



**Congressional
Research Service**

Informing the legislative debate since 1914

Social Security Disability Insurance (SSDI) Reform: An Overview of Proposals to Manage the Growth in the SSDI Rolls

(name redacted)

Analyst in Income Security

January 9, 2015

Congressional Research Service

7-....

www.crs.gov

R43054

Summary

Social Security Disability Insurance (SSDI) provides benefits to nonelderly workers with certain disabilities and their eligible dependents. As in Old-Age and Survivors Insurance (OASI)—Social Security’s retirement program—SSDI benefits are based on a worker’s past earnings. To qualify, individuals must have worked and paid Social Security taxes for a certain number of years and be unable to engage in *substantial gainful activity* (SGA) due to a severe mental or physical impairment that is expected to last for at least one year or result in death. In 2015, the monthly SGA earnings limit for most individuals is \$1,090. In general, disabled workers must be unable to do any kind of substantial work that exists in the national economy, taking into account age, education, and work experience.

Recently, some Members of Congress and the public have expressed concern over the growth in the SSDI program. Between 1980 and 2013, the number of disabled workers and their dependents more than doubled, rising from 4.7 million to 11.0 million. This increase has placed pressure on the Disability Insurance (DI) trust fund, from which SSDI benefits are paid. Over the same period, spending on benefits increased by more than 50%, from 0.54% of gross domestic product (GDP) in 1980 to 0.84% of GDP in 2013. Without legislative action, the DI trust fund is projected to be depleted by the end of 2016. After that, ongoing tax revenues would be sufficient to pay about 80% of scheduled benefits.

Most researchers agree that changes in the demographic characteristics of the working-age population account for a large share of the growth in the number of individuals on SSDI. Demographic changes consist of (1) the aging of the baby boomers, (2) the influx of women into the labor force, and (3) the overall growth in the working-age population. However, there is considerable disagreement among researchers over how much non-demographic factors contributed to the growth. Non-demographic factors include (1) changes in opportunities for work and compensation (e.g., slow wage growth for low-skilled workers and high unemployment), (2) changes in federal policy that made it easier for some people to qualify as disabled, and (3) the rise in the full retirement age for unreduced Social Security retirement benefits. In general, people who support higher spending on SSDI focus on changes in the demographic characteristics of workers. In contrast, individuals who want to limit program spending typically focus on the effect of changes in the economic incentives to apply for SSDI and legislative changes to the program’s eligibility criteria.

To assist lawmakers in addressing the sustainability of the program, this report provides an overview of proposals to manage the long-term growth in the SSDI rolls. Most of the proposals focus on reducing the inflow (enrollment) of new beneficiaries into the program. These proposals involve (1) tightening eligibility criteria, (2) improving the administration of the program, and (3) providing incentives for employers to help keep employees working when they become disabled. On the other hand, some of the proposals seek to increase the outflow (termination) of beneficiaries from the program. These proposals entail (1) providing stronger incentives for beneficiaries who can work to return to the labor force, and (2) increasing the number of periodic continuing disability reviews, which stop benefits for people found to be no longer disabled. This report does not examine options to reduce benefit levels or increase program revenues.

Although many of the options discussed in this report have the potential to slow or even reverse the growth of SSDI receipt and thus generate savings to the program over the longer term, such proposals are highly unlikely to significantly forestall the projected exhaustion of the DI trust fund. To avoid a 20% cut in benefits in late 2016, lawmakers would almost certainly have to use cash infusions to bolster the assets of the DI trust fund. For example, Congress could reallocate the Social Security payroll tax rate to give the DI trust fund a larger share (as was done in 1994),

or it could authorize interfund borrowing from the OASI trust fund or Medicare's Hospital Insurance (HI) trust fund. These short-term financing options would give lawmakers more time to develop and implement some of the longer-term proposals mentioned in the report if they wished to slow the growth in the disability rolls.

Contents

Introduction	Error! Bookmark not defined.
Background on SSDI	2
Eligibility	2
Benefits	3
Determination and Adjudication Process	3
Trends in the SSDI Program Since 1980	4
Enrollment	4
Termination	5
Program Size	8
Prevalence Rates	9
Causes of the Growth in the SSDI Rolls	10
Changes in the Demographic Characteristics of Insured Workers	11
Growth in the Working-Age Population	11
The Influx of Women into the Labor Force	12
The Aging of the Workforce	13
Changes in Opportunities for Work and Compensation	15
High Unemployment	15
The Value of Cash Benefits	16
The Value of Health Coverage	18
Changes in Federal Policy	19
The Social Security Amendments of 1983	20
The Social Security Disability Benefits Reform Act of 1984	21
Other Potential Factors	26
Changes in the Health of the Working-Age Population	26
Variation in the Disability Determination and Appeals Process	27
Reform Proposals	28
Tighten Eligibility Criteria	29
Eliminate Eligibility for SSDI Benefits at Age 62 or Later	29
Increase the Recency-of-Work Requirement	30
Adjust the Age Categories for Vocational Factors	31
Improved Administration of the Program	32
Permit SSA to Be Represented at the Hearing Level of the Appeals Process	32
Update SSA’s Listing of Impairments	36
Update SSA’s Occupational Information System	38
Increase the Number of Full Medical CDRs Conducted by SSA	39
Return-to-Work Incentives	43
Increase Awareness of Return-to-Work Services	44
Benefit Offset	45
Promote Supported-Work Policies	47
Experience Rate the Employer’s Portion of the Payroll Tax Rate	48
Employer-Sponsored Private Disability Insurance	49

Figures

Figure 1. SSDI Applications, Awards, and Incidence (Enrollment) Rates, 1980-2013	5
--	---

Figure 2. Disabled-Worker Beneficiary Termination Rates, 1980-2013 6
Figure 3. Number of Full Medical CDRs Conducted by SSA, FY1990-FY2014..... 8
Figure 4. SSDI Beneficiaries, by Type, 1980-2013 9
Figure 5. Gross and Age-Sex-Adjusted Prevalence Rates, 1980-2013 10
Figure 6. Growth in the Population Aged 20-64, 1980-2013 11
Figure 7. Percentage of the Population Ages 15-64 Insured for Disability, by Sex, 1980-2014..... 12
Figure 8. Age-Adjusted Incidence (Enrollment) Rates by Sex, 1980-2013 13
Figure 9. Percentage Distribution of SSDI Awards, by Age, 1980-2013 14
Figure 10. SSDI Applications and Awards During Economic Downturns, 1980-2013..... 16
Figure 11. Percentage Distribution of SSDI Awards, by Diagnostic Group, 1981-2013 24
Figure 12. SSDI Incidence Rates, by Diagnostic Group, 1981-2013..... 25
Figure 13. Basis for Decision of Initial SSDI Allowances, FY1980-FY2010..... 37
Figure 14. Full Medical CDR Backlog, FY2002-FY2013 41

Tables

Table 1. Hypothetical Disabled-Worker Replacement Rates at Age 55 17
Table 2. DDS Staffing, FY2008-FY2013 41

Appendixes

Appendix. Acronyms..... 53

Contacts

Author Contact Information **Error! Bookmark not defined.**

Introduction

Concern among some Members of Congress and the public over the financial sustainability of the Social Security Disability Insurance (SSDI) program has grown.¹ Under current law, the Federal Disability Insurance (DI) Trust Fund—which finances the benefits and administrative costs of the SSDI program—is projected to be exhausted by the fourth quarter of calendar year 2016.² If depleted, the DI trust fund would be able to pay about 80% of scheduled SSDI benefits.

The declining solvency of the DI trust fund is the result of an increasing imbalance between SSDI's income and outlays. Between 1980 and 2013, non-interest income to the DI trust fund (adjusted for inflation) increased 181%, while spending on benefits grew 219%.³ The increase in spending is due largely to the growth in the number of beneficiaries on SSDI. Over the same period, the number of disabled workers and their dependents more than doubled, rising from 4.7 million in 1980 to 11 million in 2013. Because benefit payments account for nearly all program spending, the growth in the SSDI rolls has contributed heavily to the financial difficulties of the DI trust fund.⁴

To assist lawmakers in addressing the sustainability of the program, this report provides an overview of reform proposals to manage the long-term growth in the SSDI rolls. The report is divided into four sections. The first section provides a brief background on SSDI, including program eligibility criteria, benefits, and the initial determination and adjudication process. The second section discusses the growth in the SSDI rolls since 1980 by examining historical entry and exit trends in the program. The third section investigates some of the causes of growth in SSDI, including changes in the demographic characteristics of the working-age population, changes in opportunities for work and compensation, and changes in federal policy. The fourth section examines various options to manage the growth in the SSDI rolls, namely, (1) stricter eligibility criteria, (2) improved administration of the program, (3) stronger return-to-work incentives, and (4) policies to encourage employers to help disabled workers continue to work.

Many of the options discussed in this report could reduce spending by slowing or even reducing the growth of SSDI over the long term; however, such options are unlikely to produce savings in time to prevent the projected exhaustion of the DI trust fund in 2016.⁵ For information on

¹ See, for example, U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *First in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, 112th Cong., 1st sess., December 2, 2011 (Washington: GPO, 2012), pp. 4-5, <http://www.gpo.gov/fdsys/pkg/CHRG-112hhrg76319/pdf/CHRG-112hhrg76319.pdf>. See also U.S. Congress, Senate Committee on Finance, *Social Security: A Fresh Look at Workers' Disability Insurance*, 113th Cong., 2nd sess., July 24, 2014, <http://www.finance.senate.gov/imo/media/doc/07242014%20Wyden%20Hearing%20Statement%20on%20Keeping%20the%20Promise%20of%20Social%20Security%20I.pdf>.

² U.S. Congress, House Committee on Ways and Means, *The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, prepared by Board of Trustees, Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, 113th Cong., 2nd sess., July 28, 2014, 113-139 (Washington: GPO, 2014), <http://www.ssa.gov/oact/tr/2014/index.html> (hereinafter cited as "2014 Trustees Report"). See also U.S. Congressional Budget Office (CBO), *Old-Age, Survivors, and Disability Insurance Trust Funds—CBO's April 2014 Baseline*, April 2014, <http://www.cbo.gov/publication/43890>. The Social Security trustees project that the DI trust fund will be exhausted in the fourth quarter of 2016 under their intermediate assumptions. Meanwhile, CBO estimates that the DI trust fund will be exhausted in early FY2017, which overlaps with the fourth quarter of calendar year 2016.

³ See Social Security Administration (SSA), "DI Trust Fund, A Social Security Fund," <http://www.ssa.gov/oact/STATS/table4a2.html>. Figures are in 2013 dollars.

⁴ *Ibid.* In 2013, benefit payments accounted for 98% of total outlays from the DI trust fund.

⁵ For actuarial memoranda on Social Security reform proposals that affect the solvency of the Old-Age and Survivors (continued...)

financing options to extend the solvency of the DI trust fund in the short term, see CRS Report R43318, *Social Security Disability Insurance (DI) Trust Fund: Background and Solvency Issues*, by (name redacted).

Background on SSDI

Enacted in 1956 under Title II of the Social Security Act, SSDI is part of the Old-Age, Survivors, and Disability Insurance (OASDI) program administered by the Social Security Administration (SSA).⁶ OASDI is commonly called Social Security. Like Old-Age and Survivors Insurance (OASI), SSDI is a form of social insurance that replaces a portion of a worker's earnings based on the individual's career-average earnings in jobs covered by Social Security.⁷ Specifically, SSDI provides benefits to insured workers under the full retirement age (FRA) who meet the statutory test of disability and to their eligible dependents.⁸ FRA is the age at which unreduced Social Security retirement benefits are first payable (currently 66).⁹ In November 2014, 10.9 million individuals received SSDI benefits, including 9 million disabled workers, 150,000 spouses of disabled workers, and 1.8 million children of disabled workers.¹⁰

Eligibility

To qualify for SSDI, workers must be (1) insured in the event of disability, and (2) statutorily disabled. To achieve insured status, individuals must have worked in covered employment (i.e., jobs covered by Social Security) for about a quarter of their adult lives before they became disabled and for at least five of the past 10 years immediately before the onset of disability.¹¹ However, younger workers may qualify with less work experience based on their age. In 2014, SSDI provided disability insurance to an estimated 151 million workers.¹²

To meet the statutory test of disability, insured workers must be unable to engage in any *substantial gainful activity* (SGA) because of a medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for at least one year.¹³ In 2015, the monthly SGA earnings limit is \$1,090 for most workers and \$1,820 for statutorily blind individuals. In general, workers must have a severe condition that prevents

(...continued)

Insurance (OASI) and DI trust funds, see SSA, Office of the Chief Actuary, "Proposals Affecting Trust Fund Solvency," <http://www.ssa.gov/oact/solvency/index.html>.

⁶ For more information on the OASDI program, see CRS Report R42035, *Social Security Primer*, by (name redacted).

⁷ SSA's Office of the Chief Actuary estimates that 165 million people worked in Social Security-covered employment in 2014. For more information, see SSA, *2014 Social Security/SSI/Medicare Information*, July 28, 2014, <http://www.ssa.gov/legislation/2014factsheet.pdf>.

⁸ For more information on the SSDI program, see CRS Report RL32279, *Primer on Disability Benefits: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)*, by (name redacted).

⁹ The FRA is currently 66; however, the FRA is scheduled to rise to 67 for workers born in 1960 or later. For more information, see CRS Report R41962, *The Social Security Retirement Age: In Brief*, by (name redacted).

¹⁰ SSA, "Monthly Statistical Snapshot, November 2014," December 2014, Table 2, http://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/ (hereinafter cited as "Monthly Statistical Snapshot").

¹¹ For more information, see SSA, "Benefits Planner: Number Of Credits Needed For Disability Benefits," accessed October 2014, <http://www.socialsecurity.gov/retire2/credits3.htm>.

¹² SSA, "Disabled Insured Workers," <http://www.ssa.gov/OACT/STATS/table4c2DI.html>.

¹³ 42 U.S.C. §423(d)(1) and 20 C.F.R. §404.1505.

them from doing any kind of substantial work that exists in the national economy, taking into account age, education, and work experience.

Benefits

Cash benefits begin five full months after a beneficiary's disability onset date.¹⁴ Initial benefits are based on a worker's career-average earnings, indexed to reflect changes in national wage levels (up to five years of the worker's low earnings are excluded).¹⁵ Benefits are subsequently adjusted to account for inflation through cost-of-living adjustments (COLA), as measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).¹⁶ However, benefits may be offset if a disabled worker also receives workers' compensation or other public disability benefits. In November 2014, the average monthly benefit was \$1,146 for disabled workers, \$309 for spouses of disabled workers, and \$343 for children of disabled workers.¹⁷

In addition to cash benefits, disabled workers and certain dependents are eligible for health coverage under Medicare after 24 months of entitlement to cash benefits (29 months after the onset of disability).¹⁸ In 2012, Medicare spending per disabled beneficiary averaged about \$9,900.¹⁹

Some SSDI beneficiaries may also qualify for Supplemental Security Income (SSI).²⁰ SSI provides cash payments to aged, blind, or disabled individuals with limited income and assets. Both programs are administered by SSA and use the same definition of disability; however, unlike SSDI, SSI has no work or contribution requirements. In most states, SSI recipients are automatically eligible for Medicaid.²¹ Over 1 million disabled workers ages 18-64 received both SSDI and SSI benefits in December 2013.²²

Determination and Adjudication Process

To apply for SSDI, an individual must first file an application with a local SSA field office. Applications that meet the work history and earnings requirements are then forwarded to a state

¹⁴ For additional information on the five-month waiting period, see CRS Report RS22220, *Social Security Disability Insurance (SSDI): The Five-Month Waiting Period for Benefits*, by (name redacted).

¹⁵ For more information on dropout years, see CRS Report R43370, *Social Security Disability Insurance (SSDI): Becoming Insured, Calculating Benefit Payments, and the Effect of Dropout Year Provisions*, by (name redacted).

¹⁶ See CRS Report 94-803, *Social Security: Cost-of-Living Adjustments*, by (name redacted).

¹⁷ Monthly Statistical Snapshot, Table 2. Benefits for spouses and children of disabled workers are also subject to certain maximum family benefit limits.

¹⁸ For more information, see SSA, "Medicare Information," accessed November 2014, <http://www.ssa.gov/disabilityresearch/wi/medicare.htm>. See also CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and (name redacted).

¹⁹ Centers for Medicare and Medicaid Services (CMS), *Medicare & Medicaid Statistical Supplement*, 2013 edition, Table 3.4, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/index.html>. Figure is *per enrollee* and includes disabled workers, disabled widow(er)s, disabled adult children, and individuals entitled to Medicare because of end stage renal disease only.

²⁰ See CRS Report RL32279, *Primer on Disability Benefits: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)*, by (name redacted).

²¹ See CRS Report R43357, *Medicaid: An Overview*, coordinated by (name redacted). Individuals enrolled in both Medicare and Medicaid are known as dual-eligible beneficiaries.

²² SSA, *Annual Statistical Report on the Social Security Disability Insurance Program, 2013*, December 2014, Table 66, http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/index.html (hereinafter cited as "SSA, SSDI Annual Report 2013").

Disability Determination Services (DDS) office for a medical determination. DDSs—state agencies that are fully funded by the federal government—decide whether applicants meet national disability standards established by SSA. State DDS examiners and medical and psychological consultants typically use medical evidence collected from the claimant’s *treating sources* (physicians, psychologists, or other acceptable medical sources) to determine the severity of the claimant’s impairment(s). If a claimant’s condition is determined to be severe and meets (or is of equal severity to) the medical criteria in SSA’s *Listing of Impairments*, the claimant is considered disabled and therefore eligible for SSDI. Claimants who do not meet the medical criteria in the listings proceed to a more individualized assessment that examines their residual functional capacity to perform any past relevant work or other work that exists in the national economy. If a claimant cannot perform such work, the claimant is awarded benefits.

Claimants whose initial applications are denied may appeal. During the appeals process, claimants may present additional evidence or arguments to support their case as well as appoint a representative to act on their behalf. The appeals process is composed of four stages: (1) reconsideration by a different examiner from the state DDS office, (2) a hearing before an administrative law judge (ALJ), (3) a review before the Appeals Council, and (4) filing suit against SSA in U.S. district court.²³ Almost all appeals reach the ALJ stage; few proceed to the Appeals Council or federal court.²⁴

Trends in the SSDI Program Since 1980

Definitions

Insured-Worker Population: The total number of workers who meet the work-history requirements for disability benefits (includes workers on SSDI).

Prevalence Rate: The ratio of the number of disabled-worker beneficiaries in current-payment status to the insured-worker population.

Disability-Exposed Population: The total number of workers who are insured but not currently receiving benefits (equal to insured-worker population minus workers on SSDI).

Incidence Rate: The ratio of the number of new disabled-worker beneficiaries awarded benefits each year to the disability-exposed population.

Enrollment

Between 1980 and 2013, the number of SSDI applications submitted to SSA’s field offices doubled, from 1.3 million to 2.6 million.²⁵ As **Figure 1** illustrates, most of that growth began around 2000. The number of awards for SSDI increased 111% over this same period, from 420,000 in 1980 to 888,000 in 2013.²⁶ At the same time, the overall incidence (enrollment) rate

²³ In 1999, SSA eliminated the reconsideration step in 10 states as part of the Disability Redesign Prototype (Prototype) initiative, which included Alaska, Alabama, California (Los Angeles West and North Branches), Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania. For more information, see SSA, Program Operations Manual System (POMS), *DI 12015.100 Disability Redesign Prototype Model*, January 2014, <http://policy.ssa.gov/poms.nsf/lnx/0412015100>.

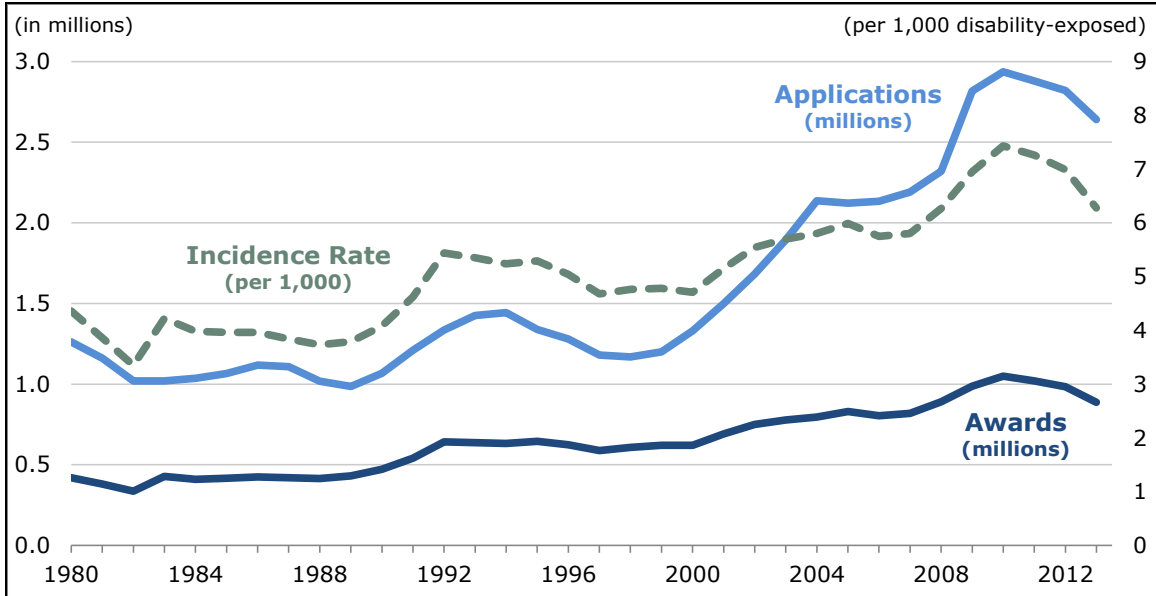
²⁴ Social Security Advisory Board (SSAB), *Aspects of Disability Decision Making: Data and Materials*, February 2012, Chart 12, p. 17, http://www.ssab.gov/PublicationViewOptions.aspx?ssab_pub=115 (hereinafter cited as “SSAB, Data and Materials 2012”).

²⁵ SSA, *Annual Statistical Supplement, 2014*, Table 6.C7, <http://www.ssa.gov/policy/docs/statcomps/supplement/2014/6c.html#table6.c7>, (hereinafter cited as “SSA, Annual Statistical Supplement 2014”).

²⁶ *Ibid.*

rose from 4.4 awards per 1,000 disability-exposed to 6.3. The *incidence rate* is the ratio of the number of new beneficiaries awarded benefits each year to the number of workers who are insured in the event of disability but not currently receiving benefits (i.e., the *disability-exposed population*).

Figure 1. SSDI Applications, Awards, and Incidence (Enrollment) Rates, 1980-2013



Source: Congressional Research Service (CRS) based on application and award data from SSA, *Annual Statistical Supplement, 2014*, Table 6.C7, at <http://www.ssa.gov/policy/docs/statcomps/supplement/2014/6c.html#table6.c7> and incidence rate data from Board of Trustees, Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, *The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, Figure V.C3, <http://www.ssa.gov/oact/tr/2014/index.html> (hereinafter cited as “2014 Trustees Report”).

Notes: “Applications” and “Awards” are in millions; the “Incidence Rate” is per 1,000 disability-exposed. The incidence (enrollment) rate is the ratio of the number of new beneficiaries awarded benefits each year to the number of workers who are insured in the event of disability but not currently receiving benefits (i.e., the disability-exposed population).

Termination

Entitlement to benefits ends when a disabled worker no longer meets the eligibility criteria for SSDI. Although the overall number of disabled-worker terminations increased 77% between 1980 and 2013, from 435,000 to 769,000, the ratio of annual disabled-worker terminations to the average number of disabled-worker beneficiaries (the *termination rate*) actually decreased 41%, from 145 disabled-worker terminations per 1,000 disabled-worker beneficiaries to 86.²⁷

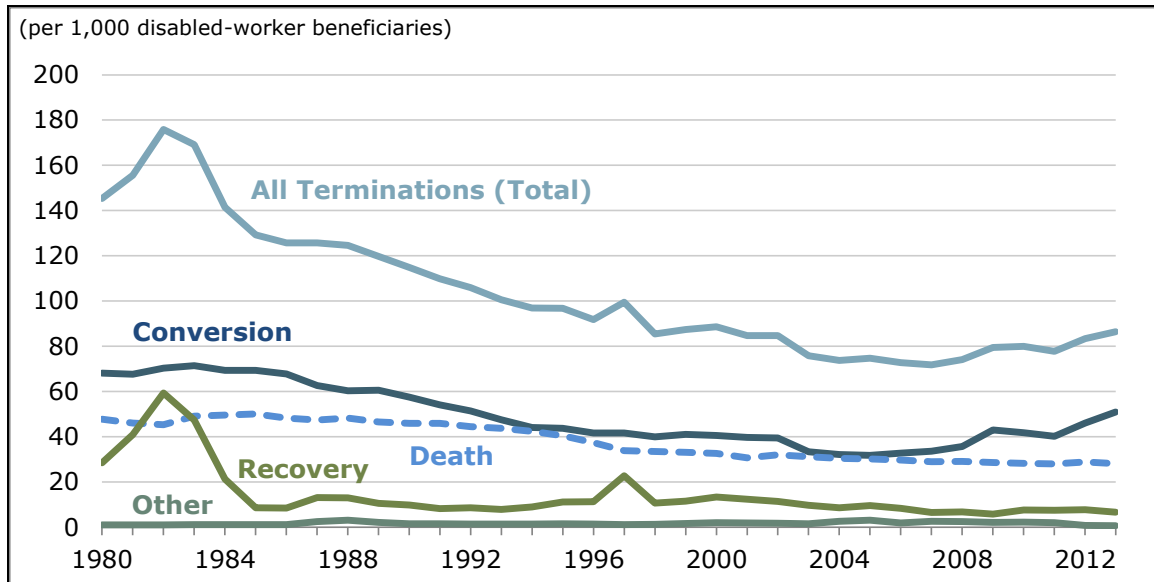
As depicted in **Figure 2**, three main factors drive the termination rate: death, recovery, and conversion. The beneficiary death rate decreased 42% between 1980 and 2013, from 48 disabled-

²⁷ Tim Zayatz, *Social Security Disability Insurance Program Workers Experience: Actuarial Study No. 114*, SSA, 1999, Table 5, <http://www.ssa.gov/oact/NOTES/actstud.html>. See also SSA, SSDI Annual Report 2013, Table 50.

worker terminations per 1,000 disabled-worker beneficiaries to 28, reflecting the trend in the U.S. population of declining mortality rates across all age groups.²⁸

Figure 2. Disabled-Worker Beneficiary Termination Rates, 1980-2013

(ratio of annual terminations to the average number of disabled-worker beneficiaries in a year)



Source: Compiled by CRS. Data for years 1980-2009 are from Tim Zayatz, *Social Security Disability Insurance Program Workers Experience*, Actuarial Study No. 114, SSA, June 1999, Table 5, and subsequent editions. Data for years 2010-2013 are from SSA, *Annual Statistical Report on the Social Security Disability Insurance Program, 2010*, November 2010, Table 50, and subsequent editions.

