Disability insurance: what are the benefits and pitfalls--and how to navigate around them?

By

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The economic rationale for mandatory disability insurance

- Most people reach old age—when young we can plan and save for the loss in earnings when old.
- A smaller number lose earning capacity when young due to major health problem (disability). Small risk of large loss. Creates need for risk-pooling through insurance.
- But people may be myopic, underestimate risk, don’t purchase enough insurance voluntarily
- Adverse selection—only those who already have health problem insure; this raises premium for average person
- Cherry-picking by insurance companies (avoid high risks)
- Mandatory insurance avoids these problems
  — prevents poverty, maintains living standard of disabled
- But many pitfalls—disability difficult to measure, often inaccurate (unlike old age); moral hazard widespread; systems can be very costly; labor supply and GDP reduced by system incentives
Typical plan before recent reforms

• Usually handled by public system (pillar 0 or 1), even in countries with multi-pillar systems (except Latin America)
• PAYG, so long-term costs are hidden
• Defined benefit, based on recent wages, even when old age system is defined contribution
• Replacement rate often high in contributory plans >70%
• Worker presents case with evidence from own GP
• Pressure on agency to be sympathetic, so low denial rate
• Criterion: inability to do regular line of work
• Eligibility often stops if recipient earns wage—so beneficiaries almost never go back to work
• Costs 1-10% of wages, 10-90% of old age spending
  – Larger plans are in middle and high-income countries
  – Low-income countries should be cautious, because of problems and complexities of running disability plans
Spending on disability benefits/old age pensions, 2005
Problems: 1. Disability is ambiguous, subjective, difficult to measure

- Intended for cases where health issues severely limit work
  - but little direct connection between observable medical diagnosis and unobservable functional capacity
- Majority of new claims are due to psychiatric or muscular-skeletal condition (arthritis, pain)-difficult to prove/disprove
- Limited information—traditionally, worker’s own GP
- So high administrative costs, very prone to errors
  - U.S. audit found 48% false denials, 19% false approvals
  - self-assessed disability compared with SSA decisions: 20% false positives, 60% false negatives (Benitez-Silva et al 2004)
  - In other high-income countries errors are 30-40%
- What is “right” mix of false positives vs. false negatives?
  - avoiding false denials raises costs. But opposite reduces benefits
- Well-trained examiners & administrators needed for accurate assessment—scarce in low-income countries
2. Moral hazard and agency problems (insurance increases risky behavior)

- People who dislike work may claim they are disabled even if they can work
- Doctors and gatekeepers may apply lax definitions of disability to keep clients happy
- Employers use disability program to get rid of low productivity workers
- Politicians use it to cut unemployment rate
- Unions use it as early retirement pathway
- Local governments use it to get people off welfare rolls
- Opportunities for moral hazard are increased by ambiguous definition
- Important object of system design—keeping moral hazard low by information and incentives
3. Systems are costly, costs are rising

- Costs <1% of GDP in low-income countries (small disability systems, low coverage), 2-6% of GDP (4-10% of wages) in high-and middle-income countries (except LAC)
- Highest in Nordic countries; also in Netherlands and Poland but they have reformed and reduced costs
- Average OECD beneficiary rate is 5.5% of WAP, but varies from <1% to >10%
- Ambiguous definition, moral hazard and generous benefit level raise benefit recipiency rate and costs
- Costs and benefit recipiency rate vary widely across time
  - (numbers are for disability +sickness leave, public + mandatory private benefits, OECD StatExtracts, from Source OECD or OECD’s iLibrary)
Public + mandatory private spending on incapacity as % of GDP, 2005
Public+mandatory private spending on incapacity as % of GDP, 1985-2005
Disability beneficiaries as % of population age 20-64, 2007
4. Systems reduce labor supply, GDP

• Studies show growth of disability system is a major reason for declining Lfpr among older men
• Benefit is intended for people who can’t work so applicants don’t work
• Beneficiaries face high implicit tax--benefit stops if they try to work so they don’t try--work disincentive effect
• Benefit provides income that enables beneficiaries to work less—income effect
• Once people start disability benefits they depend on continued benefits, practically never return to work
• Big policy push currently is how to get disabled off benefits, back to work (but this may require smaller benefits, less insurance and less moral hazard)
Why have costs and recipiency rates varied and often grown?

