

2. An Overview of Social Security Disability Insurance (SSDI)

Patricia Owens

The Social Security Disability Insurance (SSDI) program provides cash benefits for insured working-age individuals whose ability to work is compromised by one or more physical or mental impairments. The program was established in 1956 as an addition to the existing Social Security Old-Age and Survivors' Insurance (OASI) program and remains closely linked to the retirement program today.

Although the original definition of disability and criteria for receiving SSDI benefits has been modified over time, the program has and continues to cover only full disability as measured both by medical impairment and inability to engage in substantial work (Kearney 2005/2006). Specifically, to be awarded benefits a person must be unable to perform any substantial gainful activity (SGA) due to an impairment expected to last over a year or result in death. An individual must also meet the qualifications for "insured status," which are based primarily on one's work history.

Based on this criteria, roughly 9 million workers with disabilities received SSDI benefits in 2014, along with nearly 2 million spouses and children (Trustees 2015). Among workers with disabilities, average benefits total about \$15,000 per year for new recipients and \$14,000 for existing recipients. SSDI benefit payments for 2014 cost about \$142 billion, resulting in a total program cost of about \$145 billion (Social Security Board of Trustees 2015, Table III.A2).

The cost of SSDI benefits is paid for mainly from a 1.8 percent payroll tax on an individual's first \$118,500 of earnings in 2015. That tax is generally divided equally between employer and employee (or paid solely by the employee for self-employed workers), and the taxable maximum indexed to wage growth over time. Along with small amounts of income from the income taxation of SSDI benefits and interest on trust fund holdings, this tax generated about \$115 billion last year (Social Security Board of Trustees 2015, Table III.A2).

Because program costs are currently well in excess of revenue, the SSDI trust fund has been projected to deplete its reserves in late 2016 absent legislative action such as a reallocation from the old-age trust fund (Social Security Board of Trustees 2015, 24). The need for such action sparked considerable interest in SSDI program. In late 2015, Congress passed and the President signed into law the Bipartisan Budget Act of 2015, which temporarily reallocates revenue for three years, delaying SSDI trust fund reserve depletion until approximately 2022 (Goss 2015).

This chapter provides an overview of many of the aspects of the SSDI program.

HOW IS BENEFIT ELIGIBILITY DETERMINED?

In order to receive SSDI benefits, a worker must both satisfy the rules for insured status and have an impairment which meets the SSDI definition of disability. The Social Security Administration (SSA)

is responsible for issuing program guidelines, which carry out the legislative intent for making determinations of disability.

The Insured Status Requirement

Insured status is generally determined based on an individual's work history. Specifically, a worker must satisfy a duration-of-work test (fully insured) and a recency-of-work test (disability insured) based on past work in Social Security-covered employment. Credit for work is measured in quarters of coverage. Workers receive credit for one quarter of coverage for every \$1,220 in earnings in 2015, to a maximum of four per year.

To be fully insured, a worker filing for SSDI must have at least as many quarters of coverage as the number of years between the year the worker turned age 21 and the year in which he or she became disabled. To be disability-insured, the work must have earned at least 20 quarters of coverage during the 40-quarter period that ended with the quarter he or she became disabled. The requirement is eased for those who become disabled before age 31, and there are special rules for individuals who had a previous period of disability (SSA 2015a).

The Disability Requirement

In addition to meeting the insured status requirement, a worker must also meet the statutory definition of disability: "be unable to perform any substantial gainful activity (SGA) by reason of a medically-determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." To meet this definition, a person must not only be unable to perform his or her past work, but also unable to perform any other work that exists in significant numbers in the national economy.¹

To determine whether an applicant meets this statutory disability requirement, SSA uses a five-step sequential evaluation process. The disability decision maker asks five questions in a specific sequence. If a finding of "disabled" or "not disabled" can be made at any step, the evaluation does not proceed with the remainder of the steps.²

The Work Test — The first question is whether the claimant is working and earning at the level of SGA as defined in Social Security regulations. SGA is remunerative work that is substantial as determined by the amount of money earned, the number of hours worked, and the nature of the work. Generally, work is considered SGA if the person earns \$1,090 or more per month in 2015 (just over \$13,000 per year), an amount that is indexed annually to increases in the average wage level (SSA 2015b). If the applicant is working at or above SGA, the claim is denied. Otherwise, the evaluation continues to the next step.

The Severity Test — The second question is whether the claimant has an impairment or combination of impairments that interferes with basic work activities (a "severe" impairment) and is expected to last at least 12 months or result in death. Over time, SSA's interpretation of the non-severe threshold and consideration of multiple non-severe impairments has been challenged. Judicial decisions and legislation have mandated clearer guidelines. The authority to deny based on medical evidence of non-severity alone remains, but adjudicators are cautioned if they are "unable to determine clearly the effect

¹ See 42 U.S.C. § 423(d)(1)(A).

² See 20 CFR Part 404, Subpart P.

AN OVERVIEW OF SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

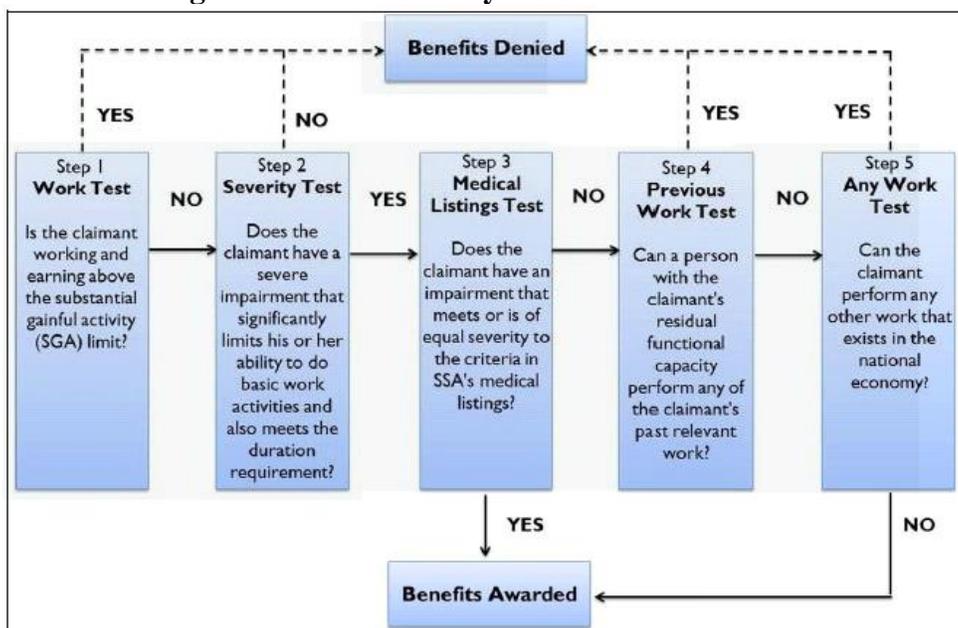
of an impairment or combination of impairments on the individual's ability to do basic work activities, the sequential evaluation process should not end with the not severe evaluation step."³

