

# Five Years of Disability Insurance Benefits: A Progress Report

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JULY 1962 marks the fifth anniversary of one of the most significant extensions of the social security system since its inception 27 years ago—the payment of monthly disability benefits as part of the old-age, survivors, and disability insurance program. This is a fitting occasion for looking back on the experience with the disability program to assess its adequacy in meeting its social objectives and to appraise the effectiveness of the policies and administrative techniques developed to assure prompt and equitable decisions on the claims of disabled persons.

Statistical indicators graphically attest to the growing, and already substantial, importance of the program in helping to prevent dependency arising from long-term disability. Chart 1 illustrates the steady growth of the disability program in terms of persons benefiting and benefits paid from 1957 through 1961. As of March 31, 1962, about 1½ million persons were receiving monthly disability benefits amounting to nearly \$1 billion a year. These beneficiaries included about 650,000 disabled workers under age 65; 440,000 dependent wives and children of these workers; and 130,000 persons with disabilities that began in childhood. An additional quarter of a million persons were receiving higher benefits—chiefly old-age benefits—because the workers' earnings records had been frozen during a period of disability.

The foregoing data are impressive as broad indicators of the success of the disability insurance program under the Social Security Act in meeting its social objectives. Equally important, however, are such considerations as the quality and equity of its case decisions, the promptness and efficiency with which claims are decided, and the effectiveness of interprogram relationships leading to rehabilitation and other services for beneficiaries.

## BASIC CHARACTERISTICS OF THE PROGRAM

Appraisal of the status of the program at this time may be made easier by reviewing briefly the

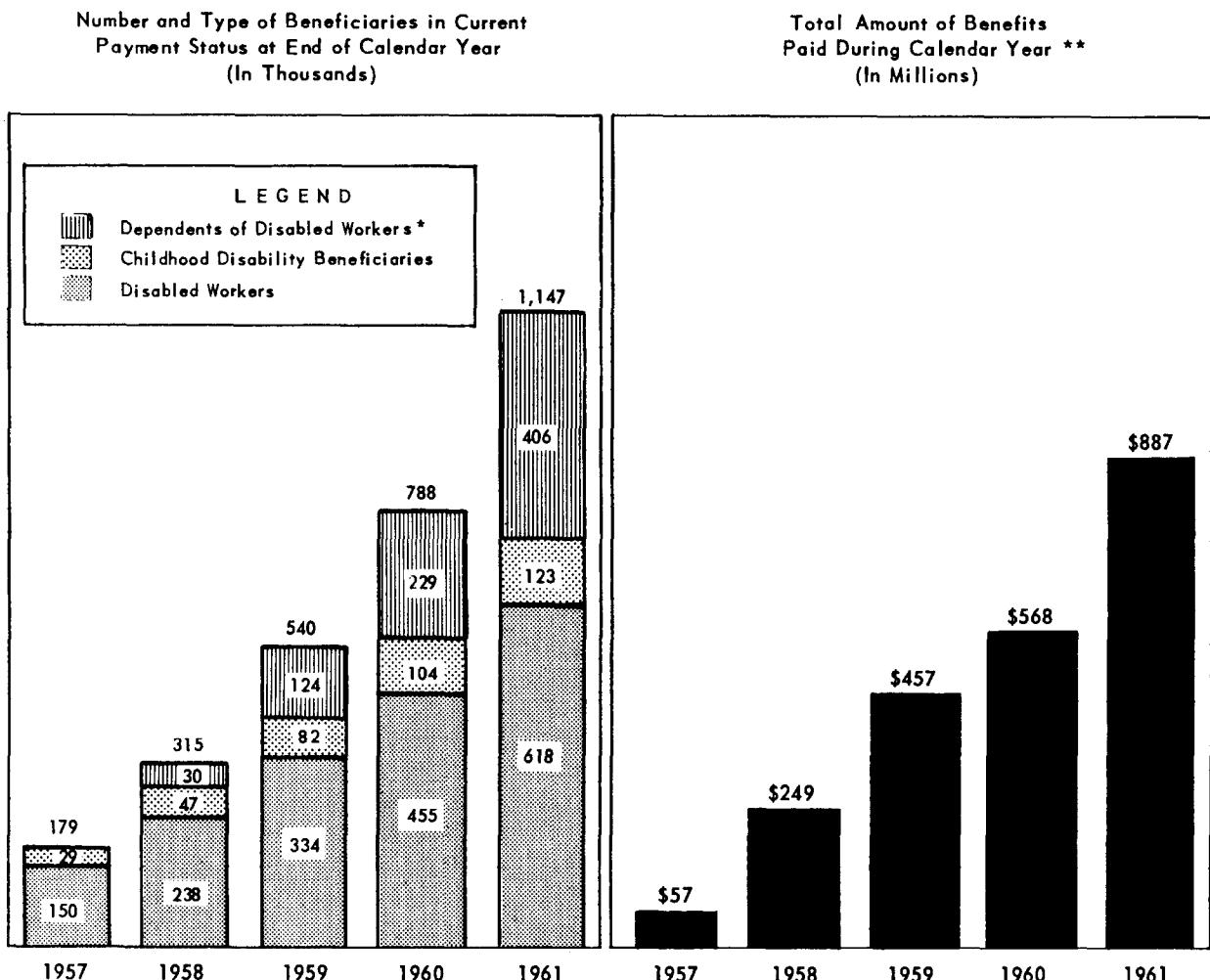
legislative decisions that have governed its development over the past 8 years. The first operative disability provisions under title II of the Social Security Act were enacted in 1954 in the form of a "disability freeze," which preserved the insurance status of workers so that absence from work because of long-term disability would not cause reduction or loss of future benefit rights and payments. Since the enactment of the "freeze" provisions, three successive major extensions—in 1956, 1958, and 1960—have been made in the scope of protection afforded by the disability program. In 1956, monthly cash benefits were added for disabled workers aged 50–64 and for the disabled sons and daughters of retired or deceased insured workers, if the child's disability began before age 18. Monthly benefits, like those provided for the dependents of old-age insurance beneficiaries, were extended in 1958 to the dependents of disability insurance beneficiaries. Recognizing the need of workers under age 50 and their families for disability payments, Congress extended monthly benefits to this group in 1960.

