



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

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Summary

Social Security Disability Insurance (SSDI) program provides benefits to insured workers with disabilities under the full retirement age and their dependents based on an individual worker's earnings and work history in covered employment. Recently, some Members of Congress and the public have expressed concern over the financial sustainability of the SSDI program. Between 1980 and 2011, the number of disabled-worker beneficiaries grew 196.6%, whereas the number of workers insured for disability increased 50.9%. This increase in the ratio of disabled-worker beneficiaries to insured workers, or prevalence rate, has placed pressure on the Disability Insurance (DI) trust fund, which the Social Security Board of Trustees projects will be exhausted in 2016.

Some of the increase in the SSDI prevalence rate stems from changes in the demographic characteristics of the insured-worker population. According to the Social Security Board of Trustees, the aging of the baby boom generation and a sharp rise in the number and incidence rate of female insured workers helped to propel the prevalence rate upward between 1980 and 2011. However, other factors may have also contributed to the growth in SSDI rolls. For example, instances of high unemployment and the increasing relative value of SSDI benefits to low-income workers may have induced more individuals to apply to the program. In addition, inconsistency in the determination and adjudication process might have increased the likelihood of denied claimants being awarded SSDI on appeal. Moreover, changes to federal policy that relaxed certain program eligibility criteria and increased the value of disability benefits relative to retirement benefits may have played a role in increasing the SSDI prevalence rate.

To assist lawmakers in addressing the sustainability of the program, this report provides an overview of reform proposals designed to mitigate the growth in SSDI rolls. Most of the proposals discussed in this report focus on reducing the inflow (incidence) of new beneficiaries into the program. These proposals include implementing stricter SSDI eligibility criteria, improving consistency in the disability determination and adjudication process, and incentivizing employers to provide supported-work services for employees following the onset of disability (i.e., rehabilitation, workplace accommodation, and a partial wage replacement). On the other hand, some of the proposals seek to increase the outflow (termination) of beneficiaries from the program. Proposals to reduce the current beneficiary population entail providing stronger incentives for beneficiaries with some residual functional capacity to return to the labor force, as well as increasing the number of continuing disability reviews (CDR) performed by the Social Security Administration (SSA).

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Introduction

Concern among some Members of Congress and the public over the financial sustainability of the Social Security Disability Insurance (SSDI) program has been growing.¹ Between 1980 and 2011, the number of disabled-worker beneficiaries in receipt of SSDI rose 196.6% (from approximately 2.9 million to nearly 8.6 million), whereas the number of workers insured in the event of disability increased 50.9% (from almost 100.5 million to more than 151.7 million).² This increase in the ratio of disabled-worker beneficiaries to insured workers, or prevalence rate, has placed pressure on the Disability Insurance (DI) trust fund, insofar as inflation-adjusted program expenditures have increased 205.5%, from \$43.3 billion in 1980 to \$132.3 billion in 2011.³ Under its intermediate-cost assumptions, the Social Security Board of Trustees estimates that the DI trust fund will be exhausted in 2016.⁴

To assist lawmakers in addressing the sustainability of the program, this report provides an overview of reform proposals designed to mitigate the growth in SSDI rolls. The report is divided into four sections. The first section provides a brief background on SSDI, including program eligibility criteria, benefits, and the determination and adjudication process. The second section discusses the growth in SSDI rolls since 1980 by examining historical entry and exit program trends. Drawing upon research from government agencies, academic researchers, and public policy organizations, the third section of the report investigates some of the potential factors behind the growth in the SSDI prevalence rate, including changes in the demographic and economic characteristics of the insured-worker population, inconsistency in the administration of the program, and legislative changes to federal policy. The fourth section of the report examines various reform proposals to abate the growth in SSDI rolls, namely, stricter eligibility criteria, improved program administration, stronger return-to-work incentives, and supported-work policies. Although this report discusses potential savings from certain reform proposals, it does not specifically examine the effects of the proposals on the solvency of the DI trust fund.⁵

¹ See, for example: U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *First in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, 112th Cong., 1st sess., December 2, 2011, Serial 112–SS11, pp. 4-5, <http://www.gpo.gov/fdsys/pkg/CHRG-112hhr76319/pdf/CHRG-112hhr76319.pdf>.

² For beneficiary data, see Social Security Administration, *Benefits Awarded by Type of Beneficiary*, <http://www.ssa.gov/OACT/ProgData/icp.html>. For insured worker data, see Social Security Administration, *Disability Insured Workers*, <http://www.ssa.gov/oact/STATS/table4c2DI.html>.

³ Social Security Administration, *DI Trust Fund, A Social Security Fund*, <http://www.ssa.gov/oact/STATS/table4a2.html>. Inflation-adjusted figures computed using the seasonally-unadjusted Consumer Price Index for All Urban Consumers (CPI-U) from the Bureau of Labor Statistics at <ftp://ftp.bls.gov/pub/special.requests/cpi/cpia1.txt>. Figures are in 2011 dollars.

⁴ U.S. Congress, House Committee on Ways and Means, *The 2012 Annual Report of the Board of Trustees of the Federal Old-Age, Survivors Insurance and Federal Disability Insurance Trust Funds*, prepared by the Board of Trustees, Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, 112th Cong., 2nd sess., April 25, 2012, H.Doc. 112-102 (Washington: GPO, 2012), pp. 2-4, <http://www.ssa.gov/oact/TR/2012/index.html>, (hereinafter cited as “2012 Board of Trustees Report”). For more information on trust fund exhaustion, see CRS Report RL33514, *Social Security: What Would Happen If the Trust Funds Ran Out?*, by Christine Scott.

⁵ For information on the Old-Age and Survivors Insurance (OASI) and DI trust funds, see CRS Report RL33028, *Social Security: The Trust Fund*, by Dawn Nuschler and Gary Sidor.

Background on SSDI

Eligibility

Enacted in 1956 under Title II of the Social Security Act, SSDI is a form of social insurance designed to provide protection against the risk of economic loss from the inability to work due to a disabling condition or impairment. Administered by the Social Security Administration (SSA), SSDI provides benefits to insured workers with disabilities under the full retirement age and their dependents (spouses, widow[er]s, and children) based on an individual worker's earnings and work history in covered employment.⁶ In general, 40 work credits (quarters of coverage) are required to qualify for SSDI, 20 of which were earned in the last 10 years ending with the year of disability onset.⁷ However, individuals who become disabled before the age of 31 need fewer work credits to qualify for SSDI benefits.⁸

To satisfy the disability requirement, an insured worker must be unable to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.⁹ For 2013, SSA defines SGA as monthly earnings above \$1,740 for statutorily blind individuals and \$1,040 for non-blind individuals.¹⁰

Benefits

Cash benefits are based on a worker's past average monthly earnings, indexed to reflect changes in national wage levels (up to five years of the worker's low earnings are excluded).¹¹ SSA annually adjusts benefit levels to account for inflation through Cost-of-Living Adjustments (COLA), as measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).¹² SSA may offset cash benefits if a disabled worker also receives workers' compensation or other public disability benefits.¹³ New beneficiaries receive cash benefits after a

⁶ For more information on the SSDI program, see CRS Report RL32279, *Primer on Disability Benefits: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)*, by Umar Moulta-Ali.

⁷ 20 C.F.R. § 404.130(b). For more information on work history requirements, see Social Security Administration, *How You Earn Credits*, <http://www.ssa.gov/pubs/10072.html>. In 2013, a worker can receive one credit for each \$1,160 of earnings, up to the maximum of four credits per year.

⁸ See 20 C.F.R. § 404.130(c) and (d). Typically, individuals aged 24 to 30 who become disabled need quarters of coverage (work credits) in at least one-half of the quarters during the period ending with that quarter and beginning with the quarter after the quarter they became 21 years old. Individuals under the age of 24 generally must have at least 6 quarters of coverage in the 12-quarter period ending with the quarter in which their disability began.

⁹ 42 U.S.C. § 423(d)(1)(A).

¹⁰ See Social Security Administration, *Substantial Gainful Activity*, <http://www.ssa.gov/oact/cola/sga.html>.

¹¹ 20 C.F.R. § 404.211(e)(3).

¹² 20 C.F.R. § 404.272(a)(1). The COLA is measured as the percentage increase in the CPI-W from the third quarter of the year in which the last COLA increase became effective to the third quarter of the current year (see 20 C.F.R. § 404.274[b][iii]). For 2013, a 1.7% COLA was applied to benefits. For more information on COLA increases, see CRS Report 94-803, *Social Security: Cost-of-Living Adjustments*, by Gary Sidor.

¹³ 20 C.F.R. § 404.408(a)(1)(i). In addition, cash benefits to dependents may be subject to certain maximum family benefit limits (see 20 C.F.R. § 404.403).

five-month waiting period from the time of disability onset.¹⁴ In March 2013, the average monthly cash benefit was \$1,129.61 for a disabled worker, \$302.75 for a spouse of a disabled worker, and \$336.84 for a child of a disabled worker.¹⁵

In addition to cash benefits, disabled-worker beneficiaries also receive health care coverage under Medicare 24 months after program eligibility begins (29 months after the onset of disability).¹⁶ Moreover, SSDI beneficiaries may also meet the eligibility requirements for Supplemental Security Income (SSI).¹⁷ SSI is a needs-based program that provides cash benefits to ensure a minimum income to aged, blind, or disabled individuals with limited income and assets.¹⁸ In 2011, nearly 1.4 million disabled workers and their dependents concurrently received SSDI and SSI cash benefits.¹⁹

Determination and Adjudication Process

To initiate the claims process for SSDI benefits, an insured worker must first file an application with SSA either through the agency's website or by making an appointment at a local SSA field office.²⁰ Applications that meet the work history and SGA requirements are then forwarded to a Disability Determination Service (DDS). DDSs, which are fully funded by the federal government, are state agencies tasked with making disability determinations based on national standards established by SSA. During the disability determination process, DDS examiners—with the help of medical and psychological consultants—evaluate a claimant's medical impairment against SSA's *Listing of Impairments*. If a claimant's impairment meets (or is of equal severity to) the criteria in the listings, SSA considers the claimant to be disabled and therefore eligible for SSDI. Claimants who do not meet the medical criteria in the listings proceed to a more individualized assessment that examines their residual functional capacity to perform either any past relevant work or other work that exists in the national economy. If a claimant cannot perform such work, SSA approves his or her application for SSDI.

¹⁴ The first month counted as part of the waiting period can be no more than 17 months before the month of application. For additional information on the five-month waiting period, see CRS Report RS22220, *Social Security Disability Insurance (SSDI): The Five-Month Waiting Period for Benefits*, by Umar Moulta-Ali.

¹⁵ Social Security Administration, *Benefits Awarded by Type of Beneficiary*, <http://www.ssa.gov/OACT/ProgData/icp.html>.

¹⁶ For more information on Medicare coverage for SSDI beneficiaries, see CRS Report RS22195, *Social Security Disability Insurance (SSDI) and Medicare: The 24-Month Waiting Period for SSDI Beneficiaries Under Age 65*, by Scott Szymendera.

¹⁷ For more information on SSI requirements, see CRS Report RL32279, *Primer on Disability Benefits: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)*, by Umar Moulta-Ali.

¹⁸ SSA offsets SSI benefits based on receipt of other public benefits, including SSDI cash benefits. For more information, see CRS Report RS20294, *Supplemental Security Income (SSI): Income/Resource Limits and Accounts Exempt from Benefit Determinations*, by Umar Moulta-Ali.

¹⁹ Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program, 2011, 2012*, Table 65, p. 157, http://www.ssa.gov/policy/docs/statcomps/di_asr/2011/index.html (hereinafter cited as "SSDI Annual Report 2011").

²⁰ Claimants may also apply for SSDI by telephone or mail. For more information on the SSDI determination and adjudication process, see CRS Report R41289, *Disability Benefits Available Under the Social Security Disability Insurance (SSDI) and Veterans Disability Compensation (VDC) Programs*, by Umar Moulta-Ali.

If a claimant's application for SSDI benefits is denied at any point during the disability determination process, he or she has the right to appeal the decision.²¹ During the appeals process, claimants may present additional evidence or arguments to support their case, as well as appoint a representative to act on their behalf.²² The appeals process is composed of four stages: (1) reconsideration by a different examiner from the state DDS office, (2) a hearing before an Administrative Law Judge (ALJ), (3) a review before the Appeals Council, and (4) filing suit against SSA in U.S. district court.²³ At each stage of the appeals process, claimants or their representatives must request an appeal to the next level, in writing, within 60 days of receiving notice of the prior decision. On rare occasions, SSDI cases are appealed beyond U.S. district court to the U.S. court of appeals and, ultimately, the U.S. Supreme Court.

Trends in the SSDI Program Since 1980

Enrollment

Over the past 30 years, SSA experienced an increase in the number of SSDI applications submitted to its offices. Between 1980 and 2011, the annual number of disability applications grew 123.1% (from nearly 1.3 million to almost 2.9 million).²⁴ As **Figure 1** illustrates, most of the growth in SSDI applications began in 2000. From 1980 to 1999, the annual number of applications received by SSA remained roughly constant, averaging about 1.1 million between 1980 and 1989, and 1.3 million from 1990 to 1999; however, between 2000 and 2009, the average annual number of applications for disability rose to more than 2.0 million.

As with applications, the number of awards for disability increased as well. Between 1980 and 2011, the annual number of SSDI awards granted by SSA grew 137.9% (from over 420,300 to more than 1.0 million). However, unlike applications, awards increased at a somewhat steadier rate, averaging 408,300 between 1980 and 1989; 601,100 from 1990 to 1999; and 796,200 between 2000 and 2009. Awards as a percentage of applications for SSDI increased from 33.3% in 1980 to 52.0% in 1998, before declining to 35.4% in 2011.²⁵

SSDI awards per 1,000 insured workers rose 58.1% during this period (from 4.3 in 1980 to 6.8 in 2011). Insured workers are individuals who meet the work-history requirements for disability

²¹ 42 U.S.C. § 405.

²² 20 C.F.R. § 404.1700. Claimants may be represented by either an attorney or non-attorney during the appeals process (as defined in 20 C.F.R. § 404.1705).

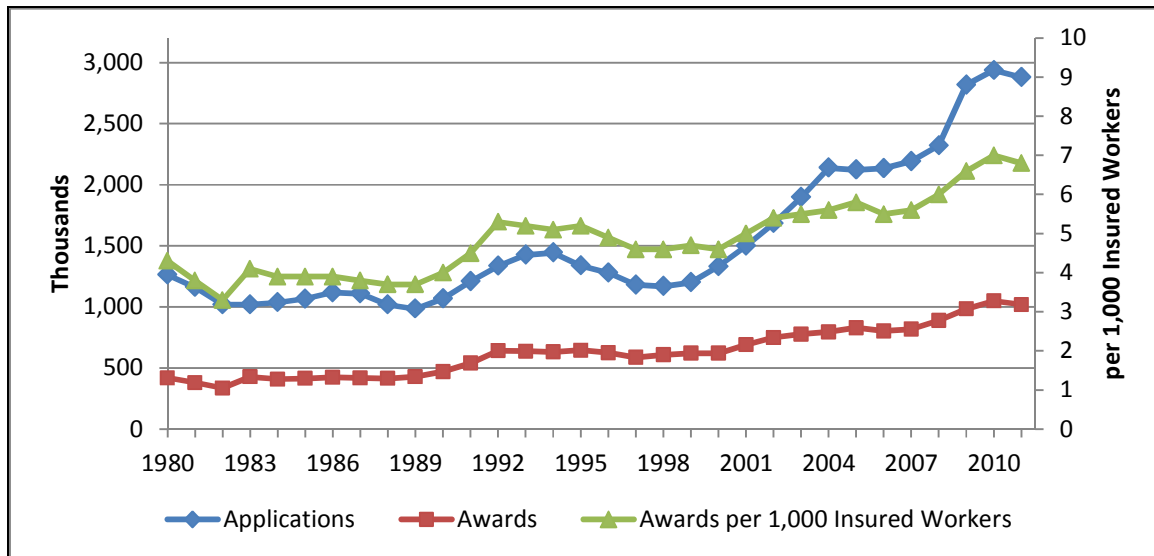
²³ See SSDI Annual Report 2011, p. 4. In 1999, SSA eliminated the reconsideration step in 10 States, as part of the Disability Redesign Prototype (Prototype) initiative, which included Alaska, Alabama, California (Los Angeles West and North Branches), Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania. Although SSA expected the initiative to result in earlier decisions and shorter wait-times for claimants, the opposite has been true. In fiscal year (FY) 2011, SSA reinstated the reconsideration step in the state of Michigan and is evaluating potential reinstatements in Colorado and other states. For more information, see CRS Report R41289, *Disability Benefits Available Under the Social Security Disability Insurance (SSDI) and Veterans Disability Compensation (VDC) Programs*, by Umar Moulta-Ali.

²⁴ Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin, 2012*, February 2013, Table 6.C7, <http://www.ssa.gov/policy/docs/statcomps/supplement/2012/6c.html> (hereinafter cited as "SSA Annual Statistical Supplement 2012").

²⁵ SSA typically measures the award rate by dividing awards by all applications minus pending claims. For more information on the award rate, see SSDI Annual Report 2011, Table 59, pp. 142-143.

benefits. The number of awards per 1,000 insured workers is a rough estimate of the enrollment (incidence) rate of disabled-worker beneficiaries in the SSDI program.²⁶

Figure I. SSDI Applications and Awards
1980-2011



Source: Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin*, 2012, February 2013, Table 6.C7.

Notes: Applications and Awards are in thousands (left axis). The measure “awards per 1,000 insured workers” is in single digits (right axis). Insured workers are individuals who meet the work-history requirements for SSDI benefits.

Terminations

In general, SSA continues to pay benefits to SSDI recipients as long as they are disabled, ineligible for OASI retirement benefits, and have monthly earnings at or below the SGA threshold. However, when SSA determines that beneficiaries no longer meet SSDI’s eligibility criteria, the agency will remove them from the program and terminate their cash and medical benefits.²⁷ Although the overall number of disabled-worker terminations increased 44.4% between 1980 and 2009 (from 434,637 to 627,648), the ratio of disabled-worker terminations to insured workers (hereinafter “termination rate”) actually decreased 45.3% (from 145.4 to 79.5 disabled-worker terminations per 1,000 insured workers).²⁸

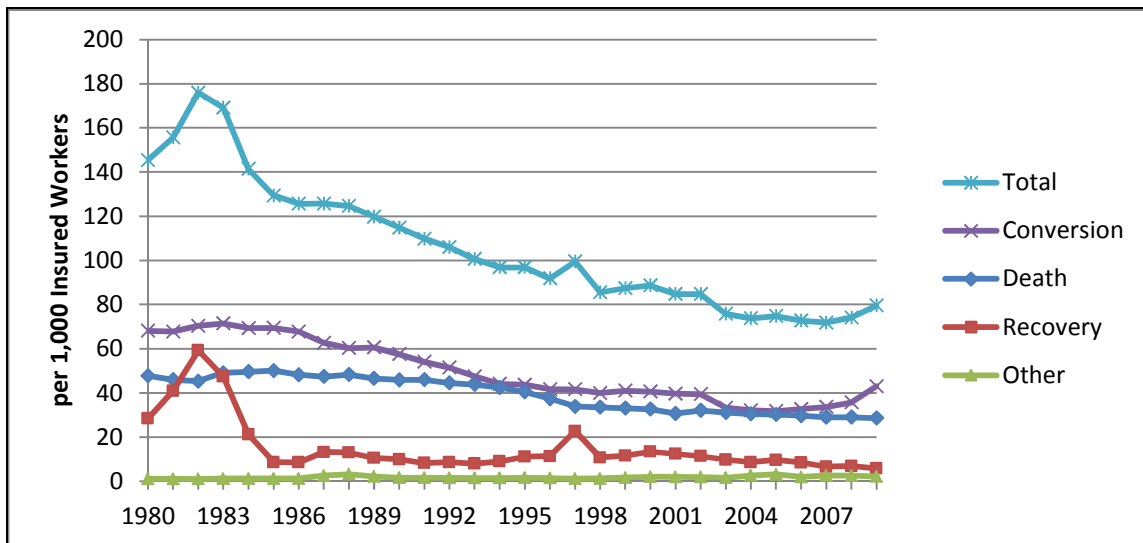
²⁶ The Social Security Board of Trustees measures the disability enrollment (incidence) rate as “the ratio of the number of new beneficiaries awarded benefits each year to the number of individuals who meet insured requirements but are not yet receiving benefits (the disability-exposed population).” For more information on the incidence rate, see 2012 Board of Trustees Report, p. 125.

