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# *The Social Security Definition of Disability*

**Social Security Advisory Board**

*October 2003*

## **Social Security Advisory Board**

An independent, bipartisan Board created by the Congress and appointed by the President and the Congress to advise the President, the Congress, and the Commissioner of Social Security on matters related to the Social Security and Supplemental Security Income programs

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# The Social Security Definition of Disability: Is it Consistent with a National Goal of Supporting Maximum Self Sufficiency?

## INTRODUCTION

When a working-age person suffers a disabling event, there are, apart from purely medical considerations, two fundamental needs that arise:

- the need to replace, at least to some degree, the income lost to the individual because of the disability, and
- the need to overcome the effects of the disability to allow the individual to resume as independent and productive a life as possible.

These objectives have both complementary and contradictory aspects, and programs designed to deal with them have adopted a variety of approaches.

When the Social Security Disability Insurance (DI) program was enacted in 1956, it was intended for the “totally and permanently disabled,” a population for whom work was not an option. But over the past half-century, there have been many changes in the Social Security disability programs and other programs, in the economy, in medicine, in rehabilitative technology, in attitudes about disability and the disabled. As a result, deciding who should receive benefits and who should receive other forms of support has become increasingly complex.

The provisions of law governing the Social Security disability programs have always included work-related elements such as incentive features and rehabilitation requirements. But these programs are based on a definition that is widely viewed as inimical to work motivation. While positive incentives can be added, as long as benefit receipt is conditional on demonstrating a lack of ability to work, disincentives will be inherent to the system.

In our January 2001 report, *Charting the Future of Social Security's Disability Programs: The*

*Need for Fundamental Change*, we raised the question of whether Social Security's definition of disability was appropriately aligned with national disability policy as reflected, for example, in the Americans with Disabilities Act. We said that there are many who believe that the Social Security definition “is at odds with the desire of many disabled individuals who want to work but who still need some financial or medical assistance” and noted that the Ticket to Work program does not fully address the basic inconsistencies. In that report, we also reported that at one of our public hearings, “witnesses stressed that programs and services are much more effective when they address what people can do rather than what they cannot do, and that with the many accommodations that exist today it is possible to fit many individuals with disabilities into a satisfying job.”

In this report, we look at the background of the program and how it has changed, the growing difficulty of appropriately determining who can and cannot work, and the various attempts to build in work incentives. While recognizing that this is a large and important part of our national income security system, the Board concludes that the Nation must face up to the contradictions created by the existing definition of disability. Our report briefly catalogs some of the alternative approaches that might, in some combination, be incorporated into a revised program. Any such changes must be made carefully and with due regard for the importance of this program to the lives of America's disabled citizens and to its impact on other elements of national income security. But the Board believes that the time has come to seriously address the definitional issue. We look for this report to focus attention on that issue, and we expect to do additional work in this area in the near future.

## BACKGROUND

When the Social Security Act was passed in 1935, it increased the authorized funding for the program of grants to the States for vocational rehabilitation programs and created a new program of grants to the States for public assistance programs for the blind. It did not, however, include any general program of disability income support either as part of the payroll-tax funded insurance program or as a part of the grant-in-aid system supporting State public assistance programs.

In 1950, the House Ways and Means Committee recommended adding disability income support programs to the Act. It recommended such programs both as a part of the Social Security social insurance program and as part of the federally assisted State public assistance system. In describing the proposed Social Security disability program, the Committee viewed it as primarily targeted at older workers who had chronic impairments forcing them to leave the workforce early with a consequent income gap during the years prior to qualifying for retirement benefits. “The addition of permanent and total disability benefits will inject more realism into the retirement concept, and will effectively counteract pressures for a reduction in the age of normal retirement.” (H.Rept. 81-1300, p. 27). The Committee saw the public assistance provisions as serving the same basic purposes for individuals who worked in non-covered employment or who had become disabled prior to qualifying for Social Security. It was a program for the “permanently and totally disabled.” The Senate Finance

Committee recommended against including either program. The legislation as enacted included the public assistance program but not the Social Security program.

When the Social Security Disability Insurance program was added to the law in 1956, the Committee report language even more explicitly depicted the program as designed for those who were forced to retire early by reason of disability, and the new program limited benefits to those age 50 and over.

The original Social Security disability programs were thus designed to serve those who had no realistic expectation of a return to the workforce because of the combination of severity of disability and attainment of near-retirement age. The legislation was not entirely single minded in that it did include some provisions for vocational rehabilitation, but the committee report noted that such programs were really more applicable to younger workers. Congress expected that it could be administered in a way that limited benefits to those for whom work was not an option. The disability programs’ definition of disability continues to embody this fundamental design concept, but there have been many changes over the past half-century which raise questions as to whether that design continues to be appropriate and sustainable or whether structural changes in the Social Security disability programs and other programs are needed to rationalize the Nation’s disability policies.

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# I. The Definition of Disability In an Evolving Program and an Evolving World

## A. Adoption of the Definition

When Congress, in 1950, created the grant-in-aid program for State public assistance programs for the disabled, it left the States the discretion of how to determine eligibility. However, the eligible population was defined, in the statute, as those who were “totally and permanently disabled.” When the Disability Insurance program was enacted in 1956, it defined disability as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.”

This definition pretty clearly envisions a program structure that neatly divides those who have work potential (and are therefore ineligible) from those who have no work potential (and are therefore eligible). It provides income support for the eligibles and nothing for the ineligible, who must therefore look to themselves, their families, or other programs to meet the needs created by their less than total and permanent disabilities.

## B. Applying the Definition

Even at the time of original enactment, the theoretical definition had to be applied in ways that undoubtedly had less than perfect results. In the program’s first five years (1957-1961), SSA handled hundreds of thousands of disability applications each year and, by the end of that period, had awarded benefits to nearly a million disabled workers. Dealing with massive numbers of claims requires the establishment of standards of proof some of which are quite objective and some of which require a great deal of subjective decision making. For an inherently multi-dimensional issue such as whether a given individual has the capacity for substantial work activity, there will always be a trade-off. The more objective the standards, the easier the program will be to administer but the more likely it will be that individuals will be incorrectly included or excluded. To give an entirely hypothetical example, to say that a claimant is automatically eligible if he or she has had a heart attack would eliminate the need for labor-intensive individualized assessment of work capacity for a large number of applicants but would also possibly allow on the rolls many who really

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could continue working. Changing to a standard that requires two heart attacks for automatic eligibility would lower the number who get on the rolls despite retaining the capacity for work but would also increase the number of cases (all those with just one heart attack) who would have to be individually assessed.

Former Social Security Commissioner Robert Ball has written that the Social Security Administration decided to adopt an approach under which an individual would be considered disabled if he or she had a medical condition which would be of sufficient severity to preclude an “average” person from working. The agency developed lists of very specific medical conditions that were considered to indicate work-preventing severity. If the claimant presented medical evidence showing that he or she had one of the specified conditions on these lists (or “listings” as they came to be called), eligibility was established as long as the claimant was not, in fact, working. If the individual did not qualify because of having a condition described in the medical listings (but did have a disability of some severity), the adjudication would move to a more individualized assessment. That assessment determined whether the limitations imposed by the conditions would prevent performing the kinds of work that might be available in light of the claimant’s age, education, training, and work experience. In the early years of the program, over 90 percent of the cases were decided on the basis that the claimant’s medical condition was specifically included in the listings or was of equal medical severity. Even in those cases, there would be close-calls in which different adjudicators might reach different conclusions as to whether the medical standards were met, but the degree of subjectivity clearly is more substantial where the decision moves from entirely medical standards to an assessment of the individual’s vocational capacity.

## ***C. A Half Century of Change***

Over the past half century, there have been many changes in the Social Security disability programs and other programs, in the economy, in medicine, in rehabilitative technology, in attitudes about disability and the disabled. Many of these changes have tended to work at cross-purposes with the original simple model of a clear-cut distinction between ability and inability to work or have tended to complicate the program in other ways.

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Major changes in the disability law itself included the extension of eligibility to workers younger than age 50, and the substitution of a 12-month minimum expected duration for the previous rule of “long-continued and indefinite duration.” Both of these changes undercut the original view of the program as an “early retirement” system. The adoption of automatic benefit increases for Social Security in the early 1970s interacted with the high inflation rates of those years to rapidly drive up benefit rates, thus also changing to some degree the relative attractiveness of work and benefits. While subsequent amendments corrected the ongoing and unintended over-indexation, replacement rates were stabilized at a somewhat higher level than the rates prevailing previously. Also in the 1970s, the enactment and implementation of the Supplemental



**Disability Benefit Percentage  
Replacement of Career Earnings\***

<b>Year</b>	<b>Low Earner</b>	<b>Medium Earner</b>	<b>High Earner</b>
1960	54.8	37.3	31.0
1965	50.1	34.6	29.9
1970	52.6	36.8	32.9
1975	66.4	48.8	44.4
1980	64.5	47.3	40.8
1985	59.9	43.7	37.3
1990	61.2	44.6	38.0
1995	61.7	45.0	38.4
2000	60.2	43.9	37.4
2002	61.9	45.1	38.5

*\*worker disabled at age 40*

*Source: Office of the Chief Actuary  
Social Security Administration*

complexity of the agency’s task and gave it responsibility for running a disability program with the same definition but applied to a population with quite different needs and characteristics.

A number of other legislative enactments, many court decisions, and regulatory initiatives have also significantly affected the nature of the program even though they did not modify the base definition of disability. For example, eligibility was tightened somewhat by amendments in 1980 requiring a substantial proportion of pre-effectuation reviews and mandating minimum levels of continuing disability reviews. Amendments adopted in 1984 made it significantly more difficult for the agency to terminate eligibility. Other elements of the 1984 amendments and their implementing regulations are also generally believed to have broadened eligibility, particularly with respect to claims based on mental impairments. Other legislative, judicial, and regulatory changes have significantly affected such areas as SSI childhood disability benefits, benefits for individuals with substance abuse problems, benefits for non-citizens, the standards for evaluating pain and other subjective symptoms, and the reliance to be placed on evidence from the applicant’s treating sources.

Security Income (SSI) program (federalizing the prior State assistance programs for the disabled) massively increased the size and

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federal income assistance program for the disabled (SSI), the integration of medical coverage with these income-support programs greatly increased the importance to individuals of qualifying and retaining eligibility. In 1973, the Medicare program extended eligibility (after a 2-year waiting period) to disability insurance beneficiaries. The Medicaid program, enacted in 1965, provided medical assistance benefits to recipients of public assistance under the State-run grant-in-aid program of Aid to the Totally and Permanently Disabled. When that program was converted to the federal SSI program under 1972 legislation, Medicaid coverage was generally made available to SSI recipients.<sup>1</sup>

Another change affecting the disability programs over the past half-century is the increasing participation of women in the labor force. Where a family has two earners, there is less of an impact on household income when one earner's income from employment is replaced by income from disability benefits. Social Security benefits make up less than half

of the income of about 52 percent of disabled worker families. In 2001, about one-quarter of disabled worker families had incomes of \$45,000 or more, and about one-quarter had income below \$15,000. (The 2001 official poverty threshold for a 3-person family was \$14,128.) To the extent the other worker in the household has employment providing family medical insurance coverage, the impact of the 2-year waiting period for Medicare may also be reduced. On the other hand, that factor also reduces the extent to which Medicare eligibility might be a major consideration in whether to apply for or try to retain disability benefit status.

Medical advances and improved rehabilitative knowledge and technology have also taken place over the past 50 years. These increasingly call into question the ability of a program to neatly draw a line between those who can and those who cannot work. To some extent, these changes can be incorporated into changed standards. But in many cases they may place increasing stress on the theoretical definition of disability.

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There have also been major changes in the nature of work and of the workforce. At the time the program was enacted in the mid-1950s work in the economy typically involved significant physical exertion. Over 40 percent of all jobs were in manufacturing, construction, or mining. By 2002, jobs in those industries represented only 18 percent of all jobs. We have become much more of a service economy where it is harder to measure the degree to which a

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<sup>1</sup> States are permitted to restrict Medicaid coverage to only those recipients who would continue to meet the former State assistance standards. However, over 95 percent of SSI recipients are also Medicaid eligible.

medically determinable impairment limits the individual's ability to engage in employment. Increasingly the question of eligibility hinges on a vocational assessment in which the decision involves a combination of factors, namely, the amount of functional capacity remaining after considering the impairment and the individual's age, education, and prior work experience. For these and other reasons, in the Disability Insurance program the proportion of initial allowances based strictly on medical factors has declined from around 93 percent in the early years of the program to 82 percent in 1983 and to a 2000 level of 58 percent. By the end of the appeals process, the proportion of allowances based on strictly medical factors is around 40 percent and, because of coding deficiencies, possibly even lower.

