fraction of the beneficiaries that have sufficient work capacity, work capacity.

To actually take advantage of the programs, perhaps your expectations to be lowered for the fractions. And secondly, perhaps we should focus these work programs on those. We can target as being most likely to respond to. Next slide please. Thank you. Thank you Robert. Now, we will hear from Kathleen Romig. Hello, thank you. I'm very excited to comment on this paper. I did a similar exercise in 2015, and I felt like this paper really deep in my understanding of these studies, and then extended it to the ones that have wrapped up since I looked at all of these things. And I very much agree with those bottom line conclusions and to begin, I would love to just review some of those major findings. Next slide, please. There we go. Before I kind of zoom back out and put these things into context. So a selection of those lessons learned, the 1st 1, is that most of these work demos do not significantly increase the, the measures that we're looking at most frequently, employment, earnings, labor force participation and even when they do earnings rarely rise above SGA. on a sustained basis, so as a result, there are essentially never increases in program exits due to the work that people do in these demos and rarely reductions in SSDI expenditures either. And then the 3rd major lesson was only a small number of SSDI

beneficiaries and the same is true for SSI try the interventions offered in the work demos probably because of limited capacity.

So that's what I'd like to really talk about. The most is, what, what kind of work capacity do we expect? Because that was really 1 of the major implications of this review. So, to be honest, these findings really didn't surprise me and not only because I did a review like this myself. But because of the population that we're talking about. So, I'm going to explain why and go through some of the implications of these findings about what we might do next slide. Please. The medical criteria for disability benefits are very strict. And are specifically designed for people whose disabilities preclude substantial work and I think it's worth going over what those criteria are, a severe mental or physical impairments expected to last, at least 12 months or result in death. This disability must render a person unable to perform substantial gainful activity. That means earnings of about 1300 dollars a month. Anywhere in the national economy, regardless of whether such work exists. Where the applicant lives, whether a job vacancy exists. Or whether he or she would be hired, given that very strict standard. 1 would expect that most beneficiaries are not able to do substantial work over a sustained period. If they could, we would have questions about whether entry into these programs was too easy. In reality, it's very difficult as shown in these statistics.

Most applicants for both programs are rejected, even after all levels of appeal. Next slide please. The 2nd reason I'm not surprised to see low levels of work among demo participants. Is that. This population by definition is in poor health, and this is dramatically illustrated when you look at death rates among the SSDI population, it's similar in the SSI population, dramatically higher among beneficiaries than among non beneficiaries. These are not healthy people. And so their health. Introduces a work barrier that doesn't otherwise exist. Next slide. Please. Another factor limiting work is limited education. This chart shows SSDI and education among SSI Recipients is even lower. Disability itself can limit a person's education, and limited education is strongly correlated with higher rates of disability. Education is an indicator of social economic status, and we know SES is highly correlated with physical and mental health. Disability and longevity, so it's not surprising to know that people with lower levels, education, lower levels of education, disproportionately qualify for disability benefits. And those disabilities together with that limited education. Really limit people's labor market experience. The 4th factor that makes it difficult for beneficiaries to work is age. Age is another strong correlate with disability. The older person gets the more likely. They are to become disabled.

We have an SSDI chart here. The curve is a little bit less dramatic for SSI, because includes people who were born with a disability or acquired a disability as children, but SSI also skews older. It's more difficult for older workers to find jobs and to shift to other kinds of work on top of the other barriers. This population faces. Next slide please, another factor is time out of the labor force. Again, we're looking at SSDI in the slide, but it's even more true for SSI where work. History is more limited, but most SSDI applicants have been out of work for at least a year before they even apply. In addition, the application process for both programs can take months or even years. If appealed adding even more time out of the labor force. During this time, a worker’s skills and connections atrophy. New employers are less likely to take on workers with substantial gaps and employment and so we have another barrier to work. Next slide please in addition to all of these barriers, people with disabilities space, lots of other employment barriers, employment, discrimination, lack of workplace, accommodations, transportation and public

transit is often unavailable. Inaccessible and unreliable access to health care, especially the long term services, and supports that many people with disabilities need in order to work.

So it's little wonder that few beneficiaries are able to do long term self, supporting work, regardless of what we're doing in these demonstration projects. Next slide please and lo, and behold beneficiaries do fair poorly in the labor market. Same is true for even rejected applicants as shown in this chart. Fair poorly in the labor market. So it shouldn't surprise us. that those who meet these strict medical criteria also struggled to do self supporting work, even when those interventions exist in these demonstrations. Now, we need to talk a little bit about the implications of this. I think there are really 2 ways of thinking about work and disability, and they are often in opposition to each other. 1st, are the traditional metrics. Budgets and caseloads and in the eyes of many policy makers, the lower, the better. By these metrics, these work demonstrations have failed. But I think we should also consider an alternative way of looking at this a more holistic way and look specifically at the beneficiaries' own preferences and to measure their well being more broadly. When you talk to disabled people themselves as you always should, when you make policies that affect their lives, you'll find many people with disabilities really want to work despite the many challenges that I just outlined. And you'll find that they reap benefits from that work - improvements in mental health community integration, economic security. intangibles a sense of purpose and connection. But as noted this morning, these metrics don't often show up.

