Vermont Legislative Joint Fiscal Office

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ISSUE BRIEF

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Why is the Prevalence of Young People on the Social Security Disability Program in Northern New England So High, And Why Has It Risen So Rapidly Since 2000?

Summary

In 2013, New Hampshire, Vermont, and Maine had the highest rates of adults under age 35 enrolled in the Social Security Disability Insurance (SSDI) program among all the states. In addition, between 2000 and 2013 the shares of people on SSDI under age 35 and ages 35 to 44 in northern New England rose almost four times as fast as the increase in the national average. The share of the population on SSDI among people ages 45 to 54 rose twice as fast as the national average. Explaining those high and rising rates is difficult. To begin the investigation, this paper will explore the situation in Vermont in particular. Four explanations seem to contribute to Vermont's high and rising prevalence of young people on SSDI: pro-active efforts by state agencies to enroll young people in the SSDI program, out-migration of able-bodied young people likely related to job opportunities, rising opiate addiction, and relatively high rates of health insurance coverage.

Policymakers need to pay attention to the number of people enrolled in the SSDI program because beneficiaries are no longer fully engaged in the labor force and contributing to the state's economy but instead rely on income support from the government. In addition, the SSDI trust fund is expected to be exhausted by the end of calendar year 2016. Unless Congress acts, SSDI benefits could be cut 19 percent at that time.

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[1] Joyce Manchester is Senior Economist in the Joint Fiscal Office. Sam Tweed was a summer intern at the Joint Fiscal Office during the early stages of this work. The authors wish to thank Senator Jane Kitchell, Representative Anne Donahue, Representative Ann Pugh, Bob Bick, Charlie Biss, Joseph Gallagher, Camille George, Jack Gettens, Emma Harrigan, Bard Hill, Nancy Hogue, Andrew Houtenville, Stephen Klein, Mary Moulton, David Stapleton, Bill Talbott, and Julie Tessler for helpful discussions and/or comments. The authors retain final responsibility for the views expressed.

The High and Growing Prevalence of Young People on SSDI

The Social Security Disability Insurance program pays cash benefits to nonelderly adults (those younger than age 66) who are judged no longer able to perform "substantial" work because of a disability but who have worked in the past. In 2014, the program paid benefits to almost 9 million disabled worker beneficiaries in the United States, or about 4.8 percent of the resident population. The average monthly benefit amount was $1,165 nationwide and about $1,097 in Vermont.[2] Disabled worker beneficiaries receive Medicare benefits as well after a waiting period of 24 months.

The northern New England states have relatively high prevalence rates—defined as the number of disabled workers on SSDI divided by resident population in the same age group (see Appendix Figure 1). Maine has the sixth highest overall prevalence rate at 7.57 percent, Vermont is eleventh at 6.15 percent, and New Hampshire is twelfth at 6.12 percent.[3]

Where northern New England stands apart from all other states is in SSDI prevalence rates for adults under age 55. In 2013, Vermont had about 11,000 SSDI disabled worker beneficiaries under age 55. Maine had about 30,000 and New Hampshire about 36,000. Those numbers translate into SSDI prevalence rates in northern New England that were much higher than the national average for individuals under age 55 (see Figure 1). For individuals ages 55 to 65, the SSDI prevalence rate in Maine was above the national average, but the prevalence rate in Vermont and New Hampshire was below the national average. (For numbers of disabled worker beneficiaries by age group for the three New England states and the U.S. in 2013, see Appendix Table 1.)

For the population under age 35, Vermont, Maine, and New Hampshire stand out with the highest rates of SSDI prevalence—between 2.05 percent and 2.31 percent—among all the states (also see Appendix Figure 2).[4] The state with the fourth highest prevalence was Arkansas with a prevalence rate of 1.55 percent. That rate is 28 percent smaller than the northern New England average of 2.16 percent. The states with the lowest prevalence among adults under age 35 were Hawaii, California, and Washington D.C.

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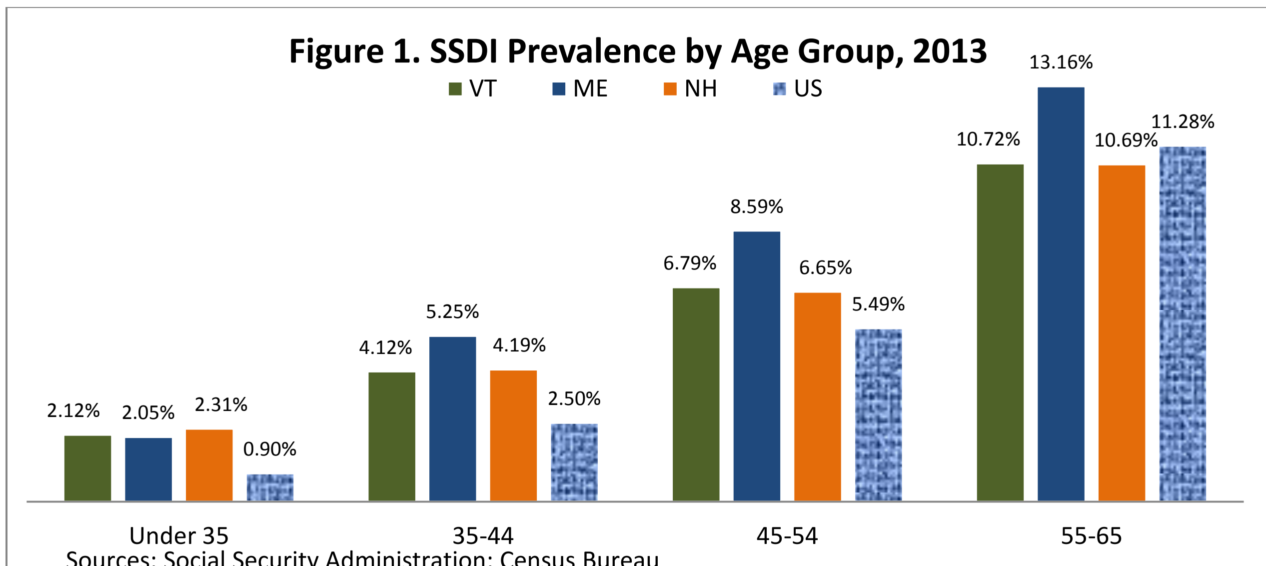
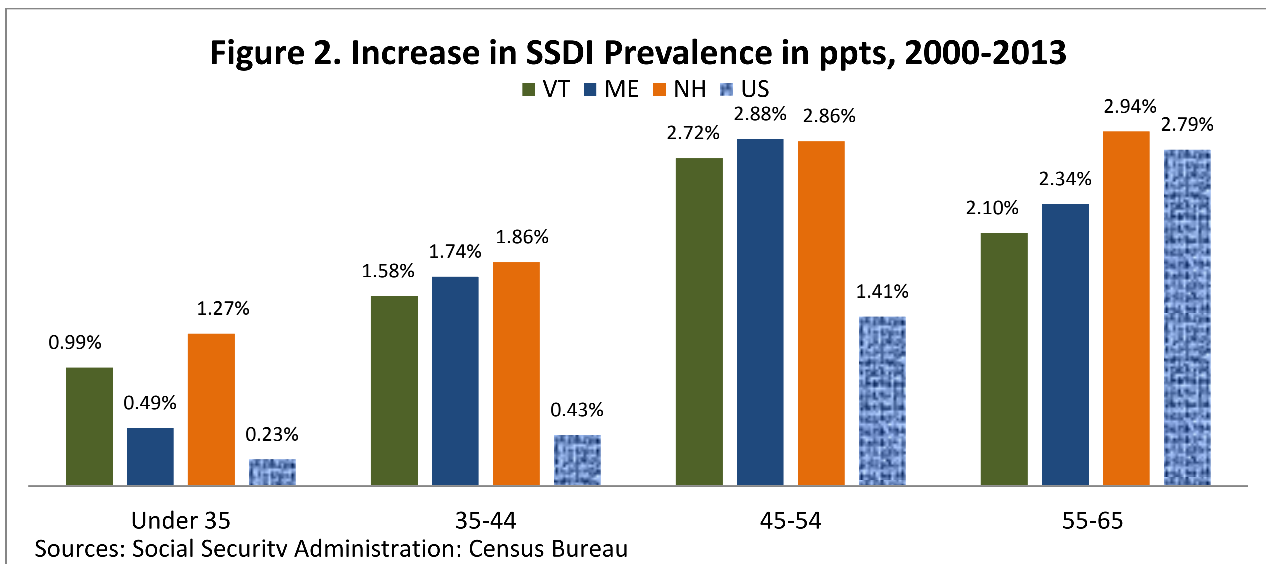
[2] The White House, *Social Security Disability Insurance: A Lifeline for American Workers and Families*, July 2015. https://www.whitehouse.gov/sites/default/files/docs/ssdi_national_report_7-17-2015.pdf