The Medical Listings Test — The third question is whether the claimant's impairment either meets or is equal to the severity of SSA's Listings of Impairments. The Listings of Impairments describe, for each major body system, diseases and conditions considered severe enough to prevent an individual from performing substantial gainful activity. Listings have been revised periodically over the SSDI program's history. If the requirements in the Listings are met or equaled, the claimant is found disabled without further consideration. Otherwise, the evaluation continues to the next step.

The Previous Work Test — The fourth question is whether the claimant can do his or her past work considering the effects of the medical condition. This requires SSA to determine the person's residual functional capacity (RFC). RFC is a person's remaining mental and physical capabilities after considering the effects of his or her medical conditions. This is compared to the work demands of the person's past relevant work. If the claimant remains capable of past work, the claim is denied. Otherwise, the evaluation continues to the last step.

The Any Work Test — The final question is whether a person, despite being unable to perform past work, can perform other work that exists in the national economy. In Step 5, the burden of proof shifts to SSA to show that work, other than the individual's past work, exists in significant numbers in the national economy and to which the claimant can make an adjustment, considering the limiting effects of the individual's impairment, age, education, and work experience. If the person cannot perform other work, the claim is allowed.

Figure 1 – The Disability Determination Process



Graphic from Congressional Research Service Report 7-5700 (Morton 2014).

³ Social Security Administration, Social Security Rulings 85-28: Titles II And XVI: Medical Impairments That Are Not Severe, SSR 85-28. https://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR85-28-di-01.html Accessed September 1, 2015.

In order to expedite favorable decisions, SSA has two fast-track processes to identify cases involving the most severe disabilities. In the Compassionate Allowance process, SSA used expert input to identify a number of diseases and other medical conditions that almost invariably qualify under the Listing of Impairments and require a minimal amount of objective medical information. This allows Disability Determination Services (DDSs) to promptly allow claims of persons with those conditions. The Quick Disability Determination process employs a computer-based predictive model to screen initial applications and identify cases in which a favorable disability determination is highly likely and medical evidence is readily available so that such cases can be expedited (Rajnes 2012).

WHO RECEIVES SSDI BENEFITS?

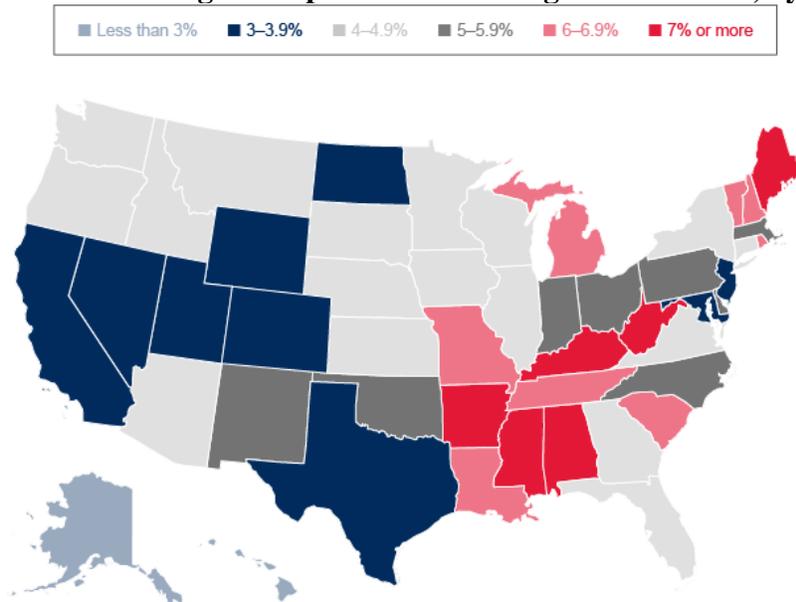
Nearly 11 million Americans receive SSDI cash benefits, the vast majority being disabled worker beneficiaries who make up about nine million beneficiaries; the other two million beneficiaries are dependents of workers with disabilities (including spouses and children) or are disabled themselves and qualify for benefits under their spouse or parent (SSA 2015b, Table 2).

In addition to their differences in qualification, SSDI beneficiaries are also very diverse in geographic location, gender, age, and condition.

Beneficiaries by Geographic Location

While about 5 percent of the U.S. population receives SSDI benefits, the distribution among states varies between 3 percent of a state's population to almost 9 percent. Alaska and Hawaii have the lowest percentage of SSDI benefits, around that 3 percent mark; West Virginia and Alabama have the highest, hovering close to 9 percent. There are also a number of Americans in the U.S. territories and abroad who receive SSDI benefits (SSA 2014a, Table 9).

Figure 2 - Percentage of Population Receiving SSDI benefits, by State



Graphic from the Annual Statistical Supplement for the SSDI Program (SSA 2014a).