Notes: The category “Other” includes disabled workers who have elected to take early retirement benefits.

Recovery refers to individuals whose benefits were terminated because of medical improvement or earnings above SGA. From 1980 to 2013, the recovery rate declined 77%, from 29 disabled-worker terminations per 1,000 disabled-worker beneficiaries to 6.7. A *conversion* termination occurs when SSA automatically converts a disabled-worker benefit to a retired-worker benefit due to a disabled worker reaching the FRA. Over this same period, the conversion rate fell 25%, from 68 disabled-worker terminations per 1,000 disabled-worker beneficiaries to 51.

The rise in the recovery rate during the early 1980s stemmed mainly from the enactment of the Social Security Disability Amendments of 1980 (P.L. 96-265), which expanded the use of continuing disability reviews (CDR) for all non-permanently disabled beneficiaries.²⁹ CDRs are periodic medical reevaluations conducted to determine if beneficiaries continue to meet SSA’s definition of disability. The frequency of CDRs is linked to a beneficiary’s probability of recovery.³⁰ A major review of the SSDI program after the passage of the 1980 amendments

²⁸ Donna L. Hoyert, *75 Years of Mortality in the United States, 1935–2010*, Centers for Disease Control and Prevention: National Center for Health Statistics, 2012, <http://www.cdc.gov/nchs/data/databriefs/db88.htm>.

²⁹ For more information on the 1980 amendments, see John R. Kearney, “Social Security and the ‘D’ in OASDI: The History of a Federal Program Insuring Earners Against Disability,” *Social Security Bulletin*, vol. 66 no. 3 (August 2006), <http://www.ssa.gov/policy/docs/ssb/v66n3/v66n3p1.html>.

³⁰ Disabled beneficiaries with a reasonable chance of recovery are scheduled to receive CDRs every three years. Beneficiaries with a high probability of medical improvement are scheduled to receive CDRs at intervals between six and 18 months, while beneficiaries with a low probability of medical improvement (permanently disabled) receive CDRs less frequently (normally every five to seven years). For more information, see SSA, POMS, “DI 13005.010 (continued...)”

resulted in a marked increase in the recovery rate between 1980 and 1982.³¹ However, the political backlash over the implementation of the reviews led to a temporary moratorium on CDRs for most mental impairment cases as well as an increase in the percentage of beneficiaries designated as “permanently disabled” and therefore subject to less frequent reviews.³² These actions, coupled with changes to the disability determination and review process stemming from the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460), contributed to the subsequent decrease in the recovery rate.³³

The 1997 increase in the recovery rate largely resulted from the passage of the Contract with America Advancement Act of 1996 (P.L. 104-121), which terminated the benefits of SSDI and SSI recipients whose drug addiction and alcoholism (DA&A) significantly contributed to their disability.³⁴ However, because DA&A beneficiaries represented less than 3% of all disabled adults on SSDI and SSI in 1996 and new applicants could no longer claim disability based on DA&A, P.L. 104-121’s impact on the overall trend in the SSDI recovery rate was minimal.³⁵

Starting in 2002, the recovery rate contracted again, in part, because of a reduction in the number of medical CDRs conducted by SSA. The Contract with America Advancement Act of 1996 authorized additional funds for CDRs but only for FY1996 through FY2002.³⁶ In FY2003, the additional funding for CDRs lapsed and SSA shifted its focus away from CDRs toward processing the growing number of initial disability claims.³⁷ As a result, the number of medical CDRs performed by SSA dropped from an all-time high of 877,000 in FY2000 to 208,000 in FY2007, before climbing back up to 526,000 in FY2014 (**Figure 3**).

(...continued)

Medical Improvement Diaries,” June 27, 2012, <http://policy.ssa.gov/poms.nsf/lnx/0413005010>.

³¹ According to SSA officials, the rise in the termination rate during the early 1980s is not entirely attributable to the accelerated use of CDRs. An initiative begun in 1981 by SSA aggressively targeted beneficiaries whom the agency deemed were unlikely to have a qualifying disability. This initiative, coupled with the increased use of CDRs, resulted in an increase in the recovery rate in the early 1980s. For more information, see U.S. Government Accountability Office (GAO), *Social Security Disability Programs: Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently*, GAO-07-8, October 3, 2006, p. 6, footnote 9, <http://www.gao.gov/products/GAO-07-8>.

³² Kearney 2006, p. 16. See footnote 30.

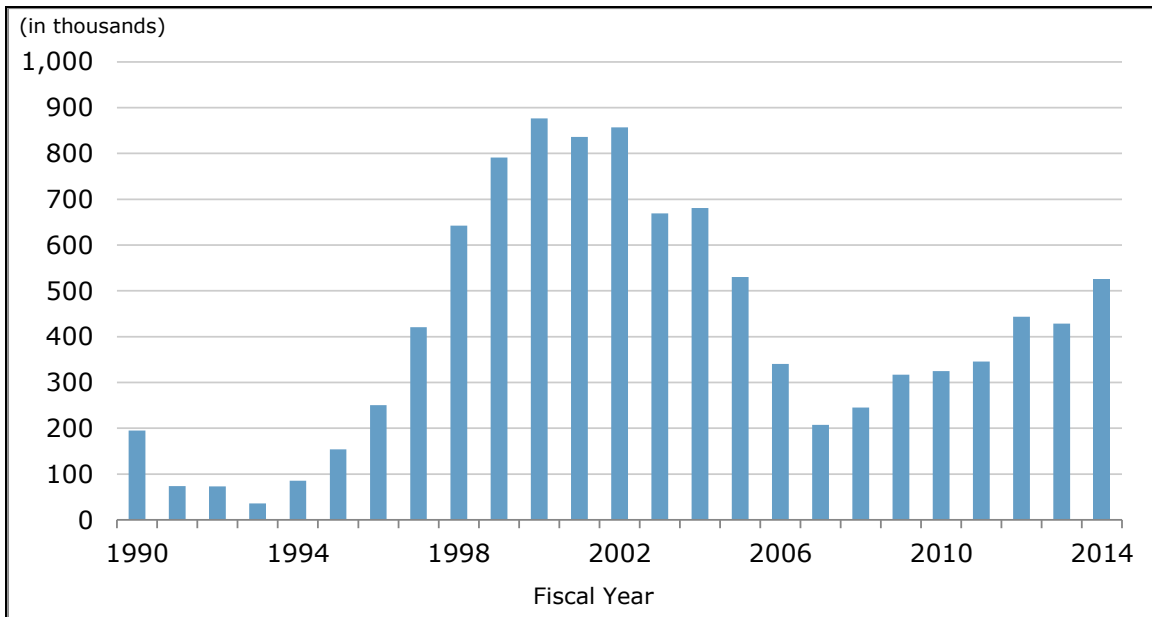
³³ The Disability Benefits Reform Act of 1984 (P.L. 98-460) enshrined some of the 1983 reforms into law. For more information on how the 1984 amendments affected program participation, see the subsection of this report titled “The Social Security Disability Benefits Reform Act of 1984.”

³⁴ The act stopped awarding benefits to DA&A claimants on the day of enactment, March 29, 1996. DA&A beneficiaries who appealed their termination continued to receive benefits while they waited for a decision. For more information, see Paul Davies, Howard Iams, and Kalman Rupp, “The Effect of Welfare Reform on SSA’s Disability Programs: Design of Policy Evaluation and Early Evidence,” *Social Security Bulletin*, vol. 63 no. 1 (July 2000), p. 4, <http://www.ssa.gov/policy/docs/ssb/v63n1/v63n1p3.pdf>.

³⁵ *Ibid.*, p. 6.

³⁶ See 42 U.S.C. §401(g)(1)(A).

³⁷ SSA, *Performance and Accountability Report for Fiscal Year 2003*, November 10, 2003, p. 44, http://www.ssa.gov/finance/2003/FY03_PAR.pdf.

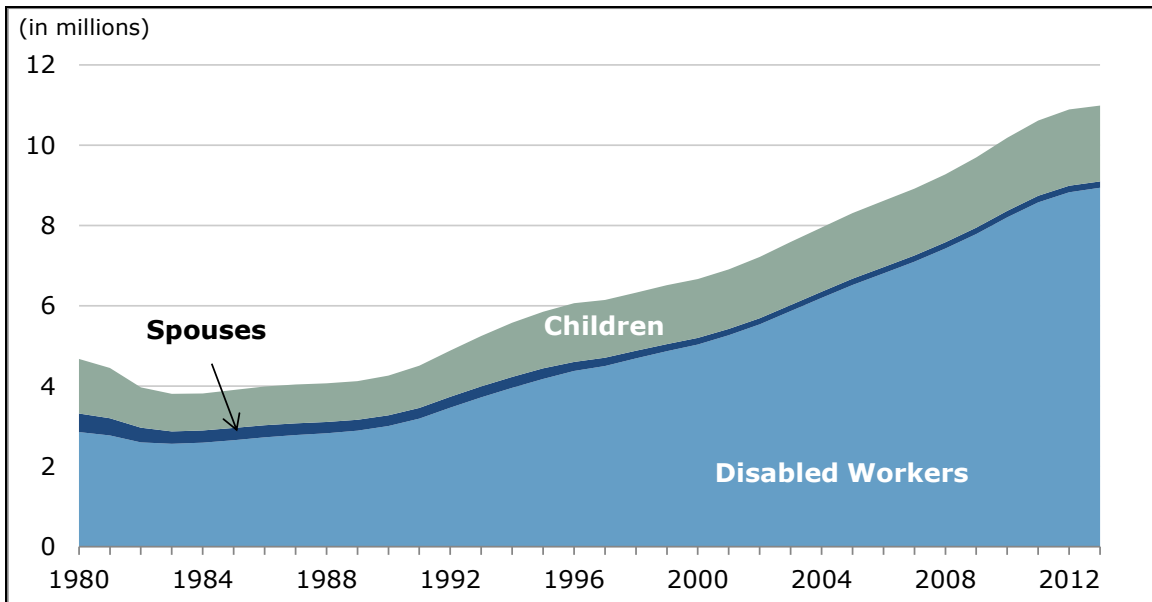
Figure 3. Number of Full Medical CDRs Conducted by SSA, FY1990-FY2014

Source: Compiled by CRS. Data for FY1990-FY2005 are from the Social Security Advisory Board (SSAB), *Aspects of Disability Decision Making: Data and Materials*, February 2012, Chart 13. Data for FY2006-FY2007 are from SSA, *Performance and Accountability Report for Fiscal Year 2012*, p. 80. Data for FY2008-FY2012 are from SSA, *Annual Performance Plan for Fiscal Year 2015 and Revised Performance Plan for Fiscal Year 2014 and Annual Performance Report for Fiscal Year 2013*, p. 119. Data for FY2013-FY2014 are from SSA, *Agency Financial Report, Fiscal Year 2014*, p. 202.

Program Size

Between 1980 and 2013, the overall number of SSDI beneficiaries increased 134%, from 4.7 million to 11 million.³⁸ Most of the growth in the program stemmed from disabled workers, whose ranks tripled, from 2.9 million in 1980 to 9 million in 2013 (**Figure 4**). In contrast, the number of spouses of disabled workers on SSDI decreased 66% during this period, from 462,000 in 1980 to 157,000 in 2013. The number of children receiving benefits grew rather modestly compared with the number of disabled workers on SSDI, from 1.4 million children in 1980 to 1.9 million in 2013.

³⁸ 2014 Trustees Report, Table V.C5.

Figure 4. SSDI Beneficiaries, by Type, 1980-2013

Source: 2014 Trustees Report, Table V.C5, at <http://www.ssa.gov/oact/tr/2014/lr5c5.html>.

Notes: The category “Children” includes dependent children under age 18, dependent student children between the ages of 18 and 19, and disabled adult children of disabled workers. Disabled adult children age 18 or older can receive benefits if they are unmarried and their disability occurred before age 22. To qualify for spousal benefits, the spouse of a disabled worker must either (1) have a child under age 16 or a disabled child in his or her care, or (2) be at least age 62. Disabled widow(er)s and disabled adult children of retired and deceased workers are not included in the graph above because their benefits are paid from the Old-Age and Survivors Insurance (OASI) trust fund.

Prevalence Rates

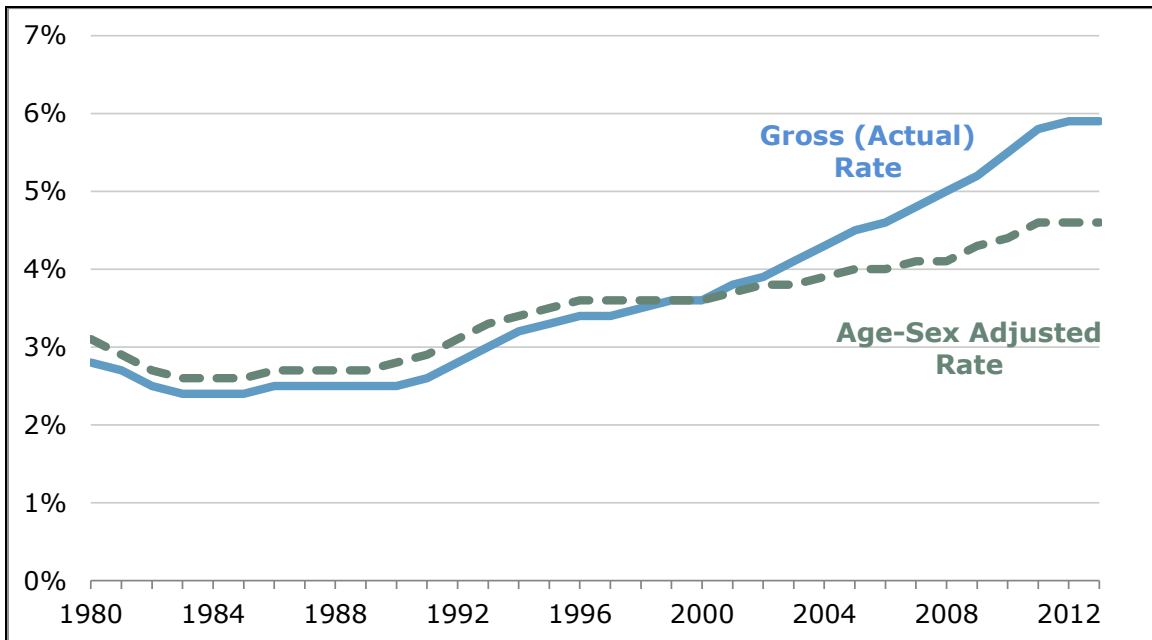
The size of the SSDI rolls is largely the function of two factors: the incidence (enrollment) rate of beneficiaries into the program and the termination rate of beneficiaries from the program. From 1980 to 2013, a marked rise in the incidence rate, coupled with a steady decline in the termination rate, resulted in an appreciable increase in the number of beneficiaries on SSDI. The prevalence rate measures the total number of disabled workers relative to the overall insured-worker population at the end of the year. The *insured-worker population* is the sum of the disability-exposed population and the number of individuals who are already receiving SSDI benefits. Between 1980 and 2013, the gross (unadjusted) prevalence rate grew from 2.8% to 5.9% (**Figure 5**).³⁹

When one adjusts the prevalence rate to control for the effects of changes in the age-sex distribution of the insured-worker population, the upward trend is less pronounced. Age-sex adjusting permits a more meaningful comparison over extended periods, insofar as it “isolates the changing trend in the true likelihood of receiving benefits for the insured population, without reflecting changes in the age distribution of the population.”⁴⁰ From 1980 to 2013, the age-sex-adjusted prevalence rate grew from 3.1% to 4.6%.

³⁹ Ibid.

⁴⁰ Ibid., p.136.

Figure 5. Gross and Age-Sex-Adjusted Prevalence Rates, 1980-2013
(percentage of insured workers in receipt of SSDI benefits)



Source: 2014 Trustees Report, Table V.C5, at <http://www.ssa.gov/oact/tr/2014/lr5c5.html>.

Notes: The age-sex-adjusted rate is set to the age-sex distribution of the insured-worker population in 2000. Insured workers are individuals who meet the work-history and contribution requirements for SSDI benefits. The Social Security trustees denote prevalence rates per *thousand* insured workers, while the graph above refers to prevalence rates per *hundred* insured workers.

Because the baby-boom generation is aging and older workers are more likely to qualify for SSDI, the gross rate would have increased even if the rate for each age group remained constant. The growth in the gross rate is due to both population aging (discussed below) and growth in the age-sex adjusted rate. The gap between the age-sex-adjusted rate and the gross rate is the growth that is attributable to changes in the age and sex distribution of the insured population.

Causes of the Growth in the SSDI Rolls

Ascribing shares of the growth in the SSDI program to specific factors has engendered disagreement among researchers, advocates, and some Members of Congress.⁴¹ In general, people who support higher spending on SSDI focus on changes in the demographic characteristics of insured workers. In contrast, individuals who want to limit program spending typically focus on

⁴¹ For a range of views, see David H. Autor and Mark G. Duggan, “The Growth in the Social Security Disability Rolls: A Fiscal Crisis Unfolding,” *Journal of Economic Perspectives*, vol. 20, no. 3 (Summer 2006), pp. 71-96, <http://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.20.3.71>; Mary C. Daly, Brian Lucking, and Jonathan A. Schwabish, “The Future of Social Security Disability Insurance,” *FRBSF Economic Letter*, June 24, 2013, <http://www.frbsf.org/economic-research/publications/economic-letter/2013/june/future-social-security-disability-insurance-ssdi/>; Kathy Ruffing, *How Much of the Growth in Disability Insurance Stems from Demographic Changes?*, Center on Budget and Policy Priorities, January 27, 2014, <http://www.cbpp.org/cms/?fa=view&id=4080>; and testimony of SSA Chief Actuary Stephen C. Goss, U.S. Congress, Senate Committee on Finance, *Social Security: A Fresh Look at Workers’ Disability Insurance*, 113th Cong., 2nd sess., July 24, 2014, http://www.ssa.gov/legislation/testimony_072414a.html (hereinafter cited as “Testimony of Stephen C. Goss, 2014”).

the effect of changes in the economic incentives to apply for SSDI and legislative changes to the program’s eligibility criteria.

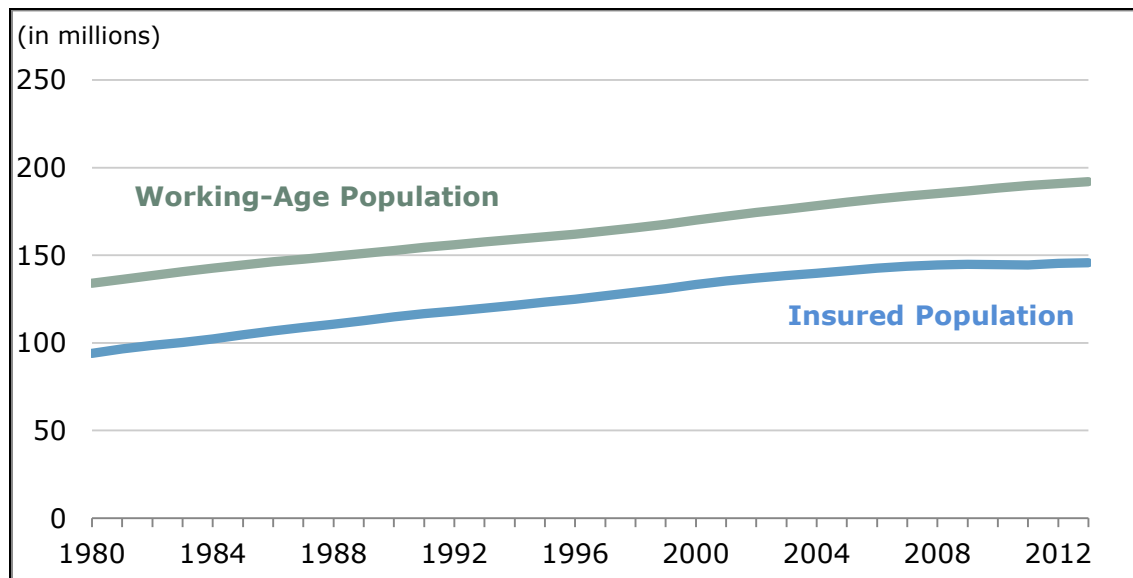
As **Figure 5** highlights, some of increase can be explained by demographic factors such as the aging of the workforce; however, the increase in the age-sex-adjusted rate means the growth in the SSDI rolls is also attributable to non-demographic factors, some of which are not well understood. This section examines some of the more salient explanations for the growth in the program and discusses other potential factors.

Changes in the Demographic Characteristics of Insured Workers

Growth in the Working-Age Population

One factor behind the increase in the *total number* of beneficiaries on SSDI is the overall growth in the working-age population (**Figure 6**).⁴²

Figure 6. Growth in the Population Aged 20-64, 1980-2013



Source: Compiled by CRS. Working-age population data are from 2014 Trustees Report, Table V.A2. Insured population data are from SSA, “Disability Insured Workers,” <http://www.ssa.gov/OACT/STATS/index.html>.

Note: Data are subject to revision.

From 1980 to 2013, the population ages 20-64 rose from 134 million to 192 million, while the insured-worker population ages 20-64 grew from 94 million to 146 million.⁴³ The growth in the

⁴² See David Pattison and Hilary Waldron, “Growth in New Disabled-Worker Entitlements, 1970–2008,” *Social Security Bulletin*, vol. 73, no. 4 (November 2013), <http://www.ssa.gov/policy/docs/ssb/v73n4/v73n4p25.html>.

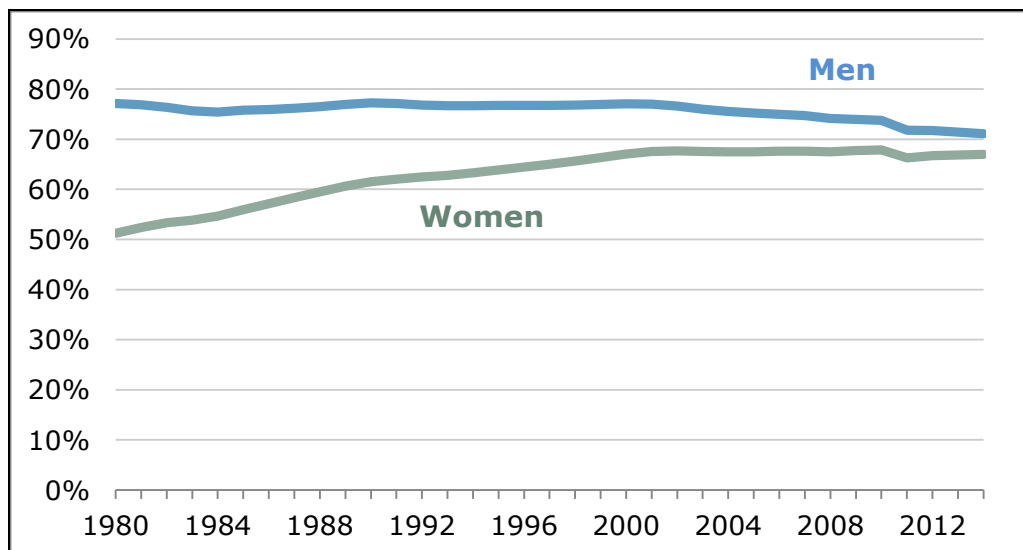
⁴³ Insured population data are from SSA, “Disability Insured Workers,” accessed November 2014, <http://www.ssa.gov/OACT/STATS/index.html>. Working-age population data are based on the Social Security Area Population for individuals aged 20 to 64 from the 2014 Trustees Report, Table V.A2. The Social Security Area Population includes (1) residents of the 50 states and the District of Columbia adjusted for net census undercount; (2) civilian residents of Puerto Rico, the Virgin Islands, Guam, America Samoa, and Northern Mariana Islands; (3) federal civilian employees and persons in the Armed Forces abroad and their dependents; (4) non-citizens living abroad who are insured for Social Security benefits; and (5) all other U.S. citizens abroad.

working-age population accounts for largest the share of the increase in the total number of beneficiaries on SSDI.⁴⁴

The Influx of Women into the Labor Force

The latter half of the 20th century witnessed a marked expansion of women in the workforce, which has contributed to the growth in SSDI. Between 1950 and 1999, the annual labor force participation rate for women age 16 and older nearly doubled, from 34% to an all-time high of 60%.⁴⁵ As a result, the share of women ages 15-64 who were insured for disability increased from 51% in 1980 to 67% in 2014.⁴⁶ The portion of men who were insured declined slightly over this period, from 77% to 71% (Figure 7).