Attitudes about disability and work have also undergone substantial change over the years. The concept of being able to categorize an individual as "unable to work" was once not generally challenged. It was particularly secure in the context of the original program that was limited to those age 50 and over and that operated in a manufacturing economy. Today, there is much less certainty about the appropriateness and even feasibility of making that distinction. One expert on vocational rehabilitation recently expressed to the Board the view that one should only feel confident

making a judgment of inability to work in the case of an applicant who is comatose. While this view may lie at one extreme, there clearly has been a marked shift in attitudes among the disabled and in society as a whole. There is no longer general support for the basic premise that one can define a set of medical conditions that appropriately classify an "average" person as unable to work. Rather there seems to be increasing recognition of a fundamental distinction between the concept of "impairment" and the concept of "inability to work." Changing public attitudes are reflected to a considerable extent in the adoption in 1990 of the Americans with Disabilities Act that required employers to make reasonable accommodations as necessary to enable the employment of disabled individuals. In its preamble, that Act condemned "stereotypic assumptions not truly indicative of the individual ability of [disabled] individuals to participate in, and contribute to, society."

The core definition of disability for the Social Security program adopted fifty years ago was inability to do substantial work by reason of a physical or mental impairment. That core definition itself remains unchanged, but the context in which it operates has changed a great deal, and its validity, both as an administratively feasible definition and as an appropriate standard of benefit eligibility, is increasingly subject to challenge.

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## II. Work as an Objective of Social Security Disability Programs

Despite their core definition of disability as inability to do any substantial gainful work, the Social Security programs include elements aimed at helping or encouraging beneficiaries to engage in work activity. Such elements have been incorporated from the very beginning. The 1956 amendments to the Social Security Act which created the Disability Insurance program included in that program provisions for referring beneficiaries to the State vocational rehabilitation agencies. That legislation also added to the grant-in-aid program of Aid to the Totally and Permanently Disabled a requirement that State plans include a description of any services provided to help applicants or recipients attain self-support.

The original inclusion of such provisions may have been intended as a counterweight to the very substantial opposition to the enactment of the program from those who felt that emphasis should be on rehabilitation rather than income support. It may have represented a recognition that, as a practical matter, the task of distinguishing those able to work from those not able to work was not likely to be fully achievable. It may have represented a simple judgment that independence and self-support are such important human values that they should never be ruled out.

Whatever the original objective or combination of objectives may have been, the programs over their history continued to include and build upon these original work-oriented provisions. Again, different policy objectives may have driven the changes. Program experience showed that, at least for some beneficiaries, rehabilitation was, in fact, a feasible objective and that, from a financial perspective, providing rehabilitation services

could be cost effective even if only a quite small proportion of the caseload participated. Programmatic changes opening eligibility to shorter-term disabilities and to younger workers also made the incorporation of work-encouraging features more obviously appropriate. Changes in medical technology and in the attitudes of the population generally, and the disabled population in particular, undermined the concept that a clear division could or should be made between inability and ability to work.

### A. Vocational Rehabilitation

The Social Security disability program, as currently defined and constituted, has as its major goal the provision of income to those who are unable to work. The national Vocational Rehabilitation program has the goal of assisting the disabled to attain independence and self-support.

Prior to World War I, there was no formal national system of addressing the employability needs of disabled Americans. With thousands of disabled veterans returning from that War, the Congress passed a series of laws dealing with rehabilitation – some directed specifically at veterans but others aimed also at the civilian population. In 1920, the Smith-Fess Act created a federally matched, State administered program of Vocational Rehabilitation. The Public Health title of the 1935 Social Security Act increased and made permanent the authorized appropriation for that Vocational Rehabilitation program. The 1935 Act also provided a grant-in-aid program to allow States to provide public assistance to the blind. The following year the Randolph-Sheppard Act was passed

## Work Incentives for DI Beneficiaries

**Trial work period** – Beneficiaries may work for nine months (not necessarily consecutive) in a 60-month rolling period without the earnings affecting their benefits. A trial work month is any month in which earnings are more than \$570. When nine trial work months are completed within a 60-month period, SSA reviews the work to see if earnings are “substantial” (generally, \$800 per month or more, \$1,330 per month for blind beneficiaries). If they are, benefits would continue for a three-month grace period and then stop.

**Extended period of eligibility** – This 36-month period follows the ending of benefits due to work. During this period, a beneficiary may receive a benefit for any month in which earnings fall below \$800 per month.

**Continuation of Medicare** – Beneficiaries who have Medicare hospital insurance and start working may have at least 8½ years of extended coverage (including the trial work period). After that they can buy Medicare coverage by paying a monthly premium. Some people with low income and few resources may be eligible for State assistance with the cost.

## Work Incentives for SSI Beneficiaries

**Continuation of SSI** – Beneficiaries who work may continue to receive SSI payments until their countable income exceeds the SSI limit.

**Continuation of Medicaid eligibility** – Medicaid eligibility will usually continue even if beneficiaries earn too much to receive SSI payments if they cannot afford similar medical care and depend on Medicaid in order to work.

**Earned income exclusion** – The first \$65 (\$85 if the beneficiary has no unearned income) of any monthly earned income, plus one-half of remaining earnings are excluded from countable income.

**Student earned income exclusion** – For students under age 22 who are regularly attending school and neither married nor the head of a household, up to \$1,340 of earned income per month, to a maximum of \$5,410 per year, is excluded from countable income.

**Work expenses of the blind** – Any income earned by a blind individual that is used to meet expenses needed to earn that income is excluded from countable income.

**Plan for achieving self-support (PASS)** – A PASS allows a disabled or blind individual to set aside income and resources to get a specific type of job or to start a business. The income and resources that are set aside are excluded under the SSI income and resource tests.

## Work Incentives for Both DI and SSI Beneficiaries

**Expedited reinstatement of benefits** – There is a 60-month period in which a former beneficiary may request reinstatement of benefits without filing a new application. For DI beneficiaries, the 60 months follow the extended period of eligibility.

**Impairment-related work expense exclusion** – The cost of certain impairment-related services and items that a beneficiary needs in order to work are excluded from countable income for SSI purposes and are deducted from earnings when determining if work is substantial.

**Continued payment under a vocational rehabilitation program** – Beneficiaries who medically recover while participating in a vocational rehabilitation program that is likely to lead to becoming self-supporting may continue to receive benefits until the program ends.



to allow blind individuals to operate vending stands in federal buildings. Major amendments to the Vocational Rehabilitation program were adopted in 1943.

During the 1950s, Congress considered highly contentious legislation to add disability benefits to the Social Security program. In 1952, the Social Security Act was amended to “freeze” a worker’s Social Security record during the years when they were unable to work due to a disability. While this measure offered no cash benefits, it did prevent such periods of disability from reducing or wiping out retirement and survivor benefits. The 1952 provision, however, was essentially a “statement of principle” since it contained self-repealing language that prevented it from going into effect. The “freeze” provisions were enacted into law again in 1954 along with a requirement for the Social Security Administration to refer applicants to the State Vocational Rehabilitation agencies. In 1956, Congress added cash disability benefits to the Social Security program. The provision for referring applicants for Vocational Rehabilitation was modified to withhold benefits for anyone who refused to accept available rehabilitation services.

In 1965, the Finance Committee report on that year’s amendments noted that very few disability beneficiaries were receiving any rehabilitation services. To address that issue, the law was amended to allow payments for such services from the Disability Insurance trust fund subject to an overall limit of 1 percent (later raised to 1.5 percent) of the disability benefits paid in the previous year. The 1972 legislation establishing the Supplemental Security Income (SSI) program included similar provisions (payable from the general fund) for rehabilitation services to SSI recipients. The Rehabilitation Act of 1973 mandated a priority to serve persons with severe disabilities and established affirmative action programs for severely disabled individuals.

Despite these changes the number of Social Security disability beneficiaries rehabilitated remained quite small. In the late 1970s, General Accounting Office reports criticized the programs for both Disability Insurance and Supplemental Security Income. In the 1981 Budget Reconciliation Act, Congress changed the funding rules. Instead of reimbursing Vocational Rehabilitation agencies for the costs of services provided to Social Security beneficiaries, reimbursement was paid for such services only if they actually restored the individual to employment at a level that resulted in benefit termination.

This change in the funding mechanism resulted in an immediate drop in the amount of funding, but it improved the extent to which the program resulted in a demonstrable net reduction in costs. The 1980 Social Security amendments called for demonstration projects to test alternative methods of encouraging employment, and, in the mid-1990s, SSA began to allow private entities to apply for rehabilitation funding in cases where a beneficiary had been referred to the State Vocational Rehabilitation Agency but that Agency did not provide services. In 1999, the system of referral for Vocational Rehabilitation services (and the penalties for refusing to participate in such services) were replaced by the Ticket to Work Act described below. Thus far, most of the Ticket to Work activity continues to involve Vocational Rehabilitation agencies, and the VR reimbursement method is still used in those areas where the Ticket to Work program has not yet been implemented.

## ***B. Ticket to Work and Work Incentives Improvement Act of 1999***

The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170)

amended the Social Security Act to create the Ticket to Work and Self-Sufficiency Program, a voucher program that allows beneficiaries a greater choice of vocational rehabilitation and employment service providers. The new law also expanded the availability of health care coverage for working individuals with disabilities, and included a number of other provisions designed to help disabled individuals to continue working or to return to work.

The centerpiece of the legislation, the Ticket to Work program, is intended to increase access to and the quality of rehabilitation and employment services available to disability beneficiaries. It provides eligible Social Security Disability Insurance and Supplemental Security Income disability beneficiaries with a "Ticket" which can be used to obtain vocational rehabilitation, training, employment services, or other support services through public and private providers. The providers can be Employment Networks (public or private organizations that take responsibility for the coordination or delivery of services), or State Vocational Rehabilitation agencies.

The program is voluntary. When an individual gets a Ticket, he or she is free to choose whether or not to use it, as well as when to use it. Generally, beneficiaries who are eligible for Tickets include current Social Security Disability Insurance and Supplemental Security Income disability beneficiaries between the ages of 18 and 65.

The Ticket program is being implemented in phases. Phase I of the program was implemented in 13 States beginning in February 2002, and Phase II in another 20 States plus the District of Columbia beginning in November 2002. Phase III of the program will be implemented in the remaining States and territories in November 2003 and continuing into 2004.

As of July 7, 2003, SSA had mailed about 4.7 million tickets to beneficiaries in the first two phases of program implementation. About 2.3 million tickets were mailed during Phase I, and 2.4 million during Phase II. SSA continued to mail tickets in the Phase II States at the rate of about 250,000 per month through September 2003. As of July 7, SSA had enrolled 809 Employment Networks in the Phase I and Phase II States, with another 109 applications under review.

Participation in the program has been minimal. As of July 2003, the program manager for the Ticket program had only handled 200,000 calls (4.3 percent of the total number of tickets mailed) from beneficiaries since the onset of the program. About 20,500 beneficiaries (about 0.44 percent of those who had been mailed tickets) had assigned their tickets. Of those, about 18,100 (88 percent) had been assigned to State Vocational Rehabilitation agencies, and about 2,400 (12 percent) had been assigned to Employment Networks. Of the tickets assigned to the State Vocational Rehabilitation agencies, 11,246 were from beneficiaries who were new to the system.

As of July 4, 2003 SSA had made over 554 outcome and milestone payments to Employment Networks, representing 196 beneficiaries working (.004 percent of those who have been mailed tickets). These payments total \$169,456.

The other key provision of P.L. 106-170 expanded the availability of health care services to working DI and SSI disability beneficiaries. The law provided several enhancements to Medicaid and Medicare including giving States more options in providing Medicaid coverage to more people ages 16-64 with disabilities who work, and extending full Medicare coverage for 4 1/2 years beyond the previous limit for Social Security disability beneficiaries who return to work.