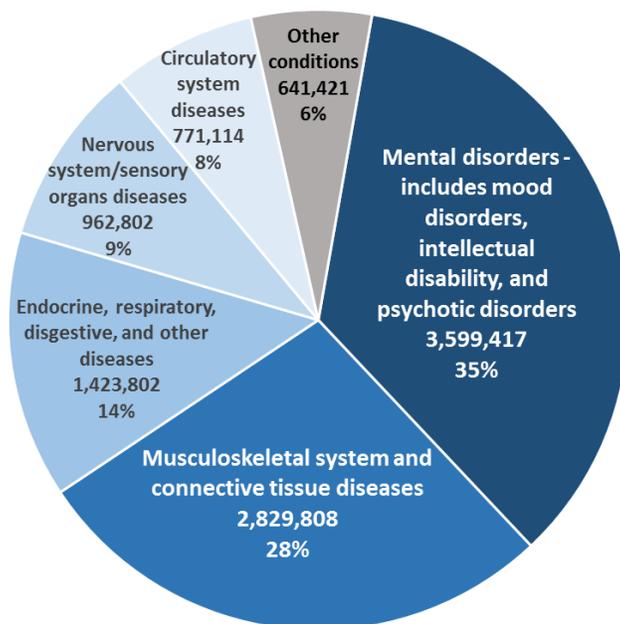
Beneficiaries by Gender and Age

Over the life of the SSDI program, gender parity of beneficiaries has changed substantially, while the average age has mostly stayed the same. In 1960, about 22 percent of beneficiaries were women; today, that number is closer to half. This change primarily reflects the evolution of the labor force over the last half-century (see section on program growth below for more details). On the other hand, the average age of beneficiaries has only varied slightly around the current average age of 53 years (SSA 2014a, Table 19).

Beneficiaries by Condition

SSA classifies SSDI beneficiaries by the primary condition under which they qualify. The nature of each impairment varies greatly, but the most common primary conditions of SSDI beneficiaries are mental and intellectual disorders, accounting for about 35 percent of beneficiaries (split between 27 percent having mental disorders and 8 percent with intellectual disorders), and musculoskeletal and connective tissue disorders, accounting for about 28 percent of beneficiaries. Both men and women tend to experience these conditions at roughly the same rates. The breakdown of qualifying conditions can be seen in Figure 3 below.

Figure 3 – SSDI Beneficiaries by primary condition, 2013



Source: Annual Statistical Supplement on the SSDI Program (SSA 2014a).

HOW ARE BENEFITS AWARDED?

In order to receive benefits, an individual must file an application and await a decision as to whether or not they meet the insured status requirement and satisfy the definition of disability. If an application is accepted at the initial level, a worker begins receiving monthly benefits and also can receive back

payments for up to a year before the application was filed. If the initial application is denied, several levels of appeal are available.⁴

The Initial Decision

Applicants for disability benefits may apply in person at a field office or by telephone, mail, or online. The application and related forms ask for a description of the claimant's impairment(s), treatment sources, the date they became unable to work, and other information that relates to the disability.

The SSA field office is responsible for verifying non-medical eligibility requirements, which may include age, employment, marital status, or insured status. While the SSA field office is responsible for verifying necessary non-medical requirements, the disability evaluation is performed by a DDS, a state agency that is federally funded and applies federal rules for developing the necessary medical and vocational information and making the initial disability decision (Wixon and Strand 2013).

A DDS tries to obtain evidence from the claimant's own medical sources. If that evidence is unavailable or insufficient to make a determination, a DDS will arrange for a consultative examination (CE) to get the needed information. A DDS may purchase the CE from the claimant's own medical source, or from a qualified independent source if the claimant's treating source cannot provide one. After completing development of the evidence, trained staff at the DDS make the initial disability determination. Normally, after a case has been fully developed, a two-person team consisting of a disability examiner and a medical consultant (a physician or psychologist) makes the decision. SSA has also been testing an alternative Single Decision Maker program (SDM) for over a decade. The SDM program authorizes disability examiners to process some cases without a medical consultant's involvement (SSAB 2015). However, a provision of the Bipartisan Budget Act of 2015 is expected to eliminate the SDM program in late 2016.⁵

The DDS then returns a completed case to the field office for appropriate action. If the DDS found that the claimant is disabled, SSA completes any outstanding non-disability determination work, computes the benefit amount, and triggers the benefit payment. If the claimant was found not disabled, the file is kept in the field office in case the claimant decides to appeal the determination.

The Appeals Process

If the applicant's claim for disability benefits is denied, he or she may appeal the decision. There are four potential levels of appeal: (1) reconsideration by the state DDS, (2) hearing by an administrative law judge (ALJ), (3) review by the Appeals Council, and (4) federal court review.

Generally, reconsideration is the first step in the appeals process, and a claimant has 60 days to request this review. Reconsideration is a case review similar to the initial determination except that the case is assigned to a different adjudication team at the DDS. The claimant is given the opportunity to present

⁴ See 404.621 U.S. Social Security Administration Effective Filing Period of Application, What happens if I file after the first month I meet the requirements for benefits?, *Code of Federal Regulations*, title 20 (2014): 213-214, <http://www.gpo.gov/fdsys/pkg/CFR-2014-title20-vol2/pdf/CFR-2014-title20-vol2-sec404-621.pdf>

⁵ See Sec. 832 of Public Law 114-74, <https://www.congress.gov/bill/114th-congress/house-bill/1314/text?overview=closed#toc-H442FB118C81C4D91A92889A527AA9599>

additional evidence, which is considered along with the evidence previously submitted. In 10 states, elimination of reconsideration is being tested and appeals are instead directed to the next level.

If the claim is denied at reconsideration (or at the initial level in states without reconsideration), the individual has 60 days to request a hearing before an SSA administrative law judge. ALJs are SSA employees tasked with hearing Social Security cases, the majority of which are disability appeals. The ALJ will hold a hearing unless the claimant requests that the decision be based on the existing written record. The ALJ is responsible for looking into all the issues and receives documentary evidence as well as the testimony of the claimant and witnesses. The ALJ will allow the claimant or the claimant's representative to present arguments and examine witnesses at the hearing. The ALJ then creates an entirely new decision evaluating the same criteria as the prior levels. Nearly a third of these cases are done by telecommunication (SSA 2015d).