The 1954 disability provisions and the successive amendments embodied several basic legislative decisions that have shaped the character of the disability program, its administrative development, and the composition of its workload over the years. Included among these decisions were: (a) restricting eligibility to persons with impairments that are expected to be of long duration and that prevent their engaging not only in their usual work but also in other substantial gainful work; (b) restricting eligibility to disabled workers with a substantial and recent attachment to the labor force; (c) providing retroactive disability protection for all persons who might have been eligible if the legislation had been in effect since the start of the social security program; and (d) requiring that determinations of disability be made by State agencies (where possible, State vocational rehabilitation agencies) under contractual arrangements with the Department of Health, Education, and Welfare.

During the period of extension of disability protection, the basic definition of disability (as distinct

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CHART 1.—Disability insurance program: Summary benefit data, 1957–61



\* Excludes childhood disability beneficiaries.

\*\* Excludes benefits paid to childhood disability beneficiaries dependent upon deceased or retired workers.

from a special provision covering the totally blind) remained unchanged. The work requirements, however, have been significantly liberalized. A disabled individual is required to have worked in employment covered under the Social Security Act for at least 5 out of the 10 years before becoming disabled.<sup>1</sup>

The 1958 amendments eliminated an earlier provision that 1½ years of work fall within the 3-year period just before the individual became disabled. Eliminating this requirement qualified for benefits

many persons with slowly progressive conditions who had stopped work longer than 1½ years before their conditions became severe enough to be considered disabling under the law. More than 50 million workers already meet the disability work requirements, and the number of workers and their families who are thus protected against loss of earnings from disability is increasing each year.

The 1954 disability legislation provided for a temporary period during which the retroactivity of disability protection could be established for all disabled persons who might have been covered if the provisions for this protection had been in effect from the time the social security program started. Through a series of congressional extensions, the period during which persons with long-existing disabilities could file claims was held open through

<sup>1</sup> Disability beneficiaries, like workers who qualify for retirement benefits, must also be fully insured. This requirement has no real effect on eligibility for disability benefits, however, until January 1, 1972. Until that date, a worker who meets the 5-year disability work test automatically meets the "fully insured" test.

June 30, 1962. Extending retroactivity to large numbers of persons who otherwise could not have qualified created a variety of administrative and adjudicative problems. Special case-processing measures were adopted to cope with the abnormal workloads resulting from the filing of applications by large numbers of persons with long-standing disabilities. (Almost 1 million applications were received during the first 3 years of program operations.)

In enacting the disability provisions Congress specified that determinations of disability should be made by State agencies under agreements with the Secretary of Health, Education, and Welfare. Such agreements are now in effect with 56 contracting State agencies in 52 jurisdictions. They provide a mechanism by which the applicant's State, in effect, acts as an agent of the Federal Government in evaluating disability, with the costs of making determinations paid by the Government. With few exceptions, the contracting agencies are those administering the State vocational rehabilitation programs. The Department itself (through the Division of Disability Operations of the Bureau of Old-Age and Survivors Insurance) makes determinations for cases excluded from State jurisdiction. It also provides uniform standards and guides followed by all States in making disability determinations and reviews and gives final effect to all State decisions. The Bureau may revise State decisions only to make them less favorable to the applicant. State decisions against the applicant cannot be reversed by the Department except after hearing or court appeal.

In stipulating that, where possible, disability determinations be made by a State vocational rehabilitation agency, Congress made clear its intent to have the program administered in such a way as to foster the rehabilitation of the disabled. This Federal-State system of administration was entirely new to the Federal social insurance system, but the innovation was considered essential to take advantage of existing State agency relationships with the medical profession at the local level and to facilitate rehabilitation contacts with the disabled. Under the policy stated in the law that all disability applicants be promptly referred to their State vocational rehabilitation agencies to be considered for possible rehabilitation services, applications filed under the disability program have become an important source of referrals to rehabilitation agencies.