Figure 7. Percentage of the Population Ages 15-64 Insured for Disability, by Sex, 1980-2014



Source: Compiled by CRS. Data for 1980-2010 are from SSAB, *Aspects of Disability Decision Making: Data and Materials*, February 2012, Chart 2b. Data for 2011-2014 are from SSA, “Statistical Tables,” <http://www.ssa.gov/OACT/STATS/index.html>.

Note: Data are subject to revision.

The growth in the share of women insured for disability coincided with an increase in the rate at which insured women were awarded benefits. As Figure 8 shows, both male and female age-adjusted incidence rates increased markedly between the late 1980s and early 1990s. However, male age-adjusted incidence rates declined following the 1990-1991 recession while female rates held steady. Researchers refer to this trend as women’s “catch-up.”⁴⁷ Since the late 1990s, age-adjusted incidence rates for women have been more or less at parity with men’s rates. Although the reason for the gap between incidence rates during the 1980s is not entirely clear, researchers

⁴⁴ See Testimony of Stephen C. Goss, 2014.

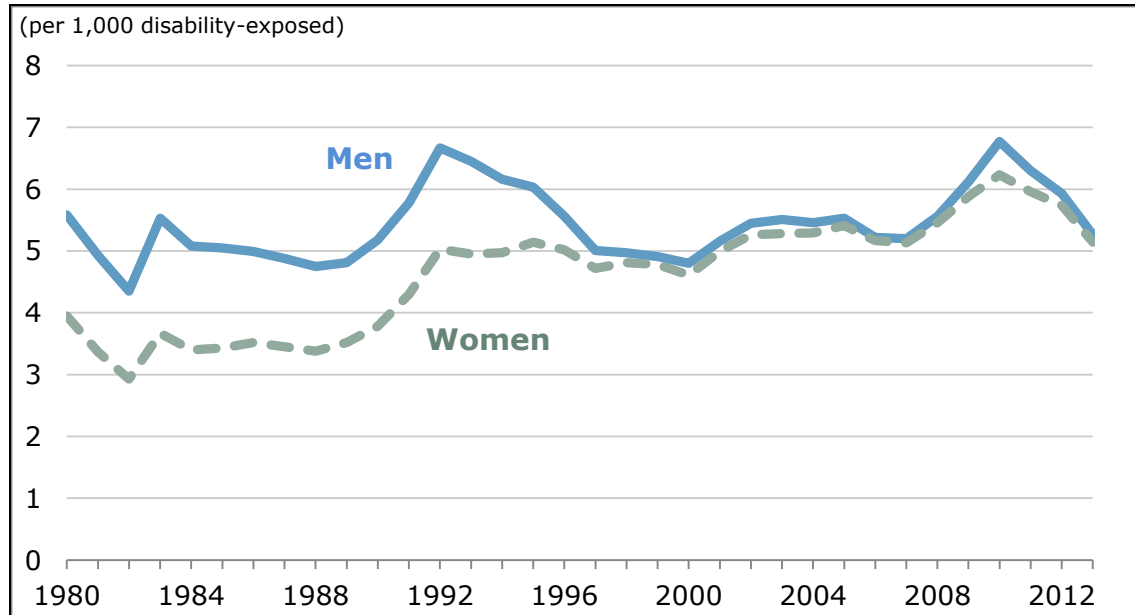
⁴⁵ U.S. Bureau of Labor Statistics (BLS), *Labor Force Statistics from the Current Population Survey*, <http://data.bls.gov/timeseries/LNS11300002>. In 2013, the annual labor force participation rate for women was 57%.

⁴⁶ Figures reflect the working population aged 15-64. 1980 figure is from SSAB, *Data and Materials 2012*, Chart 2b. 2014 figure was computed using data from SSA, “Statistical Tables,” accessed December 2014, at <http://www.ssa.gov/OACT/STATS/index.html>.

⁴⁷ Daly, Lucking, and Schwabish, “The Future of Social Security Disability Insurance.”

have speculated that past generations of women may have been less likely to know about SSDI and more likely to turn to family members or means-tested programs, such as Aid to Families with Dependent Children (AFDC), when affected by work-limiting impairments.⁴⁸

Figure 8. Age-Adjusted Incidence (Enrollment) Rates by Sex, 1980-2013



Source: Compiled by CRS. Data for years 1980-2009 are from Tim Zayatz, *Social Security Disability Insurance Program Workers Experience*, Actuarial Study No. 118, SSA, June 2005, and subsequent editions. Data for years 2010-2013 were calculated by CRS using data from SSA, *Annual Statistical Supplement*, 2011, 2012, and subsequent editions.

Notes: Incidences rates are adjusted to the age distribution of the male and female disability-exposed populations in 2000. The disability-exposed population is the total number of workers who are insured but not currently receiving benefits.

The Aging of the Workforce

The aging of the large baby-boom generation—individuals born between 1946 and 1964—played a marked role in increasing the number of individuals on SSDI.⁴⁹ Beginning in 1996, working-age baby boomers increasingly aged and became more prone to disability, resulting in a shift in the age distribution of the insured-worker population from younger workers to older workers.⁵⁰ This

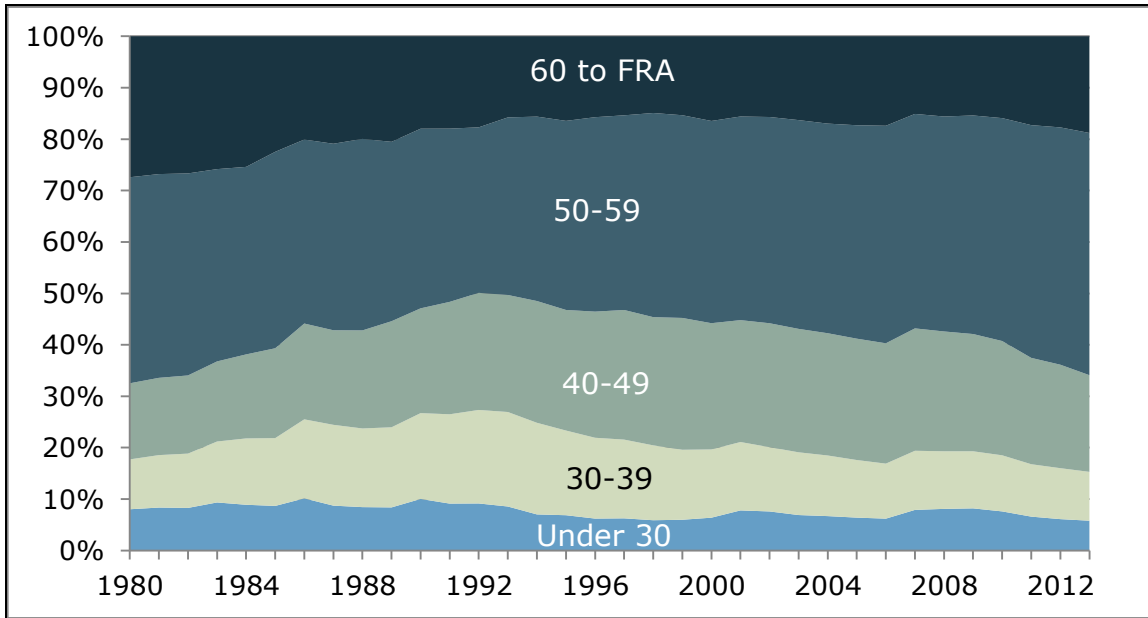
⁴⁸ Ruffing, footnote 6. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) replaced the AFDC program with the Temporary Assistance for Needy Families block grant. For more information, see CRS Report R40946, *The Temporary Assistance for Needy Families Block Grant: An Overview*, by (name redacted).

⁴⁹ 2014 Trustees Report, p. 135. See also Xuguang (Steve) Guo and John F. Burton, Jr., “The Growth in Applications for Social Security Disability Insurance: A Spillover Effect from Workers’ Compensation,” *Social Security Bulletin*, vol. 72 no. 3 (August 2012), <http://www.ssa.gov/policy/docs/ssb/v72n3/v72n3p69.html> (hereinafter cited as “Guo and Burton 2012”).

⁵⁰ See CBO, *Policy Options for the Social Security Disability Insurance Program*, July 2012, p. 7, <http://www.cbo.gov/publication/43421> (hereinafter cited as “CBO, Policy Options 2012”). See also Mark Duggan and Scott A. Imberman, “Why Are the Disability Rolls Skyrocketing? The Contribution of Population Characteristics, Economic Conditions, and Program Generosity,” in *Health at Older Ages: The Causes and Consequences of Declining Disability Among the Elderly*, ed. David M. Cutler and David A. Wise, National Bureau of Economic Research (University of Chicago Press, 2009), pp. 342-345, <http://www.nber.org/chapters/c11119>.

shift helped to increase the gross incidence and prevalence rates, inasmuch as older workers have a higher likelihood of benefit receipt relative to younger workers.⁵¹ Between 1996 and 2013, the portion of SSDI awards to disabled workers ages 50 to FRA increased from 54% to 66% (**Figure 9**).⁵² One reason for this is that older workers report suffering from work-limiting disabilities at higher rates relative to younger workers.⁵³

Figure 9. Percentage Distribution of SSDI Awards, by Age, 1980-2013



Source: SSA, *Annual Statistical Report on the Social Security Disability Insurance Program, 2013, 2014*, Table 39, http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/sect03c.html#table39.

Note: The full retirement age (FRA) was 65 for people born before 1938 and increased to 66 for those born from 1943 through 1954.

Another factor is that the definition of disability is effectively less strict at higher ages. In making a disability determination, DDS examiners take into account the claimant’s medical condition as well as vocational factors such as age, education, residual functional capacity, and work experience. Under its regulations, SSA considers advancing age to be a limiting factor in a claimant’s ability to adjust to other work.⁵⁴ Therefore, older workers are more likely to receive benefits than are younger workers, even if they have the same disability. The trustees expect the gross prevalence rates to grow at a slower pace in the future as baby boomers increasingly become eligible for full Social Security retirement benefits.⁵⁵

⁵¹ 2014 Trustees Report, p. 136. See also CBO, *Policy Options 2012*, p. 7.

⁵² SSA, *SSDI Annual Report 2013*, Table 39.

⁵³ “Prevalence and Most Common Causes of Disability Among Adults—United States, 2005,” *Morbidity and Mortality Weekly Report (MMWR)*, vol. 58, no. 16 (May 1, 2009), pp. 421-426, Table 1, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5816a2.htm>.

⁵⁴ See 20 C.F.R. §404.1563.

⁵⁵ 2014 Trustees Report, p. 127.

Changes in Opportunities for Work and Compensation

Changes in financial incentives also contributed to the growth in the program.⁵⁶ In deciding whether to apply, workers compare the value of SSDI benefits (cash payments and health coverage) with their opportunities for work and compensation. When the economy is strong, more individuals who could qualify for SSDI might decide to seek or continue employment. On the other hand, when labor market conditions are adverse, more individuals may find SSDI benefits preferable to the jobs and compensation available to them in the economy. Although the initial determination process screens out most non-meritorious claimants, SSA may grant awards to some claimants on the margin of program entry who could potentially work but choose not to due to economic circumstances. This subsection outlines how changes in the financial incentives to apply for SSDI likely increased the incidence of benefit receipt.

High Unemployment

During periods of economic weakness, individuals who might otherwise choose to work may be more likely to apply for SSDI benefits as a form of unemployment assistance. There is a positive relationship between the unemployment rate and the SSDI application rate.⁵⁷ With the exception of the period between 1980 and 1984, instances of high unemployment are associated with an increase in SSDI applications. As shown in **Figure 10**, the recent recession (December 2007 to June 2009) contributed to a conspicuous spike in the number of SSDI applications submitted to SSA; between 2007 and 2010, applications for SSDI increased 32%, from 2.2 million to 2.9 million.⁵⁸

The relationship between the unemployment rate and the approval rate is somewhat more ambiguous, inasmuch as the award year may not coincide with the application year due to a prolonged determination and appeals process.⁵⁹ Several studies have found an inverse relationship between the approval rate and the unemployment rate.⁶⁰ In other words, a claimant's *likelihood* of receiving an award at the initial determination level decreases as the unemployment rate rises. This is thought to occur because adverse labor market conditions induce more marginally

⁵⁶ See Till von Wachter, Jae Song, and Joyce Manchester, "Trends in Employment and Earnings of Allowed and Rejected Applicants to the Social Security Disability Insurance Program," *American Economic Review*, vol. 101, no. 7 (December 2011), pp. 3308-3329.

⁵⁷ See Kalman Rupp and David Stapleton, "Determinants of the Growth in the Social Security Administration's Disability Programs—An Overview," *Social Security Bulletin*, vol. 58, no. 4 (October 1995), <http://www.ssa.gov/policy/docs/ssb/v58n4/v58n4p43.pdf>; David H. Autor and Mark G. Duggan, "The Rise in the Disability Rolls and the Decline in Unemployment," *The Quarterly Journal of Economics*, February 2003, pp. 158-205; Duggan and Imberman, "Why Are the Disability Rolls Skyrocketing?," p. 356; and Guo and Burton 2012, p. 80.

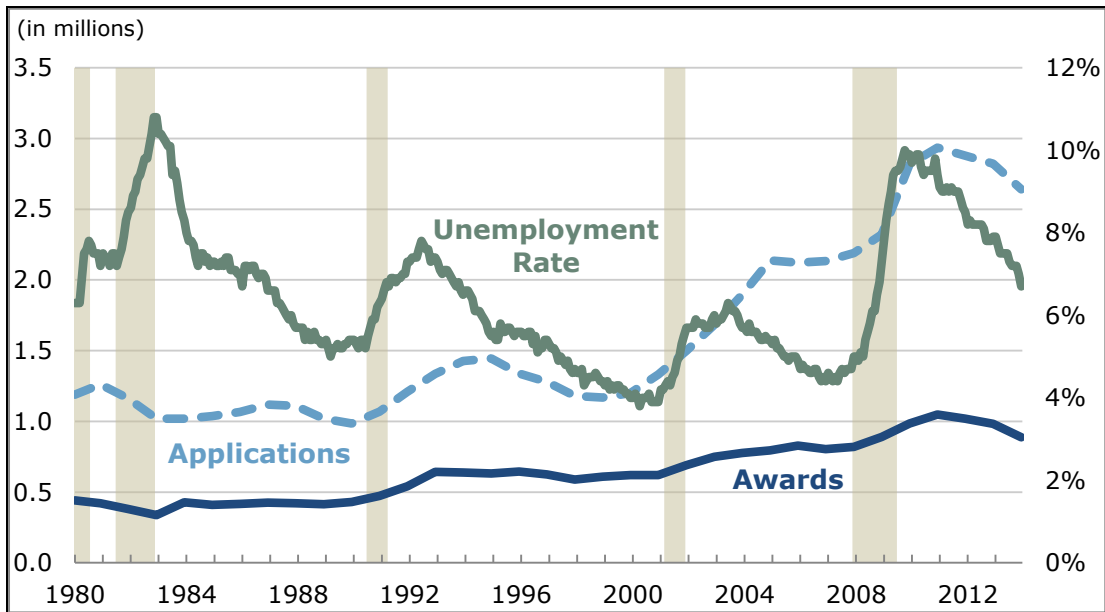
⁵⁸ SSA, Annual Statistical Supplement 2014, Table 6.C7.

⁵⁹ Duggan and Imberman, "Why Are the Disability Rolls Skyrocketing?," p. 355

⁶⁰ Kalman Rupp, "Factors Affecting Initial Disability Allowance Rates for the Disability Insurance and Supplemental Security Income Programs: The Role of the Demographic and Diagnostic Composition of Applicants and Local Labor Market Conditions," *Social Security Bulletin*, vol. 72 no. 4 (November 2012), p. 32, <http://www.ssa.gov/policy/docs/ssb/v72n4/v72n4p11.html>. Rupp found that an increase in the state unemployment rate is associated with a decrease in the initial allowance rate. The allowance rate is the number of medical allowances divided by the number of medical decisions. Unlike the award rate (awards divided by applications minus pending claims), the allowance rate does not include technical denials at the initial determination level. Technical denials are issued when a claimant fails to meet the non-medical eligibility requirements for SSDI. See also Stephen C. Goss et al., *Disabled Worker Allowance Rates: Variation Under Changing Economic Conditions*, SSA, Office of the Chief Actuary, Actuarial Note No. 153, August 2013, http://www.ssa.gov/oact/NOTES/pdf_notes/note153.pdf.

disabled individuals to apply for benefits.⁶¹ Nevertheless, the *overall number* of SSDI awards issued by SSA appears to increase during economic downturns.⁶² One possible reason for this is that some individuals who could qualify for SSDI but choose instead to work when the economy is strong are often less likely to find reemployment opportunities following a job loss when the unemployment rate is high.⁶³ Between 2007 and 2010, the number of SSDI awards granted by SSA increased 22%, from 819,000 to 1 million.⁶⁴

Figure 10. SSDI Applications and Awards During Economic Downturns, 1980-2013



Source: Application and Award data compiled from SSA, *Annual Statistical Supplement, 2014*, Table 6.C7, <http://www.ssa.gov/policy/docs/statcomps/supplement/2014/6c.html#table6.c7>. Unemployment data are from the Bureau of Labor Statistics (BLS). Recession data are from the National Bureau of Economic Research (NBER).

Notes: The unemployment rate is the number of all unemployed individuals ages 16 and older as a percentage of the civilian non-institutionalized labor force. BLS considers individuals to be unemployed if they (1) do not have jobs, (2) have actively looked for work in the past four weeks, and (3) are currently available for work. Shaded areas indicate a recession. NBER defines *recession* as a “significant decline in economic activity spread across the economy, lasting more than a few months, normally visible in real gross domestic product (GDP), real income, employment, industrial production, and wholesale-retail sales.”

The Value of Cash Benefits

Over the past few decades, SSDI appears to have become more attractive to lower-skilled workers because their potential SSDI benefits replace a larger portion of their earnings than before. The share of a worker’s pre-disability earnings replaced by cash benefits is known as the *replacement rate*.⁶⁵ Although the replacement rate depends on a worker’s past earnings, the Social

⁶¹ Rupp 2012.

⁶² See Rupp and Stapleton, “Determinants of the Growth in the Social Security Administration’s Disability Programs,” p. 56.

⁶³ Goss et al., *Disabled Worker Allowance Rates*, p. 1, footnote 1.

⁶⁴ SSA, *Annual Statistical Supplement 2014*, Table 6.C7.

⁶⁵ The computed replacement rate depends on the measure of pre-disability earnings. For more information, see Andrew G. Biggs and Glenn R. Springstead, “Alternate Measures of Replacement Rates for Social Security Benefits (continued...)”

Security benefit formula also reflects changes in the average earnings of all workers in the national economy, as measured by the Average Wage Index (AWI).⁶⁶ Due to the progressive nature of the benefit formula, replacement rates are greater for workers with low lifetime wages than for high-wage workers (Table 1).⁶⁷

Table 1. Hypothetical Disabled-Worker Replacement Rates at Age 55
(by lifetime earnings level)

Lifetime Average Earnings ^a	Annual SSDI Benefit ^b	Earnings Replaced
\$10,000	\$8,856	89%
\$20,000	\$12,048	60%
\$30,000	\$15,240	51%
\$40,000	\$18,432	46%
\$50,000	\$21,624	43%
\$60,000	\$24,672	41%
Maximum ^c	\$32,040	28%

Source: Michael Clingman, Kyle Burkhalter, and Chris Chaplain, *Illustrative Benefits for Retired Workers, Disabled Workers, and Survivors Scheduled Under Current Law*, SSA, Office of the Chief Actuary, Actuarial Note No. 2014.4, October 2014, Table 2, at <http://www.ssa.gov/oact/NOTES/ran4/index.html>.

Notes: Scaled earnings patterns reflect the actual work experience of insured workers during 1991-2010.

- a. "Lifetime Average Earnings" reflect the average of the highest 35 years of earnings (wage-indexed to 2013 levels) expected for a hypothetical worker who survives to age 65 without having a period of disability.
- b. Entitlement to benefit in 2014.
- c. Refers to workers with earnings equal to the taxable maximum for each year through 2013. The taxable maximum in 2013 was \$113,700.

Some part of the growth in SSDI is driven by rising replacement rates for low-skilled workers, which have made SSDI benefits more desirable than work for an increasing share of workers.⁶⁸ The increase in the relative attractiveness of SSDI benefits was likely strongest for low-wage workers, because they experienced slower real earnings growth over the last three decades than medium and high-wage workers.⁶⁹ This increase in wage inequality has interacted with the structure of the benefits formula to increase replacement rates for lower-skilled workers.⁷⁰ That means that SSDI is more attractive to those workers than it had been in the past.

(...continued)

and Retirement Income," *Social Security Bulletin*, vol. 68, no. 2 (October 2008), <http://www.ssa.gov/policy/docs/ssb/v68n2/v68n2p1.html>.

⁶⁶ See SSA, "National Average Wage Index," <http://www.ssa.gov/oact/cola/AWI.html>.

⁶⁷ For more information on how benefits are calculated, see CRS Report R43542, *How Social Security Benefits Are Computed: In Brief*, by Noah P. Meyerson.

⁶⁸ Autor and Duggan, "The Growth in the Social Security Disability Rolls." See also Daly, Lucking, and Schwabish, "The Future of Social Security Disability Insurance."

⁶⁹ See Autor and Duggan, "The Rise in the Disability Rolls and the Decline in Unemployment." Between 1979 and 2009, the real weekly earnings of low-wage workers (20th percentile) grew 6.6%, whereas the real weekly earnings of medium (60th percentile) and high-wage workers (95th percentile) increased 16% and 29%, respectively. For more information, see CRS Report RL33835, *Real Earnings, Health Insurance and Pension Coverage, and the Distribution of Earnings, 1979-2009*, by (name redacted). Estimates are for full-time, year-round workers.

⁷⁰ Autor and Duggan, "The Growth in the Social Security Disability Rolls," Table 2. See L. Scott Muller, "The Effects (continued...)"

While researchers generally agree that replacement rates “are rising due to the widening distribution of income,” there is some disagreement over the extent to which this increase induced low-wage workers to apply for SSDI benefits.⁷¹

The Value of Health Coverage

Access to affordable health coverage also affects an individual’s decision to apply for SSDI, but the net effect of changes in health policies on SSDI is unclear.⁷² As noted earlier, disabled workers and certain dependents are eligible for coverage under Medicare after 24 months of entitlement to cash benefits (29 months after disability onset). Congress extended Medicare to SSDI beneficiaries under the Social Security Amendments of 1972 (P.L.92-603) because the “use of health services by people who are severely disabled is substantially higher than that by the nondisabled ... yet the disabled have limited incomes in comparison to those who are not disabled, and most disabled persons are unable financially to purchase adequate private health insurance protection.”⁷³

Health care is generally more expensive for individuals with disabilities. One study found that health care expenditures per capita were over four times greater for workers with disabilities than those without disabilities.⁷⁴ Persons with disabilities have higher health care expenditures because they typically use more health services and have secondary conditions that further impair overall health.⁷⁵ These higher costs can make health care coverage prohibitively expensive for some individuals with disabilities.⁷⁶ In 2013, 39% of individuals with disabilities had private health insurance coverage, compared with 71% of individuals without disabilities.⁷⁷ The lower coverage rate for individuals with disabilities under private health insurance is due, in part, to the availability of government-sponsored health care coverage under Medicare and Medicaid.

Some research suggests that the desire to gain access to Medicare induced some individuals with disabilities to apply for SSDI.⁷⁸ However, it is difficult to know exactly how many individuals

(...continued)

of Wage Indexing on Social Security Disability Benefits,” *Social Security Bulletin*, vol. 68 no. 3 (December 2008), <http://www.ssa.gov/policy/docs/ssb/v68n3/v68n3p1.html>.

⁷¹ Muller, “The Effects of Wage Indexing on Social Security Disability Benefits,” p. 25. See also Autor and Duggan, “The Growth in the Social Security Disability Rolls,” pp. 82-83. Muller contends that “the magnitude of the increases in replacement rates, on average, does not seem to offer large incentives to leave work for disability benefits.” Autor and Duggan argue that the high-wage replacement of SSDI benefits relative to available compensation makes SSDI enrollment particularly attractive to low-income workers.

⁷² See Jae Kennedy and Elizabeth Blodgett, *Health Insurance—Motivated Disability Enrollment and the ACA*, *The New England Journal of Medicine*, September 20, 2012, <http://www.nejm.org/doi/full/10.1056/NEJMp1208212>.

⁷³ U.S. Congress, House Committee on Ways and Means, *Social Security Amendments of 1971*, report to accompany H.R. 1, 92nd Cong., 1st sess., May 26, 1971, H.Rept. 92-231 (Washington: GPO, 1971), p. 67.

⁷⁴ David Stapleton and Su Liu, “Will Health Care Reform Increase the Employment of People with Disabilities?,” Mathematica Policy Research, Inc, Center for Studying Disability Policy, November 2009, <http://www.mathematica-mpr.com/~media/publications/PDFs/disability/healthcarereform.pdf>.

⁷⁵ Wayne L. Anderson et al., “Estimates of National Health Care Expenditures Associated with Disability,” *Journal of Disability Policy Studies*, vol. 21, no. 4 (March 2011), pp. 230-240.

⁷⁶ See Jody Schimmel Hyde and Gina A. Livermore, “Gaps in Timely Access to Care Among Workers by Disability Status: Will the Patient Protection and Affordable Care Act Reforms Change the Landscape?,” *Journal of Disability Policy Studies*, August 28, 2014.

⁷⁷ U.S. Census Bureau, *Type of Health Insurance Coverage for Working-Age Adults: 2013*, Table 3, <http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/tables.html>.