[3] The numbers of SSDI beneficiaries by age group come from the *Annual Statistical Report on the Social Security Disability Insurance Program, 2013*, Social Security Administration, December 2014, Table 27. Population estimates come from *Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2013*, U.S. Census Bureau, Population Division, June 2014. http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/index.html

[4] To avoid distortions arising from population spikes or shortages among each state's college age population (generally ages 18 to 21), in this paper the prevalence rate for disabled worker beneficiaries under age 35 is calculated as SSDI worker beneficiaries under age 35 divided by the resident population ages 22 to 34.



Rates of SSDI prevalence nationwide increased markedly—by about 33 percent—between 2000 and 2013, ranging from an increase of 0.2 percentage points among people under age 35 to an increase of about 2.8 percentage points among people ages 55 to 65. In northern New England, the increase in the SSDI prevalence rate was larger than the average increase across the country for beneficiaries in each age group under age 55 (see Figure 2).[5] The prevalence rate for beneficiaries ages 55 to 65 increased more quickly than the national average in New Hampshire, but more slowly in Maine and Vermont.



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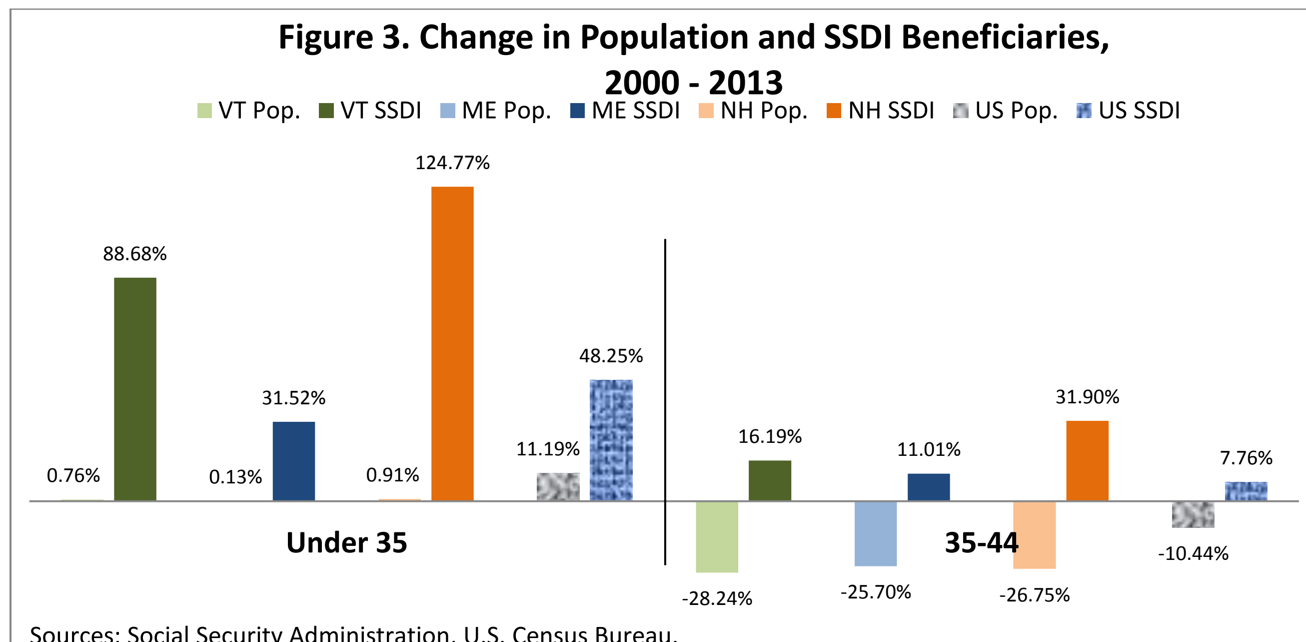
[5] *Annual Statistical Report on the Social Security Disability Insurance Program, 2000*, Social Security Administration, September 2001, http://www.ssa.gov/policy/docs/statcomps/di_asr/2000/sect04b.html; and National Intercensal Estimates (2000-2010), U.S. Census Bureau, https://www.census.gov/popest/data/intercensal/state/ST-EST00INT-02.html

Furthermore, increases in the number of SSDI beneficiaries by age group contrast with much smaller growth in the overall populations of adults under age 45 in Vermont, Maine, and New Hampshire between 2000 and 2013 (see Figure 3). In Vermont, for example, the population ages 22 to 35 barely rose at all, but the number of disabled worker beneficiaries increased almost 90 percent. Among adults ages 35 to 44, the population dropped 28 percent but the number of disabled worker beneficiaries rose 16 percent.

In many instances below, this paper will focus on the Vermont situation as a case study.



Possible Reasons for the High and Rising Rates on SSDI

Little hard data exist to explain the high and rising prevalence rates of young people on SSDI in the northern New England states, but an exploration of the Vermont situation suggests a handful of explanations. They include pro-active efforts by state agencies to enroll young people in the SSDI program, out-migration of able-bodied young people likely related to job opportunities, rising opiate addiction, and relatively high rates of health insurance coverage.

Two recent nationwide surveys help debunk one possible explanation: the three northern New England states do not have a higher proportion of working-age adults with self-reported disabilities than other states. The 2013 American Community Survey shows that Maine is ranked 9th, Vermont 21st, and New Hampshire 36th among all the states.[6] Age-adjusted data from 2013 reported in the Behavioral Risk Factor Surveillance System show that about 20

[6] Gettens, Jack, Pei-Pei Lei, and Alexis D. Henry. "Using American Community Survey Disability Data to Improve the Behavioral Risk Factor Surveillance System Accuracy," Mathematica DRC Brief #2015-05 and personal communication.

percent of Mainers reported any disability, placing it 31st among the 50 states plus the District of Columbia.[7] About 19.5 percent of people in New Hampshire reported any disability, leading to a rank of 37th; about 18 percent of Vermonters reported any disability, placing it 45th.[8]

<u>Pro-active efforts by state agencies and designated agencies to support SSDI applications among young people</u>

State agencies as well as 16 "designated agencies" and "specialized service agencies" throughout the state may help to identify people with disabilities and encourage them to apply to the SSDI program to provide federally-funded cash benefits and health insurance at a more generous level than partially state-funded Supplemental Security Insurance (SSI) cash benefits and health insurance. The maximum monthly SSI amount paid by the federal government in 2015 is $733,[9] with a state supplement on top of that benefit in all but four states. By way of comparison, the average SSDI monthly benefit nationwide is $1165. Perhaps more important, SSI beneficiaries receive Medicaid benefits partially funded by the states, whereas SSDI beneficiaries receive federally-funded Medicare benefits after a 24-month waiting period.