With the expansion in disability protection, new incentives were added to encourage rehabilitation efforts. Before October 1960, the law permitted benefits to be paid to a disabled person for a period up to 12 months while he engaged in work activity under an approved State vocational rehabilitation plan. Recognizing that persons who try to return to work often do so through their own efforts or under the auspices of private organizations or government agencies other than their State vocational rehabilitation agencies, Congress in 1960 broadened this "trial work" provision so that its advantages would accrue to all beneficiaries who attempt work despite their impairments, whether or not the work is performed under a State rehabilitation plan. Another 1960 provision benefits those workers who, following recovery from their impairments or successful rehabilitation and return to work, again become disabled within 5 years after their earlier period of disability ended. For these persons the usual 6-month waiting period is waived, and they may start receiving monthly benefits beginning with the first full month of disability.

Like retirement benefits, disability insurance payments are related to the average earnings of the insured worker; they are computed as if the worker had reached age 65 on the date his disability began. Monthly payments to disabled workers average about \$90.00. (They range from a minimum of \$40.00 to a maximum of \$127.00.) For the disabled worker with a wife and dependent children, the average monthly benefit for the family is about \$193.00. (The maximum family benefit is \$254.00.) Disability benefits stop when the worker reaches age 65, when his disability ceases, or when he dies. Since the disabled worker automatically becomes entitled to receive retirement payments at age 65, benefit continuity is maintained.

Financing the program under which these benefits are paid is part of the largest fiscal stewardship in history. The old-age, survivors, and disability insurance program is financed by taxes paid by employers and employees on employee earnings and by self-employed persons on their net earnings from self-employment. Income not needed for benefits is held in two trust funds—the Federal old-age and survivors insurance trust fund, from which benefits are paid to retired workers and their dependents and to the survivors of deceased insured workers, and the Federal disability insurance trust fund, from which benefits are paid to disabled workers and their dependents. Since 1957, bene-

fits for disabled workers and their dependents have been financed by a combined tax, paid by employers and employees, of  $\frac{1}{2}$  of 1 percent of earnings and a tax of  $\frac{3}{8}$  of 1 percent paid by self-employed persons on their earnings. By December 1961, benefits paid from the Federal disability insurance trust fund had exceeded \$2 billion, while administrative expenses paid from the fund had approximated \$165 million (8 percent of total disbursements). The fund showed a balance of about \$2 $\frac{1}{2}$  billion in December 1961.<sup>2</sup>

## CONCEPTS OF DISABILITY EVALUATION

Any discussion of the social security concepts of disability evaluation must begin with the definition of disability written into the law: "Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration."<sup>3</sup> This definition has frequently been described, in a general sense, as representing total and permanent disability. It is one that calls for a decision based on the facts of each particular case. Since it requires that the individual be disabled not only for his usual work but also for any substantial gainful activity, it excludes those who may be said to suffer from an occupational or partial disability but who are not reasonably precluded from: (1) engaging in some substantial gainful activity other than their customary work even though such work might be simpler or less rewarding than that which they have previously done or (2) continuing their customary gainful activity on a substantial, even if part-time, basis. The definition also excludes totally disabling conditions that are essentially temporary (even though they may last more than 6 months), including disabilities that are clearly remediable or from which the individual is expected to recover in a reasonable period of time.

On the basis of operating experience and research, specific criteria for evaluating disability were formulated and published in the Code of Federal Regulations. These regulations recognize that the

disabled include a large number of individuals with impairments that, viewed medically, prevent work though they may not necessarily preclude limited activities in other spheres. To identify these individuals, medical guides describing disabling impairments were developed by the Bureau with the aid of a Medical Advisory Committee that was established shortly after the program started. Examples of the medical guides were then published in the Federal Regulations. The guides have proven an effective tool for reaching an accurate, rapid decision of allowance in more than half of all claims filed. Their use has helped achieve a high level of uniformity of interpretation among the 56 contracting State agencies. Because they communicate to all adjudicating personnel descriptions of cases that should clearly be allowed, these guides are perhaps the single most effective means of assuring fair decisions for all claimants.

Consistent with the legislative intent that the inability to work must be due to impairment (and not simply to inability to find a job), the regulations also establish the basis for denial of claims from individuals with obviously slight impairments.

For the sizable number of claimants who are included neither in the group whose claims are allowed because their impairments result in functional restrictions as severe as those described in the medical guides nor in the group whose claims are denied because their impairments do not prevent them from performing their usual occupations, the regulations specify that the evaluation of disability requires, in addition to consideration of the limitations imposed by the impairment, a realistic assessment of certain relevant social and vocational factors such as the applicant's age, education, experience, and training.

These factors affecting the evaluation of disability were of special concern to a Subcommittee on the Administration of the Social Security Laws, established by the House Ways and Means Committee to inquire into the administrative problems of the disability program. In its report, the Subcommittee stated with respect to the need for refining the tools for the evaluation of disability:<sup>4</sup>

The Subcommittee believes that the Department should make a thorough study of this situation to see if criteria can be developed which retain the basic emphasis of the program on

<sup>2</sup> Administrative expenses are currently running about \$74 million per year. This includes about \$22 million for State agency operations.

<sup>3</sup> A waiting period of 6 months after the onset of disability is required before payments commence except in second periods of disability.