²⁷ Recipients whose cash benefits were terminated due to earnings above SGA may still be eligible for up to 93 months of premium-free Medicare Part A (Hospital Insurance) following a Trial Work Period (TWP). See SSDI Annual Report 2011, p. 6. For more information on return-to-work incentives and TWP, see the subsection of the report entitled “Return-to-Work Incentives.”

²⁸ Tim Zayatz, *Social Security Disability Insurance Program Workers Experience: Actuarial Study No. 114*, Social Security Administration, 1999, Table 5, and subsequent editions, <http://www.ssa.gov/oact/NOTES/actstud.html>.

As depicted in **Figure 2**, three main factors drive the termination rate: death, conversion, and recovery. The beneficiary death rate decreased 40.2% between 1980 and 2009 (from 47.8 to nearly 28.6 disabled-worker terminations per 1,000 insured workers), reflecting the trend in the U.S. population of declining mortality rates across all age groups.²⁹ Between 1980 and 2009, the conversion rate fell 36.9% (from 68.1 to almost 43.0 disabled-worker terminations per 1,000 insured workers). A conversion termination occurs when SSA automatically converts a disabled-worker benefit to a retired-worker benefit under the Old-Age and Survivors Insurance (OASI) program due to a disabled worker reaching full retirement age (FRA). FRA is the age at which unreduced retirement benefits are first payable.³⁰ From 1980 to 2009, the recovery rate declined 79.6% (from 28.5 to about 5.8 disabled-worker terminations per 1,000 insured workers). Recovery refers to individuals removed from SSDI because they no longer meet SSA’s definition of disability due either to a medical improvement or demonstrable ability to engage in SGA.

Figure 2. SSDI Disabled-Worker Termination Rates
By Type (1980-2009)



Source: Tim Zayatz, *Social Security Disability Insurance Program Workers Experience: Actuarial Study No. 114*, Social Security Administration, 1999, Table 5, and subsequent editions.

Notes: Data from 1980 to 1985 compiled from Actuarial Study No. 114, while data from 1986 to 2009 compiled from Actuarial Study No. 122.

The rise in the recovery rate during the early 1980s stemmed mainly from the enactment of the Social Security Disability Amendments of 1980 (P.L. 96-265), which expanded the use of continuing disability reviews (CDR) for all non-permanently disabled beneficiaries.³¹ CDRs are periodic medical reevaluations to determine whether disabled beneficiaries continue to meet

²⁹ Donna L. Hoyert, *75 Years of Mortality in the United States, 1935–2010*, Centers for Disease Control and Prevention: National Center for Health Statistics, 2012, <http://www.cdc.gov/nchs/data/databriefs/db88.htm>.

³⁰ FRA is currently 66; however, FRA will reach 67 for workers born in 1960 or later. For more information on FRA, see CRS Report R42035, *Social Security Primer*, by Dawn Nuschler.

³¹ For more information on the Social Security Disability Amendments of 1980, see John R. Kearney, “Social Security and the “D” in OASDI: The History of a Federal Program Insuring Earners Against Disability,” *Social Security Bulletin*, vol. 66 no. 3 (August 2006), <http://www.ssa.gov/policy/docs/ssb/v66n3/v66n3p1.html> (hereinafter cited as “Kearney 2006”).

SSA's definition of disability.³² A major review of the SSDI program after the passage of the 1980 amendments resulted in a significant increase in the recovery rate between 1980 and 1982.³³ However, the political backlash over the implementation of the reviews led to a 1983 temporary moratorium on CDRs for most mental impairment cases and an increase in the percentage of beneficiaries designated as permanently disabled and therefore subject to less frequent reviews.³⁴ Consequently, the recovery rate fell below its 1980 level.³⁵

The 1997 increase in the recovery rate largely resulted from the passage of the Contract with America Advancement Act of 1996 (P.L. 104-121), which terminated the benefits of SSDI and SSI recipients whose drug addiction and alcoholism (DA&A) significantly contributed to their disability.³⁶ However, since DA&A beneficiaries represented only around 2.6% of all disabled adults on SSDI and SSI in 1996 and new applicants could no longer claim disability based on DA&A, P.L. 104-121's impact on the overall trend in the SSDI recovery rate was minimal.³⁷

Starting in 2002, the recovery rate contracted again, in part because of a reduction in the number of medical CDRs performed by SSA. The Contract with America Advancement Act of 1996 authorized additional funds for CDRs but only for fiscal year (FY) 1996 through FY2002.³⁸ In FY2003, the additional funding for CDRs lapsed and SSA shifted its focus away from CDRs toward processing the growing number of initial disability claims.³⁹ As a result, the number of medical CDRs performed by SSA dropped from an all-time high of 876,802 in FY2000 to 207,637 in FY2007, before climbing back up to 443,233 in FY2012.⁴⁰

³² Non-permanently disabled beneficiaries with a reasonable chance of recovery receive a CDR every three years. Disabled beneficiaries with a high probability of medical improvement typically receive a CDR at intervals between 6 months and 18 months following their most recent decision. Disabled beneficiaries with a low probability of medical improvement (permanently disabled) receive CDRs less frequently, generally at intervals determined by the Social Security Commissioner (normally every five to seven years). For more information, see 20 C.F.R. § 404.1590.

³³ According to SSA officials, the rise in the termination rate during the early 1980s is not entirely attributable to the accelerated use of CDRs. An initiative begun in 1981 by SSA aggressively targeted beneficiaries whom the agency believed were unlikely to have a disability or impairment, despite being on the rolls. This initiative, coupled with the increased use of CDRs, resulted in an increase in the recovery rate for SSDI beneficiaries in the early 1980s. For more information, see U.S. Government Accountability Office, *Social Security Disability Programs: Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently*, GAO-07-8, October 3, 2006, p. 6, "The Disability Benefits Reform Act of 1984", <http://www.gao.gov/products/GAO-07-8>.

³⁴ Kearney 2006, p. 16.

³⁵ The Disability Benefits Reform Act of 1984 enshrined some of the 1983 reforms into law. For more information on how the 1984 amendments affected program participation, see the subsection of the report entitled "The Disability Benefits Reform Act of 1984."

³⁶ The act stopped awarding benefits to DA&A claimants on the day of enactment, March 29, 1996. DA&A beneficiaries who appealed the termination continued to receive benefits while they waited for a decision. For more information, see Paul Davies, Howard Iams, and Kalman Rupp, "The Effect of Welfare Reform on The SSA's Disability Programs: Design of Policy Evaluation and Early Evidence," *Social Security Bulletin*, vol. 63 no. 1 (July 2000), p. 4, <http://www.ssa.gov/policy/docs/ssb/v63n1/index.html>.

³⁷ *Ibid.*, p. 6.

³⁸ 42 U.S.C. § 401(g)(1)(A).

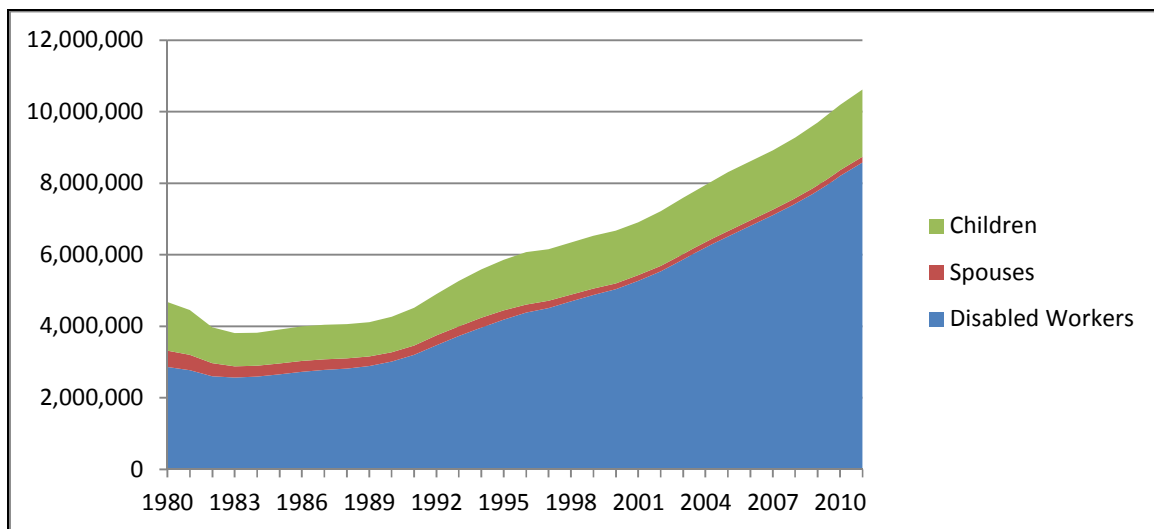
³⁹ Social Security Administration, *Social Security Administration, Performance and Accountability Report, Fiscal Year 2003*, November 10, 2003, and subsequent editions, <http://www.ssa.gov/finance/>.

⁴⁰ FY2000 data is from the Social Security Advisory Board, *Aspects of Disability Decision Making: Data and Materials*, February 2012, Table 13, p. 18, http://www.ssab.gov/PublicationViewOptions.aspx?ssab_pub=115, while FY2007 and FY2012 data is from the Social Security Administration, *Social Security Administration, Performance and Accountability Report, Fiscal Year 2012*, November 8, 2012, p. 80, <http://www.ssa.gov/finance/>.

Program Size

Between 1980 and 2011, the overall number of disabled-worker beneficiaries and their dependents increased 125.5% (from about 4.7 million to more than 10.6 million).⁴¹ Most of the growth in the program stemmed from disabled-worker beneficiaries, whose ranks rose from around 2.9 million to almost 8.6 million—an increase of 196.6% (**Figure 3**). Conversely, the number of spouses of disabled workers on SSDI decreased 64.5% during this period (from almost 461,900 to more than 164,000). The number of children of disabled workers receiving benefits expanded rather modestly compared with disabled workers, increasing 35.7% (from nearly 1.4 million in 1980 to roughly 1.9 million in 2011).

Figure 3. SSDI Disabled-Worker Beneficiaries and Their Dependents
1980-2011



Source: Computed from the Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program, 2011*, Table 1, p. 17.

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

The size of the SSDI program is largely the function of two main factors: the incidence (enrollment) rate of beneficiaries in the program and the termination rate of beneficiaries from the program.⁴² From 1980 to 2011, a marked rise in the incidence rate, coupled with a steady decline

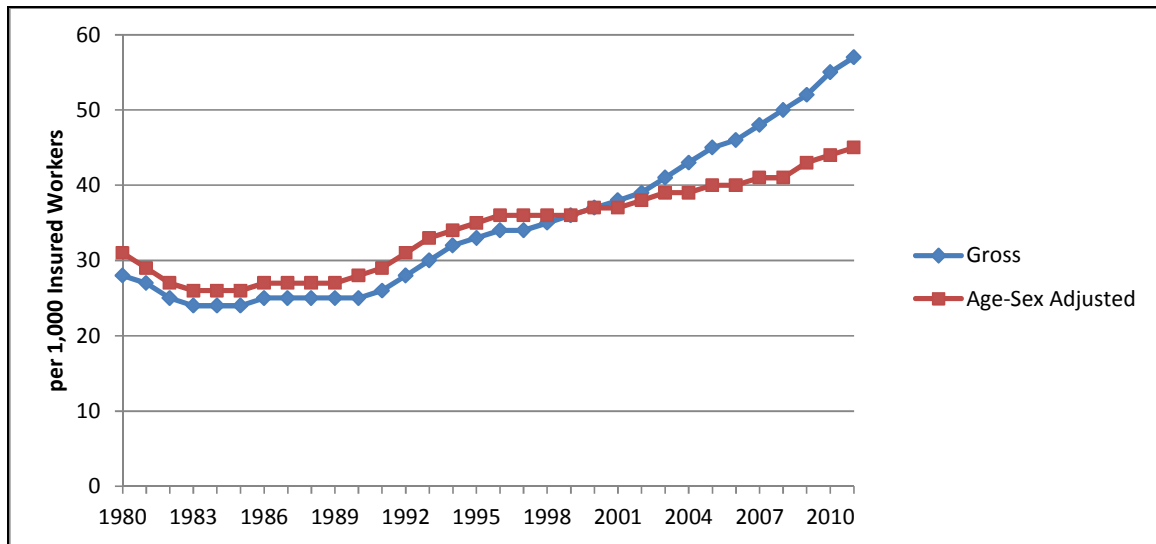
⁴¹ SSDI Annual Report 2011, Table 1, p. 17.

⁴² In addition to the incidence and termination rates, the size of the SSDI program is determined by a third factor: the duration of benefit receipt. A beneficiary’s length of stay on SSDI is primarily a function of his or her age and diagnosis. Duration of benefit receipt is discussed in the “The Disability Benefits Reform Act of 1984” subsection of the report. For more information on the determinants to program size, see Social Security Administration, *Trends in the Social Security and Supplemental Security Income Disability Programs*, SSA Publication No. 13-11831, August 2006, p. 37, http://www.ssa.gov/policy/docs/chartbooks/disability_trends/index.html (hereinafter cited as “SSA, Trends in (continued...)”).

in the termination rate, resulted in an appreciable increase in the number of beneficiaries on SSDI. The prevalence rate measures the total number of disabled-worker beneficiaries relative to the overall insured-worker population in a given year. Between 1980 and 2011, the gross (unadjusted) prevalence rate grew 103.6% (from 28 to 57 disabled-worker beneficiaries per 1,000 insured workers; **Figure 4**).⁴³ With the increase in the gross prevalence rate, the fraction of the working-age resident population (aged 18-64) receiving SSDI benefits rose from 2.1% in 1980 to 4.6% in 2011.⁴⁴

Figure 4. SSDI Disabled-Worker Prevalence Rates

1980-2011



Source: The Social Security Board of Trustees, *The 2012 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, Table V.C5, p. 131.

Notes: The age-sex-adjusted rate is set to the age-sex distribution of the insured-worker population in the year 2000.

When one adjusts the prevalence rate to control for the effects of changes in the age-sex distribution of the insured-worker population over time, the upward trend remains conspicuous, albeit somewhat less pronounced. Age-sex adjusting permits a more “meaningful comparison” over extended periods, insofar as it “isolates the changing trend in the true likelihood of receiving benefits for the insured population, without reflecting changes in the age distribution of the population.”⁴⁵ From 1980 to 2011, the age-sex-adjusted prevalence rate grew 45.2% (from 31 to 45 disabled-worker beneficiaries per 1,000 insured workers).

(...continued)

SSDI 2006”.

⁴³ 2012 Board of Trustees Report, Table V.C5, p. 131.

⁴⁴ 1980 data is from the U.S. General Accounting Office (now called U.S. Government Accountability Office), *Social Security Disability Rolls Keep Growing, While Explanations Remain Elusive*, HEHS-94-34, February 1994, p. 3, <http://www.gao.gov/products/HEHS-94-34> (hereinafter cited as “GAO, Disability Rolls Keep Growing 1994”), while 2011 data is from SSDI Annual Report 2011, Table 8, p. 29.

⁴⁵ 2012 Board of Trustees Report, p.134.

Factors Behind the Growth in SSDI Rolls

Some disagree over the primary drivers behind the increase in the ratio of disabled-worker beneficiaries to insured workers. The growing gap between the gross and age-sex-adjusted prevalence rates suggests that changes in the age-sex distribution of the insured-worker population have contributed to the increase in the SSDI prevalence rate over time (**Figure 4**). However, the increase in the age-sex-adjusted prevalence rate indicates that the growth in SSDI rolls is not entirely attributable to changes in the age-sex distribution of the population. Changes in the economic incentives to apply for SSDI, inconsistency in the administration of the program, and legislative changes to federal policy may have also helped to increase the prevalence of SSDI receipt among the insured-worker population. This section examines some of the more salient explanations for the rise in SSDI rolls, as well as discusses other potential factors.

Changes in the Demographic Characteristics of Insured Workers

Part of the reason why SSDI rolls have expanded stems from the growth in the size of the insured-worker population.⁴⁶ Between 1980 and 2010, the U.S. working-age population (aged 18-64) increased 41.6% (from more than 137.2 million to almost 194.3 million), whereas the number of workers insured in the event of disability grew 49.8% (from nearly 100.5 million to around 150.5 million).⁴⁷ The combination of an increase in the number of insured workers due to population growth and a rise in the percentage of the working-age population insured for disability resulted in an expansion in the size of the insured-worker population.⁴⁸ In addition, the rise in the incidence of benefit receipt among the disability-exposed population has played a role in exacerbating the growth in SSDI rolls. From 1980 to 2009, the gross incidence (enrollment) rate grew 56.8% (from 4.4 to 6.9 awards per 1,000 disability-exposed workers).⁴⁹ The following subsection investigates how changes in the

Helpful Definitions

Insured-Worker Population: The total number of workers who meet the work-history requirements for disability benefits

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

Disability-Exposed Population: The total number of workers who meet insured requirements but are not yet receiving benefits

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

⁴⁶ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Johnson Announces Hearing on the Financing Challenges Facing the Social Security Disability Insurance Program*, Testimony of Stephen C. Goss, Chief Actuary of the Social Security Administration, 113th Cong., 1st sess., March 14, 2013, p. 4, http://waysandmeans.house.gov/uploadedfiles/goss_testimony.pdf (hereinafter cited as “Testimony of Stephen C. Goss 2013”).

⁴⁷ The 1980 working-age population data is from GAO, *Disability Rolls Keep Growing* 1994, p. 3, while 2010 working-age population data is from the U.S. Census Bureau, *Annual Estimates of the Resident Population by Sex and Selected Age Groups for the United States: April 1, 2010 to July 1, 2011*, NC-EST2011-02, <http://www.census.gov/popest/data/national/asrh/2011/index.html>. Insured worker data computed from the Social Security Administration, *Disability Insured Workers*, <http://www.ssa.gov/oact/STATS/table4c2DI.html>.

⁴⁸ Testimony of Stephen C. Goss, 2013, p. 4. According to the Chief Actuary, the growth in the share of the population insured for disability between 1980 and 2010 increased the number of disabled-worker beneficiaries by 8%.

⁴⁹ Tim Zayatz, *Social Security Disability Insurance Program Workers Experience: Actuarial Study No. 114*, Social Security Administration, 1999, Table 4, and subsequent editions, <http://www.ssa.gov/oact/NOTES/actstud.html>. The disability-exposed population excludes insured workers who receive SSDI benefits, whereas the insured-worker population measure includes them. For more information, see 2012 Board of Trustees Report, p. 125.

demographic characteristics of the population may have increased both the size and incidence rate of the insured-worker population, thereby enlarging disability rolls.

A Sharp Rise in the Number and Incidence Rate of Female Insured Workers

The latter half of the 20th century witnessed a marked expansion of women in the labor force. Between 1950 and 1999, the labor force participation rate for women aged 16 and older nearly doubled (from 33.8% to an all-time high of 60.0%).⁵⁰ The higher participation rate afforded more women the opportunity to earn enough quarters of coverage to qualify for disability insurance. From 1980 to 2010, the number of female workers insured for disability rose 79.9% (from almost 40.2 million to more than 72.3 million).⁵¹ Whereas the share of working-age men (aged 15-64) insured for disability declined during this period from 77% to 74%, the portion of working-age women insured for disability increased from 51% to 68%.⁵²

The growth in the size of the female insured-worker population coincided with a rapid rise in the incidence rate of women in the SSDI program. Whereas the age-adjusted incidence rate for men entering the SSDI program increased 22.0% between 1986 and 2009 (from 5.0 to 6.1 awards per 1,000 disability-exposed male workers), the age-adjusted incidence rate for women rose 68.6% (from 3.5 to 5.9 awards per 1,000 disability-exposed female workers).⁵³ According to the Social Security Board of Trustees, the increase in the incidence of benefit receipt among female insured workers helped propel the age-sex-adjusted prevalence rate upward.⁵⁴ However, SSA's Chief Actuary projects that both male and female age-adjusted incidence rates should stabilize between five and six awards per 1,000 disability-exposed workers in the future.⁵⁵

A Shift in the Age Distribution of Insured Workers

In addition to the rise in women's labor force participation, the aging of the large baby boom generation—individuals born between 1946 and 1964—also contributed to the increase in SSDI rolls.⁵⁶ Beginning in 1996, working-age baby boomers increasingly entered their most disability-prone years (aged 50 to full retirement age [FRA]), thereby shifting the age distribution of the insured-worker population from younger workers (aged 25 to 44) to older workers (aged 45 to FRA).⁵⁷

⁵⁰ Bureau of Labor Statistics, *Labor Force Statistics from the Current Population Survey*, <http://data.bls.gov/timeseries/LNS11300002>. The labor force participation rate for women has since fallen to 57.1% as of March 2013.