SSDI benefits may be especially valuable to young people with disabilities because the work requirements are relatively limited. If young people manage to earn a modest wage for 2 years or more but are unable to earn substantially more because of a medical condition that is expected to last more than a year or to result in death, they meet the work history requirement of the SSDI program. If they are allowed, they receive monthly cash benefits and, after a 24-month waiting period, Medicare benefits as well. Medicare acts as the primary payer. The state pays supplemental benefits for SSI in Vermont as well as a share of Medicaid payments. Vermont pays about $52 per month to an individual on SSI who lives independently[10] as well as about 46 percent of Medicaid benefits for people on SSI. For people on SSDI, Vermont pays nothing for monthly cash benefits or Medicare benefits.

Some people believe that Vermont state agencies, designated agencies, and specialized service agencies are particularly good at identifying people who might qualify for the Social Security Disability Insurance program and supporting them as they apply for benefits. Three groups within state government seem to have the most direct contact and provide the most support to potential SSDI applicants.

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[7] Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, July 31, 2015, Table 1.

[8] The northern New England states do not have above-average rates of children under age 18 on Supplemental Security Income (SSI) who might "age" onto the SSDI program. In 2013 , prevalence rates were 1.78% for the U.S. but 1.41% for Vermont, 0.96% for New Hampshire, and 1.63% for Maine.

[9] http://www.ssa.gov/oact/cola/SSI.html

[10] http://www.ssa.gov/pubs/EN-05-11128.pdf

First, the Department of Disabilities, Aging and Independent Living (DAIL) within the Agency of Human Services (AHS) provides a variety of services to Vermonters who have a disability. The Developmental Disability Services Division helps to provide information about the availability and choice of services and strives to individualize services based on the capacities, needs, and values of each individual. One of their services is identifying children with autism spectrum disorders, people with developmental disabilities, and families of children under the age of 21 with a significant disability or health condition. (See Appendix Table 2 for an organizational chart of AHS.)

Second, DAIL's Division of Vocational Rehabilitation (DVR) works with other state departments to identify and support those who could be eligible for SSDI or SSI. DVR works with the Vermont Department of Children and Families (DCF), Division of Economic Services, and the Department of Corrections (DOC) to identify potential applicants and assist individuals with the application process. As stated in the 2011 Annual Report of the Division of Vocational Rehabilitation,[11] the Social Security Application Assistance Program works as follows:

> "People with disabilities serious enough to qualify for Social Security Administration (SSA) benefits often rely on other benefits such as Reach-Up [TANF in Vermont] and General Assistance (GA) because the SSA application process is so onerous and denials are common. Shifting these people to SSA benefits brings greater income stability and access to health care benefits that can be a critical foundation for eventual movement into employment. It also preserves State resources for those who have no other option than Reach-Up and GA. In fact, the State can "recoup" (get paid back) by SSA for benefits paid out if the person is found eligible for SSA benefits for the same period.
>
> In working with Reach-Up, GA, and offender populations, DVR has found many people with severe disabilities that have never been properly diagnosed or treated. While employment is the goal, it may not be a viable option yet. Stability comes first. To address this need, DVR joined with [the Vermont Department of Corrections] DOC, SSA, and [the Vermont Department of Children and Families] DCF to create a process for helping [the Vermont Agency of Human Services] AHS customers with severe disabilities secure SSA disability benefits. Based on a triage assessment by VR counselors, appropriate candidates are referred to DVR's Social Security Specialists who help applicants prepare for and complete the application and appeals process. The customer's connection with DVR and Benefits Counseling services is also established, to keep the door open for employment.

[11] *VocRehab Vermont 2011 Annual Report*, page 13; http://vocrehab.vermont.gov/sites/vocrehab/files/VRAnnualReport2011Final.pdf

Vermonters Served (Federal FY '11): 1,441 people were helped with SSA applications."

Third, Vermont's Department of Mental Health (DMH) designates one "designated agency" (DA) in each of 10 geographic regions of the state as responsible for ensuring needed services are available through local planning, service coordination, and monitoring outcomes within their region. The 10 DAs are nonprofit agencies that offer care to Vermonters affected by developmental disabilities, mental health conditions, and substance abuse disorders. They also help identify children and adults who might qualify for SSDI benefits. For example, the Howard Center in Burlington helped more than 16,000 people in 2014. It has an opiate treatment program that gets referrals from law enforcement, state government, and the courts; about 300 people were on the active waiting list as of early September 2015. That program must frequently handle co-occurring mental health issues. The Howard Center also runs a developmental disabilities program. To assist individuals who might be eligible for the SSDI program, the Howard Center might refer individuals to the Division of Vocational Rehabilitation or a Social Security office; in some cases, staff might assist individuals in filling out paperwork.

Between the late 1990s and 2013, the evolution of state programs in Vermont to assist young people underscores the idea of increasing support for and contact with young people who might be struggling. Vermont received a waiver in 1994 that delayed changes required by federal TANF requirements until 2001. At that time, the former welfare program was replaced by the Reach Up program to provide income support to low-income families with children. New federal rules in 2005 required greater work participation, and the Vermont legislature created two new welfare programs in 2007 to provide temporary financial aid to some families and food assistance, work supports, and case management to low-income employed families or families who receive Food Stamp benefits as they transition from public assistance. In 2010, Vermont implemented a Youth in Transition (YIT) grant to improve the system of care for Vermont young people ages 16 through 21 as they transition to adulthood. YIT creates an array of specialized mental health and other services in cooperation with a large number of state and local partners.

Additional evidence for state and community support comes from SSDI allowance (acceptance) rates. In federal fiscal year 2014, the Vermont Office of Disability Determination Services (DDS) had an initial claim allowance rate of 42.5 percent—10.2 percentage points higher than the national average.[12] Vermont also had the fourth highest audit performance on initial allowances, suggesting that the allowances follow the program rules. The high allowance rate

[12] The Vermont Department for Children and Families, "Outcomes for Vermonters," January 2015. http://dcf.vermont.gov/sites/dcf/files/pdf/reports/budget/DCF_Outcomes.pdf

suggests that the legal and medical communities work closely with other support agencies to prepare strong SSDI applications.

Vermont officials confirm that, relative to other states, Vermont provides a higher concentration of state and local services that help potential applicants learn about and apply for SSDI benefits. It is clear that many Vermonters are in contact with professionals who know about the program, and many receive help from the state during the sometimes arduous application process.

Out-migration of able-bodied young people

Many rural states experience out-migration of young people who are looking for the job opportunities and social environments that come with urban settings. Despite a large in-migration of college students, Vermont in particular has fewer young people in their 20s and 30s relative to the U.S. population as a whole. In 2005 and again in 2013, the number of Vermonters age 25, for example, was smaller than the number of Americans age 25 if the U.S. population were shrunk proportionately to equal the Vermont population (see Figure 4). In 2005, the number of Vermonters at age 25 was about 2,500 or 27 percent lower than the age distribution of the U.S. population. The difference in 2013 at age 25 was about 16 percent. At age 40, however, the difference in Vermont had decreased to less than 1 percent in 2005; in 2013, the difference at age 45 was less than 2 percent.

At the same time, Vermont has an older population than the U.S. as a whole. In 2005, Vermont had 15 percent more people at age 50 than the age distribution of the U.S. population and almost 18 percent more people at age 65. In 2013, Vermont had 10 percent more people than the age distribution of the U.S. population at age 50 and 24 percent more people at age 65.