They're not even measured in these demonstrations. I find it instructive to compare the way that we think about work to the way that we think about education for people with disabilities. The individuals with disabilities education act or IDEA Entitles, disabled students to supports that help them access school curriculums. It often costs significantly more to educate children with disabilities. They may receive specialized instruction, school based therapies, Have 1 on 1 aides, and so on, but if that's what it takes to access the curriculum, then they have a legal right to those supports. Even with this intensive and sometimes costly supports. Many students with disabilities don't perform at grade level. But that's not necessarily the standard they're expected to meet. Instead they're expected to make progress in terms of the individualized plan based on their own circumstances. Why do we see things so differently when disabled kids grow up to be disabled adults or when adults acquire disabilities? What if disabled adults were entitled to get the supports they needed to access the labor market. That might look more like, long-term services and supports which many disabled people can't access. What, if we didn't expect self supporting work for those with limited work capacity, but instead focused on.

Well being like, mental health, community engagement, which might, benefits we might reap even from more limited work. We'd have to measure those things in our studies and so for we're doing that in a pretty slipshod manner. What, if we knew that at most working beneficiaries would never reach for a sustained period we could consider topping up wages with an, like, subsidy. The authors recommend. But here's the catch, all of these things cost money and if we go beyond a targeted group as these authors recommended, and I think that's a good recommendation, it could possibly be a lot of money. But if it's true that encouraging work is our goal. It would be money well, spent. However, if the real goal here is really just to save money by reducing benefit roles, I'm afraid we're due for another round of disappointing demos. To conclude on a slightly more hopeful note. I think we have a lot of fluids about it.

Good direction. For, for essays future experiments. I, the slide is here Thank you, but I need to wrap up so you can move on. Thank you. Thank you Kathleen now, we're going to hear from Hillary Hoynes. Thank you very much. I'm Hilary Hoynes. I'm a professor at UC Berkeley and I'm delighted to have a chance to be part of this conference today and in particular to have the time to dig into the amazing summary. Um, by the authors of this of this paper. So, following the very clear presentation that Robert gave as well as Kathleen's excellent summary of a lot of their main points, I thought that I would use my time similar to Kathleen to talk about the broader context for this work and some thoughts going forward. So, I want to sort of think about this in the context of just 3 points. So you can go to the next slide. Please. And the 1st point is perhaps an obvious 1. but 1, that I wanted to think about a little bit. And that is why the focus on work, why is it that we're thinking about using these demonstration projects to learn about how to increase the employment of recipients of disability benefits? Why is that the focus of these kinds of policy endeavors? So, next slide please. I think as the authors talk about in their paper, it's clear that an important backdrop for the interest and focus on work is the quite significant increase in beneficiaries and when more beneficiaries higher costs that you can see in.

This slide really quite strikingly between around 1990. and through the beginning of the Great recession, where you see the steep increase in the caseload next slide, please. But also true and I think quite relevant in. In comparison, or in addition to showing the increase in beneficiaries and costs. Is the quite longer term trend of a decline in labor force participation and employment rates, particularly for men in the United States, which has been the object of much attention and a broad research agenda, including work specifically on disability. What you can also see in this graph is that after a very long march of increase in labor force participation for women throughout much of the twentieth century around the year 2000 we see a sort of inflection point where labor force participation and employment rates start to decline. For women as well. So I think this sort of increase in cost. Alongside a reduction in employment for the population more broadly is an important part of the motivation, I think, for why the interest in work.

So next slide please. In addition as has already been mentioned 1, also important factor that we see going on with the increase in beneficiaries is quite dramatic change in the composition of health conditions around the disabling work conditions for recipients. And so this graph is for, and you can see the quite dramatic rise of mental and musculo-skeletal conditions that are justifying receipt and the work disabling condition. So, next slide please. So, despite these longer term trends, it's also worth pointing out. I think something about the more recent history that is important to cover. So, next slide please. So, the 1st thing that I want to point out as it was clear in that in that 1st figure that I, that I showed you, is that. The most recent past shows, actual declines in the caseload. So, on this chart, the dashed line is the original graph that I showed you, although only for the years 2000 and since the year 2000, the other line gives you the new awards of so, the flows into the program year by year. The dashed line is the total number of beneficiaries are the sort of stock of of recipients and what you can see is this quite dramatic decline in the number of new awards starting around 2010 and that is sort of flattened out in the most recent years. And this graph that goes through 2019, as I mentioned prior to Covid.

Next slide, please. But something that has gotten a bit less attention is the change in the labor force participation among folks who declare themselves to have a disability. And so this comes from CPS data. This is the green line on this on this chart. And this, I should say this figure comes from a recent

summary piece by Nicole Maestas and it points out that the connection with the labor market among those with disabilities has recently increased after a period of dramatic decline and so kind of putting this all together. It seems that we've got this sort of longer term trend of increases in the caseload and reductions and the connection to the labor market, but in the recent period things look, as though they're changing in ways that I think to date, we don't fully understand next slide. Please. Uh, and as a little bit of a shameless self promotion for work in progress with Nicole Maestas and Alexey Strand from SSA, we're actually looking in to try to understand the role what's going on behind this decline in caseloads and the relationship that there is any 2 changes in employment, and what we focus on is the changes in the quite dramatic reductions in the allowance rate at the hearing level for eligibility determination process. And you can see that those allowance rates really started declining after a period of some important increases. And we are looking at the policy levers that lead to those declines in allowance rates and using that to understand the role that the program and the policy is playing and earnings and employment more generally. So. A little bit something related to this to look forward to so, next slide. Please. So, the last point that I want to make, has to do with thinking about what we sort of assessment of what to think about this broader research and demonstration projects and encouraging work. And the role that SSA policy should play in that, and I want to make 2 comments on on this and that will be. And then I will conclude the 1st, is that, as we analyze. Social safety net programs and their sort of optimality and their structure.