### ***C. Work Activity of Disability Beneficiaries***

Until this year, SSA has not tracked monthly earnings of Disability Insurance worker beneficiaries, and full-year data are not yet available. SSA began in 2001 to break out data on DI worker beneficiaries whose benefits have been terminated because of work above the level of substantial gainful activity. In 2002, 29,000 disabled worker beneficiaries, or about one-half of one percent of the total, had their benefits terminated for that reason. About a third of those terminated had a primary diagnosis of mental illness.

Under the SSI program, returning to work at the “substantial gainful activity” level does not cause benefits to stop simply because the individual has shown a capacity to work. Since SSI is a means-tested program, however, benefit levels are reduced because of earnings and phase out when the combination of earnings and other income rises above the income eligibility level. Even after benefits are reduced to zero, recipients generally continue to qualify for Medicaid. A little less than 6 percent of all disabled SSI recipients have some work activity, but two-thirds of those with earnings have \$500 or less in monthly earnings. Forty-two percent of those with earnings have a diagnosis of mental retardation.

***Despite the many work incentive features that have been incorporated into the Social Security Disability programs over the last five decades, the Social Security Advisory Board finds little evidence that those incentives have substantially encouraged self-sufficiency in the disabled population.***



### III. Conflicting Policy Objectives

Despite the many work incentive features that have been incorporated into the Social Security Disability programs over the last five decades, the Social Security Advisory Board finds little evidence that those incentives have substantially encouraged self-sufficiency in the disabled population. Nor do we find that there exists much expectation that this situation is likely to change to any significant degree in the future. At the same time, the Social Security Disability programs are an established and important part of our Nation's income security system. They provide vital ongoing income support and, through their relationship to Medicare and Medicaid, health insurance for millions of disabled Americans. In previous reports, the Board has expressed concerns over many aspects of the existing disability programs and has identified a number of areas in which major improvements are needed. In testimony before the House Social Security Subcommittee in May 2002, the Chairman of the Advisory Board said:

**As we have emphasized in our reports, disability is at the heart of SSA's many challenges. It accounts for two-thirds of the agency's administrative budget – about \$5 billion this fiscal year. Disability benefits will account for nearly \$100 billion in spending this year, or nearly 5 percent of the Federal budget. The current disability structure is seriously flawed and needs to be reformed in the interests of both claimants and taxpayers.**

The Board's 2001 report on the need for fundamental change in the disability program said "All parts of the disability policy and administrative structure are under increasing stress....The disability administrative and policy infrastructure is weak, and resources are inadequate to the task." Some of the concerns we have previously expressed, especially with respect to resources and improved systems support, are beginning to be addressed, but much remains to be done in those and other areas. This report raises an issue that we have

mentioned in previous reports but have not previously addressed fully, and that is the question of whether the very definition that is at the heart of the existing disability programs is consistent with our society's basic beliefs about disability and work. Moving away from that definition would very clearly involve significant programmatic changes. Given the importance and significance of these programs any such changes would have to be carefully developed and carefully implemented. A first step in addressing this issue would be a consideration of the competing choices policymakers would face including the issue of the extent to which the desired results could be achieved by changes within the existing programs.

*What are the major areas of concern with the existing program and its relationship to encouraging self-sufficiency?* General issues are whether the definition of disability is really administrable or whether it will always be administered in a way that provides benefits to a substantial number of impaired people who could work and/or disqualifies a substantial number of impaired people who have no realistic prospect of working. From a work-incentive perspective, the existing definition is widely viewed as inimical to work motivation in that applicants, required to prove inability to work, are likely to be reluctant to engage in activities that would undermine their claim for benefits. To the extent that the application of the definition is difficult and somewhat arbitrary, there is a question as to whether the program's benefit levels and its integration with Medicare and (for SSI) Medicaid make eligibility an attractive alternative to available work, especially for low-skilled workers. The difficulty of administering the definition also raises the question of whether the program is inherently susceptible to varying award rates based on subtle messages suggesting tighter or looser adjudication and to inconsistencies of administration—geographically, at different levels of the process, and even from one adjudicator to the next.

## Work Disincentives for Social Security Beneficiaries

**Definition of disability** – The definition of disability requires a person to demonstrate the “inability to engage in any substantial gainful activity.” Since the system rewards people that demonstrate they cannot work, applicants may be reluctant to engage in any activity that would undermine their claim for disability benefits. Work activity after becoming eligible also may result in a loss of benefits. The trial work period and extended period of eligibility mitigate this disincentive, but beneficiaries know that, at some point, attempting to work may cause benefit loss.

**Impact on attitudes and motivation** – Even apart from the financial disincentive, the desire to work is an important factor in employment of persons with impairments. To the extent the current program requires applicants to prove that they cannot work, it may undermine their motivation and desire for employment.

**Availability of health benefits** – Beneficiaries receive health benefits (Medicaid for SSI; Medicare after a waiting period for DI) in addition to their monthly payment. For many beneficiaries the health benefits may be even more important than cash benefits. Getting a job that exceeds their yearly benefit amount may not be enough if the job does not also provide adequate and dependable health insurance coverage.

**Delayed and incomplete availability of health benefits** – For certain categories of disabilities, the lack of availability of health benefits may be a significant factor in preventing an individual from seeking or engaging in employment. Health benefits become available only after the often prolonged process of establishing eligibility under SSI or DI (and, for DI, only after a 2-year waiting period). Also, in some cases, the benefits available then may not include the drugs or other services needed to permit employment.

**Delayed rehabilitation services** – The Social Security Act provisions designed to encourage and assist in rehabilitation only become available after the often prolonged period of establishing eligibility. Vocational rehabilitation experts tend to believe that rehabilitation has the best chance of success if offered early while the impaired individual still has a strong attachment to working and may also have a continuing relationship with an employer.

**Complexity of work incentives** – The number and complexity of the work incentives in the Social Security programs may be confusing to beneficiaries so that they remain suspicious that their attempt to do any work will result in termination of their benefits even in situations where that would not be the case.

**All-or-nothing choice** – The Social Security definition of disability presents a largely all-or-nothing approach to eligibility. Because of the restrictions imposed by the disability or by vocational deficits, available employment opportunities may offer income that is only marginally higher (or even lower) than what the individual gains from benefit eligibility. This situation may have been accentuated in recent years by increasing participation of other family members in the work force and by increasing benefit replacement rates for lower income workers.

***Vocational rehabilitation experts tend to believe that rehabilitation has the best chance of success if offered early while the impaired individual still has a strong attachment to working and may also have a continuing relationship with an employer.***

***What could be done within the confines of the existing program with its definition of disability as inability to work?*** More attention could be paid to policy development and better systems of quality management to improve the level of confidence that the current definition of disability is being appropriately applied. Work incentives built into the program might be used to offset to some extent the definitional contradiction. The Board has heard from several commenters that there is such a maze of different incentives that the very attempt to understand them becomes intimidating and a source of beneficiary fear about inadvertently doing something that causes benefit loss or overpayment liability. On the other hand, consideration could be given either to simplification or providing better availability of counseling. Recent efforts to improve counseling seem to have had some success, but the level of confusion and the degree of success of counseling efforts are both essentially anecdotal. It would be useful to have a carefully designed survey to help gauge the extent of misunderstanding and to identify the areas which might be most promising for better public information or simplification. The Ticket to Work program, now in its early implementation stages, is itself an attempt to encourage beneficiary employment. Thus far,

success has been limited and a number of problems have been identified, but this does represent an approach to encouraging work activity and there may be ways to improve it. There are also demonstration projects that have been done in recent years and others that are getting underway addressing possible ways to give the existing program a more effective work orientation such as:

- assigning caseworkers to encourage, monitor, and assist claimants to stay in the labor force,
- early intervention to provide work-oriented services prior to actually applying for benefits, and
- alternative benefit rules such as a gradual phase out of benefits in place of a sharp cutoff.

***Is continuing the definition of disability as “inability to work” important to maintaining support for the program?*** The adoption of the Social Security disability program was not uncontroversial. Although there was discussion of such a program as far back as the 1930s, it was not passed by the House of Representatives until 1950 and did not win Senate support even then. It was enacted into law in the 1956 Social Security

***More attention could be paid to policy development and better systems of quality management to improve the level of confidence that the current definition of disability is being appropriately applied. Work incentives built into the program might be used to offset to some extent the definitional contradiction.***

Amendments by virtue of a highly contested Senate amendment opposed by the Committee of jurisdiction. That amendment, adding a disability program to the bill, was approved by only a 2-vote margin. A major concern expressed in the debate was whether it would be possible to administer the programs in a way that limited benefits to those who were really prevented from working by virtue of their disability.

The language of the original definition responded very directly to that concern by specifying that benefits would be available only to those who, by reason of a disability, were unable to engage in any substantial gainful activity. In 1967, Congress attempted to make that policy even clearer by specifically stating that an individual could qualify only if there was no work that he or she could do that existed in the national economy even if it did not exist in the local economy or even if there was no prospect that the individual would actually be hired for that work.

***What is the realistic potential of the Social Security disability population for work?*** Is nearly everyone who is not comatose a potential candidate for work? Or is there only a very marginal group of beneficiaries who could realistically be expected to work even with appropriate supports and incentives? Both views seem to be fairly widely held. There is no doubt that all, or at least nearly all, Social Security disability beneficiaries have serious impairments. Even if one accepts the premise that, given sufficient motivation, employment opportunities, and appropriate support structures, many highly impaired individuals could work, many would argue that it is unlikely that very substantial numbers of Social Security disability beneficiaries would be good candidates for return to work. On the other hand, despite improvements in medical care and advances in rehabilitation, the incidence of Social Security disability eligibility has continued to grow. Some would argue that this is evidence that, despite its

seemingly absolute definition – or perhaps even because of the perverse incentives that definition creates – individuals who are impaired but who have realistic employment potential are winding up on the benefit rolls and will continue to do so in the absence of significant structural changes.

***How effective are the current eligibility processes at drawing the line between the able and the disabled and is significant improvement, if needed, possible?*** As discussed earlier, there have been many important developments over the history of the disability program. Some of these changes seem likely to have weakened the ability of the existing processes to draw an appropriate line between those who are and those who are not able to work. The approach of allowing claims because of medical conditions considered sufficiently severe to prevent an “average” person from working may have been a significantly better decision tool in the early days of the program. At that time eligibility was limited to those nearing retirement age and minimal medical and rehabilitation techniques existed to assist those with significant impairments to work despite those impairments. The huge caseload increases of the past decades have also forced the Social Security Administration to move to a less intense examination of eligibility. Prior to the 1970s, every claim was subjected to two levels of professional review and decision makers were required to explain in writing the reasoning behind their decision. Now reviews are much more limited and rationales are brief or non-existent.

As the Board has pointed out in previous reports, we do believe there can be improvements. SSA needs to place increased emphasis on policy development and to implement a much stronger quality management system. Many of the policy standards currently used to determine eligibility are badly outdated and do not reflect



the current state of medical knowledge or the realities of today's workplace. In developing these standards, the agency needs to be sure that it has sufficient and highly capable policy staff and that they develop policies which realistically reflect both the impact of impairments on capacity to work and the need to enable adjudicators to apply policies more objectively.

In a system that has too long operated under the pressures of inadequate resources, it is difficult to sort out the problems that are attributable to administrative limitations from those that are attributable to inadequate policy development. And it may be that an outdated definition of disability is itself a major barrier to the kind of policy development that would support more objective and consistent decision making. Moreover, even though existing processes for determining eligibility can and should be substantially strengthened, the fundamental questions remain about whether it is appropriate or feasible to base eligibility on an attempt to equate impairments with inability to work.

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The concept of disability has both medical and functional components. The world of work has a wide variety of tasks that require a range of physical and intellectual functional capacities. The qualifications for different occupations can vary from little training

and experience to advanced degrees and extensive experience.

Therefore, a given medical condition may or may not be "disabling" depending on the specific functional capacities and how they interact with the educational and vocational profile of the affected individual. A medical condition that precludes highly exertional physical activity may be "totally" disabling for an older individual with little education and an unskilled work history and not disabling for another individual who is highly skilled and educated.

In a theoretical sense, accurately determining eligibility for Social Security disability benefits would require that each individual be evaluated to determine how their medical condition limits their functional capacity and then how these limitations interact with each individual's age, work history, and education. The end result would be a decision whether the medical impact on the individual's functional capacities makes work feasible. There would still be difficult judgments about medical and functional determinations, but overall the process should attain the right results in a reasonably consistent manner.