If able-bodied people in their 20s and 30s are more likely to live outside Vermont to find jobs and establish careers, those who stay behind may be more likely to qualify for the SSDI program. Some evidence for that hypothesis comes from The Vermont Roots Migration Project, a comprehensive collection of about 3,700 individual perspectives on Vermont from present and former residents.[13] Those who left the state of Vermont identify a range of factors for leaving, including jobs, ability to earn higher wages elsewhere, and more culturally diverse communities. If jobs and higher wages elsewhere are encouraging young people to leave Vermont, the proportion of those less able to pursue such opportunities, including young people who are struggling with physical and mental impairments, may be higher than in states with less out-migration of young people.

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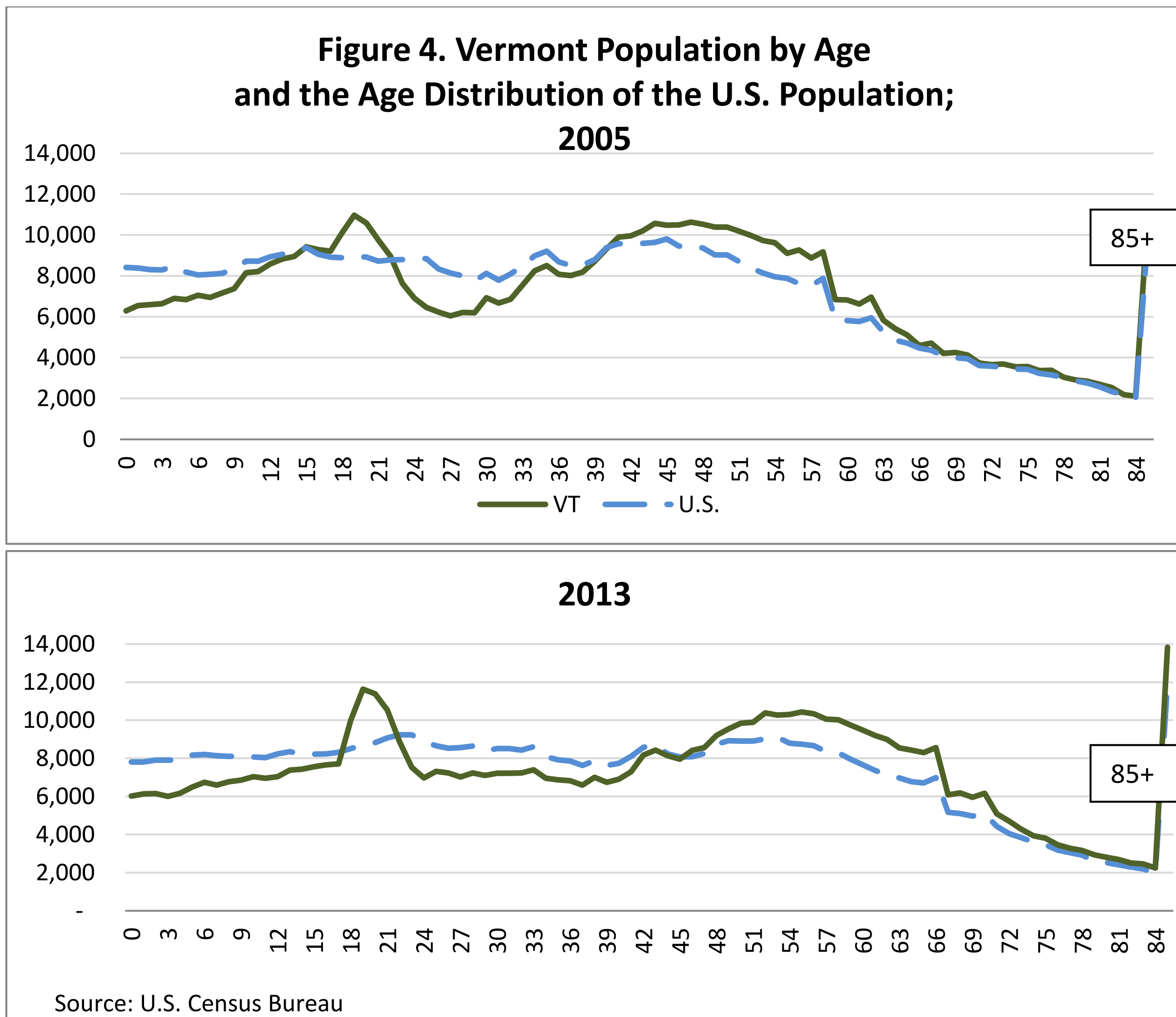
[13] Cheryl Morse and Wendy Geller, *The Vermont Roots Migration Project*, Center for Research on Vermont, The University of Vermont, May 2015, No. 1. http://www.uvm.edu/~crvt/reports/vt_migration_final.pdf

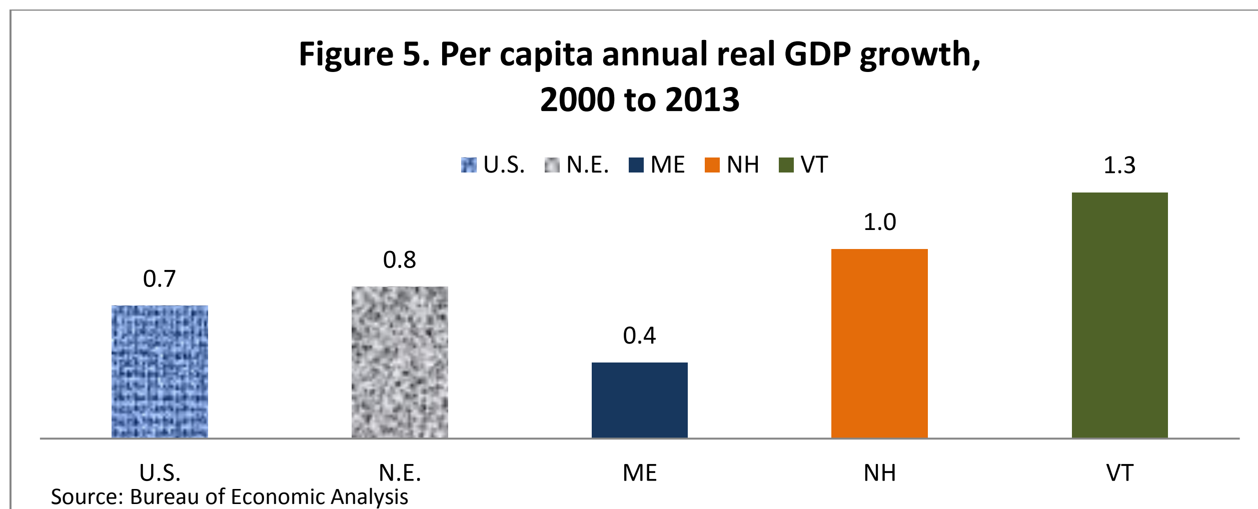


A similar story, but focused on in-migration rather than out-migration, may apply to older people. In both 2005 and 2013 Vermont had a higher proportion of people above age 45 than the U.S. as a whole and a lower proportion of people ages 55 to 65 on the SSDI program. If people migrate to Vermont at older ages for outdoor recreation and physically demanding pursuits, they could be less likely to qualify for the SSDI program.

Business cycle conditions such as poor economic growth and high unemployment rates are known to increase the likelihood of applying for SSDI benefits.[14] Looking at real GDP growth per capita in the northern New England states during the period from 2000 to 2013 removes poor

[14] Liebman, Jeffrey B. 2015. "Understanding the Increase in Disability Insurance Benefit Receipt in the United States." *Journal of Economic Perspectives*, 29(2), Spring 2015: 123-50.

economic growth as a reason for high SSDI prevalence in the case of Vermont and New Hampshire, however. Only Maine had average real per capita growth (0.4%) smaller than the national average (0.7%) (see Figure 5). Vermont's unemployment rate has generally been below the national average as well. In 2013, for example, Vermont's unemployment rate was 4.4 percent and the national average was 7.4 percent.[15] In 2005, Vermont's rate was 3.5 percent and the national average was 5.1 percent.