We, we kind of think about that within the context of the trade offs of the goal of policies to promote insurance. So to provide. cash assistance for individuals who are unable to work with the program, but we want to think about that in the tradeoff between that and the desire to encourage work and create those sorts of incentives, which is very much at the core of what this paper examines and so, it seems to me that what we need to know more about is the protective effects of and impacts more generally on the well, being of the population or the potential population and just a little bit of a shout out to work on that very much takes this lens of looking at the optimal generosity of next slide please, which is my last slide. So, the 2nd thing that I wanted to just sort of circle back to around policies, going forward is to if this paper, which shows very clearly that these financial incentives do little to change employment really makes me as somewhat of an observer of this literature to step back and ask, should we be doing more earlier in the process in order to try to encourage more work? And so that perhaps provides a very good lead in to our next session on early intervention. So I will stop here. And thank you very much. Thank you Hillary and thank you to all of our presenters. We are going to take a short break. We'll be back at 15 minutes past the hour to continue with our next session.

1:15 – 1:50 p.m. EDT: Early Intervention

Presenter: Kevin Hollenbeck, W.E. Upjohn Institute for Employment Research
Discussants: Jeffrey Liebman, Harvard University
Jennifer Sheehy, U.S. Department of Labor

Hello everyone, we will begin shortly welcome back to this day. The science meeting on lessons learned from demonstrations. We're now in session 4 on early intervention. We will hear from Kevin Hollenbeck, who's prepared a paper on early intervention he's going to talk for 15 minutes and that will be followed by discussion by Jeff Liebman and Jennifer Sheehy After the discussions have spoken, we'll have 20 minutes of Q and A, for both this session and the previous session please, as we go along, feel free to

add any questions. You'd like to ask any of the presenters or discussions to the discussion box on the bottom right. Hand corner of your Webex screen. With that we can get started with Kevin Hollenbeck, speaking on early intervention, take it away. Kevin. I want to thank the Social Security Administration for supporting this work and the Abt Associate folks for very easily administering the work. Uh, providing very helpful reviews along the way.

Next 1st line so my paper as on early interventions, as Hilary coins, gave me such a nice Segway into the paper. The definition that I'm using is that an early intervention is a policy or practice. That results in allowing individuals with disabilities to maintain, or to achieve meaningful employment and earnings. And therefore, for going applying for, or reapplying for, or. The benefits of an effective early intervention. Would be reducing benefit payments. Increasing payroll tax receipts, reducing administrative expenses associated with applications and. Hopefully to improve service efficiency for future applicants and beneficiaries. Next slide. My paper is limited to adults, age, 25, and over with disability. The next paper in the session will be in the conference we talking about transition youth. I basically tried to triangulate the size of this target population who might be influenced by early intervention by looking at those with. Work related and non work related injuries during a year as well as those applicants who are denied benefits. Because of employability, and between them, I came up with an estimate of inflow. Annually of between 1.1 and 2Million individuals.

Next slide, these individuals are disproportionately over 45. Persons of color, worked and unskilled or semi skilled occupations and. have lower levels of education next line. So, there's a almost a logical inconsistency. To want an agency such as SSA to promote or implement. A policy or practice that's aimed at keeping potential clients away. It. Really emphasizes the importance of randomized control trial design for demonstrations. So we. Know, exactly whether the early intervention was effective or not. Because SSA has no carrot or stick for potential applicants and may have lost its carrot or stick for applicants who were denied it may the agency may need to collaborate with a decentralized medical system, such as it's doing in the retain demonstration, which I'll talk about in a minute or with slightly less decentralized agencies, such as. Community Mental health or vocational rehab agencies.

Next slide so, in doing my work, I looked at the publications and information around 5 demonstrations, which are listed here and, uh, which we. Heard about, uh, throughout the day then D. E. the disability transition project. SED, retain, which I just mentioned, and promoting Work through Early Intervention Project, or P WEIP. In the next line, in addition to reviewing the evidence around those demonstrations. I've reviewed some additional evidence or papers. In particular I looked at international experiences. In the Netherlands, Sweden in England, I looked at the early intervention chapters 3 papers from the McCrary. Pomeroy initiative proceedings and then I reviewed some miscellaneous literature from authors who suggested various early interventions. Next slide. Going through the demonstration evidence. 1st, DMIE, the oldest of these demonstrations operated between 2006 and 2009 by CMS. in 4 States. Basically, there was a treatment. Consisting of medical benefits, and some financial assistance for healthcare. Findings of note from this demonstration were basically, uh, these. This treatment, these treatments had no impact on employment or earnings. But in 1 state, there was a reduction, a significant reduction in, SSDI or SSI applications. And in SSI recipients next slide. The TANF-SSI disability transition project was a series of activities basically trying to decide and determine whether TANF is a gateway into SSI. Among the activities, the 1 I looked at in particular was. A, uh, an, that was conducted in Ramsey County, Minnesota, uh, using, um. A treatment, which was essentially the individual.

placement and support treatment, they called it fast. In that experiment, basically they found a slight reduction in TANF take up, but, uh, there was no reported findings regarding SSI or SSDI or application or benefits.

Next slide The SED demonstration is an ongoing demonstration. With, uh, basically 2 treatments. The eligibility here is for. Denied applicants who have a mental health issue. It's ongoing the enrollment was conducted in 2018 and 2019. There have been no outcomes reported yet, but the evaluator did a very nice a. Evaluation of who took up the offer of the treatment and, uh, if we use that analysis to generalize. Who might take up early interventions they found the following characteristics were correlated with take up. Males higher levels of education. Individuals with limited work experience. And from areas where the unemployment rate was relatively high. But the average wage growth was also relatively high.