However, the huge volume of claims processed in the Social Security disability program makes it impossible to make highly individualized medical and vocational determinations. Consequently, the program from its very beginnings used screening devices aimed, in large measure, at enabling

*...the huge volume of claims processed in the Social Security disability program makes it impossible to make highly individualized medical and vocational determinations.*

the program administrators to handle massive caseloads. Very early in the program's history a decision was made to create a list of specific medical conditions that, if present, would presume that a claimant is disabled. In the early days of the program this seemed to be a very adequate tool. Over 90 percent of the awards were based on these lists (or "listings"). This only left a relatively small portion of disability decisions that had to be given a more individualized assessment that looked specifically at how the medical condition limited that individual's functional capacities. However, with changes in the program, in the workplace, and medical treatment, the ability to make decisions solely based on the medical listings declined. Each year an increasing number of decisions had to be made on an individualized basis that took into account the claimant's functional limitations and vocational profile. As the number of these more complex determinations increased, the agency attempted to cope with the administrative burden by developing a set of vocational standards that operated roughly in the same manner as the listings. How the medical condition affected the individual was translated into residual capacities to do such tasks as lifting, sitting, bending, and so on. These residual capacities were then compared with a set of vocational standards (called vocational grids) that took into account the claimant's age, education, and work history (for example, skilled or unskilled) to determine the disability decision.

In prior reports, the Board has expressed concern about the policy capacity of the agency to keep both the medical standards and the vocational standards up to date. Beyond this issue is the fundamental question of whether this approach is the right approach. The fundamental purpose of the listings was to simplify the administrative task by setting medical-only guidelines that would minimize the need for the more complicated task of comparing each individual's remaining functional capacities against the universe of

real jobs for which he or she had the vocational background. That worked well in a world where it was possible to find medical standards that would cover the vast majority of applicants but would not result in allowances for a substantial number of individuals who, in fact, were able to work. That seemed to have been possible in the 1950s. It is not clear that it is possible today.

In recent years there has been some discussion of moving towards a system that would make the assessment of functional limitations the primary way to evaluate disability claims. During the 1990s, the Social Security Administration proposed, but later abandoned, the idea of moving away from the listings towards a more functionally based "index" of conditions for determining eligibility. Although the complete overhaul was not implemented, changes in the listings in recent years have tended to move in the same direction, incorporating measurements of functional capacity rather than relying strictly on medical findings. Some experts have criticized these changes. They point out that this is undermining a major purpose of the listings, which was to make the program's administration easier and more consistent by creating a very objective eligibility screen based solely on medical findings. However, as indicated above it is not clear that the listings are capable of effective screening.

In looking at the question of whether the definition of disability remains appropriate, one question that needs further examination is whether the existing definition is itself the barrier to developing a more functionally-based set of eligibility standards that might, under a differently designed and defined program, reduce rather than increase the complexity of administration. Because the current definition is a one-shot, all-or-nothing proposition, the standards that are used as screening devices are somewhat broad in order to cope with the massive number of claimants. While this clearly needs more research and consideration one can hypothesize the possibility of a

bifurcated program. This program could have more narrowly drawn medical standards that identify individuals with the most serious disabilities for long-term income support. The remaining individuals would have functionally based standards to move them into an employment-oriented program.

*How does a disability program fit into the overall and greatly changing picture of income security?* The Social Security Disability programs are large and expensive. They provide an important level of income security for both their current beneficiaries and for all who face the risk of unexpectedly suffering a severe medical impairment. But the disability programs do not exist in isolation. Rather they are but one element in an overall mix of institutions and programs, which comprise our national system of income and health security. The overall Social Security tax supports not just the retirement program, but also the disability program. In the past, unexpected growth in the disability program has necessitated changing the allocation of that

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tax between the two programs. The most recent report of the Social Security trustees indicates that such action will likely be needed again since the exhaustion date for the disability fund is estimated at 2028, 14 years earlier than the more commonly cited date for the combined funds.

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In considering changes to our disability programs, it is important that policymakers attempt to consider the interactions between those programs and the context they operate in. Some recent studies, for example, have reached a conclusion that the rapid growth of the disability rolls in the 1990s reflects an interaction between loosening standards of disability and a shrinking availability of jobs for low-skill workers. Similarly, increasing health costs and their impact on employer sponsorship of health insurance can affect the incentives for impaired workers to seek either continued employment or disability benefits.

Policy changes to deal with the financial problems of the retirement program can also have important interactions with disability policy. In looking at the financial status of the retirement program, one area receiving attention is the possibility that, with increasing life spans, it may be appropriate to incorporate stronger incentives for later retirement. Recent research indicates that the long-standing trend towards earlier retirements has recently leveled off and may even have moderately reversed course. Sustaining that change would have a positive impact on the financial status of Social Security and on the economy generally. To the

extent that changes are considered in the retirement program to reflect and encourage this trend, the impact on older impaired workers will also need to be considered. For example, some proposals have been advanced for making further upward modifications in the age of eligibility for retirement benefits. The consideration of such proposals would need to take into account the fact that, while the population in general is enjoying more and healthier years, there still is a greater tendency for older rather than younger workers to have impairments and the ability of older workers to adapt to new forms of employment tends to be more restricted.

At the same time, however, broad assumptions that age in and of itself is a good predictor of inability to work are being challenged. Policies aimed at encouraging employers to make employment opportunities more available and attractive for older workers could also appropriately include both older and younger workers with impairments.

The Social Security Advisory Board's legislative mandate includes making recommendations as to how the Social Security programs should operate in conjunction with other public and private systems to "most effectively assure economic security." The Board is currently undertaking a broader study to examine those issues, but it recognizes that not only does the question of design, definition, and administration of the disability programs need to be addressed in its own right but it also needs to be addressed in that broader context.

***How can the impact of disability programs on motivation to work be improved?*** One of the most frequently heard criticisms of the existing system is that it seems designed to create precisely the wrong mindset. The adjudication process averages three months and often takes very much longer. During this period, the program gives applicants a clear message that help will be

available if, and only if, they prove to the agency that they cannot work. If, in fact, the overwhelming majority of those who wind up on the rolls are those who really have no realistic prospects of returning to work, the criticism may still be important, but if a substantial proportion of those on the rolls could work, the criticism may be crucial. Clearly, impaired individuals will find it harder to work than non-impaired individuals. Motivation may be (and is frequently cited as) the single most important determinant in whether an impaired person continues in or resumes employment. A system that primarily rewards those who can prove they cannot work undermines that motivation. The way the current program deals with health benefits aggravates this problem. For many impaired individuals the availability of health benefits may be the most important consideration. But the road to health care goes through disability benefit eligibility that, in turn, requires proving inability to work. For some individuals, this may mean that getting the medical benefits that might make work possible is only attainable by establishing that work is not possible.

***Does the disability program, as currently defined, fail to meet the legitimate needs of a significant portion of the impaired population?*** The current system devotes a substantial amount of national resources to those who "make the cut" in the Social Security definition of ability/

***Motivation may be (and is frequently cited as) the single most important determinant in whether an impaired person continues in or resumes employment. A system that primarily rewards those who can prove they cannot work undermines that motivation.***



inability to work. While research about the characteristics of those who are denied benefits is limited, the studies which have been done show that many of them do not return to work and suffer substantial reductions of income. The Board is aware that a new study based on agency administrative data is nearing completion, but more detailed research into both the work history and other characteristics of those who are denied benefits is needed. Such research could help in understanding the implications of the facially inconsistent levels of allowances that exist regionally and at different adjudication levels. It also could help to determine the extent to which the existing definition of disability, as it is applied, is appropriate and the extent to which it is an artificial construct that does not really separate the able from the unable, but rather draws a somewhat arbitrary line that has a questionable relationship to employability. The results of such research would be relevant to the question of whether resources (either new or some share of the existing Social Security resources) should be directed to serving more of the impaired population by modifying the definition of disability (or its application). For example, disability definitions along the lines of workers' compensation and veterans' compensation view disability not as an all-or-nothing condition but as a continuum in which income support can be provided in a manner that reflects the degree of impairment. Moreover, the current definition's all-or-nothing approach to income support spills over into focusing rehabilitation efforts in the same manner. One common observation of researchers is that the impaired population have a tenuous attachment to the workforce and their employability declines rapidly once they stop working. It is plausible that the existing program not only does not help those impaired individuals who are ultimately found ineligible but actually damages their capacity for self-help by putting them through a protracted adjudication process during which they dare not attempt work and are encouraged to prove themselves incapable of work.

***Should work-oriented services be targeted on beneficiaries or on applicants?*** One goal of vocational rehabilitation provisions in the disability programs (which has been carried over to Ticket to Work) is to assure that services pay for themselves. To do this, services are necessarily limited to those who have completed the process and established their eligibility for benefits so that savings can be measured by having those claimants subsequently lose eligibility by virtue of returning to work. The advantages of this approach are that it creates a self-policing system that provides strong incentives for service providers to concentrate on the kinds of services that are relevant to restoring employability. A disadvantage, however, is that this postpones the provision of services until the end of the disability adjudication process, by which time they may be too late to be effective. It also might disadvantage highly motivated but more severely impaired individuals to the extent that providers would concentrate on more obviously remediable impairments.

***What should be the role of the Social Security Administration if there is a major restructuring?*** The Social Security Administration is a large entity with enormous responsibilities for maintaining earnings histories of all workers, adjudicating claims for retirement, survivorship, and disability benefits, and paying monthly benefits to some 50 million beneficiaries. The agency takes tens of millions of actions each year to maintain the accuracy of the benefit rolls. Even though the disability caseload represents only one-fifth of the beneficiary population, the disability programs are the most complex and expensive of the administrative tasks faced by the agency.

In some respects, it would seem to make sense to give SSA responsibility for any revised disability program since the agency already is in existence and has a large presence throughout the country. However, SSA's mission and expertise are in the areas of

eligibility determination, benefit payment, and maintenance of the benefit rolls and earnings records. Operating a more services-oriented program which aims to foster the employment potential of applicants would involve quite different skills and objectives that might not fit well with the existing structure and personnel. The experience with implementing the SSI program may be somewhat instructive. Even though that program seemed to represent a good match with the agency's basic benefit payment responsibilities, it presented SSA with new challenges of operating a program based on difficult-to-determine factors of income, resources, and living arrangements.

Implementing that program seriously taxed the agency's capacity to provide a high level of service to both its new and older beneficiaries. Taking on an entirely different type of responsibility in the form of an employment-oriented program might be even more problematic. In any new approach that might be adopted, there would, of course, be a need for close coordination between SSA's traditional benefit-paying role and the new employment-related aspects. However, careful consideration would need to be given to the appropriate administrative structure to avoid disrupting the ability of SSA to carry out its other responsibilities.

***Operating a more services-oriented program which aims to foster the employment potential of applicants would involve quite different skills and objectives that might not fit well with the existing structure and personnel.***

## IV. Issues Related to Alternative Program Designs

For those disabled individuals who could work, the current program's definition of disability is an impediment to their remaining in the work force. Changing the definition, however, would not amount to tweaking the existing program. It would require a major redesign of all or part of the program. It would almost certainly have substantial implications for program costs, caseloads, and administrative resources. To the extent it involved changes in eligibility or benefit levels, a long transition would be needed to assure that current beneficiaries are not adversely affected.

Ultimately, policy makers would need to decide whether the monetary and social gains from such a major shift of direction are worth the monetary and social consequences that might result.

The existing Social Security program attempts to limit eligibility for benefits to those who are so disabled that they are unable to do any substantial work and then provides various incentives and services aimed at encouraging work on the part of those who have proven themselves unable to work. If our society should decide that it no longer thinks it appropriate to continue this approach that starts by defining disability as inability to work, there are several basic questions that would need to be answered about any alternative program, such as:

- What would be the appropriate definition (or definitions) of disability?
- Would it increase or decrease the extent of eligibility and the cost of the program?
- Would benefit levels differ from the existing program and in what ways?
- Would it continue to be administered by the Social Security Administration and, if not, by what agency or agencies?
- Would it emphasize services or just provide benefits under a different set of rules designed to rely on stronger economic incentives for working?