If a claim is denied at the ALJ level, the claimant may request (within 60 days of receiving the decision) that the Appeals Council (AC) review the case. The AC, made up of administrative appeals judges, may also motion to review a decision on its own. The AC considers the evidence of record, any additional evidence submitted by the claimant, and the ALJ's findings and conclusions. The AC may grant, deny, or dismiss a request for review. The AC may also uphold, modify, or reverse the ALJ's action, or it may remand it to the ALJ to hold another hearing and issue a new decision.

If denied or dismissed at the AC level, claimants may file a civil suit in a federal district court within 60 days after the date they receive notice of the AC's action. If the U.S. district court reviews the case record and does not find in favor of the claimant, the claimant can continue with the appellate process to the U.S. circuit court of appeals and beyond.⁶

According to the SSA, between 32 and 35 percent of applicants have been approved for benefits at the initial stage over the past five years. Of those who requested reconsideration, between 11 and 13 percent of initially denied applicants have been approved for benefits at this level. When it comes to further levels of appeal, the success rate has averaged between 45 and 62 percent at the ALJ level over the past five years, while success at the AC and federal court levels has averaged around 1 to 3 percent and 2 to 4 percent, respectively, though these appeals can also be remanded back to the ALJ level for additional consideration (SSA 2015e; SSA 2014b; SSA 2013; SSA 2012; SSA 2011).

HOW DO SSDI RECIPIENTS EXIT THE PROGRAM?

Once an individual is determined to qualify for benefits, he or she can generally continue to receive benefits until no longer considered disabled. Most beneficiaries remain on the program until they reach the Social Security normal retirement age (currently 66 and rising over the next few years to 67), at which point they convert onto the old-age program. However, some beneficiaries leave the program either due to death, because SSA determines them no longer eligible through a Continuing Disability Review (CDR), or because they choose to return to work—sometimes due to work incentives within the program.

⁶ See 416.920 U.S. Social Security Administration Evaluation of Disability, Evaluation of disability of adults, in general, *Code of Federal Regulations*, title 20 (2014): 857-858, <http://www.gpo.gov/fdsys/pkg/CFR-2014-title20-vol2/pdf/CFR-2014-title20-vol2-sec416-920.pdf>

Continuing Disability Reviews

The Social Security Administration conducts regular CDRs to determine whether an individual remains eligible for the SSDI benefit based on medical disability and continued inability to work above SGA.

There are two types of CDRs—medical and work. For medical CDRs, cases are reviewed at certain intervals, depending on the likelihood of medical improvement. Cases deemed “Medical Improvement Expected” are supposed to undergo CDRs every six months to 1.5 years. Those deemed “Medical Improvement Possible” are supposed to undergo CDRs every three years. Those deemed “Medical Improvement Not Expected” are supposed to undergo CDRs every five to seven years. However, medical CDRs often run behind schedule, and currently there is a significant backlog. While medical CDRs are scheduled, work CDRs are only conducted if SSA is notified of a beneficiary returning to work.

Medical CDRs

When it is time to conduct a CDR, SSA uses a statistical modeling system using data from beneficiary records to rate a beneficiary’s probability of having improved. This is a separate assessment from the evaluation of likelihood of medical improvement that is done when the claim was first approved. For individuals who have a high probability of having improved, the cases are sent to the state DDS for a full medical review. Individuals who have a lower probability of medical improvement receive a questionnaire—or “mailer CDR”—requesting updates on their impairments, medical treatment, and work activities. If the questionnaire indicates that there may have been medical improvement, the case is also sent to the DDS for a full medical review. Otherwise, the case is rescheduled for a later review based on the potential for improvement. CDRs are also processed when SSA receives a report of medical improvement from a beneficiary or third party (Colvin 2012).

If, as a result of a medical CDR, SSA decides that an individual’s disability has ceased, the appeals process is similar that of initially unfavorable decisions. However, while most reconsideration of initial denials involves just a file review, a beneficiary who has been found no longer disabled can request an in-person meeting with a Social Security representative.

Work CDRs

A work CDR is a review generated by reported earnings from beneficiaries or third parties, systems alerts, or earnings posted to a beneficiary’s record. The Continuing Disability Review Enforcement Operation uses Internal Revenue Service earnings data to identify possible work CDRs for SSDI beneficiaries. SSA receives about 600,000 alerts annually, and they generally prioritize alerts with the highest identified earnings. After an SSDI beneficiary completes a trial work period (TWP) and continues to work, SSA conducts a work CDR to determine if the beneficiary’s earnings preclude entitlement to payment.

Work CDRs are conducted in SSA field offices and processing centers using an automated work processing program called eWork. This program collects data; prepares forms, notices, and work report receipts; incorporates policy and decision logic; and adjusts benefits. When a beneficiary works, the return to work incentive provisions such as TWP are taken into account.

Return to Work

Each year, a small number of SSDI beneficiaries are able and choose to go back to work, temporarily or permanently exiting the SSDI program. Although there are numerous obstacles to returning to work—from a “cash cliff,” which can cause individuals to lose all benefits by earning above SGA, to the general loss of skill and attractiveness to employers for those who have spent a long time out of the labor force—SSDI includes a number of features meant to make it easier for individuals to return to work.

Many of these incentives revolve around allowing SSDI recipients to test out working and remain attached to the program during that period. These include: a nine-month TWP, during which recipients can receive earnings above SGA without experiencing reduced benefits; an extended period of eligibility (EPE), during which benefits are automatically restored if a worker makes below SGA within an additional three years; an immediate expedited reinstatement period, during which a former beneficiary can reapply and waive the waiting period for an additional two years beyond the EPE; and extended Medicare eligibility for that same time period (with a Medicare buy-in available thereafter) (SSA 2015f, 26-29).

In some cases, the program further encourages work by effectively letting recipients earn above SGA. For example, if work is subsidized or performed under special conditions, only the actual value of the work is considered in determining if the work is SGA. In addition, a worker may deduct impairment-related work expenses—the cost of certain impairment-related items and services that beneficiaries need to work—from their income in determining SGA.