Next slide retain is a very large scale demonstration that is also on going. SSA is collaborating with the Department of labor office, disability, employment policy. The treatment here is based on the principles developed. In COHE which is Washington state centers for occupational health and education. The treatment is mainly focused on very timely intervention. A coordinator of health services and centralized accessible data. It's a 2 phase demonstration phase 1 ran pilots in 8 States. 5 of those states are now starting phase 2. To gear up and do a randomized control trial. Uh, of individuals, unfortunately, we won't see outcomes for a few years.

Next slide, the final demonstration I looked at was, uh. Promoting work through early intervention. Excuse me. This is a. A project in collaboration between and ACF. It is comprised of 2. Studies 1 is BEES for building evidence on employment strategy. And the other is next generation of enhanced employment strategies or next Gen. Both of these activities are more or less, just getting underway, identifying regions and programs to study. Of interest. Is that the next gen is. Trying to find interventions involving employers or labor market broadly. 1 finding of note here is that 1 site that bees is looking at. Is the breaking barriers site in San Diego? Extending work from an evaluation that was done funded by the workforce innovation fund of the Department of labor in which they. did an RCT using again, the treatment. But the evaluation report indicated no significant. Impact on the receipt of SSI or SSDI. Next slide. So, as I mentioned, I looked at selected international evidence. I really didn't find any experiments or demonstrations. In the Netherlands and Sweden enacted reforms, intended to place more responsibility on employers. And to centralize and do more timely employability determinations, in fact, uh, the disability rolls decreased in those countries. But we can't say anything about causality.

In England, they toughened the work capability assessment. And time limited benefits for those assessed as having limited capability from work. Again, no causality found in any paper. Next slide, other early intervention suggested in the literature include experience rating of the employer portion of the SSDI payroll tax, mandating private disability insurance. Although there was a recent paper by Stepner and all that had some countervailing evidence about the efficacy of, of this. Some authors suggested some new institutions, uh, Dave Stapleton and others. Employment eligibility service, Christian and others, the health and work service. And finally there was a paper suggesting systematic uh. Offering of transition jobs to individuals at risk of going on to the rules.

Next slide, so the lessons learned, some of the promising practices that. Come out of this literature is 1st of all the importance of having a coordinator or case manager and centralized data. Secondly, timely intervention after medical events. And 3rd, uh, there's been quite a bit of, uh. Experimentation demonstration around individual placement and support. It's employment advocacy has been shown in several studies. However, there was no impact on employment or. in either the transition, the transition, I'm sorry, the TANF transition studies, or in the with funded breaking barriers effort in San Diego. However, it is being widely tested in a very large demonstration themselves. And both piece and next gen. Want to look at it as well next line. Um, the literature suggests that the targeting among. Eligible individuals for early intervention may be feasible. As I mentioned the said enrollment analysis. Pointed out a number of characteristics that. 1 might target upon and finally on the issue of employer responsibility. The Dutch and Swedish reforms, basically trying to put more responsibility on the shoulder of employers. However, there was a paper.

That indicated in, uh, the Dutch experience. A, a reduction in the hiring of individuals with disabilities. And furthermore, there's sort of the whole question of whether employer should be responsible for non work related disabilities. Next slide, what can you do. In the paper I suggest that 1 proposal where there seems to be a hole would be to look at job development and job search assistance for applicants age, 50 and over. They are disproportionately. Part of the population and the rationale of courses, they have 2 barriers, age and disability. So next slide in conclusion. I take a quote from Lisa Eckman Who wrote there is neither completed research, nor an evidence base upon which to enact nationwide early intervention. Or work support programs I believe that is still. The state of affairs 5 years later.

However, there seems to be 2 options underway. Standards standardization and coordination at the regional level. Which is being tested and retain demonstration and individualized assistance, which is being tested in the SED. Demonstration these are not necessarily in opposition to or mutually exclusive options. Unfortunately, we are not going to know the experimental demonstration impacts for a few years. Thank you. thank you Kevin. Now, we will hear from Jeff. Thank you and good afternoon I want to begin by complimenting Kevin Hollenbeck for writing an extraordinary chapter. To synthesize such a wide range of past and ongoing evaluations. Plus international evidence, plus untested ideas. All in 1 place and in such an insightful manner, it is really quite an impressive piece of work. The 2nd thing I want to say is how neat it is to see the social security administration. Partnering with other federal agencies to undertake such creative and innovative demonstration programs – SED, RETAIN, COHE, PWEIP, BEES, Next Gen. It is a really remarkable set of testing and learning that is going on. As, as Kevin notes, by the time SSA. Encounters an SSDI or SSI or applicant. The ideal time to intervene may well, have passed. So it is so important for SSA, to be working with agencies that might encounter. Future DI and SSI applicants further upstream. That have deep expertise in the health and employment aspects of interventions. These initiatives show our federal government at its best.

As a learning continuously improving organization and 1 that is capable of breaking down agency silos to provide better services. A few other thoughts that occurred to me as I read Kevin's chapter. The 1st, is that the sample sizes for many of these experiments. Are simply too small the experiments are under powered and it is going to be hard to learn anything conclusive from several of them. This is especially true if 1 does appropriate adjustment of the confidence intervals. For the fact that there are multiple outcomes being measured, Ah, with results often presented separately for different sites. There's simply some cases in which 1 needs to make the tough call to not go forward with a 5 to 10 year experiment.