Out-migration can explain some of the high prevalence rate among Vermonters ages 22 to 34 but cannot explain all the difference from the national average. If the number of Vermonters ages 22 to 34 increased to equal the number in the age distribution of the U.S. population in 2013, but none of the extra adults received SSDI benefits, Vermont's prevalence rate would drop to 1.80 percent, or about one-quarter of the distance to the national average. However, that rate would still be higher than the rate for the fourth-highest state in the country. Among older Vermonters, however, reducing the number of adults ages 55 to 65 to match the normalized U.S. population without changing the number of SSDI beneficiaries would raise Vermont's prevalence rate to match the national average.

Lack of diversity in types of jobs available and poor transportation options in rural areas may also encourage young people to either leave the state or apply for SSDI benefits. For example, total nonfarm employment in Vermont in May 2015 was about 311,000 in a state with about 626,000 people. Within some specific industries, the number of employment opportunities was quite limited. Only 700 jobs existed in the mining and logging industry, for example, suggesting that if a person lost a logging job in one region of Vermont and had no means of transportation,

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[15] Vermont Department of Labor, Economic & Labor Market Information, http://www.vtlmi.info/Labforce.cfm?qperiodyear=2013&qareatype=01&qadjusted=N; U.S. Bureau of Labor Statistics. http://data.bls.gov/pdq/SurveyOutputServlet.

it might be extremely difficult to find another logging job in Vermont.[16] Similarly, 3,200 retail jobs existed in general merchandise stores with limited opportunities in any one geographical area if a store were to close.

Wages paid for comparable jobs tend to be lower in Vermont than those in neighboring states as well. For example, elementary school teachers other than special education earned $54,260 on average in Vermont in 2014.[17] In the neighboring states of Massachusetts and New York, similar teachers earned $69,890 and $74,830. Radiologic technologists earned $57,890 on average in Vermont in 2014 but $66,280 in Massachusetts and $70,010 in New York.

Rising opiate addiction among young people

In 2010-2011, about 4.5 percent of Vermonters age 12 or older reported that they had used illicit drugs other than marijuana during the past month. That rate is the highest in the country; the rate was 3.3 percent in the United States as a whole and 2.9 percent in Utah, where illicit drug use was the lowest.[18] In New Hampshire the rate was 4.0 percent; it was 3.2 percent in Maine. Among Vermonters ages 18 to 25, the rate was 11.4 percent in 2010-2011, again the highest rate in the country. A rise in opioid overdoses and deaths from opioid abuse led to a June 2014 meeting of the New England governors to devise a regional strategy to combat the problem. Between 1999 and 2002, 85 Vermonters died from opiate overdoses; between 2009 and 2012, 182 Vermonters died from opiate overdoses.[19]

Greater awareness of the opiate issue since 2000 in Vermont has led to big increases in resources devoted to treatment, and the number of treatment admissions has risen substantially. As noted by Vermont Governor Peter Shumlin in his January 2014 State of the State speech, treatment for all opiates statewide increased more than 770 percent between 2000 and 2012.[20] Non-heroin opiate treatment admissions in Vermont for substances such as morphine, OxyContin, and methadone increased more than 1200 percent from 2000 to 2012 (see Table 1).[21] In addition, opioid-related inquiries accounted for the highest percentage of all

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[16] Vermont Department of Labor, Labor Market Information; http://www.vtlmi.info/ces.cfm
[17] Bureau of Labor Statistics, Occupational Employment Statistics, May 2014. http://www.bls.gov/oes/current/oessrcst.htm.
[18] Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. 2010-2011 Surveys from the Substance Abuse and Mental Health Services Administration. http://archive.samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/index.aspx
[19] The University of Vermont, James M. Jeffords Center's Vermont Legislative Research Service. "Addressing Opiate Overdose Problems," April 2013. http://www.uvm.edu/~vlrs/Health/Opioid.pdf
[20] http://governor.vermont.gov/newsroom-state-of-state-speech-2014
[21] http://wwwdasis.samhsa.gov/teds08/TEDS2k8Sweb.pdf , http://www.samhsa.gov/data/sites/default/files/2012QuickStatisticsTables%20/ME12.htm , http://www.samhsa.gov/data/sites/default/files/2012QuickStatisticsTables%20/VT12.htm ,

substance abuse-related nonemergency information calls to the Northern New England Poison Center hotline from 2005 through 2010.[22] During this period, the majority of opioid-related calls to the hotline, which serves northern New England, were for incidents involving oxycodone products; hydrocodone and morphine products accounted for the second- and third-highest number of calls.

Table 1. Opiate Treatment Admissions in Northern New England and the U.S., 2000 to 2012

	2000	2004	2008	2012	Percentage Increase, 2000-2012
Primary Heroin Admissions per 100,000 aged 12+					
Vermont	84	100	99	203	142%
Maine	47	106	111	139	196%
New Hampshire	41	70	68	67	63%
U.S.	119	109	110	111	-7%
Primary Non-Heroin Opiate Admissions per 100,000 aged 12+					
Vermont	33	100	331	444	1245%
Maine	71	167	386	438	517%
New Hampshire	7	22	61	75	965%
U.S.	12	25	45	67	458%
Total Opiate Admissions					
Vermont	117	200	430	647	453%
Maine	118	273	497	577	389%
New Hampshire	48	92	129	142	195%
U.S.	131	134	155	178	36%

Source: Treatment Episode Data Set (TEDS).

Over a similar time period (2002-2013), the Centers for Disease Control reported an increase of 109 percent in heroin use among young people ages 18 to 25.[23] A 2010 Treatment Episode Data Set (TEDS) report shows the highest rates of substance abuse treatment admissions for heroin and non-heroin opiates to be for men and women in their 20s, a rate that is about four times

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http://wwwdasis.samhsa.gov/webt/quicklink/US12.htm ,
http://www.samhsa.gov/data/sites/default/files/2012QuickStatisticsTables%20/NH12.htm

[22] U.S. Department of Justice, "New England High Intensity Drug Trafficking Area Drug Market Analysis 2011." September 2011. http://www.justice.gov/archive/ndic/dmas/New_England_DMA-2011(U).pdf. The NE HIDTA region comprises 13 counties in six states. The largest cities in those counties include three in Connecticut, six in Massachusetts, and Portland, Maine; Manchester, New Hampshire; and Burlington, Vermont. About 61 percent of the New England population lives in the HIDTA region. Primary distribution hubs are in the Hartford (CT)/Springfield (MA) and Lowell/Lawrence (MA) areas.

[23] http://www.cdc.gov/vitalsigns/heroin/infographic.html#graphic

larger than that for people in their 40s.[24] Thus, it is quite possible that much of the increase in opiate abuse treatment admissions in northern New England since 2000 has been due to increased opiate abuse among young people. However, those data are not available.

Many individuals suffering from substance abuse experience an onset or worsening of one or more mental disorders. The correlation is even stronger for substances as heavily addicting and harmful as opiates. Mental disorders most commonly associated with substance abuse are schizophrenia and bipolar, depressive, anxiety, conduct, and personality disorders.[25]

According to the Social Security Administration, substance addiction is a qualifying mental disorder for SSDI if an individual experiences "behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system," both of which often accompany opiate addiction.[26] However, when the onset or worsening of a mental disorder is brought about by substance abuse, the case is evaluated as if the disorder were not substance related (for example, an anxiety disorder brought about by substance abuse is evaluated as a naturally occurring case of anxiety). Some qualifying disorders related to substance addiction are depressive syndrome and anxiety, personality, and organic (arising from a medical or physical disease) mental disorders.