⁷⁸ Autor and Duggan, “The Rise in the Disability Rolls and the Decline in Unemployment,” Table 1, p. 165. See also (continued...)

awarded SSDI were motivated to apply in order to gain access to Medicare. One study found that 22% of SSDI beneficiaries ages 18-64 lacked health insurance coverage prior to their entitlement to SSDI.⁷⁹

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) is likely to influence SSDI application rates in the future, though the law's net effect on the SSDI prevalence rate is difficult to determine.⁸⁰ On the one hand, the ACA may reduce SSDI applications by increasing access to affordable health coverage, making access to Medicare less valuable. On the other hand, the ACA may increase SSDI applications by making it easier for individuals who get health coverage through their work to apply, because they could obtain Medicaid coverage or subsidized coverage in the exchange during the 24-month waiting period for Medicare.⁸¹ Recent research indicates that the health care law's effect on SSDI application rates is likely to vary by locality due to factors such as (1) the availability of Medicaid in a state, (2) local health insurance coverage rates,⁸² and (3) the availability and type of state Medicaid buy-in programs.⁸³

Changes in Federal Policy

In addition to demographic and economic changes, various amendments to the Social Security program played a role in increasing the number of people on SSDI. While some of the changes to Social Security were designed to address specific issues with SSDI, modifications to other parts of the program indirectly affected the incentives for individuals to apply for disability benefits. The following subsection examines how changes in the full retirement age for Social Security retired-worker benefits and in the evaluative criteria used to determine disability contributed to the growth in the SSDI rolls.

(...continued)

Autor and Duggan, "The Growth in the Social Security Disability Rolls," p. 81. The authors contend that the rising value of Medicare benefits increased total replacement rates (cash benefits and health coverage), which, in turn, induced some individuals to leave the labor force and apply for SSDI benefits.

⁷⁹ Gina Livermore, David Stapleton, and Henry Claypool, *Health Insurance and Health Care Access Before and After SSDI Entry*, The Commonwealth Fund, May 2009, p. 17, http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/May/Livermore%20Health%20Insurance%20and%20Health%20Care%20Access%20Before%20and%20After/1255_Livermore_hlt_ins_hlt_care_access_before_after_SSDI_entry.pdf.

⁸⁰ CBO, Policy Options 2012, p. 5. For more information on the ACA, see CRS Report R43048, *2013 Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and CRS Report R43564, *The ACA Medicaid Expansion*, by (name redacted).

⁸¹ CBO, Policy Options 2012, p. 6.

⁸² Nicole Maestas, Kathleen J. Mullen, and Alexander Strand, "Disability Insurance and Health Insurance Reform: Evidence from Massachusetts," *American Economic Review*, vol. 104, no. 5 (May 2014), pp. 329-335. See also RAND Corporation, *Effects of Health Care Reform on Disability Insurance Claiming*, 2014, http://www.rand.org/content/dam/rand/pubs/research_briefs/RB9700/RB9769/RAND_RB9769.pdf.

⁸³ Melissa McInerney, *The Medicaid Buy-In and Social Security Disability Insurance (DI) Beneficiaries: Lessons for the 2014 Medicaid Expansion and Proposals to Reform DI*, Center for Retirement Research, December 2013, p. 18, footnote 25, http://crr.bc.edu/wp-content/uploads/2013/10/wp_2013-20.pdf. Medicaid buy-in programs allow certain employed individuals with disabilities to obtain health care coverage through Medicaid when employer-sponsored health insurance is not available. For more information on Medicaid buy-in programs, see Matthew Kehn, *Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2011*, Mathematica Policy Research, May 20, 2013, http://www.mathematica-mpr.com/~media/publications/PDFs/health/medicaid_buyin_enrollment.pdf.

The Social Security Amendments of 1983

The Social Security retirement program faced serious financial challenges in the early 1980s. High inflation and low wage growth starting in the 1970s had eroded the balance of the OASI trust fund, which finances the benefits and administrative costs of the OASI program.⁸⁴ In 1982, the Social Security trustees projected that the OASI trust fund would exhaust by the middle of 1983.⁸⁵

To improve the financial condition of the OASI trust fund, Congress enacted the comprehensive Social Security Amendments of 1983 (P.L. 98-21). Among the 1983 amendments' many substantial changes was an increase in the FRA from 65 to 67.⁸⁶ Between 2002 and 2009, the FRA gradually increased until it reached 66 for workers born between 1943 and 1954. The FRA is scheduled to rise again, reaching 67 for workers born in 1960 and later.

Raising the FRA reduced OASI spending but increased DI spending in several ways.⁸⁷ First, it increased the number of workers who are eligible for SSDI. From 2003 to 2014, the number of insured workers ages 65-FRA rose from over 200,000 to more than 2.4 million.⁸⁸ Because workers aged 65-FRA are more likely to have a qualifying disability, the increase in the number of insured workers led to an increase in the number of workers awarded benefits. In 2013, over 7,400 workers aged 65-FRA were awarded benefits.⁸⁹

Second, the increase in the FRA lengthened the duration of benefit receipt for SSDI recipients near retirement age.⁹⁰ Disabled workers move from SSDI to OASI when they reach the FRA. As the FRA increased above 65, beneficiaries remained on SSDI longer. In December 2013, over 455,000 disabled workers ages 65-FRA received benefits.⁹¹

Third, the rise in the FRA increased the value of SSDI cash benefits relative to early retirement benefits.⁹² Insured workers who choose to retire between the ages of 62 and FRA are subject to a permanent reduction in their monthly cash benefits.⁹³ Prior to the 1983 amendments, the reduction for claiming retirement benefits at age 62 was 20%; with the increase in the FRA to 66, the reduction at age 62 rose to 25%.⁹⁴ That reduction will rise to 30% for workers whose FRA is

⁸⁴ Legislative changes to the program that increased benefit amounts also contributed to the OASI trust fund's imbalance. For more information, see Patricia P. Martin and David A. Weaver, "Social Security: A Program and Policy History," *Social Security Bulletin*, vol. 66, no. 1 (2005), <http://www.ssa.gov/policy/docs/ssb/v66n1/v66n1p1.html>.

⁸⁵ U.S. Congress, House Committee on Ways and Means, *1982 Annual Report, Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*, prepared by Board of Trustees, Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, 97th Cong., 2nd sess., April 1, 1982, <http://www.ssa.gov/history/reports/trust/1982/1982.pdf>.

⁸⁶ See John A. Svahn and Mary Ross, "Social Security Amendments of 1983: Legislative History and Summary of Provisions," vol. 46, no. 7 (July 1983), <http://www.ssa.gov/policy/docs/ssb/v46n7/v46n7p3.pdf>. The FRA is the age at which unreduced retirement benefits are first payable.

⁸⁷ Although it may have reduced the overall balance of the DI trust fund, the increase in the FRA also raised payroll tax revenues to the DI trust fund due to some people working longer before applying for full retirement benefits. For more information, see CBO, *Policy Options 2012*, p. 9.

⁸⁸ SSA, "Disability Insured Workers," <http://www.ssa.gov/oact/STATS/table4c2DI.html>.

⁸⁹ SSA, *SSDI Annual Report 2013*, Table 36.

⁹⁰ CBO, *Policy Options 2012*, p. 9.

⁹¹ SSA, *SSDI Annual Report 2013*, Table 2.

⁹² Svahn and Ross, "Social Security Amendments of 1983."

⁹³ See SSA, "Early or Late Retirement?," November 25, 2008, http://www.ssa.gov/OACT/quickcalc/early_late.html.

⁹⁴ For additional information on the reduction in benefits at age 62, see SSA, "Retirement Planner: Benefits by Year of Birth," <http://www.socialsecurity.gov/retire2/agereduction.htm>.

67. Because SSDI benefits are approximately the same as full retirement benefits, the increase in the FRA likely impelled some additional workers to apply for SSDI benefits in order to maximize their total cash benefits. Although recent studies suggest that an increase in the value of disability benefits relative to early retirement benefits induces individuals to apply for SSDI benefits, researchers are divided over whether such individuals are actually awarded benefits.⁹⁵

The Social Security Disability Benefits Reform Act of 1984

As noted earlier, the Social Security Disability Amendments of 1980 (P.L. 96-265) markedly expanded the use of continuing disability reviews (CDRs) as a means of reducing the growth in program costs. CDRs are periodic medical reevaluations conducted to determine if beneficiaries are still disabled. Between January 1982 and fall 1984, SSA issued benefit termination notices to 490,000 of the 1.2 million SSDI beneficiaries subjected to a CDR.⁹⁶ However, the rise in beneficiary terminations due to CDRs sparked a degree of public outcry and had “a very damaging effect on the public perception of SSA’s administration of the disability program.”⁹⁷ News stories at the time often depicted the financial and emotional difficulties faced by recently terminated beneficiaries and their dependents.⁹⁸ Ultimately, of the 490,000 beneficiaries who received termination notices, approximately 200,000 had their benefits reinstated on appeal.⁹⁹

In response to the contention over the increased use of CDRs, Congress unanimously enacted the Social Security Disability Benefits Reform Act of 1984 (DBRA; P.L. 98-460). DBRA changed the statutory standards for evaluating disability in a variety of ways.¹⁰⁰ First, it revised the medical eligibility criteria for CDRs so that SSA could terminate the benefits of a recipient due to medical improvement only if the agency found substantial evidence of medical improvement related to the recipient’s ability to work since the most recent favorable determination.¹⁰¹ Under

⁹⁵ See Norma B. Coe and Kelly Haverstick, *Measuring the Spillover to Disability Insurance Due to the Rise in the Full Retirement Age*, Center for Retirement Research at Boston College, December 2010, pp. 9-14, <http://crr.bc.edu/working-papers/measuring-the-spillover-to-disability-insurance-due-to-the-rise-in-the-full-retirement-age/>. In addition, see Mark Duggan, Perry Singleton, and Jae Song, *Aching to Retire? The Rise in the Full Retirement Age and its Impact on the Disability Rolls*, National Bureau of Economic Research, Working Paper 11811, December 2005, <http://www.nber.org/papers/w11811>. Using aggregate data, Duggan, Singleton, and Song found that the 1983 amendments increased SSDI enrollment by 0.58 percentage points for men (ages 45-64) and 0.89 percentage points for women (ages 45-64) between 1983 and 2005. Using disaggregate data, Coe and Haverstick found that a one percentage point decrease in the ratio of retirement to disability benefits resulted in a 0.28 percentage point increase in the two-year SSDI application rate for individuals born between 1938 and 1943. However, the researchers found no evidence that the increase in the FRA resulted in a rise in the incidence of SSDI receipt among individuals ages 55-FRA born between 1938 and 1941. (The 1942 and 1943 cohorts had not reached FRA.)

⁹⁶ Kearney 2006, p. 14.

⁹⁷ *Ibid.*, p. 15.

⁹⁸ “Cutoffs for Mentally Ill Bring Moratorium Plea,” *The New York Times*, April 9, 1983, <http://www.nytimes.com/1983/04/10/us/cutoffs-for-mentally-ill-bring-moratorium-plea.html?n=Top%2fReference%2fTimes%20Topics%2fSubjects%2fF%2fFinances>. See also Edward D. Berkowitz, *Disabled Policy: America’s Programs for the Handicapped* (New York City: Cambridge University Press, 1987), pp. 128-130 (hereinafter cited as “Berkowitz 1987”).

⁹⁹ Berkowitz 1987, p.127.

¹⁰⁰ See Katharine P. Collins and Anne Erfle, “Social Security Disability Benefits Reform Act of 1984: Legislative History and Summary of Provisions,” *Social Security Bulletin*, vol. 48, no. 4 (April 1985), p. 5, <http://www.ssa.gov/policy/docs/ssb/v48n4/v48n4p5.pdf>.

¹⁰¹ Department of Health and Human Services (HHS), SSA, “Supplemental Security Income; Disability and Blindness Determinations,” 50 *Federal Register* 35038, December 6, 1985. The legal standard for determining if disability continues is known as the Medical Improvement Review Standard (MIRS). For more information, see SSA, POMS, “DI 28005.001 Legal Standard for Determining If Disability Continues,” July 31, 2014, [http://policy.ssa.gov/poms.nsf/\(continued...\)](http://policy.ssa.gov/poms.nsf/(continued...))

the 1980 amendments, SSA had treated medical CDRs as a new determination and could revoke benefits even if a beneficiary's health had not changed.

Second, it required the Secretary of Health and Human Services to revise the criteria under the "mental disorders" category in the *Listing of Impairments*.¹⁰² Before the reforms, disability determinations relied primarily on medical factors, which tended to disadvantage claimants with mental impairments from benefit receipt. The revised listings for mental impairments—first published in 1985¹⁰³—"reduced the weight given to medical factors and put a greater weight on functional capacities, such as the applicant's ability to perform activities of daily living."¹⁰⁴

Third, it required SSA to consider the combined effect of multiple non-severe impairments on the claimant's ability to engage in SGA.¹⁰⁵ Prior to DBRA, a disability determination could not proceed unless the claimant had one or more independently severe impairments.¹⁰⁶ Lastly, DBRA provided a temporary statutory standard (through the end of 1986) for evaluating pain. Before the reforms, there was no "specific statement in the law" as to how pain should be evaluated.¹⁰⁷ SSA issued new pain regulations in 1991.¹⁰⁸

In enacting DBRA, Congress sought to protect the rights of "those correctly and properly allowed on the rolls" while continuing to remove non-meritorious beneficiaries from the program.¹⁰⁹ To accomplish this, Congress established a national, uniform process for determining disability, which complemented objective medical criteria with more subjective criteria such as pain and functional capacity. Congress, though, explicitly stated that the intent of DBRA was not to change the basic standard of eligibility for SSDI.¹¹⁰

Nevertheless, a number of researchers argue that despite Congress's intention, the establishment of new evaluative criteria contributed to the growth in the disability rolls by making it easier for claimants with "difficult-to-verify" impairments to qualify for SSDI, such as mental and musculoskeletal disorders.¹¹¹ For example, the revision to the "mental disorders" category in the

(...continued)

Inx/0428005001.

¹⁰² For information on the *Listing of Impairments*, please see the SSA publication *Disability Evaluation Under Social Security*, available at <http://www.ssa.gov/disability/professionals/bluebook/>. This publication is commonly referred to as the *Blue Book*. Prior to March 31, 1995, SSA was under the auspices of HHS (previously the Department of Health, Education and Welfare). For more information on SSA's organizational history, see SSA, "Organizational History," <http://www.ssa.gov/history/orghist.html>.

¹⁰³ HHS, SSA, "Federal Old-Age, Survivors, and Disability Insurance; Listing of Impairments—Mental Disorders," 50 *Federal Register* 35038, August 28, 1985.

¹⁰⁴ Kearney, "Social Security and the 'D' in OASDI," p. 17.

¹⁰⁵ HHS, SSA, "Disability Insurance and Supplemental Security Income; Determining Disability and Blindness; Multiple Impairments," 56 *Federal Register* 8726, March 5, 1985.

¹⁰⁶ SSA, *A History of the Social Security Disability Programs*, January 1986, <http://www.ssa.gov/history/1986dibhistory.html>. For more information on the distinction between severe and non-severe impairments, please see SSA, POMS, "DI 22001.015 Severe/Non-Severe Impairment(s)," March 12, 2013, <http://policy.ssa.gov/poms.nsf/lnx/0422001015>.

¹⁰⁷ U.S. Congress, Senate Committee on Finance, *Social Security Disability Amendments of 1984*, report to accompany S. 467, 98th Cong., 2nd sess., May 18, 1984, S.Rept. 98-466, p. 23, <http://www.finance.senate.gov/library/reports/committee/> (hereinafter cited as "1984 Senate Committee on Finance Report").

¹⁰⁸ HHS, SSA, "Evaluation of Symptoms, Including Pain," 56 *Federal Register* 57928, November 14, 1991.

¹⁰⁹ 1984 Senate Committee on Finance Report, pp. 6-7.

¹¹⁰ *Ibid.* See also U.S. Congress, House Committee on Ways and Means, *Social Security Disability Benefits Reform Act of 1984*, report to accompany H.R. 3755, 98th Cong., 2nd sess., March 14, 1984, H.Rept. 98-618, p. 6.

¹¹¹ David H. Autor, *The Unsustainable Rise of the Disability Rolls in the United States: Causes, Consequences, and* (continued...)

Listing of Impairments, which gave greater weight to functional capacities, may have permitted more claimants with mental impairments to qualify for SSDI. Similarly, the allowance of the combined effect of multiple non-severe impairments and the evaluation of pain may have made it easier for claimants suffering from musculoskeletal disorders (impairments involving bones, muscles, tendons, or ligaments) to enroll in the program.

As **Figure 11** illustrates, the percentage of awards due to mental and musculoskeletal impairments increased markedly following the passage of DBRA. Between 1985 and 2001, the share of newly awarded beneficiaries with mental impairments increased from 18% to 26% before declining to 17% in 2013.¹¹² According to one researcher at SSA, the increase in awards resulting from mental disorders in 1986 “is directly attributable to changes in the decision making process due to the 1984 Social Security Disability Benefits Reform Act.”¹¹³ From 1986 to 2012, the share of all beneficiaries with mental impairments increased from 24% to 31%.¹¹⁴

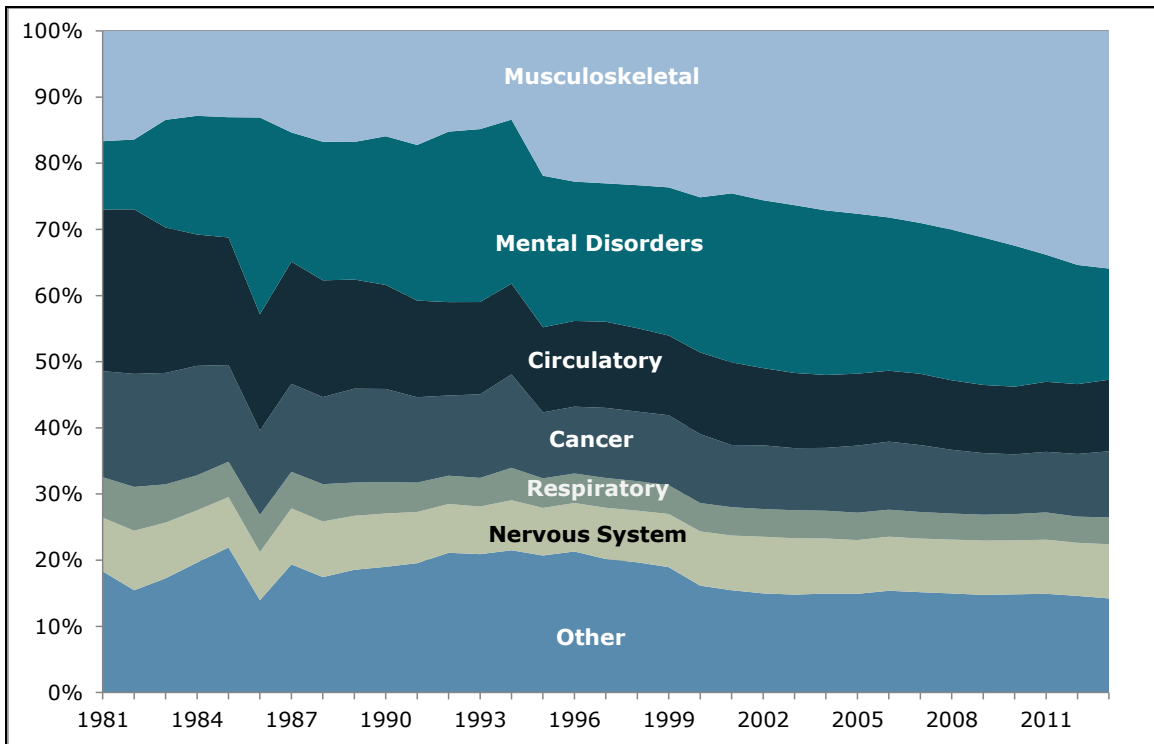
(...continued)

Policy Options, MIT and NBER, November 2011, p. 5, <http://economics.mit.edu/files/6880>. See also Autor and Duggan, “The Growth in the Social Security Disability Rolls,” p. 11; Duggan and Imberman, “Why Are the Disability Rolls Skyrocketing?”; and U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Fifth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Richard Burkhauser, Ph.D., 112th Cong., 2nd sess., September 14, 2012, http://waysandmeans.house.gov/uploadedfiles/burkhauser_testimony_ss914.pdf (hereinafter cited as “Testimony of Richard Burkhauser, 2012”).

¹¹² SSA, SSDI Annual Report 2013, Table 40.

¹¹³ L. Scott Muller et al., *Trends in the Social Security and Supplemental Security Income Disability Programs*, SSA, August 2006, p. 44, http://www.ssa.gov/policy/docs/chartbooks/disability_trends/index.html.

¹¹⁴ HHS, SSA, *Annual Statistical Supplement, 1987*, December 1987, Table 103, (hereinafter cited as “SSA, Annual Statistical Supplement 1987”) and SSA, SSDI Annual Report 2013, Table 21.

Figure 11. Percentage Distribution of SSDI Awards, by Diagnostic Group, 1981-2013

Source: SSA, *Annual Statistical Report on the Social Security Disability Insurance Program, 2013, 2014*, Table 40, http://www.ssa.gov/policy/docs/statcomps/di_asr/2013/sect03c.html#table40.

Notes: For information on the diagnostic categories, see the *Listing of Impairments* in the SSA publication *Disability Evaluation Under Social Security*, available at <http://www.SSA.gov/disability/professionals/bluebook/>. This publication is commonly referred to as the *Blue Book*.

The change in musculoskeletal impairments was even more pronounced. Between 1985 and 1994, awards based on musculoskeletal disorders remained roughly constant, rising from 13% to 13.4%. However, due to a change in the reporting method for awards, the percentage of awardees with musculoskeletal impairments jumped to 22% in 1995, later increasing to 36% in 2013.¹¹⁵ From 1986 to 2013, the share of all beneficiaries with musculoskeletal impairments grew from 18% to 31%.¹¹⁶

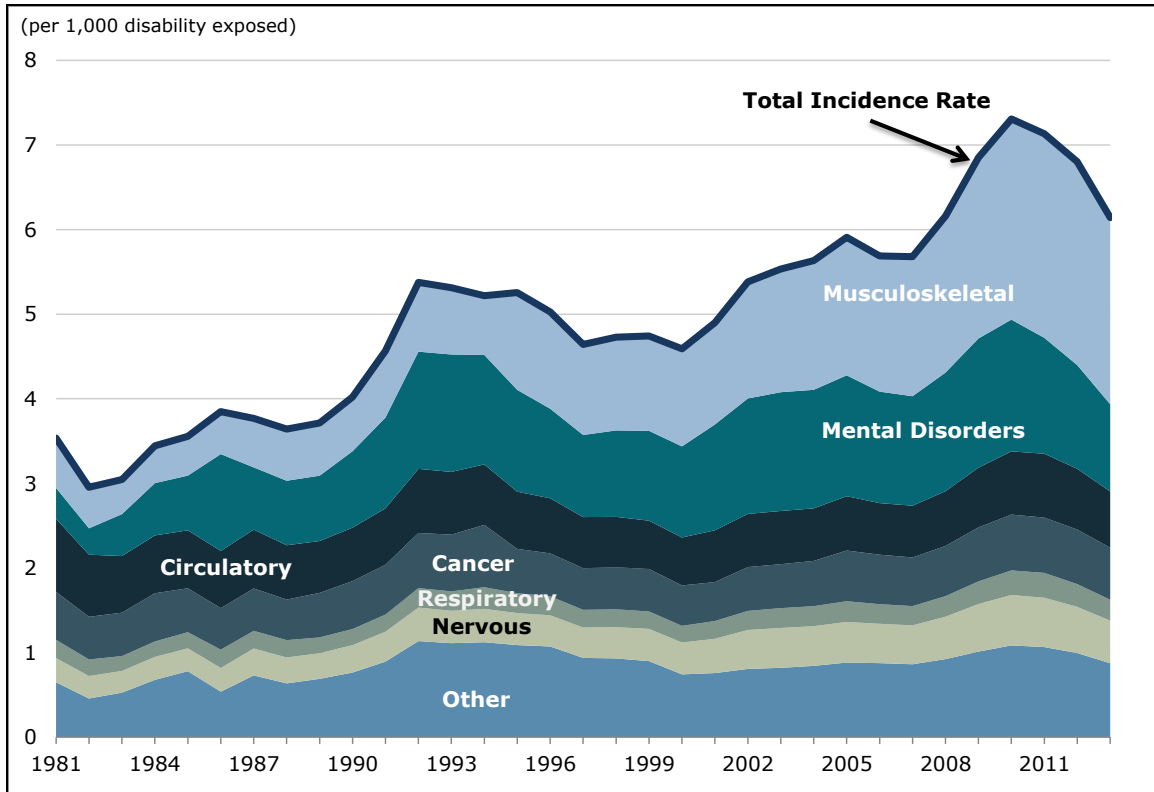
For an alternative perspective, **Figure 12** shows the change in the incidence of various diagnostic groups over time. Although the incidence of other diagnostic groups, such as circulatory-related disabilities, stayed roughly constant over the past 30 years, the growth in musculoskeletal and

¹¹⁵ Tim Zayatz, *Social Security Disability Insurance Program Workers Experience: Actuarial Study No. 122*, SSA, May 2011, p. 8. Prior to 1995, SSA reported the diagnosis of awards based on the distribution of allowances at the initial level assuming that the diagnostic data for awards at the appeals level had the same groupings as those at the initial level. Starting in 1995, SSA included diagnostic information from the reconsideration level of the appeals process in its determination of the annual number of awards. In 2003, SSA developed a new way of incorporating diagnostic information from all levels of the appeals process to report award data. Because claimants with musculoskeletal impairments tend to have higher-than-average final allowance rates, the reporting changes resulted in an increase in the annual number of newly awarded beneficiaries with musculoskeletal impairments. For more information on outcome variation by diagnostic group, see Javier Meseguer, "Outcome Variation in the Social Security Disability Insurance Program: The Role of Primary Diagnoses," *Social Security Bulletin*, vol. 73, no. 2 (May 2013), Chart 3, <http://www.ssa.gov/policy/docs/ssb/v73n2/v73n2p39.html>.