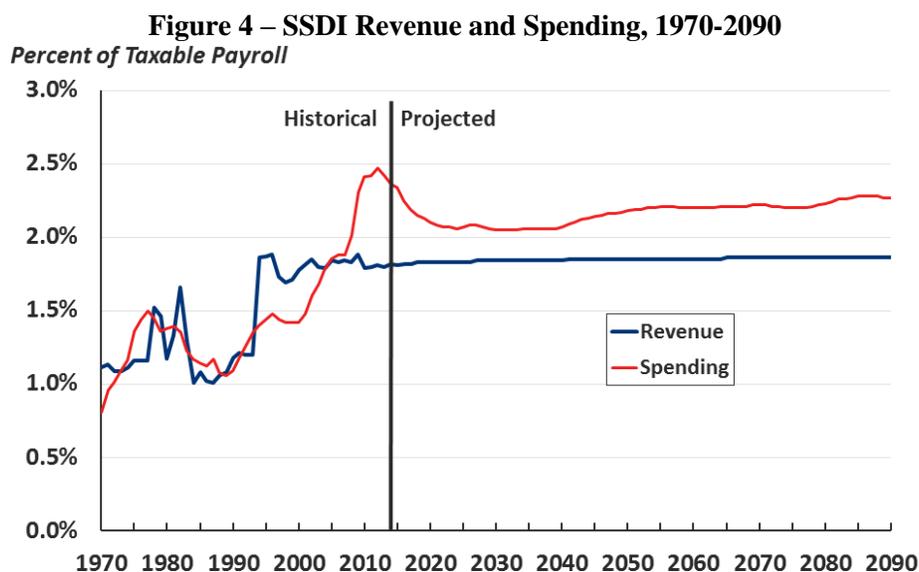
In 1999, Congress established the Ticket to Work Program, a free and voluntary program designed to give beneficiaries greater access to and choice of rehabilitation and employment services and other support services to help them get or keep a job. The program established employment networks—often state vocational rehabilitation agencies—to provide these services. The program was coupled with the Work Incentives Improvement Program (WIPA) to provide community-based work incentives expertise to beneficiaries. Program evaluations have shown that these programs have had a positive but very limited effect on employment outcomes for those on the SSDI program (Livermore et al. 2013).

In addition to these programs, SSA has been testing a number of additional work incentives through various pilots and demonstrations. For example, the Benefit Offset National Demonstration (BOND) is currently testing a change in how SSDI benefits are offset when an individual receiving them works at above the SGA level. Currently, most individuals who work after the end of their trial work period receive no cash benefit in any month they perform SGA. This abrupt loss of benefits is commonly referred to as the “cash cliff.” BOND tests a gradual reduction of benefits (\$1 of benefit reduction for every \$2 of earning above SGA). A completed pilot known as the Mental Health Treatment Study provided supported employment and systematic medication management services, coupled with the removal of some known programmatic disincentives, to SSDI beneficiaries with schizophrenia or an affective disorder. The results showed that employment supports, along with medical support and coordinated care, were successful in improving health, lowering hospitalizations, and increasing employment for SSDI beneficiaries with schizophrenia and other affective disorders. The Bipartisan

Budget Act of 2015 includes a provision requiring SSA to conduct another demonstration project similar to BOND, but with the benefit offset starting at a lower earnings threshold.⁷

HOW IS SSDI FINANCED?

Most of SSDI's funding comes from a 1.8 percent payroll tax, split evenly between employees and employers (or paid entirely by a self-employed individual), on a worker's first \$118,500 in earnings in 2015 (this amount is indexed to average wage growth). A small amount of additional income comes from the partial income-taxation of benefits received by program recipients with high income, and from interest on the trust fund's reserves. In 2014, the program took in roughly \$115 billion in revenue while incurring \$145 billion in costs, primarily in the form of paid benefits. As a result, the program ran a \$30 billion deficit—roughly 0.55 percent of payroll (Social Security Board of Trustees 2015).



Source: 2015 Social Security Trustees' Report

Immediate and Long-Term Funding Needs

According to the 2015 Social Security Trustees' Report, the SSDI trust fund was projected to exhaust its reserves by the end of 2016. Without legislative changes, this depletion would have left the program with enough revenue to pay 81 percent of scheduled benefits. However, the Bipartisan Budget Act of 2015 delayed the depletion of the SSDI trust fund reserves until approximately 2022 by reallocating payroll tax revenue from the old-age trust fund to SSDI (Goss 2015).

Despite the immediate funding issue being temporarily resolved, the SSDI trust fund still faces a long-term funding gap as program costs continue to exceed revenue raised by the 1.8 percent payroll tax. The most recent Social Security Trustees report projected costs to decline over the next few years—from 2.4 percent of payroll in 2014 to 2.1 percent in the 2020s and 2030s, and then rise to 2.3 percent of payroll by 2090. It projected the 75-year actuarial shortfall of SSDI to be about 0.31 percent of payroll (Social Security Board of Trustees 2015); the Congressional Budget Office, meanwhile,

⁷ See Sec. 823 of Public Law 114-74, <https://www.congress.gov/bill/114th-congress/house-bill/1314/text?overview=closed#toc-H442FB118C81C4D91A92889A527AA9599>

projected a 0.7 percent shortfall (CBO 2015). Although the shortfall has been reduced somewhat by the temporary payroll tax reallocation and other Social Security provisions in the Bipartisan Budget Act of 2015, it has not been eliminated.

Ultimately, additional legislation will be required to close the entire shortfall. The gap between spending and revenue could be closed by reducing projected program costs, increasing dedicated taxes, diverting further revenue from other sources such as the OASI trust fund, or some combination of the three.

WHAT EXPLAINS THE GROWTH IN THE PROGRAM?

