

The Impact of Short Term Disability Insurance Coverage on Employment and SSDI Enrollment

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The Social Security Disability Insurance system (SSDI) is one of the largest social insurance programs in the United States. Since 1990, SSDI outlays grew at 5.6 percent per year in real terms, compared to just 2.2 percent for all other Social Security spending. As a result, SSDI's share of total Social Security outlays has risen from one in ten dollars in 1988 to almost one in five dollars today. Moreover, SSDI expenditures now exceed the payroll tax revenue dedicated to funding the program by more than 30 percent, with the program's trust fund projected to be exhausted in 2016. As a result, it is critical to assess options that can reduce or even reverse the rapid growth of expenditures on this program.

One such option is to increase access to short-term disability (STD) insurance. Making STD benefits available without a waiting period may enable workers to overcome temporary health-related work limitations, and to return to work, rather than going through the long and uncertain SSDI application process. STD benefits may be particularly effective in conjunction with workplace accommodations and vocational rehabilitation. On the other hand, providing short-term disability insurance could also increase use of the SSDI system. If receipt of STD leads workers' skills to atrophy or reduces workers' commitment to employment, this would likely increase SSDI claims. STD might also increase SSDI claims by improving the financial circumstances of potential claimants during the lengthy application process, inducing more people to apply. Thus an important question is whether STD programs are a substitute for, or a pathway onto, longer-term SSDI receipt.

To address this question, we analyze the effects of the STD programs already provided by employers today. More than 40 percent of full-time workers in the U.S. have short-term disability (STD) insurance through their employers. The typical employer-provided STD policy has a maximum duration of 26 weeks, a replacement rate of 60 percent, and a maximum weekly benefit of \$550. Unlike private long-term disability insurance or Social Security Disability Insurance (SSDI) benefits, there is essentially no waiting period for STD benefits.

Accurately estimating the effect of employer-provided STD coverage on participation in the SSDI program is difficult, because workers employed by firms that offer STD coverage are likely to differ in many respects from their counterparts at firms that do not offer this coverage. As a result, a simple comparison of workers with and without STD coverage is unlikely to yield reliable estimates of the causal impacts of STD coverage on SSDI accessions. We look instead at policy-induced variation in STD coverage. Because this source of policy-induced variation should be unrelated to workers' underlying health or demand for disability benefits, it may potentially inform the question of how providing access to STD affects workers' propensity to obtain SSDI benefits.

There are currently five states in the U.S. that require employers to provide and/or finance STD coverage for their workers. Approximately 25 million workers in the states of California, Hawaii, New Jersey, New York, and Rhode Island have this coverage. An examination of data from the Bureau of Labor Statistics suggests that these state policies induce significant variation across states with respect to STD coverage. For example, in the Middle Atlantic region (which includes New York and New Jersey as well as Pennsylvania) the fraction of workers with this coverage is 68 percent versus just 33 percent in the South Atlantic.

By itself, this cross state variation in STD coverage is not suitable for assessing the impact of STD on SSDI enrollment since the states that mandate STD coverage may themselves differ from other states along a number of dimensions that impact SSDI receipt. We therefore pursue a “differences-in-differences” strategy that exploits cross-sectoral variation in the voluntary rate of STD benefits in conjunction with the policy-induced, cross-state variation in STD coverage. For example, in voluntary STD states, STD coverage rates vary from a low of 4% in repair and maintenance to a high of 94% in rail transportation. In the mandatory STD states, on the other hand, coverage is virtually 100% in all sectors. If these sectors are otherwise similar across the two groups of states, then differences between them in SSDI receipt should plausibly reflect the influence of mandatory STD benefits, and not the effect of other factors.

We find strong evidence that having legislatively induced STD coverage increases the rate of STD receipt. We additionally find some evidence that this STD coverage is also associated with lower SSDI receipt. But this evidence is unfortunately not very convincing: the patterns by gender between STD receipt and SSDI receipt do not match; there is a robust but wrong-signed impact of STD coverage on reported disability rates; and we fail a critical falsification test in terms of observable worker characteristics. We conclude that our empirical strategy is insufficient to credibly estimate the causal impact of STD availability on SSDI receipt.

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