These are difficult questions and they are, in many respects, interrelated. Given the projected large increases in future costs of entitlement programs under existing law, it may be difficult to classify as realistic any proposal which would have significant additional costs. However, since the existing definition of disability is stated as "inability to work," a change in definition might be seen as loosening that definition in a way that could increase the potentially eligible population. While proponents of such a program might argue that any increased potential eligibility would be offset by greater workforce

***Changing the definition, however, would not amount to tweaking the existing program. It would require a major redesign of all or part of the program.***

participation, it is not clear that cost-estimators would find evidence to support that argument. If increased costs are to be offset in other ways, one possibility would be to modify the existing benefit structure as it applies to new entrants into the program in such a way as to avoid increased costs. To the extent that this might mean that benefit levels would be lower than existing-law benefits for those who would have qualified under current law, such a change would likely encounter significant opposition. A program design involving intensive services is likely to be expensive and subject to considerable doubt as to the effectiveness of the services. On the other hand, the population involved is a particularly vulnerable one that might need individualized assistance.

If Congress wanted to adopt a different definition of disability, many different structures and combinations of structures are possible. Some of the possible elements that might be considered include:

- Paying benefits based on an essentially medical definition of what constitutes a “severe”<sup>2</sup> disability, without requiring a finding as to the impact of the disability on each individual’s ability to work.
- Reducing benefits gradually as earnings rise rather than cutting them off at a particular dollar level of “substantial gainful activity.”
- Divorcing eligibility for health benefits from eligibility for cash benefit programs, or perhaps, for certain categories of the disabled, providing the health care necessary for employment rather than cash benefits.
- Dividing the Social Security program into two programs. A “permanent” program roughly equivalent to the existing program would begin only after a longer waiting period (perhaps two or three years) or might be available immediately only to those with the most severe disabilities. A new temporary program would be available during that waiting period. The temporary program might differ from the permanent program by such things as having easier eligibility rules, different benefit levels, and stronger and perhaps more individualized medical and other services needed to support workforce participation. It might be available from the earliest point of disablement (or in the case of children during the transition to adulthood). A temporary program might be administered by a different agency from SSA with SSA retaining responsibility for the “permanent” program. Many variants of this approach are possible depending on program objectives and costs.
- Changing the current all-or-nothing concept of disability eligibility to a program providing percentages of disability based (at least for less than 100 percent levels) on very specific medically determinable criteria.
- Changing the disqualifying event from “becoming able to work” to something roughly along the unemployment compensation lines of failure to seek or accept work.

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<sup>2</sup> This would not necessarily be the same as the concept of “severe disability” in the current program.

## ***DEFINITIONS OF DISABILITY***

The Social Security Act and the Americans with Disabilities Act (ADA) take substantially different approaches regarding what is meant by “disability.” The Social Security Act has a very strict definition that is designed to identify people who are so disabled that they are unable to work. The ADA has a broader definition designed to prevent discrimination against disabled people who wish to work.

**Social Security definition:** The Social Security Act considers people disabled only if they have an “inability to engage in any substantial gainful activity by reason of any 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.” This disability has to be so severe as to prevent them from doing any “substantial gainful work which exists in the national economy,” whether a specific job is available or not. The disability must result from a physical or psychological abnormality that is “demonstrable by medically acceptable clinical and laboratory diagnostic techniques.”

**ADA definition:** The ADA prohibits job discrimination against an individual because of a disability who could “with or without reasonable accommodation” perform the essential functions of the job. A disabled person in the ADA means a person with a physical or mental condition that “substantially limits” a life activity, who has a record of such a condition, or who is “regarded as having” such a condition.

Many other definitions of disability exist in public and private programs. A recent publication of the Interagency Committee on Disability Research identifies 67 different statutory provisions defining disability for various federal programs. Many of these are identical or overlap in various ways, but there clearly are a substantial number of different definitions.

## V. Conclusion

The Social Security disability programs had their origins in the 1950s—a world vastly different from today’s world in several important respects including the nature of available work, the educational levels of the work force, medical capacity to treat disabling conditions, and the nature and availability of rehabilitative technology. Over the course of the past half-century, there have been a number of changes in the disability programs. But the core design of the program, rooted in a definition of disability as inability to do substantial work, has remained unchanged.

It is clear that the Social Security disability programs have assumed an important role in the Nation’s system of economic security. Each year hundreds of thousands of insured workers are found to be eligible for Disability Insurance benefits and today 5.5 million such workers and their families receive monthly payments. Another 3.5 million low-income disabled individuals receive assistance from the Supplemental Security Income program.

Yet, questions are increasingly raised as to whether these programs truly reflect our society’s attitudes toward disability. A dozen years ago, Congress passed the Americans with Disabilities Act announcing “the Nation’s proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.” The definition of disability in the Social Security Act often appears to undermine those goals by providing incentives for impaired individuals to prove to the agency and, presumably to themselves, that they are incapable of any substantial work.

On the other hand, changing the definition of disability in the Social Security programs would clearly represent a very major change in one of society’s fundamental instruments of economic security. This report has suggested some of the questions that would need to be answered, some of the policy issues that would need to be explored, and some of the options that might be available if a basic change of definition were to be pursued.

***The Social Security disability programs had their origins in the 1950s—a world vastly different from today’s world in several important respects including the nature of available work, the educational levels of the work force, medical capacity to treat disabling conditions, and the nature and availability of rehabilitative technology.***



There is always an inertia that attaches itself to the existing ways of doing business. That inertia is all the stronger when change affects an institution like Social Security disability that provides vital income support to a large and vulnerable population. But the Board believes that this is an issue that needs attention. The Board finds widespread dissatisfaction with the existing system. It may be that, in the end, the existing definition will be retained, and ways will be found to administer it in a manner more consistent with society's current approach to disability policy. Or it may be that only a definitional change will serve to meet the needs of today's impaired population in a way that society can approve. In any case, the problems and

inconsistencies of the existing system are significant and demand action. The time has come to address these issues intensively.

We hope with this report to focus more attention on these issues. We intend to follow up with a series of consultations through reports and/or one or more forum discussions to get the views of interested parties and experts on disability and rehabilitation. We encourage the Administration and the Congress to carefully consider how the Social Security Disability programs can better meet the high goals set by the Americans with Disabilities Act of assuring the disabled "equality of opportunity, full participation, independent living, and economic self-sufficiency."

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## APPENDIX A

### Approaches of European Countries

European disability systems are similar to that in the United States in several ways. Most long-term disability benefit systems for non-work-related disabilities consist of a social insurance program, similar to the U.S. Disability Insurance program, and a separate program without prior employment requirements, similar to the SSI program. Work injury plans, similar to workers' compensation in the U.S., provide coverage against loss of wages due to work-related injuries or illness.

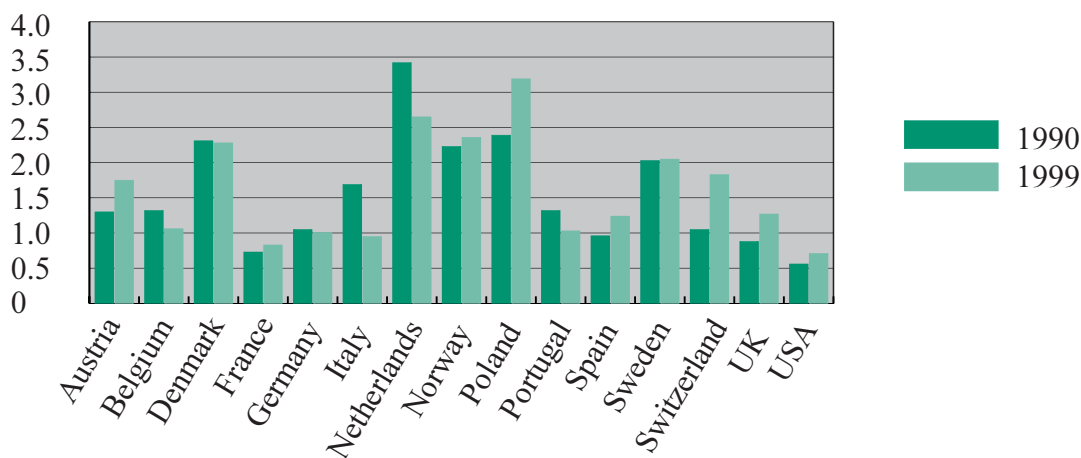
There are also some major differences. The provision of universal health care coverage removes one of the incentives that disabled people in the U.S. have to claim long-term public disability benefits. In addition, most European countries have sick-pay plans that provide coverage against the loss of wages due to temporary illness. The period of employer responsibility for sick-pay benefits varies from country to country, but these plans maintain the employer-employee relationship.

Sick-pay systems are an important element in European return-to-work efforts. In some countries, such as Sweden and the Netherlands, employers are required to develop plans for the employees' return to work. The International Labor Organization reports, "In most systems, the critical work resumption threshold has passed once the disabled worker exhausts the term of sickness or short-term disability benefit, or otherwise meets the criteria for a long-term disability benefit."

There are also differences among European programs. Among other factors, programs differ in the generosity of their benefits and their requirements to qualify for benefits. As a result, expenditures on disability programs vary widely. As Figure 1 shows, the Netherlands and Poland have had very high expenditures as a percentage of GDP. The Netherlands began tightening program eligibility in 1993, and its expenditures have fallen. Poland implemented reforms in 1997 that may have a similar effect.

**Figure 1**

#### Disability Program Expenditures as Percentage of GDP, 1990 - 1999



There are also major differences in social institutions that affect the disability system. On the continent, there is a tradition of “social partnership” between labor and management that is reflected in the institutional structures in which the labor market functions. For example, in France, Germany, Sweden, and the Netherlands, laws control how workers are hired and how they are dismissed. English-speaking countries, on the other hand, place more emphasis on individual claims and civil rights. As a result, continental countries impose obligations on employers to behave in certain ways toward defined groups, for instance through quota systems, while English-speaking countries are more likely to use disability discrimination laws that provide legal recourse to individuals.

## **EUROPEAN POLICIES AFFECTING RETURN TO WORK**

### **Wage subsidies and partial benefits**

While English-speaking countries tend to have all-or-nothing benefit systems, continental European systems tend to provide partial, as well as full, benefits, depending on the remaining capacity for work. These systems permit beneficiaries to combine earnings with partial benefits. In Sweden, for example, benefits may be paid at the 25 percent, 50 percent, 75 percent, or 100 percent level, depending on severity.

European countries also use wage subsidies, recruitment grants, and relief from national insurance contributions to create jobs for disabled people and other targeted groups, such as the long-term unemployed. In France, for example, disabled workers with reduced productivity can have their wages supplemented up to the minimum wage level. And in the Netherlands, disabled workers who accept a job with lower earnings than that on which their disability benefit was based can get a supplementary benefit.

Some subsidies support a trial return to work. In Sweden, beneficiaries can retain sickness benefits while testing their ability to do their previous job or another job to which they are better suited. Germany provides for “step-wise” rehabilitation by providing sickness benefits to supplement wages for up to six months while employees gradually increase their working hours.

### **Quotas**

Quota systems provide incentives for employing disabled people and provide funds for services for the disabled. France, for example, uses a quota-levy system. Firms of a specified size are expected to employ a target percentage of disabled workers. If they do not, they are required to pay a levy to a fund that is used to support the costs to employers of employing disabled workers and to promote the employment of disabled workers.

### **Job protection**

Germany, for example, prevents the dismissal of registered disabled workers without the approval of an agency of the state. The Netherlands prohibits the dismissal of disabled workers for two years, and then only with the approval of the authorities.

### **Public provision of rehabilitation services**

Germany and Sweden have established a strong link between benefit payments and rehabilitation. In Germany, the principle of “rehabilitation before pension” leads to the public pension funds’ considering first medical and then vocational rehabilitation, before the payment of a pension. The Swedish system works with employers to help workers regain lost ability to work.

Sweden, France, and Germany provide funding for such items as training, adaptations, wage subsidies, and services needed to return disabled people to work. The range of in-kind benefits in Germany includes modifications to the home and to transport.

## **Private insurance**

While employer-purchased private disability insurance is more common in the United States and Canada, the private insurance market has been growing in the United Kingdom and in the Netherlands. Private insurers have an interest in returning beneficiaries to work in order to minimize their payments.

## **RECOGNIZED PROBLEMS WITH RETURN-TO-WORK POLICIES**

A recent report of the International Labor Organization (ILO) noted that return-to-work policies are “often fragmented, not coordinated and sometimes even contradictory,” with little coordination across policy areas. This lack of coordination makes it difficult for agencies to maximize their effectiveness. It also makes it difficult for employers and disabled people to find their way through the maze of programs and providers. The ILO also noted that physicians play a large role as gatekeepers for both benefits and rehabilitation, although they tend to have little training in assessing work capacity and little knowledge of the workplace. In addition, it can take months to complete needed assessments, frequently delaying interventions for vocational rehabilitation until the contacts to the former employer are already broken. Beneficiaries rarely return to work once they have begun receiving long-term disability benefits, even in countries that make use of temporary or partial benefit awards.