No matter how innovative if at the end of the day budget constraints or sample recruitment challenges. mean, that the results are almost certainly going to be inconclusive. The 2nd thing I want to say is, I think we need to be clear about what is motivating us to do early intervention. And here what I say a parallel some of what Kathleen and. Uh, Hillary said, uh, a few minutes ago, 1 view is that we are trying to increase economic output. And therefore, our nation's standard of living by putting more people to work. Another view is that we are trying to reduce government spending by diverting people from claiming benefits. A 3rd view is that we are trying to improve the well being of people who are struggling with health impairments and labor market challenges. By helping them get back on their feet. I think that if our primary motivation is either of the 1st,2, we are probably destined to fail. The labor market prospects of people on the margin between receiving and not receiving. Benefits are just not all that great even in the best of circumstances.

Often the number of extra years in the labor force that can be expected even if someone returns to work. Is not all that high. The interventions are expensive. And if 1 does the benefit cost analysis properly, and subtract the workers disutility of effort from the output gains It is very unlikely we will design an intervention without put gains that exceed costs. The same is true if our motivation is government finances. These interventions typically serve quite a lot of people per person diverted from benefit receipt. Moreover, given that the beneficiaries tend to be low income workers struggling with health impairments and other challenges. People who deserve a high social welfare weight. You would have to believe the leaky bucket of our income transfer system is really leaky. In order to think we're doing good when we reduce benefit spending. So, I would argue that the main reason we should be designing implementing and evaluating early intervention programs. Is to improve the well-being of those we are providing services to. This prospective has at least 3 important implications. 1st, our primary outcome measures in our studies. Should be measures of wellbeing, pain levels, depression levels, substance use levels, divorce and domestic violence levels, happiness, longevity. Employment and benefit receipt may in some cases, the useful proxy measures. But they should not be the main or only focus.

In addition to being conceptually right Taking this approach to measuring a broader set of outcomes also makes it much more likely that we will find benefits of the intervention. There are substantial enough to exceed costs. 2nd. I think a lot of us me include included. Have a presumption that when we help someone get back to work. We are indeed doing something good for them. And conversely. Then telling someone, we will give them lifetime benefits in exchange for never working again. We may in many cases, be consigning people to misery. But we really haven't done the research necessary to know whether this is right on average. Much less for which sub population this is correct? Someone should fund a major study. Using the Maestas et al. examiner assignment instrumental variable. To compare well being impacts of receiving versus not receiving benefits. Because you would need to collect most of the outcome data directly from participants. Rather than by using administrative data, it would probably cost 20Million dollars to do this Right. But I think it's really worth it hard. In all of our early intervention studies, and then even most social experiments.

We should have an extra experimental arm where we simply give people extra cash for a few years equal to the per capita amount it costs to deliver the intervention. Determining whether our interventions are are effective. We should be held to the standard that our interventions not only work. But that they work better than giving people the same amount of cash, I can't resist throwing out 1

more intervention idea. I personally am not a fan of giving a guaranteed income to everyone in America. The amount of extra taxes it would take to fund such. A program is prohibitive. But a guaranteed income for low earners struggling in the labor market facing health impairments. That seems much more appealing. I know it's a fantasy, but I would love to see us take 1 state. And provide us assigned benefits to a targeted set of lower earners With no strings attached for, you have any limits on subsequent employment. Doing so it almost certainly increase benefit applications. If it improved well being and caused applications and the target population to double. I personally would think we had done a good thing if it cost applications to rise 10 fold. Or if it led more people to be in despair, because of a lack of purpose. I would think it was a disaster only an evaluation can help us determine, which is more likely.

Thank you thank you Jeff. Now, we'll hear from. Jenifer Sheehy., thank you. Thank you Jeff. And, uh, thank you so much Kevin. I went to echo Jeff's, um, praise of your paper. Um, we love seeing all of the different research projects. Uh, the, the findings, the. Uh, lessons and challenges and, um. It contributes to the work that we do at the federal level in the office of disability employment policy. I had my own spinal cord injury and return to work story. And a lot of the work that we've been doing is driven by my desire to see that more people can benefit from the perfect return to work experience that I had, and I was a very grateful recipient, of vocational rehabilitation, and of SSDI. I used it as a temporary benefit to get me back to work. But, without it could not have continued on the career path that I have and do the work that I do today. So, so much of what we do is to look at policies that will scale those best practices to, as many people that can benefit as possible. So some of the some of the lessons and the findings that Kevin pointed out in his paper really Go to the definition of early intervention and what I'm going to do today is talk about some of the key findings that drove us to start the retain return to work grant project and then some new policy questions for the future. And again, thank you to say, thank you to all the researchers and the presenters, because the work you do. If we look at it, we live it and we design our investments based on it. So it's. Critical and we very much appreciate it, so with regards to early intervention, there are many open questions. When is the right time to intervene. How early is early? What are the needs of the target populations and do the type of services offered meet those needs? Can the public workforce system meet the needs and are there clear ways of identifying and serving the target population?

Next slide please. Some of the lessons that we've learned from the early interventions that Kevin pointed out that they should take place as soon as possible after a work threatening injury or illness. And we'll talk a little bit about what a work disability is in a moment that the. Individuals path after that injury, or illness, be case managed and coordinated with employment and health care that we involve health care professionals who have been trained and accept. That staying at work and that work is a part of recovery, and it's a recovery strategy and it's a desirable outcome. So someone should return as soon as medically feasible. And then we target individuals or regions that, have the characteristics that data suggest are likely to succeed. But, of course, how do we target those populations? Many of the early interventions that have been discussed, consider early as prior to application for SSDI or SSI or at the point of application and the retain project, which I'm going to talk a little bit more about is really looking at early the way we define it. Which is days and very, the 1st, few weeks after a work disability. next slide. Please. So, what is retain? Retain is a demonstration that was in 8 States for planning and pilot grants. And it's now in 5 States for full implementation phase. 2 grants. retain is designed to serve thousands of participants that have a. Disability related to a work.