The cost of the SSDI program has grown considerably in recently years, from \$3.3 billion (0.81 percent of payroll) in 1970 to \$19.5 billion (1.14 percent of payroll) in 1985, \$56.8 billion (1.42 percent of payroll) in 2000, and \$145 billion (2.36 percent of payroll) in 2014 (Social Security Board of Trustees 2015, Table IV.B1 and Table VI.G8). This growth in part reflects continued increases in prices and wage growth (initial benefits grow each year with wages), but it also tracks a growth in the total number of recipients—from 2.6 million in 1970 to 11 million today (Social Security Board of Trustees 2015, Table IV.B3).

The incidence rate of working-age Americans receiving SSDI benefits has similarly increased. In the late 1970s, 2.2 percent of working-age Americans received SSDI; that share had risen to 3.5 percent leading up to the 2007-2009 recession, and was 4.6 percent in 2013 (Liebman 105, 123). In the late 1970s, 3.0 percent of working-age men received SSDI, increasing to 3.8 percent before the recession and 4.5 percent by 2013, while the corresponding SSDI receipt rates for women went from 1.4 percent, to 3.5 percent, and 4.3 percent, respectively (Liebman 2015, 128). Numerous explanations for the increase in the number of people receiving SSDI have been offered. There are three generally accepted drivers of increased costs:

- Population and demographic changes;
- Economic and labor market changes; and
- Program and policy changes.

It is difficult to attribute a specific proportion of the increase to each of those factors. Economists have used various techniques of factor analysis to help quantify the growth factors (Autor and Duggan 2003; Autor and Duggan 2006; Goss 2014; Ruffing 2014). As noted by one group of researchers, “[a]lthough researchers generally agree that a substantial portion of the SSDI program growth stems from demographic changes, . . . they disagree on the extent to which other, more difficult-to-quantify factors have played a role in SSDI program growth. . . .” (Livermore, Wittenberg and Neumark 2014, 2).

Population and Demographic Changes

One reason for the increase in the size of the SSDI program is the overall increase in working-age population and the corresponding increase in the number of people insured for SSDI. According to SSA, there were about 75 million individuals insured for SSDI in 1970. By 2014, that number had more than doubled to over 151 million (Social Security Board of Trustees 2015, Table IV.B3).

In addition, the age distribution of the working-age population also changed. Between 1970 and 1990, as the baby boomer generation (those born between 1946 and 1965) entered young adulthood, both employment and gross domestic product (GDP) rose more than SSDI cost as a result of the increase in the proportion of relatively young and healthy individuals in the workforce. However, from 1990 to 2010, the baby boomers moved to older working ages 45 to 64. The younger adult workers who followed them were from a generation with a lower birthrate, thus increasing the proportion of workers in disability-prone ages to the total population.

Another demographic factor has been the increase in the percentage of working-age women who have worked consistently enough to be disability-insured. Their number has nearly doubled since 1970 to 8.2 million. In addition, the incidence of disability among women has grown. In the late 1970s, 3 percent of working-age men received SSDI, but only 1.4 percent of working-age women did. Leading up to the 2007-2009 recession, the rate for working age men had gone up by less than a third to 3.8 percent, but the rate for women more than doubled to 3.5 percent. By 2013, the rates for men were 4.5 percent and for women, 4.3 percent (Liebman 2015, 127-128).

The increase in the Social Security full retirement age is another factor contributing to increased SSDI receipt. This contributed to the increase in the number and proportion of insured workers in their disability prone years, and also increased the total amount of SSDI benefits paid out to older workers before they are converted to retirement benefits at full retirement age. This change also increased the relative value of disability benefits compared to early retirement benefits, potentially increasing the rate of SSDI filing for duals age 62 and over (Morton 2014, 11). The effect of the rise in retirement age on SSDI awards has yet to be precisely calculated, but early research indicates that raising the retirement age would increase SSDI benefit eligibility (GAO 2010a). In addition to these causes, mortality and recovery rates must also be factored into any analysis of growth in incidence and duration (Liebman 2015).

As noted previously, there is general agreement that demographic changes in the U.S. population are an important factor in program growth; however, many disagree with the magnitude of its effect.

Program and Policy Changes

Legislative changes in the SSDI program since its inception in 1956 include a wide range of provisions: the addition of benefits for dependents, lowering of age for entitlement, liberalizing insured status requirements, and increases in benefit amounts. A quantifiable example of expansion is the effect of changing the definition of disability from an impairment that could be expected to last for a “long-continued and indefinite duration”—as defined in the 1965 amendments to the Social Security Act—to one that could be expected “to last for a period of 12 months or longer.” It was estimated that upon enactment this new language allowed for immediate entitlement of 60,000 workers with disabilities. Among other actions which have added to cost growth are increased retroactivity of benefits, reducing the waiting period for application, and providing for Medicare benefits (Kearney 2005/2006).

The last major legislatively mandated changes were contained in the 1984 amendments to the Social Security Act and required that the listings for mental impairments and the methodology for assessing the impairment impact of chronic pain (frequently an issue when evaluating musculoskeletal disorders) be updated. These new procedures have been linked to more subjective decisions, which allow greater latitude in awarding benefits (particularly for those with mental and musculoskeletal disorders) and

overall program liberalization (see, for example, Autor 2011). Others have questioned the significance of these changes (see, for example, Ruffing 2014). However, regardless of the cause, it is clear that the proportion of cases involving mental and musculoskeletal disorders has risen, while the share involving circulatory disorders and cancer has fallen (SSA 2014a, 63-64). Given that musculoskeletal and mental disorder are less likely to result in death than other impairments, “the growth in the share of beneficiaries with mental and musculoskeletal disorders likely increased the average duration of benefit receipt, as well as the total number of individuals on disability rolls” (Morton 2014, 11). The same law revised the standard for reviewing cases of continuing disability and mandated a new medical improvement standard, which tightened the criteria for stopping benefits and which may have contributed to fewer recipients being removed from the rolls.

Legislative changes outside of SSDI have also increased the size of the rolls to some degree. In particular, the increase in the normal retirement age from 65 to 66 (and headed to 67) has both extended the number of years a worker is eligible for and receives SSDI and increased the attractiveness of the SSDI benefit relative to the Social Security retirement benefit (CBO 2012).