• Health improvements should lead to less disability, but instead rates have often grown
• Disability rates are highest for older ages but population aging isn’t enough to explain growth
• High UnE—workers lose jobs, claim disability, keep it; politicians use disability to cut visible UnE rate
• Tighter early retirement--disability an alternative
• Expanded definition of disability—mental illness, AIDS, drugs, alcoholism, autism—affect younger workers
Policies are key reason for cost growth

- Studies show that variation and rise are driven by policies re benefit generosity and access (Borsch-Supan 2010)
  - Replacement rate and stringency of screening are key
  - 30% increase in benefit size -> over 40% increase in applications, 30-40% increase in awards (B&B 1999)
  - Also -> 10% increase in labor force non-participation rate (LFNP) for men 45-59 (Gruber 2000)
  - 30% decrease in denial rates leads to 8% rise in LFNP for men 45-64 (Gruber and Kubik 1997)
  - This would not happen if no moral hazard or if definition were clear-cut
Policy-makers must decide: What is right mix of benefit generosity, screening, errors of exclusion and inclusion? How to encourage work?

- **Trade-offs:**
  - Stringent screening avoids false positives, permits high benefit levels at low cost but creates false denials
  - Lax screening reduces false denials but raises false approvals, requires low benefit levels or high costs
  - Reducing benefit size cuts costs and moral hazard, raises work incentives, but gives less insurance

- **Tension is greatest in high-income countries that want to insure against disability risks but don’t want to pay price of moral hazard, loss of work incentives**

- **Latest reform efforts emphasize better information and monitoring, careful choice of gatekeepers, monetary incentives to workers and employers, private sector role, periodic reassessment**
Poland—temporary benefits

- In 1995 disability cost 5.7% of GDP, by 2005 only 2.7%. How did they accomplish that?
- Since 1999, almost all benefits are temporary
- System doctors can reassess and over-rule GP certifications that were too lax
- Replacement rates reduced
- But—many successful appeals and re-applications, may not last as early retirement is tightened
- Beneficiaries still have no incentive to work
- Employers face 6% quota for disabled. Other countries also have quotas. Do they meet quota? Do they hire own workers relabeled as disabled? Is hiring of low productivity workers a hidden cost? Evaluation needed.
Netherlands—employer responsibility

• In 1995 Netherlands had incapacity cost of 5.7% of GDP (10% of payroll)
• Employers used disability system to get rid of unwanted workers, politicians and unions to keep UnE low and permit early retirement
• By 2005 cost fell to 4.3% of GDP. What did they do?
• Major responsibility for disability was shifted to employers and private service providers
  – employer bears full cost for 2 years of sick leave
  – must use private occupational health services to monitor absent workers and get them back to work
  – this provides information about health of worker, gives employer incentive to keep worker on job by rehab and workplace modification
Netherlands 2: partial vs. full disability

• After 2 years of sickness leave, worker is assessed for disability benefit
  – If capacity loss is <35%, no disability benefit
  – If capacity loss is 35-79%, worker gets partial disability benefit as top-up to wage, if he continues to work but at lower wage
  – (if he doesn’t work he gets lower flat benefit)
  – Employer finances this for first 10 years (self-insurance or experience-rated private insurance)
  – After 10 years public system takes over
  – If capacity loss is >79%, public system pays full benefit

• Assessment by social insurance doctors & voc expert
• Criterion: ability to do any job (not one’s regular job)
• Lower replacement rate (previously 90-100%)
• 2004-9: stock of beneficiaries > age 45 reassessed
Netherlands 3: success and problems