To workers who experience disability or an exacerbation of a condition that threatens their ability to continue working. The goals are to improve employment outcomes for newly injured or ill workers and reduce the need for SSDI or SSI. We're using retain to develop. Policies that we can then look at legislative and regulatory options for, but it's important to know. Uh, a couple things 1 is that it's modeled after workers compensation program in Washington state, the COHE model and it's important to know what retain is not retain is not an attempt to federalize state workers comp systems or programs. If states can learn from our grants and the return to work strategies that we hope to show that are effective. That's terrific. But every state is individual every region, the demographics, the industries and we still and we're not trying to impose federal standards on states. It is not an attempt to reduce benefits as I mentioned those benefits are critical for the people that need them, but if we can. Keep people working and reduce the need for applications and reduce the applications. So that people who truly need benefits either, temporarily or permanently can have those, then that is a terrific goal.

Next slide. Please. So, again, we're talking about early in the sense of prior to 12 weeks following and illness or injury, that affects someone's ability to work and this is based on evidence from Washington state. But there was other research as well, that shows that the return to work dramatically declines after someone is out of work for 12 weeks. Next slide, please, what are some of the key features of retain. So retain enrollees must be workers actively working or looking for work at the time that they become participants and they cannot have already. Received or have applied for SSDI or SSI, workers are eligible if they have a condition, either through occupational or non occupational illness or injury, that inhibits or affects their ability to work. And originally it was focused on workers with musculoskeletal conditions. But most of the programs, and all of the phase 2 state programs have expanded to serve workers with any condition that inhibits their work, including mental health conditions, and this, and retain will serve those with work related and non work related conditions as I mentioned. Next slide. Please. What are some of the key challenges that we've noticed already with retain. The early stages after work disability really shaped, someone's ability to stay at work return to work and what those worker outcomes will be. The healthcare professionals that are in the return to work, or workers comp, or just in the medical business of helping someone with a non occupational injury, or illness are not typically trained in occupational health, best practices, or they may not be thinking of employment as a critical goal that they will be contributing to the systems that serve individuals at risk of dropping out of a labor force are still fragmented. And typically don't coordinate, for example, the workforce system Is administered by the Department of labor. Does not typically interact with healthcare providers, but in retain, we are looking at using the workforce system and healthcare partners, in order to intervene early with workers who experience illness or injury and a disabling work disability.

The target population is diverse and challenging to reach and engaging employers has also shown to be difficult. Some of the workers don't want us to interact with their employer. They, especially if it's a non occupational illness or injury, they want to keep that health information private and of course they should that's their. Right but it is critical to work with employers to make sure that they can get the accommodations or a. Temporary or a part time position, as they're trying to stay at work or return to work. I also want to mention here. And I think it's really critical as a principle of retain that this is supposed to be a large scale, low cost intervention. Because we don't know a lot about the target population and what services. Will help every individual stay at work if they can then we are. Basically, providing a low cost, very high volume intervention with. People in order to attach for lack of a better term, the people that will benefit most and will be able to avoid applying for because they can sustain

their, uh, their jobs and their economic stability without having to apply for SSDI or SSI. The next slide. Please. So what are some of the future opportunities for shaping earlier intervention that we've looked at? 1 of them is establishing policies to integrate key networks to help workers stay at, or return to the workplace after injury or illness. That is can we work with the workforce system?

We've got the workforce innovation and opportunity act, coming up and are there policy changes. That might help. Incorporating, stay at work, return to work services into paid, leave and medical ls s and looking at longitude, longitude, animal, survey and administrative data. I will end there. And there and thank you again. For, including ODEP Thank you, Jennifer, we're now going to move to question answers and I'd like to start by asking the paper authors. If there are if there is anything they would like to respond to any of the points made by their discussants. So, Robert would you like, is there anything you'd like to respond to. Yeah, yeah, I would like to, um, and I want to thank to both discussions and. Uh, 1 is 1st off, just mentioning 1 thing that relevant to Kevin's paper, which is also. In the chat, we did review a couple of the interventions that intervened at the application stage. I want to just make 1 point that I don't think came out about application interventions, which is that yes, you might have early interventions. which try to enable people to establish employment and not applying the 1st place. The SED demo the was actually concerning people who were rejected as applicants, but. Uh, you might want to have interventions at the application stage for, even for people who eventually are accepted and come on to DI. The problem is that before DI's cash incentives, a lot of these applicants haven't been working for a year then you come on, you apply, some people have a quick decision, Some a very long decision time. You get onto the rolls, you haven't had any contact with the workforce in a very, very long time and then it's a struggle to get back to the contact. Well, if you can intervene at the application stage, even for the people who basically come on and connect them to the to the world of work and keep them connected, you might have a much better chance of having some success later. Even if they do come on to DIa.