<sup>4</sup> *Preliminary Report to the Committee on Ways and Means*, submitted by the Subcommittee on the Administration of the Social Security Laws, March 1960, page 20.

major medical impairment, but at the same time allow for a more realistic assessment where there are multiple bars to employment, e.g., age, employer bias in hiring, and other factors that limit job opportunity.

The Subcommittee went on to say that the theoretical capacity of a severely impaired individual to engage in substantial gainful activity is meaningless if it cannot be translated into ability to compete in the open labor market. Some Federal courts, upon review of appealed departmental denials, have expressed similar concern.

The Bureau has taken concrete steps to clarify and refine its evaluation principles, giving full recognition to the realistic interrelationship of medical and occupational factors. Regulations, issued in August 1960, emphasize that, while primary consideration is given to the severity of the individual's impairment, the impairment must be evaluated for its total impact upon the individual in terms of his age, education, training, and work experience. Specific factors, such as age and education, are defined with reference to their effect upon an individual's capacity to secure and retain work in competition with others. In addition, the regulations indicate that ability to engage in substantial gainful activity includes not merely the ability to perform a particular physical activity but also the capacity for sustained and regular performance and the ability to get to and from work.

Among individuals claiming disability benefits, there is one readily identifiable group of applicants with homogeneous vocational characteristics. Recent regulations describe the characteristics of this group, just as they identify the medical impairment groupings. These regulations provide for a disability allowance when a claimant, well along in years, with limited education and a lifelong work experience confined to the performance of arduous unskilled work, has a significant impairment that prevents him from doing such work—the only kind of work for which he has demonstrated qualifications through actual work experience.

The overwhelming majority of persons applying for disability benefits are no longer engaged in any kind of work. In a relatively small number of cases, however, an individual files an application while continuing to do work of some sort or an individual who has been found disabled attempts to work. In such cases, it is necessary to determine whether this work actually shows ability to perform substantial gainful activity. If so, benefits must be denied or terminated. Among the factors con-

sidered in evaluating the effect of work activity are the earnings from work, the circumstances of the work, nature of the work, adequacy of performance, time spent at work, and special employment conditions.

It was recognized that criteria were needed for reaching equitable and uniform decisions in a wide variety of employment situations. In a program designed to afford basic protection against loss of earnings, the amount an individual could earn, with his remaining skills and capacities, seemed the most significant indication of his ability to engage in substantial gainful activity. After a study of case experience, earnings guides for evaluating work were formulated and published in the Federal regulations.

One of the earnings guides provides that, when an individual's earnings average over \$100 a month, they generally demonstrate his ability to engage in substantial gainful activity. Provision is made for exceptional situations in which earnings are not a realistic indication of ability to do substantial work. For example, if an individual is employed under special conditions in a sheltered workshop or comparable facility, only earnings attributable to his productivity as distinguished from a subsidy related to factors such as financial need, are considered in determining his ability to perform substantial gainful activity. Where the earnings fall between \$50 and \$100 per month, the aforementioned factors (see preceding paragraph) are especially significant. Earnings at a rate of less than \$50 per month do not show an ability to engage in substantial gainful activity.

Achieving equity in disability evaluation requires an individualized decision on the merits of each set of facts. All possible situations cannot be covered in specific regulations. Those cases not provided for by the medical or vocational classifications present a continuing need to blend the medical, occupational, social, and related factors into a realistic evaluation of the individual's capacity for work.

Bureau-conducted and Bureau-sponsored studies have made significant theoretical contributions in disability evaluation. One project conducted at the cardiopulmonary laboratory of the University of Maryland School of Medicine has as its primary purpose the development of more accurate and readily available methods for measuring the functional efficiency of persons with respiratory and related impairments. A second study involves an

analysis of a sample of silicosis cases and a correlation with workmen's compensation decisions to assess results derived from differing requirements for evidence of disability in cases involving respiratory impairments. Another study in progress is designed to improve methods of documenting and evaluating disability resulting from arteriosclerotic heart disease in which the chief symptom is chest pain. In cooperation with the Office of Vocational Rehabilitation a longer-range study is being conducted to determine the effect of maximum development of medical, social, and vocational evidence.

From the beginning the Bureau has been greatly indebted, for assistance and expert counsel, to non-Bureau personnel serving on work groups in an advisory capacity. Representatives from government, nongovernmental social agencies, the medical profession, labor, and industry have accepted membership in these groups to help the Bureau develop better guides for securing evidence and evaluating the effects of impairments, age, education, training, and work experience on an individual's ability to engage in substantial gainful activity. Included among these groups are the Medical Advisory Committee, the States' Council Committee on OASI Relationships, and a work group on vocational factors.

## ASSURING A PROPER DECISION

Adequate documentation of the evidence needed for evaluation is essential to a proper determination of the applicant's claim. This evidence must include not only reports from medical sources describing the impairment at the time of onset of disability and currently but also evidence as to the applicant's training and education, work experience, and daily activities both before and after the alleged onset of disability as well as other pertinent facts showing the effect of the impairment on the applicant's ability to perform substantial gainful activity.

It was recognized from the start that the claimant's own statements about his condition and the reasons he ascribes for inability to work were basic to his claim for benefits. All other evidence, both medical and vocational, is developed to corroborate and evaluate his impairment and his response to it. Special forms, instructions, and interview schedules have been developed to assist the interviewer in eliciting the detailed information needed to present

a picture of the applicant, his impairment, and how it affects him vocationally.