⁵¹ Social Security Advisory Board, *Aspects of Disability Decision Making: Data and Materials*, February 2012, Table 2a, p. 7, http://www.ssab.gov/PublicationViewOptions.aspx?ssab_pub=115 (hereinafter cited as "SSAB Data and Materials 2012").

⁵² *Ibid.*, Table 2b.

⁵³ Tim Zayatz, *Social Security Disability Insurance Program Workers Experience: Actuarial Study No. 122*, Social Security Administration, 2011, Table 4, <http://www.ssa.gov/oact/NOTES/actstud.html>. Age adjustment computed using the age distribution of the disability-exposed population in the year 2000.

⁵⁴ 2012 Board of Trustees Report, p.133.

⁵⁵ Testimony of Stephen C. Goss 2013, pp. 7-8.

⁵⁶ 2012 Board of Trustees Report, p.133-134. See also Xuguang (Steve) Guo and John F. Burton, Jr., "The Growth in Applications for Social Security Disability Insurance: A Spillover Effect from Workers' Compensation," *Social Security Bulletin*, vol. 72 no. 3, (August 2012), <http://www.ssa.gov/policy/docs/ssb/v72n3/v72n3p69.html> (hereinafter cited as "Guo and Burton, Jr. 2012").

⁵⁷ Congressional Budget Office, *Policy Options for the Social Security Disability Insurance Program*, 4207, July 2012, (continued...)

The shift from younger to older insured workers helped to increase the gross incidence and prevalence rates, inasmuch as older workers have a higher likelihood of benefit receipt relative to younger workers.⁵⁸ In making a disability determination, DDS examiners take into account the claimant's medical condition, as well as vocational factors such as age, education, and work experience. Since eligibility criteria typically become less stringent with age, SSA is more likely to award benefits to older insured workers compared to younger workers.⁵⁹ Between 1986 and 2009, the portion of SSDI benefits awarded to younger insured workers (aged 25-44) decreased from 30.0% to 22.0%, whereas the share of benefits awarded to older workers (aged 45 to FRA) increased from 66.7% to 75.5%.⁶⁰ However, the Social Security Board of Trustees expects the gross prevalence rate to grow more slowly in the future as baby boomers increasingly become eligible for full OASI retirement benefits.⁶¹

Slightly Higher Work-Limiting Disability Rates

Changing trends in the health status of the U.S. population may have also helped to enlarge SSDI rolls. Over the past 40 years, advances in medical care and technology significantly reduced the death rate in the United States.⁶² Between 1970 and 2010, the crude (unadjusted) mortality rate fell 15.4 % (from 945.3 to 799.5 deaths per 100,000 population).⁶³ When one controls for the effects of the aging U.S. population, the reduction in mortality is even more pronounced. From 1970 to 2010, the age-adjusted mortality rate declined 38.9% (from 1,222.6 to 747.0 deaths per 100,000 population).⁶⁴

The decreased likelihood of dying in a given year helped to increase the chance of an individual surviving to his or her most disability-prone years (aged 50 to FRA). One study found that only 68% of males born in 1921 survived to the age of 60 compared with 78% of males born in 1941.⁶⁵ The increased likelihood of surviving to their most disability-prone years may have lowered the overall health of the insured-worker population, consequently raising the incidence of benefit receipt. According to data from the Current Population Survey (CPS), the share of men and

(...continued)

p. 7, <http://www.cbo.gov/publication/43421> (hereinafter cited as "CBO, Policy Options 2012"). For insured worker data, see Social Security Administration, *Disability Insured Workers*, <http://www.ssa.gov/oact/STATS/table4c2DI.html>. See also Mark Duggan and Scott A. Imberman, "Why Are the Disability Rolls Skyrocketing? The Contribution of Population Characteristics, Economic Conditions, and Program Generosity," in *Health at Older Ages: The Causes and Consequences of Declining Disability among the Elderly*, ed. David M. Cutler and David A. Wise, National Bureau of Economic Research (University of Chicago Press, 2009), pp. 342-345, <http://www.nber.org/chapters/c11119> (hereinafter cited as "Duggan and Imberman 2009").

⁵⁸ 2012 Board of Trustees Report, pp.125-134. See also CBO, Policy Options 2012, p. 7.

⁵⁹ See 20 C.F.R. § 404.1563. For more information on vocational factors, please see *Appendix 2 to Subpart P of Part 404 - Medical-Vocational Guidelines* in 20 C.F.R. § 404.

⁶⁰ Tim Zayatz, *Social Security Disability Insurance Program Worker Experience: Actuarial Study No. 122*, Social Security Administration, 2011, Table 3, <http://www.ssa.gov/oact/NOTES/actstud.html>. The share of benefits awarded to workers aged 15 to 24 decreased as well, from 3.3% in 1986 to 2.5% in 2009.

⁶¹ 2012 Board of Trustees Report, pp.133-134.

⁶² David R. Francis, *Why do Death Rates Decline?*, National Bureau of Economic Research, <http://www.nber.org/digest/mar02/w8556.html>.

⁶³ Centers for Disease Control and Prevention, *Deaths: Final Data for 2010*, Table 1, http://www.cdc.gov/nchs/data/dvs/deaths_2010_release.pdf.

⁶⁴ Ibid.

⁶⁵ Duggan and Imberman 2009, p. 349.

women aged 21-64 reporting a work limitation due to a disability rose from 7.9% in 1981 to 8.5% in 2011.⁶⁶ However, some researchers contend that the health of individuals in their most disability-prone years has actually improved since 1980.⁶⁷ In fact, one study concluded that the improved health of individuals aged 50-64 might have slowed the growth in SSDI rolls between 1984 and 2002.⁶⁸

Part of the problem in determining the trend in the prevalence of work-limiting disabilities in the U.S. population stems from the fact that there is no single, universally accepted definition or measure of disability.⁶⁹ Although many of the large demographic surveys used by researchers and the federal government specifically ask questions pertaining to work-limiting disabilities, the wording and complexity of the questions often differs. Moreover, because surveys are self-reporting, the definition of what constitutes a work-limiting disability often rests entirely on the subjectivity of the respondent. That said, given the relatively small increase in the CPS measured disability prevalence rate, it seems unlikely that the change in the prevalence of work-limiting disabilities in the U.S. population can adequately explain the growth in SSDI rolls.

Changes in the Economic Incentives to Apply for SSDI

The decision to apply for SSDI may be influenced not only by health status but also by economic opportunities. The relative value of SSDI cash and medical benefits may induce individuals with limited income and assets to apply to the program. Although the initial determination process screens out most non-meritorious claimants, SSA may grant awards to some claimants on the margin of program entry who could potentially work but choose not to due to economic circumstances. This subsection outlines how changes in the economic incentives to apply for SSDI may have increased the incidence of benefit receipt and thus expanded disability rolls.

A Rise in the Unemployment Rate

During periods of strong economic growth, individuals who qualify for SSDI might forgo applying for benefits and decide to seek or continue employment. However, when adverse shocks to the national economy reduce growth and increase unemployment, individuals who might otherwise choose to work may instead apply for SSDI benefits as a form of unemployment assistance. An extensive body of literature has empirically found a positive relationship between the unemployment rate and SSDI application rate.⁷⁰ With the exception of the period between

⁶⁶ Nazarov, Z, Lee, C. G. (2012). *Disability Statistics from the Current Population Survey (CPS)*. Ithaca, NY: Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics (StatsRRTC). Retrieved February 21, 2013 from www.disabilitystatistics.org. The margin of error for both years is ± 0.2 .

⁶⁷ David Autor and Mark Duggan, *The Growth in the Social Security Disability Rolls: A Fiscal Crisis Unfolding*, National Bureau of Economic Research, Working Paper no.12436, August 2006, p. 17, <http://www.nber.org/papers/w12436> (hereinafter cited as “Autor and Duggan 2006”). See also Duggan and Imberman 2009.

⁶⁸ Duggan and Imberman 2009, p. 354

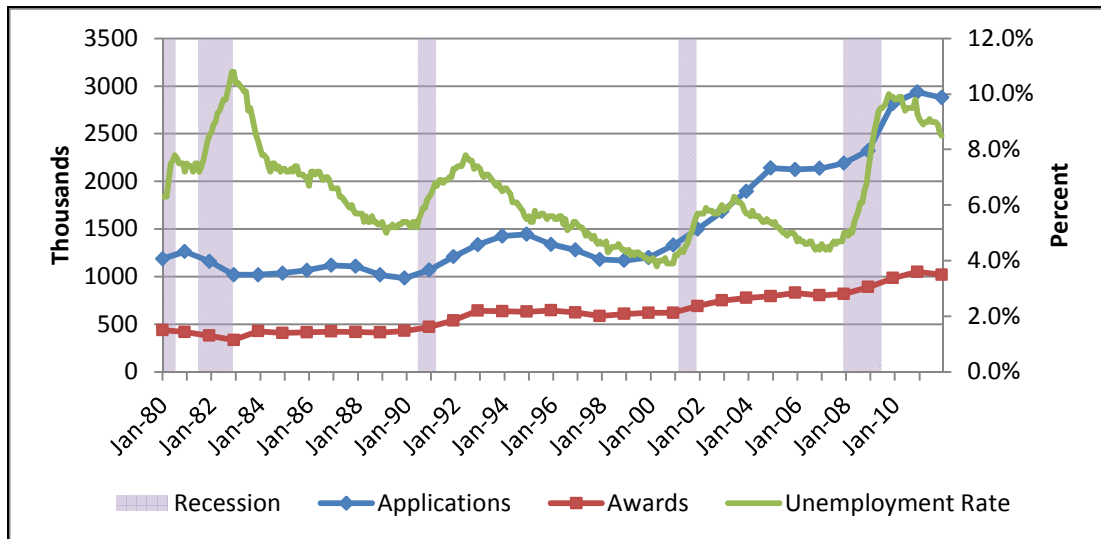
⁶⁹ Disability Statistics, *Frequently Asked Questions: What is the definition of disability?*, Maintained by Cornell University, 2013, <http://www.disabilitystatistics.org/faq.cfm#Q3>. See also SSA, Trends in SSDI 2006, p. 68.

⁷⁰ See Kalman Rupp and David Stapleton, *Determinants of the Growth in the Social Security's Administration's Disability Programs: An Overview*, Social Security Administration, vol. 58, no. 4, 1995, <http://www.ssa.gov/policy/docs/ssb/v58n4/v58n4p43.pdf> (hereinafter cited as “Rupp and Stapleton 1995”). See also David H. Autor and Mark G. Duggan, “The Rise in the Disability Rolls and the Decline in Unemployment,” *The Quarterly Journal of Economics*, February 2003, pp. 158-205. In addition, see Guo and Burton, Jr. 2012, p. 78.

1980 and 1984, instances of high unemployment are associated with an increase in SSDI applications. As **Figure 5** illustrates, the recent recession (December 2007 to June 2009) contributed to a conspicuous spike in the number of SSDI applications submitted to SSA; between 2007 and 2009, SSDI applications increased 27.3% (from almost 2.2 million to more than 2.8 million).⁷¹

Figure 5. SSDI Applications and Awards During Instances of High Unemployment

January 1980 – December 2011



Source: Application and Award data compiled from the Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin*, 2012, February 2013, Table 6.C7. Unemployment data is from the Bureau of Labor Statistics (BLS). Recession data is from the National Bureau of Economic Research (NBER).

Notes: Applications and Awards are in thousands (left axis). The unemployment rate (right axis) is the number of all unemployed individuals aged 16 and older as a percentage of the civilian non-institutionalized labor force. BLS considers individuals to be unemployed if they do not have a job, have actively looked for work in the past four weeks, and are currently available for work. Shaded areas indicate a recession. NBER defines recession as a “significant decline in economic activity spread across the economy, lasting more than a few months, normally visible in real Gross Domestic Product (GDP), real income, employment, industrial production, and wholesale-retail sales.”

The relationship between the unemployment rate and the number of SSDI awards granted by SSA is somewhat more ambiguous, inasmuch as the award year may not coincide with the application year due to a prolonged determination or appeals process.⁷² Moreover, one study found that a claimant’s likelihood of receiving an award at the initial determination level decreases as the

⁷¹ SSA Annual Statistical Supplement 2012, Table 6.C7. Although there is no official definition of recession, federal agencies such as the Bureau of Economic Analysis (BEA) generally use the definition of recession outlined by the National Bureau of Economic Research (NBER)—a private, non-profit research organization. NBER does not use the often-cited definition of recession as two consecutive quarters of decline in real Gross Domestic Product (GDP). Instead, the organization defines recession as a “significant decline in economic activity spread across the economy, lasting more than a few months, normally visible in real GDP, real income, employment, industrial production, and wholesale-retail sales.” For more information, see the National Bureau of Economic Research, *US Business Cycle Expansions and Contractions*, <http://www.nber.org/cycles.html>.

⁷² Duggan and Imberman 2009 p. 355

unemployment rate rises.⁷³ Nevertheless, the overall number of SSDI awards issued by SSA does appear to increase during instances of high unemployment, albeit to a lesser extent relative to the number of SSDI applications.⁷⁴ Between 2007 and 2009, the number of SSDI awards granted by SSA increased 20.3% (from 818,500 to 984,500).⁷⁵

An Increase in the Relative Replacement Wage

In addition to changes in the business cycle, the value of cash benefits relative to potential earnings may also affect a worker's decision to apply for SSDI. Disability insurance protects workers against the risk of economic loss from the inability to work due to a disabling condition or impairment by providing a partial replacement wage (cash benefits). Although SSA bases the value of the replacement wage on a worker's past nominal earnings, the agency also indexes or adjusts the replacement wage to reflect changes in the average national wage level over time, as measured by the Average Wage Index (AWI).⁷⁶ As a result, a high relative replacement wage may encourage workers who have the ability to obtain some form of employment not to work and apply for SSDI instead.⁷⁷

The influence of the relative replacement wage on an individual's decision to apply for SSDI may especially affect low-income workers, to the extent that said workers have experienced slower real income growth relative to medium and high-wage earners since 1980. Whereas the real earnings of low-income workers (10th percentile) grew 12% between 1980 and 2004, the real earnings of medium-income workers (50th percentile) and high-income workers (90th percentile) increased 15% and 36%, respectively.⁷⁸ The widening distribution of income during this period helped to expand the national AWI, thereby increasing the value of the indexed replacement wage for low-income workers relative to their slower growing real earnings.⁷⁹

The combination of sluggish real wage growth and rising replacement rates may have impelled low-income workers to apply for SSDI as a means of enhancing their annual compensation. One study found that the "wage gap" between low-skilled workers with only a high school degree and workers with additional education accounted for 68.4% of the variation in SSDI applications

⁷³ Kalman Rupp, "Factors Affecting Initial Disability Allowance Rates for the Disability Insurance and Supplemental Security Income Programs: The Role of the Demographic and Diagnostic Composition of Applicants and Local Labor Market Conditions," *Social Security Bulletin*, vol. 72 no. 4, (November 2012), p. 32, <http://www.ssa.gov/policy/docs/ssb/v72n4/v72n4p11.html>. Rupp found that an increase in the state unemployment rate is associated with a decrease in the initial allowance rate. The allowance rate is the number of medical allowances divided by the number of medical decisions. Unlike the award rate (awards divided by applications minus pending claims), the allowance rate does not include technical denials at the initial determination level. Technical denials are issued when a claimant fails to meet the non-disability eligibility requirements (i.e., work history and earnings).

⁷⁴ Rupp and Stapleton 1995, p. 56

⁷⁵ SSA Annual Statistical Supplement 2012, Table 6.C7.

⁷⁶ For more information on how benefits are calculated, see CRS Report R42035, *Social Security Primer*, by Dawn Nuschler.

⁷⁷ For more information, see L. Scott Muller, "The Effects of Wage Indexing on Social Security Disability Benefits," *Social Security Bulletin*, vol. 68 no. 3, (December 2008), p. 25, <http://www.ssa.gov/policy/docs/ssb/v68n3/v68n3p1.html> (hereinafter cited as "Muller 2008").

⁷⁸ CRS Report RL34155, *Income Inequality and the U.S. Tax System*, by Thomas L. Hungerford.

⁷⁹ See Autor and Duggan 2006, Table 2. See also Muller 2008, Table 1.

between 1978 and 2008.⁸⁰ However, researchers are divided over the extent to which rising replacement wage rates induce low-income workers to apply for SSDI benefits.⁸¹

The Value of Health Care Benefits

Access to health care could also affect an individual's decision to apply for SSDI. Over the years, the cost of health insurance has grown considerably. Between 1999 and 2010, the average annual total premium (employer and employee) for family coverage rose 137.8% (from \$5,791 to \$13,770).⁸² The marked increase in the cost of premiums has made it exceedingly difficult for many individuals and employers to continue paying for health insurance. From 1999 to 2010, the share of the population covered by private health insurance declined from 73.0% to 64.0%.⁸³ Because of the high cost of treating and managing chronic or severe medical conditions on their own, individuals with disabilities who lack health insurance may apply for SSDI in order to qualify for Medicare. Therefore, the rising cost of private medical insurance might have played a role in driving up the SSDI prevalence rate.⁸⁴

However, the recently enacted Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) could help to reduce the number of individuals who apply for SSDI in order to qualify for Medicare in the future. ACA is designed to increase access to affordable health insurance for individuals without coverage and make health insurance more affordable for those already covered.⁸⁵ To expand the availability of affordable health insurance, ACA requires the establishment of state-based insurance exchanges for the purchase of health insurance and sets federal minimum requirements for the private health insurance market. Moreover, the act provides federal subsidies to certain individuals and families to reduce the cost of purchasing health insurance coverage, as well as expands eligibility for Medicaid. By making health insurance more affordable for individuals without coverage, ACA may reduce the incentives to

⁸⁰ Dana A. Kerr and Bert J. Smoluk, "Macroeconomic Influences on Social Security Disability Insurance Application Rates," *Journal of Insurance Issues*, vol. 34, no. 2 (2011), pp. 112-150, http://econpapers.repec.org/article/wrijournal/v_3a34_3ay_3a2011_3ai_3a2_3ap_3a112-150.htm. The authors compute the wage gap "by dividing a national labor productivity index produced from data published by the Bureau of Labor Statistics by the annual earnings of workers with only a high school degree." The wage gap measures "the decline in relative earnings power of individuals with only a high school degree."

⁸¹ See Autor and Duggan 2006, as well as Muller 2008. Muller contends that the overall increase in the average replacement rate does not offer low-income workers large incentives to drop out of the labor force and apply for SSDI, especially since changes in replacement rates appear much smaller for low-income earners relative to medium and high-income earners (author's calculations). Autor and Duggan argue that the high-wage replacement of SSDI benefits relative to available compensation makes SSDI enrollment particularly attractive to low-income workers, citing that in 2004, males aged 40 to 64 without a high school degree were five times as likely to receive SSDI benefits relative to males with a college degree (authors' calculations).

⁸² Kaiser Family Foundation, *Health Care Costs: A Primer*, Figure 16, May 9, 2012, p. 19, <http://www.kff.org/insurance/7670.cfm>. Health insurance premiums are for family premiums based on a family of four.

⁸³ Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, Census Bureau, Current Population Reports, P60-239, Table C-1, September 2011, p. 77, <http://www.census.gov/prod/2011pubs/p60-239.pdf>. Between 1999 and 2010, the percentage of the population covered by government health insurance increased from 24.2% to 31.0%. However, the overall percentage of the population covered by any health insurance declined during this period from 86.4% to 83.7%.