Okay. Secondly, thank you, Kathleen and Hillary. Great comments. And I think you didn't find surprising, or they certainly accepted the difficulty we face and getting a large fraction of the beneficiary population to actually significant amounts. The idea that we should be looking at other outcomes is is a really great point, and certainly has major implications for what we should be measuring and future demonstrations. And I should say that some of these interventions have established that it makes the application demo did show positive effects on mental health, for example. If I may only make once 1 point there, which is that. Of course, there's the question of what the positive benefits of the cash is that the DI beneficiaries receive and let's hope that cash as some positive effects of some kind relative counterfactual, which is not having that cash. But then I think the interesting question would be to focus on these interventions. It tried to allow beneficiaries to engage more whether it's in the or employment services or whatever kind of services it is, even if it is not resulting in earnings and employment above SGA, does that have positive impacts on their sense of wellbeing and their fulfillment in life and their confidence in their capabilities simply because they are engaging. And that where I take their suggestions there, and that could be an outcome, just look at in some of these interventions. Finally, let me just say this I, I really think this is connected to targeting.

We. Jesse, and I said that in our paper, and I emphasize that in our slides. Um, let me just take our point a little bit further, which is that. Um, uh, yes. Uh, when we talked about targeting, uh, in terms of offering this financial incentives. But what, Kathleen And Hilary both said was, hey, these people have

lots of other problems, besides just a financial incentive. They have barriers to work. They have transportation problems and discrimination in the labor force they have all kinds of problems that they're trying to deal with the same time. I don't see us having any interventions to go after those barriers to work. Not instead of just manipulating their financial incentives. Why don't we help people with barriers that they actually face? One demo is very interesting in that, Is the MHTS demo, where they, for mental impairments, they had a mammoth increase in employment from 40% in the control group to 61% in the experimental group, that's 21 percentage points, increase in employment. And how did they do it? They did was by packaging a huge amount of services, like, 10 to 15, different services. Concentrated on the recipients, they got all kinds of services simultaneously, including individualized employment services. That cost 7,000 dollars per person so you're never going to do that, but you can imagine. Really packaging it, so you could go with that you can have a package of services, provide a small number of people and the EITC can be built into that, addressing their barriers to work and then see how far you can get with that and simultaneously measuring.

There's other outcomes at the same time. So those are some thoughts I had thanks, Kathleen and Hillary for the great conference. Thank you Robert. Kevin was there anything in your discussants' comments that you'd like to. Respond to before I move on to audience questions. Sure. Just a couple points briefly. The idea that Robert just brought up about, um. Trying out a demonstration at the point of applications sounds. Very good to me, because of the length of time it takes to. You know, get the application processed and then appeals and so forth. The denial is quite a bit later. And you have the individual there and you have the contact information back I think that's something that maybe they should think about. In terms of my discussants I certainly agree with Jeff about, um. We need to be focusing on a broader set. In fact, maybe. Only focusing on a broader set of outcomes, in terms of well, being and health of the. Recipients certainly a point well, taken. Um, in terms of Jennifer's, uh, comments, I appreciated the, um. More extra, the longer and more detailed explanation on The retain demonstration I think that's a real exciting. Opportunity for us to learn. And see, what what types of outcomes will. possibly turn out from these interventions. Focusing on timeliness and. Case management and coordination, so right. I appreciate the time she's spent on, uh. I'm talking about how that's rolling out.

Thank you. Thanks, Kevin. I want to come back to the topic of targeting and Robert, you're speaking about this a little bit on your response just now what we're thinking about, when a question from audience numbers, we're thinking about a targeted program for beneficiaries and somebody's ticket to work is a targeted program, because people are able to take it up and kind of make it. Find the ideally find the services that they need for themselves. So, are there any, do you have any thoughts on how ticket could be used or modified to test some of the interventions that seem promising. In return to work. How the testing targeted interventions? Is that what you said? Yes. As a, as a way to try to find hard to find and kind of personalized, individualized. Services for targeted groups. Well. I mean, I think the hard part is the targeting itself and. Um, if you look at these demos, all the evaluations. Always did some group analysis, and the subgroup analysis almost never shown any particularly strong group that had a positive impact. Uh, on the other hand, the the sub groups they're looking at are very crude, you know, and they're. Education normally, just past employment or splits by the of impairment. Things like that.

So I think I think that really hard part is, is figuring out better ways to target. And I suggest that that attempt really has not been made in a serious way. And we don't know, but we need demos that 5 different measures are targeting. We have a lot of history of people when they apply in the 1st place when they come on. We know something about their past SSA earnings. We have work CDRs, from which you have information and whether they engage in work or not. And we have a lot of and of course, just asking people and these volunteers a lot of the demo. It's just ask people. How much are you interested in working. Never discount people's own views on whether they want to work or not. So, of course, you've got to be a little careful there about just offering it to somebody because they say they want it independent of everything else, but I'd like to see some demos, which really was, you could actually do some more analysis right now. I think more subgroup analysis could have been done. Some of these demos really look at getting down to their characteristics. A data gathering exercise really figure out. If there were subgroups that really had positive impacts. So some can be done within with the current data. But certainly with future demos, there's a lot more avenues to do that the barriers to work that are related to the barriers who has the transportation problems who, who was in an area where there are no jobs where they can have a combination or receptivity and they're all kinds of dimensions, and I think when could look at that haven't been. Yeah, that's Thank you for that answer. Okay, that's it. 70 slots. Okay. If you're interested in it apply, okay, if you were assistant apply and then you sift through the applications and you take the most advantaged people you do that across. You have a fixed number of slots.