The claimant himself has certain responsibilities for establishing his claim, and the Bureau's basic administrative policy is to make every reasonable effort to help the claimant meet his responsibility and, where necessary, to supplement the steps he is able to take on his own behalf. Because the disabled as a group have special problems, special measures are taken to safeguard their rights. The Bureau assists the disability claimant in obtaining evidence from medical sources by helping him make his request to his attending physician; by guiding him to other medical sources in the community that experience has shown to be productive; and by getting in touch with medical sources on his behalf.

Close working relationships with hospitals, institutions, and government agencies have been built up over the years at the local level to protect the rights and interests of those claimants who are or have been confined in a hospital. In about 40 percent of the cases, claimants have relied upon hospitals for part or all of the medical evidence supporting their claims. To minimize the time taken by the hospital staff in preparing medical reports, the Bureau, State agencies, and hospitals have worked together in devising and simplifying procedures and report forms. The success achieved by this cooperation between the Bureau and the hospital is indicated by the "leads" provided by hospitals to help the Bureau identify prospective disability claimants. Many claimants, because of severe mental or physical incapacity, might never have filed for disability benefits, if the Bureau and the hospitals had not taken steps to identify those potentially eligible and to see that they were referred to their local district offices.

In 40-45 percent of the cases, the initial evidence obtained by the claimant and the district office from the claimant's earlier medical contacts (his attending physician and other sources of treatment or earlier examination) is sufficient for the medical considerations in the disability decision. When it is not, the evaluation team must obtain clarifying or supplementary evidence either through further communication with the claimant's medical sources or from independent medical sources. This last course of documentation entails the purchase of a special consultative examination at trust fund expense.

The policies on securing consultative examinations are intended to assure an accurate decision

and to help the applicant present a complete picture of his disability. This method of documentation is pursued only after the claimant has discharged his responsibility for furnishing evidence initially. If the evidence adduced by the claimant is sufficient to indicate (but not to establish) the existence of a severe impairment, or if the evidence is conflicting or ambiguous, the evaluating physician may request a consultative examination to provide the additional medical details needed. In many instances, sound evaluation may require highly technical data, such as the results of pulmonary function studies, that the attending physician may not need because it is not central to the medical management of the case. Such data can be obtained through examination by a physician practicing at the specialist or consulting level.

The special role played by State agencies in adapting administration of the program to local conditions is evident in arrangements to purchase medical evidence. These are made in accordance with the practices and fees established by each State in administering its vocational rehabilitation or other regular program. A single fee schedule for comparable examinations for both programs administered by the State agency avoids the difficulties in medical relationships and other policy and administrative problems that might arise from the use of dual schedules. If the complexity of the disability examination warrants a special fee, such a fee may be fitted into the State agency fee schedule.

The consultative examination with its focus on precise, current clinical information aimed at functional assessment has become increasingly important because of the changing nature of disability claims. Since it was possible in 1955 and thereafter for a person who became disabled as far back as 1941 to qualify for disability protection, the majority of early claims involved long-standing impairments. In these cases, the evidence on the clinical course for an extended period often gave a clear indication as to the current severity and prognosis and consultative examinations were therefore less important.

The "recent impairment" characteristic of present workloads requires the evaluation of current severity and prognosis without benefit of a long clinical history. In each recent year, there has been an increase in the proportion of claims involving disabilities of recent origin. To illustrate the growing importance of consultative examina-

tions, it may be pointed out that, in 1957, 1 out of every 8 cases required a consultative examination. Currently, however, 2 out of every 5 cases require such evidence. This ratio has been maintained for the past 2 years—a period during which an intensive campaign has been in progress to improve reporting from the applicant's own medical sources.

Under the Social Security Act provisions a person who is dissatisfied with the initial determination may request that his case be reconsidered. In discharging its responsibility to claimants desiring reconsideration, the Bureau informs the claimant of his rights, records his reasons for disagreeing with the initial decision, and develops additional evidence, where necessary, to clear up inconsistencies or inadequacies and to establish whether there have been changes in the applicant's condition. To assure a wholly independent attitude without any predisposition in favor of the initial determination, reconsiderations are handled in a different operating setting. Reconsideration determinations are made by persons in the State agency and reviewed by Bureau staff other than those who made the initial determination.

If the claimant is dissatisfied with the results of this reconsideration, he may request a hearing before a hearing examiner of the Social Security Administration. Then, if still dissatisfied, he may ask that the hearing examiner's decision be reviewed by the Appeals Council of the Social Security Administration. The decision of the Appeals Council may be appealed to the Federal courts.

## MEDICAL RELATIONSHIPS

Since the certification of disability is so intimately related to important facets of medical practice, the development of effective and mutually satisfactory working relationships with individual physicians and with organized medical groups has been of major importance to the program's successful administration. Equitable disability decisions depend in large part on the quality of medical evidence which physicians submit in support of their patients' claims for disability benefits; policies and procedures for procuring such evidence have been developed within the framework of prevailing patterns of medical practice and in a manner intended to avoid hampering the doctor-patient relationship. The cooperation of physicians over the coun-

try in responding to the many requests for medical information in connection with their patients' disability claims has been highly gratifying.