¹¹⁶ SSA, *Annual Statistical Supplement 1987*, Table 103, and SSA, *SSDI Annual Report 2013*, Table 21.

mental awards was such that the share of awards based on other disabilities declined (**Figure 11**). In other words, as mental and musculoskeletal awards increased in absolute terms, other impairments remained generally steady. However, because the overall rate of mental and musculoskeletal awards increased, the share of other impairments decreased.

Figure 12. SSDI Incidence Rates, by Diagnostic Group, 1981-2013



Source: Calculated by CRS based on data from SSA, *Annual Statistical Report on the Social Security Disability Insurance Program, 2013*, Tables 1 and 40, and SSA, "Disability Insured Workers."

The growth in the share of beneficiaries with mental and musculoskeletal impairments may have also increased the disability rolls by increasing the average length of time that beneficiaries stay on SSDI.¹¹⁷ Mortality rates for beneficiaries with mental or musculoskeletal impairments are lower than average, while their conversion rates are higher than average.¹¹⁸ As a result, they experience a longer-than-average duration of benefit receipt.¹¹⁹ Furthermore, because

¹¹⁷ Kalman Rupp and Charles G. Scott, "Trends in the Characteristics of DI and SSI Disability Awardees and Duration of Program Participation," *Social Security Bulletin*, vol. 59, no. 1 (January 1996), pp. 6-7, <http://www.ssa.gov/policy/docs/ssb/v59n1/index.html>. See also Autor and Duggan, "The Growth in the Social Security Disability Rolls," p. 79.

¹¹⁸ Rupp and Scott, "Trends in the Characteristics of DI and SSI Disability Awardees and Duration of Program Participation," Table 1, p. 6. See also John C. Hennessey and Janice M. Dykacz, "A Comparison of the Recovery Termination Rates of Disabled-Worker Beneficiaries Entitled in 1972 and 1985," *Social Security Bulletin*, vol. 56, no. 2 (Summer 1993), pp. 60-61, <http://www.ssa.gov/policy/docs/ssb/v56n2/v56n2p58.pdf>.

¹¹⁹ Rupp and Scott, "Trends in the Characteristics of DI and SSI Disability Awardees and Duration of Program Participation," Table 2, p. 7.

beneficiaries with mental impairments enter the program at younger-than-average ages, their time on SSDI could last decades.¹²⁰

Other Potential Factors

Changes in the Health of the Working-Age Population

It is unclear whether overall changes in population health have affected the size of the SSDI program. Although mortality rates at all ages have fallen markedly over the last half-century, indicating generally improved health, the rise in conditions such as obesity and diabetes—which may increase the risk for certain diseases and other health problems—might have increased the share of the population with severe disabilities.¹²¹

Thus far, researchers have failed to reach a consensus on whether working-age adults are healthier or unhealthier.¹²² Some research indicates that reported rates of disability have grown, especially among the younger working-age population.¹²³ On the other hand, some researchers have found that the likelihood of near-elderly individuals (ages 50-64) to report a work-limiting disability has declined, while the health of younger workers has stayed roughly the same.¹²⁴

Part of the problem in determining trends in the prevalence of disability in the working-age population stems from the fact that there is no single, universally accepted definition or measure of disability.¹²⁵ Although many of the large surveys used by researchers specifically ask questions pertaining to disability, the wording and complexity of the questions often differs. Because many surveys are self-reporting, the definition of what constitutes a work-limiting disability often rests entirely on the subjectivity of the respondent. As a result, trends in the prevalence of disability vary by survey and by the definition of disability.¹²⁶

Given the inconclusive literature, it seems unlikely that changes in the prevalence of disability in the working-age population can adequately explain the growth in the SSDI rolls.

¹²⁰ Ibid. Of a cohort of beneficiaries awarded benefits in 1972, the estimated average length of disability spells for beneficiaries ages 18 to 34 with mental disorders was 25.5 years.

¹²¹ For a discussion of the relationship between obesity, health, and non-employment, see Kristin F. Butcher and Kyung H. Park, “Obesity, Disability, and the Labor Force,” *Economic Perspectives*, vol. 32, no.1 (February 2008), Federal Reserve Bank of Chicago, <https://www.chicagofed.org/publications/economic-perspectives/2008/1qtr2008-part1-butcher-park>.

¹²² See H. Stephen Kaye, “Disability Rates for Working-Age Adults and for the Elderly Have Stabilized, but Trends for Each Mean Different Results for Costs,” *Health Affairs*, vol. 32, no. 1 (January 2013), pp. 127-134. See also Linda G. Martin et al., “Trends in Disability and related Chronic Conditions Among People Ages Fifty to Sixty-Four,” *Health Affairs*, vol. 29, no. 4 (April 2010), pp. 725-731.

¹²³ See Darius N. Lakdawalla, Jayanta Bhattacharya, and Dana P. Goldman, “Are the Young Becoming More Disabled?,” *Health Affairs*, vol. 23, no. 1 (January 2004), pp. 168-176. See also John Bound and Timothy Waidmann, “Employment Rates among Working-Aged Men and Women with Disabilities,” *Journal of Human Resources*, vol. 37, no. 2 (Spring 2002), pp. 231-250.

¹²⁴ See Duggan and Imberman, “Why Are the Disability Rolls Skyrocketing?,” p. 354. The authors found that the improved health of individuals ages 50-64 might have slowed the growth in the SSDI rolls between 1984 and 2002.

¹²⁵ Disability Statistics, “Frequently Asked Questions: What is the definition of disability?,” Maintained by Cornell University, <http://www.disabilitystatistics.org/faq.cfm#Q3>.

¹²⁶ See Andrew J. Houtenville et al., “Disability Prevalence and Demographics,” in *Counting Working-Age People with Disabilities: What Current Data Tell Us and Options for Improvement*, ed. Andrew J. Houtenville et al. (Kalamazoo, MI: W. E. Upjohn Institute for Employment Research, 2009), pp. 69-99.

Variation in the Disability Determination and Appeals Process

Some researchers have suggested that inconsistency in the disability determination and appeals process contributed to the growth in the program, but the evidence on the issue is inconclusive. Depending on the case, variation can both increase and decrease the overall allowance rate. Disability examiners and ALJs with high allowance rates may be offset by examiners and judges with low allowance rates.

As earlier noted, DDS examiners use a combination of medical and functional evidence to determine whether an impairment precludes a claimant from engaging in SGA. Although DDS examiners base their initial determinations on uniform guidelines established by the SSA, regional differences in demographic, health, and employment characteristics may produce variation in initial allowance rates among DDS offices.¹²⁷ However, one study found an appreciable degree of variation in determination outcomes across examiners *within* the same DDS office.¹²⁸ The study estimated that up to 60% of applicants “could have received a different initial determination from at least one other examiner in the DDS office.”¹²⁹ Even though the appeals process mitigated some of this variation, the study concluded that up to 23% of claimants could have ultimately received different outcomes had other examiners in the DDS office performed the determination.¹³⁰

Some have speculated that the uncertainty of an outcome at the initial determination level due to variation across DDS examiners likely encouraged denied claimants to pursue the appeals process, increasing their likelihood of SSDI receipt.¹³¹ The aforementioned study found that claimants denied by stricter examiners were more likely to appeal their determinations.¹³² Although most of the awards granted by SSA are made at the initial determination level, the hearing level has the highest allowance rate of any step in the determination and appeals process. In FY2013, the allowance rate at the hearing level was 48%, compared with 33% at the initial level, 11% at the reconsideration level, 1% at the Appeals Council level, and 2% at the federal court level.¹³³ The study found that 75% of denied claimants who contested their initial determinations had their denials overturned eventually on appeal.¹³⁴

¹²⁷ For additional information, see Alexander Strand, *Social Security Disability Programs: Assessing the Variation in Allowance Rates*, SSA, ORES Working Paper no. 98, August 2002, <http://www.ssa.gov/policy/docs/workingpapers/wp98.html>. See also Norma B. Coe et al., *What Explains Variation in SSDI Application Rates?*, Center for Retirement Research at Boston College, <http://crr.bc.edu/working-papers/what-explains-state-variation-in-ssdi-application-rates/>.

¹²⁸ Nicole Maestas, Kathleen J. Mullen, and Alexander Strand, “Does Disability Insurance Receipt Discourage Work? Using Examiner Assignment to Estimate Causal Effects of SSDI Receipt,” *American Economic Review*, vol. 103, no. 5 (August 2013), pp. 1797-1829..

¹²⁹ Testimony of Nicole Maestas, in U.S. Congress, House Ways and Means, Social Security, *Third in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, 112th Cong., 2nd sess., March 20, 2012, 112-SS14, p. 3, http://waysandmeans.house.gov/uploadedfiles/nicolemaestas_ss_3_20_12s.pdf (hereinafter cited as “Maestas Testimony, 2012”).

¹³⁰ *Ibid.* Although the study found that 23% of applicants *could* have received different outcomes, there is no guarantee that the applicants *would* have received different decisions had their cases been assigned to different DDS examiners.

¹³¹ *Ibid.*

¹³² Maestas, Mullen, and Strand, “Does Disability Insurance Receipt Discourage Work?,” p. 1821.

¹³³ SSA, *Justification of Estimates for Appropriations Committees Fiscal Year 2015*, March 2014, p. 144, Table 3.26, <http://www.ssa.gov/budget/>. The allowance rate includes SSDI, SSI, and concurrent initial disability determinations and appeals decisions.

¹³⁴ Maestas, Mullen, and Strand, “Does Disability Insurance Receipt Discourage Work?,” p. 1806.

Others contend that variation in the allowance rates at the hearing level of the appeals process contributed to the number of workers on SSDI. A 2013 report by SSA's Office of the Inspector General (OIG) discovered wide variances in the allowance rates among some ALJs within the same hearing office.¹³⁵ Additionally, an earlier OIG report found a direct relationship between the number of cases adjudicated by outlier ALJs (i.e., judges at the extreme ends of the distribution scale) and allowance rates.¹³⁶ ALJs with the highest allowance rates adjudicated more dispositions relative to the office average, while ALJs with the lowest allowance rates adjudicated fewer dispositions compared with the office average.¹³⁷ A 2014 OIG report estimated that judges with 700 or more dispositions and allowance rates of 85% or higher improperly allowed benefits in approximately 24,900 cases over a seven-year period, resulting in "questionable costs" of more than \$2 billion.¹³⁸

Even in the absence of such variation, those claimants improperly granted awards by outlier examiners and judges might have eventually been found disabled in the future. One study found that over 60% of claimants denied at the hearing level of the appeals process were later awarded benefits within 10 years.¹³⁹ One possible explanation is that the health of some initially rejected claimants with marginal disabilities may deteriorate to the point that they meet SSA's definition of disability several years later. Therefore, inconsistency in the disability determination and appeals process may simply accelerate receipt of benefits for some workers.

Reform Proposals

This section examines options to manage the long-term growth in the SSDI program. These options have been proposed by numerous sources, including researchers, advocacy organizations, federal agencies, and the Social Security Advisory Board (SSAB).¹⁴⁰ For an overview of options to reduce benefit levels or to increase program revenues, see CBO's 2012 report, *Policy Options for the Social Security Disability Insurance Program*, available at <https://www.cbo.gov/publication/43421>.

As noted previously, while many of the proposals discussed in this report have the potential to slow or even reverse the prevalence of SSDI receipt and thus generate savings to the program over the longer term, such proposals are unlikely to produce savings in time to forestall the

¹³⁵ SSA, Office of the Inspector General (OIG), *Identifying and Monitoring Risk Factors at Hearing Offices*, Audit Report A-12-12-11289, January 2013, p. 7, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-12-12-11289>.

¹³⁶ SSA, OIG, *Congressional Response Report: Oversight of Administrative Law Judge Workload Trends*, A-12-11-01138, February 14, 2012, p. 8, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-12-11-01138>.

¹³⁷ Another study found a small but statistically significant correlation between the number of cases adjudicated by ALJs and their allowance rates. However, the study's authors noted that this relationship could account for only about 2% of the variance in allowance rates. For more information, see Harold J. Krent and Scott Morris, *Achieving Greater Consistency in Social Security Disability Adjudication: An Empirical Study and Suggested Reforms*, Draft Report, March 3, 2013, p. 24, http://www.acus.gov/sites/default/files/documents/Achieving_Greater_Consistency_Draft_Report_3-3-2013.pdf. See also Robert Nakosteen and Michael Zimmer, "Approval of Social Security Disability Appeals: Analysis of Judges' Decisions," *Applied Economics*, vol. 46, no. 23 (May 6, 2014), pp. 2783-2791.

¹³⁸ SSA, OIG, *Congressional Response Report: Administrative Law Judges with Both High Dispositions and High Allowance Rates*, A-12-14-24092, November 14, 2014, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-12-14-24092>.

¹³⁹ Eric French and Jae Song, "The Effect of Disability Insurance Receipt on Labor Supply," *American Economic Journal: Economic Policy*, vol. 6, no. 2 (May 2014), pp. 291-337.

¹⁴⁰ SSAB is an independent board charged with advising the commissioner of Social Security on issues related to the OASDI and SSI programs (42 U.S.C. §903). For more information, visit <http://ssab.gov/>.

projected exhaustion of the DI trust fund. To avoid a 20% cut in benefits in 2016, lawmakers would likely need to enact some kind of short-term financing, such as a reallocation of the Social Security payroll tax rate or interfund borrowing.¹⁴¹

Tighten Eligibility Criteria

One policy option to reduce the growth in the SSDI rolls is to tighten the program's eligibility requirements. In general, the aim of tightening eligibility criteria is to mitigate the number of marginally disabled individuals on the program while continuing to grant awards to the most severely disabled individuals. Because marginally disabled individuals have some remaining capacity to work, rejecting their applications would generally cause less harm to them than to more severely disabled individuals.¹⁴² That said, there is no guarantee that all marginally disabled individuals can work. Although it is difficult to discern which type of claimants would be affected by more stringent eligibility requirements, a recent study found that marginal program entrants are more likely to be younger, suffer from mental impairments, and have low earnings histories.¹⁴³ Henry Aaron, chair of the Social Security Advisory Board, summarized that “the challenge for society is to choose a definition that best balances its willingness to award benefits to some people who do not ‘deserve’ them and to deny benefits to some who do.”¹⁴⁴

Enacting stricter eligibility criteria would also affect other federal spending and tax programs.¹⁴⁵ On the one hand, tightening standards would not only directly reduce spending through a higher rejection rate; it would also likely discourage some individuals from applying for SSDI in the first place.¹⁴⁶ Additionally, stricter standards would likely encourage some prospective applicants to continue to work, which would increase tax receipts.¹⁴⁷ On the other hand, some people who could no longer qualify for SSDI would seek other federal support. For example, individuals with sufficiently low income and assets could potentially qualify for SSI, increasing federal spending.¹⁴⁸

Eliminate Eligibility for SSDI Benefits at Age 62 or Later

As noted earlier, workers between the ages of 62 and FRA who apply for early Social Security retirement benefits are subject to a reduction in their monthly benefits. In contrast, workers between the ages of 62 and FRA who apply for SSDI benefits receive about the same benefit that they would have received had they applied for retirement benefits at their FRA. Some Members

¹⁴¹ For more information, see CRS Report R43318, *Social Security Disability Insurance (DI) Trust Fund: Background and Solvency Issues*, by (name redacted).

¹⁴² Maestas, Mullen and Strand, “Does Disability Insurance Receipt Discourage Work?,” p. 1818. The authors found that the employment of marginal program entrants would have been, on average, 28 percentage points higher two years after the initial determination had they not received SSDI. This figure dropped to 16 percentage points four years after the initial determination.

¹⁴³ *Ibid.*, p. 1801.

¹⁴⁴ Henry J. Aaron, “With Disability Benefits Running on Fumes, What to Do?,” Brookings Institution, October 28, 2014, <http://www.brookings.edu/research/opinions/2014/10/28-disability-benefits-aaron>.

¹⁴⁵ CBO, *Policy Options 2012*, pp. 8-9.

¹⁴⁶ Susan E. Chen, “Rejection from the Disability Insurance Program and Dependency on Social Support,” University of Michigan Retirement Research Center, 2014, <http://www.mrrc.isr.umich.edu/publications/papers/pdf/wp305.pdf>.

¹⁴⁷ Maestas, Mullen and Strand, “Does Disability Insurance Receipt Discourage Work?” See also David H. Autor et al., “Does Delay Cause Decay? The Effect of Administrative Decision Time on the Labor Force Participation and Earnings of Disability Applicants,” January 2015, <http://economics.mit.edu/files/10336>.

¹⁴⁸ Chen, “Rejection from the Disability Insurance Program and Dependency on Social Support,” p. 18.

of Congress have expressed concern that the differential between disability and early retirement may induce workers between the ages of 62 and FRA to apply for SSDI as a means of increasing their total benefits.¹⁴⁹ In 2013, 9% of the nearly 869,000 awards issued by SSA went to individuals between the ages of 62 and FRA.¹⁵⁰

To reduce the growth in the SSDI rolls, policymakers could eliminate eligibility for SSDI benefits starting at age 62. Instead, workers between the ages of 62 and FRA would be eligible only for early retirement benefits. Under current law, the penalty for taking early retirement at age 62 is a 25% to 30% monthly reduction in cash benefits, depending on year of birth. CBO recently estimated that preventing workers from applying for SSDI benefits after their 62nd birthday or receiving SSDI benefits if they became eligible after that date starting in 2016 would reduce federal outlays by \$10.6 billion between 2015 and 2024, or 0.6% of scheduled outlays for SSDI.¹⁵¹

One reason to eliminate eligibility starting at age 62 is that it could “encourage individuals that seek disability benefits as an early retirement program to remain in the work force.”¹⁵² However, opponents point out that this option would adversely affect older workers with little or no capacity to work in the national economy, especially those workers near or below the poverty line.¹⁵³

Increase the Recency-of-Work Requirement

To become insured under the Social Security program, workers must accrue work credits—known as *quarters of coverage*—based on their earnings in covered employment.¹⁵⁴ In 2015, workers are credited with one quarter of coverage for each \$1,220 in earnings, up to the maximum of four quarters of coverage per year.¹⁵⁵ To qualify for SSDI, workers must have earned a minimum number of quarters of coverage based on their age and generally must have earned at least 20 quarters of coverage during a 40-calendar quarter period ending with the quarter in which their disabilities began.¹⁵⁶ In other words, disability claimants must have worked for five of the past 10 years to be eligible for SSDI. That “recency-of-work” requirement—sometimes known as the 20/40 rule—restricts the program to individuals who have worked of late and for a reasonable length of time in covered employment.

¹⁴⁹ For an example, see Senator Tom Coburn, “Back in Black: A Deficit Reduction Plan,” July 2011, p. 554, <http://www.coburn.senate.gov/public/?p=deficit-reduction>.

¹⁵⁰ SSA, SSDI Annual Report 2013, Table 39. Starting in 2007, age is based on date of entitlement and not date of award.

¹⁵¹ CBO, *Options for Reducing the Deficit: 2015 to 2024*, November 2014, p. 14, <http://www.cbo.gov/budget-options/2014> (hereinafter cited as “CBO, Options for Reducing the Deficit 2014”). Estimates are relative to CBO’s August 2014 baseline projections and do not include any effects on spending for other federal programs, such as Medicare, Medicaid, and SSI.

¹⁵² Coburn, “Back in Black,” p. 554.

¹⁵³ Kathy Ruffing, “Disability Insurance Provides Vital Benefits to Vulnerable Workers,” Center on Budget and Policy Priorities, July 15, 2013, <http://www.offthechartsblog.org/disability-insurance-provides-vital-benefits-to-vulnerable-workers/>.

¹⁵⁴ For more information, see SSA, *How You Earn Credits*, 2014, <http://www.ssa.gov/pubs/EN-05-10072.pdf>.

¹⁵⁵ The amount of earnings needed for a quarter of coverage is adjusted annually based on the average wage index. For more information, see SSA, “Quarter of Coverage,” <http://www.ssa.gov/oact/cola/QC.html>.

¹⁵⁶ 42 U.S.C. §423(c) and 20 C.F.R. §404.130. Younger workers may meet the recency-of-work requirement with fewer quarters of coverage based on their age.

CBO recently estimated the impact of increasing the recency-of-work requirement on beneficiary enrollment. According to the agency, requiring non-blind disability claimants to have worked four of the past six years (instead of five of the past 10) starting in 2016 would reduce federal outlays by \$32.4 billion between 2015 and 2024, or 1.8% of scheduled outlays for SSDI.¹⁵⁷

The stricter recency-of-work requirement would likely affect individuals with intermittent work histories, specifically workers with prolonged and sustained bouts of absence from covered employment due to unemployment or withdrawal from the labor force.¹⁵⁸ One study found that while working-age men (ages 25-54) report leaving the labor force primarily because of disability, working-age women typically report leaving the labor force to care for someone in their household.¹⁵⁹ Consequently, the more stringent recency-of-work requirement may disproportionately affect women who drop out of the labor force to act as caregivers.¹⁶⁰

Adjust the Age Categories for Vocational Factors

Another option is to raise the age categories for “vocational factors.” In addition to assessing an applicant’s medical condition, DDS examiners take into account the individual’s ability to perform any past relevant work or other work that exists in the national economy. Vocational factors such as age, education, and work experience—in combination with the individual’s residual functional capacity—help an examiner to determine whether an applicant’s impairment precludes him or her from engaging in SGA. Since vocational factors such as education and work experience typically become less stringent with age, SSA is more likely to award benefits to older insured workers.

Currently, SSA categorizes older workers across four age ranges: 45-49, 50-54, 55-59, and 60 and older.¹⁶¹ CBO examined the effects of increasing the 45-49 and 50-54 age ranges by two years to 47-51 and 52-56 and making 57 to FRA the new maximum range, thereby eliminating the 45, 46, and 60 and older categories. According to CBO, if this option had been implemented in 2013, it would have decreased the number of SSDI beneficiaries by 50,000 or 0.5% in 2022, as well as reduced program expenditures by \$1.0 billion in that year.¹⁶²

¹⁵⁷ CBO, *Options for Reducing the Deficit 2014*, p. 14. Estimates are relative to CBO’s August 2014 baseline projections and do not include any effects on spending for other federal programs, such as Medicare, Medicaid, and SSI.

¹⁵⁸ Unemployment refers to all individuals aged 16 and older who (1) do not have a job, (2) have actively looked for work in the prior four weeks, and (3) are currently available for work. Individuals out of the labor force are currently not working and not actively looking for a job. For more information, see BLS, “How the Government Measures Unemployment,” June 12, 2014, http://www.bls.gov/cps/cps_htgm.htm.

¹⁵⁹ Julie L. Hotchkiss, M. Melinda Pitts, and Fernando Rios-Avila, *A Closer Look at Nonparticipants During and After the Great Recession*, Federal Reserve Bank of Atlanta, Working Paper 2012-10, August 2012, p. 6, http://www.frbatlanta.org/pubs/wp/12_10.cfm.

¹⁶⁰ For an example, see Sarah E. Hoffman, “Falling Through the Cracks: How the 20/40 Rule Discriminates Against Women Seeking Social Security Disability Insurance Benefits and What Congress Can Do About It,” *Penn State Law Review*, vol. 113, no. 2 (2008).

¹⁶¹ 20 C.F.R. §404.1563. See also SSA, POMS, “DI 25001.001 Medical-Vocational Quick Reference Guide,” January 17, 2014, <http://policy.ssa.gov/poms.nsf/lnx/0425001001>. In general, SSA categorizes claimants based on three age ranges: under age 50, age 50-54, and age 55 or over. However, the agency uses the subcategory “age 45-49” in assessing a claimant’s capacity to do sedentary work and the subcategory “age 60 or older” in determining a claimant’s ability to perform medium level work.

¹⁶² CBO, *Policy Options 2012*, p. 18. Adjusting the age ranges of vocational factors would have also decreased outlays to Medicare.

SSA explored raising the age categories in the past but ultimately decided against it. In 2005, SSA issued a Notice of Proposed Rulemaking (NPRM) to increase the age categories for older insured workers by two years.¹⁶³ However, after collecting feedback from the public, SSA withdrew the NPRM in 2009.¹⁶⁴

Improved Administration of the Program

One option is to improve the way in which SSA administers the program so that fewer non-meritorious people receive benefits. Variation in the application of program rules can distort the disability determination and adjudication process, resulting in SSA granting awards to non-meritorious claimants or denying benefits to claimants with little or no capacity to work. Similarly, diminished program integrity—whether through waste, fraud, or abuse—may permit some beneficiaries to remain on SSDI even after their health improves. This subsection outlines reforms to the administration of the program that could conceivably reduce the growth in the SSDI rolls.

Permit SSA to Be Represented at the Hearing Level of the Appeals Process

In general, a claimant displeased with the decision at the reconsideration level of the appeals process may request a hearing before an ALJ, in writing, within 60 days upon receipt of the previous determination.¹⁶⁵ At the hearing level, a claimants may present additional evidence or arguments to support the case and appoint a representative to act on his or her behalf. Most claimants are represented by attorneys at ALJ hearings.¹⁶⁶ Since SSA is not represented at the hearing, the proceeding is considered *inquisitorial* or non-adversarial.¹⁶⁷ Under the inquisitorial process, an ALJ investigates the merit of an appeal by informally questioning the claimant and any scheduled witnesses (e.g., medical or vocational experts).