In 2013, 45 percent of SSDI beneficiaries in Vermont qualified based on mental disorders.[27] Between 2000 and 2013 in the northern New England states, the percentage increase in the number of SSDI beneficiaries who qualified based on mental disorders was significantly larger than percentage increases in the overall number of SSDI beneficiaries. In the U.S. as a whole, however, the increase in SSDI beneficiaries who qualified based on mental disorders was a bit smaller than the overall increase (see Table 2).

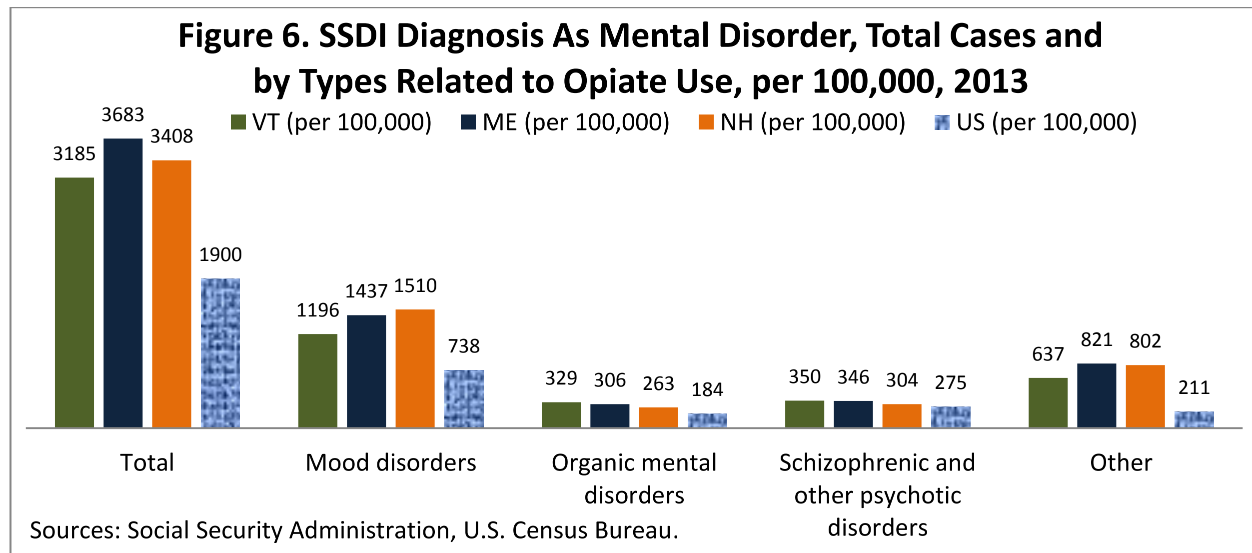
[24] http://www.samhsa.gov/data/sites/default/files/WebTEDSNational2010/TEDS2010NWeb.pdf, pages 15-16
[25] http://www.mtregis.com/opiates/effects-signs-symptoms
[26] http://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm#12_05
[27] 2013 source: http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/sect01b.html#table10; 2000 source: http://www.ssa.gov/policy/docs/statcomps/di_asr/2000/sect04a.html

Table 2. SSDI Beneficiaries based on Diagnosis: Mental Disorders and Overall

	Number of Beneficiaries with Primary Diagnosis Mental Disorders		Percentage of Beneficiaries with Primary Diagnosis Mental Disorders	Percent Increase in Number on SSDI for All Mental Disorders	Percent Increase in Overall Number on SSDI
	2000	**2013**	**2013**	**2000-2013**	**2000-2013**
VT	5,505	11,663	45.2	112	81
ME	15,562	28,829	42.8	85	69
NH	10,457	26,810	49.9	156	111
U.S.	1,982,620	3,488,004	34.1	76	78

Sources: Social Security Disability Program, U.S.Census Bureau

In 2013, SSDI prevalence for mental disorders potentially related to substance abuse was significantly higher in northern New England than nationwide (see Figure 6). As noted earlier, mental disorders potentially related to substance abuse include mood disorders such as depressive and bipolar disorders; organic mental disorders such as decreased mental function due to physical disease or caused by drug withdrawal; and other types that include anxiety-related disorders. Nationwide, 17 percent of new awards overall but 48 percent of new awards to people under the age of 35 were made on the basis of mental disorders in 2013. [28] Just 9 percent of awards to people age 50 to 65 were for mental disorders in that year.



Furthermore, the discrepancy of total mental disorder prevalence between northern New England and the U.S. average was significantly larger in 2013 than in 2000 (see Table 3). For instance, the proportion of SSDI beneficiaries who qualified on the basis of mental disorders in

[28] Annual Statistical Report, Table 44.

Vermont in 2013 was 68 percent greater than for the country as a whole. In 2000, the proportion was just 39 percent greater.

Thus, it is quite possible that some young people addicted to opiates throughout northern New England become mentally impaired (or their impairment worsens) and become SSDI beneficiaries under a qualifying mental disorder that is related to substance addiction, raising the prevalence rates for people under age 35 to disproportionately high levels. However, it is difficult to know how much of Vermont's increase in SSDI beneficiaries under age 35 from 2000 to 2013 (an increase of 1,000) can be attributed to increased opiate use. According to a comprehensive Vermont survey for 2014, about 10 percent of Vermonters (62,751) received mental health services in a 12-month period, and one percent (6,618) received substance abuse treatment (reference 2014 VT Household Survey).[29] Even if half of those receiving treatment were between ages 18 and 35 and 5 percent of those suffered such serious effects that they applied for SSDI, only about 150 people would apply in any year.

Table 3. Northern New England Diagnosis of Mental Disorder Compared to U.S., 2000 and 2013

	Amount by Which Prevalence of Mental Disorder Diagnosis in ME, NH, and VT Exceeds U.S. Prevalence	
	2000	**2013**
VT	39%	68%
ME	84%	94%
NH	23%	79%

Sources: Social Security Administration, U.S. Census Bureau.[30]

Relatively high rates of health insurance coverage among young people

High rates of health insurance coverage in Vermont and other New England states imply that young people are more likely to see health care professionals who might refer them to the SSDI program. Survey results released earlier this year indicate that the uninsured rate in Vermont matched the uninsured rate in Massachusetts in 2014: just 3.7 percent of the population in each state had no health insurance coverage in 2014.[31] Little comparative information exists for all New England states. A Gallup poll conducted from January through December 2014 reports rather different uninsured rates for Vermont (7.4 percent) and Massachusetts (4.6 percent),

[29] Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), 2014.
[30] http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/sect01b.html#table10, http://www.ssa.gov/policy/docs/statcomps/di_asr/2000/sect04a.html
[31] Vermont Legislative Joint Fiscal Office, "The 2014 Uninsured Rate in Vermont Matches That of Massachusetts at 3.7 Percent, Surveys Show," May 2015. http://www.leg.state.vt.us/jfo/healthcare/Uninsured_Rate_in_Vermont_and_Massachusetts.pdf. The 2014 Vermont Household Health Insurance Survey reports the uninsured rate for adults ages 18a to 64 was 5.4 percent. http://hcr.vermont.gov/vhhis.

suggesting a sampling method not comparable to those used in the more comprehensive surveys cited above.[32] The other New England states show uninsured rates in that poll as follows: Connecticut, 6.0 percent; Maine, 11.6 percent; New Hampshire, 12.8 percent; and Rhode Island, 9.4 percent. The overall uninsured rate for adults ages 18 to 64 was about 17.5 percent in 2013 and about 13.5 percent in 2014, reinforcing the idea that northern New England states have relatively low uninsured rates.[33]

Moreover, Vermont's uninsured rate has dropped significantly since 2000. In 2005, for example, the uninsured rate in Vermont was 9.8 percent. The uninsured rate began dropping after the state's insurance subsidy program for low-income people, known as Catamount Health, was offered in the fall of 2007. Catamount Health was replaced by premium subsidies and cost-sharing as part of the transition to the Affordable Care Act in 2014.