⁸⁴ See Jae Kennedy, Ph.D. and Elizabeth Blodgett, M.H.P.A., *Health Insurance—Motivated Disability Enrollment and the ACA*, *The New England Journal of Medicine*, September 20, 2012, <http://www.nejm.org/doi/full/10.1056/NEJMp1208212>.

⁸⁵ For more information on ACA, see CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead.

apply for SSDI in order to qualify for Medicare, thereby abating the incidence of benefit receipt. Yet, it remains to be seen whether ACA will have a meaningful effect on the SSDI prevalence rate in the future.

A Lack of Consistency in the Initial Determination Process

As earlier noted, DDS examiners used a combination of medical, vocational, and functional evidence to determine whether a claimant's impairment precludes him or her from engaging in SGA.⁸⁶ Although DDS examiners base their initial determinations on uniform guidelines established by SSA, regional differences in demographic, health, and employment characteristics may produce variation in initial allowance rates between DDS offices.⁸⁷ However, a recent study by the RAND Corporation found an appreciable degree of variation in determination outcomes across examiners within the same DDS office.⁸⁸ The study estimated that up to 60% of applicants "could have received a different initial determination from at least one other examiner in the DDS office."⁸⁹ Even though the appeals process mitigated some of this variation, the study concluded that up to 23% of claimants could have ultimately received a different outcome had another examiner in the DDS office performed the determination.⁹⁰

The uncertainty of an outcome at the initial determination level due to variation across DDS examiners may have encouraged denied claimants to pursue the appeals process, thereby increasing their likelihood of SSDI receipt. The aforementioned study found that claimants denied by strict examiners were more likely to appeal their determinations.⁹¹ Between FY1986 and FY2010, the number of dispositions conducted by Administrative Law Judges (ALJ) at the hearing level increased 242.3% (from 215,489 to 737,616).⁹² Although most of the awards granted by SSA during this period were made at the initial determination level, ALJs adjudicated the highest allowance rate of any level in the determination or appeals process.⁹³ In FY2010, the allowance rate at the hearing level was 62%, compared with 35% at the initial level, 13% at the

⁸⁶ For information on medical considerations, residual functional capacity, and vocational considerations, see 20 C.F.R. § 404.1525, 20 C.F.R. § 404.1545, and 20 C.F.R. § 404.1560, respectively.

⁸⁷ For additional information, see Alexander Strand, *Social Security Disability Programs: Assessing the Variation in Allowance Rates*, Social Security Administration, ORES Working Paper no. 98, August 2002, <http://www.ssa.gov/policy/docs/workingpapers/wp98.html>. See also Norma B. Coe et al., *What Explains Variation in SSDI Application Rates?*, Center for Retirement Research at Boston College, WP#2011-23, <http://crr.bc.edu/working-papers/what-explains-state-variation-in-ssdi-application-rates/>.

⁸⁸ Nicole Maestas, Kathleen J. Mullen, and Alexander Strand, *Does Disability Insurance Receipt Discourage Work? Using Examiner Assignment to Estimate Causal Effects of SSDI Receipt*, RAND Corporation, Working Paper WR-853.3, June 2012, p. 23, http://www.rand.org/pubs/working_papers/WR853-3.html (hereinafter cited as "Maestas, Mullen, and Strand 2012").

⁸⁹ U.S. Congress, House Ways and Means, Social Security, *Third in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, 112th Cong., 2nd sess., March 20, 2012, 112-SS14, Testimony of Nicole Maestas, p. 3, http://waysandmeans.house.gov/uploadedfiles/nicolemaestas_ss_3_20_12s.pdf.

⁹⁰ Ibid. Note that although the study found that 23% of applicants could have received a different outcome, there is no guarantee that the applicants would have received a different decision had their cases been assigned to a different DDS examiner.

⁹¹ Maestas, Mullen, and Strand 2012, p. 23.

⁹² SSAB Data and Materials 2012, Table 49, p. 54. Dispositions include decisions and dismissals. In FY2010, of the 737,616 dispositions before ALJs, 2,170 were for OASI cases, 232,801 for SSDI-only cases, 200,681 for SSI-only cases, and 301,964 for concurrent SSDI and SSI cases. For more information, see SSA Annual Statistical Supplement 2012, Table 2.F9.

⁹³ SSAB Data and Materials 2012, Table 7, p. 12.

reconsideration level, 2% at the Appeals Council level, and 4% at the federal court level.⁹⁴ The RAND study found that of the denied claimants who contested their initial determination, 75% had their denial overturned eventually on appeal.⁹⁵ The increased use of the appeals process due to variation across DDS examiners, coupled with higher allowance rates at the hearing level, may have contributed to the growth in the SSDI program.⁹⁶

Changes in Federal Policy

The SSDI program of today looks quite different from the one created in 1956. At its inception, the program only provided cash benefits to workers aged 50 to 64 and disabled adult children whose disability began before the age of 18.⁹⁷ Since then, the program has expanded to cover dependents and workers under the age of 50, as well as provide health care for disabled-worker beneficiaries. The following subsection explores how legislative changes to both program eligibility criteria and OASI benefits in the early 1980s may have helped to enlarge SSDI rolls.

The Disability Benefits Reform Act of 1984

The Social Security Disability Amendments of 1980 (P.L. 96-265) vastly expanded the use of continuing disability reviews (CDR) as a means of reducing the growth in program costs. CDRs are periodic medical reevaluations to determine whether disabled beneficiaries continue to meet SSA's definition of disability. Between January 1982 and the fall of 1984, SSA issued benefit termination notices to 490,000 of the 1.2 million SSDI beneficiaries subjected to a CDR.⁹⁸ However, the rise in beneficiary terminations due to CDRs sparked a degree of public outcry and had "a very damaging effect on the public perception of SSA's administration of the disability program."⁹⁹ News stories at the time often depicted the economic and emotional difficulties faced by recently terminated beneficiaries and their dependents.¹⁰⁰ Ultimately, of the 490,000 beneficiaries who received termination notices because of CDRs, approximately 200,000 had their benefits reinstated on appeal.¹⁰¹

In response to the contention over the increased use of CDRs, Congress unanimously enacted a series of reforms to improve consistency and uniformity in the disability determination process.¹⁰² The Disability Benefits Reform Act of 1984 (P.L. 98-460) changed the statutory standards for

⁹⁴ Social Security Administration, *SSA FY 2012 Budget Justification*, Table 3.20, February 2011, p. 103, <http://www.ssa.gov/budget/>. Since FY2010, the allowance rate at the hearing level has decreased markedly, declining from 62% in FY2010 to 52% in FY2012. For more information, see Social Security Administration, *SSA FY 2014 Budget Justification*, Table 3.26, April 2013, p. 134, <http://www.ssa.gov/budget/FY14Files/2014FJ.pdf>.

⁹⁵ Maestas, Mullen, and Strand 2012, p. 11.

⁹⁶ See Autor and Duggan 2006, p. 20-23.

⁹⁷ Kearney 2006, pp. 10-11.

⁹⁸ *Ibid.*, p. 14.

⁹⁹ Kearney 2006, p. 15.

¹⁰⁰ "Cutoffs for Mentally Ill Bring Moratorium Plea," *The New York Times*, April 9, 1983, <http://www.nytimes.com/1983/04/10/us/cutoffs-for-mentally-ill-bring-moratorium-plea.html?n=Top%2fReference%2fTimes%20Topics%2fSubjects%2f%2ffinances>.

¹⁰¹ Kearney 2006, p. 16.

¹⁰² Katharine P. Collins and Anne Erfle, "Social Security Disability Benefits Reform Act of 1984: Legislative History and Summary of Provisions," *Social Security Bulletin*, vol. 48, no. 4, (April 1985), p. 5, <http://199.173.224.108/policy/docs/ssb/v48n4/v48n4p5.pdf>.

evaluating disability in a variety of ways. First, it revised the medical eligibility criteria for CDRs so that SSA can only terminate the benefits of a recipient due to a medical improvement if the agency finds substantial evidence demonstrating medical improvement related to the recipient's ability to work since his or her most recent favorable determination.¹⁰³ Under the 1980 amendments, SSA treated medical CDRs as a new determination and therefore did not evaluate a beneficiary's impairment relative to the previous determination. Second, it amended the mental disorders category of the *Listing of Impairments* to give greater weight to functional capabilities.¹⁰⁴ Before the reforms, disability determinations primarily relied on medical factors, which tended to disfavor claimants with mental impairments from benefit receipt. Third, it required SSA to consider the combined effect of multiple non-severe impairments on the claimant's ability to engage in SGA.¹⁰⁵ Prior to the 1984 amendments, a disability determination could not proceed unless the claimant had one or more independently severe impairments.¹⁰⁶

In enacting the 1984 amendments, Congress effectively relaxed the eligibility criteria needed to qualify for SSDI—relative to the 1980 amendments—for certain diagnostic groups such as musculoskeletal and mental disorders. Whereas the revision of the *Listing of Impairments* to give greater weight to functional capabilities permitted more claimants with mental impairment to qualify for SSDI, the allowance of the combined effect of multiple non-severe impairments made it easier for claimants with musculoskeletal impairments to enroll in the program.¹⁰⁷ Consequently, the percent distribution of awards to disabled-worker beneficiaries by diagnostic group started to change over time.¹⁰⁸ As **Figure 6** illustrates, the share of newly awarded beneficiaries with mental impairments increased from 10.3% in 1981 to 19.2% in 2011, whereas the portion of newly awarded beneficiaries with musculoskeletal impairments rose from 16.7% to 33.8% during the same period.¹⁰⁹

¹⁰³ Kearney 2006, p. 17. See also 20 C.F.R. § 404.1594.

¹⁰⁴ *Ibid.* For information on the *Listing of Impairments*, please see the Social Security Administration publication *Disability Evaluation Under Social Security*, available at <http://www.ssa.gov/disability/professionals/bluebook/>. This publication is commonly referred to as the *SSA Blue Book*. For more information on functional capabilities, please see *Appendix 2 to Subpart P of Part 404 - Medical-Vocational Guidelines* in 20 C.F.R. § 404.

¹⁰⁵ Kearney 2006, p. 17. See also 20 C.F.R. § 404.1523.

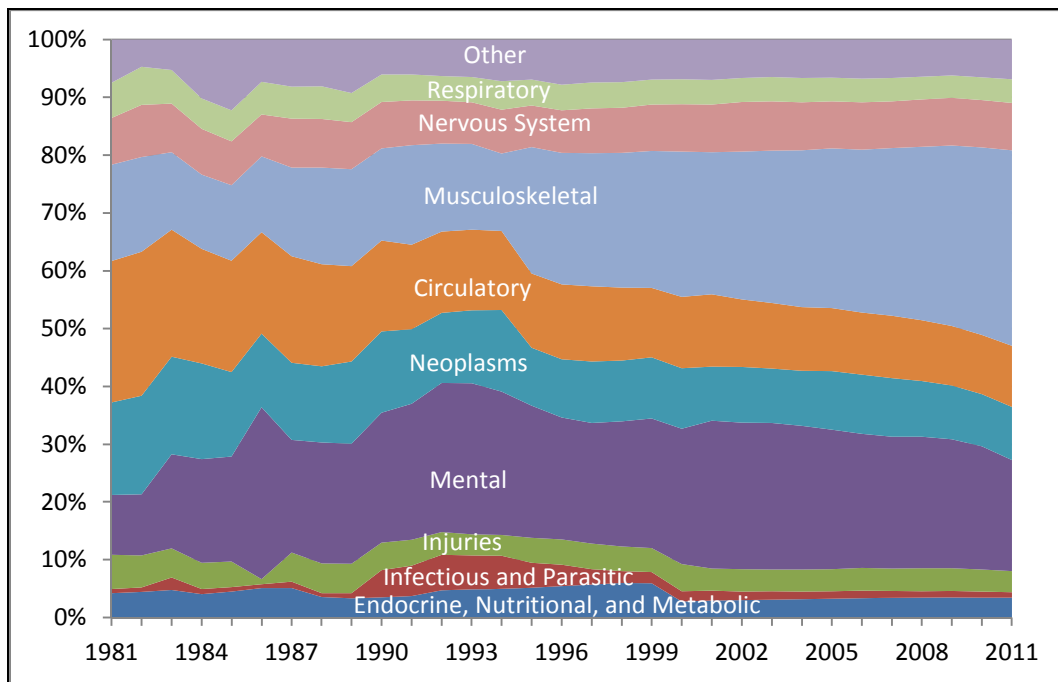
¹⁰⁶ Social Security Administration, *A History of the Social Security Disability Programs*, January 1986, <http://www.ssa.gov/history/1986dibhistory.html>. For more information on the distinction between severe and non-severe impairments, please see Social Security Administration, *DI 22001.015 Severe/Non-Severe Impairment(s)*, July 2012, <https://secure.ssa.gov/poms.nsf/lnx/0422001015>. See also 20 C.F.R. § 404.1520(c) and 20 C.F.R. § 404.1521.

¹⁰⁷ Most of the growth in mental disorders stems from workers under age 50, while most of the growth in musculoskeletal impairments stems from workers over age 50. For more information, see SSDI Annual Report 2011, Tables 41-42, pp. 109-116.

¹⁰⁸ Autor and Duggan 2006, p. 11.

¹⁰⁹ SSDI Annual Report 2011, Table 40, pp. 103-108.

Figure 6. The Percent Distribution of Newly Awarded Disabled-Worker Beneficiaries By Diagnostic Group (1981-2011)



Source: Computed from the Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program, 2011*, Table 40, pp. 103-108.

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

The change in the percentage distribution of awards to disabled-worker beneficiaries by diagnostic group may have increased the program prevalence rate, insofar as beneficiaries with mental and musculoskeletal impairments stay on SSDI longer relative to beneficiaries with certain other impairments (e.g., injuries or infections).¹¹⁰ Beneficiaries with mental or musculoskeletal impairments experience low mortality rates, moderate recovery rates, and high retirement conversion rates, all of which result in a long average duration of benefit receipt.¹¹¹ Moreover, since beneficiaries with mental impairments are typically younger, their time on SSDI rolls could last decades.¹¹²

¹¹⁰ Kalman Rupp and Charles G. Scott, "Trends in the Characteristics of DI and SSI Disability Awardees and Duration of Program Participation," *Social Security Bulletin*, vol. 59, no. 1, (January 1996), pp. 6-7, <http://www.ssa.gov/policy/docs/ssb/v59n1/index.html> (hereinafter cited as "Rupp and Scott 1996"). See also Autor and Duggan 2006, pp.11-12.

¹¹¹ Rupp and Scott 1996, Table 1, p. 6. Rupp and Scott examined the age and diagnostic mix of new SSDI cohorts between 1975 and 1993. Recovery, death, and termination rates based on the percent distribution of reasons for completion of first SSDI disability spell by diagnostic group. Musculoskeletal recovery rates are higher for younger individuals (aged 18 to 34). See also John C. Hennessey and Janice M. Dykacz, "A Comparison of the Recovery Termination Rates of Disabled-Worker Beneficiaries Entitled in 1972 and 1985," *Social Security Bulletin*, vol. 56, no. 2, (Summer 1993), pp. 60-61, <http://www.ssa.gov/policy/docs/ssb/v56n2/v56n2p58.pdf>.

¹¹² Rupp and Scott 1996, Table 2, p. 7. For a cohort of beneficiaries awarded benefits in 1972, younger beneficiaries (aged 18 to 34) under the diagnostic category "mental disorders" experienced an average duration of benefit receipt of 25.5 years.

The Social Security Amendments of 1983

Congress enacted the comprehensive Social Security Amendments of 1983 (P.L. 98-21) in response to the financial problems of the Old-Age and Survivors Insurance (OASI) trust fund identified by the National Commission on Social Security Reform.¹¹³ To address the long-term sustainability of the OASI program, Congress incrementally increased the full retirement age (FRA) from 65 to 67, thereby expanding the maximum penalty for taking early retirement at age 62 from a 20% to a 30% reduction in cash benefits (based on year of birth).¹¹⁴ The increase in FRA resulted in program savings that improved the solvency of the OASI trust fund.

However, the statutory changes to OASI eligibility rules may have also exacerbated the SSDI prevalence rate in three important ways. First, the increase in FRA expanded the share of potential SSDI applicants in their most disability-prone years (aged 50 and older). Between 2003 and 2012, the number of insured workers aged 65 to 66 rose from 228,000 to more than 2.4 million.¹¹⁵ Since older workers suffer from higher disability rates, the increase in FRA likely pushed the SSDI incidence rate upward.¹¹⁶ Second, the increase in FRA lengthened the duration of benefit receipt for recipients close to retirement age.¹¹⁷ Prior to the 1983 amendments, SSA converted beneficiaries who turned age 65 from SSDI benefits to OASI retirement benefits. However, following the implementation of the amendments, beneficiaries aged 65 and older increasingly remained on SSDI longer, consequently aggravating the program prevalence rate. In December 2011, nearly 404,800 beneficiaries aged 65 to 66 received monthly SSDI payments from SSA.¹¹⁸

Third, the rise in the maximum penalty for early retirement increased the value of disability cash benefits. Since the maximum monthly full retired-worker benefit is the same as the maximum monthly disabled-worker benefit, the maximum value of an early retirement benefit at the age of 62 is 20%-30% less than the maximum value of a disability benefit, depending on year of birth. As a result, a growing number of OASDI insured workers aged 62 to FRA may have opted to apply for SSDI benefits in order to maximize their annual compensation. Recent studies suggest that the increasing value of disability benefits relative to early retirement benefits induces individuals to apply for SSDI benefits.¹¹⁹ However, researchers are divided over the extent to

¹¹³ For more information, see the National Commission on Social Security Reform, *Report of the National Commission on Social Security Reform*, January 1983, <http://www.ssa.gov/history/reports/gspan.html>.

¹¹⁴ See Social Security Administration, *Social Security Amendments of 1983*, <http://www.ssa.gov/history/1983amend2.html>. For more information on changes to the full retirement age, see CRS Report R41962, *Fact Sheet: The Social Security Retirement Age*, by Gary Sidor. For additional information on the graduated increase in the early retirement penalty, see Social Security Administration, *Retirement Planner: Benefits By Year Of Birth*, October 17, 2012, <http://www.socialsecurity.gov/retire2/agereduction.htm>.

¹¹⁵ For insured worker data, see Social Security Administration, *Disability Insured Workers*, <http://www.ssa.gov/oact/STATS/table4c2DI.html>.

¹¹⁶ For more information, see U.S. Government Accountability Office, *Raising the Retirement Ages Would Have Implications for Older Workers and SSA Disability Rolls*, GAO-11-125, December 18, 2010, p. 27, <http://www.gao.gov/products/GAO-11-125>.

¹¹⁷ CBO, *Policy Options 2012*, p. 9.

¹¹⁸ SSA Annual SSDI Report 2011, Table 20, p. 60.

¹¹⁹ See Norma B. Coe and Kelly Haverstick, *Measuring the Spillover to Disability Insurance Due to the Rise in the Full Retirement Age*, Center for Retirement Research at Boston College, CRR WP 2010-21, December 2010, p. 9-14, <http://crr.bc.edu/working-papers/measuring-the-spillover-to-disability-insurance-due-to-the-rise-in-the-full-retirement-age/> (hereinafter cited as “Coe and Haverstick 2010”). In addition, see Mark Duggan, Perry Singleton, and Jae Song, *Aching to Retire? The Rise in the Full Retirement Age and its Impact on the Disability Rolls*, National Bureau of (continued...)

which individuals aged 62 to FRA who apply for disability benefits based on their relative value to early retirement benefits actually receive an award from SSA.¹²⁰

Overview of Reform Proposals

Since the effects of changes in the age-sex distribution of the population on SSDI rolls have for the most part run their course, SSA's Chief Actuary estimates that the cost and income to the DI trust fund as a percentage of GDP will stabilize over the long term.¹²¹ However, the Chief Actuary projects the current gap between DI revenue and expenditures to remain persistent into the future.¹²² Without appropriate action, the Office of the Chief Actuary estimates that the DI trust fund reserves will be depleted in 2016, at which point the trust fund will have only enough revenue to pay 79% of scheduled benefits.¹²³ To assist lawmakers in addressing the sustainability of the program, this section provides an overview of reform proposals to mitigate the prevalence of benefit receipt and thus reduce future program expenditures.¹²⁴ The selected proposals discussed in this section come from a variety of sources, including academic researchers, advocacy organizations, government agencies, and the Social Security Advisory Board.¹²⁵

Stricter Eligibility Criteria

One policy option to reduce the growth in SSDI rolls is to tighten the eligibility requirements for program enrollment. In general, the aim of enhancing eligibility criteria is to mitigate the number of future awardees with some capacity to work (i.e., claimants on the margin of program entry), while continuing to grant awards to claimants with little or no ability to engage in substantial gainful activity (SGA). In theory, claimants on the edge of program entry could potentially work above SGA; therefore, stricter eligibility criteria may affect marginal claimants less adversely

(...continued)

Economic Research, Working Paper 11811, December 2005, <http://www.nber.org/papers/w11811> (hereinafter cited as "Duggan, Singleton, and Song 2005").