Economic and Labor Market Changes

On the economic front, the Great Recession of 2008 resulted in lower GDP, making SSDI costs as a portion of GDP rise as GDP fell. Yet, the recession also appears to have increased costs, to some degree, in absolute terms. Historically, SSDI applications and awards have increased during economic downturns when unemployment rises (Rupp 2012). Jobs that are available for marginally disabled workers in good economic times may be much scarcer in bad times, and long spouts of unemployment likely further reduce skills and employability for many disabled workers. As a result, SSDI applications tend to increase significantly during recessions. And although award *rates* tend to go down to some degree as a response, total awards still go up.

Separate from the recession, other more structural changes to the economy may be increasing the number of individuals on SSDI. Changes in the labor market have eliminated many low-skilled jobs. This, along with more jobs requiring higher level skills, reduces the number of jobs available for unskilled workers in their disability-prone work years. And, coupled with the higher wage replacement ratios of benefits for lower wage earners, SSDI entitlement becomes more attractive to workers who might otherwise stay in the workforce.

One thing is certain: over time, many factors must be analyzed to understand the relationship between program growth and financing. Effective program improvements in design and administration require understanding the individual and interactive effects of a myriad of sometimes conflicting environmental impacts.

HOW DO OTHER PROGRAMS AND SERVICES AFFECT SSDI?

The relationships and interactions between SSDI and other benefit systems and services are important considerations in discussing the role of SSDI in the overall social insurance system. In many ways, SSDI and other programs at the federal, state, and local level as well as privately run ventures overlap and interact with each other.

At the same time, there is growing agreement about the need for coordination and integration of benefits and services for working-age persons with disability, especially in light of new and evolving

concepts of disability (GAO 2010b). For example, GAO has reported there are more than 20 federal agencies and almost 200 programs that provide a wide range of assistance to people with disabilities, including employment-related services, medical care, and monetary support (GAO 2008). These programs provide help for working-age persons with disability and also assist in providing an adequate national labor force. There is a high cost to these programs. GAO later reported on 45 programs in support of employment for persons with disabilities. The programs administered by nine federal agencies were fragmented and often provided similar services to similar populations (GAO 2015).

Although agencies may be partnering on a case-by-case basis, agency officials and experts have cited a lack of communication and comprehensive coordination among the federal programs that serve individuals with disabilities. With increasing expenditures, a growing potential beneficiary population, and the number of programs providing assistance to individuals with disabilities, the importance of modernizing and effectively coordinating federal disability programs is constantly increasing.

An appendix including a detailed discussion of a number of SSDI program interactions is available on the McCrery-Pomeroy SSDI Solutions website at <http://www.ssdisolutions.org/book>. Below is a short discussion of some of the major interactions.

SSDI and OASI

Both OASI and SSDI are social insurance programs; one pays benefits upon death or retirement, while the other replaces income when a disability occurs before retirement. Benefits are calculated using intricate earnings- and age-based formulas which have evolved over time in consideration of economic and demographic alterations in the composition of the insured population.

To calculate benefits, a worker's Average Indexed Monthly Earnings (AIME) are converted to a Primary Insurance Amount (PIA). The AIME is the annual taxable earnings from covered wages or self-employment averaged and indexed over a period that encompasses most of the worker's adult years. The PIA is the monthly benefit payable to a worker upon initial entitlement at the full retirement age (FRA) or upon entitlement to disability benefits. The formula for computing the PIA from the AIME is progressive and thus provides a higher PIA-to-AIME ratio for workers with low earnings.

Disabled beneficiaries and persons retiring at the FRA are paid 100 percent of their PIA. If a worker applies for early retirement between age 62 and their FRA, they receive proportionally reduced benefits (reduced by up to 25 percent for people who retire when they first turn 62). When disability benefits are converted to retired-worker benefits at FRA, or at early retirement for recovered workers between the ages of 62 and FRA, the years of disability are disregarded to preserve insured status and the benefit level. Alternative methods of computing the PIA apply to workers who have low earnings but a steady work history.

If a disabled worker applies for early retirement and then becomes disabled before full retirement age, he or she could be eligible for a larger disability benefit, although that benefit would be reduced somewhat based on the period of time retirement benefits had already been received before incurring a disability. A worker at least age 62 who files for disability can receive a reduced retirement benefit while the SSDI claim is being processed and, if approved for SSDI, can receive retroactive payment for the difference between their reduced retirement benefit and their full SSDI benefit. Monthly benefits payable to the worker and family members or to the worker's survivors are limited to a

maximum family benefit amount. Cost of living increases to benefits are legislatively mandated and calculated annually.

SSDI and Supplemental Security Income (SSI) Disability Benefits

SSI disability benefits are needs-based rather than coverage-based and require meeting a means test in addition to meeting the same definition of disability. SSI does not rely on a prior work qualification, and SSI beneficiaries are limited in the amount of earned and unearned income they can receive while receiving SSI, as well as how many assets they may own while receiving benefits. A person can have SSI benefits reduced or stopped because of income and/or resource ineligibility although they meet SSA disability criteria (Morton 2014). *SSDI is considered unearned income and thus reduces or can completely offset SSI cash benefits.* All but \$20 of unearned income reduces SSI benefits.

The SSDI program has a five-month waiting period after the onset of categorical eligibility as disabled, but SSI benefits can start right after the month of application. Thus, a categorically disabled person may be eligible for SSI benefits during the SSDI waiting period. Some complexities arise because of different program rules regarding the date of disability onset and the date of application for disability benefits. SSDI has the potential for 12-month retroactivity in disability benefits. The SSI payment is payable in the month of application. If part or the entire SSDI waiting period occurred prior to application for SSDI, SSI benefit eligibility may be affected for the months of SSDI payment. State Medicaid benefits may be payable for SSI beneficiaries prior to or in coordination with eventual Medicare entitlement. State rules apply and vary.