Other reasons may help to explain the high prevalence rates in northern New England as well. A number of people who work with SSDI applicants pointed to intergenerational poverty as a factor. An analysis by researchers at the Center for Retirement Research at Boston College found that demographic, health, and employment characteristics of a state have the greatest effect on state-level variations in SSDI application rates overall, explaining over 70 percent of the variation.[34] State policy that encourages mandated employer-sponsored disability insurance (also known as temporary disability insurance or TDI) has a small negative effect on overall SSDI applications. Further, state changes in health insurance regulation that impose guaranteed issue and community rating are negatively correlated with the SSDI application rate.

Discussion

Why should Vermont policymakers and citizens be concerned about the increase in the prevalence of young people on the SSDI program? First, many analysts are concerned about the rapid growth in the SSDI program nationwide in recent decades.[35] Increasing numbers of working-age people on the SSDI program imply fewer people in the labor force, often for many years into the future, and more people who rely on income support from the government. Individuals who receive SSDI benefits cannot work more than a minimal amount before losing their benefits, so they are limited in terms of job readiness as well as in how much they can

[32] Gallup-Healthways Well-Being Index, 2014. Accessed at http://www.pressherald.com/2015/02/24/number-ofmainers-without-health-insurance-plummets-poll-finds/

[33] Health Reform Monitoring Survey.

[34] Coe, Norma B., Kelly Havestick, Alicia H. Munnell, and Anthony Webb, "What Explains State Variation in SSDI Application Rates?" Center for Retirement Research at Boston College, December 2011.

[35] Again see Liebman 2015. In addition, the White House just released a report on SSDI: *Social Security Disability Insurance: A Lifeline for American Workers and Families*, July 2015, https://www.whitehouse.gov/sites/default/files/docs/ssdi_national_report_7-17-2015.pdf

contribute to the economy. Rather than being productive workers, they are recipients of transfer payments from the federal government. For some people, that path is the right one. But others might benefit from not relying on government support.

Second, the SSDI program as currently structured is not financially sound. Benefit payments come from a Disability Insurance trust fund that is projected to be exhausted by the end of calendar year 2016.[36] At that point, it is likely that transfers to the Disability Insurance trust fund will be made from the Old-Age and Survivors Insurance trust fund, a fund that itself is likely to become insolvent by 2031. Once the trust funds are exhausted, revenues are projected to drop to 81 percent of scheduled outlays, suggesting that benefits could be 19 percent less than promised unless Congress acts. Medicare is also on shaky financial ground with a significant portion of Medicare spending already coming from the general federal budget that is partially deficit-financed.[37]

Third, the state misses out on state income taxes and a boost to the state's economy when an individual becomes an SSDI beneficiary and is no longer a worker. Many states exempt SSDI benefits entirely; in Vermont, a portion of SSDI benefits is taxed only if total income exceeds a limit.[38] In addition, earned incomes from wages contribute to national income; transfer payments do not. It is true that cash benefits can be used to purchase goods and services, but the initial boost to national income does not occur. A preliminary estimate assuming that an SSDI beneficiary who worked would have paid an additional 40 percent of the median income tax payment for his or her age group suggests that Vermont would have received about $3 million more in state income tax revenue in 2013 if the prevalence rates for people under age 55 had risen with the national average by age group rather than at the faster actual rates. Such losses recur year after year once a person qualifies for SSDI benefits because few people leave the program for reasons other than reaching the full retirement age (66) and converting to Old-Age benefits or death. In 2013 in Vermont, for example, 7.7 percent of disabled worker beneficiaries had benefits terminated.[39] The majority of the terminations occurred when beneficiaries reached age 66 and converted to Old-Age benefits.

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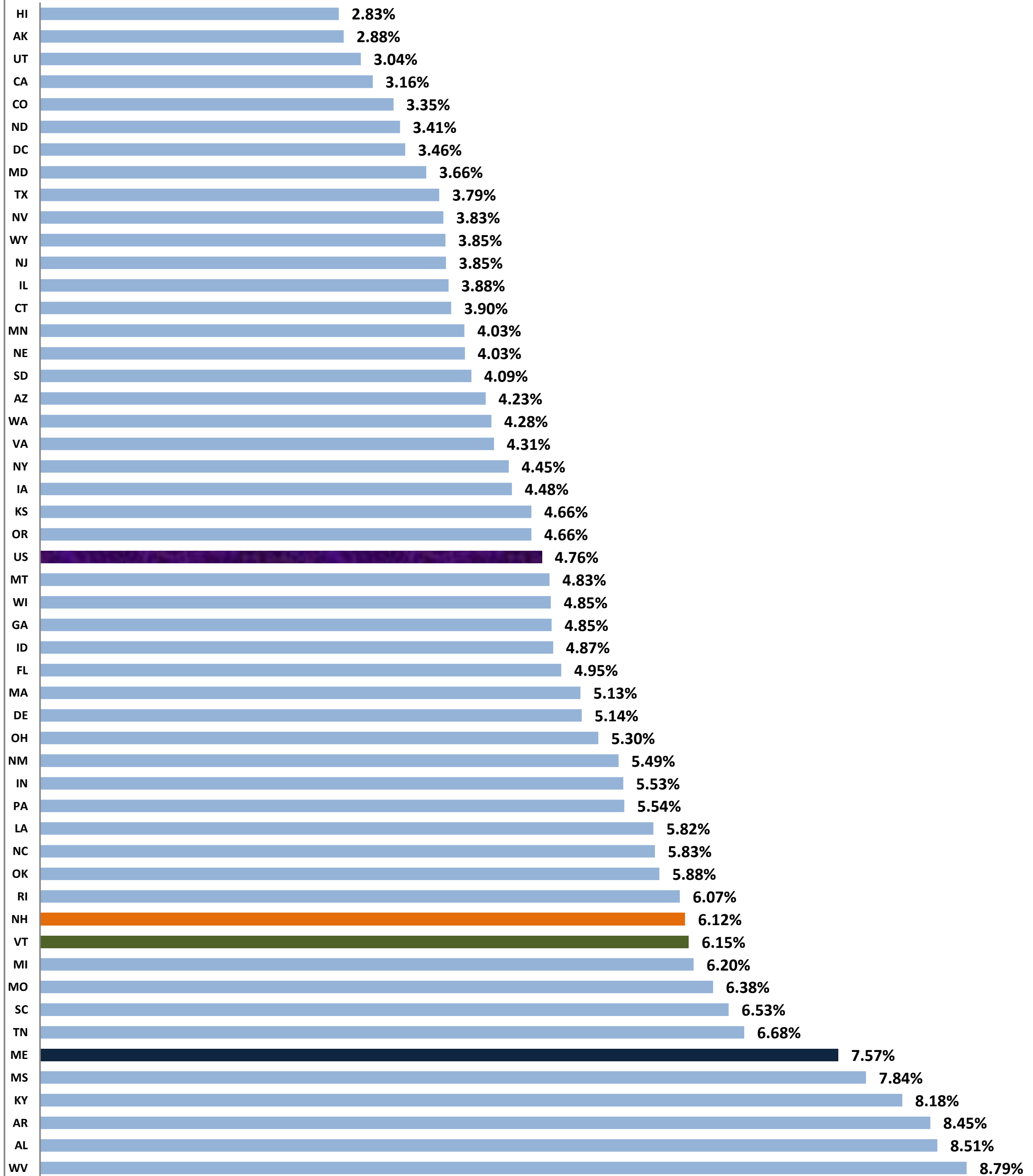
[36] *The 2015 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, http://ssa.gov/oact/TR/2015/tr2015.pdf