## **SOME RECENT DEVELOPMENTS IN RETURN-TO-WORK POLICIES**

Several countries have made changes recently to reduce the prevalence of disability benefits and to encourage reintegration of disabled workers into the work force. Following are examples of recent changes:

## **Benefits**

Germany established a new definition of disability that distinguishes between full and partial disability, based on the number of hours a claimant can work. It also requires temporary grants of benefits.

## **Assessment**

The United Kingdom has tightened its assessment of claimants’ eligibility for benefits, with an emphasis on collecting information on the claimant’s capability rather than disability.

## **Incentives**

The United Kingdom established a disabled persons’ tax credit that has the effect of providing a minimum income to disabled people who work at least 16 hours a week. The Netherlands made employer premiums for disability benefits experience-based.

## **Employment rights**

Germany has established statutory rights to work assistance, workplace accommodations, and part-time employment.

## **Support**

The Netherlands has implemented a new supported employment program and measures for subsidized employment.

## **Coordination**

Switzerland has established one-stop shops in each canton, with full responsibility for both benefit awards and rehabilitation. Sweden offers a one-stop service for employers and social insurance offices, through a contractor, at the county level. The United Kingdom merged its benefits agency and employment service to provide more integrated service. It also integrated supported and sheltered employment organizations and gave them new output-based funding provisions.

## APPENDIX B

### SSA's Previous Employment Support Demonstration Projects

Despite its longstanding commitment to providing VR services to Social Security disability beneficiaries, each year less than 1 percent of SSDI and SSI disability beneficiaries leave the rolls because they have returned to work. In an effort to improve its performance in this area, SSA – at the direction of Congress – has studied a number of approaches aimed at effective delivery of VR and employment services.

Section 505(a) of the Social Security Disability Amendments of 1980 authorized SSA to initiate vocational rehabilitation and work incentive demonstration projects. Section 12101 of the Consolidated Omnibus Budget Reconciliation Act of 1985 later extended this authority. These demonstration projects became known throughout the agency as the “505(a) demonstrations.” Between 1987 and 1989, SSA received more than 600 applications for demonstration grants to explore innovative ways of providing VR and employment services to disability beneficiaries. In order to continue building on these earlier efforts, Congress extended the 505(a) demonstration authority in 1989, and again in 1994. Ultimately, SSA awarded 116 grants to a mix of public and private organizations in 37 States and the District of Columbia.

In addition to the 505(a) demonstrations, Section 1110(b) of the Social Security Act authorized demonstration projects that assist in promoting the objectives of the SSI program, including successful rehabilitation leading to work. These demonstrations became known as the “1110(b) demonstrations.”

A major outgrowth of the 505(a) and 1110(b) demonstrations is Project NetWork,

initiated by SSA in 1991 to test four different service delivery models that offered alternatives to SSA's traditional VR program. Project NetWork used a case management approach that provided participants with a broad range of rehabilitation services, including job placement and on-the-job support. Project NetWork was designed to fully involve disability beneficiaries in setting their own employment goals and selecting service providers that were most appropriate to their own, personal situation. In conjunction with Project Network, SSA also initiated a demonstration project called Able Beneficiaries Link to Employers, or Project ABLE, to provide expanded employment opportunities through an automated referral system for SSA beneficiaries. The Project ABLE database linked disabled, job-ready beneficiaries with federal, State, and local agencies and private sector employers that needed their skills and abilities.

The findings from these early demonstrations – including both Project NetWork and SSA's tests of the effectiveness of using private providers of VR and employment services – have indicated that disabled beneficiaries can be referred to a variety of public and private VR and employment service providers and, once referred, beneficiaries do choose to receive services that lead to job placements. Results also indicated that more beneficiaries would return to work if referral for VR and employment services occurred earlier in the process – under the present system in most States – applicants for DI and SSI disability benefits are referred for VR services only after it has been determined whether or not they are disabled. The demonstrations also indicated

that further refinement of the VR system, including the use of case managers who specialize in SSA-type clients and use of specialized VR programs designed for persons with specific impairments, would increase the availability, quality, and effectiveness of VR and employment services.

However, after further analysis of Project NetWork and Project ABLE by SSA, the General Accounting Office, and a team of private economists, SSA determined that, on the whole, these demonstration projects were not as successful as they had hoped in helping people with disabilities to develop and maintain a significant relationship with the workforce. GAO, in particular, cited a lack of statistical validity to the design of these projects and was critical of the agency for insufficient follow-up of the participants. Reviewers generally agreed that it was difficult to draw conclusions from the experiences that SSA and participants had operating under these demonstrations. Both Project NetWork and Project ABLE were terminated in the mid-1990s.

However, as a result of the things that SSA did learn from Project NetWork and Project ABLE, the agency implemented an alternate payment method for VR services in June of 1996. In addition to state VR agencies, SSA expanded its VR referral and payment program to allow providers other than the designated state VR agencies to service disability beneficiaries by entering into contracts with qualified providers who responded to SSA's Request for Proposals (RFP). An alternate provider has been defined as any public or private agency (except a participating state VR agency), institution, organization, or individual with whom SSA entered into a contract for the

provision of VR services. Under this alternate payment program, SSA paid providers for the services that they provided to SSA's beneficiaries if those services resulted in the individual going to work and earning above the SGA level for more than nine consecutive months – essentially the same requirements for payment as those used to reimburse the state VR agencies. The option of serving disability beneficiaries was offered first to the state VR agencies. If, after four months from SSA's referral to the state VR agency, SSA had not been notified that the individual had been accepted for services, SSA placed that individual's name on a bulletin board that was available to alternate providers serving disability beneficiaries with similar impairments in the same geographical area. Alternate providers were not required to serve all persons whose names appear on the SSA bulletin board.

While the alternate provider program was never formally terminated, participating providers viewed these new payment rules as merely a transition toward their participation in the Ticket to Work Program that was being formulated by the agency throughout the late 1990s. With the support of disability and employment support advocates, the Ticket legislation was eventually enacted in 1999. Those providers who had participated in work support efforts under the alternate provider program did, indeed, reorganize their efforts toward becoming employment networks under the Ticket program. For all practical purposes, the new work support environment that was created by the Ticket program supplanted the alternate provider program. In addition, Section 505(a) demonstration authority was subsumed under the new Ticket act in Section 234.



## APPENDIX C

### Current and Planned Demonstration Projects

#### Early Intervention Projects

SSA's early intervention projects involve screening DI and SSI applicants during the application process in an attempt to reach a quick judgment as to who is (1) likely to be eligible for benefits based on a disability, and (2) a good return-to-work candidate. The formal disability determination process is bypassed. Those who are found to meet the test will be given immediate access to benefits for one year along with Medicare eligibility without the usual 24-month waiting period. They will then be provided with rehabilitation services to see whether they can be placed in employment that would keep them from needing to go permanently on the disability rolls. SSA's plan is to run several pilot projects in three States (New Mexico, Vermont, and Wisconsin) during the next few years and then to create a larger demonstration project that will yield nationally valid data. SSA hopes to start these demonstration projects in 2004.

#### Disability Navigators

The Department of Labor (DOL) has established a number of centers throughout the country for jobseekers called "Career One-Stops." These are places where individuals can search for jobs, locate public workforce services, explore alternative career paths, compare salary data for different occupations, and get resume writing tips and job interview strategies. Businesses can also use them to identify job-ready workers with the right skills. Recently, SSA and DOL announced that they plan to place Disability Program Navigators (similar to case managers) at the One Stops to work with individuals with disabilities (especially those connected with the Ticket to Work program) to link them to local

employers, and help them get access to housing, transportation, health care, and assistive technologies.

#### State Partnership Initiatives

In the late 1990s, SSA awarded cooperative agreements to California, New York, Illinois, North Carolina, Iowa, Ohio, Minnesota, Oklahoma, New Hampshire, Vermont, New Mexico, and Wisconsin to develop integrated service delivery systems statewide to help persons with disabilities who want to work. Each of the participating States developed its own methodology, but most of them target mentally ill SSI and/or DI beneficiaries and establish some form of benefit, work incentive, and vocational rehabilitation counseling. The agreements were awarded for 5 years, at a total cost of \$25 million.

#### Youth Transition Demonstration Project

The Youth Transition Demonstration Projects will design, implement, and evaluate approaches to improving the transition from school to work for youth aged 14-25 who receive SSI benefits, DI, or childhood disability benefits. Projects may also serve youth at risk of receiving such benefits, including those with a progressive condition or a prognosis for decreased functioning and those who may become eligible for benefits at age 18, when deemed parental income no longer applies. Activities of this initiative reflect two themes: 1) facilitating transition services and 2) altering SSI's benefit structure to increase incentives for youth to pursue further education.

SSA will award seven cooperative agreements at approximately \$500,000 annually for up to five years.

### **Sliding Scale Benefit Offset**

SSA plans to test the impact and costs of a sliding-scale benefit offset for DI beneficiaries, including a \$1-for-\$2 benefit offset. Disability benefits will be reduced by a certain amount for each dollar a DI beneficiary earns above a given threshold, probably the current substantial gainful activity amount (\$800). Currently, beneficiaries are in danger of losing their entire DI benefit if their earned income is above SGA, even by \$1. This potential complete loss of benefits and eventually of the corresponding access to Medicare benefits is thought to discourage beneficiaries from attempting to work.

## APPENDIX D

### Selected Data Related to Social Security Disability Programs

There are two separate Social Security disability programs that share a common definition of disability: Disability Insurance (DI) and Supplemental Security Income (SSI).

The Disability Insurance program provides benefits to disabled workers who have enough coverage under Social Security to meet the program's "fully insured" status requirement and who also have substantial recent work under Social Security (generally at least five years of work in the 10-year period preceding disablement). There is no minimum age requirement for disability insurance benefits, but the insured status requirement results in very few cases of entitlement prior to age 20. When disabled workers reach normal retirement age (currently 65 plus 2 months), they are converted from DI beneficiaries to Retirement Insurance beneficiaries. Benefits are also paid under the Disability Insurance program to disabled adult children of disabled worker beneficiaries and also to certain non-disabled dependents. Disabled adult children of retired and deceased workers and disabled widows and widowers also may qualify for benefits on the basis of disability that are paid from the Old-age and Survivors Insurance Trust Fund.

The Supplemental Security Income program provides an income guarantee for low-income disabled individuals without regard to whether or not they have any prior work history. Benefits are payable to children with disabilities using a special definition requiring

marked and severe functional limitations. Strictly speaking, benefits are payable at any age but non-disabled individuals can qualify for SSI at age 65. Thus, applicants age 65 and over are, in almost all cases, coded as "aged." However, those who initially become eligible on the basis of disability continue to be coded as "disabled" even past age 65. As of the end of 2002, a little less than 15 percent of SSI disabled and blind recipients were age 65 or over. SSI payments are funded from the General Fund of the Treasury on an entitlement basis but through appropriations acts.

There is also significant overlap between the Social Security DI and SSI disability programs in that individuals with small DI benefit levels and low income from other sources can qualify for additional payments from SSI. Generally speaking, however, the characteristics of the two categories of beneficiaries are substantially different.

The table on page 36 shows the various categories of individuals who receive benefits as a result of their disability or that of a family member. This table excludes SSI recipients who are coded as disabled but are age 65 or over since they would almost all qualify for SSI on the basis of age even if they were not disabled.<sup>3</sup> The table does include about 25,000 disabled adult children who are age 65 and over and also get SSI.

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<sup>3</sup> In a small number of cases involving alien status, eligibility for SSI can only be established if the individual is disabled.