¹²⁰ Ibid. Using aggregate data, Duggan, Singleton, and Song found that the 1983 amendments increased SSDI enrollment 0.58 percentage points for men (aged 45 to 64) and 0.89 percentage points for women (aged 45 to 64) between 1983 and 2005. Using disaggregate data, Coe and Haverstick found that a 1 percentage point decrease in the ratio of retirement to disability benefits resulted in a 0.25 percentage point increase in the application rate for individuals born between 1938 and 1943. However, the researchers found no evidence that the increase in FRA resulted in a rise in the incidence of SSDI receipt among individuals aged 55 to FRA born between 1938 and 1941 (1942 and 1943 cohorts had not reached FRA).

¹²¹ Testimony of Stephen C. Goss 2013, pp. 4-5. Projections based on the Social Security Board of Trustees' 2012 intermediate assumptions.

¹²² Ibid.

¹²³ Ibid., p. 1.

¹²⁴ In addition to reducing the prevalence of benefit receipt, there are a number of other reform options for improving the solvency of the DI trust fund. For example, changing the formula for calculating benefits or slowing the growth in COLAs via chained CPI would both abate future program costs (see CBO, Policy Options 2012). Alternatively, raising additional revenue by increasing the taxable earnings base would help to close the gap between program costs and income. For more information on changes to the taxable earnings base, see CRS Report RL33943, *Increasing the Social Security Payroll Tax Base: Options and Effects on Tax Burdens*, by Thomas L. Hungerford and CRS Report RL32896, *Social Security: Raising or Eliminating the Taxable Earnings Base*, by Janemarie Mulvey.

¹²⁵ The Social Security Advisory Board is an independent board tasked with advising the Commissioner of Social Security on issues related to OASDI and SSI. For more information, see 42 U.S.C. § 903.

compared to more severely disabled claimants.¹²⁶ However, there is no guarantee that all the claimants on the margin of program entry have either the capacity or opportunity to engage in SGA. Thus, stricter eligibility criteria may inadvertently deny benefits to claimants with little or no ability to work at all. Although it is difficult to discern which type of claimants would be affected by more stringent eligibility requirements, a recent study found that marginal program entrants are more likely to be younger, suffer from mental impairments, and have low earnings histories.¹²⁷

This subsection examines several options for increasing the eligibility criteria of the SSDI program, which the Congressional Budget Office (CBO) outlined and scored in its 2012 report, *Policy Options for the Social Security Disability Insurance Program*.¹²⁸

Increase the Recency-of-Work Requirement

As mentioned earlier, to qualify for disability benefits, a worker must typically have 40 credits (quarters of coverage), 20 of which were earned in the last 10 years ending with the year of disability onset.¹²⁹ In other words, disability claimants must have generally worked five of the past 10 years to be eligible for SSDI. The recency-of-work requirement (sometimes known as the 20/40 rule) restricts the program to individuals who have worked of late and for a reasonable length of time in covered employment.¹³⁰

CBO recently estimated the impact of increasing the recency-of-work requirement on beneficiary enrollment. The agency projected that requiring disability claimants to have worked four of the past six years (instead of five of the past 10) starting in 2013 would have reduced the number of SSDI beneficiaries by 4% in 2022, as well as decreased program outlays by \$8.0 billion in that year.¹³¹

The stricter recency-of-work requirement would likely affect individuals with intermittent work histories, specifically workers with prolonged and sustained bouts of absence from covered employment due to unemployment or withdrawal from the labor force.¹³² A recent study found that while men report leaving the labor force primarily because of disability, women typically report leaving the labor force to care for someone in their household.¹³³ Consequently, the more

¹²⁶ Maestas, Mullen, and Strand 2012, p. 22. Maestas, Mullen, and Strand found that the employment of marginal program entrants would have been on average 28 percentage points higher two years after the initial determination had they not received SSDI. This figure drops to 16 percentage points four years after the initial determination. However, these estimations reflect economic and labor market conditions between 2005 and 2006, and therefore may not hold during instances of high unemployment such as the December 2007 to June 2009 recession.

¹²⁷ *Ibid.*, p. 5.

¹²⁸ CBO, *Policy Options* 2012.

¹²⁹ See 20 C.F.R. § 404.130(b)(2).

¹³⁰ CRS Report (Archived), *Social Security: Summary of Major Changes in the Cash Benefits Program*, May 18, 2000, available at <http://www.ssa.gov/history/reports/crsleghist2.html>.

¹³¹ CBO, *Policy Options* 2012, p. 18.

¹³² Unemployment refers to all individuals aged 16 and over who do not have a job, have actively looked for work in the prior four weeks, and are currently available for work. Individuals out of the labor force are currently not working and not actively looking for a job.

¹³³ Julie L. Hotchkiss, M. Melinda Pitts, and Fernando Rios-Avila, *A Closer Look at Nonparticipants During and After the Great Recession*, Federal Reserve Bank, Working Paper 2012-10, August 2012, p. 6, http://www.frbatlanta.org/pubs/wp/12_10.cfm.

stringent recency-of-work requirement may disproportionately affect women who drop out of the labor force to act as caregivers.¹³⁴

Adjust the Age Categories for Vocational Factors

As noted earlier, in addition to assessing an applicant’s medical condition, DDS examiners also take into account the individual’s ability to perform either any past relevant work or other work that exists in the national economy. Vocational factors such as age, education, and work experience—in combination with the individual’s residual functional capacity—help an examiner to determine whether an applicant’s impairment precludes him or her engaging in SGA. Since eligibility criteria based on education and work experience typically becomes less stringent with age, SSA is more likely to award benefits to older insured workers. Therefore, raising the upper age categories for vocational factors could mitigate the growth in the number of older beneficiaries (aged 45 to FRA) on SSDI rolls.

Currently, SSA categorizes older workers across four age ranges: 45-49, 50-54, 55-59, and 60 and older.¹³⁵ CBO examined the effects of increasing the 45-49 and 50-54 age ranges by two years to 47-51 and 52-56 and making 57 to FRA the new maximum range, thereby eliminating the 45, 46, and 60 and older categories. According to CBO, implementing this policy option in 2013 would have decreased the number of SSDI beneficiaries by 50,000 or 0.5% in 2022, as well as reduced program expenditures by \$1.0 billion in that year.¹³⁶

Adjusting the age categories for vocational factors would likely encourage older insured workers to seek out other potential income supports. Whereas workers aged 62 to FRA could apply for early retirement benefits, workers with a recent attachment to the labor force may choose to apply for other work-related supports such as state workers’ compensation, private disability insurance, or unemployment insurance. Meanwhile, low-income claimants would most likely apply for SSI and Medicaid in response to the adjustment in the age categories.¹³⁷

¹³⁴ In *Collier v. Barnhart*, Claire Collier, a wife and mother suffering from amyotrophic lateral sclerosis (ALS; also known as Lou Gehrig’s disease), filed suit in U.S. district court in 2005 against the Commissioner of Social Security, arguing that the recency-of-work requirement (or 20/40 rule) violated the equal protection component of the Due Process Clause of the Fifth Amendment. Although Mrs. Collier satisfied the quarters of coverage requirement for her age, she did not meet the 20/40 rule due to her six years as a stay-at-home mother. Mrs. Collier argued that the 20/40 rule discriminates against stay-at-home mothers who have made “significant contributions” to SSDI and Medicare. The district court found that the 20/40 rule did not violate equal protection or due process and ultimately granted the Commissioner’s motion for summary judgment. For more information, see Sarah E. Hoffman, “Falling Through the Cracks: How the 20/40 Rule Discriminates Against Women Seeking Social Security Disability Insurance Benefits and What Congress Can Do About It,” *Penn State Law Review*, vol. 113, no. 2 (2008).

¹³⁵ Social Security Administration, *DI 25001.001 Medical-Vocational Quick Reference Guide*, May 2012, <https://secure.ssa.gov/poms.nsf/lnx/0425001001>. Although this CRS report defines older workers as individuals aged 45 and older, SSA categories individuals under the age of 50 as “younger individuals.” For more information, see *Appendix 2 to Subpart P of Part 404 - Medical-Vocational Guidelines* in 20 C.F.R. § 404.

¹³⁶ CBO, *Policy Options 2012*, p. 18. Adjusting the age ranges of vocational factors would have also decreased participation in Medicare and thus reduced Medicare outlays.

¹³⁷ For more information on other potential income supports for SSDI applicants, see CRS Report RS22220, *Social Security Disability Insurance (SSDI): The Five-Month Waiting Period for Benefits*, by Umar Moulta-Ali. Adjusting the age ranges for vocational factors would have increased participation in and outlays to SSI and Medicaid, although CBO did not provide specific estimates. For more information see, CBO, *Policy Options 2012*, p. 18.

SSA explored raising the age categories in the past but ultimately decided against it. In November 2005, SSA issued a Notice of Proposed Rulemaking (NPRM) that proposed to increase the age categories for older insured workers by two years.¹³⁸ However, after collecting feedback from the public, SSA withdrew the NPRM in May of 2009.¹³⁹

Improved Program Administration

Another reform option is to augment program consistency and integrity to reduce the number of non-meritorious claimants on SSDI. Variation in the application of SSA guidelines can distort the disability determination and adjudication process, resulting in the agency granting awards to non-meritorious claimants or denying benefits to claimants with little or no capacity to work. Similarly, diminished program integrity—whether through waste, fraud, or abuse—may permit some beneficiaries to remain on SSDI in spite of their considerable work-related medical improvements. This subsection outlines reforms to the administration of the program that could conceivably reduce the growth in SSDI rolls.

Changing the Hearing Level Process from Inquisitorial to Adversarial

Claimants displeased with a determination at the reconsideration level of the appeals process may request a hearing before an Administrative Law Judge (ALJ), in writing, within 60 days upon receipt of the determination. At the hearing level, claimants may present additional evidence or arguments to support their case, as well as appoint a representative to act on their behalf (either an attorney or non-attorney). Since SSA is not represented at the hearing, the proceeding is considered inquisitorial or non-adversarial.¹⁴⁰ Under an inquisitorial process, ALJs investigate the merits of an appeal by informally questioning the claimant, as well as any scheduled witnesses (i.e., medical or vocational experts). Proponents of the inquisitorial process argue that the informal nature of the proceedings and lack of cross-examination by an opposing attorney creates an environment conducive to a claimant sharing the information needed by the ALJ to make an informed decision.¹⁴¹

However, opponents contend that inquisitorial process encumbers the ability of ALJs to make informed decisions on a consistent basis, inasmuch as the process forces ALJs to adjudicate appeals impartially while simultaneously representing the interests of both claimants and SSA.¹⁴²

¹³⁸ For more information, see Social Security Administration, “Age as a Factor in Evaluating Disability,” 70 *Federal Register* 67104, November 4, 2005.

¹³⁹ See Social Security Administration, “Age as a Factor in Evaluating Disability,” 74 *Federal Register* 21563, May 8, 2009.

¹⁴⁰ See 20 C.F.R. § 404.900(b), 20 C.F.R. § 416.1400(b), and 20 C.F.R. § 405.1(c).

¹⁴¹ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces the Fourth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Ethel Zelenske, 112th Cong., 2nd sess., June 27, 2012, http://waysandmeans.house.gov/uploadedfiles/zelenske_testimony.pdf.

¹⁴² See Social Security Advisory Board, *Charting the Future of Social Security’s Disability Programs: The Need for Fundamental Change*, January 2001, p. 19, <http://www.ssab.gov/Publications/Disability/disabilitywhitepap.pdf> (hereinafter cited as “SSAB Fundamental Change 2001”). See also U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces the Fourth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of the Honorable D. Randall Frye, 112th Cong., 2nd sess., June 27, 2012 (hereinafter cited as “Testimony of the Honorable D. Randall Frye 2012”).

According to the Association of Administrative Law Judges (AALJ), having to wear all three “hats” during a hearing sometimes places an ALJ in an untenable situation, in which the judge must represent clients whose interests are at odds with one another.¹⁴³ Moreover, the difficulty of maintaining impartiality while simultaneously representing the interests of both parties may cause an ALJ to overlook a key piece of evidence or argument, consequently affecting the outcome of the decision.

To improve the accuracy of appeals at the hearing level, both AALJ and the Social Security Advisory Board (SSAB) advocate switching from an inquisitorial to an adversarial process in which claimants and SSA are each afforded representation.¹⁴⁴ The two organizations argue that the vigorous cross-examination of claimants by SSA representatives would provide ALJs with additional information and evidence with which to form their decisions, thereby creating greater consistency and accountability in the appeals process. According to SSAB, under the inquisitorial process, some ALJs may be reluctant to question claimants aggressively for fear of appearing to be biased.¹⁴⁵ This hesitation may prevent ALJs from discovering all the evidence necessary to make fully informed decisions, consequently affecting hearing outcomes. Therefore, adopting an adversarial model could allow ALJs to investigate the history and extent of claimants’ medical impairments more thoroughly, resulting in better-reasoned decisions and greater judicial consistency.

The potential for improved consistency and accountability at the hearing level may help to lower the overall allowance rate and thus reduce the growth in SSDI rolls. A January 2013 audit report by SSA’s Office of the Inspector General (OIG) discovered wide variances in the allowance rates among ALJs between and within hearing offices.¹⁴⁶ In addition, the report found a direct relationship between the number of cases adjudicated by ALJs (productivity) and allowance rates.¹⁴⁷ In other words, high-allowance ALJs adjudicated more dispositions relative to the office average, whereas low-allowance ALJs adjudicated fewer dispositions compared with the office average. By improving the quality of decisions, the adversarial process could theoretically help to attenuate large variances in the allowance rates among ALJs, subsequently mitigating the number of non-meritorious claimants awarded SSDI.

However, successfully implementing an adversarial process at the hearing level poses several challenges for SSA. First, switching from an inquisitorial to adversarial process would require additional expenditures to hire attorneys and appropriate staff. Disability hearings are already quite costly for SSA. In FY2011, the unit cost of adjudicating a disability hearing was \$2,752.00, whereas the unit cost of processing an initial disability claim was only \$1,058.44.¹⁴⁸ Even though SSA representation may eventually produce budgetary savings by reducing the allowance rate at the hearing level, the conversion to an adversarial process would still present SSA with substantial costs in the short term.

¹⁴³ Testimony of the Honorable D. Randall Frye 2012, p. 5.

¹⁴⁴ Ibid. See also SSAB Fundamental Change 2001, p. 19.

¹⁴⁵ SSAB Fundamental Change 2001, p. 19.

¹⁴⁶ SSA’s Office of the Inspector General, *Identifying and Monitoring Risk Factors at Hearing Offices*, Audit Report: A-12-12-11289, January 2013, p. 7, <http://oig.ssa.gov/audits-and-investigations/audit-reports/A-12-12-11289>.

¹⁴⁷ Ibid.

¹⁴⁸ Social Security Advisory Board, *Filing for Social Security Disability Benefits: What Impact Does Professional Representation Have on the Process at the Initial Level*, September 2012, p. 6, footnote 9, <http://www.ssab.gov/Reports/Third-Party-2012-Full.pdf>.

Second, it is unclear whether the adversarial process at the hearing level would survive a legal challenge from denied claimants, inasmuch a federal judge issued an injunction against SSA's previous adversarial pilot program in 1986.¹⁴⁹ Third, due to a paucity of research on the subject, the effects of switching to an adversarial process are highly ambiguous and difficult to discern. To assess the feasibility of switching to an adversarial process today, SSA may need to conduct another demonstration project to determine whether SSA representation at the hearing level could improve consistency and accountability in a cost-effective manner.¹⁵⁰

Update SSA's Listing of Impairments

During the disability determination process, DDS examiners—with the help of medical and psychological consultants—typically use medical evidence collected from the claimant's physicians, hospitals, clinics, or other institutions of treatment to determine the severity of the claimant's impairment.¹⁵¹ In order to assess whether the impairment precludes the claimant from working, DDS examiners evaluate the impairment against the *Listing of Impairments* (hereinafter "listings"), which categorizes SSA approved medical conditions for disability across 14 major body systems for adults.¹⁵² SSA designed the listings to assist examiners in expediting claims by providing a uniform collection of medical conditions that prevent individuals from engaging in SGA. Most of the medical conditions contained in the listings are permanent or expected to result in death or a specific statement of duration.¹⁵³ If the claimant's impairment meets (or is of equal severity to) the criteria in the listings, SSA considers the claimant to have a work-limiting disability. Claimants who do not meet the medical criteria in the listings proceed to a more individualized assessment that examines their residual functional capacity to work, as well as vocational factors.¹⁵⁴

¹⁴⁹ *Salling v. Bowen*, 641 F. Supp. 1046 (W.D. Va. 1986). See also Frank Bloch, Jeffrey Lubbers, and Paul Verkuil, *Introducing Nonadversarial Government Representatives to Improve the Record of Decision in Social Security Disability Adjudications*, Social Security Advisory Board, 2003, <http://www.ssab.gov/documents/Bloch-Lubbers-Verkuil.pdf>.

¹⁵⁰ SSA's demonstration authority expired in 2005. For more information, see CRS Report RL33585, *Social Security Disability Insurance (SSDI) Demonstration Projects*, by Scott Szymendera.

¹⁵¹ If the evidence from a claimant's medical sources is insufficient to make a disability determination, DDS examiners can arrange for a consultative examination of the claimant to obtain the necessary information. For more information, see Social Security Administration, *Consultative Examinations: A Guide for Health Professionals*, Part III - Consultative Examination Guidelines, March 28, 2013, <http://www.ssa.gov/disability/professionals/greenbook/ce-guidelines.htm>. This publication is commonly referred to as the *SSA Green Book*. See also Social Security Administration, *DI 22510.001 General – Consultative Examination (CE)*, November 30, 2012, <https://secure.ssa.gov/poms.nsf/lnx/0422510001>.

¹⁵² For information on the *Listing of Impairments*, please see the Social Security Administration publication *Disability Evaluation Under Social Security*, available at <http://www.ssa.gov/disability/professionals/bluebook/>. This publication is commonly referred to as the *SSA Blue Book*. For additional information, see the U.S. Government Accountability Office, *Modernizing SSA Disability Programs: Progress Made, but Key Efforts Warrant More Management Focus*, GAO-12-420, June 19, 2012, p. 3, <http://www.gao.gov/products/GAO-12-420> (hereinafter cited as "GAO, Modernizing SSA Disability Programs 2012").

¹⁵³ For more information, see Social Security Administration, *DI 34001.001 Listing of Impairments—Purpose, Parts and Use*, POMS, February 26, 2013, <https://secure.ssa.gov/poms.nsf/lnx/0434001001>.

¹⁵⁴ Social Security Advisory Board, *The Social Security Definition of Disability*, October 2003, p. 4, <http://www.ssab.gov/documents/SocialSecurityDefinitionOfDisability.pdf> (hereinafter cited as "SSAB Definition of Disability 2003").