The adherence of disability program policies and procedures to the principles that guide the practice of medicine is in part attributable also to the fact that physicians in active clinical practice have been engaged by the Bureau and State agencies to devote part of their time as consultants in the evaluation of disability claims. To assure that claims contain adequate clinical evidence, State agency medical staffs communicate with other practicing physicians in day-to-day contacts to discuss medical aspects of individual cases. Where necessary, they authorize the purchase of independent consultative examinations from private physicians under fee schedules worked out in cooperation with the medical profession in each State. They also maintain close liaison with organized State and local medical groups to develop a deeper appreciation among practicing physicians of the fact that the validity of the disability determination rests in large measure on the quality of the medical evidence supplied.

The Bureau's concern for productive relationships with the medical profession led to the early appointment of a Medical Advisory Committee to the Social Security Administration. This Committee, nationally representative of a wide variety of medical and related specialties, has assisted materially in establishing the medical framework for administering the disability program. The Committee membership as originally constituted in February 1955 remained unchanged until July 1960, when a plan for rotating the membership was inaugurated.

The Committee has met 13 times through June 1962. It has published two reports—covering all facets of the disability program that involve medical relationships and procedures. The first report was issued in July 1955; the second, issued in November 1960, expanded and replaced the earlier report.<sup>5</sup> The medical criteria for evaluating disability have been formulated and modified after consultation with the Committee. The Bureau has achieved, with the Committee's guidance and its assistance in communicating program objectives and medical reporting requirements to the medical profession,

singular success in getting physicians generally to appreciate that the program is operating from a sound medical base.

For the past 8 years, the Bureau has maintained close liaison with the American Medical Association and has worked with other organized medical groups. Early in the program's history the AMA on its own initiative prepared and published informational materials explaining to physicians facts about the program and the importance of submitting for their patients the medical information needed for disability evaluation. Many State medical societies, as well as the AMA, have distributed informational materials to their physician members. These materials included a brochure on *The Disability Decision*, which is a motion picture produced by the Department of Health, Education, and Welfare with the cooperation of the AMA. This film dramatically portrays the kinds of medical information the attending physician should submit to assure prompt and equitable decisions for his patient. It was shown for the first time at the 1960 AMA Annual Meeting. Prints were made available to interested medical groups in August 1960 through the AMA's film library, district offices of the Bureau of Old-Age and Survivors Insurance, and State agencies. To date, more than 50,000 physicians have seen the film at national and local medical meetings.

On the Bureau's invitation, representatives of the American Medical Association have attended each Medical Advisory Committee meeting. In February 1962, the Board of Trustees of the AMA designated the Committee on Federal Medical Services of their Council on Medical Service to develop and maintain closer liaison with the Bureau and the Medical Advisory Committee. This group first met with Bureau and Medical Advisory Committee representatives in April 1962.

In May 1960 the Medical Advisory Committee appointed a subcommittee to give close attention to the problem of obtaining adequate medical evidence and procedures dealing with its purchase. The subcommittee functioned for 18 months, reporting its findings and recommendations to the parent Committee in November 1961. The full Committee endorsed a broad, intensive program for communicating to physicians the program's need of detailed clinical data that adequately describe a claimant's remaining functional capacities. In so doing, the Committee acknowledged the importance

<sup>5</sup> Report and Recommendations of the Medical Advisory Committee on the Administration of the OASI Disability Provisions, November 1960.

of augmenting the bases for developing physician interest and participation in the disability program. The Committee recommended emphasis on the scientific aspects of disability evaluation and greater use of clinical and other professional settings for bringing such information to physicians. The Bureau is moving forward on several phases of these recommendations.

## PROGRAM OPERATIONS

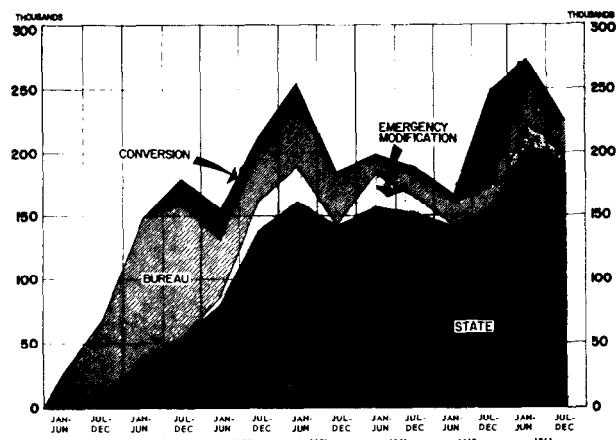
Successive legislative amendments have expanded the scope and size of the program so that today the volume of claims under the disability insurance provisions of the Social Security Act exceeds that of any other program in the United States dealing with severe long-term disability. Currently about half a million claims are being filed each year. Through December 1961, more than two and a half million determinations had been made under these provisions. This workload has created the complex and difficult operational task of maintaining balanced efforts to process claims quickly without sacrificing quality in adjudication.<sup>6</sup>

The initial "disability freeze" legislation resulted in a readymade backlog of cases because workers who had become disabled as far back as 1941 could qualify to have their earnings records frozen. Within 2 years almost 500,000 persons had filed applications. The 1956 amendments more than doubled the workloads produced by the "freeze" program. Applications for cash benefits were received from a large number of persons who, although previously eligible for the disability freeze, had not filed freeze applications. In the year following the 1956 amendments, the Bureau received about 450,000 new disability applications. At the same time, it became necessary to process an additional 110,000 cases involving disabled workers over age 50, already in freeze status, who became immediately eligible for cash benefits.