Proponents of this process argue that the informal nature of the proceedings and lack of cross-examination by an opposing attorney encourages claimants to share more information with the ALJ.¹⁶⁸ Moreover, supporters note that in *Richardson v. Perales*, the Supreme Court found that SSA hearings should be “understandable to the layman claimant, should not necessarily be stiff and comfortable only for the trained attorney, and should be liberal and not strict in tone and operation. This is the obvious intent of Congress so long as the procedures are fundamentally fair.”¹⁶⁹

Opponents contend that inquisitorial process makes it harder for ALJs to make informed decisions on a consistent basis, because they must remain impartial while simultaneously

¹⁶³ For more information, see SSA, “Age as a Factor in Evaluating Disability,” 70 *Federal Register* 67104, November 4, 2005, <http://www.gpo.gov/fdsys/granule/FR-2005-11-04/05-21975/content-detail.html>.

¹⁶⁴ SSA, “Age as a Factor in Evaluating Disability,” 74 *Federal Register* 21563, May 8, 2009, <http://www.gpo.gov/fdsys/granule/FR-2009-05-08/E9-10733/content-detail.html>.

¹⁶⁵ SSA eliminated the reconsideration step of the appeals process in 10 states. As a result, claimants who are denied at the initial determination level in these states may appeal directly to an ALJ. For more information, see footnote 23.

¹⁶⁶ SSAB, Data and Materials 2012, p. 60.

¹⁶⁷ See 20 C.F.R. §§404.900(b) and 405.1(c).

¹⁶⁸ Testimony of Ethel Zelenske in U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Fourth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, 112th Cong., 2nd sess., June 27, 2012, http://waysandmeans.house.gov/uploadedfiles/zelenske_testimony.pdf.

¹⁶⁹ *Richardson vs. Perales*, 402 U.S. 389, 400-401 (1971).

representing the interests of both claimants and SSA.¹⁷⁰ According to the Association of Administrative Law Judges (AALJ), having to wear all three “hats” during a hearing sometimes places an ALJ in an untenable situation, in which the judge must represent clients whose interests are at odds with one another.¹⁷¹ The difficulty of maintaining impartiality while simultaneously representing the interests of both parties may cause an ALJ to overlook a key piece of evidence or argument, thereby affecting the outcome of the decision.

To improve the accuracy of ALJs’ decisions, the AALJ,¹⁷² the SSAB,¹⁷³ and some Members of Congress¹⁷⁴ have advocated switching from an inquisitorial to an adversarial process in which claimants and SSA are each afforded representation. The AALJ and SSAB argue that the vigorous cross-examination of claimants by SSA representatives would provide ALJs with additional information, resulting in better decisions. According to SSAB, under the inquisitorial process, some ALJs may be reluctant to question claimants aggressively for fear of appearing to be biased.¹⁷⁵ SSAB contends that switching to an adversarial process would allow ALJs to investigate the history and extent of claimants’ medical impairments more thoroughly, resulting in better-reasoned decisions and greater judicial consistency.

Another potential advantage of the adversarial process is that government representation may reduce the number of cases that an ALJ would need to hear, which could further improve the quality of their decisions.¹⁷⁶ In 2013, SSA Deputy Commissioner Glenn Sklar testified that the agency expects ALJs to issue 500-700 decisions annually.¹⁷⁷ Some researchers speculate that the pressure to adjudicate a high number of disability claims quickly has led to poorer ALJ decisions and consequently a higher allowance rate.¹⁷⁸ According to a 2013 Senate report, this pressure

¹⁷⁰ See SSAB, *Charting the Future of Social Security’s Disability Programs: The Need for Fundamental Change*, January 2001, p. 19, <http://www.ssab.gov/Publications/Disability/disabilitywhitepap.pdf> (hereinafter cited as “SSAB, Fundamental Change 2001”). See also material submitted for the record by the Honorable D. Randall Frye, U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Fourth in a Hearing Series on Security the Future of the Social Security Disability Insurance Program*, 112th Cong., 2nd sess., June 27, 2012, H. Doc. 112-SS18 (Washington: GPO, 2012), <http://www.gpo.gov/fdsys/pkg/CHRG-112hhr80262/pdf/CHRG-112hhr80262.pdf> (hereinafter cited as “Testimony of D. Randall Frye, 2012”).

¹⁷¹ Testimony of D. Randall Frye, 2012, p. 58.

¹⁷² *Ibid.* See also AALJ, *Newsletter and President’s Report*, November 24, 2014, pp. 9-10, http://www.aalj.org/system/files/documents/aalj_newsletter_november_24_2014.pdf.

¹⁷³ See SSAB, Fundamental Change 2001, p. 19.

¹⁷⁴ See, for example, remarks of Rep. Trey Gowdy, in U.S. Congress, House Committee on Oversight and Government Reform, *Social Security Administration Oversight: Examining the Integrity of the Disability Determination Appeals Process*, 113th Cong., 2nd sess., June 10, 2014, Serial No. 113-128 (Washington: GPO, 2014), p. 58, <http://www.gpo.gov/fdsys/pkg/CHRG-113hhr89597/pdf/CHRG-113hhr89597.pdf>.

¹⁷⁵ SSAB, Fundamental Change 2001, p. 19.

¹⁷⁶ Testimony of D. Randall Frye, 2012, p. 209.

¹⁷⁷ Testimony of Glenn Sklar, Deputy Commissioner, Office of Disability Adjudication and Review, SSA, U.S. Congress, House Committee on Oversight and Government Reform, Subcommittee on Energy Policy, Health Care and Entitlements, *Continuing Oversight of the Social Security Administration’s Mismanagement of Federal Disability Programs*, 113th Cong., 1st sess., November 19, 2013, http://www.ssa.gov/legislation/testimony_111913.html (hereinafter cited as “Testimony of Glenn Sklar, 2013”).

¹⁷⁸ Jagadeesh Gokhale, “SSDI Reform: Promoting Gainful Employment while Preserving Economic Security,” Cato Institute, October 22, 2014, p. 15, http://object.cato.org/sites/cato.org/files/pubs/pdf/pa762_1.pdf. See also U.S. Congress, House Committee on Oversight and Government Reform, *Misplaced Priorities: How the Social Security Administration Sacrificed Quality for Quantity in the Disability Determination Process*, staff report, 113th Cong., 2nd sess., December 18, 2014., <http://oversight.house.gov/wp-content/uploads/2014/12/2014-12-18-Misplaced-Priorities.-How-SSA-Sacrificed-Quality-for-Quantity.pdf>.

stems from a 2007 plan by SSA to reduce its backlog of disability hearings.¹⁷⁹ One reason why the pressure to hear a large volume of cases may have increased the overall allowance rate is that issuing an award is generally not appealed by a claimant and is therefore subject to less scrutiny than a denial would be. A 2014 story on SSA's disability backlog in the *Washington Post* noted that “judges complain that saying ‘yes’ is a lot easier—and faster—than saying ‘no.’ A negative decision often requires a lengthier write-up, which goes through all the different ailments that might have rendered this person disabled. That means 10 pages of text to prepare for a future appeal. A ‘yes’ decision is rarely appealed. So, they say, it takes less writing.”¹⁸⁰ The AALJ contends that switching to an adversarial process would allow government attorneys to settle cases with a high probability of reversal before the hearing level, giving ALJs more time to adjudicate complicated cases or ones with a lower likelihood of being reversed.¹⁸¹ By allowing government representatives to decide which cases to defend, the adversarial process could reduce the pressure for ALJs to decide a high number of claims, which, in turn, could improve the quality of their decisions.

At a hearing in November 2013, SSA refuted the characterization that it is sacrificing quality by granting claims “too readily” and insisted that it is “making quicker, higher quality disability decisions.”¹⁸² The agency also noted that between FY2007 and FY2013, the share of ALJs with allowance rates of 85% or greater fell from 20% to 3%.¹⁸³

Difficulties with Switching to an Adversarial Process

Successfully implementing an adversarial process at the hearing level poses several challenges for SSA. First, it would require additional expenditures to hire attorneys and appropriate staff.¹⁸⁴ Disability hearings are already quite costly for SSA. In FY2011, the unit cost of adjudicating a disability hearing was about \$2,750, compared with about \$1,060 to process an initial disability claim.¹⁸⁵ Those extra costs would offset any savings from reduced benefit outlays.¹⁸⁶

¹⁷⁹ U.S. Congress, Senate Committee on Homeland Security and Governmental Affairs, *How Some Legal, Medical, and Judicial Professionals Abused Social Security Disability Programs for the Country's Most Vulnerable: A Case Study of the Conn Law Firm*, staff report, 113th Cong., October 4, 2013, p. 16, <http://www.hsgac.senate.gov/hearings/social-security-disability-benefits-did-a-group-of-judges-doctors-and-lawyers-abuse-programs-for-the-countrys-most-vulnerable>. At the end of FY2014, the hearings backlog stood at close to 1 million, 15% higher than at the end of the previous fiscal year. For more information, see SSA, *Agency Financial Report, Fiscal Year 2014*, November 10, 2014, p. 127, <http://www.ssa.gov/finance/>.

¹⁸⁰ David A. Fahrenthold, “Waiting on an Appeal to Social Security for Disability Benefits? Get in a Very Long Line,” *Washington Post*, October 18, 2014, <http://www.washingtonpost.com/sf/national/2014/10/18/the-biggest-backlog-in-the-federal-government/>.

¹⁸¹ Testimony of D. Randall Frye, 2012, p. 58.

¹⁸² Testimony of Glenn Sklar, 2013.

¹⁸³ *Ibid.* Figures reflect ALJs with at least 100 dispositions in the fiscal year and exclude dismissals.

¹⁸⁴ See testimony of Jeffrey Lubbers, Professor, American University Washington College of Law, in U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Fourth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, 112th Cong., 2nd sess., June 27, 2012, p. 16, http://waysandmeans.house.gov/uploadedfiles/lubbers_testimony.pdf.

¹⁸⁵ SSAB, *Filing for Social Security Disability Benefits: What Impact Does Professional Representation Have on the Process at the Initial Level*, September 2012, p. 6, footnote 9, <http://www.ssab.gov/Reports/Third-Party-2012-Full.pdf>.

¹⁸⁶ Under an adversarial process, SSA may be required to pay additional fees to claimants' representatives. For a discussion of the applicability and cost of fees permitted under the Equal Access to Justice Act, see Frank Bloch, Jeffrey Lubbers, and Paul Verkuil, *Introducing Nonadversarial Government Representatives to Improve the Record of Decision in Social Security Disability Adjudications*, SSAB, 2003, pp. 47-51, <http://www.ssab.gov/documents/Bloch-Lubbers-Verkuil.pdf>. See also SSA, POMS, “GN 03990.001 Equal Access to Justice Act—General,” February 11, (continued...)

Second, a federal judge issued an injunction against SSA's previous adversarial pilot program in 1986, so an adversarial process might require new legislative authority.¹⁸⁷ In 1982, SSA initiated the Social Security Administration Representation Project (SSARP) in five hearing offices across the country to test "whether the participation of SSA representatives in disability cases at the administrative hearing level can contribute toward improving the quality and timeliness of hearing dispositions."¹⁸⁸ Under the SSARP, government representatives reviewed hearing requests, initiated case development, and represented the agency whenever a claimant had an appointed representative at a hearing.

The SSARP sparked concern among some Members of Congress and the public over the "fairness of SSA's disability adjudication process."¹⁸⁹ One month into the pilot program, seven disability claimants challenged the SSARP in the Western District of Virginia seeking injunctive and declaratory relief.¹⁹⁰ In *Salling v. Bowen*, a district judge issued an injunction against the SSARP, finding that its procedures did not meet the standard for due process and were not "fundamentally fair."¹⁹¹ The judge also held that the pilot program violated the Social Security Act and intruded on the independence of ALJs. Although SSA appealed the court's decision, the agency ultimately discontinued the SSARP and revoked its regulations in 1987.¹⁹² According to the General Accounting Office (GAO; now the Government Accountability Office), the preliminary results of the pilot were never verified and a final report was never issued.¹⁹³

Third, the effects of switching to an adversarial process are difficult to predict. To determine the effectiveness of government representation, SSA would need to know:

- whether representation can improve the quality of ALJ decisions, and if so,
- whether higher-quality decisions reduce the overall allowance rate, and if so,
- whether the adversarial process can be done in a cost-effective manner.

(...continued)

2008, <http://policy.ssa.gov/poms.nsf/lnx/0203990001>.

¹⁸⁷ Bloch, Lubbers, and Verkuil, *Introducing Nonadversarial Government Representatives to Improve the Record of Decision in Social Security Disability Adjudications*, pp. 11-19.

¹⁸⁸ HHS, SSA, "Federal Old Age, Survivors and Disability Insurance and Supplemental Security Income for the Aged, Blind, and Disabled; Project To Improve the Hearing Process Through the Involvement of SSA Representatives," 47 *Federal Register* 36117-36118, August 19, 1982.

¹⁸⁹ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Current Problems in the Social Security Hearings and Appeals Process*, 99th Cong., 2nd sess., March 18, 1986, H.Hrg. 99-63 (Washington: GPO, 1986), pp. 2-57.

¹⁹⁰ Bloch, Lubbers, and Verkuil, *Introducing Nonadversarial Government Representatives to Improve the Record of Decision in Social Security Disability Adjudications*, p. 60.

¹⁹¹ *Salling vs. Bowen*, 641 F. Supp. 1046 (W.D. Va. 1986).

¹⁹² HHS, SSA, "Federal Old Age, Survivors and Disability Insurance and Supplemental Security Income for the Aged, Blind, and Disabled; Final Rule, Discontinuance of the SSA Representation Project," 52 *Federal Register* 17285-17286, May 7, 1987.

¹⁹³ GAO, *Social Security Disability: SSA Must Hold Itself Accountable for Continued Improvement in Decision-making*, HEHS-97-102, August 12, 1997, p. 43, <http://www.gao.gov/products/HEHS-97-102>. According to SSA, preliminary data indicated that the ALJ error rate for favorable decisions issued under the SSARP was 50% lower than the national error rate. For more information, see U.S. Congress, House Select Committee on Aging, *Government Representatives: Advocates or Adversaries*, 99th Cong., 1st sess., March 18, 1985, H.Hrg. 99-504 (Washington: GPO, 1985), p. 27.

Update SSA's Listing of Impairments

During the disability determination process, DDS examiners and medical and psychological consultants typically use medical evidence collected from the claimant's treating sources to determine the severity of the claimant's impairment.¹⁹⁴ To assess whether the impairment precludes the claimant from working, state disability examiners evaluate it against SSA's *Listing of Impairments* (hereinafter "listings"). The listings describe medical impairments that are considered severe enough to prevent an individual from performing any gainful activity for each of the 14 major adult body systems.¹⁹⁵ Most of the impairments described in the listings are permanent or expected to result in death.¹⁹⁶ All other listings must show that the impairment has lasted or is expected to last for at least one year. If the claimant's impairment meets (or is of equal severity to) the criteria in the listings, SSA considers the claimant disabled and therefore eligible for benefits. Claimants who do not meet the medical criteria in the listings proceed to a more individualized assessment that examines their remaining ability to work, taking into account certain vocational factors.¹⁹⁷

Although the listings serve as a useful guide for DDS examiners, the percentage of awards determined at the listings stage has decreased substantially over the years. Between FY1980 and FY2010, the share of initial allowances based on claimants meeting the medical listings declined from 58% to 38%, while the portion based on claimants having an impairment equal in severity fell from 16% to 8% over the same period (**Figure 13**).¹⁹⁸ SSAB, GAO, and SSA's OIG all attribute this decline to the increasingly outdated nature of the listings. In 2000, the OIG found that SSA had not updated certain listings in over 10 years; moreover, SSA had not updated the listings for mental disorders in 15 years.¹⁹⁹ In 2003, GAO identified SSDI as a high-risk program because it relied on listings that did not reflect the impact of medical and technological advances on work-limiting impairments.²⁰⁰

¹⁹⁴ If the evidence from a claimant's medical sources is insufficient to make a disability determination, DDS examiners can arrange for a consultative examination. For more information, see SSA, "Consultative Examinations: A Guide for Health Professionals, Part III - Consultative Examination Guidelines," accessed December 2014, <http://www.ssa.gov/disability/professionals/greenbook/ce-guidelines.htm>.

¹⁹⁵ For information on the *Listing of Impairments*, see SSA, "Disability Evaluation Under Social Security," <http://www.ssa.gov/disability/professionals/bluebook/>. See also GAO, *Modernizing SSA Disability Programs: Progress Made, but Key Efforts Warrant More Management Focus*, GAO-12-420, June 19, 2012, p. 3, <http://www.gao.gov/products/GAO-12-420>.

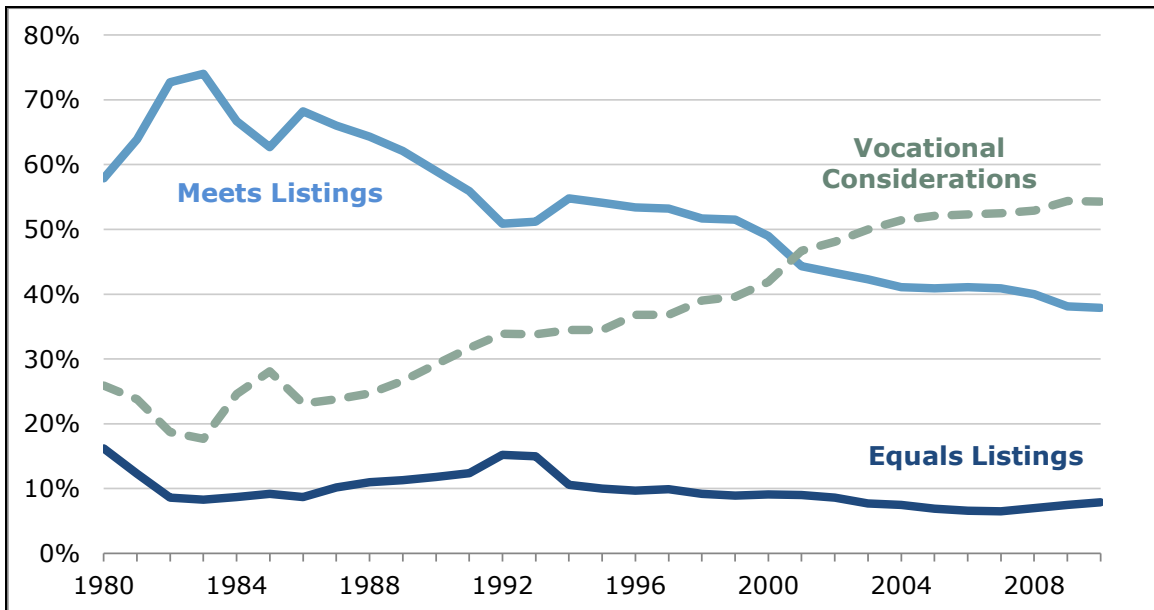
¹⁹⁶ For more information, see SSA, POMS, "DI 34001.001 Listing of Impairments—Purpose, Parts and Use," February 26, 2013, <http://policy.ssa.gov/poms.nsf/lnx/0434001001>.

¹⁹⁷ SSAB, *The Social Security Definition of Disability*, October 2003, p. 4, <http://www.ssab.gov/documents/SocialSecurityDefinitionOfDisability.pdf> (hereinafter cited as "SSAB, Definition of Disability 2003").

¹⁹⁸ SSAB, *Data and Materials 2012*, Table 40, p. 45.

¹⁹⁹ SSA, OIG, *The Social Security Administration's Listing of Impairments*, A-01-08-18023, March 27, 2009, p. 4, <http://oig.ssa.gov/social-security-administrations-listing-impairments>.

²⁰⁰ GAO, *High Risk Series: An Update*, GAO-03-119, January 1, 2003, pp. 20-21, <http://www.gao.gov/products/>. GAO designates certain federal programs as "high risk" in order to draw attention to issues related to efficiency, effectiveness, and accountability.

Figure 13. Basis for Decision of Initial SSDI Allowances, FY1980-FY2010

Source: SSAB, *Aspects of Disability Decision Making: Data and Materials*, February 2012, Table 40, http://www.ssab.gov/PublicationViewOptions.aspx?ssab_pub=115.

Note: Data do not reflect medical allowances made at the appeals levels.

To improve the quality and accuracy of disability determinations, SSA initiated a two-tiered process for updating its medical listings beginning in 2003.²⁰¹ Under the new process, the agency is to first complete a comprehensive revision of each listing category, taking into account any medical disorder or disease that may inhibit an individual's ability to work.²⁰² Once the comprehensive update is complete, SSA is to conduct periodic reviews of each listing category to ensure that the listings are current.²⁰³ SSA has completed comprehensive revisions to nine of the 14 major adult body systems.²⁰⁴

SSA has experienced delays in completing comprehensive updates to the remaining five major adult body systems.²⁰⁵ For example, SSA has still not completed a final revision of the listing for mental disorders—SSDI's second most diagnosed impairment—which last received a comprehensive update in 1985.²⁰⁶ SSA officials attribute the delay to a shortage of qualified staff and to the enormous complexity of implementing and revising new medical listings.²⁰⁷

²⁰¹ GAO, *Modernizing SSA Disability Programs*, p. 5.

²⁰² *Ibid.*, pp. 5-8. In 2010, SSA set a five-year cycle for updating listings following a comprehensive review.

²⁰³ SSA, "Appendix: Business Plan for Updating the Medical Listings," <http://www.ssa.gov/open/regsreview/EO-13563-Med-Lstngs-Biz-Prccs-4-15-11.html>.

²⁰⁴ Information based on personal communication with a SSA official on June 6, 2014.

²⁰⁵ *Ibid.* SSA is still in the process of completing comprehensive revisions to the following adult body systems: mental disorders, hematological disorders, the respiratory system, neurological disorders, and musculoskeletal disorders. The agency has issued proposed rules for all the remaining adult body systems except for the musculoskeletal body system, which is still under internal review. For more information on the status of proposed and final rules concerning adult and child body systems, see SSA, "Executive Order 13563 on Improving Regulation and Regulatory Review: Final Plan: Update of Progress on Final Plan for Retrospective Review," August 8, 2014, <http://www.ssa.gov/open/regsreview/EO-13563-Final-Plan-Progress-Update.html>.

²⁰⁶ GAO, *Modernizing SSA Disability Programs 2012*, p. 11. According to GAO, SSA published a limited update to (continued...)

Updating the listings to take into account medical and technological advances, as well as changes in the labor market, could allow DDS examiners to better identify individuals with severe work-limiting disabilities, while screening out non-meritorious claimants who could potentially engage in SGA. The impact of updated medical listings on the prevalence of benefit receipt remains unclear, because claimants denied at the medical listings stage of the determination process may still be awarded benefits based on vocational factors.

Update SSA's Occupational Information System

If a claimant fails to meet the eligibility criteria described in the medical listings, SSA is to proceed with a more individualized assessment that examines the claimant's ability to engage in SGA. To "minimize subjectivity and promote national consistency," SSA employs a system of medical and vocational rules designed to assist examiners in discerning whether a claimant can perform any past relevant work or other work that exists in the national economy.²⁰⁸ SSA considers claimants who cannot perform such work to be disabled and therefore eligible for SSDI.

Currently, SSA uses the Department of Labor's (DOL) Dictionary of Occupational Titles (DOT) to determine the physical and mental demands of available work in the national economy. Because DOT last received a major update in 1977, its occupational information is considered largely outdated.²⁰⁹ Although DOL replaced DOT with the Occupational Information Network (O*NET) in 1998, SSA concluded that O*NET's occupational information was insufficient to meet its requirements.²¹⁰ A 2012 Senate report expressed concern that DOT's increasingly outdated information may result in awards to claimants who could work in unlisted occupations.²¹¹

To improve program integrity, SSA in December 2008 established the Occupational Information Development Advisory Panel to develop a new occupational information system (OIS) for use in the vocational stages of the disability determination process.²¹² In July 2012, SSA signed an interagency agreement with the Bureau of Labor Statistics (BLS) to test the viability of using BLS's National Compensation Survey (NCS) to collect occupational data for the new OIS. In FY2013, SSA and BLS conducted a three-phase test to assess the NCS's accuracy and reliability

(...continued)

the "mental disorders" listing in 2000.

²⁰⁷ Ibid., p. 12.

²⁰⁸ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *The Third in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Michael J. Astrue, Commissioner of the Social Security Administration, 112th Cong., 2nd sess., March 20, 2012, http://www.ssa.gov/legislation/testimony_032012.html. See also GAO, *Modernizing SSA Disability Programs* 2012, p. 4.

²⁰⁹ GAO, *Modernizing SSA Disability Programs* 2012, p. 6. DOT received a minor update in 1991, albeit for only about 20% of all occupations covered in the database.

²¹⁰ Ibid., p. 14.

²¹¹ U.S. Congress, Senate Committee on Homeland Security and Governmental Affairs, Permanent Subcommittee on Investigations, *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions*, Minority Staff Report, 112th Cong., 2nd sess., September 13, 2012, p. 5, <http://www.hsgac.senate.gov/subcommittees/investigations/hearings/social-security-administrations-disability-programs>.

²¹² SSA, "Occupational Information System Project," http://www.ssa.gov/disabilityresearch/occupational_info_systems.html.

in capturing occupational data that are relevant for disability determinations.²¹³ SSA expects to start developing the new OIS in FY2015 and implement it by FY2016.²¹⁴

In the future, SSA's updated OIS may help to mitigate the growth in the SSDI rolls. According to SSA, the occupational information in DOT reflects an industrial economy, whereas today's economy has become more service oriented.²¹⁵ Therefore, modern occupations that require less physical exertion may allow individuals with certain disabilities to remain in the labor force. On the other hand, some individuals may be more likely to qualify for SSDI when evaluated using the updated OIS.²¹⁶ For example, older individuals with disabilities may have difficulty adjusting to the intensity and pressure of many of today's employment opportunities, while individuals with less extensive education may be less suited to "cognitively demanding" work.²¹⁷

Another complicating issue is that individuals with disabilities still tend to work in occupations that require physical labor.²¹⁸ For instance, one study found that individuals with cognitive or multiple disabilities are more likely to work in physically demanding, low-skilled jobs.²¹⁹ Consequently, an updated OIS may not reduce the number of individuals with certain chronic conditions from applying for benefits.