Okay. It's not open. Ended. Characteristics of people who are going to be interested in work or are going to engage in work but it is very difficult to find it in the data. And I think if we were able to. Better identify and connect with the people who are interested and work are be a huge advance. So, to turn to a different, I guess, an extension on that is, are you thinking of that this policy would then be made. Available only to a targeted group of people who had been selected, been identified or simply that it would be widely available and some people would take up the program. Because that was the program was attractive to let me throw out a really radical idea for a program. Okay you go in and you say we're going to have this Cadillac program, which provides a lot of support. And we have, um, we have. In the city of Houston, Texas, we have 70 slots. Okay, that's it. 70 slots. Okay. If you're interested in the apply, okay, if you were assistant apply and then you sift through the applications and you take the most advantage. People you do that across. You have a fixed number of slots.

Okay. It's not open. Ended. That way you can control costs and you can, um. Now, how to do that demo will strictly speaking the way you do the demo is you ask people to apply and then you randomize and so people say, yeah, I want to apply and they don't get it because they're gonna be unhappy about that but the but that's another option instead of just. letting it be open ended if you left it open ended, then you're gonna get all kinds of voluntary stuff and like to, you know, like. Who participated who didn't? Who in the control group would have participated? What's the right comparison group? What's the selection going on here? If you control the selection as a program operator, you have a leg up on trying to figure out what the impact is. Just an idea. Interesting point. All right, so I'm going to transfer a different question now, so the state Kathleen's point earlier a little differently, could it be that the low employment and earnings of beneficiaries, even with improved incentives and support indicate that the program is working that is it is working as social insurance to provide income for people who cannot be expected to work. And this question is for both panelists and all discussions. Um, whoever would like to respond to. Well, as I said, I think the, the, the good question is, if you get any impact on employment

and earnings, even though it's not above SGA, that MHTS experiment, a demo on the mental impairment, and had the 41%. Increase in the employment rate.

Sorry 21 percent, not to overdo it . 21 percentage point increase in employment. None of it was the over SGA, so I think it's successful and you had success there, you know, but somehow it doesn't get counted as success because nobody left DI or nobody. Uh, kind of worked way above high earnings, but. why not count that as a success and say, yes, the program is working. But the people who really cannot achieve any employment, they're getting their benefits and the people who can. They got they still retain their benefits and. If they were below SGA that means, they had no reduction in their benefits, but they did have an increase in their earnings, which has all kinds of positive effects in and of itself, and possibly on their mental health as well. So I'd agree. You can, you can count that as success and say that's the program's working. Anyone else want to respond. I'll jump in so I think these programs are working phenomenally well at helping people who have suddenly lost income and without them would be in. Extreme circumstances I, I think this discussion though is about. A subset of the recipients who. It's sort of a shame that all we can offer them is income if they don't work anymore. And the question is whether we could improve. 10 or 20% of applicants.

Well, being if we had some other package to offer to them. Besides lifetime benefits, if they never work again and if we could do more to help people. Uh, get back on their feet and so I think I think that these programs are incredibly successful and what they accomplish as social insurance. Um, but I think we're all interested in. Can they be even better. Let me add to that this comment on something Hillary brought up, was that the labor force participation rate of men over time, which is very important point. Which is, uh, there are many different. Speculations for the reason for that, but 1 of the leading 1, in fact, the explanation suggested by. David Autor and Mark Duggan was that, um, the reason the decline is occurring is because the jobs that are available. To unskilled men, and women have really gotten worse, offering much lower wages and given all the changes in the labor market with advanced demand for skills for at least a college education or high school education at least some computer skills. Right. Or IT or going to junior college or something. You don't have that you're really much worse off today than you used to be. And Autor and Duggan, and that was their leading explanation for the rise to the caseload, before the recent fall back there.

So, what that suggests is that, I mean, the disabled are obviously in that category where they're looking for jobs, the job that are appropriate for them. Even outside of the sheltered workshops and competitive labor market are unskilled jobs and if those are disappearing, or their wages are dropping. Um, that just means the hill we have to climb here, it's getting higher and higher to, uh, find jobs out there that individual with disabilities are able to take and earn a decent return. that makes it financially viable for them to do it. So, that's another factor. I think Kathleen brought this up. You know, she brought up some discrimination in the labor market. Well, you can say note even discrimination, but just, you know, are there enough jobs out there where employers are willing to offer the jobs of the type that that individuals with disabilities and those can reasonably take. And it could be that those are going down. And, but none of our demos focus on that demos, focus on job opportunities, and the wages that are out there, kind of the pull, it's all push to get people off. And none of the pull of how to encourage what about having an EITC. You know, so if you leave DI, we're going to subsidize your earnings. Okay. What's happening for 3 or 4 years?

Okay, if wages have been dropping out there in the private labor market for the kinds of jobs, the beneficiaries can get. Maybe we should supplement a little while and say, okay, what we'll do this. So, there are all kinds of interventions on that side of the market, at least and, and certainly more knowledge needs to be getting on that side of the market. That we have right now. Thanks. 1 of the, I think a big question here about turning to non economic measures is key outcomes is how do we find these in the data and how do we collect data on them? And how do we choose which ones are the right ones? Because we. Need to be cognizant of the fact that having too many measures is not always productive because it brings us back to the multiple comparisons issue that Jeff commented on earlier. So I'm curious if anyone has thoughts on where we should kind of what I. Thoughts on how best to collect the data, how to how to identify the key. How to identify key outcomes in the. In the, um. Demonstration. Back in 2006-2009, the evaluation leaders had some. Uh, very specific health checklist that they used. Yeah, because the intervention was, uh. Health care related 1, um. The evaluation report has a lot of information on health outcomes. So, there's, there's at least, um. All right. We are just about out of time. So, rather than asking another question in our 30 seconds left, I'm going to thank the panelists and discussants, and we're now going to move into a short break and we will be back shortly with the next panel. Thank you.