SSDI and VA Benefits

Both the Department of Veterans Affairs (VA) and Department of Defense (DOD) pay disability benefits based on service-connected health conditions. The VA disability compensation program is for veterans with a disease or injury that incurred or was aggravated during active military service. Those benefits, unlike SSDI, are not contingent on whether the veteran is working. The amount of the monthly benefit is based on a rating of the severity of the medical condition, expressed as a percentage loss of normal function. The DOD disability retirement program is for active duty service members no longer fit for duty as a result of a service-connected health condition. The benefit amount is based, in part, on the same disability percentage rating as is used in the VA compensation program, although there are differences between how the ratings are made. VA and DOD disability benefits are paid separately from SSDI, and there is no SSDI offset. (The VA also administers the veterans pension program, which is a needs-based program for veterans totally and permanently disabled due to a non-service-connected medical condition and who have limited financial resources.)

A September 2014 GAO report on disability compensation showed that 59,251 individuals received concurrent payments from DOD disability retirement, VA disability compensation, and SSDI totaling over \$3.5 billion in fiscal year 2013. Current law generally allows military personnel to receive concurrent disability compensation from DOD, VA, and SSDI. These concurrent payments ranged from \$25,000 to \$74,999 in total. As of January 2013, 48 percent of the individuals were age 60 or above. Eighty-one percent of individuals had a VA disability rating equal to or greater than 50 percent.

SSDI and State Workers' Compensation (WC)

WC benefits cover only disabilities arising out of and in the course of employment. It is compulsory and is administered by states, with each state setting its own benefits rules, usually with a schedule of payment rates. Based on the principle that employers have responsibility for the health and safety of their employees, WC is fully funded by employers through purchase of insurance or self-funding. Costs may be influenced by incidence and duration of compensable accidents or illness. The *AMA Guides to the Evaluation of Permanent Impairment* (2008) are frequently used and translated into a percentage of loss of function, which is used to measure potential income loss and then converted to a monetary award amount. The benefit period is set based on the duration and severity of the worker's disability, with lump sum settlements possible.

Cash benefits are tax free and generally payable for lost work time after a three- to seven-day waiting period and in relationship to earnings. There are four cash payment categories. Temporary total disability cash payments are the most common, and are paid when a worker is precluded from work for a defined period of time. Temporary partial disability payments are made when workers return to work before they reach maximum medical improvement and at reduced responsibilities and a lower salary. Permanent total disability payments are made if a worker has severe permanent impairments after reaching maximum medical improvement. Permanent partial disability payments are made when a worker has permanent impairments that do not completely limit the worker's ability to work. The system for determining benefits in these cases is complex and varies across jurisdictions. WC also provides death and funeral benefits to workers' survivors.

An offset for WC was contained in the original 1956 disability program. It was eliminated in 1958 and reinstated in 1965. The 1965 law, however, allowed states to reduce their benefits for a worker receiving SSDI, thus eliminating the SSDI offset for WC in those states. In 1981, PL 97-35 ended this "reverse offset" option (Reno, Williams, and Sengupta 2003/2004).

In all but 15 reverse-offset states, SSDI disability insurance benefits including family benefits may be reduced to fully or partially offset a Workers' Compensation benefit. The reduction in a SSDI benefit (and family benefits) may be made if the total benefits payable *plus* Workers' Compensation plus any public disability benefits (if applicable) exceed the higher of 80 percent of average current earnings as determined before disability began or the family's total Social Security benefit (before the reduction) (SSA 2015g).

SSDI and Private Sector Disability Insurance

Protection against the risk of work disability not incurred in the course of employment (and thus not covered by Workers' Compensation) is offered by insurers, either directly to individuals or to employers. Employers may self-fund these benefits. Medium and large employers are most likely to provide such benefits.

Short-term disability (STD) programs cover workers' absences from their usual jobs because of illness and accidents not sustained in the course of employment. To receive benefits, employees must be out of work a certain number of days, usually five. The replacement rate is typically 50 percent of wages. Medical evidence is required. The benefits are generally paid for a set period of time based on the type of illness or injury and last no longer than six months.

Long term disability (LTD) programs cover lengthy absences (after a six-month waiting period) caused by illnesses and accidents not sustained in the course of employment. Benefits are coordinated with sick pay or STD benefits. The norm is 60 percent wage replacement. The disability entitlement definition for the first six-12 months is inability to do the usual and customary occupation by reason of a medically determinable impairment. Most often, after one year, disability must cause inability to perform the functions of any occupation. Most LTD plans require that a person receive appropriate medical care.

LTD payments are generally offset by SSDI when the person becomes entitled to SSDI benefits. Insurers and employers maintain that this offset is important to the affordability of the coverage, since it covers disability of lesser severity and for longer periods of time. Insurers also make the argument that they reduce SSDI costs by their early intervention and return-to-work programs. There is a counter argument that employers and insurers may increase SSDI costs by requiring SSDI filing and providing legal representation during the claim and appeals process.

CONCLUSION

The SSDI program is a critical part of the lives of many persons with disabilities and their families. Many persons with severe disabilities cannot work even though they might want to. There is general agreement that there continues to be a need for wage replacement benefits for these workers.

At the same time, there is general agreement that the societal perspective on work disability has changed in light of the passage of the Americans with Disabilities Act, investments in adaptive technology, medical and technological advancements, and new perspectives driven in large part by the disability rights and independent living movements.

In many ways, disability policy is at a crossroads—facing two sometimes-competing goals of helping people with disabilities to enter or remain in the workforce while continuing to provide important support for the many people who will remain unable to work. These goals are in some ways in conflict under the current system, which generally sets inability to work as a criteria for receiving cash benefits and provides little support for those interested in remaining in the workforce.

Changes to the current program and how it interacts with other programs can improve this conflict on the margins and better optimize the existing program. In the future, perhaps, new approaches could be pursued in combination with SSDI to help maintain work function and increase the welfare and well-being of individuals with disabilities.

It is self-evident that disability policy initiatives should be balanced to protect those who really cannot work and provide avenues to work for those who can.

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