Increase the Number of Full Medical CDRs Conducted by SSA

As noted earlier, medical CDRs are periodic reevaluations conducted to determine if beneficiaries are still disabled.²²⁰ If SSA finds substantial evidence of medical improvement related to a beneficiary's ability to work, the agency typically considers the beneficiary no longer disabled. By increasing the number of full medical CDRs conducted each year, SSA could increase the recovery rate of beneficiaries with work-related medical improvements, which would help to reduce the disability rolls.

According to SSA, periodic medical evaluations are one of the most cost-effective tools for improving program integrity.²²¹ Of the more than 443,000 full medical CDRs conducted in

²¹³ BLS, *BLS FY 2012 Interagency Agreement Deliverable for the Social Security Administration*, September 28, 2012, <http://www.ssa.gov/disabilityresearch/documents/Plans%20for%20FY2013%20Testing%202012-09-28.pdf>.

²¹⁴ SSA, *Social Security Administration (SSA) Service Delivery Plan*, February 20, 2013, p. 19, http://www.ssa.gov/open/SDP/SDP_022013.pdf.

²¹⁵ Robert Pfaff, *Prior SSA Work to Address the DOT Concerns*, SSA, Occupational Information Development Advisory Panel, February 24, 2009, slide 2, <http://www.socialsecurity.gov/oidap/Documents/Social%20Security%20Administration.%20Prior%20SSA%20Work%20to%20Address%20th.pdf>.

²¹⁶ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces Hearing on the Challenges of Achieving Fair and Consistent Disability Decisions*, Testimony of Kathy Ruffing, Senior Fellow at the Center on Budget and Policy Priorities, 113th Cong., 1st sess., March 20, 2013, http://waysandmeans.house.gov/uploadedfiles/ruffing_testimony32013.pdf (hereinafter cited as "Testimony of Kathy Ruffing, 2013").

²¹⁷ Richard W. Johnson, Gordon B.T. Mermin, and Matthew Resseger, *Employment at Older Ages and the Changing Nature of Work*, The AARP Public Policy Institute, November 2007, p. 1, http://www.urban.org/UploadedPDF/1001154_older_ages.pdf.

²¹⁸ See David C. Stapleton, "Bending the Employment, Income, and Cost Curves for People with Disabilities," Mathematica Policy, Inc., April 2011, p. 3, http://www.mathematica-mpr.com/publications/PDFs/disability/disability_bendemploy_ib.pdf

²¹⁹ Michelle Maroto and David Pettinicchio, "Disability, Structural Inequality, and Work: The Influence of Occupational Segregation on Earnings for People with Different Disabilities," *Research in Social Stratification and Mobility*, vol. 38 (2014), p. 86.

²²⁰ CDRs are generally conducted by DDSs.

²²¹ SSA, *Agency Financial Report, Fiscal Year 2014*, November 10, 2014, p. 190, <http://www.ssa.gov/finance/> (continued...)

FY2012, SSA estimates that it will cease paying benefits to over 76,000 individuals and their eligible dependents after all appeals (a cessation rate of 17%).²²² For every dollar spent on CDRs in FY2012, the agency estimates approximately \$14.60 in future savings to the federal government.²²³ Prior to that, the CDR process yielded an estimated savings-to-cost ratio of \$10 to \$1.²²⁴ (Note that benefit savings from CDRs are not counted for congressional scorekeeping purposes.²²⁵)

However, a loss of dedicated funding for program integrity activities between FY2003 and FY2008 left SSA with fewer resources with which to conduct disability reviews, resulting in a CDR backlog (**Figure 14**).²²⁶ In 2010, the OIG estimated that if SSA had conducted all full medical CDRs when they were originally scheduled between 2005 and 2010, the agency would have removed an additional 90,000 to 180,000 SSDI and SSI beneficiaries from the rolls, thereby avoiding between \$1.3 billion and \$2.6 billion in benefit payments from 2005 to 2010.²²⁷ Despite recent efforts to reduce the backlog, SSA estimated that there were 1.3 million pending medical CDRs at the end of FY2013.²²⁸

(...continued)

(hereinafter cited as “SSA, Agency Financial Report, FY2014”).

²²² SSA, *Annual Report of Continuing Disability Reviews, Fiscal Year 2012*, October 23, 2014, <http://www.ssa.gov/legislation/FY%202012%20CDR%20Report.pdf> (hereinafter cited as “SSA, FY2012 CDR Report”). Figures reflect CDRs of SSDI, SSI, and concurrent recipients.

²²³ *Ibid.* Projected savings reflect the present value of future benefits for the OASDI, SSI, Medicare, and Medicaid programs. Projected savings do not take into account the lifetime benefits of terminated beneficiaries processed outside SSA’s central release system. The \$14.60 to \$1 savings-to-cost ratio is calculated by dividing the estimated present value of total lifetime benefits savings (\$7 billion) by the amount spent to conduct CDRs in FY2012 (\$447 million).

²²⁴ *Ibid.* Figure reflects the savings-to-cost ratio for FY1996-FY2011. According to SSA, “the higher savings-to-cost ratio in FY2012 is attributable to a variety of factors, including changes in the specific mix of CDR cases conducted, revised economic assumptions, refinements in the models used to estimate the CDR benefit savings, and variation in the cost of conducting these reviews.”

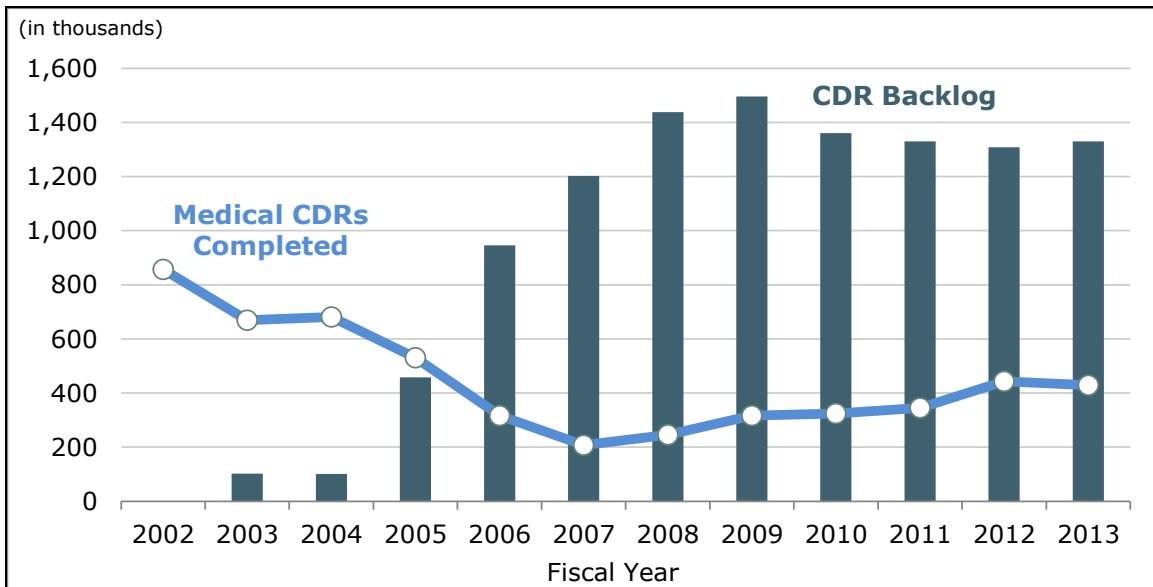
²²⁵ See letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Honorable John A. Boehner, Speaker of the U.S. House of Representatives, and the Honorable Harry Reid, Majority Leader of the U.S. Senate, August 1, 2011, p. 4, <http://cbo.gov/sites/default/files/budgetcontrolactaug1.pdf>. See also Office of Management and Budget (OMB), *Circular No. A-11: Appendix A—Scorekeeping Guidelines*, July 2014, scorekeeping guideline 3, http://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/app_a.pdf.

²²⁶ U.S. Congress, House Committee on Oversight and Government Reform, Subcommittee on Energy Policy, Health Care and Entitlements, *Examining Ways the Social Security Administration Can Improve the Disability Review Process*, 113th Cong., 2nd sess., April 9, 2014 (Washington: GPO, 2014), p. 72, <http://www.gpo.gov/fdsys/pkg/CHRG-113hhrg87819/pdf/CHRG-113hhrg87819.pdf>.

²²⁷ SSA, OIG, *Full Medical Continuing Disability Reviews*, March 30, 2010, p. 2, <http://oig.ssa.gov/full-medical-continuing-disability-reviews>. Savings do not include projected avoided payments made under Medicare or Medicaid.

²²⁸ SSA, OIG, *The Social Security Administration’s Completion of Program Integrity Workloads*, August 2014, Table C-1, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-07-14-24071> (hereinafter cited as “OIG, 2014 Report on CDR Workloads”).

Figure 14. Full Medical CDR Backlog, FY2002-FY2013



Source: Office of the Inspector General (OIG), *The Social Security Administration’s Completion of Program Integrity Workloads*, August 2014, Table C-1, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-07-14-24071>.

Reducing the CDR backlog has posed a challenge for SSA, in part because of a reduction in DDS staffing levels over the years. In response to budget deficits following the last recession, some states instituted furloughs or hiring freezes of state employees, including DDS examiners. The reduced staffing at DDSs limited SSA’s ability to conduct periodic medical reviews and contributed to the backlog of CDRs. To address the lower staffing levels, SSA transferred a portion of disability cases from furloughed DDS offices in some states to non-furloughed DDS offices in other states.²²⁹ Additionally, the agency received funding in FY2009 and FY2010 to increase the number of DDS staff by more than 2,900 employees.²³⁰ However, due to an agency-wide hiring freeze that began in FY2011, SSA did only limited critical hiring between FY2011 and FY2013.²³¹ The combination of attrition and hiring freezes during this period resulted in a net decline in DDS staffing levels (Table 2).

Table 2. DDS Staffing, FY2008-FY2013

FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
15,361	16,814	18,268	17,064	16,075	15,285

Source: SSA, OIG, *The Social Security Administration’s Progress in Reducing the Initial Disability Claims Backlog*, 2014, Table 1, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-07-13-13073>.

²²⁹ SSA, OIG, *The Social Security Administration’s Response to State Furloughs Impacting its Disability Programs*, A-01-11-11116, March 22, 2011, p. 6, <http://oig.ssa.gov/social-security-administration%3Fs-response-state-furloughs-impacting-its-disability-programs> (hereinafter cited as “OIG, State Furlough Report 2011”).

²³⁰ SSA, OIG, *The Social Security Administration’s Progress in Reducing the Initial Disability Claims Backlog*, April 28, 2014, Table 1, p. 5, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-07-13-13073>.

²³¹ SSA, *Agency Financial Report, Fiscal Year 2013*, December 9, 2013, p. 117, http://www.ssa.gov/finance/fy13_AFR.html.

To address the mounting backlog of CDRs and enhance program integrity, advocacy organizations,²³² researchers,²³³ and the Obama Administration²³⁴ have all expressed their support for increasing CDR funding. The Budget Control Act of 2011 (BCA; P.L. 112-25), which places caps on discretionary spending, includes a provision to adjust the caps to permit additional appropriations to SSA for program integrity activities such as CDRs and SSI redeterminations.²³⁵ SSI redeterminations are periodic reviews to ensure that beneficiaries meet SSI's financial eligibility requirements.²³⁶

The Consolidated Appropriations Act, 2014 (P.L. 113-76) appropriated a total of \$1.197 billion for CDRs and SSI redeterminations, which was the maximum amount allowed under the BCA for FY2014.²³⁷ With this level of funding, SSA completed nearly 526,000 full medical CDRs and 2.6 million SSI redeterminations (see **Figure 3**).²³⁸ The FY2014 appropriation also allowed the agency to hire about 2,600 DDS employees, including both replacement staff and additional hires.²³⁹

For FY2015, the Administration requested the full amount authorized for program integrity activities under the BCA: \$273 million in base funding and \$1.123 billion in cap adjustment funding. The Administration estimates that the \$1.396 billion in total program integrity funding would allow SSA to perform at least 888,000 full medical CDRs and 2.6 million SSI redeterminations in FY2015.²⁴⁰ Congress appropriated the maximum amount for FY2015 in the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235).

According to SSA, the agency would need \$11.8 billion in program integrity funding during FY2014-2023 to eliminate the CDR backlog by FY2018 and prevent it from growing back again through FY2023.²⁴¹ This level of funding would allow SSA to conduct an estimated 8.8 million full medical CDRs. However, at the funding levels prescribed in the BCA, SSA projects that it would be able to conduct only 7.8 million full medical CDRs at a cost of \$10.3 billion.

For FY2016, the Administration proposes replacing the discretionary spending caps established under the BCA with a dedicated source of mandatory funding to enable SSA to conduct more CDRs and SSI redeterminations on a consistent basis.²⁴² Under this option, SSA estimates that it

²³² Statement for the record from the Consortium for Citizens with Disabilities, U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *First in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, 112th Cong., 1st sess., December 2, 2011, Serial 112-SS11 (Washington: GPO, 2012), pp. 61-65, <http://www.gpo.gov/fdsys/pkg/CHRG-112hhrg76319/pdf/CHRG-112hhrg76319.pdf>.

²³³ Testimony of Kathy Ruffing, 2013, p. 15.

²³⁴ OMB, *Fiscal Year 2015 Budget of the U.S. Government*, 2014, pp.149-150, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/socsec.pdf>.

²³⁵ For more information on SSA budgetary issues, see CRS Report R41716, *Social Security Administration (SSA): Budget Issues*, by (name redacted).

²³⁶ See SSA, "Understanding Supplemental Security Income Redeterminations—2014 Edition," <http://www.socialsecurity.gov/ssi/text-redets-ussi.htm>.

²³⁷ The \$1.197 billion appropriated for program integrity activities in FY2014 is the sum of \$273 million in base funding and \$924 million in cap-adjustment funding.

²³⁸ SSA, Agency Financial Report FY2014, p. 202.

²³⁹ *Ibid.*, p. 131.

²⁴⁰ OMB, *Appendix, Budget of the U.S. Government, Fiscal Year 2015*, 2014, p. 1255, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/ssa.pdf> (hereinafter cited as "OMB, FY2015 Budget Appendix").

²⁴¹ OIG, 2014 Report on CDR Workloads, p. D-1.

²⁴² OMB, FY2015 Budget Appendix, p. 1256.

would conduct more than 8 million full medical CDRs at a cost of \$10.7 billion during FY2014-FY2023.²⁴³

Limitations of Full Medical CDRs

While additional funding and new hires would allow the agency to perform more full medical CDRs, the shortage of veteran examiners complicates the issue. Part of the problem stems from the fact that DDS examiners experience high rates of turnover. According to GAO, over 20% of DDS examiners hired between September 1998 and January 2006 left or were terminated within their first year.²⁴⁴ Of the examiners who remain, it takes about two years of experience before SSA considers them to be fully trained.²⁴⁵ Thus, even with additional hiring, it may take the agency years to reestablish a robust pool of highly experienced disability examiners.

Additionally, because of diminishing returns, future marginal savings from additional CDRs would be less than the past average. When SSA performs CDRs, it prioritizes the beneficiaries who are most likely to have substantial medical improvement related to their ability to work.²⁴⁶ However, as the number of completed CDRs increases, the chance of benefit cessation declines for subsequent reviews.

The savings-to-cost ratio would also decrease if former SSDI beneficiaries who were terminated due to medical improvement reapply and return to the program. According to one study, of those whose eligibility ceased after CDRs from 2003 to 2008, an estimated 20% of former SSDI-only beneficiaries will come back onto the rolls within eight years.²⁴⁷

It is important to note that program integrity activities alone would be unable to substantially improve the financial outlook of the SSDI program, because potential savings from CDRs take time to accumulate and apply to multiple programs. For example, SSA projects that the full medical CDRs conducted in FY2012 will result in a present value of nearly \$7 billion in lifetime savings to the federal government; however, these savings are spread out over decades and are attributable not only to SSDI but also to OASI, SSI, Medicare, and Medicaid.²⁴⁸

Return-to-Work Incentives²⁴⁹

Another policy option to combat the growth in the SSDI rolls is to provide stronger incentives for beneficiaries to return to work. Currently, SSA allows beneficiaries to test their ability to work by participating in a *trial work period* (TWP), during which participants may earn any amount for nine months within a rolling 60-month period without having their benefits reduced or their

²⁴³ OIG, 2014 Report on CDR Workloads, p. D-2.

²⁴⁴ U.S. Congress, House Committee on Ways and Means, Subcommittees on Income Security and Family Support and Social Security, *Hearing on Disability Backlogs and Related Service Delivery Issues*, 111th Cong., 1st sess., March 24, 2009, p. 10, <http://www.gao.gov/products/GAO-09-511T>.

²⁴⁵ Ibid.

²⁴⁶ SSA, FY2012 CDR Report.

²⁴⁷ Jeffrey Hemmeter and Michelle Stegman, "Subsequent Program Participation of Former Social Security Disability Insurance Beneficiaries and Supplemental Security Income Recipients Whose Eligibility Ceased Because of Medical Improvement," *Social Security Bulletin*, vol. 73, no. 2 (May 2013), <http://www.ssa.gov/policy/docs/ssb/v73n2/v73n2p1.html>.

²⁴⁸ SSA, FY2012 CDR Report, Table C2.

²⁴⁹ For more information on current work incentives, see SSA, *2014 Red Book: A Summary Guide to Employment Supports for Persons with Disabilities under the Social Security Disability Insurance and Supplemental Security Income Programs*, SSA Publication No. 64-030, 2014, <http://ssa.gov/redbook/>.

entitlement to SSDI terminated.²⁵⁰ In addition, SSA provides employment and support services. Still, few beneficiaries leave the program. In 2013, SSA terminated the benefits of 0.4% of all disabled-worker recipients due to earnings above SGA.²⁵¹

Increase Awareness of Return-to-Work Services

To address some of the barriers to employment faced by disabled workers, Congress enacted the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170), which established the Ticket to Work and Self-Sufficiency program (hereinafter “Ticket to Work”).²⁵² Ticket to Work assists beneficiaries between the ages of 18 and 64 in returning to the labor force by providing a voucher or *ticket* for employment, vocational rehabilitation (VR), or other support services through public or private contractors known as Employment Networks (EN), as well as through traditional state VR agencies. Participation in the Ticket to Work program is voluntary, and ticket holders (beneficiaries) decide when and whether to assign a ticket to a particular state VR agency or EN. Under the program, state VR agencies and ENs receive payments from SSA for services provided to ticket holders based on specific work-related performance measures.

Thus far, the Ticket to Work program has met with little success. Although program participants are more likely to be employed than other beneficiaries, only about 2.3% of all active tickets issued by SSA are *in use* (i.e., assigned to an EN or state VR agency).²⁵³ According to GAO, EN representatives partially attribute Ticket to Work’s low beneficiary participation rate to “a lack of understanding and awareness of the program.” Meanwhile, some disability-advocacy organizations contend that the fear of losing benefits may deter beneficiaries from participating.

To improve the return-to-work rate of SSDI recipients, researchers Bonnie O’Day and David Stapleton have proposed testing early intervention policies that provide beneficiaries with employment and other support services shortly after receipt of benefits.²⁵⁴ The researchers argue that current programs have failed to increase the return-to-work rate, because many beneficiaries “have been separated from the labor force, often for years, before they are offered assistance.”²⁵⁵ The researchers posit that beneficiaries may have a greater chance of returning to work if they receive services earlier during their stay on SSDI.

²⁵⁰ In 2015, SSA considers any month in which the participant’s earnings exceed \$780 a trial work month.

²⁵¹ SSA, SSDI Annual Report 2013, Table 57. Another way to measure the return-to-work rate is to count the number of beneficiaries who leave the rolls for work over the course of a period longer than one year (i.e., a longitudinal study). One study found that of a cohort of beneficiaries examined between 1996 and 2006, 6.5% had their benefits suspended for earnings above SGA in at least one month and 3.7% had their benefits eventually terminated due to work. For more information, see Su Liu and David C. Stapleton, “Longitudinal Statistics on Work Activity and Use of Employment Supports for New Social Security Disability Insurance Beneficiaries,” *Social Security Bulletin*, vol. 71 no. 3 (August 2011), p. 35, <http://www.ssa.gov/policy/docs/ssb/v71n3/v71n3p35.html>.

²⁵² For more information on the Ticket to Work program, see CRS Report R41934, *Ticket to Work and Self-Sufficiency Program: Overview and Current Issues*, by (name redacted).

²⁵³ SSA, *Ticket to Work: September 2014 Monthly Status Report*, accessed December 2014, <http://www.ssa.gov/work/documents/monthlystatusreportseptember2014.pdf>. According to one study, 32% of Ticket to Work participants were employed in 2004, compared with 9% of all SSDI and SSI beneficiaries. For more information, see Gina A. Livermore and Allison Roche, “Longitudinal Outcomes of an Early Cohort of Ticket to Work Participants,” *Social Security Bulletin*, vol. 71, no. 3 (August 2011), pp. 105-116, <http://www.ssa.gov/policy/docs/ssb/v71n3/v71n3p105.html>.

²⁵⁴ Bonnie O’Day and David Stapleton, *The United Kingdom Pathways to Work Program: A Path to Employment?*, Mathematica Policy Research, Inc., Number 08-02, September 2008, http://www.mathematica-mpr.com/publications/PDFs/pathways_disbrief2.pdf.

²⁵⁵ *Ibid.*, p. 1.

One early intervention option is to require all future beneficiaries to participate in work preparation counseling to educate them about available services.²⁵⁶ Beneficiaries may be more likely to participate in programs they understand. Although mandatory work preparation counseling would require new funding, the counseling might be cost-effective if it improves the return-to-work rate of SSDI recipients, especially if it targeted those with the best chance of success.

SSA oversees two voluntary grant programs aimed at increasing beneficiary awareness of return-to-work services. In addition to the Ticket to Work program, P.L. 106-170 also established the Work Incentives Planning and Assistance (WIPA) program and the Protection and Advocacy for Beneficiaries of Social Security (PABSS).²⁵⁷ WIPA awards grants to community organizations that provide education and assistance for beneficiaries interested in returning to work, and PABSS provides grants for legal assistance and advice on how to obtain VR, employment, or other services.²⁵⁸

Estimating the overall impact of mandatory counseling on the SSDI beneficiary return-to-work rate is difficult because the results of SSA's current employment-counseling initiatives are inconclusive. According to one study, the use of WIPA services possibly has a positive effect on the employment outcomes of SSDI and SSI beneficiaries.²⁵⁹ However, it is difficult to discern whether beneficiaries who received WIPA services would have enjoyed the same employment outcome in the absence of such services.²⁶⁰

Benefit Offset

One reason why few workers leave the rolls due to substantial earnings is that some beneficiaries deliberately “park” their earnings from work below the SGA threshold. After completing the TWP and a 36-month *extended period of eligibility* (EPE), beneficiaries who earn more than the SGA limit have their benefits terminated.²⁶¹ One study found that between 0.2% and 0.4% of all SSDI beneficiaries parked their earnings below SGA in a typical month from 2002 to 2006 in order to retain their benefits.²⁶²

Beneficiaries may park their earnings below SGA (sometimes called the “cash cliff”) in part because their impairment prevents them from working consistently. Another study found that

²⁵⁶ The agency could exempt beneficiaries with a low probability of recovery from the counseling requirement, because they are less likely to return to work than other beneficiaries.

²⁵⁷ Prior to 2006, WIPA was known as the Benefits Planning Assistance and Outreach (BPAO) program.

²⁵⁸ For information on WIPA, see SSA, “Work Incentives Planning and Assistance,” <http://www.ssa.gov/work/WIPA.html>. For information on PABSS, see SSA, “Protection and Advocacy for Beneficiaries of Social Security,” <http://www.ssa.gov/work/protectionadvocacy.html>.

²⁵⁹ See Gina Livermore, Sarah Prenovitz, and Jody Schimmel, *Employment-Related Outcomes of a Recent Cohort of Work Incentives Planning and Assistance (WIPA) Program Enrollees*, Mathematica Policy, Inc., September 19, 2011, <http://www.ssa.gov/disabilityresearch/documents/WIPA%20Cohort%20September%202011.pdf>.

²⁶⁰ For more evaluation reports of WIPA, see SSA, “Work Incentives Planning and Assistance (WIPA) Program Evaluation Reports,” http://www.ssa.gov/disabilityresearch/wipa_reports.htm.

²⁶¹ Upon completion of the TWP, participants enter a 36-month *extended period of eligibility* (EPE), during which they receive cash benefits only if their earnings do not exceed SGA. The EPE is also known as the re-entitlement period. The first three months of the EPE are a grace period, during which SSA pays benefits regardless of the amount of monthly earnings.

²⁶² Jody Schimmel, David C. Stapleton, and Jae G. Song, “How Common Is ‘Parking’ among Social Security Disability Insurance Beneficiaries? Evidence from the 1999 Change in the Earnings Level of Substantial Gainful Activity,” *Social Security Bulletin*, vol. 71 no. 4 (November 2011), p. 77, <http://www.ssa.gov/policy/docs/ssb/v71n4/v71n4p77.html>.