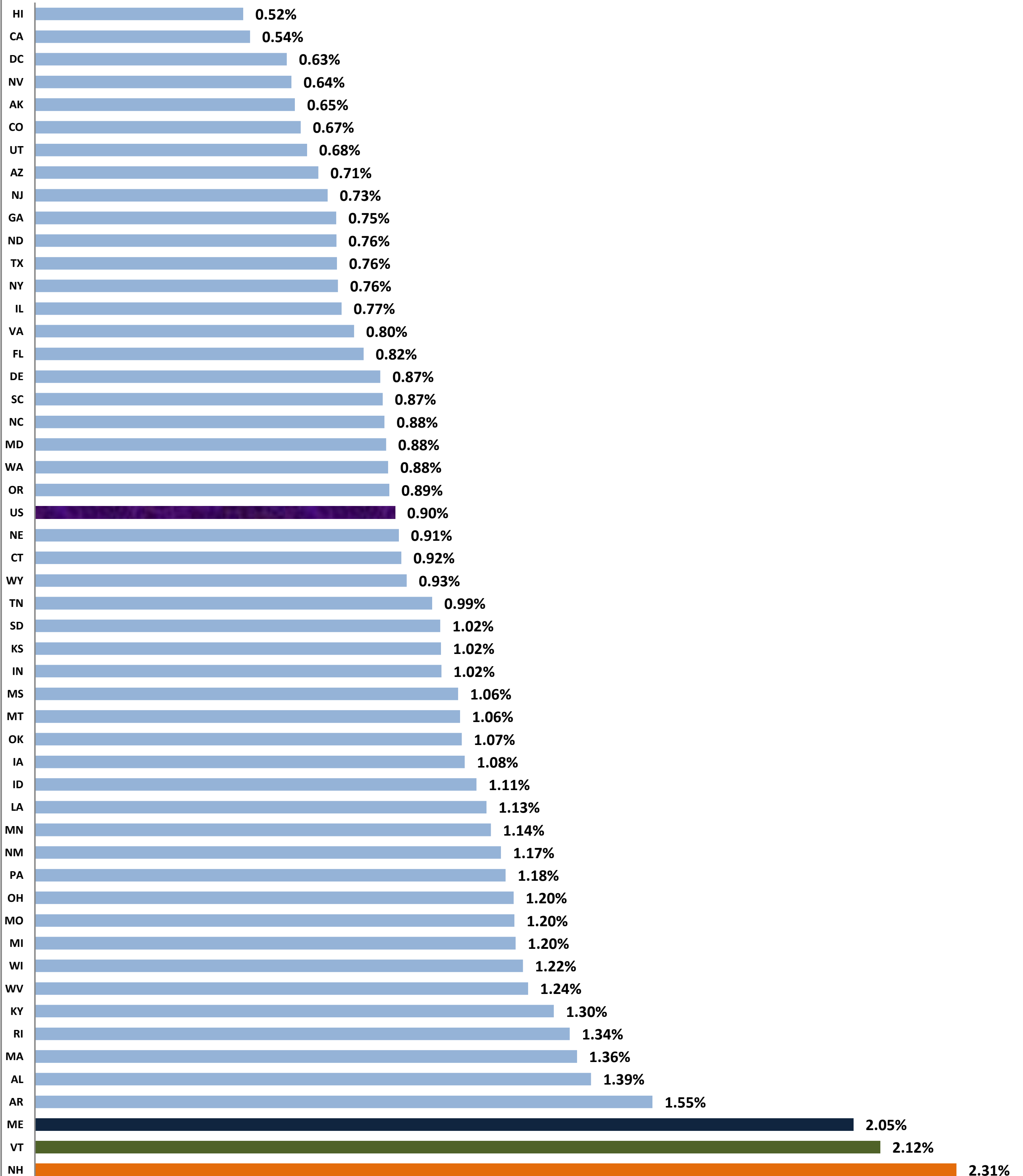
[37] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2015.pdf

[38] Vermont follows the federal rules for taxing SSDI benefits. For a single person, 50 percent of the benefit is subject to state income tax if total income is greater than $25,000 but less than $34,000; 85 percent of the benefit is taxed if income exceeds $34,000. If married filing jointly, the thresholds are $32,000 and $44,000.

[39] Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program, 2013*. Table 51. Table 50 shows that for the U.S. as a whole in 2013, 59 percent of terminations occurred when the beneficiary turned age 66, and 33 percent of terminations occurred following the death of the beneficiary. About 2 percent of beneficiaries lost benefits because they no longer met the medical standards, and about 4 percent lost benefits because they earned too much.

Recognizing the relatively high rates of young people on the SSDI program may provide more reasons to invest in enhancing job opportunities and work supports as well as strengthening educational opportunities and policies that will alleviate drug abuse and keep people off the program. In addition, policymakers may want to ask whether more can be done to help people already on the SSDI program move beyond that reliance and return to the work force.


Appendix Figure 1. SSDI Prevalence, All Ages; 2013
HI 2.83%
AK 2.88%
UT 3.04%
CA 3.16%
CO 3.35%
ND 3.41%
DC 3.46%
MD 3.66%
TX 3.79%
NV 3.83%
WY 3.85%
NJ 3.85%
IL 3.88%
CT 3.90%
MN 4.03%
NE 4.03%
SD 4.09%
AZ 4.23%
WA 4.28%
VA 4.31%
NY 4.45%
IA 4.48%
KS 4.66%
OR 4.66%
US 4.76%
MT 4.83%
WI 4.85%
GA 4.85%
ID 4.87%
FL 4.95%
MA 5.13%
DE 5.14%
OH 5.30%
NM 5.49%
IN 5.53%
PA 5.54%
LA 5.82%
NC 5.83%
OK 5.88%
RI 6.07%
NH 6.12%
VT 6.15%
MI 6.20%
MO 6.38%
SC 6.53%
TN 6.68%
ME 7.57%
MS 7.84%
KY 8.18%
AR 8.45%
AL 8.51%
WV 8.79%
Sources: Social Security Administration, U.S. Census Bureau.



Sources: Social Security Administration, U.S. Census Bureau.

Appendix Table 1. Number and Prevalence Rate of Disabled Worker Beneficiaries in Maine, New Hampshire, and Vermont; 2013

	Resident Population, Ages 22-65	Disabled Worker Beneficiaries	Prevalence Rate
Total			
U.S.	183,553,361	8,738,944	4.80%
ME	782,816	59,274	7.57%
NH	786,636	48,139	6.12%
VT	366,179	22,534	6.15%
Under Age 35			
U.S.	56,625,641	507,040	0.90%
ME	196,662	4,031	2.05%
NH	199,386	4,601	2.31%
VT	95,280	2,017	2.12%
Ages 35-44			
U.S.	40,452,690	1,009,865	2.50%
ME	158,124	8,299	5.25%
NH	162,156	6,790	4.19%
VT	72,987	3,007	4.12%
Ages 45-54			
U.S.	43,767,532	2,404,733	5.49%
ME	205,341	17,633	8.59%
NH	215,035	14,295	6.65%
VT	94,354	6,411	6.79%
Ages 55-65			
U.S.	42,707,498	4,817,306	11.28%
ME	222,689	29,311	13.16%
NH	210,059	22,453	10.69%
VT	103,558	11,099	10.72%

Note: Vermont had 11,513 beneficiaries on SSI, ages 18 to 64, in December 2013.

Source: http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2013/ssi_asr13.pdf, Table 10.

Appendix Table 2. Structure of Vermont's Agency of Human Services