Although the listings serve as a useful guide for DDS examiners, the percentage of awards determined by medical listings has decreased substantially over the years. According to SSAB, between FY1980 and FY2010, the share of initial allowances based on the claimant meeting the medical listings declined from 57.9% to 37.9%, whereas the portion of initial allowances based on the claimant having an impairment equal in severity fell from 16.2% to 7.9%.¹⁵⁵ Conversely, the percentage of initial allowances based on vocational considerations increased during this period from 25.9% to 54.3%.¹⁵⁶ SSAB, the Government Accountability Office (GAO), and SSA's OIG all attribute the decline in the percentage of cases decided based on the claimant's medical condition to the increasingly outdated nature of the medical listings. In 2000, OIG found that SSA had not updated certain listings in over 10 years; moreover, SSA had not updated the listings for mental disorders in 15 years.¹⁵⁷ In 2003, GAO identified SSDI as a high-risk program, inasmuch as the program relied on medical listings that did not reflect the impact of medical and technological advances on work-limiting medical conditions.¹⁵⁸

SSAB has expressed concern over the shift in the basis for decision from medical listings to vocational factors, to the extent that cases decided based on vocational considerations may require a more substantial degree of subjectivity relative to cases determined based on medical listings.¹⁵⁹ In other words, determinations based primarily on carefully researched medical impairments may be less prone to individual examiner bias than cases decided using the claimant's residual functional capacity to work in the national economy. Indeed, the reduced reliance on medical listings may explain some of the aforementioned variation in initial disability determinations across DDS examiners.

To improve the quality and accuracy of disability determinations, SSA initiated a two-tiered process for updating its medical listings beginning in 2003.¹⁶⁰ Under the new process, the agency first completes a comprehensive revision of each listing category, taking into account any medical disorder or disease that may inhibit an individual's ability to work.¹⁶¹ Once the comprehensive update is complete, SSA conducts periodic reviews of each listing category to ensure that the listings are current. According to SSA officials, the agency has completed comprehensive revisions to ten of the fourteen major adult body systems.¹⁶² However, SSA has experienced delays in completing comprehensive updates to the remaining four major adult body systems.¹⁶³

¹⁵⁵ SSAB Data and Materials 2012, Table 40, p. 45.

¹⁵⁶ Ibid. Figures may not equal 100% due to rounding.

¹⁵⁷ SSA's Office of the Inspector General, *The Social Security Administration's Listing of Impairments*, A-01-08-18023, March 27, 2009, p. 4, <http://oig.ssa.gov/social-security-administrations-listing-impairments>.

¹⁵⁸ U.S. General Accounting Office, *High Risk Series: An Update*, GAO-03-119, January 1, 2003, pp. 20-21, <http://www.gao.gov/products/GAO-03-119>. GAO designates certain federal programs as "high risk" in order to draw attention to issues related to efficiency, effectiveness, and accountability.

¹⁵⁹ SSAB Definition of Disability 2003, p. 4.

¹⁶⁰ GAO, *Modernizing SSA Disability Programs* 2012, p. 5.

¹⁶¹ Ibid., pp. 5-8. In 2010, SSA set a five-year cycle for updating listings following a comprehensive review.

¹⁶² U.S. Congress, House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, *Addressing Social Security Administration's Management Challenges in a Fiscally Constrained Environment*, Testimony of Carolyn Colvin, Acting Commissioner of the Social Security Administration, 113th Cong., 1st sess., March 14, 2013, p. 7, <http://appropriations.house.gov/uploadedfiles/hhrg-113-ap07-wstate-colvinc-20130314.pdf> (hereinafter cited as "Testimony of Carolyn Colvin 2013").

¹⁶³ SSA is still in the process of completing comprehensive revisions to the following adult body systems: mental disorders, hematological disorders, the respiratory system, and neurological disorders. Information based on personal communication with a SSA official, March 28, 2013.

SSA has still not completed a final revision of the listing for mental disorders—SSDI’s second most diagnosed impairment—despite the fact that the impairment category last received a comprehensive update in 1985.¹⁶⁴ SSA officials attribute the delay to a shortage of qualified staff, in addition to the enormous complexity of implementing and revising new medical listings.¹⁶⁵ The agency hopes to complete comprehensive revisions to the four remaining adult body systems by the end of FY2014.¹⁶⁶

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

Update SSA’s Occupational Information System

If a claimant fails to meet the eligibility criteria outlined in the medical listings, SSA will proceed with a more individualized assessment that examines the claimant’s ability to engage in SGA. To “minimize subjectivity and promote national consistency,” SSA employs a system of medical and vocational rules designed to assist examiners in discerning whether a claimant can perform either any past relevant work or other work that exists in the national economy.¹⁶⁷ SSA considers claimants who cannot perform any other work to be disabled and therefore eligible for SSDI.

Currently, SSA uses the Department of Labor’s Dictionary of Occupation Titles (DOT) to determine the physical and mental demands of available work in the national economy; however, because DOT last received a major update in 1977, its occupational information is largely outdated and thus unrepresentative of the employment opportunities that exist in the modern U.S. economy.¹⁶⁸ Although the Department of Labor replaced DOT with a new database in 1998—known as the Occupational Information Network (O*NET)—SSA concluded that the new database’s occupational information was insufficient to meet its requirements.¹⁶⁹ A recent Senate report expressed concern over SSA’s use of DOT, in that the system’s increasingly outdated occupational information may award benefits to claimants who could conceivably work in occupations not detailed in DOT.¹⁷⁰

¹⁶⁴ GAO, *Modernizing SSA Disability Programs* 2012 p. 11. According to GAO, SSA published a limited update to the mental disorders listing in 2000.

¹⁶⁵ *Ibid.*, p. 12.

¹⁶⁶ Testimony of Carolyn Colvin 2013, p. 7.

¹⁶⁷ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces the Third in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Michael J. Astrue, Commissioner of the Social Security Administration, 112th Cong., 2nd sess., March 20, 2012, http://www.ssa.gov/legislation/testimony_032012.html. See also GAO, *Modernizing SSA Disability Programs* 2012, p. 4.

¹⁶⁸ GAO, *Modernizing SSA Disability Programs* 2012, p. 6. DOT received a minor update in 1991, albeit for only about 20% of all occupations covered in the database.

¹⁶⁹ *Ibid.*, p. 14.

¹⁷⁰ U.S. Congress, Senate Committee on Homeland Security and Governmental Affairs, Permanent Subcommittee on Investigations, *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions*, Minority Staff Report, 112th Cong., 2nd sess., September 13, 2012, p. 5, <http://www.hsgac.senate.gov/subcommittees/investigations/hearings/social-security-administrations-disability-programs>.

To improve program consistency, SSA established the Occupational Information Development Advisory Panel in December of 2008 to research and develop a new occupational information system (OIS) for use in the vocational stages of the disability determination process.¹⁷¹ In July 2012, SSA signed an interagency agreement with the Bureau of Labor Statistics (BLS) to test the viability of using BLS' National Compensation Survey (NCS) to collect updated occupational data for the new OIS.¹⁷² According to SSA, the agency plans to conduct ongoing testing and analysis of its data collection process in FY2013 and FY2014, with the expectation of implementing the new OIS starting in FY2016.¹⁷³

In the future, SSA's updated OIS may help to mitigate the growth in SSDI rolls. According to SSA, the occupational information in DOT reflects an industrial economy, whereas today's economy has become more service oriented.¹⁷⁴ As a result, modern occupations that require less physical exertion may allow individuals with certain disabilities to remain in the labor force. By updating its OIS to reflect current jobs in the national economy, SSA could potentially reduce the incidence of benefit receipt.

However, not all individuals with disabilities have the capacity to work in today's highly competitive, albeit somewhat less physically demanding, job market.¹⁷⁵ For example, older individuals with disabilities may have difficulty adjusting to the intensity and pressure of many of today's employment opportunities, whereas individuals with less extensive education may be less suited to "cognitively demanding" work.¹⁷⁶ Thus, some individuals with disabilities may lack the capacity to perform any work in the national economy, even after taking into account updated occupational data.

Increase the Number of CDRs Performed By SSA

Unlike program consistency reforms that reduce the incidence of benefit receipt, program integrity policies such as continuing disability reviews (CDR) terminate the benefits of recipients who fail to adhere to program rules and requirements. Medical CDRs are periodic reevaluations to determine whether disabled beneficiaries continue to meet SSA's definition of disability. If SSA finds substantial evidence of medical improvement related to a beneficiary's ability to work, the agency may consider the beneficiary no longer disabled and subsequently terminate his or her benefits. Increasing the number of medical CDRs performed by SSA has the potential to expand

¹⁷¹ Social Security Administration, *Occupational Information System Project*, March 18, 2013, http://www.ssa.gov/disabilityresearch/occupational_info_systems.html (hereinafter cited as "OIS Project 2013").

¹⁷² Ibid.

¹⁷³ Social Security Administration, *Social Security Administration (SSA) Service Delivery Plan*, February 20, 2013, p. 19, http://www.ssa.gov/open/SDP/SDP_022013.pdf.

¹⁷⁴ Robert Pfaff, *Prior SSA Work to Address the DOT Concerns*, Social Security Administration, Occupational Information Development Advisory Panel, February 24, 2009, slide 2, <http://www.socialsecurity.gov/oidap/Documents/Social%20Security%20Administration.%20Prior%20SSA%20Work%20to%20Address%20th.pdf>.

¹⁷⁵ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces Hearing on the Challenges of Achieving Fair and Consistent Disability Decisions*, Testimony of Kathy Ruffing, Senior Fellow at the Center on Budget and Policy Priorities, 113th Cong., 1st sess., March 20, 2013, http://waysandmeans.house.gov/uploadedfiles/ruffing_testimony32013.pdf (hereinafter cited as "Testimony of Kathy Ruffing 2013").

¹⁷⁶ Richard W. Johnson, Gordon B.T. Mermin, and Matthew Resseger, *Employment at Older Ages and the Changing Nature of Work*, The AARP Public Policy Institute, November 2007, p. 1, http://www.urban.org/UploadedPDF/1001154_older_ages.pdf.

the recovery rate of beneficiaries with work-related medical improvements and thus abate the growth in SSDI rolls.

Periodic medical evaluations are one of the most cost-effective tools for improving program integrity.¹⁷⁷ In FY2010, the 324,567 full medical CDRs performed by the agency resulted in 82,422 initial decisions to cease benefits, as well as 2,152 initial decisions to terminate benefits because of beneficiaries' failure to cooperate (FTC) with SSA during the disability review process.¹⁷⁸ After all appeals, SSA's Office of the Chief Actuary (OCAct) estimated that the CDRs conducted in FY2010 would ultimately terminate the benefits of 57,272 disabled-worker beneficiaries and their dependents.¹⁷⁹ For every \$1.0 spent on CDRs in FY2010, OCAct estimated approximately \$9.3 in future program savings.¹⁸⁰

However, a significant reduction in funding for CDRs between FY2003 and FY2007 left SSA with fewer resources with which to conduct disability reviews, resulting in an accretive backlog of medical CDRs.¹⁸¹ In March of 2010, SSA's OIG estimated a backlog of 1.5 million full medical CDRs at the end of FY2010.¹⁸² Had SSA performed all full medical CDRs when they were originally scheduled between calendar years (CY) 2005 through CY2010, OIG estimated that the agency would have removed approximately 90,000 to 180,000 beneficiaries from the rolls, thereby avoiding between \$1.3 billion to \$2.6 billion in payments to SSI, SSDI, and concurrent beneficiaries.¹⁸³ In spite of recent efforts to address the backlog, SSA estimated 1.3 million pending CDRs at the end of FY2012.¹⁸⁴

To address the mounting backlog of CDRs and enhance program integrity, advocacy organizations, academic researchers, and President Obama all have expressed their support for increasing CDR funding.¹⁸⁵ The Budget Control Act of 2011 (P.L. 112-25), which caps

¹⁷⁷ Social Security Administration, *SSA FY 2013 Budget Justification*, February 2012, p. 2, <http://www.ssa.gov/budget/>.

¹⁷⁸ Social Security Administration, *Annual Report of Continuing Disability Reviews*, May 1, 2012, p. 2, <http://ssa.gov/legislation/FY%202010%20CDR%20Report.pdf>. Figures reflect CDRs performed under SSA's central release system, as well as CDR's conducted outside SSA's central release process.

¹⁷⁹ *Ibid.*, p. 5. Figure reflects cases processed only under SSA's central release system. In FY2010, CDRs conducted under SSA's central release system resulted in 78,433 initial cessations and 1,945 initial terminations due to FTC.

¹⁸⁰ *Ibid.* Projected savings reflect the present value of future benefits for OASDI, SSI, Medicare, and Medicaid as of September 30, 2010. Projected savings do not take into account the lifetime benefits of terminated beneficiaries processed outside SSA's central release system. The \$9.3 to \$1.0 savings-to-cost ratio is calculated by dividing OCAct's projected future savings of more than \$3.5 billion by the \$381 million spent on periodic CDRs in FY2010.

¹⁸¹ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces the Second in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Carolyn Colvin, Deputy Commissioner of the Social Security Administration, 112th Cong., 2nd sess., January 24, 2012, http://www.ssa.gov/legislation/testimony_012412.html.

¹⁸² SSA's Office of the Inspector General, *Full Medical Continuing Disability Reviews*, March 30, 2010, p. 2, <http://oig.ssa.gov/full-medical-continuing-disability-reviews>.

¹⁸³ *Ibid.*, C-3. Estimates assume a cessation rate of between 6% and 12%. Estimated savings reflect avoided SSI and SSDI payments between CY2005 and CY2010 and do not include payments made under Medicare or Medicaid.

¹⁸⁴ Social Security Administration, *Social Security Administration, Performance and Accountability Report, Fiscal Year 2012*, November 8, 2012, p. 184, <http://www.ssa.gov/finance/> (hereinafter cited as "SSA FY2012 Performance and Accountability").

¹⁸⁵ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, Chairman Johnson Announces the First in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program, Statement for the Record from the Consortium for Citizens with Disabilities, 112th Cong., 1st sess., December 2, 2011, Serial 112-SS11 (Washington: GPO, 2012). See also Testimony of Kathy Ruffing 2013, p. 15. Moreover, see Office of Management and Budget, *Fiscal Year 2014 Budget of the U.S. Government*, 2013, p. 138, <http://www.whitehouse.gov/> (continued...)

discretionary spending and increases the federal government's statutory debt limit, includes a provision to adjust the discretionary spending caps to permit additional appropriations to SSA for program integrity activities such as CDRs and SSI redeterminations.¹⁸⁶ In March 2013, SSA estimated that if Congress had appropriated the maximum amount allowed for program integrity activities in FY2012, the agency would have completed an additional 126,000 full medical CDRs, thereby saving approximately \$800 million in SSDI, SSI, Medicare, and Medicaid expenditures between FY2012 and FY2022.¹⁸⁷ Alternatively, the President's FY2014 budget proposes replacing the discretionary spending caps established under the Budget Control Act of 2011 with a dedicated source of mandatory funding to enable SSA to conduct more CDRs and SSI redeterminations on a consistent basis.¹⁸⁸ According to the President's FY2014 budget, the requested \$1.227 billion in mandatory funding and \$273 million in discretionary base funding would allow SSA to perform at least 650,000 CDRs and at least 2.6 million SSI redeterminations.¹⁸⁹

Even with additional funding, increasing the number of CDRs poses a challenge for SSA. High attrition rates, hiring freezes, and employee furloughs have affected SSA's ability to process CDRs. In response to budget deficits, some states instituted furloughs or hiring freezes for state employees following the last recession, including DDS examiners.¹⁹⁰ The contraction in the number of DDS examiners limited SSA's ability to conduct determinations and contributed to the backlog of CDRs. To combat the reduction in state DDS examiners, SSA transferred a portion of disability cases from furloughed DDS offices to non-furloughed DDS offices in other states; in addition, the agency hired more than 2,600 DDS employees in FY2009 and FY2010.¹⁹¹ However, due to an agency-wide hiring freeze starting in FY2011, SSA stopped DDS hiring in FY2011 and did only limited critical hiring in FY2012.¹⁹² The reduction in DDS hiring between FY2011 and FY2012 coincided with high rates of attrition for existing DDS employees. In 2012, 15 field offices witnessed a 30% reduction in staff levels and nearly one-third of all field offices experienced attrition rates of more than 10%.¹⁹³ Because of the combination of attrition and hiring

(...continued)

[sites/default/files/omb/budget/fy2014/assets/budget.pdf](http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf).

¹⁸⁶ For more information on SSA budgetary issues, see CRS Report R41716, *Social Security Administration (SSA): Budget Issues*, by Scott Szymendera. SSI redeterminations are periodic reviews to ensure that beneficiaries continually meet SSI eligibility requirements. For additional information on SSI redeterminations, see 20 C.F.R. § 416.204.

¹⁸⁷ Testimony of Carolyn Colvin 2013, pp. 9-10. SSA performed approximately 443,000 full medical CDRs in FY2012. Estimated savings based on FY2013 budget assumptions.

¹⁸⁸ Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2014*, 2013, pp. 148-149, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/spec.pdf>.

¹⁸⁹ *Ibid.*

¹⁹⁰ As of September 2012, only Nevada, New York, Oregon, and Washington were still furloughing DDS employees. See SSA FY2012 Performance and Accountability, p. 184. For more information on SSA workforce issues, see CRS Report R40207, *Social Security Administration: Workload and Related Issues*, by Scott Szymendera.

¹⁹¹ The SSA's Office of the Inspector General, *The Social Security Administration's Response to State Furloughs Impacting its Disability Programs*, A-01-11-11116, March 22, 2011, p. 6, <http://oig.ssa.gov/social-security-administration%3Fs-response-state-furloughs-impacting-its-disability-programs>. See also SSA FY2012 Performance and Accountability, p. 184.

¹⁹² SSA FY2012 Performance and Accountability, p. 184.

¹⁹³ U.S. Congress, Senate Committee on Finance, *The Social Security Administration: Is it Meeting its Responsibilities to Save Taxpayer Dollars and Serve the Public?*, Testimony of Michael Astrue, Commissioner of SSA, 112th Cong., 2nd sess., May 17, 2012, http://www.ssa.gov/legislation/testimony_051712.html.

freezes, SSA lost more than 1,200 DDS employees in FY2011 and 1,025 DDS employees in FY2012.¹⁹⁴

Although additional funding would augment SSA's ability to perform CDRs by allowing the agency to hire new examiners, the shortage of veteran examiners with the experience to conduct CDRs may prevent SSA from completing all scheduled disability reviews. Part of the problem stems from the fact that DDS examiners experience high rates of turnover. According to GAO, over 20% of DDS examiners hired between September of 1998 and January of 2006 left or were terminated within their first year.¹⁹⁵ Of the DDS examiners who remain, it takes on average two years of training and experience before SSA considers them to be fully trained.¹⁹⁶ Therefore, even if Congress appropriated additional funds immediately for SSA, it may take the agency years to reestablish a robust pool of highly experienced DDS examiners.

Return-to-Work Incentives

Another policy option to combat the growth in SSDI rolls is to provide stronger incentives for beneficiaries to return to the labor force. To encourage beneficiaries to return to the labor force, SSA allows beneficiaries to test their ability to work by participating in a 9-month Trial Work Period (TWP), during which participants may earn any amount within a rolling 60-month period without having their benefits terminated or reduced.¹⁹⁷ Moreover, SSA provides employment services to equip beneficiaries with the training and support structure needed to find employment in a competitive job market. In spite of the services offered by SSA, very few beneficiaries permanently leave the SSDI program. In 2011, SSA terminated the benefits of only 0.5% of all disabled-worker recipients due to earnings above SGA.¹⁹⁸ This subsection outlines policies that may help to increase the return-to-work rate of SSDI beneficiaries and thus reduce the average duration of benefit receipt.¹⁹⁹

¹⁹⁴ SSA FY2012 Performance and Accountability, p. 184.

¹⁹⁵ U.S. Congress, House Committee on Ways and Means, Subcommittees on Income Security and Family Support and Social Security, *Hearing on Disability Backlogs and Related Service Delivery Issues*, 111th Cong., 1st sess., March 24, 2009, p. 10, <http://www.gao.gov/products/GAO-09-511T>.

¹⁹⁶ *Ibid.*

¹⁹⁷ In 2013, SSA considers any month in which the participant's earnings exceed \$750 a trial work month. Upon completion of the TWP, the participant may enter a 36-month Extended Period of Eligibility (EPE), during which the participant receives cash benefits only if earnings are below SGA. The EPE is also known as the re-entitlement period. The first three months of the EPE are a grace period, during which SSA pays benefits regardless of the amount of monthly earnings. For more information, see 20 C.F.R. § 404.1592 and 404.1592a. For information on monthly TWP amounts, see Social Security Administration, *Trial Work Period*, October 16, 2012, <http://www.ssa.gov/oact/cola/twp.html>.