During the next 3 years, the number of applications received gradually decreased to pre-amendment levels. With the removal in 1960 of the age

limitation on payment of benefits, disability claims again rose to a new peak. During the first year following the 1960 amendments, about 580,000 applications for disability benefits were received; for another 100,000 persons (all under age 50), freeze status was converted to payment status. By December 1961, the number of new applications received had fallen but remained at a slightly higher level than that existing before the 1960 amendments. Chart 2 reflects the impact of the amendments on disability operations.

CHART 2.—Number of disability determinations prepared by State agencies and the Bureau of Old-Age and Survivors Insurance in initial and conversion cases, 1955-61



Initial workloads alone do not provide a complete story of the workload problems that confronted the Bureau and the State agencies. A significant proportion of the total workload is made up of reconsideration requests filed by applicants dissatisfied with the initial decision. Initial and reconsideration workloads follow similar patterns. The peaks in the reconsideration workloads followed closely the peaks of initial applications, thus further complicating the problem of expediting case decisions. Since the program's inception, reconsideration requests have added about 250,000 cases to the disability workload.

Large fluctuations in the number of applications being filed from time to time have created administrative problems at each stage of the adjudicative process. The mounting pressure of unprecedented workloads following the passage of amendments required the introduction of emergency and other administrative measures to reduce backlog. State agency and Bureau staff was increased, as needed;

<sup>6</sup> See Arthur E. Hess, "Old-Age, Survivors, and Disability Insurance: Early Problems and Operations of the Disability Provisions," *Social Security Bulletin*, December 1957, for a detailed account of the early problems faced and the steps taken to organize and staff the Federal and State operations during the first years of the disability program.

experienced personnel processed cases on overtime and were detailed temporarily to work stations where the operating situation had become critical; cases were reviewed for conversion from "freeze" to payment status before the amendments took effect; and States with abnormal backlogs transferred part of their workload to the Bureau in order to expedite processing (a step that required temporary emergency modifications to some State agreements). All told, about 125,000 cases in 28 State agencies have been transferred to the Bureau since the 1956 amendments.

As a result of these administrative measures, case-processing time, which had tended to rise and fall with fluctuations in workloads, has been sharply reduced since 1957. At the end of 1957—under the impact of the heavy workloads of new claims resulting from the 1956 amendments that authorized cash benefit payments—the median time for processing a disability case (from the date of application to the date the claimant is notified of the decision) was about 6 months if the medical documentation was complete and did not require supplementation after receipt by the State. The comparable figure for cases presenting more complex disability issues and requiring medical supplementation by the States was almost 8 months (median time).

By December 1961, median overall processing time for cases not requiring State agency development had decreased to a little over 2 months. The average case calling for State agency development was processed in somewhat less than 4 months (median time).

Not all of this period represented time needed by the Bureau or State agency to process a case; some of it was time needed by the claimant's sources of medical evidence to submit initial supporting information essential to the documentation of the claim. In December 1961, once the initial evidence was submitted, the median case that did not require State agency development was processed in a little more than 1 month, and the median case requiring development was processed in a little less than 3 months.

Although disability claims are today documented and evaluated more thoroughly than at any time in the past, improvements in processing time have been made by all organizational components engaged in the disability operation. Efforts to reduce processing time without sacrificing quality in adjudication continue to be made.

## CHARACTERISTICS OF DISABLED WORKERS

Since the beginning of the program, more than 2 million workers insured for disability benefits have applied and submitted evidence for the purpose of having the severity of their condition adjudicated.<sup>7</sup> About 2 out of 3 of these workers have been found to be disabled. The typical disability insurance beneficiary is a married man slightly under age 60 who is disabled as a result of cardiovascular disease or a disease of the nervous system. Women represent less than 20 percent of those allowed disability benefits, in part because eligibility for these benefits requires a substantial attachment to the labor force in the 10 years before the onset of disability.

Until recently, the overwhelming majority of workers on the disability benefit rolls or with their earnings records frozen have come from the older age brackets. About 80 percent have been aged 50 or over, and the median age has been 59. Before the passage of the 1960 amendments, younger disabled workers who could become entitled only to the "freeze" were underrepresented in claims filings. Since the 1960 amendments, preliminary figures indicate that workers under age 50 represent about 30 percent of all allowances, a net increase of 10 percent and an increase of 50 percent in the proportion of allowances among persons under age 50.