• Results—inflow into disability fell sharply, outflow rose, costs fell
• Potential problems: did this lead to shift to temporary contract workers who are not employer’s responsibility?
• Do employers try to avoid hiring high-risk workers?
• Are small and medium sized firms at disadvantage?
• Do official wages overstate worker productivity and understate true cost of program?
• Are administrative costs high?
• Do reassessed workers who lose benefit end up on other welfare programs?
• Would not work well in countries with much casual temporary employment, small firms
Australia—no partial dis benefits; private providers, outcome-based fees

• Concerned by rise in beneficiaries and costs 1985-95, so reformed system; costs began to fall
• No dis benefits for partial disability; they get temporary UnE benefit, retraining, job search
• Voc rehab provided by private companies who are paid based on employment outcomes—fees for 13 & 26 weeks of work
• Potential problems: do workers keep job for long term, are they good jobs, do providers try to cream healthy workers? Evaluation needed.
Denmark—wage subsidies & flex jobs

• Concerned by rising absenteeism and costs, 1990’s, early 2000’s, so reformed mid-2000’s
• Partially disabled get access to subsidized flex-jobs instead of benefits
• Municipalities given incentive for better administration
• Problems: not enough flex-jobs to meet demand
  – may lead more workers to apply, employers keep same workers on subsidized basis
  – evaluations show half of all flex jobs go to workers already employed by firm on ordinary terms
• In general, wage subsidies may lead to job retention rather than new hiring of disabled
Chile—private pension funds provide information, control costs

- Unlike most countries, disability benefits are partially pre-funded and run by private sector (but regulated)
- Since 1981 old age pensions based on individual accounts
- IA’s also provide benefit if worker becomes disabled
  - worker is promised replacement rate of 70% (50% if partial dis.)
  - if money in account isn’t enough to cover benefit, it is topped up by group insurance policy purchased by pension funds
- Pension funds and insurance companies have incentive to keep approved claims and costs low—increases profits
- Assessments are made by Medical Board chosen by public agency, but pension funds and insurance companies participate in hearings, provide information, ask questions, bring appeals
Chile: pre-funding through IA’s

• Results: low inflow into disability, lower costs, higher accuracy than other countries or old system (targets most severely disabled with highest mortality rates)

• Prefunding through individual accounts further reduces costs in long run; deters claims; higher cost due to population aging is offset by funds in account

• Problem: pension funds may try to avoid affiliating high-risk workers
  – (to avoid selection, since 2008 all workers put into one insurance pool)

• (James, Edwards and Iglesias 2008)
Lessons: process, information and incentives matter

• Keeping replacement rates low is most sure-fire way to keep disability recipiency rates and costs low and employment high—but this also means low insurance

• Careful screening is second important mechanism
  – object should be accuracy
  – should be done by system’s medical and voc experts, not individual’s own GP
  – should be based on capacity to do any job (not regular job)
  – prepare for higher denial rate when early retirement is tightened

• Mobilize self-selection whenever possible
  – allow sick and disabled workers to bear some cost—waiting period, benefit < wage, show up for work
  – in IA systems, apply balance in account toward disability benefit
  – smaller net gain will discourage healthier workers from applying
Lessons: partial vs. total disability

- Total permanently disabled are a small group, can be more objectively defined, given large benefit
- Partial and temporary are majority: can get transitional benefit, job search help, retraining
- If stay out of work for extended period, they will never return, become dependent on benefits
- Important to avoid high implicit tax on work for this group—maybe give temporary modest flat amount that they keep for several years if they work
- Subsidized wage is possible to offset lower productivity of these workers, but problems—moral hazard, employers and workers may over-use
- Periodic reassessment of beneficiaries is essential
Use monetary incentives

• Give some key party financial incentive to provide information, control costs
  – Employers in Netherlands, pension funds in Chile, private service providers in Australia
  – But this leads to selection/creaming/hiring issues

• Disability benefit should not be higher than unemployment or early retirement benefit, to minimize benefit shopping. Plan for disability benefits to rise when UnE rises and early retirement is tightened.

• Disability systems are complex, require skilled personnel. Low-income countries with limited human capital should beware of going beyond small system based on clear-cut medical conditions. Middle and high-income countries must designs systems carefully, aware of pitfalls.