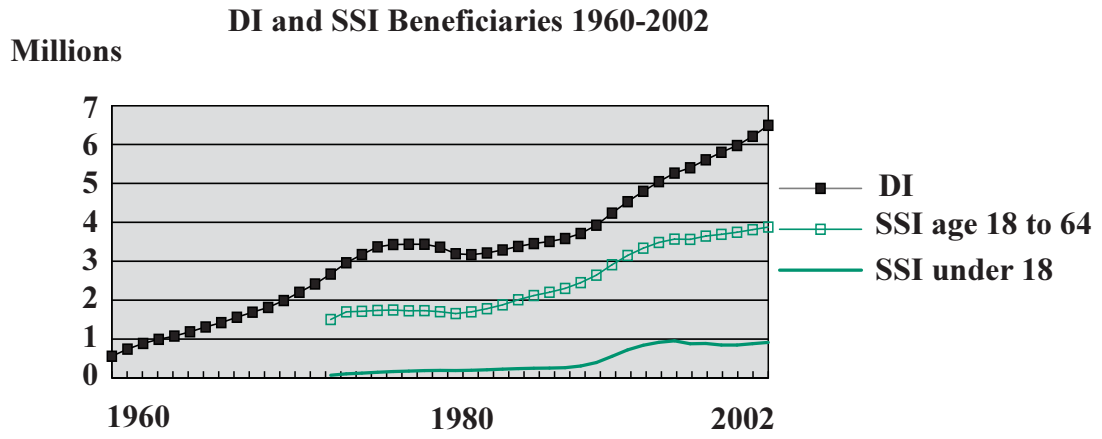
**Disability Beneficiaries Under  
Social Security Act Programs  
December 2002**

	<b>Social Security</b>	<b>Also Receive SSI</b>	<b>Receive SSI Only</b>	<b>Total</b>
Disabled Workers	5,535,860	798,740		
Disabled Adult Children	60,760	41,830		
-of disabled workers				
-of retired workers	193,150	98,060		
-of deceased workers	494,750	157,920		
Disabled Widows and Widowers	205,870	37,540	3,618,959	
Other Under-Age-65 SSI recipients				
Total Receiving Benefits Based on Own Disability	6,490,390	1,134,090	3,618,959	10,109,349
Non-disabled Spouses of Disabled Workers	151,260	10,880		
Minor Children of Disabled Workers	1,472,330	41,440		
Total Disability-Related Beneficiaries	8,113,980	1,186,410	3,618,959	11,732,939

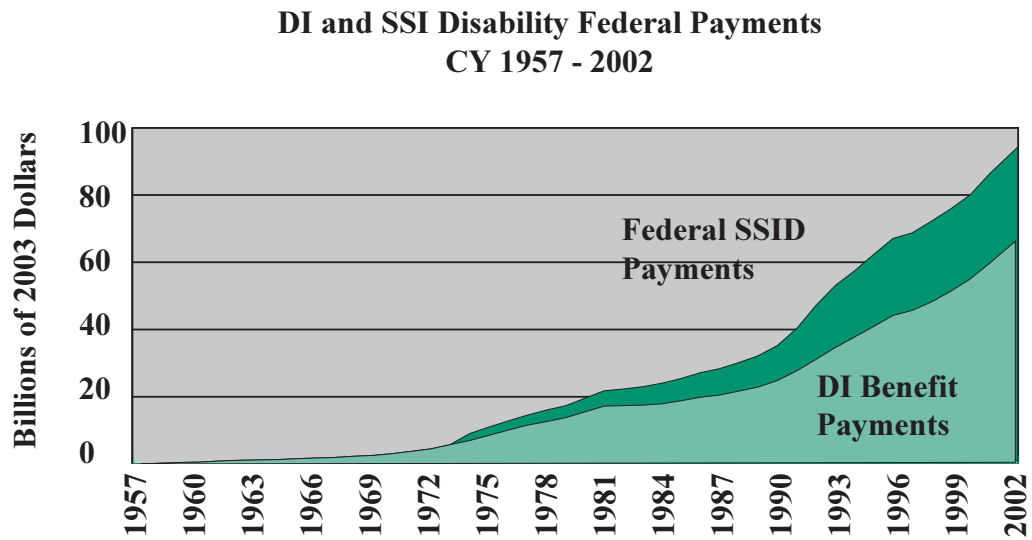
Figure 2 shows the number of individuals getting disability benefits over the history of the programs. The numbers are not additive, because a significant number of individuals get both SSI and Social Security disability benefits. The Social Security Administration does not have data which permits a breakout over the entire period of those getting benefits under a single program from those getting benefits concurrently from both programs.

Figure 3 shows the costs of the 2 programs in constant (2003) dollars. This chart does include payments to SSI disability recipients who are over age 65 because historic data is not available on a basis which excludes them.

**Figure 2**



**Figure 3**



### **Characteristics Of SSI Disabled Adults (age 18-64)**

- 48 percent of the disabled adults have 12 or more years of education
- 60 percent of the disabled adults have mental disorders as their diagnostic group.
- The most common diagnostic group for all age categories is mental disorders.

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<b>SEX</b>		<b>1995</b>	<b>2002</b>
	Men	45%	43%
	Women	55%	57%

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<b>AVERAGE AGE</b>		<b>1995</b>	<b>2002</b>
	Under 50	66%	62%
	50 and older	34%	38%

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<b>EDUCATION</b>		<b>1999</b>
	0 – 8 Years	28%
	9 – 11 Years	24%
	12 Years	34%
	13 – 15 Years	11%
	16+ Years	3%

---

<b>DIAGNOSTIC GROUP</b>	<b>1995</b>		
	<b>All</b>	<b>18-49</b>	<b>50-64</b>
Mental Disorders	59%	68%	36%
Nervous System/Sense Organs	9%	9%	6%
Musculoskeletal	7%	4%	18%
Circulatory	5%	2%	15%
All Other Disorders	21%	17%	25%

	<b>2002</b>		
	<b>All</b>	<b>18-21</b>	<b>50-64</b>
Mental Disorders	57%	66%	38%
Nervous System/Sense Organs	8%	9%	6%
Musculoskeletal	8%	5%	17%
Circulatory	4%	2%	10%
All Other Disorders	23%	19%	30%

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## **Characteristics Of Disability Insurance Beneficiaries**

- From 1996 to 2002 the percentage of disabled workers who are women increased from 35 percent to 45 percent.
- 75 percent of the disabled workers have 12 or more years of education.
- 47 percent of the disabled workers under 50 have mental disorder as their diagnostic group. This is a much higher rate of mental disorders than for older disabled workers.
- Musculoskeletal disorders is the most common diagnostic group for disabled workers over 50.
- In 1990 circulatory disorders was the most common diagnostic group (25 percent) for disabled worker over 50. This has decreased to 14 percent and is now third behind musculoskeletal and mental disorders.

<b>SEX</b>	<b>1990</b>	<b>2002</b>
Men	65%	55%
Women	35%	45%

<b>AVERAGE AGE</b>	<b>1990</b>	<b>2002</b>
Men	50	51
Women	51	51

<b>AGE DISTRIBUTION</b>	<b>Under 30</b>	<b>30-34</b>	<b>35-39</b>	<b>40-44</b>	<b>45-49</b>	<b>50-54</b>	<b>55-59</b>	<b>60-64</b>
<b>1990</b>	4%	6%	9%	10%	11%	13%	19%	28%
<b>2002</b>	3%	4%	7%	11%	14%	18%	21%	23%

	<b>1990</b>	<b>2002</b>
Under 50	40%	38%
50 and older	60%	62%

<b>EDUCATION</b>	<b>1998</b>	<b>2001</b>
0 – 8 Years	13%	11%
9 – 11 Years	18%	14%
12 Years	36%	39%
13 – 15 Years	23%	27%
16+ Years	11%	9%

<b>DIAGNOSTIC GROUP</b>	<b>1990</b>	<b>All</b>	<b>Under 50</b>	<b>50 and Over</b>
Mental Disorders		29%	44%	18%
Musculoskeletal		19%	13%	23%
Circulatory		17%	6%	25%
Nervous System/Sense Organ		11%	13%	9%
All Other Disorders		24%	24%	25%

	<b>2002</b>	<b>All</b>	<b>Under 50</b>	<b>50 and Over</b>
Mental Disorders		33%	47%	25%
Musculoskeletal		24%	16%	29%
Circulatory		10%	4%	14%
Nervous System/Sense Organ		10%	11%	9%
All Other Disorders		23%	22%	24%

## **Growth and Age Structure of The Disability Insurance Rolls**

In the last 25 years there has been significant growth of the Social Security disability rolls. Growth can be measured by absolute numbers, the number on the rolls relative to the number of insured (prevalence rate), and awards relative to the number insured (incidence rates). All three measures confirm the there has been very substantial growth despite factors that should have slowed or reversed this trend. For example, during the 1990s the growth continued despite the prosperous economy, improvements in medical treatment, and the tightening of the rules for evaluating drug addicts and alcoholics.

There has been a 36 percent increase in the disability prevalence rate since 1980 and an increase of 55 percent just since 1990. There are increases in all age categories except for 60-64. (All age categories show increasing rates between 1985 and 2002.)

### **Disability Prevalence Rates**

(Number In Current Pay per 1,000 Insured)

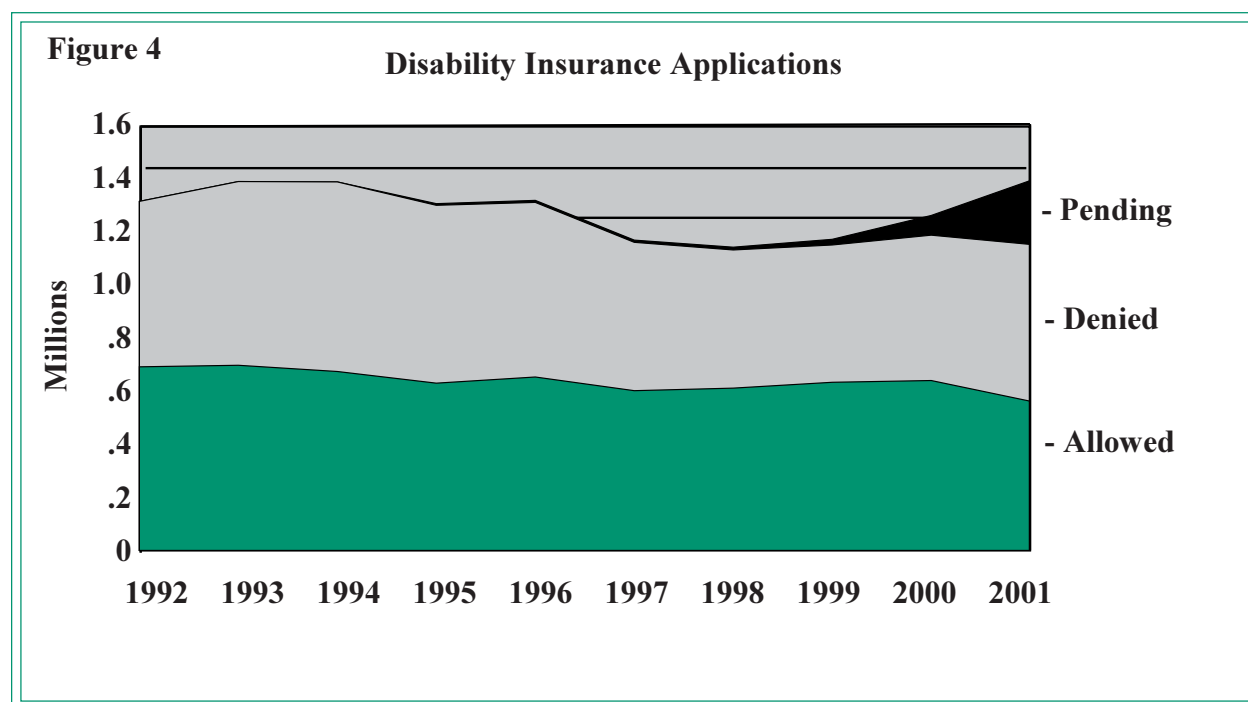
	<u>All</u>	<u>20-24</u>	<u>25-29</u>	<u>30-34</u>	<u>35-39</u>	<u>40-44</u>	<u>45-49</u>	<u>50-54</u>	<u>55-59</u>	<u>60-64</u>
1980	28.5	1.7	5.0	9.6	13.9	19.9	32.5	52.0	91.2	154.2
1985	24.2	1.7	4.8	8.8	13.0	17.9	25.8	43.9	74.3	124.2
1990	25.0	1.9	5.6	10.6	15.8	21.3	29.6	44.9	76.6	116.9
2002	38.8	3.4	7.3	12.6	21.1	31.5	43.8	62.6	98.2	146.0
% Increase / Decrease (1980-2002)	+36%	+100%	+46%	+31%	+52%	+58%	+35%	+20%	+8%	-5%

There are two important reasons for the overall increase — increased allowance rates and decreased termination rates.