59% of Ticket to Work participants reported working at a job for at least one month during 2003-2005; however, of those participants who later left work, the most cited reason was due to poor health.²⁶³ Parking one's earnings below SGA may weaken a work-oriented beneficiary's attachment to the labor force, possibly resulting in an erosion of skills and thus a reduced likelihood of returning to work following a health-related withdrawal from the labor force.²⁶⁴

To remedy the phenomenon of parked earnings, several disability-rights organizations have advocated eliminating the fixed cash cliff (SGA threshold) and replacing it with a gradual benefit-offset model that allows beneficiaries to increase their earnings while remaining on SSDI.²⁶⁵ The SSI program operates under a benefit-offset system, deducting \$1 in benefits for every \$2 in earnings over \$65.²⁶⁶ Advocates argue that a benefit-offset model would make SSDI beneficiaries "financially better off" by allowing them to maximize their total income and work potential.²⁶⁷ A benefit-offset model could also improve the finances of the SSDI program by reducing the amount of cash benefits paid out to recipients. Additionally, adopting a benefit-offset model could increase beneficiaries' attachment to the labor force by making work more attractive.

On the other hand, benefit offset may induce only a small number of beneficiaries to increase their earnings (i.e., those beneficiaries who park their earnings). Although benefit outlays from the DI trust fund would decrease under this scenario, such savings would have little impact on the solvency of the DI trust fund. Additionally, by making it easier for recipients to maintain their eligibility for benefits, benefit offset could decrease the SSDI termination rate further, which, in turn, could increase the total number of beneficiaries on the rolls. Furthermore, benefit offset may increase the attractiveness of SSDI benefits, impelling more workers to apply to the program.

SSA is currently in the process of conducting a Benefit Offset National Demonstration (BOND) project,²⁶⁸ in which treatment participants lose \$1 in benefits for every \$2 in earnings exceeding a BOND Yearly Amount (BYA) equal to 12 times the monthly SGA limit.²⁶⁹ Some BOND participants are also eligible for Enhanced Work Incentives Counseling (EWIC), which is designed to address a range of issues related to returning to work, including access to medical treatment, employment services, and job training.²⁷⁰ In implementing BOND, SSA seeks to test

²⁶³ Gina A. Livermore and Allison Roche, "Longitudinal Outcomes of an Early Cohort of Ticket to Work Participants," *Social Security Bulletin*, vol. 71, no. 3 (August 2011), p. 120, Table 11, <http://www.ssa.gov/policy/docs/ssb/v71n3/v71n3p105.html>.

²⁶⁴ For more information, see Willem Van Zandweghe, "Interpreting the Recent Decline in Labor Force Participation," *Economic Review*, First Quarter 2012, Federal Reserve Bank of Kansas City, pp. 28-29, <http://www.kc.frb.org/publicat/econrev/pdf/12q1VanZandweghe.pdf>.

²⁶⁵ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Fifth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Marty Ford, Director of Public Policy, The Arc of the United States, on behalf of the Consortium for Citizens with Disabilities Social Security Task Force, 112th Cong., 2nd sess., September 14, 2012, p. 5, http://waysandmeans.house.gov/uploadedfiles/ford_testimony_ss914.pdf.

²⁶⁶ For more information on SSI, see CRS Report 94-486, *Supplemental Security Income (SSI)*, by (name redacted).

²⁶⁷ Letter from Jeanne Morin et al., Consortium for Citizens with Disabilities, to the Social Security Advisory Board, 2013, http://www.c-c-d.org/fichiers/CCD_SSTF_Co-Chairs_comments_forSSAB7-19-13.pdf.

²⁶⁸ For more information on BOND, see CRS Report RL33585, *Social Security Disability Insurance (SSDI) Demonstration Projects*, by (name redacted) and (name redacted).

²⁶⁹ David Wittenburg et al., *BOND Implementation and Evaluation: BOND Stage 1 Early Assessment Report*, Abt Associates Inc. and Mathematica Policy, Inc., Submitted to the Social Security Administration, Deliverable 24.1, May 17, 2012, p. 1, <http://www.ssa.gov/disabilityresearch/offsetnational.htm>.

²⁷⁰ David Stapleton et al., *BOND Implementation and Evaluation: BOND Final Design Report*, Abt Associates Inc. and Mathematica Policy, Inc., December 3, 2010, p. 6, <http://www.ssa.gov/disabilityresearch/offsetnational.htm>.

whether benefit offset can increase earnings and reduce dependence on SSDI for work-oriented beneficiaries.

In preparation for BOND, SSA implemented a four-state pilot program known as the Benefit Offset Pilot Demonstration (BOPD) from 2005 to 2008.²⁷¹ According to SSA, participation in the BOPD had a positive effect on the earnings of individuals in the treatment group; however, the pilot also increased average benefit payments because of partial payments made to beneficiaries whose benefits would have been suspended under normal program rules for earning above SGA.²⁷²

In August 2013, SSAB called for the early termination of BOND.²⁷³ The board cited the implementation problems associated with the pilot program and BOND's low participation rate as evidence that BOND would likely fail to increase beneficiary return-to-work rates in a cost effective manner.²⁷⁴ SSAB estimated that terminating BOND would save approximately \$17 million in FY2015.

Promote Supported-Work Policies

Some researchers have suggested shifting the focus of SSDI reform away from terminating beneficiaries already on the rolls toward attenuating the inflow of new beneficiaries into the program.²⁷⁵ Advocates of this approach—sometimes referred to as *supported work*—argue that offering employment supports shortly after the onset of disability would allow more workers who experience disability to keep working. Most supported-work policies use financial incentives to encourage employers to provide preventive, accommodative, rehabilitative, and other return-to-work services. Although Title I of the Americans with Disabilities Act (ADA; P.L. 101-336, as amended) requires employers to provide some level of *reasonable accommodation* for employees with disabilities in the workplace, some employers fail to comply with the provisions of the ADA.²⁷⁶ Faced with few employment opportunities, individuals with disabilities who could conceivably work given appropriate accommodation may turn to SSDI as a last resort. This subsection provides an overview of two supported-work policies that have the potential to reduce the incidence of benefit receipt.

²⁷¹ For more information on BOPD, see SSA, "Benefit Offset National Demonstration," accessed December 2014, <http://www.socialsecurity.gov/disabilityresearch/offsetpilot2.htm>.

²⁷² SSA, *Annual Report on Section 234 Demonstration Projects, May 2011*, May 2011, pp. 4-5.

²⁷³ SSAB, *The Case for Terminating the Benefit Offset National Demonstration*, August 2013, pp. 1-4, http://www.ssab.gov/REPORTS/BOND_PrePublication.pdf.

²⁷⁴ According to Stapleton et al., benefit adjustments under BOPD required substantial administrative effort and were sometimes applied incorrectly, resulting in overpayments and underpayments. Additionally, beneficiaries often found BOPD's program rules confusing. The authors note these problems may have discouraged participants from earning above SGA. See Stapleton et al., p. 20.

²⁷⁵ Testimony of Richard Burkhauser, 2012.

²⁷⁶ Under the ADA, the term *reasonable accommodation* includes (1) making existing facilities readily accessible to and usable by individuals with disabilities, and (2) job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities (42 U.S.C. §12111[9]). For more information, see CRS Report R43845, *Title I of the Americans with Disabilities Act (ADA): Employment Discrimination*, by (name redacted)

Experience Rate the Employer's Portion of the Payroll Tax Rate

Experience rating is a process for determining insurance premiums based on the cost of an insurance pool's past claims. In essence, an insurer calculates a firm's insurance premium based on the likelihood, or risk, of the firm submitting a future claim given its previous behavior. Many types of employer-sponsored insurance use experience rating to determine premiums, including state workers' compensation (WC), unemployment insurance (UI),²⁷⁷ and private disability insurance (PDI).²⁷⁸ Because premiums are a function of past claims, firms' costs reflect their use of the insurance program, creating incentives for them to reduce the number of claims.

To reduce the incidence of SSDI receipt, several researchers have suggested that the federal government should experience rate the employer's portion of the payroll tax used to fund SSDI.²⁷⁹ Currently, employers pay the same payroll tax rate, regardless of the rate at which their employees enroll in the program. However, an experience rated system would link payroll tax rates to the claim rate, which would give employers an additional incentive to support disabled workers.

Proponents of experience rating often point to its use in the Netherlands' disability insurance (DI) system as evidence of its potential impact in the United States. Between 1998 and 2003, the Netherlands gradually incorporated experience rating into its DI system.²⁸⁰ According to one study, instituting experience-rated DI premiums resulted in a 15% reduction in the Dutch DI incidence rate.²⁸¹ Since the early 2000s, the Netherlands has witnessed a marked decline in its DI prevalence rate.²⁸²

Experience rating could be implemented relatively simply. Employers already report payroll tax data to the Internal Revenue Service (IRS), which the agency shares with SSA. Moreover, most employers are accustomed to the concept of experience rating because of their experience paying state WC and UI premiums. By compiling both payroll tax and beneficiary award data, SSA

²⁷⁷ For more information on UI, see CRS Report RL33362, *Unemployment Insurance: Programs and Benefits*, by (name redacted) and (name redacted).

²⁷⁸ See David C. Stapleton, *Bending the Employment, Income, and Cost Curves for People with Disabilities*, Mathematica Policy, Inc., April 2011, p. 2, http://www.mathematica-mpr.com/publications/PDFs/disability/disability_bendemploy_ib.pdf.

²⁷⁹ See Richard V. Burkhauser, Mary C. Daly, and Philip R. de Jong, *Curing the Dutch Disease: Lessons for United States Disability Policy*, University of Michigan Retirement Research Center, Working Paper 2008-188, September 2008, <http://www.mrrc.isr.umich.edu/publications/Papers/pdf/wp188.pdf> (hereinafter cited as "Burkhauser, Daly, and de Jong 2008"). Experience rating could also be applied to the payroll tax for Medicare.

²⁸⁰ Philip R. de Jong, *Recent Changes in Dutch Disability Policy*, Aarts de Jong Wilms Goudriaan Public Economics, September 2008, <http://www.ape.nl/include/downloadFile.asp?id=75>.

²⁸¹ Pierre Koning, *Estimating the impact of experience rating on the inflow into disability insurance in the Netherlands*, CBP Netherlands Bureau of Economic Policy Analysis, CPB Discussion Paper no 37, August 2004, <http://www.cpb.nl/en/publication/estimating-impact-experience-rating-inflow-disability-insurance-netherlands>. The study found the ex post (after-the-fact) effect of having to pay a premium rate in a given year due to experience rating induced Dutch employers to invest more in preventative services, amounting to a 15% reduction in the inflow of workers into the state DI system after one year.

²⁸² Testimony of Richard Burkhauser, 2012. According to Burkhauser, the decline in the Dutch DI prevalence rate stems from numerous reforms instituted over the past 15 years. Because of a series of reforms that began in 2006, Dutch employers now pay a uniform rate for all permanent disability benefits (IVA); however, employers pay experienced-rated premiums on partial disability benefits (WGA) via the state system. Although Dutch firms may opt out of the state system and purchase private insurance instead, many private DI insurance pools are experienced rated. For more information, see Organization for Economic Co-operation and Development (OECD), *Sickness and Disability Schemes in the Netherlands*, November 2007, p.16, <http://www.oecd.org/social/soc/41429917.pdf>. See also de Jong 2008, p. 13.

could experience rate the SSDI payroll tax “without imposing substantial new reporting requirements or administrative burdens on employers.”²⁸³

Opponents of experience rating argue that the policy would adversely affect some workers. For example, experience rating could make employers hesitant to hire or retain workers “perceived to be a high risk for disability.”²⁸⁴ Employers may discriminate against older workers, people with chronic conditions such as diabetes, or individuals prone to risky behaviors. To address this possibility, supporters of experience rating suggest implementing risk adjustments specific to factors such as age, occupation, and health status, as well as enforcing existing anti-discrimination laws.²⁸⁵

Critics also point out that experience rating could reduce the compensation of low-wage workers. For instance, some employers subject to higher payroll tax rates could shift the additional cost onto workers in the form of reduced take-home pay or benefits. Employers unable to shift additional labor costs onto their employees may instead offset the higher payroll tax rate by hiring fewer workers in the future.²⁸⁶ Since low-wage individuals tend to work in professions with high rates of disability, they may be disproportionately affected by employer cost avoidance and therefore more likely to suffer financially.²⁸⁷ Opponents argue that workers harmed by employer cost avoidance could end up on SSDI, increasing the size of the program.²⁸⁸

Furthermore, some critics say that while the system changes employers’ incentives, it fails to address the incentives for workers to apply for SSDI.²⁸⁹ For example, some workers may apply in response to factors beyond the employers’ control, such as low market wages.

Employer-Sponsored Private Disability Insurance

Another option to reduce the number of SSDI beneficiaries is for the federal government to promote employer-sponsored private disability insurance (PDI). PDI provides beneficiaries with a partial wage replacement and return-to-work services. As of March 2014, 40% of all workers in private industry had access to short-term disability (STD) insurance, and 34% had access to long-term disability (LTD) insurance.²⁹⁰ STD insurance typically lasts a fixed number of weeks or months, while LTD insurance can last anywhere from a year to several decades.²⁹¹ PDI is less

²⁸³ Autor, *The Unsustainable Rise of the Disability Rolls in the United States*, p. 15.

²⁸⁴ Stapleton, “Bending the Employment, Income, and Cost Curves for People with Disabilities,” p. 3.

²⁸⁵ David C. Stapleton et al., “Income Security for Workers: A Stressed Support System in Need of Innovation,” *Journal of Disability Policy Studies*, June 20, 2008, p. 11.

²⁸⁶ Employers may be unable to shift increased labor costs onto employees due to a lower bound restraint such as the minimum wage.

²⁸⁷ Stapleton, “Bending the Employment, Income, and Cost Curves for People with Disabilities,” p. 3. Stapleton would offset the reduced compensation with an expansion of the Earned Income Tax Credit (EITC) in order to bolster the after-tax income of low-wage workers. For more information on the EITC, see CRS Report RL31768, *The Earned Income Tax Credit (EITC): An Overview*, by (name redacted).

²⁸⁸ CBO, *Policy Options 2012*, p. 28.

²⁸⁹ Autor, *The Unsustainable Rise of the Disability Rolls in the United States*, pp. 15-17.

²⁹⁰ BLS, *National Compensation Survey: Employee Benefits in the United States, March 2014*, Table 16, September 2014, <http://www.bls.gov/ncs/ebs/benefits/2014/> (hereinafter cited as “BLS, National Compensation Survey 2014”). The participation rates for STD and LTD were both 97%.

²⁹¹ In March 2014, the median duration of STD benefit receipt for all workers in private industry was 26 weeks. For more information, see BLS, *National Compensation Survey 2014*, Table 25. “Short-Term Disability Plans: Duration of Benefits, Private Industry Workers.”

expensive than other forms of employer-sponsored insurance, such as health care.²⁹² In addition, employers can partially offset the cost of PDI by requiring employees to contribute to the insurance plans.²⁹³

Some researchers have advocated that the federal government should promote employer-sponsored PDI to reduce the growth in the SSDI rolls.²⁹⁴ Employer-sponsored PDI plans could reduce the incidence of SSDI benefit receipt, because they provide employment-support services soon after the onset of disability when the likelihood of recovery is highest. By intervening with robust supported-work services early in the disability process, PDI may keep workers with disabilities attached to the labor force and therefore reduce the number who apply for SSDI.²⁹⁵

Offering employers financial incentives is one way to promote employer-sponsored PDI. For example, SSA could lower the tax rate of employers who purchase PDI and whose insurance agents coordinate with SSA to manage disability cases in a cost-effective manner.²⁹⁶ Alternatively, the federal government could award subsidies or tax credits to firms that provide PDI.²⁹⁷

A second way to promote PDI would be to require all employers to provide it. Companies that refuse to provide PDI would be subject to possible legal action, financial penalties, or both.²⁹⁸ Currently, New Jersey, New York, Hawaii, and Puerto Rico require employers to contribute toward some form of STD insurance, generally known as temporary disability insurance (TDI).²⁹⁹ Employer-mandated PDI has become increasingly popular in many European countries. The Netherlands, for example, requires employers to cover the cost of sick pay for two years

²⁹² In September 2014, employee health insurance cost employers in private industry \$2.36 per hour worked, whereas employee STD cost employers \$0.06 per hour worked and LTD insurance cost \$0.05. For more information, see news release, “Employer Costs for Employee Compensation—September 2014,” BLS, December 10, 2014, Table 5, p. 10, <http://www.bls.gov/news.release/ecec.toc.htm>. According to one study, annual premiums for LTD coverage in 2010 were about \$250. For more information, see David Autor, Mark Duggan, and Jonathan Gruber, “Moral Hazard and Claims Deterrence in Private Disability Insurance,” *American Economic Journal: Applied Economics*, vol. 6, no. 4 (October 2014), p. 115.

²⁹³ In March 2014, 18% of STD plans sponsored by employers in private industry required employee contributions; 6% of LTD plans had such a requirement. For more information, see BLS, National Compensation Survey 2014, Table 23, “Short-Term Disability Plans: Employee Contribution Requirement, Private Industry Workers,” and Table 28, “Long-Term Disability Plans: Employee Contribution Requirement, Private Industry Worker.”

²⁹⁴ David H. Autor and Mark Duggan, “Supporting Work: A Proposal for Modernizing the U.S. Disability Insurance System,” Center for American Progress and the Hamilton Project, <http://www.brookings.edu/research/papers/2010/12/disability-insurance-autor>. See also Burkhauser, Daly, and de Jong, *Curing the Dutch Disease*.

²⁹⁵ See Norma B. Coe et al., “What Explains Variation in SSDI Application Rates?,” Center for Retirement Research at Boston College, <http://crr.bc.edu/working-papers/what-explains-state-variation-in-ssdi-application-rates/>. The authors found that state-mandated temporary disability insurance (TDI) has a small negative effect on SSDI applications (i.e., TDI is associated with lower SSDI application rates).

²⁹⁶ Burkhauser, Daly, and de Jong, *Curing the Dutch Disease*.

²⁹⁷ Stapleton et al., “Income Security for Workers,” p. 11.

²⁹⁸ See, for example, CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted).

²⁹⁹ U.S. Department of Labor, *Comparison of State Unemployment Insurance Laws*, 2014, pp. 8-1 through 8-9, <http://workforcesecurity.doleta.gov/unemploy/pdf/uilawcompar/2014/disability.pdf>. TDI provides a partial wage replacement due to non-occupational disability for about 26-52 weeks. California and Rhode Island also operate state TDI programs; however, employers are not required to contribute. For more information, see SSA, *Annual Statistical Supplement, 2013*, February 2014, pp. 70-71, <http://www.ssa.gov/policy/docs/statcomps/supplement/2013/tempdisability.html>.

following the onset of a disabling condition, while the U.K. requires employers to pay up to six months of statutory sick pay.³⁰⁰

Researchers David Autor and Mark Duggan have proposed requiring all employers to provide short-term PDI, which would provide workers with rehabilitation services, workplace accommodation, and a partial wage replacement for two years.³⁰¹ Under this proposal, plans would be purchased on the existing PDI market, and employers would be permitted to require employees to contribute up to 40% of the cost of their coverage.³⁰² Following the exhaustion of employer-sponsored PDI, beneficiaries who are found to be disabled would qualify for SSDI. Workers with extremely severe or terminal disabilities would be exempt from the two-year PDI requirement and would qualify for SSDI immediately.³⁰³

Using the financial incentives approach would be relatively simple, because the federal government already encourages employers to hire workers with disabilities by offering tax credits to offset the cost of providing workplace accommodation.³⁰⁴ Having SSA work with employers and insurers under an experience-rating system would likely require significantly more resources than the tax credit proposal, but the system could be structured to limit federal costs. In spite of these advantages, financial incentives might be ineffective. As noted above, the federal government currently offers employers tax incentives to hire workers with disabilities; however, the evidence that such incentives actually drive employers to hire such workers has been “limited and inconclusive.”³⁰⁵ Similarly, the lure of a lower payroll tax rate under an experience-rating model may not cause employers to purchase PDI, especially if the cost of providing PDI outweighs any savings from the reduced payroll tax rate.

A mandate, on the other hand, would likely have a larger effect. The prospect of having to pay financial penalties due to noncompliance is typically a more powerful incentive for employers than tax credits. Although a government mandate does not guarantee universal compliance because some employers could simply pay the appropriate penalty, requiring employers to provide PDI might still have a marked effect on the inflow of beneficiaries into the SSDI program.

One of the biggest unknown factors of the mandate approach outlined by Autor and Duggan is whether the private insurance market can offer an economically feasible two-year PDI plan. Most insurers sell PDI plans as either short-term (around 26 weeks) or long-term (anywhere from a year to several decades). Although both types of PDI cost employers about the same amount per hour worked, LTD insurance plans typically have stricter eligibility standards. For instance, LTD plans may have more stringent definitions of disability or have a larger list of pre-existing medical conditions that make employees ineligible. LTD plans are generally stricter because

³⁰⁰ OECD, *New Ways of Addressing Partial Work Capacity*, April 2007, pp. 10-11, <http://www.oecd.org/social/soc/38509814.pdf>.

³⁰¹ Autor and Duggan, “Supporting Work,” p. 6.

³⁰² *Ibid.*, p. 7. Under this proposal, insurance premiums would be experience-rated for firms with 50 or more full-time equivalent employees, while smaller firms would have their premiums industry rated.

³⁰³ *Ibid.*, p. 23. Unemployed workers would receive a replacement wage at their state UI rate; however, in order to protect employers from the so-called “double indemnity” of paying higher experience-rated premiums for both UI and PDI, unemployed workers would be unable to claim both UI and PDI benefits simultaneously.

³⁰⁴ For more information on federal tax credits and deductions for businesses that employ workers with disabilities, see IRS, “Tax Benefits for Businesses Who Have Employees with Disabilities,” December 2, 2014, <http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Tax-Benefits-for-Businesses-Who-Have-Employees-with-Disabilities>.

³⁰⁵ GAO, *Incentives to Employ Workers with Disabilities Receive Limited Use and Have an Uncertain Impact*, GAO-03-39, December 11, 2002, <http://www.gao.gov/products/GAO-03-39>.

beneficiaries could receive benefits for years or even decades. To offset some of the risk associated with LTD plans, insurers often require beneficiaries to apply for SSDI after the onset of disability and deduct any SSDI income from a beneficiary's LTD benefit. However, because the Autor and Duggan proposal does not permit insurers to offset part of their costs by requiring beneficiaries to apply for SSDI, such two-year PDI plans may not be financially viable in the current insurance market.

Autor and Duggan contend that their proposal would be economically feasible for insurers because their PDI plan would be less generous than current LTD policies.³⁰⁶ Based on their conversations with private insurers, they believe that two-year policies would not substantially increase the costs associated with PDI.³⁰⁷

Additionally, private insurers could simply raise premiums to a level sufficient to make two-year PDI policies profitable. The extent to which insurers could raise rates would depend on the structure of the federal mandate as well as on state insurance laws. However, if insurers raised premiums too high and compliance penalties for employers were too low or not adequately enforced, then employers could choose not to provide PDI.

³⁰⁶ Autor and Duggan, "Supporting Work," p. 21.

³⁰⁷ David Autor, remarks during a presentation at the 2014 Annual Disability Research Consortium Meeting, October 31, 2014, National Press Club in Washington D.C. For more information on the meeting, see <http://www.nber.org/aging/drc/10312014.html>.

Appendix. Acronyms

AALJ	Association of Administrative Law Judges
ADA	Americans with Disabilities Act
ACA	Affordable Care Act
ALJ	Administrative Law Judge
AWI	Average Wage Index
BEA	Bureau of Economic Analysis
BLS	Bureau of Labor Statistics
BOND	Benefit Offset National Demonstration
BOPD	Benefit Offset Pilot Demonstration
BYA	BOND Yearly Amount
CBO	Congressional Budget Office
CDR	Continuing Disability Review
COLA	Cost-of-Living Adjustment
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
DA&A	Drug Addiction and Alcoholism
DDS	Disability Determination Services
DI	Disability Insurance
DOL	Department of Labor
DOT	Dictionary of Occupational Titles
EITC	Earned Income Tax Credit
EN	Employment Network
EPE	Extended Period of Eligibility
EWIC	Enhanced Work Incentives Counseling
FRA	Full Retirement Age
FY	Fiscal Year
GAO	Government Accountability Office
GDP	Gross Domestic Product
HI	Hospital Insurance
IRS	Internal Revenue Service
LTD	Long-Term Disability
NBER	National Bureau of Economic Research
NCS	National Compensation Survey
NPRM	Notice of Proposed Rulemaking
OECD	Organization for Economic Co-operation and Development
O*NET	Occupational Information Network
OASDI	Old-Age, Survivors, and Disability Insurance
OASI	Old-Age and Survivors Insurance

OIG	Office of the Inspector General
OIS	Occupational Information System
OMB	Office of Management and Budget
PDI	Private Disability Insurance
SGA	Substantial Gainful Activity
SSA	Social Security Administration
SSAB	Social Security Advisory Board
SSARP	Social Security Administration Representation Project
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STD	Short-Term Disability
TDI	Temporary Disability Insurance
TWP	Trial Work Period
UI	Unemployment Insurance
VR	Vocational Rehabilitation
WC	Workers' Compensation

Author Contact Information

(name redacted)
Analyst in Income Security
[redacted]@crs.loc.gov7-....

EveryCRSReport.com

The Congressional Research Service (CRS) is a federal legislative branch agency, housed inside the Library of Congress, charged with providing the United States Congress non-partisan advice on issues that may come before Congress.

EveryCRSReport.com republishes CRS reports that are available to all Congressional staff. The reports are not classified, and Members of Congress routinely make individual reports available to the public.

Prior to our republication, we redacted names, phone numbers and email addresses of analysts who produced the reports. We also added this page to the report. We have not intentionally made any other changes to any report published on EveryCRSReport.com.

CRS reports, as a work of the United States government, are not subject to copyright protection in the United States. Any CRS report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS report may include copyrighted images or material from a third party, you may need to obtain permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

Information in a CRS report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to members of Congress in connection with CRS' institutional role.

EveryCRSReport.com is not a government website and is not affiliated with CRS. We do not claim copyright on any CRS report we have republished.