¹⁹⁸ SSDI Annual Report 2011, Table 57, p. 137. Some longitudinal studies indicate slightly higher return-to-work rates relative to the cross-sectional statistic published in SSA's Annual Statistical Report. One longitudinal study found that of a cohort of beneficiaries examined between 1996 and 2006, 6.5% had their benefits suspended for earnings above SGA in at least 1 month and 3.7% had their benefits eventually terminated due to work. For more information, see Su Liu and David C. Stapleton, "Longitudinal Statistics on Work Activity and Use of Employment Supports for New Social Security Disability Insurance Beneficiaries," *Social Security Bulletin*, vol. 71 no. 3, (August 2011), p. 35, <http://www.ssa.gov/policy/docs/ssb/v71n3/v71n3p35.html>.

¹⁹⁹ For more information on work incentives, see Social Security Administration, *The Red Book - A Guide to Work Incentives*, SSA Publication No. 64-030, <http://ssa.gov/redbook/>.

Increase Awareness of Return-to-Work Services

To address some of the barriers to employment faced by beneficiaries with disabilities, Congress enacted the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170), which established the Ticket to Work and Self-Sufficiency program (hereinafter “Ticket to Work”).²⁰⁰ Ticket to Work assists beneficiaries between the ages of 18 and 64 in returning to the labor force by providing a voucher or ticket for employment, vocational rehabilitation (VR), or other support services through public or private contractors known as Employment Networks (EN), as well as traditional State VR agencies (SVRA). Participation in the Ticket to Work program is voluntary, and ticket holders (beneficiaries) decide when and whether to assign a ticket to a particular EN or SVRA. Under the program, SVRAs and ENs receive payments from SSA for services provided to ticket holders based on specific work-related performance measures.

Thus far, the Ticket to Work program has met with little success. Although program participants are more likely to have employment relative to other beneficiaries, only about 2.2% of all “active” tickets issued by SSA are “in use” by beneficiaries (i.e., assigned to an EN or SVRA).²⁰¹ According to GAO, EN representatives partially attribute Ticket to Work’s low beneficiary participation rate to “a lack of understanding and awareness of the program,” while some disability-rights organizations contend that the fear of losing benefits may deter beneficiaries from taking part in the program.²⁰²

To improve the return-to-work rate of SSDI recipients, researchers Bonnie O’Day and David Stapleton have proposed testing early intervention policies that provide beneficiaries with employment and other support services shortly after receipt of benefits.²⁰³ The researchers argue that current employment services such as Ticket to Work have failed to increase the return-to-work rate, inasmuch as many beneficiaries “have been separated from the labor force, often for years, before they are offered assistance.”²⁰⁴ By providing beneficiaries with employment and other support services earlier during their stay on SSDI (i.e., when their attachment to the labor force is relatively strong), the researchers posit that said beneficiaries may have a greater chance of returning to work.

One early intervention option is to require all future beneficiaries to participate in mandatory work preparation counseling in order to educate them on the variety of return-to-work services offered by SSA.²⁰⁵ Mandatory counseling has the potential to elucidate beneficiary confusion

²⁰⁰ For more information on the Ticket to Work program, see CRS Report R41934, *Ticket to Work and Self-Sufficiency Program: Overview and Current Issues*, by Umar Moulta-Ali (hereinafter cited as “CRS Report R41934”).

²⁰¹ Gina A. Livermore and Allison Roche, “Longitudinal Outcomes of an Early Cohort of Ticket to Work Participants,” *Social Security Bulletin*, vol. 71, no. 3, (August 2011), pp. 105-116, <http://www.ssa.gov/policy/docs/ssb/v71n3/v71n3p105.html>. According to the study, in 2004, 32% of Ticket to Work participants were employed compared with only 9% of all SSDI and SSI beneficiaries. For more information on the number of tickets “in use,” see CRS Report R41934.

²⁰² U.S. Government Accountability Office, *Ticket to Work Participation Has Increased, but Additional Oversight Needed*, GAO-11-324, May 6, 2011, p. 11, <http://www.gao.gov/products/GAO-11-324>.

²⁰³ Bonnie O’Day and David Stapleton, *The United Kingdom Pathways to Work Program: A Path to Employment?*, Mathematica Policy Research, Inc., Number 08-02, September 2008, http://www.mathematica-mpr.com/publications/PDFs/pathways_disbrief2.pdf (hereinafter cited as “O’Day and Stapleton 2008”).

²⁰⁴ *Ibid.*, p. 1.

²⁰⁵ The agency could exempt beneficiaries with a low probability of recovery from the counseling requirement, since they are less likely to return to work compared to other beneficiaries.

regarding return-to-work services, which may in turn increase the likelihood of beneficiary participation in programs such as Ticket to Work. Although mandatory work preparation counseling would require new funding to hire additional SSA affiliated counselors, the counseling may be cost-effective if it improves the return-to-work rate of SSDI recipients.

To demonstrate the benefits of early intervention, O'Day and Stapleton point to the United Kingdom's (UK's) recently discontinued Pathways to Work program as an example of how mandatory participation in work preparation can improve beneficiary employment outcomes.²⁰⁶ Like Ticket to Work, Pathways to Work was designed to encourage beneficiaries with disabilities to return to work by providing employment support services. Although participation in Pathways to Work was voluntary, starting in 2008, new beneficiaries were required to participate in six Work Focused Interviews (WFI), during which advisors provided beneficiaries with information on optional employment services and financial incentives for returning to work.²⁰⁷ A cost-benefit analysis conducted by the UK's Department of Work and Pensions concluded that WFIs and return-to-work tax credits were the most expensive components of Pathways to Work; however, the study noted that the program ultimately yielded a net societal benefit of £3.06 (\$5.56) for every £1.00 (\$1.82) invested in Pathways to Work.²⁰⁸ Another study found that the Pathways to Work program increased the probability of a beneficiary having a job by 7.4 percentage points.²⁰⁹

Currently, SSA oversees two voluntary grant programs aimed at increasing beneficiary awareness of return-to-work services. In addition to the Ticket to Work program, P.L. 106-170 also established the Work Incentives Planning and Assistance (WIPA) program and the Protection and Advocacy for Beneficiaries of Social Security (PABSS).²¹⁰ The WIPA program awards grants to community organizations that provide education and assistance for beneficiaries interested in returning to work, whereas the PABSS program provides grants for legal assistance and advice on how to obtain VR, employment, or other services for work-oriented beneficiaries.

Estimating the overall impact of mandatory counseling on the SSDI beneficiary return-to-work rate is difficult because the results of SSA's current employment-counseling initiatives are inconclusive. According to one study, the use of WIPA services possibly has a positive effect on

²⁰⁶ O'Day and Stapleton 2008. In 2011, the U.K. government replaced Pathways to Work with the Work Programme, which is a consolidation of all U.K. welfare-to-work programs. For more information, see U.K. National Audit Office, *Department of Work and Pensions: The Introduction of the Work Programme*, Report by the Comptroller and Auditor General, HC 1701 Session 2010–2012, January 24, 2012, <http://www.official-documents.gov.uk/document/hc1012/hc17/1701/1701.pdf>.

²⁰⁷ New beneficiaries with a low probability of recovery or high likelihood of returning to work without additional assistance were required to attend only one WFI. Existing beneficiaries were required to attend three WFI unless given exemption. For more information, see Stuart Adam et al., *A Cost-Benefit Analysis of Pathways to Work for New and Repeat Incapacity Benefits Claims*, U.K. Department of Work and Pensions, Research Report No 498, 2008, p. 8, <http://discovery.ucl.ac.uk/17916/1/17916.pdf>.

²⁰⁸ *Ibid.*, pp. 131-132. The savings-to-cost ratio to the government (Exchequer) was £1.51 (\$2.75) to £1.00 (\$1.82). Cost estimates pertain to the 12-month period between April 2005 and March 2006. U.S. dollar amounts reflect the 2005 annual average exchange rate from The World Bank, *Official exchange rate (LCU per US\$, period average)*, <http://data.worldbank.org/indicator/PA.NUS.FCRF?page=1>.

²⁰⁹ Helen Bewley, Richard Dorsett, and Getinet Haile, *The Impact of Pathways to Work*, U.K. Department for Work and Pensions, Research Report No 435, 2007, p. 2, <http://research.dwp.gov.uk/asd/asd5/rports2007-2008/rrep435.pdf>. The employment rate of the control group was 29.7%.

²¹⁰ Prior to 2006, WIPA was known as the Benefits Planning Assistance and Outreach (BPAO) program. Although authorization for WIPA and PABSS expired on June 30, 2012 and September 30, 2012, respectively, the Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6) appropriated money to both programs through the rest of FY2013. For more information, see CRS Report R41934.

the employment outcomes of SSI/SSDI beneficiaries; however, the study's researchers cautioned against drawing a causal relationship between receipt of WIPA services and employment outcomes.²¹¹ In essence, the researchers were unable to discern whether beneficiaries who received WIPA services would have enjoyed the same employment outcome in the absence of such assistance.

In addition, program rules concerning eligibility and benefit levels could make SSDI less responsive to the positive effects of mandatory counseling relative to other disability programs, such as the United Kingdom's.²¹² According to O'Day and Stapleton, SSDI benefits are significantly more generous compared with UK incapacity benefits; moreover, SSDI's stricter eligibility requirements suggest that SSDI beneficiaries are less likely to have some residual functional capacity to work relative to UK beneficiaries.²¹³ Therefore, SSDI beneficiaries presumably have less incentive to return to work. Although mandatory counseling could improve the return-to-work rate of SSDI beneficiaries, the effect may be smaller compared with the impact of WFIs on UK beneficiary employment outcomes.

Benefit Offset

Another reason behind the low return-to-work rate stems from the fact that some beneficiaries deliberately “park” their earnings from work below the SGA threshold. After completing the TWP and 36-month Extended Period of Eligibility (EPE), beneficiaries must earn below SGA or risk having their benefits terminated.²¹⁴ Consequently, some beneficiaries may intentionally keep their earnings below SGA in order to maintain receipt of SSDI benefits. One study found that between 0.2% and 0.4% of all SSDI beneficiaries parked their earnings below SGA in a typical month from 2002 to 2006.²¹⁵

Beneficiaries may park their earnings below SGA (sometimes called the “cash cliff”), in part, because their impairment prevents them from returning to work on a consistent basis. Another study found that 59.0% of Ticket to Work participants returned to work at some point between 2003 and 2005; however, of those participants who left work, the most cited reason was due to poor health.²¹⁶ Parking earnings below SGA may weaken a work-oriented beneficiary's attachment to the labor force, possibly resulting in an erosion of skills and thus a reduced likelihood of returning to work following a health-related withdrawal from the labor force.²¹⁷

²¹¹ Gina Livermore, Sarah Prenovitz, and Jody Schimmel, *Employment-Related Outcomes of a Recent Cohort of Work Incentives Planning and Assistance (WIPA) Program Enrollees*, Mathematica Policy, Inc., Final Report, September 19, 2011, p. 51, <http://www.ssa.gov/disabilityresearch/documents/WIPA%20Cohort%20September%202011.pdf>.

²¹² O'Day and Stapleton 2008, p. 3.

²¹³ Ibid.

²¹⁴ For more information, see footnote 197.

²¹⁵ Jody Schimmel, David C. Stapleton, and Jae G. Song, “How Common is “Parking” among Social Security Disability Insurance Beneficiaries? Evidence from the 1999 Change in the Earnings Level of Substantial Gainful Activity,” *Social Security Bulletin*, vol. 71 no. 4, (November 2011), p. 77, <http://www.ssa.gov/policy/docs/ssb/v71n4/v71n4p77.html>.

²¹⁶ Gina A. Livermore and Allison Roche, “Longitudinal Outcomes of an Early Cohort of Ticket to Work Participants,” *Social Security Bulletin*, vol. 71, no. 3, (August 2011), p. 120, Table 11, <http://www.ssa.gov/policy/docs/ssb/v71n3/v71n3p105.html>.

²¹⁷ For more information, see Willem Van Zandweghe, “Interpreting the Recent Decline in Labor Force Participation,” *Federal Reserve Bank of Kansas City Economic Review*, First Quarter 2012, pp. 28-29, <http://www.kc.frb.org/publicat/econrev/pdf/12q1VanZandweghe.pdf>.

To remedy the phenomenon of parked earnings, some disability-rights organizations have advocated eliminating the fixed cash cliff (SGA threshold) and instead adopting a gradual benefit-offset model that allows beneficiaries to increase their earnings while remaining on SSDI.²¹⁸ The SSI program operates under a benefit-offset system, deducting \$1 in benefits for every \$2 in earned income above \$65.²¹⁹ Benefit offset has the potential to reduce the average duration of benefit receipt, by increasing the time spent off SSDI rolls for beneficiaries engaged in work. Hence, benefit offset could lower overall SSDI program costs, while increasing beneficiary earnings and attachment to the labor force.

Benefit Offset National Demonstration

SSA is currently in the process of conducting a Benefit Offset National Demonstration (BOND) project, during which treatment participants lose \$1 in benefits for every \$2 in earnings exceeding a BOND Yearly Amount (BYA) equal to 12 times the monthly SGA amount.²²⁰ BOND participants can also receive Enhanced Work Incentives Counseling (EWIC), which is designed address a range of issues related to returning to work, including access to medical treatment, employment services, and job training.²²¹ In implementing BOND, SSA seeks to test whether benefit offset can increase earnings and reduce dependence on SSDI for work-oriented beneficiaries (i.e., beneficiaries with some, albeit limited, capacity to work).²²²

In preparation for BOND, SSA implemented a four-state pilot program known as the Benefit Offset Pilot Demonstration (BOPD) from 2005 until the end of 2008.²²³ According to SSA, participation in BOPD had a positive effect on the earnings of individuals in the treatment group; however, BOPD also increased mean benefit payments due to partial payments made to beneficiaries whose benefits would have been suspended under normal program rules for earning above SGA.²²⁴

In addition to increasing beneficiary earnings, BOND could conceivably increase the return-to-work rate and therefore abate the growth in SSDI rolls. For example, beneficiaries with an above

²¹⁸ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces the Fifth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Marty Ford, Director of Public Policy, The Arc of the United States, on behalf of the Consortium for Citizens with Disabilities Social Security Task Force, 112th Cong., 2nd sess., September 14, 2012, p. 5, http://waysandmeans.house.gov/uploadedfiles/ford_testimony_ss914.pdf.

²¹⁹ 20 C.F.R. § 416.1112(c)(5) and (7). For more information on SSI, see CRS Report 94-486, *Supplemental Security Income (SSI)*, by Umar Moulta-Ali.

²²⁰ David Wittenburg et al., *BOND Implementation and Evaluation: BOND Stage 1 Early Assessment Report*, Abt Associates Inc. and Mathematica Policy, Inc., Submitted to the Social Security Administration, Deliverable 24.1, May 17, 2012, p. 1, <http://www.ssa.gov/disabilityresearch/offsetnational.htm>.

²²¹ David Stapleton et al., *BOND Implementation and Evaluation: BOND Final Design Report*, Abt Associates Inc. and Mathematica Policy, Inc., submitted to the Social Security Administration, Deliverable 2.2, December 3, 2010, p. 6, <http://www.ssa.gov/disabilityresearch/offsetnational.htm> (hereinafter cited as “BOND Final Design Report 2010”).

²²² To determine the offset amount, SSA initiates a work CDR of a participant’s earnings. Similar to a medical CDR, a work CDR allows SSA to determine whether a beneficiary meets SSDI eligibility criteria regarding earnings. Although BOND participants are exempt from termination due to earnings above SGA, they are still subject to periodic medical CDRs. For more information, see Security Administration, *DI 60099.040 Benefit Offset National Demonstration (BOND) Offset*, January 18, 2012, <https://secure.ssa.gov/poms.nsf/lnx/0460099040>.

²²³ BOND Final Design Report 2010, p. 19.

²²⁴ Social Security Administration, *Annual Report on Section 234 Demonstration Projects, May 2011*, May 2011, pp. 4-5, <http://www.ssa.gov/disabilityresearch/newsarchive/2011news.htm>.

average likelihood of recovery but whose impairment results in considerable employment instability would benefit from the BOND program through increased labor force attachment. Under BOND program rules, said beneficiaries could maximize their potential labor force participation while they recover from their impairment, thereby increasing their likelihood of one day permanently returning to work.

Promote Supported-Work Policies

Some researchers have suggested shifting the focus of SSDI reform away from reducing the current beneficiary population toward policies designed to attenuate the inflow of beneficiaries into the program.²²⁵ Advocates of this approach, sometimes referred to as “supported work,” argue that offering employment supports shortly after the onset of disability would allow more workers who experience disability to remain attached to the labor force and therefore less likely to apply for SSDI. Most supported-work policies use financial incentives to encourage employers to provide preventative, accommodative, rehabilitative, and other return-to-work services as a means of reducing employee enrollment in the SSDI program. Although Title I of the Americans with Disabilities Act (ADA; P.L. 101-336, as amended) requires employers to provide some level of “reasonable accommodation” for employees with disabilities in the workplace, some employers fail to comply with the provisions of ADA, creating a barrier to employment for many workers with disabilities.²²⁶ Faced with few employment opportunities, individuals with disabilities who could conceivably work given appropriate accommodation may turn to SSDI as a last resort. This subsection provides an overview of two supported-work policies that have the potential to slow the incidence of benefit receipt and thus reduce the growth in disability rolls.

Experience Rate the Employer’s Portion of the Payroll Tax

Experience rating is a process for determining insurance premiums based on the cost of an insurance pool’s past claims. In essence, an insurer calculates a firm’s insurance premium based on the likelihood, or risk, of the firm submitting a future claim given its previous behavior. Many types of employer-sponsored insurance use experience rating to determine premiums, including state workers’ compensation (WC), unemployment insurance (UI), and private disability insurance (PDI).²²⁷ By making premiums a function of past claims, experience rating adjusts the firm’s costs to reflect its use of the insurance program. Consequently, experience rating creates

²²⁵ U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Chairman Johnson Announces the Fifth in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program*, Testimony of Richard Burkhauser, Ph.D, 112th Cong., 2nd sess., September 14, 2012, http://waysandmeans.house.gov/uploadedfiles/burkhauser_testimony_ss914.pdf (hereinafter cited as “Burkhauser Testimony 2012”).

²²⁶ Under ADA, “reasonable accommodation” is defined as making existing facilities readily accessible to and usable by individuals with disabilities, and job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, adjustment of examinations or training materials or policies, provision of qualified readers or interpreters or other similar accommodations. See 42 U.S.C. §12111(9). For more information, see CRS Report 98-921, *The Americans with Disabilities Act (ADA): Statutory Language and Recent Issues*, by Cynthia Brougher.

²²⁷ David C. Stapleton, *Issue Brief: Bending the Employment, Income, and Cost Curves for People with Disabilities*, Mathematica Policy, Inc., Number 11- 01, April 2011, p. 2, http://www.mathematica-mpr.com/publications/PDFs/disability/disability_bendemploy_ib.pdf (hereinafter cited as “Stapleton Issue Brief 2011”). Insurance premium determination systems and methodologies vary by state. Workers’ compensation provides medical benefits and a partial wage replacement to insured workers whose impairment or condition stems from their employment. Unemployment insurance provides a partial wage replacement to insured workers who become involuntarily unemployed.

financial incentives for employers to prevent employees from needing specific insurance services in the first place.

To reduce the incidence of SSDI receipt, researchers Richard V. Burkhauser, Mary C. Daly, and Philip R. de Jong have suggested that the federal government should implement some form of experience rating to the employer's portion of the payroll tax used to fund SSDI and Medicare.²²⁸ Currently, employers pay the same payroll tax rate on their employees' earnings for SSDI, regardless of the rate at which their employees enroll in the program.²²⁹ Under the current system, employers have little incentive to make robust investments in preventative, accommodative, or rehabilitative services, because employees with disabilities can transition to SSDI without any additional cost to the employer. However, under an experience rated system, employers whose employees enroll in SSDI at rates above the national average would pay a higher payroll tax rate, whereas firms whose employees enter the program at below average rates would pay a lower payroll tax rate. In theory, the experienced-rated payroll tax should incentivize employers to provide supported-work services, in order to reduce their employees' enrollment rate in SSDI and subsequently lower their labor costs.