## **Allowance Rates**

In 1980, the allowance rate (awards as a percentage of applications) was 31.4 percent. The allowance rate remained at this level until 1984. Starting in 1984, the allowance rate steadily increased until it reached a high of 52 percent in 1998. Allowances rates have decreased since 1998, but the 2002 allowance rate of 44.6 percent is still significantly higher than 1980.

Although there are many factors that influence allowance rates, one of the most important is the increase in the number of claims allowed with mental impairments. This increase can, at least in large measure, be traced to the 1984 Amendments and the revised criteria for evaluating mental impairments that were published in the *Federal Register* in August of 1986. In 1986, 20 percent of disabled workers on the rolls had a mental illness diagnosis. In 2002, that had increased to 28 percent.



Application rates also affect the rate of growth of the rolls. As Figure 4 shows, the number of disability insurance applications rose in the early 1990s, dropped somewhat in the mid-1990s, and rose again at the end of the 1990s and since. To a considerable extent, the increasing allowance rate offset the lower application rate in the mid-1990s. (This chart is based on the year of application and includes decisions at all levels.)

## **Termination Rates**

In 1980 the rate of benefit termination (the number per 1,000 beneficiaries) was significantly higher than in 2002. In 1980 the termination rate was 145 per 1,000 and in 2002 the termination rate was 85 per 1,000. The significantly higher termination rates for 1980 hold true for the three primary reasons why benefits are terminated — death, conversion, and recovery (which includes the return to substantial work activity).

## Termination Rate

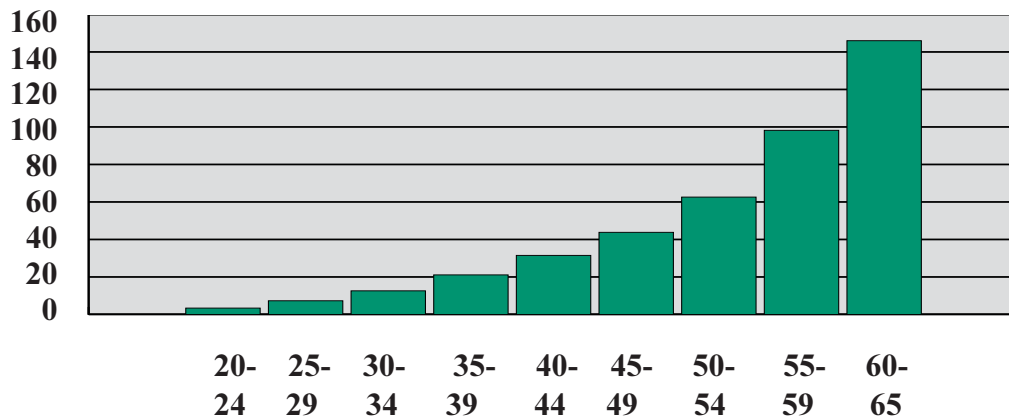
(Number of Terminations per 1,000 on the Rolls)

	<b>Total</b>	<b>Death</b>	<b>Conversion</b>	<b>Recovery</b>	<b>Other</b>
1980	145	48	68	28	1
2002	85	32	39	11	2

The decrease in the death and conversion termination rates is the result of a combination of factors, including improved medical treatment, the significant increase in the number of young beneficiaries, and an increase in the number of awards based on mental and other conditions with lower mortality rates. The reduction in the recovery termination rate can be traced, in part, to the 1984 Amendments. The 1984 legislation established a strict medical improvement standard that required substantial evidence of medical improvement before benefits could be terminated. Termination rates can also be adversely affected by limited agency resources, which result in fewer continuing disability reviews.

**Figure 5**

**DI Beneficiaries, per 1,000 Insured, by Age (2002)**

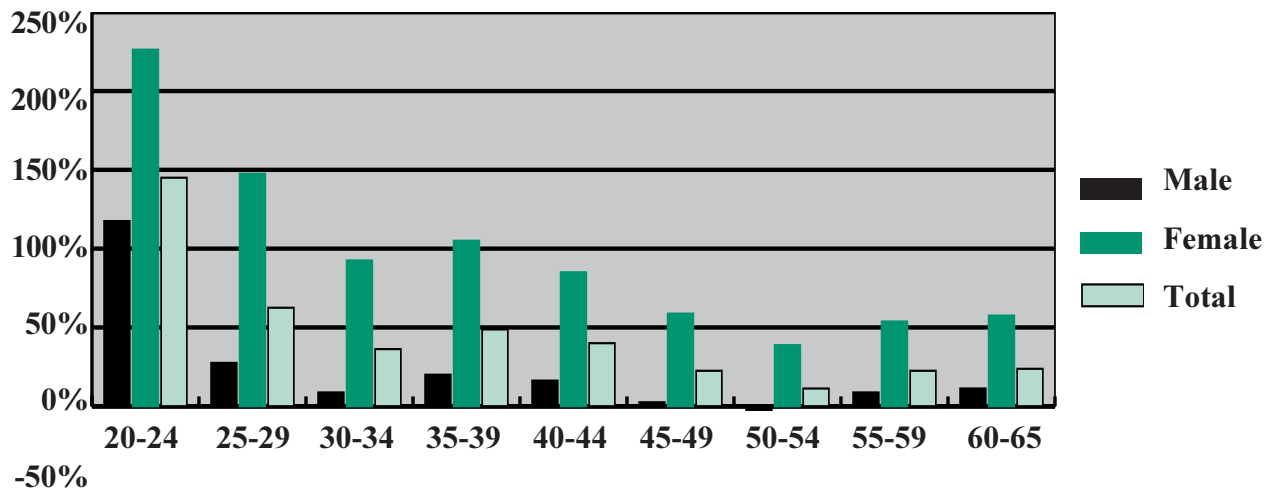


As Figure 5 shows, workers at older ages are more likely to be on the disability rolls than younger workers. This reflects both the fact that older workers are more at risk of disabling disease and disability and the fact that the disability program standards are designed to make it easier for older workers to qualify on the basis of vocational factors. However, Figure 6 shows that the incidence of disability, that is the number of workers per 1,000 insured, has been growing more rapidly for younger workers over the years since 1985. This trend has been particularly true of women. Factors which may explain the male-female differential include possible differing impact of the liberalization of disability standards since 1984 and the increasing participation of women in occupations formerly performed mainly by men. However, there do not appear to be any research results available to validate those hypotheses.



**Figure 6**

**Percentage Increase in Incidence Rates  
from 1985 to 2002,  
by Sex and Age Group**



## *The Social Security Advisory Board*

### ***Hal Daub, Chairman***

Hal Daub is currently a partner with the law firm of Blackwell Sanders Peper Martin in Omaha, Nebraska and Washington, D.C. Previously, he served as Mayor of Omaha, Nebraska from 1995 to 2000, and as an attorney, principal, and international trade specialist with the accounting firm of Deloitte & Touche from 1989 to 1994. Mr. Daub was elected to the United States Congress in 1980, and reelected in 1982, 1984, and 1986. While there he served on the House Ways and Means Committee, the Public Works and Transportation Committee, and the Small Business Committee. In 1992, Mr. Daub was appointed by President George H.W. Bush to the National Advisory Council on Public Service. From 1997 to 1999, he served on the Board of Directors of the National League of Cities, and from 1999 to 2001 served on the League's Advisory Council. He was also elected to serve on the Advisory Board of the U.S. Conference of Mayors, serving a term from 1999 to 2001. From 1971 to 1980, Mr. Daub was vice president and general counsel of Standard Chemical Manufacturing Company, an Omaha-based livestock feed and supply firm. A former member of the U.S. Army, Mr. Daub is a graduate of Washington University in St. Louis, Missouri, and received his law degree from the University of Nebraska. Term of office: January 2002 to September 2006.

### ***Dorcas R. Hardy***

Dorcas R. Hardy is President of Dorcas R. Hardy & Associates, a government relations and public policy firm serving a diverse portfolio of clients. She was Commissioner of Social Security from 1986 to 1989. Ms. Hardy launched and hosted her own primetime, weekly television program, "Financing Your Future," on Financial News Network and UPI Broadcasting. She has also hosted "The Senior American," an NET political program for older Americans. She speaks and writes widely about domestic and international retirement financing issues and entitlement program reforms and is the author of *Social Insecurity: The Crisis in America's Social Security System*, and *How to Plan Now for Your Own Financial Survival*. Ms. Hardy consults with seniors organizations, public policy groups and businesses to promote redesign and modernization of the Social Security and Medicare systems. She received her B.A. from Connecticut College, her M.B.A. from Pepperdine University and completed the Executive Program in Health Policy and Financial Management at Harvard University. She is a Certified Senior Advisor and serves on the Board of Directors of The Options Clearing Corporation, Wright Investors Service Managed Funds, and First Coast Service Options. She is also a member of the Board of Visitors of Mary Washington College and the Board of Rehabilitative Services of the Commonwealth of Virginia. Term of office: April 2002 to September 2004.

### ***Martha Keys***

Martha Keys served as a U.S. Representative in the 94th and 95th Congresses. She was a member of the House Ways and Means Committee and its Subcommittees on Health and Public Assistance and Unemployment Compensation. Ms. Keys also served on the Select Committee on Welfare Reform. She served in the executive branch as Special Advisor to the Secretary of Health, Education, and Welfare and as Assistant Secretary of Education. She was a member of the 1983 National Commission (Greenspan) on Social Security Reform. Martha Keys is currently

consulting on public policy issues. She has held executive positions in the non-profit sector, lectured widely on public policy at universities, and served on the National Council on Aging and other Boards. Ms. Keys is the author of *Planning for Retirement: Everywoman's Legal Guide*. First term of office: November 1994 to September 1999. Current term of office: October 1999 to September 2005.

### ***David Podoff***

David Podoff is a visiting Associate Professor at the Baruch College of the City University of New York. Previously he was Minority Staff Director and Chief Economist for the Senate Committee on Finance. He also served as the Committee's Minority Chief Health and Social Security Counselor and Chief Economist. In these positions on the Committee he was involved in major legislative debates with respect to the long-term solvency of Social Security, health care reform, the constitutional amendment to balance the budget, the debt ceiling, plans to balance the budget, and the accuracy of inflation measures and other government statistics. Prior to serving with the Finance Committee he was a Senior Economist with the Joint Economic Committee and directed various research units in the Social Security Administration's Office of Research and Statistics. He has taught economics at the University of Massachusetts and the University of California in Santa Barbara. He received his Ph.D. in economics from the Massachusetts Institute of Technology and a B.B.A. from the City University of New York. Term of office: October 2000 to September 2006.

### ***Sylvester J. Schieber***

Sylvester Schieber is Director of the Research and Information Center at Watson Wyatt Worldwide, where he specializes in analysis of public and private retirement policy issues and the development of special surveys and data files. From 1981 to 1983, Mr. Schieber was the Director of Research at the Employee Benefit Research Institute. Earlier, he worked for the Social Security Administration as an economic analyst and as Deputy Director at the Office of Policy Analysis. Mr. Schieber is the author of numerous journal articles, policy analysis papers, and several books including: *Retirement Income Opportunities in An Aging America: Coverage and Benefit Entitlement*; *Social Security: Perspectives on Preserving the System*; and *The Real Deal: The History and Future of Social Security*. He served on the 1994-1996 Advisory Council on Social Security. He received his Ph.D. from the University of Notre Dame. First term of office: January 1998 to September 2003. Current term of office October 2003 to September 2009.

### ***Gerald M. Shea***

Gerald M. Shea is currently assistant to the president for Government Affairs at the AFL-CIO. He previously held several positions within the AFL-CIO, serving as the director of the policy office with responsibility for health care and pensions, and also in various executive staff positions. Before joining the AFL-CIO, Mr. Shea spent 21 years with the Service Employees International Union as an organizer and local union official in Massachusetts and later on the national union's staff. He was a member of the 1994-1996 Advisory Council on Social Security. Mr. Shea serves as a public representative on the Joint Commission on the Accreditation of Health Care Organizations, is a founding Board member of the Foundation for Accountability, Chair of the RxHealth Value Project, and is on the Board of the Forum for Health Care Quality and Measurement. He is a graduate of Boston College. First term of office: January 1996 to September 1997; current term of office: October 2000 to September 2004.

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