A look at the prevalence of particular diseases among disability insurance beneficiaries reveals a pattern similar to that in the Nation as a whole, as shown in such surveys as the National Health Survey. By far the greatest proportion of disability insurance beneficiaries are disabled as a result of chronic and progressive conditions. Diseases of the heart and circulatory system are the major causes of disability in 31 percent of all cases. Arteriosclerotic heart disease alone accounts for 20 percent of all cases. Second in prevalence are diseases of the nervous system and sense organs (18 percent). Other leading causes of disability (about 10 percent each) are mental disorders (chiefly schizophrenia), neoplasms, and musculoskeletal impairments. Individuals whose major impairment results from pulmonary tuberculosis constitute 4 percent of disabled workers. The following tabulation shows the relative frequency for the diagnoses occurring

<sup>7</sup> In addition, some 460,000 applications were filed that did not require determinations on the issue of disability. In these cases the application was disallowed on grounds unrelated to the issue of disability—the worker lacked insured status, for example.

most often among disability insurance beneficiaries, as indicated by disability determinations made in 1960.

	<i>Percent of disabled workers</i>
Arteriosclerotic heart disease.....	20
Neoplasms.....	10
Pulmonary emphysema.....	7
Cerebral vascular accidents.....	7
Arthritis.....	6
Hypertensive heart disease.....	5
Pulmonary tuberculosis.....	4
Schizophrenia.....	4
Diabetes mellitus.....	3

The prevalence of different diseases among disabled workers varies significantly, according to age. For workers under age 50, the major cause of disability is mental disorder (28 percent of the cases). Tuberculosis is primarily responsible for the disability among 10 percent of those under age 50. Cardiovascular disease is primarily responsible for only 13 percent of the disabilities among workers under age 50.

The occupational distribution of workers receiving disability insurance benefits differs somewhat from that of the overall population of the United States. Approximately 75 percent of the disabled-worker beneficiaries held blue-collar (manual, craft, and service) positions, in contrast to a blue-collar representation of about 60 percent in the civilian working population of the United States. This difference is partially attributable to the fact that many white-collar, professional occupations have only recently come under the coverage of the Social Security Act. In addition, manual workers suffering from heart disease and similar chronic conditions are less likely to be able to continue working than are professional or white-collar workers with the same conditions. Then, too, the lack of alternative or transferable vocational skills, a factor entering into the evaluation of a person's ability to engage in substantial gainful activity, weights the distribution of filings and allowances towards arduous, unskilled occupations.

disability program. They are the disabled, dependent sons and daughters of retired, disabled, and deceased insured workers. About half are men and half are women, with a median age in the mid-thirties.

More than four-fifths of these beneficiaries were disabled at birth or during their first year of life. About 70 percent of them are mentally retarded. An additional 6 percent suffer from schizophrenic disorders. In 20 percent of the cases, mental deficiency is associated either with epilepsy or with cerebral palsy. The latter two conditions without mental deficiency account for an additional 6 percent of these beneficiaries.

The early age at which most childhood disability beneficiaries became disabled and the nature of their impairments are reflected in the level of their educational attainment and their mobility status. Almost half of them never attended a regular school, and 40 percent are either institutionalized or housebound.

## BENEFIT TERMINATIONS

Of the 1.3 million disabled workers who at one time or another were found disabled under the Social Security Act, about 700,000 are no longer receiving disability benefits. About 325,000 have died; another 330,000 attained age 65 and began receiving old-age benefits in place of their disability benefits; 36,000 terminations have resulted from the beneficiary's resumption of substantial work activity. Close to 9,000 cases have been terminated because medical recovery or improvement was established.

About four-fifths of those who return to work do so in competitive private wage employment. Approximately 3 percent work in sheltered workshops or under similar special conditions. The remainder are either self-employed or work for a government agency.

Two factors associated with termination are length of disability and age. The younger the worker and the less prolonged the disability, the greater the likelihood of recovery or return to work. In fact, persons under age 50 represent two-thirds of all persons whose benefits have been terminated because of recovery or return to work even though persons under age 50 have made up only 20-25

## CHARACTERISTICS OF CHILDHOOD DISABILITY BENEFICIARIES

About 130,000 persons are currently receiving childhood disability benefits under the social security

percent of those who were allowed a period of disability.

The relationship between age and termination of benefits reflects the previously discussed relationship between age and type of disability. Thus, two types of disease found more frequently in the younger age group—tuberculosis and mental disorders—account for close to three-fourths of all benefit terminations for recovery or return to work. Of persons under age 50 whose benefits were terminated, more than 80 percent were originally found to be disabled by virtue of tuberculosis or mental illness.

Termination experience differs radically with respect to workers suffering from the chronic progressive diseases that are the two leading causes of disability. Thus, beneficiaries disabled because of cardiovascular disease or diseases of the nervous system together represent only 15 percent of benefit terminations resulting from the beneficiary's regained capacity for substantial gainful activity.

## CONCLUSION

Measured against the entire 27-year history of the social security program, the disability insurance program is still new and still assimilating experiences that will shape its future growth. Although disability insurance benefits have been in effect only 5 years, the disability program has gone far toward assuring basic economic security for the disabled American worker and his family.

During this 5-year period of legislative amendments and heavy workloads, disability evaluation policies have been refined; new ways have been developed to help claimants present their claims; good working relationships with the medical profession have been established; and the time required to process a claim has been substantially reduced. In broadening the scope of disability protection under the social security provisions, Congress has given evidence of its confidence in the disability program and its administration.