Supporters of experience rating often point to its implementation in the Netherlands' disability insurance (DI) system as evidence of its potential impact in the United States. Between 1998 and 2003, the Netherlands gradually incorporated experience rating into its DI system, charging Dutch employers a differentiated premium rate based on their employees' past enrollment in the DI system.²³⁰ According to one empirical study, the effect of instituting experience-rated DI premiums amounted to a 15% reduction in the enrollment of workers in the Dutch DI program.²³¹ Since the early 2000s, the Netherlands has witnessed a marked decline in its DI prevalence rate.²³²

²²⁸ Ibid., p. 3. See also Richard V. Burkhauser, Mary C. Daly, and Philip R. de Jong, *Curing the Dutch Disease: Lessons for United States Disability Policy*, University of Michigan Retirement Research Center, Working Paper 2008-188, September 2008, <http://www.mrrc.isr.umich.edu/publications/Papers/pdf/wp188.pdf> (hereinafter cited as "Burkhauser, Daly, and de Jong 2008").

²²⁹ SSDI and Medicare's Hospital Insurance (HI; also known as Part A) are financed primarily through the Federal Insurance Contributions Act (FICA) payroll tax and the Self-Employment Contributions Act (SECA) tax, to which all workers and employers in covered occupations (including military personnel) and self-employed individuals contribute. In 2013, the total payroll tax rate is 15.3% on earnings split equally between employees and employers. The SSDI portion of the payroll tax is 1.8% (0.9% each per employee and employer) up to a taxable maximum of \$113,700 in 2013. The HI portion of the payroll tax is 2.9% (1.45% each per employee and employer) on all earnings subject to the tax. For more information on OASDI payroll taxes, see CRS Report R41648, *Social Security: Temporary Payroll Tax Reduction*, by Dawn Nuschler. For more information on Medicare's HI portion of the payroll tax, see CRS Report R41436, *Medicare Financing*, by Patricia A. Davis.

²³⁰ Philip R. de Jong, *Recent changes in Dutch disability policy*, Aarts de Jong Wilms Goudriaan Public Economics (APE), September 2008.

²³¹ Pierre Koning, *Estimating the impact of experience rating on the inflow into disability insurance in the Netherlands*, CBP Netherlands Bureau of Economic Policy Analysis, CPB Discussion Paper no 37, August 2004, <http://www.cpb.nl/en/publication/estimating-impact-experience-rating-inflow-disability-insurance-netherlands>. The study found the ex post (after-the-fact) effect of having to pay a premium rate in a given year due to experience rating induced Dutch employers to invest more in preventative services, amounting to a 15% reduction in the inflow of workers into the state DI system after one year.

²³² Burkhauser Testimony 2012. According to Burkhauser, the decline in the Dutch DI prevalence rate stems from numerous reforms instituted over the past 15 years. Because of a series of reforms that began in 2006, Dutch employers now pay a uniform rate for all permanent disability benefits (IVA); however, employers pay experienced-rated premiums on partial disability benefits (WGA) via the state system. Although Dutch firms may opt out of the state system and purchase private insurance, many private DI insurance pools are experienced rated. For more information, (continued...)

Another potential advantage of the experience rating option is its relative simplicity. Employers already report payroll tax data to the Internal Revenue Service (IRS), which the agency shares with SSA. Moreover, most employers are accustomed to the concept of experience rating stemming from their experience paying state WC and UI premiums. By compiling both payroll tax and beneficiary award data, SSA could conceivably initiate an experience rating system to the SSDI payroll tax “without imposing substantial new reporting requirements or administrative burdens on employers.”²³³

Notwithstanding the potential for reduced enrollment in SSDI, implementing an experience rating system to the employer’s portion of the payroll tax may adversely affect some workers. For example, experience-rated payroll taxes could make employers hesitant to hire or retain workers “perceived to be a high risk for disability.”²³⁴ Employers may discriminate against older workers, people with chronic conditions such as diabetes, or individuals prone to at-risk behaviors (e.g., alcohol or substance abuse) in order to avoid paying a higher payroll tax rate on their employees’ earnings. To address this possibility, supporters of experience rating suggest implementing risk adjustments specific to factors such as age, occupation, and health status, as well as enforcing existing anti-discrimination laws.²³⁵

In addition, experience rating could conceivably reduce the compensation or employment opportunities of low-wage workers. Some employers subject to higher payroll tax rates could shift the additional cost onto workers in the form of reduced take-home pay and benefits. Alternatively, employers unable to shift additional labor costs onto their employees may instead offset the higher payroll tax rate by hiring fewer workers in the future.²³⁶ Since many low-wage individuals typically tend to work in professions with high rates of disability, they may be disproportionately affected by employer cost avoidance and therefore more likely to suffer financially as a result.²³⁷ Opponents of experience rating argue that workers adversely affected by employer cost avoidance could turn to SSDI as a last resort, thereby increasing worker enrollment in the SSDI program.²³⁸

Furthermore, some critics of experience rating have expressed concern that while the system changes the incentives of employers with respect to program enrollment, it fails to address the incentives of workers to apply for SSDI.²³⁹ Some workers may apply for SSDI because of

(...continued)

see Organization for Economic Co-operation (OECD), *Sickness and Disability Schemes in the Netherlands*, November 2007, <http://www.oecd.org/social/soc/41429917.pdf>.

²³³ David H. Autor, *The Unsustainable Rise of the Disability Rolls in the United States: Causes, Consequences, and Policy Options*, National Bureau of Economic Research, NBER Working Paper No. 17697, December 2011, p. 15, <http://www.nber.org/papers/w17697> (hereinafter cited as “Autor NBER Working Paper 2011”).

²³⁴ Stapleton Issue Brief 2011, p. 3.

²³⁵ David C. Stapleton et al., “Income Security for Workers: A Stressed Support System in Need of Innovation,” *Journal of Disability Policy Studies*, June 20, 2008, p. 11 (hereinafter cited as “Stapleton et al. Income Security for Workers 2008”).

²³⁶ Employers may be unable to shift increased labor costs onto employees due to a lower bound restraint such as the minimum wage.

²³⁷ Stapleton Issue Brief 2011, p. 3. Stapleton would offset the reduced compensation with an expansion of the Earned Income Tax Credit (EITC) in order to bolster the after-tax income of low-wage workers. For more information on the EITC, see CRS Report RL31768, *The Earned Income Tax Credit (EITC): An Overview*, by Christine Scott.

²³⁸ CBO, *Policy Options 2012*, p. 28.

²³⁹ Autor NBER Working Paper 2011, pp. 15-17.

economic circumstances such as unemployment or low wages.²⁴⁰ Although the initial determination process screens out most non-meritorious claimants, SSA may grant awards to some claimants on the margin of program entry who could potentially work but choose not to due to economic circumstances. Under an experience rating system, the former employers of these new beneficiaries could have their payroll tax rate increased, even though the beneficiaries based their decision to apply for SSDI primarily on factors unrelated to health status or disability. As a result, said employers would be penalized twice for terminating a worker, insofar as their UI rate would increase, as well as their payroll tax rate for SSDI and Medicare. Given this scenario, opponents contend that experience rating the employer's portion of the payroll tax does little to address the moral hazard of workers applying to the program for reasons unrelated to health status or disability.²⁴¹

Employer-Sponsored Private Disability Insurance

Another policy option to stem the flow of beneficiaries into SSDI is for the federal government to promote employer-sponsored private disability insurance (PDI). PDI provides beneficiaries with a partial wage replacement, as well as workplace accommodation, rehabilitation, and other return-to-work services. As of March 2012, 39% of all workers in private industry had access to short-term disability insurance, whereas 33% of said workers had access to long-term PDI.²⁴² Short-term PDI typically lasts a fixed number of weeks or months, whereas long-term disability insurance can last anywhere from a year to FRA.²⁴³ Compared with other forms of employer-sponsored insurance such as health-care, PDI is relatively inexpensive.²⁴⁴ In addition, employers can partially offset the cost of PDI by requiring employees to contribute to the plan.²⁴⁵

Some researchers have advocated that the federal government should promote employer-sponsored PDI to reduce the growth in SSDI rolls.²⁴⁶ Employer-sponsored PDI plans have the potential to reduce the incidence of SSDI benefit receipt, inasmuch as they provide employment-support services soon after the onset of disability when the likelihood of recovery is highest. By

²⁴⁰ For more information, see the “Changes in the Economic Incentives to Apply for SSDI” section of the report.

²⁴¹ Autor NBER Working Paper 2011, p. 16. Moral hazard refers to the tendency for individuals to engage in risky behavior when they are not fully exposed to the consequences of their actions.

²⁴² Bureau of Labor Statistics, *Insurance benefits: Access, participation, and take-up rates*, Table 16, March 2012, <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/private/table12a.htm>.

²⁴³ In March 2012, the median duration of benefit receipt on short-term PDI for all workers in private industry was 26 weeks. For more information, see Bureau of Labor Statistics, *Short-term disability plans: Duration of benefits*, Table 25, March 2012, <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/private/table35a.htm>.

²⁴⁴ In December 2012, employee health insurance cost employers in private industry \$2.23 per-hour worked, whereas employee short-term disability insurance cost \$0.05 and long-term disability insurance cost \$0.04 per-hour worked. For more information, see Bureau of Labor and Statistics, *Private industry, by major occupational group and bargaining status*, Table 5, December 2012, <http://www.bls.gov/news.release/ecec.t05.htm>.

²⁴⁵ In March 2012, 19% of short-term PDI plans sponsored by employers in private industry required employee contributions, whereas 8% of long-term PDI plans had such a requirement. For more information, see Bureau of Labor Statistics, *Employee Benefit Survey: Tables Organized by Benefit*, March 2012, <http://www.bls.gov/ncs/ebs/benefits/2012/benefits.htm#life>.

²⁴⁶ David H. Autor and Mark Duggan, *Supporting Work: A Proposal for Modernizing the U.S. Disability Insurance System*, The Center for American Progress and The Hamilton Project, <http://www.brookings.edu/research/papers/2010/12/disability-insurance-autor> (hereinafter cited as “Autor and Duggan 2010”). See also Burkhauser, Daly, and de Jong 2008.

intervening with robust supported-work services early in the disability process, PDI may keep workers with disabilities attached to the labor force and therefore less likely to apply for SSDI.²⁴⁷

The promotion of employer-sponsored PDI could come about in either one of two ways: (1) encouragement through incentives or (2) a government mandate. Under the former option, the federal government would offer employers financial incentives to provide PDI for their employees. For example, if the federal government adopted an experience rating system to the employer's portion of the SSDI and Medicare payroll tax, SSA could further lower the payroll tax rate of employers who purchase PDI and whose insurance agents coordinate with SSA officials (gatekeepers) to manage disability cases in a cost-effective manner.²⁴⁸ Alternatively, the federal government could award subsidies or tax credits to firms that provide PDI.²⁴⁹

Under the latter option, the federal government would require all employers to provide PDI for their employees. To enforce the mandate, employers who fail to provide PDI would likely face financial penalties for their non-compliance. In 2010, only New Jersey, New York, Hawaii, and Puerto Rico required employers to provide some form of short-term PDI—known as temporary disability insurance (TDI)—or contribute to a state-operated fund.²⁵⁰ Employer-mandated PDI, however, has become an increasingly popular approach to finance disability insurance in many European countries. The Netherlands, for example, now requires employers to cover the cost of sick pay for the first two years following the onset of a disabling condition, whereas the U.K. requires employers to pay up to six-months of statutory sick pay.²⁵¹

Researchers David H. Autor and Mark Duggan have proposed requiring all employers to provide medium-term PDI, through which workers with disabilities would receive rehabilitation services, workplace accommodation, and a partial wage replacement for two years.²⁵² Plans under this proposal would be purchased on the existing PDI market, and employers would be permitted to require employees to contribute up to 40% of the cost of their coverage.²⁵³ Following the exhaustion of employer-sponsored PDI, SSA would transition beneficiaries who still lack the ability to engage in SGA onto SSDI. Workers with extremely severe or terminal disabilities would be exempt from the two-year PDI requirement and would instead be immediately fast-tracked onto SSDI.²⁵⁴

²⁴⁷ See Norma B. Coe et al., *What Explains Variation in SSDI Application Rates?*, Center for Retirement Research at Boston College, WP#2011-23, <http://crr.bc.edu/working-papers/what-explains-state-variation-in-ssdi-application-rates/>. The authors found that state-mandated temporary disability insurance (TDI) has a small negative effect on overall SSDI applications.

²⁴⁸ Burkhauser, Daly, and de Jong 2008.

²⁴⁹ Stapleton et al. *Income Security for Workers* 2008, p. 11.

²⁵⁰ CRS Report RL34088, *Leave Benefits in the United States*, by Linda Levine. TDI typically provides partial compensation due to non-occupational disability for approximately 26 to 52 weeks. For more information, see Social Security Administration, *Social Security Programs in the United States*, No. 13-11758, July 1997, p. 46, <http://www.SSA.gov/policy/docs/progdesc/sspus/>.

²⁵¹ Organization for Economic Co-operation and Development, *New Ways of Addressing Partial Work Capacity*, April 2007, pp. 10-11, <http://www.oecd.org/social/soc/38509814.pdf>.

²⁵² Autor and Duggan 2010, p. 6.

²⁵³ *Ibid.*, p. 7. Under this proposal, insurance premiums would be experienced rated for firms with 50 or more full-time equivalent employees, whereas smaller firms would have their premiums determined based on differentiated rates by industry.

²⁵⁴ *Ibid.*, p. 23. Unemployed workers would receive a replacement wage at their state UI rate; however, in order to protect employers from the so-called “double indemnity” of paying higher experienced-rated premiums for both UI and (continued...)

Each approach to promoting PDI has its strengths and weaknesses. The financial incentives approach is advantageous, to the extent that its implementation would be simple by comparison. The federal government already encourages employers to hire workers with disabilities by offering tax credits to offset any workplace accommodation that workers with disabilities may require.²⁵⁵ Therefore, expanding employer incentives to provide PDI via tax credits would entail minimal additional resources to institute. Although establishing SSA gatekeepers to work with employers and insurers under an experience rating system would likely require significantly more resources relative to the tax credit proposal, the net cost to the government could be limited, depending on the structure of the experience rating system.

In spite of these advantages, the voluntary nature of the financial incentives approach may not induce enough employers to purchase PDI plans to have an appreciable impact on the incidence of SSDI receipt. As noted above, the federal government currently offers employers tax incentives to hire workers with disabilities; however, the evidence that such incentives actually drive employers to hire said workers has been “limited and inconclusive.”²⁵⁶ Similarly, the lure of a lower payroll tax rate under an experience-rating model may not cause employers to purchase PDI, especially if the cost of providing PDI outweighs the savings from the reduced payroll tax rate.

On the other hand, the government mandate approach solves many of the inducement-related problems associated with voluntary financial incentives. After all, the prospect of having to pay financial penalties due to non-compliance is a more powerful incentive for employers relative to optional tax credits.²⁵⁷ A government mandate under this approach, however, does not necessarily guarantee universal compliance because employers could opt out of carrying PDI by simply paying the appropriate penalty. Nevertheless, the increased incentive for employers to provide PDI may have an appreciable effect on the inflow of beneficiaries into the SSDI program.

However, it is difficult to discern whether a government mandate to require employers to provide PDI is economically feasible using the existing PDI market. Currently, most private disability insurers sell PDI plans as either short term (around 26 weeks) or long term (anywhere from a year to FRA). Although both types of PDI cost employers about the same amount per-hour worked, long-term disability (LTD) insurance plans typically have stricter eligibility standards. For instances, LTD plans may have more stringent definitions of disability or more expansive exclusionary criteria concerning pre-existing medical conditions compared with short-term disability (STD) insurance.

(...continued)

PDI, unemployed workers would be unable to claim both UI and PDI benefits simultaneously.

²⁵⁵ Internal Revenue Service, *Tax Benefits for Businesses Who Have Employees with Disabilities*, September 24, 2012, <http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Tax-Benefits-for-Businesses-Who-Have-Employees-with-Disabilities>. To offset the cost of workplace accommodation, the federal government provides employers with tax credits under the Disabled Access Credit and the Barrier Removal Tax Deduction. In addition, the federal government offers the Work Opportunity Tax Credit to employers who hire members of certain targeted groups, including workers with disabilities.

²⁵⁶ U.S. General Accounting Office, *Incentives to Employ Workers with Disabilities Receive Limited Use and Have an Uncertain Impact*, GAO-03-39, December 11, 2002, <http://www.gao.gov/products/GAO-03-39>.

²⁵⁷ For more information on how the employer penalties work under ACA, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey.

Private disability insurers often incorporate stricter eligibility standards into their LTD plans because such plans are inherently riskier. After all, a LTD beneficiary could potentially receive benefits for years or even decades. To offset some of the risk associated with LTD plans, insurers often require beneficiaries to apply for SSDI after the onset of disability. Insurers deduct any subsequent SSDI income from a beneficiary's LTD benefit, thereby reducing their exposure to loss.

Therefore, mandated medium-term PDI plans—as outlined in the Autor and Duggan proposal—may not be financially viable in the current PDI market, to the extent that such plans do not permit insurers to offset part of their costs by requiring beneficiaries to apply for SSDI. While the increase in revenue stemming from more insurable workers may partially negate some of the increased risk of insuring people for disability over a longer period, it remains to be seen whether the PDI market can produce an economically feasible medium-term PDI plan.

Appendix. Acronyms

AALJ	Association of Administrative Law Judges
ADA	Americans with Disabilities Act
ACA	Patient Protection and Affordable Care Act
AIP	Adjudicatory Improvement Project
ALJ	Administrative Law Judge
APE	Aarts de Jong Wilms Goudriaan Public Economics
AWI	Average Wage Index
BEA	Bureau of Economic Analysis
BLS	Bureau of Labor Statistics
BOND	Benefit Offset National Demonstration
BOPD	Benefit Offset Pilot Demonstration
BPAO	Benefits Planning Assistance and Outreach Program
BYA	BOND Yearly Amount
CBO	Congressional Budget Office
CDR	Continuing Disability Review
COLA	Cost-of-Living Adjustment
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
CPI- U	Consumer Price Index for All Urban Consumers
CPS	Current Population Survey
CY	Calendar Year
DA&A	Drug Addiction and Alcoholism
DDS	Disability Determination Service
DI	Disability Insurance
DOT	Dictionary of Occupational Titles

EITC	Earned Income Tax Credit
EN	Employment Network
EPE	Extended Period of Eligibility
EWIC	Enhanced Work Incentives Counseling
FICA	Federal Insurance Contributions Act
FRA	Full Retirement Age
FTC	Failure to Cooperate
FY	Fiscal Year
GAO	Government Accountability Office
GDP	Gross Domestic Product
HI	Hospital Insurance
IRS	Internal Revenue Service
LTD	Long-Term Disability
NBER	The National Bureau of Economic Research
NCS	National Compensation Survey
NPRM	Notice of Proposed Rulemaking
O*NET	Occupational Information Network
OASDI	Old-Age, Survivors and Disability Insurance
OASI	Old-Age and Survivors Insurance
OCAct	Office of the Chief Actuary
OIG	Office of the Inspector General
OIS	Occupational Information System
PABSS	Protection and Advocacy for Beneficiaries of Social Security
PDI	Private Disability Insurance
SECA	Self-Employment Contributions Act

SGA	Substantial Gainful Activity
SMI	Supplementary Medical Insurance
SSA	Social Security Administration
SSAB	Social Security Advisory Board
SSARP	Social Security Administration's Representation Project
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STD	Short-Term Disability
SVRA	State Vocational Rehabilitation Agency
TDI	Temporary Disability Insurance
TWP	Trial Work Period
UI	Unemployment Insurance
U.K.	United Kingdom
VR	Vocational Rehabilitation
WC	Workers' Compensation
WFI	Work-Focused Interviews
WIPA	Work Incentives Planning and Assistance

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